

# **PROBLEMS IN PROVIDING PRIMARY HEALTH CARE SERVICES: LIMPOPO PROVINCE**

by

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submitted in fulfillment of the requirements for  
the degree of

**MASTER OF ARTS**

in the subject

**HEALTH STUDIES**

at the

**UNIVERSITY OF SOUTH AFRICA**

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**November 2009**

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## **Summary**

A quantitative, descriptive, explorative design was applied to study the problems that hindered the Primary Health Care (PHC) nurses in rendering quality health care in the health facilities in Limpopo province South Africa. The sample consisted of 53 PHC nurses who completed a pre-tested questionnaire which covered various aspects related to the provision of quality PHC services. The data were analysed by computer using SPSS version 15 soft ware. The findings revealed that most of the problems could be attributed to financial constraints, poor budgeting, and shortage of staff to manage large number of patients, lack of enough support from other professional staff, unreliable referral systems and communication networks. PHC nurses work under difficult conditions and often have to improvise to care for patients, but unless more funds are allocated to rural health care facilities and these problems are addressed, more nurses will work under difficult circumstances.

### **KEY TERMS:**

District health services; managerial; personnel; referral system; training opportunities; infrastructure; migration of staff; multi-disciplinary team; patients.

## Acknowledgements

I give thanks and praise to the Almighty who gave me the opportunity to complete this study. I would like to thank the following people for their support and encouragement:

- To my supervisor Mrs MM van der Merwe and joint supervisor Mrs JE Smith for their guidance.
- Mrs TA Burger, the UNISA librarian for several searches in order to identify lots of literature sources related to the title.
- The founders of Health Systems Development Unit, Tintswalo Hospital in Acornhoek and all those who were involved in educating Primary Health Care learners under the training programme.
- The Tintswalo Hospital PHCNET (Primary Health Care Nurse Education and Training) where the topic of this research originated and staff and all professionals who trained in this colleges.
- The health authorities of Mpumalanga and Limpopo province for allowing me to pre-test and to conduct the main study respectively.
- All health personnel working in Limpopo province.
- Mr F van der Merwe who helped me with the statistical analysis of data.
- The editor, Mrs I Cooper, for editing the whole dissertation.
- And most importantly the Kellogg Foundation for offering me a bursary

*To all of you, may God bless you.*

# *Dedication*

*I dedicated this dissertation:*

- *To my late father, PC Baloyi who will always be remembered for his passion for education.*
- *My mother, Mrs BM Baloyi.*
- *My only brother and my three sisters and their children.*
- *My only child Carol for love and support.*
- *All the teachers who taught me and nurse educators who played a role towards building me academically and professionally.*
- *All my colleagues in the health care sector.*
- *All patients and clients that I have come across who contributed to my professional development.*

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## List of abbreviations

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Aids	Acquired immune-deficiency syndrome
DHS	District Health System
DOH	Department of Health
DPSA	Department of Public Services and Administration
HIV	Human Immuno-Deficiency Virus
IPHC	Integrated Primary Health Care
MDR	Multi-drug-resistance
PHC	Primary Health Care
RSA	Republic of South Africa
SA	South Africa
SANC	South African Nursing Council
TB	Tuberculosis
UK	United Kingdom
WHO	World Health Organization

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# **CHAPTER 1**

## **ORIENTATION TO THE STUDY**

### **1.1 INTRODUCTION**

Many health care problems, such as poor sanitation and water supply, and a lack of proper health services, together with poor housing and poverty existed during the 1970s, particularly in the rural areas of developing Africa. These problems contributed to high morbidity and mortality rates of conditions that could have been prevented with the correct measures. Consequently, at the Alma Ata Conference held in Geneva in 1978 member states of the World Health Organization (WHO) adopted a strategy to address these problems. The WHO considered Primary Health Care (PHC) the only strategy comprehensive enough to address the financial, developmental, health, educational and other problems that existed in these countries and which affected the quality of life (Dennill, King & Swanepoel 1999:36).

As the Republic of South Africa (RSA) also experienced similar problems, though to a lesser extent, the proposed PHC strategy was seen as a way of providing quality comprehensive health care to all its citizens. The Department of Health (DOH) subsequently adopted primary health care (PHC) and in 1996 this strategy was incorporated in the national health plan for South Africa (Dennill et al 1999:36).

The RSA experienced serious problems in the delivery of health care as the health services were fragmented and ineffective; infants and mothers were dying of preventable conditions; there was a shortage of medical practitioners, and very few of them were willing to work in remote under-developed rural areas.

The South African Nursing Council (SANC) attempted to overcome the shortage of medical personnel by training registered nurses in PHC. Mabaso (2006:118) found

nurses practising in PHC clinics in the Limpopo province competent to stand-in for medical practitioners, whenever needed. However, poor water supply to clinics; unavailability of necessary equipment; large patient/staff ratios due to free health services and the HIV/Aids pandemic among other problems hindered the effective provision of PHC (Mabaso 2006:118; Rapakwana 2004:92; Uys 2004: 81, 82, 85, 98). These findings indicate that without proper management; personnel; supplies; drugs; equipment; infrastructure; referral systems, and the cooperation of all the members of the multi-disciplinary team including the patient and traditional healer, having qualified and competent PHC nurses does not guarantee the provision of good quality PHC services.

## **1.2 BACKGROUND TO THE STUDY**

The need to address the many problems affecting the health of communities in developing countries, particularly in Africa, lead to the development of PHC as a strategy at the Alma Ata Conference in 1978 (Dennill et al 1999:2). The problems included poor governance by the ruling parties with subsequent lack of policies or unrealistic policies and legislation, which did not address the needs of their people, but were skewed to provide funds for high technological development and arms to conduct war. Governments were not committed to improving the health of their citizens, and inappropriately used taxpayers' money which resulted in the subsequent increasing number of people living in impoverished conditions. This was compounded by poor education, which caused a vicious cycle of illiteracy and unemployment, poverty, poor health, as well as high birth and death rates (Dennill et al 1999:36). Prevailing poor environmental and infrastructural conditions lead to a shortage of proper housing, lack of proper sanitation, lack of safe water supply, and inadequate functioning of health and other systems, which affected the health of the people.

Health services were not designed according to the needs of the community but rather to the curative, high technological models applied in the rich developed countries of Europe and America. Health services were understaffed, and personnel not properly

trained. There was a serious shortage of medical practitioners willing to work in the most remote rural areas, for various reasons.

The RSA experienced almost identical problems to the above, though to a lesser extent perhaps, therefore the government also adopted PHC to address the needs of its citizens. In 1996 the national health plan, focused on implementing PHC, was introduced to ensure the provision of cost-effective PHC to all inhabitants of South Africa (Dennill et al 1999:36).

Although PHC has been implemented in the RSA with a certain level of success, conditions that necessitated the development of the PHC strategy have returned and new problems have emerged. In some cases these problems appear to be even worse than those that existed in the seventies (Dennill et al 1999:36).

The global outbreak of human immuno-deficiency virus (HIV) and acquired immune-deficiency syndrome (Aids) pandemic has severely impacted the lives of communities and the economy of countries. Moreover, HIV and Aids have greatly aggravated the global morbidity and mortality rates for infective conditions in general and tuberculosis (TB) in particular. The RSA is one of the countries most affected by HIV/Aids and its effect on TB. As HIV/Aids lowers people's immunity, they are more prone to infectious diseases such as TB. An estimated 1 000 people died monthly from TB in 1996. TB is also responsible for the death of more people in the RSA than any other infectious disease (Mkuzo 2005:5).

Anti-retroviral drugs are in short supply and the roll-out programme of these drugs was delayed for various reasons, including politics and lack of trained personnel. Mabaso (2006:118) found that the newly qualified PHC nurses in Limpopo province also reported frequent shortages of drugs in the clinics.

No government can provide for all its people's needs, particularly if they are plagued by problems such as a high population rate with its impact on the environment and economy. The population growth rate in the RSA is increasing daily. This growth rate is

not attributed to a high birth rate but rather to the increase in legal and illegal immigrants from neighbouring countries (Du Toit 2004:4). The RSA population has grown to 46 million people and there are an estimated four to eight million illegal immigrants within the South African borders. Furthermore, job creation has not kept pace with the growth rate, expected impact on the macro-economy, and the increasing number of people living in poverty. In conditions of prevailing high population growth rates, high morbidity rates due to HIV/Aids and TB, high unemployment rates, shortage of housing, lack of infrastructure, and lack of basic needs such as water, electricity, roads, health services and drugs, there will also be a shortage of well trained health professionals (Du Toit 2004:4).

According to Mabaso (2006:25), there was and still is a shortage of medical practitioners *per se* but especially those interested in working in the remote under-served areas. To fill this gap, nurses are being trained with the necessary knowledge and skills to stand-in for medical practitioners and pharmacists. Thus, for example, Mabaso (2006:119) found that the newly trained PHC nurses in Limpopo province were competent enough to render quality PHC without the support or presence of a medical practitioner.

Mabaso (2006:118) also revealed that some of the problems mentioned made the provision of quality PHC impossible, particularly if they prevailed much longer. In a study of PHC services in the Southern Cape in the Karoo region, Uys (2004:112-116) found various obstacles to the provision of good quality PHC.

Management factors that impeded PHC included

- rapid changes from the inside versus institutional tenure
- managers' lack of interest in improving their knowledge or qualifications in their career field
- autocratic decision making by management
- lack of managerial support, supervision and leadership
- apparent unavailability of accreditation by organisation

- inadequate role modelling by managers

Personnel problems included

- shortage of staff with increasing workload
- personnel spending less time with patients
- lack of training sessions, particularly in-service training
- lack of professionalism, and low morale and productivity

Limited finance, inadequate supplies of stock and drugs, and shortage of equipment hindered PHC service delivery.

Poor infrastructure, such as inadequate facilities; inadequate water supply, and inaccessibility of service due to poor roads and inconvenient clinic hours, impacted negatively on PHC service.

The higher volume of patients per day; high prevalence of HIV/Aids and TB; patients' delay in seeking health care at the PHC clinic; patients' low literacy rate, language differences, and communication problems, and patients' making use of free health services even if not really necessary also affected PHC service.

Rapakwana (2004:78, 93) found that patients in some areas of Limpopo province were dissatisfied with certain aspects of the provision of PHC such as long waiting times at the PHC clinics. Their frustration was often compounded by the fact that they had to leave without seeing a health professional or without medication. Clients lose their confidence in the health service, or become ill, and cannot return for a prescription or further treatment. This lowers the compliance rate of patients with conditions such as TB with devastating effects for the individual and country (Mkuzo 2005:5).

The above findings indicate that well-trained and competent registered PHC nurses also need the necessary commitment by the responsible authorities, proper infrastructure and resources to render good quality health care (Uys 2004:62, 81, 82, 85; Mkuzo

2005:133, 134; Rapakwana 2004:78, 92; Mabaso 2006:118). Accordingly, the researcher wished to establish whether these problems existed in Limpopo province and, if so, the extent and seriousness thereof.

### **1.3 RATIONALE FOR THE STUDY**

Newly registered PHC nurses were competent enough to stand-in for medical practitioners in the PHC facilities when necessary (Mabaso 2006:131). However, these PHC nurses often had to deal with problems resulting from lack of infrastructure, and shortages of resources and equipment that hindered the provision of quality PHC services (Uys 2004:113-116; Rapakwana 2004:78). Shortages of drugs, for example, could lower the compliance rate of patients with conditions such as TB, leading to uncontrolled Multi-Drug-Resistance (MDR) with devastating effects (Mkuzo 2005:130). Finally, the population growth from the flow of often already infected illegal immigrants, which adds to the already serious HIV/Aids rate in the RSA, emphasises the urgency of ensuring that the problems of the 1970s which lead to the development of PHC are not repeated.

In the light of the above, the researcher considered it important to determine the existence and extent of problems of the PHC services in Limpopo province before the current knowledgeable and skilled PHC nurses in the province leave due to frustration, de-motivation and despair or fail to provide care despite their competence.

### **1.4 STATEMENT OF THE PROBLEM**

According to Mabaso (2006:119), newly qualified PHC nurses were competent enough to stand-in for medical practitioners in Limpopo province in the respective PHC facilities when they were not available. With the necessary support from government, financial and other resources, and other measures in place, these nurses should therefore be able to render health care service at PHC level where it is needed by the community.



Nevertheless, research findings suggest that serious problems are starting to emerge. Should these problems be allowed to continue, the RSA might regress to the situation that existed in the developing countries during the 1970s that necessitated the global initiative of the development of the PHC strategy.

The research problem raised the following questions in the researcher's mind:

- What problems, according to the opinions of registered PHC nurses in the Limpopo province, existed that hindered the provision of good quality PHC? How serious were these problems according to their opinion?
- What were the characteristics of registered PHC nurses who worked in PHC facilities in Limpopo province? How old were they, what were their qualifications and what other training did they have?
- Were there any problems in personnel related matters that hindered the delivery of quality PHC services in Limpopo province, such as: personnel shortages, knowledge and skills, increased workload of personnel, morale and productivity?
- Were there any problems in the management of PHC services in Limpopo province that hindered the delivery of quality PHC services such as: problems caused by the managerial style, role models, motivation of staff, communication, support and supervision?
- Were there any problems in the provision of supplies and resources that hindered the delivery of PHC services in Limpopo province, such as: financial resources, equipment and stock?
- Were there any problems with the infrastructure in the PHC services in Limpopo province that hindered the delivery of quality care, such as: availability of facilities, condition of roads, water supply, and accessibility of service and convenience of clinic hours?
- Were there any problems related to the referral system that might have hindered the successful provision of quality PHC in clinics in Limpopo province, such as: distance between clinic and referral hospital, ambulance services, general communication with regard to transferring of patients to and from referral hospital and feedback from doctors?

- Were there any problems related to training of personnel that might have hindered the successful provision of quality PHC in clinics in Limpopo province, such as: training opportunities and training needs?
- Were there any problems related to the multi-disciplinary team that might have hindered the successful provision of quality PHC in clinics in Limpopo province, such as: support received from medical practitioners, social workers, physiotherapists, ophthalmic nurses, and other members of the team?
- Were there any problems that could be attributed to patients visiting PHC services in the Limpopo province that hindered the delivery of quality care, such as: cultural issues, participation of patients, adherence to clinic hours, health seeking behaviour, and ignorance?

## **1.5 PURPOSE OF THE STUDY**

The aim of the study was to determine whether registered PHC nurses experienced problems similar to those found by Uys (2004:82, 85, 95) in the PHC clinics of the Southern Cape/Karoo region, also emerging in Limpopo province, which would hinder them in rendering quality health care.

Accordingly, the objectives of the study were to

- describe the biographical characteristics of PHC nurses who work in PHC clinics in Limpopo province, RSA
- explore and describe the managerial problems and the extent thereof in the PHC system that might have hindered the successful provision of quality PHC, in clinics in Limpopo province, RSA
- explore and describe the personnel problems and the extent thereof that might have hindered the successful provision of quality PHC, in clinics in Limpopo province, RSA
- explore and describe any problems in the provision of equipment and other resources as well as the extent thereof that might have hindered the successful provision of quality PHC, in clinics in Limpopo province, RSA

- explore and describe any problems with the infrastructure and the extent thereof that might have hindered the successful provision of quality PHC, in clinics in Limpopo province, RSA
- explore and describe any problems related to referral systems that might have hindered the successful provision of quality PHC, in clinics in Limpopo province, RSA
- explore and describe any problems related to training of personnel that might have hindered the successful provision of quality PHC, in clinics in Limpopo province, RSA
- explore and describe any problems related to the multi-disciplinary team that might have hindered the successful provision of quality PHC, in clinics in Limpopo province, RSA
- explore and describe any problems that could be attributed to the behavior of patients that might have hindered the successful provision of quality PHC, in clinics in Limpopo province, RSA

## **1.6 SIGNIFICANCE OF THE STUDY**

In undertaking research, a “crucial factor in selecting a problem to be studied is its significance to nursing, especially nursing practice” (Polit & Beck 2008:64-65). The significance of a study should contribute meaningfully to nursing knowledge. Some of the questions that should be asked regarding the significance are: Is the problem an important one? Will patients or the broader health community or the society benefit? (De Vos, Strydom, Fouche & Delport 2005:116).

Highlighting the factors that make it difficult for PHC nurses to provide PHC services effectively will provide knowledge to PHC nurses, PHC managers and the Department of Health (DOHA) in Limpopo province, which could be applied to improve and maintain quality PHC services in the province and elsewhere.

## **1.7 RESEARCH DESIGN AND METHODOLOGY**

The researcher conducted a quantitative, explorative and descriptive study to investigate the existence and extent of problems hindering the delivery of PHC according to the perception of PHC nurses in Limpopo province, RSA.

### **1.7.1 Quantitative**

Polit and Beck (2008:763) describe quantitative research as an investigation of phenomena that lend themselves to precise measurement and quantification, often involving a rigorous and controlled design. The researcher considered a quantitative approach the most suitable paradigm to explore, measure, and describe the existence and extent of problems in PHC delivery.

### **1.7.2 Explorative**

Explorative research is conducted to gain insight into a specific situation or phenomenon. Explorative research can be conducted to obtain basic information about an area of interest (De Vos et al 2005:106). In this study, the researcher explored whether the same problems identified by Uys (2004:113-116) in the Southern Cape/Karoo region also existed in the Limpopo province. Furthermore, Mabaso's (2006:118, 134) findings suggest the emergence of problems in the PHC delivery system of Limpopo province. The researcher found no other research on the existence or extent of these problems in the province. Consequently, the study wished to explore the phenomenon.

### **1.7.3 Descriptive**

Descriptive research provides a picture of the situation or phenomenon being explored (Polit & Beck 2008:752). In descriptive research the frequency with which a phenomenon occurs is thoroughly outlined, described and contrasted with literature

sources. This study wished to describe problems identified in PHC clinics affecting the provision of quality PHC services.

#### **1.7.4 Conceptual framework of the study**

A conceptual or theoretical framework is used to organise research in a logical manner. As this study was a full dissertation, not based on a theory or with the aim of testing a theory, the researcher made use of a conceptual framework (De Vos et al 2005:29). The study used the main problems identified by Uys (2004:113-116) as the framework (see chapter 2).

### **1.8 POPULATION AND SAMPLE**

A research population includes all members who are under study; that is, the totality of all the respondents or members that possess specific characteristics that are important for the study (Polit & Beck 2008:337; De Vos et al 2005:193). Burns and Grove (2005:213) describe a research population as “all the elements, which may be individuals, objects, events or substances, in which a researcher is interested; it is sometimes referred to as target population”. In this study, the research population consisted of all registered PHC nurses who rendered PHC services in PHC clinics to clients in the five districts of Limpopo province.

Polit and Beck (2008:765) describe sampling as the process of selecting a portion of the population to represent the entire population, as it is impossible to study an entire population. By means of sampling a researcher selects groups of people, events, behaviour or other elements that have the same characteristics as the research population with which a study is conducted (Burns & Grove 2005:750).

The researcher used stratified sampling to select a sample of 53 respondents (see chapter 3). Between 7 and 13 respondents were selected from each of the five districts.

## **1.9 DATA COLLECTION**

Data collection is a way of gathering relevant information in order to address a research problem (Burns & Grove 2005:733; Polit & Beck 2008:751).

A research instrument is “the device used to collect data such as a questionnaire or observation” (Polit & Beck 2008:755). The researcher selected a questionnaire as data-collection instrument in order to collect data in a standardised manner (see chapter 3 and annexure H). As the respondents were all literate, well educated, and fluent in English, the questionnaire was seen as an appropriate instrument to collect data (Polit & Beck 2008:729).

Questionnaires can be sent to respondents by post (mail) or used as an interview schedule during interviews. The researcher decided to distribute the questionnaires personally to ensure a good response rate.

## **1.10 DATA ANALYSIS**

Data analysis in quantitative research involves the proper planning of the research instrument, in this case the correct coding of the questions in the questionnaire, the entering of the responses on the questionnaires into a computer programme, and presentation and discussion of the findings. Mouton (2004:108) points out that it is the responsibility of the researcher to “break up” the obtained information in order to understand the relationships between concepts. It is also vital for the researcher to interpret findings correctly. The researcher compiled the questionnaire with the guidance of the supervisors and a statistician. A coding system was used to facilitate data analysis by means of the SPSS computer program version 15. The findings were then presented in tables and figures and discussed (see chapter 4).

## **1.11 RELIABILITY AND VALIDITY**

Research findings are worthless unless it could be proved that the processes applied were reliable and valid, and the research instrument was tested for reliability and validity.

### **1.11.1 Reliability**

Reliability is the degree of consistency or dependability with which the instrument measures the attribute it is designed to measure. If the instrument is reliable, the results will be the same each time the test is repeated (Polit & Hungler 1997:308; Polit & Beck 2008:764). The use of the research instrument by an independent researcher should therefore give the same results if used under the same conditions. The instrument should be consistent and dependable.

The questionnaire used in this study was compiled by the researcher, taking into account the problems identified by Uys (2004). In addition, the researcher conducted a literature review and consulted experts in the field to determine whether the instrument would be suitable and reliable and would yield the appropriate data.

### **1.11.2 Validity**

Validity refers to the degree to which an instrument measures what it is supposed to be measuring (Polit & Beck 2008:730). An instrument is considered valid if it measures what it is supposed to measure.

The research instrument in this research was tested for face and content validity, by consulting experts in the field of research and in the PHC services (see chapter 3).

## **1.12 ETHICAL CONSIDERATIONS**

Ethics deals with matters of right and wrong. *Collins English Dictionary* (1995:533) defines ethics as “a social, religious, or civil code of behaviour considered correct, esp. that of a particular group, profession, or individual”. Accordingly, the researcher obtained permission to conduct the study, and respected the respondents’ right to self-determination, privacy, anonymity, and confidentiality.

### **1.12.1 Permission**

The researcher obtained written permission to conduct the study from the DOH, Limpopo province and the managers of the specific clinics (see annexure A and B).

### **1.12.2 Self-determination**

The right to self-determination is based on respect for persons and indicates that people are capable of controlling their own destiny. They should be treated as autonomous agents, who have the freedom to conduct their lives as they choose without external controls (Burns & Grove 1999:158).

The researcher respected the respondents’ right to self-determination by explaining the purpose and significance of the study, that participation was voluntary and required their consent, and they could choose to participate or not. Furthermore, they had the right to withdraw from the study at any time without penalty. Informed consent was obtained from all the respondents (see annexure G).

### **1.12.3 Privacy**

Privacy is the freedom of individuals to determine the time, extent and general circumstances under which private information will be shared with or withheld from others (Burns & Grove 1999:158). The respondents’ privacy was protected by obtaining informed consent voluntarily from them before participation.



#### **1.12.4 Anonymity and confidentiality**

Confidentiality means that information provided by respondents will not be divulged or made available to any other person. Anonymity is when even the researcher cannot trace the data to specific subjects (Brink & Wood 1998:51).

To ensure the respondents' anonymity, they were not asked to provide their names on the questionnaire. The researcher also emphasised that all information would be treated as strictly confidential. The ethical factors considered, in this research were also discussed in chapter 3.

### **1.13 DEFINITIONS OF KEY TERMS**

For the purpose of this study, the following terms are used as defined below.

#### **► Problem(s)**

*Collins English Dictionary* (1995:1237) defines a *problem* as “anything, matter, person that is difficult to deal with, solve, or overcome”. Problems might make life difficult and might need to be investigated before they can be solved.

In this study, *problems* refer to situations or factors identified by registered PHC nurses in Limpopo province, RSA that hinder the successful provision of good quality PHC.

#### **► Primary Health Care (PHC)**

The Alma Ata Declaration (WHO 1978:428) defines PHC broadly as “essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in communities through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. PHC should form an integral part of a country's national health system.”

In more practical terms, PHC is seen as the preventive, promotive, curative and rehabilitative care rendered to patients as they present themselves at the entrance level of the health system (WHO 1978:428; Dennill et al 2004:2; Mabaso 2006:10).

In this study, PHC refers to the preventive, promotive, curative and rehabilitative care provided by specially trained and registered PHC nurses at the clinics in Limpopo province to clients and patients who present with a health problem.

#### ► **Deliver(y) of services**

The *Concise Oxford Dictionary* (2006:379) defines *deliver* as “to bring, hand over, to provide” and *delivery* as “the action of delivering something”. In health care, delivery also means to render a service.

In this study, delivery of services means the services performed to provide health care services in the different PHC settings in Limpopo province.

#### ► **Render/rendering of service**

The *Concise Oxford Dictionary* (2006:1217) defines *render* as “to provide or give” and *rendering* as “the action of giving or surrendering something”.

In this study, *render of service* refers to the actual performance of caring for as well as the provision of PHC by registered PHC nurses to clients who present with health problems at clinics in Limpopo province.

### **1.14 OUTLINE OF THE STUDY**

Chapter 1 briefly describes the background to, purpose and objectives of the study; the research design and methodology, including population and sample, and data collection and analysis; discusses ethical considerations, and defines key terms.

Chapter 2 discusses the literature review.

Chapter 3 covers the research design and methodology in detail.

Chapter 4 discusses the data analysis and interpretation, and literature control.

Chapter 5 concludes the study, briefly discusses its limitations, and makes recommendations for practice and further research.

## **1.15 CONCLUSION**

This chapter briefly described the background to, purpose and objectives of the study. The study wished to explore and describe problems hindering the successful rendering of PHC services by registered nurses in Limpopo province and make recommendations to address the problems identified as well as for further research. The chapter also gave an overview of the research design and methodology, and ethical considerations, defined key terms, and outlined the study.

## CHAPTER 2

### LITERATURE REVIEW

#### 2.1 INTRODUCTION

Chapter 1 described the background to, rationale for and purpose of the study. This chapter discusses the literature review conducted for the study. The literature review focused on problems that hampered registered PHC nurses from rendering PHC services effectively.

In an evaluation of the decentralised PHC training programme in Limpopo province, Mabaso (2006:119) found that newly qualified PHC nurses practising in clinics were competent and confident enough to stand-in for medical practitioners when they were not available. These findings also confirmed those of Rapakwana (2004:92) and Uys (2004:65, 66) that other factors such as poor infrastructure, management problems, and shortage of supplies affected the delivery of quality PHC services.

Dennill et al (1999:6-7) emphasise that for PHC to be successful, good policies and infrastructure should be in place. Lack of good policy, resources and infrastructure hinder PHC nurses from delivering PHC services effectively.

A key principle of a national health system is to provide PHC services. However, the following factors are essential for PHC to be successful:

- *Managerial teams with realistic health plans.* Human resources are crucial in planning and health plans should make provision for a wide spectrum of members of the multi-disciplinary team (Barron 2000:3, 4; Mello 2002:93). PHC

nurses need support from the members of the multi-disciplinary team for specific clients and patients.

- *Good infrastructure and sufficient financial and human resources to deal with large numbers of patients.* Strategies should be put in place to retain and recruit personnel (Barron 2000:3, 4; Mello 2002:93). This, in turn, requires the availability of resources and finance to ensure retention of members of the health team.
- *Adequate drug supplies, proper transport and means of communication.* Mabaso (2006:119, 131) found that PHC nurses were competent in taking patients' history, conducting physical examinations, and making a diagnosis. Nevertheless, the competence of the PHC nurse alone is not sufficient. Management needs to take seriously the matter of policies on how to function in order for nurses to provide quality health care. Proper training, salaries and fringe benefits should be provided so that competent practitioners can be made available and retained for PHC services (Dreyer, Hattingh & Roos 2006:140).
- *Committed, competent health care professionals.* Health services need committed health care professionals with relevant competence (Barron 2000:3, 4).

The above factors emphasise the need for research into problems that prevent PHC nurses from rendering quality health care to their communities (see chapter 1).

## **2.2 PROBLEMS IN PHC SERVICES**

Management problems, job dissatisfaction, shortage of staff, increased patient load from free health services, shortage of resources, safety issues, poor infrastructure, and problems with the multi-disciplinary team were the main obstacles to effective PHC services.

### **2.2.1 Management problems**

Managers or administrators should be able to plan, organise, direct staff and have control mechanisms in place for facilities to run smoothly (Booyens 2005:5). Managers

should perform their key tasks so as to enable those at functional level to provide a service with minimal problems that can be attended to or resolved without seriously affecting the service. Mello (2002:12) maintains that this is particularly important for the government sector. Managers and staff members should be committed to the organisation's plans.

Proper management of PHC services would therefore imply the implementation of well-planned and appropriate policies, proper financing, good organisation of services, good planning and control of human and other resources, and procedures. All these components should be in place for the smooth maintenance and delivery of quality PHC services. People at functional level depend on managers to enable them to perform their duties accordingly.

#### **2.2.1.1 *Lack of support for nurses***

Support by management is crucial. The management team needs committed members who are motivated to manage the organisation (Booyens 2005:604). Health services cannot function effectively if the health personnel feel that management does not value, appreciate and support them.

In England, Young (2002:10), a primary care advisor, found that it is important to make the workforce happy.<sup>1</sup> Part of ensuring this is through supporting and motivating staff. Young (2002:10) emphasises that it is vital for managers to develop innovative leadership methods, and not always stick to old traditional managerial methods. Managers should be skilled enough to prevent human resource problems and to support PHC nurses.

Frustration and unhappiness in the workplace could hinder the effective rendering of health services. In Canada, Besner (2004:354) found that nurses were frustrated when the organisation did not support them in their quest for a holistic approach to nursing

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<sup>1</sup> It should be noted that PHC in England is rendered in hospitals and therefore totally different to PHC in SA. What Young (2002:10) says about leadership methods could nevertheless be universal.

services. It is important to support PHC nurses to prevent frustration at functional level by doing everything possible at managerial level.

Effective leadership is vital for quality PHC services. Applying their knowledge and experience, and supporting nurses would limit frustration in the workplace, which would have a positive effect on health care services (Besner 2004:354). Less frustrating situations improve productivity and ultimately benefit patients. Lack of support has a negative impact especially on nurses who are determined to work in disadvantaged and rural areas.

Lack of managerial support for PHC nurses is a problem (Uys 2004:112; Mello 2002:65). For example, Mello (2002:63) found inadequate coordination in PHC services of the Emfuleni local authority and Uys (2004:116) found limited collaboration between community health care services in the Southern Cape/Karoo region, RSA.

Gasa (2003:7) found no support and guidance from district managers in the community health centres of the central Witwatersrand health region, Gauteng province. Moreover, planning by senior nurses at functional level was sometimes discouraged and did not motivate the staff providing PHC services (Gasa 2003:7). A further cause for concern was problems in the formation of health committees in the central area of the Witwatersrand health region (Gasa 2003:8). Since health committees take part in the planning and smooth running of clinics, it is important that such committees be formed. One of their functions is to support nurses and mediate issues in the community.

#### **2.2.1.2 *Poor leadership style***

Community Primary Health Care Nurses (CPHCN) reported that changes made in PHC services were not only slow but the nurses were not involved in decision-making for change (Uys 2004:111). They experienced the managerial style as authoritative, which caused nurses at functional level to rebel. This problem could have been prevented or rectified if the managers had improved their managerial skills through further training. Consequently, Uys (2004:118-119) emphasises that managers need training in problem solving, conflict management and in the development of a more democratic

management style. Generally, PHC facilities need managers with good leadership styles that can be utilised effectively.

#### **2.2.1.3 *Managers as poor role models***

Uys (2004:115) found that managers were often poor role models for PHC nurses and failed to create an environment conducive to quality PHC services. They often demonstrated non-professional behaviour and lack the knowledge and skills expected from nurses in leadership roles. Leaders who are good role models are needed so that sub-ordinates can copy their behaviour.

Mello (2002:2) stresses strategies to improve the quality of health care services. Nurse managers should lead by example and develop appropriate skills and knowledge because they play a vital role in PHC services, which deal with lives of people (Mello 2002:138). Junior staff can copy positive aspects if those in authority are dedicated role models.

Jooste (2003:42-43) maintains that leaders are not born, but developed. Managers in the PHC setting need to be developed and kept updated on current health issues. This is necessary to enhance the management of situations and challenges daily. Well-developed managers who play their role effectively have a positive impact on their staff and the provision of quality PHC.

#### **2.2.1.4 *Poor problem-solving skills***

In the Karoo region it was found that managers could not handle problems adequately. CPHC nurses felt that part of the stress they experienced in the clinics and health centres was related to the way in which managers dealt with some problems. Managers often did not follow problems up that were raised by CPHC nurses. More over some of the reported problems had to be resolved by CPHC nurses themselves (Uys 2004:115). Although CPHCNs could solve problems themselves they often



needed a second opinion or support from managers. This was of particular importance where suggested solutions needed authorisation.

#### **2.2.1.5 Problems in decision making**

Managers should be expected to be able to implement suitable problem-solving styles in the work situation. The consultative style and group style are more appropriate as sub-ordinates are consulted in decision making. Utilising the group style is more advantageous as solutions are based on ideas generated by the group during discussion, where the manager is the chairperson. Resolutions based on consensus ensure that sub-ordinates are committed, make them feel that they have made a contribution and are therefore valued (Booyens 2005:515). When managers involve all stakeholders in seeking solutions, the decisions are accepted and problems solved satisfactorily. The consultative strategy and group method stimulate staff members to make proposals and managers' base decisions on the suggestions (Booyens 2005:516).

The authoritative leadership style is acceptable in crisis situations and should not be used on a daily basis, as this leads to aggression and lack of innovation by subordinates (Uys 2004:113). Furthermore, making unilateral decisions was not only dangerous but also caused employees to feel inferior. Involving all relevant parties in seeking solutions to identified problems ensures acceptance of measures to be taken and their successful implementation (Uys 2004:113).

Mohale (2005:71) found that nurse managers agreed that problems at clinic level should be solved by registered nurses themselves whereas registered nurses felt that problems should be solved by management. This indicated that the nurse managers assumed that the registered nurses had the same problem-solving skills as managers. Both the managers and registered nurses at clinic level were clearly uncertain about their role in problem solving and decision making. Clarifying roles and acting accordingly prevents confusion.

### **2.2.1.6 Poor administration at clinic level**

Good management of PHC services is essential in minimising problems to ensure conditions suitable for effective service delivery. Implementing managerial tasks is the foundation of good administration.

A lack of means to evaluate health care services contributed to poor administration at clinic level (Uys 2004:115). Moreover, in some clinics there was no job description for professional nurses that specified tasks and the execution of duties. This meant that job descriptions could not be evaluated or revised annually. Job descriptions clarify relationships between jobs, improve work flow, help employees better understand their jobs, and orientate new employees to their jobs (Booyens 2005:232). Institutions cannot function effectively without job descriptions.

Rapakwana (2004:69:90) found the ordering and availability of some drugs a problem due to managerial policies and clinic procedures. For example, some medications were issued and delivered when there were names for specific patients, which meant that those drugs were not ordered routinely. Mashego and Peltzer (2005:19) found similar conditions in PHC services in the Makotopong, Dikgale and Solomondale (Sebayeng) areas in Limpopo province, which hindered the delivery of quality PHC services. It is therefore clear that nurses can be hampered in their task to deliver quality PHC when services are not properly administered at clinic level.

### **2.2.2 Nurses' job dissatisfaction**

Job dissatisfaction has a negative impact on personnel and ultimately influences the quality of health care services rendered (Booyens 2005:299).

