

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

The national health policy of The Republic of South Africa (RSA) is based on the principle of comprehensive, integrated primary health care, which is the key element of the plan to transform the health system in the country (Department of Health 2001a: 7). It is expected of all registered nurses rendering primary health care services to be able to provide a one-stop service for meeting clients' basic health care needs. This expectation has resulted in the formulation of health policies at national and regional levels in the RSA, aimed at implementing integrated service delivery. Registered nurses' perceptions regarding their role in integrated primary health care delivery influence their role performance.

Quantitative, descriptive research was done to determine the perceptions of the registered nurses and the nurse managers regarding the role of the registered nurse in integrated primary health care delivery and to identify any discrepancies between the two groups of respondents. The findings revealed that there were some areas where there is a lack of congruence between the perceptions of the registered nurses and nurse managers regarding some of the functions that registered nurses perform in such delivery. However, there are areas where there was no significant difference between the perceptions of the registered nurses and nurse managers regarding some of the functions that registered nurses perform in integrated primary health care delivery.

1.2 BACKGROUND INFORMATION ABOUT THE RESEARCH PROBLEM

1.2.1 The source of the research problem

Discussions by the researcher with colleagues in the clinical setting brought to light that they have different perceptions regarding the integration of services in primary health care and its implications for their role. The role performance of the registered nurses is influenced by their perceptions, because performance and co-operation is influenced by one's perception. The different

perceptions will result in different behaviours within the same setting and this may lead to conflict and confusion amongst registered nurses. The researcher pondered these issues and the question that came to mind was whether there were any discrepancies between the role performance of the registered nurses and role expectations.

1.2.2 Background to the research problem

Since 1994, the present South African government has introduced new health legislation, policies and guidelines, as an attempt to find new and more effective ways of delivering health care to communities. The entire health system has been affected by these changes. Patterns of health care delivery have changed. The transformation of the health system requires re-orientation of existing personnel and fuller use of their present skills to enable them to play a more effective role in promoting health (African National Congress (ANC): 1994:79). The White Paper on the Transformation of Health Services (South Africa 1997a) was the basis for the restructuring of the national health system in the RSA. Some of the principles included in the paper are: overcoming fragmentation of services and establishing comprehensive integrated services. Integration of primary health care services therefore became a priority. According to the Northern Province Health Services Act 5 of 1998, district health authorities are accountable for the provision of comprehensive primary health care services in the communities that they serve.

In 1995, the Committee of Inquiry into a National Health Insurance System compiled a document on the restructuring of the public and private health sector in the RSA. The Committee found that primary health care delivery was rendered in a fragmented and inefficient manner and that there was a need to integrate various health services into a comprehensive primary health care delivery system. It was recommended that district health services should be planned, managed and delivered in a comprehensive, integrated manner. The previous practice of local authorities rendering preventive care while the provincial health service provided curative services had to be discontinued (South Africa: 1996a: 41-45).

As health care costs become out of reach for many people there is a demand for more services at a lesser cost (Lancaster 1999:181). In the RSA the complexity of people's needs resulted in an increase in the number of services and programmes to be rendered. This led to fragmentation and duplication of services, and escalating health care costs. Breakey (1996:8) believes that integration

is therefore important to rationalise such programmes. Resources are pooled together and planning is simplified.

In terms of the Constitution of the Republic of South Africa Act no 108 of 1996 (as amended) everyone has the right to have access to health care services, and it is the responsibility of the state to ensure that this right is realised. All provinces in the RSA, including the Limpopo Province, consequently started on a process of restructuring services into a comprehensive, integrated primary health care delivery system whereby promotive, preventive, curative and rehabilitative services were to be integrated. This was in response to a previous health care dispensation in which preventive and curative services were rendered separately and in a fragmented manner. Traditionally the principle of division of labour prevailed in health care services. More than one practitioner rendering specialised care served a client in a single visit or clients had to visit clinics repeatedly in order to seek care for multiple health problems (Unger & Criel 1995:114). This resulted in the creation of single function staff with restricted job descriptions and specialised training (Health Systems Trust & Department of Health 1997:14). In the new dispensation, the restrictive job description of registered nurses changed in order to enable them to provide comprehensive integrated primary health care. According to Coddington, Chapman and Pokoski (1996:120) integration of care means having a single source responsible for the health of individuals and their families. Clinics, which provided only one or a few facets of care, are now required to offer a comprehensive and integrated range of preventive, promotive, curative and rehabilitative services (Gilbert, Selikow & Walker 1996:187; Whittaker 2000:40). By 1997, about 70% of health facilities in the Limpopo Province offered comprehensive maternal and child care services (Health Systems Trust & Department of Health 1997:63).

The move towards integrated health care delivery was in response to changed health care needs and prevalent economic restrictions. LaFond (1995:144) points out that as health needs increase and become more complex, managing preventive, curative, promotive and rehabilitative care services separately would be costly and ineffective as each have separate planning and training requirements, and require unique resources and activity schedules. The health needs of communities are changing as disease patterns change and primary health care should be designed to meet these changing needs if it is to be effective (Lundeen, Friedbacher, Thomas & Jackson 1997:11). Flarey (1995:15) believes that developing and third world countries cannot cope with the rising health costs and the increasing burden of disease. Integrated primary health care delivery could be one way to cut costs and improve care. Reducing costs could be achieved by ensuring that

communities are presented with only one affordable health care package that addresses all their health needs, through the integration of programmes at local level. Integration enhances rationalisation of the use of health resources and thus improves the chances of implementation of health care at an affordable cost, making it possible to sustain intervention locally. This will also improve service accessibility (Monekosso 1994:66).

The developments in the RSA are consistent with developments internationally. The International Council of Nurses (ICN) and its member associations worldwide support and embrace primary health care as a strategy for achieving the health needs of the people (ICN position 2000:24; McElmurry & Keeny 1999:242; Whyte & Stone 2000:58). There is now consensus in the international community that comprehensive integrated primary health care could accelerate the attainment of health for all. According to the World Health Organisation (WHO), qualified health personnel should be able to deliver basic health care in an integrated manner (Monekosso 1994:78). There is a minimum comprehensive, integrated primary health package based on the Alma-Ata declaration on primary health care. This package includes health related interventions, basic health and priority health. Health related interventions include adult health literacy, adequate food supply, proper nutrition, adequate water supply and basic sanitation. Basic health care include interventions that can be readily integrated by health personnel in the clinics without collaboration with other sectors, like maternal and child health, family planning, treatment of common diseases and injuries, prevention and control of locally endemic diseases. In priority health interventions, the key issues are provision of essential drugs and financial and logistic support by the district health authority (Monekosso 1994: 24-25).

Despite the government's effort to provide comprehensive integrated primary health care there are still facilities whose services are not fully integrated (Toomey [Sa]: 9). Xako (2000:1) reported that, in the RSA, a preliminary survey of primary health care revealed fragmentation, a lack of continuity and no coordination in the delivery of primary health care services. Some programmes were still running vertically and in a fragmented manner, like mental health, tuberculosis (TB) and family planning services. Kraus (1999) posed the question: "Why are we struggling to improve delivery of primary health care services in the RSA?" In an attempt to answer this question Kraus (1999:12) identified lack of resources, poorly motivated workers, poor management, shortage of staff and financial constraints as some of the reasons.

According to Drazen and Metzger (1999:11) a need to integrate a fragmented health system in the United States of America (USA) was identified. Lancaster (1999:179) has mentioned that health care systems in the USA have shifted from a cure to a care mode. Koponen, Helio and Aro (1997: 42) have observed that Finland also identified a similar need after experiencing problems in primary health care services. Long waiting time and poor continuity of care were seen to be the result of fragmented and uncoordinated services. In an attempt to address some of the concerns, community involvement and service integration were initiated.

Integrated primary health care has implications for nursing education and practice. Lundeen et al. (1997:9) believes that there is a commitment, in the USA, within the nursing profession and among nurses to provide comprehensive, integrated primary health by rendering care beyond disease management. However in practice, registered nurses who previously performed limited functions by providing preventive health care only, encounter problems in rendering integrated primary health care because of their lack of experience in the provision of curative services (Whittaker 2000:40). In the United Kingdom (UK), the authorities supervising the National Health Service (Britain 2000: 70) advocate that services should merge. This requires multi-skilled health care providers who are able to deliver a one-stop package of care. Whittaker (2000: 41) indicates that changes in the delivery of primary health care services have resulted in the registered nurses' role being redefined and extended. Existing routines have to be adapted as the delivery of care changes. This is because of the changed role, as registered nurses are now expected to offer a wide range of services in an integrated manner. They have to acquire new skills to meet the challenge of providing care to patients whose health needs are ever changing (Albarran 1999:2). Integration of services therefore calls for provision of training, re-training and re-orientation of health professionals, including nurses.

In the RSA, the Health Systems Trust (1997:28) recognises the need to prepare registered nurses for integrated primary health care delivery by updating their knowledge and skills. Ross (1999:47) states that a debate about the new emerging role of the registered nurses resulted in two opposing ideas: whether there should be a new corps of nurses trained to render integrated primary health care or whether one should empower trained nurses with new skills to meet the new demands. Koponen et al. (1997:42) believe that through experience and in-service training registered nurses can develop skills to meet the demands of their new role. In Britain training programmes were to be established in order to assist registered nurses to take on this new role (Britain 2000:84). Understanding of the perceptions of the registered nurses regarding their roles in integrated primary

health care delivery could serve as a foundation for the development of such reorientation programmes.

1.2.3 Research problem

Ross (1999: 47) points out that a focus on primary health care places new demands on registered nurses and that this requires role changes. Eventually new roles will emerge. There is a need for reorientation programmes for registered nurses and nurse managers in the RSA in order to prepare them to meet the demands of integrated primary health care delivery. It is also important to identify obstacles in integrated primary health care delivery in order to enhance the effectiveness and quality of service delivery.

In the RSA, changes in the registered nurses' role and job description coupled with inadequate preparation for this changed role, may have resulted in perceptions regarding their role in integrated primary care delivery that are different from role expectations. Registered nurses in clinics are primary care givers. Their perceptions regarding their role in integrated primary health care delivery seem to greatly influence their behaviour and the extent to which the system is efficiently and effectively implemented. If their perceptions are not in line with the changed demands on their role performance, this could have a negative impact on achieving the intended outcomes of integrated primary health care delivery. Similarly if the perceptions of registered nurses regarding their role in integrated primary health care are incongruent with the role expectations of the authorities there could be discrepancies between the role expectations held by authorities and the actual role performed by registered nurses. This research therefore focused on perceptions of registered nurses regarding their role in integrated primary health care delivery as reflected by their role performance. The focus was also on perceptions of nurse managers concerning the registered nurses' role. The researcher assumed that the nurse managers' perceptions represent role expectations. The problem statement for this study was therefore:

What are the perceptions of registered nurses about their role with regard to integrated primary health care compared with role expectations?

1.3 AIM OF THE STUDY

1.3.1 Research purpose

The purpose of this research was to describe the perceptions of the registered nurses regarding their role in integrated primary health care delivery, as compared to the role expectations of the nurse managers. The recommendations would be used to establish personnel development programmes, which contribute towards role performances that are in accordance with the principles of integrated primary health care delivery and role expectations.

1.3.2 Research objectives

The research objectives were to:

- determine the perceptions of registered nurses regarding their role in rendering integrated primary health care
- determine the perceptions of nurse managers regarding the registered nurses' role in rendering integrated primary health care
- compare registered nurses' perceptions with those of nurse managers.

1.4 SIGNIFICANCE OF THE STUDY

The results of this study should contribute towards improved integrated primary health care delivery, as personnel development programmes on the role of the registered nurse in rendering integrated primary health care can be planned in accordance with the findings of this study.

1.5. DEFINITIONS OF TERMS

1.5.1 Integrated primary health care

Integrate means putting different parts together to form a whole. In the field of health care, it applies to activities, programmes, plans and services (Monekosso 1994:139). "Integration is designed to bring together a collection of separate and independent units and programmes which

previously tended to pursue their own objectives into a cohesive and unified structure” (LaFond 1995:113).

“*Primary health care* is essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development, in the spirit of self-reliance and self-determination. It forms an integral part both of a country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care service” (Monekosso 1994:16).

Integrated primary health care therefore refers to putting different primary health care programmes together into a cohesive and unified primary health care programme by combining comparable services and activities.

1.5.2 Perception

Perception refers to intuitive recognition of a truth, a way of seeing and understanding things (*The South African Pocket Oxford Dictionary* 2000: 708). According to King (1981:20) perception is each person’s representation of reality. Within the context of this study, perception refers to the way in which respondents view and understand the registered nurse’s role in integrated primary health care delivery.

1.5.3 Registered nurse

A *registered nurse* is a person registered as a nurse under Section 16 of the Nursing Act 19 of 1997, as amended. For the purpose of this study registered nurse refers to those individuals who are registered as nurses under section 16 of the Nursing Act 19 of 1997, as amended, and who participate in integrated primary health care delivery.

1.5.4 Role

A *role* is a way of behaving or a social prescription for a person with a specific position in a group (Douglas 1996:71). King (1981:93) defines role as behaviour that is expected of one who occupies a given position. Within the context of this study, role refers to the expected functions of the registered nurse who renders care in integrated primary health care services.

1.6 FOUNDATIONS OF THE STUDY

Metatheoretical assumptions and a nursing theory formed the basis for this study.

1.6.1. Metatheoretical assumptions

The assumptions underlying this study were:

- Human beings are open systems in constant interaction with their environment.
- The essence of the being of a professional person is defined in terms of his/her professional role.
- Dramatic social change could lead to role confusion in individuals.
- Functions performed represent role perceptions.
- Perception is a quantifiable variable and therefore structured data collection methods and statistical analysis are appropriate.

1.6.2 Theoretical framework

King's Theory of Goal Attainment served as the theoretical foundation for this study. First, King's open systems framework is outlined and then attention will be given to King's theory of goal attainment.

1.6.2.1 King's open systems framework

King developed a conceptual framework, which depicts nursing as involving three interacting systems, namely the personal system (individuals), interpersonal system (dyads, triads, small

groups and large groups) and a social system (health care systems and organisations) (George 2002:242; King 1981:10-11).

Personal systems

The personal system pertains to an individual. The nurse or the client as a person is a total system. Concepts relevant to comprehending human beings as persons are perception, self-growth and development, body image, space, learning, and time. Individuals are perceiving, purposeful and goal directed beings. Perception is a core concept of a personal system, as people's perceptions influence interaction with others and the environment. It is subjective and is based on information that is available. Individuals are active participants in the situations that they perceive as they interact with others and the environment. The interaction influences their behaviour, and provides meaning to their experience and the individual's image of reality (George 2002:244-245; King 1981: 10).

Based on King's definition of personal systems, the perceptions of the registered nurses about their role in integrated primary health care delivery are based on the information that is available to them about what integrated health care and their role entail. Their image of reality is based on their perceptions and is therefore subjective. Each registered nurse perceives his/her role in a unique manner. The way they carry out their duties is influenced by their perceptions. If information about a changed health care system is not disseminated to them, there is a risk of misperception that may hamper effective role performance. In order to influence the perceptions of registered nurses, information regarding their role and the principles inherent in an integrated health care system should be made available to them.

Interpersonal systems

Interpersonal systems are formed by two or more interacting individuals. Relevant concepts are interaction, communication, role, and stress. The major concept is interaction, which is influenced by perception. Interaction is behaviour that is observed between an individual and the environment or between two or more individuals. Stress is a state whereby an individual maintains balance through interaction with the environment. The nurse-client interaction is an interpersonal system, and the interaction leads to the attainment of mutually agreed upon goals. Communication is a process whereby information is transferred from one person to the other. Through communication

the client and the nurse set goals, and explore and agree on means to achieve them (George 2002:246; King 1981:10).

