

**PRIMARY HEALTH CARE CHALLENGES IN  
EKURHULENI METROPOLITAN MUNICIPALITY: AN  
EXPLORATION OF BARRIERS TO IMPLEMENTATION  
OF PRIMARY HEALTH CARE SERVICES**

BY

**MSHONI ANGELINE NDHAMBI**

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**SUPERVISOR: PROFESSOR TENNYSON MGUTSHINI**

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## DECLARATION

**Student number: 0803-905-4**

I hereby declare that: PRIMARY HEALTH CARE SERVICE DELIVERY WITHIN THE EKURHULENI METROPOLITAN MUNICIPALITY is my own work and that the sources that I have used or quoted have been indicated and duly acknowledged by means of complete references.

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Mshoni Angeline Ndhambi

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Date

## DEDICATION

This study is dedicated to my grandmother Bihani Ninnette Sono.

## ACKNOWLEDGEMENTS

I am deeply indebted to the following people for the successful completion of this research project. First and foremost I need to cite the wise traditional phrase that “*Munhu i munhu hikwalaho ka va nwani vanhu.*” This expression means that a person is deemed such because of other people. The collective effort by different people made this study possible, and I wish to express my heart-felt gratitude to the following:

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# ABSTRACT

## **OBJECTIVE/ METHOD**

The study examined implementation challenges faced by primary health care workers within the Ekurhuleni Metropolitan Municipality in Gauteng South Africa. Data collection was based on semi-structured interviews carried out on a purposive sample (n=19) of frontline clinicians working within the district as primary health care practitioners.

## **RESULTS**

Participants confirmed that work within the primary health care service disproportionately focussed on curative and rehabilitative functions of their roles with little prioritisation of preventive and promotive interventions. Primary identified reasons included, institutional culture that prioritised short-term curative approaches. Clinicians also cited a range of other organisational barriers, such as – poor strategic planning, and a lack of understanding of health promotion and illness prevention.

## **CONCLUSIONS**

Although the challenges that exist in implementing primary health care are clearly understood, clinicians perceive the solutions for these as being within the control of policy makers and those with power within the organisation.

## **KEY TERMS**

Antenatal care, Chief Community Health Nurse, Primary Health care Nurse, Health promoter, Department of Health, Ekurhuleni Metropolitan Municipality, Expanded programme on immunization, Intergrated management on childhood diseases, Mobile clinic, Maternal and Child health care, HIV/AIDS, Prevention of mother to child transmission, Voluntary counselling and testing, World Health organization, National Health System.

## LIST OF ABBREVIATIONS

<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ANC</b>	Antenatal Care
<b>BP</b>	Batho-pele principles
<b>CBC</b>	Community based care
<b>CH</b>	Community Health
<b>CHC</b>	Community health care centre
<b>CCHN</b>	Chief Community health nurse
<b>COP</b>	Community orientated primary care
<b>DoH</b>	Department of Health
<b>EMM</b>	Ekurhuleni Metropolitan Municipality
<b>EPI</b>	Expanded programme on immunisation
<b>FAS</b>	Foetal Alcohol Syndrome
<b>FP</b>	Family Planning
<b>HAST</b>	HIV and AIDS, Sexually transmitted infection and tuberculosis
<b>HCS</b>	Health care services
<b>HFA</b>	Health for All
<b>HIV</b>	Human Immunodeficiency Virus
<b>HPCSA</b>	Health Professional of South Africa
<b>HSRC</b>	Human Science Research Council
<b>ICN</b>	International council of nurses
<b>ILL</b>	Inter Library Loan
<b>IMCI</b>	Integrated management on childhood illness
<b>MC</b>	Mobile clinic
<b>MCHC</b>	Maternal and child health care
<b>MDG</b>	Millennium Developmental Goals
<b>MOU</b>	Maternal and obstetric unit
<b>NGO</b>	Non-governmental organisation
<b>NHS</b>	National Health system
<b>PDoH</b>	Provincial Department of Health
<b>PHC</b>	Primary health care
<b>PHCFC</b>	Primary health care facility committee
<b>PHCNP</b>	Primary health care National programme
<b>PMTCT</b>	Prevention of mother to child transmission

<b>PNC</b>	Post natal care
<b>PRC</b>	Patient right charter
<b>SPSS</b>	Statistical Package for Social Scientists
<b>STI</b>	Sexually transmitted infection
<b>TB</b>	Tuberculosis
<b>UNISA</b>	University Of South Africa
<b>US</b>	United States
<b>VCT</b>	Voluntary counselling and testing
<b>VHV</b>	Village Health Volunteers
<b>VHC's</b>	Village Health Communicators
<b>WHO</b>	World Health Organization

# ORGANISATION AND STRUCTURE OF THE STUDY

## **Chapter 1: A Theoretical Overview to Primary Health Care**

The chapter focuses mainly on background of Primary Health Care and how it is seen as the solution to address the inadequate illness Management systems that had developed throughout the world.

## **Chapter 2: Literature Review**

This chapter explores a range of primary and secondary sources that were consulted in providing a literature based context for the thematic focus of the research topic itself .It is on the basis of the sources that the empirical contest of the study is complemented. The orientation of the review of Literature was focused on providing the 'spinal framework' for the collection of the data on the subject of primary health care challenges in general ;and in particular the extent of its application in the Southern Region in Ekurhuleni Metropolitan Municipality.

## **Chapter 3: Research Design and Methodology and Data Collection**

This Chapter is essentially a terrain within the study to explore the types of data collection method are applied.

## **Chapter 4: Data presentation, Analysis and interpretation**

In this chapter , both the accumulated qualitative and quantitative data and information relating to Primary Health Care challenges are presented , interpreted and analysed , using tables , graphs and other statistical tools as the evidence base. It is on the basis of the accumulated data that the findings (results) and conclusion could be arrived at in a scientifically credible manner.

## **Chapter 5: Research findings, Recommendation and Conclusions**

In addition to the interpretation and analysis based on the collected data , the primary focus of the research findings is "...to consolidate and integrate the thematically and



topically resonant trends , issues and debates that have been found and identified to have had a major impact in the development, implementation and evaluation ...[relating to a specific body of knowledge, in this case, the primary health care system in the Southern Region of the Ekurhuleni Metropolitan Municipality]" (Mkonto, 2007: 402).

This chapter also translates itself into the extent to which the study has, or has not managed to make an impact on the body of knowledge on Primary Health care challenges, it also focuses on the extent to which the research objectives have been met; as well as the extent to which the research problem and the research questions have been resolved. The study's conclusions are then entirely confined within these parameters.

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## CHAPTER ONE

### A THEORETICAL OVERVIEW TO PRIMARY HEALTH CARE

#### 1.1 INTRODUCTION

Primary health care (PHC) globally and indeed within South Africa has come a long way since the World Health Organisation (WHO) Alma Alta Declaration in 1978, during which it was declared as the main strategy for achieving health for all by the year 2000 (Litsios, 2004). At its inception PHC was seen as the solution to the inadequate illness management systems that had developed throughout the world. The primary basis for this expectation was guided by the widely held view that, PHC's balanced system of treatment and disease prevention would address some of the major inequalities in healthcare systems that were typical both within a country and between countries. In their conceptualisation of Primary Health Care, the WHO had envisaged that the place of receiving/ delivering treatment should be as near as possible to where people lived and worked (WHO, 2000).

However, at the turn of the century, initial aspirations about the eventual success of PHC as the primary driving force behind the achievement of Health for All by the year 2000 had not been wholly successful. Within sub-Saharan Africa, the HIV/AIDS epidemic in the 1990's reversed thirty years of any success gained in life expectancy and other health outcomes. Several alternative reasons for the lack of complete success in the implementation of PHC have been quoted in a number of literary sources including Barry (2007), Lewis (2011) and Travis et al (2010), whose summations point to inadequate governmental commitment, the politicisation of Health and poverty-related inequalities as key reasons for the lack of progress in fully achieving the goals of PHC.

During South Africa's transition to democracy, following its first democratic elections, health reforms in the country's health services delivery system were inevitable. A unified National Health System – which was initiated in 1995 – emerged out of the National Health Care Policy discourse of decentralising the Health Care System. In keeping with the ethos of decentralised health provision, the 1997 White Paper on Health Transformation provided a framework for the unification of the racially and

socio-economically fragmented Health Care system in order to promote "... equity, accessibility and community participation" (The South African Department of Health, 1997a: 15). As one of the direct consequences of this, the National Department of Health institutionalised a decentralised form of Primary Health Care, which would constitute the core focus of a community based Health Care Strategy. Collins & Green (1994:460) succinctly describe the decentralisation process as implying a shift of authority, power and functions away from the centre (i.e. central government) to peripheral units in order to afford them. The peripheral units proved to have a semi-autonomous status. This process forms the basis of the principle of PHC, and is seen as being effective in facilitating greater community involvement, equity, service efficiency, as well as reducing excessive bureaucratic processes (Ngwenya 2010).

As was true of the Alma Alta aspirations, South Africa's ambitions for a seamless transition into an effective Primary Health Care model faced a number of notable challenges. Greenhalgh (2007), Digby (2006) and Ngwenya (2010) provide important summations of some of the key shortcomings that emerged as the South African health system attempted to embrace and effectively implement the tenets of decentralised, equitable and effective care services. With its complicated political history and the disproportionate division of wealth, South Africa's care challenges centre on the exceptionally high prevalence of extreme poverty, high unemployment, and cumulative social disadvantage. It is notable that between 70% and 90% of all recorded illnesses were poverty related (Netangaheni, 2009). A debate about the exact reasons why Primary Health Care has not been as effective as expected in reducing the burden of illness within the country continues. And to date, no consensus view is accepted as offering a wholly truthful overview of the challenges that have compromised the success of PHC interventions especially at a local level. The lack of agreement is supported by many within the domain including, Akinsola (2007), Ngwenya (2010) and Travis et al (2010), who strongly argue that South Africa is itself so diverse that the challenges of implementing effective PHC most certainly differ from district to district. Furthermore, there is acceptance that by that virtue, different localities need to be understood individually so emergent patterns can be appropriately contextualised. The study is set in Ekurhuleni Metropolitan Municipality Health department – a district situated in the Gauteng Province.

## 1.2 DEFINING PRIMARY HEALTH CARE- A LINGUISTIC ANALYSIS

Before engaging in meaningful dialogue relating to Primary Health Care, this approach to care delivery needs to be specifically clarified. Ellis Stoll and Popkess-Vawter (1998) draw attention to the likely difficulties that exist within discussions about Primary Health Care discourse, as a result of the use of poorly defined terms. They also argue that the interchangeable use of terms such as “primary health care” and “community based care” by many is common, especially in day to day conversation engaged in by those involved with health care delivery. This use of conceptually different words occurs with little clarifications on the likely connotations. With this in mind, it is important to clarify what the term “primary health care” relates to and most specifically, to operationalise its use within the current study. It is noteworthy too, that the definition of Primary Health Care appears to have geographical determinants, i.e. it may mean different things to people in different geographical regions across the globe. For that reason, the analysis of its meanings focuses firstly on the global definition, then systematically at a range of definitions including the definition adopted within South Africa.

At its most basic level, Primary Health Care is defined as the care that is provided at the first point of contact with the health system. It is characterised by a broad approach to basic health services delivery and community development. Primary healthcare focuses on the community that is in need of health care services. Primary Health Care is also defined in Stanhope and Lancaster (2006: 36) as an essential healthcare service based on practical, scientifically acceptable methods and technology made universally accessible to individuals and families in the community through their full participation, at a cost that the country can afford and maintain at every stage of development in the spirit of self-reliance and self-determination (Greenhalgh, 2007).

PHC encompasses all the major health concerns, and is provided in clinics, hospitals and communities. A comprehensive focus is maintained by incorporating community development/ Participation and health care service delivery. Health care professionals alone cannot implement primary health care; therefore other professionals are also involved in the delivery of the service. Primary health care serves as a “framework” for health care delivery system, which can be adapted and

applied as the prevailing situation demands. The World Health Organization publication 'Women as providers of health care', nurses need to function effectively in the primary health care team, i.e. they must be able to identify, define and solve problems, to work in collaboration with other health workers and members of the community. Furthermore, they should be able to apply epidemiology methods in determining health needs, research, delegate tasks, supervise, train and evaluate other health workers. Analytically determine the cost of services, and assume leadership (Greenhalgh, 2007).

In the context of the above, the Primary Health Care facility has to be the first-level contact that individuals, the family and the community have within the National Health system. Bringing health care as close as possible to where people live and work (access as measured by the proportion of people living within 5km radius of the clinic), PHC constitutes the first element of the health care process (Stanhope and Lancaster 2006: 172).

### 1.3 AN INTERNATIONAL PERSPECTIVE OF THE PRIMARY HEALTHCARE SYSTEM

While the WHO has since the Alma-Ata Declaration lent an entirely health-oriented and socio-economically viable interpretation of the PHC system, the latter has in its evolution attracted various political insinuations within different countries. In some countries, it is viewed more as a political statement similar to the MDGs (Millennium Development Goals), while in others it is interpreted as a methodology or system of health care. However, a comprehensive approach of PHC needs to be interpreted by each country in the context of its culture, health needs, resources, and the system of government prevalent in the particular country (Greenhalgh, 2007).

#### 1.3.1 The Primary Healthcare Approach in Canada

The status of Primary Health Care in Canada is emerging as an issue of concern for nurses who understand the potential benefits of the PHC strategy as outlined and conceived by the WHO-ICN perspective in various international gatherings. Lundy & Jones (2009: 288) emphasise that Canada has a two-pronged approach to primary healthcare. Firstly, there is support for PHC – as demonstrated in the Ottawa Charter

for Health Prevention. Secondly, there is a serious financial commitment to establish PHC as a unifying health strategy. The duality of Canada's response to PHC illustrates an orientation towards the alleviation of primary healthcare challenges. In addition, financial support gives meaning to the conceptual premises of the PHC approach. Such an orientation provides affordable, available, and equitable access to PHC. (Lundy & Jones 2009)

### 1.3.2 The Primary Healthcare Approach in Thailand

Lundy & Jones (2009: 287) emphasise that the healthcare system in Thailand has changed radically. Thailand has adopted the 1978 WHO policy and integrated PHC as part of its national strategy to achieve the goals of "health for all by 2000" as articulated by the WHO. There is a concerted focus on primary; secondary and tertiary care for the sick. In the development of its national PHC programme, the Thailand government sponsored several pilot projects to identify effective strategies for delivering quality healthcare services to the entire population. The goal of the project was to ensure access to healthcare for all citizens, particularly the rural majority of the Thailand population who constituted eighty per cent of the population. Thailand has realised the goal of simultaneously promoting health and the prevention of diseases, by designating members of the community as village health volunteers (VHVs) and others as village health communicators (VHCs). Who work with trained health personnel at the local PHC facilities? This community-based response resulted in the community's involvement, which constitutes a critical component of PHC (World Health Organisation, 1978). The strategy of community involvement and participation in the implementation of PHC programmes is more applicable in the context of South Africa.

### 1.3.3 The Primary Healthcare Approach in the United States

The response of the United States (US) to PHC was through the endorsement and adoption of the WHO's vision of health for all by the year 2000. However, PHC is fundamentally not the primary US strategy for improving the health of the American population. The Pan American Health Organization's (PAHO's) description of a local health system is a PHC model that has been submitted to the World Health Organisation and may eventually be found useful in the United States. At present,

healthcare in the United States has developed as a system dominated by hospital - based medical care for disease-specific treatment. The national plan of the United States focuses on disease prevention and health promotion in the areas of most concern in the nation. Such an approach is dominated by health insurance, which is a controversial subject in US history (Stanhope & Lancaster, 2006).

#### 1.3.4 A South African Perspective of the Primary Healthcare

In terms of the Constitution of the Republic of South Africa (Act Number 108 of 1996, as amended), everyone has a right to access healthcare services, and it is the responsibility of the state to ensure that this right is realised. The White Paper for the Transformation of the Health System, in South Africa, presents various implementation strategies designed to meet the basic needs of all South African citizens irrespective of scarce limited resources. Strategically, the focus is on the provision of a comprehensive primary health care system (Department of Health, 2001).

The focus on PHC as dictated by the South African Constitution focuses specifically on the devolution of certain responsibilities for health service provision, at the provincial and municipal levels of government. Within a South African conceptualisation of primary health care, the focus of care has been devolved to the district health system (DHS) (Department of Health, 2001). Significantly, the South African government identified several key principles that planners had to include in their plans for developing effective primary health care services. These were:

- Re-focussing efforts on preventative health practices instead of only focussing on curative service provision.
- Overcoming fragmentation in service provision and delivery.
- Promoting equity, comprehensive service delivery.
- Ensuring effectiveness and efficiency in the delivery of service.
- Continuous quality enhancement.
- Improving access to service both in terms of availability and cost, at point of access.
- Building a sense of local accountability.

- Showing unwavering commitment to promoting community participation. (Department of Health, 2001).

Initial assessments of the success of PHC services paint a picture, which suggests limited progress only in some areas that relate to primary health care with some aspects showing very little progressive development. It is notable however that, many of the critical debates on the state of PHC have been driven by political critics without a clear contribution from the health practitioners who are at the frontline of care delivery (Ngwenya, 2010). Clearly, Ngwenya's (2010) observation draws attention to a need for clinicians to provide insight into the challenges they experience in trying to make the implementation of PHC initiatives seamless.

#### 1.4 THE PRINCIPLES INHERENT IN THE PRIMARY HEALTH CARE APPROACH

The principles inherent in the Primary Health Care Approach, emanated from a range of issues and debates arising from the literature search pertaining to the literature research itself. If these principles are not clarified, it might diminish the thematic centrality of the concept of primary healthcare as an integral component of the research topic.

##### 1.4.1 The Health Information System

Appropriate and reliable data will be systematically collected and analysed, as part of the comprehensive health information system, essential for planning and managing the NHS. According to the national health system, primary health care should exist within a five-kilometre radius. It should be accessible and available at all times, rendering PHC services seven days per week, and twenty-four hours a day, including Saturdays and Sundays (African National Congress, 1994).

Comprehensive primary health care (PHC) service is good if it can meet the following criteria as stipulated by Greenhalgh (2007):

- PHC is provided by a team, but this is not always possible in rural areas, where geographical location may present infrastructural challenges;

- PHC is attached to a base hospital with referral facilities. In Ekurhuleni there are Natalspruit Hospital, Tambo Memorial Hospital, Pholosong Hospital, Tembisa Hospital and the Far East Rand Hospital;
- The quality of PHC service rendered at a clinic is manned by trained personnel in primary health care;
- The clinic is accessible to healthcare consumers who are within a five kilometre radius of the PHC facility;
- The community participates in the PHC programme through the services of the community's own health worker. The Gauteng Provincial Department of Health has established Primary Health Care Facility committees (PHFC's) that consist of community members within the area where the clinic is located. Community participation is both recognised and encouraged. The role of the primary health care worker, or practitioner, is to act as a facilitator, and to empower individuals and communities so that they can develop their own potential for healthcare practice and consciousness. Community participation will increase the likelihood of the health care being acceptable to the community. Primary healthcare is about supporting people's faith in their own ability to protect their health. People should desist from a paternalistic wisdom that creates dependence (The South African Department of Health, 2001; Greenhalgh, 2007). Primary health provides more than medical care, as it includes programmes such as poverty alleviation, and indigent programmes.

