

**THE EXPERIENCES OF COMMUNITY MEMBERS REGARDING THEIR
PARTICIPATION IN HOSPITAL BOARDS IN DR KENNETH KAUNDA DISTRICT,
NORTH WEST PROVINCE**

By

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UNIVERSITY OF SOUTH AFRICA

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DECLARATION

I declare that **THE EXPERIENCES OF COMMUNITY MEMBERS REGARDING THEIR PARTICIPATION IN HOSPITAL BOARDS IN DR KENNETH KAUNDA DISTRICT, NORTH WEST PROVINCE** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.



.....

SIGNATURE

Keneilwe Cynthia Modise

30 November 2015

DATE

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DEDICATION

I wish to dedicate this study to my late father, I know without any shred of doubt that this achievement would have brought joy into your heart. Your philosophy of life of always ensuring whatever you do, you do it to the best of your ability is what kept me going.

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ABSTRACT

The purpose of this study was to explore and describe the experiences of community members regarding their participation in hospital boards in Dr Kenneth Kaunda district, North West Province. A qualitative exploratory-descriptive research was conducted on a purposively selected sample of community members who served in the board for a minimum period of two years. Data were collected by means of individual interviews and analysed by means of thematic data analysis. Three themes that emerged from data analysis were creation of opportunities, benefits and challenges. A mix of positive and negative experiences was expressed by community representatives regarding their participation in hospital boards. Participants described their experiences as enjoyable and empowering while others described it as a learning experience through which they acquired knowledge and new skills. The challenges experienced whilst serving in hospital boards included ineffective communication, poor relations and role conflict as a result of lack of role clarification. The findings from the study may be used to enhance the effectiveness of hospital governing boards through the participation of community members.

KEY CONCEPTS

Community, community participation, community representatives, experiences, hospital boards, participation.

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CHAPTER 1

ORIENTATION OF THE STUDY

1.1 INTRODUCTION

The mode of delivery of health care services in South Africa was transformed from hospital-based to primary health care (PHC) in 1994 (Harrison 2009:2). One of the principles of PHC is community participation and involvement in the planning, provision, control and monitoring of health services (ANC1994a:19; South Africa 1997:15). In order to promote community participation and involvement in health care, the clinic committees, health centre committees and hospital boards were established (South Africa 1997:16).

Hospital governing boards are mechanisms that seek to promote public accountability, dialogue and feedback between the public and health providers (Macha, Mushi & Borghi 2011:14). They form part of the governance in the hospitals. McNatt, Thompson, Menistu, Tatek, Linnander, Ageze, Lawson, Berhanu and Bradley (2014:178) explain that hospital governing boards are mechanisms by which strategic planning, financial planning management, and human resource management are devolved from the central authorities to local communities and provider organisations. They are accountable and responsible for the successful operations of the entire organisations (Corbett-Nolan & Hazan 2010:1)

In countries such as Great Britain, hospital boards are body corporate consisting of executive and non-executive directors (Health and Social Care Act 2012). Hospital governing boards in the United States are accountable for the quality of patient care using mechanisms such as the development of strategic goals for quality improvement, the use of dashboards to track performance, and follow up on corrective actions related to adverse events (Curran & Totten 2010:273). Within the South African context, hospital boards are statutory bodies constituted in terms of the National Health Act, 2003 (Act No. 61 of 2003) as amended. According to section 41 of the Health Act, 2003 (Act No 61 of 2003) as amended the Minister appoints

hospital boards for each central hospital or group of central hospitals. The establishment of hospitals boards for other public health establishments is the responsibility of the member of the Executive Council (MEC) in the different provinces (South Africa 2003). In terms of section 16(1) of the National Health Act, 2003 (Act No 61 of 2003) as amended the hospital boards have non-executive status and are appointed in an advisory capacity. Some of the primary objectives of the boards are to ensure that the hospital management meets its performance obligations and is responsive to community needs and views. The responsibilities of community representatives include participation in the planning, provision, control, monitoring and evaluation of health services in their respective areas (ANC 1994b:44; South Africa 1997:37).

1.2 BACKGROUND INFORMATION ABOUT THE RESEARCH PROBLEM

North West Province is one of the first provinces to promulgate the North West Health, Developmental Social Welfare and Hospital Governance Institutions Act, 1997 (Act No. 2 of 1997) as amended in line with the White Paper for the Transformation of the Health System. Prior to 1997 nomination for membership in the hospital boards was made through traditional structures such as tribal authorities with the final appointments made by the MEC for health in the province (Policy for the Development of the District Health System for South Africa 1995:29).

The promulgation of the North West Health, Developmental Social Welfare and Hospital Governance Institution Act, 1997 (Act No. 2 of 1997) as amended led to changes regarding the constitution and nomination of the board members. The boards comprised community representatives nominated by community health forums, representative from each of the local authorities and nongovernmental organisations, an expert having business and/or financial background. Officials from the department of health were appointed by virtue of their positions and included the hospital manager, district health manager and a representative of the staff in the hospital. North West Health, Developmental Social Welfare and Hospital Governance Institution Act, 1997 (Act No 2 of 1997) as amended was subsequently amended in 2010 to ensure it was aligned with the National Health Act, 2003 (Act No. 61 of 2003). The newly proposed changes prescribed that the number of board

members shall not exceed eighteen and that the representatives from faith-based organisations, traditional leaders, the youth and the disabled forum be included.

The powers and functions of the boards were limited to making recommendations or advising the hospital management. The boards advised the hospital management on matters relating to policy and strategy formulation and implementation, appointment of senior managers of the hospital, the resolution of employment disputes, erection and maintenance of the hospital buildings and equipment. Section 16(2)(b) of the North West Health, Developmental Social Welfare and Hospital Governance Institution Act, 1997 (Act No. 2 of 1997) as amended states that the boards should participate in hospital inspections including monitoring of patients complaints, hospital finances and revenue targets.

Dr Kenneth Kaunda District became the leader in the establishment of clinic committees and hospital boards within the province following the promulgation of the North West Health, Developmental Social Welfare and Hospital Governance Institution Act, 1997 (Act No. 2 of 1997) as amended. The district was able to establish a partnership with the University of the North West to ensure that their board members were capacitated to perform their roles and responsibilities effectively.

1.3 STATEMENT OF THE RESEARCH PROBLEM

The interest in this research topic was stimulated by the observation of an increase in the number of negative media publicity of negligence, lack of care and large amounts of money paid out by health institutions for liabilities (Cullinan 2012:84). Community members serving in hospital boards are responsible for assisting management in ensuring quality care. The assumption in this study is that the community representatives serving in hospital boards are aware of their responsibilities regarding the issues of lack of care and negligence raised by the media about health services. The researcher identified a need to explore the experiences regarding their participation in hospital boards.

Since the establishment of hospital boards in North West Province, and specifically in Dr Kenneth Kaunda district, little is known about the experiences of community members regarding their participation in hospital boards. A literature search on participation of community members in hospital boards yielded limited results hence the focus on the experiences of community members regarding their participation in hospital boards in this study.

1.4 RESEARCH PURPOSE AND OBJECTIVES

1.4.1 Research purpose

The purpose of this study was to explore and describe the experiences of community members regarding their participation in hospital boards in Dr Kenneth Kaunda District.

1.4.2 Research question

The study sought to answer the following research question: "What are the experiences of the community members regarding their participation in hospital boards in Dr Kenneth Kaunda district?"

1.5 SIGNIFICANCE OF THE STUDY

The findings of this study have the potential to add to the body of knowledge regarding the contribution and experiences of community representatives serving in hospital governing boards. The findings from the study may highlight the challenges and maximise the benefits and opportunities of community participation and involvement in hospital boards as experienced by community members serving in hospital boards. The benefits and the challenges derived from the study may be used to inform future policy decisions relating to hospital governing boards.

1.6 DEFINITIONS OF TERMS

1.6.1 Community

According to the Longman Dictionary of Contemporary English (2009:305) a community is “a group of people living together and/ or united by shared interests, religion and nationality. Mubyazi and Hutton (2012:55) define a community as “a group of people living in the same geographic area with the same degree of common interest”. The term community is used in this study to refer to a group of people living in Dr Kenneth Kaunda district North West Province.

1.6.2 Experiences

Experiences are defined as the knowledge or skills that are gained from doing a job or activity, or the process of doing that (Longman Dictionary of Contemporary English 2009:593). Burns and Grove (2009:9) view personal experience as “the knowledge that comes from being personally involved in an event, situation, or circumstance”. For the purpose of this study, experiences refer to knowledge, skills, attitudes gained from and challenges experienced as a result of being personally involved in hospital boards as reflected on and shared by community members who served in hospital boards in the Dr Kenneth Kaunda District.

1.6.3 Hospital board

A hospital board is defined as the group of people responsible for the safe and efficient running of a hospital (Collins English Dictionary 2014). According to McNatt et al (2014:178) hospital governing boards are mechanisms by which strategic planning, financial management, and human resource management are devolved from central authorities to local communities and provider organisations. In the context of this study, hospital boards are part of the governance structures of the health facility responsible for the safe and efficient running of health care services in Dr Kenneth Kaunda District.

1.6.4 Participation

Participation is defined as an act of taking part in an activity or event (Longman Dictionary of Contemporary English 2009:1269). Community participation is explained by Mubyazi and Hutton (2012:51) as "taking part in the process of formulation, passage and implementation of public policies through action by citizens with the aim of influencing decisions which are, in the most cases, ultimately taken by public representations and officials". Participation in the context of this study refers to involvement of community members in the activities of the hospital boards.

1.7 RESEARCH PARADIGM

De Vos et al (2011:266) explain that qualitative researchers approach their studies with a certain paradigm or world view and a basic set of beliefs or assumptions that guides their inquiries. These beliefs relate to the nature of reality; the relationship of the researcher to that being studied; the role of values in a study and the process of research (methodological issue).

A paradigm is defined as "a way of looking at natural phenomena, which encompasses a set of philosophical assumptions that guide one's approach to inquiry" (Polit & Beck 2012:736). A paradigm plays an important role of directing research efforts and organising core ideas, theoretical framework and research methods. This study is informed and guided by the constructivist/qualitative paradigm.

1.7.1 Assumptions on which the study was founded

Assumptions refer to statements taken for granted or considered true, even though they have not been scientifically tested (Burns & Grove 2009:688). The study was founded on the following assumptions:

- Community members serving in the hospital boards are important stakeholders in the management of hospitals. It is assumed that their participation in hospital

boards results in improved service delivery, responsiveness and client satisfaction.

- The participants are autonomous people who will share information willingly and will give honest responses to the questions during interviews.
- Qualitative research provides an account of the experiences as lived and shared by the study participants.
- Qualitative research yields information that meets the requirement of rigorous science and scientific knowledge when abstracted sufficiently.

1.8 RESEARCH DESIGN AND METHOD

1.8.1 Research design

According to De Vos et al (2011:339) qualitative research design in its broadest sense refers to "research that elicits participants' accounts of meaning, experience or perceptions". Qualitative exploratory-descriptive research was found to be the appropriate design for achieving the study purpose and for answering the research question. Burns and Grove (2009:199) define exploratory research as research conducted to gain new insights, discover new ideas and/ or increase knowledge of a phenomenon. Descriptive research in qualitative studies refers to a more intensive examination of phenomenon and their deeper meanings, thus leading to thicker description (De Vos et al 2011:109).

1.8.2 Study setting

The study was conducted in the Dr Kenneth Kaunda district of the North West province of South Africa.

1.8.3 Research methods

The research methods used in the study included the population, sample and sampling procedures, data collection and data analysis.

1.8.3.1 Study population

The target population for the study comprised past and current elected community representatives who served in hospital boards located in Dr Kenneth Kaunda District for a minimum period of two years.

1.8.3.2 Sample and sampling procedures

Non probability, purposive sampling was used to select study willing participants who met the inclusion criteria. Purposive sampling was relevant because it was based on the selection of participants who possessed rich information about the phenomenon of interest and were able to share such information on the phenomenon (Taylor (2014:193).

1.8.3.3 Data collection

The method used to collect data was unstructured interviews and the researcher was the only person who was involved in the collection of data. The aim was to ensure consistency of data collection (Creswell 2014:185; Robson 2011:133).

1.8.3.4 Data analysis

Thematic content analysis, defined as a generic approach to the analysis of qualitative data was used. It was used as a method to report experiences, meanings and the reality of participants (Robson 2011:474). Details regarding research design and methods are described in chapter 3 of this study.

1.9 ORGANISATION OF THE REPORT

The layout of the study is divided into five chapters as follows:

Chapter 1: Overview of the study.

Chapter 2: The literature review.

Chapter 3: Research design and methods that will be used in the research.

Chapter 4: Analysis, presentation and description of the research findings.

Chapter 5: Discussion of findings, summary, conclusions and recommendations are presented as well as some of the limitations of the study.