In Birmingham, United Kingdom (UK), Shadder, Broome, Broome, West and Nash (2001:210) found that inflexibility towards the needs of nurses and a lack of strong leadership by nurse managers led to job dissatisfaction and high staff turnover. Managers need to be innovative and support different programmes as this would result

in job stability (Shadder et al 2001:214). Booyens (2005:299) emphasises that without motivation and job satisfaction employees usually waste time on unnecessary issues. Management should implement strategies to enhance motivation, satisfaction and commitment (Booyens 2005:299).

Regarding the role of clinic managers, Wentzel (2008:255) found that respondents were dissatisfied with the provision and procurement of equipment and supplies, labour relations, and general management. Staff dissatisfaction impacts negatively on the standard of service delivery.

### **2.2.3 Shortage of staff**

Shortage of staff was one of the major problems that hampered the efficient delivery of PHC services in Gauteng (Sibaya & Muller 2000:8). In Zimbabwe, the problem of shortage of nursing staff in PHC was worsened by the challenge of recruitment and retention, and nurses' reluctance to work in rural areas (Woelk 1994:1032).

In Mangaung, Free State, Blignaut, McDonald and Tolmie (2001:68-75) found that a shortage of staff left PHC nurses with an excessive workload, which was exacerbated by having to master a computerised patient record information system. Having to cope with this new experience on top of their increasing workload put additional strain on the already stressed and overworked nurses, and impacted on patients' waiting time. The boundaries of their work became less clear. The PHC nurses were expected to cope not only with the increasing workload and their traditional duties, but had to execute tasks normally done by the doctor, and now work that should have been done by administrative personnel.

In some parts of province, Mabaso (2006:117) found a shortage of preceptors/mentors to guide PHC students during their training. Those who were available were often too busy coping with the patient load and therefore did not have time to guide students.

Challenges for management, when looking to the future, are the retain PHC nurses who plan to leave health services as a result of burnout, as losing them for the services would cause low morale amongst the remaining staff (Shadder et al 2001:210). It also has a snowball effect as it leaves fewer committed nurses to deal with the ever-mounting workload (Jenkins-Clarke & Carr-Hill 2001:843). Muller, Bezuidenhout and Jooste (2006:282) describe burnout as the most severe state of distress. Stress and burnout make it difficult, if not impossible, to deliver quality services. Jenkins-Clarke and Carr-Hill (2001:848) maintain that it is a major task to successfully resolve the shortage of nursing staff, and in the meantime cope with the negative impacts on provision of quality health care services.

#### **2.2.4 Free health care services and increased patient numbers**

In 1982 the Zimbabwean government introduced programmes to provide free health care to communities with a limited income. This strategy was also used in South Africa to redress the inequalities that existed in health care services (Dennill et al 1999:54). In Zimbabwe it was however proved to be unsuccessful and health care services were affected negatively due to the financial burden on the government and the increasing level of poverty in communities. Health care services were fragmented before independence and then centralised. During this period there were serious shortages of resources especially human resources (Dennill et al 1999:55).

Free health services at PHC level have been available in South Africa since 1994 for children under the age of six years and pregnant women with the intention to ensure the provision of affordable and accessible quality health care services for communities. This policy was implemented by all clinics and PHC centres (Dennill et al 1999:175).

Netshandama, Nemathaga and Shai-Mahoko (2005:65) found that the introduction of free health care services caused an increase in the number of consultations and overcrowding of health services in the Vhembe area, Limpopo province. Overcrowding was also experienced at health care facilities in the Bronkhorstspuit area (now called Kungwini local municipality area) after the implementation of free health service (Mashia & Van Wyk 2004:36).

Although the philosophy of free health care services for the needy has advantages, its failure would have devastating effects on various sectors and individuals, even for those who can pay for their own health care services.

Certain problems have been identified since the implementation of free health care services. For example, some patients tend to move from one clinic to another for the same health problem not realising that their health-seeking behaviour raises the cost of health care services (Kraus 1999:13). Moreover, some patients consult health care services at night for minor issues such as family planning when only a few personnel are on duty for emergency cases. This should rather be done during the day when there are more nurses on duty (Kraus 1999:13). Uys (2004:117) found that patients making use of free counselling services tend to continuously return for further counselling, resulting in overworked and stressed nurses. According to Uys (2004:117), there was no indication of a cost-effective service.

Overcrowding at clinics increased after the implementation of free PHC, and contributed to the deterioration of clinic management due to PHC nurses' strain, stress and burnout (Netshandama et al 2005:65). In the Bronkhorstspuit area, free health care services resulted in complaints about long waiting hours, congested waiting areas and shortage of staff, which affected the accessibility of district health services of the area (Mashia & Van Wyk 2004:43).

Patients also experienced difficulties as a result of overcrowding at clinics after the introduction of free health care services. Long queues were observed outside clinic buildings (Kraus 1999:13). With regard to their perceptions of the quality of PHC services, Mashego and Peltzer (2005:19) found that patients were dissatisfied with the time spent queuing at clinics in some of the rural communities in Limpopo province. Similarly some patients were dissatisfied with long waiting times as consultations were done without securing an appointment in the Taung district of North-West Province (Bediako, Nel & Hiemstra 2006:14). Due to the large number of patients, waiting time increased.

The number of patients referred to hospitals was reduced, which suggested that most patients were seen and managed at clinics and health centres (Kraus 1999:14). At the same time, however, this also contributed to the increase in patient numbers and workload at PHC level. The workload of PHC nurses also increased because patients are kept overnight for observation in PHC clinics that operate for 24 hours.

Quality care is compromised due to increased patient numbers versus shortage of staff. Netshandama et al (2005:65) found that some patients were not thoroughly examined, which could lead to incorrect diagnosis and the issuing of unnecessary or incorrect medicine which again raises costs and leads to a shortage of medication. This situation hampers the delivery of quality PHC services.

Qolohle, Conradie, Ogubango and Malete (2006:17) point out that PHC made the introduction of free health care services popular in South Africa, which resulted in an increased workload at PHC level. Even though most people benefited from the implementation of these free health services, there were not sufficient human resources to make the policy successful, and a discrepancy developed between patient numbers and the provision of human resources (Netshandama et al 2005:64; Govender 2005:40).

### **2.2.5 Shortage of resources**

The increased patient load aggravated the shortage of resources, such as medicines, supplies and equipment.

#### **2.2.5.1 Medicine**

The shortage of medicine contributed to some patients' health-seeking behaviour. Some patients consult a number of clinics within a short space of time and receive medication on each visit without waiting to see the effectiveness of the first prescription. Mashego and Peltzer (2005:18) maintain that patients apparently no longer take

responsibility for their own health and need treatment for every ailment. Bediako et al (2006:13) found that patients expressed dissatisfaction with medicines and availability of supplies in the Taung district of North-West province.

#### **2.2.5.2 *Supplies and equipment***

Medical and non-medical supplies are the second most important part of a health care service (Booyens 2005:173). An organisation that functions without the required supplies poses a problem to those providing the service. This applies to health care services, especially at PHC level where a PHC nurse is obstructed from delivering services efficiently. Sibaya and Muller (2000:8) found a shortage of supplies and equipment as well as the poor state of available equipment in some clinics an obstacle to the delivery of quality health care services.

Shortage of equipment also affected the quality of follow-up of patients diagnosed with diabetes. Some of the specific procedures that could not be done were checking of weight and blood pressure (Louwagie, Bachman & Reid 2002:36). Even though some nurses were well trained it was difficult for them to make a difference due to shortage of equipment. Some of the problems that patients present with cannot be managed successfully without the availability of the relevant equipment. PHC nurses need equipment to properly assess patients.

Rapakwana (2004:60) found that Modimolle municipality in Limpopo province also experienced problems with the availability of equipment and supplies, particularly emergency equipment like suction machines and oxygen, which could not only prevent quality PHC services but also put patients' lives at risk. Emergency equipment must always be available and be in good working order as emergencies can occur at any time in a PHC setting.

Mabaso (2006:97) found that the situation had not improved. There were no thermometers in some clinics in Limpopo province, which is a basic but important piece of equipment in any PHC clinic, as well as glucometers and ophthalmoscopes (Mabaso

2006:118). The early diagnosis of diabetes mellitus requires the appropriate equipment followed by proper monitoring, also with the appropriate equipment. Theft of equipment is another problem that negatively impacts on the type of quality care the community receives, especially the poor who depend on public service (Gasa 2003:7).

### **2.2.6 Safety issues**

Jooste (2003:57) emphasises that every health care provider needs to work in a safe environment as safety is a basic human need and right. This right should be afforded any health worker, irrespective of the environment where the service is provided. A safe environment ensures free movement and execution of tasks in a relaxed atmosphere. A stable community is the one that is “safe and healthy” (Dreyer et al 2006:116). PHC nurses need safe environments to deliver health care.

The safety of PHC nurses “whilst on duty has recently become a serious concern” (Mello 2002:97). Safety of PHC personnel is of particular importance as they are mostly female and only a few nurses are on duty at certain times of the day and night. The lack of safety for PHC nurses in PHC settings exacerbates the shortage of staff. PHC nurses on night shift may be more at risk of thugs threatening them, especially if security staff members are few and not well armed.

### **2.2.7 Infrastructure**

Members of communities prefer good quality health care and proper health education over good infrastructure or equipment in the health services (Kraus 1999:13). However, they do not always have the insight to realise that poor infrastructure or lack of proper equipment hampers the delivery of quality health care.



### **2.2.7.1 *Inadequate clinic buildings***

Makhubela (2002:35) found that together with a shortage of health care professionals, most rural clinics in Swaziland appeared to be too small for the provision of health care needed.

Uys (2004:113) found clinics in the southern Cape/Karoo region too small for the number of patients who visited them on a daily basis. Some clinics in the Taung district, North-West province had inadequate waiting rooms and consulting room facilities, which resulted in dissatisfaction amongst patients. Moreover, patients' dissatisfaction affected the PHC nurses negatively (Bediako et al 2006:13). Nurses who provide PHC need private working areas to enable them to take patients' history and conduct physical examinations (Kraus 1999:13; Mashego & Peltzer 2005:19).

Due to the high HIV/Aids prevalence, PHC clinics provide mainly counselling for non-hospitalised patients. Existing clinic buildings became inadequate after the outbreak of HIV/Aids as more private consulting rooms were needed for counselling services. Most clinics were built for general consultations, dressings, special observation, mother and child services, family planning, and dispensing of medicine with no special sessions for voluntary counselling and testing.

Rapakwana (2004:69) found that some clinics did not have sufficient consulting rooms and used alternative buildings to provide health care services. Existing clinic buildings in some areas needed urgent renovation, as the buildings were not properly maintained. This problem impacted negatively on the delivery of health care services.

### **2.2.7.2 *Transport problems***

Transport facilities are an important indicator of the mobility of a particular community. The members of the community should be able to travel from their respective homes to a health facility (Dreyer et al 2006:116).

In Zimbabwe, Woelk (1994:1032) found that a shortage of transport seriously affected the provision of health care services and outreach programmes, including mother and child services, expanded programme of immunisation, and the supervision of health care services provided. Nurses in the rural areas, in particular, could not move from one point to another due to lack of transport. This affected nurses who did not live near the clinics. These were among the problems encountered by the public sector in relation to PHC services after the introduction of free health care services in Zimbabwe.

According to Mello (2005:135), transport problems in the Emfuleni municipal area, RSA, prevented nurses from doing home or school health visits. Mabaso (2006:118) found that nursing students experienced serious transport problems when they had to do their practical training in rural areas in particular.

The success of PHC services depends on a good referral system that also includes reliable transport (Dennill et al 1999:23). Patients need to be transferred to referral hospitals when referred for more specialised treatment. Rapakwana (2004:70) found that ambulances were only called for emergencies and maternity patients while other referrals either had to use their own transport or resort to public transport.

Staff transport between services and to attend courses or workshops should also be available without compromising other services.

#### ***2.2.7.3 Water supply and sanitation in PHC clinics***

The availability of water is a “prime indicator of health in the community” (Dreyer et al 2006:115). PHC nurses reported unreliable water supply to some PHC clinics in the Molemole municipality, Limpopo province (Rapakwana 2004:69). A simple procedure like washing hands between consultations or before a procedure is very important in a health care facility to prevent cross-infection. Health care services cannot be rendered properly in such conditions as they increase the possibility of cross-infection. Mashego and Peltzer (2005:14) found a shortage of water in a few clinics in the central region of Limpopo province.

#### **2.2.7.4 *Lack of proper accommodation for nurses***

In Zimbabwe, Woelk (1994:1032) found a chronic shortage of accommodation for nurses. Most health care workers resided in urban areas and did not have accommodation in the rural areas where they worked. In addition, they did not wish to move to the rural areas where they were most needed, due to transport problems as they needed to send their children to the urban areas for access to good schools.

Mabaso (2006:118) found that PHC students did not always have accommodation in the rural areas where they did their practical work. PHC nurses who provide 24-hour service need to be within reach of patients who may require attention at night.

### **2.2.8 Multi-disciplinary team**

The multi-disciplinary team consists of members of a wide spectrum of services to provide optimal health care for patients (Dennill et al 1999:70).

Teamwork between all members of the multi-disciplinary team is vital for the success of PHC delivery, particularly between the medical doctor and PHC nurse, and between the nurse and community. PHC nurses cannot render a service to meet all the needs of the community unless they are supported by other members of the multi-disciplinary team to render holistic health care (Dennill et al 1999:73; Besner 2004:354). Uys (2004:115) found collaboration between team members was often problematic. Good communication and prompt interaction among all key role players contributes to the smooth running of institutions.

#### **2.2.8.1 *Relationship between PHC nurse and medical doctor***

The relationship between doctors and nurses should be based on collaboration, as nurses are expected to stand-in for medical doctors when they are not available (Laurent 2005:380). The introduction of the district health system (DHS) in South Africa

made the role of PHC clinics important, and put PHC nurses at the forefront. They need doctors to support them by visiting them at the clinics according to a planned schedule. Visiting doctors form part of the health care team hence a good relationship between PHC nurses and doctors is important (Couper 2003:8).

The relationship between doctors and nurses in clinics should be one of teamwork. Good communication between doctors and nurses is vital and also promotes good relationships, reduces problems and enhances quality health care. The lack of a healthy relationship between doctor and nurse has a negative impact on the quality of care provided during doctors' visits. Qolohle et al (2006:17) found that some doctors acted in a domineering manner, but nurses did not have a forum at which this problem could be discussed. They also found that nurses did not wish to refer patients to doctors with a superior attitude.

Doctors often blame nurses for incorrect execution of tasks which could be attributed to poor feedback or communication between both parties. Nurses were also blamed for the shortage of supplies, equipment, and medicines (Couper 2003:7). Some nurses felt that medical doctors did not respect them and that also affected their relationship with patients (Couper 2003:45). Furthermore, they felt that doctors made no effort to understand the conditions under which they had to render PHC services or to promote rapport.

Couper, Hugo and Van de Venter (2005:65) found that since transport was not always available for personnel, doctors either had to use their own transport to visit clinics or often opted not to visit the clinics. Doctors' problems with transport made patients wait for a long time and created problems for the PHC nurses when doctors could not come as they were the ones confronted with patients.

Referring to the training of PHC nurses to render curative services and stand-in for medical doctors when they are not available, a doctor commented that nurses were making themselves doctors now and "those who want to be doctors must go to MEDUNSA" (Omole, Marincowitz & Ogubango 2005:55). This could indicate that they

either felt threatened by qualified PHC nurses or did not understand their role (Omole et al 2005:55). PHC nurses will never be able to take over the role of medical doctors, but have to stand-in for them when they are not available due to the shortage of doctors in PHC clinics.

#### **2.2.8.2 *Poor feedback from doctors***

A good referral system consists not only of transport, but also, more importantly, feedback from medical doctors on the patients referred by PHC nurses. Not only is this courteous, but it is also necessary for good patient record keeping. Doctors' feedback to nurses contributes to improved communication and promotes continuity of patient care, further education of PHC nurses and professional support (Gasa 2004:95).

Multiple factors contribute to negative effects of visiting doctors. In the Odi and Brits districts of the North-West province these problems included poor feedback, patients being sent away, blaming of nurses, not examining patients, and not showing respect to nurses and patients (Couper 2003:8). Gasa (2004:95) and Mello (2002:135) found problems related to referral systems and poor communication between hospitals and clinics following the decentralisation of health care services.

In the rural area of Bothaville sub-district, Free State Province, RSA, Janse van Rensburg, Steyn and Matebesi (1999:51) found that insufficient information was given as feedback, especially in relation to the treatment given and continued treatment.

PHC nurses also experience problems in taking over the management of patients from medical doctors as they often do not write clinical notes of the care provided to the patient or what the nurse should do thereafter. In the Taung district, North-West Province, patients were dissatisfied with referrals to other hospitals and to specific specialists (Bediako et al 2006:4).

Couper (2003:8) emphasises that there should be formal meetings between doctors and nurses in the rural areas to discuss issues that will assist them to know the roles each has to play so that the team approach in PHC settings can be a success.

Doctors and nurses working at referral institutions should be willing to take over from PHC nurses. The referral system and services provided should be of a high quality as PHC will never be successful unless there is a well operating secondary and tertiary level of health care service delivery in place for patients who need medical and specialised health care.

## **2.3 OTHER FACTORS**

Factors like urbanisation, increase of foreign or illegal immigrants, and the change in disease profile make the delivery of quality PHC services, planning and budgeting difficult.

### **2.3.1 Change in disease profile**

HIV and Aids put a further strain on the provision of health care (Couper 2003:7). More and more people consult health care workers due to opportunistic infections caused by HIV and Aids and pulmonary tuberculosis (TB). The incidence of pulmonary TB in South Africa is 536 cases per 1 000 000 annually and 61% of patients diagnosed with TB are monitored at clinics for six to eight months (Wilson 2005:23).

An estimated 24.6% of the adults in Zimbabwe have HIV. This necessitated complementing hospitalisation with home-based care, which led to the implementation of the national policy on home-based care for Zimbabwe (Ministry of Health and Child Welfare of Zimbabwe 2004:1). Clinics have to provide assistance and support to patients who are cared for at home. The effectiveness of home-based care depends on those support services.

HIV/Aids resulted in an unanticipated situation and have “become a major cause of burden in Sub-Saharan Africa and South Africa in particular” (Muller et al 2006:207). The sectors worst hit are health, education, household and community (Muller et al 2006:208). PHC nurses who are at the forefront of health care are among those who

feel this burden. Patients go to the clinic for consultation, where their condition indicates whether they can be fully treated or need referral. Continuous care is also rendered to these patients in the PHC facilities as opportunistic infections may develop which are usually managed at clinic level.

This implies that PHC nurses are faced with large number of patients who are either affected or infected by HIV. PHC nurses have to diagnose the patients early for good prognosis. At the same time they have to provide continued counselling on lifestyle modification, help the patients and their families to cope with HIV/Aids, strengthen their compliance with TB treatment, treat opportunistic infections, and provide focused care and frequent monitoring.

Makhubela (2002:35) points out that since more people need to be nursed at home, nurses are faced with the challenge of providing home care or doing more home visits, in the case of Swaziland. This compounds the problem of the shortage of personnel and other problems, as nurses themselves are often infected or personally affected by the pandemic (Salmon 2002:12).

Nurses have to find the time to empower themselves with knowledge and skills not only to manage the large numbers of patients in need of counselling, testing and treatment, but also for the education of the community regarding safer sex practices to improve awareness on HIV/Aids and care of family members. This is of particular importance for young people.

### **2.3.2 Urbanisation**

Urbanisation played a significant part in increasing the population to be served in urban areas hence the long queues at the clinics (Mello 2002:96). At the Emfuleni local authority it was found that some patients from rural areas attended the clinics in urban areas, because they were looking for work. Informal settlements mushroomed around cities in the RSA after the first democratic elections in 1994 in expectation of improved socio-economic conditions and due to the lifting of legislation regulating the formation of

townships. The unexpected increase in population in urban areas impacted negatively on health services because local authorities had to provide health services for people for whom they had not budgeted (Mello 2002:97).

### **2.3.3 Patient-related problems**

Some communities did not accept the professional nurses and did not take part in community health projects (Mello 2002:135). For instance, instead of supporting the clinics, some community members stole equipment and medicines from them. Densely populated areas and theft, then, hindered the provision of quality PHC services (Mello 2002:135).

South Africa and Zimbabwe are among the countries most affected by HIV/Aids (Govender 2005:42). In South Africa and Zimbabwe many females are semi- or totally illiterate. Illiteracy impacts negatively on women in a pandemic such as HIV/Aids. In the Karoo region of the southern Cape, Uys (2004:115) found the literacy level very low, which made the provision of health education more challenging as patients were not able to read HIV/Aids pamphlets. In the rural areas of the Bothaville district of the Free State, Janse van Rensburg et al (1999:51) found that patients' inability to read diminished the opportunity to acquire knowledge from pamphlets or handouts containing health information.

### **2.3.4 Communication between nurses and patients**

Communication is an essential requirement for effective patient care (Dennill et al 1999:142). There are numerous barriers to communication in institutions including personal prejudice, language, cultural issues or ignorance (Dennill et al 1999:144). Language, gender stereotypes, group identity, social background and culture are some of the issues that cause misunderstanding and confusion and ultimately poor relationships between health workers and patients (Tjale & De Villiers 2004:113). Intercultural communication is very important in health care (Tjale & De Villiers



2004:132). PHC nurses and all members of the health team should be able to communicate effectively with people as they come into contact with different cultures.

According to Uys (2004:115), language differences also complicated the delivery of quality PHC services in the southern Cape/Karoo region, and made it difficult for CPHC nurses to explore patients' problems. Counselling services were virtually impossible because nurses and patients could not converse in the same language. This situation required the nurses to learn the language as quickly as possible to promote good communication.

Communication is of primary importance in HIV counselling. Patients need to be motivated to have their HIV status confirmed. When patients do not know their HIV status, it is difficult for PHC nurses to evaluate their condition and prescribe the correct treatment (Mashia & Van Wyk 2004:44; Nala 2006:37). Differences in language, culture and socio-economic status can be a barrier in the delivery of quality PHC services, as patients do not readily accept advice from individuals of a different culture. At the same time, however, public employees like nurses are expected to function in a manner that promotes the *Batho Pele* ("People first") principles by giving information, promoting consultation, and providing service that shows value for money.

### **2.3.5 Problems related to cultural practices**

Culture also influences many aspects of health care delivery, and PHC nurses are expected to work with patients of diverse cultures, which are often different from their own (Peu, Troskie & Hattingh 2001:49). People understand illness according to their culture, and attach a specific explanation to the cause of diseases and how they should be treated. This could be in contrast to the expectations of PHC nurses trained in Western medicine.

Peu et al (2001:49) found that the majority of the nurses expected patients to consult PHC nurses at the clinics before going to traditional healers. The nurses also expected traditional healers to refer patients to clinics in order to prevent complications (Peu et al

2001:53). Although most black South Africans believe in traditional healers, the nurses expressed concern that traditional healers did not have adequate knowledge regarding health promotion (Peu et al 2001:54).

The Traditional Health Practitioners Act of 2004 recognises traditional practitioners and traditional midwives and makes provision for all health care providers to work together and include the traditional healer (TH) in the multi-disciplinary team. This cannot be avoided since many of the black population practise traditional healing as part of their culture. Western medicine does not trust the practice of alternative medicine as traditional healers often have limited skills, unscientific knowledge and untested treatment (Meissner 2004:90). Meissner (2004:90) points out that the main concern in the formal health system is that THs' practice is not regulated and training is not standardised. Since regulations are not adhered to, it is difficult for the state to apply disciplinary measures (Meissner 2004:902). This situation creates challenges for PHC nurses, thus they should be culturally sensitive, treat patients with respect and dignity even if they delayed seeking treatment early because they first consulted a traditional healer.

#### **2.4      *BATHO PELE* (“PUTTING PEOPLE FIRST”) PRINCIPLES AND PATIENTS' RIGHTS**

In 1997, in an effort to improve the quality and accessibility of all public services, including PHC services, the Department of Public Services and Administration (DPSA) introduced the *White Paper for the Transformation of Public Service Delivery*, which included the *Batho Pele* (“Putting people first”) principles, and the DOH introduced the *White Paper for the Transformation of the Health System in South Africa*. The *Batho Pele* principles and patients' rights charter were introduced to transform service delivery in the public sector with the aim of improving quality. The *Batho Pele* principles include consultation, service standards, access, courtesy; information openness and transparency, redress and value for money. At the same time, patients have the right to a healthy and safe environment, access to health care, confidentiality and privacy, informed consent, be referred for a second opinion, exercise choice in health care,

continuity of care, participate in decision making that could affect their health, be treated by health care providers that identify themselves, refuse treatment, be fully informed about their health insurance/medical aid scheme policies, and complain about health care services. The DOH translated the principles into the eleven official languages to inform all people. The provision of information was also ensured by health workers like nurses in their respective communities.

The implementation of this approach gives patients the latitude to complain about health care services rendered and the quality of care provided by PHC nurses (Bediako et al 2006:12). The Patients' Rights Charter stipulates patients' rights in health care delivery as well as their responsibilities.

## **2.5 CONCLUSION**

The literature review focused on problems that made it difficult for PHC nurses to provide quality PHC services. The problems included poor management; shortage of staff, equipment and supplies; poor infrastructure; the multi-disciplinary team, as well as change in the disease profile and its effects on health care services personnel. Problems in relationships between members of the multi-disciplinary team also affect the referral of patients, as well as PHC nurses' workload.

Chapter 3 describes the research design and methodology of the study.

## **CHAPTER 3**

### **Research design and methodology**

#### **3.1 INTRODUCTION**

This chapter outlines the research design and methodology, including research population, sampling, sample, data collection, data-collection instrument, pilot study, reliability and validity, and ethical considerations.

#### **3.2 PURPOSE OF THE STUDY**

The aim of the study was to determine whether registered PHC nurses experienced problems similar to those found by Uys (2004:82, 85, 95) in the PHC clinics of the Southern Cape/Karoo region, also emerging in Limpopo province, which would hinder them in rendering quality health care.

##### **3.2.1 Objectives**

The objectives of the study were to

- describe the biographical characteristics of PHC nurses who work in PHC clinics in Limpopo province, RSA.
- explore and describe the managerial problems and the extent thereof in the PHC system that might have hindered the successful provision of quality PHC, in clinics in Limpopo province, RSA.
- explore and describe the personnel problems and the extent thereof that might have hindered the successful provision of quality PHC, in clinics in Limpopo province, RSA.

- explore and describe any problems in the provision of equipment and other resources as well as the extent thereof that might have hindered the successful provision of quality PHC, in clinics in Limpopo province, RSA.
- explore and describe any problems with the infrastructure and the extent thereof that might have hindered the successful provision of quality PHC, in clinics in Limpopo province, RSA.
- explore and describe any problems related to referral systems that might have hindered the successful provision of quality PHC, in clinics in Limpopo province, RSA.
- explore and describe any problems related to training of personnel that might have hindered the successful provision of quality PHC, in clinics in Limpopo province, RSA.
- explore and describe any problems related to the multi-disciplinary team that might have hindered the successful provision of quality PHC, in clinics in Limpopo province, RSA.
- explore and describe any problems that could be attributed to the behaviour of patients that might have hindered the successful provision of quality PHC, in clinics in Limpopo province, RSA.

### **3.2.2 Research questions**

The research questions were:

- What problems, according to the opinions of registered PHC nurses in the Limpopo province, existed that hindered the provision of good quality PHC? How serious were these problems according to their opinion?
- What were the characteristics of registered PHC nurses who worked in PHC facilities in Limpopo province? How old were they, what were their qualifications and what other training did they have?

- Were there any problems in personnel related matters that hindered the delivery of quality PHC services in Limpopo province, such as: personnel shortages, knowledge and skills, increased workload of personnel, morale and productivity?
- Were there any problems in the management of PHC services in Limpopo province that hindered the delivery of quality PHC services such as: problems caused by the managerial style, role models, motivation of staff, communication, support and supervision?
- Were there any problems in the provision of supplies and resources that hindered the delivery of PHC services in Limpopo province, such as: financial resources, equipment and stock?
- Were there any problems with the infrastructure in the PHC services in Limpopo province that hindered the delivery of quality care, such as: availability of facilities, condition of roads, water supply, and accessibility of service, convenience of clinic hours?
- Were there any problems related to the referral system that might have hindered the successful provision of quality PHC in clinics in Limpopo province, such as: distance between clinic and referral hospital, ambulance services, general communication with regard to transferring of patients to and from referral hospital and feedback from doctors?
- Were there any problems related to training of personnel that might have hindered the successful provision of quality PHC in clinics in Limpopo province, such as: training opportunities and training needs?
- Were there any problems related to the multi-disciplinary team that might have hindered the successful provision of quality PHC in clinics in Limpopo province, such as: support received from medical practitioners, social workers, physiotherapists, ophthalmic nurses, and other members of the team?
- Were there any problems that could be attributed to patients visiting PHC services in the Limpopo province that hindered the delivery of quality care, such as: cultural issues, participation of patients, adherence to clinic hours, health seeking behaviour, and ignorance?

### **3.3 RESEARCH DESIGN AND METHODOLOGY**

Research methodology refers to researchers' decisions during the research process that ultimately result in the actual findings (Burns & Grove 2005:211). Methodology refers to the "entire strategy for the study", including stating the problem and plans to collect data (Burns & Grove 2005:211). A research design is "the overall plan for addressing a research question, including specifications for enhancing the study's integrity" (Polit & Beck 2008:765). It is the main guide or format. The researcher conducted a quantitative, explorative and descriptive study to investigate the existence and extent of problems hindering the delivery of PHC according to the PHC nurses in Limpopo province, RSA.

#### **3.3.1 Quantitative**

Neumann (2005:747) defines quantitative research "as a formal, objective and systematic process to describe and test relationship and to examine cause-and-effect interactions among variables".

Polit and Beck (2008:763) describe quantitative research as the investigation of phenomena that lend themselves to precise measurement and quantification.

This study wished to measure whether and to what extent problems, identified in other areas of South Africa that hindered PHC nurses from rendering quality care to their communities, also existed in Limpopo province. It is because measurement of variables was done in this study that quantitative research was the most suitable paradigm for this study.

#### **3.3.2 Explorative**

Explorative research focuses on exploring the dimensions of a specific phenomenon, including how the phenomenon prevails, and other associated factors related to the presence of that phenomenon (Brink 2003:11). According to Neumann (2005:33:34),

the purpose of explorative research is to familiarise a researcher with basic facts and concerns around a problem. This study explored the problems hindering the provision of PHC services in Limpopo province and factors associated with those problems.

### **3.3.3 Descriptive**

The purpose of descriptive research is “to expose complete and accurate information regarding a phenomenon under study” (Brink 2003:11).

According to Mouton (2004:102), descriptive data describes how things are and what the real state of affairs is. The main purpose of a descriptive design is that it reveals facts regarding a situation to give a picture using words or numbers and to classify answers that will help in answering questions such as what, where and how (Neumann 2005:35). It gives a detailed picture and describes why something happens.

This study wished to describe the problems existing in PHC service delivery in Limpopo province and contrast them with similar findings of other research; therefore it is also descriptive in nature.

### **3.3.4 Delimitation of the study**

Neumann (2005:158) points out that the social context is very important in understanding the social world. This study was conducted in the context of the PHC services in Limpopo province, RSA.

## **3.4 RESEARCH POPULATION**

A research population refers to individuals in the universe who possess specific characteristics that are important for the study (De Vos et al 2005:193). Polit and Beck (2008:761) refer to a population as “the entire set of individuals (or objects) having some common characteristics”.



In this study the population consisted of all registered PHC nurses providing services in Limpopo province at PHC level in the public sector. A total of 613 registered PHC nurses were at functional level just before data was collected. Other PHC nurses who were not at functional level were excluded.

### **3.5 SAMPLING AND SAMPLE**

Polit and Beck (2008:765) describe sampling as the process of selecting a portion of the population to represent the entire population, as it is impossible to study an entire population. By means of sampling a researcher selects groups of people, events, behaviour or other elements that have the same characteristics as the research population with which a study is conducted (Burns & Grove 2005:750).

Burns and Grove (2005:750) define a sample as a “subset of the population that is selected for a study”.

The researcher received a list of health centres and clinics in each of the five districts in order to identify clinics with a PHC nurse. In this study registered PHC nurses who worked in the PHC clinics were identified and approached to take part in the study. In this study, the research population consisted of registered PHC nurses who rendered PHC services in PHC clinics to clients in the five districts of Limpopo province.

The researcher used stratified sampling to select a sample of 53 respondents. Between 8 and 13 respondents were randomly selected from each of the five districts. Stratified sampling allows for the possibility of including sub-groups (De Vos et al 2005:200). The sample consisted of 8.6% of the population. The largest number of respondents worked in the Vhembe district and the fewest worked in the Waterberg district.

The researcher visited the majority of the respondents at their clinics and phoned a few times to establish whether they would be willing to be included in the sample. The sample comprised PHC registered nurses, as they would be knowledgeable on the conditions that prevailed in the clinics.

Sampling criteria are the characteristics essential for membership in the target population (Burns & Grove 2005:750). To be included in the study, the respondents had to be:

- Male or female PHC registered nurses registered with the South African Nursing Council (SANC) with the qualification of Diploma in Clinical Nursing Science: Health Assessment, Treatment and Care.
- Employed by the Department of Health, Limpopo province as full-time employees.
- Working in any of the five districts, namely Waterberg, Vhembe, Sekhukhune, Capricorn, and Mopani.
- Working at functional level at a PHC setting (dealing directly with clients and patients).

### **3.6 DATA COLLECTION**

Data collection is a way of gathering information relevant to the study conducted (Burns & Grove 2005:733). Information is gathered using the most precise (exact) and systematic methods. In this study the researcher selected a questionnaire as research instrument. The researcher obtained a list of all PHC facilities and an indication of those that had registered PHC nurses employed at the various clinics and health care centres in the province from the senior manager and district managers of Limpopo province.

The researcher obtained permission to conduct the study from the senior manager at the provincial Head Office and the district managers (see annexure A and C). A letter from the Senior Manager: Integrated Primary Health Care Service from the provincial Head Office was also sent to the districts (clinics) to confirm that the study had been approved by the provincial authority (see annexure B). In addition, the district managers and the chief community liaison officers contacted the person-in-charge of the clinics and health care centres to request their support and cooperation.

The district managers gave their consent and sent information from the Senior Manager: Integrated Primary Health care (IPHC) regarding the research to the institutions where the identified registered PHC nurses worked. The nurses in charge of these health care facilities were requested to identify a suitable date for data collection and allow the respondents to take the time to complete the questionnaires (see annexure H). The registered PHC nurses randomly selected to be part of the sample were contacted telephonically to determine whether they would be willing to take part in the research. The objective of the research, their ethical rights and the process to be followed were explained to them.

Due to the geographical vastness of the province it was not possible for the researcher to reach all the clinics on the same day. A period of four to five working days was necessary to cover each district. Appointments were arranged with each of the five district managers for the respondents to be available for individual data-collection sessions. The date on which the data would be collected was arranged and confirmed telephonically to ensure that the respondents were available.

**Table 3.1 Dates and venues of data collection**

<b>District</b>	<b>Date</b>	<b>Respondents</b>
Sekhukhune	2008/02/2-6	12 (22.6%)
Mopani	2008/02/12 & 13	10 (18.9%)
Waterberg	2008/02/14 & 15	7(13.2%)
Capricorn	2008/02/19-21	11 (20.8%)
Vhembe	2008/02/15-27	13 (24.5%)
<b>Total</b>		<b>53</b>

On the day of the appointment, the researcher explained the purpose of the study, the respondents' ethical rights and what the researcher expected of them. Consent forms were then distributed to and signed by the respondents (see annexure G). Only two of the respondents, who had initially consented to take part, subsequently indicated that

they were no longer able to participate as they were too busy, or that “the authorities would think that we do not have enough work!”

