

PERCEPTIONS OF REGISTERED NURSES ON THE FACTORS
INFLUENCING SERVICE DELIVERY REGARDING EXPANSION
PROGRAMMES IN A PRIMARY HEALTH CARE SETTING

By

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degree of

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In the

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DECLARATION

Student number: 26394261

I, Anna Nnoi Xaba, declare that the dissertation

**"PERCEPTION OF REGISTERED NURSES ON FACTORS INFLUENCING
SERVICE DELIVERY REGARDING EXPANSION PROGRAMMES IN A
PRIMARY HEALTH CARE SETTING"**

is my original work and that it has not been submitted before for any degree or at any other institution. All sources that have been used or quoted have been acknowledged by means of complete reference in the text and in the list of sources.

ANNA NNOI XABA

DATE

DEDICATION

I dedicate this study to the following people, who were very instrumental in supporting me throughout the course of my study.

- My late husband, Piet Jipi Xaba.
- My children, Tebogo, Dithoriso, Boitumelo and Mpho, who motivated me and supported me, especially with technology.
- My family and friends, brothers and sisters, who provided their time, love, moral support and motivation during this period.

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ABSTRACT

PERCEPTIONS OF REGISTERED NURSES ON THE FACTORS INFLUENCING SERVICE DELIVERY REGARDING EXPANSION PROGRAMMES IN A PRIMARY HEALTH CARE SETTING

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DEGREE : Magister Curationis, University of Pretoria
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The aim of this study was to explore and describe the perceptions of registered nurses regarding the factors that influence service delivery in expansion programmes in a primary health care setting. A qualitative approach was used to conduct this study. Purposive sampling methods were used to select participants from the registered nurses who had been working in the clinics for more than two years and had been exposed to the expansion programmes in the clinics. The researcher collected data by means of focus group interviews, conducted in a neutral setting. Data were analysed, according to the Tesch method of data analysis, by the researcher and an independent co-coder. Categories, sub-categories and themes were identified. The categories that form the basis of the discussion are: disabling factors, enabling factors, client related factors, service related factors and solutions of problems. It was recommended that the integration and coordination of programmes at provincial level should be planned in conjunction with the training. The regional information system should introduce an electronic recordkeeping system, which links all clinics to one database, allowing these clinics to monitor clients who shop around and move between clinics. Training in expansion programmes should be continually conducted in the region in the form of in-service training.

Key words: Perceptions, expansion programmes, primary healthcare setting, primary healthcare package, service delivery.

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LIST OF ABBREVIATIONS

AIDS	-	Acquired Immunodeficiency Syndrome
ANC	-	African National Congress
ANC	-	Antenatal Care
ART	-	Antiretroviral Treatment
DOH	-	Department of Health
DOTS	-	Directly Observed Treatment, Short-Course
DPSA	-	Department of Public Service and Administration
EDL	-	Essential Drug List
EPI	-	Expanded Programme on Immunisation
GOBI-FFF	-	<u>G</u> rowth, <u>O</u> ral Rehydration, <u>B</u> reastfeeding, <u>I</u> mmunisation, <u>F</u> eeding, <u>F</u> amily Planning and <u>F</u> ood Supplements
HIV	-	Human Immunodeficiency Virus
ID	-	Identity Document
IMCI	-	Integrated Management of Childhood Illnesses
MOU	-	Maternal Obstetrical Unit
NGO	-	Non-Governmental Organisation
PEP	-	Post-Exposure Prophylaxis
PHC	-	Primary Health Care
PMTCT	-	Prevention of Mother to Child Transmission
PNC	-	Post-Natal Care
RDP	-	Reconstruction and Development Programme
SANC	-	South African Nursing Council
SIP	-	Service Improvement Plan
STI	-	Sexually Transmitted Infection
TB	-	Tuberculosis
UNICEF	-	United Nations Children's Fund
VCT	-	Voluntary Counseling and Testing
WHO	-	World Health Organization
XDRTB	-	Extreme Drug Resistant Tuberculosis

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CHAPTER 1

INTRODUCTION TO AND BACKGROUND OF THE STUDY

1.1 INTRODUCTION

Since 1994, the transformation process within the health care system in South Africa has expanded from the arena of policy development to include policy implementation. Many policies have been put in place and the major challenge to improving the health care system lies in overcoming the problems of implementing these policies (*South African Health Review* 2002:203). In the organisation of the South African health care system, one of the priorities identified was the expansion of programmes in the delivery of primary health care services. A decision was taken to expand primary health care services over a period of five to 10 years (DOH 1996:5). This expansion had to occur within the existing constraints and the available resources of the health care system.

The district health care system was introduced as a vehicle to drive the primary health care approach. Health care service delivery was based on comprehensive primary health care and was to be a population-based delivery approach (ANC 1994:19-20; DOH 1996:6). The researcher observed that the ever-changing community profile posed challenges to the progress of the expansion of the programmes. The number of clients has escalated over the past five years, affecting the progress of the expansion of services in the primary health care setting (Gauteng Department of Health 2004-2006:70).

Muller (2000:63) commenting on the quality of nursing service management in South African hospitals, names factors such as equipment, structures and systems that impact on service delivery. These factors need to be addressed in order to ensure effective health care provision. Another factor found in literature is the marketing of primary health care services by registered nurses

(Rall & Meyer 2006:11). Gaps still exist in primary health care services, despite the fact that some of these factors have been attended to. Van Rensburg (2004:446) documented these gaps, both in the rural and in urban areas. They were related to limitations of the facilities, which failed to offer the full spectrum of the primary health care package (Van Rensburg 2004:446).

The researcher thus wished to explore and describe the perceptions of registered nurses regarding the factors that influence service delivery in the primary healthcare setting, specifically with regard to the expansion of services.

1.2 BACKGROUND OF THE STUDY

1.2.1 The health care system

The need to restructure the national health system increased over time. The burden on health care services increased due to the rapid rise in the incidence of the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and other chronic diseases (DOH 1996:5). Policies were put in place to facilitate the restructuring of the existing health services in South Africa. The aim of the restructuring was to develop a comprehensive, efficient, equitable national health system. One of the objectives of the Reconstruction and Development Programme (RDP), in line with the improvement of services, was as follows:

The substantial, visible and sustainable improvements to the accessibility, efficiency and effectiveness of the publicly funded primary health care services.

(DOH 1996:5)

Basic principles were introduced to guide the transformation of the public-funded health care system. The focus was on strengthening the public primary health care delivery system and aligning the services with other levels of health care delivery (DOH 1996:7). The best human resources and physical

structures in the public-funded system were utilised in the delivery of primary health care services to the majority of the population. The transformation process was based on ten basic principles identified in the South African Department of Health (DOH) policy document *Restructuring the National Health Care System for Universal Primary Health Care* (DOH 1996:7) but only four of these principles have been related to this study.

One of the principles, namely the *principle of universal access to health care*, implies that all the barriers to accessing primary health care services, whether financial, geographical or other barriers, as well as the quality of service delivery, should be *equivalent for all users of the health care system*.

According to these four principles, the national health system was expected to *strengthen the existing public primary health care service*. It had to be congruent with and strengthen the emergency district-based health care system. The principles identified in the policy document maintain that the *national health system should be based on a comprehensive healthcare approach* (DOH 1996:7-8).

This study examines the perceptions of registered nurses regarding the factors that influence service delivery. It focuses on registered nurses, as they play a vital role in rendering primary health care, and are exposed to different situations and experiences in the primary health care setting. The implementation of the above-mentioned principles forms part of their daily activities because these factors are the driving force behind primary health care service delivery.

The health care system, social services and environmental health are the most important determinants of health. The health care system consists of three components: structure, process and outcome (Starfield 1992:14). Each health care system has a structure, which enables the effective provision of services. The structure is made up of several aspects, of which the range of services is one. The range of services varies, depending on the health care

systems and the needs in the communities (Starfield 1992:15). Registered nurses are involved in all three components of the healthcare system.

Health care delivery in South Africa has been facing a number of problems and challenges. These challenges are related to the expansion of the existing resources and the strengthening of primary health care service delivery (DOH 1996:2). During transformation, the need to restructure the national health system was identified. One of the priorities of this restructuring process was to expand health care programmes, to combat the changing community profile and strengthen existing services (DOH 1996:3). The public sector has, in the meantime, been trying to redress the historical inequalities in the distribution of health services in the provinces (DOH 1996:3).

In terms of improving service delivery, the interaction between the service provider and health service provision is of great importance. In strengthening the health service, it is important to listen to the service providers with regard to the programmes that are provided (Modiba, Gilson & Schneider 2001:188).

1.2.2 District health system

The district health system is the cornerstone of the national health system and aims to strengthen the primary health care service. This system is the vehicle through which a comprehensive range of primary health care services can be provided. This includes preventive, promotive, curative and rehabilitative services (Gauteng Department of Health 2004-2007:53). In the restructuring of the health care system in 1994, the district health system was introduced as a model for service delivery at that time to be able to provide primary health care services (Modiba *et al.* 2001:188).

1.2.3 The comprehensive primary health care package

The primary health care package outlined the comprehensive services that were supposed to be delivered in a primary health care setting. This package contained a list of service components, as well as target dates for the

implementation of services and specific service norms and standards (DOH 2001). Services described in the package include district hospital services, environmental services and other preventive, promotive health services, comprehensive emergency ambulatory services and essential medicines (DOH 1996:10). Prioritisation of the health services was essential because the implementation of the package was to occur within the already identified resource constraints (DOH 1996:10). The list of services identified were in line with the basic elements of the primary health care approach. This approach guided the delivery of care. The Alma-Ata Conference Declaration identified the eight basic elements of primary health care (De Haan, Dennill & Vasuthevan 2005:25). These basic elements are utilised as indicators for the implementation and evaluation of the primary health care approach. The primary health care services are also explained as the point of entry into the health care system. A client can then be transferred to a secondary service for further management (Dennill, King & Swanepoel 1999:3). The professional nurse at the primary healthcare clinic is the first contact person with the client; hence the importance of well-trained clinic nurses in primary health care in managing clients effectively.

1.2.4 The evolution of primary health care from 1978 to 2007

The primary health care approach was discussed at an international conference organised by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) at Alma-Ata in 1978 (Dennill *et al.* 1999:2). At this conference, a declaration was made that primary health care should be essential, affordable and acceptable to all communities (Hatting, Dreyer & Roos 2006:53). This philosophy was adopted in order to address health problems globally. The theme, "*Health for all by the year 2000*", was adopted. Primary health care was defined as essential health care, made available and universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community can afford (De Haan *et al.* 2005:10; Dennill *et al.* 1999:2). It was also explained as the actions that are taken by health care professionals to protect and promote the health of the communities.

Comprehensive health care and its success depend on a comprehensive approach and community development (Dennill *et al.* 1999:3). A clear understanding of the definition and goals of primary health care can make nurses more effective and better prepared for its implementation. Schoultz and Hatcher (1997:23) explain this when they note the difference between primary care and primary health care. Primary health care goes beyond primary care, to include community participation. It recognises socioeconomic knowledge as essential for the development of nurses (Schoultz & Hatcher 1997:24). Primary health care also calls for the redefining of goals and roles of health care providers so that they become partners in health with the community and not merely providers (Schoultz & Hatcher 1997:25). Primary health care as a strategy is broad and demands attention to community development and intersectional collaboration, within which primary care lies (Schoultz & Hatcher 1997:26).

The commitment to the primary health care approach was confirmed at a conference on health promotion in Ottawa in 1986 (Hattingh *et al.* 2006:53). This conference built on the progress made through the declaration regarding primary health care. This was followed by the Jakarta Declaration, which was concluded in 1997 as a global commitment (Hattingh *et al.* 2006:53). The Jakarta Conference on Health Promotion declared that health is a basic human right and is essential for social and economic development (Hattingh *et al.* 2006:54). The primary health care approach advocates health care that allows people to receive the care that enables them to live socially and economically productive lives. Therefore, primary health care nurses are expected to render comprehensive health care to communities. At this Conference, eight principles of primary health care were identified, which formed the basis of the primary health care package. All programmes offered in a primary health care setting should be based on these principles (De Haan *et al.* 2005:10).

According to various authors, primary health care entails the following:

- It is the first level of contact of individuals, families and communities with the national health system (Hattingh *et al.* 2006:61).

- It brings health care closer to where people live or work (Hattingh *et al.* 2006:61).
- It constitutes the first element of a continuing health care process (Hattingh *et al.* 2006:61).
- Health professionals are to collaborate with other sectors of the community, such as religion, transport, media, education, housing, and environment, in order to ensure the development of the community (Schoultz & Hatcher 1997:26).
- The current political and economic environment requires that nurses are able to recognise that the determinants of health often lie beyond personal health services. Hence it is important to render a comprehensive healthcare service (Schoultz & Hatcher 1997:26).

In its transformation of the healthcare system in 1994, the African National Congress (ANC) continued with the primary health care approach for the South African health system. It was maintained as the underlying philosophy in the restructuring of the health care system (Hattingh *et al.* 2006:54). The abovementioned principles form the basis of this study.

1.2.5 Current situation

In the Gauteng Province, primary health care services are currently being provided jointly by the province and local government. The Gauteng Service Improvement Plan (SIP) guides the delivery of services to ensure sustainability and cost containments (Gauteng Department of Health 2004-2006:68). The SIP ensured that the expansion of programmes and services was initiated and was phased in in the districts. The introduction of certain services into all districts was identified as a priority for the health care system.

The focus of this study is on the perceptions of registered nurses regarding the factors, as well as the constraints, that influence the progress of the implementation of the SIP in Region C of the Gauteng Province. The following

constraints were identified in the Gauteng Department of Health Strategic Plan (2004-2006:68):

- Shortage of primary health care nurses,
- Lack of access to primary health care,
- Slow mobilisation of resources to address equity,
- Increased HIV/AIDS caseloads, and
- The challenge of releasing more professional nurses to undertake primary healthcare skills training.

Further challenges and constraints in the primary health care setting were identified in a study conducted in the Gauteng Province by Sibiyana and Muller (2000:8). This study revealed that, during the transformation period, the fears of managers and constraints on the service resulted in the deterioration of the quality of service and increased the need for training (Sibiyana & Muller 2000:8). The study recommended that the primary health care and resource management process should be reviewed. This would result in the improvement of the quality of the delivery of primary health care services (Sibiyana & Muller 2000:11). For this reason, the researcher explored and described the perceptions of registered nurses regarding the factors that influence service delivery in a primary health care setting, as it could help identify the factors that enhance the delivery of primary health care services.

A study conducted in the Limpopo Province, on the provision of primary health care services, revealed that primary health care nurses experienced failure in the provision of adequate services due to increased workload, misuse of free health services, and lack of security in the health centres (Netshandane, Nemathaga & Shai-Mahoko 2005:59). These factors are linked to poor service delivery in the Limpopo Province (Netshandane *et al.* 2005:59). Investigation into the delivery of primary health care services in the Gauteng Province could produce valuable information. The need for information motivated the researcher to explore and describe the factors that affect the delivery of primary health care services in Region C of the Gauteng Province. The recognition of the factors identified in this study, as well as the

recommendations made, could accelerate primary health care service provision.

A study conducted by Heunis, Van Rensburg and Claassen (2006:43) revealed gaps in the delivery of primary health care services. These gaps were related to the lack of available resources, the dedication of supervisory staff, and the skills and abilities of the frontline staff responsible for primary health care delivery. The study also revealed that a lack of awareness and ownership of the primary health care package has contributed to the poor service delivery (Heunis *et al.* 2006:44).

The delivery of service is related to the quality of care provided. The factors that affect service delivery become a priority in enhancing the quality of primary health care services. A study conducted by Mashego and Peltzer (2005:13) attempted to identify the factors that are related to quality improvement in a primary health care setting. This study identified factors that affect the quality of care as support to the clinics, drug availability, interpersonal skills and technical care (Mashego & Peltzer 2005:13). The study found that the quality of care and the utilisation of services are related to the outcomes of service delivery (Mashego & Peltzer 2005:13). It was thus the purpose of this study to explore and describe the factors that affect service delivery, with the aim of improving the quality of care.

The primary healthcare approach is central to the transformation of the healthcare system in South Africa (Dennill *et al.* 1999:2). This approach places emphasis on care that is affordable, accessible and acceptable to clients, as well as the effective management of clients in the clinics. The success of primary health care service delivery lies in the comprehensive approach, community development, well-trained professional nurses and the availability of necessary resources. The changing health profile of the community is the driving force behind the increasing importance of primary health care. It created a need for the acceleration of the expansion of certain programmes in the health care system. Thus this study focuses on the factors that affect service delivery to the community.

1.3 PROBLEM STATEMENT

The Gauteng Department of Health, in dealing with the transformation of the health care system, identified the SIP. This plan entailed a phased decentralisation of services and resources, linked to the progress of the expansion of certain programmes in the primary health care setting (Gauteng Department of Health 2004-2006:70). Also linked to this plan were the gaps identified by Heunis *et al.* (2006:44) in their study on the implementation of the primary health care package. The study revealed some disparities in the services related to the primary health care package. This is in line with the researcher's observation that a lack of staff in the clinics and poor service delivery, which are the result of *inter alia* a shortage of resources, impact on the quality of care rendered. The gaps identified by Heunis *et al.* are experienced differently by registered nurses in the primary health care setting, resulting in different perceptions of the factors that affect service delivery. The accessibility of healthcare services increased with the SIP, which caused an increase in the number of clients. In addition to this, the changing community health profile created the need for the expansion of certain programmes in the primary healthcare setting. These challenges occurred within the transformation process and the efforts to implement the primary health care package (Gauteng Department of Health 2004-2006:70).

The researcher observed that programmes, such as the Integrated Management of Childhood Illnesses (IMCI) and Prevention of Mother to Child Transmission (PMTCT) programmes and the rollout of antiretroviral treatment, have been phased in. The concern with regard to the services is the improvement of access and mobilisation of resources in order to address equity. The researcher identified gaps in relation to the shortage of staff and an inability to release staff for training in Region C clinics of the Gauteng Province. These gaps are related to those identified by Heunis *et al.* (2006:44) and are linked to poor service delivery. This explains the need to explore and describe the perceptions of registered nurses regarding the factors which affect service delivery in a primary health care setting.

The researcher views the implementation of the primary health care package as an example of policy implementation. This implies that the delivery of services in the primary health care setting is affected in the Gauteng Province as reported by Heunis *et al.* (2006:44). The purpose of this study was to explore and describe the perceptions of registered nurses regarding the factors that influence primary health care service delivery in Region C of the Gauteng Province, with the aim of monitoring, controlling and reducing their impact, and improving service delivery.

1.4 SIGNIFICANCE OF THE STUDY

The findings of the study will contribute to identifying the factors that affect service delivery and provide strategies to monitor and control these factors. This could result in the improvement of the quality of care in programmes being expanded in the primary health care setting. The findings of the study will also contribute to the body of knowledge regarding primary healthcare service delivery.

1.5 RESEARCH QUESTION

The following research question will guide the study:

What are the perceptions of registered nurses regarding factors that influence service delivery in programmes being expanded in a primary health care setting?

1.6 PURPOSE OF THE STUDY

The purpose of this study was to explore and describe the perceptions of registered nurses regarding factors that affect service delivery in programmes being expanded in the primary health care setting, in order to be able to monitor and control these factors.

1.7 DEFINITION OF KEY CONCEPTS

1.7.1 Primary health care

Primary health care is defined as essential health care, made available, affordable and universally accessible to individuals and families in the community, by means acceptable to them, through their full participation and at a cost that the community can afford (De Haan *et al.* 2005:10). It is an essential part of comprehensive health care and its success lies in community development and a comprehensive approach to health care (Dennill *et al.* 1999:3). A primary health care approach advocates that people should receive the health care that enables them to live socially and economically productive lives (De Haan *et al.* 2005:10).

1.7.2 Primary health care setting

For the purposes of this study, the primary health care setting refers to the facilities in Region C of the Gauteng Province that offer comprehensive primary health care and first contact with individuals, families and communities.

1.7.3 Comprehensive health care

Comprehensive health care is defined as health care that includes integrated, promotive, preventive, curative and rehabilitative components. This includes the promotion of community participation and the utilisation of the available resources in the community. It is based on the primary health care approach (De Haan *et al.* 2005:23).

1.7.4 Region C

The Gauteng Province is divided into three regions: Region A, Region B and Region C. The regions are further divided into health districts and subdistricts. Region C consists of two health districts, Tshwane and Metsweding districts.

The study was conducted in the Tshwane District (Gauteng Department of Health 2004-2006:61). Permission to conduct the study was obtained from the Gauteng Department of Health.

1.7.5 Service delivery

Service delivery in this study is defined as the day-to-day provision of health care to individuals, families and the community, at a primary health care clinic. Service delivery is also related to the introduction of specific priority programmes into the health care system, in confrontation to the challenges created by the changing community profile. Service delivery is related to the implementation of the district health system, as a vehicle for the primary healthcare approach. The expansion of programmes includes the PMTCT programme, the strengthening of control of tuberculosis (TB) and other life-threatening diseases, and the IMCI programme. The SIP guides the delivery of services in order to ensure sustainability and cost containment (Gauteng Department of Health 2004-2006:68).