#### 1.4.2 The National Health System

A single comprehensive, equitable and integrated National Health System (NHS) has been opted for by the state. This is intended to redress fragmentation and duplication inherited from the erstwhile era of the race-based healthcare system. There will be single government structures dealing with health, based on national health guidelines, priorities and standards. It will coordinate all aspects of both public and private healthcare delivery and will be accountable to the people of South Africa through democratic structures (ANC 1994).



#### 1.4.3 The Primary Healthcare Approach

There are multiple merits to primary healthcare (Greenhalgh, 2007: 85). The African National Congress (ANC) is committed to the promotion of health through prevention and education. The primary healthcare approach is the underlying philosophy for the restructuring of the health system. It embodies the concept of community development and is based on full participation in the planning, provision, control and monitoring of healthcare services. It aims to reduce inequalities with regard to access to health services, especially in the rural areas and deprived communities.

#### 1.4.4 The primary health care package for South Africa — a set of norms and standards.

Primary healthcare is at the heart of plans to transform health services in South Africa. An integrated package of essential primary healthcare services available to the entire population will provide the solid foundation for a single, unified healthcare system. It will be the driving force for promoting equity in healthcare. There is a set of standards that is made available in the essential package of primary health care services. These norms and standards will enable individuals to be aware of the quality of PHC services they can expect to receive from the clinics. Health legislation requires that provinces provide health services at acceptable levels using norms and standards. Providing acceptable levels of service to all people will help the process of redistribution and redressing past inequalities. Targets for the year 2000 included the objective of having defined comprehensive services, to be delivered at primary health care service (South African Department of Health 1997)

#### 1.5 PRIMARY HEALTH CARE PRIORITIES - THE SOUTH AFRICAN CONTEXT

Stack and Hlela (2002: 6) contend that sustainable healthcare priorities should focus on the improvement of access to the healthcare system, a decrease in the medication costs, and free healthcare to children and pregnant women. Accordingly, health services would be planned and regulated to ensure that resources are rationally and effectively used to make basic health care available to all South Africans, giving priority to the vulnerable groups. A comprehensive national primary

healthcare service package of priority areas in South Africa includes the following health concerns:

- child health, infectious diseases, and immunisation;
- sexually transmitted diseases and HIV/AIDS;
- tuberculosis;
- reproductive health: Antenatal, prenatal, and postnatal care, and family planning;
- mental health;
- the promotion of adequate nutrition;
- rehabilitation; and
- oral health. (Wittenberg 2008).

#### 1.6 THE GEOGRAPHICAL CONTEXT OF THE STUDY

The Ekurhuleni Metropolitan Municipality (EMM) is one of the three municipalities situated in the Gauteng Metropolis of Gauteng Province, South Africa. Ekurhuleni was formerly known as the East Rand. This region is made up of the following towns and adjacent “townships”: Alberton, Boksburg, Benoni, Germiston, Kempton Park, Tembisa, Springs, Brakpan and Nigel. The total human population of Ekurhuleni is approximately 3, 5 million. The Ekurhuleni Metropolitan Municipality is divided into three regions; namely, the Southern region, the Eastern region, and the Northern region. The Southern region includes Alberton, Boksburg and Germiston; while the Eastern region is comprised of Brakpan, Benoni, Springs and Nigel. The Northern region consists of Kempton Park, with Tembisa – a predominantly African township – as its adjacent neighbour. In the context of this study, an integrated approach is viewed as the most viable option to achieving effective and quality primary healthcare in the Ekurhuleni Metropolitan Municipality, as articulated in the Alma-Ata Declaration. (ANC, 1996)

Like other districts in South Africa, Ekurhuleni’s (the focus area for this study) local health care system is a product of the South African process of decentralisation

## 1.7 BACKGROUND AND CONTEXT OF THE STUDY

It has long been accepted that access to a responsive public health service is the rightful expectation of all citizens, especially those who were previously disadvantaged due to a range of political, cultural, socio-economic factors. Communities are encouraged to participate in the decision making and planning of health services. This form of participation is intended to improve and optimise service delivery for the benefit of the entire community. As with other districts across the country, Ekurhuleni's health services have been divided according to function into three functional categories namely, preventative, curative and rehabilitative ([www.Ekurhuleni.gov.za](http://www.Ekurhuleni.gov.za) accessed January 4, 2011). Evaluations of service success have showed a disproportionate spread of success and failure between each of these provisional areas with the least success being reported in the preventative functional category (Stanhope and Lancaster, 2006) – i.e. precisely the area of care delivery in which the majority of PHC occurs. This further illustrates the challenges that have resulted in this need to be clarified and service providers and clinicians are arguably well positioned to offer insights into why this otherwise well specified area of need has not been positively responded to.

## 1.8 THE PARAMETERS OF THE RESEARCH

The Ekurhuleni Health Department consists mainly of four directorates, namely: the Family Health/Clinic Services; Community Development; Special Programmes (which deals with Research and Health Promotion); and the Epidemiology and Support Services directorate. ([www.Ekurhuleni.gov.za](http://www.Ekurhuleni.gov.za) accessed January 4, 2011)

The Family Health/Clinic Services directorate is the largest division within the Ekurhuleni Municipality's Health Department, and is mainly responsible for the effective delivery of PHC services; including preventive, promotive and curative healthcare services. In particular, there are three approaches taken to PHC implementation, the prevention as primary level calls for the health education, immunizations and change in health behaviours related to lifestyle. The orientation towards secondary level requires the provision of medicine (Curative) a patient with high blood pressure. Thirdly, the orientation towards tertiary level entails the provision of a self-management (Rehabilitation) the services that are provided by the Rehab

team, e.g. patient who had stroke need to to be rehabilitated. (Stanhope and Lancaster, 2006: 44).

The Community Development directorate is primarily responsible for family and community development issues; which are addressed through a focus on vulnerable groups such as the youth, the elderly, the disabled, and children; as well as on the issues of poverty alleviation and management. There are also special programmes that focus on research, epidemiology, monitoring and evaluation. The Support Services directorate is responsible for financial and logistical support, human resource management, administration, and training. The following tabular presentation depicts the location of various PHC facilities under the EMM's Department of Health. ([www.Ekurhuleni.gov.za](http://www.Ekurhuleni.gov.za) accessed January 7, 2011)

**Table 1.1: Distribution of Ekurhuleni PHC Facilities**

Type of PHC Facility	EMM REGION			Total for District
	East	North	South	
Community Health Centre (MOU+24hr PHC)	3	1	3	7
Community Day Centre	1	0	0	1
Clinic	28	17	29	74
Satellite Clinic	0	2	0	2
Health Post	1	1	1	3
Mobile Clinic	3	1	1	5
Dental Clinic (Stand alone)	0	1	0	1
Un-operational Facilities	0	0	1	1
<b>TOTAL</b>	<b>36</b>	<b>23</b>	<b>35</b>	<b>94</b>
<i>*Classification of facilities is according to the latest PHC Package of Service</i>				

In spite of the EMM's PHC clinics subscribing to the core standards outlined in the White Paper on the Transformation of the Health Care delivery system, the capacity to address the burden of disease in the Gauteng region still poses a formidable challenge. The core norms and standards for PHC clinics is described in the White Paper on the Transformation of the Health Care Delivery System (1996) as follows:

- A clinic that renders comprehensive integrated PHC services using a one stop approach for at least 8 hours a day, and five days a week;
- Access is measured by the proportion of people living within a radius of 5 kilometres from the clinic;
- The maternity and obstetric units are expected to be operational continuously for 24 hours, including Saturdays and Sundays;
- The clinic usually has at least one member of staff who has completed a duly recognised PHC course;
- Doctors and other specialised professionals are accessible for consultation, support and referral, and to provide periodic (sessional) visits;
- Clinic managers receive training in management and facilitation skills of PHC services (Department of Health 2007).

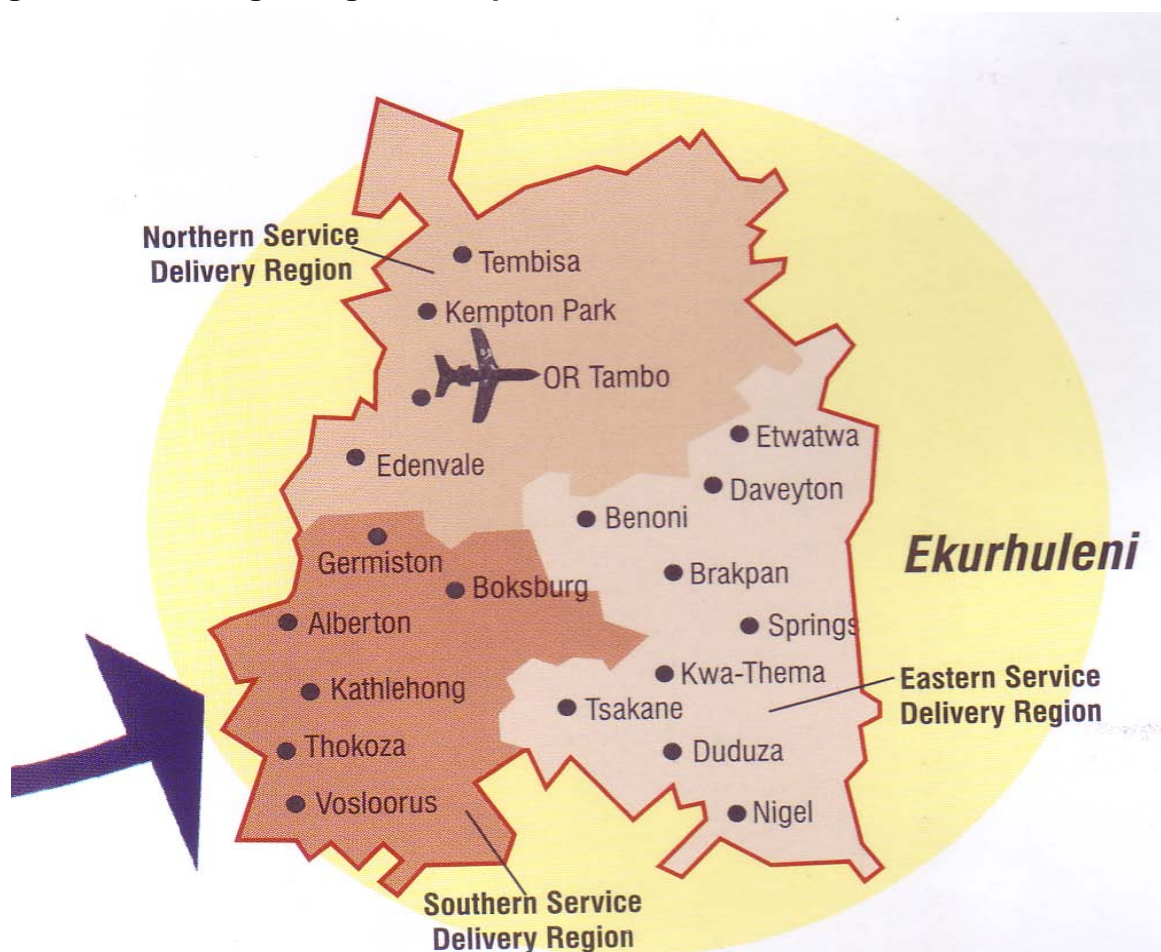
#### 1.8.1 The Research Setting

Ward based primary health care can be an effective tool to deliver health promotion, disease prevention, early identification and effective curative intervention as well as rehabilitative services if all other hurdles are addressed. The first contact is in the community (wards), if it can be implemented properly there, the number of patients presenting themselves at the clinics will be reduced. ([www.Ekurhuleni.gov.za](http://www.Ekurhuleni.gov.za) accessed January 14, 2011)

The entire conglomerate known, as the Ekurhuleni Metropolitan Municipality, comprises of eighty-eight wards that are managed by Ward Councillors. Within these wards there are ten representatives for each sector, including the health sector. The health sector usually has its own Ward Health Sub-committee consisting of fifteen members, proportionally distributed according to geographic size. The fifteen members oversee the healthcare issues and needs within their wards. Their roles and responsibilities are to give reports to the health representative, who will in turn report back to the Ward Councillor. Some wards employ Community Development Workers, who work closely with the Ward Councillor. Their functions include assisting with the detection and identification of community based health challenges in the wards and referring these to the relevant departments within the EMM. At the time of this research project's undertaking, the Ekurhuleni Health Department's priorities ([www.Ekurhuleni.gov.za](http://www.Ekurhuleni.gov.za)) were as follows:

- Improvement of the management of non-communicable diseases and communicable diseases, including HIV and AIDS;
- Effective community participation;
- Improvement of the district information system;
- Promotion of healthy lifestyles;
- Strengthening of medical-legal services;
- Human resources development.

**Figure 1.1: Enlarged regional map of Ekurhuleni.**



*Source: Ekurhuleni Integrated Development Plan Booklet 2004*

The map above provides a bird's eye view of the urban location of the EMM regions. Despite the metropolitan placement of these regions, the legacy of the past still has to be overcome in order that satisfactory levels of primary health care delivery are achieved. The actual healthcare conditions of Ekurhuleni warrant that a relentless

intervention is made to integrate primary health care as part of a concrete response to the burden of disease in the region.

## 1.9 OPERATIONALISING THE PRIMARY HEALTHCARE MODEL.

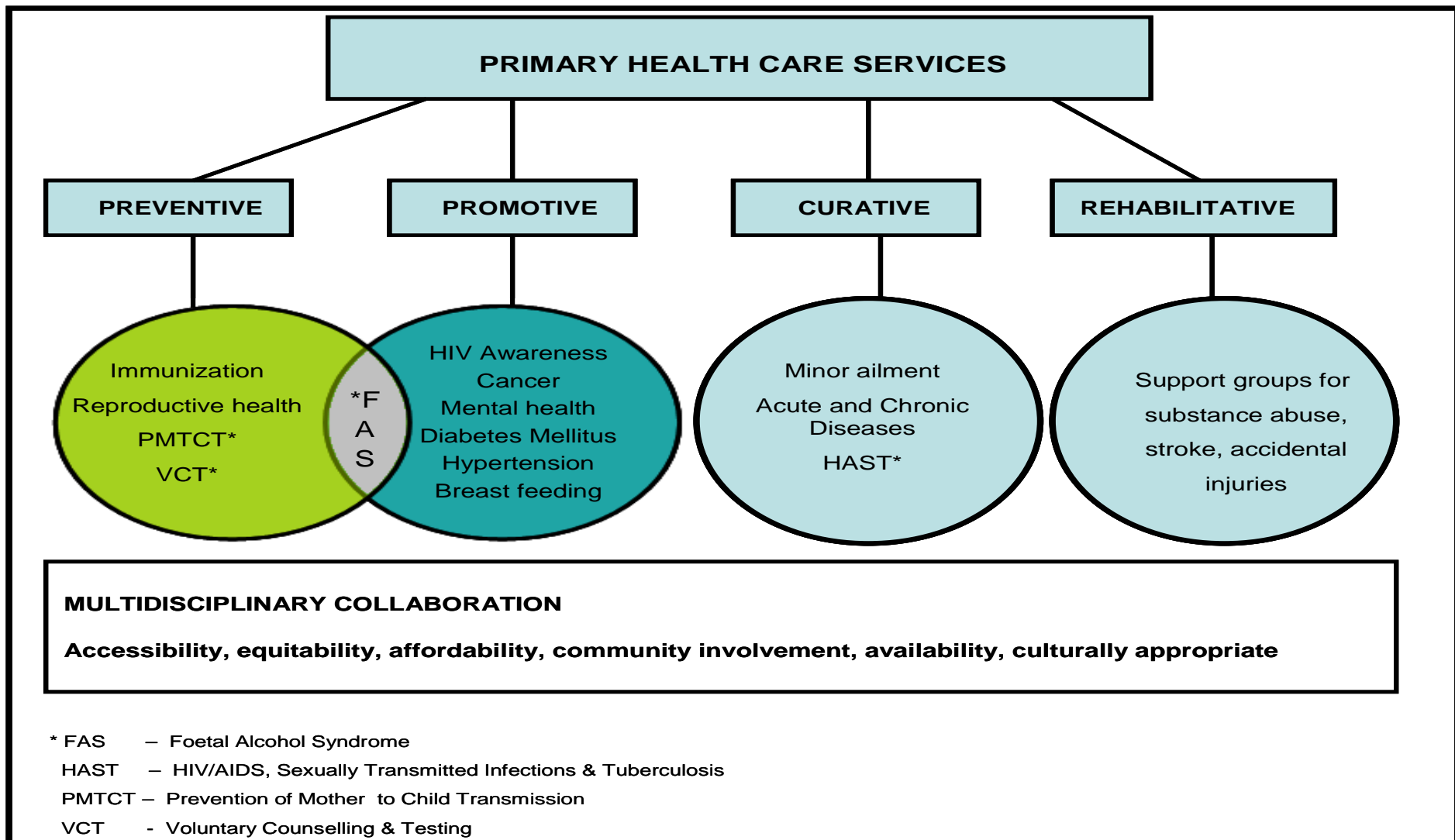
### 1.9.1 A collaborated community-oriented primary healthcare model

Figure 3 below provides a graphic and visual representation of the structure of the EMM's healthcare services provided to the community. The integration of primary healthcare services has undergone a similar process to the fragmented approach of the erstwhile fourteen departments of health during the era of race-based discrimination. Greenhalgh (2007) stresses that a comprehensively integrated PHC system encompasses the four critical domains of healthcare, namely; the promotive, the preventive, the curative and the rehabilitative aspects (Greenhalgh 2007).

#### **1.9.1.1 *The preventive phase***

Preventive programmes such as the immunisation of children from birth until the age of twelve, assist in combating diseases before they occur. In terms of the new immunisation schedule and antenatal practices, voluntary counselling and testing is particularly recommended for pregnant women so that PMTCT could be applied as a preventive measure (Department of Health, 2001).

Figure 1.2: Primary Health Care Services





### **1.9.1.2 *The promotive phase***

The first level of preventive medicine (primary prevention) is health promotion and specific protection. At this level the individual is not ill yet. Steps are taken to promote optimum health among and between individuals and communities. Health promotion is advocated through healthy living measures such as: adequate and balanced nutrition; ensuring high standards of environmental hygiene through the provision of suitable housing, satisfactory ventilation and the prevention of overcrowding; as well as satisfactory standards of personal hygiene and cleanliness. It is at this stage that using effective health education and awareness campaigns could advance the aims and objectives of promotive health. The National Health Department has a calendar of events that is followed religiously to create awareness and promotion of health (Department of Health 1997).

