QUALITY MANAGEMENT: BARRIERS AND ENABLERS IN A CURATIVE PRIMARY HEALTH CARE SERVICE

by

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DECLARATION

I declare that **QUALITY MANAGEMENT: BARRIERS AND ENABLERS IN A CURATIVE PRIMARY HEALTH CARE SERVICE** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

SIGNATURE   DATE

………………………

(CORNELLE UYS)

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DEDICATION

Dedicated to:

-the memory of my father TA (Babbie) Robertson whose life will always be remembered as a mover and a shaker

-my mother, Anemone Robertson, who provided love, stability and taught me endurance

-my children Simone and Robert who taught me about unconditional love and unending patience

QUALITY MANAGEMENT: BARRIERS AND ENABLERS IN A CURATIVE PRIMARY HEALTH CARE SERVICE

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ABSTRACT

Curative primary health care nurses are the first level of contact with health personnel the patient has when entering the district-driven health system of South Africa. It is imperative that these nurses are competent, or patients may suffer. Several factors exist as barriers to competent curative care. Donabedian's structure-process-outcome framework has been used in the study of these factors. Literature were selected from international and national studies of nursing to discover barriers and enablers in general nursing care but also specifically in curative primary health care.

The curative primary health care nurses in the Southern Cape/Karoo region were used as a sample for the study. Data gained from questionnaires were organised to present the findings: Barriers to a curative PHC service seem to be multifactorial, with scarce resources causing great

stress for the workforce. This have a negative impact on relationships between employer and employee, CPHCNs and their patients, the type of managing that take place, and the quality of the examination and treatment of patients. Slow changes frustrates workers, causing more stress and poor attitudes, feelings of not being valued, and not being motivated (internally and externally).

Enablers examined showed that although the workforce may be discontented and overworked, they still try to deliver their best, with few medical mistakes. Patients still have a lot of respect for their healthcare deliverers, but this trend may not continue for much longer. Patients are already returning more often to clinics, causing even more stress for staff.

KEY CONCEPTS

Curative primary health care, community health nursing, structure, process, outcome, district health system.

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LIST OF ABBREVIATIONS

PHC   primary health care

CPHCN   curative primary health care nurse

SANC   South African Nursing Council

PAWC Provincial Administration of the Western Cape

EDL   Essential drug list

Pts   Patients

Drs   Doctors

CHAPTER 1

OVERVIEW OF DISSERTATION

1.1 INTRODUCTION

Curative primary health care nurses (CPHCN) are the first level of contact with health personnel when entering the district-driven health system of South Africa. Therefore they should be competent enough to stand in for a medical practitioner and pharmacist where none are available. On this level health complaints are sorted out - attended to or referred to the next level where the medical personnel functions.   It is necessary that the skills used at this level are optimal, or the whole system fails. An organisation is as strong as its <u>weakest</u> link. Matzner (1991: 92) says that the level of care in health departments is interdependent The excellent performance of one department and the poor performance in another results in overall average performance.

The CPHCN functions at the first level of care and are often accused of rendering poor care. Several factors contribute to the acquisition of poor health care delivered by the CPHCN on this level, e.g.

>lack of experience (Louwagie, Reid & Bachman 2001:1-10);
>lack of knowledge (Gwala 1995: 18;Louwagie et al 2001:1-10);
>poor motivation (Health Systems Trust 1996:9-11);
>lack of management support (Gwala 1995: 18);
>lack of evaluation by self/peers/management and thus lack of feedback about practice (Gwala 1995: 18) and
>unequal standards expected by the many different schools offering primary curative care (PCC) courses (Ntshona, 2000:3)

In spite of the apparent poor quality of services, there is a need for curative PHC services. Therefore there is a need to uplift the standard of care in on the curative PHC level.

Trim (2000: 24) quote the following as being enablers of quality nursing:
   professional development
   currency of knowledge
   professional competence
   monitoring and improvement of quality.

This study aims to examine barriers and enablers of quality care, experienced by CPHCN and their supervisors, in the rendering of a health service in local authorities of the Southern Cape/Karoo region.

1.2 BACKGROUND

It is necessary to examine why curative PHC services exists and to understand the purpose, role and necessity of these services in an South African context. This will be discussed below.

1.2.1 Objectives of Curative PHC and the role of a CPHCN

Curative PHC focuses on the prevention of diseases, trauma and disabilities by rendering health care timeously on the primary health care (PHC) level.

The Declaration of Alma-Ata in 1978 of "Health for all by 2000" introduces important components for PHC. The proper treatment of general diseases and injuries and the provision of essential drugs are two of these components (Searle, Brink & Grobbelaar 1990: 148).

The main attributes of a curative PHC service are:
 health advice about lifestyle, health needs and dangers from birth to death,
 early diagnosing and treatment of diseases,
 early referral of conditions to prevent serious disabilities (Searle et al 1990:151).

A South African post Alma-Ata workgroup has identified the role of registered nurses in PHC:
 assessing the needs of the individual, family, community and identifying the resources to meet these needs
 planning the nursing care
 implementing the plan
 evaluating the consequences
 documenting the process
 identifying areas for research to increase knowledge

educating nursing personnel and the public
collaborating with other disciplines to provide a service to the client
(Searle et al 1990: 153)

1.2.2 Responsibilities within levels of health care

In South Africa the government renders health care on primary, secondary and tertiary levels. The patient's entry to the system is on the primary level at a clinic or community health center (CHC). At this level the CPHCN sees the patient, diagnose and treat, or refer the patient to the doctor, which is sometimes either on the same level (day hospital/CHC), or on secondary level (hospital).

District hospitals function on secondary level. Patients are referred to secondary level if they need surgical or more intensive medical care.

Referrals to tertiary level are done from secondary level if specialist care is needed. Hospitals like Tygerberg, Rooikruis and Valkenburg are delivering tertiary care in the Province of the Western Cape.

1.2.3 Development and problems of curative health care services on primary level

South African registered nurses have been trained since 1982 (Regulation R 48, 1982) in rendering curative PHC. They have been practicing in clinics and CHCs. The shift from hospital-based care to care in the community necessitated this step. Another contributing factor was the insufficient ratio of state doctors to the population. Registered nurses with clinical skills to assess a patient, diagnose a condition and treat appropriately are pillars of support of the district health service (Ministerie van Gesondheid en Maatskaplike Dienste :Strategiese Bestuursplan 1995:31).

The declaration of free medical services for the whole population in April 1996 (Department of Health: 1996:1) had a massive influence on the caseloads of these CPHCN. Health budgets for service delivery has not been adapted to the increased population loads.

This placed a tremendous amount of strain on the country's nursing resources. Two other factors that are also affecting the nursing resources are:
the transfer of nurses from hospitals to clinics without the necessary training. Without any training and orientation in primary health care it can be expected that they will not function to their full potential.
Severance packages offered and marketing for overseas nursing jobs drained the country of skilled nurses (Geyer 1999:3) and CPHCNs are also lost to the private sector and middle management (Strasser 1999:8).

1.2.4 Distribution of CPHCNs

Strachan (1999: 8) quotes David McCoy: "There is a serious shortage of nurses who are competent in consulting, diagnosing and treating a patient". There is a desperate need for nurses with post basic training in primary clinical care nursing skills.

In December 1993 there were 1229 CPHCNs, in December 1998 this number increased to 3000 "...with some form of this training..." (Strachan 1999:6). The number of nurses trained with this qualification is not enough. Universities and provincial health departments run several training programs. These programs are poorly co-coordinated. There is also not enough attention paid to underlying factors like working conditions, that cause non-implementation of that which is learned (Strachan 1999:6).

Curative PHC services are maldistributed throughout the country. Strachan (1999:6) says that there are 3500 clinics staffed and managed by CPHCNs with little or no help from doctors. She quotes the following table from the 1998 South African Health Review to confirm her opinion:

Table 1.1 Percentage of clinics per 4 Provinces with CPHCNs

Province	% of clinics with a CPHCN nurse	Total clinics
Eastern Province	0.0	66
Northern Province	24.4	45
Gauteng	75	16
Western Cape	84.4	32

This table of available provinces shows that these CPHCNs are not evenly distributed; the Eastern Cape has the least (0%) in its clinics, while the Western Cape has a staggering 84,4% in its clinics (Strachan 1999:6). This correlates with data quoted by Brodie (2001:36) "the Western Cape has the highest ratio of health professionals relative to its population: 143,8:100 000".

1.2.5 Quality in health care:

Before the democratic dispensation in South Africa with the subsequent governmental changes in 1994, Green and Pinkney-Atkinson (1994:129) stated that "Questioning the quality of health care has not been part of the ethos of health care in this country. But patients are starting to challenge medical decisions. It seems as if accountability and consumerism have at long last arrived in South Africa".

Each level of health services is responsible for assuring quality of care given to the patient:

The State or Chief directorate is the policy-makers who develop policies, norms, and standards together with examining and statutory bodies (Department of Health 1997:26).
At Provincial level secondary and tertiary care are delivered; provincial health policies, norms, standards and legislation are formulated. This level is also responsible for quality control of all health services and facilities (Department of Health 1997:27).
Local districts render primary level care. At District level quality care should be assured by delivering of a comprehensive service which is effective, efficient, accountable locally and sustainable (Department of Health 1997: 27).

1.3   PROBLEM STATEMENT

There is no formal knowledge of the factors that influence the quality of health care given by CPHCNs. Before quality can be managed, an in-depth study should be done to investigate barriers and enablers that influence the quality of care rendered.

1.4   SIGNIFICANCE OF THE RESEARCH

No research findings could be found of research that had been done locally in the Southern Cape/Karoo region of the Western Cape or nationally in South Africa on barriers or enablers to quality PCC.

Nurses are accountable to their patients and society to provide quality cost-effective care, and to seek ways to improve that care. By doing this, positive patient outcomes are ensured (Burns & Grove 1997:4).

This study is important because it will increase knowledge and skills and change attitudes about quality curative PHC. Factors, which are barriers to deliver a good service as well as those, which enable delivery of a good service, will be identified. Solutions will be considered to identified barriers. Those factors that enable good service delivery will be made public and recommended to service deliverers.

1.5   RESEARCH QUESTION

The following research questions will direct this research:

what barriers do CPHCN and their supervisors identify that prevent the CPHCN to render quality curative PHC in the Southern Cape/Karoo region?

what enablers do these parties identify that help the CPHCN to render quality curative PHC in the Southern Cape/Karoo region?

what support systems do the CPHCN have in the Southern Cape/Karoo region to enable them to deliver a quality service?

1.6   OBJECTIVE OF THE RESEARCH

The objectives of this research therefore are as follows:

To explore and describe barriers CPHCNs and their supervisors experience in delivery of a quality curative PHC service in the Southern Cape/Karoo region.

to identify enablers to a quality curative PHC service in the Southern Cape/Karoo region.

to identify support systems for a quality curative PHC service in the Southern Cape/Karoo region.

to make recommendations for further research.

1.7   OPERATIONAL DEFINITIONS

It is necessary to define some terms that will be used in this research:

Quality health care: Muller (1988: 42) states that quality means different things to different people. The professional practitioner sees quality in professional performance. The client regards accessible and compassionate care as quality. Managers look for efficiency and fiscal stability. She observes that internationally, quality means safe, advanced, efficient and acceptable health care. To these last four dimensions of quality, Maxwell adds two more: relevance and equity (Dunn 1995:15).
Donabedian (Lancaster & King 1999:43) said that structural and procedural excellence, as well as positive outcomes reflect quality of care.

In this research, quality of care is seen as a combination of abovementioned factors, namely knowledgeable, compassionate, professional, efficient, safe care. It means that the CPHCN knows how to interview, diagnose, treat a condition or emergencies and refer the patient when necessary, and what health advice to render. It means that she is given adequate support from her supervisors and has enough resources available for her to perform these duties. It means that her supervisors as well as her clients are satisfied with her services.

<u>PHC</u>: Primary health care is the health care delivered to the patient on first level of contact. This care is preventative, promotive, curative and rehabilitative and aims to keep the patient out of secondary and tertiary health care institutions (hospitals), as these are quite expensive for the patient, as well as the state. The world has been concerned with promotion of primary health care for the last three decades; internationally countries have realised that this is the only cost-effective way to ensure that their nations stay healthy.

<u>Curative PHC</u>: This is the health care delivered by any registered nurse in the service of the Department of Health, a provincial administration, a local authority, authorised by the Director-General, Director of hospital services, medical officer of health, performed in the course of their service. It includes the following:

- the physical examination of individuals (clients)
- the diagnosing of any physical defect, illness or deficiency
- the keeping, supply, administering or prescribing of medicines
- the promotion of family planning (South Africa 1978: art.38a)

In this research curative PHC is the health care given by a trained PCCN on first level of contact with the patient at a clinic, mobile or community health centre (CHC). This includes examination, diagnosis and treatment or referral of a patient with a health problem. This involves more the curative aspects and less the promotive and preventative aspects of primary health care, although health advice is a big feature in this service.

Primary clinical care nurse (CPHCN): This is a registered nurse who did a SANC certified curative care course as stipulated under Regulation 48 of 1982 and its guidelines (SANC 1982) at a tertiary institution/hospital/Department of Health, enabling the person to practice in a local authority by examination, diagnosing, treatment of ill patients. This individual renders a curative service because the poor ratio of state/local authority-employed doctors to the number of non-private, non-paying patients.

In this research a CPHCN is a registered nurse delivering a curative service for a local authority: the municipality.

1.8   RESEARCH DESIGN

The research design is an overall plan, or blueprint, of how the research is going to be conducted (Polit & Hungler 1999:32, Mouton 2001:55).

The design of this study is quantitative, descriptive and contextual and exploratory in nature.

It is *quantitative*, as the variables are numerical and can be counted. The aim was to study the extent of the factors that are enablers/barriers to quality care. These enablers/barriers will be described as variables inter alia: age, level of basic and post basic education, amount of experience in the CPHC field, kind of CPHC course done, amount of years spent at the organisation.

It is *exploratory*, as the relationships between the variables and the cause-effect interactions between them will be examined, to explore the perceived problem and generate new knowledge about services and situations in the Southern Cape/Karoo region.

It is *descriptive*, as it is aimed at giving an accurate account of the characteristics of a particular group, the PCCN, as well as what entails a quality service delivered by them. It thus gives new meaning, describe what exists and comments on frequency of occurrences, as well as categorising them (Burns & Grove 1997: 30).

It is *contextual*, as the study was conducted in the PHC clinics/CHCs. It includes registered nurses delivering curative PHC, as well as their supervisors.

The methodology followed has been discussed in more detail in Chapter 3.

1.9   THEORETICAL FRAMEWORK

Donabedian (Lancaster & King 1999: 43), an American doctor acquainted the medical world with the idea of quality from an industrial perspective. He suggested that quality should be broken down in three main components. These components represent the various aspects of the whole production process.

The first component is the *structure* of the service. A health care service needs structural input to be able to function. These are matters like staff, infrastructure (buildings) and money.

The second component is the *process* of service delivery. Services are delivered in a certain way. If the way that they are delivered is not effective, e.g. staff is not well trained or is lazy, quality decrease.

The last component is the *outcome* of the whole exercise of service delivery and infrastructure input. This entail the result of the care given and input used, in numbers, e.g. the mortality rate, the number of patients seen and experience(satisfaction) of the clients.

It is obvious that these three components are interdependent and influence each other. Without infrastructure, no service can be delivered. Without service, a satisfactory outcome is impossible. Without outcomes measured, infrastructure and service delivery cannot improve.

In this study these components of Donabedian was used to study the status of CPHCNs and the barriers and enablers to service that exists.

The theoretical framework will be discussed in more detail in Chapter 2.

1.10 RESEARCH METHOD

The steps, procedures and strategies for gathering and analysing the data in a research investigation are called the method of research (Polit & Hungler 1999: 646).

1.10.1 Population and sampling

According to Mason (1997:70) professionals are the only people sufficiently informed to judge technical competence of care delivery systems. Professionals were used in this study to comment on barriers and enablers as well as the state of the quality of their care. The professionals used in this study were those that deliver curative PHC, as well as theirs supervisors.

The population was all the registered nurses working in the CHC's and clinics in the Southern Cape/Karoo region, and their supervisors. From this research population a sample will be taken.

This study makes use of nonprobability, purposive sampling methods. Nonprobability sampling is less likely than probability sampling to produce accurate and representative samples, but is used in the vast majority of samples in most disciplines, including nursing. Elements are selected by nonrandom methods, which means that there is no assurance that every element does have a chance for inclusion (Polit & Hungler 1999:209).

Participants were selected using purposive sampling (the conscious selection by the researcher of certain participants to include in the study) according to Burns and Grove (1997: 306). An underlying assumption is that any errors in judgment will in the long run, balance out. With care in the selection of the sample, a conservative interpretation of the results, and replication of the study with new samples, this method can be successful (Polit & Hungler 1999:209-214).

The criteria for sampling was:
registered nurses doing curative PHC in clinic/CHC at least once a week or more;
registered nurses that hold a primary clinical care qualification of some kind.
supervisors of these CPHCNs, who are registered nurses and in the community health nursing field

The research population and sampling have been discussed in more detail in Chapter 3.

1.10.2 Collection of data

Collection of data was done by a questionnaire, a method of gathering self-report information from respondents through self-administration of questions in a paper-and-pen format. A well-designed and properly conducted study normally achieves a response rate in the vicinity of 80% to 90%, decreasing biases (Polit & Hungler 1999: 349-350).

Telephonic contact with nursing supervisors was made, explaining the purpose of the study. Questionnaires were supplied to the respondents. Using questionnaires ensured that all the informants (registered nurses in charge and CPHCN) was asked the same questions, so that data could be compared. Self-addressed envelopes were supplied for questionnaires to be returned to the researcher.

1.11   PRE-TEST OF THE INSTRUMENT

The researcher tested the research instrument, by establishing the time it will take the respondents to complete the questionnaire and also determine if the respondents understand all the questions. This was done by handing the questionnaire to five respondents of the sample

1.12   DATA ANALYSIS

Data analysis entails the methods of organising data so that research questions can be answered (Polit & Hungler 1999: 525).

The quantitative data was entered and analysed with the help of a personal computer and a professional statistician. Data was organised to explain the barriers and enablers of quality curative PHC.

1.13   OVERVIEW OF ETHICAL CONSIDERATIONS

Relationship to the practice of science: Limits of the study has been be considered in the research report and findings has been reported on fully, with objectivity and integrity (Mouton 2001:240).

Relationship to the subjects of science:
Consent was obtained from the Regional Provincial Authority (Annexure A). A letter of introduction to the study was send to all persons in charge of CHC, as well as their local authority departmental heads (the right to full disclosure about the research). In this letter they were asked to take part in this study. This letter

was telephonically followed up to confirm that the questionnaires arrived and was given to respondents.

Right to privacy: No one was forced to take part in the study against his or her will.

Right to anonymity and confidentiality and not to be harmed in any way (Mouton. 2001:15) : People taking part was ensured of their anonymity and that information would not be used against them, and that they would not to be harmed in any way – physically, psychologically or mentally Mason (1997:70) also emphasises the importance of sensitivity and confidentiality, and says that a climate of mutual trust must exist between parties searching and giving information. The accompanying letter explained the advantages of the study to the profession and the nurses rendering a curative primary care. The researcher herself being a CPHCN encouraged participation, as she understands their problems and has developed sensitivity to them.

1.14 VALIDITY/RELIABILITY

Factors that threatened the validity and reliability of this study were the low response rate, 66 out of 110 (60%) of the CPHCN, and the inability to ascertain how many were supervisors, so that their response rate could be calculated accurately. Two service points did not respond either, which makes the results unrepresentative of the whole area.

The researcher established the time it will take to answer the questionnaire. The study supervisors at Unisa (a panel of experts in this field of research) corrected the research instrument. The final report and data interpretations were handed to the study supervisors for comment and judgment as to the relevance towards the research questions and will be discussed in more detail in chapter 3.

1.16 SUMMARY

The Western Cape has the largest number of health personnel per capita in the whole country. This province also has the most CPHCNs. Even though this Province is better staffed and staff members are better qualified, problems of quality of Primary Curative Care still exists. This chapter introduced some of the barriers and enablers to nursing care generally, and curative PCC specifically, and explained why CPHCN should be able to deliver a quality service.

In chapter 2 the literature research results are explained, and some barriers and enablers internationally and locally were explored and put into the framework of Donabedian's model for quality management. Chapter 3 describes the research process and steps that were taken. In chapter 4 the results of the study are given, and graphically explained. Chapter 5 deals with the conclusions,

limitations and the applicability of the study. Chapter 6 shows all the literary resources that was used to produce this research.

CHAPTER 2

LITERATURE REVIEW

2.1   INTRODUCTION

The majority of the South African population utilizes public health services for their needs, starting at the first contact point, which is primary health care. This type of care is supposed to empower people to lead healthy lifestyles. Primary health care is therefore an investment in human potential (Crisp 1997: 46-47) and there is a desperate need for quality in delivery of this service (Moholo & Khoza 1999:34).

Health departments are dependent on each other for the assurance of quality patient care. The excellent performance of one and the poor performance of another results in an overall average performance (Matzner 1991:92). When the overall quality is poor, with only islands of excellence, the profession should investigate all the internal and external factors that influence service delivery.

2.2   PURPOSE OF THE LITERATURE REVIEW

The purpose of this review has been to examine the concept of quality. Factors contributing to quality care and barriers to quality care, internationally and locally in South Africa were studied. Focus was on studies in primary health care settings, though a larger context of different nursing settings has been studied. Donabedian's theory of structure/process and outcome components of quality care has been used to explain these barriers and enablers to quality care.

2.3   QUALITY IN HEALTH CARE

Quality is about bringing out the good in employees so that they practice with exceptionally high standards. This is a difficult feat to attain and sustain. Quality must continually be recreated. It may not be recognized, except by experts. It requires modeling, coaching, and nurturing. It manifests from the innate ethic of the individual (Trim 2000:24).

2.3.1   Definitions

Quality has many dimensions and/or features. The different role-players in health define quality according to their need for it.

For health professionals, quality means excellence, perfection and technical expertise. It is an ideal to strive towards, the ability to meet a given end and/or a faultless outcome (Stanhope & Lancaster 1988:12; Roemer & Montoya-Aguilar 1988:10-11; Nel 1995:15; Williams 1998b: 266-267).

For the receiver of care, the patient, the humanistic dimensions of quality are important, like social, personal and culturally acceptability and ethical care. Attention in quality care is given to physical, social and psychological needs of patients. It gives people what they need, as well as what they want (Roemer & Montoya-Aguilar 1988:10-11; Mason 1997: 9-10; Williams 1998b: 262-267).

Managers want to ensure a quality and cost-effective service and thus define quality as encouraging uniformity and reduction of variation in a continuous and dependable way (Roemer & Montoya-Aguilar 1988: 10-11; Mason 1997: 9-10;). The ideal definition as formulated by Mason (1997: 9-10), describes quality as being a philosophy, which includes a set of methods, essential to the survival of a service because it improves service, cut costs and raise productivity. The reality definition of quality care is value for money or an interest on input. It has as its goal accrediting, approval, and resource allocation, identifying of needs, making of improvements and certification/reward. It is also transformation – a change from one condition to another (Nel 1995: 15).

2.3.2   Quality in curative primary health care and community care

In the South African context quality curative health care is the ability of services to meet the health-related needs of the population consistent with local and national goals, as well as resource constraints. A minimum level of service provision (physical infrastructure, staffing, and supplies) is necessary. Access of the population, an adequate management system and commitment to priority health issues in the area (Bamford 1997: 1-3) are important concepts.

2.3.3   Donabedian's framework for quality

Quality is a composite concept that can be broken down into manageable components. These are designed to evaluate the quality of a product or a process. A product needs not excel in all the components, but the aim is to determine an optimum combination to ensure a quality product (Matzner 1991:22).

Donabedian, the American father of quality control, broke quality down in three components, namely structure, process and outcome (Lancaster & King 1999: 43).
Structure refers to the human and material resources and organizational framework that is necessary for the work to be done.
Process deals with how the service is carried out. This is the interaction between the nurse and other health care workers and the patient.
Outcomes are the end result of the care activities. Most people agree that the best measure of patient care is to look at the outcome (Shongwe 2000:21).

These components are interdependent, if the structure component is inadequate, this will influence service delivery in the process component. For instance if there is not enough staff or money to pay staff, fewer patients will be seen and more illnesses will prevail in the community. This means that the morbidity and mortality for the community will be high, which impact on the outcome component. If the outcome component is unsatisfactory, more work has to be done by less people, thus the outcome component influences the process component.

In this study, Donabedians's framework has been used to examine and explain the barriers and enablers of quality nursing internationally and locally, with special focus on primary curative health care.

2.4   BARRIERS AND ENABLERS TO QUALITY CARE

Trim (2000: 24) challenges all nurses to examine and debate enablers and barriers in their area of practice, as well as to consider strategies for change. Barriers are the factors that prevent quality care to take place and thus for the patient to receive compassionate and knowledgeable care. Enablers are those factors that facilitate good nursing care.

2.4.1 Barriers to *structural* components of health care

The structural components entail infrastructure, staffing and supplies. If shortages and problems exist here, it can negatively influence the whole process of nursing care, as well as the outcomes of care. Because of structural faults the possibility of medical mismanagement exist and the patient can suffer or die.

2.4.1.1   Rapid changes from outside versus institutional tenure

South African health services have been in a state of transformation for quite a couple of years now. Crisp (1997: 46-49) predicted that corporate engineering on this large scale was likely to last long and have serious complications. Two years later, Kraus (1999:12) still reports on inappropriate resource planning and slow organizational transformation of services. There obviously was an underestimation of the magnitude of restructuring the district health service.

Change in the environment affects quality of care in organizations negatively in the following ways:

> The more experienced workforce feel threatened and the more they are unwilling to give up functions of their jobs (Williams 1998b:262-267). They assume that the organization will always take care of them. Negative attitudes therefore prevail.
> Groups may import and use expressions of external cultures/influences to promote their own interest. This may unfortunately not be in the interest of the whole organization (Bloor 1995:162-79). This is especially true of situations where unions play a large role. Unions bring into a caring health care situation the idea of entitlement and materialism (e.g. working for minimum salary). The unions also discourage those employees who are not striking, to do the urgent work of the striking employees. While nurses' rights should be protected, it should not be at the cost of the patient.
> Increase in the formal education of the population, as well as political promises made, has a negative effect on the rendering of quality of care. Public expectations are often higher than the standard that can be delivered. Consumers are not aware of the structural problems and blame nurses and the process of nursing entirely. It is always easier to verbally blame the person you have direct contact with, than those far away in Parliament or on policymaking level. Consequently nurses are often subject to the frustration of the general public as a result of the ailing health system. Chirwa (2000:11) says that this sort of problem demoralizes and marginalises the nurse further.

2.4.1.2 Limited resources

A minimum level of service provision, physical infrastructure, staffing, supplies and time to do work effectively, is necessary for effective service delivery (Bamford 1997: 28-31). Expanding services and increased demands for health care impact negatively on the amount of work a small workforce has to do (Williams 1998b: 262-267). Curative primary health care nurses find constraints imposed on achieving quality because of resource limitations (Clark & Maben 1999:107).

2.4.1.3 Staffing

Adequacy of nurse staffing is important for a positive patient outcome. Twenty-first century health care has brought many opportunities for nurses. Employers with a limited budget are unable to compete for and retain the best qualified nursing personnel. For those nurses left behind in the workforce, dissatisfaction exists because of burnout and job-strain. There is intent and tendency to leave at high levels. About a quarter of English and American nurses planned to leave their jobs in 2001, leaving an aging workforce behind. There is not enough nurses left to provide high quality care (Aiken, Clarke, Sloane, Sochalski, Busse, Clarke, Giovannetti, Hunt, Rafferty & Shamian 2001: 4-10). Third world countries like India report the same tendency (Khan 1999:173). From the African continent, Malawi nurses echoes problems of long working hours and poor working conditions for the remaining workforce (Chirwa 2000:11).

This dissatisfaction and drop in numbers of nursing results in an increase in patient accidents and medical errors. The patient's families are complaining and remaining nurses are more exposed to verbal abuse and thus even more job-strain. The working environment is not humane anymore and contributes to burnout. Nurses feel that they are under siege and vacant posts can not be filled (Aiken et al 2001: 2-10).

South African health services also have unrealistic low staffing levels. Currently it is roughly a half to a third of what it should be. Shifts in human resources in accordance with the movement from hospital-based care to the community, are not taking place and a lack of progress in hospital rationalization exists (Kraus 1999: 12). Nursing staff is bearing the brunt of clinical care because of the scarcity of doctors (Crisp 1997:46). This results amongst other things, also in poor continuity of care (Elgoni 2001:1).

The scenario sketched above is rather dark and somber for nursing internationally and nationally. These symptoms suggest a major flaw in the design of curative PHC and/or an inability to adapt to a changing world environment. To retain qualified nurses in a competitive labor market, employers should realize the importance of personnel policies and benefits (Aiken et al 2001:43-53).