1.7.6 Expansion of programmes

The expansion of programmes in this study is defined in relation to the Gauteng Department of Health Strategic Plan and SIP, and includes the following:

- Introduction of 24-hour service primary health care facilities in each subdistrict.
- The improvement of access to mental health services.
- The improvement of access to primary health care facilities for people with disabilities.
- Strengthening the TB control.
- Strengthening programmes to reduce infant mortality and maternal morbidity.
- Strengthening child health care through the introduction of child survival strategies, such as the IMCI programme.

- The promotion of health priorities associated with lifestyle modification.
- Rollout of HIV/AIDS comprehensive care and antiretroviral treatment.
- Rollout of PMTCT in all antenatal clinics.
- Rollout of post-exposure prophylaxis (PEP) for sexual assaults in all hospitals.
- The consolidation of services for home-based care.
(Gauteng Department of Health 2004-2007:68.)

1.7.7 Perceptions

According to the *Concise Oxford Dictionary of Current English*, perception is the ability of the mind to refer sensory information to an external object (Allen 1990:883). It is making sense of and giving meaning to what a person experiences in life, and may differ in interpretation from person to person. In other words, one event could be interpreted in two different ways (Carson 2000:170; Rawlins, Williams & Beck 1993:170). In this study, the perceptions of registered nurses are defined as the ways in which they interpret and give meaning to the factors that they experience as affecting service delivery when dealing with clients daily. The factors affecting service delivery could be experienced differently by each nurse.

1.8 RESEARCH METHODOLOGY

The study followed a qualitative approach and focused on the perceptions of registered nurses regarding factors that affect service delivery, with regard to the expansion of certain programmes in a primary health care setting. The study was conducted in selected clinics in the Gauteng Province. The researcher chose a qualitative approach in order to highlight issues that are critical in the way they impact on service delivery in a primary health care setting. The study also followed an exploratory and descriptive approach in order to be able to explore and describe the factors that affect service delivery in a primary health care setting, through the descriptions provided by the

registered nurses involved in the provision of health care (Brink, Van Der Walt & Van Rensburg 2006:113).

The researcher selected the focus group interview as data collection method. In qualitative studies, interview methods are used to obtain meaning from the subject's perspective (De Vos, Strydom, Fouché & Delport 2005:242). The population for the study consisted of all the nurses employed in a primary healthcare setting by the Gauteng Provincial Government.

1.9 ETHICAL CONSIDERATIONS

Polit and Beck (2006:87) explain and classify the three main ethical principles in research as beneficence, respect for human dignity and justice. These principles were observed in the course of this research, and participants were afforded the right to fair treatment, and the right to privacy and anonymity (Polit & Beck 2006:91). The following ethical considerations were observed during this study:

1.9.1 Beneficence

Beneficence is the protection of participants from harm, discomfort and exploitation. It is the researcher's duty to minimise harm and maximise benefits for the participants. The participants in this study were protected. They were given a full explanation of the study, and its benefits and risks to them were carefully weighed.

The study was explained to the participants in order to enable them to make an informed decision regarding their participation and to ensure freedom from any harm. The participants were protected from physical, emotional, social or financial harm and discomfort in any form (Polit & Beck 2006:87).

1.9.2 Respect for human dignity

Respect for human dignity includes protecting the participants' right to self-determination and the right to full disclosure. Human beings are respected as capable of controlling their own activities and should not be forced to participate. Full disclosure means that the subject was given a full explanation of the study. The participants were given information regarding their right to withdraw from the study at any time, as well as the risks and benefits of participation (Polit & Beck 2006:89).

1.9.3 Informed consent

The study was explained to the participants to enable them to give informed written consent and ensure their freedom from harm (Polit & Hungler 1995:119). Informed consent entails giving participants adequate information regarding the research and the power of free choice (Polit & Beck 2006:93). In a qualitative study, the consent may be viewed as an ongoing, transactional process, referred to as process consent. The researcher may need to have repeated contact with the participants. The researcher therefore continuously negotiates the consent and allows the participants to play a collaborative role in decision-making (Burns & Grove 1999:169; Polit & Beck 2006:93).

1.9.4 Permission to conduct the study

Permission to conduct the study was obtained from the Gauteng Department of Health and letters of permission were obtained from the area managers in Region C clinics. Written permission was obtained from the participants of the study. The study was approved by the Ethics Committee of the University of Pretoria. The permission was granted after a full disclosure on the study was given to the relevant authorities (Cormack 2000:130).

1.9.5 Justice

This is the principle that covers the right to fair treatment and the right to privacy. The procedures observed in this study avoided the violation of confidentiality. Participants' right to privacy and anonymity were also observed (Polit & Beck 2006:91). The right to privacy was protected by conducting the interviews in a private room. The results of the study were made available to participants on request (Polit & Beck 2006:125). Extra precautions were taken to safeguard the participants' privacy, as anonymity is rarely possible. Information regarding the ages of the participants was withheld (Polit & Beck 2006:95).

1.9.6 Deception of subjects

Deception involves withholding information or offering incorrect information in order to ensure participation. The researcher ensured that no form of deception was practised on the participants during the focus group interview (De Vos, Strydom, Fouché, Poggenpoel, Schurink & Schurink 1998:61; Welman, Kruger & Mitchell 2005:118). The participants were informed of the findings of the study, without offering details, as a form of recognition and gratitude for their participation (Polit & Beck 2006:59).

1.10 DATA ANALYSIS

Data collection and analysis were conducted simultaneously, with analysis occurring after each focus group interview. Field notes and the transcripts were analysed, and categories, subcategories and themes identified and controlled with literature. (For a more detailed methodology, see Chapter 2).

1.11 CONCLUSION

Chapter 1 gave an overview of the study's purpose and the methodology followed to obtain the necessary data to reach the study's aim. A qualitative, exploratory and descriptive approach was followed to explore and describe

the views of registered nurses regarding the factors that influence service delivery in programmes being expanded in a primary health care setting. Data were obtained by means of focus group interviews. Chapter 2 contains an in-depth discussion of the research methodology of the study.

1.12 ORGANISATION OF THE STUDY

The study is structured as follows:

CHAPTER 1:	Introduction to and background of the study
CHAPTER 2:	Research methodology
CHAPTER 3:	Discussion of the results and literature control.
CHAPTER 4:	Conclusions, implications, recommendations and limitations of the study.

CHAPTER 2

RESEARCH METHODOLOGY

2.1 INTRODUCTION

This chapter describes the research methodology used in the course of the study. The research design was qualitative and explored the perceptions of registered nurses regarding the factors that influence service delivery in programmes being expanded in a primary health care setting. The population, sampling method, data collection method and the measures used to ensure trustworthiness are discussed together with the data analysis.

2.2 RESEARCH DESIGN

A qualitative design that is explorative and descriptive was adopted in order to explore and describe the perceptions of registered nurses regarding the factors influencing service delivery in programmes being expanded in a primary health care setting. A qualitative approach is concerned with subjective explorations of reality from the perspective of the insider, and the gaining of understanding by acquiring first-hand knowledge about the meaning that the people attach to everyday life (De Vos *et al.* 2005:74). Qualitative research is a systematic approach used to describe experiences of phenomena, and is rooted in the three traditional disciplines of anthropology, sociology and psychology (Brink *et al.* 2006:113; Burns & Grove 1999:338; Polit & Beck 2006:53).

Through qualitative enquiry, the registered nurses' perceptions, assumptions, judgments, fears and suppositions were explored and discussed in the context of their working experiences and first-hand knowledge was obtained (Polit & Beck 2006:17). The registered nurses were involved in the study as people who deliver healthcare services daily. They each had different perceptions

and their insights into the factors that affect service delivery in a primary health care setting were of great importance. The qualitative descriptions were based on the nurses' perceptions and broad explorations of reality because of their exposure to different programmes in the primary healthcare setting.

2.2.1 Exploratory design

Exploratory research is defined as a study that explores the dimensions of a phenomenon and areas of interest, with the aim of investigating the full nature of the phenomenon, which, in this case, is service delivery and its related factors (De Vos *et al.* 2005:307; Polit & Beck 2006:20). An exploratory research design provided in-depth information on the perceptions of registered nurses regarding factors that influence service delivery, thus identifying factors for future monitoring and control in a primary healthcare setting. This was done with the hope of identifying strategies to improve service delivery in the primary healthcare setting.

The exploratory research design was appropriate for this study as it provided in-depth information regarding the factors that influence service delivery. Health care service delivery is a priority to a healthy nation, especially when a changing community profile poses a challenge to the service delivery of the national health system.

The research question *“What are the factors that influence service delivery with regard to programmes being expanded in a primary health care service?”* is in line with the recommendations made by Brink (1999:11), as it helped to explore the dimensions of and provided insight into the factors that influence service delivery.

2.2.2 Descriptive design

A descriptive design is defined by Burns and Grove (1999:193) as a design that gathers information about the characteristics, and describes the aspects, of a situation as it occurs. Polit and Beck (2006:20) further explain that

researchers in descriptive studies use in-depth methods to describe the dimensions, variations and importance of the phenomena.

Brink (1999:11) states that the descriptive design helps to obtain complete and accurate information about a phenomenon through observation as it occurs. The descriptive design provided the researcher with the perceptions, fears and assumptions of registered nurses regarding the factors that influence service delivery in a primary health care setting. These perceptions were originated in the primary health care setting and give a clear picture of the factors influencing service delivery. Thus the situation was studied as it occurred within the programmes being expanded in the primary health care setting (Brink *et al.* 2006:102).

2.3 POPULATION

Population refers to all the elements in the universe that are of interest to the researcher and meet the criteria for inclusion in the study (Brink *et al.* 2006:123; De Vos *et al.* 2005:193). In this study, the population consisted of all registered nurses employed by the Gauteng Department of Health in Region C clinics and who have been exposed to a primary health care setting.

Access to the population was negotiated with the area managers and the facility managers because the clinics were used as the venues for conducting the focus group interviews. The Region C clinics in the Tshwane District are divided into three subdistricts. According to Brink *et al.* (2006:124), the inclusion criteria for a population should be clearly stated, especially if the population is wide. In this study, focus group interviews were conducted with registered nurses from two of the subdistricts. The population of the study consists of a wide range of registered nurses.

2.3.1 Sample

The sample of a study is defined as a part of a whole that is selected from a group of elements by the researcher. The part is selected from a defined

population to participate in the study (Brink 1999:133; Brink *et al.* 2006:124). Sampling is the process of selecting a portion of the population as the subjects of a study. The subjects should be representative of the population (Brink *et al.* 2006:124; De Vos *et al.* 2005:193). The sample in this study was selected through purposive sampling, which is based on the belief that the researcher's knowledge about the population can be of help in handpicking the participants.

Purposive sampling is sometimes called judgmental or theoretical sampling. It is a type of sampling where the researcher selects the participants based on his or her knowledge of the participants' experience and expertise regarding the phenomena under study (Brink *et al.* 2006:134). The researcher chose registered nurses for the study's sample from the community health centres in the three subdistricts as most of the programmes being expanded were offered in these centres. The criteria for inclusion in the study were identified as the following:

- Registration as a general nurse and midwife with the South African Nursing Council (SANC).
- Registration with the SANC for a Diploma in Clinical Nursing Science, Health Assessment, Treatment and Care (R48).
- Two years' experience or more in a comprehensive health care service in a primary healthcare setting.
- Willingness to participate in the study and sign the consent form.

These inclusion criteria were decided on because, in the primary health care setting, several categories of nurses are involved in the delivery of health care. The researcher selected these particular participants, according to the criteria, because she had previously worked with the participants and had knowledge of their involvement in the primary healthcare setting. The researcher also gave preference to certain participants because of their position and their experience as registered nurses in the primary health care setting. The researcher believed that the participants had more information on the factors that influence service delivery due to their active involvement in

providing primary health care (De Vos *et al.* 2005:203; Welman *et al.* 2005:204).

According to Burns and Grove (2001:366), sampling criteria are a list of characteristics that are essential for participants to be included in the sample. The criteria link with the research problem and the purpose of the study. The researcher thought critically about the parameters of the population in order to choose the sample accordingly. The managers in the clinics played an important role in the selection of the participants from the different programmes in the clinics.

The registered nurses who participated in the study were directly and indirectly involved with the programmes being expanded and were also involved in offering preventive, promotive, curative and rehabilitative care to individuals in the clinics.

De Vos *et al.* (2005:329) state that the purposeful selection of participants represents a key decision point in a qualitative study and clear criteria must be in place. De Vos *et al.* (2005:328) further add that the sample size in qualitative research depends on what the researcher would like to know and the purpose of the study. The decision regarding the sample size in this study was based on the needs related to the purpose of the study. The number of focus group interviews conducted depended on the saturation of information. Saturation is reached when the themes and categories in the data became repetitive and redundant, such that no new information is collected (De Vos *et al.* 2005:306; Polit & Beck 2006:59).

2.4 DATA COLLECTION

Data collection is a process that is very important for the success of the study. Creswell (1994:110) defines data collection as a series of interrelated activities aimed at gathering information that is needed to answer the research question. Without quality data collection techniques, the accuracy of the study's conclusions may be challenged. It is therefore important that the

researcher be familiar with the technique together with the advantages and disadvantages of the preferred technique (Brink *et al.* 2006:141). The researcher selected the focus group interview as the appropriate method for collecting data. The study followed three phases, namely: the preparatory phase and pilot testing, interview phase, and the post-interview phase during which data collection took place.

2.5 PREPARATORY PHASE AND PILOT TESTING

The preparation phase involved the steps explained by De Vos *et al.* (2005:303) and Rossouw (2003:143). First, the researcher identified potential participants and made contact with them. These potential participants were representative of registered nurses employed in Region C clinics and homogeneity was maintained. The researcher first contacted the participants telephonically, with the aim of building rapport and a relationship with the potential participants. The aim was also to discuss the involvement of the participants in the study and plan a date for the information session. The researcher also defined the purpose of the study and discussed the permission required to participate in the study. The researcher then compiled a list of participants for the two focus groups and secured the dates of the interviews with the participants. The researcher also obtained the contact numbers of the participants for future communication regarding the information session. The date, time and venue of the information session were communicated to the area managers, as both the information session and the focus group interviews were to be conducted at the clinics (De Vos *et al.* 2005:303).

The researcher identified a colleague to be a second facilitator and communicated the date of the information session and other plans to her. The second facilitator was a primary healthcare trainer in the region, who was involved in the accompaniment of students in the clinics. The role of the second facilitator was to operate the tape recorder and take field notes. The researcher trained the second facilitator in the operation of the tape recorder and the logistics of the proceedings, including taking field notes, before the

information session and the pilot testing were conducted. The researcher also helped the second facilitator plan time off from work to help with the sessions. A tape recorder was prepared with new batteries in order to tape the focus group interviews (Burns & Grove 1999:357). The researcher also prepared introductory information regarding the study for the information session that was held with the participants prior to the focus group interviews.

The researcher asked one main question to guide the discussion (De Vos *et al.* 2005:293), and asked further probing questions for clarity and confirmation. The main question for discussion in all the group interviews was:

What are the factors that influence service delivery in programmes being expanded in a primary health care service?

2.5.1 Information session

The information session was conducted one week before the focus group interviews. During the information session, the researcher discussed issues related to the expectations from the participants, the purpose of the research and the research question.

The researcher confirmed the list of participants by discussing the dates, times and venues with them. The participants checked their programmes and had to request time to participate in the study at work. The researcher confirmed the date of the interviews with the clinic managers and phoned the participants about the final preparations.

The consent form was explained to the participants. The researcher also explained the use of the tape recorder and the presence of the second facilitator. The participants were told about their right to withdraw from the study at any time without experiencing any negative outcomes. The researcher also discussed the possibility of further contact sessions with the participants and gave her contact details to the participants. The facilitator

provided participants with support throughout the discussions, as well as after the sessions.

Conducting a focus group interview involves building relationships with the participants and obtaining permission from the relevant authorities. In order to obtain permission for the participants to take part in the interviews, the researcher had to write letters and contacted the managers telephonically in the region (Cormack 2000:130). Gaining access to the clinics was done according to regional protocols with the managers (Seidman 1998:31). The researcher contacted the Research Department in the region and permission was obtained to communicate with the area managers to plan the interview sessions. Support for the study was received from the managers and maintained until the research was complete. The researcher was known to most of the participants as a colleague, which ensured a relaxed and supportive atmosphere.

Rossouw (2003:143) states that the researcher should be trained as an interviewer. The quality of the interview depends on the communication and interpersonal skills of the interviewer. The researcher also needs facilitation skills to manage the focus group. Training is important in order to familiarise the researcher with the topic and strategies to cope with the challenges. The facilitator was trained in facilitation skills and had been involved in facilitating certain modules in the region (De Vos *et al.* 2005:293; Welman *et al.* 2005:166).

The two venues for conducting the focus group interviews were prepared in advance. The researcher identified two clinics in the region which were central in location to the participants of the two groups and were easily accessible to all participants.

Pilot testing was conducted two weeks before the actual data collection. Three primary healthcare trainers were selected to conduct the pilot testing. During the pilot testing, the main question was piloted and some probing questions were utilised. The researcher identified some complexities which were

corrected and some communication problems were also rectified. De Vos *et al.* (2005:331) state that pilot testing is usually informal and a few participants who possess the same characteristics as the sample can be involved. The purpose of pilot testing is to determine whether relevant information can be obtained from the participants. Furthermore, the pilot test allows the researcher to focus on specific areas that are not clear.

Qualitative researchers believe that pilot testing is actually the first focus group interview with the research team, the experts and potential participants. In this study, the pilot test helped determine whether the interviews would be successful and effective, as areas which needed to be revised were identified (De Vos *et al.* 2005:309). Seidman (1998:32) urges qualitative researchers to conduct a pilot test in order to really test the research questions and the skills of the researchers. The researcher also had to come to grips with some aspects of conducting an interview (De Vos *et al.* 2005:294).

2.6 INTERVIEW PHASE

2.6.1 Conducting the focus group interview

A focus group is defined by De Vos *et al.* (2005:300) as a carefully planned group interaction of about ten people, to obtain perceptions of a defined area. The method is highly interactive and gives the participants a chance for full disclosure. The researcher is able to obtain more information from the participants in a relaxed and participative way (Rossouw 2003:143).

This method also allows the researcher to understand the diversity of the topic under study (Polit & Beck 2006:292). The researcher was aware of the shortcomings of this particular method of data collection and managed to overcome bias and deal with some passive participants, as the researcher was trained in the facilitation of interviews (Brink & Wood 2001:124).

The researcher facilitated the focus group interviews with the help of the second facilitator. The clinic environment was a suitable, quiet and relaxed

venue for the participants. No disruptions were encountered during the facilitation and the participants were able to freely express their views. First, the participants were given a warm welcome by the facilitator. The purpose of the study was explained again, the participants' confidentiality was confirmed, as no names were used and the recording process was explained. According to De Vos *et al.* (2005:294), the setting should provide privacy, comfort and a non-threatening atmosphere, as well as being accessible.

A tape recorder allows for a much fuller record of the interview than field notes and gives the researcher time to focus on the facilitation of the interview. The second facilitator took field notes, which were complemented by the tape recordings. The advantages of a tape recorder are:

- It preserves the words of the participants.
- Some aspects that are not clear in the transcripts and field notes can be checked.
- It enhances a greater rapport by allowing a more natural setting.
- Supplies in-depth information and a picture of the session.
- Can be repeated for clarity.
- Helps the researcher to concentrate on the proceedings of the discussion.

(Seidman 1998:87.)

During the interview, the researcher found the tape recorder to be of great value in capturing the discussion, in conjunction with the field notes taken by the second facilitator and the personal field notes taken by the facilitator. The tape recorder did not inhibit the participation of the participants.

Two sessions of interviews were conducted on different dates, with each focus group consisting of ten participants. The interview commenced after the participants had signed a consent form. The researcher started by introducing herself to the participants and indicated that the permission for the interview had been obtained. The central question "*What are the factors that influence service delivery in programmes being expanded in a primary health care service?*" was used during both interviews.

The participants were given time to think before they responded. The response was spontaneous and the facilitator maintained the focus of the discussion. The participants' responses to the question were a narrative way of expressing their perceptions regarding the factors that influence service delivery. The participants were very eager to respond, and sufficient information and clarity could be obtained. The researcher's non-verbal communication, such as eye contact and listening skills, made the participants feel less threatened. The following facilitation skills were used during the focus group interview: probing, reflection, clarification, listening skills and paraphrasing.

(i) Probing

The purpose of probing is to deepen the response to a question in order to increase the richness of the data obtained. Probing persuades participants to give more information about the issue under study (De Vos *et al.* 2005:290). The facilitator followed up with questions about the participants' comments in order to gain more clarity and meaning. An example of a probing question that was used is *"You mentioned the attitudes of the staff – what do you mean by the attitudes of the staff?"*

Neuman (1997:257) also confirmed that probing can be used to clarify ambiguous questions. In this study, probing was used very carefully in order not to limit the time given to the participants to engage in discussions and not to lose focus.