### **1.9.1.3 *The curative phase***

The curative level is concerned with stopping the progress of the disease and preventing complications. At this level, the individual is already suffering from one form of disease or the other, and the measures which are taken are directed at rendering the patient non- infectious in as short a time as possible; so as to prevent and halt the spread of the disease (Lewis, 2011: 333). Prompt diagnosis, effective treatment and the early diagnosis of possible complications are important factors in the limitation of disability (The South African Department of Health, 2001). Where necessary, prompt and appropriate curative measures may include isolation of the individual, notification of the disease to the appropriate authorities and treatment and control of patient contact with others (The South African Department of Health 2001).

### **1.9.1.4 *The rehabilitative phase***

This level aims at returning the individual sufferer to his/her community, ensuring that further deterioration of the health condition is prevented. Where necessary, physiotherapy, vocational guidance, retraining programmes, sheltered employment and social services, such as a disability grant, should be at the disposal of the individual sufferer (The South African Department of Health 2001).

Greenhalgh's (2007: 238) levels of PHC development advocate the type of primary health care that is community oriented. This PHC prototype highlights the primary health care team's role to provide basic services to the local communities. The health practitioners' role towards developing a definitive 'healthy community' ascribes a unique developmental character to this model. In Ekurhuleni, there is a considerable attempt to provide preventive, promotive, curative, and rehabilitative health services (The South African Department of Health, 2001). The Ekurhuleni Health Department provides comprehensive PHC five days per week at the local clinics.

#### 1.10 PROBLEM STATEMENT

As noted briefly in earlier discussion, the implementation of PHC principles and the lack of progress in areas related to prevention have been seen as indicative of a level of failure in the country's plans for developing effective PHC. As expected, this has prompted questions about the range of causative factors that may have contributed to this, especially as the South African government has reported year on year increases on their capital investment in prevention and other PHC provisions. Netangaheni (2009) supports this focus and goes further to confirm that he believes that healthcare policy reform warrants a continuous and protracted means of attention, review and analysis, so reasons behind successes and failures can be better understood as a first step to service improvement. Within the current discourse, it has become evident that very limited explorations of challenges related to the implementation of PHC have been carried out with the frontline clinicians who have the primary role of service delivery.

The Ekurhuleni Metropolitan Municipality, like most other metropolitan districts in South Africa, has inherited a diverse range of service related challenges. These include the prevalence of extreme poverty, high unemployment rates, and social health problems all of which cumulatively compromise the effectiveness of primary health care services. It is notable that debate about the real impact of these challenges rages on within the discourse with contributors such as Travis et al (2010) putting forward research evidence to show that, the challenges faced in the effective implementation of PHC are far more complex and that they can only be understood by undertaking a local level analysis, preferably with stakeholders who have firsthand experience of the day to day challenges of service delivery. The influence of poverty,

social health problems and high unemployment is also downplayed by Pollock & Majeed (2011) who is of the view that these factors alone cannot be exhaustive reasons why implementation efforts related to PHC have been less successful than expected. This argument is well asserted by many including Benzeval et al (2009) and Schater et al (2011) who support their conclusion by arguing that, between 70% and 90% of illnesses are poverty related and up to 30% are related to late intervention by primary services and other related health care providers. Their study of PHC implementation challenges also confirms that the reasons for a lack of success within PHC endeavours are firmly located within the mind-set of politicians, clinicians and other health care professionals who have long prioritised curative services over prevention. Informed by these and other considerations, the current study explores clinician's attributions and explanations for the lack of success in the implementation of PHC in the Ekurhuleni district of Gauteng, South Africa.

#### 1.10.1 Inadequate Delivery of Primary Healthcare Services

Currently, the delivery of primary healthcare services within the EMM regions is the greatest challenge being faced by the EMM's Department of Health. To date, very limited or no research at all, has been conducted to determine the lack of effectiveness of primary health care programmes in this region. Furthermore, no published studies have been undertaken to explore the quality of primary healthcare services in the Ekurhuleni area (EMM Integrated Development Plan, 2004; Greenhalgh 2007).

The preponderance of the HIV/AIDS pandemic also limits the effectiveness of the Department's Human Resource Plan. Staffing is the next greatest issue being faced by the EMM's Department of Health, and serves to exacerbate any problems being faced at all other levels. A lack of sufficient planning, monitoring and evaluation procedures and systems, inhibits the availability of expert and professional personnel to alleviate the delivery capacity of the EMM's Health Department to render quality healthcare services. Consequently, there is a lack of skilled and experienced personnel to plan and implement the much desired integrated healthcare approach (strategy) that would give a practical meaning to the notion of community based health as envisaged by the World Health Organisation's vision of "Health for All" by 2014 (Greenhalgh 2007; WHO 2000).

## 1.11 PURPOSE OF THE STUDY

In addition to the specific focus on understanding the factors that have hindered the effective implementation of PHC from clinicians' perspectives, the broader intention (Henning, 2005: 1; Mouton, 2001: 122) of the research project has been to explore, create and extend the knowledge base on primary health care (PHC) services in the Ekurhuleni Metropolitan Municipality (EMM). Using Miles & Huberman's (2004) excerpt; methodological considerations for this project will entail clarification through description of "...the ways people in particular settings come to understand, account for, take action, and otherwise manage their day-to-day situations" (Miles & Huberman, 2004: 4). Upon completion of the research project the researcher hopes to develop a framework of recommendations to assist primary healthcare practitioners to be more efficient and effective in primary healthcare service delivery in the EMM's Southern region (Polit & Beck, 2009).

### 1.11.1 Objectives of the study

As opposed to the more general intentions of the study, the objectives (Henning, 2005: 1; Mouton, 2001: 122) of this research project focused on the factors that affect the efficacy of PHC service delivery in Ekurhuleni Metropolitan Municipality.

- To determine the range of modifiable factors that impact on the efficacy of PHC service delivery from the perspectives of practising health care professionals in Ekurhuleni.
- To identify and clarify the range of professional and organisational barriers that clinicians face in implementing the principles of PHC as described by the Department of Health.
- To propose an explanatory framework on the correct interventions of the delivery of PHC.
- Develop a strategy for improving EMM PHC service on preventive and promotive care.

## 1.12 SIGNIFICANCE/JUSTIFICATION OF THE RESEARCH PROJECT

The burden of preventable illness and the cost of providing health care continue to rise globally and indeed in South Africa (Ngwenya 2010). Effective intervention at the primary care level will reduce the need for costly hospitalisation with some projections suggesting that up to 53% of current health care costs is a result of failures in the preventive function of PHC. In addition to the economic imperative, the current project offers a rare opportunity for clinicians at Ekurhuleni to have their collective views about the challenges to be collated in a way that offers an opportunity for corrective actions to be taken. The overall background information of the research project provides historic dynamics and the state of primary healthcare in the Ekurhuleni Metropolitan Municipality. It is necessary to determine if the provision of primary healthcare services in the Ekurhuleni Metropolitan Municipality was adequately responsive to the health needs of the Ekurhuleni community. The specific objectives of this study focused on the nature of healthcare and quality of services that the primary health care practitioners provided. It was also critical that the study explores the issues, experiences and challenges concerning the quality of PHC; and most significantly, whether there were opportunities for improvement. Eventually, it is envisaged that practical guidelines would be developed with the aim of correcting the situation (Polit and Beck 2004; Burns & Grove 2005).

In the context of the above, this study has several important contributions to make to the delivery of healthcare services in South Africa. The data obtained is considered sufficiently representative, as Ekurhuleni Metropolitan Municipality is a very large area and the sample includes all healthcare categories. The diverse infrastructure is an advantage as it enabled the researcher to understand the 'real world' and 'social context' of the research problem and phenomenon being investigated. The geographic spread of EMM addresses variations within the research setting, and facilitated the ability to classify the research setting across Ekurhuleni. The study is of further practical significance, as the researcher is an employee of the EMM's Department of Health. In that respect, the researcher would be appropriately suited to offer realistic advice and guidelines to the EMM Health Department on the improvement of its primary healthcare system, in particular, and healthcare policy in general (The South African Department of Health 1997).

### 1.13 RATIONALE FOR SCOPE OF STUDY

The current study specifically focuses on practitioner's views on the challenges they face in trying to deliver PHC in line with the Alma Ata principles. The exclusive focus on clinicians allows for a more targeted exploration than would be possible in a study looking at multi-facets of this issue. Additionally, by virtue of this being a dissertation of limited scope, as prescribed within the University of South Africa's (UNISA) guidelines (UNISA, 2011), the study remit was limited to a very specific focus.

### 1.14 CONCLUSION

Informed by the articulated need for a clearer understanding of the range of challenges that exist in the implementation of PHC in Ekurhuleni. The current study explores the factors that primary health care clinicians identify as possible reasons for the lower than expected successes in the implementation of PHC within Ekurhuleni. Before engaging in that investigatory phase, a review of the literature was conducted to specifically identify the state of knowledge within current literary sources.

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 INTRODUCTION

As acknowledged earlier, previous research on the difficulties associated with the effective implementation of primary health care has so far failed to consistently describe the range of facts that play a noteworthy contributory role from the perspectives of practising primary health care practitioners. To provide a comprehensive overview of current viewpoints and existing research evidence, a comprehensive review of related literature was conducted to determine prominent viewpoints in the study area. The University of York's NHS Centre for Reviews and Dissemination offer a definition of literature reviews and view them as being about

*“...locating, isolating, appraising and synthesising evidence...from studies in order to obtain a reliable overview”.* (University of York NHS Centre for Reviews and Dissemination, 2005;04).

In addition to the synthesis function, the review was concerned with drawing attention to the range of previously published challenges that exist when implementing PHC.

In other words, the purpose of a literature review is to demonstrate to the reader that one has a good grasp of the main published work concerning a particular topic or question in the identified field. According to Lobiondo-Wood & Haber (2006), the review should not just be a description of what other people have published but a critical discussion that presents insight and an awareness of the different arguments, approaches and theories. In achieving this, a systematic approach was utilised in line with guidance suggested by Parahoo (2006).

#### 2.2 DATA SEARCH STRATEGY

Initially the University library was used to search for books and journals that related to the topics of aggression and substance use. The use of libraries is seen as an excellent starting point as it allows the gathering of information and access to

alternative sources (Cormack, 2006). Simultaneously, the use of electronic databases was also used to offer a wider range of literature. Polit & Beck (2004) emphasise the importance of the reviewer possessing the skills necessary to perform a comprehensive search of the available literature and to this end, private effort was given to gain familiarity with a range of health related databases.

Before engaging in the searches, a set of keywords was decided upon. In order to assemble the group of keywords that would be used in the search, a mind map was drawn so that core elements and arguments could be highlighted. Bell (2005) and Hart (1998) emphasise the use of a mind map to guide an initial understanding of the topic.

The creation of a mind map to aid in the formulation of keywords helped to identify key search terms. Identifying keywords for the subject before initiating any literature search would ensure that correct results are obtained. In contrast, any omission of keywords may result in an incomplete and unfocused search (Burns and Grove, 2005). The following keywords and phrases were used:

- Primary Health Care delivery.
- Challenges with implementing PHC.
- Primary Health Care Implementation
- Efficiency of PHC as an approach to care delivery.
- Problems / challenges with Community Health Care

Each of the search terms were initially used individually, and then combined using Boolean operators AND, and OR. The use of Boolean operators allows a wider exploratory search of the literature (Wood, 1999).

The resources that were available for the literature search were books, journals, which included both hardcopy and electronic databases. The initial hard-copy library search did not reveal many current sources, and therefore, primary focus was on searching various electronic databases as summarised below:



- Unabridged Medline (Jan1976-Feb 2010)
- CINAHL- The Cumulative Index of Nursing & Allied Health Literature (Feb 1965-2010).
- OVID – an online database that searches across several medical and nursing online sources.
- Cochrane Database of Systematic Reviews (1996-2010).
- A hand-search of local South African Journals at the Local Health Authority library.

The University of South Africa's (UNISA's) vast array of library resources (including databases) were optimally utilised for local and international input through the ILL (inter-library loan) system. The latter enabled the researcher to obtain documentary and electronic information and data that are only available at other academic institutions and organisations to which the UNISA library is affiliated. The archives, databases and websites of other local and international sources of information, such as reputable research institutions and organisations (e.g. the Human Sciences Research Council (HSRC), the Health Professions Council of South Africa (HPCSA), and DENOSA (Democratic Nursing Organisation of South Africa, Stats SA (Statistics South Africa), the International Council of Nursing (ICN), and the World Health Organisation (WHO) were consulted in the quest of obtaining a multi-perspective approach to the research topic.

### 2.3 CRITERIA FOR INCLUSION AND EXCLUSION

The initial search, using each of the primary search terms independently, identified over four hundred potential sources. However, the inclusion of other parameters, such as 'primary research' and 'English', led to an enormous reduction in the potential references of interest to 27. It is critical to highlight that not all of the 27 identified references were found to be relevant to the review question. This conclusion was reached when detailed inclusion and exclusion criteria, listed below, were applied to the literature or studies obtained for review.

### 2.3.1 Inclusion criteria

- Studies that focussed on implementation issues related to PHC services.
- Studies that focus on the impact of policies and politics on the development of health services.

### 2.3.2 Studies published in English

Given the difficulties that exist in authenticating data from the worldwide web (internet), only literature from validated academic databases such as OVID via Athens and CINAHL were considered for inclusion within the review.

Furthermore, the reviewer, as a means of validating their existence, manually sourced hard copy paper versions of studies retrieved from internet sources.

### 2.3.3 Exclusion criteria

- Studies whose academic credibility could not be authenticated.
- Studies written in languages other than English
- Studies published before 1980.

After applying each of the above criteria, only 12 literary sources (six of which were original research) met the strict criteria for inclusion, and also satisfied the academic and scientific rigor expectations for inclusion in the review. The primary research studies that fully satisfied the inclusion criteria are reviewed in the following chapter.

## 2.4 APPRAISAL OF IDENTIFIED STUDIES FOR THE LITERATURE REVIEW.

Table 2.1 below offers a summary of each of the primary research studies included within this literature review. Once identified for inclusion within the review, the process of reviewing each study was based on established and validated models of critical appraisal, such as those offered by Depoy and Gitlin (2005) and Creswell (2000). The decision to use a combination of frameworks is in keeping with guidance from Silverman (2004). He stipulated that different, or a mixture of appraisal frameworks, must be used for appraising qualitative and quantitative research

sources, as these literature sources are inherently different in terms of the quality of evidence they can offer. Although not wholly similar, each of these appraisal frameworks focuses on exploring a combination of methodological issues and the contribution each literary source made to the body of knowledge. In essence, the review of individual studies was weighted on the knowledge-contribution made to current understanding of PHC and implementation issues related to this area of health care. To be more specific, the studies were evaluated in terms of their rigour, validity, reliability, dependability and transferability to the practice context (Polit and Beck, 2008). Additional factors explored within the review process included the researcher(s) apparent clarity in their formulation of the study question(s), whether or not the methods of data collection adopted were scientifically sound and appropriate to the issue under investigation. Further attention was given to the handling of data within each of the reviewed sources, including how well researchers addressed potential limitations of their studies.

**Table 2.1: Summary of primary research work reviewed.**

<b>AUTHOR/ DATE</b>	<b>SAMPLE SIZE/ (N)/DESIGN/ CLIENT GROUP</b>	<b>RESEARCH OBJECTIVE</b>	<b>RESULTS/ CLAIMS</b>
<b>Stack &amp; Hlela (2002).</b>	N=14 (social policy developers)-Cohort case study.	Understanding the factors that influence public health priorities.	*Short term health outcomes most important determinant of priorities. *Health promotion initiatives unpopular sue to long-term nature of behaviour modification.
<b>Farmer (2005)</b>	N=231 – Postal survey to government workers.	Affordability of health care- the range of impacts on professional practice.	*Health promotion and education seen as costly compared to acute treatments. *Short-term budget considerations prioritise initiatives that can be measured within 1 calendar year.
<b>Department of Health (2001).</b>	N=64. Health service managers and administrative staff.	Clarifying the real impact of decentralization.	* local health authorities unable to provide for all budgeted PHC functions and attribute this to inadequate funding. * Belief that clinicians were not maximising their input as expected and PHC shortfalls were unrelated to

			budget constraints.
<b>Covadia &amp; Wittenberg (1998).</b>	N=39 health care workers in hospitals in Thailand	Curative versus preventive care-that deserves the most capital investment.	* Preventative approaches seen to be more cost efficient in the medium to long term than acute treatment but expected behaviour changes can be difficult to maintain
<b>Greenhalgh (2007)</b>	N=67 Retrospective case-analysis.	Equity and accessibility – a determination of enhancing factors.	* Capital investment in community engagement initiatives an important first step in encouraging public participation and empowerment. * Critically important to create increase health education initiatives within the community.
<b>MacDonald (2009)</b>	N=167 A survey of mentally ill patients recently discharged from inpatient treatment.	Empowerment of patients – Assessing six month outcomes after health improvement education programs.	*Public empowerment is poorly understood and need for wider public engagement evident from the limited service-user satisfaction. * Mentally ill are particularly marginalised despite the health area being a focus of targeted health improvement programmes. * Clinicians feel inadequately trained in health promotion and public empowerment action.

## 2.5 A REVIEW OF THE LITERATURE – CORE EMERGING THEMES EXPLORED

### 2.5.1 Promotive **and** Preventive Health care – Unmeasureable Priorities

Despite a generalised acceptance that Health Promotion initiatives have a beneficial long-term impact on the health of individuals and communities (MacDonald, 2009). The ever-increasing costs of health care have re-ignited general questions about the affordability of general Health Promotion initiatives such as community engagement programmes, Health Education drives, and awareness programmes that are directed at well populations. Within the developing world, the issue of future financial

resources has often been the most dominant consideration within decision making about where and how resources should be spent. In this regard, the focus has usually ended up with the consideration of seemingly imperatives, in this case deciding whether expenditure should be focussed on curative and rehabilitative services over preventive and promotive options.

Greenhalgh's (2007) study of the affordability of Health promotion initiatives offers a specific exploration of the real value for money to be realised from Health Promotion and preventive approaches to health care delivery. The retrospective analysis of patients' experiences (n=67) within a semi-urban service highlighted a number of factors that had an impact on service accessibility for the patient. Greenhalgh's finding indicates that access to health care services prioritised those who had more acute health problems – with less access being given to individuals whose health needs fall within the promotive and/or preventive realm. Much of this is identified as being a function of the reactive stance that health and social care provider's priorities have been centred on. To this end, the criteria used for bench marking the quality of delivered services focussed on factors such as "cure-rates" and response time to acute emergencies as the most important measures of service quality. By contrast, "softer-targets" as described by Greenhalgh (2007) focussed on issues such as behaviour modification and resulting success/failure of health education initiatives was very difficult to quantitatively evaluate within the 12-month evaluative periods adopted within most service areas. Greenhalgh's study (2007), offers important insights into how access and equity, and affordability interrelate in everyday service delivery. The findings of the study have been questioned by some, including (Farmer 2005), who feel that the measurement of affordability has always been portrayed to suggest that health providers lacked the ability to recognise the long-term gains of promotive care – when in fact the real area of contention was that budgets were often earmarked at governmental level – little could be done locally.