2.4.1.4   Finances

Financing of personnel and their benefits, as well as amenities and equipment are very important for personnel retainment and adequate patient care. As services expand and demands for health care increase, so does cost. In the effort to reduce cost, quality may be sacrificed (Green & Pinkney-Atkinson 1994: 129; Khan 1999:173). A tension thus exists between quality and cost-effectiveness (Clark & Maben 1999: 107).

South African health care has been under increased financial strain (Kraus 1999:12). Gwala (1995:18) estimated that the average cost of a health

consultation in 1995 ranged between R29 and R139. She predicted that four health visits per person in the primary health care setup in the year 2000 would cost the state R7.9 billion. This money is sorely needed and not necessarily available.

In reality the average number of visits per person per annum to clinics are often much more than 4 per person, causing severe financial restraints and shortages of medicine. This inability to finance health consultations causes referral systems to collapse and limits outreach programmes and interaction with communities, especially preventative activities (Gwala 1995:18).

2.4.1.5   Infrastructure

Infrastructural problems also cause poor quality care. Lack of facilities and unavailability of space and equipment can result in patients not receiving care in the time span that they need it or in a safe environment (Katz & Green 1992:9).

South Africa, like other third world countries, also has infrastructure shortages. Buildings are often in a poor state and there is a lack of necessary facilities (Seshoka 2001:31), especially consultation rooms (Gwala 1995:18). Moholo and Khoza (1999: 34) report unavailable treatment. Patient's healthcare services also need to be accessible and available. It is of no use for a community to have a clinic, which hours are such that the majority of the population cannot attend the clinic. A profile analysis of the local community is necessary to determine the needs regarding the hours suitable for service delivery.

2.4.1.6   Time

The amount of time available for care depends on the number of staff and technology available. Often when people experience that they are understaffed, they feel that they cannot render quality care.

Williams and Irurita (1998: 36-44) found time the most important condition necessary for the development of a therapeutical relationship between the nurse and the patient and thus perceived quality of care by patients. Low levels of intimacy were found when time was limited. Positive effects on nurse and patients were perceived and described as 'therapeutic reciprocity' when their relationship was more intimate. Staff members may experience more work satisfaction, while the patients will benefit from the open communication lines to communicate their needs while the care will improve. Greater work satisfaction, better communication of needs, and open communication lines and continuity of care is the result.

Bowers, Lauring and Jacobson (2001:484-494) found that nurses tend to divide their time in 'must do' and 'should do' activities. They emphasize time as a limited commodity. Nurses tried to work faster when time ran short. They

combined tasks, cut 'should do' tasks, become inaccessible to outside needs, convert 'downtime' to task completion, skip or shorten breaks and lunch times, reassign work to aids or to the next shift. Some choices, such as skipping medications, leaving minor infections untreated, ignoring patient interactions, might have ethical or legal implications. A major source of job stress and dissatisfaction was a lack of time for the 'should do' tasks. To make things worse, Aiken et al. (2001:2-10) point out that nurses still waste time on non-nursing tasks.

In South African clinics certain services like preventative care had to be sacrificed for more urgent, curative ones. Dennill (2002:1) says the need for curative care is great and is overtaking the need for preventative care. Nurses currently spend so much time treating the hoards with medicine for symptoms that preventative care is totally scaled down. The number of patients to be seen causes a lack of time to spend on each patient (Maholo & Khoza 1999:34)

2.4.1.7   Training

Training should be an important enabler of quality health care. Unfortunately uncertain competencies, poor training opportunities, substandard education and lack of in-service programmes are still reported (Carlson & El Ansari 2000:68; Khan 1999:173). Training in the twenty-first century is still reactive and focused on care of individual patients, instead of being proactive with the focus on the population/community.

In South Africa a lack of clinical knowledge, inability to, and/or lack of motivation to integrate new knowledge and use it, is reported (Gwala 1995: 18; Louwagie et al 2001:18). Elgoni (2001:1) states that training is haphazard and not related to needs, while Pillay and Asia (1999:16) say it is not evaluated in terms of applicability either. Mulaudzi (2001:25) recognizes a lack of ethics in nursing and states that graduates are produced with a lack of moral wisdom to guide them in decision-making and practice. Nel (1995: 74) reports that mass teaching and equal opportunities open the doors of learning to all – but also creates the situation 'more means worse', meaning that there are more graduates, but of lesser quality. She motivates for continuous learning and recertification, so that knowledge will be increased and renewed instead of becoming stagnant.

2.4.1.8   Disparity in equity

Equity is an important concept of a quality health service. In third world countries two medical systems are often in place – one for those that can afford it and another for those that cannot pay. The latter often is not so available as people have to travel long distances to get to services and often have fewer infrastructures due to cost. Because of this Jewkes (1995:985) reports a disparity in equity of services for the rich and for the poor, or between different

parts of the health system. Health care is also unequally distributed, with the Western Cape and Gauteng better served by health personnel, but the Eastern Cape and Natal poorly supplied.

2.4.2   Enablers to the structural component of healthcare

Enablers facilitate quality health care and are factors like education and training, accreditation, information systems and quality assurance programs.

2.4.2.1   Education and training

Inadequate training can be detrimental to quality care, as demonstrated above. Less qualified nurses are unable to offer total care because they cannot think beyond the task at hand (Williams & Irurita 1998:36-44). The goal of education is for the nurse to make her profession an art. To master this art, ethics, social and organizational skills as well as a holistic approach to the patient must be taught at colleges. Education and training should be viewed as an ongoing process, therefore it is also important to keep contact with educational facilities, so that knowledge can be kept up to date.

For nursing to become an art (so that the individual can take lead in practice and health service developing), the person must go through certain phases. At first the nurse enculturates the theory and practice of nursing. Secondly nursing becomes a craft when she appropriate beliefs, emotions and motivations of nursing. Thirdly insight and personal contribution are developed (Glen 1998:95-102). For all above to happen, she has to have sufficient training in procedures, fact and information (Moholo & Khoza 1999:34). Professional learning thus is an empowerment process of individualization, independent thinking and practice within a changing profession or social context (Glen 1998: 95-102).

Quality nursing results from improvement of emotional and motivational tendencies. This means that nurses must develop themselves to accept responsibility for changing attitudes and motivations (Glen 1998:95-102). Moholo and Khoza (1999:34) emphasise the importance for people to understand their own behaviour and motivation.

There should be a focus in nursing colleges on a patient-centered approach. The topic of quality should be reinforced with teaching-learning activities. Ethical issues should be addressed, as a solid ethical base necessary for delivery of quality care (Shongwe 2000:33). Mulaudzi (2001:21) agrees by saying that the principles of Ubuntu (morality, interdependence, compassion) and Batho Pele must be included in the curriculum.

Social and organizational skills must also be taught in college, as well as cultural sensitivity. This will enable nurses to problem solve, make group decisions and learn to communicate effectively. This way the community nurse will experience

more job satisfaction because she will be able to make community level interventions and have a holistic approach to the patient, the family and the community (Carlson & El Ansari 2000:172; Moholo & Khoza 1999:34)

Consistent and renewed training are necessary, especially if based on latest research results. Continual research is necessary for a knowledgeable practice. Employer organizations need to encourage further learning by ensuring that nurses in practice have relationships with educational facilities. This will ensure that they are kept up to date with new developments and research in both administrative and technical areas. This will result in competent and expert care (Matzner 1991:56; Williams 1998b: 262-267; Trim 2000:24).

2.4.2.2.   Accreditation

Accreditation can be seen as one of the external mechanisms for controlling the quality of health care (Unisa 2001:70). It is important that nurses are qualified to render healthcare according to the scope of practice of their profession.

Kells in Nel (1995:53) says that it is important that institutions and professions regulate themselves. This will ensure self-knowledge, self-control, self-regulation and change. In this way, they will control the future, become stronger, accept and adapt to challenges and use these challenges for growth. Nursing organizations should lay down standards for statutory vigilance. Inspection needs to be done to see that basic requirements are met, negligent practices are examined and action against malpractice can be taken (Khan 1999:173). The South African Nursing Council fulfills this function. In addition Provincial authorities hold inspections in state institutions to examine structure, process and outcomes of healthcare. CHOSASA (Muller 1998:623) is a registered non-profit company with the aim to assist health care facilities (including primary health care services) with the process of continuous quality management.

2.4.2.3   Information systems

An information system gives feedback about outcomes to the profession. Without seeing the results of their service provision nurses can not plan and implement improved care. Green and Pinkney-Atkinson (1994:29) is of the opinion that a national strategy for monitoring progress towards an equitable health service to all is necessary. Blair (1995:26) asks for standard measures of service effectiveness for the monitoring of productivity and client satisfaction, available only after data is analyzed and the norms worked out from information systems. A good management information system will include the extent of the workload, comprehensive statistics, activities and audits for the appraisal of quality care (Khan 1999: 173).

In South Africa the District Health Information System is not fully implemented yet, but hold great promise to monitor and give feedback about effectiveness of service (Solomon 2002:1).

2.4.2.4 *Quality management program*

A quality management programme is necessary for a cost-effective service (Blair 1995:26). America, Europe and Scandinavia have been the leaders in this field, developing programmes for health services, adapted from the industrial sector. Quality control programmes in the primary health care sector exist and continue to grow in South Africa (Muller, Van der Berg, Ford, Mulder, Visser, Horst, Rossouw, Hurwitz, Rothberg, Malkin, Whittaker, Fisher & Brink 1995: 134). Initiatives focused on quality ssurance like the National Adolescent Friendly Clinic Initiative encouraging clinics to improve and get quality ratings (Dickson-Tetteh, Ashton, Silimpieri, Moleko, & Ladha 2002:)

Professionals are valuable sources of monitoring quality and should be encouraged to take part in quality control programmes. They are the only people with enough knowledge and technical competence of care in delivery systems. Evaluation of publicly available summary reports by staff working in similar areas can result in opportunities for best practice and ideas on how they might be simulated. Best practices are often occurring in isolation. It is necessary to educate personnel and improve services and to celebrate recognition of peers (Mason 1997: 70-4).

2.4.3 Barriers to the process component of healthcare

This component deals with the process of caring: the interpersonal exchanges and interactions between the nurse and the patient. Barriers here can have the patient experience poor quality care if it is not compassionate, ethical and does not take into account the culture of the patient.

2.4.3.1 *Lack of professionalism, low morale and productivity*

Lack of professionalism stems from inadequate qualifications, lack of motivation, lack of staff discipline and poor knowledge of philosophy of the institution. Factors like union involvement, political change, downsizing and re-engineering and traditional military influence on nursing, negatively affects morals and productivity.

Professional nurses show confident leadership, delegate tasks to subordinates and solve problems adequately. Non-assertive nurses cannot be patient advocates (Williams & Irurita1998:36-44). Unprofessional attitudes of nurses thus causes the patient to be without an advocate while laissez faire leadership and lack of problemsolving skills causes poor leadership with resulting lack of

confidence in leadership, and feelings by employees of not receiving support from above.

Khan (1999:173) underlines the lack of motivation, poor staff discipline, absence of knowledge about the philosophy of care as factors affecting quality nursing.

Nurses' involvement in unions created a 'job versus career' choice. Nurses thus are less dedicated to the job – they just go to work to get their pay cheque, rather than being dedicated to the care of patients (Williams 1998b: 262-267). Kraus (1999:12) agrees that the workforce is focused on entitlement rather than productivity.

Apartheid in South Africa created racial and language barriers in nursing. The new political dispensation led to changes, where there were questioning of principles and rules. Undermining of management, and chaos were the result. Those in comfortable positions felt threatened and felt they had to defend the status quo. The disadvantaged were angry and venomenous, so that when they were liberated, undermining of management and chaos were the result. Thus the integrity and the image of the profession were lowered (Mulaudzi 2001:24).

Financial constraints caused Government to downsize and re-engineer services. This further demoralized nurses and decreased their energy, affecting their moral commitment. To earn more money they moonlight, which can result in fatigue and burnout (Mulaudzi 2001:24).

Nurses have a culture of silence and do not question what is wrong in the profession. This bottled-up anger and frustration leads to unrest, toi-toing and strike and a demonstrated lack of professional commitment (Mulaudzi 2001:24).

Above factors resulted in extremely low morale (Crisp 1997: 46-49; Elgoni 2001: 1). Characteristics of this low morale are as follows:

> Negative attitudes towards patients (Moholo & Khoza 1999:34;
> Elgoni 2001: 1; Seshoka 2001:36),
> low productivity levels in the public sector (Kraus 1999:12),
> inefficiency, negligence, abuse of patient's basic rights (Elgoni 2001: 1).

2.4.3.2 Organizational culture

Each organization has a certain culture, which influences the atmosphere positively or negatively for the employees as well as the patients. Lack of communication and collaboration causes staff to feel not valued (Williams 1998b: 262-267). Staff who does not feel valued, has poor attitudes about patients. Patients feel unhappy around moody nurses. They want to be shown empathy, compassion and to be treated as individuals. Nurses' communication skills,

personality and willingness to go the extra mile are important attributes in the healing process (Williams & Irurita 1998: 36-44; Elgoni 2001:1).

Subcultures in the organization can be problematic. Some may even be counter-cultures that reject the dominant values of the organization and seek to alter the mission and practices. Subcultures may serve to maintain the *status quo* in terms of power relations between groups, or they may act as major transforming influences within the organization, refining and amending existing systems. Subcultures are therefore sources of flexibility, innovation and change, as well as potential sources of conflict (Bloor 1995: 162-179).

2.4.3.3   *Supervision*

Leadership, supervision and on-site management are key elements [and Gwala (1995:18) says more important than the availability of money] in the facilitation of quality activities. Supervision influences work by reducing errors and increasing competence (Nicklen 1995:24; Shongwe 2000:33). Leaders can reduce these errors by encouraging staff to get it right the first time. Nurse managers who do not accept their responsibility and accountability for quality activities do not sustain such activities in their units (Moholo & Khoza 1999:34).

Worldwide there is a lack of proper supervision, lack of knowledge thereof and lack of support to nursing supervisors. The nursing supervisors experience a lack of guidance and support to improve efficiency of utilization, correct unrealistic staffing expectations and improve productivity (Kraus 1999:12).

Nicklen (1995:24) and Khan (1999:173) support this view on a lack of sufficient and well-trained supervisors. Supervisors often act as relief staff when staff members are absent from duty. Lack of policy, procedural and administrative manuals, evaluation techniques, written job descriptions and job specifications in the nursing workplace, especially in the third world can be seen as a major barrier to quality in health care.

System errors are the responsibility of management (Matzner 1991:54-55) but nursing staff still gets blamed. Deming (Matzner 1991:45) reasons that quality programs are to start at the top, moving downwards through the entire organization to grass root level. Valuable input from the actual workers are necessary, as they are directly involved with the problem areas. This will make them feel valued.

2.4.3.4   *Patient aspects*

Patient features can make quality nursing difficult, especially aspects like age, special needs, dependency, literate or education level, cultural and gender issues. The mere fact that they are simply not feeling well sometimes makes patients miserable to be with.

It was found that dependant patients are more exhausting, especially those with special needs like deafness and the aged.
Cultural differences negatively affect communication (e.g. people not looking each other in the eye) (Williams & Irurita 1998: 36-44).
Rural patients perceived receiving less care because they felt lonely and in need of support (Williams & Irurita 1998: 36-44).
Male patients are reported to experience difficulty in communicating with female nurses (Tornkvist, Gardulf and Strender 2000:72)
Illness and anxiety levels caused patients to be experienced as very unreasonable (Khan 1999:173).

2.4.4 Enablers of the process component of healthcare

Enablers of the process component are those elements in the interaction between the nurse in the patient that makes nursing easier and leaves the patient more satisfied. Good role models, management support, a focus on the patient's needs and collaboration have been found to be enablers.

2.4.4.1 Role modeling and management support

Nursing has a high incidence of occupation-related stress associated with absenteeism. The support provided by supervisors has the potential to reduce illness, absence, misery and cost (Nicklen 1995: 125; Carlson & El Ansari 2000:12). The heart of quality is not in technique, but commitment with persistence and passion by management to its people and product (Mason 1997:6-10; Carlson & El Ansari 2000:172).

Nurse leaders must be role models and display good values and behavior, morality, intellectual honesty, dedication, generosity, forgiveness, genuineness, empathy and acceptance. Nurse leaders must analyze criticism, suggestions, bewilderment, fears, and compliments and have the highest ethical standards despite difficult working conditions (Moholo & Khoza 1999:34; Carlson & El Ansari 2000:172). This is setting good examples for patient-centered care and putting the patient first. It is essential that nurses should believe that management desires and expect quality care (Mason 1997:7-10; Williams 1998b:265; Trim 2000:20)

The above is to be realized only if a democratic approach is followed. Democracy brings autonomy in decision making and structuring of own work. Employee capabilities are build, power is shared and employees are allowed to help shape the culture of the organization.
It brings variety and facilitates learning. A democratic organization that shows these characteristics learns continuously and improves by analyzing, monitoring,

developing and aligning (Bloor 1995: 162-179). Employees and patients should get ownership of services and health by following these steps:

> listening should take place actively
> constructive challenging about acts and omissions should take place (Mason 1997:6-10)
> higher standards should be set
> motivation to keep spirits high should take place, so that people can relate to each other effectively
> job mastery should be encouraged
> problem solving skills should be encouraged and people should be encouraged to become self-driven, assertive, and accept challenges (Moholo & Khoza 1999:34).

2.4.4.2   *Focus on the patient/family/community and their needs*

Care has to be patient/family/community-centered.   It is important that the client is empowered to look after his own health. Equipping clients with knowledge, offering them information to make their own health care decisions and thus make a difference in their lives is the goal of quality health care (Williams 1998b:263).

In primary health care the community is an important client. Projects that bring together the community and practitioners should be undertaken. Community needs should be assessed, with the community partaking in assessment, setting of own objectives and monitoring own progress (Carlson & El Ansari 2000:12).

2.4.4.3   *Collaboration*

Multi-disciplinary planning and focusing on collective accountability rather than individual responsibility must take place (Moholo & Khoza 1999:34) to encourage the whole system to deliver quality care. Every individual must feel that they are part and has responsibility, not only those in responsible positions.

Collaboration between different parties is essential for quality of care:

> Teamwork amongst staff members and between managers and clinical personnel is necessary to solve problems with flexibility and spontaneity. For this staff must feel free to give opinions (Whittaker, Shaw, Bruwer, Green, Taljaard & Skibbe 1994b:132; Bloor 1995:162-179; Maholo & Khoza 1999:34). Sharing of experience will increase knowledge and sympathy for each other, preventing subcultures from developing (Bloor 1995:162-179)
> Contact between academia and CPCHN are necessary for breaching the gap between knowledge generation and the application of it (Anderson 1998:257).

Coordination of health with social and economic sectors are more effective than singular efforts in influencing the political agenda (Carlson & El Ansari 2000:168; Clark & Maben 1999:107).

It is obvious from above that multi-disciplinary planning and collective accountability will facilitate quality care more than individual responsibility (Maholo & Khoza 1999:34).

2.4.4.4   Professional development

Professional development is the process where the person accepts responsibility for changing own core attitudes and motivation in improved performance (Glen 1998: 95-105). This will be attained by continuous and in-service education (Williams & Irurita: 199836-44).

The result will be professional nurses whom will demonstrate confident leadership, delegate tasks to subordinates and solve problems adequately. Thus nurses ensure accountability to the patients and the nursing profession (Shongwe 2000:34).

2.4.4.5   Experience

Practical experience in primary curative care plays a positive role in the management of sicknesses (Louwagie et al 2001:180). The more experience a person has, the more capable he/she is of making the right decisions (Rice & Van Niekerk 2000:36).

2.4.5   Barriers to the outcome component of healthcare

The outcome component is used to measure the result of the nursing care. The structural and procedural components have an effect on the outcome of the nursing care. If the structural input (lack of infrastructure, staff and money) and the procedural input (no compassionate and knowledgeable care, supervision, etc) is lacking, the outcome would be poor.

2.4.5.1   Inability to prove cost-effectiveness

For any service to be successful, it has to be shown as being cost-effective (Williams 1998b: 262-267). This is the same with the health care sector, whether it is privately run or by the state. Nursing includes many qualitative activities like listening, communication, counseling and support of emotional problems that is not easily measured (Mason 1997:6). Qualitative outcomes are often ignored because it is not as measurable as quantative outcomes. Data in the form of numbers of patients seen, amount of visits, episodes of services delivered, which

are mostly quantitative, have to be used to evaluate quality of service. Inability to prove effectiveness of care pushes qualitative nursing programmes low on the political agenda when money is allocated (Clark & Maben 1999:107).

2.4.5.2 *Medical mismanagement*

The cost of quality can be expensive. There is failure costs, appraisal costs and prevention costs, of which the first are the most costly. These are the costs of doing things incorrectly (75-80% of the cost). Appraisal costs (15-20%) are those incurred during monitoring and evaluation, while prevention costs 0-10% are those associated with activities designed to prevent problems (Katz & Green 1992:217). These figures actually show that prevention is better than cure!

If nurse shortages and resultant workload is taken into account, it is surprising that according to Qvretveit (2000:74-79) only four percent of hospital patients suffer avoidable injury and that only seven percent experience some medical mismanagement. However, any number of injuries or medical mismanagement of patients is unacceptable, as it is traumatic and tragic for patients and devastating for medical personnel. Depression, nervous breakdowns, leaving the profession, suicide are common reactions, but high prices to pay for the risks the personnel have to take in their daily work (Rice & Van Niekerk 2000:36).

Patients have always been careful to choose a health care professional or facility, which they think will not harm them, or cost them too much. When there has been choice, patients often decide not to use a health care facility, or turn to alternative medicine (Qvretveit 2000:74-79).

2.4.6 Enablers of the outcome component of health care

Katz and Green (1992:9) list concepts of quality that has to be measured as outcomes to prove the quality of care:

> effectiveness (the degree that nursing is delivered in the correct manner, considering the current state of the art),
> efficacy (the degree to which the service have the potential to meet need which it is used for),
> appropriateness (the degree to which the care received matches the needs of the patient),
> efficiency (the degree to which the service has the desired effect with the minimum of effort, expense, waste),
> continuity (the degree to which the care needed by the patient is coordinated effectively), and
> participation of family and patient in care.

The clients' needs should be considered if any significant care is to be given. Voices of the persons delivering the care should be heard about problems in

service delivery. Lastly, medical mistakes must be looked at, to ensure that they are not repeated.

2.4.6.1   *Consideration of the needs of the client*

One has to ask the question who the client is. One of the reasons South Africa is still confusing sophisticated care with quality care is that the focus is still on the individual patient, not the community (Crisp 1997: 46-49).

The patient/community is the main reason for the existence of health care service. Therefore what the client wants is of utmost importance. Too often services become centered around the hustle and bustle of the care delivery, and the reason for the existence of the service (the client) is forgotten.

If its needs is to be addressed, nurses need to get out there and find out what the community wants. This is the only logical way to satisfy clients/community and include them in the improvement of their own health status. Katz and Green (1992:9) also include participation of the patient and family as a factor of quality care: their involvement in the decision making process is important. Clients need to be equipped with knowledge to make their own health care decisions that can positively impact on their lives. Satisfied clients use services and motivate others to use them. Satisfied clients lead to increased service provider job satisfaction and improve the health care facility reputation. Utilization and coverage will improve, as well as health status of the patient (Elgoni 2001: 1;Williams 1998b: 265).

2.4.6.2   *Nurse participation*

Moholo and Khoza (1999:34) plead for freedom of expression of staff, so that opinions can be given about care. Krairiksh and Anthony (2001: 16-23) agree when they contend that enhancing nurse participation on all levels of clinical decisions, planning and structure should improve outcomes and nurse satisfaction.

Too often decision-making are autocratic and made by those running the service, with no input from the persons with the direct contact with the client. It must be realized that the client has little contact with the policy makers. The persons delivering care are the ones that experience the clients' frustration with the service setup. The persons delivering direct patient care may feel that their hands are also being tied, because of resource constraints. This causes great frustration. An outlet for this bottled-up frustration is necessary, as this just leads to burnout and experienced personnel leaving the service for greener pastures.

2.4.6.3   *Examination of medical mistakes*

Medical mistakes are easily blamed on the person making them, without considering the system's role in the making of the mistake. The smallest detail that caused them should be examined. Systems should be designed that will prevent medical mistakes having disastrous consequences, making errors predictable and thus preventable (Rice & Van Niekerk 2000:34).

At the same time introspection needs to be done by nurses. Because people are easily blamed for their mistakes, dirt is swept under carpets as soon as they occur. A willingness to look at mistakes and faults is necessary, showing true accountability for their practice by professionals (Seshoka 2001:37). Reporting and record keeping are important acts to safeguard the nurse against legal action.

Patient surveys will be help towards detection of delays in attendance, discourtesies, lack of amenities, incidents of incorrect treatment (Khan 1999:173). This information needs to be used pro-actively in a situation where the nurses' opinion is also sought.

2.5   FOLLOW-ON FROM LITERATURE REVIEW

When studying the relevant literature, the reader is confronted with the fact that political changes a decade ago in 1994 did not bring intersectoral coordination, better-coordinated services and less duplication in health service rendering as promised. The reality of the situation is that political fights on provincial government level are responsible for much inaction and inadequate changes. Freezing of posts and resulting loads of work to the already overloaded staff causes burnout and dissatisfaction. This cause experienced and well qualified personnel to give up and leave for greener pastures. First world countries are benefiting from this brain drain out of the third world, a situation that the latter can ill afford. But the reality is that South African nurses earn pounds and dollars in these other countries.

What then is the problem locally?   Why the brain drain, especially amongst those having the privilege to have had their scope of practiced enlarged, to be able to diagnose, treat and prescribe medication? Answers to these questions might be found in studying the barriers and enablers to the PCC service.

If South Africa really values its working force at primary health care level, the voices of their CPHC should be heard about daily frustrations caused by their professional duties.

2.6   SUMMARY

In this literature review it was established that overall and consistent quality CPHC are necessary, because it is often the first and only contact the South African population has with medical care.

Because of nursing being a responsible and accountable profession, and having an ethical and moral basis, it is necessary that practices have to be examined, altered, renewed, and aligned. This is especially necessary after the instability that transformation from one government to another caused.

Definitions of quality care impress the urgency on the reader to look at quality from the perspectives and needs of the role-players in the field: the client, the professional and the manager/employer.

By studying the literature for the enablers and barriers of delivery of nursing care using Donabedian's (Lancaster & King 1999:43) structure/process/ outcome framework, recurring problems and suggested solutions to them were found.

Structural barriers mostly focused on the negative impact of change on institutions. Limited resources like staff, finances, infrastructure and time have the most limiting impact of all on already crippled services. Training is inadequate and South Africa still has not reached equity in services, no matter how hard people have been working towards it, mostly because of the shortage of resources. Structural enablers to overcome these problems are and should be excellent education and training, accreditation, adequate information systems to give feedback about level of care delivered and a quality management program involving employees at every level.

Process barriers are those found in the interpersonal process of nursing. Lack of professionalism, low morale and productivity, poor organizational culture, inadequate supervision by the nurse, supervisor/employer cause unhappy patients and employees. Care can be professional and expert, but if not delivered with compassion and moral integrity, it would not be valued. Process enablers of good nursing care are the availability of good role models and support by management, a focus on the needs of the client, collaboration between the role-players, professional development and experience of the nurse.

Barriers to the outcome component are the inability to prove cost effectiveness and medical mismanagement. To be able to counteract these barriers, the enablers ask for input of the client and the service provider (the nurse) to democratically participate in management. Every single medical mistake must also be examined with care and acted upon to prevent further mistakes.

CHAPTER 3

METHODOLOGY OF STUDY

3.1 INTRODUCTION

This chapter explains the methodology used in this dissertation. The research design, methods and plan for data analysis have been described, discussed and implemented.

3.2 RESEARCH DESIGN

The research design is an overall plan, or blueprint, of how research is going to be conducted and include data collection, analysis and enhancement of validity (Polit & Hungler 1999:32, Mouton 2001:55).

The design of this study is quantitative, descriptive, exploratory and contextual in nature.

3.2.1 Quantitative

Quantitative research is a formal, objective, systematic process in which numerical data are used to describe variables, examine relationships between them and thus obtain information about the world (Burns & Grove 1997:27).

This study is quantitative, as the aim was to study the factors that are barriers and enablers to quality curative PHC care. These enablers/barriers will be described as variables, for instance age, level of basic and post basic education, amount of experience in the curative PHC field, type of curative PHC courses done, number of years spent in the organisation and so forth. The relationships between the variables and the cause-effect interactions between them were studied. The numerical data are used to compare services and situations in the Southern Cape/Karoo region with each other.

3.2.2 Descriptive

The study is descriptive, as it is aimed at giving an accurate account of the characteristics of a particular group, the CPHCN, as well as what a quality service delivered by them entails. The researcher could translate in understandable language the verbalised opinions of registered nurses delivering a curative PHC service. It thus gives new meaning, describe what exists and comments on frequency of occurrences, as well as categorising them (Burns & Grove 1997:30).