The respondents were requested to read the questionnaire carefully and then answer the questions as honestly as possible. The researcher was present at the venues to answer or clarify any questions and to ensure that there was no interference that might influence data collection. In the area where four respondents completed the questionnaire in the same venue (the district office) together, no discussion amongst respondents was permitted. In all the other cases, the respondents were alone in the respective facilities (see table 3.1: dates and venues of data collection).

The completed questionnaires were perused by the researcher to ensure that the respondents had entered the relevant code in the spaces provided on the questionnaire to facilitate data capturing. The researcher collected the completed questionnaires and sent them to the statistician for analysis (De Vos et al 2006:168-169). All completed questionnaires could be used which means the response rate was 100%.

### **3.6.1 Data-collection instrument**

Quantitative studies usually utilise structured data-collection instruments (Brink & Wood 1998:285). Since the study was quantitative, the researcher used a questionnaire to gather data about problems that obstructed the respondents in the provision of PHC services. A questionnaire is a device or technique used to obtain data from respondents in a self-administered pen-and-paper format (Polit & Beck 2008:755; Burns & Grove 2005:739).

### **3.6.2 Format of the questionnaire**

The researcher compiled the questionnaire on the basis of knowledge gained through a review of the literature. The questionnaire comprised mainly closed questions to facilitate data analysis. Some open-ended questions were also included in order to

obtain the respondents' personal perceptions or clarification on certain issues. The questionnaire consisted of ten sections:

- Section A: Respondents' biographical data.
- Section B: Problems in PHC services related to personnel
- Section C: Problems in PHC services related to managerial matters
- Section D: Problems related to supplies and equipment
- Section E: Problems related to infrastructure
- Section F: Problems related to referral systems
- Section G: Problems in training of personnel
- Section H: Problems with the multi-disciplinary team approach
- Section I: Problems related to patients
- Section J: Rating of seriousness of the problems in the PHC services

Finally, the respondents were asked to make recommendations to improve the provision of PHC services in the province.

A critical reader proofread the questionnaire before it was sent to the supervisors at the University of South Africa (Unisa). This reader was an experienced medical practitioner involved in full-time teaching of theory and clinical skills to PHC students and also worked as a visiting doctor at clinics in Limpopo province and areas outside the province (see copy of questionnaire in annexure H).

### **3.6.3 Coding of the questionnaire**

The items in the questionnaire were coded to facilitate the analysis of the data using the SPSS computer software program and with the help of the system analyst and supervisor.

### **3.7 PRE-TESTING OF THE INSTRUMENT**

A pre-test of the research instrument involves the testing of the data-collection tool in order to identify any problems in the structure of the instrument, the wording of the questions, and the coding of the responses and to determine the time taken to complete it (Polit & Hungler 1997:465).

The researcher pre-tested the questionnaire with five registered PHC nurses in Bohlabela district (which is now Enhlazeni district) in Mpumalanga province. This area was previously the sixth district in Limpopo province, before being allocated to Mpumalanga province. The PHC nurses involved in the pre-test were not included in the main study. Permission to test the instrument was requested and granted by the Mpumalanga Research Ethics Committee (see annexure E).

The objectives of the pre-test were to identify

- questions that needed simplification
- important aspects not included in the instrument
- specific aspects of the questionnaire requiring modification
- mistakes in sentence construction
- typing errors and errors in the numbering or coding of items

Following feedback from the pre-test, the researcher included:

- A wider age range, respondents' short courses completed and positions held.
- Questions on the migration of nurses affecting the rendering of PHC services.
- Additional information on problems related to specification of supplies and equipment.
- A section for rating the seriousness of the problems in the PHC service.

### **3.8 DATA ANALYSIS**

A statistician analysed the data, using the SPSS version 15 computer software. The results were presented in percentages, frequency tables and graphs.

### **3.9 RELIABILITY AND VALIDITY**

The quality of research and research instruments is determined by their validity and reliability. Burns and Grove (1998:28) describe study validity as “a measure of the truth or accuracy of the claim and an important concern throughout the research process”.

#### **3.9.1 Reliability**

Reliability is “the degree of consistency or dependability with which the instrument measures the attribute it is designed to measure. If the instrument is reliable, the results will be the same each time the test is repeated (Polit & Hungler 1997:308; Polit & Beck 2008:764). Cozby (2001:85) refers to reliability as the consistency or the stability of measure of behaviour. Reliability is therefore concerned with accuracy, consistency, precision<sup>2</sup>, stability<sup>3</sup>, equivalence<sup>4</sup> and homogeneity<sup>5</sup>.

According to Polit and Beck (2008:374), reliability of an instrument that yields quantitative data is a major criterion for assessing its quality and adequacy. For the research findings to be reliable, the research instruments should accurately reflect or measure true scores of the attributes. In this study, the researcher ensured reliability by:

- Discussing the questionnaire with the supervisors (who have wider experience in the use of reliable instruments) prior to actual data collection.
- Pre-testing the questionnaire, to avoid words that were vague or would yield data that was not in-line with the research questions.

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<sup>2</sup> Exactness of the measure used in an observation or description of an attribute.

<sup>3</sup> Instrument's ability to produce the same result with repeated testing.

<sup>4</sup> The tool produces the same results when equivalent or parallel instruments or procedures are used.

<sup>5</sup> All the items in a tool measure the same concept or characteristic.

### 3.9.2 Validity

Validity is the extent (degree) to which an instrument measures what it is intended to measure (Burns & Grove 2005:376; Polit & Beck 2008:768). Validity is also referred to as the extent to which a specific measurement provides data related to commonly accepted meanings of a particular concept under consideration. In this study, the questionnaire was designed to measure the extent or degree to which problems prevailed in Limpopo province that hindered the effective delivery of PHC services.

*Face validity* means that the measure appears to accurately assess the intended variables (Cozby 2001:90). *Criterion* or *predictive validity* is used to predict or estimate the probability of a specific outcome in a given situation that can be achieved through research (Burns & Grove 2005:376:377). *Construct validity* is based on the logical relationship among variables, and *content validity* refers to how much a measure covers the range of meanings included in the concept.

In this study, the following procedures were followed to ensure validity:

- The questionnaire was formulated and cross checked by the supervisors.
- The questionnaire was pre-tested and corrected where necessary before the main study.

### 3.10 ETHICAL CONSIDERATIONS

Ethics deals with matters of right and wrong. *Collins English Dictionary* (1995:533) defines ethics as “a social, religious, or civil code of behaviour considered correct, especially that of a particular group, profession, or individual”. De Vos et al (2005:69) refer to ethics as a set of moral principles that are widely accepted, which guide the researcher in observing the rules.



Respondents should be treated with respect and dignity during the collection of data. The rights of the respondents in this study were observed and precautions taken to prevent the violation of their ethical rights (Polit & Beck 2008:141).

The following steps were taken to ensure that the research was conducted in an ethical manner.

### **3.10.1 Permission**

Permission to conduct the research was requested and obtained from the following authorities and services:

- Department of Health and Social Development the Provincial Head Office (Polokwane) (see annexure A).
- The Senior Manager: Integrated Primary Health Care Services at the Head Office in Polokwane (see annexure B).
- District managers of Vhembe, Waterberg, Sekhukhune, Capricorn and Mopani (see annexure C).
- Managers in charge of clinics (see annexure D).
- Research and Ethics Committee, Department of Health Studies, Unisa (see annexure F).

### **3.10.2 Informed consent**

Neumann (2005:135) says consent is “the prospective subject’s agreement to participate in a study as a subject”. It is ethically compulsory for the researcher to obtain consent from the respondents. In this study the researcher ensured that all respondents were properly briefed on the aim of the research, their rights and what was expected of them before they were approached and asked to take part in the research. On the day of data collection, the researcher gave them a list of their rights to read and ask questions, if they so wished. They were then asked to sign the consent form if they agreed to take part (see annexure G).

### **3.10.3 Principle of beneficence**

The right to protection from discomfort and harm is based on the ethical principle of beneficence. The principle of beneficence states that one should do good and, above all, do no harm (Burns & Grove 1999:165). Discomfort and harm can be physical, emotional, economic, social or legal. In this study, there were no risks of exposing the respondents to discomfort or harm.

Precautions were taken to protect the respondents against any form of discomfort (Polit & Beck 2008:43). The research did not involve any financial implications for the respondents, cause any physical strain or traumatise them psychologically. Instead they would benefit if the Department of Health could implement the recommendations of the study.

### **3.10.4 Freedom from exploitation**

The researcher did not exploit the respondents as they were free to participate or refuse to participate in the study (Neumann 2005:142). Moreover, the respondents were not vulnerable; they were all mature, responsible professionals and were willing to share their experiences in the PHC services.

### **3.10.5 Right to self-determination**

The right to self-determination is based on respect for persons and indicates that people are capable of controlling their own destiny. They should be treated as autonomous agents, who have the freedom to conduct their lives as they choose without external control (Burns & Grove 1999:158). The respondents were informed that participation was voluntary and that they could withdraw at any time from the research process without being penalised (Polit & Beck 2008:171:172). They were also informed that they were free to ask questions and would not be coerced through threats or penalty if they did not participate.

### **3.10.6 Right to full disclosure**

According to Polit and Beck (2008:172), the principle of respect for human dignity “encompasses people’s right to make informed choices, voluntary decisions about study participation, which requires full disclosure”. In this study full information regarding the study was discussed with the respondents, and every respondent was given a document with information of their rights (see annexure G). Respondents were also allowed to ask for clarification during data collection.

### **3.10.7 Right to fair treatment**

Study participants “have the right to fair and equitable treatment before, during and after their participation in the study” (Polit & Beck 2008:173). In this study, the respondents were fairly selected to participate in the study and their cultural preferences taken into consideration. Moreover, the researcher took into consideration the fact that Limpopo province had absorbed the previous four homelands and therefore required her to be culturally sensitive to some of the respondents. The respondents were treated courteously, tactfully and fairly throughout the study.

### **3.10.8 Right to privacy**

Privacy is the freedom individuals have to determine the time, extent and general circumstances under which private information will be shared with or withheld from others (Burns & Grove 1999:158; 2005:186).

The respondents’ privacy was protected by obtaining their informed consent and assuring them that there would be no invasion of their privacy. The information collected would only be used for research purposes. The researcher ensured that the respondents’ dignity was respected throughout the study. The respondents completed the questionnaire in a private room at the particular clinics allocated specifically for this purpose.

### **3.10.9 Anonymity and confidentiality**

Anonymity refers to protection of respondents in a study so that even the researcher cannot trace the data to specific subjects (Brink 1990:51; Polit & Beck 2008:747). To ensure the respondents' anonymity, they were not asked to provide their names on the questionnaire (see annexure H). Instead, the researcher numbered the questionnaires.

Confidentiality refers to the way in which researchers hold all matters coming to their knowledge as confidential as possible (De Vos et al 2005:61). Confidentiality means that information provided by respondents will not be divulged or made available to any other person.

The researcher emphasised that all information would be treated as strictly confidential and only available to the researcher and those directly involved with the study. All data gathered would be kept confidential. Subsequent to the acceptance of the research report, the researcher would destroy the completed questionnaires. In the research report, statistics would be used and no individuals' names mentioned. The respondents, health institutions, and health authorities were aware, however, that the results of the research would be offered for examination and published as a dissertation and in an article.

### **3.11 CONCLUSION**

This chapter covered the research design and methodology, including the population, sample, data collection and research instrument, data analysis, reliability and validity, and ethical considerations.

Chapter 4 discusses the data analysis and interpretation.

## **CHAPTER 4**

### **DATA ANALYSIS AND INTERPRETATION**

#### **4.1 INTRODUCTION**

Chapter 3 described the research design and methodology. The researcher conducted a quantitative, explorative and descriptive research study. This chapter discusses the data analysis and interpretation.

#### **4.2 RESEARCH OBJECTIVES AND RESEARCH QUESTIONS**

The study wished to determine whether registered PHC nurses perceived problems similar to those found by Uys (2004:82, 85, 95) in the PHC clinics of the Southern Cape/Karoo region, also emerging in Limpopo, which would hinder the rendering of quality health care.

The objectives of the study were to

- describe the biographical characteristics of PHC nurses who work in PHC clinics in Limpopo province, RSA.
- explore and describe the managerial problems and the extent thereof in the PHC system that might have hindered the successful provision of quality PHC, in clinics in Limpopo province, RSA.
- explore and describe the personnel problems and the extent thereof that might have hindered the successful provision of quality PHC, in clinics in Limpopo province, RSA.
- explore and describe any problems in the provision of equipment and other resources as well as the extent thereof that might have hindered the successful provision of quality PHC, in clinics in Limpopo province, RSA.

- explore and describe any problems with the infrastructure and the extent thereof that might have hindered the successful provision of quality PHC, in clinics in Limpopo province, RSA.
- explore and describe any problems related to referral systems that might have hindered the successful provision of quality PHC, in clinics in Limpopo province, RSA.
- explore and describe any problems related to training of personnel that might have hindered the successful provision of quality PHC, in clinics in Limpopo province, RSA.
- explore and describe any problems related to the multi-disciplinary team that might have hindered the successful provision of quality PHC, in clinics in Limpopo province, RSA.
- explore and describe any problems that could be attributed to the behaviour of patients that might have hindered the successful provision of quality PHC, in clinics in Limpopo province, RSA.

### **4.3 DATA ANALYSIS**

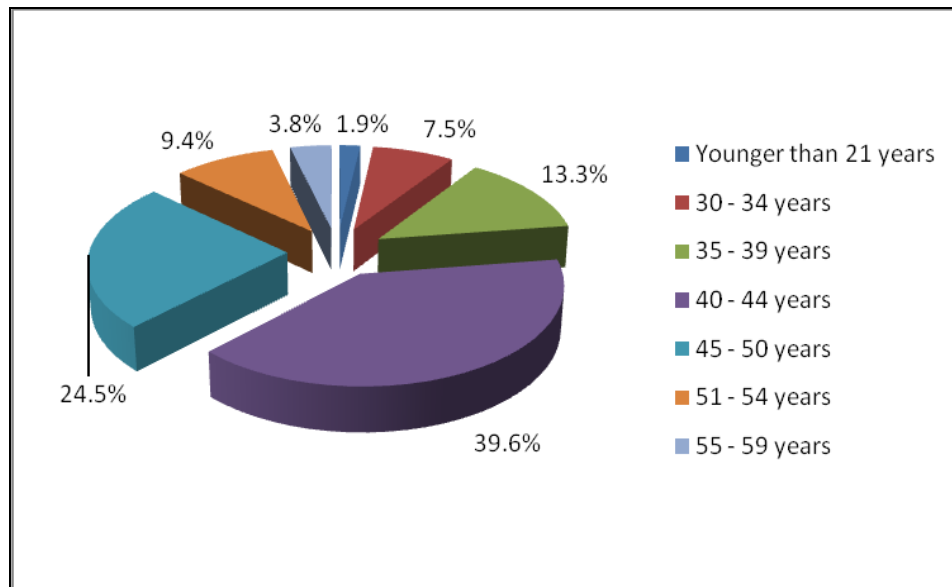
The data was analysed using the Statistical Package for Social Sciences (SPSS) program, version 15. Data was collected from 53 respondents at PHC clinics and health institutions in the five districts of Limpopo by means of a questionnaire consisting of ten sections. The analysed data is discussed according to the sections of the questionnaire.

#### **4.3.1 Section A: Biographical data**

This section dealt with the respondents' biographical data including age, gender, name of the institution, district, year of completion of PHC diploma, years of working as a PHC nurse, qualifications, short courses attended, position at work and monthly income.

#### **4.3.1.1 Item A1: Respondents' age (N=53)**

Of the respondents, 1.9% (n=1) was younger than 29 years old; 39.6% (n=21) were between 40 and 44, and 3.8% (n=2) were between 55 and 59 (see figure 4.1).



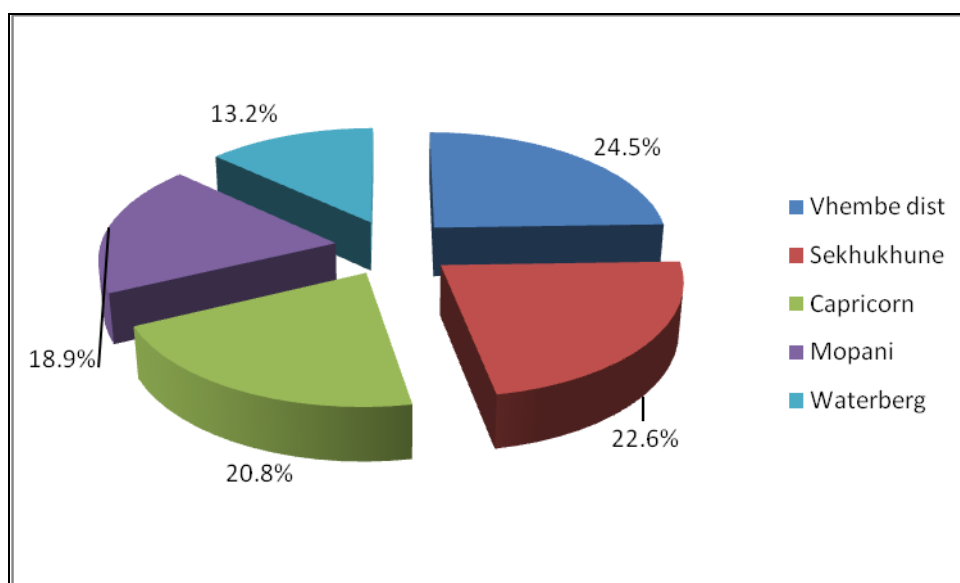
**Figure 4.1 Respondents' age**

#### **4.3.1.2 Item A2: Respondents' gender (N=53)**

Of the respondents, 88.7% (n=47) were females and 11.3% (n=6) were males.

#### **4.3.1.3 Item A3: Districts where respondents worked (N=53)**

The respondents (PHC nurses) were selected from all five districts. Of the respondents, 24.5% (n=13) were from Vhembe; 22.6% (n=12) were from Sekhukhune; 20.8% (n=11) were from Capricorn; 18.9% (n=10) were from Mopani, and 13.2% (n=7) were from Waterberg (see figure 4.2).



**Figure 4.2 Respondents' districts of work**

#### **4.3.1.4 Item A4: Respondents' working experience in PHC (N=53)**

Of the respondents, 47.2% (n=25) had six or more years' experience in PHC; 18.9% (n=10) had 4 to 5 years' experience; 24.5% (n=13) had 2 to 3 years' experience, and 9.4% (n=5) had a few months' experience (see table 4.1). This indicated that most of the respondents had a lot of experience in a PHC facility. The respondents were thus able to describe problems in the PHC services, especially in the rural areas.

**Table 4.1 Respondents' years in PHC services (N=53)**

Period working in PHC service	N	%
A few months	9.45	5
2-3 years	24.5	13
4-5 years	18.9	10
6 or more years	47.2	25
TOTAL	53	100

#### **4.3.1.5 Item A5: Respondents' qualifications (N=53)**

The respondents were asked to indicate their qualifications registered with the South African Nursing Council (SANC). All the respondents (100.0%; n=53) had qualified in general nursing and primary health care (PHC). In addition, 98.1% (n=52) had qualified



in midwifery; 81.1% (n=43) in community health nursing; 54.7% (n=29) in psychiatric nursing; 54.7% (n=29) in nursing education, and 39.6% (n=21) had qualified in health services management (see table 4.2).

**Table 4.2 Respondents' qualifications registered with SANC (N=53)**

<b>Qualifications</b>	<b>Percentage</b>	<b>Frequency</b>
<b>General nursing</b>	100.0	53
<b>Midwifery</b>	98.1	52
<b>Community health</b>	81.1	43
<b>Psychiatric nursing</b>	54.7	29
<b>Health services management</b>	39.6	21
<b>Nursing education</b>	54.7	29
<b>Primary Health Care</b>	100.0	53

Community health nursing is very important for working in rural PHC clinics as it complements the diploma in general nursing and PHC nursing and promotes insight into the needs of communities (Uys 2004:56).

It was encouraging to note that 54.7% (n=29) of the respondents had diplomas in psychiatry, as this ensures a holistic approach in patient care and the delivery of quality service to patients in need of mental health services.

Of the respondents, 39.6% (n=21) had a qualification in health services management. Knowledge of administration is important for a PHC nurse (Uys 2004:119).

The number of respondents who were nurse educators (54.7%; n=29) was encouraging because background knowledge and understanding of nursing education facilitates and promotes an environment conducive to learning. One of a nurse's main functions is to teach therefore this qualification is necessary for teaching subordinates and the community.

#### **4.3.1.6 Item A6: Short courses completed (N=53)**

The respondents were asked to indicate which of the short courses listed in the questionnaires they had completed (see table 4.3).

Of the respondents, 81.1% (n=43) were trained in *Prevention of Mother-to-Child Transmission* (PMCT) and 88.7% (n=47) in *Voluntary Counselling and Testing* (VCT). PMCT is important to reduce the number of children born HIV positive in the province and the country as a whole. In addition, many patients attend clinics to determine their HIV status, which emphasises the need for nurses with counselling skills. Some patients also present with opportunistic infections and require ongoing counselling.

Of the respondents, 96.2% (n=51) had trained in *integrated management of childhood illness* (IMCI). IMCI is a requirement for PHC nurses in order to assess, classify, treat or refer children accordingly. This is a way to lower the infant morbidity and mortality rates.

Pulmonary TB is one of the opportunistic medical conditions affecting HIV-positive patients (Mainga 2008:77-79). The majority of the respondents (84.9%; n=45) were trained in *TB management*. This is a critical qualification, given the high morbidity rate of TB in the RSA. Training in TB management facilitates early diagnosis, proper management and prevention of complications. This assists in reducing unnecessary deaths and serious problems like multi-drug resistance (MDR) to pulmonary TB drugs, which poses a threat to health workers and the community as a whole.

**Table 4.3 Respondents' short courses completed (N=53)**

Short course	Percentage	Frequency
Prevention of mother-to-child transmission (PMCT)	81.1	43
Voluntary counselling and testing (VCT)	88.7	47
Integrated management of childhood illness (IMCI)	96.2	51
TB management	84.9	45
(NAFCI)	18.9	10
Logistic management	5.7	3
Sexually transmitted infections (STI)	79.2	42
Couple counselling	64.2	34
Preceptor course	64.2	34
Dispensing course		
Drug supply management	45.3	24
HIV/Aids	52.8	28
Financial management	22.6	12
Youth-friendly initiative	22.6	12

Most of the respondents (79.2%; n=42) had undergone training in *Sexually Transmitted Infections* (STIs). This would facilitate the prevention of these diseases and Aids, as there is a direct relationship between repeated STIs and HIV. There is sometimes a need to deal with couples who are affected or infected by HIV, according to the recommended guidelines, without causing constraints in the relationship. Of the respondents, 64.2% (n=34) were trained in couple counselling and 88.7% (n=47) were trained in VCT. However, only 52.8% (n=28) of the respondents were trained in HIV/Aids. This training is essential for PHC nurses in order to provide comprehensive services.

Although only 54.7% (n=29) of the respondents indicated that they were registered nurse educators, training them as preceptors would ensure a favourable clinical situation where most staff members would be able to train prospective PHC nurses. Students need someone with nursing education or preceptor skills to guide and support them during clinical sessions. Mabaso (2006:133) maintains that strategic planning sessions would help to solve the shortage of preceptors which creates “poor support and supervision” of students undergoing decentralised training.

Of the respondents, 45.3% (n=24) were trained in drug supply. Handling drugs is one of the key functions for the curative tasks of a PHC nurse. Mabaso (2006:117, 134) points

out the need for PHC nurses to train in drug supply and to keep their knowledge of drugs up to date.

Regarding management, only 22.6% (n=12) of the respondents indicated that they were trained in financial management; 39.6% (n=21) of the respondents were qualified nurse administrators, and 5.7% (n=3) were trained in logistical management. Most of the activities in the PHC setting involve finance and a good knowledge of budgeting while logistical management assists nurses in organising the logistics of a PHC facility.

Of the respondents, 22.6% (n=12) were qualified in the youth-friendly initiative course. As the majority of the South African population consists of young people, the Department of Health (Baloyi 2006: 55) launched this initiative to make PHC clinics more youth friendly and improve nurse-patient relationships in dealing with health matters important to adolescents.

#### **4.3.1.7 Item A7: Respondents' positions held (N=53)**

The respondents were asked to indicate the positions they held. The respondents' positions included operational manager or facility manager; second in charge; third in charge; chief professional nurse; senior professional nurse; coordinator of mother and child services, and clinical nurse practitioner.

#### **4.3.1.8 Item A8: Remuneration (N=53)**

Regarding remuneration, of the respondents, 47.2% (n=25) were satisfied with their salaries; 37.7% (n=20) were dissatisfied; 11.3% (n=6) were uncertain, and 3.8% (n=2) did not answer.

#### **4.3.1.9 Item A9: Reasons for the above answer (N=53)**

In an open-ended question the respondents were asked to indicate the reason for their satisfaction or dissatisfaction. Many of the respondents were satisfied with their new

salaries, as they were now able to meet their needs. In general the respondents were of the opinion that “upgrading of salaries has made a difference. Since December 2007 most PHC nurses started to see improvement in salaries.”

The respondents who were dissatisfied indicated the following reasons:

- The work that was performed was worth more than the salary they got, as the patient-nurse ratio was too high.
- Unfairness in the occupation specific dispensation (OSD), as some nurses were put on a better scale than others, irrespective of experience.

#### **4.3.2 Section B: Personnel-related problems in PHC services**

This section explored staff-related problems in PHC services, such as number of personnel at the clinic/health centre; qualified PHC nurses; volume of patients dealt with on a daily basis; patient-nurse ratio, and total number of patients attended per day in a facility.

##### **4.3.2.1 Item B1: Number of nurses in institutions (N=53)**

The respondents indicated that eight clinics had 12 nurses and the highest number of nurses in a health facility was 39. This health centre provided a 24-hour PHC service. Mello (2002:97), Netshandama et al (2005:67) and Rapakwana (2004:94) also found inadequate staff numbers.

##### **4.3.2.2 Item B2: Number of qualified PHC nurses (N=53)**

All the respondents (100%; n=53) indicated that their health services had at least one registered PHC nurse on duty (see table 4.4). The number of registered PHC nurses in the health services ranged between 1 and 9 per institution.

**Table 4.4 Number of PHC nurses in health services (N=53)**

Number	Percentage	Frequency
1	47.2	25
2	32.1	17
3	7.5	4
4	5.7	3
5	3.8	2
8	1.9	1
9	1.9	1
<b>Total</b>	<b>100.0</b>	<b>53</b>

Vhembe district had the most registered PHC nurses. Of the respondents, 3.8% (n=2) indicated that their facilities had only one registered PHC nurse. This would mean that they did not have a PHC nurse when she had a day off or attended a meeting or course.

#### **4.3.2.3 Item B3: Number of registered nurses (N=53)**

Of the respondents, 43.4% (n=23) indicated two to five registered nurses on their staff. The highest number of registered nurses was 17 in one clinic, namely the Vhembe Health Centre which provides 24-hour PHC service. This finding was better than the situation in some districts of the Eastern Cape province where there is only one registered nurse at a clinic, irrespective of population size and health trends (Masondo 2008:1[Online]. Available: URL.

<http://www.samedia.uvs.ac.za/cgi-bin/getpdf?year=2008&refno=7668&topic=1>).

#### **4.3.2.4 Item B4: Seriousness of shortage of nurses (N=53)**

Of the respondents, 17.0% (n=9) indicated that services *had to close* due to shortage of staff; 26.4% (n=14) indicated most services *were affected but could continue*; 22.6% (n=12) indicated that their services were only mildly affected; 15.1% (n=8) indicated that services were not affected; 17.0% (n=9) indicated no shortage of staff, and 1.9% (n=1) did not answer (see table 4.5).

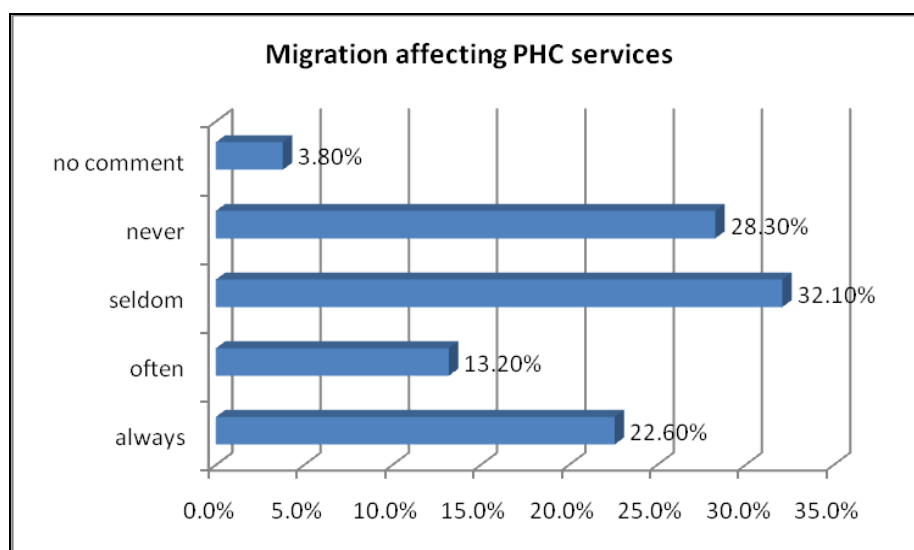
**Table 4.5 Seriousness of staff shortage in institutions (N=53)**

Seriousness	Percentage	Frequency
Services had to close	17.0	9
Most services affected but services did continue	26.4	14
Services mildly affected	22.6	12
Services not affected	15.1	8
No shortages	17.0	9
Did not answer	1.9	1
Total	100.0	53

The findings therefore indicated that in most clinics the provision of quality services was possible, although difficult at times.

#### **4.3.2.5 Item B5: Migration of staff affects PHC service delivery (N=53)**

Of the respondents, 22.6% (n=12) indicated that migration of nurses *always* affected PHC services; 13.2% (n=7) indicated that migration *often* did; 32.1% (n=17) indicated that it *seldom* did; 28.3% (n=15) indicated it *never* did, and 3.8% (n=2) did not comment.



**Figure 4.3 Migration affecting PHC services**

#### **4.3.2.6 Item B6: Ways in which migration of staff affected services (N=53)**

This question probed the ways in which migration affected the delivery of quality PHC services.

- *Item B6.1: Migration of staff is a bigger problem than the mere shortage of staff (N=53)*

Of the respondents, 24.5% (n=13) indicated that migration of nurses is *always* a bigger problem than the mere shortage of staff; whilst 13.2% (n=7) said it is *often* a bigger problem; 7.5% (n=4) indicated that migration of staff is *seldom* bigger than the fact that more staff are not available to fill the posts, and 7.5% (n=4) indicated that migration is *never* a bigger problem than the shortage of staff.

- *Item B6.2: New staff needs to be oriented and it takes time (N=53)*

Of the respondents, 26.4% (n=14) indicated that new staff *always* needed to be orientated; 11.3% (n=6) indicated *often*; 5.7% (n=3) indicated *seldom*; 5.7% (n=3) indicated *never*, and 50.9% (n=27) did not answer the question.

- *Item B6.3: New staff had to attend short courses before they could be fully applied (function fully) (N=53)*

All the respondents (100.0%; n=53) indicated that new staff did not have to attend short courses before they could function fully.

- *Item B6.4: Reasons why staff migrate (N=53)*

In an open-ended question the respondents were asked to indicate why staff migrated and how this affected service delivery. Reasons given:

- "... looking for greener pastures"
- "... over working conditions"



- “... to work where there are enough resources”
- “... a few migrated due to family-related issues”
- “... a few were treated unfairly by their managers”

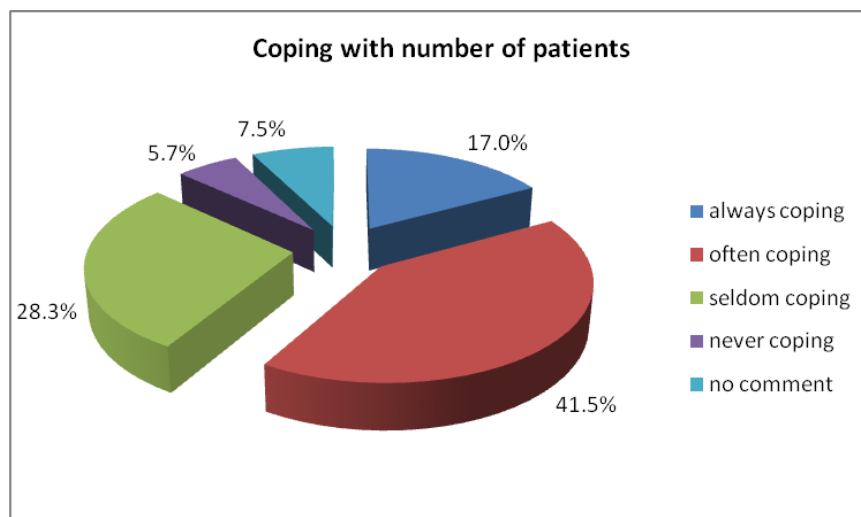
Regarding effects on service delivery:

- “This leads to skilled staff leaving PHC facilities and creating more shortages. These nurses cannot be replaced”.
- “Migration has a negative impact on staffing levels of facilities in Limpopo”.

Purnell and Horner (2001:186) found that nurses left as a result of disenchantment with conditions of service, poor salaries, nurse-patient ratios, and a lack of basic requirements.

#### **4.3.2.7 Item B7: Nurses can cope with the number of patients who attend the health services every day (N=53)**

Of the respondents, 17% (n=9) indicated that they always coped with the number of patients; 41.5% (n=22) often coped; 28.3% (n=15) seldom coped; 5.7% (n=3) never coped, and 7.5% (n=4) did not answer the question (see figure 4.4).



**Figure 4.4 Coping with the number of patients**

#### **4.3.2.8 Item B8: Respondents' number of patients seen per day (N=53)**

Of the respondents, 81.1% (n=43) saw 40 or more patients per day; 16.9% (n=9) saw 35 or less patients per day, and 1.9% (n=1) did not indicate.

In some districts of the Eastern Cape Province, Masondo (2008:1 [Online]. Available: URL. <http://www.samedia.uvs.ac.za/cgi-bin/getpdf?year=2008&refno=7668&topic=1>) found that nurses saw between 80 and 120 patients per day.

#### **4.3.2.9 Item B.9: Number of patients attending the clinic per day (N=53)**

The respondents generally indicated that between 100 and 250 patients attended the clinic per day, while three respondents (5.7%) indicated 300 patients per day and one (1.9%) indicated 400.

In the Eastern Cape Masondo (2008:1) [Online]. Available: URL. <http://www.samedia.uvs.ac.za/cgi-bin/getpdf?year=2008&refno=7668&topic=1>) found that so many patients visited the clinics per day that they could not be helped and had to be turned away.

#### **4.3.2.10 Item B10: Optimal number of patients PHC nurses could see per day (N=53)**

Of the respondents, 30.2% (n=16) felt that 30 patients per day would be the optimal number a PHC nurse should see to be able to render quality care. According to Masondo (2008:1), [Online]. Available: URL. <http://www.samedia.uvs.ac.za/cgi-bin/getpdf?year=2008&refno=7668&topic=1>) a PHC nurse should not consult more than 35 patients per day.