#### 2.5.2 Promotive **and** Preventive Care- Affordability Questioned.

Farmer's (2005) survey on government workers offers further insights into issues related to affordability of health care and whether this played a significant role on whether preventive and promotive health care approaches received more attention and capital investment. Farmer (2005) carried out a postal survey of government

workers (n=231) across departments that dealt with health financing. The survey revealed some interesting common views as summarised below: -

84% of respondents (n=231) confirmed that they had little knowledge about preventive health services where they lived and were only aware of places to attend when they were acutely ill and in need of urgent intervention. The lack of knowledge about the existence of preventive/ promotive health provision spoke to two possibilities. Firstly, the fact that health services did not readily publicise their existence and, secondly that the perception of health care by members of the public did not include prevention and health promotion per se. Farmer (2005) also studied the issue of equity in accessing PHC services and his study had noted that residents of affluent suburbs and those who had very comprehensive medical aid packages tended to have more access to the whole spectrum of PHC services from preventive, promotive, curative and rehabilitative. A fact that once again suggested that access to holistic care options was a function of social and economic standing.

### 2.5.3 Empowerment as a key attribute of PHC services.

The findings from Farmer's (2005) study are extended on in a separate U.K. based study by MacDonald (2009), which looks at one of the key aspects of Health Promotion, i.e. the empowerment of patient populations via health education and other health promoting interventions. MacDonald (2009) investigates 6-month outcomes of health empowerment targeted at mentally ill patients (n=167) recently discharged from inpatient treatment. This is an especially noteworthy study with regard to empowerment and community participation, mainly because mental health patients represent a particularly disempowered client group and research into the challenges of empowering this group has transferable relevance to other groups, where significant challenges exist. The low priority given to public empowerment with respect to primary health care issues poses an equally significant challenge for Ekurhuleni Health Department. In his study, MacDonald (2009) reports on key theories that warrant further exploration, Firstly he concludes that public population empowerment poses a particular challenge to the delivery of health because it challenges the traditional power hierarchy. By empowering lay populations, health professionals may feel that their power as experts is downplayed - and in some cases, he concludes that the resistance to this change in power relations was the

primary barrier that hindered progress. The debate about empowerment of patient populations and the public-extends to the challenges that have been described in the study of decentralisation issues (MacDonald 2009).

#### 2.5.4 Decentralisation – A challenge for PHC service developers .

An earlier study by The South African Department of Health (2001) identified a number of key barriers to decentralisation and these were loosely related to power issues, e.g., a reluctance at central government level to delegate fiscal control of health budgets to the local community level and at times, to the level where the public were empowered to negotiate the priorities they wanted expenditure to be directed towards. Although a bit outdated The South African Department of Health (2001) study raises a number of key questions and observations that resonate well with questions central to the current study, e.g., in this study, the Department of Health concluded that the failures in delivering PHC effectively across the key principle domains, i.e. promotive-preventive, curative and rehabilitation, was an area that needed to be understood further through exploratory research. They also deduced that an understanding of the gains and losses for all key stakeholders within PHC was indicated so a better understanding of motivating and deterrent factors could be understood. Stack & Hlela (2002) present complementary research based on a cohort-case study (n=14) in their study of the social policy developers, the researchers conclude that the factors that influence public health provinces are a complex combination of political, and health-outcome related factors. By this deduction, they were promoting the view that the reasons why certain areas of health care receive higher priority and others do not is not entirely based on the health impact, but can be a function of politically guided motives.

This conclusion has particular significance because it formally acknowledges the fact that, if clinicians want to have a real influence on health priorities, they need to engage with the political milieu.

## 2.6 DIRECTION FOR FUTURE WORK WITHIN THE PARADIGM

On reviewing the above quoted primary research and other literary services within the domain, it becomes clear that there are some emergent issues that appear to

connect studies and literature to each other. Equally evident, is the fact that the study of challenges related to implementing PHC principles is an area worthy of further exploration especially from more diverse perspectives than has been achieved thus far. Published studies to date have focussed on specified variables that look at specific and limited empowerment and equity challenges – with minimal exploration of the global picture. To this end, and in acknowledgement of this, the current enquiry conducted a global exploration of challenges, so the inter- relatedness between the politics of health and the scientific imperative could be better understood.

The focus on clinicians is an acknowledgement of the fact that this group (like other stakeholders) will have a unique experience to describe and as a starting point, it is important to exclusively consider their attributions for challenges as perceived by them

## 2.7 CONCLUSION

Literature has revealed that since 1995 Primary health in South Africa, in all the provinces is being implemented, however the implementation of comprehensive PHC is still a challenge. The HIV/AIDS epidemic has an effect on the impact of rendering PHC. The primary health care trained nurses are providing quality PHC, but there are lots of challenges such as training (PHC post basic course), resources, and integration of services and staff .We still have staff that are employed by the municipality and those that is employed by the Provincial Government under the same facility. The next chapter will discuss the research design, methodology and data collection.

## 2.8 SUMMARY

The chapter dealt with the literature review which defines primary health care as an essential form of health care made universally accessible to individuals and families in communities by means accessible to them, with their full participation and at the cost that the community and the country can afford to maintain at every stage of development, in the spirit of self reliance and self determination. Primary health care will form an integral part of the country's National health system, of which it will be the



central focus, while PHC approach will guide the overall social and economic development of the community.

The literature review provides evidence that the commitment to the goal HFA, and PHC as the vehicle to achieving and improving health services is primary concern to the nursing profession and Government. Despite the realization that there were barriers to nurses assuming and maintaining key roles to PHC, this was clearly occurring in some countries.

## CHAPTER THREE

### RESEARCH DESIGN, METHODOLOGY AND DATA COLLECTION

#### 3.1 INTRODUCTION

A systematic enquiry on the extent of PHC service delivery in the Ekurhuleni Metropolitan Municipality is inherently a complex state of affairs. The complexity is a result of a range of variables; including the fragmentation and reported duplication of healthcare services inherited from the homeland system; continuing democratisation of society, constitutionally necessitating unconstrained and affordable access to healthcare by all citizens; funding capacity on the part of the state; and appropriateness of PHC approaches, given various socio-economic and cultural dynamics throughout the country. The complexity described above necessitated that the researcher utilised a diversity of approaches that would optimally lend credence to scientific value of the study as a whole (Greenhalgh 2007; Polit & Beck 2004).

The most important purpose of this chapter is to demonstrate – theoretically, conceptually and practically – the manner in which the study's broader and more specific intentions were realised. The extent of the study's realisation was collectively shaped and influenced by a range of research-related factors such as the purpose of the study, the research questions, the research problem, data collection and analysis procedures as well as the research design and methodology. Mouton (2001: 55) argues that the terms 'research design' and 'research methodology' are used interchangeably by different social scientists, depending on the individual researcher's scholarly and intellectual orientation and persuasion. Some researchers use the two terms as synonymous, while others regard the terms as two distinct, but inter-related. For purposes of this research project, the two terms have been used as two distinct, but closely related phenomena. Mouton (2001: 56-57) states further that the distinction between 'research design' and 'research methodology' lies in the fact that the former primarily concerns the type of study being undertaken to confront the research problem or research questions whereas the latter relates to all the qualitative issues addressing the purpose and objectives of the study.

### 3.2 RESEARCH DESIGN AND METHODOLOGY

In this study, the research design and methodology pursued a generalised qualitative (descriptive/exploratory) approach with minimal integration of quantitative (statistical) approaches. This combination of approaches is hailed by Carr (2004) as typical of most studies within the human sciences. The focus on nursing research, it asserts the view that purist qualitative enquiry or purist quantitative approaches limit the applicability of findings and a combination of both designs allows for a better description of human phenomenon. The qualitative aspects of the research design refer to the non-statistical and descriptive elements that rely mainly on the researcher's analytic and interpretive acumen, while the quantitative domain is primarily numerically/statistically inclined. The research design specifically refers to the broader **action plan** that was employed in enabling the study to achieve its aim and purpose; while the research methodology refers to the specific **tools/instruments** that were used by the researcher to implement the action plan (Mouton, 2001: 55, 114). Henning (2005: 142) refers to the research design as "... the management plan" of a study, to the extent that it outlines and charts a course of action along which the processes and procedures of the study will finally come into completion. (Mouton, 2001: 56,114). By employing both exploratory (qualitative) and statistical (quantitative) approaches, the researcher ensured that the study's ultimate findings were arrived at on the basis of the maximisation of both the research "management plan" and the research tools; maximising the theoretical perspectives complementarily with the research tools. The combined qualitative and quantitative perspectives enhanced a triangulated approach towards arriving at the findings of the study (Henning, 2005: 103).

The quantitative domain of the study (derived mainly from the demographic descriptors that form the short- pre interview questionnaire) lent a statistically (numerical and measurable) defined interpretation and analysis of the research process. Qualitatively, the research design conformed to the principles of generic qualitative investigation. The researcher needed to be aware of the different dynamics in order to attempt to give meaning to the daily challenges of the different role players, PHC nurses, health promoters, and administrative officers (Byrne, 2001). The generic qualitative approach to research chosen was largely due to its appropriateness to study participants' descriptions of their difficulties in delivery of

PHC and the services they gave to patients. It was also envisaged by the researcher that a qualitative enquiry research design provided the participants' own perspectives, open insights into their experiences; and the manner in which they expressed and described these would be taken into consideration. Especially during the empirical phase of the study, the specific focus was on their views about the barriers and supportive structures they had encountered in their attempts at adhering to the principle tenets of PHC, including any of those PHC service delivery issues that participants' had suggestions for improvement on. This social reality/social world from the participants' own perspectives would eventually provide an understanding of how and why the current primary health care program may be failing to respond to the health needs in the Ekurhuleni Metropolitan Municipality.

Personal research on the key principles central to qualitative approaches initially prepared the researcher for primary data collection. Silverman's (2004) guide on conducting qualitative research offered a systematic process for the researcher to process and central to this was, a commitment to ensuring that objectivity was maintained as far as possible throughout the research process. This process had to be enhanced through cautious literature review. In addition, the researcher dealt with all the pre-conceived ideas, conducted a comprehensive introspection, and consulted an independent assessor to eliminate bias as much as possible. Impartiality is critical for the integrity and credibility of the research process (Polit & Beck, 2004). The elimination of researcher bias and prejudice enhanced a process of immersion of the researcher into the various critical aspects of the research project. The repetitive assessment of the questionnaires, the description and the participants' personal accounts were continuously assessed and reflected upon. Since the researcher was the sole investigator, there was minimal concern regarding interpreter reliability issues (Polit & Beck, 2004).

### 3.2.1 Triangulated research design

Triangulation is described as "... the use of multiple methods or perspectives to collect data, describe, explain and interpret data about a phenomenon so as to converge on an accurate representation of reality [which in this instance, was on PHC reality in the EMM Region]" (Polit, Beck & Hungler, 2001: 472). The multiple methods and perspectives of data collection and research instrumentation (tools)

were complementary and further enhanced the validity and findings of the study (Polit & Beck, 2004). Dick (1998) refers to this complimentarily as the “truth value” of a study. The complexity and inter-disciplinary nature of PHC policy development and implementation necessitated that multiple approaches be utilised in advancing both the purpose and objectives of the study (Burns & Grove 2005).

### **3.2.1.1 Data and method triangulation**

A review of the primary and secondary sources of literature on primary healthcare became a qualitatively beneficial and preliminary data collection mechanism for the researcher. The combined usage of data and method triangulation optimised the broad representativity of the lived experiences of the respondents. While the questionnaire is characteristically a quantitatively inclined data collection instrument, its combined utilisation together with the questionnaire and interview techniques accorded to the study an integrated and comprehensive understanding of the PHC situation in the chosen research sites. The interview sessions themselves simultaneously afforded a participant observation opportunity to the researcher (Morse & Field, 2002: 76, Polit & Beck, 2004: 280). During the interview, the researcher was able to inter-act first-hand with the participants and observe at the same time the manner in which they expressed their real-world experiences unconstrained.

### **3.2.1.2 Rationale for triangulation**

The rationale for the blending of the qualitative and quantitative research approaches for this research is, amongst other factors, to minimise researcher bias and reduce quantitative margins of error throughout the entire research process. Polit and Hungler (1999: 257) advocate the integration of qualitative and quantitative approaches in one study, because neither method is perfect even in its area of greatest potential that it cannot be supported by other methods. These two authors articulate the advantages of not relying on one method thus: “Researchers address their problems with methods and measures that are invariably fallible. By integrating different methods and modes of analysis, the weakness of a single approach may be diminished or overcome” (Polit & Hungler, 1999: 258).

In addition to enhancing the complementarities and validity of the research project, the triangulated research design and method enhanced the pace with which the research process was undertaken. Most importantly, triangulation enabled the study to develop beyond conceptual limitations (Dick, 1998; Polit & Beck, 2004). This means that while the research topic is fundamentally a health concern, other real-life issues outside of healthcare are also integrated thematically in the discussion.

The most compelling justification for the utilisation of triangulation in the study lies in the complexity of PHC as a field of study (body of knowledge) on its own merits. In its attempt to develop a meaningful and credible knowledge base, the investigation necessitated that various disciplines/professions be included in order to converge at an uncompromised “truth value” of the extent to which the EMM was able or not, to render effective and satisfactory levels of PHC delivery to all the communities under its fiduciary domain. A comprehensively designed community oriented primary healthcare strategy involves three main stakeholders: the (national and provincial) government through the respective departments of health, the local communities; and the role of the private sector as a key employer. It is in this regard that social, economic, cultural, political and other fields of knowledge necessarily become part of an integrated response to the development and implementation of appropriate and relevant policies that would accurately describe an effective PHC framework (The South African Department of Health 2001).

### **3.2.1.3 *Exploratory research design***

The exploratory phase of the study refers to the pre-investigation stage, which addressed mainly three research concerns (Adler & Adler, 1998: 81). Firstly, it helped to outline early how the study as a whole progressed. Secondly, it assisted in refining the compatibility of the research instruments to the research environment. Lastly, the pre-investigation stage assisted the researcher early enough “... to gain new insight and better understanding of the variety of critical units of analysis and phenomena entailed... [in the research topic]” (Adler & Adler, 1998: 82).

The exploratory aspect of the research design was introduced so as to exclude and eliminate any preconceived ideas about the research topic and its concomitant problematic areas (Adler & Adler, 1998: 80-82). Furthermore, the exploratory phase

enabled the researcher to determine the extent to which practical PHC realities in the EMM region conformed, or deviated from international trends and practices as accruing from the literature review. In addition to the pre-testing (pilot study) phase of the investigation, the convenience sampling technique was used with a snowball effect being adopted to ensure that a reasonably large and representative sample was accomplished. It is the exploratory aspect of the investigation that expanded the pre-testing aspect to develop into a more structured and complete whole (Burns & Grove, 1999: 40).

The limited availability and paucity of systematic research on the state of community based primary healthcare in the Ekurhuleni Metropolitan Municipality necessitated that a pilot pre-testing phase be conducted first, so as to determine the extent of the research project's feasibility.

#### **3.2.1.4 *The pilot project***

A pilot project was undertaken to refine the questionnaire as research instrument. The fact that the researcher is an employee of the EMM Department of Health posed an advantage of familiarity with the research site. However, this did not compromise the researcher's impartiality and objectivity. Despite the questionnaire being the primary research instrument during the piloting of the study, the researcher applied intermittent observation spans to document all observations as much as possible during the participant observation stages of the pilot pre-stages. In addition, the documentation that was relevant to the observation was collected to augment to the transcripts that were compiled. The respondents were equally accommodating because some provided documents for perusal during the interview sessions. It was imperative though that all the observed respondents not be made self-conscious (Burns & Grove 2005).

#### **3.2.1.5 *The negotiated entry and the research environment***

In terms of the dictates of a whole range of ethical considerations in research, the researcher could not just invade the research sites without due approval being granted by the concerned health authorities. In addition, the respect for the human dignity of all participants warranted that they be formerly notified and requested to

participate in both the pre-trials and the actual investigation. The pilot project was conducted at nineteen primary healthcare facilities within the three EMM regions. The following table indicates the geographic location of the pilot site.

**Table 3.1: Distribution of the sample size by region**

<b>Region</b>	<b>PHC fixed Facilities</b>	<b>Sample</b>
Northern	25	3
Southern	32	9
Eastern	31	7
<b>Total</b>	<b>88</b>	<b>19</b>

*(Source: - Ekurhuleni Metropolitan Municipality 2010)*

### **The rationale of the pilot project**

In this study, the pilot phase served as a catalyst for the preliminary stages of the empirical component of the study. Mouton (2001: 113) ascertains that the empirical stage of a study enhances the results and findings of the study itself. The findings of the study themselves could be based on any single, or combination of the following research approaches:

- empirical (based on observation);
- descriptive (explains trends or patterns of phenomena);
- causal (explains and describes links between variables);
- theoretical (situatedness of new evidence to explain new or existing theory);
- interpretive (based on the researcher's own analytic perspectives);
- evaluative (based on the assessment "... of outcomes, benefits, or impact of certain interventions" (Mouton, 2001: 113).

Notably, this pilot project accomplished multiple goals. It provided an opportunity for the validation of the research process. The pre-testing of the interview process and the proposed interview questions enhanced the study's reliability and validity as ambiguous questions and other emergent flaws were identified and later clarified. In addition, the rapport between the researcher, the participants, and the research participants was cordially enhanced (Burns & Grove 2005).



The pilot project also highlighted the fact that; irrespective of the location of the primary healthcare facility, there was an overarching concern regarding the dominance of curative aspects of care surpassing the preventative interventions.

### 3.3 DATA COLLECTION METHODS AND PROCEDURES

Babbie and Mouton (2001: 563) most poignantly point out that: “The worth of all scientific findings depends heavily on the manner in which the data was collected and analysed”. The premise of argumentation here is that if the methods and procedures of data collection in a study are not commensurate with the intended purpose of the study, the outcome is certainly bound to yield information and data that will not contribute to the successful resolution of the research problem. It is mainly for this reason that the researcher discreetly attempted to employ triangulated data collection strategies that would optimise the meaningfulness of the research to the real-life situation and lived experiences of the communities within the Ekurhuleni Metropolitan Municipality jurisdiction, insofar as the availability and provision of primary healthcare in their residential and work environments is concerned. The data collection methods and procedures employed in this study encompassed both the theoretical/conceptual and the empirical/experiential domains of the study. The latter (triangulated) approach enhances the elimination of methodological imperfections that may arise (Burns & Grove 2005).

#### 3.3.1 Data collection and instrumentation

With regard to the gathering of relevant data and information, ‘instrumentation’ relates to the identification and application of either literature-based or empirical techniques/tools that complement and contributes to a better understanding of the phenomenon or phenomena under investigation. In this specific instance the phenomenon relates to the state of primary healthcare in the EMM’s Southern Region. It is important to note that the instrumentation/tools are *not* the data itself. Rather, the data collection instruments used enabled the researcher to obtain the data and information that were pertinent to resolving the research problem. As a result, the types of instrumentation used, necessarily determined the extent to which the investigated phenomenon could be understood from multiple perspectives. That is to say, data collection instruments do influence and shape nature and quality of the

data analysis and interpretation. To a large extent then, the 'instrumentation' contributed in 'answering' the profound research questions and the identified research problem (Burns & Grove 2005).