The behaviour manifested during interaction is influenced by the perceptions of both the client and the nurse regarding, amongst others, their respective roles. In interpersonal systems those who interact fulfill specific roles. A role consists of a set of expected behaviours of those who occupy a position in a social system. It is a set of procedures or rules that define the obligations and rights associated with a position and the relationship between two or more people interacting for a purpose (George 2002:246; King 1981:141).

This study examines the perceptions of the registered nurses about their role in integrated primary health care delivery because such perceptions influence their interactions with clients and role inactment. Registered nurses are expected to behave and carry out their duties in accordance with the principles and set of rules within the integrated primary health care delivery system. The actual behaviour displayed is influenced by the individual registered nurse's perception of his/her role.

Social systems

Social systems are organisations formed by groups with special interests and needs. Social systems are organised boundary systems of social rules, behaviours and practices developed to maintain values and regulate practices and roles. Families, work systems, health care and educational systems are examples of social systems. The major concept of social systems is organisation. Such a system is made up of individuals with prescribed roles and positions, and resources are used to meet personal and organisational goals (George 2002: 247-248; King 1981:115).

Integrated primary health care delivery is a social system formed to achieve specific goals. The nurse and the client each have a role to play during their interactions within the system. The changed health care dispensation may have resulted in changed prescriptions regarding the role of the registered nurses within the integrated primary health care delivery paradigm. A lack of preparation of registered nurses for their changed roles may have resulted in uncertainty amongst nurses, concerning what is expected from them.

1.6.2.2 King's theory of goal attainment

The major elements of the theory of goal attainment are seen in the interpersonal systems, where two persons interact. Individuals are purposeful and goal directed. Individuals involved in interaction bring different perceptions to the exchange. This will influence the decisions and actions that they take. According to King (1981:94) distorted perceptions of a role may negatively impact upon achievement of set goals. A transaction is the observable behaviour of persons interacting with their environment that is influenced by perception. Successful transactions that occur between the nurse and the client lead to goal attainment (George 2002:249). Perceptions of registered nurses regarding integrated primary health care goals have a positive or negative effect on goal attainment.

This research contributes towards promoting clarity among registered nurses, about their role within the integrated primary health care delivery as one prerequisite to enhance goal attainment in the clinical settings. Within integrated primary health care delivery, the role of the registered nurses should be clearly defined by authorities and understood by the registered nurses in order to avoid role conflict and confusion. The effective implementation of the integrated primary health care delivery is influenced by the perceptions of the registered nurses about their role. Accurate role perceptions will make it possible for set goals to be achieved, as each person knows what is expected of him/her.

1.7 RESEARCH DESIGN AND METHOD

A quantitative, descriptive study was conducted to determine the perceptions of the registered nurses and nurse managers regarding the role of the registered nurse in integrated primary health care delivery, and to compare their perceptions. The respondents in this study fell into two categories: a group of registered nurses rendering direct care in integrated primary health care settings, and a group of nurse managers of integrated primary health care services. This was a population study and therefore sampling was not relevant. Two structured questionnaires were used to collect data, one for registered nurses and the other for nurse managers. Data was analysed using descriptive and inferential statistics.

1.8 SCOPE OF THE STUDY

The study was conducted in primary health care clinics in the Tzaneen sub-district of the Limpopo Province of the RSA. The findings of the study are relevant to this sub-district only and could not be generalised to other sub-districts in the province because the populations were limited to the Tzaneen sub-district. The population consisted of registered nurses working in clinics and health care centres and nurse managers of integrated primary health care. Other categories of nurses were excluded. Registered nurses working in hospital outpatient departments rendering primary health care services were not included in this study.

1.9 STRUCTURE OF THE DISSERTATION

Below is the structure of the dissertation in a tabular form.

Table 1.1 Structure of the dissertation

CHAPTER	TITLE	CONTENT DESCRIPTION
1.	Introduction and overview	Overview of the research problem, purpose, and the significance of the study. Description of the theoretical foundation of the study. Overview of the research design and method.
2.	Literature review	Overview of King's theory, role, perception, primary health care and integrated primary health care.
3.	Research method	Research design and method applied, and ethical principles adhered to.
4.	Research findings	Discussion of the research findings.
5.	Conclusion	Summary of the research findings, conclusions and recommendations

1.10 CONCLUSION

The new political dispensation in the RSA has brought with it numerous changes. New health legislation and policies have introduced changed patterns of health care delivery. These policies and laws have resulted in a shift in focus to integrated primary health care as a way of ensuring

health for all. This shift in focus has influenced the role of the registered nurses, as it was redefined and extended. The perceptions which registered nurses have regarding their new role in integrated primary health care delivery influence their role performance. Quantitative research was done to determine the registered nurses perceptions regarding their new role, in order to contribute towards role performances that are in accordance with principles of integrated primary health care delivery and role expectations. King's Theory of Goal Attainment was used as a theoretical basis for this study. Chapter 2 entails a detailed discussion of relevant literature that includes discussions about integrated primary health care, comprehensive health care, and the major concepts such as perception and role.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The aim of the literature review was to obtain comprehensive information about primary health care, integrated primary health care, comprehensive care, holistic care, role and perceptions. In this chapter, attention is given to national and international views on integrated primary health care. The researcher also discusses comprehensive health care and how it fits into integrated primary health care delivery. The role of the registered nurse within the integrated primary health care delivery model is discussed. The main focus of the study is on the perceptions of registered nurses regarding their role in integrated primary health care delivery. Therefore, the concept of perception has also been analysed.

2.2 PRIMARY HEALTH CARE

2.2.1 The concept of primary health care

Primary health care is care that is provided at the first point of contact with the health system. It is characterised by a broad approach to basic health services delivery and community development. Primary health care focuses on the community in need of health care (McElmurry & Keeny 1999: 241). It encompasses the main health problems and is provided in clinics, hospitals and communities. It addresses many of the determinants of health. A comprehensive focus is maintained by incorporating community development and health service delivery. Health professionals alone therefore cannot implement primary health care, since other professionals are also involved (Shoultz & Hatcher 1997: 24). It brings health care closer to where people live and work and as a result health services become more accessible (Barnes, Eribes, Juarbe, Nelson, Proctor, Swayer, Shaul & Meleis 1995: 8; Denill, King & Swanepoel 1999: 3; World Health 1998:7).

2.2.2 Approaches to primary health care

2.2.2.1 Comprehensive versus selective primary health care

Selective primary health care is an approach that deals with the management of identified health problems. It is aimed at improving the health status of many individuals at the lowest cost. An example of selective primary health care is the World Health Organisation's Expanded Programme on Immunisation (EPI). Comprehensive health care, on the other hand, is aimed at developing the community as a whole. It emphasises change in the community rather than concentrating on a single programme as is the case with selective primary health care (Denill et al. 1999:16-17).

2.2.2.2 Microscopic versus macroscopic (medical versus health) model

The microscopic or medical model focuses on curative services with no consideration of the community or environment where the patient comes from, whereas the macroscopic or health model acknowledges the effect that environment has on one's health. The focus of the macroscopic approach is on the promotion of healthy lifestyles and the creation of an environment that prevents ill health. The macroscopic approach focuses on prevention rather than cure. Comprehensive health care accommodates both approaches, with an emphasis on the macroscopic or health model (Denill et al. 1999:18).

2.2.3 Goals of primary health care

According to Strasser (1999:7) primary health care is needed in the RSA as there is a serious mismatch between income and health outcomes. There is a disparity between the poor and the rich regarding basic conditions of life and health outcomes. Primary health care aims to reduce inequalities in access to health services, especially in rural and deprived communities, and to ensure universal coverage. It is aimed at addressing global inequalities in basic health status through development of sustainable health programmes that are accessible at a cost that the people can afford (McElmurry & Keeny 1999: 241, 244). Shoultz and Hatcher (1997:26) believe that such programmes could eventually improve the health of an entire nation.

2.2.4 Main characteristics and components of primary health care

The components of primary health care include:

- basic need provision (nutrition, shelter, water, basic sanitation, clothing, prevention of hunger and starvation)
- prevention of health problems (through health promotion, health education, sifting programmes)
- management of health problems (health education, curative services, home-based care, referrals)
- rehabilitation services (health education on optimal living with disabilities, disability care, referrals)

(LaFond 1995:16; McElmurry & Keeny 1999:241; Shultz & Hatcher 1997:24-25).

Registered nurses are in a position to effectively implement primary health care policies because of the nature of their work. They form the backbone of primary health care in the RSA because in rural and remote areas they are mostly the only health care providers. They are the principal providers in all levels due to their large numbers. The registered nurse utilises each encounter with the client to render preventive care. Doctors and other specialised professionals are accessible for consultation, support and referral, and provide periodic visits (Chalmers, Bramadat & Sloan 1997: 80; Department of Health 2001b:12; ICN position 2000:24; Petersen 1999:908).

2.2.5 Principles inherent in the primary health care approach

2.2.5.1 Equity

Primary health care entails rendering essential services since it includes social and economic development as a way of attaining health for all. It concerns universal distribution of essential services. These are services without which a healthy life style is not possible, like safe water, a food supply and shelter (Barnes et al. 1995:11-12).

Primary health care aims to provide equal access to basic health care to all people. The poor, the aged and the disadvantaged especially in remote and rural areas should also have equal access to

health services. The health needs of the whole population should be met. There should be no discrepancies in the provision of health care (Bryar 1994:73; Denill et al.1999: 6).

2.2.5.2 Affordability

Services are provided at a cost that the community and the country can afford. People are not to be denied health care because of lack of money (Barnes et al. 1995:12; Denill et al. 1999:6).

2.2.5.3 Accessibility

Primary health care contributes towards ensuring accessibility of services to all citizens because all citizens have a right to basic health care. Primary health care reaches out especially to disadvantaged communities. There is a continuing organised supply of health services to people by overcoming geographical and financial barriers. Providing care that is culturally sensitive increases the accessibility of the services, as more people will utilise the services offered. Ideally all clinic services are available to clients anytime of the day. Health services are within walking distance, and provide care that the community needs and considers important. Such care is also concerned with availability of well-equipped clinics and a supply of essential drugs. (Chalmers, Luker & Bramadat 1998:68; Denill et al. 1999:6; McElmurry & Keeny 1999:241).

2.2.5.4 Availability

Primary health care ensures sufficient, appropriate and high quality health care delivery, which fosters lifestyle changes and positive health. Primary health care facilities provide the most appropriate care for the identified health needs of a community or for the problem the client presents with (Denill et al. 1999:6; McElmurry and Keeny 1999:244). Appropriate technologies are utilised. The simplest but not necessarily the cheapest technology is used with regard to equipment and procedures, considering the level of training of health professionals (Chalmers et al.1998: 70; Denill et al.1999: 6).

2.2.5.5 Effectiveness

A collaborative effort amongst sectors like housing, education, social welfare, business, agriculture and non-governmental organisations is required in order to meet the basic health needs of the

people. Primary health care entails a multi-sectoral approach to health in order to bring about conditions which enhance health, and prevent or manage conditions influencing ill health (Chalmers et al. 1998:69; Shoultz & Hatcher 1997:23).

For the success of any primary health care programme full community participation is essential. It is the corner stone of actualising primary health care. The community participates in the planning, provision, control and monitoring, and evaluating of services. There is an equal partnership amongst the beneficiaries, providers and managers. Communities take responsibility for their health and must prioritise their own needs. Community participation improves the acceptability and appropriateness of care (Barnes et al. 1995:11; Heaver 1995:26; McElmurry & Keeny 1999:245).

Primary health care aims to remedy the causes of health inequality through community empowerment. It also promotes self-reliance and reduces dependence on health professionals, as communities are encouraged to take responsibility for their own health. Civilians and communities are empowered to enable them to provide for their own basic health needs and to improve their quality of life. Primary health care can only be successful if it is part of an overall community development strategy (Denill et al. 1999:3; Heaver 1995:26; Unger & Criel 1995:115).

2.2.5.6 Efficiency

Efficiency is another principle on which a successful strategy for implementing primary health care should be based. What is achieved should be proportional to the amount of money, resources, effort and time spent (Denill et al. 1999:7).

2.2.6 Primary health care priorities

A national comprehensive primary health care service package of priority areas in the RSA includes:

- Child health, in particular infectious diseases
- Sexually transmitted diseases and Acquired Immune Deficiency Syndrome (AIDS)
- Tuberculosis (TB)
- Reproductive health: Antenatal, perinatal and postnatal care, and family planning
- Mental health

- Chronic diseases: Hypertension, cardiac failure, asthma, and diabetes mellitus
- Trauma and injuries
- Disabilities (Department of Health 2001a: 7).

2.2.7 Potential benefits and outcomes

Primary health care contributes towards the universal access of all people, especially in poor and remote areas, to basic and appropriate health services. It improves the health of the entire community by addressing the more general, social and economic issues that affect health. Resources are equally distributed, based on needs. Primary health care services are driven by communities and they take full responsibility for their own health (Barnes et al. 1995:12-13). This leads, not only to the development of communities, but also to attainment of optimal health.

2.2.8 Problem areas

Traditionally primary health care consists of a collection of separate vertical programmes. Each programme pursues its own narrow and unique objectives and there is limited co-ordination between programmes. This is costly and ineffective. Funds are likely to be wasted through duplication of functions and resources. It causes inconvenience to clients, as services associated with different parts of the primary health care package must be sought at different sites. It is costly for clients who have to utilise the various resources and costly for the government to maintain duplicated and fragmented services. In developing and poor countries with financial shortages this could pose a serious threat to the sustainability of the programmes (Health Systems Trust 1997:28; LaFond 1995:170; Toomey [Sa]:14).

A fragmented health care system treats problems and not people. Registered nurses working in vertical programmes are unable to address patients' needs in totality as they only concentrate on one or at most a few aspects of such health needs. LaFond (1995:109), and Lee and Zwi (1997:161) state that health professionals working in such a system do not detect problems falling outside their scope, like detecting sexually transmitted infections in a family planning clinic. They may fail to solve a health problem or successfully treat a disease because associated problems and contributing factors are not identified and managed.

For a primary health care system to be effective there must be a developed infrastructure, a sufficient number of skilled personnel and ongoing training. This could be a problem in developing countries, which struggle to establish and maintain infrastructure because of financial constraints, and experience a shortage of suitably qualified registered nurses. The success of primary health care is based on community participation. To get communities to fully participate and be the driving force in health care matters is a challenge. As an approach, it takes time to become fruitful (LaFond 1995: 170; Toomey [Sa]: 14).

2.3 INTEGRATED PRIMARY HEALTH CARE

There is a need to do away with the separation of curative and preventive services (Gilbert, Selikow & Walker 1996: 164; Health Systems Trust 1997:4). All clinics in the RSA are required to render comprehensive integrated primary health care services using a one-stop, affordable approach to care (Department of Health 2001b: 12).

2.3.1 The concept of integrated primary health care

Integrated primary health care is designed to manage a patient's health in totality (Denill et al.1999: 18; Drazen & Metzger 1999:11). It reduces the division between curative and preventive health services, because vertical programmes are combined and run as one programme (Health Systems Trust 1997:28; LaFond 1995:113-114).