1.10 CONCLUSION

This chapter included an orientation to the study. The background, the purpose and the significance of the study were described. Research methodology was also introduced. The next chapter will focus on literature review.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter provides background information on hospital governing boards and the role that community representatives should play in hospital boards. In the first section of the chapter, the meaning of key and related terms, the history of hospital governing boards and the theories of governance of hospital boards are discussed. In order to conceptualise an understanding on the evolution and the history of hospital boards in South Africa, secondary sources more than five years have been used. The second section presents the legislation governing hospital boards and the role of governing boards in terms of quality and patient safety. The last section of the chapter discusses community participation as a strategy and philosophy in hospital boards.

2.2 SCOPE OF THE LITERATURE REVIEW

The available literature on hospital boards was reviewed. The literature review included various reports, statistics, and studies conducted on hospital boards globally including the country of the study, South Africa and North West Province. The key concepts used for the review were hospital boards, governing boards, community members and community participation.

2.3 HOSPITAL BOARDS

This section of the literature review was approached by focusing attention on the definition of hospital governing boards and related terms, the history of hospital boards and the theories of governance of hospital boards.

2.3.1 Hospital governing boards

There is a plethora of literature on the definition and meaning of hospital governing boards. They are defined as the group of people responsible for the safe and efficient running of the hospital (Collins English Dictionary 2014). According to Macha, Mushi and Borghi (2011:14), hospital governing boards refer to a mechanism by which public accountability, dialogue and feedback between the public and health providers are promoted. McNatt, Thompson, Mengistu, Tatek, Linnander, Ageze, Lawson, Berhanu and Bradley (2014:178) explain that hospital governing boards are mechanisms by which strategic planning, financial management, and human resource management are devolved from the central authorities to local communities and provider organisations. From the definitions of hospital board by various authors, governance and public accountability were identified as concepts central to the explanation of the meaning of hospital boards.

2.3.1.1 Governance

According to the World Health Organization (2011) governance is defined as the traditions and institutions by which authority in a country is exercised for the common good. Siddiqi, Masud, Nishtar, Peters, Sabri, Bile and Jama (2009:14) indicate that governance comprises the complex mechanisms, processes and institutions through which citizens and groups articulate their interest, mediate their differences and exercise their legal rights and obligations. Kickbusch and Gleicher (2011:77) view health governance as "actions and means adopted by a society to organise itself for the promotion, protection of the health of its population".

Furthermore, hospital governance is explained as a set of processes and tools related to decision making in steering the totality of institutional activity, influencing the most major aspects of organisational behaviour and recognising the complex relationships between multiple stakeholders (Saltman, Duran & Dubois 2011:38). Whilst there is a general acceptance on the meaning of the term, many proponents of governance argue that the concept has different meaning in different contexts. Saltman et al (2011:24) and McCoy, Hall and Ridge (2011:460) support the view that

what is seen as appropriate regulations for particular hospitals in one country may not be appropriate for hospitals in other countries.

2.3.1.2 Public accountability

Accountability as a concept is viewed as component of governance that refers to the responsibility and ability of one group to explain their actions to another (Hyder et al 2007 cited in Kessy 2014:17). According to Molyneux, Atela, Angwenyi and Goodman (2011:54) public accountability refers to a spectrum of approaches, mechanisms and practices used by stakeholders concerned with public services to ensure a desired level and type of performance. Joshi (2013:4) explain that public accountability comprises a relationship between the power holder (account-provider) and the delegator (account-demander) and include four elements, namely; setting standards, getting information about actions, making judgement about appropriateness and sanctioning unsatisfactory performance. Within the context of this study public accountability refers to the approaches and mechanisms used to listen and respond to the views and aspirations of communities.

2.3.2 History of Hospital Governing Boards

The historical backgrounds of hospital governing boards' (HGB's) are discussed under the headings establishment, composition and constitution and powers and functions of hospital boards.

2.3.2.1 Establishment of Hospital Governing Boards

The history of HGB's in Europe dates back to the eighteenth century and were philanthropically founded with many of the major donors being able to vote at governing meetings, though executive management boards took critical decisions (Cherry 1998:2). The reforms that were introduced by Thatcher in England in 1989 allowed hospitals to apply to be self-governing with some additional reporting to the Secretary of State. However, these developments were short-lived and some gains were reversed when the Labour party came into power in 1997 (Saltman et al 2011: 114). The challenges experienced with centralisation of power compelled the

Secretary of State to make fundamental policy decisions that hospitals that met certain criteria would be allowed to apply to become National Health System (NHS) Foundation Trust. The NHS Foundation trust had legal status aimed at promoting greater local responsiveness in hospital policy (Saltman et al 2011:116).

In New Zealand, the locally elected HGB's which started in the 1980s and this development was influenced by international trends (Gauld 2010:370; Barnett Tenbenschel, Cumming, Clayden, Ashton, Pledger, & Burnett 2009:120). The governance of the boards was based on hierarchical model with some local control. After 1990 the decision to replace locally elected boards with board of directors was influenced by the need to bring a business focus to the hospital governance. It was believed that the business focus would deliver allocative as well as technical efficiencies. However in 1999 there was a change from the market to the service model which culminated in the establishment of District Health Boards (DHBs). The shift away from the market model was because it lacked accountability to the central government and local communities. The service model was opted for as it was believed it would allow the boards to be responsible for the level, mix and quality of the services and for meeting the health goals, targets and standards set by the Ministry of Health (MoH) (Gauld 2010:370; Barnett et al 2009:120).

The HGB's in Tanzania were first introduced under the Local Government Act of 1982, linked to the Alma Ata Declaration of 1978 (Macha et al 2011:14) whilst in Ethiopia they were introduced in 2005-2006 as a mechanism for broader community participation and involvement in local health development (McNatt et al 2014:178).

In South Africa, the HGB's were introduced in the 1890s (Botha 1959:922). Somerset hospital, one of the oldest public hospitals in the then Cape Colony is regarded as a pioneer in the establishment of hospital boards. The board at Somerset hospital comprised five government nominees and twenty-five elected representatives, and their term of office was three years. The board controlled all the property and the funds of the hospital and it had the power to appoint and dismiss staff (Centenary 1959:922). When Ordinance 5 of 1912 was promulgated, all the hospitals in the Cape Peninsula fell under the control of the Cape Hospital Board (Botha 1959:923; Levy 2010:358).

There were hospital boards and clinic committees in rural and other parts of the country but these boards exercised very little power and did not represent the interest of the community served by the hospitals. It is stated that the boards had no structured mechanism for listening or accounting to the local community. They fulfilled ceremonial roles and raised funds for specific projects (South Africa 1997:173). A new vision for the transformation of the health system was developed after 1994 resulting in the development of new policies and governance structures for hospital boards (South Africa 1997:34).

2.3.2.2 *Composition and constitution of hospital boards*

In developed countries, for example the UK the boards were appointed as body corporate consisting of executive and non-executive directors (Steel & Cyrus 2012:22). The board comprised a non-executive chair, appointed by the Secretary of State. There were varying number of non-executive directors appointed by the Secretary of State, but as representatives of particular stakeholder interests such as the board's employees, the area clinical forum, and each of the local authorities in the board's area. There were also six executives appointed by virtue of their positions, for example the Chief Executive, Medical Director, Nursing Director, Finance Director, Director of Public Health. The Health and Social Care Act (2012) required that there be majority or equal number of non-executives (Saltman et al. 2011:127).

Similarities were identified between the boards in the UK and the boards in New Zealand (Gauld 2010:178; Barnett et al 2009:120). Governing boards in New Zealand consisted of seven members elected through public vote every three years, and four appointed by the Ministry of Health (MoH). There was a requirement that at least two Maori members be appointed to represent the interests of New Zealand's indigenous people. The CEO was accountable to the board for the overall financial results and service delivery performance.

In developing countries such as Ethiopia and Tanzania, the situation was unique as the boards comprised a mixture of health personnel, officials, councillors, traditional leaders, and other community representatives (McCoy, et al 2012:454). In Ethiopia,

the boards were selected by the Federal Ministry of Health and Regional Health Bureaus and comprised 5-7 members with key consideration given to gender and community representation. The governing boards in Tanzania comprised eight members, five elected members of the community and three appointed members from the government and health providers. Out of the five elected members, it is stated that three were representatives from the community without political affiliations, with at least one female member (Macha et al 2011:14).

According to the National Policy Framework on Decentralisation of Hospital Management (1995) cited in the Monitor (1996:6) the new vision was that hospital board members would be empowered to participate in the setting of policy and strategy for their hospitals, as well as oversee the performance of hospital management against specified measures. The objectives in terms of the new vision were that:

- The hospital boards will be able to make recommendations to hospital management, rather than issue instructions on any issues within the Board's jurisdiction. Hospital management will be legally obliged to respond adequately to the concerns of Boards and the communities they represent. This power, coupled with the technical support and expertise provided by the board will provide Hospital Boards with the necessary level of influence over hospital management.
- The range of functions performed will vary between provinces, between hospitals within provinces, and also over time, depending upon a variety of local circumstances, including the capacity of Boards and hospital management, and local political conditions.
- The powers and functions of Hospital Boards will be set out in clear terms of reference which also specify the reporting requirements of hospital management to Board and Board to MEC. In addition, the terms of reference will clarify the scope of Board interventions to ensure that the Board does not intervene unduly in the detailed day-to-day running of the hospital. The terms of reference will be agreed between the PHA and the Board in a memorandum of agreement, and will require the endorsement of the MEC.

It was envisaged that each hospital board would comprise approximately fifteen (15) persons, of whom the majority was to be community representatives, with the balance made up of about seven (7) nominated experts. The hospital CEO, a representative from the Province and one or more representatives of the hospital staff were to be appointed as ex officio members. The board members were to be appointed by the provincial MEC, following nominations from different forums (Monitor Company 1996:6-7).

The hospital board members would be entitled to remuneration for expenses incurred in travelling to and attending meetings, but no additional remuneration for time spent on board business as board membership were to be viewed as voluntary community service (Monitor Company 1996:6-7).

According to section 15(1) of the North West Health, Developmental Social Welfare and Hospital Governance Institution Act, 1997 (Act No 2 of 1997) as amended the board is comprised of the following members:

- (a) Community representatives appointed by the responsible member from the persons nominated by Community Health Forums;
- (b) One representative from each of the local authorities in the health and developmental social welfare district;
- (c) One lay expert having business and/or financial background appointed by the responsible member from nominations submitted by the general public;
- (d) A health and welfare institution manager in respect of which the board is constituted;
- (e) District Health Manager ex Officio;
- (f) District Developmental Social Welfare Manager ex Officio;
- (g) A representative of the staff of the hospital or hospital in respect of which the board is constituted elected by the staff of such hospital or hospitals; and
- (h) One representative appointed by the responsible member from persons nominated by health nongovernmental organisations within the health developmental social welfare district. Provided that ex officio members shall exercise the same voting rights as other members of the boards.

With respect to the North West Health, Developmental Social Welfare and Hospital Governance Institution Act, 1997 (Act No 2 of 1997) as amended the board is comprised of the following members:

- Hospital Manager;
- Representatives from the Municipalities served by that hospital;
- Directly elected members of the community as determined by the health support groups and;
- Traditional healers.

According to section 17(1) of the North West Health, Developmental Social Welfare and Hospital Governance Institution Act, 1997 (Act No 2 of 1997) as amended a clear distinction was made between the composition of the board for district hospitals and provincial hospitals. In the case of provincial hospitals, the exclusion criteria that were set up in the Act included the following:

- any person under the age of twenty-one years;
- any person who is of unsound mind and has been so declared by a competent court or judicial officer;
- any person who is an un-rehabilitated insolvent;
- any person who has at any time been convicted of an offence;
- any person who is interested in any contract made for or on behalf of any hospital for which the board of which he or she is a member or a prospective member has been constituted.

According to its constitution, board members were to hold office for a period of two years from the date of their appointment. The board was expected to hold not less than six ordinary meetings in every financial year. The quorum of the board was to consist of not less than one third of the number of members. The chairperson was to preside at the meeting of the board. The secretary of the board was to give members seven days' notice in writing of an ordinary meeting of the board and such notice was to state the date, time and place of the meeting and the business to be transacted

thereat. Every question before the board was to be decided by the majority of the votes of the members present (South Africa 1997: s 18) as amended.

The North West Health, Developmental Social Welfare and Hospital Governance Institution Act, 1997 (Act No 2 of 1997) as amended gave the MEC the powers to terminate the period of office of all members of the board if at any time the board neglected for a period of six months to hold a meeting. The other factors that were likely to lead to the board being dissolved were if it failed or refused to perform any duty imposed upon it by the Act or intended to involve itself in illegal or grossly irregular acts (South Africa 1997:s 18) as amended.

2.3.2.3 Powers and functions of the hospital boards

Community members serving in the hospital boards were viewed as the representatives of their communities. Kamozura , Maluka, Ndawi, Byskov and Hurtig (2013:) state that strategies to involve community representatives in board proceedings were likely to restore trust, improve accountability and secure cost effective priorities within health. McCoy et al (2012:454) reported an increased utilisation in facilities with active governance structures which impacted positively on the health status of the communities unlike in facilities without these structures. It was further noted that these facilities tended to be better staffed and better funded; contributing significantly towards safer and high quality of care as well as ensuring there was responsiveness to the needs and aspirations of the communities.