3.2.3 Exploratory

The study is exploratory, as it will generate new knowledge and explore a perceived problem. It is not intended for generalisation to large populations, but to increase the knowledge of the field of study (Burns & Grove 1997:302), which is curative PHC, delivered by registered nurses.

3.2.4 Contextual

The study is contextual, as it was conducted in the CPCH clinics and CHC and includes registered nurses delivering a curative PHC service in the Southern Cape/Karoo region.

3.3 GEOGRAPHICAL AREA

In describing the geographical boundaries, an explanation of the District Health System (DHS) is necessary. The World Health Organisation defines a DHS as "…a more or less self contained segment of the National Health System. It comprises first and foremost a well-defined population living in clearly delineated administrative and geographical areas, whether rural or urban. It includes all institutions and individuals providing health care in the district, whether governmental, non-governmental, private or traditional district will be a multi-sector service-area, with health as one of the services delivered. The whole

province will be divided in adjoining districts, which will be the responsibility of the district authority" (Dept of Health 2001:5). The South African definition is that of a multi-sector service area with health as one of the services delivered. The whole province will be divided in adjoining districts, which will be the responsibility of the district authority (Ministerie van Gesondheid en Maatskaplike Dienste: Strategiese Bestuursplan 1995:8).

South Africa consists of 9 Provinces, each Province consists of regions, each region consists of districts, and each district consists of communities.

The Western Cape Province has the following 4 regions: Metropolitan, West Coast, Boland/Overberg; Southern Cape/Karoo (Ministerie van Gesondheid en Maatskaplike Dienste: Strategiese Bestuursplan 1995:9).

Each region exists out of type A, B or C District municipalities. Provinces take responsibility for primary health care, but may delegate this to a municipality (Cupido 2002: 1-10). Type A municipalities are large metropolitan ones, like the Cape metropole. Type B municipalities are smaller ones, like those found in towns, e.g. George. Type C municipalities have a couple of Type B municipalities within their boundaries, like the Tuinroete/Kleinkaroo district municipality.

The Southern Cape/Karoo region has the following two Type C municipalities with examples of the Type B municipalities within their boundaries:

Table 3.1 The South Cape/Karoo Region's Municipalities

Type C	Type B
Tuinroete/Kleinkaroo District municipality	Knysna, Plettenberg Bay, George, Mossel Bay, Heidelberg, Riversdale, Oudtshoorn, Calitzdorp, Prins Albert
Central Karoo District Municipality	Beaufort-Wes, Murraysburg, Ladismith, Laingsburg

Currently the Type B municipalities still delivers a primary health care service. Provincial government plans to decentralise provincial functions to local government (Type A or C municipalities), together with funding so that municipal health services can be provided for by them, by July 2004 (Cupido 2002):

In this research the DHS of the Southern Cape/Karoo region, with the Type B and C municipalities delivering the health care as delegated by the Provincial Administration of the Western Cape are studied. It includes all institutions and individuals providing health care in the district.

A community health center is responsible for the co-ordination of the health services of a determined community, satellite clinics, outreach community

services, environmental health officers and community health workers (Ministerie van Gesondheid en Maatskaplike Dienste: Strategiese Bestuursplan 1995:4).

In this research, a CHC is a building or mobile unit in which primary care is rendered: promotive, preventative, curative, rehabilitative and staffed with CPHCNs who primarily are the service deliverers.

3.4 POPULATION

This is the entire set of individuals who meet the sampling criteria. In some studies the entire population is the target of study because the entire population of interest is very small and well defined (Burns & Grove 1997:292-294).

The population for this study was all the nurses working in curative PHC and CHC in the Southern Cape/Karoo region as well as their supervisors. From this research population a sample was taken.

3.5 SAMPLING AND SAMPLING METHOD

Sampling involves the selection of a group of people, events, behaviors or other elements with which to conduct a study (Burns & Grove 1997:192).

3.5.1 Sampling method

This study made use of nonprobability sampling methods. Not every member of the population has an opportunity for being included in the sample. As such, it falls in the category given by Kraemer and Thiemann in Burns and Grove (1997: 302) of exploratory studies not intended for generalisations to large populations, but designed to increase the knowledge of the field of study.

Purposive sampling was done. Subjects in such a study happen to be in the right place at the right time. Available subjects are simply entered into the study until the desired sample size is reached (Burns & Grove 1997:306). All supervisors at service points were contacted and asked to hand out the questionnaires in group context, for instance at a meeting. All registered nurses rendering curative PHC care were given a questionnaire by their supervisors to fill in, together with a self-addressed envelope to post it back on completion. There were two questionnaires, one for the supervisors, and one for the practitioners of curative PHC. In some cases, supervisors who also rendered a curative PHC service had to complete questionnaires, one from a supervisor's point of view, and another one from the practitioner's point of view.

Mason (1997:70) says that professionals are the only people sufficiently informed to judge technical competence of care delivery systems. These certain individuals/professionals were those that deliver curative PHC.

3.5.2 Size of the sample

The size of the sample was all CPHCNs in the SouthCape/Karoo region (110). For the study to reflect the opinions of the CPHCN and the true situation in the area studied, an attempt was made to assure that as much as possible people responded, by introducing the study to the supervisors and to explain the purpose, and to follow up those that did not respond.

3.5.3 Criteria for inclusion of the respondents

The criteria for inclusion in this research has been:

- Respondents should be registered nurses
- Render curative PHC
- Employed in curative CHC in the Southern Cape/Karoo region
- Should render curative PHC at least once a week or more
- The certificate/qualification in curative PHC was not a pre-requisite for inclusion.

3.6 DATA COLLECTION

Data collection is the process of selecting subjects and gathering data from these subjects (Burns & Grove 1997:394).

3.6.1 Research instrument

This study made use of the survey as data collection approach. With this data collection technique questionnaires (collected by mail or in person) are used to gather data about an identified population. Questionnaires can be designed to determine facts about the subject or persons known by the subject; facts about situations known by the subject, opinions and can be distributed to large samples (Burns & Grove 1997: 258) and were therefore used in this study to determine the factors regarded by respondents as enablers or barriers to quality care.

A questionnaire is a printed self-report form designed to elicit information that can be obtained by written responses of the subject (Burns & Grove 1997:358).

A questionnaire was constructed for this study, to elicit responses from the CPHCNs to explore the problems that exist in their field. The information gained from the literature was used to develop the questionnaire. The questionnaire consisted of those problems identified from the literature, especially in the South African context.

3.6.2   Administration of the questionnaire

A letter of introduction was sent to all supervisors of clinics in the Southern Cape /Karoo region, together with the questionnaires. This letter explained the purpose and importance of the study to the field of practice, and encouraged supervisors and CPHCNs to complete the questionnaires, to further the knowledge in this field. Supervisors were asked to fill in their questionnaires, and to hand out the questionnaires to the CPHCNs they were responsible for. The supervisors were asked to hand out the questionnaires, to gain their support and also to show this support to the study to the employees, to ensure a greater response rate. To ensure anonymity, respondents were given a self-addressed envelope, and asked to post it themselves on completion. In this way it did not have to be returned via the supervisor, ensuring that the CPHCN would feel free to comment on the service. If the supervisor were asked to be responsible for the return of the questionnaires, the response rate would be better, but unfortunately confidentiality could not be guaranteed.

3.6.3   Advantages and disadvantages of a questionnaire for this study

The questionnaire was advantageous for this study, as it ensured anonymity for the respondent, from the supervisor, as well as the researcher. Because of its structured status, certain answers could be obtained, as related to the literature study, and compared with the findings of the literature study. While mostly structured questions were asked, open-ended questions were also included, especially where the researcher thought that there could be more responses than those provided. This ensured more complete answers.

The specific questionnaire was quite long, and this probably had a negative effect on the return rate. People do not like to spend time on long questionnaires, especially in a busy clinic, with reduced administration time.

3.6.4   Format of the questionnaire

The questionnaire had several sections, with biographical data about the respondent as the first (A) section. The following B and C sections covered the structural/process and outcome barriers and enablers to quality care according to the theoretical framework.

The available possible answer (each with a number value) had to be chosen, and the particular number had to be entered in a block provided on the right-hand side. This coding ensured that the information could be entered with ease into a computer.

3.6.5   Pre-testing of the instrument

The instrument was pre-tested by the researcher in her clinic to determine how long it took to complete, as well as to eliminate ineffective questions. It was found to take a considerable amount of time, and therefore several questions were eliminated that were of lesser relevance to the study.

It appeared that all the questions were well understood and only small corrections were necessary to enhance the understanding of certain questions.

3.7 RELIABILITY AND VALIDITY

Reliability represents the consistency of measure obtained and should express three aspects, namely stability, equivalence and homogeneity (Burns & Grove 1997:327). Validity is a measure of the truth or accuracy of a claim/proposition. This is the extent to which the questionnaire will include all the major elements relevant to the construct being measured. This evidence is obtained from the literature, the population and the content experts. Validity and reliability are not an all or nothing phenomena, but rather matters of degree. No instrument is completely valid or completely reliable (Burns & Grove 1997:228, 330).

The questionnaire was developed after an extensive literature study was done. The concepts identified as barriers and enablers to good nursing in the literature study was translated to questions in the questionnaire, to determine whether the respondents experienced the same as those in the literature study. It was then given to the promoters of the study to assess, for validity, as well as afterwards to five CPHCN to pretest the instrument.   There was a correlation between the problems identified in the literature study and those identified by the research.

3.7.1 Reliability

The reliability of an instrument refers to the degree of consistency which the instrument measures the attribute (Polit & Hungler 1993:244). The pretest as earlier mentioned tested also for reliability. Questions were clearly worded to be interpreted properly. Simple language was used to ensure that all respondents understood the questions. Questions that were not interpreted correctly were changed.

3.7.2 Validity

Content validity was obtained from two sources, namely the literature studied and the experts consulted. The relevant population was not being consulted to investigate the questionnaire as this might have weakened the study.

Statistical conclusion validity (the conclusion about relationships drawn from statistics, which are hopefully a true reflection of the real world) has been ensured by seeing that the sample was as large as possible.   The sample of all CPHCNs was more or less homogeneous, as they all were delivering the same

kind of service. Extraneous factors like number and variety of staff, crises and work patterns might impact on the validity of this study (Burns & Grove 1997:228). To ensure this type of validity, the following was done: numbers were given to all respondents, after supervisors supplied numbers of staff. Supervisors were contacted when questionnaires were not received back, to encourage their staff to reply.

Internal validity is the extent to which the effects detected in the study are a true reflection of reality, rather than the effects of extraneous variables (Burns & Grove 1997:228). This was difficult to obtain in this study, as the respondents had to respond on their own and when they had time, thus the same situation could not be provided or ensured to each respondent.

Construct validity examines the fit between conceptual and operational definitions. Examination of construct validity determines whether the instrument actually measures the theoretical construct. The following factors could influence construct validity in this study:

- Hypothesis guessing. Respondents could have behavioral changes when guessing the hypothesis.
- Evaluation apprehension. Respondents might have wished to be seen in a favorable light, as competent and psychologically healthy. Anonymity was assured, thus this factor would play a minimal influence.
- Experimenter expectancies. The expectancies of the researcher might bias the sample (Burns & Grove 1997:228). The promoters of the study were asked to give their opinions of questionnaire too, which reduced this factor.

External validity is the extent to which study findings can be generalised beyond the sample used in the study. The following influenced this type of validity:

- Interaction of selection and treatment of individuals. If a large portion of respondents decline to participate, or only certain respondents, the study cannot be generalised. In this study the number of respondents who refused to partake have been reported, so that external validity could be judged.
- Interaction of setting and treatment. Some organisations often do not encourage participation in studies. All nursing supervisors and authorities involved in this research have been contacted and they gave their permission for the study to take place and for their members of staff to take part. A few phoned to ask what the study entails, and requested feedback.
- Interaction of history and treatment (Burns & Grove 1997:228). The changes taking place in the politics of the Western Cape and South Africa needs to be taken in consideration when research results are screened.

3.8 ETHICAL CONSIDERATIONS

Mouton (2001:240) states that because scientific research is a form of human conduct, it follows that such conduct has to conform to generally accepted norms and values. Care must be taken to ensure that the rights of the people taking part in the research will be protected.

3.8.1 Permission to conduct the study

Consent was obtained from the Regional Provincial Authority of Health (Annexure A). A letter of introduction to the study was sent to all persons in charge of curative PHC, as well as their local authority departmental heads (the right to full disclosure about the research). In this letter they were asked to take part in this study (Annexure B). All of them replied and gave permission that their staff could be involved, as long it was not inconvenient to the staff and work situation. The cover letter to the respondents also mentioned that all the relevant authorities gave permission (Annexure C).

3.8.2 Informed consent

The reason for the research was explained to participants (see Annexure C). They were informed that although their supervisors and the Provincial Health Department gave permission to do the research, they still had a choice to partake or decline to partake, as part of their right to privacy. The aims of the investigation were communicated to the respondent as well as possible, as well as the foreseeable repercussions, any risks or discomfort, benefits, the researcher's name and the possibility of receiving a summary of the results.

3.8.3 Confidentiality and anonymity

The respondents have the right to remain anonymous.   Individuals can share personal information to the extent that they wish to do so, and are entitled to have secrets, and whom to share personal information with. The researcher has an obligation to maintain confidentiality (Burns & Grove 1997:204). Informing respondents that the information would not be linked to them ensured anonymity. Names of institutions and of participants are not mentioned in the dissertation. Permission to make the results public was requested in the covering letter. By ensuring that the supervisors hand out the questionnaires, but that the respondents send them back themselves, anonymity was assured.

3.9 ANALYSIS OF DATA

The quantitative data was entered and analysed with the help of a personal computer and a professional statistician at Unisa. Services and situations were compared with each other.

3.10 SUMMARY

In this chapter each step of the research process was explained, from the grand plan or blueprint, to the smaller detail of how each step was going to be implemented. By doing this, the whole process of research was thought through logically to ensure that nothing was omitted.

CHAPTER 4

DATA ANALYSIS AND DISCUSSION

4.1   INTRODUCTION

This chapter presents the data obtained from the sixty-six analysed questionnaires from the original hundred-and-ten which were sent to the CPHCNs and the nineteen questionnaires returned from the forty sent to supervisors at clinics in the Western Cape/Karoo region. The response rate therefore was sixty and forty eight percent respectively.
From two areas, there was no response at all. No further questionnaires were received in spite of further telephonic inquiries made by the researcher to the supervisors, who were asked to distribute the questionnaires among their CPHCNs.
The data have been presented in three sections.
Section A consists of the biographical data from the CPHCNs as well as the supervisors.
Section B focuses on data obtained from the supervisors while Section C contains the data from the CPHCNs.

SECTION A

This section deals with the biographical data from both the supervisors and the CPHCNs.

4.2 BIOGRAPHICS, EDUCATION AND EXPERIENCE OF CPHCNs AND THEIR SUPERVISORS

The biographical characteristics of the CPHCNs and their supervisors were included in the questionnaire in order to obtain correlations between data and the characteristics of the respondents.

4.2.1 Age

The age distribution of the respondents indicated in Figure 4.I demonstrates that twenty-six (39.4%) of the sample of CPHCNs in the Western Cape/Karoo region consisted of people in the age group 40 – 49 while twenty-three (34.9%) of the respondents were 30-39 years of age. Fourteen (21%) were fifty years and older.
In comparison, supervisors were generally older and it is therefore no surprise that more than a half (10; 52.6%) were in the age group 40 – 49 and five (26.3%) older than 50 years.
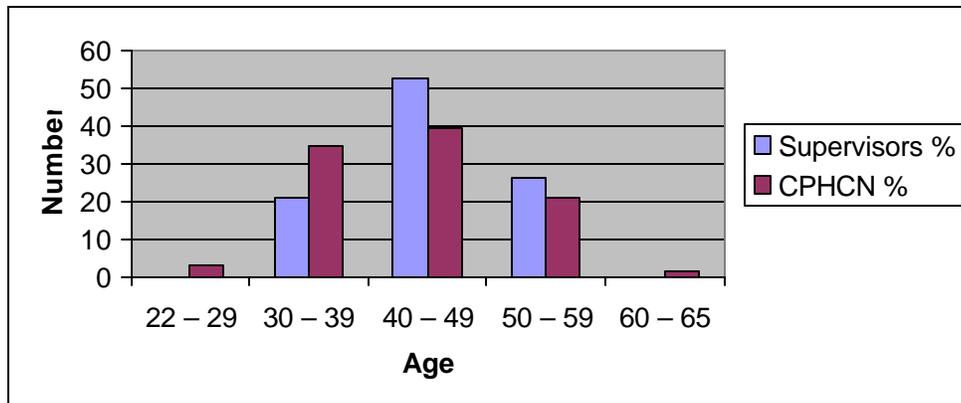
Figure 4.1 Age distribution of respondents (Supervisors n= 19; CPHCNs n= 66)

4.2.2 Gender

Only one (1.5%) of the CPHCN and one (5.3%) of the supervisors were male. This correlates also with the general gender profile of nurses in South Africa where only 6.8 % are male (SANC Statistics 2002).

4.2.3 Educational characteristics

According to most job descriptions in the Western Cape/Karoo region it is expected from CPHCNs as well as their supervisors to have a qualification in community health nursing and midwifery, as well as curative PHC. Van Tonder (1984:20) expected from area supervisors to have qualifications in nursing education, administration and their area of specialization (in this case community health nursing and curative PHC.

The qualifications of the respondents are portrayed in Figure 4.2. All of the respondents were qualified as general nurses.
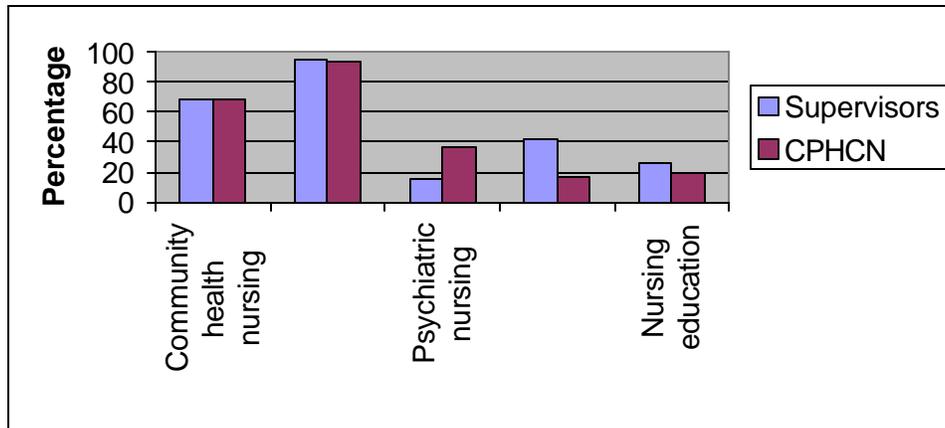
Figure 4.2 Basic and Post basic qualifications of the respondents

As expected more supervisors (8; 42.4%) were better qualified in nursing administration and education than the CPHCNs (13; 9.7%). This is also an indication that some of the CPHCNs have knowledge on nursing administration and education.

Both groups were equally qualified in midwifery, a qualification much needed for ante- and postnatal care in the community. It is interesting to note that just over 68% (supervisors n=13 and CPHCNs n= 45) of each group was qualified in community health nursing. Community health nursing and midwifery were recently included in the basic training of nurses. This can be a reason why these courses are not so frequently organized in the area as previously. Nurses working in the community seem to be less motivated to study on their own (through Unisa or other tertiary institutions available, for instance the University of Stellenbosch, the University of Port Elizabeth and the North West University) than their peers working in hospitals. One would want all community health nurses to be qualified in their specialist field.

Thirteen (68.0%) of supervisors reported that all their nurses are trained in curative PHC. This is a satisfactory large number of professional nurses in possession of this qualification, but not enough if job descriptions for CPHCNs are considered. One expects a doctor to have specialized education and training to able to treat patients, equally so a CPHCN.

Figure 4.3 shows that the preferred mode of study for curative PHC seems to be through the hospital or PAWC (supervisors 9; 47.4% and CPHCNs 39; 59.9%). It also indicates that more supervisors (2; 10.5%) than CPHCNs (4; 6.1%) is working with experience only, and not qualified in curative PHC. This might cause frustration to the CPHCNs, working under them.
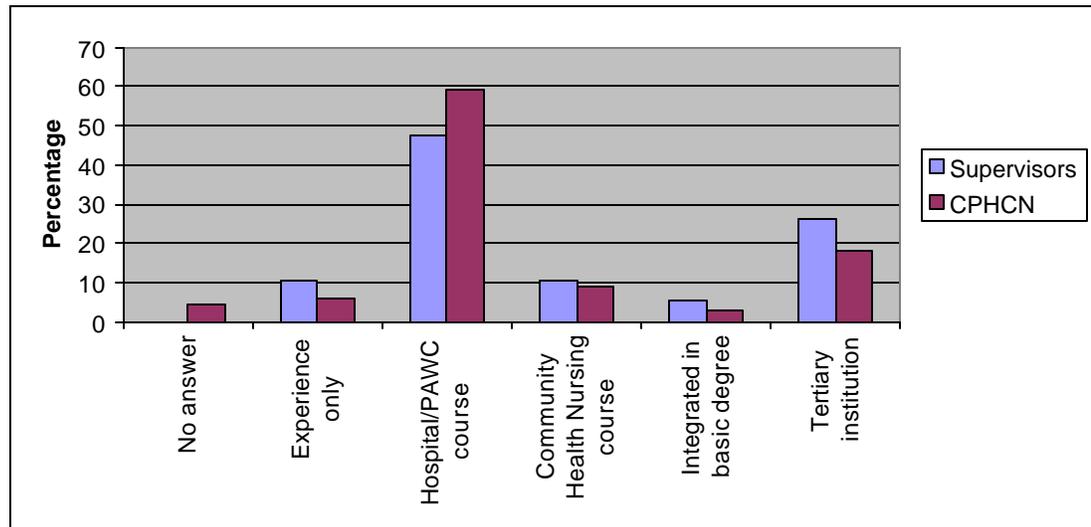
Figure 4.3 Means by which curative PHC certificate were obtained

4.2.4 Experience

Most of the supervisors (12; 63.1%) had more than 14 years experience while only (13; 19.7%) of the CPHCNs indicated that they had more than eight years of experience in the community health field (See Table 4.1). This reflects positively on the excellent experience of the supervisors, but could negatively on their set ways that might frustrate those that have been in the service for a shorter period, for instance most of the practitioners.

The experience of the respondents in primary curative care is also reflected in Table 4.1. The supervisors have between 7 – 20 years + experience, while the CPHCNs are a younger group, with less experience. They might thus rely more upon the support and guidance of their supervisors. There seems to be more CPHCNs with longer curative PHC experience, than those with general CHN.

Table 4.1 Experience in CHN and PHC (Supervisors n=19 CPHCNs n=66)

	<2 yr	2-7 yr	8-13 yr	14-20 yr	>20 yr	No answer
Supervisors *CHN*	0	10.6 (2)	26.3 (5)	47.4 (9)	15.9 (3)	0

CPHCNs *CHN*	6.1 (4)	21.2 (14)	45.5 (30)	27.3 (18)	0	0
Supervisors *CHN*	0	31.6 (6)	47.4 (9)	15.9 (3)	0	5.3 (1)
CPHCNs *PHC*	0	9.1 (6)	40.9 (27	45.5 (30	4.6 (3)	0

SECTION B

This section deals with data obtained from the supervisors, and comparisons between relevant data of supervisors and CPHCNs.

4.3   THE HEALTH SERVICE WHERE CURATIVE PHC IS RENDERED

4.3.1 Authority responsible for the management of the curative PHC clinic

Figure 4.4 indicates the authority responsible for the immediate management of the service. Most of the services are run by local municipalities, probably because they are financially stronger than district municipalities.
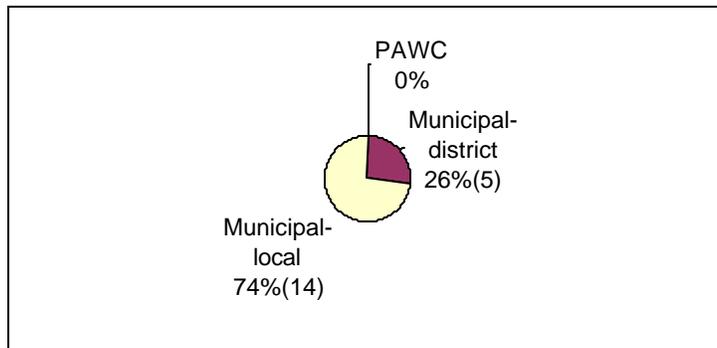
Figure 4.4 Authorities responsible for the immediate management of curative PHC clinics

4.3.2 Number of authorities operating under one roof

Figure 4.5 demonstrates the number of authorities operating under one roof and thus employing staff, rendering the same services, but working under different service conditions and often having two departments to report to. Nearly half (9; 46%) indicated that their employing authorities are PAWC as well as the local municipality.
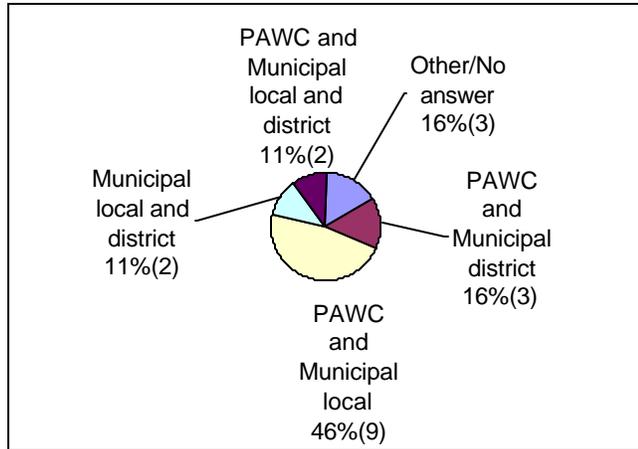
Figure 4.5 Authorities responsible for curative PHC
Services in the Southern Cape/Karoo region

4.3.3 Integration of services

The status of the integration of services is portrayed in Figure 4.6.
Most of the supervisors (17; 89%) reported that services were semi- to
fully integrated and worked together already, while only eleven percent
(n=2) reported no integration at all.
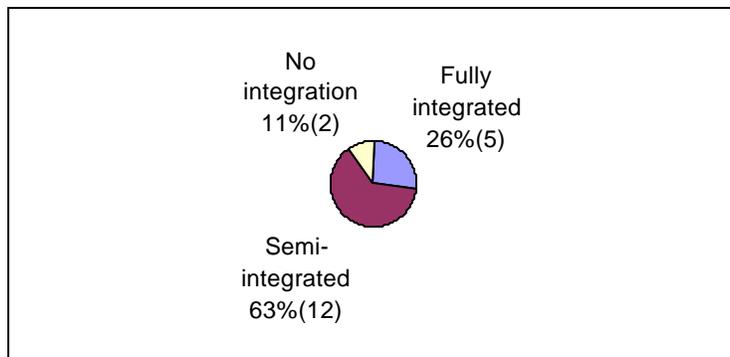
Figure 4.6 Status of integration of services

4.3.4 Problems experienced with the integration of services

Transformation of services is often accompanied with problems (Krause
1992:12). The transformation of services in the SouthCape/Karoo region
is not different from others.