Comprehensive integrated primary health care offers a one-stop health care approach. It is a strategy aimed at improving service delivery as clients receive all the primary health care services they require in a single visit. They do not have to go elsewhere or come back another time or day (Toomey [Sa]: 13). Clients use one entry point for all the different services and information which they require. This minimises the time the client spends in the facility trying to secure the parts of the primary health services they require (Britain 2000:70; Drazen & Metzger 1999:90; Health Systems Trust 1997:27; Toomey [Sa]: 14). Ideally preventive, promotive, curative and rehabilitative services are available daily. Services are rendered for at least eight hours a day, five days a week.

2.3.2 Main goals of integrated primary health care

Maintaining wellness is a major aim of integrated primary health care. Other goals include access to comprehensive and holistic health care, the provision of quality care, improved health for the citizens of a nation and ensuring cost effectiveness for both the client and the health system (Drazen & Metzger 1999:11; Health Systems Trust 1997:28).

2.3.3 Principles of integrated primary health care

2.3.3.1 Small institutions and populations

Not all health facilities are suitable to provide integrated primary health care delivery because of economic and functional reasons. For a facility to render comprehensive, integrated and continuous care it should have a relatively small population to care for, small buildings and a limited number of personnel (Unger & Criel 1995:115).

2.3.3.2 A manageable number of functions

According to Heaver (1995:5) a primary health care package should incorporate a relatively limited number of manageable functions as he believes that practitioners are more efficient when they focus on doing a few functions well. If practitioners are expected to do too many tasks this may negatively affect the quality of care that they render.

2.3.3.3 A balanced, comprehensive health care approach with an emphasis on prevention

Demands for the provision of curative services may compromise preventive care as more and more clients present with minor ailments (Denill et al. 1999:18; Whittaker 2000:41). However, in integrated primary health care emphasis should be placed on prevention rather than cure, although curative and rehabilitative care is rendered together with promotive and preventive care. Integrated primary health care focuses on the determinants of health that lie beyond personal factors, namely political, social and economic factors. A preventative approach therefore warrants that these factors that influence health be dealt with, together with personal factors that influence an individual's health.

2.3.3.4 Holistic care

Care should be holistic and comprehensive for it to be integrated. Petersen (1998:196) cites Orley and Sartorius (1986) who mention that when rendering integrated services, clients' health problems should be addressed by meeting their physical, social, spiritual and psychological needs.

2.3.4 Potential benefits and outcome

Integration cuts short the number of visits and the time that clients spend in health facilities trying to utilise the different services. Patients are generally satisfied and continuity of care is also improved. Integration of services eliminates duplication of services and tests, and paperwork that consumes time. Patients' records are integrated and streamlined. This allows the health service providers sufficient time to spend on actual client care. Provision of optimal care is possible as the health needs of clients are attended to holistically (Drazen & Metzger 1999:1; Toomey [Sa]: 14). Community relations with the health facility become sound as the community representatives give input on the running of the clinics, and the facility becomes more sensitive to concerns of the community like violence and abuse (Whittaker 2000:41).

According to Rispel, Price and Cabral (1996: 60) experiences in countries like Bangladesh have shown that integration increases the accessibility and appropriateness of health services. The overall provision of optimal care becomes more effective and efficient (Drazen & Metzger 1999:12; Whittaker 2000:41).

Registered nurses enjoy increased professional fulfillment as they are able to exercise greater breadth in their clinical skills and render a broader range of patient care (Toomey [Sa]: 39; Whittaker 2000:41).

2.3.5 Problem areas

Rispel et al. (1996:60) point out that there is still debate regarding which services are to be integrated and to what extent services should be integrated. This is based on concerns that services like family planning may receive lesser attention if integrated with the general health services, while on their own such programmes can be effective. There is another concern, that of increased waiting time in one-stop clinics.

Integration means that functions, which were previously performed in different areas, are combined, and registered nurses are expected to be able to perform a range of tasks for which they may have to acquire additional skills in order to become competent multi-skilled nurses. This brings the problem of training to the fore. Standards of care may decline if nurses are not properly trained. For instance, nurses are expected to provide mental health services as part of the primary health care package but in reality many nurses are not trained in mental health or have not used their skills for an extended period of time (Rispel et al. 1996:60; Toomey [Sa]: 20). Integration of services has created a need for the establishment of personnel development programmes to train and reorient registered nurses about their new role. This has placed more demand on human and material resources.

The requirement of having to be a multi-skilled nurse, and uncertainty about role expectations, could lead to resistance due to fear, uncertainty and insecurity. Managers who were running vertical programmes in Ghana resisted the idea of integrating programmes (LaFond 1995:114). This might have been due to fear of losing their positions, and uncertainty about the changes and what their new roles entailed. Continuity of care is part of integrated primary health care and according to Heaver (1995:21) if the care that is provided is to be comprehensive, integrated and continuous, registered nurses should make home visits. However, he goes on to say that this is time consuming and adds to the registered nurses' workload. This can contribute further to resistance.

In the RSA registered nurses manage clinics with little or no support from doctors and other health professionals, as they are not always available (Geyer 1998:32; Strasser 1999:7). This lack of support means not only an increase in the workload but also fear of harming clients if registered nurses perform tasks that they have not been trained to do.

Rispel et al. (1996:123) have indicated that the introduction of new services into the primary health care package may require extra resources. Lack of resources like transport and personnel can be hindrances, especially in poor countries.

2.4 COMPREHENSIVE HEALTH CARE

Denill et al. (1999:17) defines comprehensive primary health care as a strategy which is designed to improve the general health of the population. Health care should be comprehensive for it to be

integrated, which involves teamwork. According to Flarey (1995:111) nursing can provide comprehensive care through integration of the different primary health care services.

Comprehensive health care takes into account the different aspects of primary health care: prevention of disease, promotion of healthy living, provision of curative services and rehabilitation of the chronically ill, the disabled, the elderly and the terminally ill (Strachan 1999: 8).

Comprehensive health care entails the interaction between biological, social, cultural, spiritual and psychological factors and their influence on illness, and therefore supports a holistic approach. In comprehensive care there is a move beyond treatment; other aspects of the patient's life, which have a bearing on the illness, are addressed too. This requires knowledge of the social, epidemiological, economic and political situation of the community that is served (Bryar 1994:75; Denill et al. 1999:17; Petersen 1999:908).

Culture can be a barrier to service accessibility, and therefore comprehensive health care should entail culture congruent care. Culture influences the way the clients experience and respond to illness. The meanings that clients attach to illness are vital and should be acknowledged, as they will determine the outcome of the nurse-client encounter. Based on the culturally relevant information provided by the client, the registered nurse plans and implements culture congruent care. In order to provide such care, registered nurses should improve their knowledge about the culture of the community they serve and of the principles inherent in culture congruent care. Registered nurses should understand specific factors that influence a client's illness and health behaviours, and acknowledge their significance. Registered nurses should show respect for the culture of their clients, because culture defines what is acceptable to the community and what not. This will ensure the delivery of culturally acceptable, locally appropriate and client sensitive care (Giger and Davidhizar 1999: 4-9; Petersen 1999:908-909).

2.5 ROLE

2.5.1 The concept role

Douglas (1996:71) and George (2002:249) define role as a set of expected behaviours for a person with a specific position in society. Role is not synonymous with function. According to Searle and Pera (1995:223) the functions of a registered nurse are defined as a group of key activities seen to

be essential for the delivery of acceptable health care. Roles are impersonal because the position and not the individual determines role expectations (Badenhorst 2001:291). Role requires a particular behaviour from a person. Role implies transaction with others during social interactions between individuals, which depend on social norms. Norms lead to conformity as boundaries are established and this provides a framework for performance.

In Mead's (1934:145) view human beings interact in terms of symbols. Symbolic interaction emphasises the meanings that individuals assign to symbols and their consequent behaviour. Communication is possible if members of the society largely share the meanings of symbols. Interaction can take place only if the participants attempt to understand each other's symbolic gestures by assuming the position of those with whom they interact. This is called role taking, which allows the actor an opportunity to be able to interpret the meaning and intention of the other's symbolic gestures, and then make their own response based on the interpretation. Having understood the other's behaviour the actor modifies his/her own behaviour to sustain or alter the interaction. This provides a basis for a cooperative process. The actor's behaviour is validated by the response of the other individual. The conduct of one individual affects the other in carrying out acts in which they are both engaged (Mead 1934:145-146, 254-256). When registered nurses interact with clients their role performance will be validated by the reactions of the clients. For a successful interaction to take place registered nurses should modify their behaviour to accommodate the client's needs. Cooperation can be attained if registered nurses empathise with their clients through role taking.

According to King's theory, an interpersonal system involving rendering of nursing care is influenced by a social system and a personal system. Role performance is influenced by perceptions and expectations. Behaviour is regulated in terms of the expectations of others. Expectations are placed on the registered nurse by the health care system (social system) and by the client (personal system). People are expected to do what is appropriate for their role (Gordon 1999:62; King 1981:214). Health care system (social system) expectations are specified by means of job descriptions, procedures, rules and regulations, guidelines and protocols. These expectations provide guidance for individuals regarding their conduct (Badenhorst 2001:291; King 1981:94).

Clients (the personal system) bring with them particular expectations to the interpersonal system (nurse-patient encounter) which involves nursing care. The source of clients' expectations is the patient's rights (Douglas 1996:72). Patients place expectations on the institution (social system)

and on the registered nurse (King 1981:94). The expectations of the client influence role performance by the registered nurse. According to Douglas (1996:289) clients expect continuous, quality care and expect registered nurses to do what is appropriate for their role. Fulfillment of the client's expectations is the core of nursing. However, registered nurses have their own perceptions about what is expected of them. Their perceptions will determine their actual behaviour within the interpersonal system. The perceptions of the registered nurse should indicate their awareness of their changing role and changing patterns of health care delivery (Douglas 1996: 71; King 1981:94).

According to Gordon (1999:31) managers and subordinates often perceive the same situation differently and this can be a source of conflict. Role conflict can be a consequence of inconsistency between expectations and perceptions. If registered nurses' perceptions are inconsistent with the expectations of the client and/or the institution, role conflict may develop and this could negatively impact upon achievement of health care goals (Badenhorst 2001: 291-292; Douglas 1996:71).

2.5.2 Role changes

Lancaster (1999:176) states that any role that an individual assumes in society is continually evolving over time. According to Hardy and Conway (1988:69) health professionals are faced with the continuing need to redefine and realign their roles because of an expansion of knowledge and of demands made by consumers seeking ready access to care. Role making is a process that takes place when role change is consciously entered into and there is restructuring of the interaction. Role making occurs when the response of the role partner is different from the one expected and the actor modifies his or her behaviour to sustain the interaction. The altered relationship is validated by the response of relevant others. Revised expectations emerge for this altered relationship. Role modification can be a way of avoiding conflict (Hardy & Conway 1988:244). Registered nurses are also faced with role change as their clients' and the authority's expectations change.

In health care the focus has shifted from institutionalised and mainly curative care to community-based primary health care as a way for all nations to achieve health for all. This shift has, according to Akinsola and Ncube (2000:50), given nurses a much wider role and more responsibilities, especially in developing countries where they are the main providers of primary health care and work in isolation most of the time. This entails role change.

2.5.2.1 Consequences and problems associated with a changed role

There is ongoing demand for nurses to understand and respond to challenges, threats and opportunities within the profession (Lancaster 1999:25). The health care system operates in a context that is characterised by social, scientific and technological changes. Registered nurses are forced to constantly adapt to such changes to ensure the continued relevancy of health care delivery. This often entails role change, which is accompanied by a whole new set of professional demands, for which registered nurses are not necessarily prepared. In any situation change creates a feeling of vulnerability and may have positive or negative consequences (Douglas 1997:74; Williams and Sibbad 1999:743).

In the UK, a study by William and Sibbad (1999:739) revealed that nurses were concerned about their lack of education for their new role and uncertain about their new responsibilities that were brought about by a change in government policy, which focused attention on improving the cost-effectiveness of primary health care provision. Registered nurses in the RSA are positive that integrated health care will improve comprehensive health care delivery. They are, however, uncertain about how it should be implemented. Integration requires a multi-skilled nurse, and they feel that inadequate preparation for this role may compromise quality and lower the standard of care (Lee and Zwi 1997:160). A feeling of helplessness and frustration may overwhelm registered nurses if they find themselves unable to meet changed role expectations. This was found to be true by Bryar (1994:78), whose research indicated that primary health care nurses in Botswana were frustrated by their lack of skills.

In the UK a change in policy, that entailed a shift in focus to primary health care, increased the workload for nurses providing care in the communities (Albarran 1999:21; Ross 1999:46). In the RSA a study conducted by Daniels, Biesma, Otten, Levitt, Steyn, Martell, and Dick (2000:1208) revealed that health professionals working in primary health care facilities were found to be reluctant to implement national guidelines on the management of chronic diseases at primary health care level, because they felt this would increase their workload. This is in accordance with a previous study in the RSA by Lee and Zwi (1997:160), which revealed that registered nurses working in integrated primary health care were concerned about a potential increased workload. The perception amongst registered nurses that integration of services will increase their workload may influence their behaviour in the health care setting.

Shoultz and Hatcher (1997:23) point out that registered nurses form part of a multidisciplinary primary health care team and are expected to have knowledge of how such teams work. They should understand their role, functions, required skills and responsibilities within the primary health care team and those of other team members if they are to make a meaningful contribution. They are faced with a challenge to learn interdisciplinary negotiation. Denill et al. (1999: 68) state that registered nurses can view this challenge as an opportunity to acquire collaboration and negotiation skills.

Within the nursing profession itself there are different categories of nurses who fulfill different roles. Role conflict and confusion could occur if the roles of all categories are not clearly described. Such occurrences can affect service delivery negatively. Although role conflict and confusion can be a consequence of a changed health care dispensation, registered nurses could use this time of uncertainty to make themselves more marketable by acquiring new and/or advanced skills and by growing professionally. Ambiguity can create multiple role opportunities for registered nurses (Lancaster 1999:181; Toomey [Sa]: 24). According to Albarran (1999:21) nurses in the UK acquired new skills in an attempt to rise to the challenge of providing a wide and comprehensive range of services which they did not provide before.

2.5.2.2 Preparing nurses for role changes

Health care authorities and registered nurses are responsible for responding to altered role expectations that accompany changes in a health care system.

- ***Responsibilities of the authorities***

The authorities should effectively communicate the need for change and negotiate its implementation. The way in which the change is communicated will influence whether the change is acceptable or not to registered nurses (Badernhost 2001:300; Toomey [Sa]: 29). The provincial health department should provide the vision and expected outcomes and explain how each person's new role affects the bigger picture. This must be supplemented with consultations involving all those who are expected to implement the changes. There must be ongoing dialogue to negotiate changes regarding new roles and responsibilities (Lancaster 1999:177; Toomey [Sa]: 29). Flarey (1995:70) and Luthans (1998:344) both share the opinion that it is imperative that authorities should listen to suggestions and be sensitive to the concerns of the nurses regarding the changes.

George (2002:249) and Lancaster (1999:26) both point out the importance of clarification of expectations and new responsibilities to avoid role conflict and confusion. The responsibilities and skills required should be delineated in a clearly written job description accompanied by supervisors giving guidance on role performance. This would enhance registered nurses' confidence in providing care according to their changed role. Unclear, ambiguous and insufficient information from different sources may cause conflict and poor performance (Douglas 1996:72; Rispel et al. 1996:32; Whyte and Stone 2000:63). Perception is based on available information. Within the context of this research, to influence the perceptions of registered nurses authorities should provide them with information about integrated primary health care delivery. This should include the underlying principles, objectives, their role and the potential benefits of implementing such a system. Realistic and shared perceptions support effective care delivery.