The core regimes of the data collection and analysis instrumentation (literature review, pilot testing, and interviews) were developed prior to the actual execution of the research project. Some qualitative researchers contest this approach (of prior instrument development), on the basis that such an orientation "... is a misnomer for fieldwork, where everything unfolds during the study" (Sarantakos, 1998: 167). Contrasting this view is the perspective by other social scientists who justify the development of research instruments prior to the actual undertaking of the study. The protagonists of this latter justification cite that prior instrument development "... helps to avoid collection of too much superfluous information" (Sarantakos, 1998: 168). From this researcher's personal experience during the empirical stage of the study, the prior development of the interview schedule in particular, had the added advantage of applying standardisation, consistency, and accurate measurability of the data/evidence.

Miles and Huberman (2004) illuminate that the quality and relevance of both the data and its instrumentation to translate into meaningful and convincing analysis, it (the data) has to be subjected to three phases of quality control:

- **Data display:** the accumulated theoretic/conceptual and empirical PHC-related evidence was visually presented in the form of graphs, tables, and figures (especially in the ensuing chapter 5), in order that the presented aspects of the study are intelligible to the readers and the broader research audience;
- **Data reduction:** the accumulated theoretic/conceptual and empirical PHC-related evidence was subjected to a process of elimination and prioritisation, according to which redundant and repeated information was excluded;
- **Data interpretation:** the accumulated theoretic/conceptual and empirical PHC-related evidence was subjected to a process of meaningfulness in respect of the real world. The abstract was translated into the practical, and

the theoretic was accorded the level of applicability. In this manner, data interpretation and analysis became the method and primary instrument by which a point of convergence was drawn between the purpose of the study and its final outcome (Burns & Grove 2005)

### 3.3.2 The context of the empirical phase

The empirical phase of the study entails the fieldwork activities by which the researcher gained important insights into the research problem as she interacted with the research subjects (Delaine, 2000: 11-12; 148). It is this aspect of the study that enabled the researcher to have the respondents' perspectives and understanding of the state of primary healthcare delivery in the Ekurhuleni Metropolitan Municipality's Southern Region.

In essence, the fieldwork undertaken in the research project helped to deconstruct the real and actual from the abstract and theoretical; while also providing the researcher with the opportunity to refine the research instrument (i.e. the interview schedule). In this context, the fieldwork then became a quality assurance mechanism for fulfilling the purpose of the study; while also addressing the research problem. Ethical considerations played a very significant role during the experiential phase. The fact that the researcher is also an employee of the EMM Department of Health suggests that a maximum sense of objectivity be applied in order that researcher prejudice does not diminish the essence and purpose of the fieldwork itself. Delaine (2000: 4-5) emphasis this point thus:

“Ethical and moral dilemmas are an unavoidable consequence, or an occupational hazard of fieldwork. Dilemmas and ambivalences do not always reveal themselves clearly and are virtually impossible to plan for in advance ... An ethical dilemma may be described as a problem for which no course of action seems satisfactory; it exists because there are ‘good’ but contradictory ethical reasons to take conflicting and contradictory courses of action ... Ethical decision making includes being consciously aware of one’s values, principles and allegiance to ethical codes ... the traditional impersonal and objective ethical model assumed the researcher and researched, but the new

fieldwork being practiced suggests less distance or detachment between researchers and researched; and a new ethic or moral imperative that is not yet codified” (Delaine 2000:4-5).

### 3.3.3 Pre-study Ethical Considerations

The adherence to ethical norms and standards is critically relevant as they “... mostly affect the stages of planning and data collection” in research (Gibbs, 2007: 7). To that end, the researcher sought and received ethical clearance from the University of South Africa (UNISA), Department of Health Studies Higher Degrees Committee and from the Ekurhuleni Health Department. As part of that process, the researcher had to demonstrate a well-informed understanding of the likely range of possible ethical complications that may have arisen as a result of the study. The ethical considerations in this research project relate to three levels of ensuring that the study was conducted in a scientifically acceptable manner.

#### **3.3.3.1 *Researcher and Research Focused Ethical Considerations***

Annexure A to D indicate the various protocol observance phases the study underwent prior to its execution. The researcher could not independently embark on the study without appropriate protocol being observed. Ethical clearance and approval from the Ekurhuleni Department of Health office had to be acquired, as the research sites are jurisdictionally under their authority. The University of South Africa’s Higher Degrees Committee also had to grant permission for the study’s execution, after it was satisfied that the study conformed to acceptable scientific norms and standards. It was absolutely imperative that the entire protocol described above be observed, as failure to do so would compromise the ethical correctness of the study, and also jeopardise its scientific value. The researcher was therefore bound by these protocol-induced ethical considerations, in order that the relevant legal and scientific apparatus was not contravened (MNUALL University of South Africa 2011).

#### **3.3.3.2 *Explanation of the research***

Researcher and research focused ethical considerations do not only serve as a research quality control mechanism. These considerations also assist in validating

the credibility of the entire research process. In recognition of the human dignity of the participants, the entire research process had to be explained to the respondents, whose partial or complete non-participation would have compromised the specific and general intentions of the study. From this study's viewpoint, explanation of the research process to the respondents was empirically critical, given that the lack of literature on the research topic lent the study more viable on the basis of the respondents. Given the low levels of literacy in the community, the respondents' oral participation and personal experiences with the researcher made it very necessary for the research process to be explained entirely (Burns & Grove 2005).

While the explanation of the research process enhanced researcher-participant trust and the efficacy of the study, it also consolidated the level of openness and transparent purpose of the study to the participants. Engagement with the research subjects ensured that any resentment and feelings of intimidation did not exist on the part of the former (Lo Biondo –Wood & Haber 2006). The respondents were given the assurance that there would be no invasive or intrusive procedures.

### 3.4 RESPONDENT/PARTICIPANT BASED ETHICAL CONSIDERATIONS

Participant based ethical considerations – as opposed to the research and researcher focused ethical considerations regulating the researcher's behaviour – mainly relate to the researcher's attitude towards, and treatment of the research subjects (Burns & Grove, 1999: 157-158). In a relatively embryonic culture of human rights for a country such as South Africa, the humane treatment of research subjects is a primary requirement. In the view of this study, most if not all participant-related ethical considerations could be pivotally linked to the pursuance of the human rights culture recognising the respect for human dignity. For instance, the right to privacy (which is a factor of the principle of justice) could arguably be linked to the right to self-determination (a factor of the principle of human dignity).

#### 3.4.1 The principle of respect for human dignity

With no regard to race, creed, culture, or any other social constructs – the respondents' right to be respected is a sacrosanct human right (Republic of South Africa Constitution, 1996: 3, 6-8). The researcher's respect for the human dignity of

the respondents encompasses the latter's right to make informed voluntary decisions to be involved in the research project. This right further implies that at no stage of the investigation were research participants subjected to clinical experimentation on any communicable or non-communicable disease (Adler & Adler, 1998: 82). The principle of the respect for human dignity significantly entails the following rights:

#### 3.4.2 The right to informed consent and withdrawal

Participants were provided with a consent form to sign after the research explanation process, and that withdrawal from the study would not prejudice them in any way. Voluntary participation was crucial, especially for the study's empirical context. The researcher was responsible for explaining the participants' informed consent and voluntary participation to them. Most importantly, the purpose of the research project was explained in detail to the participants, and the approval and clearance letters shown to them to alleviate any concerns of misdemeanour on the researcher's part. In addition to explaining the research to the participants, their informed consent and voluntary participation were pivotal to ensuring that their rights were protected individually and collectively. Furthermore, they were assured that they could withdraw their participation from the study at any time in the most unlikely event that they felt their human rights were being violated (Polit & Beck, 2994). The withdrawal clause within the framework of ethical considerations also guaranteed that the research participants' right to self-determination was observed. Accordingly, the respondents were given the right to act as autonomous beings that could make their own decisions with no threat of reprisals for those who did not wish to be part of the research.

#### 3.4.3 The right to privacy and confidentiality

The respondents' right to privacy was guaranteed with the adoption of pseudonyms in order to conceal their true identities. Information and data that would reveal their true identities or prejudice them in any way was concealed from the attention of unauthorised persons. This was especially pertinent in a study where participants may have had cause to criticise the support their employers were offering to them or to the pursuit of PHC principles. The fact that the researcher was employed within EMM was in itself an area that needed to be addressed to assure participants that

their responses would be kept confidential and that any future use of data from the study would be completely anonymous.

#### 3.4.4 The observation of research subjects

The observation of research participants/subjects was conducted within the confines of scientifically acceptable research ethics and practices; especially on the part of the researcher, who had to be conscious of these norms and standards throughout the research process. The participant observation phase straddled both the pre-testing and the actual investigative phase of the research project. It was during these research stages that the researcher was able to interact with the sampled participants in their naturalistic (physical) environment and habitat (psycho-social). The researcher conducted the participant observation during the semi-structured interview sessions. As no experimental/clinical activity was required for this study, no formal session was actually required (Gibbs, 2007: 150) for the observation of the nineteen sampled respondents at the designated research sites (see Table 4.1 above, in Section 4.2.2.1). During the empirical stages of the study, the researcher's participant observation notes were guided primarily by the following:

- The desire to find out the extent to which the notion of primary healthcare was known or understood by the various categories of all the stakeholder and respondent constituencies;
- Clinicians' perceptions of the extent to which their everyday practice reflected the principles of primary health care.
- The respondents' actual attitudes towards healthcare delivery in particular, and overall municipality service delivery in general;
- The extent of community based healthcare in the designated research sites;
- Healthcare practitioners' roles in the prevailing state of affairs.
- Healthcare practitioners views about possible remedial actions that could be implemented in the future to reduce the barriers that limited their to work towards the primary goals of PHC (Gibbs 2007:150).

The participant observation stage was not a once-off event. Research subjects' views, attitudes, and understanding on the state of PHC delivery were formally observed during the entire interview sessions and recorded separately.

### 3.5 INTERVIEW METHODS AND PROCEDURES

Individual clinician interviews were conducted on a purposive sample of PHC practitioners (n=19) currently employed in different health centres within the Ekurhuleni health department catchment area. The interviews offered a unique opportunity for the researcher to explore issues relating to the challenges experienced by PHC practitioners in working to the principles of primary health care.

With respect to exploiting the opportunities for interaction with participants provided by the interview process- the researcher took additional care to reflect on the fact that she, like the interviewees, was a clinician and may have had preconceptions which could have potentially biased and clouded her involvement as the researcher. The potential drawbacks arising from the researcher being an 'insider' were managed in two specific ways (i). Firstly, the researcher had built in mechanisms into the interview process to allow participants opportunities to confirm the accurateness of recorded responses. (ii). Secondly, the researcher had made a conscientious decision to personally acknowledge the possible conflict in roles and not only declared this to participants but actively re-emphasised the separateness of the current role as a researcher from that of clinician.

The role of interviews in research is succinctly encapsulated by Miller and Brewer (2003: 166) who contend that

“Interviews are not just conversations. They are conversations with a purpose – to collect information about a certain topic or research question. These ‘conversations’ do not just happen by chance, rather they are deliberately set up and follow certain rules and procedures”.  
(Miller & Brewer 2003:166).

The contexts of the empirical stage of the research determined the structure of the conversational engagements with the research subjects. Due to the idiosyncratic differences of the research participants (such as age, literacy level (which affected written and oral response to research questions), and occupational dynamics), the semi-structured interview was deemed most appropriate.



The semi-structured interview sessions also provided the researcher with the opportunity for participant observation. Each interview session lasted approximately thirty minutes (Polit & Beck 2004). These sessions did not deviate much from the participant observation guidelines (appearing in the bulleted segment of the second paragraph of p. 48 above). As indicated earlier, each interview was preceded by a short “pre-interview” questionnaire that the researcher completed on behalf of the participant. The questionnaire collated basic background information about the participant including their professional discipline, years of experience and factual information about previous study related to their role as PHC workers. The semi-structured nature of the interview sessions allowed for conversational flexibility, according to which some questions were developed as follow-up questions as the conversations were unfolding, sometimes allowing for conversations that did not directly impact on the research topic (Miller & Brewer, 2003: 167, 169).

It is this flexibility that also contributed to the refinement of the more formal nature of the questionnaire, as the researcher became aware of flaws that might have been inherent in the original structuring of the questionnaire. In this regard, the semi-structured interviews conformed to Sarantakos’s (1998: 247) observation that such interviews have “... no restrictions in the wording of the questions, the order of the questions or the interview schedule” (Ngwenya, 2010).

### 3.5.1 Translation of narrative statements

The process of integrating narrative statements and observation of any emerging themes was implemented to identify common and emerging patterns, themes and trends. Codes were developed from the transcripts and eventually categories and themes were identified to put meaning into the descriptions (Miles & Huberman 1994).

Face-to-face interviews were conducted in English as all participants were in employment where the corporate language of communication was English. Semi structured interviews were conducted with each of the participants. Interview questions focussed primarily on the following themes

- Eliciting practitioners' views about their experiences of working within a Primary Health Care context.
- How much of their day-to-day clinical practice they believed was focussed on prevention, health promotion, and community empowerment, as dictated by PHC practice principles.
- Eliciting viewpoints on attributions for the reported implementation challenges that existed for clinicians with respect to focussing their practice on preventive care.
- The barriers they had experienced in maintaining a focus on PHC principles in their day to day to work.
- What actions they thought could be supported by the Municipality to eliminate identified barriers to a purist PHC focus.

### 3.5.2 Interview Schedule development and administration

The loose-format interview schedule used in the research formed the pivotal element of the research instrumentation. However, it is equally critical to take note of the fact that "... [it has been argued since the 1980s that] a coherent theory of interview-schedule design remains elusive" (Gendall, 1998: 1). Notwithstanding the latter author's assertion, the researchers attempted as much as possible, to logically and coherently locate the fundamental units of study and analysis (the state of PHC within EMM's Southern Region *vis-à-vis* community based primary healthcare) within the schedule's thematic framework.

The interview schedule developed by the researcher was utilised as a means of guiding the researcher through the planned interviews (see Annexure D for template of questions). The schedule's framework was guided by the following nuances (Delpont, 2002: 175-176; Gendall, 1998): arrangement of questions in a preferred logical sequence; wording of questions such that specific responses are expected to be elicited; and diversification of questions for a variety of responses. The above-cited nuances themselves are intrinsic to the merging of both the theoretical/conceptual and empirical/experiential aspects on PHC in general. This complementarity enabled the study to achieve its stated objectives and outcomes (Miles & Huberman 2004: 195).

The questions that were presented to participants are contained in the interview schedule in Annexure D. In the formulation and development of interview items, the critical focus was on three thematically related factors with a direct bearing on the state of PHC delivery in the Southern Region of the Ekurhuleni Metropolitan Municipality. These are: the professional profile of PHC practitioners; the level and nature of community involvement in PHC delivery; and practitioners' views about actions that can be taken to improve the commitment to PHC principles throughout Ekurhuleni based PHC facilities.

The actual administration of the questionnaire as research instrument was implemented in accordance with the sampling parameters of the study. Table 4.1 above (p. 42) shows the distribution of the PHC facilities across the EMM region, as distributed in accordance with the type of healthcare services these PHC facilities provide. The target population for the pilot study was the primary health care practitioners, administrative personnel and health promotion workers. The database of the research sites consisted of sixteen primary health care facilities in the Ekurhuleni Metropolitan Municipality. ([www.Ekurhuleni.gov.za](http://www.Ekurhuleni.gov.za)) and each had an average of one representative who met the participant criteria and/ had consented to taking part in the study.

It is absolutely necessary to determine whether or not primary healthcare in the Ekurhuleni Metropolitan Municipality was responding to the healthcare needs of the Ekurhuleni community and most importantly whether the practitioners who were employed to work within its principles were, in fact, effectively engaging in primary health care activities without substantial hindrance. The specific objectives of this study focused on the healthcare and services that the primary healthcare practitioners provided in this area of Gauteng Province.

### 3.5.3 Sampling methods and Procedures

In order to establish an empirical representativity of the research subjects, a targeted research population had to be obtained, as not all primary healthcare practitioners and providers in the EMM area could be engaged in the research project due to practical logistical and financial constraints. As defined by various authors, a population is the entire group of persons or objects that is interest to the researcher

or that meet the criteria the researcher is interested in studying. For instance, (Polit & Beck, 2008: 56) refers to the study population as “all the individuals or objects with common, defining characteristics” On the other hand, Burns and Grove (2003: 491) define a population as “all elements (individuals, objects, events or substances) that meet certain criteria for inclusion in a study; sometimes referred to as a target population”. Babbie (2001: 110) describes a population as that group (usually of people) about whom you want to draw conclusions.

The target population for the study was the service providers these are PHC nurses, health promoters, administrative staff and attending the clinic within the EMM Southern Mancho area. The Southern region of the Ekurhuleni Metropolitan Municipality in Gauteng Province was the most feasible research site as it greatly exhibited characteristic features of the research topic and its concomitant research problem (Sarantakos, 1998: 141). Considerable effort was made by the researcher to ensure that the sample extracted from the population was as representative as possible. The targeted population for this investigation comprised of clinic managers (also known as the Facility Heads); health promoters and primary healthcare nurses. All members of the study population were from the Southern Region of the Ekurhuleni Metropolitan Municipality’s primary healthcare facilities. A convenience sampling technique was used with a snowball effect being adopted to ensure that a reasonably large and representative sample was accomplished. The entire parent population was relatively small given the specialist nature of Primary health care and the very specified geographical locus of the study.

#### **3.5.3.1 Sampling criteria**

By definition, a sample is a part or fraction of a whole, or a subset of a larger set, selected by the researcher to participate in the research project (Brink, 1996: 133). A sample consists of a selected group of the elements or units from a defined population. It refers to the process of selecting the sample from the population in order to obtain information regarding a phenomenon in a way that represents the population of interest (Brink, 1996: 133). The respondents who were most available at the respective primary healthcare centres served as the purposive sample. The sample size of interviewees was continually increased until data-saturation was reached i.e. until the point when responses from interviews were revealing repetitive

themes and no new information was being elicited (Polit & Beck 2004). Care was taken to ensure that all the different categories of participants such as PHC nurses, clinic managers, as well as health promoters and administrators were all represented within the final sample of interviewees.

### **3.5.3.2 Representativeness**

The total number of participants who took part in the full interviews was nineteen. Table 3.2 below offers a descriptive summary of all the primary healthcare facilities that were part of the EMM area, as well as the types of healthcare services that these facilities primarily offered. It should be noted that, despite the apparent wide spread of service areas- not all the facilities had designated PHC personnel and in some instances, one PHC frontline worker was allocated to work between two service areas.