As community members became more knowledgeable about priority setting, they were able to take up matters with regard to medicines availability in health facilities and ensured revitalisation of village health workers (Smith, Anell Busse, Crivelli, Healy Lindahl, Westert, & Kene 2012:38; Kamozura et al 2013:10; McCoy et al 2012:455).

In England and New Zealand, locally elected members possessed supreme authority in the hospitals and were responsible for the management, control and operation of the hospitals (Corbett-Nolan 2010:2). They were responsible for the appointment of the chair and non-executive directors (Salt et al. 2011:127; Barnett et al 2009:120).

They also approved the choice of the board's Chief Executive Officer (CEO). Despite locally elected boards wielding significant influence in terms of key appointments, Saltman et al (2011:130) in practice these powers were not realised. Locally elected and appointed board members were expected to establish the strategic direction for the hospital within the policy and funding framework set out by parliament, define annual and longer term objectives and agree on plans to achieve them, monitor performance against agreed upon objectives and targets and ensure corrective action when necessary. They were also expected to establish an effective system of corporate governance, safeguard the public reputation of the Trust and support internal and external communications and participate in meetings with other external organisations (Saltman et al 2011:1).

The measures used to achieve these responsibilities included setting the overall policy and strategic direction for the Trust, approving business plans, budgets and major capital expenditure, meeting regularly to retain full and effective control over the organisation and serving as members of committees such as the remuneration committee and audit committee and operating as and exercising their corporate responsibilities.

In Tanzania and South Africa, the boards are involved in the planning, provision, control, monitoring and evaluation of health services (South Africa 1997:34; Macha et al 2011:14). Their responsibilities are expected to be realised through the following means:

- supporting management in bearing the greater burden of responsibility attached to increased delegation of powers;
- ensuring that hospital management were responsive to community needs and views
- ensuring that hospital management meets its obligations in terms of its performance agreement with the province (South Africa 1997:107).

According to section 16 of the North West Health, Developmental Social Welfare and Hospital Governance Institution Act, 1997 (Act No 2 of 1997) as amended the rights, powers and functions of the hospital boards are delineated as follows:

- make recommendations to or advise the management of any hospital, for which such board has been constituted;
- consider the suitability and efficiency of senior officers on the staff of any hospital for which such board has been constituted and make recommendations to the hospital management
- make recommendation and advise the hospital management on the erection of the hospital buildings and maintenance programmes as well as the purchasing of equipment;
- the resolution of employment disputes;
- development of human resources policies;
- the appointment of senior managers and clinicians, their remuneration and other conditions of their employment.

However, the situation in South Africa and Tanzania was different as locally elected members possessed no authority in the hospitals and were not responsible for the management, control and operation of the hospitals. Their powers and influence were limited to giving inputs and feedback into the planning, provision, control, monitoring and evaluation of health facilities (Macha et al 2011:24; South Africa 1997:34). In the case of Tanzania, community representatives were nominated and voted into committees by their constituencies. According to section 15(a) of the North West Health, Developmental Social Welfare and Hospital Governance Institution Act, 1997 (Act No 2 of 1997) as amended community representatives in South Africa were expected to be elected from a forum of community structures that exist in their area.

2.3.3 Theories of governance

Models of governance in health services existed in various forms; from hierarchical to market and recently networks arrangements (Barnett et al, 2009:119; Smith et al

2012:37). These models were linked to different governance theories, namely, theories of bureaucracy, economics and sociology.

2.3.3.1 Bureaucracy

According to Campbell (2011:400), the first model of governance in the United States of America (USA) was based on the traditional approaches of rigidity and top-down control. The model was influenced by the need to ensure patients had legitimate rights to fair and equitable health care system. The trend was not unique to the USA. Barnett et al (2009:119) reports that this model was also implemented in other countries, such as the United Kingdom (UK), New Zealand and Canada.

2.3.3.2 Markets / Economies

Campbell (2011:400) and Smith et al (2012:37) explain that the second theory of governance emphasised a shift in the governance from top down control towards markets. This model was premised on the belief that individuals should be given options to choose health insurance and health services based on their own financial resources.

2.3.3.3 Networks arrangements/ Sociology

This model of governance strives to move away from market arrangements towards participation and involvement of people in the work of government (Campbell 2011:400; Saltman et al 2011:23). The characteristic elements of the model include network and partnership, governing at a distance and negotiated self-governance. Some of the key features of this theory are as follows:

- A move away from hierarchy and competition as alternative models for delivering health services, towards networks and partnerships traversing the public, private and voluntary sectors;
- Recognising the blurring of boundaries and responsibilities for tackling social and economic issues;

- Recognising and incorporating policy networks into the process of governing;
- Replacing traditional models of command and control with "governing at a distance";
- Developing more reflexive and responsive policy tools;
- A shift of the role of government to a focus on providing leadership, building partnership, steering and coordinating and providing system wide integration and regulation;
- Opening up decision-making to greater participation by the public; innovation in democratic practices as a response to problems relating to the complexity and fragmentation of authority, and the challenges this presents to traditional democratic models; and
- A broadening of focus by government that goes beyond institutional concerns to encompass the involvement of civil society in the process of governance.

2.3.4 Legislation

The new governance model in England was behind the establishment of the Foundation Trust and the subsequent review of the Community Health and Standards Act 2003 (Saltman et al 2011:116). The Foundation Trust as a legal entity seeks to promote accountability to the local people, patients and staff. The legislative requirement was that hospitals and other health care providers would apply to be Foundation Trust if they could demonstrate that they were capable of meeting the performance, governance and other criteria. They were allowed to elect governors responsible for appointing board members. According to Saltman et al. (2011:129) governors formed an advisory body that provided a guidelines on how the Foundation Trust should operate to meet the needs of the its members.

Section 14(1) of the North West Health, Developmental Social Welfare and Hospital Governance Institutions Act, 1997 (Act No 2 of 1997) as amended stipulates that the boards shall consist of not more than 18 members, the majority of whom shall be community representatives nominated by Community Health forums. Community representatives shall include one representative from the local authority in the health and developmental social welfare district, one lay expert having business and/ or

financial background. The ex-officio members shall include health and welfare institution manager, district health manager, district developmental social welfare manager and representative of staff and elected by the staff of such a hospital.

2.3.5 The roles of hospital boards in quality and patient safety

This section will focus on some of the intervention strategies used by boards in quality and patient safety in developed and developing countries. In the UK, it was reported that as many as 34 000 deaths each year were attributable to errors in the healthcare system, making it the third most common cause of death after heart disease and cancer (Corbett-Nolan & Hazan 2010:4). In order to reduce that number, the board patient safety template report was introduced, comprising five components namely, incident management, incident patterns and quality problems, harm reducing and resources saved and instituting improvement. In addition, a board maturity matrix was introduced to enable board members to monitor progress based on the recommendations developed (Corbett-Nolan & Hazan 2010:12).

In the USA, medical errors remained one of the leading causes of accidental deaths in hospitals (Curran & Totten 2010:273). The boards visited clinical units to obtain information from patients, families, nurses and physicians as part of measures to deal with medical errors-related deaths. Furthermore, the board members received ongoing development by ensuring that issues of quality and patient safety were discussed at every board meeting (Curran & Totten 2010:273; Jiang 2009:15).

A survey conducted by Curran and Totten (2010:273) on how hospital board chairs rated quality, revealed that less than half of the boards rated quality of care as one of their top priorities. The same authors reported that only a few of the hospital board chairs received training in quality. Leotsakos, Caisley, Karga, Kelly, O'Leary and Timmons (2009:19) reported that data on medical errors was non-existent in developing countries. It was argued that incidences of medical errors could be double or threefold that of developed countries due to the increased burden of diseases and the high infant and maternal mortality rate that many of the developing countries faced. In closing the gaps identified, a number of initiatives were

introduced which included patient/ citizen charters, suggestion boxes and health volunteers (Molyneux, Atela, Angwenyi & Goodman 2011:541).

The situation in South Africa was not entirely different from the other African regions. Ndinokubwayo (2010) conducted an eight country study on medical records, aimed at determining incidences of adverse events. The findings revealed that incidences of adverse events were linked to inadequate training or supervision of clinical staff, non-availability of policy or the failure to implement and inadequate communication or reporting. Whilst board members were expected to provide oversight role and ensure there was responsiveness to the needs and views of their communities, information in this regard was not available.

2.3.6 Community participation in health

The World Health Organization (WHO) conference on PHC held in Alma Ata in 1978 declared community participation as "the process by which individuals and families assume responsibility for their own health and welfare and that for those of the community, and develop the capacity to contribute to their and the community's development. They come to know their own situation better and are motivated to solve their common problems. In addition, communities become active participants in their own development instead of passive beneficiaries (WHO 1978:42-43).

Community participation is regarded as a human rights principle as it allows for sustainable health services that effectively address local needs (Meier, Pardue & London 2012:13). According to the ANC (1994a:21) effective community participation as envisaged in the PHC approach can only be realised if democratically elected representatives integrate with stakeholders from other sectors in order to exercise their powers on health issues. Other benefits of community participation identified entailed policy responsiveness to community needs, building of mutual respect and trust and informed citizens who are actively involved in community partnership, thus contributing to improved health outcomes (Meier et al 2012:14).

2.4 CONCLUSION

Background information on hospital governing boards and the role that community representatives should play in hospital boards was provided in this chapter. The meaning of key and related terms, the history of hospital boards, theories of governance the legislation governing hospital boards as well as the role of governing boards in terms of quality and patient safety and were also presented. The research design and methods are discussed in the next chapter.

CHAPTER 3

RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

This chapter provides a description of the methodology used in the study. It begins with a discussion of the research design followed by a description of the research methods used. The discussion of related ethical issues and measures taken to enhance trustworthiness is included.

3.2 RESEARCH DESIGN

Research design is defined as the overall plan for connecting the conceptual research problem to the pertinent and achievable empirical research (Schutt 2009:334). According to Burns and Grove (2009:195) research design is a blueprint for conducting a study with maximum control over factors that may interfere with the validity of the findings. Gilson (2012:52) further explain that the research design comprise the study purpose, particular question to be addressed, strategy for data collection and analysis, sampling strategy and theory to be used with the study. A qualitative exploratory-descriptive design was found to be more appropriate for achieving the study purpose and for answering the research question stated in chapter 1.

3.2.1 Qualitative research

Qualitative research is a form of inquiry in which researchers make an interpretation of what they see, hear and understand (De Vos et al 2011:65). Qualitative researchers obtain information on human experience, perceptions, motivations, intentions and behaviour and its goal is to develop a rich understanding of a phenomenon as it exists in the real world and as it is constructed by individuals in the context of that world (Polit & Beck 2012:120; Schutt 2009:321). Gilson, Hanson, Sheikh, AkuaAgyepong, Ssenkooba and Bennett (2011:2) (2011:2) corroborate this view by stating that qualitative research studies human behaviour in everyday or

natural setting generates data that are primarily analysed inductively to generate categories and explanations of experience. Thus qualitative research involves sustained interaction with the people being studied in their own language, and on their own understanding. It relies on methods that allow the researcher into the personal world of participants through the use of varied strategies and methods such as interviews and observations (Brink 2009:123).

The use of qualitative research in this study was intended to enable the researcher to develop an in-depth understanding of the experiences of community board members from their own viewpoint and in the context in which their participation in governing boards took place.

3.2.2 Exploratory research

Burns and Grove (2009:313) define exploratory research as research conducted to gain new insights, discover new ideas and/ or increase knowledge of a phenomenon. Robson (2011:202) explains that exploratory research seeks to establish what is happening in a situation where little is known and in the process generate new ideas and hypotheses for future research. There existed very little research on the problem under study. The researcher selection of the exploratory method was aimed at gaining new insight and developing a better understanding of what the experiences of community members was with regard to their participation in hospital boards in Dr Kenneth Kaunda district.

3.2.3 Descriptive research

According to Gilson et al (2011:49) descriptive research seeks to give an accurate profile of people, events, situations and covers aspects such as who, what, where, how many and how much. Burns and Grove (2009:201) state that descriptive research is designed to provide a picture of a situation as it naturally happens and it is mainly done to describe a set of observations or the data collected in order for the researcher to gain a better understanding of a topic. The same authors further explain that through descriptive designs, researchers are able to explore and

describe what exists in practice, discover new information and promote understanding of situations.

Descriptive research within the context of this study means soliciting meaning, in depth understanding of elected community members' participation in hospital as they experienced it. Qualitative descriptive research design was used in this study as an empirical method aimed at describing the informants' experiences of their participation in hospital boards.

3.3 RESEARCH METHODS

According to Schutt (2009:327) research methods focus on the individual steps in the research process and the most objective procedures to be employed. Research methods include the context or study setting or context, population, sample and sampling procedures, the specific methods used for data collection and analysis.