The authorities should identify ways of using change to inspire personnel. Role motivation refers to the willingness on the part of registered nurses to carry out their new role, and is influenced by their experiences, interests, needs and desires (Douglas 1996:288). The authorities should identify ways to motivate registered nurses and to secure and sustain their commitment. The registered nurses should be informed about the benefits of providing integrated primary health care as opposed to traditional primary health care. Timely, helpful, and positive performance feedback and regular information updates about work related decisions could motivate them. They should be told about the meaning and value of acquiring new skills and changing the old ways of doing things. Administrators should acknowledge efforts to implement the changes and recognise achievement. They should give credit where it is due and convey appreciation. This will encourage the registered nurses to increase their commitment to change (Flarey 1995: 8; Luthans 1998:424; Toomey [Sa]: 24).

Authorities should create a supportive environment and allow registered nurses an opportunity to develop insight into their new role with proper guidance (Lancaster 1999:176). According to Douglas (1996:288) it is the responsibility of the authorities to provide registered nurses with professional preparation and to offer them opportunities to grow professionally. Training and development programmes should be in place for developing new values and skills in preparation for a new role. They should be encouraged to change their self-image as they assume their new roles. Authorities should arrange for seminars and in-service education programmes, based on the

needs identified, in order to empower nurses (Douglas 1996:288; Lancaster 1999:180; Luthans 1998:424; Toomey [Sa]: 56).

Preparation is an essential part of role change, but allowing registered nurses to actually implement the changes is the most effective way of assisting them to learn (Toomey [Sa]: 23). The authorities can create a supportive environment by allowing nurses to participate in decision making, encouraging upward communication flow, giving them more control over their jobs, and can prevent and reduce stress by being more flexible (Luthans 1998:344).

Authorities should also identify and manage limiting conditions such as an authoritarian leadership style and an organisational climate that is centralised, as it does not allow registered nurses to participate in decision-making (Badenhorst 2001:300).

McElmury and Keeny (1999:246) reported that primary health care nurses, in the USA, felt marginalised during the process of change in primary health care and were not satisfied about this. Similar findings were reported in two different studies conducted in the RSA by Daniels et al. (2000:1210) and Lee and Zwi (1997:160): namely, registered nurses and other health care providers in primary health care facilities felt that they were not part of the new developments in the health system, because of lack of information and relevant training. They had problems in implementing new treatment guidelines. They felt they had been insufficiently informed about policy changes. It is important that the people who are expected to implement new policies be included in the transformation process, or they may be unwilling to embrace the changes if they do not perceive that they are part of the process.

- ***Responsibilities of the registered nurses***

Registered nurses should take personal responsibility to upgrade their professional skills and keep themselves abreast of professional developments, especially in their field of practice. This information can be acquired through reading professional journals, and attending in-service education sessions and formal education initiatives (Searle & Pera 1995:241; Lancaster 1999:182).

It is the responsibility of registered nurses to commit themselves fully to their new role. Registered nurses should accept that uncertainty and ambiguity are part of the change process and must hold themselves accountable for achieving outcomes irrespective of change. They ought to strive to add

value to the services they render to clients. Registered nurses should take it upon themselves to adapt to changes in the work environment because change is inevitable and trying to maintain a status quo is a mistake. They should stay flexible and embrace change and look for better ways to accomplish a task (Douglas 1996:218). Within the context of integrated primary health care, registered nurses should question the traditional boundaries of their roles, which interfere with expected and desirable outcomes, if they are to improve integration and continuity of care in a changing health care dispensation (Ross 1999: 49). Registered nurses should be willing to solve problems that result from the role changes and avoid blaming others. Instead of focusing on negative aspects of their work place, nurses should think positively and feel good about their accomplishments, no matter how small (Douglas 1996:218; Lancaster 1999: 180-183).

2.5.3 The role of the registered nurse: general comments

Role is a set of expected behaviours in any given position. According to Parsley and Corrigan (1995:155) role determines what intellectual and physical work the registered nurse should actually perform. The perceived role of the registered nurse is determined by institutional requirements (rules, regulations, policies, and job descriptions), clients' needs, peer group expectations (group norms) and the nurse's conception of what behaviour the role implies (Douglas 1996: 72). In terms of King's Theory (refer to sections 1.6.2.1 & 2.5.1), role perception is thus influenced by the social, interpersonal and personal systems that come together in the health care setting.

King (1981:94) points out that role conflict may be a result of inconsistency between role perceptions and role expectations. According to Douglas (1996:290) role incongruity can occur when there has been a failure to communicate role expectations. It is important to find out if the perceived role of the registered nurses is congruent with the prescribed role and also to gain clarity as to whether the prescribed role is actualised. It is also important to identify how the perceived role differs from the prescribed role (Luthans 1998:102). In this research, the perceptions of registered nurses about their role, as reflected in their role performance in an integrated primary health care setting, were therefore compared with role expectations of nurse managers.

2.5.3.1 The dimensions of the registered nurse's role

Discussions on the role of the registered nurse in integrated primary health care were derived from professional literature, the Nursing Act 50 of 1978 (as amended), the Scope of Practice of Persons

who are Registered or Enrolled under the Nursing Act, (SANC 1984 (as amended)) and Rules setting out the Acts or Omissions in Respect of which the Council may take Disciplinary Steps (SANC 1985, as amended). In general, the role of the registered nurse possesses various dimensions, as outlined in this following section.

- ***Clinical***

Registered nurses work as independent practitioners in the primary health care setting. They have an obligation to carry out their clinical duties in a professional manner and have the right to decide whether they have the knowledge and competence to independently make decisions and intervene. They have a duty to act responsibly. Registered nurses are accountable for their acts and omissions (Fako & Forcheh 2000:11; Searle & Pera 1995:226).

Registered nurses are the first point of contact with the health system for clients. They do the initial health assessment of patients. They assess their patients holistically, diagnose and make decisions regarding initial management, either to treat or to refer (Fako & Forcheh 2000:11; Strasser 1999:6).

Registered nurses ensure the general wellbeing of clients. They provide care to individuals, families, groups and the community throughout the lifespan of clients. They render holistic care to clients by rendering physical, social, emotional and spiritual care. They provide comprehensive health services. All actions by the registered nurse must contain preventive, promotive, curative, rehabilitative and palliative care components (Akinsola & Ncube 2000:52; Searle & Pera 1995:179).

- ***Prevention and promotion***

Registered nurses manage prevention and health promotion programmes. They promote self-care and positive health practices, and help clients to live healthier lives. They help prevent ill health and diseases by means of immunisation. Registered nurses are responsible for early detection of health problems and risk factors. They render screening services for diseases like cervical cancer (Petersen 1999:908; Toomey [Sa]: 20). They provide Voluntary Counselling and Testing (VCT) and Prevention of Mother to Child Transmission (PMTCT) programmes. Registered nurses provide reproductive health care and provide services for the termination of pregnancies. They render

prenatal, perinatal, and postnatal care. They provide infant and well baby care. Registered nurses participate in school based disease prevention and feeding programmes. They render special services for adolescents and the elderly (Akinsola & Ncube 2000:52; Chalmers et al 1998: 68; Department of Health 2001b: 18; Geyer 1998: 29; Strasser 1999:6).

- ***Curative care***

Registered nurses manage actual and potential health problems but refer more complex cases to the doctor or other professional members of the multidisciplinary team. They treat and manage most prevalent diseases such as sexually transmitted infections, including AIDS. They manage most of the acute health problems and chronic illnesses like hypertension, diabetes mellitus and asthma. According to Section 38(A) of the Nursing Act 19 of 1997 (as amended) registered nurses may prescribe medication up to schedule four including antibiotics, using the agreed treatment protocol (South Africa 1997b: 935, 937). They dispense medication. Registered nurses should therefore have knowledge of the essential drugs. They provide follow-up care for mentally ill patients and monitor their compliance with treatment (Fako & Forcheh 2000:11; Geyer 1998:29; Petersen 1999:910; Strasser 1999:6).

- ***Rehabilitative and palliative care***

Registered nurses do follow-up and home visits for people with disabilities and those recuperating from serious health problems. They identify those clients that require rehabilitation services and refer them accordingly. They help people to cope with their health problems and lead a normal life considering their limitations. They liaise with other stakeholders regarding receiving and re-issuing of assistive devices (Chalmers et al. 1998:68; Fako & Forcheh 2000:11; Strasser 1999:6). Registered nurses are involved in the provision of palliative care. They play a vital role in home-based care for the terminally ill and the elderly (Akinsola & Ncube 2000:52; Chalmers et al. 1998:68; Strasser 1999:6).

- ***Counselling and support***

Registered nurses are sources of support and comfort, and they create and maintain intimate relationships with clients and their families. They identify and manage human emotional responses

to diseases. They counsel clients with physical disabilities, debilitating diseases, social problems, economic problems and psychological problems. They provide counselling for clients with HIV/AIDS. They counsel clients faced with death and dying. Registered nurses provide counselling to victims of violence, crime, and abuse such as sexual, child and spousal abuse. They should possess listening and counselling skills to be able to help clients solve their own problems (Akinsola & Ncube 2000:52; Department of Health 2001b: 7; Petersen 1999: 909; Searle & Pera 1995:181; Spradley & Allender 1996:420).

- ***Coordination***

According to Spradley and Allender (1996:107) coordinating involves bringing people and activities together so that they work in harmony while pursuing common desired goals. Registered nurses consequently play an important role as coordinators and facilitators of the primary health care services. They coordinate the services rendered by the multidisciplinary team. Registered nurses ensure full participation of all members, and by so doing, ensure that clients receive all the health care they need. They are also agents for change, as they coordinate community initiatives to address economic, social and environmental issues that affect health. Registered nurses ensure full participation of individuals, families and communities by providing information and mobilising communities to campaign for a better health care dispensation. They liaise with protective services, teachers, social workers, social security officers, civic committees, health committees and non-governmental organisations (NGOs) to promote and facilitate primary health care strategies. They collaborate with community leaders on health issues. Registered nurses refer clients to other appropriate primary health care professionals. In cases where clients require services that are not provided at primary health care facilities the registered nurses will refer clients to those services (Akinsola & Ncube 2000:52; McElmurry & Keeny 1999: 244, 257; Searle & Pera 1995:182).

- ***Management and leadership***

Registered nurses perform the following policy making and planning functions in fulfilling their managerial and leadership roles:

- participating in planning of health services at district level
- planning health services and developing operational plans for care delivery at local level
- designing local policies in collaboration with stakeholders

- overseeing the implementation of policies and protocols
- compiling a budget, and ensuring optimal use of financial resources and effective utilisation of human and material resources

(Akinsola & Ncube 2000:52; Barnes et al. 1995:15; Douglas 1996:73; Lancaster 1999:429; Spradley & Allender 1996: 106).

Registered nurses perform the following functions in fulfilling their managerial and leadership roles to ensure high quality, effective service delivery:

- delegating functions appropriately and supervising staff
- overseeing client care and ensuring smooth running of services
- solving problems and making decisions regarding the day to day running of the services
- disseminating information pertaining to health care to staff members
- ensuring accurate record keeping of services rendered
- taking charge in conflict resolution especially where such conflict impedes necessary work
- upkeeping of physical resources like buildings
- designing and implementing quality control strategies
- conducting personnel performance appraisals

(Akinsola & Ncube 2000:52; Barnes et al. 1995:15; Douglas 1996:73; Lancaster 1999:429; Spradley & Allender 1996: 106).

In addition to managing health services, registered nurses manage community health promotion programmes and assist communities in managing self-help projects. They provide leadership to clinic committees, care and support groups (Akinsola & Ncube 2000:52; Barnes et al. 1995:15; Douglas 1996:73; Lancaster 1999:429; Spradley & Allender 1996: 106).

- ***Education***

Teaching is an integral part of the registered nurses' role. Registered nurses participate in designing, managing and monitoring health education programmes at provincial, district and local level. They participate in health education campaigns through dissemination of information to communities. They coordinate the implementation of health education programmes at local levels. Registered nurses render health education to individuals, families and groups and inform them about key health issues such as nutrition and safer sex practices. They assess the learning needs of

traditional healers and lay care givers and offer appropriate training. They develop health education media or use media that have been developed by media experts (Akinsola & Ncube 2000:52; Douglas 1996:291; McElmurry & Keeny 1999:257; Strasser 1999:6).

Registered nurses act as preceptors for colleagues. They have a duty to ensure that primary health care staff members have the knowledge and skills they need to perform their duties, by assessing their learning needs and rendering in-service education. Registered nurses identify learning needs of student nurses and provide clinical accompaniment to students (Searle & Pera 1995:178).

- ***Advocacy***

According to Searle and Pera (1995:182) advocacy involves speaking or acting on behalf of clients, so that they receive the care that they need and deserve. It also means that registered nurses should use their knowledge and skills to the benefit of their clients. Registered nurses inform clients about their rights and responsibilities in terms of the Batho Pele Standards. According to these standards all citizens should be given full and accurate information about the public services they are entitled to receive. Citizens should have equal access to the services to which they are entitled and should be treated with courtesy and consideration (Department of Health 2001a:10). Registered nurses help clients to gain self-determination, so that they are able to access appropriate services independently. This they do by showing clients what services are available, which ones they are entitled to and how to obtain them. They negotiate on behalf of clients and ensure that available services are relevant to communities' and individual clients' needs (McElmurry & Keeny 1999:254; Searle & Pera 1995: 182; Spradley & Allender 1996:105). They act as advocates for clients who are subjects in research studies, thus protecting their rights (Brink 1996:14).

- ***Research***

Registered nurses initiate research projects or participate in research projects of other members of the multidisciplinary team. They identify problem areas suitable for research. They are involved in the collection and analysis of data. They conduct health surveys in the community on clients' perceptions of the quality and convenience of services. Registered nurses have a responsibility to identify and evaluate research findings relevant to their field of practice. They should be familiar with research findings and their usefulness in nursing. Registered nurses compile and read research

reports and apply research results and recommendations in clinical practice. They compile reports and statistics needed by administrators for planning purposes (Akinsola & Ncube 2000:52; Barnes et al. 1995:15; Brink 1996:14).

2.6 PERCEPTION

Individuals respond to a situation based on their perception. Perception is, according to King (1981:20), each individual's representation of reality, and is based on an interpretation of available information. A person's perception of the world is subjective. According to Ungerer (2001:116) perception is a process that individuals use to understand reality. Perception is selective and subjective because people choose what to include in their perceptual space. Each person has a unique way of perceiving a situation. People in the same environment may observe the same situation but respond to it differently (Mead 1934:35). Luthans (1998:101) states that perceptions may yield a picture quite different from reality. Mistakes in decision-making can be the result of subjective perception. It is therefore important that people should understand their perceptual biases (Lancaster 1999:280; Luthans 1998:112). In the context of this study perception refers to the way in which registered nurses understand their role in integrated primary health care delivery and perform their functions based on their understanding.

The personal characteristics of the perceiver influence the way a situation is perceived. Perceptions can differ according to gender, where men and women perceive things differently. A generation gap may also contribute towards differing perceptions in situations where young and old people view the same situation differently. The level of intelligence influences the ability of an individual to process and analyse available information (King 1981:24; Lancaster 1999:256; Luthans 1998:113).