(ii) Reflection

This is a process in which the researcher repeats the participant's ideas, thoughts and feelings to check if these were well understood. The researcher repeated some key words with the purpose of stimulating the participants to give more information. An example of this is *"You mentioned the issue of transport as a problem with the ambulances, did you mean that the response time was long?"* (De Vos *et al.* 2005:290). The facilitator repeated some ideas

as they related to the factors that were mentioned by the registered nurses to gain more understanding. The facilitator also reflected on the feelings that participants experienced in their working environment.

(iii) Clarification

Clarification is a technique that is used to gain clarity on some statements. The facilitator asked questions in order to gain clarity on the phenomenon under study. An example of this is: *“You mentioned that the area for supervision is too wide. How many clinics are you supervising?”* (De Vos *et al.* 2005:289). In this study, clarification helped to link the perceptions and factors identified in the two different interviews, which gave a better understanding of the factors influencing service delivery.

(iv) Listening skills

A facilitator is expected to have good listening skills to be able to obtain quality information during an interview. Listening skills enable the facilitator to have more understanding and encourages the participants to talk more when they are given a hearing (De Vos *et al.* 2005:301). The facilitator showed interest in the participants by using responses, such as *“mmm”* or *“okay”*, and nodding her head. By using these listening skills, the facilitator was able to maintain continuous interaction with the participants and obtained clarity and meaning regarding the factors identified by the participants.

(v) Paraphrasing

Paraphrasing is a process in which the facilitator enhances meaning by stating the participants' words in a different form but with the same meaning (De Vos *et al.* 2005:301). The participants used words, such as *“accessibility”*, which had different meanings to different participants. For example, the facilitator asked questions, such as *“You mentioned that the services are not available during the weekends and people can only access them during the*

week. *What do you mean by available and accessible?*” The facilitator was able to obtain more information by asking follow-up questions.

2.7 POST-INTERVIEW PHASE

The focus group interviews lasted for one hour as agreed with the participants. The sessions ended with the facilitator thanking the participants. The relationship between the facilitator and the participants was good. Participants were informed of the possibility of further contact, should the need for clarity arise and the contact numbers of the participants were again verified. After the participants left, the researcher immediately sat down to write field notes related to the session in order to minimise the loss of information (De Vos *et al.* 2005:298).

2.8 MEASURES OF TRUSTWORTHINESS

Lincoln and Guba (1985:290) describe trustworthiness as the ability of the researcher to persuade the audience that the findings of the study are worth paying attention to. This is how one can establish confidence in research studies. According to Polit and Beck (2006:332), Lincoln and Guba (1985) suggest the criteria for establishing the trustworthiness of qualitative data as credibility, dependability, confirmability and transferability.

De Vos *et al.* (2005:346) refer to these criteria as the true value of the study, its applicability, consistency and neutrality. These criteria also reflect the assumptions of the qualitative paradigm.

2.8.1 Credibility

Credibility refers to confidence in the truth of the data. It is also defined as an alternative to internal validity. The goal of credibility is to determine that the subjects were accurately identified and described (Brink *et al.* 2006:118; De Vos *et al.* 2005:346; Polit & Beck 2006:332).

The credibility of a study can be ensured by engaging in activities that have a likelihood of producing credible data, such as prolonged engagement, persistent observation, external checks, member checking, researcher credibility and data triangulation (Polit & Beck 2006:332). These activities, as well as the clear definition of the parameters of the setting and population, helped ensure the validity of the findings.

Brink *et al.* (2006:118) explain these techniques, used to achieve credibility, as remaining in the field for a longer period and having several contacts with the participants.

(i) Prolonged engagement

Prolonged engagement refers to investing sufficient time in the data collection to have sufficient, quality time to understand the phenomena (De Vos *et al.* 2005:350; Polit & Beck 2006:332). In order to ensure the credibility of the study, the researcher made a day appointment with the participants after the data collection to verify the data and check their reaction to the findings of the study. Some of the participants worked in the clinic where the focus group interviews were conducted and the researcher spent the rest of the day at the clinic with them. The researcher visited the participants in their different working situations in the different programmes, which helped to build further rapport and trust. The researcher could also clarify any misunderstanding. The participants felt honoured to be visited, which enhanced the credibility of the data collected.

During the visit, the participants were given a chance to ask questions related to the study and its findings. The researcher had a chance to continue negotiating the consent of the participants in order to be able to follow up some of the statements which were not clear. This boosted the morale of the participants as they felt respected.

(ii) Persistent observation

Persistent observation is another activity that ensures the credibility of a study. This refers to the researcher focusing on some aspects of the situation that are relevant to the phenomena under study (Polit & Beck 2006:337).

The researcher spent a day in the clinics where the focus group interviews were conducted, observing some of the services, such as the IMCI, TB and HIV/AIDS programmes, under study. This helped the researcher with the verification of some of the data collected during the interview. The researcher was also involved in the compilation of situational analyses of some of the programmes in the clinics.

(iii) External checks

External checks refer to two activities, peer debriefing and member checks, which establish credibility. The researcher exposed the preliminary findings of the study to the participants of the study, as well as expert peers. This was done internally during data collection or formally at the end of data collection (Polit & Beck 2006:334).

Member checking also entailed gauging the reaction of the participants regarding the interpretation of findings, which strengthened the relationship between the participants and the researcher. The preliminary findings were given to a coordinator of the expansion programmes to verify the data and identify any mistakes. A session was held with the peers to verify the findings. The findings were also provided to an expert in qualitative studies and a supervisor in research studies (Mayan 2001:28).

(iv) Researcher credibility

Researcher credibility refers to the faith that can be put in the researcher as a data collection instrument, based on his/her qualification, experience and training (Polit & Beck 2006:334). The researcher in this study was a primary

healthcare trainer, who regularly visited clinics during the accompaniment of students. The researcher was also involved with the implementation of some of the programmes being expanded.

(v) Data source triangulation

Data source triangulation refers to the use of multiple sources or referents in order to draw conclusions about the truth. This provides the basis for the convergence of the truth and the sifting out of true information from errors in order to enhance credibility (Brink *et al.* 2006:116; Polit & Beck 2006:333).

Diverse informants, such as the coordinators of the programmes, were interviewed on the same research question. The interviews were arranged with the coordinators of the Expanded Programme on Immunisation (EPI), as well as the IMCI and HIV/AIDS programmes, in order to triangulate data.

2.8.2 Dependability

De Vos *et al.* (2005:346) state that dependability is an alternative to reliability, in which the researcher has to account for changing conditions in the phenomena under study. The dependability of data refers to the stability of the data over time and conditions. There can be no credibility without dependability. The dependability of data can be ensured by conducting another study of the same nature at a different time (Polit & Beck 2006:335).

An enquiry audit is one technique to confirm the dependability of a study and involves the scrutinising of data and relevant supporting documents by an external interviewer (Brink *et al.* 2006:119; Polit & Beck 2006:335). In this study, the researcher ensured dependability through an enquiry audit, in which the supporting documents, such as the transcripts and the tape, were scrutinised by an independent expert in qualitative research studies and the field of primary health care.

Generalisability could not be considered in this study, as the study was limited to Region C in the Gauteng Province.

2.8.3 Confirmability

Confirmability refers to the objectivity of the data. It guarantees that the findings, conclusions and recommendations are supported by the data and that there is internal agreement between the researcher's interpretation and the actual evidence. Congruency may be between two or more independent people (Brink *et al.* 2006:119; Polit & Beck 2006:335).

De Vos *et al.* (2005:347) state that it is important to ask whether the findings of the study could be confirmed by another person in order to ensure confirmability. In this study, an audit trial was created in which all the documents were compiled and handed over to an independent auditor to make conclusions about the data. The transcripts and the tape were also handed over to an expert in qualitative studies, in order to conduct an enquiry audit on the data and the meaning attached to it.

2.8.4 Transferability

Transferability is referred to as external validity and is defined as the degree to which the results of the study can be generalised to other settings or samples (Brink *et al.* 2006:119; De Vos *et al.* 2005:346). The aim of the study was not to generalise but to understand the perceptions of the registered nurses and identify the factors that influence service delivery in a primary health care setting so as to be able to improve the quality of service delivery (Mayan 2001:9).

To enhance generalisation, multiple sources were used, including the coordinators of the programmes being expanded. The researcher also supplied thick description of the setting, transactions and processes of the data collection, for comparison. Thick description is a rich, detailed and

thorough description of the research context in a qualitative study (Polit & Beck 2006:511).

TABLE 2.1: FOUR MEASURES OF TRUSTWORTHINESS

Strategy	Criteria	Technique
Credibility	Prolonged engagement	<ul style="list-style-type: none"> Investing sufficient time in data collection during the interview Visiting participants to verify data Spending a day in the clinic to clear misinformation and build trust
	Persistent observation	<ul style="list-style-type: none"> Spending the day at the clinic working in some of the programmes (e.g. IMCI, TB, HIV/AIDS) with the nurses in order to continue observation after the interview
	External checks	<ul style="list-style-type: none"> <u>Peer debriefing</u>: the researcher consulted with programme managers and experts in qualitative research and aspects of research to discuss the findings <u>Member check</u>: the researcher internally solicited the reaction of the participants to the preliminary findings and interpretations of the study
	Researcher credibility	<ul style="list-style-type: none"> The researcher was trained in interviewing and research The information about the researcher's credentials and personal connection with the topic and population studied was revealed

	Data source triangulation	<ul style="list-style-type: none"> The researcher interviewed programme coordinators in the regional office
Dependability	Inquiry audit	<ul style="list-style-type: none"> The supporting documents were scrutinised by the external reviewer and the supervisor who was an expert in qualitative studies
Confirmability	Audit trial	<ul style="list-style-type: none"> The investigator in the inquiry audit developed an audit trial consisting of transcripts and tapes This was collected systematically from sources to allow for conclusions
Transferability	Thick description	<ul style="list-style-type: none"> A full description of the setting and process, and the transactions and processes, was supplied The researcher showed the findings to the programme managers in the clinics to check for congruency in the information

(De Vos *et al.* 2005:345-7; Polit & Beck 2006:332-3; Welman *et al.* 2005:362-3.) (Modified.)

2.9 DATA ANALYSIS

Data analysis is described as a systematic organisation of the transcripts and field notes until they are clear and give meaning. Data analysis involves making sense out of the text and image data (Creswell 1994:190; De Vos *et al.* 2005:334). Brink *et al.* (2006:170) define data analysis as categorising, ordering, manipulating and summarising data in order to be able to describe it

in meaningful terms. In qualitative studies, there is an inseparable relationship between data collection and data analysis (De Vos *et al.* 2005:334). The collection and analysis of the data progress concurrently and the researcher gains insight into new questions as he/she sifts through new information during the process of analysis (Polit & Beck 2006:16). In this study, the researcher began the data analysis during the data collection, after each interview and throughout all the subsequent interviews. The actual process of data analysis involved a few steps in clustering together related types of narrative information and making sense out of the data. The analysis followed an analytical circle with some of the generic steps overlapping, as they only serve as a guideline (De Vos *et al.* 2005:334). In the process of data analysis, the field notes and transcripts were analysed. The steps of data analysis were followed as described by Tesch (1990) in Creswell (1994:154).

The researcher started by listening to the tape repeatedly and transcribing all the information verbatim onto a script. The researcher then read through all the transcripts and the field notes to get some sense of the data and to gain background information. Some ideas that came up were written down.

The researcher selected one interesting interview transcript and reread it in order to try and focus on the meaning and the relation of the content to the topic. Some topics, which matched the content, were identified and listed.

The researcher then read through all the other transcripts and identified topics. Attention was given to the meaning of the data. The researcher then compiled a list of all the topics and organised them in a column. Similar topics were identified and clustered together into major topics. The best fitting name was selected for the clusters of major topics. The researcher then created columns for the unique cluster topics and the topics that could not be clustered or fit into other columns were listed in a separate column for leftovers.

The topics were interpreted, and the clustered topics and unique topics were abbreviated as codes. The codes were written next to the relevant segments.

The organised data were now ready for refinement and descriptive wording of the topics. These topics then became categories, which were matched with other similar topics to reduce the number of categories. A final abbreviation of the categories' names was chosen and each code was alphabetised. When the coding with the independent co-coder was complete, the content of each category was summarised. The researcher also identified similarities, uniqueness, contradictions and missing information from the categories and parts were discarded as irrelevant. The researcher met with an expert in qualitative studies to discuss the verbatim transcripts, field notes and the protocol, and reached a consensus (Creswell 1994:155). The categories, subcategories and themes identified are discussed in Chapter 3.

2.10 CONCLUSION

In this chapter, the research design and methodology were discussed in depth. The activities around the focus group interviews were outlined with the preparations and plans for the interviews. The population and the sample, as well as the analysis of the data, were described. The focus group interviews and the data collected focused on the perceptions of registered nurses regarding the factors that influence service delivery in a primary healthcare setting. The measures of trustworthiness were also outlined. In the next chapter, the data analysis and interpretation are discussed.

CHAPTER 3

DISCUSSION OF THE RESULTS AND LITERATURE CONTROL

3.1 INTRODUCTION

In Chapter 2, the research methodology of the study is discussed. It also describes how the results were obtained from the analysis of transcripts. This chapter encompasses the data collected during the focus group discussions and is made up of the results of the study, the literature control and a discussion of the field notes as adjunct to the data obtained from the interviews. The literature control is a further measure of validating the findings of the research.

3.2 OPERATIONALISING THE FIELD RESEARCH

A total of two focus group interviews were conducted with registered nurses in a primary health care setting in two separate community health centres in the region. Each focus group consisted of ten participants who were selected purposively from various clinics in the region. Purposive sampling was used to ensure that those participants who had the best experience of the programmes being expanded were included. The participants represented various categories of nurses in the primary health care setting. The demographic characteristics of the participants are illustrated in Table 3.1 on page 41.

In the pilot study, no difficulties were encountered with the wording or content of the central research question *“What are the factors that influence service delivery with regard to programmes being expanded in a primary health care setting?”*

TABLE 3.1: SAMPLE DEMOGRAPHIC INFORMATION (N=20)

CRITERION	CHARACTERISTICS	FREQUENCY	PERCENTAGE
Gender	Female	20	100%
Years of service in primary health care	<ul style="list-style-type: none"> • 3 – 5 years • 6 – 10 years • 11 – 15 years • 16 – 20 years • 21 – 25 years • 26 – 30 years 	<p style="text-align: center;">-</p> <p style="text-align: center;">4</p> <p style="text-align: center;">5</p> <p style="text-align: center;">10</p> <p style="text-align: center;">1</p> <p style="text-align: center;">-</p>	<p style="text-align: center;">-</p> <p style="text-align: center;">20%</p> <p style="text-align: center;">25%</p> <p style="text-align: center;">50%</p> <p style="text-align: center;">5%</p> <p style="text-align: center;">-</p>
Designation	<ul style="list-style-type: none"> • Registered nurse with Diploma in Clinical Nursing Science, Health Assessment, Treatment and Care. • Registered nurse with Community Health Nursing Science. • Registered nurse with Midwifery. • Registered nurse with Psychiatric Nursing Science. • Registered nurse with all of the above qualifications. 	<p style="text-align: center;">5</p> <p style="text-align: center;">15</p> <p style="text-align: center;">20</p> <p style="text-align: center;">4</p> <p style="text-align: center;">-</p>	<p style="text-align: center;">25%</p> <p style="text-align: center;">75%</p> <p style="text-align: center;">100%</p> <p style="text-align: center;">20%</p> <p style="text-align: center;">-</p>
Involvement with the expansion programmes	<ul style="list-style-type: none"> • Direct involvement • Indirect involvement 	<p style="text-align: center;">15</p> <p style="text-align: center;">5</p>	<p style="text-align: center;">75%</p> <p style="text-align: center;">25%</p>

The research question was clear and easily understood, and prompted a spontaneous response from the participants. Valuable information related to the research question was obtained in just an hour. Saturation of information was reached, as some of the factors were repeated in the two focus group interviews and no new factors were mentioned.

The researcher made use of interpersonal and communication skills, such as probing, clarification, listening and reflection, to get sufficient data, related to the factors that influence service delivery in programmes being expanded in a primary healthcare setting, from the participants.

3.3 PROCESS OF DATA ANALYSIS

The researcher commenced with data analysis independently of the co-coder. The researcher read through the verbatim transcripts and started underlining the words and phrases of the participants' responses to the research question. Universal categories for the study were identified and subcategories developed, within the framework of the categories, as the analysis proceeded. In this way, new categories were developed, which had not been previously identified. The refining and definition of the developed categories then followed so that the criteria for homogeneity, inclusiveness, usefulness, mutual exclusiveness, clarity and specificity could be met (Wilson 1989:467-77). The co-coder was given unmarked copies of the transcripts, as well as the field notes. Consensus was reached regarding the findings and the method of analysis of data. The researcher and the co-coder agreed on the categories and the themes identified in the transcripts. A summary of the categories, subcategories and themes can be found in Table 3.2.

TABLE 3.2: DATA ANALYSIS OF FOCUS INTERVIEW

CATEGORIES	SUBCATEGORIES	THEMES
Disabling factors (3.4.1)	Time limitations (3.4.1.1)	<ul style="list-style-type: none"> • Lack of extended hours for some programmes for TB and antiretroviral treatment services • Family planning services not available after-hours for learners and workers • Statistical errors with records during weekends and after-hours

	Budgetary constraints (3.4.1.2)	<ul style="list-style-type: none"> • Limited funds affected by patient turnover • Need for more stock and pharmacy supplies • Escalating client numbers affecting the quality of care • Escalating client numbers affecting the nurse-client ratio • Small buildings and some scattered buildings • Not all programmes can be rendered in some clinics
	Infrastructural problems (3.4.1.3)	<ul style="list-style-type: none"> • Lack of space for different programmes in a clinic • Close proximity of some clinics to the hospital • Lack of equipment
	Inadequate skills (3.4.1.4)	<ul style="list-style-type: none"> • Shortage of doctors and physiotherapists • Training in short courses expensive • Rotation of nurses in different programmes and services adds to the lack of necessary skills
Enabling factors (3.4.2)	Integration of IMCI into primary health care (3.4.2.1)	<ul style="list-style-type: none"> • Positive improvement in care of children under five years old • IMCI training of great help • Integration of IMCI into other services, such as PMTCT, positive
	Utilisation of IMCI nurses for programmes (3.4.2.2)	<ul style="list-style-type: none"> • IMCI nurses utilised for other programmes such as antenatal care (ANC) and postnatal care (PNC)

	Non-government organisation (NGO) contribution (3.4.2.3)	<ul style="list-style-type: none"> Caregivers trained and funded by NGOs help with home-based care
Client related factors (3.4.3)	Client service preferences (3.4.3.1)	<ul style="list-style-type: none"> Stereotype on certain clinics because of time factor and staff attitude Cross-border issue increasing staff workload
	Service duplication (3.4.3.2)	<ul style="list-style-type: none"> Client shopping around for diagnosis Clients misuse services due to denial and stigma Clients not revealing their status and ending up having two files in one clinic Clients using wrong addresses making follow-up difficult
	Scramble for free service (3.4.3.3)	<ul style="list-style-type: none"> Foreigners utilising the free services Cross-border issue
	Client entrepreneuring with services (3.4.3.4)	<ul style="list-style-type: none"> Foreigners collecting medicines to sell to others at their homes TB positive clients selling positive sputum 'as a way of getting a social grant'
	Poor adherence to PMTCT (3.4.3.5)	<ul style="list-style-type: none"> HIV positive clients on PMTCT programme not complying with the formula Confidentiality and stigmatisation are problems Family and community cultural practices and queries on breastfeeding Clients not ready to disclose their status

Service related factors (3.4.4)	Involvement of health promoters (3.4.4.1)	<ul style="list-style-type: none"> • Involvement of health promoters affecting trust and confidentiality
	Competing of programmes (3.4.4.2)	<ul style="list-style-type: none"> • Programmes such as EPI and IMCI not regarded as important • HIV/AIDS given first preference
	Lack of continuity of care (3.4.4.3)	<ul style="list-style-type: none"> • Clients moving from one clinic to another
	Lack of security in clinics (3.4.4.4)	<ul style="list-style-type: none"> • Security breaches by clients
Solutions to problems (3.4.5)	Need to integrate services (3.4.5.1)	<ul style="list-style-type: none"> • Integration of HIV/AIDS and mother and child services
	Need for electronic recordkeeping (3.4.5.2)	<ul style="list-style-type: none"> • The use of technology to manage extreme drug resistant TB (XDRTB) • The use of technology in maternal obstetrical units (MOUs) for foetal monitoring and graphs • The use of technology to prevent patients from having more than one file in one clinic • The use of ID numbers in clinics, with the clinics linked to the ID system and database • The use of technology to control drugs issued to clients to avoid double collection in one month in different clinics • The use of technology to fast-track the management of clients in different expansion programmes • The use of technology to curb health facility shopping by clients

	<p>Strengthening the support groups (3.4.5.3)</p>	<ul style="list-style-type: none"> • Strengthening the available support groups to include nutrition and expansion programmes
	<p>Healthcare worker training (3.4.5.4)</p>	<ul style="list-style-type: none"> • Upgrading the training of older nurses on expansion programmes on a continual basis • More nurses to be trained in expansion programmes to allow for continuity of care and rotation of staff • More nurses to be trained in primary mental health
	<p>Community education (3.4.5.5)</p>	<ul style="list-style-type: none"> • The use of clinic committee members to educate the community on health service operational issues and to create awareness of available services

3.4 RESULTS AND LITERATURE CONTROL

Data from the focus interview transcripts were grouped into five main categories: disabling factors, enabling factors, client related factors, service related factors and solutions. These were further divided into subcategories. Themes were identified and developed to substantiate each subcategory.