**Table 3.2: A provincial sample of Primary Health Care Facilities in the Ekurhuleni Metropolitan Municipality**

<b>Southern Region</b>	<b>PHC FACILITY</b>
Katlehong	Tswelepelo Clinic offers a variety of all primary Health care Services on a daily basis. These include services such as prenatal service
Vosloorus	J.D.Dumane Clinic offers a variety of all primary Health care Services on a daily basis. These include services such as prenatal service. These services include roll out programme for the ART for all affected community.
Katlehong	Motsamai Clinic offers a variety of all primary Health care Services on a daily basis. These include services such as prenatal service
Edenpark	Eden Park Clinic offers a variety of all primary Health care Services on a daily basis. These include services such as prenatal service
Alberton	Brackenhurst Clinic offers a variety of all primary Health care Services on a daily basis. These include services such as prenatal service offers a variety of all primary

<b>Southern Region</b>	<b>PHC FACILITY</b>
	Health care Services on a daily basis. These include services such as prenatal service
Thokoza	Phenduka Clinic offers a variety of all primary Health care Services on a daily basis. These include services such as prenatal service
Boksburg	Boksburg North Clinic offers a variety of all primary Health care Services on a daily basis. These include services such as prenatal service
Katlehong	Magagula Clinic offers a variety of all primary Health care Services on a daily basis. These include services such as prenatal service
Katlehong	Greenfield Clinic offers a variety of all primary Health care Services on a daily basis. These include services such as prenatal service
<b>Northern Region</b>	<b>PHC FACILITY</b>
Kempton park	Kempton Park Clinic offers a variety of all primary Health care Services on a daily basis. These include services such as prenatal service
Edenvale	Edenvale Clinic offers a variety of all primary Health care Services on a daily basis. These include services such as prenatal service
Tembisa	Tembisa Clinic offers a variety of all primary Health care Services on a daily basis. These include services such as prenatal service
<b>Eastern Region</b>	<b>PHC FACILITY</b>
Duduza	Duduza Clinic offers a variety of all primary Health care Services on a daily basis. These include services such as prenatal service
Tsakani	Tsakani Clinic offers a variety of all primary Health care Services on a daily basis. These include services such as prenatal service
Benoni	Kemston Clinic offers a variety of all primary Health care Services on a daily basis. These include services such as

Southern Region	PHC FACILITY
	prenatal service
Brakpan	Kingsway Clinic offers a variety of all primary Health care Services on a daily basis. These include services such as prenatal service
Nigel	Nigel Clinic offers a variety of all primary Health care Services on a daily basis. These include services such as prenatal service
Springs	First Avenue Clinic offers a variety of all primary Health care Services on a daily basis. These include services such as prenatal service
Daveyton	Etwatwa Clinic offers a variety of all primary Health care Services on a daily basis. These include services such as prenatal service

Source: ([www.Ekurhuleni.gov.za](http://www.Ekurhuleni.gov.za) - accessed January 23, 2011).

For the main study, sixteen clinics from the Southern Region were eventually selected. The Southern Region consists of thirty-two healthcare facilities (clinics); that is thirty fixed clinics, one satellites and one mobile clinic. The entire region has a staff complement of 290 PHC health nurses/community and 33 health promoters and each Clinic has a clerk (Administrator).

### **3.5.3.3 Inclusion criteria**

In determining potential interviewees, key inclusion criteria were applied and these included: -

- That the respondents must be frontline clinicians working either as PHC nurses or health promoters working in any of the healthcare service facilities in the Ekurhuleni Metropolitan Municipality;
- That the respondents' had worked in a PHC capacity for at least 12 months within the Ekurhuleni catchment area.

The researcher recognises and appreciates the importance of the multi-disciplinary primary healthcare provision team to be included in the study. In order to limit the

prevalence of bias, the views of the respondents (PHC nurses and health promoters) were sought to make sense of PHC service delivery in its context as a phenomenon (Polit & Beck, 2004). The target population was meant to yield sufficient information, to facilitate understanding of frontline clinician viewpoints, and to clarify the delivery and quality of primary health care services in the Ekurhuleni Metropolitan Municipality.

#### **3.5.3.4 Exclusion criteria**

The exclusion criteria focused on those participants who did not have the required level of experience within the same PHC facility. Secondly, all the PHC service providers at mobile and satellite clinics were excluded, as these did not render substantive healthcare services to a proportionally reasonable number of clients.

#### **3.5.3.5 Justification of sampling methods**

The rationale for the approach to convenient and purposeful sampling techniques is premised on the fact that certain methodologists caution against unsystematic sampling and its randomness because they assert that “Qualitative researchers do not consider randomness a useful tool for understanding phenomena” (Polit & Beck (2007: 45). In addition, the advantage of judgement sampling is that it enhances the purpose of acquiring well-informed respondents whose answers to the research questions will be well informed and refined to enrich the construct under investigation. LoBiondo-Wood & Haber (2006: 94) regard convenient sampling as reliable, because respondents are available for the research project and a high response rate is assured. The respondents who were voluntarily reachable and met the inclusion criteria were easy to account for (Loiselle, Profetto-McGrath, Polit & Beck, 2007: 45). The quest for in-depth qualitative accounts from respondents necessitated a more targeted and limited focus on fewer participants than would be the case with quantitative enquiry (LoBiondo-Wood & Haber, 2006: 266).

This study is concerned with the practice world of clinicians who practice in primary health care within the Southern Region of EMM. The research design and methodology pursued is primarily qualitative in order to enhance understanding of the day-to-day challenges faced by practitioners in their roles as primary health care



workers. The process of studying research participants involved a multifaceted consideration of a range of issues –one of which was the likely ethical complications that may have arisen as part of the study.

## CHAPTER FOUR

### DATA PRESENTATION, ANALYSIS AND INTERPRETATION

#### 4.1 INTRODUCTION

Whereas the previous chapter addressed the methodological and design aspects of the study, the current chapter focuses on the specific means by which the data is to be presented, analysed, and interpreted. The semi-structured interviews were the means by which data was gathered. The items included in the interview schedule reflected the various dynamics of both the research subjects (respondents) and PHC delivery as the research phenomenon under investigation. The information gathered from the interviews was transcribed verbatim. The variables explored within the interviews related to the range of the preventive, promotive, and curative healthcare, as well as community participation. These variables were included to determine whether comprehensive health services in the Southern Region of the EMM area were provided according to the primary healthcare core package (Polit & Beck 2004; Netangaheni 2009).

Ensuring that issues pertinent to understanding the challenges of working to the PHC model were explored enhanced the validity and credibility of the data. Gibbs (2007: 93-940 states that the validity of a study is determined by the degree to which the study is able to achieve its stated original intentions. According to Babbie (2001: 143) validity is the ability of the data collection tool to measure the truthfulness or falsify the real meaning of the questions. Content validity was achieved by introducing thematically focused questions on PHC as a phenomenon of investigation. It was crucial to determine the extent to which the respondents were familiar with the notion of primary healthcare. It is noted that by virtue of being a largely qualitative enquiry, the current study had limited generalisability beyond the area that was being studied. On initial analysis, this may appear to be an insurmountable limitation but as pointed out by Delport (2002) and Moji (2006), small scale qualitative studies can be important in establishing initial understanding of a previously poorly understood issue. Subsequent researchers in the field can expand on these initial findings and in some cases; they can test their generalisability to other contexts.

The credibility of this research project rested on the extent of its truth-value, which itself is the product of all the inter-related dynamics associated with the accuracy of information and data collected. Lincoln and Guba (1985) and (Polit and Beck, 2004) point out that the credibility of an investigation involves two aspects:

1. Carrying out the investigation in such a way that not distorting or exaggerating the information accruing from the research instruments enhances the believability of the findings;
2. The application of triangulation to improve the likelihood of qualitative findings (Netangaheni 2009; Moji 2006; Polit & Beck 2004).

#### 4.2 DATA PRESENTATION AND ANALYSIS

First and foremost; qualitative data was obtained mainly by means of the review of literature, the interviews, and the narrative statements from the respondents (Mashazi 2002; Miles & Huberman 2004; Polit & Beck 2004; Netangaheni 2009). The process of integrating narrative statements and participant observation was used to identify any emerging themes, patterns and trends relevant to the research topic. Codes were developed from the transcripts and eventually categories and themes were identified to put meaning into the descriptions (Polit & Beck, 2004; Netangaheni 2009). Simple Thematic analysis was primarily applied to analyse the feedback elicited from study participants. As an adjunct, content analysis was superficially applied to limited aspects of the collated data. The use of a combination of data analysis approaches follows the advice of others such as Addison (1999) and Silverman (2004) who argue that, limiting the approach of data analysis to a single style of analysis is oversimplification and often limits the scope of interpretation for the researcher.

Content analysis as described by Krippendorff (1980) centres on analysing data with an emphasis on identifying and counting words and phrases that recur within the textual data. Categories of clinician-identified challenges related to PHC delivery were allowed to emerge out of the transcribed data and once identified; this data from the interviews was brought together under category headings. Sommer & Sommer (1999) see

*“the use of qualitative content analysis as an effective way of ensuring a systematic description of written, spoken or visual communication”*  
(Sommer & Sommer 1999:112)

Content analysis was specifically applied (as an initial crude analysis procedure) to the data from all the sources to enable the researcher to ‘numerically express’ the frequency with which particular words, phrases and themes were reported by participants.

#### 4.3 STANDARD THEMATIC ANALYSIS

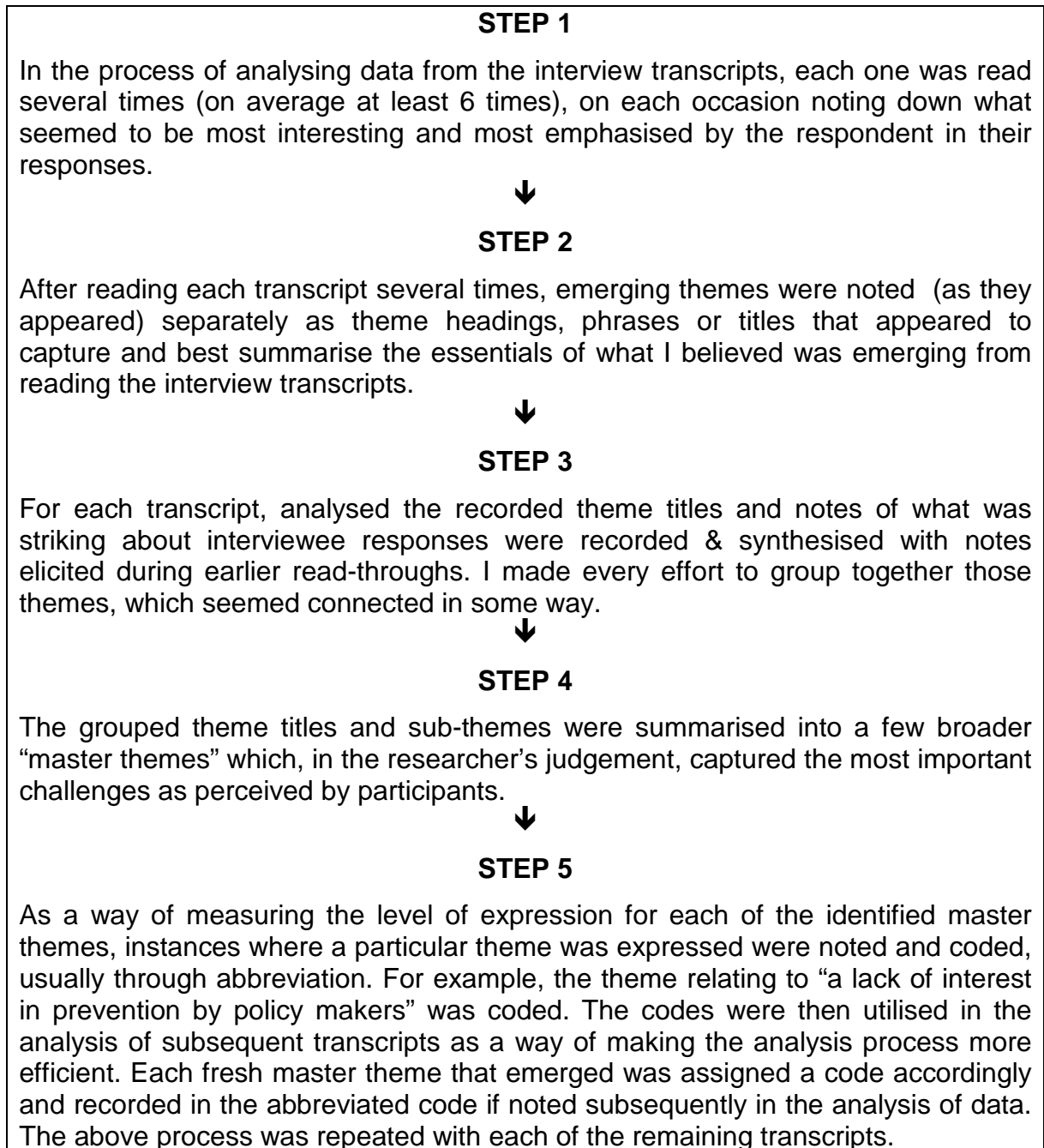
As already indicated, Thematic Analysis (TA) was applied to interview data from the practitioner interviews. Thematic Analysis, as argued in Weaver & Muller (2003), is an especially useful approach, for drawing out and highlighting themes from qualitative data, in this instance, the interview data from practicing clinicians (n=19). Described in Silverman (2004) and Boyatzis (1998), thematic analysis is seen as a process for encoding qualitative information in a manner that enables communication with a broad audience. If required, this process allows for the translation of qualitative data into quantitative information. Boyatzis (1998) suggests that,

*“it allows a researcher using a qualitative method to more easily communicate his or her observations, findings and interpretation of meaning to others who are using different methods...and can assist in communication between positivist science and interpretive science”.*  
(Boyatzis 1998; 06)

For the researcher, being able to apply thematic analysis requires a number of notable competencies and underlying abilities including (i) pattern recognition. (ii) Openness and flexibility to be able to perceive and recognise “codable moments”. (iii) Planning and ‘system thinking’ i.e. being able to organise observations and identified patterns into a ‘usable system’. Prior to the process of encoding data, the researcher is expected to recognise patterns within the information being analysed, followed by being able to devise a system for organising the observations in a way that can be used by others.

In reviewing and analysing data, a modified 5 step thematic analysis procedure was applied, the stages and details of which are provided in the summary Table (Figure 6) below: -

**Figure 4.1: A structure for thematic analysis within the study**



As the process of analysis progressed, was keen to systematically consider what each identified theme meant and whether or not the views evident from the themes were suggesting a tangible explanation or theory about what the study was discovering.

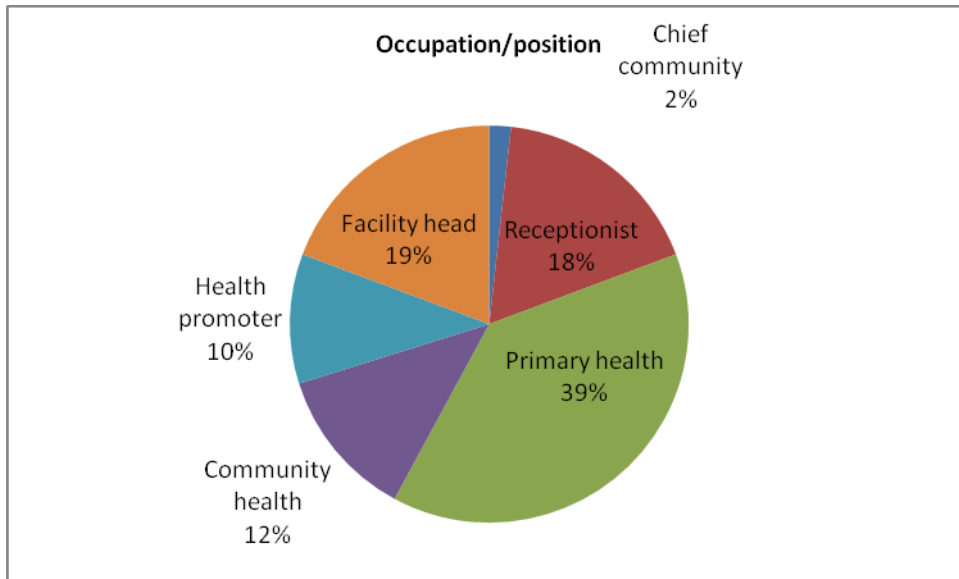
## 4.4 PRESENTATION OF RESEARCH FINDINGS

### 4.4.1 Presentation Analysis of results

During the semi-structured interviews, open-ended questions were used to facilitate discussion and also to attain narrative statements to ensure a summative evaluation. The first part of the data collection process focussed on collating basic differentiating information about the participants such as their different discipline areas within which they practiced, clinicians' previous training in primary health care related activities and the types of primary health care activities participants had received training in their careers. Collating this information offered the possibility for the analysis of findings to be contextualised in more varied ways and offered an essential backdrop to a more accurate understanding of the possible confounders that may have impacted participants' views and attributions.

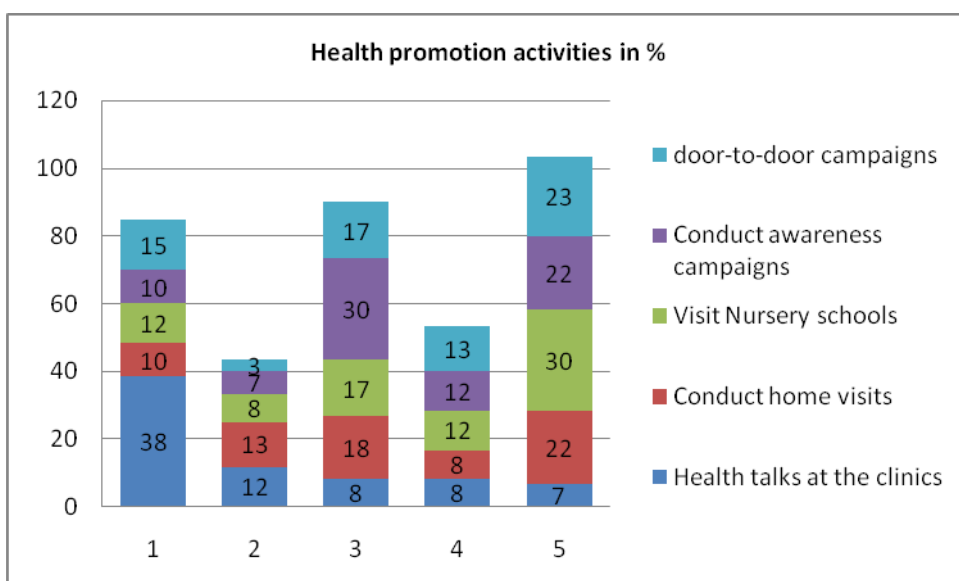
Figure 4.2 below indicates that primary healthcare nurses constituted 39% of the group of employees of EMM. Administrative staff and facility heads comprised 37%. Community Health nurses were 12%, and health promoters constituted 10%. Interviewees (n=19) were only selected from the frontline clinician sub-groups i.e. the PHC nurses and health promoters. The representation by discipline within the participant group was relative to their representation within the employee population across services in Ekurhuleni. The representation of Health promoters within the final sample of interviewees was notable lower than expected considering that all the clinics have a health promoter to give health talks at clinic level and community level about prevention and promotion of healthy life styles and the management of support groups. This was a consequence of two related factors i.e. some of the facility heads were initially employed as Health Promoters but had chosen to describe their discipline identities as Facility heads rather than Health promoters. Secondly, a number of the teams had vacancies for health promoters, which they had not yet recruited into.