Figure 4.7 gives an idea of the problems experienced due to the
integration process or the lack there-of. Lack of collaboration is the main
presenting problem in sixteen (84.2%) of reported cases. Jealousy about
differences in salary (12; 63.2%) and difference in the treatment of staff

(10; 52.6%) seems to be problems experienced by more than half of the supervisors. Though less reported, non-acceptance (7; 36.9%) and aggressiveness towards staff (8; 42.1%) exist and could therefore not be ignored. These were the negative attitudes prevailing, as predicted by Williams (1998b 262-267).
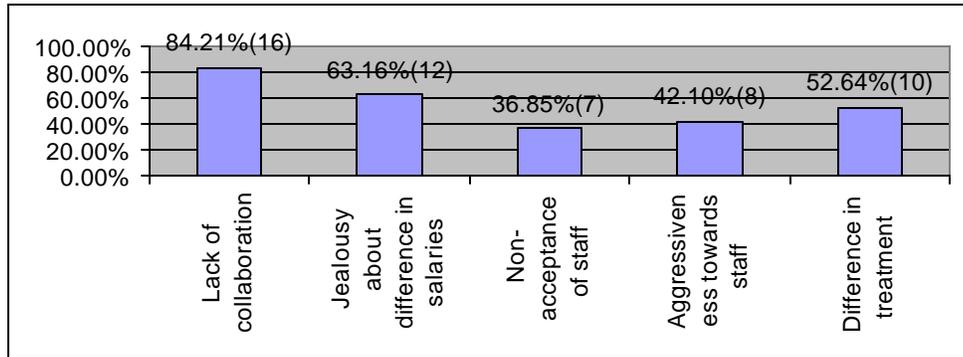
Figure 4.7 Problems experienced with the integration of services

4.3.5 Turnover of staff in the service

Figure 4.8 shows the staff turnover. Although a total of 10 nurses resigned in 2001 and 9 in 2002, at certain clinics more nurses left the service in 2002 than in 2001. At some clinics less employees resigned as in the previous year while other clinics showed having a larger turnover than others.
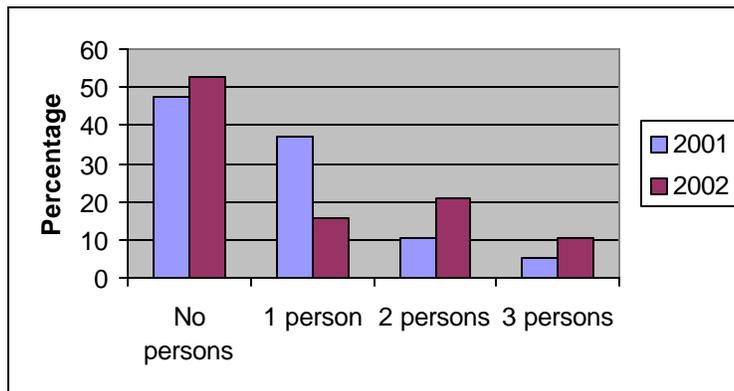
Figure 4.8 Turnover of staff during the period 2001/2001

4.3.6 Reasons why nursing staff leave the services

Nursing staff was leaving the clinics for different reasons (Figure 4.9). It seemed as if personal reasons (11; 57.9%) were more likely to be the cause of nursing staff to leave the clinics than dissatisfaction with salaries (2; 10.5%) or working conditions (4; 21.1%). However one has to

remember that unhappy staff often does not report the real reason for their decision to resign, as they are scared of victimization while in the service.
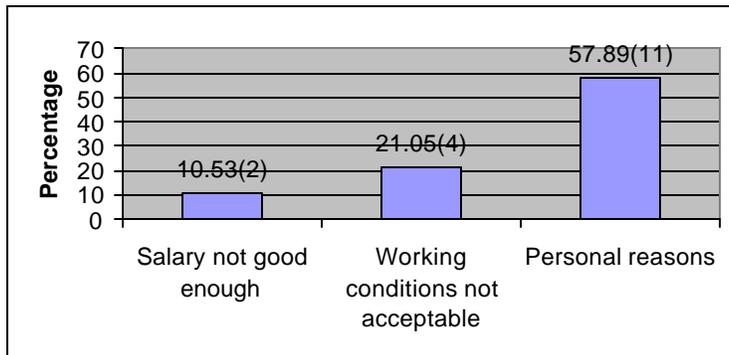
Figure 4.9 Reasons given by nurses for leaving the service

4.3.7 The amount of stress supervisors perceive the nursing staff is experiencing versus the actual amount of stress experienced by CPHCNs

Supervisors generally (16; 84.2%) realised that the stress experienced by the nursing staff *is at times unendurable* Most (40;60.6%) CPHCNs however indicated that they experience stress *as totally unendurable.*

4.3.8 Factors causing stress in the services

According to Cranwell-Ward, Bacon and Mackie (2002:205) factors causing excessive stress at work are among others intrinsic job factors, their role in the organization, relationships at work, career development, organizational structure and culture and home-work interface. Different factors that could cause stress in the service were explored and results of supervisors and CPHCNs were compared in Table 4.2

It is obvious that the number of patients, the lack of resources and the lack of support from authorities, as well as the lack of experience of supervisors were causing severe stress to both parties. Supervisors also felt that they themselves suffered from too many responsibilities and that subordinates were not adequately trained. CPHCNs blamed lack of experience and lack of training of self and colleagues, too much responsibilities of self/ colleagues, patients being too demanding, too many changes, not enough staff and not enough time for patients as stressors.

Table 4.2 The stressors in a Curative PHC Service

	Supervisors n =19		CPHCNs n = 66	
	Some effect % (n=)	Serious effect % (n=)	Some effect % (n=)	Serious effect % (n=)
Lack of training of subordinates	68.4 (13)	5.3 (1)	-	-
Lack of training of self/colleagues	-	-	68.2 (45)	12.1 (8)
Lack of training of supervisors	57.9 (11)	15.8 (3)	47.0 (31)	21.2 (14)
Lack of experience of subordinates	63.2 (12)	10.5 (2)	-	-
Lack of experience of self/colleagues	-	-	57.6 (38)	12.1 (8)
Lack of experience of supervisors	68.4 (13)	5.3 (1)	45.5 (30)	24.2 (16)
Too much responsibilities of subordinates	63.2 (12)	15.8 (3)	-	-
Too much responsibilities of self/colleagues	-	-	54.6 (36)	40.9 (27)
Too much responsibilities of supervisors	36.8 (7)	47.4 (9)	51.5 (34)	24.2 (16)
Too many patients	26.3 (5)	73.7 (14)	42.4 (28)	54.6 (36)
Not enough resources	36.8 (7)	63.2 (12)	43.9 (29)	43.9 (29)
Not enough support from authorities	52.6 (10)	47.4 (9)	31.8 (21)	57.6 (38)

Not enough support from personnel in service	52.6 (10)	21.1 (4)	57.6 (38)	16.7 (11)
Long working hours	47.4 (9)	10.5 (2)	45.5 (30)	7.6 (5)
Patients too demanding	-	-	39.4 (26)	50.0 (33)
Too many changes	-	-	65.2 (43)	19.7 (13)
Not enough staff	-	-	24.3 (16)	62.1 (41)
Continuous turnover of staff	-	-	34.9 (23)	9.1 (6)
Not enough time for patients	-	-	28.8 (19)	57.6 (38)

4.3.9 The number of nurses per category working in the services and registration as a CPHCN

In Figure 4.10 the category of nurses in the service are portrayed. It is an indication that most reported nurses (102; 69%) in the services are registered professional nurses and most (80; 78%) of these reported registered nurses do hold a curative PHC qualification (Figure 4.11).
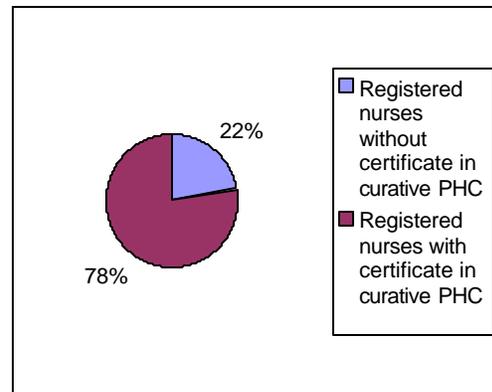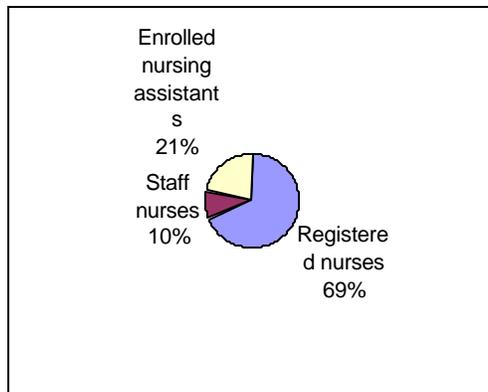
Figure 4.10 Categories of nurses in the service.

Figure 4.11 Qualified CPHCNs

4.3.10 Important management functions of supervisors in the service

Supervisors have a variety of management functions. All these functions did not receive equal attention. The response of the supervisors is portrayed as in Figure 4.12.
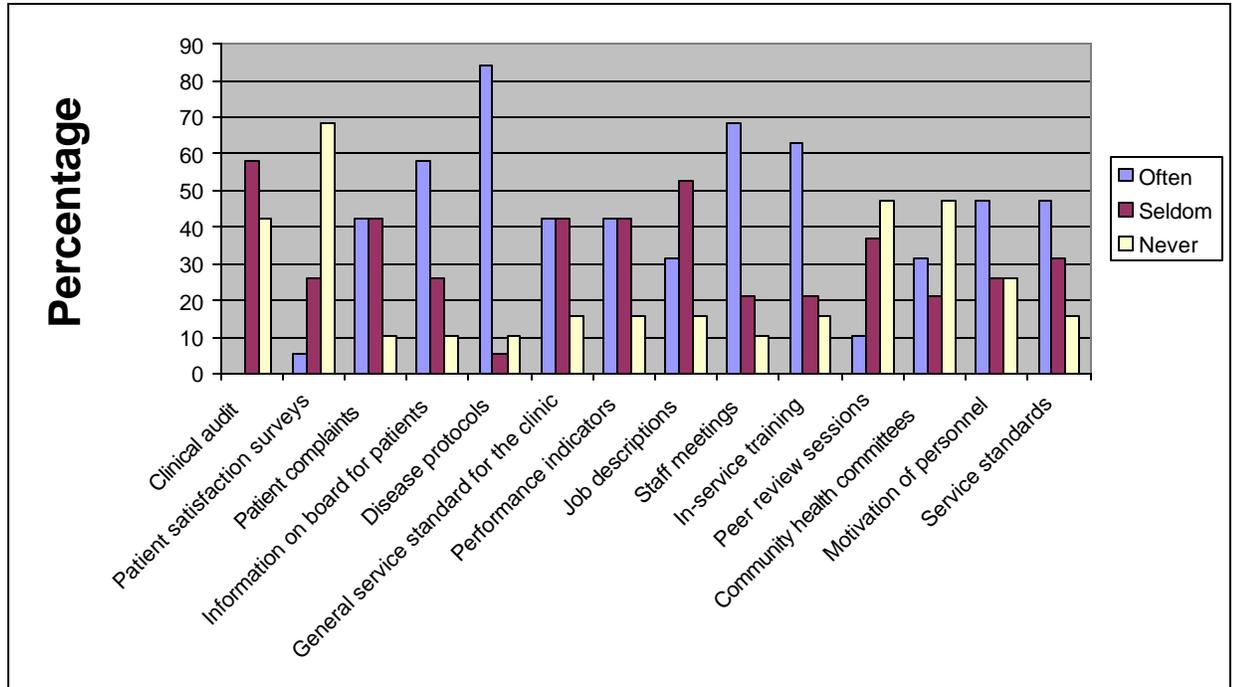
Figure 4.12 Important management functions of supervisors in a service

Frequent attention was thus given to disease protocols (16: 84.2%), staff meetings (13; 68.4%), and in-service training sessions (12; 63.2%). Some supervisors gave regular attention to motivation of staff (9; 47.4%) and service standards (9; 47.4%). Clinical audits (11; 57.9%), job descriptions (10; 52.6%) were seldom done, while peer reviews, general service standards for the clinic, patient complaints, and performance indicators were seldom done by about 40% (n=8) of respondents. Patient satisfaction surveys, peer review sessions, community health committees were generally ignored.

4.3.11 Human resources

The staff of a health service is its most valuable asset (Booyens 1998:381). Since 1995 all services rendering to mothers and children under the age of six years are free of charge. This increased the workload of the staff rendering these services. Of the supervisors 84.2 percent (n=16)) reported no staff increases to meet the increased workload. As it is 89.5 percent (n=17) already indicated that they did not have enough staff members for the facility. This caused a severe workload.

4.3.12 Material resources (equipment and supplies)

Figure 4.13 shows how often staff were unable to obtain stock, such as blood pressure apparatus, stethoscopes, glucometers, bandages, linen savers, disposable needles, syringes, gloves and medicine. Most of the

respondents (10; 52.6%) report that they often experienced problems when ordering stock from the stores.
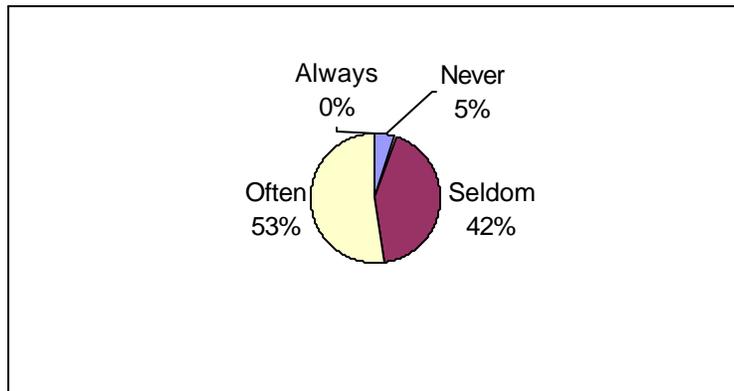
Figure 4.13 Frequency staff experienced problems
             obtaining stock for the clinic

4.3.13 Adequacy of the budget

Figure 4.14 demonstrates the view of the respondents regarding the adequacy of the budget to cover the needs of the whole service. Only three (15.8%) of the respondents indicated that they felt that their budget is adequate to cover the needs of the whole service.
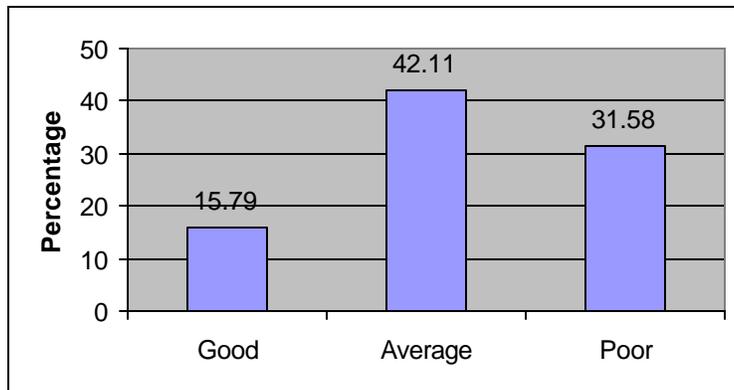
Figure 4.14 Adequacy of budget to run the service

4.3.14 Building facilities

It was found that thirteen (68%) of the sample was of the opinion that the building is inadequate; that there were *inter alia* not enough waiting rooms for the patients, toilet facilities for the staff or for the patients.

4.3.15 Computerization of services

Computerization of services was only partial according to ten (53%) of the respondents while six (47%) reported no computerization at all in their services. None of the services were completely computerized.

4.3.16 Complaints received by supervisors about the service

One of the functions of supervisors is to handle the complaints of patients. Figure 4.15 indicates the complaints received by supervisors about the service. The long waiting times (13; 68.4%) seemed to be the problem occurring most often, followed by distance to clinic (10; 52.6%) and the inconvenient clinic hours (7; 36.8%). As much as a fourth (5; 26.3%) reported the 'unavailability of services to state patients' as complaints received by supervisors.
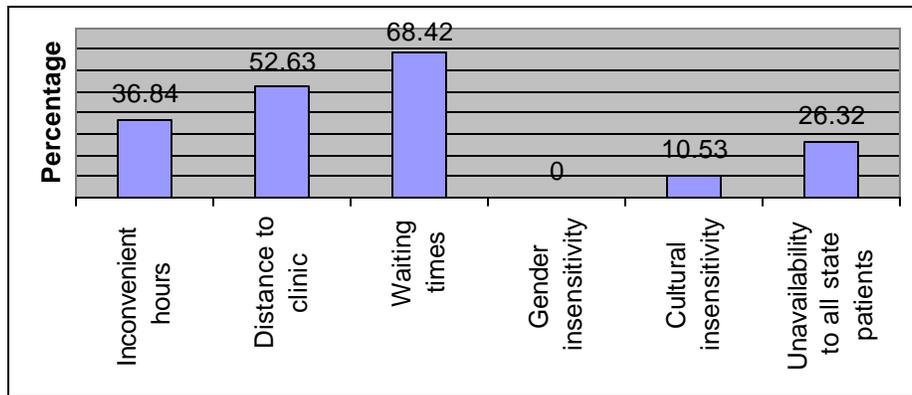
Figure 4.15 Complaints received by supervisors about service by patients

4.3.17 Factors perceived by supervisors as indicative of safe functioning of nurse practitioners

On the question what supervisors perceived as safe functioning of nurse practitioners the supervisors indicated that all the factors listed in the questionnaire were highly indicative of safe functioning with slightly less focus on complete and orderly patient notes, use of medical terms and clear diagnosis relevant to the main complaint, system examined and diagnosis as Table 4.3 demonstrates.

Table 4.4 shows that 16 (84.2%) supervisors indicated that if patients were not examined, it is seldom or never indicative of safe functioning on the part of the nurse. Thirteen (68.4%) supervisors say that patients not receiving medicines for their complaints, are seldom or never indicative of safe functioning of the nurse.

Table 4.3 Factors indicative of safe functioning of CPHCNs (n=19)

Factors	With every patient managed %	With every 2-10 patients managed %	Every 10-30 patients %	Very seldom %	Not answered %
Patient notes are complete and orderly	73.7 (14)	10.5 (2)	0	10.5 (2)	5.3 (1)
The main complaint is stated	89.5 (17)	0	0	10.5 (2)	0
The systems examined are relevant to the main complaint	89.5 (17)	5.3 (1)	5.3 (1)	0	0
The diagnosis is clearly stated and relevant to the main complaint and systems examined	79.0 (15)	10.5 (2)	5.3 (1)	5.3 (1)	0
The prescription is relevant to the main complaint, system examined and the diagnosis	89.5 (17)	5.3 (1)	0	0	5.3 (1)
The nurse prescribes according to the EDL	89.5 (17)	5.3 (1)	0	0	5.3 (1)
The nurse use medical terms	73.7 (14)	15.8 (3)	0	0	10.5 (2)

Table 4.4 Patients not examined and not receiving medicines as
Indication of safe functioning as CPHCNs (n=19)

Factors
With every pt managed %
With every 2-10 pts managed %

With every 10-30 pts managed %
Very seldom %
Never %
No answer %

Patients *not* examined
0
5.3 (1)
5.3 (1)
36.8 (7)
47.4 (9)
5.3 (1)

Patient *not* receiving medicines for their complaints
10.5 (2)
0
10.5 (2)
36.8 (7)
31.6 (6)
10.5 (2)

4.3.18 Effective policy for handling unsafe CPHCN practices

Only three (16.0%) of the supervisors reported that they have an effective policy in place for handling of unsafe CPHCN practices as indicated in Figure 4.16. The rest either did not have any policy in place, or the policy was outdated. A policy regarding the handling of unsafe practices is of utmost importance in any health service. None of the respondents were of the opinion that the policy was unsuitable.
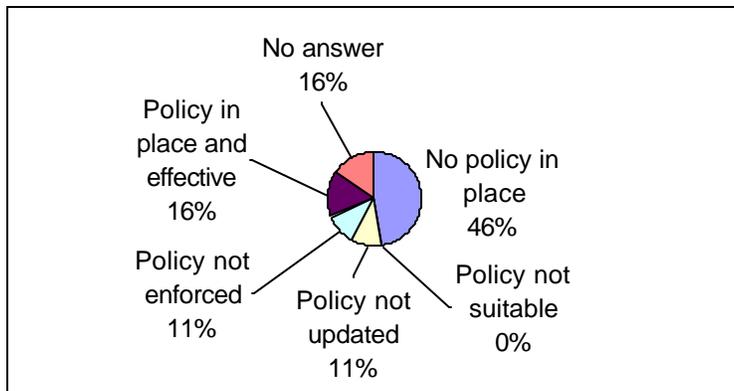
Figure 4.16 State of policies about unsafe practices

4.3.19 The reported number of unsafe practices

There seemed to be a slight increase in cases of unsafe practices from 2001 to 2002 (Figure 4.17) where 1-2 cases increased from three (15.8%) to four (21.1%).
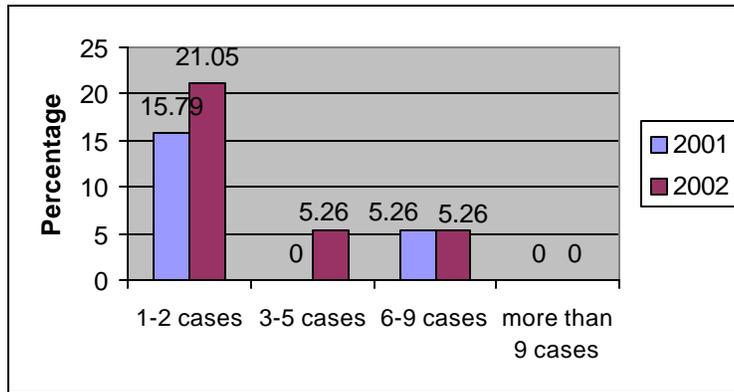
Figure 4.17 Increase in cases of unsafe practice

4.3.20 The handling of complaints of unsafe practices by the supervisors

Figure 4.18 indicates the way supervisors handle complaints of unsafe practices of staff. One would like these statistics to be closer to 100%. It seems as if supervisors don't see the importance of involving staff members and the patients in handling complaints about unsafe practices.
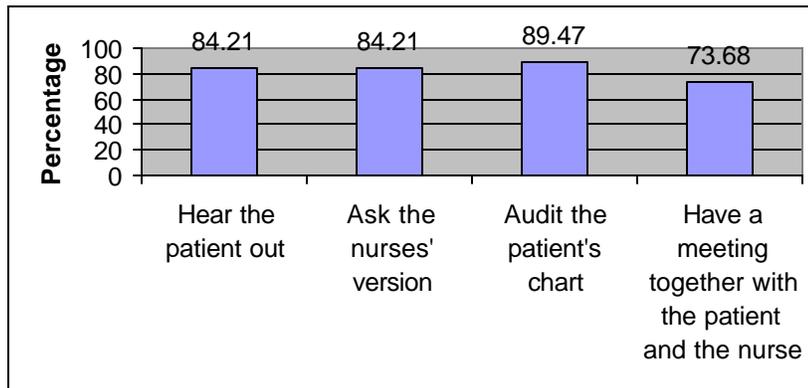
Figure 4.18 Handling of complaints about unsafe practices

Figure 4.19 shows that three (11.0%) of the supervisors were of the opinion that complaints of patients were always and twelve (63.0%) were sometimes and one (5.0%) were often substantiated. This is an indication that unsafe practices do occur in services; therefore policies should be in place on handling unsafe practices.
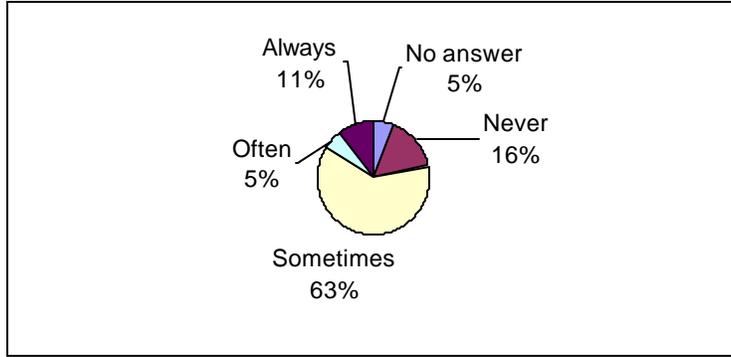
Figure 4.19 The supervisors' perceptions if complaints are substantiated

4.3.21 The causes of unsafe practices

Figure 4.20 presents the main cause of unsafe practices according to the supervisors. Not having enough time to see the patients as well as too many patients to be seen seemed to be two of the major unsafe practices identified by 84.2% (n=16) supervisors followed by nurses that are not being thorough enough (9; 47.4%), personal characteristics of the nurse (8; 42.1%) while roughly half (10; 52.6%) of the supervisors perceived communication problems affecting the services. About a fourth (5; 26.3%) complained about knowledge not being kept up to date by the CPHCNs.
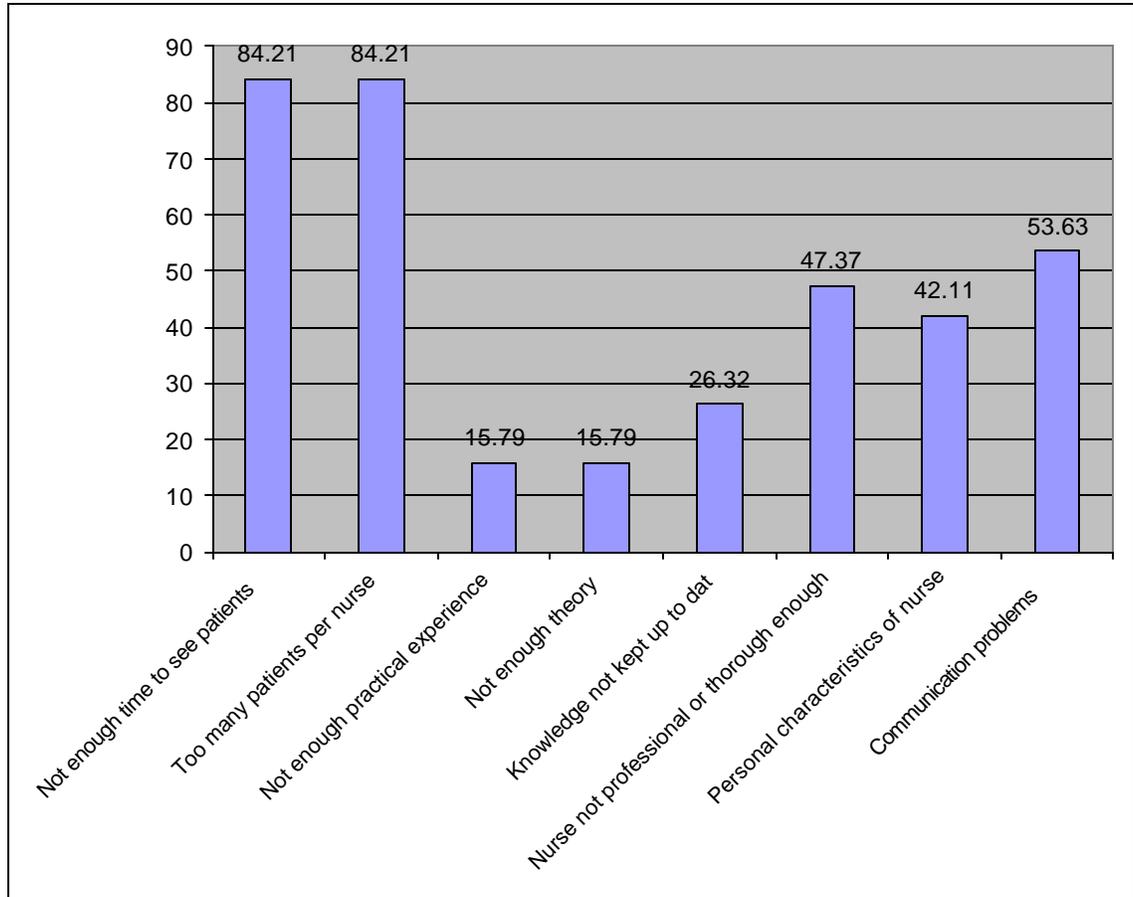
Figure 4.20 Causes of unsafe practice in service

4.3.22 The frequency of absenteeism of registered nurses

As demonstrated in Figure 4.21 absenteeism didn't seem to be such a major problem for supervisors as sixteen (84.0%) reported that absenteeism does not occur too frequently in their services, while three (16.0%) reported that absenteeism often take place in their services.
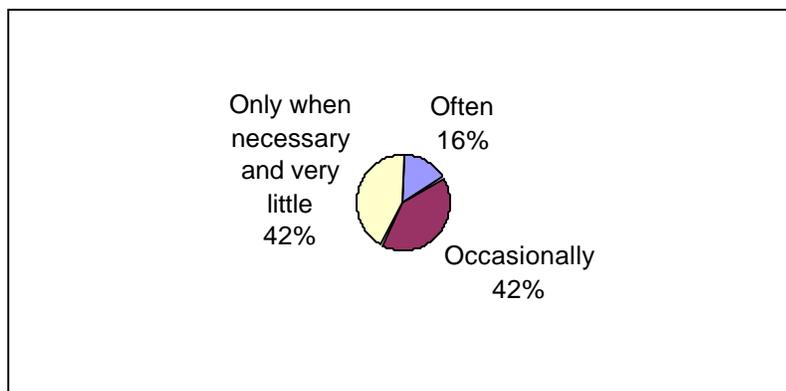
Figure 4.21 Frequency of absenteeism of registered nurses