3.3.1 Study context

De Vos et al (2011:326) explains 'context' as the study of people in their natural setting in order to understand their life worlds. According to Polit and Beck (2012:743) study context or setting means the physical location and conditions in which data collection takes place (Polit & Beck 2012:743). The study was conducted in Dr Kenneth Kaunda District, which is one of the four districts in the North West Province. Dr Kenneth Kaunda District was selected for the study because it was one of the first districts to establish hospital boards in line with the North West Health, Developmental Social Welfare and Governance Institution Act, 1997 (Act No. 2 of 1997) as amended.

There are five (5) public hospitals in the district and these include 1 provincial hospital in the city of Matlosane, 1 regional hospital in the City of Tlokwe, 1 specialist hospital and 2 district hospitals located in Ventersdorp and Wolmaranstad respectively. All these hospitals have governing boards with elected community representatives serving in them.

3.3.2 Population

Schutt (2009:149) defines a population as the entire set of individuals or other entities to which study findings are to be generalized. In the context of the study population included all democratically elected community representatives attached to governing boards of district, regional, psychiatric and provincial tertiary hospitals in North West Province. According to Burns and Grove (2009:343), the target population refers to groups of individuals who meet the eligibility criteria and to which the study findings will be generalised while the accessible population is the aggregate of cases that meet the inclusion criteria and are available for the study (Polit & Beck 2012:744). The target population included all past and current elected community representatives attached to governing boards of district, regional, psychiatric and provincial tertiary hospitals in Dr Kenneth Kaunda District, North West Province.

3.3.3 Sample and sampling procedures

A sample is a subset of a population that is used to study the population as a whole (Schutt 2009:149) while sampling refers to a process of drawing a representative sample from a population (Polit & Beck 2012:742). A non-probability, purposive sampling method was used.

Non-probability is a sampling method in which the probability of selection of population elements is unknown (Schutt 2009:156). Purpose sampling which is based on the selection of participants and sites that can inform an understanding of the research problem was used (Creswell 2014:189). Burns and Grove (2009:355) further explain that purposive sampling is based on the selection of participants who possess rich information about the phenomenon of interest and are able to shed light on the matter. There was need to select study participants who had knowledge and experience of serving in the hospital boards in Dr Kenneth Kaunda District. The names of current and past elected community representatives were obtainable from the Director Hospital Services for Dr Kenneth Kaunda Hospital and Chief Executive Officers (CEOs). A total of 283 community representatives served in hospital governing bodies in Dr Kenneth Kaunda District from 1997 to 2014.

3.3.4 Inclusion/ Eligibility criteria

Eligibility criteria refer to a list of characteristics essential for membership in the study (Burns & Grove 2009:344). To be included in the study, the participants had to be:

- residing in the Dr Kenneth Kaunda District;
- serving or have served on hospital boards in the district for a minimum period of two years;
- willing and available for participation in the study

3.3.5 Data collection

Individual face-to face unstructured interviews were used to collect data from the participating elected community representatives who met the inclusion criteria described in 3.3.4. The aim was to obtain a deeper understanding of their experiences of participating in hospital boards and how they made meaning of their own experiences (Yin 2011:133).

The individual interview guide was used as a data collection instrument. The interview guides consist of a question or questions written to guide the interviewer and to enable the research to cover all areas required (Polit & Beck 2012:731). The participants had to respond to one central question “*What is your experience regarding your participation in hospital governing in Dr Kenneth Kaunda district?*”

All the participants were given the necessary information regarding the dates, times and venues for the interviews. The researcher was the only person involved in the collection of data. The aim was to ensure consistency of data collection (Creswell 2013:185; Robson 2011:133). The interviews were conducted in English in a private, quiet room allocated by the hospital. Data were collected from the month of July 2014 to November 2014 and the duration of each interview session was between 10-15 minutes.

The researcher created a relaxed and non-threatening environment by introducing herself to the participants and by explaining the purpose and the process of the interview before the consent forms were signed. The participants were reminded of their right to willingly agree or refuse to participate in the study. They were also informed of their right to withdraw their participation without explanation or consequence. In addition confidentiality and anonymity were ensured (Polit & Beck 2012:157).

Before the commencement of the interview, informed consent to participate in the study was confirmed. With the permission of the participants, a digital audio recorder was used during the interview to ensure accuracy of data collection. In addition recording the interview ensured that the researcher focused on the conversation rather than on note taking (De Vos et al 2011:350). The researcher also made notes using mind mapping to serve as a reminder. During the interview, several communication skills such as listening, clarifying, paraphrasing, and probing were used to enhance understanding and to guide the participants to elaborate on their responses. These skills enabled the participants to respond freely to open-ended questions using their own words, giving in-depth information about their experiences regarding their participation in hospital boards. The researcher became aware of the details that made up the interview context including non-verbal communication, confidence in answering questions, hesitations, the tone of participants as well as the shared experiences of researcher and participants. These observations and experiences were recorded in the researcher's notes and they formed part of the data.

3.3.6 Data analysis

According to De Vos et al (2011:397) data analysis is the process of bringing order, structure and meaning to the mass of collected data. The data analysis approach employed was thematic analysis. Robson (2011:474) explains that thematic analysis is a generic approach to the analysis of qualitative data and can be used as a method to report experiences, meanings and the reality of participants. Green and Thorogood's (2014:210) view of thematic analysis is a "map of the content and topics across your data set, and a way of summarizing the variation and regularities within

the data" The rationale for choosing thematic analysis was based on the research question which sought to gain an understanding of the community representatives experiences of participating in the hospital boards. The following steps of thematic analysis as outlined by Green and Thorogood (2014:210) were followed:

3.3.6.1 *Familiarising oneself with the data*

The researcher listened to the interview recordings and downloaded the recordings from the digital-recorder to the researcher's computer (Mills & Birks 2014:37; Yin 2011:183). Files of all the recordings were created and labelled accordingly (De Vos et al 2011:408; Robson 2011: 476). All the interview data verbatim transcriptions were done by the researcher and this approach afforded the researcher an opportunity to get immersed in the data and in the process ensured familiarity with the data that was collected (Yin 2011:183). Later electronic copies of all the transcriptions were made as back-up in case of computer problems (De Vos et al 2011:408).

3.3.6.2 *Identifying codes*

Coding is described by Hammond and Wellington (2013:22) as "the process of applying tags, names or labels to items of data". It is a process of breaking up the narratives into smaller parts to identify key meanings and attaching a label to them (Creswell 2014:198; Hammond & Wellington 2013:9). Robson (2011:467) further explain that coding is not linked to any particular theoretical perspective and all or parts of the data should be coded and labelled.

In preparation for coding, the pages of each data transcript were set with wide margins so that there was enough space for jotting down labels, codes and notes (Green & Thorogood 2014:211). The researcher ensured that the information that could identify participants as well as place of facility was removed from the transcript. This was replaced with a transcript identifier which was put as a footer on duplicate copies which corresponded with the master list e.g. P1 (Participant number 1) and date.

Once the coding was done and before the researcher could start cutting up the codes, a master copy of the coded transcript was made and filed (De Vos et al 2011:408). The other set of transcript was prepared for cutting and ensuring each piece of text could be traced back to their original source. This was done by using different colours of highlighter marking pens for each category of study participants.

3.3.6.3 Organizing themes

During this phase further reading was done and similar codes were clustered together to make up themes. Creswell (2014:199) state that themes are the ones that appear as major findings in qualitative studies and are often used as headings in the finding sections. Green and Thorogood (2014:212) further explain that themes not only serve as a way of collecting together utterances using the same words but are used to collect utterances that are conceptually similar.

The researcher embarked on a process of grouping together codes with the same label as themes and finding descriptive words to represent those themes. The approach used by the researcher was to lay out pieces of paper on the table which were conceptually similar and reading them together. During this process the researcher reflected on the meaning of the data and assigned themes to them. The various themes were interconnected to form a story line and provide an explanation of the phenomenon under study (Creswell 2014:200) using relevant quotes from the interviews.

3.4 ETHICAL CONSIDERATIONS

In research there are certain ethical guidelines or principles that have to be observed in order to protect the rights of the participants and also to ensure the general ethical conduct of the study. The following ethical issues were given priority by the researcher to ensure that the study was underpinned by high level of moral standards.

3.4.1 Ethical clearance

The higher degrees committee of the Department of Health Studies, UNISA issued an ethical clearance certificate and granted the researcher permission to conduct the study. The ethical clearance certificate is included as Annexure A.

3.4.2 Approval

Permission to carry out the study was obtained from the North West Department of Health as well as the Dr Kenneth Kaunda District Health Office. The letters of request and the letter granting permission to conduct the study are included as Annexure B & C.

3.4.3 Informed consent

All the participants who agreed to take part in the interviews were given the necessary information regarding the purpose and objectives of the study as well as the interview process before they signed consent forms indicating their voluntary willingness to participate in the study and for the use of digital audio recorder during the interviews. The study participants were also made aware of their rights to decide whether they wished to participate in the study or not and their rights to withdraw from the study at any time without prejudice (De Vos et al 2011:116). The consent forms are included as Annexure D.

3.4.4 Confidentiality and anonymity

Confidentiality means that the information that researcher obtains about and from the participants for research purposes should be protected from unauthorised access, disclosure and use without their permission. Anonymity, on the other hand, means that the researcher should ensure that no participant in the study can be identified from any of the responses that they have given (Polit & Beck 2012:158). The measures that were taken to ensure confidentiality and anonymity included

- The protection of identities of participating hospital governing boards; in that their identities were not disclosed in any way.
- The participants were assured that all information (opinions and views) they divulged with pertinent reference to any hospital governing board was treated with the necessary confidentiality and anonymity.
- The raw data were kept safe and confidential, locked up with no unauthorised access.
- Data were reported in a manner that did not identify or link the participants with the information.

3.4.5 Justice

In order to uphold the principle of justice, the researcher made use of the predetermined eligibility criteria to select participants for the study to ensure proper representation in the research samples (Holloway & Wheeler 2010:55).

3.4.6 Beneficence and non-maleficence

Beneficence refers to the principle of doing 'good' and protection of participants from physical, emotional, social and psychological harm (Polit & Beck 2012:171) while non-maleficence means not doing harm to the research participants. The researchers have an ethical obligation to maximise benefits and to minimise harm to the research participants. The participants were at no foreseeable physical harm from the study as it involved participation in interviews only. The researcher gave the participants the necessary information and provided opportunities for them to ask questions and to raise their concerns during all information giving sessions in order to prevent anxiety. Respect for the principles of beneficence and non-maleficence was also shown by upholding confidentiality because breach of confidentiality can cause psychological and/or social harm.

3.4.7 Scientific integrity

The selected research design and methods were followed and documented to ensure that reliable and valid data, as well as outcomes addressed the research objectives. The research methods were not manipulated in any way to support the researcher's viewpoints and all the sources used were acknowledged accordingly.

3.5 MEASURES TO ENSURE TRUSTWORTHINESS

Hammond and Wellington (2013:146) explain that trustworthiness is an alternative to the traditional notions of reliability and validity in qualitative research. The four criteria for establishing trustworthiness of qualitative research as suggested by Lincoln and Guba (1985) cited in Creswell (2013: 244) were used. The criteria included credibility, transferability, dependability and confirmability.

3.5.1 Credibility

De Vos et al (2011:419) describe credibility as the alternative to internal validity, in which the goal is to demonstrate that the inquiry was conducted through accurate identification and description of study participants. Gilson et al (2012:56) further explain that credibility seeks to find a match between participants' views and the researcher's reconstruction of them. In order to improve on the credibility of the study, the following strategies were used;

- **Prolonged engagement**

According to Polit and Beck (2012:599), prolonged engagement is an important step in establishing rigour and integrity in qualitative research. Prolonged engagement involves spending sufficient time in the data collection process so that participants feel enough confidence and trust in the researcher to allow for adequate study of the cultural context and adequate checks for misinformation and distortions (Hammond & Wellington 2013:164).

The researcher spent considerable time interacting with the participants during individual interviews in order to develop a rich understanding of their experiences of being involved in hospital boards until data saturation. The time spent during data collection was sufficient to establish rapport with the participants.

- **Member checking**

Member checking, also known as informant feedback, involves returning to persons from whom data were collected and asking them if they can recognise the data interpretation reported as themes and categories as accurate representations of their experiences (Polit & Beck 2012:599; Tracy 2013:236). On the spot member checking was done by summarizing the content of the interview to understand and verify if the researcher has captured what the individual participants wished to impart. Through member checking, feedback was given to the participants and their reaction to the data and findings were obtained. The researcher could also obtain feedback regarding the participants' response to their interpretation of the data from them as individuals (Holloway & Wheeler 2010:305).

- **Thick description**

Thick description involves a detailed description of the process, context and people in the research including the meaning and intentions of the participants' and researcher's conceptual developments (Holloway & Wheeler 2010:310). Thick description necessitates prolonged engagement in the setting (Holloway & Wheeler 2010:311). Prolonged engagement in the setting and immersion in the data were discussed in the previous paragraphs.