**Figure 4.2 Respondent's occupational ranking**



The clinician representation as a percentage of the whole of the EMM Primary health care team offered interesting insights into the availability of practicing clinical staff, compared to non-clinicians and in particular, it helped to offer possible explanations for the pressure of work reported by the primary health care practitioners in their day to day working. Figure 4.3 below further illustrates the range of expectations that PHC clinicians had placed on them with regard to the range of roles that were identified as key promotive activities. Understanding the range of health promotion activities engaged in, offered important insights into the likely day to day roles and activities that were typical of a clinicians' working routine.

**Figure 4.3: Respondents' health promotion activities**



The daily health promotion activities that EMM clinicians engaged as a proportion of their full working day are shown on Figure 4.3. These activities include the following:

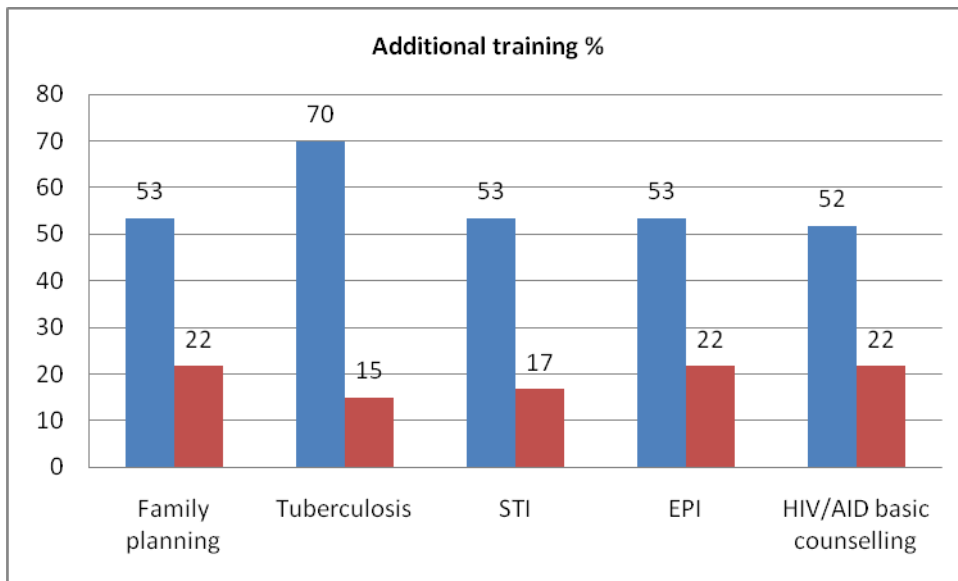
- providing health talks at the clinics on daily basis, according 38% of the respondents;
- conducting home visits, as shown by 10% of the daily operations or activities;
- visits to nursery schools, attested to by 12% of the respondents; conducting awareness campaigns, as shown by 10% of the respondents. This section under Figure 4.3 is in consort with the question: “How often do you undertake the following activities?” Clinic operating hours accommodate “...conducting awareness campaigns.” This coincides with the research finding as documented in the doctoral thesis (Netangaheni 2009)
- conducting door-to-door campaigns during outbreaks, which represented 15% of daily activities.

It is notable that each of the commonly identified key roles within a PHC working environment are time intensive activities that need to be repeated numerous times before the expected positive health effects can be realised. As a consequence, it becomes clear that the need for repeated reinforcement of health actions places an additional resource pressure that restricts an already pressurised service area.

Literary sources that have looked at some of the barriers that exist in the implementation of effective PHC services have alluded to the possible involvement of clinicians’ limited training in PHC work as a restrictive factor (MacDonald 2009). As a way to gaining insight into this, the pre-interview questionnaire collected information of participants’ recent history of training which they believed to have added value to their effectiveness as workers within their work in the PHC field. It is noteworthy that all PHC workers were expected to have a diploma in Primary Health Care, for them to be seen as a validated primary health care worker.

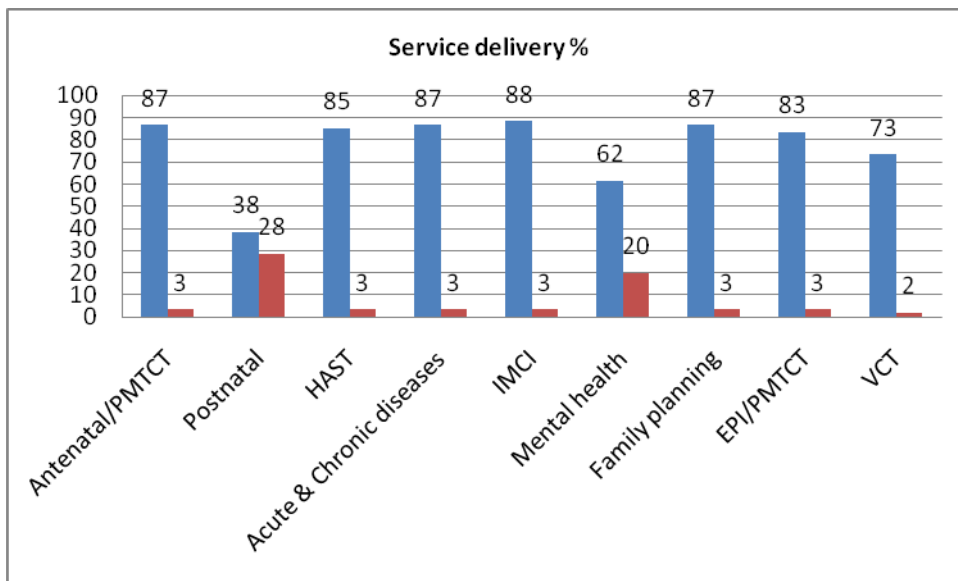


**Figure 4.4: Recent additional training (within the last 12 months) within the Public Health related areas.**



According to figure 4.4 above, 53% of the sample completed a short course in Family Planning while only 22% has not done or completed the course. Similarly, 70% of the population size completed a course in Tuberculosis while 15% has not yet done so. It was notable that none of the respondents confirmed having had training in other key PHC focus areas such as mental health. This issue was explored with some of the respondents who suggested that the focus of their development had, in recent years, focussed on areas of practice that related to HIV/AIDS as an illustration of the dominance of HIV/AIDS in most of their day to day work.

**Figure 4.5: Level of service delivery to the public**



The schematic presentation above is a clear indication of the unambiguous function of prenatal services and the Prevention of Mother-to-Child Transmission of HIV to the unborn child. This is one of the most important preventive measures in PHC.

87% believe there is a high level of service delivery of antenatal/, and only 3% of respondents doubted service delivery.

**Figure 4.6: Curative services**

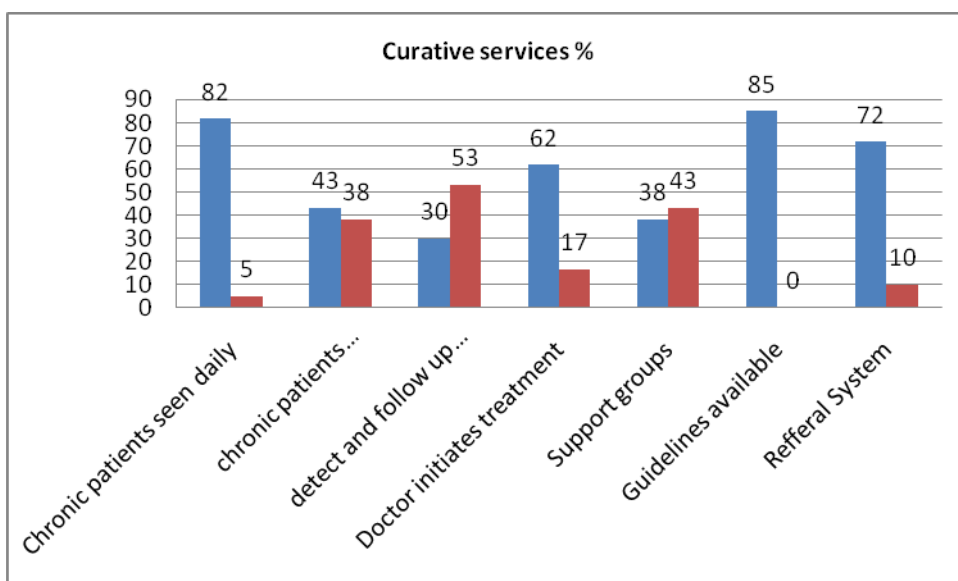


Figure 4.6 above indicates that with regard to the curative services, 82% of chronic patients are seen daily, and also that 85 % of the healthcare provision centres have guidelines on patient management. This is disproportionately high compared to promotive and preventive care areas where clients can be seen as infrequently as once a month. This further illustrated a need for a reevaluation of the imbalance between curative provision and preventive provision within the EMM area.

During the interviews a number of key themes emerged with regard to clinicians experiences of working towards the achievement of PHC principals at EMM. The emergent theories were recorded in distinct categories as detailed below: -

#### 4.5 RESTRICTED INTEREST IN PROMOTIVE ACTIVITIES .

Nearly all participants (n=17) highlighted, during their interviews, that they felt that the “real interest” of the employing authority lay in dealing with acute health issues rather than focusing on Health Education, Health Promotion and prevention. One of the respondents captured this viewpoint well on the response: -

*“My weekly work schedule is focused on duties to do with treating people who are already unwell. My plans to do Outreach health promotion always gets postponed because of more pressing demands from management to work with Acutely ill individuals” (Participant – 16).*

This general view was typified by other respondents and communicated a general view that management was only paying lip service to promotive and preventive interventions and that instead, the day-to-day expectations focused primarily on the curative and rehabilitative aspects of practice. This observed pattern concurs with previous research in Health Promotion, which has repeatedly shown that policy makers often overlook Health Promotion interventions – in preference for a focus on the more immediately recognisable benefits of working with acute health problems.

#### 4.6 OVER-EMPHASIS ON YEAR-TO-YEAR MEASURABLE

Secondary to a limited bureaucratic interest in promotive and preventive interventions, participants felt that the prioritisation of short-term measurable made the PHC principles of prevention and community engagement less preferred because the outcomes related to these were often long-term and not immediately evident. This long-term impact associated with PHC activity was seen as being unpopular in a context that bases its measurement on success and failure using yearly review cycles. This observation is well captured by one of the quoted participant responses,

*“My manager wants to know how many patients the team has treated, and doing preventative work is never measured. No one really accepts the resources we save by preventing things before they happen. We only focus on people we have cured”. (Respondent 8)*

#### 4.7 PROMOTIVE HEALTH INTERVENTIONS ARE TOO LABOUR INTENSIVE

The general view that PHC as a way of working was more time intensive than alternative approaches, was alluded to by respondents in varied ways. As noted above, the view that a curative focus yielded more expedited results expanded on by some of the participants who felt that all the core principals of PHC may have been overly ambitious especially in a time of service reductions in all areas. This view was contradicted by some respondents who argued that the difficulties they had experienced with implementing PHC principles was in part, a result of the fact that the prescribed principles were overly westernised and did not transfer well to the South African context where patient populations were more significantly disempowered, and only often sought help after they had become ill. As a result, the focus on curative interventions was in response to this more an evident need rather than a clear rejection of principles such as

1. Community Involvement.
2. Preventive Interventions.

#### 4.8 PHC PRINCIPLES ARE NOT WELL UNDERSTOOD AND THIS MAY HAVE BEEN A CONSEQUENCE OF UNMET TRAINING NEEDS THAT EXISTED FOR CLINICIANS.

The issue of training with regard to PHC was not as frequently expressed, but the four respondents who noted this, were very explicit in their assertion, that they had not been trained exclusively in PHC but that their pre-registration training had emphasised competency development in curative and rehabilitative skills. As a consequence of this, practitioners felt more ready to offer expertise with curative and rehabilitative aspects of nursing. In particular, the primary health nurses identified a need for training. Notably, the health promoters (n=6) interviewed expressed greater levels of confidence in skills such as patient empowerment; community participation, behaviour modification and they attributed this to their basic training as health promoters.

#### 4.9 PATIENTS DO NOT ALWAYS RESPOND WELL TO HEALTH EDUCATION – PATIENT EMPOWERMENT GONE

Importantly, some of the participants drew attention to the fact that many of the activities that they engaged in as part of their primary health care function were not always received well by patients and service-users. One respondent spoke about the work that she had been doing on substance-misuse and described recurrent difficulties with non-receptive patient populations to extents where she felt that the public actually complied more with curative involvement rather than the promotive work central with PHC activity. Further to this, there were views expressed that suggested that service provision did not take account of the relatively more substantial investment that was needed to initiate preventative drives by comparison to curative activities.

#### 4.10 FOCUS ONLY ON SERIOUS PHYSICAL ILLNESS.

Most interviewees (n=15) strongly echoed the view that HIV/AIDS had become the primary focus of all service activity primarily because of the scale of the problem and general governmental interest- so much so that any issues that did not relate directly to HIV/AIDS were automatically demoted to a lower priority. By this observation, it

was evident from participant responses that HIV/AIDS and other related physical illnesses had very clear protocols for service delivery whilst by contrast, the less well defined activities such as “patient empowerment” and “community engagement” were seen as soft goals and had no specified budgets to support them. The response from one of the participants captures this well as shown below: -

*“HIV/AIDS is where the interest in our department lies. All our funding has to do with that and any preventative work we do is only related to that...it seems like we have all forgotten that there is more to health than HIV/AIDS. I can't do awareness work on nutrition and health when all we think about is HIV.” (Respondent 8)*

The confirmation of this disparity offered important insights into some of the challenges that have limited the implementation efforts in some areas of primary health care.

#### 4.11 PERCEPTIONS THAT PHC APPROACHES ARE INEFFECTIVE

The stark absence of promotive health activities in the summary of EMM's areas of activity in Figure 4.5, quoted earlier, indicates that there is still emphasis on curative and preventative healthcare delivery. In this regard, it still demonstrates that concerted efforts still need to be utilised to educate and train the community on the importance of PHC. As part of the interview, each participant was asked to specify the single most important factor that they believe had influenced the imbalance in service focus. The view that “PHC approaches are seen as being too long term and ineffective” was the most commonly reported barrier and participants believed that policy makers needed to be educated to understand the need for prevention and the long term benefits that it facilitated. The general view was that, short-time thinking within the political arena resulted in programmes that only lasted the political term of the ruling party and that this approach was in total contrast to the ethos of PHC which focuses more on generational improvements to health outcomes.

In addition to feedback on the general barriers that existed within EMM service areas, some of the participant feedback referred to operational issues that increased the challenges of delivering effective service. These were recorded separately as

operational factors and included factors such as unsustainable nurse-patient ratios, lack of follow-up services for clients who defaulted from treatment and general geographical challenges that made service delivery complex.

#### 4.12 NURSE PATIENT RATIO

The participants felt that the nurse-patient ratios were unfavourable to engaging in preventive and promotive work and aligned better with curative working practices. For example, clinicians described having to see about 35 patients per day according to the norms and standards of PHC, this would be impossible if they focussed attention on health promoting activities as well. The feeling was that, in traditionalist promotive working environments, clinicians may only see 10 patients per day and that this ratio was well beyond what EMM was able to support (MacDonald 2009). Most of the EMM participant's responses seemed consistent with this narrative statement:

*On average, it is 35 patients per nurse per day that we are asked to aim for. This mostly applies to PHC curative services, as we focus on Family Planning and immunization, usually one nurse can consult more than 35 patients per day (Respondent 12).*

More intensive attitude changing interventions were not supported as clearly within EMM provision of PHC services.

#### 4.13 COMMUNITY PARTICIPATION

From the perspective of the EMM directorate, the Community participation programme centred on approaches that gave the community a voice to express their views about health services. In most clinics, this was usually in the form of suggestion boxes and effective complaints management procedures. This view of community participation was much more limited than that described by Collins & Green (1994), who see community participation as the active involvement of community members at all stages of service development i.e. from service design to service evaluation. By that definition, the EMM model of community participation did not fully reflect the principles of PHC. One respondent drew attention to this and in so doing reflected on his experiences in another service area.

*“Community members only get involvement in complaining about the services we offer- I had hoped that we would engage the community in discussing how best to design future services to meet their needs...I’m never sure that we meet their needs with what we offer”. (Respondent 5)*

#### 4.14 CHALLENGES WITH WORKFORCE TURNOVER

Some of the respondents identified difficulties associated with frequent clinician turnover as a source of difficulty that hindered the development of cohesive response teams. Within their responses, clinicians (n=6) reported unacceptable high rates of staff turnover. One respondent offered a possible explanation for this in his response.

*“Half our team are employed by the Local government and the other are employed by the Province and over time staff move from one employer to the other depending on the remuneration packages on offer at the time. I have moved from one employer to the other 3 times in the last three years just to keep up with the salary changes. Every new role requires that I spend some time orientating myself and not doing active clinical work”. Respondent 4.*

#### 4.15 CHALLENGES WITHIN PHC DELIVERY

According to EMM (2004), 88 % of service rendered at clinic level is curative care, as compared to preventive and promotion of health. There are financial problems, as it is expensive to render curative as compared to preventive services. There is a shortage of qualified staff to render the service; there is shortage of medicine and equipment. There is also a high percentage of staff losses as they seek “greener pastures abroad”. HIV/AIDS and TB are very high in EMM. HAST needed more resources, especially with the rollout of HIV/AIDS from the hospitals to the clinics. Nurses complained that they worked as doctors and pharmacists on a daily basis, rather than act as promoters of holistic health.



#### 4.15 CONCLUSION

The above narrative statements and reported findings reveal that respondents agree that there was some dominance of curative services for chronic ailment whilst, focus on preventative and promotional services seems to be limited. Participant's views highlight a number of areas that pose challenges to them in trying to adhere to purist PHC principles. In particular, participant responses identified an over-emphasis on short-term curative interventions along with a generalised lack of financial commitment to PHC principles as one of the primary challenges that limited progressive changes within EMM health services. Issues relating to a lack of specialised training within the practitioner population also restricted the efficacy of interventions. Community participation is not implemented in its widest sense and needed to be better understood as a concept.

## CHAPTER FIVE

### RESEARCH FINDINGS, RECOMMENDATIONS AND CONCLUSIONS

#### 5.1 INTRODUCTION

The purpose of the research project was to identify the range implementation challenges that existed within the Ekurhuleni health district in adhering to the principles of Primary Health care as initially identified with the Alma Ata Declaration (WHO 1978). Qualitative Data was primarily obtained via semi-structured interviews of a sample of practising clinicians in the Ekurhuleni catchment area. Using Miles & Huberman's (2004) quote methodological considerations for this project included the clarification and description of "...the ways people in particular settings come to understand, account for, take action, and otherwise manage their day-to-day situations" (Miles and Huberman, 2004:7); and to eventually suggest recommendations to assist primary healthcare practitioners to be more efficient and effective in primary health care service delivery.