3.4.1 Category 1: Disabling factors

The disabling factors emerged as the first category. The following subcategories were identified under this category: time limitations, budgetary constraints, infrastructural problems and inadequate skills. These subcategories can be found in Table 3.3 on page 47.

TABLE 3.3: DISABLING FACTORS

SUBCATEGORIES	THEMES
Time limitations (3.4.1.1)	<ul style="list-style-type: none"> • Lack of extended hours for some programmes for TB and antiretroviral treatment services • Family planning services not available after-hours for learners and workers • Statistical errors with records during weekends and after-hours
Budgetary constraints (3.4.1.2)	<ul style="list-style-type: none"> • Limited funds affected by patient turnover • Need for more stock and pharmacy supplies • Escalating client numbers affecting the quality of care • Escalating client numbers affecting the nurse-client ratio • Small buildings and some scattered buildings • Not all programmes can be rendered in some clinics
Infrastructural problems (3.4.1.3)	<ul style="list-style-type: none"> • Lack of space for different programmes in a clinic • Close proximity of some clinics to the hospital • Lack of equipment
Inadequate skills (3.4.1.4)	<ul style="list-style-type: none"> • Shortage of doctors and physiotherapists • Training in short courses expensive • Rotation of nurses in different programmes and services adds to the lack of necessary skills

3.4.1.1 Subcategory 1: Time limitations

In this subcategory, the following themes emerged: lack of extended hours for some programmes for TB and antiretroviral treatment services, family planning services not available after-hours for learners and workers and statistical errors with records during weekends and after-hours.

- **Lack of extended hours for some programmes for TB and antiretroviral treatment services**

The participants indicated that some of the priority programmes were not accessible to all clients, despite the fact that the service hours had been extended. This was expressed as follows:

“We are a 24-hour health service but some programmes are not covered in the 24-hour service”.

The participants also indicated that the clients who were most affected were those that worked or attended school, as they came to the clinics during their off-time in the afternoon. This was expressed as follows:

“Clients who came after-hours or during the weekends requesting TB or ART [antiretroviral treatment] services are turned away and given another time”.

- **Family planning services not available after-hours for learners and workers**

The participants also indicated that family planning services were offered only at primary level, whereas they had previously been available at hospitals. When they were available at hospitals, clients could access the service during the weekend. Now, these services were only offered at primary level, where some facilities did not have extended hours. This was expressed as follows:

“I have one problem with family planning services; it is not accessible where it is offered at primary level”.

“Scholars cannot access family planning services after-hours”.

- **Statistical errors with records during weekends and after-hours**

According to the participants, the fact that some services were not accessible during weekends and after-hours had an impact on the statistics of the clinic. The clients were put on clinic records, but could not access the service, resulting in statistical errors. The participants expressed this as follows:

“Some of our clients are working and cannot access HIV counselling services and they are being recorded as being in the list of clients”.

Literature control: Time limitations

The primary healthcare package sets out the norms for service delivery. One of the norms in the package is that primary healthcare facilities should serve as a ‘one-stop’ provider of health care, for a minimum of eight hours per day, five days a week (DOH 2001:12). The expansion of programmes in relation to time included making these services available to working people after-hours, as well as the provision of maternity emergency services 24-hours a day (Hattingh *et al.* 2006:65).

The availability of services entails that services should be open at the time that they are needed. Availability also means that services should be functionally accessible to people who work office hours. According to the Gauteng Department of Health Strategic Plan 2004-2006, the hours of many clinics have been extended to ensure their accessibility and availability during working hours as well as after-hours (Gauteng Department of Health 2004-2006:52).

A survey in the Gauteng Province revealed that at least 87 per cent of fixed facilities offered family planning services daily, including emergency contraceptives. The study also showed that people who work office hours have no access to public primary health care services as some clinics continued to schedule certain services on certain days. The expansion of services required a commitment on the part of the provincial authorities

(Meyer, Heunis, Janse van Rensburg-Bonthuyzen, Engelbrecht & Summerton 2003:9).

Another study, conducted in the Limpopo Province, revealed that primary health care clinics were opened only during the week. There was concern regarding the flexibility of service being rendered within specific times (Mashego & Peltzer 2005:18).

3.4.1.2 Subcategory 2: Budgetary constraints

In this subcategory, the following themes were identified: limited funds affected by client turnover, need for more stock and pharmacy supplies, escalating numbers affecting the quality of care, escalating numbers affecting the nurse-patient ratio, small buildings and some scattered services.

- **Limited funds affected by patient turnover**

The participants perceived that the escalating number of clients affected the limited budget. The participants believed that the limited budget affected many other issues, such as workload and equipment. This was expressed as follows:

“Patient turnover exceeds our budget ...”.

- **Need for more stock and pharmacy supplies**

The participants perceived that the escalating number of clients affected the limited budget by increasing the need for more stock and pharmacy supplies. This was expressed as follows:

“Patient turnover exceeds our budget ... and the stock of supplies and pharmacy is strained”.

“We have to order more supplies than we can afford”.

- **Escalating client numbers affecting the quality of care**

The participants expressed that the escalating numbers also affected the quality of care provided. This was expressed as follows:

“The growing number of clients makes the quality of our service to go down”.

- **Escalating client numbers affecting the nurse-client ratio**

The participants also indicated that the escalating number of clients affected the ratio of staff members to clients. This was expressed as follows:

“The ratio of staff per number of patients is more than the required values”.

- **Small buildings and some scattered buildings**

The smallness of buildings used for MOUs was also attributed to budgetary constraints. The participants indicated that there was not enough space for such services. This was expressed as follows:

“I have been to some of these MOU facilities, the physical structure does not accommodate them, and they are small”.

The participants also indicated that some of the services were scattered because buildings were too far apart. Some services, such as voluntary counselling and testing (VCT) and IMCI, were as far as 100 metres apart. The budgetary constraints affected the building of new clinics and some services were being rendered in buildings that were not built to be clinics.

This was expressed as follows:

“Some of the structures are not feasible for some functions like delivery services”.

“I think it is a matter of budget; to improve the structure you actually need a complete change of facility structures to make them nurse friendly and client friendly”.

“Yes, in the clinic there are structural problems ... some clinics are very small and we cannot render all required services”.

“The buildings are scattered ... you have to walk from one building to another”.

“I think the distance also affect the management at the clinic ... it is difficult to control”.

- **Not all programmes can be rendered in some clinics**

The participants perceived that because of limited resources, which affected the availability of space, some of the programmes could not be introduced in certain clinics.

“Yes, in the clinic there are structural problems ... some clinics are very small and we cannot render all required services”.

“Some of the structures are not feasible for some functions like delivery services”.

Literature control: Budgetary constraints

The Gauteng Department of Health Strategic Plan 2004-2006 indicated that the measures to build financial capacity, the challenges related to

transformation and the implementation of the primary health care package have an impact on the budget (Gauteng Department of Health 2004-2006:69). The transformation of the healthcare system had to occur within the existing resources of the public sector.

A study conducted on the perceptions of nursing managers revealed that, without proper structures, it is difficult to function effectively, especially during the transformation period. It was also revealed that inadequate resources were a contributory factor to ineffective management and shortages of equipment. The researchers concluded that a lack of material and resources has an effect on the quality of care (Buys & Muller 2000:53).

Another study, conducted by Peltzer, Skinner, Mfecane, Shisana, Nqeketo, Mosala & Orkin (2005:30), confirmed that health services are under-funded and hence are unable to provide a full package of primary health care services. This is an indication that the budget in all health systems is the most important aspect of service delivery, because all the plans revolve around the availability of funds. Funds are needed to buy equipment, build sufficient facilities, buy medicines, and employ and train enough staff.

3.4.1.3 Subcategory 3: Infrastructural problems

In this subcategory, the following themes were identified: lack of space for different programmes in a clinic, close proximity of some clinics to hospitals and lack of equipment.

- **Lack of space for different programmes in a clinic**

The participants indicated their concern about the lack of space available to render some of the programmes in the clinics. The participants indicated the need for privacy and a waiting area, especially if the 'supermarket approach' was to be used, with the introduction of IMCI, PMTCT and VCT.

This was expressed as follows:

“You must have space to render programmes like IMCI and PMTCT, maybe need waiting area for these people and privacy for VCT”.

“You might also need space to offer procedures as drawing of blood”.

- **Close proximity of some clinics to the hospital**

The participants perceived that because some clinics were nearer to the hospital than others, clients preferred to go to the hospital, hoping to see a doctor. The hospital then referred the client back to these clinics, resulting in overloads for the clinics. This was expressed as follows:

“Patients who are from nearby villages, come to us because of the close proximity of the clinic to the hospital. They come hoping to be treated at the hospital and are then referred to the clinic”.

- **Lack of equipment**

The participants also expressed their concerns about the shortage of equipment to deliver programmes, such as the Expanded Programme on Immunisation (EPI). This was expressed as follows:

“You will find that the clinic has only one refrigerator and vaccines must not be mixed with other items ... you must have a dedicated refrigerator, yaaahh ...”.

“If proper chain management is not followed you can inject the children with the vaccine that is not potent and children later develop measles when you investigate you find that the cold chain was not maintained when the child was immunised”.

“You also need extra equipment like refrigerators”.

The participants also expressed that there was a lack of electronic equipment in some MOUs, such as Doptones used to monitor the foetal heart during labour, which is very important. This can save the life of the baby and has reduced the number of stillbirths in the labour ward. The participants also indicated that the MOUs did not have enough supplies of medicine or basic equipment, such as a delivery trolley, which is essential. This equipment is needed in order for a labour ward to be fully functional and effective. This was expressed as follows:

“I will give an example ... a maternity service whereby, mmm ... some of the clinics do not have doptones, or an electronic foetal monitor that can help to monitor the fetal heart”.

“And these are some of the things that cause complications”.

“Also shortages of supplies whereby things like medicines are initial equipment like ... mmm, delivery trolley, yaaah ... and an MOU needs these things to be fully operational and those have an impact on the expansion of the programmes and quality of care”.

Literature control: Infrastructural problems

The objective of the Gauteng Department of Health Strategic Plan 2004-2006 was to reduce the backlog of infrastructure and equipment and ensure that the construction, rehabilitation, upgrading and maintenance of infrastructure were linked to the SIP (Gauteng Department of Health Strategic Plan 2004-2006:215). This entire plan was linked to the budget. The expansion of certain programmes had to occur within the available resources and according to the priorities that were identified.

A study conducted by Ijumba (2002:195) revealed that a lack of provision of infrastructure in some clinics hampered service delivery. Issues, such as frequent breakdowns, lack of transport for patients and lack of telephones, were identified. The health providers in this study also indicated that lack of

space grossly affected the quality of care. Heunis *et al.* (2006:44) also state that some clinics were not designed for the provision of a primary healthcare package. As a result, some equipment, such as examination lights, was in short supply in many facilities. In addition to the shortages, the maintenance of equipment was also poor in some cases.

Another study, conducted in the Limpopo Province, on the community perceptions of the quality of health care services, revealed that small buildings were inadequate to provide a good service. The clients stated that they had no place to sit and wait for the service, reducing the proper reception of clients who need a good reception as part of their recovery process. Clients had to queue outside, under the trees, even on rainy and cold days (Mashego & Peltzer 2005:18).

3.4.1.4 Subcategory 4: Inadequate skills

The following themes emerged in this subcategory: shortage of doctors and physiotherapists, training of short courses expensive and rotation of nurses in different programmes and services adds to the lack of the necessary skills.

- **Shortage of doctors and physiotherapists**

The participants universally perceived that there was a shortage of skills because of the 'brain drain', despite training having conducted in the region for programmes being expanded. Some participants expressed the feeling that the shortage was mostly in experienced nurses, but also included other professions, such as doctors and physiotherapists. Clinics were left with newly qualified nurses who still needed to be upgraded on certain skills. The participants also indicated that some training, like IMCI, had to be cancelled because of a shortage of doctors to do the clinical accompaniment.

This was expressed as follows:

“We do conduct training but because of this brain drain, like you train nurses today and the person with the information is gone tomorrow and we start again to train others ...”.

“... and highly experienced nurses leaving the country and with this age we really experience that drainage of nurses, doctors and physiotherapists”.

- **Training in short courses expensive**

A lack of skills was also perceived by some participants as being related to the high cost of short courses, as nurses could not afford to pay for training. This was expressed as follows:

“Again lack of skills by the professional nurses because some of the short courses are expensive and people cannot afford”.

- **Rotation of nurses in different programmes and services adds to the lack of necessary skills**

The participants indicated that the lack of skills was related to the rotation of nurses around the different services and programmes in the clinic. When rotation occurs, the nurse first had to be orientated before he/she became familiar with the routine and processes of the programme and this caused delays in service delivery. This was expressed as follows:

“... the rotation of staff in clinics like maybe somebody has to rotate the services or be allocated to a different service in a clinic, and then it is a person without IMCI who does not have the information ...”.

“The only problem is that nurses do not stay long in the programme because, as they are allocated daily, they move to other programmes and quality is affected”.

Literature control: Inadequate skills

A characteristic of an ideal primary healthcare service is that it is effective. Therefore, health care providers should be appropriately qualified and should not be expected to render services that are not applicable to their level of training (Hattingh *et al.* 2006:65). One of the key challenges reported in the Gauteng Department of Health Strategic Plan 2004-2006 was the retention of highly skilled and scarce skilled professionals in the public sector, including specialist nurses and emergency care personnel (Gauteng Department of Health 2004-2006:198).

The Gauteng Department of Health Strategic Plan 2004-2006 further confirmed that one of the constraining factors was a shortage of qualified primary health care nurses due to their inability to release staff for long periods of training. Lengthy procurement procedures were also identified as hindering courses being efficiently and timeously conducted (Gauteng Department of Health 2004-2006:201).

Inadequate skills were also reported in a study that was conducted on the assessment of the implementation of the primary healthcare package. The study revealed a lack of training in most of the programmes being expanded. In some places, only one nurse could be trained in a specific programme, resulting in a gap to service delivery when that nurse was absent or on leave (Heunis *et al.* 2006:44).

In a survey conducted by Ijumba (2002:183), primary healthcare providers revealed that due to their workload and a shortage of staff, it was impossible for them to attend some of the in-service training opportunities in order to update their skills.

The issue of in-service training being planned and the number of programmes in existence also impacted on service delivery. This was voiced by managers who felt that they are burdened by multiple and conflicting demands for in-service training made from the different programmes, such as TB, HIV/AIDS and PMTCT. All these put a burden on service delivery (Leon, Bhunu & Kenyon 2002:217).

3.4.2 Category 2: Enabling factors

The second category that was formulated was enabling factors. The following subcategories emerged from this category: integration of IMCI into primary health care, utilisation of IMCI nurses for programmes and NGO contribution. These subcategories can be found in Table 3.4.

TABLE 3.4: ENABLING FACTORS

SUBCATEGORIES	THEMES
Integration of IMCI into primary health care (3.4.2.1)	<ul style="list-style-type: none"> • Positive improvement in care of children under five years old • IMCI training of great help • Integration of IMCI into other services, such as PMTCT, positive
Utilisation of IMCI nurses for programmes (3.4.2.2)	<ul style="list-style-type: none"> • IMCI nurses utilised for other programmes such as ANC and PNC
NGO contribution (3.4.2.3)	<ul style="list-style-type: none"> • Caregivers trained and funded by NGOs help with home-based care

3.4.2.1 Subcategory 1: Integration of IMCI into primary health care

The following themes emerged from this subcategory: positive improvement in the care of children under five years old, training on IMCI of great help and integration of IMCI into other services, such as PMTCT, positive.

- **Positive improvement in care of children under five years old**

The participants indicated that the integration of IMCI had a positive outcome on the survival of children under the age of five. This was expressed as follows:

“The nurses are able to refer in time when necessary or keep the child in the clinic for rehydration”.

- **IMCI training of great help**

According to participants, training had been conducted and was still continuing. This was expressed as follows:

“With the IMCI skills, nurses are able to identify and manage diarrhoea related dehydration in the under-five children”.

- **Integration of IMCI into other services, such as PMTCT, positive**

The participants felt that the integration of health services for the mother and child, such as IMCI and PMTCT, could promote the survival of children. Integration could be extended to using one record for the mother and the child. This would help to render comprehensive health care to the mother and the child. This was expressed as follows:

“Integration of IMCI is like if a child comes for IMCI brought by mother, the sister will immediately check for immunisation and be referred, even in ANC also it is important to integrate”.

“I think the integration with other services is very important because if they are isolated it poses a problem”.

The participants also confirmed the integration being planned by the Government could improve the care of the mother and child. This was expressed as follows:

“Yes, actually, the department is at the moment looking at the integration of the programmes as IMCI and PMTCT”.

This integration entails that when a mother comes to the clinic with a child, information about the mother would also be indicated on the baby’s card and the nurse would also be able to attend to the mother’s needs. This integration could later be extended to include antiretroviral treatment and other services.

Literature control: Integration of IMCI into primary health care

The IMCI strategy was developed by the WHO and UNICEF in 1995 and adopted by South Africa in 1996. IMCI offers a set of interventions that promote the rapid recognition and effective treatment of the major killer-diseases amongst children younger than five years. It also promotes improved nutrition, including breastfeeding, use of micronutrients, treating susceptible populations of worms, vaccination and signs at home that require immediate treatment at a health facility (WHO & UNICEF 2003:7). Training on the IMCI strategy has been introduced in post-basic courses, as well as pre-service training for basic nursing programmes and medical doctors since 2002 (WHO & UNICEF 2003:103).

The integration of the IMCI strategy into primary health care services has been planned from the introductory phase because it was regarded as a survival strategy for children and had to be integrated with other survival strategies. According to a survey report by the WHO and UNICEF, IMCI advocates the coverage of all missed opportunities in immunisation, which points toward the integration of IMCI and EPI (WHO & UNICEF 2003:21). The survey identified a shortage of vaccines, power cuts and a lack of segregated refrigerators as constraints to service delivery, which impacted negatively on the effectiveness of immunisation services (WHO & UNICEF 2003:22). The

survey further recommended integration with other services, starting with coordination at national and provincial level to ensure that all programmes and training courses are linked during training, including HIV/AIDS programmes (WHO & UNICEF 2003:26).

3.4.2.2 Subcategory 2: Utilisation of IMCI nurses for programmes

The following theme emerged from this subcategory: nurses trained for IMCI utilised for other programmes, such as Ante-Natal Care(ANC) and Post-Natal Care(PNC).

- **IMCI nurses utilised for other programmes, such as ANC and PNC**

Participants indicated that nurses trained for IMCI were being utilised for specific programmes, such as ANC and PNC, which was viewed as an enabling factor. This was expressed as follows:

“Yes we have specific nurses allocated to specific programmes, in IMCI sometimes you will be allocated to do ANC and sometimes you do PNC and this is an enabling factor”.

Literature control: Utilisation of IMCI nurses for programmes

Heunis *et al.* (2006:44) state that nurses should be trained in numerous key programmes in order to be able to implement the primary healthcare package effectively. This will deal with the gaps and discontinuity in the implementation of specific programmes. The primary health care package includes different priority programmes, such as PMTCT, IMCI, VCT and antiretroviral treatment, which all require skilled nurses. A shortage of nurses in these programmes will impact on the quality of care (Buys & Muller 2000:53).

Hattingh *et al.* (2006:115) state that the effectiveness of the programmes depends on the optimal utilisation of the available human resources. Effective

service provision requires qualifications, levels of experience and specific skills.

3.4.2.3 Subcategory 3: NGO contribution

The following theme was identified in this subcategory: NGOs training caregivers to help with home-based care.

- **Caregivers trained and funded by NGOs help with home-based care**

The participants acknowledge that NGOs were really helping and used to be of great assistance in the antiretroviral treatment and home-based care services but had had problems with funding. Caregivers were trained comprehensively by NGOs and were serving great parts of the community. This was expressed as follows:

“The NGO used to help but now they have not been funded and they were not paid and now the caregivers feel very demotivated”.

“With regard to poverty, the NGOs are helping some clients and this improves compliance”.

“We have NGOs that give ART at other places around us and are really helping those who cannot”.

Literature control: NGO contribution

The key priority actions in implementing the SIP with regard to NGOs was to consolidate home-based care programmes into over-all community healthcare programmes, and improve the quality of care provided by community healthcare workers through NGOs (Gauteng Department of Health 2004-2006:68). The Gauteng Department of Health Strategic Plan 2004-2006 explains that volunteerism is being promoted, specifically through the use of community health care workers for programmes such as Directly Observed Treatment, Short-Course (TB DOTS), HIV/AIDS, PMTCT and VCT, and

including health promotion (Gauteng Department of Health 2004-2006:54). The report also confirms that NGOs are being supported in implementing outreach programmes related to the programmes being expanded in an integrated manner (Gauteng Department of Health 2004-2006:54).