In addition, the individual interviews were audio-recorded to document the findings and to serve as a backup method for the enormous amount of data that emerged during the discussions. Data from information-rich participants were collected until data saturation was reached. The researcher provided a detailed report of the rich description and explication of the research phenomenon in order to provide sufficient information to permit judgments about contextual similarity.

3.5.2 Transferability

Transferability refers to the degree to which the results of a study can be generalised to settings other than the ones studied (Hammond & Wellington 2013:175). In qualitative research, the intention is not to generalize the findings (Robson 2011:205) but qualitative researchers have a responsibility to produce sufficient data that is conceptually representative of the people studied within a specific context and they need to account for contextual factors when data is transferred from one situation to another (Ulin, Robinson & Tolley 2005:27). In this study, background information was provided to establish context of the study and a detailed description of the phenomenon to allow comparisons to be made. The findings of this study are transferable to the participants in the context of this study.

3.5.3 Dependability

Hammond and Wellington (2013:175) view dependability as equivalent to reliability in quantitative studies. Dependability refers to the stability of data over time and over conditions (Polit & Beck 2012: 584). It is also about whether the findings of the study would be consistent if the study was replicated with the same participants in a similar context. Dependability involves accounting for all the changing conditions in whatever is being studied as well as any changes in the design of the study that were needed to get a better understanding of the context. Dependability was promoted by the use of an audit trail which ensured that the processes of data collection, analysis and interpretation were reported in detail. This was done by providing a description of what was planned, providing detail of what was going to be done at the field and lastly providing an evaluation of the effectiveness of the process of enquiry would be undertaken (Hammond & Wellington 2013:175).

3.5.4 Confirmability

Confirmability, which is equivalent to objectivity in qualitative studies, refers to the degree to which study findings are supported by the data (Hammond & Wellington 2013:163). According to Holloway and Wheeler (2010:303) the findings of research are confirmable if the readers of the study are able to trace data to their original

sources. Confirmability was enhanced by ensuring the work and findings are the results of the experiences and ideas of the study participants, rather than the characteristics and preferences of the researcher. This was achieved by going back to the participants and sharing preliminary interpretations with them so that they can evaluate whether the researcher's thematic content analysis was consistent with their experiences (Tracy 2013:236).

3.6 CONCLUSION

In this chapter, the researcher provided a detailed discussion on the methodology used in the study. The ethical considerations and measures taken to ensure trustworthiness were described. In the next chapter, the focus will be on the data analysis, presentation, description and the discussion of the research findings.

CHAPTER 4

DATA ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

This chapter provides a description of the data analysis, the presentation and the description of the findings of the study. Data were collected by means of individual interviews. The data collection and analyses presented in this chapter occurred according to the research methods as described in chapter 3.

4.2 DATA MANAGEMENT AND ANALYSIS

The verbatim transcriptions of interview data from the audio-recordings and notes made during the interviews provided a record of the raw data. The data collected were stored electronically as audio recordings to use as a form of backup and the transcriptions and notes were stored as MS word files. The MS word files were password protected to ensure confidentiality. Data from individual interviews were analyzed using thematic analysis, a process of searching across a data set to find repeated patterns of meaning (Polit & Beck 2012:745).

4.3 RESEARCH FINDINGS

The participants had to respond to the question: *What is your experience regarding your participation in hospital governing boards?* Data were collected until data saturation was reached, which was, after eight participants had been interviewed. All the participants gave informed consent to participate in the study and permission for the interview to be audio recorded and for the researcher to make notes, during the interview.

4.3.1 Sample description

The sample consisted of 8 community members who served on hospital boards of regional, district and psychiatric hospitals in Dr Kenneth Kaunda district. All the participants were residents of Dr Kenneth Kaunda district, who held various positions in the board as shown in table 4.1.

Table 4.1 Participants' description

Participant	Position	Experience in years
P1	Chairperson of the board	2½ years
P2	Former chairperson and currently ordinary board member	17 years
P3	Chairperson of the board	4 years
P4	Former chairperson and currently ordinary board member	10 years
P5	Former chairperson and ordinary board member	6 years
P6	Ordinary board member	4 years
P7	Former chairperson and currently ordinary board member	10 years
P8	Ordinary board member	7 years

According to the National Health Act, 2003 (Act No. 61 Of 2003) as amended, the term for serving in the hospital boards is 3 years, however the researcher found there were community representatives that had served for more than 10 years in different positions. All the participants met the inclusion criteria of serving in the board for a minimum of 2 years. It is interesting to note that serving for more than 3 years in the hospital boards did not affect the process by which data was gathered and recorded.

4.3.2 Themes

Three themes emerged from the data analysis and these were: creation of opportunities, benefits and challenges experienced by hospital board members.

Within the theme three categories, namely; learning experience, better understanding of hospitals and contribution to service delivery were identified and the subcategories were as shown in table 4.2

Table 4. 2 Theme 1 Creation of opportunities

Theme	Categories	Subcategories
1 Creation of opportunities	1.1 Learning experience	i. Acquisition of new skills ii. Appreciation of nurses' hard work and commitment
	1.2 Better understanding of hospital	iii. Hospital and its operations iv. Challenges facing health workers in hospitals
	1.3 Contribution to service delivery	v. Listening and dealing with patients' and families' complaints vii. Monitoring quality viii. Community education

4.3.2.1 Creation of opportunities

Creation of opportunities as a theme is presented with the categories of learning experience, better understanding of hospitals and contribution to service delivery. Several subcategories also emerged and are discussed together with the categories as follows:

4.3.2.1.1 Learning experience

Learning experience emerged as the first category. According to the findings, participation in hospital boards was described as a learning experience. Within this category, two subcategories, namely acquisition of new skills and appreciation of nurses' hard work and commitment were identified.

- *Acquisition of new skills*

The participants reported that their participation in hospital boards created opportunities for them to acquire new skills related to their expected roles and responsibilities. From the participants' responses, the acquired skills included report

giving, fund raising, gardening, priority setting, and cost cutting measures. The sample responses include

- P1: "I remember it was at the 2012 Lekgotla where I had to give report on these [patient safety] issues. Now because management did have the records, it was very easy to take it from there and to report it.'
- P2: "We participated in making sure every community had its own clinic, you know, fund raising, trying to work with government on building such facilities where people can be served... That was one of my biggest nice experiences you know, there was this working together with the government on this issue".
- P3: "I can say we have managed to make gardening. We have sold some of the vegetables like spinach, onions for fund raising".
- P6: "The experience that you get, you learn how to save, to prioritise and you save in such a way not to compromise your community and all that".
- P8: "We are going to sharpen cost cutting measures. Those are the experiences that you could implement in your home".

Previous studies by Mubyazi and Hutton (2012:57) and McCoy et al (2012:186) also found that participation of community representatives in hospital boards leads to the development of skills and competencies which might be used for future community development. In addition, according to the same authors, community members serving in hospital boards were able to use the knowledge and skills acquired to influence health care utilisation and revenue generation. In a study conducted by Kessy (2014: 14) on improving health services through community participation in health governance structures, it was found that fund raising was facilitated for improving infrastructure at the health facilities in Tanzania.

- *Appreciation of nurses' hard work and commitment*

According to the findings, the participants stated that as a result of their participation in hospital boards, they learned to appreciate the nurses' hard work and commitment to their work. This finding is illustrated by the following responses:

- P3: "My experience err, I have that experience after I was in the board and working with the nurses, so I started to understand the difference between the nurse and the patients. Not as the people outside say the nurses treat the patients err, in a way that they are not

happy. But when we are inside looking, we see the big difference that the nurses, they try hard to work with the patients".

P2: "Those people (nurses) are committed about their job. You can point them and say this one and that one. They are very committed to their job.

P7 "the staff nurse you will get when you get to the hospital they will be telling you, when three are on duty during the course of the day, at night there will be two and when you look around they will be telling you about the shortage".

The study participants stated that they had the opportunity of taking part in nurses' events' in order to encourage and motivate them to continue to do their best and to share the vision and strategy of the board of improving their working conditions. This finding was reflected in the following statements

P6: "I was even there on the International Nurses day where I took the message of the board to the nurses, that the board want to see improvement, "the board wants make you comfortable, for example, we were thinking of getting them err, what we call a tea machines in their ward where they can just press and get their tea unlike they must go out and go for their tea They must be a chair, a massage".

P1: "and you have to keep on encouraging staff and say please do your best, you are shining. So you encourage staff, encouraging them to say let's talk. Then they will say Ok, this is what was done.

According to Rothenberg and Haderlein (2013:28) the growing shortage of primary care physicians in the United States of America led to an enormous value being placed on the nurses as they champion quality improvements, spearhead research innovation, advocating for patient rights and helping patients and their families confront complex ethical issues such as end-of-life-care.

4.3.2.1.2 Better understanding of the hospital

Better understanding of the hospital boards was the second category to emerge and the subcategories included hospital and its operations and challenges facing health workers in hospitals.

- *Hospital and its operations*

According to the findings, participation in hospital boards created opportunities for community representatives to develop a deeper understanding of the hospital and its operations. This was made possible through participation in committees of the boards as well as sub-district and hospital strategic planning sessions. The finding was apparent in the following sample responses:

- P1: "I remember it was at the 2012 Lekgotla where I had to give report on these [patient safety] issues. Now because management did have the records, it was very easy to take it from there and to report it. "Have to know exactly how the hospital operates. Must know from management level up till down to the workers level, the ordinary cleaners. But what is important, when it comes to management issues, know the dynamics especially on finance".
- P2: "We are invited to such Lekgotla's. what we do, we do the evaluation of the whole process on the discussion that have been taking place for that particular period. If it is for 3 days, each and every day we make notes to say where we can go right, where do you see there is something wrong, how we can change, what's the better way to go".
- P3: "The board found somebody from HR, the one who was in the department of finance to give us short workshop about financing at the hospital to the board and how can we manage some of the things at the hospital".
- P6: "I am in the finance one (*committee*). I can tell you about the hospital budget, the expenses of the laundry, the boiler, I can tell you anything to do with the money, the filling records, whatever because that is where I like to participate."
- P7: "When I was serving as the chair for the very first time, I served on the interview, short listing process and I gained a lot of experience about that process on its own to say, we are able to deal with about thousand applications. Those are some of the benefits that, you learn a lot as the chair, you know".

These findings are similar to those of previous studies on governing public hospitals by McCoy et al (2012:454) and Saltman et al (2011:1) which found that board members in England were able to develop a better understanding of the hospital and its operations as they were involved in setting the overall policy and strategic direction for the Trust, approving business plans, budgets and major capital expenditure. According to Kessy (2014:27) involvement of community representatives in review processes led to them being increasingly aware of issues relating to medicine stock-outs, inadequate human resource for health, and overcrowded health facilities among others. However, McNatt et al (2014:185) states

that even though governing boards in Ethiopia had significant influence on hospital operations, they nonetheless had limited ability to control financial decisions in comparison to their counterparts in high income countries.

- *Challenges facing health workers*

It emerged from the findings that, active involvement of community representatives in hospital and district review processes enabled them to understand some of the challenges that health workers faced. The challenges facing health workers that were mentioned by study participants included manpower shortage, old equipment and infrastructure. This is reflected in the following statements:

P1: "But also there is a serious shortage of manpower. You will always get a cleaner that is busy on one section and he/she will tell you by this time I will be there. For me, I see that as a result of short age of manpower".

P2: "The delegations, really we need to look into that in terms of the signing powers to financial expenditure. We have lost a lot of things. Presently we are working with an old X-ray machine. We were allocated funds to do that but because the CEO could not sign, he took the papers to somebody else but that particular person could not sign until we lost that money. It was not utilised and it was taken back".

P6: "We've got for example in our hospital shortage of nurses, they took their packages, and others retired due to age and so on. Because of the administration, we cannot hire. One day I visited ... in the hospital and found that situation but we understand it is due to the fact that our hospital is too small and the people from [...], [...],[...] and [...] four towns with one hospital, too many patients.

P7: "At some stage you will find that at night there will be one doctor and maybe err, the staff nurse you will get when you get to the hospital they will be telling you, when three are on duty during the course of the day, at night there will be two and when you look around they will be telling you about the shortage".

P8: "Let me say for the past years we've been having problems of err, err hospital lifts. So it's a problem. How do you get a patient to the surgery and the surgery is up and the lift is a very serious concern come year in year out. According to the rounds, the quality reports, there is a lot of complaints. You find out the bathrooms are not up to standards and sometimes you have patients that complain of not having hot water".

The challenges mentioned by the study participants are similar to those highlighted by hospital board members in the 2008 Annual Report of the Office of the Auditor

General of Ontario (2008:312), and they include manpower shortage and the need for expanded or renovated facilities to meet patient needs.

4.3.2.1.3 Contribution to service delivery

Contribution to service delivery included dealing with patients and families' complaints, monitoring quality and community education.