Psychological factors like goals, motives, past experiences, interests, attitudes, self-image, open-mindedness and personal expectations can influence perception. Personal expectations can distort perception because people are inclined to see what they expect to see regardless of the reality of the situation. People are inclined to pay attention to things which hold their interests. A person with a high need for power or achievement will be attentive to a situation. The way in which a person perceives the world depends on past experiences. People pay more attention to a new thing than an old one (Mead 1934:114). Motives may also exert an influence on perception. If a person has devious intentions he or she is more likely to see others also as devious. People who hold different

attitudes regarding a situation will perceive the same situation differently. A person with a positive self-image has confidence and is likely to perceive things in a positive way. Open-minded persons are more receptive to change and will perceive it differently from those who are dogmatic, because they do not accept new ideas easily. Stress, anger, fatigue, personal conflict, alcohol and drugs can distort perceptions (Lancaster 1999:256; Luthans 1998:112; Robbins 1996:133-134; Ungerer 2001:127).

According to King (1981:21) one's perception is based on social values, needs, and educational background. People who hold different social values and needs will interpret an event differently. People learn how to perceive things, and therefore the educational background and information that an individual possesses on a subject may influence their perception. Existing knowledge provides an interpretation framework by which people make sense of their world, and leads them to make unique choices and perceive realities uniquely (King 1981:21; Lancaster 1999:256; Luthans 1998:111-113). The culture to which people belong influences the way they see the world, by determining the way they interpret messages or situations (Lancaster 1999:280; Ungerer 2001:128).

As remarked above, registered nurses are expected to implement integrated primary health care delivery. The social expectations presuppose that nurses correctly interpret their roles and responsibilities, have the knowledge and skills to carry out the activities of primary health care, and are willing to change their professional behaviour. This presupposition could be the reason why there is little empirical evidence regarding the perceptions of registered nurses about their role in integrated primary health care (Chalmers et al. 1997:80; Daniels et al. 2000:1210; Lee and Zwi 1997: 160).

Flarey (1995:7) points out the importance of doing surveys or focus group interviews to identify the perceptions of service providers regarding any changes and developments in the health system. According to Lancaster (1999:256) in clinical practice nurses make decisions based on their perceptions of the situation. These perceptions may be different from reality (Luthans 1998:101). It is the registered nurses' perception of the situation that becomes the foundation on which they base their behaviour. According to Robbins (1996:141) there is an impressive amount of evidence to show that people will attempt to validate their perceptions, even if these perceptions are incorrect. It is therefore important to determine whether registered nurses' perceptions of their role are in line with the role expectations laid down by the authorities. It is also vital to know if this ideal role is actualised in the practical situation, and if not, to identify the constraints that registered nurses face.

This study examines the perceptions of registered nurses regarding their role in integrated primary health care delivery as compared to the role expectations of the nurse managers. Because little is known about the perceptions of health care providers regarding the changes brought about by integration of services, it is important that this study be done in a specific area (the Tzaneen sub-district) so that basic knowledge can be recorded regarding the perceptions of registered nurses in this sub-district regarding their role in integrated primary health care delivery.

2.7 ETHICAL ISSUES CONCERNING THE LITERATURE REVIEW

According to Brink (1996:47) researchers must be honest in whatever they do. In this study so as to apply this principle in the literature review a variety of sources were consulted in order to obtain a balanced view on the research topic by including a range of ideas in the review. The researcher took care to report on the literature consulted in an accurate and unbiased manner. Sources used in this study were fully acknowledged by the researcher to avoid plagiarism, which is presenting the work or ideas of others as one's own (Babbie 1998: 18).

2.8 CONCLUSION

The literature review assisted in providing a better understanding of integrated primary health care and of different views on what role registered nurses should play. It highlighted the dynamics of this system and the many functions of registered nurses. Both the authorities and the registered nurses have responsibilities in ensuring that role change is successful. The next chapter deals with the research method applied in conducting this study.

CHAPTER 3

RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

The study aims to identify discrepancies between the role perception of the registered nurses and the role expectations of the authorities represented by nurse managers of the health service. This chapter describes the research design and method used.

3.2 RESEARCH DESIGN

Quantitative, descriptive research was conducted to:

- determine the perceptions of registered nurses regarding their role in rendering integrated primary health care
- determine the perceptions of nurse managers regarding registered nurses' role in rendering integrated primary health care
- compare registered nurses' perceptions with those of nurse managers.

“Quantitative research is a formal, objective, systematic process in which numerical data are utilised to obtain information about the world” (Burns & Grove 1997: 27). The purpose of quantitative methods is to generate precise measurements of phenomena that can be explained by the accumulation of statistical data (Gilbert, Selikow & Walker 1996: 31). Quantitative research involves the use of structured procedures and formal instruments to collect data. To enhance objectivity, analysis of data is done using statistical procedures (Polit & Hungler 1995: 15). In this research a structured questionnaire was used to collect data which was susceptible statistical analysis.

The purpose of descriptive designs is to observe, describe and document aspects of a situation as it naturally occurs and to provide a complete description of a single broad variable or concept within a given population (Brink & Wood 1998: 289). The focus of this study was on a single variable,

namely certain perceptions. A descriptive design is used when very little is known about a topic or to explore a research question (Talbot 1995: 229). Within the context of this research, the perceptions of registered nurses and nurse managers in the Tzaneen sub-district have not been documented before. In descriptive research the research variable is examined, as it exists without investigator interference. Control over the research setting is limited (Brink & Wood 1998: 289-291). In this study there was no manipulation of variables and data quality was enhanced by promoting external validity.

3.3 RESEARCH METHOD

3.3.1 Sampling

3.3.1.1 Population

According to Burns and Grove (1997:41) a population is the entire set of individuals or elements which meet the sampling criteria. Two categories of respondents were involved in this study. The first category comprised registered nurses who were directly involved in health care delivery in integrated primary health care clinics in the Tzaneen sub-district of the Limpopo Province, at the time of data collection. The second category comprised nurse managers of integrated primary health care services at sub-district, district and provincial level.

3.3.1.2 Sampling

Sampling is a process of selecting a sample from the population of interest so that data can be collected regarding a given variable. Population studies do not involve sampling, as data is collected involving the entire population. Population studies are ideal for a comprehensive description of the population characteristics (Brink & Wood 1998:292; Burns & Grove 1997:294). In this descriptive research the total accessible population participated in data collection because the population of both categories of respondents was well defined and manageable in size.

3.3.1.3 Ethical issues related to sampling

The provincial and district authorities gave the researcher permission to obtain a list of the managers of integrated primary health care, and of all registered nurses who were directly involved

in integrated primary health care delivery. As sampling was not done the issue of fair selection was not relevant. Participation was voluntary and respondents were informed of their right to withdraw at any time during the course of the study.

3.3.1.4 *Sample*

Talbot (1995:241) defines a sample as a portion of the population that has been selected to represent the population of interest. This study was a population study. Forty (40) registered nurses and 20 nurse managers participated in the study.

3.3.2 Data collection

3.3.2.1 *Data collection approach and method*

Data was collected using a structured self-report data collection method. Structured data collection involves the use of formal instruments comprising pre-defined items and response options. Self-report data collection involves directly asking the respondents about the study variable. If a researcher wants to obtain information about attitudes, feelings, beliefs or any other information that cannot be easily observed, the most direct means is to ask questions of respondents (Talbot 1995: 293). Structured self-report data collection is strong in respect to its directness and versatility, and content coverage. It yields information that would be difficult, if not impossible, to gather by any other means (Polit & Hungler 1995: 254-255).

3.3.2.2 *Development and testing of the data collection instrument*

Two structured questionnaires were developed using the literature review as a frame of reference. One questionnaire was aimed at registered nurses and the other at nurse managers. The questionnaires comprised identical items, covering aspects pertaining to the registered nurses' role in integrated primary health care. The introductory sentence of each section of the questionnaires differed in order to accommodate the two categories of respondents. The dimensions of the registered nurses' role, discussed in chapter 2 (refer to 2.5.3.1) were used as a basis to structure the questionnaires.

Instrument validity refers to whether an instrument accurately measures what it is supposed to measure, given the context in which it is applied (Brink 1996: 167). This was enhanced by testing the questionnaires for face validity and content validity. The researcher enhanced content validity by structuring the questionnaires according to the dimensions of a registered nurse's role (refer to 2.5.3.1). The questionnaires were submitted to experts in the fields of research and integrated primary health care to enhance their content validity. Corrections were made as recommended by the experts. Face validity was enhanced by asking nurse practitioners and managers, who were not involved in data collection, to evaluate the questionnaire according to specified criteria. The criteria related to technical aspects, clarity and relevance of items (Annexure D). Again, changes were made where problems existed.

3.3.2.3 Characteristics of the data collection instrument

The researcher developed structured questionnaires. Such questionnaires allow respondents to indicate responses to pre-defined items. They comprise close-ended items, worded in such a way that respondents are limited to specified, mutually exclusive response options. Close-ended items facilitate the coding and statistical analysis of data. This also ensures that the researcher obtains the desired information, which can increase the reliability of the study (Talbot 1995: 294-295).

Questionnaires are generally cost effective in terms of finance and time taken to administer them. A structured questionnaire allows gathering of information from a large sample relatively quickly and inexpensively (Talbot 1995: 293). It offers the possibility of complete anonymity. A disadvantage of questionnaires is that the only information obtained is what is asked, so there is always the possibility that other equally important information may not be retrieved (Polit & Hungler 1995:288-289; Talbot 1995: 293).

The questionnaires (Annexure G) were structured according to identical sections that contained identical items apart from the introductory sentence to each section. Each questionnaire was divided into eight sections. Sections A-G were designed to elicit respondents' perceptions with regard to the registered nurse's role in integrated primary health care. These sections were structured according to the dimensions of the registered nurse's role; clinical, counselling and support, coordination, managerial and leadership, educational, advocacy and research. Section H, which sought biographical data like educational and professional background, was deliberately put

last so that respondents would not feel that the research concerned their educational and professional qualifications.

A four-point Likert scale was included in the questionnaires. The Likert scale is designed to determine the opinion or viewpoint of a respondent and contains a number of declarative statements, followed by a rating scale where respondents indicate the extent to which they agree with each statement. The purpose of using scales is to quantitatively discriminate among people with different opinions or perceptions (Burns & Grove 1997:163; Polit & Hungler 1995: 279). In this study a series of statements were presented to respondents. Each statement described a function of registered nurses in the integrated primary health care setting. The respondents were asked to indicate the extent to which they agreed or disagreed that the corresponding statement was appropriate to the role of the registered nurse, considering the introductory sentence. A key was included to make it easier for the respondents to interpret the scale. The responses were later scored. *Strongly agree was given a score of four and strongly disagree a score of one.*

Reliability of a data-collection instrument refers to the degree to which a data collection instrument can be depended upon to yield consistent results if used repeatedly over time on the same person, or if used by two different investigators. Sections A-G of the questionnaire were submitted to the Chronbach alpha test. The scores are incorporated in table 3.1.

Table 3.1 Chronbach alpha scores

Section	Coefficient alpha
A	.9614
B	.9031
C	.9470
D	.9445
E	.7785
F	.8425
G	.9226

3.3.2.4 Data collection process

A low response rate is a disadvantage when using questionnaires (Polit & Hungler 1995: 288). To ensure a high response rate the researcher personally distributed the questionnaires to respondents.

As the clinics are scattered over a large geographical area, this was done over a period of two days. For those respondents who were not on duty when the questionnaires were being distributed, a questionnaire and clear instructions were left with a co-worker. Respondents were given the freedom to complete the questionnaire at their own pace. The questionnaire was accompanied by a letter explaining the purpose of the study and clear instructions on how to complete it (Annexure E). The researcher also gave a detailed verbal explanation to clarify the purpose of the research. Appointments were then made for collection of the completed questionnaires.

Of the 45 questionnaires that were sent to registered nurses, 40 were returned and subjected to data analysis. The sample size of this group was therefore 40 and the response rate was 88.8%. In the nurse managers' group, 30 questionnaires were distributed and 20 were subsequently returned. The sample size of this group was 20 and the response rate was 66.6%. According to Babbie and Mouton (2001:261) a response rate of 70% is considered to be very good.

3.3.2.5 Ethical considerations related to data collection

Ethical principles as described by Brink (1996:39-47) and Neuman (1997:443-450) guided data-collection in this study. Permission to conduct the study in the clinics was granted by the Department of Health (Limpopo Province). The supervisors of the clinics and health centres were also informed of the study. Informed consent was received from the respondents, indicating their willingness to participate in the study. The consent form incorporated an explanation of the purpose of the study, and what the study involved. Respondents were in no way coerced into participating in this study. They were also informed of their right to withdraw from the study at any time even after agreeing to participate. The researcher explained that there were no personal benefits for participating in the study but that their participation would contribute towards improved integrated primary health care delivery. Anonymity and confidentiality were assured, as respondents were not expected to write their names on the questionnaires. This was important as registered nurses were asked to make statements about their role perceptions, which might not have been in agreement with the expectations of the authorities.

3.3.3 Data analysis

Data was analysed by calculating descriptive and inferential statistics. According to Brink (1996: 179) descriptive statistics allow the researcher to organise the data in ways that give meaning and

facilitate insight. The researcher calculated percentages, measures of central tendency (mode, mean, median) and standard deviations (Burns and Grove 1997: 430).

In addition to descriptive statistics, the Mann-Whitney U-test was applied to determine whether there were any differences in the perceptions of registered nurses compared to nurse managers. This was however, not hypothesis testing research, as there was only a single research variable. A null hypothesis was formulated which stated that no differences exist between the perceptions of the registered nurses and nurse managers on the role of the registered nurse in integrated primary health care delivery.

Ethical principles are also in play during data analysis (Brink 1996:47). The researcher ensured that data was analysed as proposed and refrained from fabricating data. The researcher also ensured that data was appropriately analysed and accurately interpreted with no distortions.

3.4 INTERNAL AND EXTERNAL VALIDITY OF THE STUDY

According to Brink (1998:106) internal validity refers to the degree to which the outcome of an experiment can be attributed to the independent variable rather than the uncontrolled extraneous factors. Descriptive research is low on internal validity. Measures employed in this study to enhance internal validity were to:

- use a reliable and valid data collection instrument
- apply structured data collection techniques to minimise the effects of external events on the responses by respondents (Polit & Hungler 1995:217-219).

External validity is the degree to which the results of a study can be generalised to settings or samples other than the ones studied (Brink 1998: 124). External validity is an important issue in descriptive research. For each category of respondents, the total population was selected for participation to enhance external validity. External validity can however, become problematic if the rate of refusal to participate is high (Brink & Wood 1998: 292). However, this study was not hampered by high rates of refusal to participate.

Threats to external validity in this study included the Hawthorne effect and social desirability. The Hawthorne effect occurs when respondents respond or behave in a particular manner because they

are aware of their participation in a study. Social desirability occurs when respondents give the answers which they perceive to be acceptable (Polit & Hungler 1995: 222). This was controlled by assuring subjects of anonymity and privacy which ensured that respondents completed the questionnaire truthfully, as some may have been reluctant to give critical answers if they feared identification and victimisation.

3.5 CONCLUSION

Quantitative, descriptive research was conducted to answer the research questions. Structured, self-report data collection was applied, involving registered nurses and nurse managers. Their responses were analysed to determine the similarities and differences in their perceptions on the role of the registered nurse in integrated primary health care delivery. The following chapter presents an analysis of data collected from the respondents in the Tzaneen sub-district of the Limpopo Province.

CHAPTER 4

ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

Quantitative, descriptive research was conducted to determine the perceptions of registered nurses and nurse managers with regard to the role of the registered nurse in integrated primary health care and to compare the perceptions of the two categories of nurses.

The research objectives were to:

- determine the perceptions of registered nurses regarding their role in rendering integrated primary health care
- determine the perceptions of nurse managers regarding registered nurses' role in integrated primary health care
- compare registered nurses' perceptions with those of nurse managers.