#### **4.3.2.11 Item B11: Extent to which statements applied to the PHC in the respondents' institutions (N=53)**

- *Item B11.1: PHC nurses keep their knowledge updated (N=53)*

Of the respondents, 34.0% (n=17) strongly agreed and 49.1% (n=26) agreed that most of the PHC nurses kept their knowledge updated, 18.9% (n=10) did not agree. This appeared to indicate that there are ample opportunities for PHC nurses to update their knowledge and that they make use of it. Uys (2004:113) found inadequate opportunities for nurses to keep updated, such as in-service or refresher courses.

- *Item B11.2: PHC nurses prescribe medicine for every patient (N=53)*

Of the respondents, 32.1% (n=17) disagreed and 22.6% (n=12) strongly disagreed that PHC nurses prescribed medicine for every patient, while 18.9% (n=10) agreed that medicine was prescribed for every patient, and 3.8% (n=2) did not respond to the question.

- *Item B11.3: PHC nurses know the side-effects of drugs (N=53)*

Of the respondents, 11.3% (n=6) strongly agreed and 54.7% (n=29) agreed that PHC nurses knew the side-effects of drugs; 24.5% (n=13) disagreed; 5.7% (n=3) strongly disagreed, and 3.8% (n=2) did not respond.

- *Item B11.4: PHC nurses write proper clinical notes (N=53)*

Of the respondents, 58.5% (n=31) strongly agreed and 11.3% (n=6) agreed that PHC nurses wrote proper clinical notes, and 30.1% (n=16) did not agree. Mabaso's (2006:120) found that nurses "were able to write correct clinical notes". Unfortunately the respondents who did not agree were not asked why they believe that PHC nurses could not write proper clinical notes.

- *Item B11.5: PHC nurses know how to prescribe according to the Essential Drug List (EDL) (N=53)*

Of the respondents, 90.5% (n=48) strongly agreed that PHC nurses prescribed medicine according to the EDL. This indicated that they used the EDL as reference.

- *Item B11.6: PHC nurses give health education to every patient (N=53)*

Of the respondents, 41.5% (n=22) strongly agreed and 39.6% (n=21) agreed that PHC provided health education to every patient. This was encouraging that 81.1% (n=43) of the respondents believe that PHC nurses give health education to every patient since non-drug management is a priority in PHC. This concurred with Mabaso's (2006:115) finding that most nurses knew what health education to give to the patients.

- *Item B.7: PHC nurses waste supplies (N=53)*

Of the respondents, 37.3% (n=20) strongly disagreed and 41.5% (n=22) disagreed that PHC nurses waste supplies. It could be that the rest of the respondents did not really know whether PHC nurses seem to waste supplies as 79.2% (n=42) did not respond or they did not want to confirm that there is a problem.

- *Item B11.8: PHC nurses have good rapport with patients (N=53)*

Of the respondents, 30.2% (n=16) strongly agreed and 58.5% (n=31) agreed that PHC nurses had good rapport with patients, and 11.3% (n=6) of the respondents did not respond to the question.

- *Item B11.9: PHC nurses work together as a team (N=53)*

Of the respondents, 34.0% (n=18) strongly agreed, 49.1% (n=26) agreed that PHC nurses worked together as a team, and 17.0% (n=9) of the respondents felt that they did not work together as a team. Team spirit is highly needed in a PHC setting where people deal with others' lives. Uys (2004:116) found that team work was present but

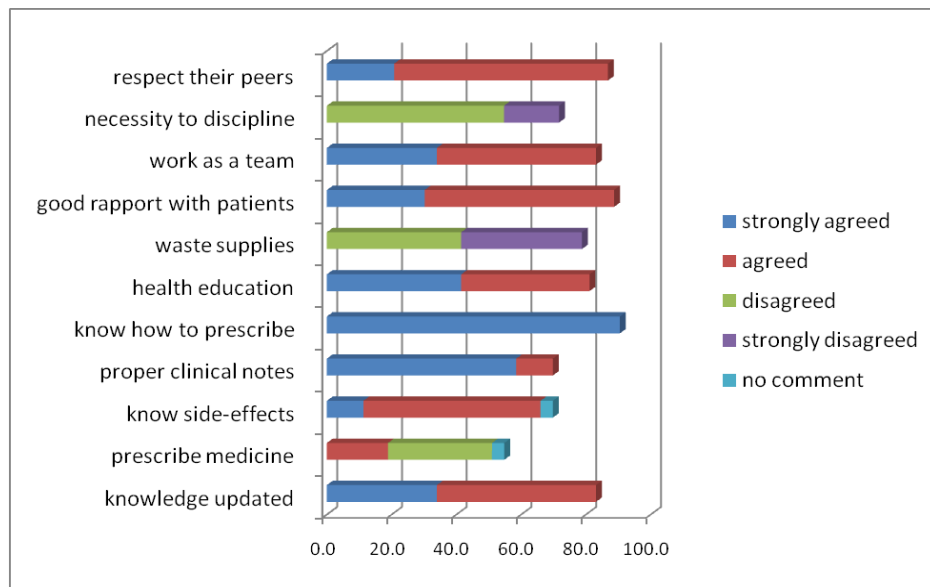
with some clashes due to cultural differences. The ethnic and cultural background of the respondents of this study was not investigated, so it cannot be assumed that it could be that cultural difference caused 17.0% of the respondents to disagree with the statement.

- *Item B11.10: Necessary to discipline PHC nurses (N=53)*

Of the respondents, 54.7% (n=29) disagreed and 17.0% (n=9) strongly disagreed that it was necessary to discipline PHC nurses, and 28.3% (n=15) of the respondents agreed. Although this was not statistically confirmed the 15 respondents who felt that the PHC nurses needed to be disciplined were of the group of 34 managers who answered Section C. As PHC nurses often have to stand-in for medical doctors and pharmacists, they take on great responsibilities. PHC nurses who work in these settings are well qualified and professional and know their responsibilities, and therefore should not need to be disciplined.

- *Item B11.11: PHC nurses respect their peers (N=53)*

Of the respondents, 20.8% (n=11) strongly agreed and 66.0% (n=35) agreed that PHC nurses respect their peers. Only 13.2% (n=7) of the respondents felt that PHC do not respect their peers. Respect for peers and patients are part of a professional approach to health service delivery and necessary to create a harmonious relationship between members of the multi-disciplinary team. Uys (2004:114) found a spirit of solidarity among employees.



**Figure 4.5** *Statements applicable to the PHC in the respondents' institutions (N=53) (Item B11)*

#### **4.3.2.12** *Item B12: Respondents' perception of which capabilities of PHC nurses should improve (N=53)*

In this section the respondents had to indicate how strongly they agreed with listed statements on the capabilities of PHC nurses in general.

- *Item B12.1: PHC nurses should spend more time with patients (N=53)*

Of the respondents, 60.4% (n=32) strongly agreed and 34.0% (n=18) agreed that more time should be spent with patients, while 5.6% (n=3) disagreed.

- *Item B12.2: PHC nurses should improve their history taking skills (N=53)*

Of the respondents, 52.8% (n=28) strongly agreed; 39.6% (n=21) agreed and 7.6% (n=4) disagreed that history taking should be improved. This concurred with Mabaso's (2006:117) findings who found that the newly qualified diplomates in her study also did not give enough attention to history taking and did not do it too well.

- *Item B12.3: PHC nurses should improve their physical examination skills (N=53)*

Of the respondents, 47.2% (n=25) strongly agreed and 39.6% (n=21) agreed that nurses should improve their physical examination skills while 13.2% (n=7) disagreed. It is therefore clear that 87.0% (n=46) of the respondents were of the opinion that the PHC nurses' physical examination skills need to be improved. Although the participants in the study conducted by Mabaso (2006:117) executed the physical examinations correctly, they indicated that they felt unsure about their abilities and would have liked more training in physical examination.

- *Item B12.4: PHC nurses should improve their diagnostic skills (N=53)*

Of the respondents, 49.1% (n=26) strongly agreed and 37.7% (n=20) agreed that diagnostic skills should be improved while 13.2% (n=7) disagreed. It is therefore clear that the majority of the respondents 86.8% (n=46) were of the opinion that the PHC nurses' diagnostic skills are not good enough. Bester and Engelbrecht (2009:111) found in their study conducted among PHC nurses in the Free State that the respondents referred to the stressful nature of not being able to make the correct diagnosis as their training did not equip them with the necessary diagnostic skills.

- *Item B12.5: PHC nurses should improve their knowledge of medications (N=53)*

Of the respondents, 58.5% (n=31) strongly agreed, 35.8% (n=19) agreed and 5.7% (n=3) disagreed that nurses' knowledge of medication should be improved. Here again it seems that the majority of respondents 94.3% (n=50) believed that the PHC nurses' knowledge of medication is not good enough, although the respondents indicated in item 11.3 that PHC knew the side-effects of drugs.

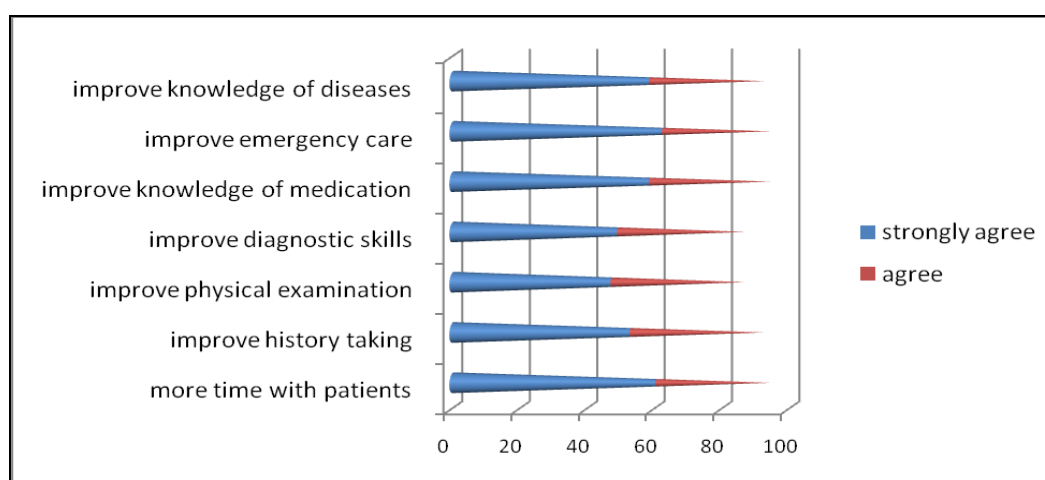
- *Item B12.6: PHC nurses should improve their emergency care skills (N=53)*

Of the respondents, 62.3% (n=33) strongly agreed and 32.1% (n=17) agreed while 5.7% (n=3) disagreed that nurses should improve their emergency skills. This finding appeared to indicate a need to improve emergency care skills since most of the clinics where the respondents worked were situated in the deep rural parts of Limpopo province, and far from hospitals. For example, one PHC facility was 96 km from the referral hospital, therefore PHC nurses need to be able to provide emergency services as patients' lives depend on their knowledge and skills (see item F1).

- *Item B12.7: PHC nurses should improve their knowledge of diseases (N=53)*

Of the respondents, 58.5% (n=31) strongly agreed and 34.0% (n=18) agreed that PHC nurses' knowledge of diseases should be improved and 7.5% (n=4) disagreed. Again it seems that the majority of respondents 92.4% (n=49) felt that the PHC nurses' knowledge of diseases is not good enough and need to improve. They should be able to make correct diagnosis. In item 12.4 the respondents indicated that PHC nurses' diagnostic skills should improve.

Figure 4.6 represents the areas that the respondents indicated PHC nurses should improve their skills and knowledge in order to provide quality PHC service.



**Figure 4.6** *Where PHC should improve*



#### **4.3.2.13      *Item B13: How often PHC nurses in the clinic have to do certain tasks (N=53)***

This section examined how frequently the respondents had to perform certain functions and duties.

- *Item B13.1: Frequency with which PHC nurses have to stand-in for a medical doctor (N=53)*

Of the respondents, 60.4% (n=32) indicated that PHC nurses had to stand-in for a medical doctor 9 or more times per month; 1.9% (n=1) indicated 5 to 8 times a month; 9.4% (n=5) indicated 2 to 4 times a month; 9.4% (n=5) reported at least once a month, and 18.9% (n=10) indicated that they never had to stand-in for a medical practitioner. This concurred with Mabaso's (2006:118) finding that some clinics in Limpopo did not have a visiting medical doctor.

- *Item B13.2: Frequency with which PHC nurses have to stand-in for a pharmacist (N=53)*

Of the respondents, 54.7% (n=29) indicated that they had to perform the functions of a pharmacist 9 or more times per month; 1.9% (n=1) indicated 5 to 8 times a month; 7.5% (n=4) indicated 2 to 4 times a month; 11.3% (n=6) indicated at least once a month; 24.5% (n=13) indicated that they never had to do it, and 1.9% (n=1) did not answer the question.

In the Eastern Cape, Masondo (2008:1[Online]. Available: URL. <http://www.samedia.uvs.ac.za/cgi-bin/getpdf?year=2008&refno=7668&topic=1>) found that, irrespective of their workload, PHC nurses also had to dispense medication, particularly to patients with chronic conditions such as TB.

- *Item B13.3: Frequency with which PHC nurses have to do the work of an administrative clerk (N=53)*

Of the respondents, 24.5% (n=13) indicated that they had to do clerical work 9 or more times a month since they did not have a clerk; 7.5% (n=4) indicated 2 to 4 times a month; 11.3% (n=6) indicated at least once a month, and 1.9% (n=1) did not answer the question. From this finding it was clear that some of the hours that could be dedicated to purely nursing functions were used for clerical work.

- *Item B13.4: Frequency with which PHC nurses have to perform social worker's duties (N=53)*

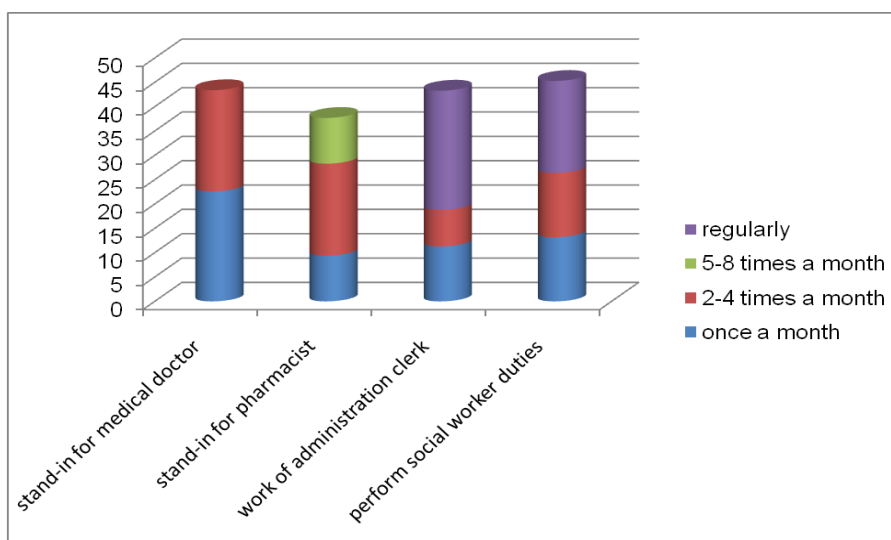
Of the respondents, 47.2% (n=25) indicated that PHC nurses had to perform the duties of a social worker 9 or more times a month; 7.5% (n=4) indicated 5 to 8 times a month; 13.2% (n=7) indicated 2 to 3 times a month; 13.2% (n=7) indicated at least once a month, and 18.9% (n=10) indicated never.

- *Item B13.5: Frequency with which PHC nurses have to do the work of other support personnel (N=53)*

On occasion nurses found themselves standing in for other members of the multi-disciplinary team not mentioned above.

Of the respondents, 45.3% (n=24) indicated that they had to do the work of other support personnel at least 9 or more times a month; 9.4% (n=5) indicated 5 to 8 times a month; 11.3% (n=6) indicated 2 to 4 times a month; 7.5% (n=4) indicated at least once a month; 22.6% (n=12) indicated never, and 3.8% (n=2) did not answer the question. When PHC have to do the work for other members of the multi-disciplinary team then they will not be able to provide quality PHC services to the patients.

Figure 4.7 depicts the frequency with which the respondents had to perform other functions besides their nursing duties.



**Figure 4.7 Frequency with which PHC nurses in the clinic have to do certain tasks**

- *Item B13.6: Reasons for doing work of other members of the multi-disciplinary team (N=53)*

The respondents were asked to indicate the reasons for having to perform functions other than their nursing duties. The following reasons were given by the respondents in this open-ended question:

- *“Patients need total care and it is only the nurses who are usually available”.*
- *“There are problems in some facilities. Members of the multi-disciplinary team do not visit at all due to different reasons”.*
- *“In some clinics there is no visiting doctor at all, due to shortage of doctors in hospitals, so it is not possible for clinics to be allocated with a visiting doctor”.*
- *“In some cases social workers do not visit due to the shortage of transport”.*
- *“Most clinics have no administrative clerks, no visiting social worker, no visiting ophthalmic nurse, and no visiting physiotherapist”.*
- *“A PHC nurse has to be a ‘Jack of all trades’, address social problems, write files, and issue files for patients”.*

Doctors complained that they often did not have all the people needed in the multi-disciplinary team in the rural areas, which placed added stress on staff due to a lack of back-up services (Beresford 2008:16) [Online]. Available: URL. <http://www.samedia.uvs.ac.za/cgi-bin/getpdf?year=2008&refno=7668&topic=16> .

#### **4.3.2.14 Item B14: Statements applicable to the staff in the institution (N=53)**

This section required the respondents to indicate statements that applied to the staff at their clinics.

- **Item B14.1: Are absent from work without reason (N=53)**

Of the respondents, 69.8% (n=37) reported that staff were *never* absent without a legitimate reason; 20.8% (n=11) indicated *seldom*; 3.8% (n=2) indicated *always*, and 5.7% (n=3) indicated *often*. Absence from work without reason was therefore not a problem among the personnel in the PHC health services of Limpopo province. This concurred with Uys' (2004:72) finding that absenteeism was not a big problem in the Southern Karoo region.

- **Item B14.2: Are professional in their conduct (N=53)**

Of the respondents, 49.1% (n=26) indicated that their staff members were *always* professional in their conduct; 30.2% (n=16) indicated *often*; and 20.8% (n=11) of the respondents did not respond. Although Uys (2004:114) found that lack of professionalism was a barrier to providing quality care, it does not seem that this was a serious problem in Limpopo province.

- **Item B14.3: Are happy with their working conditions (N=53)**

Of the respondents, 13.2% (n=7) indicated that the staff were *always* happy with their working conditions; 43.4% (n=23) indicated *often*, and the rest did not respond. Although the findings indicate that just over half 56.6% (n=30) of the staff could be

considered generally happy with the working conditions, it is also, on the other hand, a clear indication that they are not very happy with their working condition, particularly if the shortage of personnel, stress and other problems are also considered.

- *Item B14.4: Experience stress (N=53)*

Of the respondents, 13.2% (n=7) indicated that the staff *always* experienced stress; 37.7% (n=20) indicated *often*; 45.3% (n=24) indicated *seldom*, and only 3.8% (n=2) indicated *never*.

Stress contributes to staff unhappiness and poor professionalism. According to Muller, Bezuidenhout and Jooste (2006:282), stress in the workplace can be caused by factors like disagreements with supervisors or employees, not being sure of roles, no communication, heavy workload and harassment. Uys (2004:103, 106) found that PHC nurses in the Southern Cape in the Karoo region experienced stress because their problems were not addressed. According to Bester & Engelbrecht (2009: 111) one of the most frequent reported stressors experienced by PHC nurses in the Free State was frustration due to excessive work load and time pressures, working long hours, overtime, insufficient time to complete administrative tasks and pressures to implement a variety of programmes amidst staff shortages.

- *Item B14.5: Staff morale is high (N=53)*

Of the respondents, 28.3% (n=15) indicated that their staff morale was *always* high; 41.5% (n=22) indicated *often*; 26.4% (n=14) indicated *seldom*, and 3.8% (n=2) indicated *never*. High morale is necessary for achieving quality service.

- *Item B14.6: Work together as a team (N=53)*

Of the respondents, 49.1% (n=26) agreed that staff *always* worked as a team; 41.5% (n=22) indicated *often*, and 9.4% (n=5) disagreed. Muller et al (2006:294) emphasise that an important aspect of effective leadership and supervision is to develop a spirit of

teamwork amongst employees.

- *Item B14.7: Are productive (N=53)*

Of the respondents, 39.6% (n=21) indicated that the staff were *always* productive and 54.7% (n=29) indicated *often*, while 5.7% (n=3) disagreed. For nurses to be productive there must be a balance between the workload and the number of nurses in the different categories (Booyens 1998:577). Uys (2004:114) found that a high level of stress impacted negatively on productivity. Seeing that the respondents indicated that the majority of them tend to experience some degree of stress at some time this could also be the reason that they felt that they were not productive.

- *Item B14.8: Enough staff to supervise junior nurses (N=53)*

Of the respondents, 37.7% (n=20) indicated that there were *always* and 43.4% (n=23) *often* staff to supervise junior staff, while 11.3% (n=6) *seldom* and 7.5% (n=4) *never* had supervisors for junior staff. Supervision is essential in any organisation. This result concurred with Mabaso's (2006:118) finding that supervision of junior staff was a problem in some clinics. This finding is in line with the finding in item B4 that the respondents were of the opinion that there is a shortage of staff in PHC services in Limpopo province.

- *Item B14.9: Tend to work in the same clinic for many years (N=53)*

Of the respondents, 49.1% (n=26) indicated that PHC nurses in Limpopo province *always* worked in the same clinic for many years; 35.8% (n=19) indicated *often*; 9.4% (n=5) indicated *seldom*, and 5.7% (n=3) indicated *never*. In Item A4 47.2% (n=25) of the respondents indicated that they had worked 6 and more years in a PHC health facility. Whether this was spent in the same facility was unfortunately not asked.

- *Item B14.10: Have thought about changing to another field of nursing (N=53)*

Of the respondents, 13.2% (n=7) indicated that staff *always* thought of changing to another field of nursing; 11.3% (n=6) indicated *often*; 28.3% (n=15) indicated *seldom*; 47.2% (n=25) indicated *never*, and 3.8% (n=2) did not answer the question. It is therefore clear that 52.8% (n=28) have thought about changing to another field in nursing.

- *Item B14.11: Report for duty on time every day (N=53)*

Of the respondents, 32.1% (n=17) indicated that staff *always* arrived on time; 39.6% (n=21) indicated *often*, and 28.3% (n=15) indicated *seldom* or *never*. Of the respondents 71.7% (n=38) arrived on time for duty, which could be considered as not good enough. The reasons for the late arrival were not asked.

- *Item B14.12: Leave the clinic early without permission (N=53)*

Of the respondents, 73.6% (n=39) indicated that staff *never* went off duty early without permission; 18.9% (n=10) indicated *seldom*, and 7.5% (n=4) indicated *often*. Any PHC nurse that leaves her post without permission could be considered unprofessional.

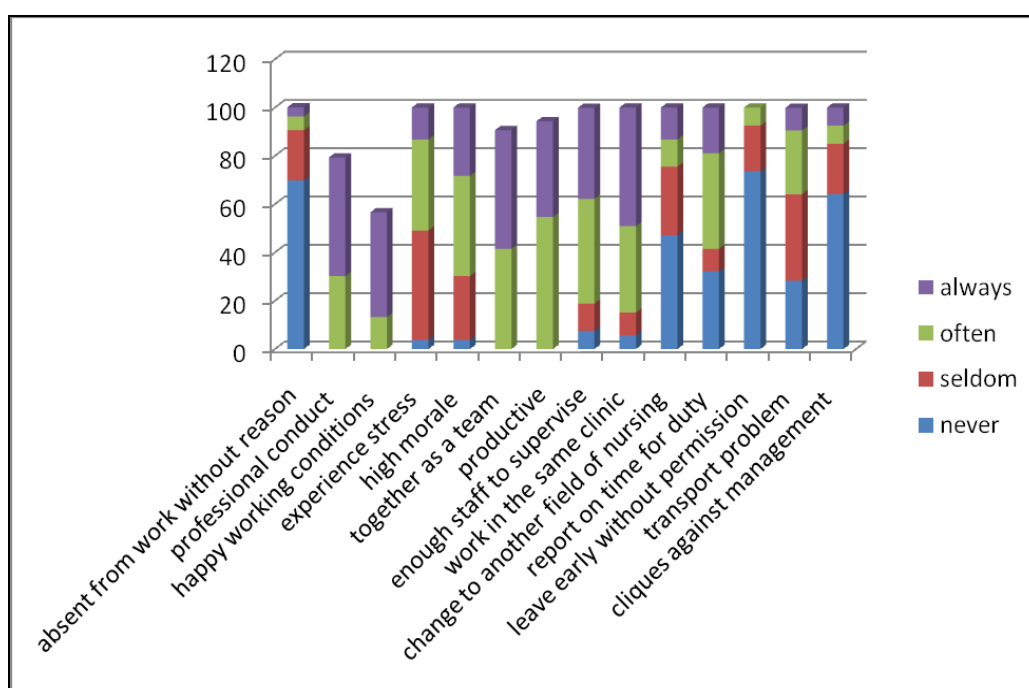
- *Item B14.13: Experience transport problems (N=53)*

Of the respondents, 51.9% (n=27) *always* or *often* had transport problems, while 35.8% (n=19) *never* and 13.2% (n=7) *seldom* did. In item B14.11 and Item B14.12 14 and 15 respondents respectively indicated that staff was not punctual in arriving and leaving the clinic. Transport problems could be the reason why the members of staff had to arrive late or leave early from work. This question was not however asked to the respondents. Mabaso (2006:118) however found that PHC nurses experienced transport problems in some areas in Limpopo province.

- *Item B14.14: Tend to form cliques to work against management (N=53)*

Of the respondents, 7.5% (n=4) indicated that staff *always* formed small groups to work against management; 7.5% (n=4) indicated *often*; 20.8% (n=11) indicated *seldom*, and 64.2% (n=34) indicated *never*. In the initial questionnaire this question was not included, but with the pre-test some respondents mentioned it and it was then included in the final copy. Although this does not seem to be a serious problem it should be investigated to prevent negative feelings of spreading which would ultimately affect the rendering of quality PHC care. Bester and Engelbrecht (2009:112) found in their study that the respondents felt that staff and co-workers were unreliable which contributed to dissatisfaction.

Figure 4.8 depicts the respondents' perceptions of aspects that applied to their workplace.



**Figure 4.8** *Statements applicable to the staff in your institution*



### **4.3.3 Section C: Management-related problems in PHC services**

This section concentrated on management-related problems or issues that would hinder the successful provision of quality PHC services.

All the respondents who were in-charge of the PHC services were asked to answer all the questions in section C. Those who were not in-charge were asked not to answer question C1.

#### **4.3.3.1 Item C1: Statements related to person in-charge of the PHC service**

Only respondents who were in-charge of the facility were asked to answer this question. Of the respondents, 34 answered the question, thereby indicating that 34 of the 53 respondents were in-charge of their PHC services. The respondents had to indicate to what extent they agreed with the statements about themselves as person in-charge of the PHC service.

- *Item C1.1: Manager should be the only one to make decisions (n=34)*

Of the respondents, 52.5% (n=18) strongly disagreed/disagreed and 47.5% (n=16) agreed that decisions should be made by the in-charge only. This finding is not in line with the finding in the Southern Cape, Karoo region, where it was found that nurses in-charge of PHC services were autocratic and believed that they alone should make decisions (Uys 2004:115).

- *Item C1.2: The person in-charge should allow staff to voice their views (n=34)*

Of the respondents, 96.53% (n=32) strongly agreed/agreed that the person in-charge should allow the other members of staff to give their own views, and only 3.47% (n=2) disagreed.

- *Item C1.3: Managers audit service regularly (n=34)*

Of the respondents, only 29.4% (n=10) strongly agreed whereas 63.2% (n=24) disagreed that managers audit services regularly. This finding is in line with the findings of Uys (2004:115) who found that auditing of PHC services was not done regularly due to inadequate time and lack of knowledge. These reasons given in the study by Uys (2004:11) could also be applicable to the situation in Limpopo province.

- *Item C1.4: Managers can cope with workload (n=34)*

Of the respondents, only 26.4% (n=9) agreed while 41.1% (n=14) strongly disagreed or disagreed that they were able to cope with the workload, and 32.5% (n=11) did not answer the question (see item C2.2).

- *Item C1.5: Managers had enough time to attend to problems (n=34)*

Of the respondents, 79.3% (n=27) strongly agreed or agreed that they had enough time to attend to problems, while 21.7% (n=7) disagreed.

- *Item C1.6: Managers motivate staff (n=34)*

Of the respondents, 79.3% (n=27) strongly agreed or agreed and 21.7% (n=7) disagreed that they motivated their staff. Jooste (2003:56) maintains that staff should be motivated by the person in-charge and a good leader should always do so. Uys (2004:115) emphasises that motivation is “an important enabler” in the provision of quality PHC services.

- *Item C1.7: Managers spend more time solving problems than on patient care (n=34)*

Of the respondents, 82.9% (n=28) strongly disagreed or disagreed and only 17.1% (n=6) strongly agreed/agreed that they spent more time solving problems than on

patient care. In item C1.5 most of the respondents indicated that managers had enough time to attend to problems. It therefore appears that managers spent more time tending to patient care than attending to problems.

- *Item C1.8: Managers spend too much time on administrative tasks (n=34)*

Of the respondents, 47.1% (n=16) strongly agreed or agreed and 52.9% (n=18) strongly disagreed or disagreed that they spent too much time on administration. The respondents were clearly divided in their opinion on the time managers spend on administrative tasks.

- *Item C1.9: It is necessary for managers to adopt an authoritarian management style (n=34)*

Of the respondents, 61.6% (n=21) strongly disagreed or disagreed and 38.4% (n=13) strongly agreed/agreed that it is necessary to adopt an authoritarian style. In item C1.2 it was found that most of the respondents were of the opinion that the person in-charge should allow staff to voice their views. Uys (2004:113), however, found that managers in her study made autocratic decisions.

#### **4.3.3.2 Item C2: Extent to which personnel in their departments would agree with the listed statements (N=53)**

In this section all the respondents had to indicate how strongly the personnel would agree to the listed statements on the managerial skills of the manager.

- *Item C2.1: The manager's managerial style was conducive to provision of quality PHC (N=53)*

Of the respondents, 18.9% (n=10) indicated that personnel would strongly agree that the managerial style of their manager was conducive to the provision of quality care; 64.2% (n=14) indicated that they would agree; 11.6% (n=6) indicated that they would

disagree; 1.9% (n=1) indicated that they would strongly disagree, and 3.8% (n=2) did not answer the question. It is therefore clear that only 45.3% (n=24) of the respondents were of the opinion that the management style in their health services was conducive to the provision of quality PHC services. So, the fact that most of the managers felt that their management style was such that they: did not make the decision on their own, that members of staff should voice their opinions, that it was not necessary to adopt an authoritarian management style; that they themselves were involved in patient care, and most respondents felt that the staff in the services would agree that the managerial style was conducive to the provision of quality PHC.

- *Item C2.2: Managers could cope with their workload (N=53)*

Of the respondents, 13.2% (n=7) indicated that personnel would strongly agree, 52.8% (n=28) indicated that they would agree that the managers could cope with their workload, and 34.0% (n=18) disagreed with the statement. This implies that the respondents who were non-managers felt that managers in PHC services could cope with their workload, hence 26.4% (n=14) of the manager in item C1.4 indicated that they could cope with their own workload.

- *Item C2.3: Managers understood that staff were overworked (N=53)*

Of the respondents, 26.4% (n=14) indicated that personnel would agree, 43.4% (n=23) of the managers knew and understood that the staff were overworked, whereas 18.9% (n=10) disagreed, 5.7% (n=3) strongly disagreed with the statement and 5.7% (n=3) did not provide an answer. Most of the respondents therefore were of the opinion that staff in their clinics would believe that managers understood that they were overworked.

- *Item C2.4: Staff could rely on managers to solve problems (N=53)*

Of the respondents, 18.9% (n=10) indicated that the personnel would strongly agree, 43.4% (n=23) indicated that they would agree that they could always rely on their managers to solve problems, while 37.7% (n=20) disagreed or strongly disagreed that

they would resolve the problem. Uys (2004:115) found PHC nurses often had to solve problems themselves although they did not have the authority to do so, and the findings of this item indicated that more than half of the respondents felt that they could not rely on managers to solve problems.

- *Item C2.5: Managers help staff despite their busy schedules (N=53)*

Of the respondents, 32.1% (n=17) strongly agreed; 41.5% (n=22) agreed and 5.7% (n=3) disagreed that staff would be of the opinion that managers helped staff despite their busy schedules. The remaining 20.7% (n=11) respondents did not answer the question. This implies that managers tend to help PHC nurses to care for patients.

- *Item C2.6: Managers motivate staff (N=53)*

Of the respondents, 39.6% (n=21) indicated that personnel would strongly agree and 39.6% (n=21) indicated that they would agree that their managers motivate their staff, while 20.7% (n=11) respondents did not answer the question. Uys (2006:112) found that managers did not motivate staff.

- *Item C2.7: Managers were professional in their conduct (N=53)*

Of the respondents, 34.0% (n=18) indicated that the staff would strongly agree and 50.9% (n=27) indicated that they would agree that their managers were professional in their conduct, and 15.1% (n=8) disagreed. Uys (2004:115) found lack of professionalism a barrier in the provision of quality PHC.

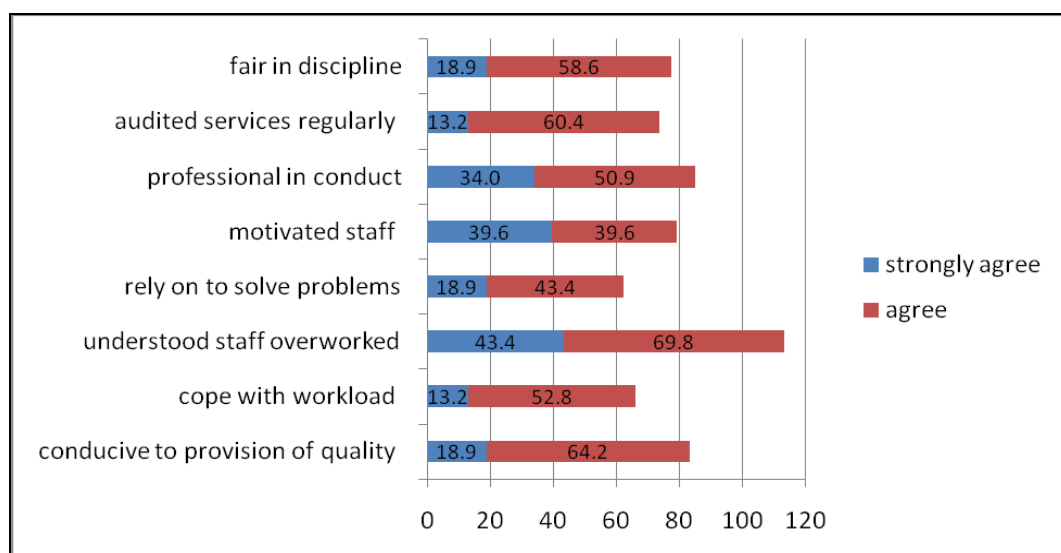
- *Item C2.8: Managers audit services regularly (N=53)*

Of the respondents, 13.2% (n=7) indicated that the staff would strongly agree and 60.4% (n=32) indicated that they would agree that the managers audited services regularly, and 13.2% (n=7) strongly disagreed. In Item C1.3 of the managers 26.4% (n=14) however strongly disagreed/disagreed that they audited services regularly. The

respondents were therefore of the opinion that services were regularly audited where as the managers themselves revealed that this was not the case. This finding is congruent with the study done by Uys (2004:115) where she found that managers did not regularly audit services in the Southern Cape, Karoo region.