4.3.23 The supervisors' perceptions of their own leadership qualities

Generally supervisors rated themselves well, mostly above 50 percent on most of the leadership qualities provided on the questionnaire. Only one (5.3%) supervisor rated him/herself low on having a forgiving attitude, being a constructive listener and challenger. There was also only one respondent (5.3%) who rated him/herself low on theoretical knowledge, managerial skills, motivation of staff and being a trainer. Although this person is very honest, it could cause problems for the subordinates who wanted to see the supervisor as a role model. One would think that a supervisor would have realized by now that these skills are needed and attempt to develop them. The leadership qualities are displayed in Figure 4.22.
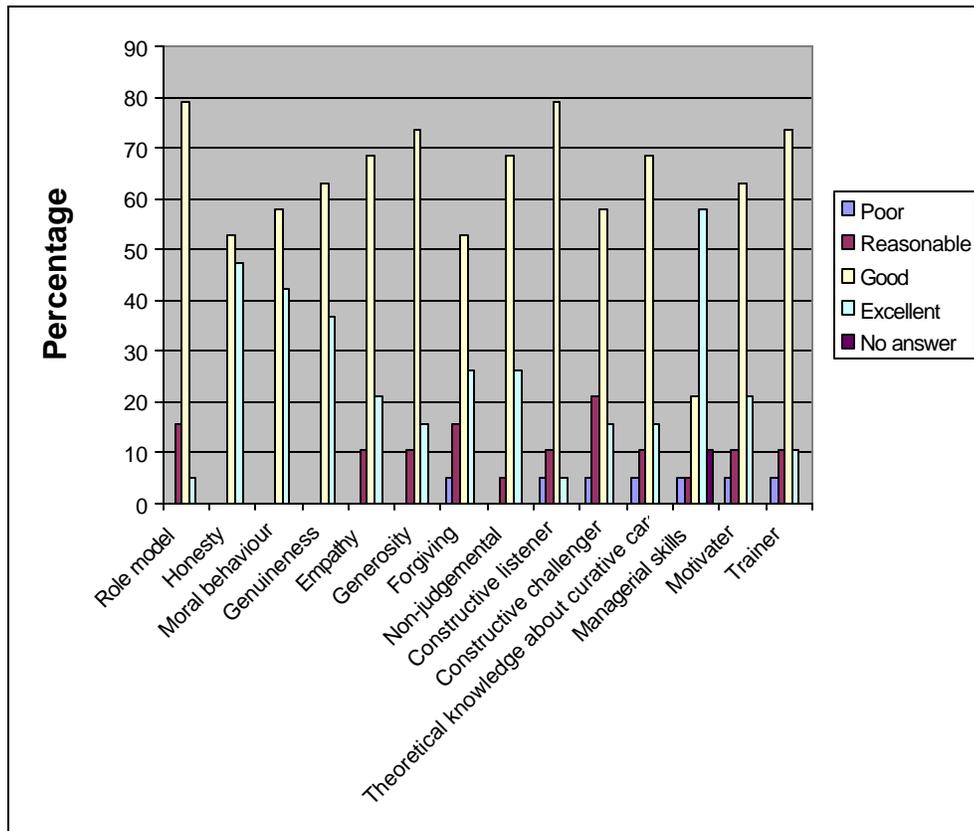
Figure 4.22 Supervisors perceptions of their own leadership qualities

4.3.24 Supervisors relieving CPHCNs

More than a fourth (5; 30.0%) of the supervisors indicated that they have to relief staff on a daily basis, two (13.0%) on a weekly and monthly basis. See Figure 4.23. The fact that supervisors frequently need to relieve other

staff members interferes with the managerial duties of the supervisors, who have to cut out managerial functions to manage time. On the other hand, it gives the supervisor first hand knowledge of what is happening in the service, and is therefore kept on top of demands and changes in practice.
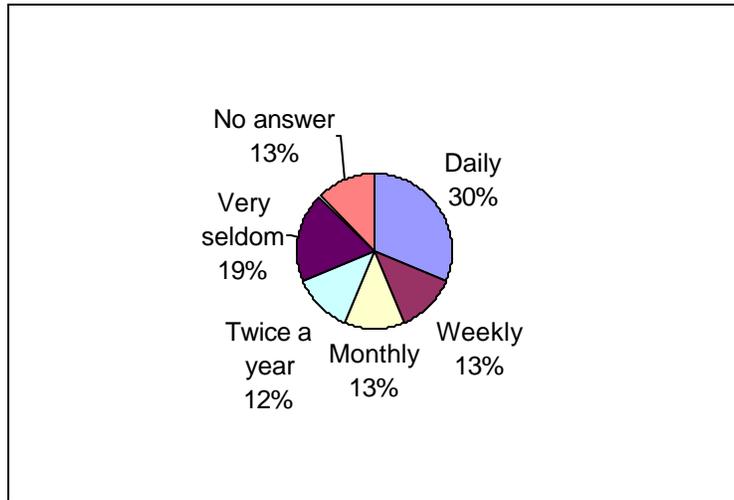
Figure 4.23 Frequency of supervisor relieving staff

4.3.25 Attendance of refresher courses

Refresher courses reflect on up to date knowledge. To keep updated with recent trends in heath care and new diagnostic and treatment techniques, the care and operation of new equipment, the optimal use of supplies and new policies, employees need to attend in-service education sessions and refresher courses on a regular base (Booyens 1998:384).

It is reason for great concern to note that according to Table 4.4 most of the refresher courses were done more than 3 years ago by both the supervisors and the CPHCNs.

Table 4.5 Refresher course attendance – Supervisors n=19, CPHCNs =66

	1 yr ago	2yrs ago	3 yrs ago	>4 yrs ago	Never	No answer
Supervisors – PHC	10.5 (2)	5.3 (1)	10.5 (2)	47.4 (9)	21.1 (4)	5.3 (1)
Supervisors – pharmaceutics	5.3 (1)	15.8 (3)	5.3 (1)	47.4 (9)	26.3 (5)	0
CPHCNs – PHC	24.3 (16)	25.8 (17)	18.2 (12)	13.6 (9)	16.7 (11)	1.5 (1)
CPHCNs-pharmaceutics	12.1 (8)	21.2 (14)	15.2 (10)	33.3 (22)	16.7 (11)	1.5 (1)

4.3.26 Furthering studies

The majority of the supervisors (15; 79.0%) and CPHCNs (61;92.4%) are currently not furthering their studies. Two (10.5%) of the supervisors and 2 (3.0%) of the CPHCNs who indicated that they are involved in further studies, are doing so in other areas than nursing. This does not bode well for the nursing profession's professional status. None of the supervisors were involved in studies in curative PHC, pharmacology, nursing administration or nursing education. One (1.5%) of the CPHCNs was studying nursing administration. According to paragraph 4.2.3 there is much room for improvement for all nursing qualifications used in the community health and management fields.

Both groups of respondents seemed to be well informed about the benefits of furthering their studies. Nine supervisors (48.0%) and 39 (59.1%) CPHCNs admitted that it would increase their knowledge when they study further, while 8 (42.0%) and 22 (33.3%) CPHCNs acknowledged being out of touch with recent developments. This correlates with supervisors already being better qualified and CPHCNs being more in the practice of things, and having had more recent refresher courses, as indicated in paragraph 4.3.25.

4.3.27   The reasons for rotation of CPHCNs

Supervisors were asked to describe the reason why nurses were rotated in their facility. Ten (52.6%) rotate the CPHCNs to enrich their jobs and develop their skills. Six (31.6%) used rotation of CPHCNs as a problem solving strategy to remove fighting parties from each other. This reflects on quite a lot of interpersonal conflict in PHC services. The fact that supervisors mention conflict between personnel as a reason (6; 31.6%) is in line with the findings about the number of authorities working under one roof (item 4.3.2), the integration of services (item 4.33) and the problems experienced with the integration of services (item 4.3.4). Figure 4.24 shows this distribution.
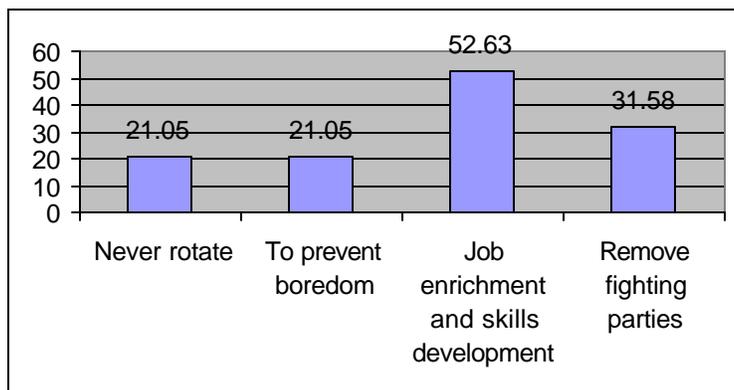
Figure 4.24 Reasons for rotation of nurses in service

4.3.28 Problems experienced by supervisors and CPHCNs

Supervisors seldom (8; 42.1%) or never (9; 47.4%) experienced problems with unions.

Communication channels were perceived as generally open between supervisors and their management, as reported by sixteen (84.2%) of the respondents. See Table 4.6. CPHCNs (45:68.2%) also reported general satisfaction with open channels.

There are larger numbers of CPHCNs reporting no follow-up of problems, supervisors leaving everything for them to resolve, and delegation of duty by supervisors, not authority. Delegation of duties without authority seems to be an equally big problem for both groups of respondents.

Usually staff was held responsible for duties, but was not given authority to enforce people to do them. This caused a lot of uneasiness, especially with middle management, and could be the cause of the poor delegation to the further category: the CPHCNs..

Table 4. 6 Communication with management Supervisors=19, CPHCNs n=66

	Open communication	No follow-up of problems	Leave everything for staff to resolve	Delegation of duty, not authority		
Supervisors	84.2% (16)	15.8% (3)	15.8% (3)	31.6% (6)		
CPHCNs	68.2% (45)	30.3% (20)	28.8% (19)	34.9% (23)		

4.3.29 Attributes of CPHCNs

As presented in Figure 4.25, attitude towards work, morale, independent thinking, productivity, self-drive, compassion and empathy towards patient and professionalism of the CPHCNs were all reportedly good in about 60.0 percent of cases. According to eight (42.1%) supervisors CPHCNs had an average morale (8; 42.1%), a third of the CPHCNs were regarded as only average on their independent thinking skill. Average professionalism was reported by five (26.3%) supervisors.
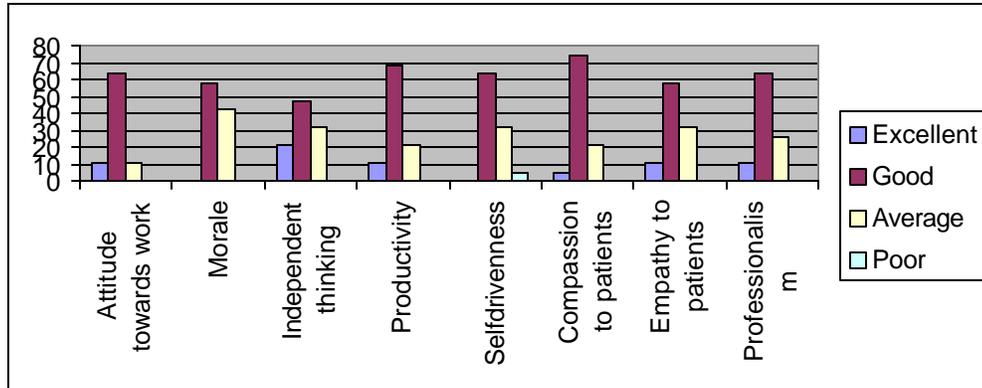
Figure 4.25 Attributes of staff as reported by supervisors

Sixteen (84.2%) of the supervisors rated their own morale as good, with only three (15.8%) rating it as average.

Staff generally coped well with new ideas (15; 79.0%). Supervisors and CPHCNs said that staff seldom had cultural clashes. Only two supervisors (10.5%) and four (6.1%) CPHCNs reported cultural clashes that took place quite *often*. Generation gaps were reported by three (15.8%) supervisors and nine (13.64%) CPHCNs.

4.3.30 Reasons given why CPHCNs moonlight

More than a half of the CPHCNs reported that they do not moonlight (36;54.0%). Eight supervisors (42.1%) also indicated that the CPHCNs in their services do not moonlight.
Supervisors (8; 47.0%) and CPHCNs (23; 34%) in this study indicated that the CPHCNs moonlight because of a lack of money,

4.3.31 Self-worth of supervisors and CPHCNs

The thought processes of supervisors and CPHNs were explored in order to establish how they value themselves in the service. Table 4.7 shows that the two groups feel equally valued as workers, being recognized for their contributions, motivated by supervisors to work hard, and that salaries relates to qualifications.   Generally CPHCNs feel much less that they are remunerated enough for what they do and that their supervisors listen to their problems. The habit of not being valued and motivated and listened to are carried over from supervisors to their CPHCNs, probably because they did not experience it themselves.

Table 4.7 Feelings of self-worth of supervisors and CPHCNs (n=)

	I feel valued as a worker	I am recognized for my contribution	I am remunerated enough for what I do	My salary relates to my qualifications	My supervisor always listens to our problems	I am motivated by my supervisor to work hard
Super-visors	57.9% (11)	47.4% (9)	47.4% (9)	42.2% (8)	73.7% (14)	42.1% (8)
CPHCNs	57.6% (38)	44% (29)	24.3% (16)	37.8% (25)	59.1% (39)	44.0% (29)

4.3.32 Community involvement in services

Community involvement in services as experienced by the supervisors was scrutinized and is displayed as Figure 4.26.   Eight (42.1%) reported that health committees were a way for the community to participate in health. Twelve (63.2%) believed community members could present themselves as volunteers. Only five (26.4%) of the supervisors asked their community to supply letterbox complaints, while none handed out questionnaires to ask the opinion of the community about the service. There thus seems to be a lack of feedback from the community about the services they receive at the clinics.
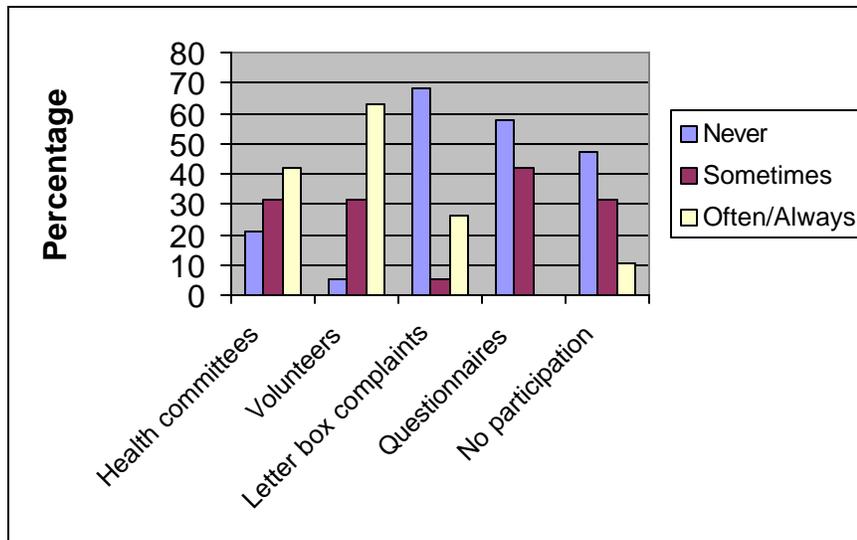
Figure 4.26 Participation of community in services

4.3.33 Perception of the supervisors about the effectiveness of contact with other role players

Figure 4.27 demonstrates the effectiveness of contact with principle role-players. The most effective contact appeared to be with teachers

(11; 57.9%) and ministers (7; 36.8%). Contact with members of local council was only reported by three (15.8%) to be effective. This is disappointing, as one would want local council members to be informed and active in their communities' health care needs. Traditional healers do not play such a great role in the study because the clinics are situated in an urbanized area.
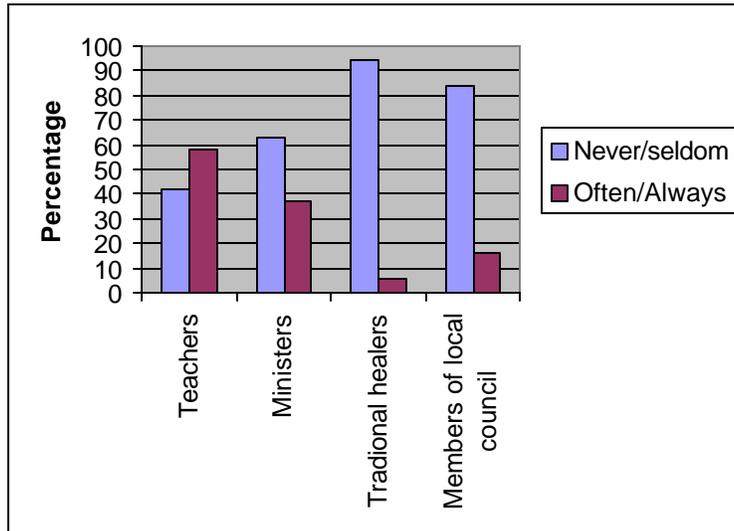
Figure 4.27 Effectiveness of contact with role-players

4.3.34 The role the community have in the service

It seems as if the supervisors were not in agreement about the value of members of the community in the health service. Six (26.0%) of the supervisors reported that the involvement of the community improved the health care while the same percentage (26.0%) reported that the involvement of the community never improved healthcare. The improvement in health of the community due to involvement of role players in the community (as perceived by supervisors) is demonstrated in Figure 4.28.
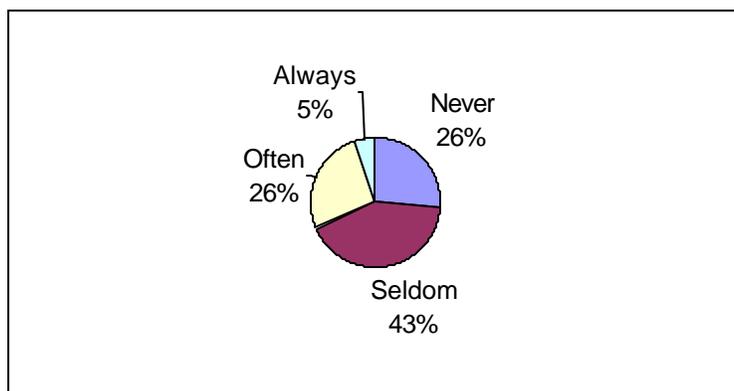
Figure 4.28 Improvement of health because of involvement of role players in the community

4.3.35 Factors important for delivery of an appropriate and efficient service

Appropriateness refers to "*the degree to which the care /intervention provided is relevant to the patient's clinical needs*" while efficiency (efficacy) relates to "*the ratio of the outcomes (results of care/intervention) for a patient to the resources used to deliver the care*" (Shelton 2000:55-56). The response of the supervisors about the importance of specific factors in the rendering of an appropriate and efficient service is reflected in Figure 4.29. EDL and policies seemed of major importance (17; 89.5%) while not wasting resources was also regarded as highly important (16; 84.2%). Although auditing of records was seen as of less importance than the former two, managers also rated the importance thereof as thirteen (68.4%).
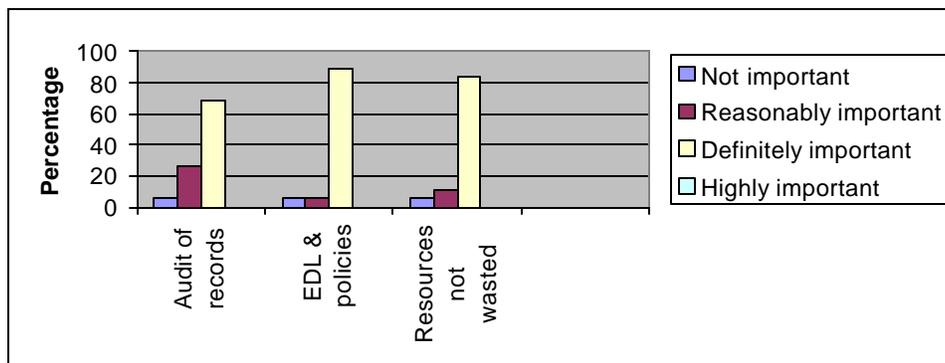
Figure 4.29 Factors important for delivery of an appropriate and efficient service

4.3.36 Reasons for delay to be seen by the curative nurse

Shelton (2000:97) describes waiting time for health care as stressful and "*the wait is usually unoccupied time, waiting mostly for preprocess services, the personnel too busy or unconcerned to inform the patient of the reason for the wait*". The supervisors contributed the reasons for delay of more than 2 hours to be seen by a curative nurse mainly to the overcrowding of clinics (14; 73.7%) and shortage of staff/equipment (12; 63.2%). The attitude of staff, the curative PHC approach and the lack of skills and poor organization did not seem to be such big problems for the supervisors.
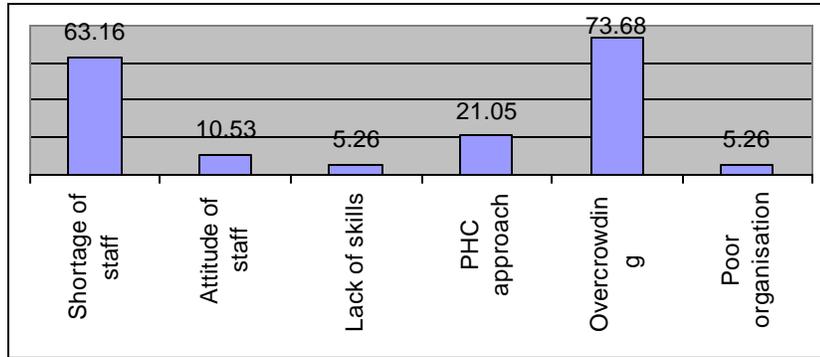
Figure 4.30 Reasons for delay to be seen by curative nurse

4.3.37 Constraints to delivery of a quality service

The perceptions of the supervisors about the importance of constraints in developing of a quality service are reflected in Figure 4.31. The lack of staff (16; 84.2%) was regarded as the most important constraining factor to delivery of a quality service. The second important factor was the attitude of staff (14; 73.7%), followed by lack of money for supplies (13; 68.4%) and morale of staff (11; 57.9%).
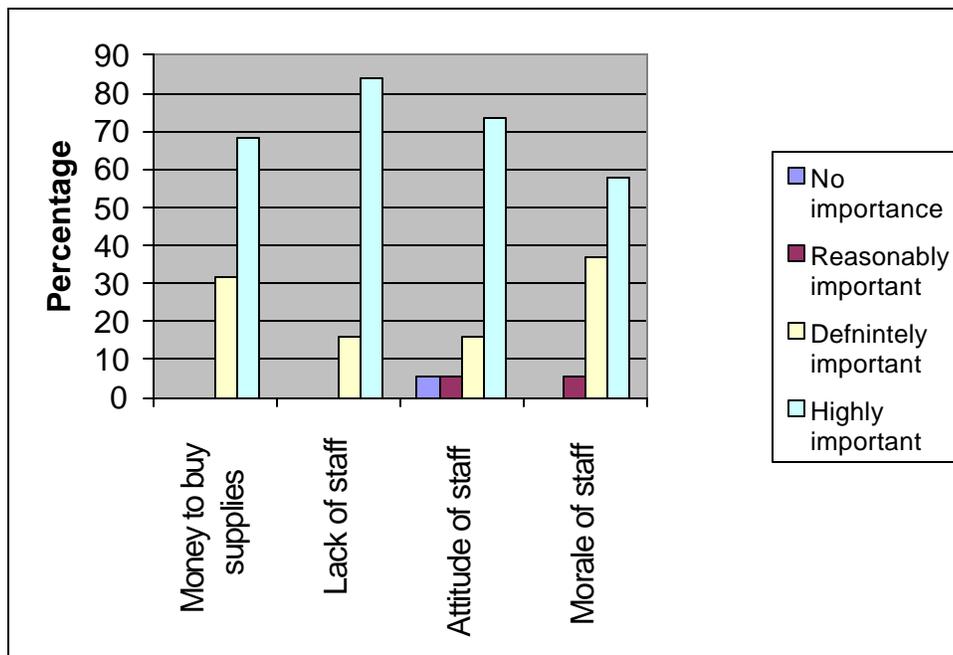
Figure 4.31 Importance of constraints to delivery of a quality service

4.3.38 The average number of visits to the clinic per year and the same patient return with same complaint

According to most respondents patients visited the clinic 6-10 times per year (Figure 4.32). This must have been quite a burden to the clinic staff. The respondents reported that some of the patients often (4; 21.1%)

returned with the same complaint, while 15(79.0%) reported that patients sometimes returned with the same complaint. This placed another burden on the services (almost a quarter of patients returning often for the same complaint).
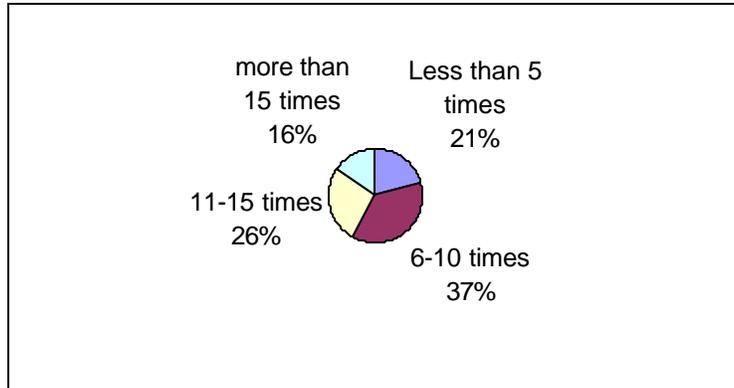
Figure 4.32 Average amount of visits to clinic per year

SECTION C

This section deals with data obtained from the practitioners (CPHCNs) about their own service delivery.

4.4   CURATIVE PHC SERVICE DELIVERY

The questionnaire to the CPHCNs yielded the following results:

4.4.1   Operating hours and days of the services

The majority (55; 82%) of the respondents worked in services functioning 5 days a week providing services mostly (62; 94%) between 08:00 and 16:00. See Table 4.8.

Table 4.8 Number of days that services function

Number of days	N = 66	%
No answer	2	3.0
1 day	3	4.6
2 days	1	1.5
3 days	1	1.5
4 days	3	4.6
5 days	55	83.3
6-7 days	1	1.5

4.4.2 Visits of medical practitioners to services

A medical practitioner visited the services as follows: Most services

(21; 31.8%) refer to another point, e.g. clinics to day hospital in coverage area. Of the rest, thirteen (19.7%) have doctors stationed at their service. About 40,0% respondents indicated that a medical practitioner visited their clinic from respectively one to five times a week.
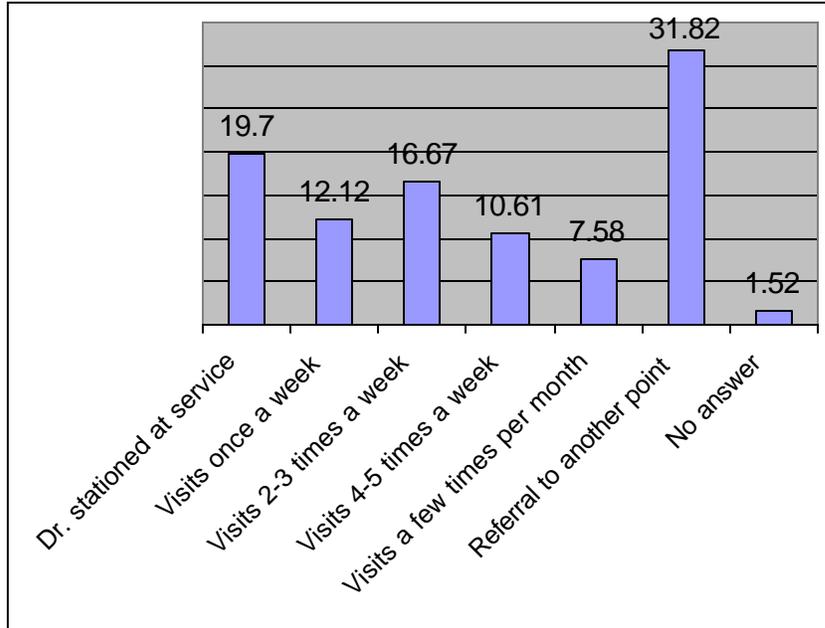
Figure 4.33 Medical practitioner coverage of clinic

4.4.3   Referral to other members of multi-disciplinary team

The purpose of multi-disciplinary teams is to improve complex patient care processes in which they participate (Stanhope & Lancaster 1988:138). An important facet of the multi-disciplinary approach is that members of the multi-disciplinary team will refer patients to other members of the team whenever necessary. Figure 4.34 indicates the members of the multidisciplinary that CPHCNs refer patients to: dentists (63 or 95.5 %) dieticians (59 or 89.4%) and physiotherapists (49;74.2%). Traditional healers and midwives were never referred to, but 40-60% of respondents indicated that their patients did consult them directly.
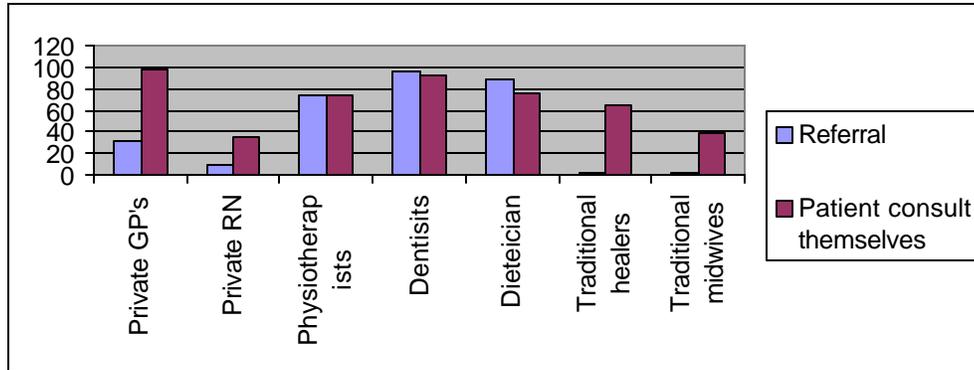
Figure 4.34 Medical team referral and direct consult by patients

4.4.4 Complaints of patients

Shelton (2000:235) defines a complaint as "*a patient's statement about expectations that have not been met*". He adds that this also provides the service with an opportunity to satisfy a dissatisfied patient and preventing a service breakdown.