4.2 DATA MANAGEMENT AND ANALYSIS

Two categories of respondents were involved in this study, and therefore two questionnaires were developed and administered, as explained in section 3.3.2.2. The items on the questionnaire were coded as indicated on the questionnaires (refer to Annexure G). The questionnaire consisted of eight sections, namely sections A-H. The nature of sections A-G of the questionnaire is depicted in table 4.1. Section H elicited the biographical data of the respondents.

Table 4.1 Sections of the questionnaires

SECTION	FUNCTIONS COVERED
A	Clinical
B	Counselling
C	Coordinating
D	Managerial and leadership
E	Educational
F	Advocacy
G	Research

SPSS 10.0 for Windows was utilised for data management and analysis. The researcher calculated the frequencies, and the mode and median scores of the registered nurses' and nurse managers' responses on each item. The Mann-Whitney U-test was utilised to determine whether there were significant differences between the responses of the registered nurses and the nurse managers on each item. The chosen level of significance was 0.05. The null hypothesis stated that there are no differences in the perceptions of the registered nurses and those of nurse managers. A significant difference obtained on an item would mean that there is a difference between role perceptions and the role expectations. Where no differences were identified, role perceptions are in accordance with role expectations.

In this report, the results of the Mann-Whitney U-tests are discussed in order to directly address the research problem. References are only made to the frequencies of responses where significant differences exist between the responses of registered nurses and those of nurse managers on any given item.

4.3 RESEARCH RESULTS

The research results are discussed by referring to the sample characteristics, and the congruence, or lack thereof, of the perceptions of registered nurses compared to those of the managers. Due to the limited scope of the dissertation only the results of the Mann-Whitney U-test are discussed in the instances where congruence has been found between the perceptions of the registered nurses and those of managers. Where incongruencies were found, the results of the Mann-Whitney U-test have been supplemented with the descriptive statistical scores.

4.3.1 Sample characteristics

The sample size for the registered nurse group was 40, and for the nurse managers group, 20. Section H of the questionnaire comprised of two items pertaining to the biographical data of the respondents and two items on their professional profile.

4.3.1.1 Age

The ages of the registered nurses (n=40) ranged between 56 and 24. The mean age was 39 years and the mode, 43 years. The standard deviation (SD=8.15) indicates that the sample was heterogeneous in terms of age. The nurse manager group comprised 20 respondents, whose ages (n=20) ranged between 59 and 40. The mean age was 48 years and the mode, 54 years. The standard deviation (SD=5.07) indicates that the sample was less heterogeneous in terms of age compared to the registered nurses.

4.3.1.2 Professional registrations

The professional registrations of the registered nurses (n=40) indicated that all respondents were registered general nurses. Twelve (30%) were registered psychiatric nurses, 21 (52.5%) were registered community nurses while 35 (87.5%) were registered midwives. Seven (17.5%) were registered clinical nurses. One respondent (2.5%) was a registered nurse manager and one (2.5%) a registered nurse educator. One respondent (2.5%) was a registered paediatric nurse.

In the nurse manager group (n=20) all respondents were registered general nurses and midwives. Four (20%) were registered psychiatric nurses, 16 (80%) were registered community nurses and five (25%) were registered clinical nurses. Five (25%) were registered nurse educators while 14 (70%) were registered nurse managers. There was one registered ophthalmology nurse and one occupational health nurse.

4.3.1.3 Highest nursing qualifications

In the registered nurses group (n=40), 28 (70%) held a basic nursing diploma as the highest nursing qualification. This is the entry qualification into the nursing profession. Nine (22.5%) held a post

basic nursing diploma and three (7.5%) held a post basic nursing degree. There is therefore evidence of further educational development amongst the registered nurses group.

In the nurse manager group (n=20), five (25%) held a post basic nursing diploma as the highest nursing qualification. Thirteen (65%) held a post basic nursing degree while two (10%) held an honours degree. This indicates that all nurse managers have acquired additional qualifications and have been involved in continuing educational development.

4.3.1.4 Years of experience in working in a primary health care setting

The years of primary health care experience of registered nurses varied between one and 26 years. The mean score was 7.7 years, and the mode, 1. The standard deviation (SD=5.5) indicates that the sample was heterogeneous in terms of years of primary health care experience.

The nurse managers' years of primary health care experience varied between 3 and 27 years. The mean was 13 years of experience and the mode 7. The nurse managers were thus more experienced than the registered nurses. The standard deviation (SD=6.6) indicates that the sample was more heterogeneous than the registered nurses in terms of years of primary health care experience.

4.3.2 Clinical functions of the registered nurse

Section A of the questionnaire comprised 34 items pertaining to the clinical functions of the registered nurse. The Mann-Whitney U-test indicated that there is congruence between the perceptions of the registered nurses and managers pertaining to the function of registered nurses to:

- participate in feeding programmes (Item A1: p=0.407)
- render preventive health care (Item A2: p=0.101)
- render screening services (Item A3: p=0.263)
- provide voluntary counselling and testing(VCT) services (Item A4: p=1.000)
- participate in mother to child transmission programmes (Item A5: p=0.124)
- conduct health assessments (Item A6: p=0.096)
- treat minor ailments (Item A7: p=1.000)
- treat acute health problems (Item A8: p=0.136)
- treat chronic health problems (Item A9: p=0.485)

- treat sexually transmitted diseases (Item A10: $p=0.660$)
- participate in termination of pregnancies (Item A11: $p=0.177$)
- render rehabilitative care (Item A12: $p=0.637$)
- render palliative care (Item A13: $p=0.800$)
- participate in home care programmes (Item A14: $p=0.701$)
- render prenatal care (Item A16: $p=1.000$)
- render perinatal care (Item A17: $p=0.846$)
- render postnatal care (Item A18: $p=0.841$)
- render reproductive care (Item A19: $p=0.947$)
- render mother to child care (Item A20: $p=0.497$)
- render school health care (Item A21: $p=0.214$)
- meet the health needs of adolescents (Item A22: $p=0.856$)
- render geriatric health care (Item A23: $p=0.828$)
- meet the physical needs of clients (Item A24: $p=0.498$)
- meet the psychological needs of clients (Item A25: $p=0.432$)
- meet the mental health needs of clients (Item A26: $p=0.469$)
- meet the social needs of clients (Item A27: $p=0.086$)
- meet the spiritual needs of clients (Item A28: $p=0.133$)
- render care to individuals (Item A29: $p=0.062$)
- render care to families (Item A30: $p=0.849$)
- render occupational health care (Item A31: $p=0.699$)
- render care to specific interest groups (Item A32: $p=0.705$)
- prescribe medication (Item A33: $p=0.179$)
- dispense medication (Item A34: $p=0.580$).

The Mann-Whitney U-test indicates that there is a lack of congruence between the perceptions of the registered nurses and nurse managers with respect to the function of registered nurses to:

- manage communicable diseases (Item A15: $p=0.011$).

The frequencies of responses for item 15 revealed that six (30%) nurse managers ($n=20$), and 26 (65%) registered nurses ($n=40$) strongly agreed that the management of communicable diseases is a function of the registered nurse. Fourteen (70%) of the nurse managers, compared to 14 (35%) of the registered nurses, agreed. This is an indication that the registered nurses (mode=4; median=4) were

more inclined than nurse managers (mode=3; median=3) to perceive the management of communicable diseases as a function of the registered nurse.

4.3.3 Counselling functions of the registered nurse

Section B of the questionnaire comprised 11 items pertaining to the counselling functions of the registered nurse. The Mann-Whitney U-test indicated that there is congruence between the perceptions of the registered nurses and nurse managers pertaining to the function of registered nurses to counsel:

- clients with physical disabilities (Item B2: p=0.173)
- clients with debilitating diseases (Item B3: p=0.883)
- clients with economic problems (Item B5: p=0.728)
- clients with psychological problems (Item B6: p=0.255)
- clients faced with death and dying (Item B7: p=0.842)
- victims of violence (Item B8: p=0.300)
- victims of crime (Item B9: p=0.617)
- victims of sexual abuse (Item B10: p=0.663)
- victims of child abuse (Item B11: p=0.083)
- victims of spousal abuse (B12: p=0.159).

The Mann-Whitney U-test indicates that there is lack of congruence between the responses of registered nurses and nurse managers with regard to the perception that registered nurses:

- counsel clients with social problems (Item B4: p=0.013).

The frequencies of the responses obtained revealed that three (15%) nurse managers (n=20), and 19 (48.7%) registered nurses (n=39) strongly agreed that counselling clients with social problems is a function of the registered nurse. Sixteen (80%) nurse managers and 19 (48.7%) registered nurses agreed. One (5%) nurse manager and one (2.5%) registered nurse disagreed. This is an indication that the registered nurses (mode=3 & 4; median=3) were more inclined than the nurse managers (mode=3; median=3) to perceive counselling of clients with social problems to be a function of the registered nurse.

4.3.4 Coordinating functions of the registered nurse

Section C of the questionnaire comprised 20 items pertaining to the coordinating functions of the registered nurse. The Mann-Whitney U-test indicated that there is congruence between the perceptions of the registered nurses and the nurse managers pertaining to the function of registered nurses to:

- coordinate services rendered by the multidisciplinary team (Item C1: $p=0.759$)
- liaise with protective services (Item C2: $p=0.092$)
- liaise with teachers (Item C3: $p=0.053$)
- liaise with social security (Item C5: $p=0.114$)
- liaise with civic committees (Item C6: $p=0.146$)
- refer clients to other appropriate primary health care professionals (Item C9: $p=1.000$)
- refer clients to appropriate health services not provided at primary health care level (Item C10: $p=0.801$)
- participate in clinic committee meetings (Item C11: $p=0.798$)
- coordinate community initiatives to address economic issues that affect health (Item C12: $p=0.778$)
- coordinate community initiatives to address environmental issues that affect health (Item C13: $p=0.339$)
- coordinate community initiatives to address social issues that affect health (Item C14: $p=0.256$)
- mobilise communities to campaign for a better health care dispensation (Item C15: $p=0.350$)
- assist communities in managing self help projects (Item C16: $p=0.384$)
- secure collaboration with community leaders on health (Item C17: $p=0.085$).

The Mann-Whitney U-test indicates that there is lack of congruence between the perceptions of the registered nurses and nurse managers with respect to the function of registered nurses to:

- liaise with social workers (Item C4: $p=0.024$).

The frequencies of the responses revealed that three (15%) nurse managers ($n=20$), and 19 (47.5%) registered nurses ($n=40$) strongly agreed that it is a function of the registered nurses to liaise with social workers. Seventeen (85%) nurse managers and 20 (50%) registered nurses agreed. One (2.5%) registered nurse disagreed. This is an indication that the registered nurses (mode=3;

median=3) were more inclined than nurse managers (mode=3; median=3) to perceive liaison with social workers as a function of the registered nurse.

The Mann-Whitney U-test indicates that there is lack of congruence between the perceptions of the registered nurses and nurse managers with respect to the function of registered nurses to:

- liaise with health committees (Item C7: $p=0.024$).

The frequencies of the responses revealed that three (15%) nurse managers ($n=20$), and 19 (47.5%) registered nurses ($n=40$) strongly agreed that it is the function of the registered nurse to liaise with health committees. Seventeen (85%) nurse managers and 20 (50%) registered nurses agreed. One (2.5%) registered nurse disagreed. This is an indication that the registered nurses (mode=3; median=3) were more inclined than nurse managers (mode=3; median=3) to perceive liaison with health committees as a function of the registered nurse.

The Mann-Whitney U-test indicates that there is lack of congruence between the perceptions of the registered nurses and nurse managers with respect to the function of the registered nurses to:

- liaise with NGO's (Item C8: $p=0.041$).

The frequencies of the responses revealed that two (10%) nurse managers ($n=20$), and 14 (35%) registered nurses ($n=40$) strongly agreed that liaison with Non-Governmental Organisations (NGO's) is a function of the registered nurse. Eighteen (90%) nurse managers and 26 (65%) registered nurses agreed. This is an indication that registered nurses (mode=3; median=3) were more inclined than nurse managers (mode=3; median=3) to view liaison with NGO's as an important function of the registered nurse.

The Mann-Whitney U-test indicates that there is lack of congruence between the perceptions of the registered nurses and nurse managers with respect to the function of the registered nurses to:

- negotiate on behalf of clients to ensure that they obtain appropriate care (Item C18: $p=0.011$).

The frequency of the responses revealed that four (20%) nurse managers ($n=20$), and 22 (55%) registered nurses ($n=40$) strongly agreed that negotiating on behalf of clients to ensure that they obtain appropriate care is a function of the registered nurse. Sixteen (80%) nurse managers and 18

(45%) registered nurses agreed. This is an indication that registered nurses (mode=4; median=4) were more inclined than the nurse managers (mode=3; median=3) to view negotiation on behalf of clients as a function of the registered nurse.

The Mann-Whitney U-test indicates that there is lack of congruence between the perceptions of the registered nurses and nurse managers with respect to the function of registered nurses to:

- empower communities to take responsibility for their own health (Item C19: $p=0.043$).

The frequency of the responses revealed that five (25%) nurse managers ($n=20$), and 22 (55%) registered nurses ($n=40$) strongly agreed that empowering communities to take responsibility for their own health is the function of the registered nurse. Fifteen (75%) nurse managers and 17 (42.5%) registered nurses agreed. One (2.5%) registered nurse disagreed. This is an indication that the registered nurses (mode=4; median=4) were more inclined than the nurse managers (mode=3; median=3) to perceive community empowerment to take responsibility for their own health as an important function of the registered nurse.

The Mann-Whitney U-test indicates that there is lack of congruence between the perceptions of the registered nurses and nurse managers with respect to the function of registered nurses to:

- empower communities to independently seek appropriate health care (Item C20: $p=0.023$).

The frequency of the responses revealed that five (25%) nurse managers ($n=20$), and 22 (56.4%) registered nurses ($n=39$) strongly agreed that empowering communities to independently seek appropriate health care is a function of the registered nurse. Fifteen (75%) nurse managers and 17 (43.5%) registered nurses agreed. This is an indication that registered nurses (mode=4; median=4) were more inclined than the nurse managers (mode=3; median=3) to view empowerment of communities to independently seek appropriate health care as an important function.

4.3.5 Managerial functions of the registered nurse

Section D of the questionnaire comprised 23 items pertaining to the managerial and leadership functions of the registered nurse. The Mann-Whitney U-test indicates that there is congruence between the perceptions of the registered nurses and nurse managers pertaining to the functions of registered nurses to:

- conduct health surveys (Item D1: $p=0.706$)
- design local policies in collaboration with stakeholders (Item D2: $p=0.359$)
- plan health services at local level (Item D3: $p=0.804$)
- develop operational plans for care delivery (Item D4: $p=0.838$)
- participate in planning of health services at district level (Item D5: $p=0.306$)
- oversee implementation of policies (Item D6: $p=0.132$)
- oversee the implementation of procedures (Item D7: $p=0.558$)
- manage community health promotion programmes (Item D8: $p=0.452$)
- ensure optimal use of financial resources (Item D10: $p=0.638$)
- ensure effective utilisation of human resources (Item D11: $p=0.660$)
- ensure effective utilisation of material resources (Item D12: $p=0.985$)
- conduct stock management of medicine supplies (Item D13: $p=0.055$)
- ensure the upkeep of physical resources (eg buildings) (Item D15: $p=1.000$)
- delegate functions appropriately (Item D16: $p=0.663$)
- supervise staff (Item D17: $p=0.713$)
- conduct performance appraisals (Item D18: $p=0.428$)
- disseminate information, pertaining to health care, to staff members (Item D19: $p=0.423$)
- design quality control strategies (Item D20: $p=0.459$)
- implement quality control strategies (Item D21: $p=0.689$)
- ensure accurate record keeping of services rendered (Item D22: $p=0.277$)
- compile statistical reports (Item D23: $p=0.465$).