- *Item C2.9: Managers were fair in the way they disciplined personnel (N=53)*

Of the respondents, 58.6% (n=30) indicated that the staff would agree and 18.9% (n=10) indicated that they would strongly agree that the managers were fair in the way they disciplined staff. Only 13.2% (n=7) disagreed and 3.8% (n=2) strongly disagreed. Four respondents 7.5% did not answer the question.



**Figure 4.9 How personnel would see managerial staff members**

#### **4.3.3.3 Item C3: Extent to which managerial problems hindered quality PHC service delivery (N=53)**

Of the respondents, 54.7% (n=29) indicated that existing managerial problems did not hinder quality PHC service delivery; 34.0% (n=18) indicated that they hindered service delivery to a certain extent; 7.5% (n=4) indicated that managerial problems seriously hindered service delivery, and 3.8% (n=2) did not comment.

According to Beresford (2008:16), [Online]. Available: URL. <http://www.samedia.uvs.ac.za/cgi-bin/getpdf?year=2008&refno=7668&topic=16>), one of the biggest failings in rural health care, is management. Due to the shortage of skilled managers, a decent manager can easily get a job in the city with better pay than in rural health services. Bester and Engelbrecht (2009:112) found in their study in the Free State some managerial problems related to the fact that promises were not kept or staff members were not promoted in the PHC services.

#### **4.3.3.4 Item C4: Rating of communication between staff and management (N=53)**

Of the respondents, 11.3% (n=6) rated communication between staff and management extremely good; 45.3% (n=24) rated it good; 32.1% (n=17) rated it acceptable, and 5.7% (n=3) rated it poor. Uys (2004:115) found lack of communication by managers in the PHC services in the Southern Karoo region, SA.

#### **4.3.3.5 Item C5: Extent to which policies such as free health service hinder quality PHC service delivery (N=53)**

Of the respondents, 52.8% (n=28) indicated that the policy regulating free health care services hindered quality PHC service delivery to a certain extent; 15.1% (n=8) indicated that it hindered service delivery seriously, and 28.3% (n=15) indicated that it created problems but did not hinder services. Netshandama et al (2005:5) and (Uys 2004:117) found that services became overloaded due to the policy of free health services which hindered quality PHC service delivery.

#### **4.3.3.6 Item C6: Other policies that hinder the provision of quality care (N=53)**

This open-ended question required the respondents to indicate other policies that hindered the delivery of quality PHC care. According to the respondents:

- *“24-hour service – where nurses are on duty for 24 hours and then have to sleep in the busy clinic, as they are then on call. Nurses’ [services] are abused with this policy.”*
- *“The Patients Rights Charter, [because] patients misinterpret it.”*
- *“Termination of pregnancy – increases workload. There is not enough staff for this. It even allows 12-year-olds to terminate pregnancy.”*
- *“The HIV policy which restricts nurses telling relatives about a patient’s status. It ultimately increases the workload.”*
- *“The child support grant is causing an overload of antenatal services since young mothers want money and this causes a negative impact on HIV.”*
- *“The payment of on-call system which was only applied when a nurse touched [sic] a patient hands on.”*

#### **4.3.4 Section D: Problems related to supplies and equipment**

This section covered various problems related to supplies and equipment, medicines or drugs, cleaning materials, stationery, and dry stock used at PHC facilities.

##### **4.3.4.1 Item D1: Extent to which problems related to supplies and equipment interfered with the delivery of quality PHC services (N=53)**

The respondents were asked to indicate how seriously problems listed on the questionnaire affected their services.

- *Item D1.1: Shortage of medication interfered with service delivery (N=53)*

Of the respondents, 37.7% (n=20) indicated that shortage of drugs seriously interfered with service delivery; 26.4% (n=14) indicated that it interfered to a certain extent; 34.0% (n=18) indicated that although a shortage of medication was a problem at times, this did not seriously hinder service delivery, and 1.9% (n=1) said that they did not experience that problem. This concurred with the findings of Uys (2004:98), Mabaso (2006:118), Netshandama et al (2005:65) and Gasa (2003:6). Rapakwana (2004:97) found that the



shortage of medicine was due to delivery-related problems.

- *Item D1.2: Expired drug supplies interfered with delivery of quality PHC (N=53)*

Of the respondents, 37.7% (n=20) indicated that expired drugs did not seriously hinder service delivery; 11.3% (n=6) indicated that it interfered to a certain extent, and 7.5% (n=4) indicated that it seriously interfered with service delivery, while 43.4% (n=23) indicated that they did not have this problem.

- *Item D1.3: Shortage of cleaning materials interferes with service delivery (N=53)*

Of the respondents, 18.9% (n =10) indicated that a shortage of cleaning materials was a serious obstacle to service delivery; 35.8% (n=19) indicated that it interfered to a certain extent; 26.4% (n=14) indicated that although this was a problem it did not hinder service delivery, and 18.9% (n=10) did not experience this problem. Therefore, more respondents 54.7% (n=29) agreed that this was a problem and 45.3% (n=14) was of the opinion that shortage of cleaning materials did not interfere with the delivery of quality health services.

- *Item D1.4: Shortage of stationery interfered with service delivery (N=53)*

Of the respondents, 26.4% (n=14) found the shortage of stationery seriously hampered service delivery; 34.0% (n=18) found it a considerable problem; 34.0% (n=18) indicated that services were not hampered although it was a problem, and 5.7% (n=3) indicated no shortage of stationery.

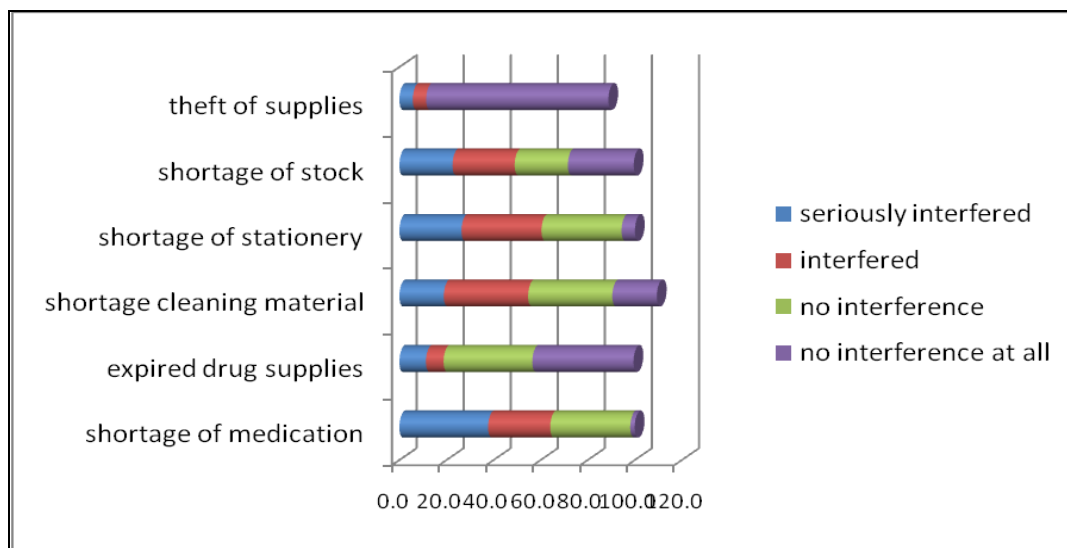
- *Item D1.5: Shortage of stock interfered with service delivery (N=53)*

Of the respondents, 22.6% (n=12) indicated no shortage of dry stock; 22.6% (n=12) indicated that shortages of dry stock seriously hampered service delivery; 26.4% (n=14) services indicated that shortages hampered service delivery to a certain extent, and

28.3% (n=15) indicated that a shortage of dry stock was a problem, but the nurses improvised so that care could be rendered. Uys (2004:113) found a shortage of stock and equipment a serious problem in the Southern Cape, Karoo region.

- **Item D1.6: Theft of supplies interfered with service delivery (N=53)**

Of the respondents, 77.4% (n=41) indicated that they did not experience theft of stock in their clinics; 5.7% (n=3) indicated that theft of supplies seriously hampered service delivery, and 5.7% (n=3) indicated that this problem hampered service delivery to a certain extent. The remaining six respondents (11.4%) did not respond to the question.



**Figure 4.10 Problems related to supplies and equipment interfere with the delivery**

#### **4.3.4.2 Item D2: Extent to which a shortage of equipment hindered quality PHC service delivery (N=53)**

This section required the respondents to indicate how the shortage of equipment hindered PHC service delivery.

- *Item D2.1: Shortage of thermometers (N=53)*

Of the respondents, 56.6% (n=30) indicated no shortage of thermometers; 24.5% (n=13) indicated that the shortage did not hinder service delivery; 1.9% (n=1) indicated it a considerable hindrance in service delivery and 17.0% (n=9) indicated that the shortage of thermometers was a serious obstacle to service delivery.

- *Item D2.2: Shortage of glucometers (N=53)*

Of the respondents, 39.6% (n=21) indicated no problem with a shortage of glucometers; 17.0% (n=9) indicated that the shortage of glucometers did not hinder service delivery; 20.8% (n=11) said it hindered service delivery to a certain extent, and 22.6% (n=12) indicated that the shortage of glucometers seriously hampered service delivery. This concurred with Mabaso's (2006:116) finding of a shortage of thermometers and glucometers in clinics in Limpopo province.

- *Item D2.3: Shortage of ophthalmoscopes (N=53)*

Of the respondents, 30.2% (n=16) indicated no problem with a shortage of ophthalmoscopes; 34% (n=18) indicated that the shortage did not affect service delivery; 24.5% (n=13) indicated that it hindered service delivery to a certain extent, and 11.3% (n=6) indicated that it seriously hampered service delivery. Mabaso (2006:96-97) found that a shortage of ophthalmoscopes contributed to poor competency in the examination of patients' eyes and the monitoring of a patient with hypertension.

- *Item D2.4: Shortage of Baumanometers (BP apparatus) (N=53)*

Of the respondents, 39.6% (n=21) indicated no shortage of Baumanometers in their PHC facilities; 20.8% (n=11) indicated that the shortage existed, but did not affect services; 17.0% (n=9) indicated that it hindered services to a certain extent, and 22.6 % (n=12) indicated that it seriously hampered service delivery.

- *Item D2.5: Shortage of stethoscopes (N=53)*

Of the respondents, 15.1% (n=8) indicated that the shortage of stethoscopes existed and seriously hindered service; 11.3% (n=6) indicated that it hindered service delivery to a certain extent; 17.0% (n=9) indicated that the shortage seldom hindered service delivery, and 56.6% (n=30) indicated no shortage of stethoscopes in their PHC clinics.

- *Item D2.6: Shortage of diagnostic sets (N=53)*

Of the respondents, 17.0% (n=9) indicated a shortage of diagnostic sets which seriously hindered service delivery; 26.4% (n=14) indicated that it hampered services to a certain extent; 22.6% (n=12) indicated that the shortage did not hinder services, and 34.0% (n=18) indicated no shortage of diagnostic sets.

- *Item D2.7: Shortage of scales to weigh children (N=53)*

Of the respondents, 71.7% (n=38) indicated no shortage of scales to weigh children; 9.4% (n=5) indicated that the shortage did not affect the services; 13.2% (n=7) indicated that the shortage of scales interfered with service delivery to a certain extent; and 5.7% (n=3) indicated that it seriously hindered service delivery.

- *Item D2.8: Shortage of scales to weigh adults (N=53)*

Of the respondents, 64.2% (n=34) indicated no shortage of adult scales; 15.1% (n=8) indicated a shortage but it did not hinder service delivery; 13.2% (n=9) indicated that the shortage hampered service delivery to a certain extent, and only 3.8% (n=2) indicated that it seriously hindered service delivery.

- *Item D2.9: Shortage of nebulizers (N=53)*

Of the respondents, 17.0% (n=9) indicated that the shortage of nebulizers seriously interfered with service delivery; 18.9% (n=10) indicated that it hindered services to a

certain extent; 13.2% (n=7) indicated that the problem did not affect service delivery, and 50.9% (n=27) indicated that they did not have this problem in their PHC services.

- *Item D2.10: Shortage of drip stands (N=53)*

Of the respondents, 67.9% (n=36) indicated no shortage of drip stands in their health facility; 18.9% (n=10) indicated that the shortage did not interfere with service delivery; 5.7% (n=3) indicated that it hindered services to a certain extent, and 7.5% (N=4) indicated that it seriously hindered service delivery.

- *Item D2.11: Shortage of delivery beds (N=53)*

Of the respondents, 7.5% (n=4) indicated that the shortage of delivery beds seriously hindered service delivery; 11.3% (n=4) indicated that it hindered service delivery to a certain extent; 20.8% (n=11) indicated that the problem did not hinder service delivery, and 58.5% (n=31) indicated no shortage of delivery beds. Three respondents (5.7%) did not answer this question.

- *Item D2.12: Shortage of incubators (N=53)*

Of the respondents, 18.9% (n=10) indicated that they had no incubators in their PHC clinics, which seriously hindered service delivery; 7.5% (n=4) indicated that the shortage hindered service delivery to a certain extent; 24.6% (N=14) indicated that the problem did not hinder service delivery; 43.4% (n=23) indicated no shortage of incubators, and 3.8% (n=2) did not answer the question.

- *Item D2.13: Shortage of cribs for infants (N=53)*

Of the respondents, 56.6% (n=30) indicated no shortage of cribs for infants; 20.8% (n=11) indicated that the shortage did not hinder service delivery; 7.5 % (n=4) indicated that it hindered services to a certain extent, and 13.2% (n=7) indicated that it seriously compromised service delivery. One respondent 1.9%) did not answer the question.

- *Item D2.14: Shortage of neonatal resuscitation trolleys (N=53)*

Of the respondents, 20.8% (n=11) indicated that the shortage seriously hindered service delivery; 9.4% (n=5) indicated that it hindered service delivery to a certain extent; 26.4% (n=14) indicated that the problem did not hinder service delivery, and 41.5% (n=22) indicated no shortage of neonatal resuscitation trolleys.

- *Item D2.15: Shortage of refrigerators for vaccines (N=53)*

Of the respondents, 84.9% (n=45) indicated no shortage of refrigerators for vaccines; 5.7% (n=3) indicated that the problem did not hinder service delivery; 3.8% (n=2) indicated that the problem hampered service delivery to a certain extent, and 5.7% (n=3) indicated that the shortage seriously hindered service delivery.

- *Item D2.16: Shortage of tables in consulting rooms (N=53)*

Of the respondents, 77.4% (n=41) indicated no shortage of tables in the consulting rooms; 7.5% (n=4) indicated that the problem did not hamper service delivery; 9.4% (n=5) indicated that it hindered service delivery to a certain extent, and 5.7% (n=3) indicated a shortage that seriously interfered with service delivery.

- *Item D2.17: Shortage of chairs for patients (N=53)*

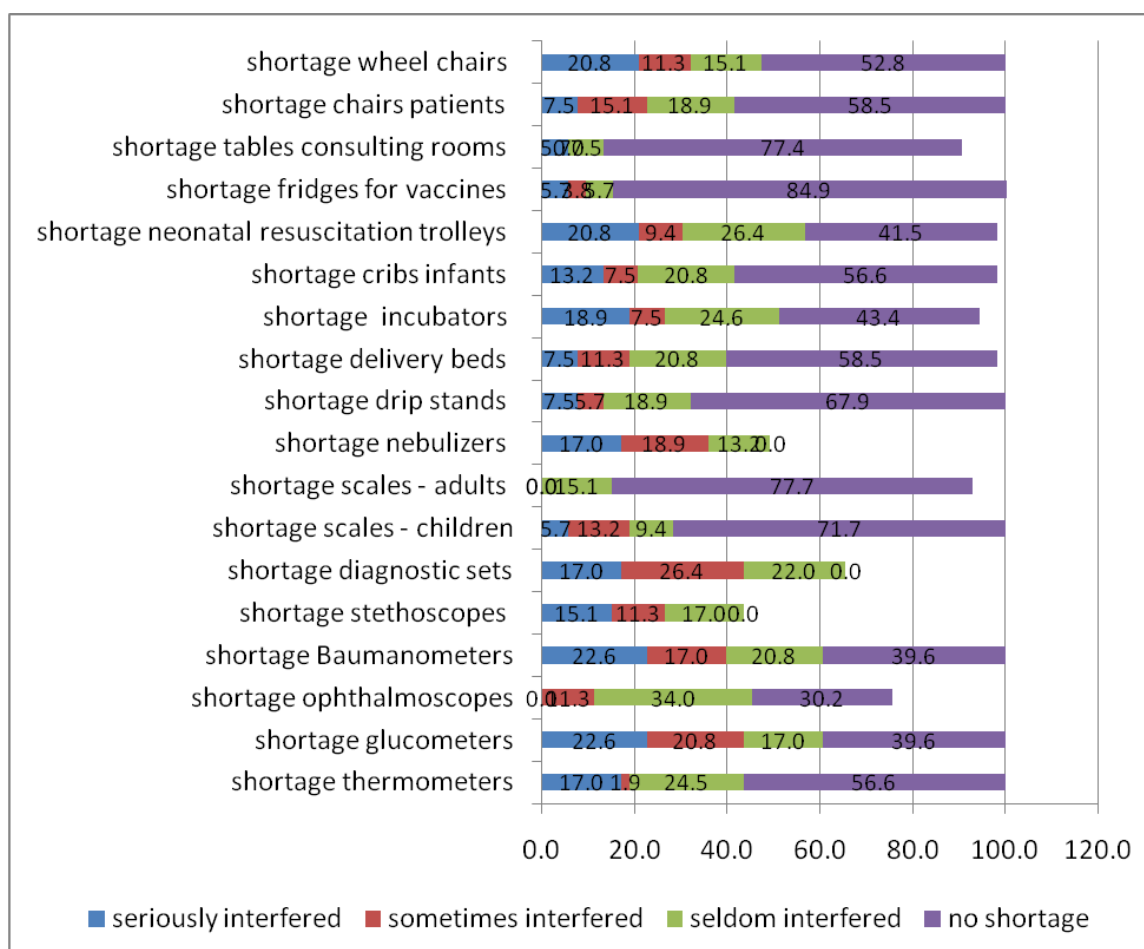
Of the respondents, 7.5% (n=4) indicated that a shortage of chairs seriously hindered the smooth running of PHC services; 15.1% (n=8) indicated shortages that hindered service delivery to a certain extent; 18.9% (n=10) indicated that the shortage did not hinder service delivery, and 58.5% (n=31) indicated no shortage of chairs for patients.

- *Item D2.18: Shortage of wheelchairs (N=53)*

Of the respondents, 20.8% (n=11) indicated that the shortage of wheelchairs seriously hindered service delivery; 11.3% (n=6) indicated that it hindered service delivery to a

certain extent; 15.1% (n=8) indicated that the shortage did not hinder service delivery, and 52.8% (n=28) indicated no shortage of wheelchairs.

Bester and Engelbrecht (2009: 111) found that the second most frequent problem in PHC services that caused stress among staff were the shortage of resources, such as unavailability of medicines, insufficient space and infrastructure of facilities and unreliable ambulance services.



**Figure 4.11 Extent to which a shortage of equipment hinders quality PHC service delivery**

#### **4.3.4.3 Item D3: Reasons for shortage of supplies and equipment (N=53)**

The respondents were asked to indicate reasons for the shortages of supplies and equipment that applied to their facilities.

- *Item D3.1: Delay in placing orders by clinic personnel (N=53)*

Of the respondents, 28.3% (n=15) indicated that there were no delays in placing orders; 28.3% (n=15) indicated that delays were often a problem, 24.5% (n=13) indicated they were seldom a problem, and 18.9% (n=10) indicated that clinic staff always delayed placing orders.

- *Item D3.2: Inability to predict larger volume of patients (N=53)*

Of the respondents, 43.4% (n=23) indicated that they seldom had a problem predicting the volume of patients; 43.4% (n=23) never had a problem; 11.3% (n=6) indicated that they often had unexpected volumes of patients that caused shortage of supplies, and 1.9% (n=1) did not answer the question. In some areas of Vhembe district illegal refugees from the neighbouring countries attend the PHC clinics and this depletes the available supplies.

- *Item D3.3: Delay in delivery by suppliers (N=53)*

Of the respondents, 18.9% (n=10) *never* had delays in the delivery of supplies; 15.1% (n=8) *always* had delays; 32.1% (n=17) *often* had delays, and 30.2% (n=16) *seldom* had delays. Two respondents (3.8%) did not answer the question.

- *Item D3.4: Delay in approval of orders (N=53)*

Of the respondents, 24.5% (n=13) *always* had delays in the approval of orders; 22.6% (n=12) *often* had delays; 20.8% (n=11) *seldom* had delays; 30.2% (n=16) *never* had delays, and 1.9% (n=1) did not answer the question.

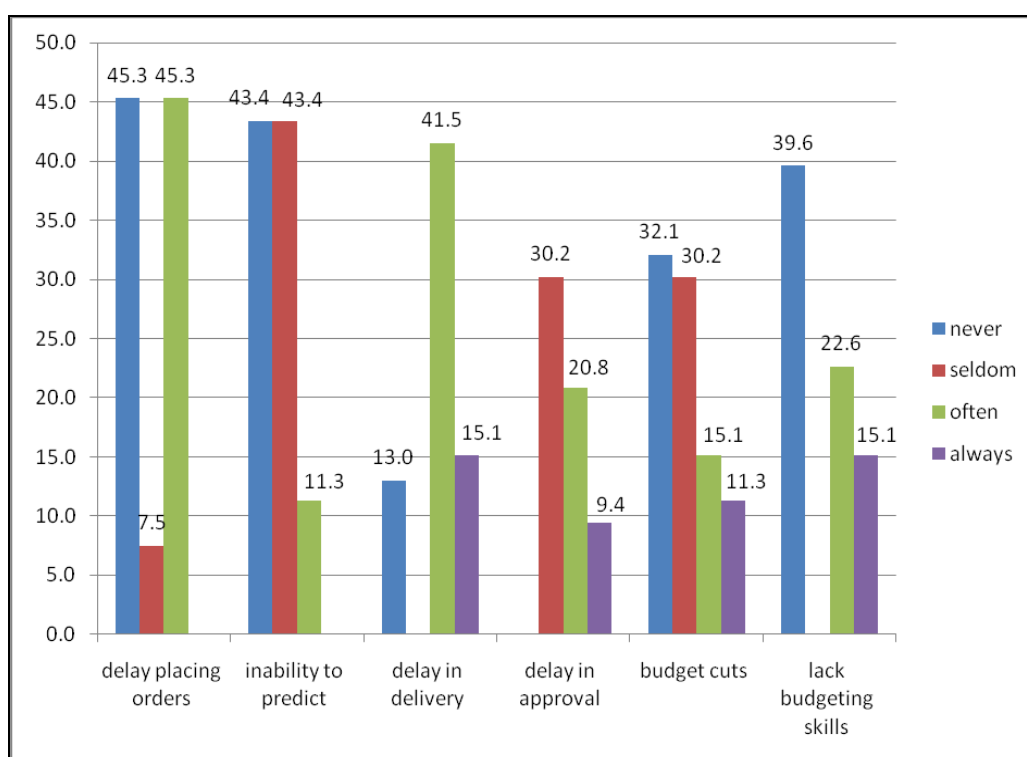


- *Item D3.5: Budget cuts (N=53)*

Budget cuts never affected the availability of supplies in the health services of 18.9% (n=10) of the respondents; 15.1% (n=8) seldom experienced this problem; 20.8% (n=11) often did; 28.3% (n=15) always did, and 17.0% (n=9) did not answer the question.

- *Item D3.6: Manager's lack of budgeting skills (N=53)*

Of the respondents, 39.6% (n=21) indicated that they never had shortages due to the manager's budgeting skills; 22.7% (n=12) often did; 15.1% (n=8) always did, and 22.7% (n=12) did not answer the question.



**Figure 4.12 Reasons for shortage of supplies and equipment**

#### **4.3.4.4 Item D4: Other reasons for shortage of supplies**

An open-ended question required the respondents to provide other reasons for the shortages of supplies and equipment. According to the respondents:

- *“Supplying clinics with things that were not needed instead of those highly needed.”*
- *“Poor quality of equipment or cheap equipment that breaks easily.”*
- *“Being told that there is no money, having to wait for the next financial year.”*
- *“Supplier delivered wrong equipment or supplier did not have enough.”*
- *“Change to another supplier who deals with government institutions.”*
- *“Orders that were made without consulting clinic staff.”*
- *“Sometimes it was caused by communication breakdown between clinic and pharmacy.”*

#### **4.3.4.5 Item D5: Other shortages in PHC services**

This section required the respondents to indicate other shortages in the facilities.

- *Item D5.1: No emergency trolleys in PHC clinic (N=53)*

Of the respondents, 7.5% (n=4) indicated that a shortage of emergency trolleys was always a problem; 1.9% (n=1) indicated that it was often a problem; 15.1% (n=8) indicated it was seldom a problem, and 75.5% (n=40) never had a shortage of emergency trolleys.

- *Item D5.2: Poorly equipped emergency trolleys (N=53)*

Of the respondents, 3.8% (n=2) indicated that the emergency trolleys were always poorly equipped; 15.1% (n=8) indicated that they were often poorly equipped; 34.0% (n=18) indicated that they were seldom poorly equipped, and 45.3% (n=24) never had

poorly equipped emergency trolleys. One respondent (1.9%) did not answer the question.

- *Item D5.3: Shortage of fire extinguishers (N=53)*

Of the respondents, 9.4% (n=5) indicated that they always had a shortage of fire extinguishers; 9.4% (n=5) indicated that they often did; 15.1% (n=8) seldom did, and 66.5% (n=35) never had a shortage of fire extinguishers.

Gasa (2003:7), Rapakwana (2004:6) and Mabaso (2006:118) found serious problems with regard to supplies and equipment, including shortages, late delivery, poor quality, and unavailability of some resources.

Masondo (2008:1), [Online]. Available: URL. <http://www.samedia.uvs.ac.za/cgi-bin/getpdf?year=2008&refno=7668&topic=1> ) found that rural health services in the Eastern Cape face a gradual collapse of health infrastructure like mobile clinics and vehicles; a severe shortage of critical equipment like blood pressure apparatus, and severe cuts in repairs and maintenance of clinic buildings.

#### **4.3.5 Section E: Infrastructure-related problems**

This section focused on problems related to infrastructure, namely clinic buildings, waiting areas, consultation rooms, roads to clinic or health centre, water supply, toilet facilities, telecommunication, working space and any other problem that might hinder provision of quality PHC services.

Various problems related to the infrastructure were listed in the interview schedule and respondents had to indicate to what extent they hindered the rendering of quality PHC.

##### **4.3.5.1 Item E1: Rating of the infrastructure (N=53)**

The respondents had to rate the following items:

- *Item E1.1: Sufficient consulting rooms for medical practitioners (N=53)*

Of the respondents, 18.9% (n=10) strongly disagreed; 37.7% (n=20) disagreed that they had sufficient consulting rooms for the medical doctors, 26.4% (n=14) strongly agreed, and 17.0 % (n=9) agreed. Makhubela (2002: 35) and Rapakwana (2004:69) found inadequate consulting rooms a serious obstacle to service delivery.

- *Item E1.2: The structure of the building is in a good condition (N=53)*

Of the respondents, 24.5% (n=13) strongly agreed and 30.2% (n=16) agreed that their buildings were in good condition, while 24.5% (n=13) disagreed and 20.8% (n=11) strongly disagreed. Masondo (2008:1), [Online]. Available: URL. <http://www.samedia.uvs.ac.za/cgi-bin/getpdf?year=2008&refno=7668&topic=1>) found that clinic buildings in the Eastern Cape were old as the last clinics had been erected in 1988.

- *Item E1.3: The roof leaks (N=53)*

Of the respondents, 17.0% (n=9) strongly agreed; 17.0% (n=9) agreed; 28.2% (n=15) strongly disagreed and 37.7% (n=20) disagreed. This finding revealed that 34.0% (n=18) of the respondents clinics have leaking roofs.

- *Item E1.4: Broken windows (N=53)*

Of the respondents, only 28.3% (n=15) agreed that clinic windows were broken. This finding indicated that broken clinic windows did not seriously hinder service delivery.

- *Item E1.5: Ample exit doors in the building (N=53)*

Of the respondents, 7.5% (n=4) strongly agreed that there are not enough exit doors in the building, and 7.5% (n=4) agreed that there were not enough exit doors in the building. This therefore implied that the number of exit doors in the facilities was not a

major problem. Adequate doors are essential to reduce congestion or problems in case of fire or other disasters.

- *Item E1.6: Waiting area can accommodate all patients (N=53)*

Of the respondents, 38.4% (n=23) agreed; 54.7% (n=29) disagreed that the space in the waiting area was adequate for patients, and 6.9% (n=1) did not answer the question. Mashego and Peltzer (2005:19) found that waiting areas in PHC clinics tended to be inadequate. In cold weather this is a serious problem, especially for weak patients and small children who have to wait outside if the waiting room is full. Nemathaga et al (2005:19) found that only 4 out of 6 facilities had adequate waiting areas for patients.

- *Item E1.7: Sufficient consulting rooms for the nurses (N=53)*

Of the respondents, 42.5% (n=23) agreed and 56.6% (n=30) disagreed that there were sufficient consulting rooms for nurses. Uys (2004:113) and Rapakwana (2004:69) found that some clinics needed more consulting and counselling rooms.

- *Item E1.8: Room available for the social worker to see clients (N=53)*

Social workers form part of the multi-disciplinary team. Of the respondents 35,8% (n=19) strongly agreed that they had a room for a social worker; 17.0% (n=9) agreed; 11,3% (n=6) disagreed and 35.8% (n=19) strongly disagreed. It is therefore clear that 52.8% (n=36) of the respondents were of the opinion that there were rooms available for social workers to see their clients which is more that the 47.1% (n=35) who were of the opinion that there were no rooms available for social workers.

- *Item E1.9: Equipped rooms available for the physiotherapists (N=53)*

Of the respondents, 75.5% (n=40) indicated that they did not have rooms for physiotherapists; 15.1% (n=8) did have rooms for physiotherapists, and 9.4% (n=5) did not answer the question (see also item H3.3).

- *Item E1.10: Privacy when seeing patients (N=53)*

Of the respondents, only 54.7% (n=29) strongly agreed that privacy could be created to consult patients; 26.4% (n=14) agreed; 7.5% (n=4) disagreed and 11.3% (n=6) strongly disagreed. This findings therefore revealed that 81.1% (n=43) respondents indicated that privacy could be maintained for consulting.

- *Item E1.11: Ample storage space for stock (N=53)*

Of the respondents, 24.5% (n=13) strongly agreed; 24.5% (n=13) agreed; 32.1% (n=17) disagreed; and 17.0% (n=9) strongly disagreed that there is enough space for storage and 1.9% (n=1) did not comment.

- *Item E1.12: Medications can be stored in the prescribed conditions (N=53)*

Of the respondents, 52.8% (n=28) strongly agreed that medications were stored in the correct conditions; 28.3% (n=15) agreed; 9.4% (n=5) disagreed and another 9.4% (n=5) strongly disagreed with the statement. The findings therefore indicated that the majority 81.1% (n=43) of the respondents believed that medication could be stored in the correct prescribed conditions in the health facilities.

- *Item E1.13: Building is too small for its purpose (N=53)*

Of the respondents, 20.8% (n=11) strongly agreed; 34.0% (n=18) agreed; 13.2% (n=7) disagreed, and 32.1% (n=17) strongly disagreed that the buildings were too small. Rapakwane (2004:69) found that some clinic buildings were very small.

**Table 4.6 Respondents' rating of infrastructure**

<b><i>Rating of the infrastructure</i></b>	<b>Strongly agree</b>	<b>Agree</b>	<b>Disagree</b>	<b>Strongly disagree</b>
<i>Sufficient consulting rooms for medical practitioners</i>	26.4%	17.0%		
<i>Buildings were in good condition</i>	24.5%	30.2%		
<i>Roofs of the buildings were leaking</i>	17.0%	17.0		
<i>Broken windows</i>	9.4%	18.9%		
<i>Not enough exit doors</i>	7.5%	7.5%		
<i>Waiting area can accommodate all clients/patients</i>	23.3%	15.1%	30.2%	24.5%
<i>Sufficient consulting rooms for nurses</i>	24.5%		32.1%	24,5%
<i>Rooms for the social worker to see clients</i>	35.8%	17.0%		
<i>Equipped rooms for the physiotherapists</i>			15.1%	75.5%
<i>Privacy when seeing patients</i>	54.7%	26.4%		
<i>Storage space for stock</i>	24.5%	24.5%		
<i>Medications could be stored in the prescribed conditions</i>	52.8	28.3%	9.4%	9.4%
<i>Building was too small for its purpose</i>	20.8%	34.0%	13.2%	32.1%

#### **4.3.5.2 Item E2: Problems in the working environment**

This section required the respondents to indicate which of the aspects listed applied to their facilities.

- **Item E2.1: Condition of access roads to the clinic poor (N=53)**

Of the respondents, 11.3% (n=6) indicated that the condition of roads to access the clinic seriously hindered service delivery; 13.2% (n=7) indicated that poor roads hindered service delivery to a certain extent; 22.6% (n=12) indicated that the poor condition of the roads did not hinder provision of services, and 52.8% (n=28) indicated

no problem with roads. It therefore appears that the condition of access roads is not a major problem.

- *Item E2.2: Bridge for clients to cross river unsafe (N=53)*

Of the respondents, 73.6% (n=39) indicated no problem with bridges existed; 9.4% (n=5) indicated that unsafe bridges over the river seriously hindered service delivery; 11.3 (n=6) indicated that the poor bridge hindered service delivery to a certain extent, and 5.7% (n=3) indicated that the problem did not hinder. The bridge over the river appears not to be a major problem for most of the respondents as 79.2% (n=42) respondents were satisfied with the conditions.

- *Item E2.3: Poor electricity supply to the health service (N=53)*

Of the respondents, 43.4% (n=23) indicated no problems with poor electricity supply to the clinic existed; 30.2% (n=16) indicated that the poor electricity supply existed but did not hinder PHC service delivery; 22.6% (n=12) indicated that the poor electricity supply hindered services to a certain extent, and only 3.8% (n=2) indicated that the poor electricity supply seriously hindered service delivery. Electricity is essential in PHC facilities for the use of equipment like blood pressure machines, nebulisers, suction machines, and air conditioners to maintain the correct dispensary temperature, and lights for night duty.

- *Item E2.4: Poor water supply to the health service (N=53)*

Of the respondents, 62.3% (n=33) indicated no problem with water supply to the clinics; 20.8% (n=11) indicated that the poor water supply did not hinder service provision; 7.5% (n=4) indicated that the shortage of water hampered service provision to a certain extent, and 9.4% (n=5) indicated that the water supply to the clinics seriously interfered with service provision. Most of the clinics had water tanks while some facilities had boreholes to assist in supplying water. Water is essential in a health institution for most tasks or services. For example, nurses wash their hands between patients and during



maternity deliveries to prevent and control infection. Mabaso (2006:118) found one facility with no water supply.