The only complaint the patients were reported to 'always' have is the long waiting time. In all the other cases respondents reported the complaints more as *often* than *always*. The complaint about the long waiting times should be considered as serious, as it scored the highest of the scores about complaints often made by patients.

Respondents gave the following data about complaints of patients:

- poor quality of the service (16;34.3%)
- treatment did not work properly, so they had to return (15;22.7%)
- not enough medicines given (11;16.7%),
- the nurse is not as good as the doctor (11;16.7%)
- inconvenient clinic hours (11;16.7%)
- unfriendly staff (9;13.6%)
- clinic too far away (10;15.2%)
- unavailability to some state patients (10;15.2%)
- health problems not properly managed (10;15.2%)
- not being properly examined (9;13.6%).

4.4.5 Supervision and feedback received by CPHCNs

"*One of the biggest complaints that team members have is that many leaders are unwilling to confront and resolve issues associated with inadequate performance*" (Fitzpatrick 2003:139). It is therefore of great concern that many of the respondents indicated that they never (21; 31.8%) or seldom (14; 21.2%) receive any feedback about their service from their supervisors (Figure 4.35). This shows a serious lack of communication from the supervisors. Those (18; 27.8%) that reported regular feedback, received it 1-3 monthly.
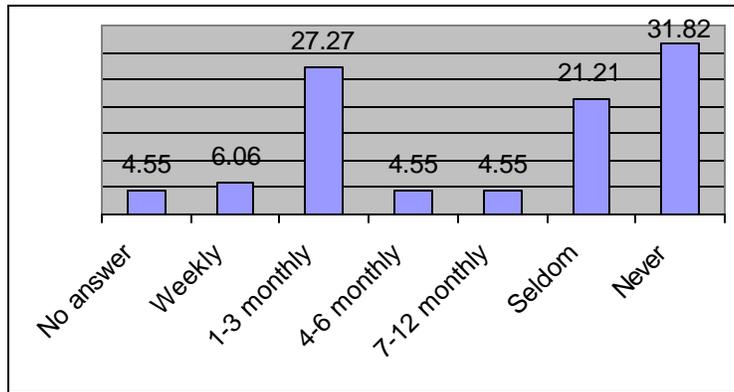
Figure 4.35 Frequency of feedback about service

4.4.6 Professional and thorough examination of patients

Table 4.9 shows aspects of professional care rendered by CPHCNs. Twenty-one (32%) respondents only reported complete and orderly notes with 81-100% of their patients. Accurate documentation on all records is essential in order to protect the patient, the nurse and the institution from litigation process (Troskie 2001:349). The number not to comply with complete record keeping is too large to ignore.

Most of the CPHCNs (44 or 66%) state the main complaint of patients in the notes at least 81-100% of the time. The same amount also indicated that the systems examined is relevant to the complaints of 81 to 100 % of patients.

The diagnosis is clearly stated and relevant to the main complaint and systems examined for half of the respondents (36; 54.6%). About a third reports the same with 61-80 percent of patients.

Forty (60.61%) respondents reported that their prescriptions are relevant to the main complaint, systems examined and diagnosis with 81-100% of the patients, and 42 (63.64%) indicated that the nurse prescribes according to the EDL with 81-100% of the patients.

It is indicated by 32 (48.5%) respondents that they use medical terms most of the time, while 20 (30.30%) use it at least 61-80 percent of the time. Most of the respondents (48 or 72.73%) examine about eighty to hundred percent of their patients; while11 (16.67%) does it 60-80 percent of the time. Only twelve (18%) respondents said that less than eighty percent of their patients do not receive medicines for their complaints.

Table 4.9 Occural of professional and thorough examination of patients

Factor	With 1-20% pts	With 21-40% pts	With 41-60% pts	With 61-80% pts	With 81-100% pts	No answer
Patient notes are complete and orderly	6.1(4)	1.5 (1)	18.2 (12)	37.9 (25)	31.8 (21)	4.6 (3)
Main complaint is stated	1.5 (1)	1.5 (1)	3.0 (2)	24.2 (16)	66.7 (44)	3.0 (2)
Systems examined are relevant to main complaint	0	0	6.1 (4)	24.2 (16)	66.7 (44)	3.0 (2)
Diagnosis is clearly stated, relevant to the main complaint, the systems examined and the diagnosis	0	3.0 (2)	6.1 (4)	33.3 (22)	54.6 (36)	3.0 (2)
Prescription relevant to main complaint, systems examined and diagnosis	1.5 (1)	0	3.0 (2)	31.8 (21)	60.6 (40)	3.0 (2)
Prescribed according to EDL	0	0	6.1 (4)	27.3 (18)	63.6 (42)	3.0 (2)
Medical terms used	3.0 (2)	0	15.2 (10)	30.3 (20)	48.5 (32)	3.0 (2)
Patients not examined	72.7 (48)	16.7 (11)	1.5 (1)	3.0 (2)	0	6.1 (4)
Patients not receiving medicines for complaints	77.3 (51)	9.1 (6)	1.5 (1)	3.0 (2)	4.6 (3)	4.6 (3)

4.4.7 The causes of unsafe practices

As indicated in Figure 4.36, CPHCN's (56 or 84.9%) blamed the number of patients that each nurse has to see, as well as lack of time to see the patients (48; 72.7%) as the cause of unsafe practices. The third important factor is knowledge that was not kept up to date (31; 47.0%). Thorough examination not being done is also given as a factor by quite a large number of respondents (25; 37.9%). Poor communication with the patients (22; 33.3%) was also given up by too large a group of respondents to be comfortable with.
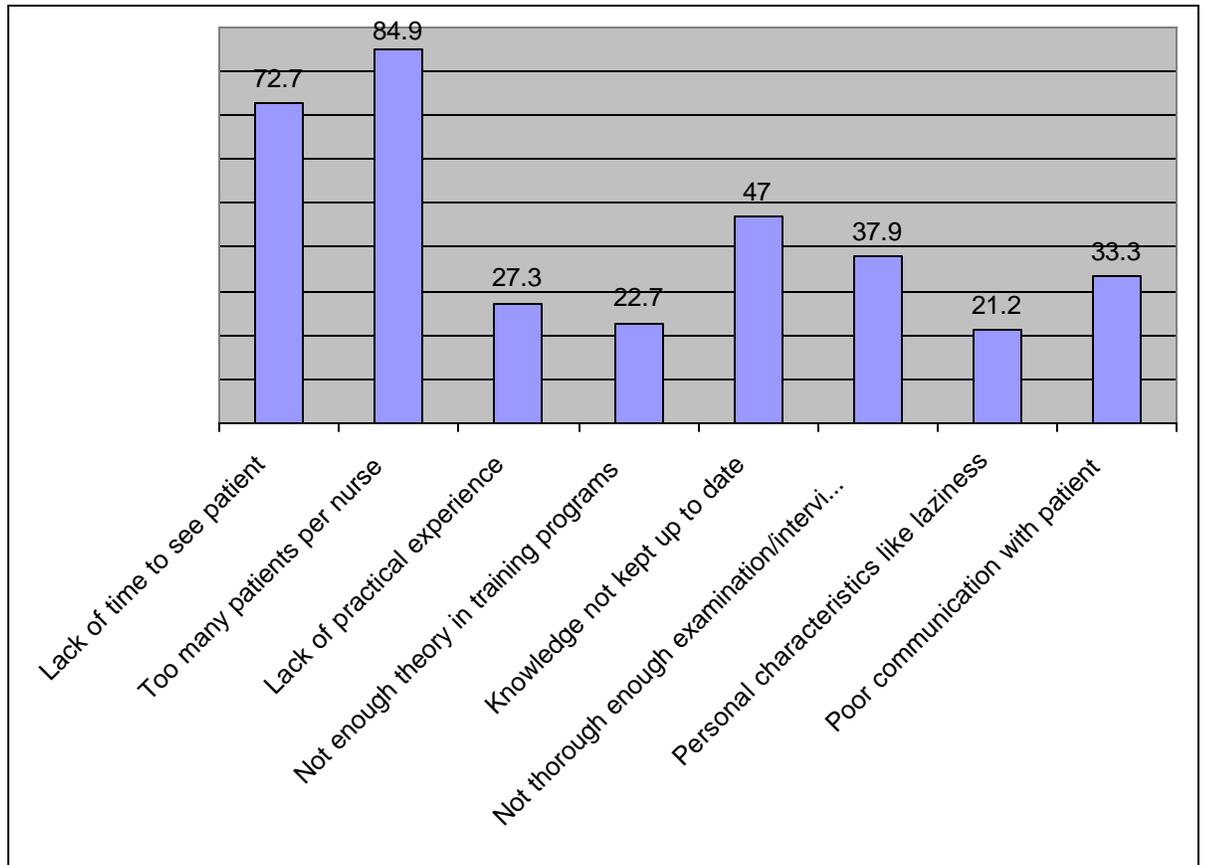
Figure 4.36 Causes of unsafe practice

4.4.8 Curative time spent by CPHCNs

Curative services occupied most of the CPHCNs time as thirty-three (50%) indicated that they delivered curative care full-time, while a little more than quarter (26%) delivered curative care for 25-32 hours per week. The remaining (24%) only delivered it 1-24 hours per week, as Figure 4.37 shows.
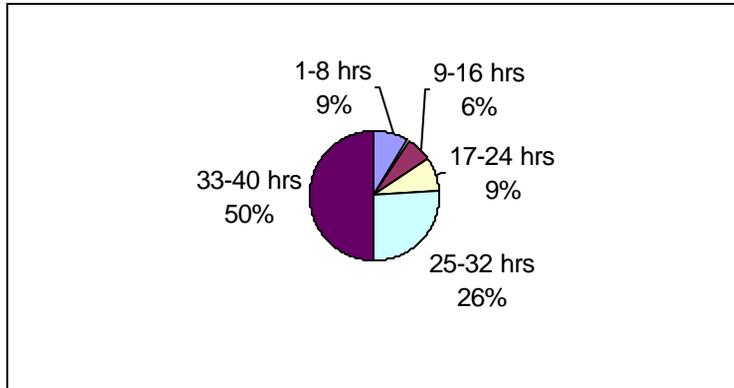
Figure 4.37 Hours spent in curative care per week

4.4.9 Other services rendered by the CPHCNs

CPHCNs indicated that they are also held responsible for the smooth running of other services, and thus are not only expected to be specialists in their own field, but also to be generalists. Only a small percentage of CPHCNs are allowed to be specialists in their field only. They are also offering
- a family planning service on a daily basis (52 or 78.8%),
- a TB service daily (46 or 69.7%),
- a healthy baby clinic (31 or 47.0%),
- dressings (44 or 66.7%),
- feeding schemes (30 or 45.5%),
- HIV counseling (46 or 69.7%),
- antenatal services (22 or 33.3%),
- postnatal services (22 or 33.3%),
- preventative projects (24 or 36.4%).

See figure 4.38.
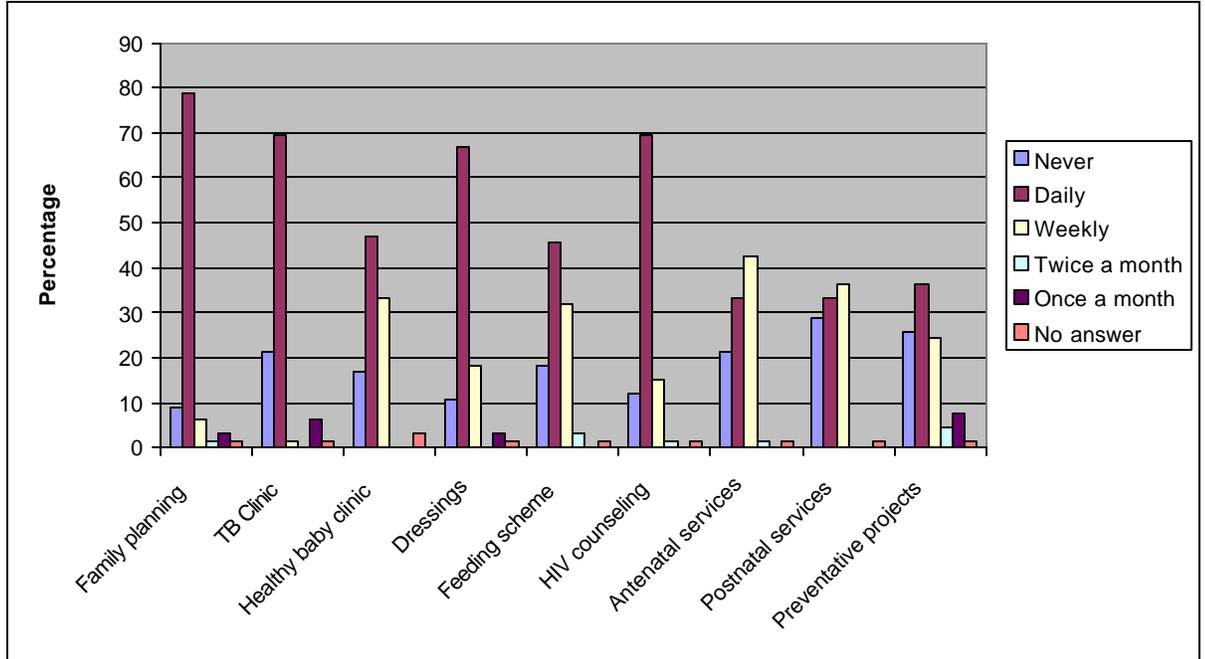
Figure 4.38 Other services CPHCNs are responsible for

4.4.10 The number of patients the CPHCNs refer to doctors

Most of the time the CPHCN' were capable of rendering the necessary services to the patients on their own without reference to the doctor. This is demonstrated in Figure 4.39 where most CPHCNs (39 or 59.1%) only refer 1-10% of their patients to the doctor.
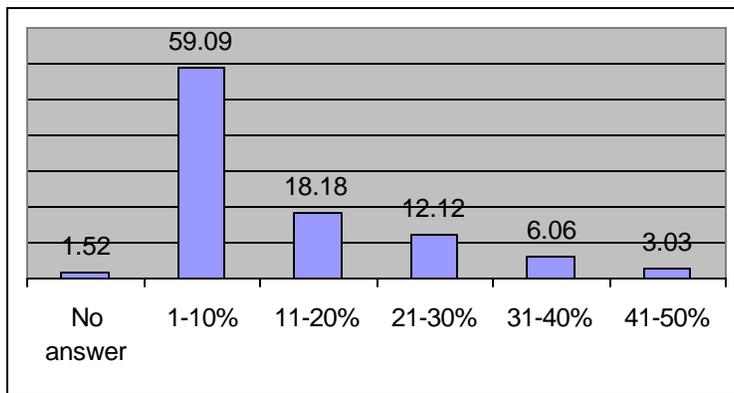
Figure 4.39 Number of patients referred to doctor

4.4.11 The extent of consultation time of CPHCNs

The average time spent on consultation per patient is in 54.0 percent of cases less than 6-10 minutes. Ten minutes is very short to interview, examine, diagnose patients, and these nurses function under tremendous pressure. This state of affairs can also be very annoying to patients who

waited 2-4 hours for the consultation and when it is time for their consultation, the practitioner is in a hurry.

A large number of CPHCNs (25 or 38.0%) indicated that they take a bit longer to consult a patient, namely 11-15 minutes.
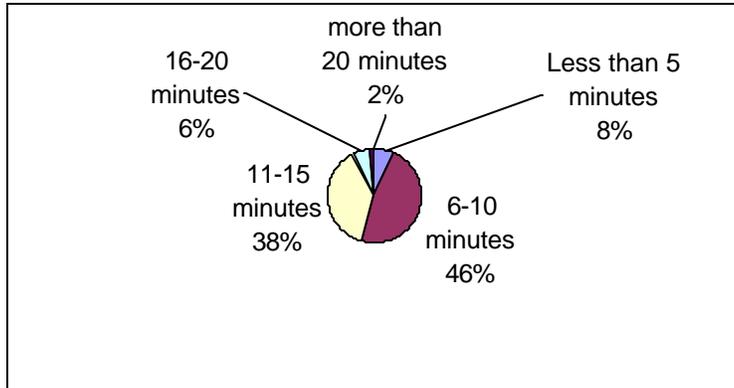
Figure 4.40 Amount of time spent on each patient

4.4.11 The extent of physical examination of patients by CPHCNs and reasons for overlooking it

Only five (7.6%) CPHCNs indicated that they do a full physical examination on a patient in 6-10 minutes. The most do it either in 11-15 minutes (31;47.0%) or 16-20 minutes (25;37.9%).

Most CPHCNs indicated that they do a physical examination
- often (26 or 39.39%)
- sometimes (27 or 40.9%)
- seldom (91.1% or 6).

When they were asked for the reasons not doing a full physical examination on *all* patients, an alarming number (34 or 51.5%) indicated that they felt it was unnecessary. The majority (46 or 69.7%) said that they did not have the time to do it as illustrated in Figure 4.41.

This means that they either have developed ways of screening the patient quickly, that patients are coming in large numbers with minor complaints,

or that serious conditions were overlooked which would be prevented
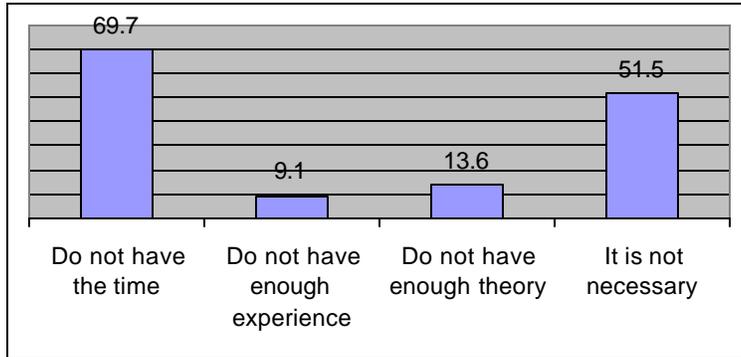
Figure 4.41 Reasons why no physical examination done

4.4.13 Handling of patients when there is a lack of time

When the CPHCNs were asked what they do when they do not have enough time to handle all the patients, the following was reported:
- They felt stressed (48;72.7%),
- They worked faster and leave out less important detail (37;56.1%).
- They send patients away (usually to another health center) (18;27.3%),
- They become impatient and cross (7 or 10.6%).

4.4.14 Attitudes of CPHCNs, colleagues, patients

The CPHCNs was asked to rate attitudes of their colleagues on the following: Attitude towards work, morale, independent thinking, productivity, self-drivenness (ability to do things out of own motivation instead of being motivated by external forces), compassion and empathy towards patients and professionalism. Most thought that their colleagues scored average or poor, as demonstrated in Figure 4.42.
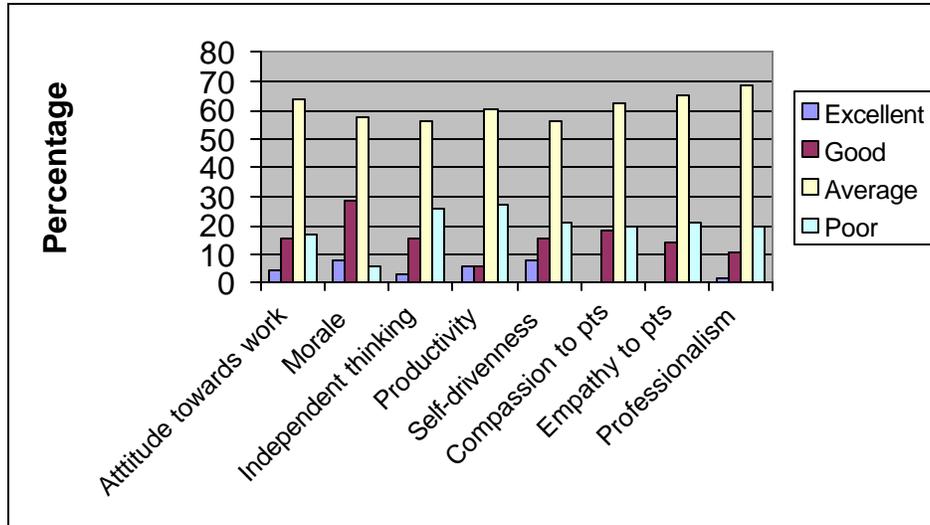
Figure 4.42 Rating of colleagues' attitudes and qualities

Own attitudes towards working conditions were reported to be good by most (48;72.7%)and excellent by eleven (16.7%).

The CPHCNs experienced patients as follows. They were often
- demanding (47;71.2%),
- thankful (48;72.7%),
- collaborative (44;68.1%),
- unreasonable (29;43.9%)
- aggressive (15;22.7%)

4.4.15 Influences on communication between CPHCNs and patients

Communication between patients and CPHCNs is very important and can contribute to the speedy recovery and well-being of patients and the community. Lack of privacy (34.5%) and cultural differences (33.3%) were reported by a third of the respondents as the biggest problems. The low literacy levels of the patient (30.3%) and impatience of the nurse (27.3%) is the next largest reasons given for poor communication between the CPHCNs and the patients. Physical disabilities of patients were reported by about a fifth (19.7%) of the respondents as being a problem. See figure 4.43.
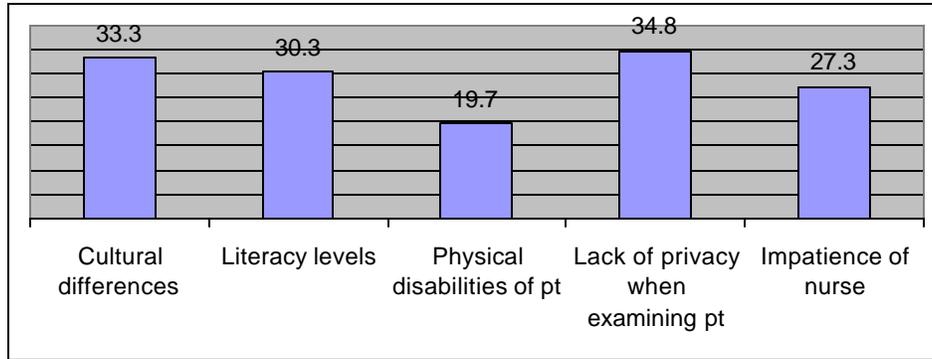
Figure 4.43 Influences on communication between nurse and patient

4.4.16 Quality of the curative service as rated by the CPHCNs

Muller (1998:595) describes quality as an integral part of health care and as part of its professional standards, guidelines and codes.
Most of the respondents (43:65.6%)perceived themselves generally as having good to excellent skills in the qualities mentioned on the questionnaire. Doing a full physical examination is rated excellent or good by forty-three (65.6%). More CPHCNs also rated themselves good or excellent on safety, competence, interpersonal relationships, compassion, taking a comprehensive history, proper record keeping and giving health education. Most gave themselves excellent to good marks for continuity, work ethics, accountability, and diagnosis of the condition, prescribing treatment and knowledge when to refer.

4.5   SYNTHESIS OF FINDINGS

Spearman's' correlation coefficient was used to determine the relationships between variables, as the data is ordinal and categorical. Correlation refers to the degree of correspondence or a relationship between two variables. It measures the strength of the linear relationship between them. The correlation coefficient is an index of the strength of this relationship, e.g. with a positive relationship, a higher score on one variable will be associated with an higher score on the second variable (Roscoe 1975:93-94). Throughout the synthesis of findings, it will be indicated where such relationships were found.

4.5.1   Biographical data

The age of the supervisors in this study were generally 40-49 years, while those of the PCCN's were 30-49 years. The workforce is already elderly, with few youngsters, as Aiken et al (2001:4-10) found. The gender of both groups of respondents (supervisors as well as CPHCNs) consists mainly out of females, which is in accordance with the gender composition of the nursing profession.

4.5.2 Perceptions of supervisors and CPHCNs

The following is a summary of the information the questionnaires yielded:

4.5.2.1 Management/ Policy of Government and politics of change

- There are still different authorities under one roof of which PAWC and the local municipalities are the most common role-players. CPHCNs doing the same work, but receiving different categories of salaries are working side by side.

- Most of the services are semi- or fully integrated, meaning that there is coordination of tasks. There are a few institutions that still deliver the same services, without coordination.

- Problems due to different authorities and lack of integration reported by supervisors are generally lack of collaboration amongst CPHCNs, jealousy about difference in salaries and non-acceptance of staff and aggressiveness towards each other. Rotation to different clinics is sometimes used as a tool to remove conflicting parties from each other.

- Turnover does not seem to be a large problem, although there is a slight upwards tendency. Absenteeism is also only reported to be high in a small number of services and is generally not frequently observed.

- Generally supervisors reported that staff copes well with new ideas

4.5.2.2 Resources

Clark and Maben (1999:107) reports that staff have constraints imposed upon the quality of their service due to resource limitation. The nurses in the Southern Cape/Karoo region also experience these. Eighty percent of CPHCNs and ninety percent of supervisors report that lack of resources causes them stress.

- Human
  Lack of staff is the most important factor for delivery of a quality service. It is therefore worrying that there have been no recent increases in staff reported by as much as 84% of supervisors. As well as this problem, 89% supervisors reported a lack of staff to adequately cover the services. This causes a delay in seeing patients. A slight increase in turnover was reported. Staff turnover causes the need for regular orientation to take place.

  Kraus (1999:12) are thus spot-on when he says that nursing has unrealistic low staffing levels. Because of lack of staff, a third of supervisors have to relief CPHCNs on a regular basis, neglecting some of their own management tasks in the process. Elgoni (2001:1) predicted that this was

going to cause an inability to deliver continuity of care. A highly significant correlation (probability = 0.0027) was found between this perceived lack of staff and the amount of stress that CPHCNs experience.

Gwala (1995:18) predicted that 4 health visits would cost the state 7.9 billion rand in 2000. Workloads have increased, with an average of 6-10 visits per patient per year. Supervisors (42%) report that patients mostly visit the clinic more than 11 times a year, with all patients at least sometimes (79%) or often (21%) returning with the same complaint. This is spreading the resources very thinly. In local clinics it was experienced that patients were told to get cough mixtures and pain tablets at local pharmacies in town, as chronic patients needs' (often receiving 6 drugs at a time) take precedence over coughs and minor illnesses. Imagine what this would do to a person, having to obtain transport from a far-off farm, waiting in the waiting room for hours to be seen, to be told that he cannot be helped, and must go buy his own medicine in town! Yet posts are frozen and governmental representatives and politicians tell the community and staff outright that there is no money for more resources.

The clinics are open mostly 5 days a week, from 08:00 to 16:00. Patients complain about inconvenient hours (36% of respondents) and long waiting times (68% of respondents) at the clinic. This causes problems for working people and parents arriving home after work to find their children sick. Weekend health coverage are also provided by provincial hospitals, often far from clinics and community members who visit them. These are all problems of infrastructure as reported by authors every year from 1995 to recently: Gwala (1995:15) , Maholo and Khoza (1999:34) and Seshoka (2001:31). No improvement seems to take place, and the problem seems to be worsening.

Although reported working hours are quite acceptable, CPHCNs experienced them to be long. This is therefore contributing to their stress levels, as the correlation coefficient indicates (probability significant = 0.0122).

According to 74% of respondents, most of the clinics have good referral systems in place, with multi-disciplinary teams consisting of dentists, dieticians and physiotherapists available for the public.

- Material
Obtaining stock and or equipment are often a problem for 53% of supervisors, as stores often do not have adequate amounts. The budgets allocated to clinics are also insufficient as 75% of supervisors indicated.

- Buildings
Most buildings (68% of supervisors reported) are inadequate for the number of patients it has to accommodate. Waiting rooms are too small and shortage of toilets is a general problem for staff and patients. Distances patients have

to travel to clinics are frequently reported as a complaint to 52% of supervisors.

- Computerization

Services (47% respondents reported) do not have the use of computers, and are thus unable to use and plan according to available statistics. A large amount (53%) of supervisors reported that their services are partially computerized, meaning that they cannot fully make use of computer systems.

4.5.2.3   Experience, educational opportunities and status

- Supervisors have more than 14 years experience in the field of community health nursing, while most CPHCNs have 0-7 years experience. Experience is necessary for dealing with unique problems. The more experience you have, the more you are able to deal successfully with a large amount of situations. Fortunately there seems to be more CPHCNs with longer curative PHC experience than general community health nursing experience. It also seems like the experienced people are not practicing, but managing, as found by Strachan (1999:8).