- *Listening and dealing with patients and families' complaints*

Opportunities were created for the community to make their concerns and complaints known to officials and health care workers and for the board to give the community feedback. This finding was apparent in the following statements;

- P1: "There was a complain about patient treatment in the ward. Some of the patients complained about slippers, that they don't get and the gowns (coughing). When we monitored that, it happened, yes it did happen, but the complainant family was not informed that it was attended to immediately".
- P3: "Yes, we have one of the village called [...] we go there and management was there and even some of the stakeholders, Social and Agriculture, they were there in that village, hearing about how do they feel as the people from the village when they come to the hospital, what treatment they get in the hospital. They give their story."
- P5: "Definitely, what the board would actually do, the chairperson of quality assurance portfolio committee, err, we agreed that she, would sit with the official, the manager of quality and link with the communication officer and out of the suggestion box they would together open the suggestion box and read all those particular things, you know, complaints, comments and come up with remedial steps in order to remedy the situation".
- P6: "We went an extra mile, we called people who were patients, people who were outpatients to come and talk personally in front of everybody, officials, nurses, doctors, ourselves and they listened to these people... We invite them, we don't depend on paper only, because some of the people don't write, they talk and we do check articles in the newspapers, what they are saying about us".
- P8: When we make a follow up on the complaints, the patient will be saying this is what happened, this is what happened, and then it ended here and I was helped by this person. So we get those written, we also test the verbal le di response [and the responses].

McNatt et al (2014:286) conducted a study on views about the implementation of hospital governing boards and found that the hospitals with more positive patient experiences had governing boards that reviewed patient complaints quarterly or more frequently. McCoy et al (2012:454) emphasise the importance of engaging stakeholders (patients and families) about their complaints because they raise issues about poor quality of healthcare delivery services in health facilities, bad language of the health workers, general cleanliness in the health facilities and ineffectiveness of the drugs dispensed by the facilities. One participant in the current study mentioned that the community made the board members aware of long waiting time; *'as I told you there will be an issue of medications when the community members tell you since I have been there from seven o'clock till five o'clock. So there is also the issue of long waiting time for medicines which impact on service delivery.*

Some of the study participants in the current study reported positive patients' outcomes as a result of the time they spent listening to the community's concerns and complaints and the feedback they gave regarding the resolution of their complaints. This finding was apparent in the following responses;

P3: "Yes exactly, they are happy because we take time with the patients; we tell him that he must not fear anything. What is important is his health.

P7: "Anyhow, we are assisting our community and we are giving them feedback and the time".

The United States of America introduced a system of incorporating patient stories into their board meetings as one way to better understand the problems and how they affect patients and their families (Curran & Totten 2010:275). Kessy (2014:275) conducted a study in Tanzania on improving health services through community participation and concluded that in instances where strong there is a strong link between the community and the authorities exist complaints were decreased.

In addition the study participants stated that they made recommendations relating to patients and families' complaints. This finding complies with the statutory requirements in section 16(a) of the North West Health, Developmental Social

Welfare and Hospital Governance Institution Act, 1997 (Act No 2 of 1997) as amended which states that the board should make recommendations relating to any complaint by a patient, member of the public or a private medical practitioner. The sample responses included;

- P4 "Now that program I would lead as the chair. I would do it together with the management. All of them, as and when communities are asking critical questions as the chair I would say hospital, a person dealing with ambulances here's the concern and the manager of ambulances must respond to issues to say why turnaround of hospitals when they are called, what is the problem".
- P5: "The manager of quality with the communication officer would together open the suggestion box and read all those particular things, you know, complaints, comments and come up with remedial steps in order to remedy the situation
- P6: "We've got a box there, you throw your complaint. At every meeting we want to know the successes, percentage, how many people were replied and see it going down".
- P7: "I am from the disability sector, the issue of access and other issues... These are the issues that I raised from my side to make sure that the hospital is complying with the issues of the disabled people.

These findings were different from those of a study on assessment of roles and responsibilities of hospital boards by Tshimawu (2010:38), which found that the community representatives serving in hospital boards in the Limpopo province of South Africa did not provide a forum for dealing with the community complaints and grievances. According to the findings of the same study, there was no monitoring, no investigation of complaints and no complaints resolution progress reports. A study done by Rutebemberwa, Ekirapa-Kiracho, Okui, Walker, Mutebi & Pariyo, (2009:146) on lack of effective communication between communities and hospitals in Uganda found that there was lack of effective communication between the communities and the hospitals that serve them. This deprived the communities of the right to participate in the improvement of the services they receive. In the same study some community members serving in the board perceived they would be harassed if they complained and had reached a state of resignation preferring instead to endure the problems quietly.

- *Monitoring quality*

The findings revealed that opportunities were created for all community representatives to monitor quality which included reading of complaints and suggestions from the boxes, interviewing health care consumers and inspections. The sample responses from the sample of participants are illustrated in the following statements;

P1: "I must say twice a week we go around and check the complaint boxes, check what is the complain and also check whether the necessary complaint, is it relevant and have they attended to issues raised. We even go to the extent of calling the complainant after collecting all those forms, we call the complainant to say, heh! Ntate [/Sir/] (coughing), you are complaining about this issue, can you be clear and tell us more about this issue".

P2: "I was invited to do the monitoring and evaluation which was also one of my biggest experience. We always make sure there are visits, rounds done by the board and then we come up with reports on the visit, look unto problems and see how we could work around them. At the end of the day, we want to give service to the people and a better one for that matter."

P3: "We ask him (patient) about the treatment given by the nurses and how do they respond. So they give us the negative and they give us the positive. We are looking and conduct inspections about the places that is clean, the place that they working with err, places like operation, the places like maternity ward, we were searching all over inside in the kitchen and around so that how clean is the hospital.

P4: "Our role is ... positive because we want to know that is inside things that are in place so that we have to understand between our community and the hospital what is going on. They bring the budget issues to the meeting. They do presentations. Then we engage them on the issues. They will even tell us the personnel that were appointed. We will advise them".

P8: We do conduct hospital rounds and interview patients on the quality of care they are receiving. In our rounds we really have everybody, we check security, and check the place is healthy, flowers and that type".

This finding complies with the statutory requirements in section 16(2b) of the North West Health, Developmental Social Welfare and Hospital Governance Institution Act, 1997 (Act No 2 of 1997) as amended which states that the board should inspect the hospital at least once every three months. McNatt (2014:286) observed that governing boards that reviewed performance in several domains quarterly or more frequently had more positive patient experiences. The same author further explain

that such boards were able to develop new revenue sources, determined services to be outsourced and reviewed patient complaints.

Bjorkman and Svesson's (2009:376) report on a study conducted in Uganda state that through community monitoring, immunisation of children, waiting time, examination procedures, and absenteeism improved significantly in the treatment communities. Jiang (2009:28) explain that in the United States organisations that monitored their quality performance through the use of national bench marks enabled the board members to hold the senior executive leadership accountable for the outcomes.

- *Community education*

According to the findings, participation in hospital boards created an opportunity for community representatives to educate communities about a number of topics related to the functioning of hospitals using a variety of media such as print media (newsletters, local newspapers, and notice boards), local radio stations, seminars, meetings at clinics and community halls, awareness campaigns and roadshows. The sample responses are reflected in the following statement;

P4: "Most of the time I have tried to, I have held road shows in a number of, I would travel to [...], get to [...] addressing communities. I would travel to clinics, community halls. Now that program I would lead as the chair".

P5: "Sometimes we would say once we have an activity we want to organise a particular activity, the communication officer will take the photos and then write a story and sent it to that particular newspaper for them to publicise whatever information they actually need.

P6: "I like to use the vision, the mission; at the community they will be self-reliant if empowered with information. We did it in the radio when we were faced with shortage of nurses. They must not be surprised ha batho ba bona ba dischargiwa [/when their families are discharged/] before the time.

P7: " There was one church that was having err, seminar and they did invite us to come and tell the community what it is that we render to the community of [...].We also have a newsletter that you can use to source some additional information. We take a group

photo, put it in the local newspaper and inform the community that this is the newly appointed board....."

P8: "We also have a radio slot where a board member would accompany one of the hospital management members". we need to teach our people to have something like a code of conduct to say when you are going to lodge with your child we are going to need you to say I, mang, mang [/so and so/], I do. One other thing that we are trying to teach our community is that the criteria that is being used to go to the hospital. You have to first start at the clinic. But now there is that culture from our people that what they get from the hospital is better than what they get from the clinic. So they refuse to go to the clinic. They want to take a taxi and go to the hospital".

Berlan and Shiffman (2011:6) identify information provision as one of the important interventions for changing behaviour of health consumers. The same authors further explain that communities that have access to information fare significantly better and this was evidenced by an improvement in the number of community members who used the clinic services. The findings also revealed that the participants worked closely with the community liaison officer in the hospital to encourage the local media to provide coverage on some of the key projects within the hospital. One participant stated that *"We had an opportunity where a patient was running positive issues here in the hospital. According to him he was critical and got good treatment here. We do get positive coverage. We also have the local radio station and you could phone {coughing}. In terms of the media, we have to drag them to say this is not a bull shop, this is a public entity, please give us the coverage"*.

Kamuzora et al (2013:9) indicate that community participation can be effective in terms of improving the quality and coverage of healthcare, as well as impacting on health outcomes. According to Saltman et al (2011:130) locally elected and appointed board members are expected to safeguard the public reputation of the Trust and support internal and external communications and participate in meetings with other external organisations.

4.3.2.2 Benefits

The second theme that emerged from data analysis was benefits. Within the theme one category, namely training opportunities was identified as shown in table 4.3

Table 4.3 Theme 2 Benefits

Theme	Categories	Subcategories
Benefits	2.1 Training opportunities	(i) Acquisition of new knowledge

'Benefits' as a theme presented with the category of training opportunities. One subcategory also emerged and is discussed together with the category as follows:

4.3.2.2.1 Training opportunities

According to the findings, participation on hospital board benefitted the community representatives serving in them in that they acquired new knowledge necessary for the execution of their expected roles and responsibilities. From the participants' responses, new knowledge was acquired through attending orientation programmes and workshops on topics such as monitoring and evaluation, finance, priority setting, organising and control of health services. The sample responses include;

- P1: "Yeah! we went through the orientation and induction programme conducted by the hospital management and also the university of [...]"
- P2: "They took me to the University of [...] for a course on monitoring and evaluation".
- P4: "There was a unit that was appointed, what is that university, err, err, the university of [...] to train on transformation, monitoring and evaluation, finance, you know, the last issue on report writing skills and all that".
- P5: "The management would assist the people instead of us waiting for the province to come and train us. That's basically, what was actually happening".

The finding is consistent with a study by Greer, Stewart, Wilson & Donnelly 2013:225 on health board participation which found that the elected board members in Scotland received induction training at their local sites on National Health Service management and board procedures. In Tanzania, health facility governing committee members were given training on the hospital and its operations and consequently the board members were able to follow up on the issues of staff recruitment, medicine stock outs, management of patients, rehabilitation and construction issues (Kessy

2014:21; Macha et al 2011:37). Tshimauswa (2010:66) reported that newly appointed hospital board members in the Limpopo province of South Africa were trained after several months on a variety of topics by an appointed external provider. The training of community representatives on provincial health policy, local health priorities, the structures and functions of the hospital and the relationship between the hospital and other local or regional health services was in accordance with the provisions of the draft National Policy Framework on Decentralisation of Hospital Management (Monitor company 1996:36).

Probst, Adams and Martin (2010:20) conducted a study on education needed for hospital board directors in South Carolina and found that even though the board chairpersons were orientated and received ongoing development, they did not express confidence in how well developed the orientation for new members was and whether the orientation covered a broad range of topics. A study conducted by McNatt et al (2014:178) and Meier et al (2012:22) found that board members did not have the needed background or training to be effective in the position because there was lack of training and orientation for governing board members. According to David, Murphy and Mullaney (2011:279) in America where hospital governing boards have statutory and fiduciary obligations, key steps were taken to introduce formal training for board education and training falling into 3 categories, 1) voluntary board and director certificate/ certification programs, 2) legislative mandate (state law) and 3) pay driven governance education. Molyneux et al (2011:545) report that, committee members in Mexico, were not given due recognition in terms of support and training initiatives, and they had no inputs into their communities' health service targets and programmes.

4.3.2.3 Challenges experienced by hospital board members

The third theme that emerged from data analysis was challenges experienced by hospital board members. Within the theme two categories, namely; ineffective communication, poor relationships and role clarification were identified and the subcategories were as shown in table 4.4

Table 4.4 Theme 3 Challenges experienced by hospital board members

Theme	Categories	Subcategories
Challenges experienced by hospital board members	3.1 Ineffective communication	(i) Delays in responding to concerns (ii) Information essential for decision making not shared
	3.2 Poor relationships	(iii) Community representatives and management (iv) Management, staff and unions
	3.3 Role clarification	(v) Loss of focus (vi) Accountability

Challenges experienced by hospital board members as a theme is presented with the categories of ineffective communication, poor relationships and role clarification. Several subcategories also emerged and are discussed together with the categories as follows:

4.3.2.3.1 Ineffective communication

Ineffective communication emerged as the first category of theme 3. Within this category, two subcategories, namely delays in responding to concerns and information essential for decision making not shared were identified.