- *Item E2.5: Poor sanitation system of the health services (N=53)*

Of the respondents, 69.8% (n=37) indicated no problem with sanitation; 13.2% (n=7) indicated that although a problem existed, the poor sanitation did not hinder service delivery; 9.4% (n=5) indicated that the problem hindered service delivery to a certain extent, and 7.5% (n=4) indicated that the poor sanitation seriously hindered service delivery. Therefore the majority of respondents (83.0%; n=44) indicated that their clinics did not have a problem with poor sanitation.

- *Item E2.6: Condition of toilets (N=53)*

Of the respondents, 67.0% (n=36) indicated no problem with the condition of the toilets; 15.1% (n=8) indicated that although the toilets were in poor condition, it did not compromise service provision; 9.4% (n=5) indicated that the poor condition of the toilets hampered service provision to a certain extent, and 7.5% (n=4) indicated that the poor condition of the toilets seriously hindered service delivery. The condition of the toilets appeared not to be a major problem.

- *Item E2.7: Availability of patient toilets (N=53)*

Of the respondents, only 5.7% (n=3) indicated that inadequate (or unavailability of) toilets for patients seriously hindered service delivery; 13.2% (n=7) indicated that it hindered service delivery to a certain extent; 13.2% (n=7) indicated that this problem existed but did not hinder service delivery, while 69.8% (n=37) did not have this problem at all. Although most of the respondents (69.8%; n=37) reported that they did have toilets for patients, all clinics should have toilets for patients.

- *Item E2.8: Separate toilets for personnel (N=53)*

Of the respondents, 77.4% (n=41) indicated that they had separate toilet facilities; 11.3% (n=6) indicated that the lack of separate toilets for staff did not hinder service provision; 9.4% (n=5) indicated that the lack of separate toilets for personnel hindered service delivery to a certain extent, and 1.9% (n=1) indicated that the lack of separate toilets for personnel seriously hindered service delivery.

- *Item E2.9: Telecommunication system (N=53)*

Of the respondents, 39.6% (n=27) indicated that the telecommunication system was good; 26.4% (n=14) indicated that the telecommunication system was a problem but did not hinder service delivery and 13.2% (n=7) indicated that this problem hindered service delivery to a certain extent, while 20.8% (n=11) indicated that the poor telecommunication system was a serious obstacle to quality PHC service delivery. All PHC clinics should always be able to rely on a good telecommunication system to summon a doctor or ambulance in an emergency or for referral of patients.

- *Item E2.10: Condition of buildings (N=53)*

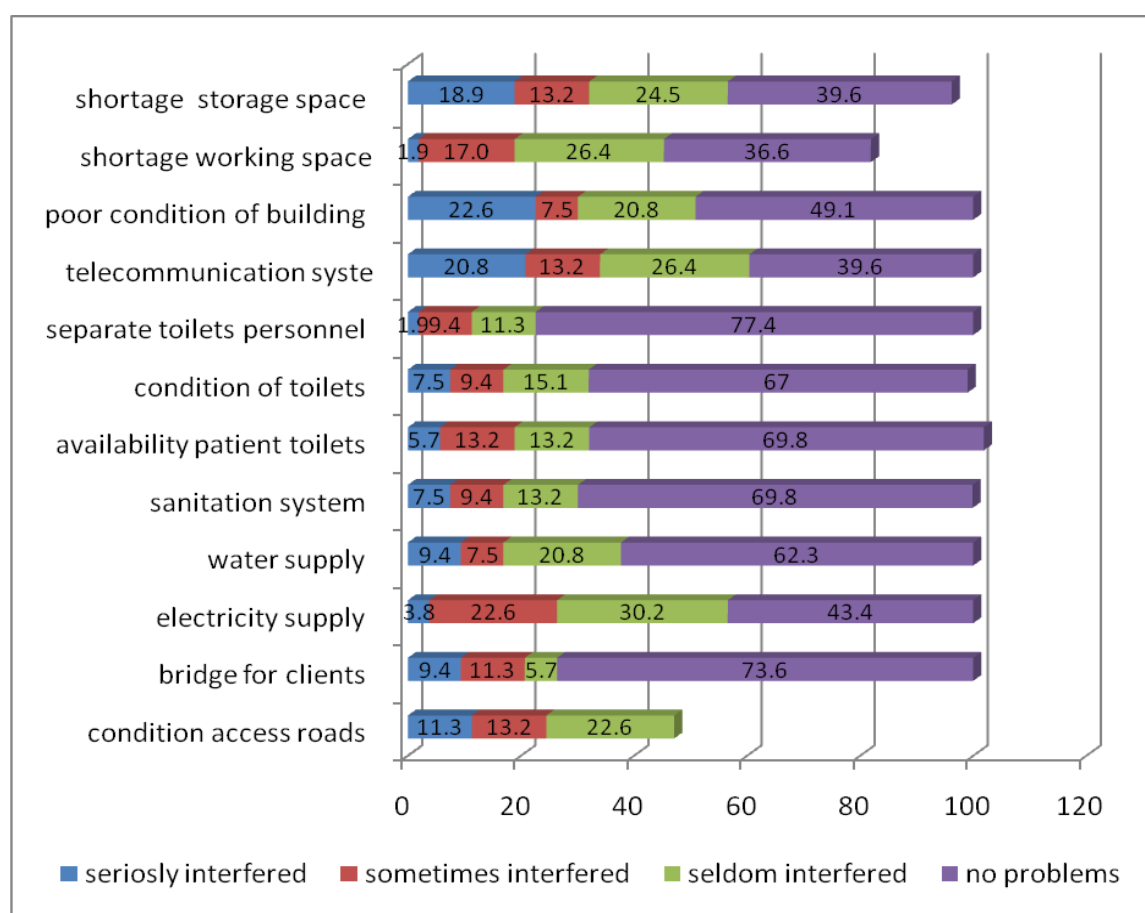
Of the respondents, 47.2% (n=25) indicated that they had no problems with the condition of the clinic buildings; 20.8% (n=11) indicated that the condition of the buildings was a problem but did not hinder service provision; 7.5% (n=4) indicated that the poor condition of buildings did hamper service delivery to a certain extent, while 22.6% (n=12) indicated that the poor condition of the buildings seriously hindered service provision, and 1.9% (n=1) did not answer the question. Rapakwana (2004:7) emphasises that health facility buildings should always be in good condition otherwise the services delivered would not be accepted by the community.

- *Item E2.11: Shortage of working space (N=53)*

Of the respondents, 36.6% (n=21) indicated adequate working space in their clinics; 17.0% (n=9) indicated that a shortage of working space did hamper service delivery to a certain extent; 26.4% (n=14) indicated that the shortage of working space did not hamper service delivery, and 17.0% (n=9) indicated that the inadequate working space seriously hindered service delivery. Shortage of working space therefore did not appear to be a major problem.

- *Item E2.12: Shortage of storage space (N=53)*

Of the respondents, 39.6% (n=21) indicated no shortage of storage space in their clinics; 24.5 (n=13) indicated that shortage of storage space was a problem, but did not hinder service provision; 13.2% (n=7) indicated that the shortage of storage space hampered service delivery to a certain extent, while 18.9% (n=10) indicated that the shortage of storage space seriously hindered service delivery, and 3.8% (n=2) did not comment. Uys (2004:113) found that buildings were inadequate.



**Figure 4.13 Problems in the working environment**

#### **4.3.5.3 Item E3: Other problems in the infrastructure that hinder the delivery of quality PHC (N=53)**

In an open-ended question the respondents were asked to list other problems in the infrastructure that hindered the provision of quality PHC services. According to the respondents the following problems prevented them from meeting all the needs of the patients and nurses:

- “[There is] *no nurses home.*”
- “[There is] *no accommodation for standby (on call) nurses, they have to sleep in the clinic building or improvise and have to share bathroom facilities with post-delivery women.*”
- “*The waiting area [is] not conducive on cold days.*”

- “[There is] *no kitchen and no rest room for nurses.*”
- “[There is] *no burglar proofing at the clinic (safety not ensured).*”
- “*There are no adequate open areas [in the clinic] to host awareness days (clinic yard small).*”
- “*We have leaking roofs, taps and geysers, and poor maintenance system.*”
- “[There is] *not enough water so toilets do not flush (have to use a bucket to collect water).*”

#### **4.3.5.4 Item E4: Measures taken by nurses to solve some of the problems (N=53)**

Nurses often take their own measures to solve some of the problems in the clinics. The respondents were therefore asked to indicate how often they took certain of the listed measures to solve problems.

- *Item E4.1: Use their own cellular phones to make official calls (N=53)*

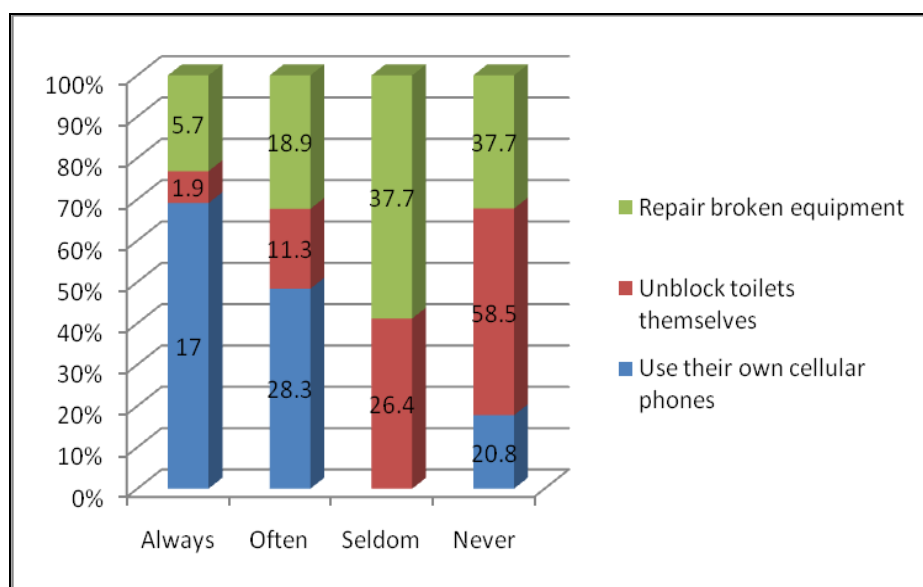
Of the respondents, 17.0% (n=9) indicated that they always used their personal cellular phones to make official calls; 28.3% (n=15) often had to use their own cellular phones; 34.0% (n=18) indicated that they seldom did so, and 20.8% (n=11) indicated that it was never necessary for them to use their own cellular phones. Rapakwana (2004:91) found that nurses used public phone cards to make official calls at their own expense. Registered nurses therefore did what they could, to the extent of using their own cell phones to deliver health services to their patient.

- *Item E4.2: Unblock toilets themselves (N=53)*

Of the respondents, only 1.9% (n=1) indicated that they always had to unblock toilets; 11.3% (n=6) often had to do so; 26.4% (n=14) seldom had to do so, and 58.5 (n=31) never had to unblock toilets.

- *Item E4.3: Repair broken equipment (N=53)*

Of the respondents, 37.7% (n=20) never had to repair broken equipment themselves; 37.7% (n=20) seldom had to do so; 18.9% (n=10) often had to do so, and only 5.7% (n=3) always had to repair broken equipment.



**Figure 4.14 Measures taken by nurses to solve some of the problems**

#### 4.3.6 Section F: Problems related to the referral system

This section dealt with problems related to referral issues and referral systems in general. The focus was specifically on the distance between clinic and referral hospital, ambulance services, general communication with regard to transferring patients to and from referral hospital, feedback from doctors, or any other problems concerning the referral system that hindered the provision of quality PHC service.

- *Item F1: Distance between clinic and nearest hospital (N=53)*

There has been a variety of distances from the clinic to the nearest hospital. The kilometres ranged between 2 km and 96 km. The average distance was 50 km.

In the following items the respondents had to indicate how the following occurs related to the referral system.

- *Item F2.1: Ambulance comes quickly when summoned (N=53)*

Of the respondents, 13.2% (n=7) indicated that the ambulance always arrived quickly when summoned; 69.8 (n=37) said that the ambulance often did; 15.1% (n=8) indicated that it seldom did, and 1.9% (n=1) indicated that it never arrived quickly when summoned.

- *Item F2.2: Problems with communication with emergency service (N=53)*

Of the respondents, 34.0% (n=18) never experienced problems with communication with emergency services; 41.5% (n=25) seldom did; 15.1% (n=8) often did, and 9.4% (n=5) always did.

- *Item F2.3: Problems in communicating with referral hospital (N=53)*

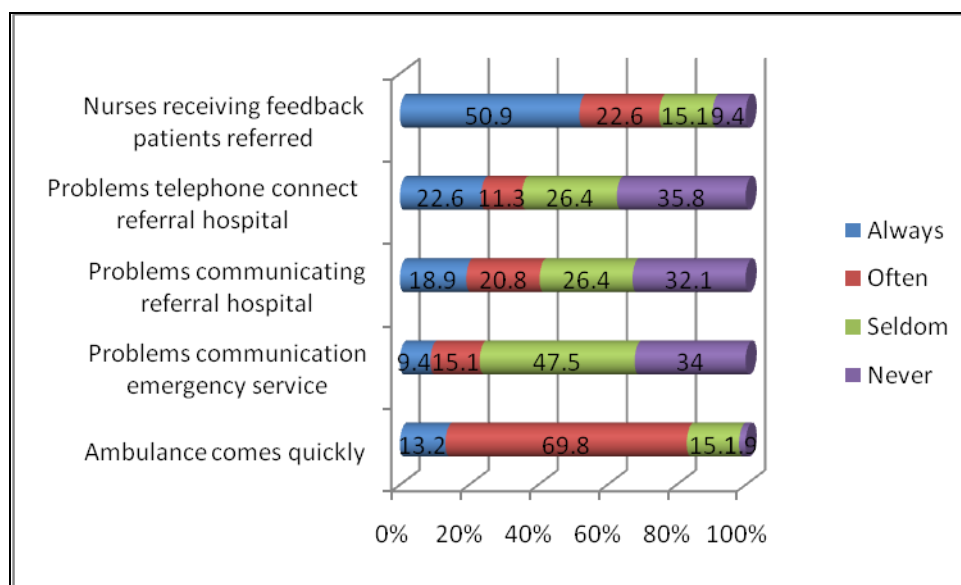
Of the respondents, 32.1% (n=17) never had any problems communicating with referral hospital; 18.9% (n=10) always did; 20.8% (n=11) often did; 26.4% (n=14) seldom did, and 1.9% (n=1) did not answer this question.

- *Item F2.4: Problems with telephone connection to the referral hospital (N=53)*

Of the respondents, 35.8% (n=19) never had a problem with telephone connections to the referral hospital; 22.6% (n=12) always did; 11.3% (n=6) often did, and 26.4% (n=14) seldom did. Two respondents (3.8%) did not answer the question.

- **Item F2.5: Receive feedback on patients referred (N=53)**

Of the respondents, 50.9% (n=27) always had a problem receiving feedback on patients they referred; 22.6% (n=2) often had a problem; 15.1% (n=8) seldom had a problem; 9.4% (n=5) never had a problem receiving feedback, and 1.9% (n=1) did not answer the question. Janse van Rensburg et al (1999:51) found poor feedback from doctors in the Bothaville sub-district, Free State.



**Figure 4.15 Problems related to the referral system**

#### 4.3.6.1 **Item F3: Other problems related to the referral system (N=53)**

In an open-ended question the respondents were asked to describe problems with the referral system other than those listed in the questionnaire that hindered service delivery. According to the respondents:

- *“Especially midwifery patients and general [health problems].”*
- *“Unwillingness of patients to be referred, forcing personnel to treat most health issues at the clinic.”*
- *“Chronic patients come back from hospital with no follow-up dates.”*
- *“Patients who were referred come back without being seen by the doctor (seen by a non-trained PHC nurse).”*



- *“Nurses at the hospital complain [about the patients who have been referred] even when the patient meets the criteria for referral.”*
- *“Referral hospital is far (patients are forced to be attended at a specific hospital - due to boundary or demarcation issues).”*
- *“Personnel from EMS sometimes tend to give nurses instructions which cause conflict between them.”*
- *“Patients who warranted admission (should have been admitted to hospital) were at times given medicine or treatment to take home.”*

Although the referral systems were found to be less problematic in most of the facilities, many of the respondents complained about a lack of feedback from doctors and having to use their mobile phones to communicate regarding referral of patients. This concurred with Couper’s (2003:12) finding that feedback on referrals was poor.

#### **4.3.7 Section G: Staff training problems**

This section focused on problems in staff training, including aspects like opportunities to attend workshops or courses, necessary topics and other matters deemed relevant for PHC nurses by the respondents.

##### **4.3.7.1 Item G1: Attendance of workshops and courses (N=53)**

- *Item G1.1: Members of staff given equal opportunities to attend workshops (N=53)*

Of the respondents, 37.7% (n=20) indicated that members of staff always had an equal opportunity to attend workshops; 30.2% (n=16) indicated that they often did; 26.4% (n=14) indicated that they seldom did, and 5.7% (n=3) indicated that staff were never given equal opportunities to attend workshops or courses. In the study done by Bester and Engelbrecht (2009:111) it was found that of the problems identified by PHC nurses were the fact that they were not sent for training courses in the Free State. Uys

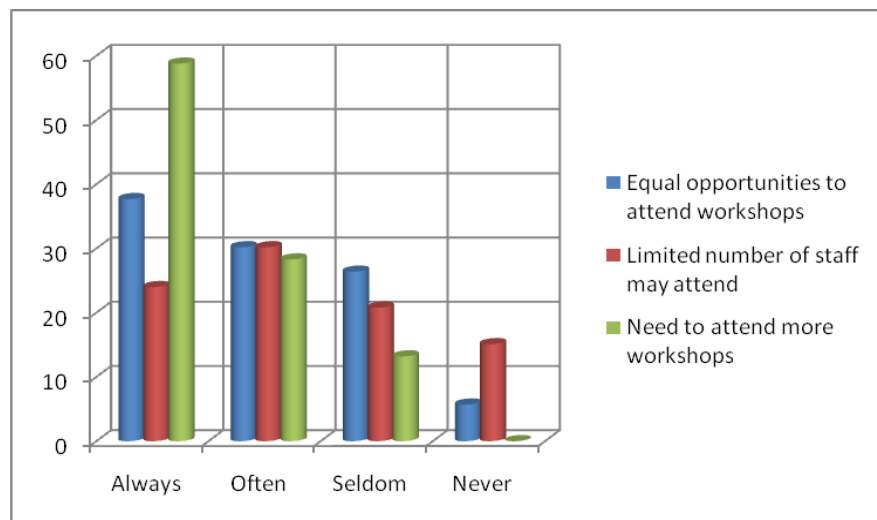
(2004:113) found that CPHC nurses and supervisors in the Karoo region had little opportunity to attend workshops.

- *Item G1.2: Only a limited number of staff may attend workshops at a time (N=53)*

Of the respondents, 34.0% (n=18) indicated that only a limited number of staff could always attend workshops at a time; 30.2% (n=16) indicated that this was often the case; 20.8% (n=11) indicated that this was seldom the case, and 15.1% (n=8) indicated that it was never the case that only a limited number of staff could attend workshops. The researcher also noted the respondents' sense of responsibility in that while some staff members attended workshops, there was a need for others to take care of patients.

- *Item G1.3: Staff members need to attend more workshops to improve knowledge (N=53)*

Of the respondents, 58.5% (n=31) indicated that staff members always need to attend more workshops to improve their knowledge; 28.3% (n=15) indicated that they often needed to do so, and 13.2% (n=7) indicated that staff members seldom needed to attend workshops to improve their knowledge.



**Figure 4.16 Attendance of workshops and courses**

#### **4.3.7.2    *Item G2: Importance of topics listed for training of staff to enable them to render quality PHC services***

The respondents were asked to rate the importance of the training topics listed for quality PHC service delivery.

- *Item G2.1:    Genetic counselling (N=53)*

Of the respondents, 69.8% (n=37) indicated that genetic counselling was necessary but training was not critical at that moment; 20.8% (n=11) indicated that PHC nurses could not do without training in genetic counselling and it was needed immediately, and 9.4% (n=5) indicated that it was not necessary and PHC nurses could do without it.

- *Item G2.2:    Facilitation skills for supervisors (N=53)*

Of the respondents, 37.7% (n=20) indicated that training in facilitation skills for supervisors was needed immediately because supervisors could not do without it; 56.6% (n=30) indicated that it is necessary but not crucial, and 5.7% (n=3) indicated that it was not necessary and supervisors could do without it.

- *Item G2.3:    ARV management (N=53)*

Of the respondents, 67.9% (n=36) indicated that staff could not do without knowledge of ARV management and needed this training immediately to be able to render quality PHC services, and 32.1% (n=17) indicated that it was necessary, but training was not critical.

- *Item G2.4:    HIV/Aids counselling (N=53)*

Of the respondents, 90.6% (n=48) indicated that HIV/Aids counselling was essential and staff could not do without it; 7.5% (n=4) indicated that training is necessary, but not critical at the moment, and 1.9% (n=1) indicated it as necessary to train in HIV

counselling, but staff could do without it. The majority of the respondents (90.6%; n=48) indicated the need for training in HIV/Aids counselling.

- *Item G2.5: Reproductive health (N=53)*

Of the respondents, 77.4% (n=41) indicated that PHC nurses could not do without training in reproductive health and training was immediately needed; while 20.8% (n=11) indicated that training was necessary but not critical, and 1.9% (n=1) indicated that it was not necessary and staff could do without it.

- *Item G2.6: Report writing (N=53)*

Of the respondents, 52.8% (n=28) indicated that PHC nurses could not do without training in report writing, and it was needed immediately; 41.5% (n=22) indicated that it was necessary but training was not critical at the moment; 15.1% (n=8) indicated that it was often necessary, and 5.7% (n=3) indicated that it was not necessary and staff could do without it.

- *Item G2.7: Keeping statistics (N=53)*

Of the respondents, 60.4% (n=32) indicated that training in keeping statistics was very important and PHC staff could not do without; 30.2% (n=16) indicated that it was necessary but training was not critical, and 9.4% (n=5) indicated that it was not necessary and staff could do without it.

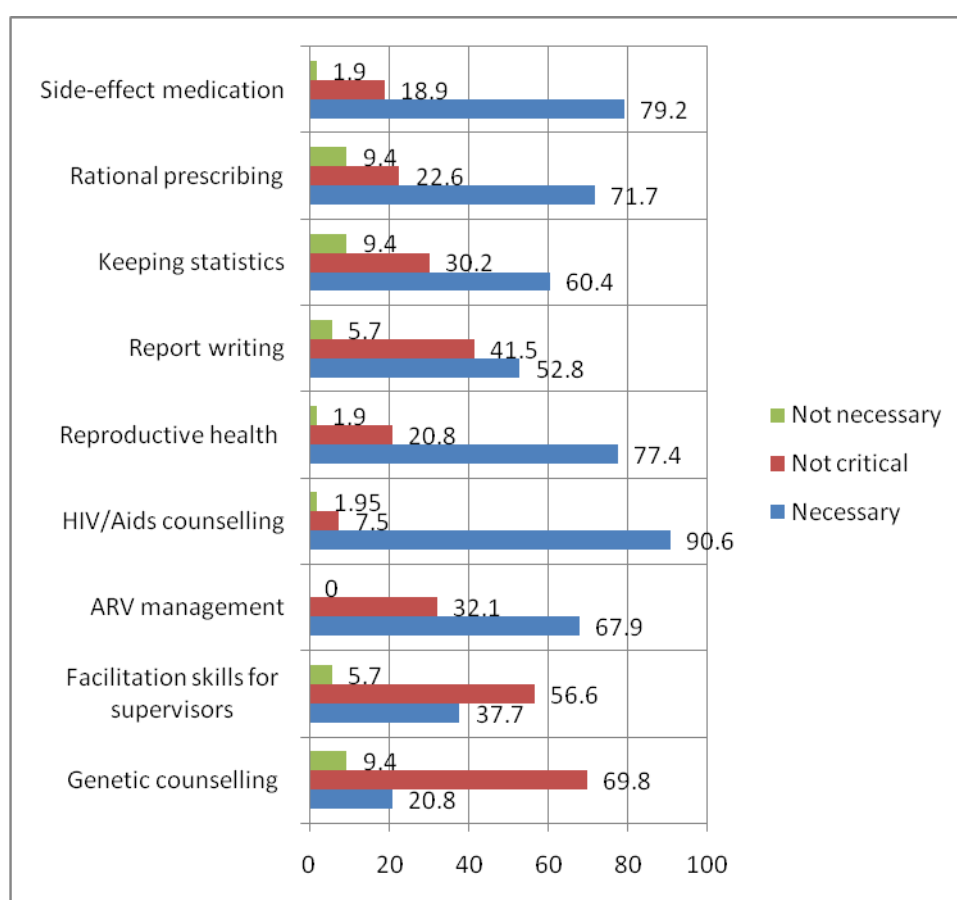
- *Item G2.8: Rational prescribing (N=53)*

Of the respondents, 71.7% (n=38) indicated that rational prescribing was necessary and PHC staff members could not do without it and needed it immediately; 22.6% (n=12) indicated that it was necessary to train for rational prescribing, but not critical, and 5.7% (n=3) indicated that it was not necessary and staff members could do without it. In item B11.5 the majority of respondents 90.5% (n=48) indicated that PHC nurses knew how to prescribe according to the EDL, and in item B11.2 only 18.9% (n=10) indicated that

PHC nurses prescribed medication for every patient. PHC nurses, according to this study knew when and how to write a prescription for a patient.

- *Item G2.9: Side-effects of medications (N=53)*

Of the respondents, 79.2% (n=42) indicated that training in side effects of drugs was necessary and PHC nurses should do it, but it was not critical; 18.9% (n=10) indicated that it was necessary but not critical, and 1.9% (n=1) indicated that it was not necessary and nurses could do without it. In item 11.3 respondents indicated that PHC nurses knew the side-effects of drugs.



**Figure 4.17 Importance of topics listed for training of staff to enable them to render quality PHC service**

- *Item G2.10: List of important topics for training programme (N=53)*

In an open-ended question the respondents were asked to list topics they considered important that should be included in the training programme. According to the respondents, the following topics should be included in the curriculum:

- Basic antenatal care
- Computer literacy
- Mental health management
- Chronic disease management
- Financial management
- Pap smears
- Geriatric health care
- Team building
- Crisis intervention
- Project management
- Personnel and victim empowerment
- Expanded programme on immunisation

#### **4.3.8 Section H: Problems in the multi-disciplinary team approach**

This section dealt with problems in relation to the multi-disciplinary team. It is widely acknowledged that PHC nurses cannot work alone in the PHC setting and need to be supported by medical practitioners, social workers, physiotherapists, ophthalmic nurses, and dentists. The comprehensiveness and totality of managing patients at PHC level depends on the involvement of the members of the multi-disciplinary team and the frequency of their visits to the facility.

#### **4.3.8.1 Item H1: Support received from other members of the multi-disciplinary team (N=53)**

The respondents were asked to indicate the support of members of the multi-disciplinary team.

- *Item H1.1: Extent to which medical practitioners supported PHC nurses (N=53)*

Of the respondents, only 11.3% (n=6) indicated that medical practitioners always supported PHC nurses; 35.8% (n=19) indicated that they often did so; 37.7% (n=20) indicated that they seldom did, and 13.2% (n=7) indicated that they never received support from doctors.

- *Item H1.2: Extent to which social workers supported PHC nurses (N=53)*

Of the respondents, 18.9% (n=10) indicated that social workers always supported PHC nurses; 32.1% (n=17) indicated that they often did; 22.6% (n=12) indicated that they seldom did, and 26.4% (n=14) indicated that they never did. The complete lack of support from social workers poses a serious problem since most of the people who present with social problems also have economic problems. This aggravates the situation because the only resort is to refer them to a facility where a social worker is situated in the office.

- *Item H1.3: Extent to which medical practitioners shared knowledge with PHC nurses (N=53)*

Of the respondents, 18.9% (n=10) indicated that the medical practitioners always shared their knowledge with the PHC nurses; 24.5% (n=13) indicated that they often did; 30.2% (n=16) indicated that they seldom did, and 26.4% (n=14) indicated that they never did. Mabaso (2006:118) found that doctors could not share their knowledge because there were not enough medical practitioners to visit the clinics.

- *Item H1.4: The traditional healer as a member of the multi-disciplinary team (N=53)*

Of the respondents, 18.9% (n=10) indicated that a traditional healer was always a member of the health team; 22.6% (n=12) indicated often; 35.8% (n=19) indicated seldom, and 22.6% (n=12) indicated never.

- *Item H1.5: The traditional healer has a role to play in a health team (N=53)*

Of the respondents, 18.9% (n=10) indicated that traditional healers always have a role to play in the health team; 22.6% (n=12) indicated that they often did; 35.8% (n=19) indicated that they seldom did, and 22.6% (n=12) respondents indicated that they had no role in the health team.

- *Item H1.6: Traditional healers do not cause problems in the provision of quality health care (N=53)*

Of the respondents, 20.8% (n=11) indicated that traditional healers often caused problems in the provision of quality health care; 28.6% (n=15) indicated that they seldom did; 45.3% (n=24) indicated that they never caused problems, and 5.7% (n=3) indicated that traditional healers did not cause problems.

- *Item H1.7: PHC nurses refer patients to traditional healers (N=53)*

Of the respondents, only 1.9% (n=1) always referred patients to traditional healers; 1.9% (n=1) often did; 20.8% (n=11) seldom did, and 75.5% (n=40) never referred patients to a traditional healer.

- *Item H1.8: Traditional healers refer patients to clinics (N=53)*

Of the respondents, 13.2% (n=7) indicated that they always received referrals from traditional healers; 39.6% (n=21) often did; 35.8% (n=19) seldom did, and 9.4% (n=5)



never received referrals from traditional healers. One respondent (1.9%) did not answer the question. It is therefore clear that there is a good relationship between the personnel of the PHC clinics in Limpopo province and the traditional healers

#### **4.3.8.2        *Item H2:    Frequency of personnel of multi-disciplinary team visiting the PHC service***

In this section the respondents were asked to indicate how often the listed health personnel visited the PHC clinic.

- *Item H2.1:    Visits to PHC service by medical practitioners (N=53)*

Of the respondents, 22.6% (n=12) indicated that medical practitioners never visited their facilities; 20.8% (n=11) indicated that they visited at least once a month; 49.1% (n=26) indicated that they did at least two to four times per month, and 7.5% (n=4) indicated that the clinics were visited more than five times a month.

- *Item H2.2:    Visits to PHC service by social workers (N=53)*

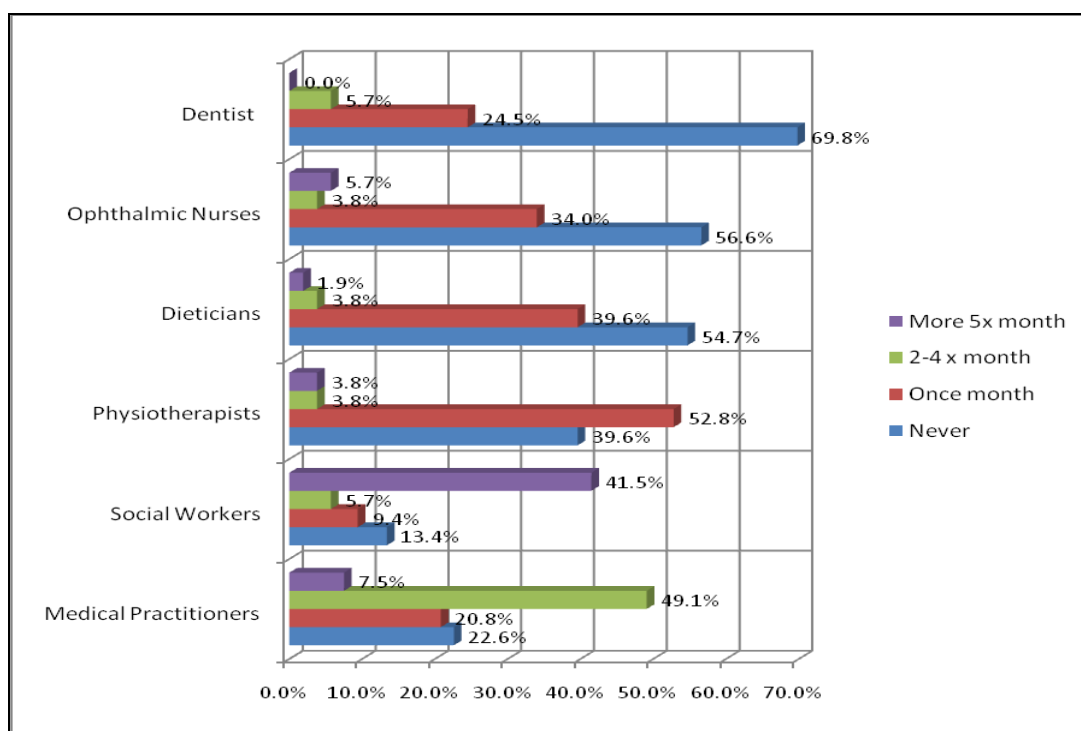
Of the respondents, 43.4% (n=23) indicated that social workers never visited their facility; 41.5% (n=22) indicated more than five times per month; 9.4% (n=5) indicated at least once a month, and 5.7% (n=3) indicated two to four times a month.

- *Item H2.3:    Visits to the PHC service by physiotherapists (N=53)*

Of the respondents, 39.6% (n=21) indicated that physiotherapists never visited their clinics; 52.8% (n=28) indicated at least once a month; 3.8% (n=2) indicated two to four times a month, and 3.8% (n=2) indicated more than five times a month.

- *Item H2.4: Visits to PHC service by dieticians (N=53) (Item G2.4)*

Of the respondents, 54.7% (n=29) indicated that dieticians never visited their clinics; 39.6% (n=21) indicated at least once a month; 3.8% (n=2) indicated at least two to four times a month, and 1.9% (n=1) indicated more than five times a month.



**Figure 4.18 Frequency of personnel of multi-disciplinary team visiting the PHC service**

- *Item H2.5: Visit to PHC by ophthalmic nurses (N=53)*

Of the respondents, 56.6% (n=30) indicated that ophthalmic nurses never visited their clinics; 34.0% (n=18) indicated once a month; 3.8% (n=2) indicated two to four times a month, and 5.7% (n=3) indicated more than five times a month.

- *Item H2.6: Visits to PHC service by dentist (N=53)*

Of the respondents, 69.8% (n=37) indicated that dentists never visited their clinics; 24.5% (n=13) indicated once a month, and 5.7% (n=3) indicated two to four times a month.

#### **4.3.8.3 Item H3: Frequency of need for services of the members of the multi-disciplinary team**

The respondents were asked to indicate how frequently they needed the services of members of the multi-disciplinary team.