Primary health care services form part of a comprehensive health service and have been described by the World Health Organization as "essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford (WHO, 1978). Following the Alma Ata Primary Health Care World Conference, the World Health Organization had to lay down certain basic principles for the organization of Primary Health Care Services:

- Primary health care should be shaped around life patterns of the population and should meet all the daily needs of the community;
- It should form an integral part of the National Health Care Service, and the other levels of health care services should be designed to support the primary health care services;
- Primary Health Care services should be integrated with other services concerned with community development, such as agricultural (poverty alleviation), educational services and communications;

- The local population must be actively involved in all health care activities. Community participation plays a very important role in addressing health related issues, hence the formation of Primary Health Care Facility Committees;
- PHC should offer a comprehensive approach of promotive, preventive, curative and rehabilitative services.

Ekurhuleni's model of care focussed more explicitly on curative and rehabilitative aspects with very limited attention on the promotive and preventive aspects and as a result fell short of achieving complete fidelity to the PHC standard. The current study looked specifically at clinician attributions for the limited focus on preventive and promotive care aspects as an initial step. Clinician perceptions of barriers to the achievement of the gold standard of PHC gave meaningful insights into areas of practice where clinicians perceived a need for support. In summary, clinicians identified seven specific areas where barriers to practice were evident. These included

- (i) generalised lack of active interest by policy makers in promotive activities as a result of a more reactive stance to health care.
- (ii) A tendency towards short-termism in which the easy-to-measure impact from curative interventions was preferred over the more long-term goals those are associated with preventive and promotive interventions.
- (iii) A view that promotive and preventive health interventions were overly labour intensive and the health authority did not have the resources to sustain likely manpower requirements.
- (iv) A lack of understanding and clarity about the whole range of interventions that are encapsulated within PHC.
- (v) Less-than-promising responses from patients when exposed to promotive and preventive care practices.
- (vi) An exclusive focus on reactive health care related to HIV/AIDS with limited focus on non-physical illness and gradual behaviour change within client groups and
- (vii) finally a perception that preventive and promotive interventions were not entirely effective.

Each of these themes gave the basis upon which the researcher was able to develop a responsive set of practice recommendations, which are detailed below.

## 5.2 RECOMMENDATIONS

The study of challenges that clinicians experience when working within a PHC context – particularly in working towards promotive and preventive objectives, has offered important insights into areas that warrant some attention. Primary Health Care should focus more on prevention of disease and promotion of health especially as the evidence reviewed in advance of the current study showed a disproportionate preference for curative and rehabilitative service provision. Health promotion should be the core concept of Primary Health Care especially as it is hailed as the cornerstone of prevention of more serious and more costly health conditions in the medium to long term. These and other noted imperatives form the basis of the ten practice recommendations being suggested here.

### **Recommendation One: Re-orientate service design to increase fidelity with the primary principles of PHC as articulated within the Alma-Ata Declaration.**

Current service designs lend themselves to a disproportionate focus on curative and rehabilitative services. There is a need for local services to look at service models from areas that have successfully adhered to the Alma-Ata principles. One area where this could be done is by encouraging the development of more community led services in which members of the public have a greater voice.

### **Recommendation Two: Development of a Reward System**

Current service configuration rewards those areas and teams that perform best in terms of curative aspects. Primary health care systems need to be re-organized in such a way as to create incentives for the PHC practitioners to show improvement in the delivery of prevention services through health education, campaigns on immunization, HIV/AIDS, mental illness, breast and cervical cancer screening, breastfeeding, promotion of healthy lifestyles; including collaborating with other units to increase community involvement.

### **Recommendation Three: Facilitating task-specific training for Health Promoters and PHC Clinicians**

The study showed a general requirement for clinicians to receive more specific training about working within a PHC service area. Most clinicians had developed skills in PHC work through experiential learning. Eventual competence in areas such as health promotion was an exclusive result of “on-the-job” experience. This is unacceptable especially as PHC is in itself a speciality that requires specialist clinical skills that represent the entire spectrum of promotive, preventive, curative and rehabilitative competencies.

### **Recommendation Four: Educate Policy Makers about the real gains of Preventive and Promotive approaches through a rational-empirical approach**

Some of the limited focus on preventive and promotive aspects of PHC was attributed to a general lack of understanding of the long-term benefits associated with these, amongst policy makers. One way of addressing this may be for EMM to develop a basic training programme for policy makers, which looks at the empirical support for preventive and promotive care approaches.

### **Recommendation Five: Develop and utilise more comprehensive Empowerment models that invite real community participation at all levels of service development.**

Exploration of existing community participation drives within EMM showed a need for more profound engagement of the public –well beyond the use of suggestion boxes. There is a need for more explicit community engagement efforts that engage the wider public community in all areas of service delivery from conception to evaluation.

### **Recommendation Six: Challenge the principle of short-termism.**

One of the barriers repeatedly echoed by study participants and indeed within related literature, is the fact that discussions about PHC have tended to be short-sighted often neglecting the midterm to long term benefits that are likely to form preventive and promotive interventions. Within current services designs, EMM conducts yearly

evaluations of service performance and in so doing; they overlook the salient impacts that health promotion activities are having on the health of the community.

### **Recommendation Seven: Multidisciplinary Collaboration**

Collaborative efforts, engaging and interacting with other members of the multidisciplinary sector is necessary to elicit support and to harmonise the use of resources. It was clear from the interviews that different disciplines within the PHC sector had differing expertise and that much would be gained from the sharing of expertise across disciplines e.g. the Health promoters within the study group reported exceptional competence with health promotion activities and less confidence in curative work. By contrast, generic nursing staff expressed the exact opposite skill distribution. If utilised appropriately, this skill mix could offer rich cross learning between disciplines.

### **Recommendation Eight: Resources**

The primary health care practitioners need to be encouraged and enabled to augment resources for their personal and professional development through research and participate in both national and international conferences. Fundraising events to generate funds are necessary to encourage further development.

### **Recommendation Nine: Primary health care as specialty**

Primary health care service (as a requirement) specialty for the nurses would enable them to render a comprehensive primary health care service and they will play a very important role in the implementation of primary health care services. Much like other areas of nursing e.g. intensive care nursing, PHC nursing should be seen as a specialty in its own right and it is here that the spectrum of PHC principles could be indoctrinated to PHC practitioners.

### **Recommendation Ten: Role Clarification for Health Promoters**

The health promoter's role should be well clarified and their capacity to give health education at the clinic's and the community is tangible. Currently the health

promoters are providing and being used as administrative staff at the facility and only assist if there is a need. There is lack of or insufficient information on health and diseases, it is important for community members in particular to get information on primary health care aspects.

### 5.3 LIMITATIONS OF THE STUDY

This study was designed as a dissertation of limited scope as required for the study programme the researcher was registered on and as a result, the chosen focus had to be appropriately limited. This required a very specific focus on the identified study and associated methodologies utilised within the study hence the decision to focus only on clinicians and to conduct a primarily qualitative enquiry into the clinician viewpoints of 19 practitioners currently working in clinical roles within Ekurhuleni Metropolitan Health Department. The small sample size was typical of qualitative research and allowed for very in-depth discussions of issues with participants in ways that would not have been possible with much higher participant numbers. Geographically, it is important to note that the study was only done in the Southern Mancho Area of the Ekurhuleni Metropolitan Municipality, in Gauteng, South Africa. This will have impacted on the generalisability of findings to other populations in different settings.

- Even though the percentage of the health promoters who responded was relatively low as most of them were participating in the awareness campaign during data collection the researcher managed to acquire data saturation through triangulation of data collection methods;
- The Southern Region consists of 32 facilities, and the study was only done at 16 facilities due to resource limitations and the limited scope of the study. With access to greater resources, the researcher would have preferred to cover the entire spectrum;
- Finally; the conditions under which the research project was conducted may have made it difficult to get even a larger sample size. The impact on the measles outbreak coincided with the collection of data for this research project. The so-called “catch up campaign” kept the primary health care practitioners unusually busy. For ethical reasons, incentives for participation were not available.

#### 5.4 CONCLUSIONS

Primary health care (PHC) was identified as the vehicle by which Health for All would become reality (WHO, 1978). It was seen as a solution to the inadequate illness management systems that had developed throughout the world. The Philosophy underpinning PHC is that of social justice, which seeks to bring a personal state of well being within reach of everyone in a given country. In its purist form, PHC practice involves practice across the promotive, preventive, curative and rehabilitative spheres and it is in this form that it was seen as the cure for the world's health difficulties. The reality of implementing PHC in line with the principles set out in the Alma Ata declaration has been fraught with difficulties. The current study explored clinician explanations of the range of barriers that have resulted in the incomplete application of PHC within the Ekurhuleni Municipality and doing so offered a number of possible actions that could be implemented to increase fidelity to the key PHC principles.



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## ANNEXURE A: RESEARCH REQUEST SUPPORT

Prof. O.N. Makhubela-Nkondo  
UNISA  
University of South Africa  
Department of Health Studies  
TVW 7-151  
Muckleneuk Campus  
Tel: 27-12-4296588  
Fax: 27-12-4296688  
Email: [makhuon@unisa.ac.za](mailto:makhuon@unisa.ac.za)  
22 December 2008



Dr. M.I. Mashazi  
Head of Health Department

### **Research request support** A.M. Ndhambi – Student number 8039054

This letter serves to support the request that permission be granted for a postgraduate student to undertake her research at your health institution and to authenticate the candidature of Mrs. Angeline Mshoni Ndhambi; as an enrolled student at the University of South Africa pursuing her Master's degree in the Health Studies.

The Clearance Certificate also signals acquiescence for the candidate to resume the research should your institution deem it necessary. Please contact 012-4296588 should you need additional information in this regard.

Sincerely

A handwritten signature in black ink, appearing to read "O.N. Makhubela-Nkondo".

Professor O.N. Makhubela-Nkondo  
Department of Health Studies  
University of South Africa



University of South Africa  
Preller Street, Muckleneuk Ridge, City of Tshwane  
PO Box 392 UNISA 0003 South Africa  
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150  
[www.unisa.ac.za](http://www.unisa.ac.za)

## ANNEXURE B: APPLICATION TO CONDUCT RESEARCH

LETTER SEEKING CONSENT FROM THE EKURHULENI METROPOLITAN MUNICIPALITY DEPARTMENT OF HEALTH.

P.O.BOX 2518

Alberton

1450

03 December 2008

Head of the Health department

Ekurhuleni Metropolitan Municipality

Alberton

1450

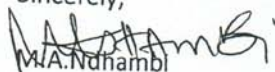
Re: Application to conduct research study

I am currently enrolled in masters degree in health studies with the University of South Africa; I am expected to conduct a research study as a requirement for the degree. I request your permission to conduct this study in the Ekurhuleni Metropolitan municipality.

The topic for the research is Primary Health Care services in the Ekurhuleni Metropolitan municipality.

This is both quantitative and qualitative study which involves the use of a structured questionnaire to collect data. Please feel free to contact me at this number (0823378810) if there are questions.

Sincerely,

  
M.A. Ndhambi

**ANNEXURE C: CLEARANCE CERTIFICATE**

**UNIVERSITY OF SOUTH AFRICA  
Health Studies Research & Ethics Committee  
(HSREC)  
College of Human Sciences**

**CLEARANCE CERTIFICATE**

Date of meeting: **20 October 2008** Project No: **8039054**

Project Title: **Primary Health Care Challenges in the Ekurhuleni Metropolitan Municipality.**

Researcher: **Ms M.A. Ndhambi**

Supervisor/Promoter: **Prof ON Makhubela-Nkondo**

Joint Supervisor/Joint Promoter:

Department: **Health Studies**

Degree: MA Cur

**DECISION OF COMMITTEE**

Approved



Conditionally Approved



Date: **4 November 2008**

**Prof L de Villiers  
RESEARCH COORDINATOR: DEPARTMENT OF HEALTH STUDIES**

**Prof SM Mogotlane  
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES**

**PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES**

## ANNEXURE D: Approval to conduct research

# Memorandum



**Ekurhuleni**  
METROPOLITAN MUNICIPALITY

Southern Service Delivery Region  
ALBERTON SERVICE DELIVERY CENTRE

Health Department

Civic Centre  
Alwyn Taljaard Street

P O Box 4  
Alberton  
1450

Tel: (011) 861-8865  
Fax: (011) 861-2134  
www.ekurhuleni.com

To: Mrs.M.A.Ndhambi

Ref:

From: Dr. I. Mashazi

Enq: Dr. Mashazi

E-mail: imogenm@ekurhuleni.com

Date: 12 January 2009


**SUBJECT :APPROVAL TO CONDUCT RESEARCH:PRIMARY HEALTH SERVICE DELIVERY IN EKURHULENI METROPOLITAN MUNICIPALITY**

Approval is granted to conduct the above study in the Ekurhuleni Metropolitan Municipality (Southern Region).Kindly make arrangement with the director special programmes (Research) and the Regional Manager clinic services for suitable times and dates..

The letter should be attached to the Questionnaire.

Hoping that the results of the study will be use to improve the quality of primary health care services in Ekurhuleni.

Kind regards

  
DR. I. MASHAZI  
ED: HEAL

## ANNEXURE E: PRE-INTERVIEW QUESTIONNAIRE

1. For the sake of confidentiality your name or any other information that will reveal your identity will not appear or asked from you. All information will be treated with the utmost confidentiality and anonymity at all times
2. Please ensure that you answer with an (X) in the appropriate box, except where a specific answer is requested.
3. Section 1, please answer all the questions.
4. Section 2 – a semi-structured interview.

### PRIMARY HEALTH CARE PRACTITIONERS PROFILE

#### 1. Demographic characteristics

Please circle the appropriate (applicable) number

- (a) Category or Directorate (Circle only the number that is most appropriate)

Primary health care nurse-----	1
Community health nurse-----	2
Health promoter-----	3
Other-----	4

- (b) Age (Circle one number that is most appropriate)

21-30-----	1
31-40-----	2
41-50-----	3
51-60 and above-----	4

- (d) Gender

Male -----	1
Female -----	2

(d) What is your highest qualification related to Primary Health care work.

**(Circle one number that is most appropriate)**

- Short course (duration less than 6 months)----- 1
- General Nurse training----- 2
- Diploma in Primary Health----- 3
- Specialist practitioner Course(Primary Health)-- 4
- Other----- 6

**2. Professional qualifications**

What is your highest professional qualification as a PHC service provider?

No	Qualification	Yes	No
1	Diploma in Primary Health care	1	2
2	General nursing	1	2
3	Community health nursing	1	2
4	Nursing administration	1	2
5	Nursing Education	1	2
6	Midwifery	1	2
7	Psychiatry/Mental health nursing	1	2
8	Dispensing license	1	2
9	Other Health Allied course	1	2

**3. Additional Qualifications**

Have you completed the following short courses?

No	Qualification/Short courses	Yes	No
1	Family planning	1	2
2	Tuberculosis	1	2
3	STI	1	2
4	EPI	1	2
5	HIV/AIDS basic counseling	1	2
6	PMTCT	1	2
7	IMCI	1	2
8	VCT	1	2

Please specify.

1 (d) Please prioritise the most important aspects of your job in order of importance to you (starting with most important).

- |                             |   |
|-----------------------------|---|
| Promotive health care-----  | 1 |
| Preventive Health care----- | 2 |
| Curative -----              | 3 |
| Rehabilitative -----        | 4 |

Answer : - please list in order of importance starting with most important first.

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Reason for choice:- please justify/support your answer with a brief rationale for your decision.

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Thank you for taking part in the brief pre-interview questionnaire. You will now take part in a short interview in which I will ask you some questions so I can better understand the challenges that you faced in implementing Primary health care principles.

## **SECTION B – SEMI-STRUCTURED INTERVIEW**

1. Please can you explain what your role is within the Primary Health care service is? What are the key responsibilities of your position?
2. Please explain, what activities you are engaged in, an average day? (Participants should be directed to discuss how their time is divided out between job related activities).

### **Health promotion-**

- (a) What aspects of your role do you see as serving a health promoting function?
- (b) How does your service promote / support health promotion activities?
- (c) What are the examples of health promotion strategies currently being implemented within your locality?
- (d) What challenges do you face in delivering health promotion? (Participants should be prompted to discuss the availability of support to undertake health promotion- what barriers they have experienced and how they feel that these barriers could be minimised?)

Community participation – how does your service promote community participation?  
Additional prompts – (a) Do you have a clinic committee, and is it active? (b) Do you have a suggestion box at the clinic?

How are community members engaged in primary health issues? What barriers have you experienced in facilitating community participation? What interventions do you think could help to reduce the impact of the barriers that you have identified?

### **Preventive care**

- (a) What aspects of your role do you see as serving a preventive care function?
- (b) How does your service promote / support health preventative activities?



- (c) What are the examples of health prevention strategies currently being implemented within your locality?
- (b) What challenges do you face in delivering preventive services? (Participants should be prompted to discuss the availability of support to undertake preventive work- what barriers they have experienced and how they feel that these barriers could be minimised?)

## **CURATIVE CARE**

Curative Care-

- (a) What aspects of your role do you see as serving a curative care function.
- (b) How does your service promote / support curative care activities?
- (c) what are the examples of curative strategies currently being implemented within your locality?
- (b) What challenges do you face in delivering curative care services? (Participants should be prompted to discuss the availability of support to undertake curative work- what barriers they have experienced and how they feel that these barriers could be minimised?)

## **REHABILITATIVE CARE**

Rehabilitative care-

- (a) What aspects of your role do you see as serving a rehabilitative care function.
- (b) How does your service promote / support rehabilitative care activities?
- (c) what are the examples of rehabilitative care strategies currently being implemented within your locality?
- (b) What challenges do you face in delivering rehabilitative care? (Participants should be prompted to discuss the availability of support to undertake rehabilitative care - what barriers they have experienced and how they feel that these barriers could be minimised?)

Thank the participants for their involvement and reassure them again that their responses will be kept confidential.

## **ANNEXURE F: LETTER TO RESPONDENTS**

**P.O.BOX 2518  
ALBERTON  
1450**

### **CONSENT FORM (FOR PHC Service Providers)**

Dear colleague,

I am registered with the University of South Africa, as a Masters student in the Department of health studies. I have to fulfil the academic requirements as stipulated by the university by conducting a research on Primary Health care services in Ekurhuleni Metropolitan Municipality.

You have been included to participate in the study towards the improvement of PHC services. There will be no payments for participating in this study, as it is voluntary.

You are requested to complete the questionnaire by marking the appropriate box with an X, as an affirmation with the statements. Anonymity will be maintained, and all collected data will be held in strict confidentiality. This means that your name should not be included in the questionnaire; only a number will appear for administrative purposes. Only the researcher and those who assist will have access to the information you provide.

Thank you very much for your co-operation.

Yours sincerely,

M.A.Ndhambi