The main role of NGOs is to contribute to the improvement of the quality of care in the communities and families (Uys & Cameron 2003:6). The involvement of caregivers was highly recommended because if care is to be comprehensive and cost effective, it must be conducted as much as possible in the community. One of the benefits of home-based care is that it is less expensive, more personalised and helps the family come to grips with the illness (Uys & Cameron 2003:3).

3.4.3 Category 3: Client related factors

The third category that was identified was client related factors. The following subcategories emerged from this category: client service preference, service duplication, scramble for free services, client entrepreneuring with services and poor adherence to PMTCT. These are represented in Table 3.5.

TABLE 3.5: CLIENT RELATED FACTORS

SUBCATEGORIES	THEMES
Client service preferences (3.4.3.1)	<ul style="list-style-type: none"> • Stereotype on certain clinics because of time factor and staff attitude • Cross-border issue increasing staff workload
Service duplication (3.4.3.2)	<ul style="list-style-type: none"> • Client shopping around for diagnosis • Clients misuse services due to denial and stigma • Clients not revealing their status and ending up having two files in one clinic • Clients using wrong addresses making follow-up difficult
Scramble for free service (3.4.3.3)	<ul style="list-style-type: none"> • Foreigners utilising the free services • Cross-border issue
Client entrepreneuring with services (3.4.3.4)	<ul style="list-style-type: none"> • Foreigners collecting medicines to sell to others at their homes

	<ul style="list-style-type: none"> • TB positive clients selling positive sputum 'as a way of getting a social grant'
Poor adherence to PMTCT (3.4.3.5)	<ul style="list-style-type: none"> • HIV positive clients on PMTCT programme not complying with the formula • Confidentiality and stigmatisation are problems • Family and community cultural practices and queries on breastfeeding • Clients not ready to disclose their status

3.4.3.1 Subcategory 1: Client service preferences

In this subcategory, two themes emerged: stereotype on certain clinics because of time factor and staff attitude, and cross-border issue increasing the workload of staff.

- **Stereotype on certain clinics because of time factor and staff attitude**

The participants indicated the fact that clients from neighbouring villages were leaving their clinics and preferred to come to that particular clinic, resulting in the staff being overworked. This was expressed as follows:

“We have a problem of people leaving clinics near their homes to overcrowd our clinics because they believe that the service here is better”.

“They say they have problems with the attitudes of the staff in their clinics”.

- **Cross-border issue increasing staff workload**

The perception of the participants was that clients were seeking out the best clinics and did not attend the clinics near their own villages. The clients seemed not to have a problem paying for transport as long as they did not have to stand in long queues. The participants called this a ‘cross-border issue’. This was expressed as follows:

“They just favour our clinic”.

Literature control: Client service preferences

The Bill of Rights enshrines clients’ right to freedom of movement and right to choice in life (Hattingh *et al.* 2006:67). Clients can therefore not be denied treatment because of their preferences. One of the characteristics of primary health care is that it should be comfortable. Overcrowded primary health care facilities are uncomfortable for both clients and healthcare workers and therefore needs to be corrected (Hattingh *et al.* 2006:66).

Peltzer *et al.* (2005:30) state that the district boundaries for primary healthcare delivery are co-terminus with the political boundaries. This means that people living in a particular health district are expected to obtain health services within their boundaries.

3.4.3.2 Subcategory 2: Service duplication

The following themes were identified in this subcategory: clients shopping around for diagnosis, client misuse of services due to stigma and denial, clients not revealing their status and ending up having two files in one clinic, and clients using wrong addresses making follow-up difficult.

- **Client shopping around for diagnosis**

The participants perceived that, because of the close proximity of the villages and the clinics, and because of the availability of public transport in their areas, clients, especially VCT and HIV positive clients, had a tendency of ‘shopping around’. They felt that clients would go around to several clinics, shopping around for a diagnosis and that this contributed to increased workloads and shortages of staff. This was expressed as follows:

“Clients misuse the services ... the VCT patients move from one clinic to another to test, seeking for a better diagnosis”.

- **Clients misuse services due to denial and stigma**

The participants also perceived that clients from the other villages preferred to attend the clinic in the next village where they were not known if they had a major ailment. The participants perceived this as denial and avoiding stigmatisation. This was expressed as follows:

“Denial makes them not to believe that they have tested HIV positive ... they want to confirm the diagnosis elsewhere”.

“Particularly with the clients who are HIV positive, because of stigma, they feel that if they go to a facility they are not known, they feel better, to hide their status and this shows that they are in denial”.

- **Clients not revealing their status and ending up having two files in one clinic**

The participants perceived that clients who attended the same clinic ended up having two files in one clinic because they did not want to reveal their status. A client may have had a file with the antiretroviral treatment service and then, when he/she came again for a minor ailment, opened another file. This was possible because at a community health centre clients were seen by different doctors and staff in different sections. This was expressed as follows:

“The patient will come and open a file down there with PHC [primary health care] and also have a file with the ART”.

“Really the client does not tell you that he has a file with the ART and the patient ends up with more than one file, has files all over the clinic”.

“They go to a new service and don’t tell the nurses about their HIV status because of denial and stigma of the condition”.

- **Clients using wrong addresses making follow-up difficult**

The participants also indicated that clients used incorrect addresses in order to be able to shop around in the nearby clinics, making follow-up difficult, especially patients with sexually transmitted infections (STIs) and PMTCT clients. The participants saw this as extra work for the staff and believed that it affected the quality of services rendered. This was expressed as follows:

“The other issue is that people from the nearby villages give wrong addresses. When you want to follow them up to the address there is nobody. This is a problem”.

Literature control: Service duplication

A health survey conducted on the responses of individual people to their HIV status revealed different reactions ranging from anger, suicide, denial and fear of death. The study also revealed that the respondents' own responses to their HIV positive diagnosis affected their utilisation of health services. The respondents explained that they presented themselves several times for HIV testing, hoping that things might change. Seven revealed that they tested up to seven times and had used several health facilities to confirm their status (Modiba *et al.* 2001:191). Such behaviours were related to individuals' understanding and denial of the diagnosis.

A study conducted by Botma, Motiki and Viljoen (2007:48) on knowledge regarding VCT also confirmed that fear of a positive diagnosis was linked to suicide and shopping around for a diagnosis. Two studies confirmed that stigma and disclosure is still a problem in the communities (Peltzer *et al.* 2005:29; Shapiro, Lockman, Thior, Stocking, Kebarabetswe, Wester *et al.* 2003:221).

3.4.3.3 Subcategory 3: Scramble for free service

Two themes emerged from this subcategory: foreigners utilising free services and the cross-border issue.

- **Foreigners utilising the free services**

The participants expressed their perception that foreigners were overutilising free health services. According to the participants, foreigners knew that the health services were free and collected treatment, especially chronic treatment, from different clinics to last them longer, as they could only enter South Africa two times in a year to get treatment. This was expressed as follows:

“They know that treatment is free and they collect two months' supply, especially the chronic cases; then they go to the next clinic, collect another two months' supply until the client has enough to go back home and stay for plus-minus six months”.

“We have clients that come for their chronic treatment from other countries crossing the borders and overloading the services”.

- **Cross-border issue**

The participants also perceived this as a cross-border issue as the clients were using bus services from outside the country. This was expressed as follows:

“This is a cross-border problem”.

“The clients are honest to tell you that they are going back to their country and need more treatment”.

Literature control: Scramble for free services

After the introduction of the free health services policy in the primary health care services in 1996, a survey was conducted to review South African experiences of free maternal health care and its impact on health care. The results revealed that the introduction of the policy led to the abuse of services, with clients collecting drugs with the intention of selling them. It was indicated that foreigners would come and utilise the free services (Schneider & Gilson 2000:89). Clients would come to the clinic on a Monday for headaches, on the Wednesday for stomachache and, on Friday, for an old sprain, for example, all with the purpose of getting pain tablets (Schneider & Gilson 2000:99).

The study conducted by Ijumba (2002:185) confirmed the abuse of services related to free health services and even suggested that clients should be charged a small fee to try and control the abuse. It was revealed that clients would come to the clinic every week, complaining of small things.

Another study, conducted on facility managers, also revealed that free health services and PMTCT programmes resulted in an increase in the workload of healthcare workers because access to healthcare facilities increased (Leon *et al.* 2002:318).

Buyts and Muller (2000:54) conducted a study on the perceptions of nursing managers regarding the transformation of health services. Contrary to the other studies, their study revealed that the introduction of the policy on free health services had a positive effect, especially for disadvantaged communities, as primary healthcare services became accessible, affordable and equitable to all.

3.4.3.4 Subcategory 4: Client entrepreneuring with services

Two themes emerged from this subcategory: foreigners collecting medicines to sell them to others at their homes and TB positive clients selling sputum 'as a way of getting a social grant'.

- **Foreigners collecting medicines to sell to others at their homes**

The participants voiced their concerns that foreigners were selling treatment to other people. This was expressed as follows:

“Yes, the other factor is that clients will come over and over again to collect medicines and sell them outside. When you find out that they sell the medications, they change the clinic”.

“Yes, they collect medications from several clinics around here and they go and sell outside South Africa in the neighbouring countries”.

“Patients give wrong addresses and it is difficult to follow them up ... the reason is that they sell the medicine”.

- **TB positive clients selling positive sputum 'as a way of getting a social grant'**

The participants expressed the belief that clients were aware that an HIV positive person who was diagnosed with TB qualified for a social grant. Poverty has driven them to the extent that they sold TB positive sputum to others, so that these people could get a grant. This was expressed as follows:

“Because of poverty some of the TB patients sell their sputum to others with a hope of getting a social grant if they tested positive for TB”.

“All these clients now give wrong addresses so you cannot trace them”.

Literature control: Client entrepreneuring with services

The abuse of services and other problems related to the free health service have been documented in studies. In some cases, clients sell treatment to others and others sell their TB positive sputum to allow access to social grants (Ijumba 2002:185; Schneider & Gilson 2000:89).

The escalating dual epidemics of HIV/AIDS and TB put a burden on health services, and the utilisation of clinics is high (Ijumba 2002:182). The link between TB and HIV has been noted and documented, with almost 50 per cent of HIV positive clients developing TB, thus increasing the incidence of TB infections (Uys & Cameron 2003:3). Mugenyi (2007:1) explains that it is conservatively estimated that about 60 per cent of clients presenting with TB are co-infected with HIV, hence the importance of an integrated approach to the control programmes for HIV/AIDS and TB.

3.4.3.5 Subcategory 5: Poor adherence to PMTCT

The following themes emerged from this subcategory: HIV positive clients on PMTCT programme not complying, confidentiality and stigma is a problem, family and community practices, and queries on breastfeeding and clients not ready to disclose.

- **HIV positive clients on PMTCT programme not complying with the formula**

The participants expressed their perceptions regarding the behaviour of clients that were put on the PMTCT programme and did not comply with using of formula, rather than breastfeeding. During pregnancy and labour, clients cooperated, were given the correct treatment, and received relevant education and counselling regarding breastfeeding. Some were started on using formula after delivery and counselled about its use, but stopped complying once they arrive at home, in the postnatal period. These clients still breastfed their baby. This was expressed as follows:

“Most of them, even if they take the formula ... they breastfeed”.

“It becomes a problem as most of them, when they get home, they still breastfeed”.

- **Confidentiality and stigmatisation are problems**

The participants perceived that the community was stigmatising these clients, who consequently decided to breastfeed their baby to avoid stigma. This was expressed as follows:

“People are clever now, they ask why not breastfeed? They just put the baby on the breast to avoid talks”.

“Maybe it’s the pressure from the family, the stigma from the family and the expectations from the family and community - if she gives the baby a bottle and they prefer just to give the baby the breast”.

- **Family and community cultural practices and queries on breastfeeding**

The participants also expressed their belief that the community was aware of the association between PMTCT, HIV/AIDS and the advice to put the baby on formula. This led them to the conclusion that if a mother returns from the hospital and gives her baby formula rather than breast milk, that she was HIV positive. The perception of the participants was that cultural practices and expectations of family were putting pressure on clients to disregard the advice of the PMTCT programme. This was expressed as follows:

“This is a problem maybe when they are queried why they do not breastfeed”.

“I think it has something to do with the family”.

- **Clients not ready to disclose their status**

The perception of the participants was that the issue of breastfeeding as opposed to putting a baby on formula showed that these clients were not ready or had not yet disclosed their HIV status. This was expressed as follows:

“With PMTCT you can never be sure. Most of them are provided with PMTCT in the labour ward and some still behave as if they do not know anything”.

“Confidentiality and stigmatisation is a problem”.

Literature control: Poor adherence to PMTCT

The PMTCT programme was introduced in all facilities following a court order, with certain standards set by the WHO. One of these principles was that HIV positive women were to be counselled about their choices regarding baby feeding and supported regardless of what option they chose (Peltzer *et al.* 2005:27). In the Gauteng Province, the provision of PMTCT was implemented as early as 2001, starting with piloted sites, but now the service has been expanded to many other facilities (Kenyon, Heywood & Conway 2001:161).

Several studies have been conducted on the effect of stigma on the provision of health services. A study conducted by Greeff and Phetlhu (2007:13) revealed that societal stigma was identified as a limiting factor in primary and secondary HIV/AIDS prevention and care. Another study, conducted by Botma *et al.* (2007:48), acknowledged that stigma was the biggest challenge to the prevention and care of HIV/AIDS.

The findings of a study conducted in Botswana support the perception that, as a result of the stigma of HIV/AIDS, HIV positive women may choose to avoid potentially disclosing their status by feeding according to traditional practices.

This may have led to some women in this study breastfeeding their baby rather than using formula (Shapiro *et al.* 2003:201).

Contrary to these findings are the findings of a study conducted by Peltzer, Mosala, Shisana and Nqeteko (2006:59), which revealed that mother-in-laws did not have a negative impact, but indicated that they knew that HIV could be passed onto the child through breastfeeding and that they encouraged their children to go for HIV testing. Nor did they have problems with different delivery options.

3.4.4 Category 4: Service related factors

The fourth category that was formulated was service related factors. The following subcategories were identified in this category: involvement of health promoters affecting trust and confidentiality, competing of programmes, lack of continuity of care and lack of security in clinics. These subcategories are represented in Table 3.6.

TABLE 3.6: SERVICE RELATED FACTORS

SUBCATEGORIES	THEMES
Involvement of health promoters (3.4.4.1)	<ul style="list-style-type: none"> • Involvement of health promoters affecting trust and confidentiality
Competing of programmes (3.4.4.2)	<ul style="list-style-type: none"> • Programmes such as EPI and IMCI not regarded as important • HIV/AIDS given first preference
Lack of continuity of care (3.4.4.3)	<ul style="list-style-type: none"> • Clients moving from one clinic to another
Lack of security in clinics (3.4.4.4)	<ul style="list-style-type: none"> • Security breaches by clients

3.4.4.1 Subcategory 1: Involvement of health promoters

The following theme was identified in this subcategory: the involvement of the health promoters as volunteers affecting trust and confidentiality.

- **Involvement of health promoters affecting trust and confidentiality**

The perception of the participants was that, in relation to HIV/AIDS, there was a need for clients to trust and be ensured of confidentiality in order to accept their diagnosis and get support. The participants believed that the involvement of health promoters increased the number of staff members who attended to the clients, which was a threat to the clients' right to privacy and confidentiality. A client who came for VCT was attended by three people. The participants believed that this threatened trust and confidentiality. This was expressed as follows:

“With regard to what has been practice, with VCT, we realise that the health promoters are being used for counselling the clients and thereafter the registered nurse will come and prick”.

“After pricking, a different health promoter will divulge the results”.

“I feel that one person should be used for VCT ... and we will get a better response”.

Literature control: Involvement of health promoters

According to the Gauteng Department of Health Strategic Plan 2004-2006, the strengthening of community participation and the community health worker programme were implemented to create a unit of volunteers with standard skills for community based care (Gauteng Department of Health 2004-2006:66). The training of community health workers has been conducted in the province with the help of NGOs and a career path developed to further train them. The involvement of community members enables the community to make informed decisions and participate in the management of their health (Hattingh *et al.* 2006:51).

In a study conducted by Peltzer *et al.* (2005:37), HIV positive clients expressed appreciation for the involvement of health promoters. These clients explained that the health promoters provided education regarding HIV/AIDS, started vegetable gardens and encouraged them to come to the clinic. The clients were also taught about PMTCT and nutrition.

3.4.4.2 Subcategory 2: Competing of programmes

The following themes emerged in this subcategory: programmes, such as EPI and IMCI, not regarded as important and HIV/AIDS given first preference.

- **Programmes, such as EPI and IMCI, not regarded as important**

The participants felt that a lot of programmes, such as EPI and IMCI, had been introduced in the clinics and required a lot of training. The perception was that some programmes had been given more attention and that EPI and IMCI were not regarded as important. This was expressed as follows:

“I think it is still equally important because EPI prevents diseases and, if compared to HIV and AIDS, you get a lifelong immunity and it also saves lives”.

“Yes, I think another challenge will be competing of programmes, we have many programmes like the mother and child, with a manager for EPI and manager for IMCI”.

“You cannot compete with HIV and TB actually and sometimes such programmes as EPI suffer because they are just taken as a normal strategy”.

- **HIV/AIDS given first preference**

The participants perceived that HIV/AIDS as a challenge to health also contributed to the problems with service delivery, as more training and

updating were needed in order to deal with the HIV/AIDS pandemic. This led to some professionals involved in other programmes, such as EPI and IMCI, having feelings of inferiority. The participants claimed that HIV/AIDS was given first preference. This was expressed as follows:

“It is like if one does IMCI and then HIV and AIDS is really disadvantaging as everybody is concentrating on HIV and AIDS ... as it is the most important”.

Literature control: Competing of programmes

A survey report by the WHO and UNICEF (2003:103) indicated that IMCI, EPI and PMTCT, as components of mother and child health, need to be integrated with nutrition and other strategies in order to ensure the survival of children. The Gauteng Department of Health Strategic Plan 2004-2006 also identified the integration of these programmes with the PMTCT programme as a means of fighting the HIV/AIDS pandemic (Gauteng Department of Health 2004-2006: 90).

In a study conducted by Masilela, Molefakgotla and Visser (2001:242), district managers emphasised the importance of the integration of programmes at provincial level in order to avoid vertical programmes which cause problems with implementation. The managers felt that they were bombarded with a lot of vertical programmes in the healthcare services.

3.4.4.3 Subcategory 3: Lack of continuity of care

The following theme emerged from this subcategory: clients moving from one clinic to another.

- **Clients moving from one clinic to another**

The participants indicated that clients from neighbouring villages, as well as from outside the province, came to the hospital for consultation and ended up being referred to the clinic. Follow-up of such clients was difficult, as they

returned to their homes and subsequently attended the clinics nearby. Some clients also gave false addresses, making it difficult to follow them up. This was expressed as follows:

“The other issue is foreigners who attend our clinic and the partner is in Johannesburg or the partner has gone back to their country and he has another partner here while the wife is at home”.

“Some clients move from one clinic to the other around our villages, especially those with STIs, and VCT and follow-up is difficult”.

“The neighbouring villages have clinics the same as us and clients open a file with us and also go to the next clinic for the same problem”.

“Patients give wrong addresses and it is difficult to follow them up ... the reason is that they sell the medicine”.

Literature control: Lack of continuity of care

The management of clients in the clinics is guided by certain protocols and guidelines as prescribed in the essential drug list (EDL) book. The guidelines on the management of STIs prescribe that clients must be followed up and also advocate treatment of the partner. The continuity of treatment is affected by the difficulty in following up on clients.

The movement of clients between clinics was confirmed as resulting in a lack of continuity of care. Client-held records are a way of ensuring continuity of care when users find themselves in a clinic in another area than they normally use (Heunis *et al.* 2006:44).

3.4.4.4 Subcategory 4: Lack of security in clinics

The following theme was formulated in this subcategory: security breaches by clients.

- **Security breaches by clients**

The participants expressed fear of lack of security and protection from clients. The participants explained that some clients passed through the security gates and came into the consulting room with guns. The nurses only discovered this when they asked these clients to undress for examination and this made them feel very uneasy. The participants felt that security was being breached by clients. This was expressed as follows:

“The security at our clinic is very poor ... clients come with guns and they pass through security offices freely”.

“I once became very scared when I discovered a gun on a patient during examination”.

Literature control: Lack of security in clinics

Security in health facilities remains a concern. It has to cover both the clients and the health providers. Hattingh *et al.* (2006:66) state that only safety for the client has been ensured through the utilisation of properly qualified and trained professional nurses. However, safe care cannot be rendered in overcrowded healthcare facilities. Overcrowding may result in threats to staff and stolen babies. Facility managers' concerns about lack of security and crime have been documented by Leon *et al.* (2002:218), who highlight concerns about hijacking, stolen cars, stolen babies and the threatening of staff in facilities. The participants felt that they were not safe and needed extra security, especially in the clinics.