- *Item H3.1: Need for services of medical practitioners (N=53)*

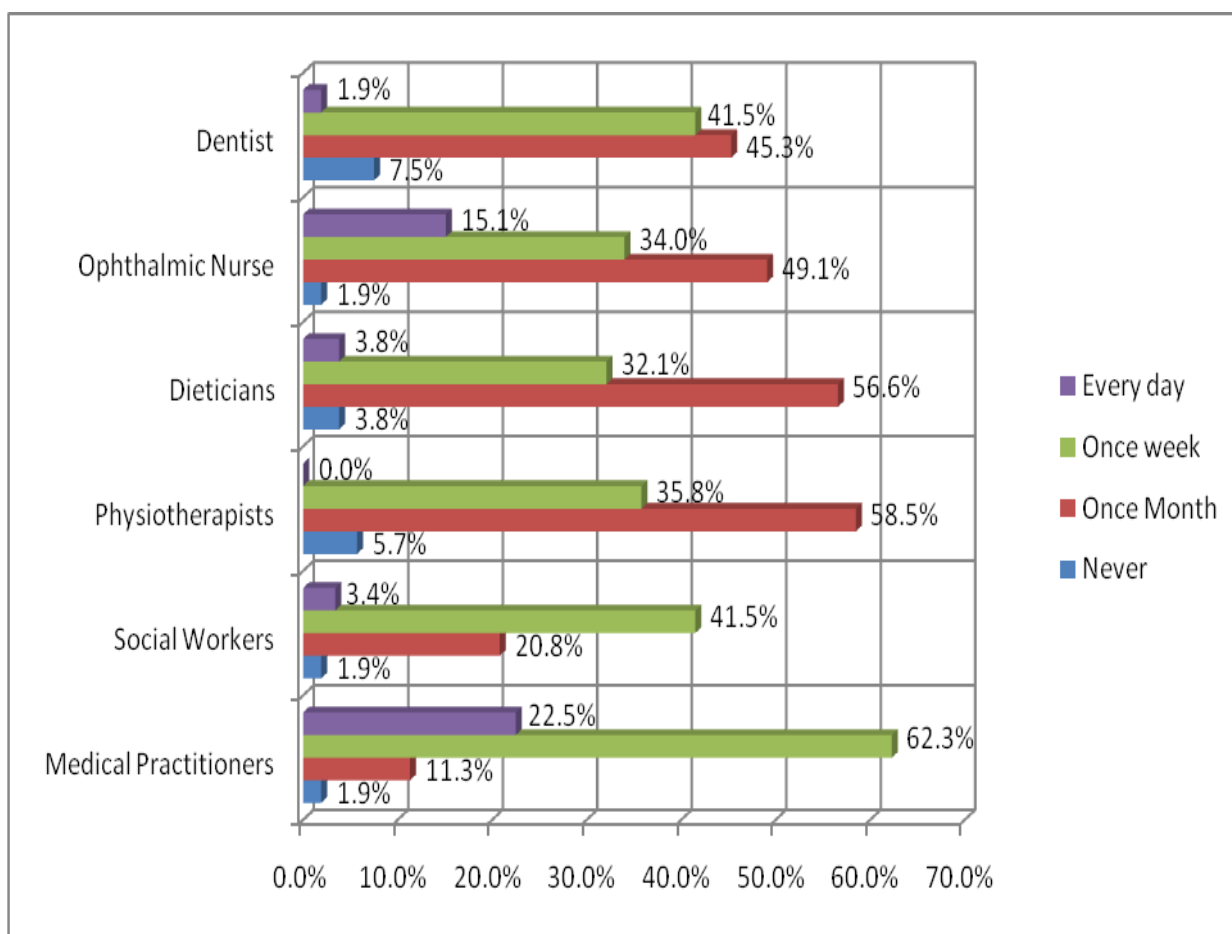
Of the respondents, 62.3% (n=21) indicated that they needed a medical practitioner at least once a week; 22.5% (n=12) needed a doctor almost every day; 11.3% (n=6) needed one at least once a month, and only 1.9% (n=1) indicated there was never a need for a medical practitioner. One respondent (1.9%) did not answer the question.

- *Item H3.2: Need for services of social workers (N=53)*

Of the respondents, 34.0% (n=18) indicated that the social worker should be available every day; 41.5% (n=22) indicated more than once a month; 20.8% (n=11) indicated at least once a month, and 1.9% (n=1) indicated that they never needed a social worker.

- *Item H3.3: Need for services of physiotherapist (N=53)*

Of the respondents, 58.5% (n=31) needed a physiotherapist once a month; 35.8% (n=19) indicated at least once a week, and 5.7% (n=3) indicated that there was never a need for a physiotherapist. According to item E1.9 the PHC clinics also did not have the necessary equipped rooms for physiotherapists.



**Figure 4.19 Frequency of need for services of the members of the multi-disciplinary team**

- Item H3.4: Need for services of dieticians (N=53)**

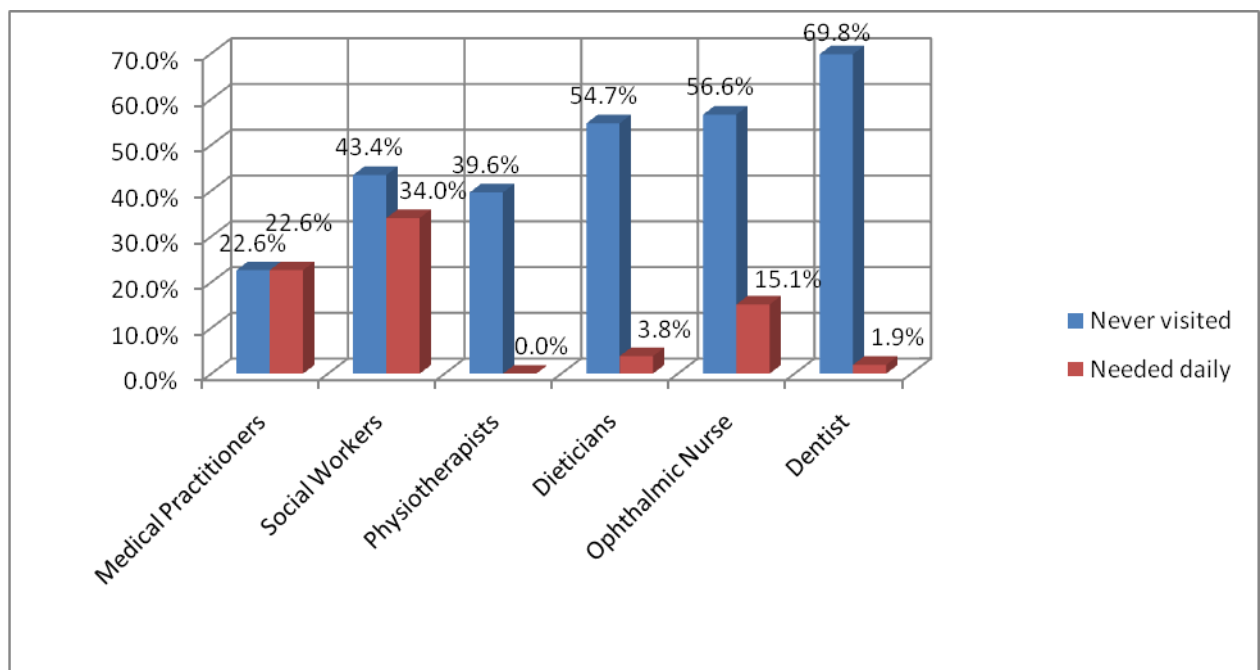
Of the respondents, 56.6% (n=30) needed a dietitian at least once a month; 32.1% (n=17) indicated at least once a week; 3.8% (n=2) indicated almost every day, and only 3.8% (n=2) never needed the services of a dietitian. Two respondents (3.8%) did not answer the question.

- *Item H3.5: Need for services of ophthalmic professional nurse (N=53)*

Of the respondents, 49.1% (n=26) needed a visit by an ophthalmic nurse at least once a month; 34.0% (n=18) indicated at least once a week; 15.1% (n=8) indicated almost every day, and only 1.9% (n=1) indicated never.

- *Item H3.6: Need for services of dentist (N=53)*

Of the respondents, 49.0% (n=26) needed dental services at least once a month; 41.5% (n=22) indicated at least once a week; 1.9% (n=1) indicated almost every day, and 7.5% (n=4) indicated that they never needed dental services.



**Figure 4.20** *Frequency of personnel visits versus perceived needs*

#### **4.3.8.4 Item H4: Other problems related to multi-disciplinary team that hindered provision of PHC service**

In an open-ended question the respondents were asked to indicate other multi-disciplinary team-related problems that hindered service delivery. The respondents listed the following problems:

- *“Failure [of members of the multi-disciplinary team] to adhere to drawn schedule for the visits.”*
- *“One medical officer allocated to many clinics, leading to poor quality service.”*
- *“A medical practitioner can only assess a stipulated number of patients (15) before having to proceed to another clinic.”*
- *“[There is] no environmental health officer visiting the clinic.”*
- *“Patients wait for a long time and no member of [multi-disciplinary team] comes because of transport problems.”*
- *“Physiotherapists do not bring equipment along.”*
- *“Members omit some visits; coming once every three months instead of monthly.”*

#### **4.3.9 Section I: Patient-related problems**

This section examined problems emanating from patients who received service, taking into consideration cultural issues; possible complaints raised; their knowledge about illness, the time for seeking help or to consult; literacy levels; adherence to treatment; adherence to return dates; prevalence of HIV/Aids and TB, and the utilisation of free health care services by the community.

##### **4.3.9.1 Item I1: Factors interfering with the rendering of quality PHC services**

The respondents were asked to indicate how often they encountered certain patient-related problems or how seriously the problems interfered with the rendering of quality PHC services.

- *Item I1.1: Cultural issues (N=53)*

Of the respondents, 11.3% (n=6) indicated that they did not encounter cultural problems; 37.7% (n=20) indicated that cultural problems hindered service delivery to a certain extent; 34.0% (n=18) indicated that these problems did exist but did not hinder service delivery, and 15.1% (n=8) indicated that they seriously hindered service delivery. One respondent (1.9%) did not answer the question. Tjale and De Villiers (2004:113) found cultural practices may have hindered service delivery.

- *Item I1.2: Apathy of community members (N=53)*

Of the respondents, 20.8% (n=11) indicated no apathy on the part of community members; 22.1% (n=17) indicated that it hindered service delivery to a certain extent; 35.8% (n=19) indicated that members were apathetic, but this did not hinder service delivery, and 9.4% (n=5) indicated that the apathy of members of the community seriously hindered service delivery. One respondent (1.9%) did not answer the question

- *Item I1.3: Patients do not keep to stipulated clinic hours (N=53)*

Of the respondents, only 9.4% (n=5) indicated that patients' failure to keep to the stipulated clinic hours was not a problem; 22.6% (n=12) indicated that it hampered service delivery to a certain extent; 43.3% (n=23) indicated that it was a problem but did not hinder service delivery, and 22.6% (n=12) indicated that it seriously hindered service delivery. Uys (2004:113) found that patients abused the availability of nurses. One respondent (1.9%) did not answer the question.

- *Item I1.4: Patient complaints (N=53)*

Of the respondents, 9.4% (n=5) indicated that they had no problems with patients' complaints; 66.0% (n=35) indicated that patients' complaints were a problem, but did not hinder service delivery; 18.9% (n=10) indicated that patients' complaints hindered service delivery to a certain extent, and 5.7% (n=3) indicated that some patients'

complaints seriously hindered service delivery. Constant negative complaints and criticism from patients were also mentioned in the study done by Bester and Engelbrecht (2009:111) which negatively impacted on the service delivery.

- *Item I1.5: Patients see traditional healers before they come to the clinic (N=53)*

Of the respondents, 3.8% (n=2) indicated that they did not have this problem; 34.0% (n=18) indicated that this problem hindered service delivery to a certain extent; 49.1% (n=26) indicated that this was a problem, but did not hinder service delivery, and 11.3% (n=6) indicated that the fact that some patients saw traditional healers before coming to the clinic seriously hindered service delivery. One respondent (1.9%) did not answer the question.

- *Item I1.6: Patients tend to wait too long before they come to the clinic (N=53)*

Of the respondents, only 3.8% (n=2) indicated that they did not have the problem of patients waiting too long before visiting the clinic; 41.5% (n=22) indicated that the tendency of some patients to wait too long before visiting the clinic was a problem but did not hamper service delivery; 37.7% (n=20) indicated that it hindered service delivery to some extent, and 17.0% (n=9) indicated that this problem seriously hampered service delivery.

- *Item I1.7: Patients are poorly informed about their condition (N=53)*

Of the respondents, 32.1% (n=17) indicated that they did not have the problem of patients being poorly informed about their condition; 34.0% (n=18) indicated that this problem hampered service delivery to some extent; 28.3% (n=15) indicated that this was a problem but did not hinder service delivery, and 5.7% (n=3) indicated that the fact that patients were poorly informed about their condition seriously hampered service delivery.



- *Item I1.8: Patients do not comply with treatment (N=53)*

Of the respondents, 17.0% (n=9) indicated that non-compliance with treatment was not a problem; 30.2 % (n=16) indicated that non-compliance hindered service delivery to some extent; 24.5% (n=13) indicated that although non-compliance was a problem, it did not hinder the provision of services, and 28.3% (n=15) indicated that it seriously hindered service delivery.

- *Item I1.9: Prevalence rate of HIV/Aids (N=53)*

Of the respondents, 39.6% (n=21) indicated the prevalence of HIV/Aids and HIV/Aids-related problems seriously hindered the provision of quality PHC service; 16.4% (n=24) indicated that it hindered service delivery to some extent, and 15.0% (n=8) indicated that this problem did not hinder service delivery. In the Free State PHC nurses reported that the burden of HIV/Aids, caring for these patients and dealing with death contributed to work-related stress and job dissatisfaction (Bester & Engelbrecht 2009:112).

- *Item I1.10: Prevalence rate of TB (N=53)*

Of the respondents, 32.1% (n=17) indicated that the prevalence rate of TB only hampered service delivery to some extent; 34.0% (n=18) indicated that it did not hinder service delivery, and 34.0% (n=18) indicated that it seriously hindered service delivery.

- *Item I1.11: Patients' low literacy rate (N=53)*

Of the respondents, only 3.8% (n=2) indicated that the patients' low literacy rate did not hinder service delivery; 26.4% (n=14) indicated that it hindered service delivery to a certain extent; 43.4% (n=23) indicated that the problem existed but that it did not hinder service delivery; 24.5% (n=13) indicated that the low literacy rate among patients seriously hampered service delivery, and 1.9% (n=1) did not answer the question.

- *Item I1.12: Patients' non-adherence to return dates (n=53)*

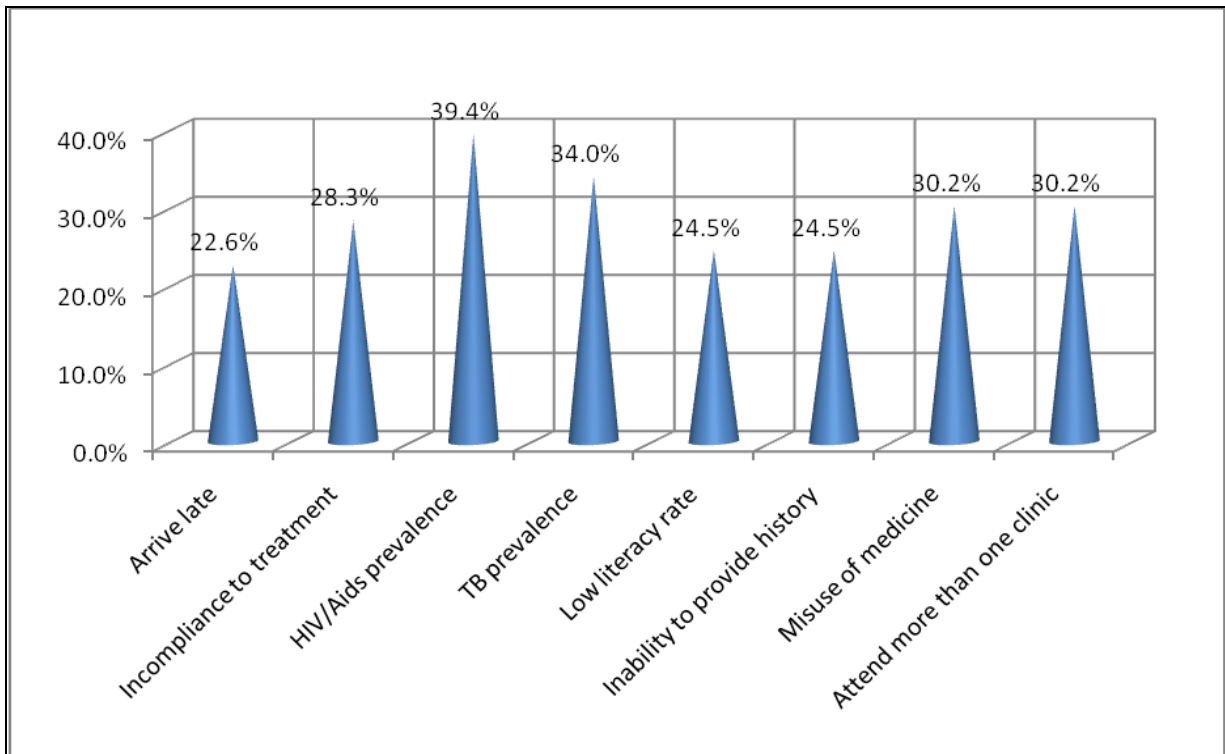
Of the respondents, 5.7% (n=3) indicated that their patients adhered to return dates; 32.1% (n=17) indicated that non-adherence hindered service delivery to a certain extent; 41.5% (n=24) indicated that non-adherence did not hinder service delivery, and 17.0% (n=9) indicated that it seriously hindered service delivery.

- *Item I1.13: Inability of patients to provide proper history (n=53)*

History taking is important in guiding diagnosis (Mabaso 2006:113). Of the respondents, 9.4% (n=5) indicated that they did not have the problem of patients not being able to provide an accurate history; 30.2% (n= 16) indicated that this problem hindered service delivery to a certain extent; 35.8% (n=19) indicated that this problem did not hinder service delivery, and 24.5% (n=13) indicated that this problem seriously hindered service delivery.

- *Item I1.14: Patients misuse prescribed medicine (n=53)*

Of the respondents, only 7.5% (n=4) indicated that prescribed drugs were not misused; 34% (n=18) indicated that this problem hindered service delivery to a certain extent; 28.3% (n=15) indicated that this problem did not hinder service delivery, and 30.2% (n=16) indicated that the misuse of prescribed drugs seriously hindered quality care.



**Figure 4.21 Serious problems related to patients**

- **Item I1.15: Patients' use of over-the-counter medication (N=53)**

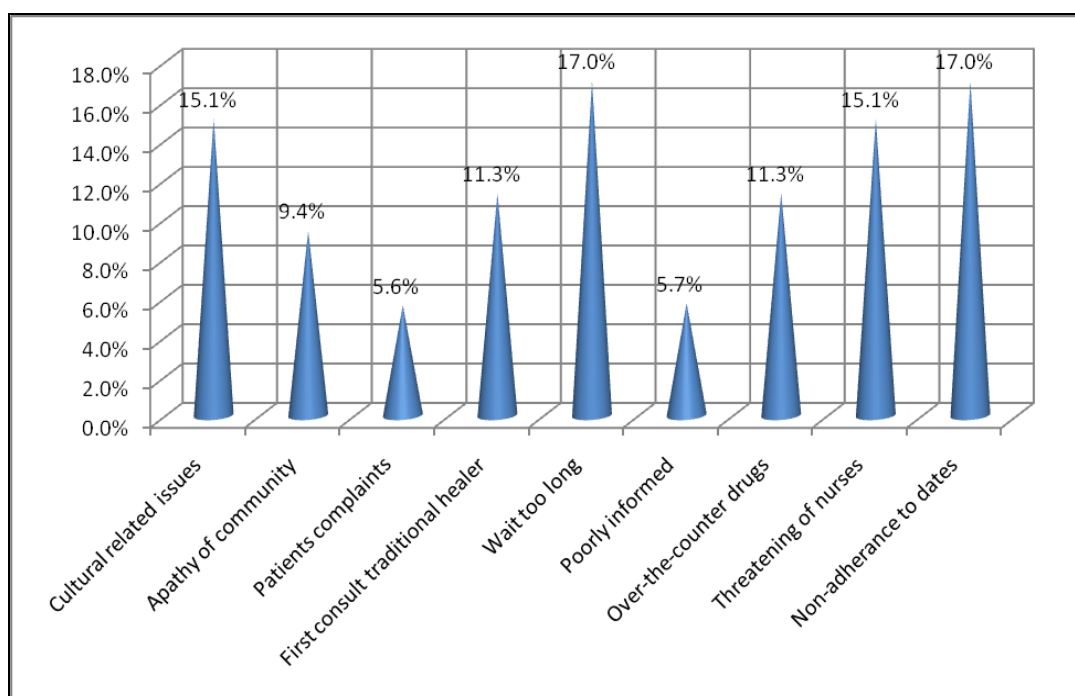
Of the respondents, 41.5% (n=22) indicated that patients' use of over-the-counter medication was not a problem that hindered service delivery; 37.7% (n=20) indicated that it hampered service delivery to a certain extent; 11.3% (n=6) indicated that it seriously hampered the rendering of quality PHC services, and 9.5% (n=5) did not answer the question.

- **Item I1.16: Patients attend more than one clinic for the same complaint (N=53)**

Of the respondents, only 9.4% (n=5) indicated that patients' attending more than one clinic for the same complaint was not a problem; 24.5% (n=13) indicated that it hampered service delivery to a certain extent; 35.8% (n=19) indicated that it did not hamper service delivery, and 30.2% (n=16) indicated that it seriously hindered service delivery.

- **Item I1.17: Patients' threatening behaviour towards nurses (N=53)**

Of the respondents, 26.4% (n=14) did not experience this problem; 45.3% (n=24) indicated that it did not interfere with service delivery; 13.2% (n=7) indicated that it did hinder service delivery to a certain extent, and 15.1% (n=8) indicated that patients' threatening behaviour towards nurses it seriously hindered service delivery.



**Figure 4.22 Less serious problems related to patient behaviour**

#### **4.3.9.2 Item I2: Other factors related to patients**

The respondents were asked to indicate how often the listed factors applied to their health facilities.

- **Item I2.1: Patients did not complain without reason (N=53)**

Of the respondents, 13.2% (n=7) indicated that when patients complained it was *always* for genuine reasons; 35.8% (n=19) indicated that it was *often* for a reason; 39.6%

(n=21) indicated that it was *seldom* for a reason, and 7.5% (n=4) indicated that it was *never* for a reason.

- *Item I2.2: Patients' complaints were dealt with immediately (N=53)*

Of the respondents, 43.4% (n=23) said that patients' complaints were *always* dealt with immediately; 53.0% (n=18) indicated that they were *often* dealt with immediately; 17.0% (n=9) indicated that they were *seldom* dealt with immediately, 1.9% (n=1) indicated that patients' complaints were *never* dealt with immediately. Two respondents (n=3.8%) did not answer the question.

- *Item I2.3: Survey was conducted on patients' satisfaction (N=53)*

Of the respondents, 26.4% (n=12) indicated that patients' surveys were *always* conducted; 34.0% (n=18) indicated that they were *often* conducted; 28.3% (n=15) indicated they were *seldom* conducted, and 11.3% (n=6) indicated that surveys were *never* conducted.

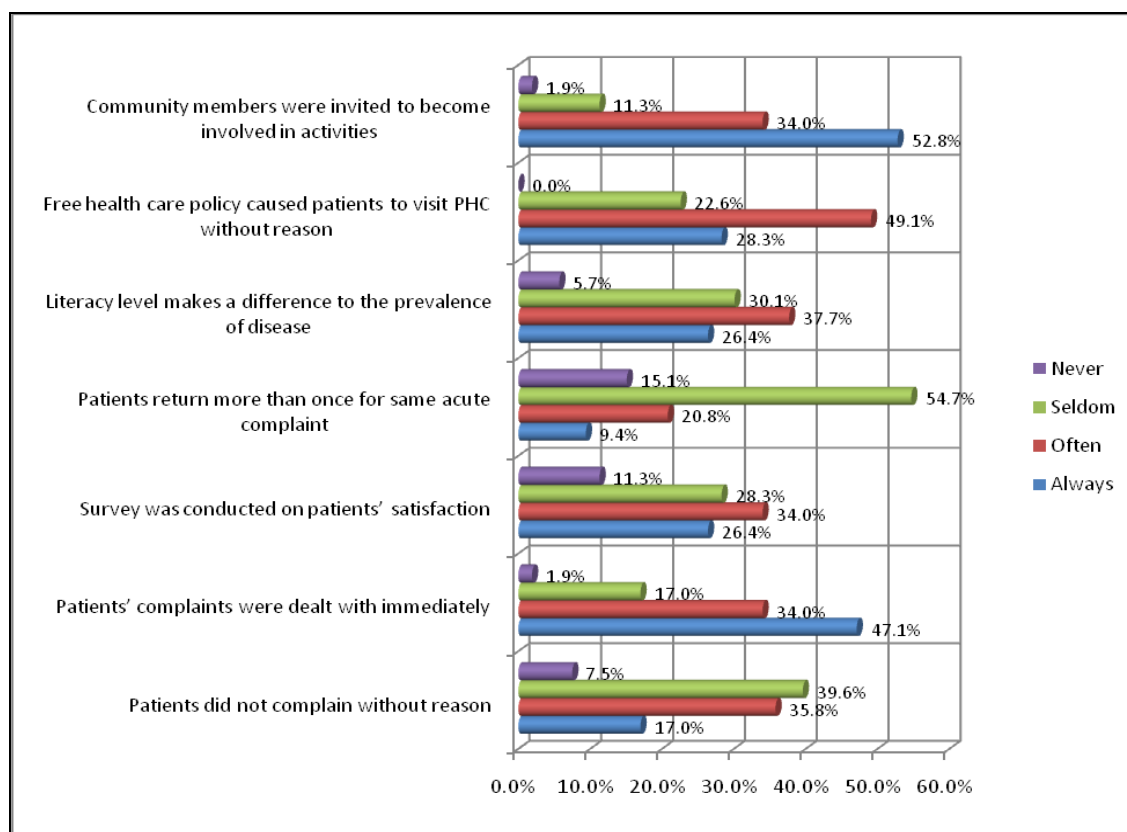
- *Item I2.4: Patients return more than once for same acute complaint (N=53)*

Of the respondents, 11.3% (n=6) indicated that patients *never* returned more than once for the same acute complaint before it was resolved; 20.8% (n=11) indicated that patients *often* did so; 54.7% (n=29) indicated that they *seldom* did, and 9.4% (n=5) indicated that patients *always* returned more than once for the same acute complaint before it was resolved. Two respondents (3.8%) did not answer the question.

- *Item I2.5: Literacy level makes a difference to the prevalence of disease (N=53)*

Of the respondents, 26.4% (n=14) indicated that patients' low literacy level *always* played a role in the prevalence of disease; 37.7% (n=20) indicated that it *often* did so;

30.1% (n=16) indicated that it *seldom* did, and 5.7% (n=3) indicated that it *never* played a role in the prevalence of disease.



**Figure 4.23 Other factors related to patients**

- **Item I2.6:** *Free health care policy caused patients to visit PHC without reason (N=53)*

Of the respondents, 24.5% (n=28) indicated that patients *always* visited the clinic for no reason because health services were free; 49.1% (n=26) indicated that this *often* occurred, and 22.6% (n=12) indicated that this was *seldom* the reason for clinic visits. Uys (2004:113) found that patients had a tendency to abuse free health care services.

- *Item 12.7: Community members were invited to become involved in activities (N=53)*

Of the respondents, 47.2% (n=25) indicated that members of the community were *always* invited to become involved in the activities of PHC service; 34.0% (n=18) said this was *often* done; 11.3% (n=6) indicated it was *seldom* done, and 1.9% (n=1) indicated that it was *never* done. Three respondents (5.7%) did not answer the question.

#### **4.3.9.3 Item 13: Number of hours that patients have to wait to be seen by health professionals (N=53)**

Of the respondents, 58.5% (n=31) indicated that patients usually had to wait for less than an hour to be seen by a health professional; 24.5% (n=13) indicated at least one to two hours, and 15.1% (n=8) indicated two to three hours. One respondent (1.9%) did not answer the question.

#### **4.3.10 Section J: Respondents' rating of the seriousness of problems in the PHC service**

This section required the respondents to rate the seriousness of problems in general (as a whole) according to their perception starting from personnel, managerial, supplies and equipment, infrastructure, referral system, training, and multi-disciplinary team issues specifically related to the provision of PHC services in the five districts of Limpopo.

At the end of the questionnaire in Section J, the respondents were asked to rate the seriousness of the problems they experienced. Managerial problems were rated by 45.0% of the respondents as the most serious, 44% rated the shortage of supplies and equipment and 40.0% rated problems with the multi-disciplinary team as the most serious followed by training problems. Most of the respondents rated the referral system as one of the less serious problems.

Finally, the respondents were asked for their comments or recommendations to improve quality of services in the different clinics and health centres. No comments were received.

#### **4.11 CONCLUSION**

This chapter covered the data analysis and interpretation of the problems the respondents encountered in rendering PHC service. The questionnaire covered staff-related problems, including shortage of staff, training needs, and opportunities for in-service training; managerial issues, such as feedback from management; shortage of supplies and equipment; infrastructural problems, such as very small clinics, inadequate electricity and water supply, inadequate toilet facilities, poor roads, lack of transport, and communication problems ranged from lack of feedback when patients came back from referral hospitals, telephones that did not function, and the distance between the referral hospital and PHC facilities. The data indicated serious problems related to assistance and support by the multi-disciplinary team in visiting PHC services. Patient-related problems included the abuse of free health care services; failure to comply with treatment and dates for visits; illiteracy, and a lack of knowledge and understanding of their conditions.

Chapter 5 presents the findings, briefly discusses the limitations of the study, and makes recommendations for practice and further research.



## **CHAPTER 5**

### **FINDINGS, LIMITATIONS AND RECOMMENDATIONS**

#### **5.1 INTRODUCTION**

Chapter 4 discussed the data analysis and interpretation, presenting the findings in percentages, pie diagrams and bar graphs. This chapter concludes the study, summarises the findings, discusses its limitations, and makes recommendations for practice and further research.

#### **5.2 BACKGROUND TO THE STUDY**

PHC service delivery is a major component of South African health care provision, especially the District Health System (DHS). PHC services should be available, accessible, and acceptable to consumers as well as affordable for them and the country. PHC should be delivered properly and to the benefit of the consumer. The delivery of quality PHC services is vital for the health of a nation, particularly for communities who reside in rural areas such as in Limpopo province. These patients are far from medical doctors, academic hospitals and other health facilities and have to rely on the health services offered by registered PHC nurses. Mabaso (2006:119) found that newly qualified PHC nurses practising in clinics in Limpopo province were competent and confident enough to stand-in for medical practitioners when they were not available. Rapakwana (2004:92) and Uys (2004:65, 66), however, found that poor infrastructure, management problems, shortage of supplies, and other factors hindered the delivery of quality PHC services.

These findings motivated the researcher to investigate and determine the existence and extent of problems that hampered service delivery in the different districts of Limpopo province. The researcher found no literature available on findings of this nature and accordingly assumed that such research had not been conducted.

### **5.3 RESEARCH DESIGN AND METHODOLOGY, AND CONCEPTUAL FRAMEWORK**

The researcher conducted a quantitative, explorative and descriptive study to explore and describe the existence and extent of problems hindering the delivery of PHC according to the perception of PHC nurses in selected health care facilities in the five districts of Limpopo province, RSA (see chapter 3). The study used the main problems identified by Uys (2004:113-116) as the conceptual framework (see chapter 2).

Data was collected from 53 respondents by means of a questionnaire covering the biographical data of the respondents and problems related to management, personnel (shortage and training), provision of equipment and other resources, infrastructure, referral systems, communication, and patient behaviour that hindered service delivery.

The respondents all worked at the functional level and dealt directly with patients on a daily basis at the selected PHC facilities. A pre-test of the research instrument was conducted in Bohlabela, with five respondents who did not participate in the main study (see chapter 3). The purpose of the pre-test was to ensure validity and reliability.

The researcher upheld the ethical considerations of permission, self-determination, privacy, anonymity and confidentiality (see chapter 1 and 3). The questionnaire consisted mostly of closed questions (which could be coded) to facilitate analysis. A number of open-ended questions were also included to allow the respondents to express their own perceptions, experience and comments. A statistician analysed the data from the closed questions, using the SPSS version 15 computer program, and the researcher analysed the open-ended questions.

### **5.4 FINDINGS**

The findings were presented according to the sections of the questionnaire.

#### **5.4.1 Respondents' biographical data**

Of the respondents, 88.7% (n=47) were females and 11.3% (n=6) were males. The respondents were all registered PHC nurses who also had a wide range of qualifications. The majority of the respondents were between 40 and 44 years old, and had six or more years' experience.

#### **5.4.2 Managerial problems**

It was of concern that 41.7% (n=22) of the respondents indicated that managerial problems hindered service delivery and in section 5, 45.0% of the respondents perceived it as the most serious problem. Only 5.7% (n=3) respondents indicated that there was poor communication between managers and staff.

It was however found that managers created an environment conducive to quality PHC service delivery; could cope with the workload; could be relied on to solve problems; helped staff despite their heavy workloads, and audited services regularly. At the same time, however, many respondents indicated that managers could not help staff because of their busy schedules; did not audit services regularly; and were not fair in the way they disciplined staff.

#### **5.4.3 Personnel-related problems**

Most of the respondents indicated the shortage of staff as a problem that made it difficult to cope with the workload. For example, the majority had to consult more than 30 patients per day. Although not a major issue, staff migration added to the shortage because new nurses were not available to take the place of those who had left. Other problems involved standing-in for doctors, pharmacists, social workers and other support personnel as well as doing clerical/administrative work. The findings therefore indicated that in most of the clinics the provision of quality services was possible despite personnel-related problems, although difficult at times.

#### **5.4.4 Problems related to the provision of equipment and supplies**

Problems pertaining to equipment and supplies included shortage of medicines, equipment, cleaning materials, and stationery as well as delays in approval of orders and in delivery of supplies and equipment. Budget cuts and lack of budgeting skills also exacerbated the problem of shortage of equipment and resources. These problems seriously hampered service delivery and was perceived by 44.0% of the respondents as the most serious of all the problems investigated in this study.

#### **5.4.5 Problems related to the infrastructure**

Infrastructural problems included insufficient consulting rooms; inadequate waiting areas for patients; poor condition of buildings; insufficient storage space; lack of electricity and water supply; lack of staff toilets; inadequate toilet facilities, and lack of regular and effective maintenance. The respondents perceived problems related to infrastructure as serious and that it hampered the delivery of quality PHC services.

#### **5.4.6 Problems related to training of personnel**

Although the majority of the respondents indicated that there were opportunities to attend workshops and courses, only a limited number of staff could attend at a time. Training was important to them, but their workload and shortage of personnel often made it difficult to attend courses. Forty percent of the respondents perceived problems related to training of personnel as a serious problem (see section 5 in chapter 4).

#### **5.4.7 Problems related to referral system**

Regarding referral system problems, the focus was specifically on the distance between the clinic and the referral hospital; ambulance services; general communication with regard to transferring patients to and from referral hospital; feedback from doctors, and any other referral problems that hindered the provision of quality PHC service. The respondents indicated the following problems with the referral system:

- Distance between the clinics and the referral hospitals varied between 2 and 96 kilometres.
- Ambulances not always prompt to arrive when summoned.
- Frequent problems with the telephone connection between clinic and hospital.
- Little or no feedback on patients they referred.
- Patients unwilling to be referred to hospital.
- Patients referred back from hospital without being seen by a doctor.
- Chronic patients return from hospital with no follow-up dates.