The Mann-Whitney U-test indicates that there is lack of congruence between the perceptions of the registered nurses and nurse managers with respect to the function of the registered nurses to:

- compile a budget (Item D9: $p=0.043$).

The frequencies of the responses revealed that four (20%) nurse managers (n=20), and six (15.3%) registered nurses (n=39) strongly agreed that compiling a budget is a function of the registered nurse. Fourteen (70%) nurse managers and 17 (42.5%) registered nurses agreed. Two (10%) nurse managers and 14 (35.8%) registered nurses disagreed. Two (5.1%) registered nurses strongly disagreed. This is an indication that nurse managers (mode=3; median=3) were more inclined to view compiling a budget as an important function than the registered nurses (mode=3; median=3).

The Mann-Whitney U-test indicates that there is lack of congruence between the perceptions of the registered nurses and the nurse managers with respect to the function of the registered nurses to:

- maintain stock records of medicines (Item D14: p=0.019).

The frequency of the responses revealed that six (30%) nurse managers (n=20), and 25 (64.1%) registered nurses (n=39) strongly agreed that maintaining stock records of medicines is the function of the registered nurse. Fourteen (70%) nurse managers and 15 (38.4%) registered nurses agreed. This is an indication that registered nurses (mode=4; median=4) were more inclined than the nurse managers (mode=3; median=3) to view maintaining of stock records of medicines as a function of the registered nurse.

4.3.6 Educational functions of the registered nurse

Section E of the questionnaire comprised 25 items pertaining to the educational functions of the registered nurse. The Mann-Whitney U-test indicated that there is congruence between the perceptions of the registered nurses and nurse managers pertaining to the functions of the registered nurses to:

- provide clinical accompaniment to students (Item E1: p=0.620)
- assess the learning needs of students (Item E2: p=0.290)
- assess the learning needs of community interest groups (Item E4: p=0.384)
- assess the learning needs of traditional healers (Item E5: p=0.633)
- assess the learning needs of lay care givers (Item E6: p=0.233)
- provide clinical accompaniment to students (Item E7: p=0.645)
- render in-service education to primary health care staff (E8: p=0.660)
- render training to lay care givers (Item E10: p=1.000)
- participate in designing health education at provincial level (Item E11: p=0.979)

- participate in designing health education at district level (Item E12:p=0.510)
- participate in designing health education at local level (Item E13:p=0.247)
- co-ordinate the implementation of health education programmes at local level (Item E14: p=0.956)
- develop the content for health education (Item E15: p=0.217)
- use content that has been developed by experts for use in health education (Item E16: p=0.499)
- develop audio-visual health education media (eg posters and pamphlets) (Item E17: p=0.247)
- use audio-visual health education media that has been developed by media experts (Item E18: p=0.860)
- initiate the use of electronic media (eg TV and radio) for health education (Item E19: p=0.229)
- render health education to individuals (Item E20: p=0.093)
- design health education campaigns (Item E22: p=0.096)
- manage health education campaigns that are in progress (Item E23: p=0.160)
- participate in health education campaigns through dissemination of information to communities (Item E24: p=0.144)
- monitor health education campaigns (Item E25: p=0.487).

The Mann-Whitney U-test indicates that there is lack of congruence between the perceptions of the registered nurses and nurse managers with respect to the function of the registered nurses to:

- assess the learning needs of primary health care staff (E3: p=0.040).

The frequencies of the responses revealed that four (20%) nurse managers (n=20), and 21 (52.5%) of registered nurses (n=40) strongly agreed that assessing the learning needs of primary health care staff is the function of the registered nurse. Sixteen (80%) nurse managers and 17 (42.5%) registered nurses agreed. Two (5%) registered nurses disagreed. This is an indication that registered nurses (mode=4; median=4) were more inclined than nurse managers (mode=3; median=3) to view assessing the learning needs of primary health care staff as a function of the registered nurse.

The Mann-Whitney U-test indicates that there is lack of congruence between the perceptions of the registered nurses and nurse managers with respect to the function of the registered nurses to:

- render training to traditional healers (Item E9: $p=0.003$).

The frequencies of the responses revealed that six (30%) nurse managers ($n=20$), and six (15%) registered nurses strongly agreed that rendering training to traditional healers is a function of the registered nurse. Fourteen (70%) nurse managers and 18 (45%) registered nurses agreed. Fourteen (35%) registered nurses disagreed, and one (5%) strongly disagreed. This is an indication that the nurse managers (mode=3; median=3) were more inclined than the registered nurses (mode=3; median=3) to view training of traditional healers as the function of a registered nurse.

The Mann-Whitney U-test indicates that there is lack of congruence between the perceptions of the registered nurses and nurse managers with respect to the function of registered nurses to:

- render health education to groups (Item E21: $p=0.011$).

The frequencies of the responses revealed that six (30%) nurse managers ($n=20$), and 26 (65%) registered nurses ($n=40$) strongly agreed that rendering health education to groups is a function of the registered nurse. Fourteen (70%) nurse managers and 14 (35%) registered nurses agreed. This is an indication that registered nurses (mode=4; median=4) are more inclined than nurse managers (mode=3; median=3) to view rendering of health education to groups as a function of the registered nurse.

4.3.7 Leadership functions of the registered nurse

Section F of the questionnaire comprised 12 items pertaining to the leadership functions of the registered nurse. The Mann-Whitney U-test indicated that there is congruence between the perceptions of the registered nurses and nurse managers pertaining to the function of the registered nurses to:

- solve problems related to clinical care (Item F1: $p=0.367$)
- solve problems related to human resources (Item F2: $p=0.610$)
- solve problems related to material resources (Item F3: $p=0.393$)
- solve problems related to physical resources (Item F4: $p=0.251$)

- implement the decisions made by higher authorities to enhance optimal service delivery (Item F6: $p=0.609$)
- independently make decisions to enhance optimal service delivery (Item F7: $p=0.780$)
- use a participatory decision making approach to enhance optimal service delivery (Item F8: $p=0.638$)
- act as a change agent (Item F9: $p=0.119$)
- render training to lay care givers (Item F10: $p=0.138$)
- exercise leadership in community committees (Item F11: $p=0.396$)
- take charge in conflict resolution (Item F12: 0.164).

The Mann-Whitney U-test indicates that there is lack of congruence between the perceptions of the registered nurses and nurse managers with respect to the function of registered nurses to:

- rely on higher authorities to solve problems in the clinical setting (Item F5: $p=0.001$)

The frequencies of the responses revealed that one (5%) nurse manager ($n=20$), and seven (17.5%) registered nurses ($n=40$) strongly agreed that registered nurses rely on higher authorities to solve problems in the clinical setting. One (5%) nurse manager and 14 (35%) registered nurses agreed. Eleven (55%) nurse managers and 15 (37.5%) registered nurses disagreed, while seven (35%) nurse managers and four (10%) registered nurses strongly disagreed. This is an indication that registered nurses (mode=2; median=3) were more inclined than the nurse managers (mode=2; median=2) to view solving of problems in the clinical setting as the responsibility of higher authorities.

4.3.8 Research functions of the registered nurse

Section G of the questionnaire comprised five items pertaining to the research functions of the registered nurse. The Mann-Whitney U-test indicated that there is congruence between the perceptions of the registered nurses and nurse managers pertaining to the function of the registered nurses to:

- participate in research projects of other members of the multidisciplinary team (Item G2: $p=0.504$)
- read research reports (Item G3: $p=0.477$)
- compile research reports (Item G4: $p=0.106$)
- apply research results in care delivery (Item G5: $p=0.768$)

The Mann-Whitney U-test indicates that there is lack of congruence between the perceptions of the registered nurses and the nurse managers with respect to the function of the registered nurses to:

- initiate research projects (Item G1: $p=0.019$).

The frequency of the responses revealed that three (15%) nurse managers ($n=20$), and seven (17.5%) registered nurses strongly agreed that initiation of research projects is a function of the registered nurse. Seventeen (85%) nurse managers and 16 (40%) registered nurses agreed. Sixteen (40%) registered nurses disagreed and one (2.5%) strongly disagreed. This is an indication that managers (mode=3; median=3) were more inclined than registered nurses (bimodal; median=3) to view initiating research projects as a function of the registered nurse.

4.4 OVERVIEW OF THE RESEARCH FINDINGS

The results of the Mann-Whitney U-test on the level of congruence between the perceptions of the registered nurses and nurse managers, with respect to the functions of the registered nurses in integrated primary health care, are summarised below:

The nurse managers placed more weight than registered nurses on the following functions:

- compiling a budget (Item D9)
- rendering training to traditional healers (Item E9)
- solving problems in the clinical setting rather than relying on higher authorities (Item F5)
- initiating research projects (Item G1)

The registered nurses placed more weight than the nurse managers on the following functions:

- managing communicable diseases (Item A15)
- counselling clients with social problems (Item B4)
- liaising with social workers (Item C4)
- liaising with health committees (Item C7)
- liaising with NGO's (Item C8)
- negotiating on behalf of clients to ensure that they obtain appropriate care (Item C18)
- empowering communities to take responsibility for their own health (Item C19)
- empowering communities to independently seek appropriate health care (Item C20)

- maintaining stock records of medicines (Item D14)
- assessing the learning needs of primary health care staff (Item E3)
- rendering health education to groups (Item E21)

4.5 CONCLUSION

This section of the report gave a detailed discussion of the research findings. All the sections in the questionnaire were analysed and the findings discussed. The findings revealed that there are some areas where there is lack of congruence between the perceptions of the registered nurses and the nurse managers regarding the functions of the registered nurse in integrated primary health care. The findings also highlighted areas of congruence where there was no significant difference between the perceptions of the registered nurses and the nurse managers. Chapter 5 encompasses a summary of the research findings and provides detailed discussions of the conclusions, based on the findings and recommendations formulated by the researcher.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter presents a discussion of the research design and method, a summary and interpretation of the research findings related to the congruence between the perceptions of the registered nurses regarding their role in integrated primary health care delivery and the role expectations of the nurse managers. Recommendations for further research are also highlighted.

5.2 RESEARCH DESIGN AND METHOD

A quantitative, descriptive research study was carried out to address the research problem (Refer to section 1.2.3). The problem statement for this study was:

What are the perceptions of registered nurses about their role with regard to integrated primary health care compared with role expectations?

Quantitative, descriptive research was conducted to:

- determine the perceptions of registered nurses regarding their role in rendering integrated primary health care
- determine the perceptions of nurse managers regarding registered nurses' role in rendering integrated primary health care
- compare registered nurses' perceptions with those of nurse managers.

Data was collected using self-administered, structured questionnaires. Forty (40) registered nurses who render direct outpatient care, and 20 nurse managers of integrated primary health care services at sub-district, district and provincial level participated in the study. Data was analysed by mainly calculating descriptive and inferential statistics. This was not hypothesis testing research. However, a null hypothesis was formulated predicting that no differences exist between the responses of the

registered nurses and those of the nurse managers. The Mann Whitney U-test was applied to test the null hypothesis. Rejection of the null-hypothesis indicated that differences of perceptions did exist. The chosen level of significance was 0.05.

5.3 SUMMARY AND INTERPRETATION OF THE RESEARCH FINDINGS

A comprehensive summary and interpretation of the research findings are presented in this section. Where necessary, reference is made to correlation coefficient results to assist in the interpretation of the results.

5.3.1 Clinical functions of the registered nurse

There was congruence between the perceptions of registered nurses and those of the nurse managers on all but one of the clinical functions of the registered nurse (Refer to section 4.3.2). The highest level of congruence was obtained with regard to the registered nurse's function to provide voluntary counselling and testing (VCT) services, to treat minor ailments and to render prenatal care. This implies that registered nurses' perceptions of their clinical functions are congruent with role expectations. This is supportive of the attainment of integrated primary health care goals with regard to clinical service delivery. It is, however, necessary to scrutinise perceptions on the registered nurse's function to meet the social needs of clients. Although the null hypothesis was not rejected, the obtained value ($p=0.086$) on this item warrants attention. This low p -value, together with the fact that incongruencies in responses occurred with regard to counselling of clients with social problems (Refer to section 5.3.2) and liaison with social workers (Refer to section 5.3.3), indicates that meeting the social needs of clients is a problematic function.

A lack of congruency existed between the perceptions of registered nurses and those of the nurse managers on the clinical function of managing communicable diseases. All respondents indicated that managing communicable diseases is a function of the registered nurse. The lack of congruence resided in the differences in level of agreement indicated by respondents rather than in disagreement on whether this is a registered nurse's function. The registered nurses agreed more strongly than the nurse managers that this is a registered nurse's function. These differences may result in confusion and role conflict among registered nurses, which could ultimately impede control of communicable diseases through immunisations, screening and care delivery. Evidence of congruence between the perceptions of the registered nurses and those of nurse managers will enable the realisation of the

clinical dimension of the registered nurses' role (Refer to section 2.5.3.1). Inconsistence with regard to perceptions on this function may negatively impact on the implementation of the primary health care package (Refer to section 2.2.6).

5.3.2 Counselling functions of the registered nurse

There was congruence between the perceptions of registered nurses and those of the nurse managers on all but one of the counselling functions of the registered nurse. The shared perceptions on most of the counselling functions facilitate fulfilling the counselling dimension of the registered nurse's role (Refer to section 2.5.3.1). The highest level of congruence was obtained with regard to the registered nurse's function of counselling clients with debilitating diseases and clients having to cope with death and dying.

There appears to be lack of congruence between the perceptions of the registered nurses and those of the nurse managers on the function of the registered nurse to counsel clients with social problems. Registered nurses agreed more strongly than the nurse managers that this is a registered nurse's function. Almost all respondents indicated that it is a function of the registered nurse to counsel clients with social problems. However, the fact that some respondents (5% registered nurses; 5% nurse managers) did not regard this to be a registered nurse's function must be explored. It may be due to confusion as to what counselling entails and whether it is possible to refer clients without having done some counselling. This could potentially compromise the primary health care principle of holistic care, which also entails meeting the social needs of clients (Refer to section 2.3.3.4).

5.3.3 Coordinating functions of the registered nurse

The research findings revealed congruence with regard to many coordinating functions of the registered nurse. The highest level of congruence was identified with regard to the function of referring clients to other appropriate primary health care professionals, followed by referrals to appropriate services not provided at primary health care level. The principle of referrals is thus entrenched in the perceptions of both groups of respondents.

The coordinating functions of the registered nurse appear to be problematic despite the congruencies that were identified. This may undermine collaboration, which is one of the principles

inherent in a primary health care approach (Refer to section. 2.2.5.5). A strong partnership is needed amongst all stakeholders for effective service delivery. This is not possible without coordination of the services. Incongruence emerged between the perceptions of registered nurses and those of nurse managers on the functions of liaising with social workers, health committees and NGO's. Registered nurses agreed more strongly than the nurse managers that these are functions of the registered nurse. Role conflict could result when nurse managers convey messages to registered nurses regarding these functions, which are inconsistent with the perceptions of the registered nurses themselves. The primary health care principle of collaboration in the interest of comprehensive and effective health care delivery may be compromised (Refer to section 2.2.5.5).

Although all the respondents indicated that it is a function of the registered nurse to negotiate on behalf of clients to ensure that they obtain appropriate care, evidence of incongruity occurred in the level of agreement. Registered nurses agreed more strongly than the nurse managers that this is a registered nurse's function. Role conflict with regard to negotiation on behalf of clients to ensure that they obtain appropriate care may hamper achievement of the primary health care principle of client advocacy (Refer to section 2.5.3.1).