Ijumba (2002:193) confirmed that nurses are three times more likely to experience crime and violence in the workplace than other occupational groups. It is important that health workers feel secure, especially at night.

3.4.5 Category 5: Solutions to problems

The fifth category that emerged was solutions to problems. The following subcategories were identified: need to integrate services, need for electronic recordkeeping, strengthening support groups, health care worker training and community education. These are indicated in Table 3.7.

TABLE 3.7: SOLUTIONS TO PROBLEMS

SUBCATEGORIES	THEMES
Need to integrate services (3.4.5.1)	<ul style="list-style-type: none"> • Integration of HIV/AIDS and mother and child services
Need for electronic recordkeeping (3.4.5.2)	<ul style="list-style-type: none"> • Use of technology to manage XDRTB • The use of technology in MOUs for foetal monitoring and graphs • The use of technology to prevent patients from having more than one file in one clinic • The use of ID numbers in clinics with the clinics linked to the system and database • The use of technology to control drugs issued to clients to avoid double collection in one month in different clinics • The use of technology to fast-track the management of clients in different expansion programmes • The use of technology to curb health facility shopping by clients
Strengthening the support groups (3.4.5.3)	<ul style="list-style-type: none"> • Strengthening the available support groups to include nutrition and expansion programmes
Healthcare worker training (3.4.5.4)	<ul style="list-style-type: none"> • Upgrading the training of older nurses on expansion programmes on a continual basis • More nurses to be trained in expansion programmes to allow for continuity of care and rotation of staff • More nurses to be trained in primary mental health
Community education (3.4.5.5)	<ul style="list-style-type: none"> • The use of clinic committee members to educate the community on health service operational issues and create awareness of available services

3.4.5.1 Subcategory 1: Need to integrate services

The following theme emerged from this subcategory: the integration of HIV/AIDS services with mother and child services.

- **Integration of HIV/AIDS and mother and child services**

Most participants felt that the programmes being expanded could be integrated, with one person coordinating all of them. This would be beneficial, especially in the case of the integration of HIV/AIDS, and mother and child health services. Survival strategies, such as EPI and IMCI, could also be integrated and could even include PMTCT, to the benefit of the children. This was expressed as follows:

“Isolation of certain services poses a problem”.

“Integration of IMCI would enable the nurse to identify immunisation problems or needs and also the EPI would refer to IMCI”.

“Integration of PMTCT to all mother and child health services, even IMCI, could make the services be more comprehensive”.

Literature control: Integration of services

The integration of the IMCI strategy into primary healthcare services has been planned from the introductory phase because it was regarded as a survival strategy for children and had to be integrated with other survival strategies. The WHO and UNICEF (2003:21) reported that IMCI advocates the coverage of all missed opportunities in immunisation, which points toward the integration of IMCI and EPI. The survey identified a shortage of vaccines, power cuts and a lack of segregated refrigerators as constraints to service delivery, which impacted negatively on the effectiveness of immunisation services (WHO & UNICEF 2003:22). The survey further recommended integration with other services, starting with coordination at national and

provincial level to ensure that all programmes and training courses are linked during training, including HIV/AIDS programmes (WHO & UNICEF 2003:26).

3.4.5.2 Subcategory 2: Need for electronic recordkeeping

The following themes were formulated in this subcategory: the use of technology to manage XDRTB, the use of technology in MOUs for foetal monitoring graphs, the use of technology to prevent clients from having more than one file in one clinic, the use of ID numbers in the clinics, with the clinics linked to the system and database, the use of technology to control drugs issued to clients to avoid double collection in one month from different clinics, the use of technology to fast-track the management of clients in different programmes being expanded and the use of technology to curb health facility shopping by clients.

- **The use of technology to manage XTB**

All the participants felt that the introduction of electronic recordkeeping in clinics would help with the management and control of clients on treatment for XDRTB as they would be easily traced. This was expressed as follows:

“There is an urgent need to initiate technology in our services ... managing XDRTB”.

“I think they can use computers and it can help”.

- **The use of technology in MOUs for foetal monitoring and graphs**

The participants felt that the use of electronic monitors in the labour wards could help with the prevention and management of complications during labour.

This was expressed as follows:

“Usually if you have electronic monitors that can help monitor the foetus during labour and the nurse will be able to identify any problems”.

“Foetal monitoring could also improve quality of care”.

“The nurses need to improve electronic records and use and interpretation of graphs”.

- **The use of technology to prevent clients from having more than one file in one clinic**

The participants perceived that the problem of clients moving between different clinics could be solved by having computers in all the clinics linked to one database. This could also solve the cross-border issue. This was expressed as follows:

“Technology can help that if a patient gets to one clinic he is captured in the system that will reveal him when he gets to the other clinic that he has been given treatment at such a clinic”.

- **The use of ID numbers in clinics with the clinics linked to the system and database**

The participants believed that the clients' ID numbers could be used for identification in the clinics. This was expressed as follows:

“The ID can also help if all the clinics are linked to one system, most of the duplication of service by clients cannot be there anymore because the client will be seen immediately”.

- **The use of technology to control drugs issued to clients to avoid double collection in one month from different clinics**

The participants also felt that technology could solve the problem of clients' collecting treatment from several clinics in one month. This was expressed as follows:

"The information on drugs can also be captured in the computer".

"Information about drugs can be captured electronically and save time".

- **The use of technology to fast-track management of clients in different expansion programmes**

The participants perceived that the use of technology could improve the management of the programmes being expanded in all the services. This was expressed as follows:

"The use of computers in our facilities will also improve the expansion programmes".

"Using computers to keep patient data would help fast-tracking the management of clients".

- **The use of technology to curb health facility shopping by clients**

The participants perceived that computers could curb clients' shopping around in different clinics. This was expressed as follows:

"The use of computers will help us to capture information regarding the patient's problems that were reported in other clinics ... this will curb health facility shopping around by clients".

Literature control: Need for electronic recordkeeping

The need for technology in these times of increasing demands on the health sector is of great importance. In all planning, the emphasis should be on equipment and materials, including the availability of skilled nurses (Hattingh *et al.* 2006:123). It is also important to consider the acceptability of technology to both clients and health care providers – including the cost of computerising records to health care providers (Hattingh *et al.* 2006:123).

Hattingh *et al.* (2006:90) state that change is the order of the day and new technology, electronic workstations and internal communication networks will change the health care environment and subsequently the training of staff.

3.4.5.3 Subcategory 3: Strengthening the support groups

The following theme was formulated in this subcategory: strengthening of the available support groups to include other essential services, such as nutrition and programmes being expanded.

- **Strengthening the available support groups to include nutrition and expansion programmes**

The participants acknowledged the presence of support groups in the community and other services, and felt strongly that these groups should be strengthened. Support programmes should be more integrative and include other essential services, such as nutrition and programmes being expanded. This was expressed as follows:

“We need to strengthen the support groups to meet the needs of various groups of patients ... nutrition groups, breastfeeding groups and mental health groups”.

“We should create more awareness about the usability and user-friendliness of our programmes”.

Literature control: Strengthening the support groups

Botma *et al.* (2007:48) state that the greatest barrier to VCT is the fear of a positive diagnosis, but also report that people would go for VCT if they could count on support from the community. This supports the strengthening of community based support groups for people living with HIV.

The *South African Health Review* documents a study by Modiba *et al.* (2001:192) in which service users were interviewed. The affected clients revealed that they belonged to a support group as a way of preventing boredom. They also stated that, in the support groups, they were seen as important and were provided with material support, such as clothes and food, as well as emotional support, which assisted them to cope.

3.4.5.4 Subcategory 4: Healthcare worker training

The following themes were formulated under this subcategory: upgrading of the training of older nurses on a continual basis, training of more nurses in programmes being expanded to allow continuity of care and rotation of staff, and training of more nurses in primary mental health.

- **Upgrading the training of older nurses in expansion programmes on a continual basis**

The participants felt that, with the introduction of these programmes, it was important to continually update and train all nurses who were in the service. This was expressed as follows:

“Nurses need to be upgraded in their skills by means of in-service training”.

- **More nurses to be trained in expansion programmes to allow continuity of care and rotation of staff**

The participants believed that nurses needed to be more skilled in newly introduced programmes being expanded, such as IMCI and PMTCT. The participants felt that it was important to upgrade the skills of nurses in order to improve the quality of care. This was expressed as follows:

“Courses in the primary health care services need to be updated ... PMTCT, IMCI and others”.

“We need to upgrade our professional nurses to be user-friendly and face the problems of upgrading and reach out to the nearly qualified nurses”.

“We need to skill all the nurses so that they could rotate in all the services because this is comprehensive health care ... we continue skilling them everyday”.

- **More nurses to be trained in primary mental health**

The participants also felt it was important to have more mental health nurses to care for the clients in the clinics. This was expressed as follows:

“We should also look into mental health and train more nurses to give specialised care to mental health clients”.

“Mental health patients prefer continuity ... they find it difficult to be helped by different nurses each time they come to the clinic”.

“Mental health clients want to get used to one person”.

Literature control: Healthcare worker training

Heunis *et al.* (2006:44) state that nurses should be trained in numerous key programmes in order to be able to implement the primary health care package effectively. This will deal with gaps and discontinuity in the implementation of specific programmes.

Nursing service managers experienced a lack of training for health workers because bursaries and study leave were difficult to obtain. The lack of own professional development hindered the managers in managing the service effectively as they needed to acquire the necessary competencies for effective change management (Buys & Muller 2000:53). Professional development remains an important issue in healthcare delivery and should be continuous.

The challenges in the health care system require that the training of healthcare professionals be multidisciplinary in order to prepare them for comprehensive health care delivery. They need to be continuously developed with appropriate training in all categories of health care in order to make a useful contribution to the promotion of health and prevention of illness (Hatting *et al.* 2006:93).

3.4.5.5 Subcategory 5: Community education

The following theme was identified in this subcategory: the use of clinic committee members to educate the community on health service operational issues and create awareness of available services.

- **The use of clinic committee members to educate the community on health service operational issues and create awareness of available services**

The participants felt that it was important to use clinic committee members from the community to communicate with the community about the clinics' services, to create awareness of the available services, to motivate and to

inform the community about the operational hours of the clinics. This was expressed as follows:

“Clinics committees must be reintroduced for better participation”.

“People undermine primary healthcare clinics and think the hospital gives them better or different services”.

“It is important to educate the community about the operational hours of various services”.

Literature control: Community education

In a study conducted by Heunis *et al.* (2006:39), the use of clinic committees was motivated as a good strategy to invite community participation. Heunis *et al.* (2006:44) state that community participation is an essential pillar of primary health care and can be effected through clinic committees. Informing the community about the operational hours of clinics is one of the aspects of the ‘Batho Pele’ principles, which was introduced by the Department of Public Service and Administration (DPSA) in 1997 to guide the health services of South Africa. These principles entail putting people first in the delivery of health care, no matter what their characteristics (Hattingh *et al.* 2006:65). Involving community members in participating in the issues related to their health was also identified as an important aspect of health promotion, which helps to empower community members (Hattingh *et al.* 2006:43).

Peltzer *et al.* (2005:39), in their study of the factors that influence PMTCT, concluded that family and community support should be improved through peer support groups and the training of community counsellors. This could also be done by fostering couple and community discussions.

Botma *et al.* (2007:53) suggest that, in order to integrate topics on HIV/AIDS into the education of the community, the community be educated on parental and school guidance.

3.5 FIELD NOTES

Field notes are defined as a written account of what the researcher sees, experiences and thinks during the course of the interviews. Through field notes, the researcher can obtain clues and information, such as the values, preferences, interests, attitudes and experiences of the participants, which can be valuable to the study. In this study, field notes included the empirical, observational and interpersonal in both sessions (De Vos *et al.* 2005:298). The researcher facilitated and made observations during the sessions. The researcher made field notes after each direct encounter with the participants. The researcher also used a tape recorder to capture the communication, which helped with the compilation of field notes.

The second facilitator also made notes on her personal experiences and observations, including the participants' comments and responses. The following field notes were made during and immediately after the two focus interview sessions.

3.5.1 Observational notes

Observational notes are the description of events and personal experiences by the facilitator of the sessions. The notes include any non-verbal clues that were observed during the sessions (Neuman 1997:361). The facilitator made notes of the events and experiences that were obtained through watching and listening. A warm atmosphere was observed and participants showed an interest and willingness to participate. The warm welcome and relaxed environment allowed participants to release their tension and stress.

The participants spontaneously responded to the question, indicating their interest. The participants felt honoured to be selected to participate in the research study and indicated that they would like to be involved again in such studies. The participants did not feel threatened at all, but were very relaxed and showed excitement. The expressions of the participants showed a real understanding of the factors and gave a true reflection of the factors.

3.5.2 Theoretical notes

Theoretical notes include both the observational notes and their interpretation. The theoretical notes were derived from the meaning that was attached to the observational notes and formed part of the data analysis as part of the steps defined by Tesch (1990:90). The researcher took observational notes and then interpreted them. The non-verbal clues and responses of the participants helped the researcher to attach meaning to what was said while transcribing and analysing the focus group interviews (Neuman 1997:365). The observational and theoretical notes are given in Table 3.8.

TABLE 3.8: FIELD NOTES

OBSERVATIONAL NOTES	THEORETICAL NOTES
The participants were all on time and happy to be there. They admired the room where the focus group interviews were to be held.	The clinics where the focus group interviews were conducted were familiar to all the participants. The venue for the interviews was convenient for all of them and within their reach.
The participants appreciated the warm welcome, as well as the setting, which included comfortable chairs.	This facilitated the participants' attention and spontaneous, continuous communication.
Participants sat around the table and made eye contact with one another.	This showed a willingness to participate. The participants were well informed regarding the study and understood the phenomena.
The participants were relaxed and did not find the environment threatening.	The participants related their experiences, felt motivated and expressed that they were honoured to be included in the study.
The participants showed excitement on arrival and were willing to express their perception with full understanding.	The facilitators were known to the participants, motivating them and making them willing to participate.
The responses of the participants during the discussion were spontaneous and perceptions were expressed clearly and fully with examples. The participants spoke continuously.	This showed that language was not a problem. Communication flowed freely and the participants had a lot of perceptions to express.

<p>The use of the tape recorder was very effective and the participants' information was captured.</p>	<p>The participants accepted the use of the tape recorder and were not intimidated by it.</p>
<p>The participants were all attentive during the discussion and kept on nodding as they listened to the others. They used expressions as "yaaah" and "mmm" to indicate that they were listening.</p>	<p>This was an indication that the participants were interested and willing to participate.</p>
<p>The participants gave each other a chance to talk and each one cited a new item for discussion.</p>	<p>This indicated that there was mutual agreement on the perceptions that were expressed and that there were no contradictions or arguments.</p>
<p>The participants knew each other and related to one another as they expressed their perceptions.</p>	<p>This showed mutual respect, the participants were well informed regarding the factors that influence service delivery in a primary healthcare setting.</p>
<p>The facilitator was in full uniform during the sessions in order to be more familiar to the participants and create a feeling of inclusiveness.</p>	<p>This motivated the participants and made them feel as if they were included in the study.</p> <p>The facilitator asked all the participants to introduce themselves. The facilitator also introduced herself and the second facilitator to the participants, which alleviated their fears and facilitated free flowing communication.</p>
<p>Participants expressed perceptions in broader senses, as they were involved in the programmes being expanded. The facilitator had to practise bracketing and listen very well.</p>	<p>This showed that the participants were well informed by listening, talking and leaning forward in order to be ready to say something.</p>
<p>The participants remained active throughout the session and even helped clean the room after the session.</p>	<p>The session did not exceed the agreed time of one hour and the registered nurses were very eager to continue.</p>

3.5.3 Personal notes

Personal notes are notes regarding the researcher's own reactions, reflections and experiences during the interview sessions. Personal notes help the researcher to instruct and critique him/herself and his/her tactics and deal with approaches taken to the interview. The researcher is then able to deal with the process more effectively by improving some steps (Neuman 1997:366). In this study, the personal notes were more analytical and were written immediately after each session. They provided a way of coping with the stress of the interview process. The notes also helped with the interpretation of the observational notes (Neuman 1997:366). The researcher experienced problems during the planning process when communicating telephonically. Delays were experienced as a result of voicemail messages that were not returned. The researcher then made personal contact with the potential participants. The researcher's communication skills improved with each new contact.

The researcher also made notes of the facilitation skills and the experience gained in the use of these skills during the interviews. At the beginning of the first session, the researcher experienced feelings of anxiety and nervousness, but this improved during that session and the next session. The researcher made notes on listening skills, which helped make the group more manageable. The researcher's reactions of "okay" and "yaah" indicated that she was listening and motivated the participants to talk. Probing questions were asked to gain clarity on some points. The sessions sometimes became very exciting and the researcher made remarks, such as "aahhh..." and this motivated the participants to engage more in discussing the factors.

The researcher was very strained, both mentally and physically, after the sessions, as listening skills had to be exercised and probing questions carefully asked. The researcher had to listen carefully to prevent having to organise another session, because it was difficult to choose a convenient time as the participants were all working.

After each session, the researcher had to pack up and clean the room, as well as take field notes before leaving. The participants helped to clear the room, which showed that they had a good rapport with the researcher.

3.6 CONCLUSION

This chapter outlines the main findings that arose from the focus group interviews that were conducted in order to answer the research question *“What are the factors that influence service delivery in programmes being expanded in a primary health care setting?”*

The chapter contains data from the two focus group interviews presented in the following five main categories: disabling factors, enabling factors, client related factors, service related factors and solutions. The literature control for the subcategories and themes that were identified is also presented.

The next chapter concludes the study by discussing the findings, limitations, implications and recommendations of the study in order to address some of the key factors identified.

CHAPTER 4

CONCLUSIONS, IMPLICATIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

4.1 INTRODUCTION

In the previous chapter, the results of the study and the literature control are presented. The categories and subcategories of the perceptions discussed during the two focus group interviews are identified. The themes related to each subcategory are also discussed and accompanied by a literature control. In this chapter, the discussion is based on the conclusions, implications, recommendations and limitations of the study. The discussion is guided by the categories identified in Chapter 3.

4.2 CONCLUSIONS OF THE STUDY

The discussion of the research process was guided by the purpose of the study.

4.2.1 Purpose of the study

The purpose of this study was to explore and describe the perceptions of registered nurses regarding the factors influencing service delivery in programmes being expanded in a primary health care setting in order to monitor and control these factors. The identification of the factors means they can be addressed in order to improve the quality of service delivery in the primary healthcare setting.

4.2.2 Summary of the categories

Based on the results of the study, the following five categories were identified: disabling factors, enabling factors, client related factors, service related factors and solutions to the problems. Discussion of the conclusions of the study is directed by these categories.

4.2.2.1 Category 1: Disabling factors

The findings of the study revealed the following disabling factors: time limitations, budgetary constraints, infrastructural problems and inadequate skills. The following conclusions were made:

(i) Time limitations

It is evident from the perceptions of the participants that the availability of certain services, such as family planning and TB services, was still a concern, especially to clients who worked or attended school. These clients could not access the services, despite the fact that clinic hours had been extended to twenty-four hours a day in community health centres. The services were also not accessible on weekends, even if, geographically, the clinic complied with the requirement of being within a five-kilometre radius. Availability entails that the clinic services should not only be comprehensive but should also be offered when there is a need for them (Hattingh *et al.* 2006:64). Functional accessibility also means that the appropriate type of care should be available to individuals when they are in need of care (Hattingh *et al.* 2006:121). The expansion of services included making these services, as well as maternity services, available twenty-four hours a day.

The antiretroviral treatment services were also identified as not being accessible or available after-hours. The participants perceived this as affecting the daily statistics of clinics, as clients who reported after-hours were not likely to be counted for statistical purposes.

The South African Department of Health resolved to strengthen the district health system and improve accessibility by planning to have at least one facility in each subdistrict offer a 24-hour service at community health centres (Gauteng Department of Health 2004-2006:66). This has been achieved in some subdistricts with the introduction of MOUs. The hours of certain services were extended but not to weekends. The availability of family planning, TB and antiretroviral treatment services was identified as a gap that existed and was a concern to the participants.

(ii) Budgetary constraints

It was evident from the findings that a limited budget, affected by the escalating number of clients, was having a negative impact on the rendering of services. The expansion of programmes had to be achieved within the existing resources, both in terms of material and human resources. This affected the ratio of nurses to clients in the clinic. The shortage of human resources included other health professionals, such as doctors and physiotherapists.

The limited budget also affected the availability of buildings in the clinics. Some clinics occupied old buildings which were not erected for that purpose. The MOUs that were introduced in some clinics utilised old buildings, also not built for that purpose, which was perceived as affecting the delivery of service. This is an indication that new buildings could not be built for the expansion of the programmes. According to Buys and Muller (2000:53), limited resources and inadequate infrastructure are linked to the budget in most health systems. They also noted from their findings that, due to a limited budget, some clinics could not introduce some of the programmes being expanded. The participants felt that the expansion of these programmes required enough space to be able to render quality care. Clients needed privacy, counselling and room for procedures, such as pricking, waiting areas, toilets, and the storing of drugs and equipment. Doctors also needed space for consulting clients. All these factors are linked to the budget and infrastructure.