- General nursing and midwifery are the basic educational characteristics of the majority of CPHCNs and supervisors. About 68% of both groups have community health nursing as a qualification. A small number of CPHCNs (6.06%) and supervisors (10.53%) are functioning without a curative PHC qualification. In the case of CPHCNs it can be the cause of medico-legal hazards, and in the case of supervisors, a lack of understanding what their CPHCNs have to deal with. A very small number of both supervisors and CPHCNs do have psychiatric nursing. It is interesting that a positive correlation existed between those that has psychiatric nursing as an qualification and those that reported an ability to think independently (probability = 0.0166).

- Refresher courses in PHC and pharmaceutics were done more than 3 years ago by 48% of supervisors, as well as 50% of CPHCNs. No recent new knowledge has been obtained. A large number of supervisors and CPHCNs acknowledged being out of touch with recent developments in their area of work.

- Supervisors are not furthering their professional studies, although they are aware of the importance of updating their knowledge for professional development. Only about 60% of supervisors have community health nursing, 40% has nursing administration, and 20% have nursing education. While the CPHCNs are generally less qualified than the supervisors, at least 2% of them are studying nursing administration and 3% community health nursing. One wonders at the reasons for this small

numbers studying further. It seems as if there is a general disinterest in nursing.

- Rotation as an educational tool is used by half of the supervisors.

4.5.2.4 Leadership qualities of supervisors

- Management generally takes place by encouragement to follow disease protocols, having staff meetings and in-service training sessions. A few supervisors give attention to motivation of staff and setting of service standards. Attention is seldom given to clinical audits and enforcing staff in following of job descriptions. Generally nobody looks at patient complaints/satisfaction surveys/opinion of community health committees or performance indicators and peer reviews.

- Supervisors believe that using the EDL and policies are important for proper care, and prevent wasting of valuable resources.

- Audit of records are also important to 68% of managers.

- Supervisors give themselves credit for all the good qualities supervisors should have (being good role models, generous, constructive listeners, having empathy with CPHCNs, being non-judgmental, good trainers, and having a good theoretical knowledge, being honest, genuine, having moral behavior, being forgiving, constructively challenging).

- CPHCNs do not experience this to be true. Many (43%) of the respondents indicated that they seldom or ever get any feedback from their supervisors. There seems to be a great lack of communication in this area, according to CPHCNs. A third of CPHCNs feel that management do not follow up reported problems, leave everything for nurses to resolve themselves, gives no support, delegate duties without authority.

  Correlation studies show a significant positive relationship ($p = 0.0344$) between CPHCNs perception of the lack of experience of supervisors, and the amount of stress the CPHCNs have. A highly significant correlation ($p = 0.0003$) exists between perception of not receiving enough support from authorities and amount of stress experienced by CPHCNs. There is also a negative correlation between the amount of supervisors reporting honesty, and the amount of CPHCNs not experiencing support from management ($p = 0.0274$). A negative correlation also exists between the amount of supervisors reporting themselves to have empathy with the CPHCNs and the number of CPHCNs reporting that management does not follow up reported problems ($p = -0.0326$). Another negative relationship exists between the number of supervisors describing

themselves as a good trainer, and the number of CPHCNs that report that their supervisors do not follow-up reported problems.

- Delegation of duties, but not authority to carry them through, seems to be a problem for 31.58% of supervisors and 35% of CPHCNs. Middle management (supervisor-level) and CPHCNs are held responsible for duties, but are not able to enforce staff to carry them through. One comes to the conclusion that good examples/knowledge about proper delegation is lacking in the service.

- There is only a small percentage of supervisors that recognize that they are lacking some skills: having a forgiving attitude, being a constructive listener, challenger, having enough theoretical knowledge, managerial skills and being a good trainer and motivator. A larger percentage (40%) CPHCNs feel that supervisors do not listen to their problems.

- Union interference does not seem to be such a great group influence, as Bloor (1995:162-179) expresses in his literature in this area. Probably because communication channels generally are reported to be open between supervisors and management. The potential for union interference do exist with CPHCNs experiencing less open communication channels between them and their supervisors.

- Although supervisors see themselves as having above good qualities, they do not really feel that their employers, as also reflected by their salaries, value their services. This is also the opinion of the CPHCNs, as just under a half of the respondents feel they are not valued as workers, and only a quarter feel that they are remunerated enough for what they do.

- Supervisors as well as CPHCNs generally feel that they do not receive much motivation from above, and are mostly self-driven or totally unmotivated to do anything. This reflects on both groups' morale.

4.5.2.5   Service delivery

- Fifty percent of CPHCNs are able to specialize full-time, while the rest has to be generalists and also deliver preventative care, like family planning, healthy baby clinic, feeding scheme, HIV counseling, ante- and postnatal services and preventative projects. While this allows the person to deliver holistic care, it also expects CPHCNs to be knowledgeable about and able to deliver a large range of care.

- CPHCNs generally (59%) are managing most of their patients and referring the minimum to the doctors. This can be a reflection of the

experience and expertise of CPHCNs, but also a reflection of the burdens they have to carry because of the lack of doctors generally in the country.

- Most (54%) CPHCNs spend 6-10 minutes per patient. This seems to be a short time to take history, examine, make a diagnosis and prescribe. In such a short time, signs and symptoms might be missed, and the patient might not get the proper medical care. It is not surprising that only six percent report that they are able to do a full examination in the time available. Most CPHCN' see it as unnecessary, as they do not have the time for it.

- Generally CPHCNs handle the time problem as follows: feel stressed but work faster and leave out less important detail. A third send patients away, and a small number (11%) get impatient and cross.

- Only 66% of CPHCNs always state the main complaint of patients in the notes. The main complaint stated makes it easier to decide whether the right systems were examined, and if the patients received care for the specific problem they visit the clinic for. It is good to diagnose other problems, but if the main complaint is ignored, the patient will come back continuously, putting more workload on the already stretched services. It is interesting to see that there is a positive correlation between those CPHCNs stating their main complaint regularly and those qualified in community health nursing ($p = 0.0156$) and psychiatry ($p = 0.0240$). This must be an indication that those qualifications makes one aware of the necessity for the main complaint stated, more so than other qualifications.

- Systems examined are relevant to the complaints for most of the patients, according to 67% of CPHCNs. It is problematic that this is not the case for the rest of the cases, as 33% is too high a number to have irrelevant examinations, wasting time of the nurse, as well as the patient. As with the previous point, those with qualifications in CHN ($p= 0.0240$) and psychiatry ($p= 0.0399$) have a positive correlation with relevant systems examined according to main complaint. The same assumption than with the previous point can be made here.

- The diagnosis is clearly stated and relevant to the main complaint and systems examined for half of the respondents. This makes it difficult for follow-up, especially if another CPHCN has to see the patient. A great degree of reading must be done to obtain the history, especially in medically illiterate patients. If the diagnosis is not properly stated, it takes longer to catch up on the patient's history, and some CPHCNs might even ignore the history and thus miss some signs and symptoms and measures already taken. This causes discomfort to the patient and medical-legal issues to the nurse.

- Only 60% of CPHCNs say that the prescriptions are relevant to the main complaint, the systems examined and the diagnosis, and only 64% prescribes according to the EDL for most of the patients. This will cause unsatisfied patients, as the main complaint has been ignored, and will decrease amount of money available for state patients, as EDL has not been followed. Most CPHCNs say that at least 80% of their patients receive medicines for their complaints. This is a good number, in the sense that many patients come to the clinic, sit there the whole day waiting, to hear that they need cough syrup, or rubbing ointment, but that the clinic is out of stock, and that they have to buy some at the local pharmacy. This also increases the frustration of the patients, who takes it out on the nearest health service provider, the CPHCN, instead of those that allocate the budget and the politicians, whom they cannot reach.

- Using medical terms in notes is important, as it gives an indication to peers that CPHCNs are still thinking scientifically. It is necessary to explain to the patient in lay terms about disease and process, but using medical terms helps peers to understand the diagnosis, as there is many confusing lay terms that does not necessarily pinpoint the problem scientifically. Less than half of the respondents (48%) uses medical terms most of the time, pinpointing a need for relevant and recent service programs.

- Most of their patients are examined according to most CPHCNs (73%). One does worry about the number that has been diagnosed and medicine being prescribed without being examined in one way or another. A CPHCN cannot go on history alone, and always has to at least see the progress of the disease even with something so mundane as a follow-up.

- Almost a third (32%) of CPHCNs report that their notes are orderly and complete in most cases. The rest report that this takes place in 80% and less of cases. The number that is incomplete is worrying.

- Most CPHCNs generally see themselves as good or excellent in continuity of care, work ethics, accountability, diagnosing a condition, prescribing for the right condition, knowing when to refer a patient to the next level. A slightly smaller amount (but still above 81%) generally see themselves as safe and competent practitioners, with good interpersonal relationships, taking a comprehensive history, keeping record properly, giving adequate health education. A smaller number (65%) rates them excellent on doing a proper physical examination. There is thus room for improvement, especially on the most important topic for curative care rendering.

4.5.2.6   Professionalism and safe functioning

- Supervisors see the importance of patients being properly examined and diagnosed. There is a significant proportion that believes that patients do not necessarily always have to receive medicines for their complaints.

- A slight increase of unsafe practices from 2001 to 2002 was reported.
- Unsafe practices do occur in practice, as most supervisors report that patient's complaints about poor services are at least sometimes substantiated.

- The causes for these unsafe practices according to supervisors and CPHCNs are the lack of time to see patients, large amount of patients that has to be seen and knowledge not kept up to date, as well as poor communication with the patient. CPHCNs says that a thorough examination not being done also causes unsafe practices, while supervisors also blames personal characteristics of the nurse.

4.5.2.7   Stress, morale and productiveness

- Stress levels amongst CPHCNs are high. Supervisors report them to be unendurable at times, but 60% of CPHCNs themselves say that they are experiencing unendurable stress all the time. Both groups say that the reasons for this are the numbers of the patients, lack of support from authorities, lack of resources, especially human and too many responsibilities of self and colleagues. Supervisors also add bad attitude and morale of staff, while CPHCNs add that they simply do not have time for all the patients.

- Sixty percent of supervisors are happy with CPHCNs attitude, morale, independent thinking, drive, compassion and empathy towards patients. This leaves 30% of supervisors who experience CPHCNs as having inadequate qualities as mentioned, a rather large number of CPHCNs that seem to be unhappy and lack drive and productivity and independent thinking. CPHCNs do not share the same opinion about their colleagues' attitude, etc. than the supervisors. Most of them think they score average or poor on above-mentioned qualities. Most CPHCNs also describe above-mentioned qualities for themselves as average or poor most of the time.

- Morale of supervisors are generally high, with about 16% with an average morale, leaving room for improvement. Morale of the CPHCNs generally scored average (58%), with only about a third (29%) with a good morale.

- Eighty percent of supervisors think that staff copes well with new ideas.

- Cultural clashes and generational gaps takes place often in certain places, but these are in the minority, as reported by both supervisors and CPHCNs. It is interesting to see that generational gaps (14%) cause a bigger problem than cultural clashes (6%), as reported by CPHCNs.

- Moonlighting by CPHCNs take place according to about half of supervisors (47%) because of lack of money. The majority supervisors' report that their CPHCNs do not moonlight, however. Thirty-four percent of CPHCNs report that they do moonlight to earn extra money. Moonlighting can increase stress levels, because staff has to juggle two jobs and have less time to rest.

4.5.2.8   Community Involvement

- Supervisors and CPHCNs recognize that patients have complaints about the service, like long waiting times, poor quality of service, treatment that did not work properly (so they had to return), not enough medicines given, the nurse not being as good as the doctor, inconvenient clinic hours, unfriendly staff, clinic too far away, unavailability to some state patients, health problems not properly managed and not being properly examined. Nursing staff has little control over these complaints from the public. This corresponds with the statement that public expectation and education are higher than the standard that can be delivered as reported by Chirwa (2000:11) in Malawi, and can further demoralize the PCCN. Although the public's expectations may be unrealistic, they do not generally seem to have a valid forum through which to voice their unhappiness with the service, or where problems can be explained to them. The following came to light:

- CPHCNs experienced the patients as generally demanding, but also collaborative, and thankful. A third found them often unreasonable and about a fifth experience them as aggressive at times. But even though a small amount of the public is aggressive and unreasonable, these few can make the working days of the PCCN miserable.

- Generally supervisors do not recognize health committees as a valid way of the community to participate in health care deliverance or improving health services, only 42% believe that this is an option.

- Most supervisors (63%)do believe that the community can be involved with health by volunteering in the clinic.

- Letterbox complaints of questionnaires are not used in clinics to get feedback from the community; there is thus a lack of communication with the community.

- Contact with teachers and ministers are the most effective channels in trying to communicate with the community and its needs, according to supervisors. Local councilors do not play a significant role.

- Communication problems with the public are generally because of a lack of privacy, cultural differences, literacy levels of the patients and impatience of the nurse. Physical difficulties, like deafness also contribute to communication problems.

4.6   SUMMARY

This chapter addressed the descriptions of data obtained from the two questionnaires completed by supervisors and CPHCNs at clinics in the Southern Cape/Karoo region.

The data included biographical characteristics (age and gender) of the respondents, which brought to light that most were older than 30 years, and female.

Educational characteristics were explored through the data. Most have the CHN and curative PHC qualification, but there are some supervisors that need more management qualifications. It was also found that CPHCNs and their supervisors do not keep up to date with refresher courses or further studies in nursing, probably because of time, financial and managerial constraints. This can be the reason for potential medico-legal hazards.

The two different groups' perceptions of the barriers and enablers of their workplace were examined, and these were multifactorial, showing that resources are very scarce, and this caused great stress for the workforce. The effects of these scarce resources have a negative impact on relationships between employer and employee, CPHCNs and their patients, the type of managing that take place, and the quality of the examination and treatment of patients. Change also takes place too slowly, and frustrates workers, causing more stress and even poor attitudes.

Because of all these factors, employees do not feel valued, and are unmotivated. This correlates with data found in the literature search of the state of the Primary Health Clinical Care services in South Africa and health services internationally.

Surprisingly, few medical mistakes are reported, and though the workforce may be discontented and overworked, they still try to deliver their best. It seems that patients generally still have a lot of respect for their healthcare deliverers, although all warning signs are going off for problems in the

future. Already patients are returning more often to clinics, because their original complaint was not solved (or diagnosed and treated properly?). One can only wonder what the state of affairs is in other provinces with fewer resources.

In chapter 5 the limitations, conclusions and recommendations will be discussed.

CHAPTER 5

SUMMARY, LIMITATIONS, CONCLUSIONS, RECOMMENDATIONS

5.1   INTRODUCTION

In the previous chapter data, obtained form questionnaires were analysed and presented graphically. In this chapter the research findings are summarized, research limitations, conclusions of the research and recommendations from the research are discussed.

The goal of the research was to study the factors influencing the delivery of a curative primary health care service by registered nurses:

> To explore and describe barriers CPHCNs and their supervisors experience in delivery of a quality curative PHC service in the Southern Cape/Karoo region.
>
> to identify enablers to a quality curative PHC service in the Southern Cape/Karoo region.
>
> to identify support systems for a quality curative PHC service in the Southern Cape/Karoo region.
>
> to make recommendations for further research.

5.2   SUMMARY OF THE RESEARCH

The research population was the CPHCNs and their supervisors in the Curative Primary Health Care setup. The sample was the CPHCNs and their supervisors in the Southern Cape/Karoo region.

 Data was gathered by applying questionnaires to both groups. Data was analysed by a statistican from Unisa and presented visually with the aid of graphs and tables.

Barriers to a curative PHC service seem to be multifactorial, with scarce resources causing great stress for the workforce. This have a negative impact on relationships between employer and employee, CPHCNs and their patients, the type of managing that take place, and the quality of the examination and treatment of patients. Slow changes frustrates workers, causing more stress and poor attitudes, feelings of not being valued, and not being motivated (internally and externally).

Enablers examined showed that although the workforce may be discontented and overworked, they still try to deliver their best, with few medical mistakes. Patients still have a lot of respect for their healthcare deliverers, but this trend may not continue for much longer. Patients are already returning more often to clinics, causing even more stress for staff.

5.3   LIMITATIONS

•   The response rate from supervisors was low, probably because of a lack of proper definition who they were. Not all supervisors wanted to fill in two questionnaires, as were expected of them if they were also practicing primary health care.

•   Two areas within the Southern Cape/Karoo region gave no response at all despite of the fact that the researcher contacted them, encouring them to participate.

•   The CPHCNs and supervisors were very busy, and the questionnaires were lengthy and took some time to complete.

•   Questionnaires were only set in English, while mostly handed out in an Afrikaans speaking community. Some respondents commented that they would have preferred to answer it in their own language.

•   Only curative PHC centers in the Southern Cape/Karoo region were part of the study and thus it cannot be generalized beyond this area.

5.4   CONCLUSIONS

The conclusions will be explained with the aid of Donabedians' structure/process/outcome model.

5.4.1 Structure

Barriers and enablers of structural nature will be discussed next:

5.4.1.1   *Barriers*

•   *Rapid changes from the outside versus institutional tenure*: The changes in the political climate have been much faster than the changes in institutions themselves. Full integration of services are slow to happen, with the resulting lack of coordination and collaboration.
•   *Resources are more limited than ever*. Staffing levels are unrealistically low, vacant posts are frozen and staff have to cope with the increased workload and increasing demands of the public, as well as expectations from management and government. Obtaining stock and equipment is a

major problem, and most curative PHC centers functions with a deficient budget. Buildings are inadequate and not close enough to patients.

- *Convenient hours for the public to use the service* were not even to be considered, because of lack of staff and facilities.

- *Time spent with patients was less* because of staff limits. More time was spent on curative services and less on preventative projects.

- *Training sessions and development opportunities are greatly lacking particular in in-service training*, mostly because of inability to spare staff to go on these ventures. Rather new curative courses have been discontinued because of lack of finances (George Hospital and PAWC courses was discontinued in 2002). If nurses do not arrange for these out of their own pockets and time, it does not take place. Refresher courses have not been organized or attended for a couple of years by most of the sample.

- *Furthering their studies in their chosen career field* did not seem to be an interest of CPHCN and their supervisors in the Southern Cape/Karoo region.

- *Autocratic decisions were made by management*, with little input from nurses on grass root level. This caused stress and lack of job satisfaction, and lack of problem solving skills, because nurses were not expected to think for themselves. *Information systems* by the way of computers were absent or not used to their potential, thus continuous and relevant feedback about the service is nearly impossible

- *Accreditation* by organizations like COHSASA was not an important issue in this area. Quality management programmes did not exist in the area. Lack of time seemed to be a restriction in implementing these programmes.

5.4.1.2   *Enablers*

There seems to be few structural enablers present in the Southern Cape/Karoo region.   Training, information systems and quality management programmes was identified in the literature study as enablers, but in this study it was identified as lacking, and thus barriers to the structural component of the South Cape/Karoo region.

- *Good referral systems* with a large multidisciplinary team existed in the region.

5.4.2 Process

The barriers and enablers of process phase will be discussed nest

5.5.2.1   Barriers

- *Lack of professionalism, low morale and productivity:* CPHCNs identified poor attitude amongst their colleagues, and supervisors amongst their employees as having an effect of low morale. Stress levels influence productiveness.

- *Organizational culture:* No evidence of subcultures was found in the area. Unions did not play a significant role in the region in influencing nurses' attitudes negatively, neither are cultural or generational clashes, although they do occur occasionally. There seems to be some solidarity between employees versus (vs) management in both categories of respondents, who feels they lack managerial support.

- *Supervision and leadership* seems to be a problem in the area. Some excellent management methods (audit, upkeep of job descriptions) were not used, probably because of lack of time or lack of knowledge. There was a discrepancy between the supervisors' self-reported leadership skills and the perceived leadership skills of management by those working under them. Both categories respondents reported a general lack of support from their management. Lack of communication was also reported by CPHCN between them and management.

- *Patient aspects* identified that influenced nursing care were culture, literacy levels, language differences and therefore communication problems, physical attributes of patients, for instance deafness.

- *Role-modelling and support by management* were experienced by both of the two groups as inadequate. Generally CPHCNs felt: that management do not follow up reported problems, leave nurses to resolve their own problems while delegate duties without authority to carry them through. This translates into more stress experienced. While it is good to learn problem-solving skills, one would like some support for your ideas, to legalize them and see if you are on the right track. Feedback was not given often and also seems to be a problem in this category. Lack of listening skills and communication were two other problems reported in the employee –manager relationships that were unsatisfactory. Neither of the two study groups reported being motivated by their superiors. Motivation is an important enabler of the process of health care.

- *Focus on the patient/family/community and their needs:* While attention to individuals was given in a curative consultation, this is not true of family or community needs. Little time was left for meetings with the community through forums or contact with local role-players. Staff was not doing surveys or requesting community membership/patients to complete questionnaires. No interest was shown in having letterboxes for complaints.

- *Professional development* was not given serious consideration by most of the respondents, who replied that they are not furthering their studies or keeping up dated with refresher courses.

5.3.2.2   Enablers

Lack of role modeling and support from management, lack of professional development and lack of focus on the individual/family community seem to be barriers in this study. These are factors that can contribute to a good service, but because of the lack of these, it is barriers in the Southern Cape/Karoo region.

- *Collaboration* between team members was possible, especially since there was such a large team. Because of staff not studying, lack of collaboration existed between academic institutions and the (practical) workers in the field. There was also a lack of collaboration between other sectors of the community and health services. Teamwork seemed to be present, although incidences of clashes due to culture and generation gaps were also reported.

- *Experience* is a great enabler in these services. Most of the supervisors had extensive experience, and the respondent who replied with the least experience, already had two years of working experience. This was probably the reason for the reported low incidence of medical mistakes.

5.4.3 Outcome

The barriers and enablers of the outcome phase will be discussed

5.4.3.1   Barriers

- *Inability to prove cost-effectiveness:* A significant amount of patients were reported to return to the clinic, oftenwith the same complaint. Although not all patients were given medication for their complaints (reported to be unnecessary), one wonders whether this would be the reason for patients' return to clinic with the same complaint. Nurses also gave free advice and support as well as counseling to patients. As patients receive these services free, there is a tendency to return to counselors whom

understand them. This might overload the service, and are not reflected as cost-effective.

- *Medical mistakes* also occurred, but surprisingly little was reported in this study, with only a slight increase in substantiated complaints by patients about improper care. According to the reported services rendered by CPHCN, most do a thorough examination. Experience had also taught nurses to work quicker and do an asessment of the patient fast.

5.3.3.2   *Enablers*

- *Effectiveness* was compromised by the number of return visits reported, but substantiated by the small amount of problems reported by the community.
- *Efficiency* of the general curative PHC services were questionable, as PHC was built on the premise of prevention and promotion, and curative services infringe on this preventative services.
- Appropriateness and accessibility:The services were not absolutely appropriate, as there was still an amount of patients reporting inability to get to the clinic, due to hours open and lack of staff at clinic. CPHCNs reported having to send patients away at times, or working faster, which means that the patient may not be thoroughly examined.
- *Continuity* seems not to be a problem, as at most of the smaller clinics, the patient will see the same service provider again and again.
- *Participation* of the patient and family was a problem, as they did not have much input via health committees or letterbox complaints, as mentioned earlier.
- *Examination of mistakes was done by those supervisors whom receive the complaint.* They mostly heard the patient out, some of them might consider the opinion of the staff member involved, but very few got the two parties together for a problem solving session. Generally this seems to be the only way of examining mistakes. Little use was made of auditing to identify problems and correct them by giving feedback to staff and proactive ways of preventing mistakes.

5.5   RECOMMENDATIONS FOR IMPROVEMENT OF CURATIVE PRIMARY HEALTH CARE SERVICES

5.5.1 Structure:

- Integration needs to take place as soon as possible, so that staff can work together with the same conditions of service. Management should assertively strive for this goal, which would greatly reduce unhappiness.
- Resources needs to be re-assessed and budgets accordingly re-allocated. Human resources are being depleted because material and equipment are unavailable. Nurses have to be creative and innovative, but at the

expense of their own time and those of the patients, because of lack of resources. Human resources should be developed and not taken advantage off, to squeeze the last ounce of productivity out of them.

- When resources have been supplied, health services must look at the needs of the community they serve, by adapting consulting hours to be convenient to the public, by implementing health committees and having letterbox complaints, and acting on requests from these areas. Management of health services needs to become more democratic. A health committee in name that is not really functioning, is of no use whatsoever to the service.

- Managers need to be knowledgeable about all facets of the service, latest management principles, should attend regular training sessions for this, should keep contact with academia and professional organizations, should give feedback about these events and information received to their employees. It is of no use to send one person to an expensive symposium and not organizing for that person to give feedback. That would be throwing money in the water.

- Managers and practitioners should keep up to date about the newest trends in their chosen career field, and strive to be part of renewal that these initiatives (for instance adolescent-friendly initiative, district health information systems) bring. Excuses of not having time will negate the amounts of time that could be saved by initiating these programmes. Some of these programs provide advice and support to initiate them, services are not expected to do this on their own.

- Accreditation should be a sought after as an achievement by all health services as a basic standard.

5.5.2   Process

- Managers on top level should address lack of motivation, poor morale, and bad attitude. One of managers' most important functions is motivation of their staff. Covey (:) said that employees are the golden goose that lays the egg. If you kill the golden goose, you rid yourself of your source of income, work, and your employees' loyalty. That would be too high a price to pay, as the workers of the Southern Cape/Karoo region are still amazingly productive, even with all the odds against them, with little union problems. But for how long?

- Communication and feedback to employees are a great issue and needs to be looked at as soon as possible. It is a crime to let people work and not let them have goals, give them feedback about how they are progressing, show them where they should change direction.

- Democracy is also needed in the hierarchy of the health services. Middle managers and top managers of services are not only the employees of the state, but are also the advocates of those supervised by them, as the CPHCNs are theadvocates of the client. These managers must be able to realize what problems are faced on grass root level from input from those

working on this level, and be able to actively influence politicians and those above them.

- Contact with academic institutions is necessary, so that feedback can be given about research results and practices found to be worth sharing.

5.5.3 Outcome

- Medical mistakes should be examined. Regular audit sessions are necessary. Complaints from patients should not be seen as a session where you deny all responsibility, but as a learning situation for employee and the patient.   This way the patient learns about the medical culture and the nurse about the patients and their circumstances, so that their needs can be identified and addressed.

5.6 RECOMMENDATION FOR FURTHER RESEARCH

- The replication of this study in other areas would yield interesting results, especially to ascertain whether other cultural areas' CPHCN experience the same problems.
- The actual practice of CPHCNs would be interesting to pursue, to be able to compare between different ways they might be addressing same problems, to compare accuracy, occurrence of medical mistakes and to thus improve practice.
- Resignation interviews would be a way to determine the real reasons nurses are leaving a stimulating field of nursing.

5.6 SUMMARY

In this chapter, limitations of the study were examined. It was found that it was applicable only for the area of study, the Southern Cape/Karoo region. Despite its limitations, constructive recommendations could be made for the conclusions that were reached. Following these recommendations should benefit the service greatly. The field of primary health care is highly specialized, but also entails a large area. It is expected of CPHCNs to be knowledgeable about all aspects, and still to specialize in curative health care. This feat is not expected of any other member if the health care team as doctors and others tend to specialize on their small field of knowledge, and become super specialists. The CPHCNs must be generalists and specialists, but also have to practice under management less knowledgeable than themselves that often does not have insight in the unique problems they face, and that often does not give the necessary support.

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44Palgrave St
George
6530
14 March

2003

Dear respondent,

You are requested to take part in this research. The aim is to create an understanding of the problems the curative sisters face in delivery of primary curative health care service in the Southern Cape and Karoo region.

The curative sisters are currently under a lot of pressure to perform – they must see large amounts of patients in a small amount of time. This survey will add to the body of knowledge of nursing and bring problems under the attention of supervisors and directors, so that changes for the better can take place.

Your anonymity are guaranteed – the information you give can not be traced back to you.

It would be greatly appreciated if you could spare an hour of your time and assist in the above mentioned research by completing the attached questionnaire.

> Section A is for all sisters rendering a curative service, trained or untrained in primary curative care.
> Supervisors are asked to complete Section B.
> If supervisors are also delivering a primary curative care, they are asked to complete both sections, as a service renderer (Section A), as well as a supervisor (Section B).

Your time spent on these questionnaires are really appreciated, and the researcher hope that you will also greatly benefit from the information gained and used.

Please return the questionnaire in the attached self-addressed envelope by the 30th of April 2003.