- *Delays in responding to concerns*

According to the participants, there were delays in responding to their concerns. Participants reported that the delays were as a result of red tapes. In addition the participants indicated that the red tape delayed the process of addressing the concerns. The following were the sample responses:

P2: "I mean we have lost a lot of things, for example some of the money that we were supposed to utilise within the hospital had to go because somebody up there could not sign in time. He goes to leave and he cannot leave somebody that he can give powers to continue"

- P6: "Those things need to change and that power must be given to the downstream where there is a great need... What is important is to take away this responsibility from ...and bring it down to the department where when we want to do something it can be done speedily".
- P4: "Now as the sub district and the board, we take our issues to the district and the district takes their issues to the MEC directly. That is how they were processed and obviously there were no responses on the issues.
- P5: "What we always do, the engagement with the MEC, we did not have a program as such to say this is our program to meet with the MEC because of non-availability of the MEC. When you recall, there is a lot of red tape in order to ensure we meet with the MEC".
- P8: "Yes, these issues are raised with the MEC. And one thing, you find out that the response from the MEC is very slow in terms of addressing our concerns.

According to McNatt et al (2014:183) ineffective communication and lack of collaboration between the board and the regional health boards limit the functioning of the board. According to the annual report of the office of the Auditor-General of Ontario, Canada (2008:317) board members indicated communication challenges with the Local Health Integration Network (LHIN) including not receiving timely responses to requests and information that allow them to understand what activities the LHINs monitors.

- *Information essential for decision making not shared*

Participants reported that information that was essential for decision making was not always shared with them. As a result of these challenges, community representatives were not able to make the decisions on certain processes such as priority setting and budget planning processes as reflected in the following sample responses:

- P1: "Sometimes you will get some nurses who want to keep it back and don't want us to know about it.
- P4: "To say there were issues that they wanted the board to know about and other issues they would say these were administrative issues.
- P7: "when the CEO is appointed, the board members are not part of taking the decisions of appointing the CEO. We will just be given a CEO by the Minister or the MEC of health from the province".

P5: "We would have to make them accountable based on the information they are giving us, not misleading, because when we make decisions as the board we must make them based on that information".

The study conducted by Goodman et al (2011:305) on health facility committees also found that community members in Kenya were not informed of the activities happening in the hospital and this made them unable to make proper and well considered interventions in the case of challenges. Ndinokubwayo (2010) in a study conducted on low and middle income countries indicate that incidences of adverse events were linked to inadequate communication or reporting as well as inadequate training or supervision of clinical staff, non-availability of policy or the failure to implement and inadequate. Whilst board members were expected to provide oversight role and ensure there was responsiveness to the needs and views of their communities, information in this regard was not available. McNatt et al (2013:9) posit that the lack of information about policies, laws, people's rights made it difficult for the boards to influence quality of the decentralised health planning and priority-setting processes.

4.3.2.3.2 Poor relationships

Poor relationships emerged as the second category of theme 3. Within this category, two subcategories, namely community representatives and management as well as management, staff and unions.

- *Community representatives and management*

It emerged from the findings that in some hospitals the relationships between management and community representatives were strained. Participants attributed the poor relationships to negative attitude, and staff undermining the level of education of community members. This was supported by the following responses:

P2: "I think sometimes it is the question of attitude and approach because I think the staff themselves underestimates people that come from the community, to say sometimes they know people are not educated, that's the advantage they took sometimes.

- P4: "I just want to illustrate on how paralysed the board was becoming at one particular point. The attitude and the issues that were coming from that subcommittee especially from the management side, they were reducing the members of the board to nothing in that subcommittee".
- P5: "It's an issue of the relationship and not understanding your role. That is why I was saying when you end up being part of management, forgetting you are a board member, management will end up not taking you seriously".

The findings are consistent with the study by Mosquera et al (2001 cited in Molyneux et al 2012:457), that the strained relationship between community representatives and health workers were as a result of health workers being unhappy with community supervision and management of facilities, seeing it as interference in their work by unqualified people. Mubyazi et al (2012:59) indicate that in some countries low community involvement was due to district-level managers undermining or questioning the ability of local community leaders to represent their people at district council meetings as they perceived their level of education to be too low. Barasa et al (2014:7) explain that in Uganda, the minimal involvement of the community and patients were attributed to the perception that the community and the patients lack understanding of medical issues and would represent a biased opinion by arguing for the merits of a particular intervention for which they were concerned. Kessy (2014:22) found that inadequate training provided to the board limited the understanding of the nature of the relationship they need to forge with other structures at the council level. According to Tshimawu (2010:44) the views from representatives of management was that the blame should be put on the community representatives behaving as if they were above management and wanted to give instructions to management.

There were different findings in other studies. Probst et al (2010:17) reported that in South Carolina, the board members functioned in a collegial, team building manner as they understood their relationship to management, employees and medical staff. In Kenya, Goodman et al (2011:229) found that though the relationships between health facility committees and health workers were generally good, there was some mistrust expressed.

- *Management, staff and unions*

According to participants, tension existed between management and staff in some of the health facilities which was aggravated by management having to take action against staff perceived to have violated patient rights. However, staff who felt aggrieved by the action of management approached their union representatives. The role that the board played under these circumstances was to promote an environment conducive for both patients and staff. The sample responses from participants are illustrated in the following statements;

P6: "The Sister that was in charge there chased me away, literally saying to me, we are closed, we are not going to attend to you, you must come tomorrow. Not only me but the other members of the community as well. What I did, I called the manager on the spot

P1: "Sometimes you will get some nurses next time when you meet him/her, ... will say I am going to the union and all that, and then you will say it is your right as a union member to go, you can raise it with the union but can we solve it at this level first without going to the union (coughing)".

P8: "The other challenge from my experience is the relationship between the unions and management, the relationship being not so good".

The finding is consistent with the study by Alexander, Lee, Wang and Margolin (2009:193) on monitoring and oversight practices of governing boards that trustees in the United States of America were at times placed in a position where they had to mediate between the potentially conflicting interest of medical staff and management. Barasa et al (2014:7) corroborates the finding and explain that in Uganda the tension and conflict was linked to the different actors' value systems. According to Deffenbaugh (2015:415) strained relationships between management and staff in the United Kingdom National Health System were attributed to management failure to ensure that information should be brought together at organisational level, where the decisions were being made.

According to Anderson and Catclove (2012:21) conflict and tension could be minimised by ensuring effective change management, facilitating increased clinician and community inputs into decision making and strategic planning.

4.3.2.3.3 Role clarification

Role clarification emerged as the third category of theme 3. Within this category, two subcategories, namely loss of focus and accountability were identified.

- *Loss of focus*

It emerged from the findings that some of the participants could not make a clear distinction between roles that belonged to management and those that belonged to the board. As a result of the role confusion, role conflict, tension developed which impacted negatively on the ability of community representatives to function effectively within the hospital board. This is illustrated in the following sample responses:

- P2: "If I am given an opportunity to conduct a meeting, if certain decision need to be done by the board and the management want to entertain it, I will tell the CEO this not your issue, it will be seen by the board after this meeting".
- P4: "Now that has to do, the role that the board had to play actually did not have that significant importance and impact on the part of accountability, especially when decision of the board are not honoured. If we were to tell them you are not accounting on this particular matter, they would say, no, we are accountable to our employer, the employer in this instance is the department of health".
- P5: "That is the problem which I think is giving us a challenge. There need to be clarity in terms of the roles played by board members in general. Why I am saying we have this identity problem is that instead of playing our role as the board members, we end up forgetting ourselves and thought that we are members of management.
- P6: "It's because you are given a mandate to call everybody to order if they don't treat community as they are supposed to treat them. We've got an issue which worries me, that's the negative part of it; we cannot go beyond the hospital. What I am trying to say as a board member I don't have access to clinics".

The finding is in line with a study by Human (2009:74) conducted in the KwaZulu Natal province of South Africa, who found that there was lack of clarity in terms of the real purpose and functions of hospital boards, other than acting as a link between the hospital and the health service users. McNatt et al (2014:186) and Goodman et al (2011:7) indicate that participants articulated boundary problems with the hospital management, being unclear about what was under the authority of the

hospital management versus the governing board. The areas of disagreement revolved around decisions relating to financial incentives for the staff, handling of ethical issues, drug procurement, corrective action for employees, CEO supervision and the overall budgeting for the hospital. However, Kelly (2014:22) maintains that inadequate training provided to the board and committee members after selection was partly to blame for the incomplete understanding among members of their responsibilities including the limited understanding of the nature of the relationship they needed to forge with other structures.

- *Accountability*

It was observed from the findings that, as a result of role ambiguity, participants were unclear about what role was under the authority of the hospital management versus governing board. Due to these challenges participants had difficulties in ensuring that the hospital meets its objectives. This was apparent in the following sample responses:

- P1: "But then what I said to them, it is of no use to raise issues here at the district because we also need the timeframes. When will we get a response. All those things are loose, your [...] or higher management are not accountable to really come back and say because of this and that issue this is the reply".
- P2: "So hospital need to be given the powers to do their own things. That is why we fail because we are relying on other people that sometimes don't have even, you talk about [...] and they do not even know where [...] is. Those things need to change and that power must be given to the downstream where there is a great need".
- P4: "The issue that was coming very strong was the fact that the board is not the employer of this management. If we were to tell them you are not accounting on this particular matter, they would say, no, we are accountable to our employer, the employer in this instance is the department of health".
- P5: "So I would look, there was a situation where sometimes I would look at the report and I would recall these figures are the very same figures I had the last three months and I would ask why are these figures the same that I got three months ago. Now the officials need to explain why they are the same".

The findings are consistent with the views of Berlan and Shiffman (2011:277) study that board members in many of the low income countries were not effective and this led to health care providers treating consumers poorly and with no respect.

According to the finding of the same study, nurses in a maternity service used violence against women as a means of asserting their social superiority to their patients (Abrahams et al (2001 cited in Berlan & Shiffman 2011:7). McCoy et al (2012:454) contend that failure of community representatives to hold management accountable was due to lack of knowledge about health resources, staffing levels or budget processes, as well as officials and health professionals not seeing such roles as being within the ambit of community members.

4.4 OVERVIEW OF THE RESEARCH FINDINGS

Three themes that emerged from the data analysis were creation of opportunities, benefits and challenges experienced by hospital board members. According to the findings, a mix of positive and negative experiences was expressed by community representatives regarding their participation in hospital boards. Some of the participants described their experiences as “nice”, enjoyable, wonderful, and empowering while others described it as a learning experience. The findings were apparent in the following sample responses;

P1 "I really enjoy it I have learnt a lot.'

P2: "That was one of my biggest nice experiences you know, there was this working together with the government on this issue".

P6: "It's been a wonderful experience, an empowered experience because we were workshopped on our duties and all that".

P7: "Yes, we have been developed and empowered. What I remember, between [...] and [...], there is a farm where we went for training for a week. It was a five days training".

P8: "In 2012 we had a very wonderful monitoring and evaluation workshop".

With regard to participation in hospital boards as a learning experience, the participants indicated that opportunities were created for them to acquire new skills that enabled them to carry out their expected roles and responsibilities. The mentioned skills included chairing meetings, report giving, fund raising, gardening, priority setting, and cost cutting measures. One participant mentioned that the skills acquired could be used in one's life *"We are going to sharpen cost cutting measures. Those are the experiences that you could implement in your home"*.

It also emerged from the findings that participation in hospital boards enabled the community representatives to understand some of the challenges facing health workers. Those challenges included manpower shortage, old equipment and infrastructure. A noteworthy finding was that the better understanding of challenges facing health workers led to the community workers' appreciation of the nurses' hard work and commitment in spite of the mentioned challenges.

Participation in hospital boards created opportunities for community representatives to develop a deeper understanding of the hospital and its operations as well as an opportunity to serve the community. The community representatives were able to listen and deal with patients and families' complaints, to monitor the quality of care and to educate the community. There is adequate evidence in literature that governing boards that reviewed patient complaints quarterly or more frequently had more positive patient experiences and fewer complaints. Some of the study participants in the current study reported positive patients' outcomes as a result of the time they spent listening to the community's concerns and complaints and the feedback they gave regarding the resolution of their complaints. One participant in the study said: *"Yes exactly, they are happy because we take time with the patients; we tell him that he must not fear anything"*.

Quality was monitored by means of the reading of complaints and suggestions from the boxes, interviewing health care consumers and inspections. Through the use of suggestion boxes, the community raised issues of poor quality of healthcare delivery services in health facilities and general cleanliness in the health facilities. The community representatives serving in hospital boards who took part in this study complied with the statutory requirements in section 16(2b) of the North West Health, Developmental Social Welfare and Hospital Governance Institution Act, 1997 (Act No 2 of 1997) as amended which states that the board should inspect the hospital at least once every three months. With regard to education, the community representative serving in hospital boards presented a number of topics related to the functioning of hospitals using a variety of media such as print media, local radio stations, seminars, meetings at clinics and community halls, awareness campaigns and roadshows.