(iii) Infrastructural problems

The participants expressed a concern regarding the close proximity of some clinics and the hospital, as this contributed to clients moving around between clinics and not adhering to the boundaries of the villages. The availability of transport in the villages also contributed to this, as clients could access any clinic they preferred, not realising that this could overburden the clinic. The overpopulation of townships around the villages also contributed as clients who could afford transport avoided long queues at their clinic and overcrowded clinics in other villages.

A lack of equipment was discovered in some clinics that offer programmes being expanded. Clinics that introduced MOUs did not have essential equipment, such as electronic dopplers to monitor foetal heart rates. Another concern was the lack of enough refrigerators to store vaccines, which are necessary to reach the goals of the EPI. It was evident that the government's SIP was in place to ensure the construction and upgrading of infrastructure and that this was linked to the budget constraints (Gauteng Department of Health 2004-2006:215).

The shortage of resources was also linked to the increased workload and escalating number of clients, affecting the already scarce resources, which either needed to be upgraded or replaced. Nursing service managers attributed the ineffectual management of facilities to inadequate resources, as there was no time and money for professional development (Buys & Muller 2000:54).

(iv) Inadequate skills

Based on the results of the study, it was revealed that a shortage of skills was being experienced with regard to the programmes and their implementation. The participants felt that some courses, such as IMCI, needed doctors in order to follow up on the students, as part of clinical instruction for the course. Some training courses had to be cancelled because of lack of doctors. It was

also evident that the 'brain drain' on nurses was affecting the programmes as nurses were trained in the programmes but then left the country. A shortage of skills was also related to the rotation of the nurses in different programmes in the clinics. This was due to the fact that there was a need to orientate the nurses in order to meet the daily allocations of the clinics, which had a negative impact on service delivery.

It is also clear from the study that there was a relationship between inadequate skills and a shortage of staff, increasing workloads. The participants also expressed that the short courses were expensive, as they had to pay for the training themselves. A study on managers' perception of the programmes being expanded revealed that the need for in-service training created a burden on service delivery as a result of the multiple and conflicting demands of training for programmes, such as TB DOTS, HIV/AIDS, PMTCT and antiretroviral treatment roll-out (Leon *et al.* 2002:217).

In this study, the participants voiced the need for updating of skills, in order for the programmes to be able to function effectively. The updating courses should be conducted continuously so as to equip more nurses with the skills to allow for the rotation of staff.

Another challenge that was documented was the retention of highly skilled and scarce skilled professionals. This was also discussed in this study as, after receiving training, nurses left the public service.

The conclusion of the study is that continuous training and updating is of great importance, as it is necessary for adequately skilled professionals to deliver health services in the programmes being expanded. It is evident that inadequate skills affect the delivery of service and the quality of care rendered. The relation of other factors, such as a shortage of staff, a lack of equipment, a lack of space and increased workloads, needs to be addressed as they have a negative impact on the ability of nurses to practise their skills.

4.2.2.2 Category 2: Enabling factors

Based on the findings of the study, the integration of the IMCI strategy into primary health care was viewed as a positive factor. The utilisation of trained nurses in the integration of this strategy with other programmes, such as ANC and PNC, was also viewed positively. The integration of this strategy with PMTCT was also lauded, and the need for this integration to be extended to HIV/AIDS comprehensive management and care identified. It was evident that the EPI was already being integrated as a child survival strategy for children.

The utilisation of nurses trained in IMCI for other programmes was an indication of the comprehensiveness of this strategy, as well as a positive integration of knowledge and skills. Integrated training strategies are needed for programmes being expanded, such as IMCI, in order to improve service delivery. The integrated training of nurses has been implemented and has been introduced into the pre-service training of doctors and nurses in training institutions. The IMCI strategy is a national programme and other provincial programmes, such as EPI, and nutrition and health promotion, are coordinated from within the province.

4.2.2.3 Category 3: Client related factors

(i) Abuse of services

The findings of this study revealed that client preferences and stereotypes regarding certain clinics created a 'cross-border' issue. The issue was that clients chose to go to specific clinics because of time factors and the attitudes of the nurses, resulting in some clients duplicating and abusing services. The results of the study also revealed that clients who were HIV positive went to several different clinics, hoping for a different diagnosis in another clinic. This indicates that denial is a problem for clients who have been diagnosed as HIV positive.

It was also clear from the discussions that the issue of clients revealing their status was still a problem. In order to keep their status secret, clients opened two files in the same clinic and would give incorrect addresses so that they could not be followed up.

Furthermore, the results of the study proved that clients from outside the country abused the services by collecting the same treatment from several clinics to supply themselves for six months. Other clients collected treatments from different clinics and sold these to other clients who could not manage to pay for transport to go to the clinics. This behaviour was also noted by Schneider and Gilson (2000:89) during a survey conducted on the impact of free health care on service delivery.

The study further revealed the abuse of services by foreigners made the follow-up of clients very difficult, especially with regard to the management of STIs. In the management of STIs, it is protocol that the client's partner must also be treated. However, partners could not be traced as clients gave incorrect addresses and utilised different clinics, or that the partners either stayed far apart from the client.

The issue of 'shopping around' for diagnosis has been documented by Modiba *et al.* (2001:91). This study suggests that this behaviour continues and has contributed to the increase in workload of healthcare professionals involved in delivering community services. The programmes most affected by this are those related to HIV/AIDS.

The participants in the study also indicated that healthcare professionals' compliance with the patient's rights, as stated in the 'Batho Pele' principles, resulted in unreasonable demands from the clients. The nurses could not send clients away, but had to attend to them and give them medicines, which impacted on the health budget and the availability of medicines.

(ii) Client enterpreneurering

The findings of the study further indicated that clients who were infected with TB made use of the opportunity to sell the positive TB sputum to other clients who were HIV positive but not infected with TB so that these clients could receive a social grant. The participants were concerned about the control of TB infections, as TB is an air-borne disease and the exchange of TB positive sputum creates a risk. This also affected the TB control programmes in the clinics.

(iii) Poor adherence to PMTCT

It has been documented that the stigma surrounding HIV/AIDS is a limiting factor to the primary and secondary prevention and care of HIV/AIDS. It is the biggest challenge in service delivery today (Botma *et al.* 2007:48; Greeff & Phetlhu 2007:12-23). This is a result of the community's stigmatisation of individuals who are HIV positive.

The findings of this study show that stigma is a barrier to the management of HIV positive mothers in the PMTCT programme. These HIV positive mothers were not ready to disclose their HIV status to the family because of the fear of stigmatisation, which resulted in poor adherence with the programme. Despite the provision of counselling, these two factors, the fear of stigmatisation and not being ready to disclose status, affected service delivery (Kenyon *et al.* 2001:180).

The findings of a study conducted in Botswana on HIV positive mothers revealed that they preferred to breastfeed babies for fear of being stigmatised by their family (Shapiro *et al.* 2003:201). The mothers therefore did not comply with the PMTCT programme as a result of pressure from their families. Breastfeeding was expected of them in their culture and they did not disclose their status. The fear of positive diagnosis and disclosure was also revealed in this study to be a barrier to VCT and affected the continuity of care. Clients ended up moving between clinics, thus affecting service delivery by

overloading the service, as a result of denial, disbelief, despair, guilt and anxiety (Evian 2000:42).

The prevention and care of HIV/AIDS are real threats to service delivery as indicated in the study by Peltzer *et al.* (2006:59). Annual ANC surveillance in 2001 revealed that 34,5 per cent of pregnant women between the age of 25 and 29 years were HIV positive, and 29 per cent of pregnant women aged between 30 and 34 years were living with the virus in South Africa.

The issue of the confidentiality of the results was also identified as a barrier to the prevention and management of HIV/AIDS. The participants felt that it was worsening the situation and needed to be reviewed with a critical eye, especially in relation to human rights and the disclosing of clients' HIV status to partners.

4.2.2.4 Category 4: Service related factors

The service related factors that emerged from the findings of this study were related to the involvement of health promoters in the VCT programmes. The participants were concerned that the involvement of health promoters was a threat to confidentiality and clients' right to privacy. Available literature indicated that the involvement of the health promoters was appreciated in the community (Peltzer *et al.* 2005:37).

Another factor related to services was that some professionals working in specific programmes, such as IMCI and EPI, felt inferior to those working in other programmes. Participants felt that first preference was given to HIV/AIDS programmes.

A lack of security, especially in the clinics, was evident. Participants were concerned that clients could pass through the security gates and come into the consulting rooms with guns, which were only discovered during the physical examination. The fact that the nurses felt insecure and unsafe had a

negative impact on the implementation of examination skills and service delivery was hampered.

4.2.2.5 Category 5: Solutions to problems

Participants suggested the following solutions to the factors affecting service delivery that they had identified.

(i) Need to integrate services

The participants felt that the integration of HIV/AIDS programmes into mother and child health services could help to minimise the existence of vertical programmes, solving the training problems and utilising the skilled nurses for many programmes. The researcher as a primary healthcare nurse has observed that nurses who were trained on the IMCI strategy were able to integrate HIV/AIDS and nutrition with other programmes when rendering service. The PMTCT programme also integrated HIV/AIDS into midwifery and child survival strategies. The researcher has been involved with the training of some of these programmes and integration could be of help.

(ii) Need for electronic recordkeeping

The participants indicated the need for an electronic, computerised database for clients in all clinics, with the ID number of the clients used to number their file. Participants believed that this could solve some of problems, such as the misuse of services, experienced by clinics. Once a client's information was captured in the database, he/she would not be able to move between clinics. The issue of overcrowding could be controlled, together with the escalating number of clients. The participants believed that technology could also help with the control and management of TB programmes, which would improve the cure rate. The participants also believed that the care of clients in labour could be better monitored electronically, thereby improving service delivery.

(iii) Community education

Community education was another means suggested by participants to improve service delivery. The use of clinic committees was perceived as a way of informing the community on matters related to the problems experienced in the clinics, as well as health service operational issues.

The use of the support groups was also identified as a possible solution and is in line with the principles of primary health care identified by the WHO (Hattingh *et al.* 2006). Community participation and involvement were perceived as important to improving service delivery, and clinic committees and support groups in the community could be of help in this regard.

4.3 RECOMMENDATIONS

It is clear from the findings of this study that the factors that affect service delivery in a primary health care setting are interrelated and for the most part have a negative impact on the quality of care. The following recommendations are based on the findings of this study:

- **Integration of services regarding expansion programmes**

According to the results of the study, the integration of services should include training in these programmes. The child survival strategies, the IMCI strategy and EPI, together with the PMTCT programme, form part of mother and child health services. Integration of these services would improve service delivery, as the nurse would be able to manage the client's health comprehensively. The inclusion of nutrition and growth monitoring would complete this package and be in line with the requirements of the principles of growth, oral rehydration, breastfeeding, immunisation, feeding, family planning and food supplements (GOBI-FFF) (Hattingh *et al.* 2006:168).

Integrating these services into one programme would allow for the records of the child to be combined with the mother's records. The PMTCT programme,

as part of HIV/AIDS management and care, would apply IMCI and the immunisation principle, forming a comprehensive approach to managing the health of the child. The PMTCT programme also forms part of the neonatal care of the child. The implication is that the midwife attending to the child's needs during this period must have the knowledge and skills to attend comprehensively to the child.

PMTCT management and care could also involve dealing with antiretroviral treatment, implying that a professional nurse attending to an HIV positive child under five years of age should have the skills and knowledge regarding all programmes related to mother and child health care.

- **Training on the expansion programme**

It is clear from the study that information regarding the programmes being expanded is regularly updated. New research is constantly being conducted and treatment protocols change regularly. This creates the need for all nurses to be continuously updated and upgraded on these programmes. In order to do this, nurses need to have leave and go for in-service training regularly. The release of nurses for training adds to the shortage of staff. It is important that the training for these expansion programmes be integrated so as to release one nurse at a time. Integrated training will produce a nurse who is comprehensively updated on all the programmes and would minimise the problem of releasing staff. The researcher also believes that the problem of inadequate skills and the shortage of staff would be minimised.

- **Electronic recordkeeping**

Based on the solutions identified by the participants, the use of computers to keep records could help with the control of clients who move between different clinics. The clients' ID numbers could be used to number their files at the clinic. The participants felt that this system would alleviate the problems of clients having more than one file at the same clinic, as well as clients who

collect drugs from different clinics to last them six months. The issue of clients' entrepreneuring with the services could also be controlled.

- **Infrastructural problems**

The results of the study revealed that some of the clinics were small and had no space for the expansion of programmes. The integration of these programmes could minimise the problem of space as they would be sharing space. This would also make planning easier and the allocation of staff more effective. It is clear from the study that space affects service delivery and can lead to inadequate skills, as participants felt they could not practise their skills correctly in such limited spaces.

- **Availability and accessibility of services after-hours**

Based on the reports from the Gauteng Department of Health Strategic Plan 2004-2006, it was evident that hours had been extended and 24-hour services introduced in clinics in the subdistrict. However, participants still felt that services, such as family planning, should be extended to weekends and after-hours for clients who work or attend school during the day. It is recommended that youth services, such as the LoveLife campaign are used to incorporate family planning services for learners. The integration of mother and child services would allow for family planning services to be integrated into the MOU, which is open twenty-four hours a day. Family planning services should be available during weekends and after-hours.

4.4 RECOMMENDATIONS FOR FURTHER RESEARCH

The findings of this study indicated that there was a relationship between inadequate skills and a shortage of staff, lack of equipment and increased workloads, which all led to a compromised quality of care. It is recommended that further research be conducted on the actual effects of these factors on the quality of service delivered. The researcher further recommends that the

issue of the availability of space for the programmes being expanded be investigated. This would have an impact on the integration of services in a primary healthcare setting.

4.5 IMPLICATIONS

The factors identified in this study are interrelated. Most of them have been linked to their impact on quality of care and service delivery. Based on its findings, the following implications of the study have been identified:

4.5.1 Nursing practice

Nursing care and improvements in the quality of service delivery depend on the new information being supplied through statistics in the clinics. This information is important for future research and evidence based practice in the field of nursing. It is expected that nursing practice always be provided by nurses that maintain excellence, credibility and competence through continuing education. This is outlined in the Charter of Nursing Practice (SANC 2004:29). Nursing practice and health should also improve continuously through research and the utilisation of research findings (SANC 2004:29). Statistical errors have a major impact on the supply of information and should be attended to.

It is evident from the results of this study that one factor in the service delivery may be linked to another. A series of factors may interact, impacting on the availability of human resources and equipment, and ultimately compromising the quality of care. When service delivery is delayed, it implies that the implementation of the primary healthcare package is hampered.

4.5.2 Community nursing practice

The results of the study indicated that clients travel to other villages for health care, showing that transport has improved. The infrastructure of health care delivery should also accommodate the fact that clients are able to move

between clinics. This matter will create problems in service delivery if the development of the health sector is not parallel to the development of other infrastructure.

4.5.3 Provincial government

The stigmatisation and denial of HIV/AIDS affect the prevention of the disease and care of the infected clients. This, as well as the management of STIs in the health sector, impacts on the delivery of health care for these conditions. Provincial control programmes have been introduced. What is now called for is the monitoring and evaluation of these programmes at provincial level, in order to improve service delivery.

The participants in this study voiced concern about confidentiality, as they felt that it impacted on the improvement of service delivery. Policies are being developed for the implementation of the programmes being expanded. There is a need to educate the community about issues of confidentiality and respect for human beings. It is also important to inform the community about the importance and the benefits of disclosing one's HIV status.

4.5.4 Nursing education

According to the results of the study, the success of the expansion programmes lies in the training of the personnel in the different programmes. The training of nurses should be integrated to allow those in the primary health care service to perform effectively. The provision of health care should be comprehensive and, consequently, nurses also need to be comprehensively trained in these programmes.

4.6 LIMITATIONS OF THE STUDY

The researcher conveniently identified the criteria for inclusion in the study and considered only professional nurses in the primary healthcare setting. The researcher is aware of other categories of health professionals and

primary health care workers, such as enrolled nurses, doctors, social workers and physiotherapists, as well as administration staff, who were excluded from the study. These healthcare workers could have diverse perceptions regarding the factors influencing service delivery.

The researcher is aware of the fact that the study was conducted in a primary health care setting, where multiple races of professional nurses are employed, and that health professionals of all races were not included in the study.

4.7 FINAL CONCLUSION

The objective of this study was to explore and describe the perceptions of nurses regarding the factors influencing service delivery in programmes being expanded in a primary health care setting. A qualitative approach was utilised to answer the research question. Certain factors influencing service delivery were identified and possible solutions suggested. The identification of the factors means they can be addressed to improve the quality of service delivery in primary health care. Based on the findings of the study, it can be concluded that the objective of the study has been achieved. It is hoped that measures will be put into place to control and monitor these factors in order to improve service delivery in the primary healthcare environment. The researcher has made recommendations based on the study to the relevant bodies and this report will also be disseminated to them.

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**LETTER TO REQUEST PERMISSION TO
CONDUCT THE STUDY IN THE
REGION C CLINICS**



P.O. Box 140
TEMBA
0407
09 April 2007

Attention: Ms. L. Volkwyn
Director Region C (Nursing Services)
Karel Schoeman Building
Pretoria.
0100.

SUBJECT: PERMISSION TO CONDUCT RESEARCH PROJECT

Your permission is hereby requested to conduct a qualitative study on a topic approved by the Pretoria University. I am registered with the University of Pretoria for a Masters Degree programme for the year 2006 and 2007. My student number is 2639426 and I am presently employed at S.G. Lourens Nursing College.

The topic of the study reads; "*The factors influencing service delivery with regard to expansion of programmes in a primary health care setting*". Permission is hereby requested to conduct the research in the Region C clinics in the Tshwane /Metsweding District.

The purpose of the study is to explore and describe the factors that affect the progress in the expansion of the programmes in a primary health care setting with the aim of monitoring and controlling these factors.

It is anticipated that the study will assist in identifying the strategies to monitor and control these factors and result in the improvement of service delivery. It is believed that the findings of the study will contribute to the body of knowledge in relation to primary health care service delivery. In order to attain this purpose your permission is requested to conduct a focus group interview from the registered nurses who are employed in the Region C clinics.

I would also like to promise that anonymity as an ethical principle will be highly maintained and respect to humanity. An informed consent will be obtained from the individual participants of the focus group interview and no institution will be identified or be able to be linked to the information during the analysis of the data.

I would like to thank you for your time and attention to this request and any suggestions will be appreciated.

Yours sincerely,

Mrs. A N. Xaba

**LETTER TO REQUEST PERMISSION TO
CONDUCT THE STUDY FROM
GAUTENG HEALTH
DEPARTMENT**



Enq : Ms. AN. Xaba
Tel No : (012) 319-5729
Fax No : (012) 319-5742

19 June 2007

ATT : Ms. D.G. Joseph
Chief Director
Human Resource Directorate
Gauteng Department of Health
Private Bag X085
Marshalltown
2107

RE: PERMISSION TO CONDUCT RESEARCH PROJECT

Permission is hereby requested to conduct a qualitative study on the topic as approved by the University of Pretoria. I am registered with the University for a Masters Degree programme for the year 2006 and 2007. My student number is 2639426 and I am presently employed at S.G. Lourens Nursing College.

I have been advised by the Region C Director Nursing Service's office to channel my request for permission to the Chief Director's office at the Central's office.

Attached kindly find the details of the original application that was send to Region C.

Your cooperation will be highly appreciated.

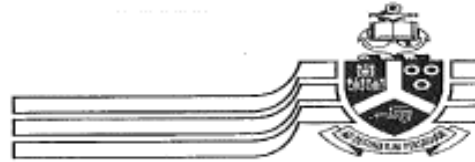
Yours sincerely



MRS. A.N. XABA

19/06/2007
DATE

**APPROVAL LETTER FROM THE
UNIVERSITY OF PRETORIA
ETHICS COMMITTEE**



University of Pretoria

31 Bophelo Road P O Box 667
HW Snyman South Building Pretoria
Level 2, Room 2.33 0001

Faculty of Health Sciences Research Ethics Committee
University of Pretoria
Tel: 012 354 1677 Fax to E-Mail: 086 6516047
E-Mail: deepeka.behari@up.ac.za
Date: 16/11/2007

Number : S110/2007
Title : Perceptions of registered nurses regarding factors influencing service delivery in expanding programmes in a primary health care setting
Investigator : A N Xaba; Department of Nursing Science, University of Pretoria (SUPERVISOR: MRS M PEU)
Sponsor : None
Study Degree: MCur

This Student Protocol has been considered by the Faculty of Health Sciences Research Ethics Committee, University of Pretoria on 16/11/2007 and found to be acceptable.

Advocate AG Nienaber (female)BA(Hons) (Wits); LLB; LLM (UP); Dipl.Datametrics (UNISA)
Prof V.O.L. Karusseit MBChB; MFGP (SA); M.Med (Chir); FCS (SA): Surgeon
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DR R SOMMERS; MBChB; M.Med (Int); MPhar.Med.
SECRETARIAT of the Faculty of Health Sciences
Research Ethics Committee
University of Pretoria

DR L SCHOEMAN; Bpharm, BA Hons (Psy), PhD
CHAIRPERSON of the Faculty of Health Sciences Research
Students Ethics Committee – University of Pretoria

**INFORMATION LEAFLET
AND CONSENT FORM FOR
THE PARTICIPANTS**

INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE STUDY

Perceptions of registered nurses regarding factors influencing service delivery in expanding programmes in a primary health care setting.