Yours sincerely

Cornelle Uys

Practitioners

1-3 ÿ ÿ ÿ

QUESTIONNAIRE BARRIERS AND ENABLERS OF PRIMARY CURATIVE HEALTH CARE

A **BIOGRAPHICAL INFORMATION**

1 Age
(Key: 22-29 =1
 30-39 =2
 40-49 = 3
 50-59 = 4

 60-65 = 5)   V1 ÿ 4

2 Gender

(Key: Male = 1 Female = 2   V2 ÿ 5

B   CHANGES/INSTITUTIONAL TENURE

3 How much stress do you endure in rendering a curative primary care service ?
(Key: No stress = 1
 Normal stress = 2
 Undurable at times only = 3

 Totally undurable = 4   V3 ÿ 6

4 Rate the extent that the following have on your stress levels:
(Key: no effect = 1
 some effect = 2
 serious effect = 3

Lack of training of self/colleagues

Lack of training of supervisors   V4 ÿ 8

Lack of experience   of self/colleagues   V4 ÿ 9

Lack of experience of supervisors   V4 ÿ 10

Too much responsibilities of self/colleagues   V4 ÿ 11

Too much responsibilities of supervisors   V4 ÿ 12

Too many patients   V4 ÿ 13

Not enough resources   V4 ÿ 14

Not enough support from authorities   V4 ÿ 15

Not enough support from personnel in service   V4 ÿ 16

Long working hours   V4 ÿ 17

Patients too demanding   V4   18

Too many changes   V4   19

Not enough staff   V4   20

Continuous turnover of staff   V4   21

Not enough time for patients   V4   22

Others (Please specify)………………………………………………………………

………………………………………………………………………………………
….

C   RESOURCES

5   How many days per work does your service operate?   V5 ÿ 23

6   What is the service's operating hours?
(Key: 08:00-16:00 = 1
       08:00-12:00 = 2
       07:00-10:00 = 3
       07:00-19:00 = 4

       07:00-07:00 = 5   V6 ÿ 24

7   How often does a medical practitioner visit your service?
     (Key: Doctor stationed at service = 1
             Visits once a week = 2
             Visits 2-3 times a week = 3
             Visits 4-5 times a week = 4
             Visits a few times per month = 5
             Referral of patients to another point = 6

                                                          V7 ÿ 25

8   Do you refer patients to any of the following members of the multi-
     disciplinary team?
     (Key: Yes = 1   No = 2)

     Private medical general practioners   V8 ÿ 26

     Private nurse practitioner   V8 ÿ 27

     Physiotherapist   V8 ÿ 28

     Dentist   V8 ÿ 29

     Dietician   V8 ÿ 30

     Traditional healers   V8 ÿ 31

     Traditional midwifes   V8 ÿ 32

     Other (Specify)

     9   Are you aware that any of your clients use the services of the following members
          of the multi-disciplinary team?

(Key: Yes = 1 No = 2)

Private medical general practitioners   V9ÿ 33

Private nurse practitioner   V9ÿ 34

Physiotherapist   V9ÿ 35

Dentist   V9ÿ 36

Dietician   V9ÿ 37

Traditional healers   V9ÿ 38

Traditional midwifes   V9ÿ 39

Other (Specify)

10   Which of the following are generally the aspects your clients complain
        about your service?
        (Key: Always complain about this = 1
                Often complain about this = 2
                Sometimes complain about this = 3
                Never complain about this = 4)

Have to wait too long to be seen   V10ÿ 40

Not enough medicine   V10ÿ 41

Nurse is not as good as the doctor   V10ÿ 42

Medicine is not of a good quality   V10ÿ 43

Quality of service is poor   V10ÿ 44

The hours are inconvenient   V10ÿ 45

Personnel are unfriendly   V10ÿ 46

Clinic is too far from home   V10ÿ 47

Gender insensitivity   V10   48

   Cultural insensitivity   V10   49

   Unavailability to some state patients   V10   50

   Health problem not properly managed   V10   51

   Not being examined properly   V10   52

   Treatment did not work properly and had to return to `   V10   53
health service for same complaint

   Others (please specify
……………………………………………………………….

………………………………………………………………………………………
….

D   PROFESSIONAL TRAINING

11 Where did you obtain your training in curative PHC?
   As part of:
   (Key: Experience only = 1
         Primary curative certificate George Hospital = 2
         Primary curative certificate Diploma in Community Health Nursing =
3
         Primary curative short course done in basic degree/diploma = 4
         Primary curative certificate done through tertiary institution = 5

         Other ………………………..)   V11 ÿ 54

12 Which of the following qualifications do you have?
   (Key: Yes = 1 No = 2

     Community health nursing   V12 ÿ 55

     Midwifery   V12 ÿ 56

     Psychiatric nursing   V12 ÿ 57

     Nursing Administration   V12 ÿ 58

Nursing Education V12ÿ 59

Other ………………………)

E   SUPERVISION

13 How often do you get feedback from supervisors about quality of your service/service point?

(Key: Weekly = 1
       1-3 monthly = 2
       4-6 monthly = 3

       7-12 monthly = 4 V13ÿ 60

14 How often does the following take place in the clinic?
    (Key: With 1-20% of patients = 1
          With 21-40% of patients = 2
          With 41-60% of patients = 3
          With 61-80% of patients = 4
          With81-100% of patients = 5)

Patient notes are complete and orderly V14ÿ 61

The main complaint of the patient is stated V14ÿ 62

The systems examined are relevant to the main complaint V14ÿ 63

The diagnosis is clearly stated and relevant to the main

complaint and systems examined V14ÿ 64

The prescription is relevant to the main complaint, systems

examined and the diagnosis V14ÿ 65

The nurse prescribes according to the EDL V14ÿ 66

The nurse use medical terms V14ÿ 67

Patients not examined V14ÿ 68

Patients not receiving medicines for their complaint V14ÿ 69

Others (please specify…………………………………………………………..

15 Which of these are the causes of unsafe practices in your service?
     (Key: Yes =1 No = 2)

Lack of time to see patient   V15ÿ 70

Too many patients per nurse   V15ÿ 71

Lack of practical experience of nurses   V15ÿ 72

Not enough theory in nurses training programs   V15ÿ 73

Nurses' knowledge not kept up to date   V15ÿ 74

Nurse not thorough enough when interviewing/examining

patient   V15ÿ 75

Personal characteristics of nurse, like laziness, uncaring

attitude   V15ÿ 76

    Poor communication between nurse and patient   V15ÿ 77

    Other (please specify………………………………………………………………

    ……………………………………………………………………………………………………

G   EXPERIENCE AND UP TO DATE KNOWLEDGE

16 How many years experience do you have in the field of community health nursing?
     (Key: Less than 2 yrs = 1
          2-7 yrs = 2
               8-13 yrs = 3
               14-20 yrs = 4   )

            V16ÿ 78

17 How many years' experience do you have in primary curative services?
     (Key: Less than 2 yrs = 1
          2-7 yrs = 2
          8-13 yrs = 3

          14-20 yrs = 4)   V17ÿ 79

18 When did you last attend a refresher course in primary health care?
     (Key: 1 year ago = 1
            2 years ago = 2
                 3 years ago = 3

more than 3 years ago = 4

never = 5)   V18 ÿ 80

19 When since you last had a refresher course in pharmaceutics?
(Key: 1 year ago = 1
2 years ago = 2
3 years ago = 3
more than 3 years ago = 4

never = 5)   V20 ÿ 81

20 What are you currently studying?
(Key: Not studying = 1
Studying PHC = 2
Studying pharmaceutics = 3
Studying nursing admin = 4
Studying community health = 5
Studying nursing education = 6

Other studies than nursing = 7   V21 ÿ 82

Other (please specify…………………………………………………………

…………………………………………………………………………………..

22   Why do you feel a need to update your knowledge in curative primary health
care?
(Key: I do not feel it is necessary = 1
I am out of touch with relevant developments = 2

I need more knowledge = 3   )   V22 ÿ 83

Others (please specify…………………………………………………………..

…………………………………………………………………………………..

H   SERVICE DELIVERY

23   How many hours per week do you spend on rendering a curative service?
(Key: 1-8 hours = 1
 9-16 hours = 2
17- 24 hours = 3
25-32 hours = 4

33-40 hours = 5   V23 ÿ 84

24   How often are you as curative nurse involved in other Primary Health Care functions?
(Key: Never = 1; daily = 2; weekly = 3)

Family planning   V24 ÿ 85

TB clinic   V24 ÿ 86

Healthy baby clinic   V24 ÿ 87

Dressings   V24 ÿ 88

Feeding scheme   V24 ÿ 89

HIV counselling and testing (MTCT & VCT)   V24 ÿ 90

Antenatal services   V24 ÿ 91

Postnatal services   V24 ÿ 92

Preventative projects   V24 ÿ 93

Other (please specify)…………………………………………………..

25 In your opinion, what percentage of your curative patients do you send to a doctor?
    (Key: 1-10% =1
            11-20% = 2
            21-30% = 3
            31-40% = 4
             41-50% = 5
             51-60% = 6
             61-70% = 7
             71-80% =8
             81-90% = 9

            91-100% = 10   V25   94

26 How much consultation time do you take per curative patient on average?
    (Key: Less than 5 minutes = 1
             6-10 minutes = 2
             11-15 minutes = 3
             16-20 minutes = 4

              more than 20 minutes = 5)   V26 ÿ 95

27 How often do you do a full physical examination on patients?
    (Key: Always = 1
            Often = 2
            Sometimes = 3

            Seldom = 4)   V27 ÿ 96

28 What is the reason a full physical examination is not done on all patients?
    (Key: Yes = 1   No = 2)

    Do not have the time   V28 ÿ 97

    Do not have enough experience   V28 ÿ 98

    Do not have enough theory   V28 ÿ 99

    It is not necessary   V28 ÿ 100

        Other (please specify)………………………………………………………..
        ………………………………………………………………………………………….

29 Do you always explain condition to the patient and advise him about treatment?
    (Key: Never =1
           Sometimes =2
           Most of the time = 3

        Always = 4)   V29 ÿ 101

30 What do you do when there is too many patients and too little time to consult everyone?
    (Key: Yes = 1 No = 2)

    Send patients away   V30 ÿ 102

    Become impatient and cross   V30 ÿ 103

    Feel stressed   V30 ÿ 104

    Work faster and leave out less important detail   V30 ÿ 105

    Other (please specify…………………………………………………………………
    …………………………………………………………………………………………

I   MOTIVATION AND MORALE

31 Rate the communication between you and your management?
    (Key: Yes =1 No = 2)

    Open communication channels exist   V31 ÿ 106

    Management does not follow up reported problems   V31 ÿ 107

    Management leaves everything for nurses to resolve

themselves,   V31   108

   There is no support from management to nursing staff   V31 ÿ 109

   Management delegate duties, but not authority to carry

   Them through   V31 ÿ 110

  Other (please specify………………………………………………………….

…………………………………………………………………………………………

32 Please rate the following of the staff working with you:
    (Key: Excellent = 4
                Good = 3
          Average = 2
                Poor = 1)

   Attitude towards work   V32 ÿ 111

   Morale   V32 ÿ 112

   Independent thinking   V32 ÿ 113

   Productivity   V32 ÿ 114

   Self-drivenness   V32 ÿ 115

   Compassion   towards patients   V32 ÿ 116

   Empathy towards patients   V32 ÿ 117

   Professionalism   V32 ÿ 118

33 Rate your own attitude towards your working conditions:
    (Key: Excellent = 4
          Good = 3
          Average = 2

   Poor = 1)   V33 ÿ 119

34 How do you experience patients attending primary health care clinics?
          (Key: Always = 1
                  Often = 2
                  Seldom = 3

Never = 4)

Demanding   V34 ÿ 120

Unreasonable   V34 ÿ 121

Aggressive   V34 ÿ 122

Thankful   V34   123

Collaborative   V34   124

35 Are there any cultural clashes amongst personnel?
     (Key: Always = 1
                    Often = 2
            Seldom = 3

            Never = 4)   V35 ÿ 125

36 Do you experience generation gaps between personnel?
     (Key: Always = 1
                    Often = 2
            Seldom = 3

            Never = 4)   V36 ÿ 126

37 What are the reasons registered nurses in your facility work in other places besides their full-
     time job (moonlight)?
            (Key: They do not moonlight = 1
            Lack of money = 2
            More stimulation = 3
                    Plan to change jobs = 4

            Other (please specify)   V37 ÿ 127

     …………………………………………………………………………….

38 Which of the following statements are applicable to your position?
     (Key: Always = 1
            Most of the time = 2
            Sometimes = 3
            Never = 4)

     I feel valued as a worker   V38 ÿ 128

     I am recognised for my contribution   V38 ÿ 129

I am remunerated enough for what I do   V38 ÿ 130

My salary relates to my qualifications   V38 ÿ 131

I feel that my supervisor always listens to our problems   V38 ÿ 132

I am motivated by my supervisor to work hard   V38 ÿ 133

J   COMMUNITY INVOLVEMENT/COLLABORATION

39 To what extent may the following influence communication between nursing staff and patients:
    (Key: Very high = 1
          High = 2
          Low = 3
          Very low = 4)

Cultural difference   V39 ÿ 134

Literacy level of patient   V39 ÿ 135

Physical disabilities of patient   V39 ÿ 136

Lack of privacy when examining patient   V39 ÿ 137

Impatience of nurse   V39 ÿ 138

K   OUTCOME

40 Rate the quality of the curative service you render yourself:
    (Key: Poor = 1
           Average = 2
           Good = 3
           Excellent = 4)

Safety   V40 ÿ 139

Competence   V40 ÿ 140

Interpersonal relationships   V40 ÿ 141

Compassion   V40 ÿ 142

Continuity   V40 ÿ 143

Work ethics	V40 ÿ	144
Accountability	V40 ÿ	145
Taking comprehensive history	V40	146
Doing full physical examination	V40	147
Diagnosis of condition	V40	148
Proper record keeping	V40	149
Prescribing treatment for diagnosed condition	V40	150
Giving health education	V40	151
Know when to refer patient to the next level of health care	V40	152

THANK YOU FOR PARTICIPATING IN THE RESEARCH

SUPERVISORS ONLY

1-3 ÿ ÿ ÿ

QUESTIONNAIRE BARRIERS AND ENABLERS OF PRIMARY CURATIVE HEALTH CARE

A   BIOGRAPHICAL INFORMATION

1 Age
  (Key: 22-29 =1
     30-39 =2
     40-49 = 3
     50-59 = 4

     60-65 = 5   V1ÿ◙

2 Gender

  (Key: Male = 1 Female = 2   V2ÿ↵

B   CHANGES/INSTITUTIONAL TENURE

3 Which authority is responsible for the immediate management of the service?
  (Key: PAWC = 1
     Municipal-district = 2
     Municipal-local = 3

     Other (Specify)   V3ÿ₡

4 Which of the following authorities are under one roof?
  (Key: PAWC + Municipal district = 1
     PAWC + Municipal-local = 2
     Municipal-local +Municipal district = 3
     PAWC + Municipal-local +Municipal district = 4

     Other (Specify)   V4ÿ✍

5 What is the current status of integration of your service?
  (Key: Already fully integrated = 1
     Semi-integrated = 2

  No sign of integration = 3   V5ÿ8

6 Rate the extent that the following may influence the integration process in your services:
  (Key: No problems = 1
     Some problems =2
     Serious problems = 3)

     Lack of collaboration   V6ÿ9

     Jealousy about difference in salaries for same

category of staff, paid by different authorities V6ÿ10

Non acceptance of staff of other authorities V6ÿ11

Aggressiveness towards staff of other authority V6ÿ12

Difference in treatment of same categories of staff V6ÿ13

Other (Specify)

7 How many nurses (of all categories) left your service during 2001?

V7ÿÿ┌◙

8 How many nurses (of all categories) left your service during 2002?

V8ÿÿ15

9 What reasons did they provide for leaving your service?
   Key: Yes = 1 No = 2)

Salary not good enough V9ÿ16

Working conditions not acceptable V9ÿ17

Personal reasons V9ÿ18

Other (Specify)

10 How much stress does the personnel rendering curative primary care in your service endure?
    (Key: No stress = 1
           Normal stress = 2
           Undurable at times only = 3

           Totally undurable = 4) V10ÿ┌□

11 Rate the extent that the following have on the stress levels in your service:
    (Key: no effect = 1
            some effect = 2
            serious effect = 3

Lack of training of subordinates V11ÿ20

Lack of training of supervisors V11ÿ21

Lack of experience   of subordinates V11ÿ22

Lack of experience of supervisors V11ÿ 23

Too much responsibilities of subordinates V11ÿ 24

Too much responsibilities of supervisors V11ÿ 25

Too many patients V11ÿ 26

Not enough resources V11ÿ 27

Not enough support from authorities V11ÿ 28

Not enough support from personnel in service V11ÿ 29

Long working hours V11ÿ 30

Others (Please specify)…

12 How many nurses per category are currently working in your service?

Registered nurses V12ÿÿ 31

Staff nurses V12ÿÿ 32

Enrolled nursing assistants V12ÿÿ 33

Other (Specify)

13 How many of the registered nurses are qualified to

render curative primary care? V13ÿÿ 34

14 How often do you give attention to the following in your service?
(Key: Often = 1
        Seldom = 2
        Never = 3)

Clinical audit V14ÿ 35

Patient satisfaction surveys V14ÿ 36

Patients complaints V14ÿ 37

Information on board for patients V14ÿ 38

Disease protocols V14ÿ 39

General service standard for the clinic   V14ÿ 40

Performance indicators   V14ÿ 41

Job descriptions   V14ÿ 42

Staff meetings   V14ÿ 43

In-service training   V14ÿ 44

Peer review sessions   V14ÿ 45

Community health committees   V14ÿ 46

Motivation of personnel   V14ÿ 47

Service standards   V14ÿ 48

Other…

C   RESOURCES

15   Are there increases in staffing levels to meet the increased workload?
      (Key: Yes = 1
            No = 2

            Don't know = 3)   V15ÿ 49

16 Are there enough staff members for this facility?
      (Key: Yes =1
            No =2

            Don't know = 3)   V16ÿ 50

17 How often do you experience problems in obtaining equipment/stock?
      (Key: Never = 1
            Seldom = 2
            Often = 3

            Always = 4)   V17ÿ 51

18 How adequate is your budget to run the service?
      (Key: Good = 1
            Average = 2

            Poor = 3)   V18ÿ 52

19   Does the building comply to the requirements of the service, e.g. enough toilets, waiting rooms, especially for patients?

(Key: Yes = 1 No = 2)   V19ÿ 53

20   To what extent is your services computerized?
      (Key: Completely = 1
            Partially = 2

            Not at all = 3)   V20ÿ 54

D   PROFESSIONAL TRAINING

21 Where did you obtain your training in curative PHC?
   As part of:
   (Key: Experience only = 1
          Primary curative certificate George Hospital = 2
          Primary curative certificate Diploma in Community Health Nursing =
   3
          Primary curative short course done in basic degree/diploma = 4
          Primary curative certificate done through tertiary institution = 5

          Other ……………………..)   V21ÿ 55

22 Which of the following qualifications do you have?
   (Key: Yes = 1 No = 2

          Community health nursing   V22ÿ 56

          Midwifery   V22ÿ 57

          Psychiatric nursing   V22ÿ 58

          Nursing Administration   V22ÿ 59

          Nursing Education   V22ÿ 60

          Other ……………………….)

E   EQUITY

23 Have you had any complaints from patients about the following:
   (Key: Yes = 1 No = 2)

Inconvenient hours   V23 ÿ 61

Distance to clinic   V23 ÿ 62

Waiting times   V23 ÿ 63

Gender insensitivity   V23 ÿ 64

Cultural insensitivity   V23 ÿ 65

Unavailability to all state patients   V23 ÿ 66

24 Which of the following will be indicative of safe functioning of nurse
   practitioners?
   (Key: With every patient managed = 1
          With every 2-10 patients managed = 2
          With every 10-30 patients managed = 3
          Very seldom = 4
          Never = 5)

Patient notes are complete and orderly   V24 ÿ 67

The main complaint is stated   V24 ÿ 68

The systems examined are relevant to the main complaint   V24 ÿ 69

The diagnosis is clearly stated and relevant to the main

complaint and systems examined   V24 ÿ 70

The prescription is relevant to the main complaint, system

examined and the diagnosis   V24 ÿ 71

The nurse prescribes according to the EDL   V24 ÿ 72

The nurse use medical terms   V24 ÿ 73

Patients not examined   V24 ÿ 74

Patients not receiving medicines for their complaint V24 ÿ 75

        Others (please specify…..)

25 Which of the following statements regarding the handling of an unsafe
   practitioner is true?
   Key: No policy in place = 1
         Policy not suitable = 2
         Policy not updated = 3

Policy not enforced = 4

Policy in place and effective = 5   V25ÿ76

26 How many cases of unsafe practice were reported in 2001?
   (Key: none = 1
        1-2 = 2
        3-5 = 3
        6-9 =4

        more than 9 = 5)   V26ÿ77

27 How many cases of unsafe practice were reported in 2002?
   (Key: None = 1
        (Key: none = 1
              1-2 = 2
              3-5 = 3
              6-9 = 4

              more than 9 = 5   V27ÿ78

28 How do you handle patient complaints of unsafe practices by staff?
   (Key: Yes = 1 No = 2)

   Hear the patient out   V28ÿ79

   Ask the nurse's version   V28ÿ80

   Audit the patient's chart   V28ÿ81

   Have a meeting together with the patient and the nurse   V28ÿ82

   Other…….

29 Is the patient's complaint substantiated?
   (Key: Never = 1
        Sometimes = 2
        Often = 3

        Always = 4   V29ÿ83

30 What are the causes of unsafe practices in your service?
   (Key: Yes =1 No = 2)

   Not enough time to see patient   V30ÿ84

   Too many patients per nurse   V30ÿ85

   Not enough practical experience   V30ÿ86

Not enough theory   V30ÿ 87

Knowledge not kept up to date   V30ÿ 88

Nurse not professional or thorough enough   V30ÿ 89

Personal characteristics of nurse   V30ÿ 90
    Communication problems

    V30ÿ 91
    Other (please specify…….)

31 What is the frequency of absence in your service for all registered nurses?
    (Key: Often = 1
        Occasionally = 2
        Only when necessary and very little = 3

                                            V31ÿ 92

32 Rate yourself as supervisor on the following qualities:
  (Key: poor = 1
      reasonable = 2
      good =3
      excellent = 4)

Role model   V32ÿ 93

Honesty   V32ÿ 94

Moral behaviour   V32ÿ 95

Genuineness   V32ÿ 96

Empathy   V32ÿ 97

Generosity   V32ÿ 98

Forgiving   V32ÿ 99

Non-judgemental   V32ÿ 100

Constructive listener   V32ÿ 101

Constructive challenger   V32ÿ 102

Theoretical knowledge about curative care   V32ÿ 103

Managerial skills   V32ÿ 104

Motivator   V32ÿ 105

Trainer   V32ÿ 106

33 How often does the conditions in the service necessitate the supervisor to relief staff?
(Key: Daily = 1
        Weekly = 2
        Monthly = 3
        Twice a year = 4

        Very seldom = 5)   V33ÿ 107

F   EXPERIENCE AND UP TO DATE KNOWLEDGE

34 How many years experience do you have in the field of community health nursing?

                                                                 V34ÿ ÿ 108

35 How many years' experience do you have in primary curative services?

                                                                 V35ÿ ÿ 109

36 When did you last attend a refresher course in primary health care?

                                                                 V36ÿ ÿ 110

37 When since you last had a refresher course in Primary health care?
(Key: 1 year ago = 1
      2 years ago = 2
          3 years ago = 3
      more than 3 years ago = 4

      never = 5)   V37ÿ 111

38 When since you last had a refresher course in pharmaceutics?
(Key: 1 year ago = 1
2 years ago = 2
3 years ago = 3
more than 3 years ago = 4

never = 5)   V38ÿ 112

39 What are you currently studying?
(Key: Not studying = 1
       Studying PHC = 2
       Studying pharmaceutics = 3
       Studying nursing admin = 4

Studying community health = 5
Studying nursing education = 6

Other studies than nursing = 7   V39 ÿ 113

40   Why do you feel a need to update your knowledge in curative
primary health care?(Key: I do not feel it is necessary = 1
        I am out of touch with relevant developments = 2
        I need more knowledge = 3

Other……   V40 ÿ 114

41 What percentage of nurses not trained in curative services are doing
curative work?

                                                  V41 ÿ 115

42 How does the rotation of nurses affect the quality of care at this facility?
(Key: Yes = 1 No = 2)

Never rotate   V42 ÿ 116

To prevent boredom   V42 ÿ 117

Job enrichment and skills improvement   V42 ÿ 118

To remove fighting parties from each other   V42 ÿ 119

Others (please specify…..)

G   MOTIVATION AND MORALE

43 Do you experience problems with unions?
(Key: All the time = 1
        Often = 1
        Seldom = 2

        They never cause problems = 3   V43 ÿ 120

44 How would you rate the communication between you and your
management?
(Key: Yes =1 No = 2)

Open communication channels   V44 ÿ 121

They do not follow up problems reported   V44 ÿ 122

They leave everything for me to resolve, there is no

support V44ÿ 123

They delegate duties, but not authority to carry

them through V44ÿ 124

45 Please rate the following of the staff working with you:
(Key: Excellent = 4
   Good = 3
   Average = 2
   Poor = 1)

Attitude towards work V45ÿ 125

Morale V45ÿ 126

Independent thinking V45ÿ 127

Productivity V45ÿ 128

Self-driven V45ÿ 129

Compassion towards patients V45ÿ 130

Empathy towards patients V45ÿ 131

Professionalism V45ÿ 132

46 Rate your own morale:
(Key: Excellent = 4
   Good = 3
   Average = 2

   Poor = 1) V46ÿ 133

47 How does staff cope with new ideas?
(Key: Excellent = 4
   Good = 3
   Average = 2

   Poor = 1) V47ÿ 134

48 Are there any cultural clashes between personnel?
   (Key: Always = 1
      Often = 2
      Seldom = 3

Never = 4)   V48ÿ 135

49 Do you experience generation gaps between personnel?
(Key: Always = 1
            Often = 2
        Seldom = 3

        Never = 4)   V49ÿ 136

50 What are the reasons registered nurses in your facility work in other
    places besides their full-time job (moonlight)?
        (Key: They do not moonlight = 2
        Lack of money = 1
        More stimulation = 2
            Plan to change jobs = 3

        Other (please specify)   V50ÿ 137

51 Which of the following statements are applicable to your position?
(Key: Always = 1
        Most of the time = 2
        Often = 3
        Sometimes = 4
        Never = 5)

    I feel valued as a worker   V51ÿ 138

    I am recognised for my contribution   V51ÿ 139

    I am remunerated enough for what I do   V51ÿ 140

    My salary relates to my qualifications   V51ÿ 141

    I feel that my supervisor always listens to our problems V51ÿ 142

    I am motivated by my supervisor to work hard   V51ÿ 143

H   COMMUNITY INVOLVEMENT

52   Do community members have the opportunity to participate in the
        service through:

(Key: Never = 1
     Sometimes = 2
     Often = 3
      Always = 4)

Health committees   V52ÿ 144

Volunteers   V52ÿ 145

Letter box complaints   V52ÿ 146

Questionnaires   V52ÿ 147

No participation   V52ÿ 148

53 Rate the effectiveness with your contact with principle role-players in your community:
(Key: Never = 1
      Seldom = 2
      Often = 3
      Always = 4)

Teachers   V53ÿ 149

Ministers   V53ÿ 150

Traditional healer   V53ÿ 151

Members of Local council   V53ÿ 152

Other (Please specify…)

54 Does the contact with role players in your area improve the healthcare?
(Key: Never = 1
     Seldom = 2
     Often = 3

      Always = 4)   V54ÿ 153

55 Rate the importance of the following factors in the rendering of an appropriate and efficient service:
(Key: No importance = 1
      Reasonably important = 2
      Highly important = 3)

Audit of records   V55ÿ 154

Following of EDL and policy manuals   V55ÿ 155

Resources are not wasted   V55ÿ 156

Other (please specify….)

56 What is the reason for delay of more than two hours to be seen by the
curative nurse:
(Key: Never = 1
       Seldom = 2
       Often = 3
        Always = 4)

   Shortage of personnel or equipment   V56ÿ 157

   Attitude of health personnel   V56ÿ 158

   Lack of skills   V56ÿ 159

   The PHC approach   V56ÿ 160

   Overcrowding   V56ÿ 161

   Poor organisation   V56ÿ 162

57 Rate the importance of the following constraints in the development of a
quality service:
(Key: No importance = 1
        Reasonably important = 2
        Definitely important = 3
        Highly important = 4)

Money to buy supplies   V57ÿ 163

Lack of staff   V57ÿ 164

Attitude of nursing personnel   V57ÿ 165

   Morale of nursing personnel   V57ÿ 166

   Other (Please specify)………..

58 How many times does an average patient visit the clinic per year:
     (Key: Less than 5 times = 1
      6-10 times =2
      11-15 times = 3

      more than 15 times = 4   V58ÿ 167

59 How often does a patient return to the clinic for the same complaint?
(Key: Never = 1

Sometimes = 2
Often = 3

Most of the time = 4)   V59 ÿ 168

THANK YOU FOR YOUR PARTICIPATION!