There appears to be incongruence between the perceptions of registered nurses and those of nurse managers on the functions of registered nurses to empower communities to take responsibility for their own health and to independently seek appropriate health care. The registered nurses agreed more strongly than the nurse managers that these are functions of the registered nurse. All nurse managers indicated that empowerment of communities to take responsibility for their own health and to independently seek appropriate health care are functions of the registered nurse. However, one (2.5%) registered nurse disagreed that it is a function of the registered nurse to empower communities to take responsibility for their own health. The lack of congruence between the perceptions of the nurse managers and the registered nurses may undermine the achievement of one of the primary health care goals of promoting self-reliance through community empowerment (Refer to section 2.2.5.5), and the achievement of the Batho Pele Standards through client advocacy.

5.3.4 Managerial functions of the registered nurse

There appears to be congruence in perception with regard to most of the managerial and leadership functions of the registered nurse. The highest level of congruence was identified with regard to the

registered nurse's function of ensuring the upkeep of physical resources (eg buildings), followed by effective utilisation of material resources. Other areas of congruence include the functions of planning services at local level and developing operational plans for care delivery.

Compiling a budget appears to be a controversial function, as disagreements occurred among the respondents on whether this is the registered nurse's responsibility. The managers overall tended to agree more strongly than the registered nurses that this is a registered nurse's function. However, a few respondents disagreed (nurse managers: 10% disagreed; registered nurses: 5% strongly disagreed, 35% disagreed). Most of the managers, because of their positions, compile budgets regularly and may be more experienced as a result. It may therefore be deduced that possession of budgeting skills may have influenced the perceptions of nurse managers in agreeing that compiling a budget is a function of the registered nurse. The other influencing factor could be the years of experience of working in a primary health care setting. Respondents with less experience may tend to perceive the compiling of a budget differently from the more experienced respondents. The nurse managers' mean years of experience were 13 years compared to the 7.7 years of the registered nurses. As budgeting is an important financial management tool, it is important that nurse managers and registered nurses agree on whether it is expected of registered nurses to fulfil this function.

Although all the respondents from both groups agreed that maintaining stock records of medicines is the function of the registered nurse, there was a lack of congruence between the perceptions of the nurse managers and registered nurses. Registered nurses agreed more strongly than the nurse managers that this is a registered nurse's function. It is necessary also to scrutinise perceptions of the registered nurse's function to conduct stock management of medicine supplies. Although the null hypothesis was not rejected, the obtained value ($p=0.055$) on this item warrants attention. This low p-value is an indication that management of medicine supplies, together with maintaining stock records, are problematic functions. Ineffective management of medicine supplies may hamper efforts of registered nurses to plan to ensure optimal levels of medicine supplies and manage available supplies. Failure to manage medicine supplies compromises the primary health care principle of rendering the curative aspects of comprehensive health care (Refer to section 2.3.3.3).

5.3.5 Educational functions of the registered nurse

There were many congruencies with regard to most of the educational functions of the registered nurse. The highest level of congruence was identified on the function of rendering training to lay caregivers. High levels of agreement were also obtained on the registered nurse's functions to:

- participate in designing health education at provincial level
- coordinate the implementation of health education programmes at local level
- use audio-visual health education media that have been developed by media experts.

A primary health care principle is to render care, including health education, to individuals, groups and communities (Refer to sections 2.2.5.1, 2.2.5.4). Although all the respondents indicated that it is a function of the registered nurse to render health education to groups, evidence of incongruity occurred in the level of agreement with regard to this function. Registered nurses agreed more strongly than the nurse managers that this is a registered nurse function. Failure to agree on the importance of rendering health education to groups, compromises the ability of registered nurses to render health education to the community (eg. lay caregivers, traditional healers and clients) and to render in-service education (Refer to section 2.5.3.1).

Incongruence emerged between the perceptions of registered nurses and nurse managers, regarding the function of registered nurses to assess the learning needs of primary health care staff. Registered nurses agreed more strongly than the nurse managers that this is a registered nurse's function. This is despite the fact that two (5%) registered nurses disagreed that assessing the learning needs of primary health care staff is the function of the registered nurse, while none of the nurse managers disagreed. This finding must be viewed in the light of the fact that there was congruence in perceptions that rendering in-service education to primary health care staff is a function of the registered nurse ($p=0.660$). If a needs assessment is not done prior to rendering in-service education, the possibility of irrelevant training sessions exists. It is therefore important that registered nurses and nurse managers should share the same level of agreement that both assessment of learning needs and rendering in-service education are functions of the registered nurse. The Spearman's Rho Correlation Coefficient was conducted to determine how responses to the function of assessing the learning needs of primary health care staff correlated with the responses to rendering in-service education to the staff. Table 5.1 is an indication of significant correlation obtained at the 0.01 level of significance.

Table 5.1 The Spearman's Rho Correlation Coefficient for selected educational functions

Functions	Registered nurses	Nurse managers
Assessing the learning needs of and rendering in-service education to primary health care staff	$r_s=0.719$	$r_s=0.302$

A significant correlation was found in the registered nurse group regarding the functions of assessing the learning needs and rendering in-service education to primary health care staff. This means that registered nurses significantly correlated a needs assessment and rendering in-service education functions. The responses of the nurse managers revealed a weaker correlation.

Rendering training to traditional healers appears to be a controversial function. Respondents disagreed on whether this is the registered nurse's responsibility. A large proportion of registered nurses (5% disagreed, 35% strongly disagreed) indicated that rendering training to traditional healers is not a function of the registered nurse, as compared to all (70% agreed, 30% strongly agreed) the nurse managers who agreed that this is a registered nurse's function. Inconsistencies with regard to perceptions on this function may lead to neglecting the educational role applied to traditional healers (Refer to section 2.5.3.1) and failure to achieve the primary health care principle of collaboration (Refer to section 2.2.5.5).

5.3.6 Leadership functions of the registered nurse

The research findings revealed congruence with regard to most of the leadership functions of the registered nurse. The highest level of congruence was identified with regard to the function of independently making decisions to enhance optimal service delivery. This is followed by solving problems related to human resources, using a participatory decision making approach to enhance optimal service delivery and implementing the decisions made by higher authorities to enhance optimal service delivery. This is an indication that respondents viewed problem solving and decision making as a registered nurse's function.

There were high levels of disagreement on whether registered nurses rely, or should rely, on higher authorities to solve problems in the clinical setting. Registered nurses were more inclined than nurse managers to agree that problem solving is the responsibility of higher authorities. This is in contrast

with the other problem solving functions, on which congruence between the registered nurse and nurse manager responses was obtained. The fact that the registered nurses had less working experience than nurse managers, could have influenced their perceptions about relying on higher authorities to solve problems in the clinical setting. It is possible that as years of experience increase, problem-solving skills would also increase. Furthermore, training in health services management may also contribute to enhanced problem solving skills. It is therefore possible that the nurse managers took their own problem solving skills for granted and assumed that registered nurses had similar problem solving abilities to themselves. Problem solving in clinical settings may be compromised if registered nurses rely on higher authorities (such as nurse managers), while nurse managers expect that registered nurses should be independent problem solvers.

5.3.7 Research functions of the registered nurse

There was congruence with regard to the functions of the registered nurse to participate in research projects, read research reports and apply research findings. The highest level of congruence was identified with regard to the function of applying research results in care delivery, followed by that of participating in research projects of other members of the multidisciplinary team. The Spearman's Rho Correlation Coefficient was conducted to determine how responses to the function of applying research correlated with the responses to the other functions. Table 5.2 is an indication of significant correlations obtained at the 0.01 level of significance:

Table 5.2 The Spearman's Rho Correlation Coefficient for selected research functions

Functions	Registered nurses	Nurse managers
Initiate research projects and apply research results	$r_s=0.531$	$r_s=1.000$
Participate in research projects and apply research results	$r_s=0.810$	$r_s=1.000$
Read research reports and apply research results	$r_s=0.674$	$r_s=0.728$
Compile research reports and apply research results	$r_s=0.748$	$r_s=1.000$

Significant levels of correlations were found with regard to applying research results and all the other listed research functions. These mean that all respondents, especially the nurse managers, significantly correlated applying of research results with the other research functions. Applying of research findings is therefore regarded as being part and parcel of the other research functions.

Incongruence emerged between the perceptions of registered nurses and nurse managers, regarding the function of registered nurses to initiate research projects. The nurse managers agreed more strongly than the registered nurses that this is a registered nurse's function. Referring to table 5.2, all nurse managers who indicated that registered nurses should initiate research projects, also indicated that they should apply research results. Registered nurses' responses indicated that they were less inclined to correlate these functions than nurse managers. The registered nurses' reluctance to initiate research projects could possibly be attributed to a lack of research skills, knowledge and experience on their part.

5.4 CONCLUSIONS

According to King's theory of goal attainment (Refer to section 1.6.2.2) individuals involved in interaction bring with them different perceptions to the exchange. Effective interactions would lead to successful transactions, namely goal attainment. Within the health care context, registered nurses' role performance is influenced by their role perceptions and by role expectations. Appropriate role perceptions and effective nurse-client interactions would enhance goal attainment. Inappropriate perceptions will impede attainment of integrated primary health care goals. The study has indicated the perceptions of both the registered nurses and the nurse managers regarding the role of the registered nurse in integrated primary health care. It has also revealed areas of congruencies and discrepancies between the perceptions of the registered nurses and nurse managers. The conclusion reached by the researcher is focussed on the areas of discrepancies which emerged from the research results.

There appears to be a lack of congruence between the perceptions of the registered nurses and the role expectations of the nurse managers, and possible conflict in registered nurses, with regard to the following functions:

- performing the clinical function of managing communicable diseases
- meeting the social needs of clients through counselling clients with social problems and liaison with social workers
- coordinating health service delivery through liaison with health committees and NGO's
- performing client advocacy by negotiating on behalf of clients to ensure that they obtain appropriate care

- empowering communities to take responsibility for their own health and to independently seek appropriate health care
- performing financial management by means of compiling a budget
- ensuring availability of medicine supplies through stock management and maintaining stock records
- rendering appropriate in-service education to primary health care staff by assessing their learning needs
- rendering health education to groups
- enhancing cooperation with traditional healers by rendering training to them
- demonstrating independent leadership by relying on higher authorities to solve problems in the clinical setting
- contributing to the knowledge base of nursing by initiating research projects.

These discrepancies may hamper the effectiveness of registered nurses in achieving the goals of integrated primary health care.

5.5 RECOMMENDATIONS

According to Douglas (1996:290) role incongruity occurs when there has been failure to communicate role expectations, or when confusing messages are communicated. The importance of ongoing dialogue to negotiate new roles and expectations cannot be over emphasised. Authorities should inform registered nurses about the meaning and value of acquiring new skills and changing old ways of doing things. This could be achieved through changing the perceptions of the registered nurses, by giving them information pertaining to role expectations. The following recommendations are based on the research findings discussed in the preceding sections of the report.

Strategic planning sessions should be conducted, involving registered nurses and nurse managers, to clarify specific functions of registered nurses

During strategic planning sessions, clarity should be obtained on whether it is a registered nurse's function to:

- manage communicable diseases
- counsel clients with social problems and liaise with social workers
- liaise with health committees and NGO's

- negotiate on behalf of clients to ensure that they obtain appropriate care (client advocacy)
- empower communities to take responsibility for their own health and to independently seek appropriate health care
- compile a budget
- manage medicine stocks and maintain stock records
- assess the learning needs of primary health care staff
- render health education to groups
- render training to traditional healers
- rely on higher authorities to solve problems in the clinical setting
- initiate research projects.

Personnel development sessions should be conducted, involving registered nurses and nurse managers, to explicitly communicate the functions of registered nurses

After completion of the strategic planning sessions personnel development sessions should be conducted, in the clinical setting, for both registered nurses and nurse managers so as to clearly communicate the functions of the registered nurses in integrated primary health care. It is also recommended that registered nurses be offered opportunities to grow through provision of in-service education on the principles of integrated primary health care and the expected outcomes of such a service. Registered nurses should be motivated to embrace equally all the different dimensions of the role that they are expected to perform, as they are expected to be multi-skilled practitioners. The personnel development programmes will assist registered nurses with the process of role taking, as they will be given an opportunity to understand the meaning and objectives inherent in integrated primary health care delivery and understand the role expectations.

Personnel development sessions should be conducted, involving registered nurses and nurse managers, to enhance their role performance

Where necessary, as based on a needs assessment, personnel development programmes are required to assist registered nurses in updating their knowledge and skills to effectively perform their functions.

In-service education, aimed at nurse managers, is required to update them about what integrated primary health care entails, so that they can provide the necessary support to the registered nurses. Another suitable topic is how to effectively communicate role expectations.

Further research should be done to answer questions that emerged from the research results

The following questions should be addressed through research:

- What functions are involved in the management of communicable diseases and do registered nurses and nurse managers perceive each of the identified functions as being a registered nurse's function?
- Are there any discrepancies between how registered nurses conceptualise their role and actual role performance?
- What are the similarities and differences in how registered nurses and nurse managers conceptualise the nature of the following functions:
 - meeting the social needs of clients
 - liaison with stakeholders in health care
 - client advocacy
 - community empowerment
 - financial management
 - stock management applied to medication
 - health education aimed at clients, peers and traditional healers
 - independent problem solving
 - independent research.

5.6 CONTRIBUTIONS OF THE STUDY

The study has highlighted the areas of potential effective role performance and areas of potential role conflict in integrated primary health care. The research recommendations will contribute towards clarifying those functions of the registered nurse in terms of which role performance and role expectations are in conflict. The study could contribute towards effective and efficient integrated primary health care delivery by assisting registered nurses and nurse managers in adopting realistic perceptions of the functions registered nurses are expected to perform.

5.7 LIMITATIONS OF THE STUDY

The research was conducted in the Limpopo Province in the Tzaneen sub-district. The findings of the study are relevant to this sub-district only and cannot be generalised to other sub-districts in the Province.

The researcher intended to involve 40 registered nurses and 40 nurse managers in the study, but it proved difficult to obtain 40 respondents from the nurse managers' group. The researcher furthermore experienced problems in obtaining the completed questionnaires, especially from the managers. However, after repeated reminders and personal contact 20 questionnaires were received. The eventual sample size was therefore 20. The researcher considered this in selecting appropriate statistical tests to analyse the data.

It is possible that the nurse managers could have misinterpreted item A15, namely the function to manage communicable diseases. The term *manage* in the item could have been interpreted differently by the two groups of respondents. To overcome this limitation the researcher recommended follow up research to determine what functions are involved in managing communicable diseases and to compare the registered nurses and nurse managers' perceptions regarding each of the identified functions.

5.8 CONCLUDING REMARKS

This descriptive, quantitative study sought to describe the perceptions of the registered nurses concerning the functions that they perform and to identify any discrepancies between the registered nurses' perceptions and the role expectations of the managers. These findings highlighted the state of affairs in a particular integrated primary health care facility. The study included 40 registered nurses and 20 nurse managers who volunteered to participate in the study. Self-administered, structured questionnaires were used to collect data. Data was analysed by using descriptive and inferential statistics. The results indicated that there were some areas where there was lack of congruence between the perceptions of the registered nurses regarding the functions that they perform and the role expectations of the nurse managers. These differences may result in confusion and role conflict among registered nurses, which could ultimately impede attainment of integrated primary health care goals. The researcher therefore recommended that the Department of Health of the Limpopo Province should consider the establishment of personnel development programmes.

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