CANDIDATE : Ms. A.N. Xaba

SUPERVISOR: Mrs. D. Peu

CO-SUPERVISOR: Mrs. S. Phiri

The study will be conducted by Ms. A.N. Xaba as part of her Master's degree studies at the Department of Nursing Science of the University of Pretoria.

INTRODUCTION

You are invited to volunteer in a research study. The information will help you to make an informed decision to participate in the study. You have to understand fully what is involved before you agree to participate in the study. Do not hesitate to ask the researcher if you have questions about information in this leaflet. You should not take part unless you are completely happy about all the procedures involved.

PURPOSE OF THE STUDY

The purpose of the study is to explore and describe the factors that affect service delivery with regard to the expansion of programmes in a primary health care setting.

DESCRIPTION OF THE PROCEDURE

You will be expected to take part in one session of the planned focus group interviews, which will be conducted in an environment that is free from noise and interruptions. The focus group interview will be conducted in stages. The researcher will communicate to you if there is a need for further sessions of interviews.

The first meeting will be the introductory meeting, where the researcher will get to know you, take contact details and introduce the group to the facilitator and the assistant facilitator. Both of whom are knowledgeable and experienced in conducting focus group interviews, and who will provide you with contact details in order to prepare subsequent meetings. During this meeting you will be "exploring and describing the factors that affect service delivery with regard to expansion of programmes in a primary mental health care setting". The preliminary question will be:

"What are the factors affecting service delivery regarding expanding programmes in a primary health care setting?"

Various communication skills such as probing, paraphrasing, listening and reflecting will be used to obtain the factors that affect service delivery. The researcher will facilitate the group discussion.

A group of five (5) to ten (10) members will be formed. The number of group sessions will be determined by saturation of data (if nothing can be added, data will be considered saturated and the focus group interviews will not be continued). You will be requested to take part while the tape recorder is used to record the sessions. Field notes will be taken. These will be used during data analysis. Focus group sessions will last for an hour.

THE RIGHTS OF PARTICIPANTS

Your participation in this study is voluntary and you can refuse to participate or you may decide to stop at any stage of the study. Refusing to participate will involve no penalty or loss of benefits. The results of the study will be provided to you on request. Extra precautions will be taken to safeguard you with regard to anonymity. Information regarding sexes and ages will be withheld.

RISK OF DISCOMFORT

There are no risks involved with this study. The study will not include any experiments. You will be free from discomfort or injury.

CONFIDENTIALITY

Information obtained from this study will be kept strictly confidential. No one will have access to the information unless through legal accredited journal publication system. No names will be used.

EXPLANATION OF WHOM TO CONTACT:

RESEARCHER : Ms. A.N. Xaba - 072-835-1797

SUPERVISOR : Mrs. D. Peu - 082-534-4245

Mrs. S. Phiri - 072-783-1843

INFORMED CONSENT

I hereby confirm that Ms. .AN. Xaba has informed me about the nature, benefits, confidentiality, discomfort, purpose and description of the procedure.

I have read all the above, had time to ask questions and received answers concerning areas I did not understand. I am aware that the results, including personal details regarding my profile, will be anonymously treated.

PARTICIPANT'S SIGNATURE.....DATE.....

INVESTIGATOR'S SIGNATURE.....DATE.....

WITNESS SIGNATURE 1.....DATE.....

WITNESS SIGNATURE 2.....DATE.....



ANNEXURE E

INTERVIEW GUIDE

QUESTION

What are the factors that influence service delivery with regard to expanding programmes in the primary health care service?

**COPY OF THE FOCUS GROUP
INTERVIEWS TRANSCRIPTS OF
THE PARTICIPANTS**



TRANSCRIPT FOR A FOCUS INTERVIEW SESSION 1

- **Question by Facilitator** : What are the factors that influence service delivery in expanding programmes in a primary health care setting?
- Silence.....**
- **Response** : With regard to priority programmes I am going to start with the disabling factors.
- The time frame erh.....we have a... This is a 24hr health service but eh... we do have programmes which are not covered in the 24hr service.
- So we find that on weekends specifically we have clients who come in requesting for TB or ART, but because the service is not there during the weekends and we have to schedule the client for another time.
- **Response 2** : Our clients are working and cannot come during the week. They are available over the weekends, which makes it very difficult and in our statistics will be saying may be say ahh so many.....HIV positive pregnant women and this number is infect it is not a true reflection.
- **Facilitator** : Do you mean the services are all not available during the weekends?
- **Response 2** : But we do have after hours service like the MOU is available even in the medico-legal emergency and TB services, we have counsellors at night.
- **Response 3** : But we have services after 16:00hrs like if somebody can come for VCT, and this service can be offered after hours.



- **Facilitator** : Ok.....
- **Response 3** : Yes if one is busy with Medico-Legal service, the other one attend to the VCT.

- **Facilitator** : Are all the other service also available during the weekend?

- **Response 2** : No not all are there although some like TB can be helped but not a full service.

- **Facilitator** : Oh...that was the time factor.

- **Response 4** : Yes TB and FPC are not there during weekends.

- **Facilitator** : You agree that the services are there but needs to be extended or expanded to weekends.

- **Response 3** : Yes.

- **Facilitator** : Ok..... what about other services like IMCI are they also available during weekends.

- **Response 3** : They are covered.

- **Facilitator** : Ok.....

- **Response** : and FPC?

- **Response 4** : FPC is not covered.

- **Response** : What about the minor ailments?

- **Response** : They are covered.

- **Facilitator** : Are there any other factors that are not covered.

- **Response** : Silence.....

- **Question 2** : If you look at the utilization of the clinic what is their experience on the burden on clients?

- **Response** : Silence.....



- **Response 3** : There is a very big problem with our clinic. There are clinics outside around our village. People from around the area come to our clinic. People from the nearby areas which has clinics and hospital come to our area.
- **Facilitator** : Yes people from nearby come to our clinic and this is a real cross border issue.
- **Facilitator** : So how do you cope with this?
- **Response 4** : We have a problem because there is a hospital nearby, there are service available at their areas but people come to our clinic.
- **Facilitator** : So why do people come to your clinic?
- **Response 4** : When you ask them usually they are here I can see that these people are from nearby village because I used to work in that area and they answer that they have problem with the attitude of the staff in the clinic.
- **Response 4** : I think people do not really mean say the truth because they are not willing to stand in long ques and they are afraid of long ques at some clinics.
- **Facilitator** : So the attitude is with the client.
- **Response 3** : Yes because the services are there.
- **Response** : Yes because in that particular clinic there is a lot of clients. Already at 06:00 in the morning people are standing in a que outside the clinic to open.
- **Response 2** : If you think of que you really understand why the clients come here because by the the time you stand in a que at 06:00. The client can get here at 07:00hrs.



The clients know that they can be helped and even go back early rather than standing in the long que.

- **Facilitator** : What about poverty (money for transport).
- **Response 1** : They do not mind the distance and travelling.
- **Response** : The area next to them is surrounded by squatter camps and the clients feel that the waiting time at our clinic is not bad.
- **Response 2** : With regard to poverty are NGO's that help them and this improves compliance.
- **Response 3** : We have NGO's that give ART, at other places around us and are really helping those who cannot.
- **Facilitator** : Ok and compliance is improved.
- **Response 4** : I think we also have a problem of duplicating services. They are misusing the services.

The client has a file with us, and goes to next village, also has a file there and in other places around us. Especially clients with STI's and VCT.

Ok.....

- **Response 5** : They shop around to avoid the diagnosis and go around.
- **Response 2 and 3** : Yes that is denial of the diagnosis.
- **Facilitator** : What is it that makes them have many files.
- **Response 5** : They do not believe what you tell them and they want to confirm the diagnosis with the other people.
- **Response** : We cannot refuse them treatment



and now they really affect our budget.
They affect our stocks and we have
to order more.

- Facilitator : Mmm.....yeah.....
- Response 4 : The other issue again is the foreigners who attend our clinics. Especially when treating partners. You find that the partner is in Johannesburg and he is sick.
- Response 3 : Or the partner has gone back to their country. Sometimes you find that he has another partner here and the wife is at home. The third partner is also somewhere. The condition keeps on recurring again and again mmm.....
- Response 1 : The other issue is that people from the nearby village give wrong addresses.

Ohh.....

When you want to follow them up, go back to the address and there is nobody there. This is a problem.

- Facilitator : No how do you confirm that the person is healed?
- Response : The problem is that now the young people keep on infecting others.
- Facilitator : What is the reason for not giving Correct addresses?
- Response : The reason is they are selling the medication.

OK.....This is a problem...

- Facilitator : What is the situation with PMTCT and the others?
- Response 4 : Is also the same. They give incorrect addresses and confidentiality there is



- **Response 3** : also a problem.
Some of the PMTCT do give correct addresses but.....
- **Response 4** : Confidentiality and stigmatization is a problem.
- **Response 1** : With PMTCT you can never be sure. Most of them we provide them with PMTCT in the labour ward up to delivery and some still behave as if they do not know anything.
- : We have a problem they want to breastfeed, and looking at the socio economic factors they opt for breastfeeding, but they still have problems and now most of them even if they take the formular they breastfeed.
- : I don't know if it has something to do with the formular, they don't .erh they don't, so it becomes a problem for most of them they get home they still breastfeed.
- **Response 3** : This is a problem maybe when they are queried why they do not breastfeed.
- : People are clever now they ask why not breastfeeding. They just now put the baby on the breast to avoid talks.
- **Response 2** : I think it has something to do with the family.
- **Response 2** : May be it's the pressure from the family. The stigma from the family and the expectations from the family and community is she gives the baby a bottle and the prefers just give the baby the breast.
- **Facilitator** : Do they attend the services.
- **Response 2** : Yes the services are well attended.
- **Facilitator** : How is compliance with treatment?



- **Response** : Yes it is good.
- **Facilitator** : How is compliance with ART?
Silence
- **Response 2** : The service is there and we even have prisoners from correctional services who attend treatment there and the clinic is very busy.
Ok
- : This gives hope to us. Even the care of PEP are also put on treatment.
- : I think now.....the people are erh... becoming aware. They are disclosing and opening up, some just come to check.
- **Response 4** : I have a big problem. The patient will come and open a file down there then come to PHC to be consulted and has a file also at ART
- **Facilitator** : Really the patient does not tell you that he has a file with ART.
- **Response** : Yes... and the patient has more than one file, he has files all over the clinic.
- **Facilitator** : Do you use different files for minor ailments and for VCT and ART.
- **Response** : Yes they have different files and they have their own doctors for minor ailments and they have a different doctor for ART. They are afraid to be asked because of stigmatization.
Ok.....yaah.....
- **Response** : The fact that they are using the services is a positive sign. The community is aware.
- **Response 1** : Even with ante-natal women even



when they refuse to be tested previously they will come and say "now I want to test".

Ok.....

- **Response** : I think the fact that the age group is getting younger and younger that are positive so they rather be tested and given treatment otherwise we might have a generation gap.

- **Facilitator** : Ok.....

- **Response** : Some young people just came in to be tested to be sure that some are really willing to fight this battle.

- **Facilitator** : Ok.....

Silence

- **Facilitator** : What are other factors influencing home based care.

- **Response 3** : The care givers cover a wider part of the area. The area is wide so they cannot walk ehh.....the area is too wide. The NGO used to help, but now they have not been funded and they were not paid and now the care givers feel very de-motivated.

Ohh.....

- **Facilitator** : When you select common health workers do they look at areas or they just choose anybody?

- **Response** : Yeahh..... They look at their respective place to allocate them to the place nearer their home.

Ok.....

- : But you find that in some areas they do not cover the areas well.

Ohh.....



- **Facilitator** : What about the services there?
- : The services there are under the clinic but for payment they are under the NGO.

Ohh.....

- **Facilitator** : What about their training? Are they Comprehensively train to be able to Check the home?

- **Response** : Yes they are comprehensively trained to do DOTS and check children IMCI and referral.

They have a trained sister that is monitoring. It is only the clinic sister who is remaining with them.

Ok.....

- **Facilitator** : When we come to the last point I think have covered most of the factors. Are there any other factors before we get to the health providers.

- **Response 4** : Yes the other factor is that the clients will come over and over again to collect medicines and sell them outside. When you find out you discover that they sell the medication outside. They change clinic.

- **Facilitator** : Where is "outside".

- **Response** : Yes they collect medications from several clinics around here and they go and sell outside SA in the neighbouring countries.

Aho.....ohh.....then.....?

- **Response 4** : They know that treatment here is free and they collect for two months, especially the chronic cases. Then go to the next clinic collect another two months until the client has enough to go back home and some sell it to the others and some will collect for themselves for ±6 months.



- **Facilitator** : How do they get it right?
- **Response** : The clients use the bus service from their country and request treatment for ±3 months because they are going back home and do the same in other clinics around and after enough they go back to their country.

Mmm.....

- **Response** : This is a cross boarder problem.

Silence.....

- **Response** : and nurses cannot refuse them treatment.

- **Response** : The issue of foreigners is really a problem some clients also say "give me your sputum and I give you money" to get the grant for TB and HIV.

Yoooh

- **Response** : Then we have a problem of TB and MDR continuing.

- **Facilitator** : Do they get a grant for TB?

- **Response** : They know that if you are a TB patient and you are positive then you get a grant.

Yoooh.....

- **Response** : Don't you get a grant after testing blood?

- **Response** : Yes you do get for HIV and get blood to qualify.

- **Response 3** : It is like having a baby to get a grant. This is really wrong.

I think if they can use computers can help. Technology can help that is a



patient get to one clinic he is captured in a system that will reveal him when he gets to the other clinic that he has been seen and given treatment at such a clinic.

- **Response** : The ID can also help and all the clinics are linked to one system. Most of the duplication of services cannot be there anymore because the client will be seen immediately.

- : This can really help because the clients do not tell the truth.

- **Response** : Regarding health providers the especially in the primary health care setting it is the training of the health providers – updating courses especially PMTCT, IMCI and others.

PHC nurses need to be updated for They must know what they are doing.

It like PHC or whoever go far extensive training.

- **Response 4** : Oh yes.....reinforcing.....

- **Response** : The new developments and the updates even the protocols that came and the IMCI, some of the things have been changed.

- **Response** : You don't even know that they have changed.

- : Especially with IMCI some things changed.

Yaahh.....

- : We need to know exactly what is changing like referring to the ARV's.

- : We need to be able to see if they patients are reaching or not especially with ARV's and others.

- : If we are trained and updated we



- : already know what blood to take and and what to do.
- : I think the updates could be done in the form of in-service training.
- **Facilitator** : What about the problems of releasing other for training?
 - **Yes.....**
 - : Fortunately most have the training especially the new ones and the old one release one another to attend the training e.g. ARV.
 - **Yaahh.....**
 - : Some are too long e.g. ARV is one month and we can only send one person for training.
 - **Response** : We also need to look at mental health to train more people at least more than 2 people.
 - **Ok.....**
 - We have people that are trained. The nurses work there for long time and clients get used to them, when the person leaves the clients get it difficult to get used to the new person. It is better to get used to more people and the clients do not like this.
 - **Yaahh.....**
 - **Response 2** : Psychiatric patients need a person that they know and not change them regularly.
 - It would be better if a person stays for at least 6 months.
 - **Yaahh.....**
 - **Response 1** : When you go for a month and you come back it is like the patients revolt against you and they should



say "We need so and so".

They get used to a person and if you introduce another person they don't like him.

Ohh.....

They now rather default. They can even ask the nurse "what are you doing here".

If you came in the morning and you have 20 clients and you really need to talk with them it is really too much. You need at least 2 nurses to attend to the clients properly.

Ok.....

- **Response 5** : If we really talk of quality we really need more than one person.
- **Researcher** : Are there more factors that can be identified.
- **Respondent** : Yes the escalating numbers of clients makes the quality to go down.
- **Response 4** : The escalating numbers is also the clients around we've got patients that came from their chronic medications from other countries crossing the borders and overload the services.
- **Response 5** : This affect the health budget.
- **Response** : And they are very honest they tell you that they are going back to their country and need more treatment.
- **Facillitator** : Thanking the participants.

**COPY OF THE PERMISSION
LETTER FROM
REGION C**



DEPARTMENT
OF HEALTH

Karel Schoeman Building
179A Skinner Street
2nd Floor
Room 269
PRETORIA
0002

21 August 2007

Enquiries : Dr K M Htwe
Telephone : (012) 303-9205
Fax No : (012) 303-9050

RE : REQUEST TO CONDUCT A RESEARCH PROJECT

(refer to your fax dated the 17th of August 2007 regarding the abovementioned matter.

Approval is hereby given to you to conduct your research "Factors influencing Service Delivery in Expanding Programmes in a Primary Health Care Setting".

Please contact the Facility Manager of the Clinic that will be allocated to you for further arrangements.

Yours sincerely

M. de Jager
DR K M HTWE
SENIOR MEDICAL ADVISOR

ANNEXURE H

COPY OF THE PERMISSION

LETTER FROM

GAUTENG DEPARTMENT OF

HEALTH (PROVINCE)



PROVINCIAL RESEARCH COMMITTEE.

RESEARCH PROPOSAL EVALUATION FORM FOR APPROVAL BY THE HEAD OF THE DEPARTMENT.

Principal Investigator: N.A Xaba

Researcher's contact details: Tel 012 319 5729 F: 012 319 5742

Research Topic: Perceptions of registered nurses regarding factors influencing service delivery in expanding programmes in a Primary Health Care setting

Supervisor's Name: Mrs. MD Peu

Co Supervisor: Mrs. S Phiri

Date submitted: 10 September 2007

Date Reviewed: 11 September 2007

Reviewer's name: Dr ML Likibi

SECTION A

	YES	NO	N/A
1. Is this research project within the scope of the Department of Health key policy priorities/directives?	X		
2. Content of Research:			
Original work	X		
• New facts, ideas			
• Confirmation of uncertain data	X		
• Repetition of known data and consequently of limited importance		X	
• Unreliable and/or inadequate		X	
• Confusion of topics/questions		X	
• Intervention study		X	
3. Is the title of the research project suitable?	X		
4. Are the objectives of the research project adequate?	X		
5. Could the objectives be limited to better focus on the project's main objective?		X	

Research Topic: Perceptions of registered nurses regarding factors influencing service delivery in expanding programmes in a Primary Health Care setting



6. Writing style			
• The text of the proposal is clear	X		
• The nomenclature used is correct	X		
• The references used are relevant, comprehensive and accurate (corrected)	X		
• The spelling and grammar are correct	X		
• The language needs improvement		X	
• The research proposal needs restyling and rewriting		X	
7. Are the research methods appropriate to the study	X		
8. Does the study have ethical approval? If yes, name the ethics committee University of Pretoria	X		
9. Is the definition and measurement of variables consistent with the scope of the proposal	X		
10. Is data collection method in line with study design?	X		
11. Is time frame of the proposal adequate to meet the objectives?	X		
12. Is it stated in the proposal the method of dissemination of the results of the research project?	X		
13. Is the possible conflict of interests clarified? Are financial implications and financial support transparent?	X X		

Summary of the proposed study

The purpose of this study is to explore and describe the perceptions of registered nurses regarding factors that affect the progress in the expanding programmes in a primary health care setting. The aim is to monitor and control these factors. The study will reveal the factors that could be addressed. The focus of the study will be on the factors that affect the progress on expansion programmes in a primary health care setting.

Research Question

What are the perceptions of registered nurses regarding factors influencing service delivery in expanding programmes in a PHC setting?

Study design: Qualitative study employing the explorative and descriptive methods

Study Site: Tshwane District Health Services

Population and sample: Purposive sampling of professional nurses trained in PHC

Data collection: 02 focus group discussion with PHC nurses

Publication and dissemination of project findings: Masters Degree Research Report

Budget: Graduate student funded research project, no cost to the Gauteng Department of Health other than nurses time for group discussion

Research Topic: Perceptions of registered nurses regarding factors influencing service delivery in expanding programmes in a Primary Health Care setting



Evaluator's Comments

Ethical clearance is given for this Masters degree research project by the University of Witwatersrand and there are no financial implications for the GDoH. Therefore, we do not have any objection to recommend that the study be conducted in Gauteng Province. It is the responsibility of the principal investigator to ensure that:

- Permission to access research participants is granted by the management of the institutions before data collection commence
- A research report is submitted to the Gauteng DoH Research Unit and the findings are communicated to appropriate Units within Gauteng DoH on completion.
- Details of future publications of the findings are disclosed to the Gauteng Department of Health
- The researcher is further invited to present the findings at the next PRAKASH VALLABH PHC research conference (2008)

Reviewer's final conclusion: Accept without change

Dr ML Likibi
Medical Specialist, Research Epidemiology

Research Topic: Perceptions of registered nurses regarding factors influencing service delivery in expanding programmes in a Primary Health Care setting