Another positive experience was related to the benefits such as training opportunities. The findings revealed that participation in hospital board benefitted the community representatives serving in them in that they acquired new knowledge necessary for the execution of their expected roles and responsibilities. The new knowledge acquired was through attending orientation programmes and workshops on topics such as monitoring and evaluation, finance, priority setting, organising and control of health services. Orientation and induction was organised for newly appointed board members and the training focused on committee roles in general. Further training was organised with institutions of higher level and the main people targeted were chairpersons of the boards.

With regard to negative experiences, community representatives serving in hospital boards experienced the following challenges;

- Ineffective communication; which resulted in delays in responding to hospital board members' concerns. According to the participants the delayed the process of addressing the concerns was caused by "red tape". Another finding was that the information that is essential for decision making was not shared with community representatives serving in hospital boards.
- Poor relationships between community representatives and management, as well as between staff and unions.
- Role clarification; according to the findings, there was role confusion and tension because some of the participants could not distinguish between the roles that belonged to management and those that belonged to the board.

4.5 PERSONAL REFLECTIONS

Upon self-reflection, the researcher realised that she had preconceived ideas and values regarding community members serving in hospital boards. These preconceived ideas and values were changed as a result of interaction with study participants during the individual interviews.

According to the researcher's observations, the participants who had more than five years serving in the hospital boards answered the interview question with a high

level of confidence, talking at length about their experience of serving in hospital boards. However, those participants with less than three years' experience were not as confident and open about sharing their experiences and the researcher had to continually probe for additional information.

On a personal note, the finding that some of the participants mentioned that they learned to appreciate nurses' hard work and commitment in spite of the challenges they face was noteworthy given the fact that the concern for negative publicity of health care services and nurses prompted me to do the study. One participant was highly critical of community representatives that had served in the boards for long, perceiving them as thinking that they were part of management.

4.6 CONCLUSION

In this chapter, data analysis was described. The findings of the study were presented and described. In the next chapter, conclusions and recommendations are made.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In this chapter, a summary and discussion of the study findings are presented, followed by a discussion of conclusions drawn from the study, the identified limitations as well as the recommendations. Suggestions for future research in the area of community participation in hospital boards are also included.

5.2 RESEARCH DESIGN AND METHOD

The purpose of the study was to describe the experiences of community members regarding their participation in hospital boards in Dr Kenneth Kaunda District. An exploratory-descriptive qualitative design was used. Individual interviews provided richness and depth of understanding of the individual experiences of participation in hospital boards from their own perspective, stated in their own words and in the context in which they live and work. The thematic analysis of interviews was done and categories from the qualitative data were supported by literature. The researcher was the main instrument in interpreting the data.

5.3 SUMMARY AND INTERPRETATION OF THE RESEARCH FINDINGS

The presentation of the summary and interpretation of the research findings is presented based on the aim of study, which was to describe the experiences of the community members regarding their participation in hospital boards in Dr Kenneth Kaunda district.

5.3.1 Description of the participants' experiences regarding their participation in hospital boards

Based on the findings, the experiences of community members serving in hospital boards were more positive than negative. The community members serving in

hospital boards in Dr Kenneth Kaunda described their experiences positively as enjoyable, wonderful, and an empowering learning experience through which they acquired knowledge and new skills that enabled them to carry out the expected role and responsibilities.

5.3.1.1 *Creation of opportunities*

New knowledge was acquired through orientation programs and workshops on topics such as monitoring and evaluation, finance, priority setting, organizing and control of health services. The acquired skills included report giving, fund raising, gardening, and cost cutting measures. In addition, the community members serving in the hospital boards were able to develop a better understanding of the hospital and its operations as well as appreciation of the nurses' hard work and commitment in spite of the challenges of manpower shortage, old equipment and infrastructure. The interpretation is that participation in hospital board members resulted in a positive change in the views of community members of health workers and nurses.

Furthermore, participation in hospital boards provided the community members serving in them an opportunity to listen and to deal with patients and families' complaints. They were invited to read the contents of the complaint boxes, and to provide feedback to patients and families on the progress regarding resolution of their complaints. Community representatives conducted hospital rounds as part of their monitoring and evaluation role; interviewing patients in order to understand how they perceived the care they received. The participants also described how they communicated with the community, through clinic and community meetings and through a variety of media such as print media and local radio stations, community awareness campaigns and roadshows. The role played by the community representatives in this regard conforms to section (16(2)(b) of the North West Health, Developmental Social Welfare and Hospital Governance Institution Act (Act No. 2 of 1997) as amended which stipulate that the board should participate in hospital inspections and monitoring of patients complaints.

5.3.1.2 Benefits

Participation of community members in hospital board was therefore empowering in that it provided the knowledge that contribute towards improving the performance and the effectiveness of hospital boards. The new knowledge acquired was through attending orientation programmes and workshops on topics such as monitoring and evaluation, finance, priority setting, organising and control of health services. Further training was organised with institutions of higher level and the main people targeted were chairpersons of the boards.

5.3.1.3 Challenges experienced by hospital board members

Despite the positive experiences described, there were challenges that community members participating in hospital boards faced. The challenges included ineffective communication, poor relationships and role conflict and confusion.

Communication challenges that community representatives experienced were as a result of the delay in responding to their concerns which was attributed to “red tape” by the participants. Another communication challenge was the important information necessary for decision-making was not shared with them.

Poor relationship between community representatives and the management was viewed a matter of great concern. They attributed the strained relationships to the negative attitude of the staff towards community members, the tendency of staff to undermine people that came from the community as well as the negative perception of community members as uneducated with no understanding of the hospital environment. Some of community representatives were reported an observation of failure to distinguish between the roles that belonged to them and that of management, stating that some of community representatives thought that they were part of management. This might be explained by inadequate training.

5.4 CONCLUSIONS

Based on the findings of the study, the following conclusions were reached:

- Qualitative research used in this study provided an account of the experiences of community members regarding their participation in hospital as lived and described by the study participants
- With regard to dealing with and monitoring patients and families' complaints, the participation of community members serving in hospital boards in the Dr Kenneth Kaunda district is in compliance with section (16(2)(b) of the North West Health, Developmental Social Welfare and Hospital Governance Institution Act (Act No. 2 of 1997) as amended which stipulates that the board should participate in hospital inspections and monitoring of patients complaints.
- Participation in hospital boards is empowering in that it created opportunities for community representatives to learn and acquire knowledge and skills important through orientation and induction programs as well as on-going training. This enabled them to exercise their governance roles and responsibilities. However, some of the participants raised a concern that the orientation and induction of new community members serving in hospital boards were conducted months after they had been appointed. Furthermore, opportunities for community education were created for community members serving in hospital boards.
- Participation of community members in hospital boards resulted in the positive change in their views about nurses and created appreciation of their hard work and commitment in spite of challenges of lack of resources
- Members of the community serving in hospital boards were faced with communication challenges and role conflict situations.

5.5 RECOMMENDATIONS

The recommendations are discussed as implications for governance practice and suggestions for further research.

5.5.1 Recommendations for governance practice

It is recommended that:

- New community members serving in hospital boards be given orientation and induction before resuming their role as board members.
- Training of community members is focused on their roles and responsibilities in the hospital board in order to resolve role conflict and confusion they experienced.
- With regard to poor relationships between community members serving in hospital boards, management and staff, team building activities are suggested

5.5.2 Recommendations for further research

It is recommended that:

- Further research focusing on other districts of the North West Province needs to be conducted using the same research methodology as this study.

5.6 CONTRIBUTIONS OF THE STUDY

The findings of this study have contributed to the body of knowledge regarding the contribution and experiences of community representatives serving in hospital governing boards. The findings from the study have highlighted the opportunities, benefits and challenges as experienced by community members serving in hospital boards. The benefits and the challenges derived from the study may be used to enhance the effectiveness of hospital governing boards through the participation of community members.

5.7 LIMITATIONS OF THE STUDY

Even though the qualitative approach used in this study provided rich and deep contextualised understanding of experiences of community members regarding their

participation in hospital boards in Dr Kenneth Kaunda district, the findings cannot be generalised to other districts of North West Province.

5.8 CONCLUSION REMARKS

A summary and discussion of the study findings were presented, conclusions drawn from the study were made and the study limitations were identified. The recommendations for practice and further research were also included in this chapter.

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ANNEXE A

ETHICAL CLEARANCE CERTIFICATE

**UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE**

HS HDC 54/2011

Date of meeting: 2 December 2011

Student No: 9054-504-4

Project Title: Experiences of community members regarding their participation in hospital boards in Dr Kenneth Kaunda District, North West Province.

Researcher: Keneilwe Cynthia Modise

Degree: Masters in Public Health

Code: DIS533N

Supervisor: Mrs ME Chauke
Qualification: MA in Health Studies
Joint Supervisor: Prof TR Mavundla

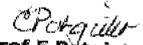
DECISION OF COMMITTEE

Approved



Conditionally Approved




Prof E Potgieter
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE


Prof MC Bezuidenhout
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXE B

LETTER REQUESTING PERMISSION
TO CONDUCT THE RESEARCH

P O Box 301
Noordwyk
1687

19 September 2011

Major General Dr MM Radebe
Head of Department
Department of Health
Private Bag x2068
MMABATHO
2745

Fax no: 018 387 5816

Dear Sir,

PERMISSION TO CONDUCT RESEARCH

I KC Modise, an employee of the National Department of Health, am currently studying towards a Masters degree in Health Science with the University of South Africa. I wish to conduct a research project to enable me to fulfill the requirements to complete a Masters degree.

The title of the research is: The experience of community members regarding their participation in hospital boards in North West Province.

The purpose of the study is to describe the experiences of community members regarding their participation in hospital boards in Dr Kenneth Kaunda District, North West Province.

Community participation and involvement are central in the primary health care approach. The findings from the study will highlight the challenges and maximize the benefits and opportunities of community participation and involvement in hospital boards as perceived by the community members serving in the boards.

From:

To: 0866327441

19/09/2011 16:14

#572 P. 002/002

This study will comprise past and current representatives of the community serving or have served on boards of hospitals located in Dr Kenneth Kaunda district, North West province for a minimum of two years.

Unstructured interviews will be used to collect data from individual community members who serve in the hospital boards. The interview will be guided by one main question;

"What are your experiences as a community representative with regard to your participation in a hospital board in Dr Kenneth Kaunda district?"

The researcher will be the main instrument, meaning that she will be the only person who is going to be involved in the collection of data

Confidentiality will be promoted by ensuring information provided in confidence will not be reported in such a manner that it identifies the study participants.

The research will be conducted under the supervision of Mrs ME Chauke and Ms MC Matlakala from the College of Human at the University of South Africa.

The results will be shared with your department, and will be used solely for department use unless written approval is received to make the result available outside the department people.

I appreciate your attention to this issue and hoping for a favourable response to this request.

Yours sincerely



Ms KC Modise

ANNEXE C

LETTER GRANTING PERMISSION TO
CONDUCT THE RESEARCH



health

Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

2ND Floor Tirelo Building
Dr. Albert Luthuli Drive
Mafikeng, 2745
Private Bag X2068
MMABATHO, 2735

Tel: (018) 387 5757
kshogwe@nwpg.gov.za
www.nwhealth.gov.za

POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

To : Ms K.C Modise

From : Policy, Planning, Research, Monitoring & Evaluation

Subject: The experience of community members regarding their participation in hospital boards in North West province.

Purpose

To inform your good selves that permission to undertake the above mentioned study has been granted by the North West Department of Health. The researcher is expected to issue this letter to the districts or health facilities as proof that the Department has granted approval of the study.

Arrangements in advance with managers at district level or facilities shall be facilitated by the researcher. The department expects to receive the final research report upon completion.

Kindest regards

Director: Policy, Planning, Research, Monitoring & Evaluation
Mr B Redlinghys

12/03/2012
Date



Healthy Living for All

1

ANNEXE D

CONSENT FORM

I KC Modise, am a registered student at Unisa. I am conducting a study on: The experiences of community members regarding their participation in hospital boards in Dr Kenneth Kaunda District, North West Province as a requirement for the degree Master of Arts Public Health.

The purpose of the study is to describe the experiences of community members regarding their participation in hospital boards in Dr Kenneth Kaunda District.

You are requested to participate in this study by signing the consent form below.

CONSENT FORM

In signing this document, I voluntarily agree to an interview to be audio taped by the researcher. I understand the purpose of the study and that the researcher may contact me for more information after the initial interview.

I understand that my identity and all responses I give will be kept completely confidential. I retain the right to withdraw from the study at any time, without any feeling of victimisation.

SIGNATURE: PARTICIPANT.....

RESEARCHER.....

DATE.....