The respondents pointed out a serious need to improve emergency care skills since most of the clinics were situated in the rural areas and far from hospitals, therefore PHC nurses need to be able to provide emergency services as patients' lives depend on their knowledge and skills.

#### **5.4.8 Problems related to the multi-disciplinary team**

The comprehensiveness and totality of managing patients at PHC level depends on the involvement of the members of the multi-disciplinary team and the frequency of their visits to the facility. The main problems with the multi-disciplinary team involved support received from them; doctors sharing their knowledge with the respondents; frequency of their visits to the health care facilities, and the need for regular visits (see chapter 4, section 4.3.7). Forty percent of the respondents indicated that the problems related to the multi-disciplinary team were serious.

The study found that of the respondents,

- 50.9% (n=27) indicated that doctors seldom or never supported them
- 49.0% (n=26) indicated that social workers seldom or never supported them
- 56.6% (n=30) indicated that doctors seldom or never shared their knowledge with them

- 22.6% (n=12) indicated that doctors never visited the clinics
- 43.4% (n=23) indicated that social workers never visited their facility
- 39.6% (n=21) indicated that physiotherapists never visited their clinics
- 56.6% (n=30) indicated that ophthalmic nurses never visited their clinics
- 69.8% (n=17) indicated that dentists never visited their clinics

These findings indicate the need to effectively implement the multi-disciplinary team approach. The lack of support from social workers poses a particularly serious problem since most of the patients who present with social problems also have economic problems. This aggravates the situation because the only resort is to refer them to a facility where a social worker is permanently stationed.

To further demonstrate the importance of and urgency for multi-disciplinary team services, the respondents were asked to indicate how frequently they needed these services (see chapter 4, section 4.3.7.2 and 4.3.7.3). The findings indicated that of the respondents,

- 84.8% needed a doctor at least once a week or almost every day
- 75.5% needed a social worker every day or more than once a month
- 94.3% needed a physiotherapist once a month or at least once a week
- 88.7% needed a dietician at least once a month or once a week
- 83.1% needed an ophthalmic nurse at least once a month or once a week
- 86.8% needed dental services at least once a month or once a week

#### **5.4.9 Patient-related problems**

Patient-related problems included cultural issues; possible complaints raised; their knowledge about illness, clinic operational hours; delays in seeking help or consulting the clinic; literacy levels; adherence to treatment; adherence to return dates; prevalence of HIV/Aids and TB, and the utilisation of free health care services by the community (see chapter 4, section 4.3.8).

The study found the following patient-related problems seriously impacted on service delivery. Of the respondents,

- 52.8% (n=28) indicated that cultural issues hindered service delivery
- 45.3% (n=24) indicated that patients did not adhere to stipulated clinic operational hours
- 45.3% (n=23) indicated that patients' first consulting traditional healers hampered service delivery
- 54.7% (n=29) indicated that patients' waiting too long before coming to the clinic hindered service delivery
- 50.9% (n=29) indicated that poor literary levels hindered service delivery
- 84.9% (n=45) indicated that the prevalence of HIV/Aids hindered service delivery
- 66.1% (n=35) indicated that the prevalence of TB hindered service delivery
- 64.2% (n=34) indicated that patient misuse of prescribed medication hindered service delivery
- 54.7% (n=29) indicated that patients' visiting more than one clinic hindered service delivery
- 73.6% (n=39) indicated that patients abused the free health services, thereby negatively impacting on service delivery

Other problems included patients' non-adherence to return dates (49.1%), use of over-the-counter (OTC) medicines (49.0%), patient complaints (24.6%), and threatening behaviour towards nurses (24.5%).

## **5.5 LIMITATIONS**

The researcher identified the following limitations in the study:

- The study was restricted to the five districts of Limpopo province, therefore the findings cannot be generalised to other provinces or regions as they differ in number of inhabitants, level of development and geographical features.

- Other findings could have been generated with the same sample if other research methods such as observation had been used.
- The respondents were all registered PHC nurses therefore the findings were based on their perceptions. Other health workers, managers or patients could possibly have generated different findings.

## **5.6 RECOMMENDATIONS**

Based on the findings, the researcher made the following recommendations for practice and further research.

### **5.6.1 Practice**

#### *5.6.1.1 Staff shortages*

Provision should be made to recruit and employ more registered PHC nurses at the health facilities in Limpopo province. Statistics on daily patient visits to health facilities should be used to determine staffing for PHC facilities and time needed for patient care. This would enhance the provision of quality PHC. The availability of more registered PHC nurses would

- allow more staff to attend workshops and courses, including refresher courses
- improve knowledge, skills, morale and quality of care
- relieve stress
- allow more time with patients
- enhance job satisfaction.

Provision should be made for day and night staff. More members of the multi-disciplinary team should be allocated to the health facilities to provide comprehensive service delivery.



#### *5.6.1.2 Management*

The DOH should make provision for more registered PHC nurses to be employed at the health facilities in order to enable managers to assist nurses, supervise junior staff, audit services regularly, budget; communicate with staff, and attend to personnel problems.

#### *5.6.1.3 Provision of supplies and equipment*

The DOH should address the problem of shortages of equipment and supplies, including stationery and office supplies, as well as delays in approving and delivering orders. PHC nurses should be involved in decisions on what equipment and supplies need to be ordered.

#### *5.6.1.4 Infrastructure*

New PHC facilities should be planned to include adequate waiting area for patients, consultation rooms, staff and patient toilet facilities, and storage space. Special attention should be given to health facilities on the borders of the country in respect of the increasing illegal immigrant patient visits.

Older PHC facilities should be renovated to include ample patient waiting areas and consultation rooms as well as storage space as well as rooms for the members of the multi-disciplinary team. In addition, rest rooms and accommodation should be available for personnel on night duty or on call at all the clinics.

The DOH should approach the relevant departments and local authorities to improve the condition of roads too, telecommunication systems for and the supply of electricity, water and sanitation to PHC facilities.

#### *5.6.1.5 Referral systems*

Urgent attention should be given to the referral systems between PHC facilities and hospitals to provide uninterrupted, regular service provision between them. Clear guidelines for referral and the role of each individual and service involved in the process should be available. Reliable and prompt transport, including ambulance services, between the facilities and referral hospitals is crucial.

Communication and feedback between the referral hospital and health facility should be improved for quality service delivery and follow-up.

#### *5.6.1.6 Multi-disciplinary team*

The DOH should give urgent attention to the recruitment and appointment of members of the multi-disciplinary team, especially in the rural areas. Incentives should be given to those employed in rural areas. This would ensure their regular services at the clinics and the delivery of comprehensive PHC services.

Medical doctors should be encouraged to share their knowledge with the nurses in the health facilities. This would not only improve their collegial relationship but improve the knowledge and skills of the PHC nurses.

#### *5.6.1.7 Patient-related problems*

The DOH should make provision for educational materials to be provided to all PHC facilities so that PHC nurses can educate the community on the importance of taking medication as prescribed, attending scheduled visits, and their rights as well as their responsibilities in health care. Collaboration between the facilities and the local communities should be encouraged in order to determine ways to improve literacy levels through cooperation and support.

### **5.6.2 Further research**

Further research should be undertaken on the following topics:

- An investigation into problems in PHC delivery in all provinces of South Africa (This would provide a broader picture of the status of PHC services that could form a basis for government intervention at national level).
- A repeat study with the same sample after three to five years to determine improvement in the problems identified.
- An investigation into the role of the multi-disciplinary team in the provision of quality PHC services.
- The role and cost-effectiveness of PHC nurses who are supposed to stand-in for medical practitioners in health care provision and alleviating the workload of doctors.
- An investigation into patient satisfaction with PHC services in Limpopo province.

### **5.7 CONCLUSION**

The study examined the existence and extent of problems hindering service delivery in selected PHC facilities in the five districts of Limpopo province. Despite the problems, most of the respondents seem committed to continue to provide quality PHC. The findings supported those of Uys (2004:118), Mabaso (2006:118) and other researchers, thus emphasising the urgency of improving PHC service delivery through effective implementation of the multi-disciplinary team approach, upgrading of infrastructure, including roads, transport and telecommunication, improving the referral system, and recruitment and training of staff.

The recommendations based on the findings should assist the DOH in policy development and implementation as well as budgetary allocation to provide the quality PHC service vital for the nation's health, particularly for rural communities in Limpopo province and throughout the country.

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# **ANNEXURE A**

**REQUESTING AND OBTAINING PERMISSION TO  
CONDUCT THE RESEARCH FROM THE DEPARTMENT  
OF HEALTH AND SOCIAL DEVELOPMENT,  
POLOKWANE**

Seeing that the anonymity of all the participants of this research was promised, the letters of permission which would identify the individuals involved were not included in this final copy. These letters are however available on the computers of the researcher and supervisors should anyone like to peruse it.

## **ANNEXURE B**

**REQUESTING AND OBTAINING PERMISSION TO  
CONDUCT THE RESEARCH FROM THE SENIOR  
MANAGER, INTEGRATED PRIMARY HEALTH CARE  
SERVICES, POLOKWANE**

Seeing that the anonymity of all the participants of this research was promised, the letters of permission which would identify the individuals involved were not included in this final copy. These letters are however available on the computers of the researcher and supervisors should anyone like to peruse it.

## **ANNEXURE C**

**REQUESTING AND OBTAINING PERMISSION TO  
CONDUCT FROM THE DISTRICT MANAGERS OF  
VHEMBE, WATERBERG, SEKHUKHUNE, CAPRICORN,  
AND MOPANI**

Seeing that the anonymity of all the participants of this research was promised, the letters of permission which would identify the individuals involved were not included in this final copy. These letters are however available on the computers of the researcher and supervisors should anyone like to peruse it.



## **ANNEXURE D**

**REQUESTING (VERBALLY) PERMISSION TO  
CONDUCT RESEARCH FROM THE MANAGERS  
IN-CHARGE OF CLINICS**

# **ANNEXURE E**

**MPUMALANGA PROVINCIAL GOVERNMENT**

Seeing that the anonymity of all the participants of this research was promised, the letters of permission which would identify the individuals involved were not included in this final copy. These letters are however available on the computers of the researcher and supervisors should anyone like to peruse it

## **ANNEXURE F**

**APPROVAL FROM THE RESEARCH AND ETHICS  
COMMITTEE, DEPARTMENT OF HEALTH STUDIES,  
UNIVERSITY OF SOUTH AFRICA**

PO Box 596  
THULAMASHE  
1365  
2007-06-21

Research and Ethics Committee  
Department of Health Studies  
University of South Africa

Dear Professors

### **REQUESTING PERMISSION TO CONDUCT RESEARCH**

I am hereby requesting permission to collect data for my master's dissertation with the title: **Problems in providing Primary health care services: Limpopo Province.**

My supervisor is Mrs MM van der Merwe, and co-supervisor Mrs JE Smith.

Methodology information related to the study.

A quantitative research design is used.

- (1) The objective of the research is to determine whether problems exist in Primary health-care clinics of Limpopo province that would hamper the rendering of quality health care.
- (2) Registered PHC nurses who render PHC services in PHC clinics to clients in the five districts of Limpopo province make out the research population.
- (3) A stratified sampling method will be used to select the respondents from the sic districts of Limpopo province.
- (4) A questionnaire has been compiled and will be sent to these nurses.
- (5) The data will be analysed by the SPSS computer program.

My supervisors have made sure that all relevant ethical aspects have been considered and will monitor the research process.

Mrs Van der Merwe will provide you with a copy of the questionnaire, should you need to see it.

Yours faithfully

Ms LF Baloyi

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

**CLEARANCE CERTIFICATE**

**12 September 2007** **582-632-2**  
Date of meeting: ..... Project No: .....

Project Title: **Problems in Primary Health Care delivery**

Researcher: **Mrs L Baloyi**

Supervisor/Promoter: **Mrs MM van der Merwe**

Joint Supervisor/Joint Promoter: **Mrs JE Smith**  
Department: **Health Studies**

Degree: MA in Health Studies

**DECISION OF COMMITTEE**

**Approved**



**Conditionally Approved**



**23 August 2007**  
Date: .....

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

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

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

## **ANNEXURE G**

### **INFORMED CONSENT FROM THE RESPONDENTS**

## RESPONDENT

**Please mark your answer by encircling the choices provided.**

Yes No

Yes No

Yes                      No

Yes                      No

Yes                      No

Yes                      No

I agree to take part in this study. I agree to be interviewed for the purposes described in the information letter. I understand that my name will not be associated with the collected information and that identifiers will be removed.

.....

Date \_\_\_\_\_

Printed name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

.....  
Signature of researcher

Date \_\_\_\_\_

Printed name



## **ANNEXURE E**

## **RESPONDENTS**

- ◆ I am Mrs LF Baloyi student at the University of South Africa
- ◆ I need to collect data for my research, and have chosen you to take part.
- ◆ The purpose of the research is to study the problems that might exist in the delivery of primary health care.
- ◆ The objectives are to see whether the problems that have been found in other studies of this nature and in the literature are also present in the Limpopo province and to what extent they are detrimental for the success of the delivery of primary Health Care.
- ◆ Data will be collected by means of questionnaires which will be provided to the registered nurses who indicated that they are willing to take part in the research.
- ◆ The completion of the questionnaire should not take more than 30 minutes.
- ◆ You are requested to answer the questions as honestly and truthfully as possible.
- ◆ The results of the research will be printed in the master's dissertation of the researcher and will be examined by examiners to establish whether the researcher is able to do research on her own. This research is therefore only for the researcher's own development and studies.
- ◆ The findings of this research will be confidential as no name will be mentioned and in no way will it be possible to identify the respondents.
- ◆ Your participation is voluntary and you may withdraw at any stage of the study if you feel threatened.
- ◆ No harm will be done to you and no information you share with the researcher will be used to harm you.
- ◆ The information collected might however benefit patients in the clinics should it be possible to make suggestions to improve service delivery of health.
- ◆ Your privacy will be ensured during the completion of the questionnaire.
- ◆ Should you feel uncomfortable during the data collection process, please discuss it with the researcher.
- ◆ Should you have any questions at any time, please direct it to the researcher.

# **ANNEXURE H**

## **QUESTIONNAIRE**

# PROBLEMS IN PROVIDING PRIMARY HEALTH CARE SERVICES: LIMPOPO PROVINCE

## QUESTIONNAIRE

1-2

Answer the questions by entering the number allocated to the choices provided in the key, into the blocks in the right hand margin. Please ignore the coding of the blocks.

### SECTION A – BIOGRAPHICAL DATA

#### 1 How old are you?

Key: Younger than 29 years	=	1
Between 30 - 34 years	=	2
Between 35 - 39 years	=	3
Between 40 - 44 years	=	4
Between 45 - 49 years	=	5
Between 50 - 54 years	=	6
Between 55 - 59 years	=	7
Older than 59 years	=	8

A1

#### 2 What is your gender?

Key: Male	=	1
Female	=	2

A2

#### 3 In which district are you working?

Key: Bohlabela	=	1
Waterberg:	=	2
Sekhukhune	=	3
Vehmbe	=	4
Mopani	=	5
Capricorn	=	6

A3

#### 4 How long have you been working as a Primary health-care nurse?

Key: A few months to one year	=	1
2-3 years	=	2
4-5 years	=	3

6 and more years = 4

A4

**5 Indicate your qualifications**

5.1 General nursing

A5.1

5.2 Midwifery

A5.2

5.3 Community health nursing

A5.3

5.4 Psychiatry

A5.4

5.5 Nursing administration

A5.5

5.6 Nursing education

A5.6

5.7 Primary health-care

A5.7

**6 Indicate which of the short courses you have completed.**

6.1 Prevention of Mother to Child Transmission (PMTCT).

A6.1

6.2 Voluntary Counselling and Testing.

A6.2

6.3 Integrated management of Childhood Illnesses (IMCI).

A6.3

6.4 Tuberculosis management.

A6.4

6.5 National Adolescent Friendly Initiative (NAFCI).

A6.5

6.6 Logistic management.

A6.6

6.7 Sexually Transmitted Infections (STI).

A6.7

6.8 Couple counselling.

A6.8

6.9 Preceptor course.

A6.9

6.10 Dispensing course.

A6.10

6.11 Drug supply management.

A6.11

6.12 HIV/Aids.

A6.12

6.13 Financial management.

A6.13

6.14 Youth friendly initiative.

A6.14

**7 Please indicate the position you hold in the health service. (A7)**

---

**8 Do you believe that you are remunerated sufficiently for the work you do?**

Key: Yes = 1

No = 2

Uncertain = 3

A8

**9 Provide a reason for your choice in the above question. (A9)**

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## SECTION B – PROBLEMS IN PHC SERVICES RELATED TO PERSONNEL

**1 How many nurses are working in your institution?**

**B1**

**2 How many qualified PHC nurses are in your institution?**

**B2**

**3 What are the total number registered nurses in your institution?**

**B3**

**4 How serious is the shortage of nurses in your institution?**

Key: The health service had to close due to the shortage = 1  
Most services could not be provided = 2  
Some services could not be provided = 3  
Service delivery was hampered, but did continue = 4  
Services were mildly affected = 5  
Services were not affected = 6  
There is no shortage = 7

**B4**

**5 Does the migration of nurses affect the rendering of quality PHC services?**

Key: Always = 1 (Answer questions 6)  
Often = 2 (Answer questions 6)  
Seldom = 3 (Skip question 6 and move to question 7)  
Never = 4 (Skip question 6 and move to question 7)

**B5**

If you have chosen 1 or 2 in the above question, answer questions 6. If not, move to questions 7.

**6 Indicate how the migration of staff PHC services.**

Key: Always = 1

Often	=	2
Seldom	=	3
Never	=	4

6.1 The migration of staff is a larger problem than a shortage of staff.

**B6.1**

6.2 New staff needs to be orientated and it takes time.

**B6.2**

6.3 They have to attend short courses before they can be applied fully

**B6.3**

**6.4 Provide reasons why staff migrate. (B6.4)**

---



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**7 Nurses can cope with the number of patients who attend the health service every day.**

Key: Always	=	1
Often	=	2
Seldom	=	3
Never	=	4

**B7**

**8 How many patients do you personally see per day?**

**B8**

**9 How many patients attend the clinic per day?**

**B9**

**10 What is the optimal number of patients a PHC nurse could see per day?**

**B10**

**11 Indicate to what extent you agree with the following statements related to the PHC nurses in your institution.**

Key: Strongly agree	=	1
---------------------	---	---

Agree	=	2
Disagree	=	3
Strongly disagree	=	4

11.1 They keep their knowledge up-dated.

**B11.1**

11.2 They prescribe medicine for every patient who visits the clinic with a health problem.

**B11.2**

11.3 They know the side-effects of all the drugs.

**B11.3**

11.4 They write proper clinical notes.

**B11.4**

11.5 They know how to prescribe according to the Essential Drug List (EDL)

**B11.5**

11.6 They give health education to all patients.

**B11.6**

11.7 They waste supplies.

**B11.7**

11.8 They have good rapport with the patients.

**B11.8**

11.9 They work together as a team.

**B11.9**

11.10 It is not necessary to discipline the nurses.

**B11.10**

11.11 They respect their peers.

**B11.11**

## 12 Indicate to what extent you agree with the following statements.

Key: Strongly agree	=	1
Agree	=	2
Disagree	=	3
Strongly disagree	=	4

12.1 PHC nurses should spend more time with patients.

**B12.1**



12.2 PHC nurses should improve their history taking skills.

**B12.2**

12.3 PHC nurses should improve their physical examination skills.

**B12.3**

12.4 PHC nurses should improve their diagnosing skills.

**B12.4**

12.5 PHC nurses should improve their knowledge of medication.

**B12.5**

12.6 PHC nurses should improve their emergency care skills.

**B12.6**

12.7 PHC nurses should improve their knowledge of diseases.

**B12.7**

**13 Indicate how often the PHC nurses are required to do the following in the health institution?**

Key: Never = 1

At least once a month = 2

2-4 times a month = 3

5-8 times a month = 4

9 and more times a month = 5

13.1 Stand in for the medical practitioner

**B13.1**

13.2 Stand in for the pharmacist.

**B13.2**

13.3 Do the work of an administration clerk (Opening retrieving files)

**B13.3**

13.4 Do the work of a social worker.

**B13.4**

13.5 Do the work of the other support personnel,

**B13.5**

**13.6 Provide reasons why members of staff do the work of support staff. (B13.6)**

---

---

**14 Which of the following statements are applicable to the staff in your institution?**

Key: Always = 1  
Often = 2  
Seldom = 3  
Never = 4

14.1 Absent from work without reason.

**B14.1**

14.2 Professional in their conduct.

**B14.2**

14.3 Happy with their working conditions.

**B14.3**

14.4 Experience stress

**B14.4**

14.5 There is a high morale amongst them.

**B14.5**

14.6 They work together as a team.

**B14.6**

14.7 They are productive.

**B14.7**

14.8 There is enough trained staff to supervise junior nurses.

**B14.8**

14.9 They tend to work in the clinic for many years.

**B14.9**

14.10 They thought of changing to another field of nursing.

**B14.10**

14.11 They report for duty on time every day.

**B14.11**

14.12 They leave the clinic early without permission.

**B14.12**

14.13 They experience transport problems.

**B14.13**

14.14 They tend to form cliques against management.

**B14.14**

## SECTION C - PROBLEMS IN PHC SERVICES RELATED TO MANAGERIAL MATTERS

If you are in-charge of the health service, answer all the questions in this section.

If you are not in-charge of the health service, please do not answer question 1.

### 1 As person in charge of the health service to what extent do you agree with the following statements?

Key: Strongly agree = 1

Agree = 2

Disagree = 3

Strongly disagree = 4

1.1 You are the only one who should make the decisions.

C1.1

1.2 Your personnel are allowed to voice their views.

C1.2

1.3 You audit the services on a regular basis.

C1.3

1.4 You can cope with your work load.

C1.4

1.5 You have enough time to attend to problems.

C1.5

1.6 You motivate your staff.

C1.6

1.7 You spend more time solving personnel problems than on patient care

C1.7

1.8 Your administration tasks take too much of your time.

C1.8

1.9 It is necessary for managers to adopt an authoritarian management style.

C1.9

**2 To what extent would personnel in your department agree with the following statements?**

Key: They would strongly agree = 1  
They would agree = 2  
They would disagree = 3  
They would strongly disagree = 4

2.1 The managerial style in the health service is conducive to the provision of quality  
PHC services.

**C2.1**

2.2 The managers can cope with their workload.

**C2.2**

2.3 Managers understand that the staff is over worked.

**C2.3**

2.4 Staff can rely on the managers to solve problems.

**C2.4**

2.5 Managers help staff in the health services despite their busy schedule.

**C2.5**

2.6 Managers motivate staff.

**C2.6**

2.7 Managers are professional in their conduct.

**C2.7**

2.8 Managers audit the services.

**C2.8**

2.9 Managers are fair in the way they discipline their personnel.

**C2.9**

**3 To what extent do managerial problems hinder the rendering of quality health services?**

Key: Seriously interferes = 1  
Interferes to a certain extent = 2  
Problems exist, but do not hinder service = 3

**C3**

**4 Rate the communication between staff and management.**

Key:	Extremely good	=	1
	Good	=	2
	Acceptable	=	3
	Poor	=	4
	Very poor	=	5

**C4**

**5 To what extent do policies (e.g. free health services) of the institution hinder the provision of quality care?**

Key:	Seriously interfere	=	1
	Interfere to a certain extent	=	2
	Do not interfere	=	3

**C5**

**6 Please indicate which policies hinder the provision of quality care and in what way. (C6)**

---

---

**SECTION D – PROBLEMS RELATED TO SUPPLIES AND EQUIPMENT**

**1 Indicate to what extent does the following problems, related to supplies, interfere with the provision of good quality PHC services?**

**Choose the statement that best describes the situation in your institution.**

Key:	Seriously interferes	=	1
	Interferes to a certain extent	=	2
	Problem exist, but do not hinder service	=	3
	This problem does not exist	=	4

**1.1 Shortage of medication.**

**D1.1**

1.2 Expired drug supplies.

D1.2

1.3 Shortage of cleaning material.

D1.3

1.4 Shortage of stationary.

D1.4

1.5 Shortage of stock (e.g. syringes, dressings).

D1.5

1.6 Theft of supplies.

D1.6

**2 Indicate to what extent the shortage of the following equipment and measures hinder the rendering of quality PHC services in your clinic.**

Choose the statement that best describes the situation in your institution.

Key:	Seriously interferes	=	1
	Interferes to a certain extent	=	2
	Problem exist, but does not hinder service	=	3
	This problem does not exist	=	4

2.1 Shortage of thermometers.

D2.1

2.2. Shortage of glucometers.

D2.2

2.3 Shortage of ophthalmoscopes.

D2.3

2.4 Shortage of Baumann-meters (BP apparatus).

D2.4

2.5 Shortage of stethoscopes.

D2.5

2.6 Shortage of diagnostic sets.

D2.6

2.7 Shortage of scales to weigh children.

D2.7

2.8 Shortage of scales to weigh adults.

D2.8

- 2.9 Shortage of drip stands. D2.9
- 2.10 Shortage of nebulisers. D2.10
- 2.11 Shortage of delivery beds. D2.11
- 2.12 Shortage of incubators. D2.12
- 2.13 Shortage of cribs for the infants. D2.13
- 2.14 Shortage of neonatal resuscitation trolleys. D2.14
- 2.15 There is no refrigerator for vaccines. D2.15
- 2.16 There is a shortage of tables in the consulting rooms. D2.16
- 2.17 There is a shortage of chairs for patients. D2.17
- 2.18 There is a shortage of wheelchairs. D2.18

**3 How often are the following factors the reason for the shortage of supplies and equipment?**

Key: Always = 1  
Often = 2  
Seldom = 3  
Never = 4

- 3.1 Delay in the ordering of supplies in time by clinic personnel. D3.1
- 3.2 Inability to predict larger volume of patients D3.2
- 3.3 Delay in the delivery of supplies by suppliers. D3.3
- 3.4 Delay in the approval of orders. D3.4

3.5 Budget cuts.

D3.5

3.6 Lack of budgeting skills of managers.

D3.6

**4 Please provide other reasons for shortages of supplies. (D4)**

---

---

**5 Which of the following shortages are also present in the PHC service?**

Key: Always = 1  
Often = 2  
Seldom = 3  
Never = 4

5.1 No emergency trolley.

D5.1

5.2 Poorly equipped emergency trolley.

D5.2

5.3 Shortage of fire extinguishers.

D5.3

---

## **SECTION E – PROBLEMS RELATED TO INFRASTRUCTURE**

**1 How would you rate the infrastructure of the PHC health service?**

Use the key that best describes the situation in your institution.

Key: Strongly agree = 1  
Agree = 2  
Disagree = 3  
Strongly disagree = 4



- |      |  |       |                      |
|------|--|-------|----------------------|
| 1.1  | There are sufficient consulting rooms for the medical practitioners. | E1.1  | <input type="text"/> |
| 1.2  | The structure of the building is in a good condition.                | E1.2  | <input type="text"/> |
| 1.3  | The roof of the building is leaking.                                 | E1.3  | <input type="text"/> |
| 1.4  | Windows of the building are broken.                                  | E1.4  | <input type="text"/> |
| 1.5  | Not enough exit doors in the building.                               | E1.5  | <input type="text"/> |
| 1.6  | The waiting area can accommodate all the clients/patients.           | E1.6  | <input type="text"/> |
| 1.7  | There are sufficient consulting rooms for the nurses                 | E1.7  | <input type="text"/> |
| 1.8  | There are rooms for the social worker to see clients                 | E1.8  | <input type="text"/> |
| 1.9  | There are equipped rooms for physiotherapist                         | E1.9  | <input type="text"/> |
| 1.10 | It is possible to provide privacy when seeing patients.              | E1.10 | <input type="text"/> |
| 1.11 | There is ample storage space for stock.                              | E1.11 | <input type="text"/> |
| 1.12 | Medication could be stored under the prescribed conditions.          | E1.12 | <input type="text"/> |
| 1.13 | Building is too small for its purpose.                               | E1.13 | <input type="text"/> |

**2 To what extent do the following problems hinder the delivery of quality PHC services?**

Choose the statement that best describes the situation in your institution.

Key:	Seriously interferes	=	1
	Interferes to a certain extent	=	2
	Problem exist, but do not hinder service	=	3
	This problem does not exist	=	4

- |      |   |       |                      |
|------|---|-------|----------------------|
| 2.1  | Condition of access roads to the clinic.              | E2.1  | <input type="text"/> |
| 2.2  | Unsafe bridge for clients to cross over nearby river. | E2.2  | <input type="text"/> |
| 2.3  | Poor supply of electricity to the health service.     | E2.3  | <input type="text"/> |
| 2.4  | Poor water supply to the health service.              | E2.4  | <input type="text"/> |
| 2.5  | Poor sanitation system for the health services.       | E2.5  | <input type="text"/> |
| 2.6  | Not enough toilets for clients/patients.              | E2.6  | <input type="text"/> |
| 2.7  | Toilets are not working.                              | E2.7  | <input type="text"/> |
| 2.8  | No separate toilets for personnel.                    | E2.8  | <input type="text"/> |
| 2.9  | Poor telecommunication system.                        | E2.9  | <input type="text"/> |
| 2.10 | Poor conditions of the building.                      | E2.10 | <input type="text"/> |
| 2.11 | Shortage of working space.                            | E2.11 | <input type="text"/> |
| 2.12 | Shortage of storage space.                            | E2.12 | <input type="text"/> |

**3 Please list other problems in the infra-structure that hinder the provision of quality PHC services. (E3)**

---

**4 Please indicate how often the following measures are taken by nurses to solve the problems listed in 1 and 2.**

Key: Always	=	1
Often	=	2
Seldom	=	3

Never = 4

4.1 Use own cell phones to make official phone calls.

E4.1

4.2 Unblock toilets.

E4.2

4.3 Repair broken toilets.

E4.3

4.4 Repair broken equipment.

E4.4

---

## SECTION F – PROBLEMS RELATED TO THE REFERRAL SYSTEM

1 How many kilometres is the nearest referral hospital?

F1

2 How would you rate the following aspects related to the referral system.

Use the key that best describes the situation in your institution.

Key: Always = 1

Often = 2

Seldom = 3

Never = 4

2.1 The ambulance comes quickly when summoned.

F2.1

2.2 There are problems in communicating with emergency services.

F2.2

2.3 There are problems in communicating with the referral hospital.

F2.3

2.4 There are problems with the telephone connection to the referral hospital.

F2.4

2.5 PHC nurses receive feedback on patients they have referred.

F2.5

**3 Please list other problems in the referral system that hinders the provision of quality PHC. (F3)**

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**SECTION H – PROBLEMS IN TRAINING OF PERSONNEL**

**1 How would you rate the opportunities staff has to attend workshops?**

Use the key that best describes the situation in your institution.

Key: Always = 1  
Often = 2  
Seldom = 3  
Never = 4

1.1 Staff members get equal opportunities to attend workshops.

H1.1

1.2 Only a limited number of staff may attend workshops at a time.

H1.2

1.3 Staff members need to attend more workshops to improve knowledge.

H1.3

**2 Which of the topics listed below should be offered to your personnel to render quality PHC services?**

Key: Cannot do without, need it immediately = 1  
Necessary, but training not critical at the moment = 2  
Not necessary, can do without it = 3

2.1 Genetic counselling.

H2.1

2.2 Training in facilitation skills for supervisors.

H2.2

2.3 ARV management.

H2.3

2.4 HIV/AIDS counselling.

H2.4

2.5 Reproductive health.

H2.5

2.6 Report writing.

H2.6

2.7 Keeping of statistics.

H2.7

2.8 Rational prescribing.

G2.8

2.9 Side effects of medication.

H2.9

2.10 Other topics

H2.10

**2.11 Please list the other topics (H3)**

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## **SECTION G – PROBLEMS IN THE MULTI-DISCIPLINARY TEAM APPROACH**

### **1 How would you rate the support you get from members of the multi-disciplinary team?**

Use the key that best describes the situation in your institution.

Key: Always = 1

Often = 2

Seldom = 3

Never = 4

1.1 Nurses are supported by medical practitioners.

G1.1

1.2 Nurses are supported by social workers.

G1.2

1.3 The medical practitioners share their knowledge with nurses.

G1.3

1.4 The traditional healer is a member of the multidisciplinary team.

G1.4

- 1.5 The traditional healer has a role to play towards health care in your clinic. **G1.5**
- 1.6 The traditional healers do not cause problems for the provision of quality health care in your clinic. **G1.6**
- 1.7 Nurses refer patients to the traditional healers. **G1.7**
- 1.8 Traditional healers refer patients to the clinic. **G1.8**

**2 How often do the following personnel visit the PHC service?**

Key: Never = 1  
 At least once a month = 2  
 2-4 times a month = 3  
 More than 5 times a month = 4

- 2.1 Medical practitioner. **G2.1**
- 2.2 The social worker. **G2.2**
- 2.3 Physiotherapist. **G2.3**
- 2.4 Dietician. **G2.4**
- 2.5 Ophthalmologist. **G2.5**
- 2.6 Dentist. **G2.6**

**3 How often do you need the services of the following members of the multi-disciplinary team to render quality PHC services?**

Key: Never = 1  
 At least once a month = 2  
 At least once a week = 3  
 Almost every day = 4

3.1 Medical practitioner.

G3.1

3.2 The social worker.

G3.2

3.3 Physiotherapist.

G3.3

3.4 Dietician.

G3.4

3.5 Ophthalmologist.

G3.5

3.6 Dentist.

G3.6

**3 Please list other problems related to multi-disciplinary staff that hinder the provision of quality PHC. (G4)**

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## **SECTION I – PROBLEMS RELATED TO PATIENTS**

**1 To what extent do the following patient related issues hinder the rendering of quality PHC services?**

Use the key that best describes the situation in your institution.

Key: Seriously interferes	=	1
Interferes to a certain extent	=	2
Problem exist, but does not hinder service	=	3
This problem does not exist	=	4

1.1 Cultural related issues of patients.

I1.1

1.2 Apathy of members of community.

I1.2

1.3 Patients do not keep to stipulated clinic hours.

I1.3

- |      |  |       |                      |
|------|--|-------|----------------------|
| 1.4  | Patient complaints.  | I1.4  | <input type="text"/> |
| 1.5  | Patients see a traditional healer before they visit the clinic.                | I1.5  | <input type="text"/> |
| 1.6  | Patients do not visit the clinic with the first symptoms of a disease.         | I1.6  | <input type="text"/> |
| 1.7  | Patients are poorly informed about their condition.                            | I1.7  | <input type="text"/> |
| 1.8  | Non-compliance to prescribed treatment.  | I1.8  | <input type="text"/> |
| 1.9  | The prevalence rate of HIV/Aids.   | I1.9  | <input type="text"/> |
| 1.10 | The prevalence rate of tuberculosis.   | I1.10 | <input type="text"/> |
| 1.11 | Low literacy rate of patients.   | I1.11 | <input type="text"/> |
| 1.12 | Non adherence to return (dates) appointments for chronic conditions.           | I1.12 | <input type="text"/> |
| 1.13 | Inability of patients to provide a proper history of their condition.          | I1.13 | <input type="text"/> |
| 1.14 | Patients' misuse of prescribed medication.                                     | I1.14 | <input type="text"/> |
| 1.15 | The use of over-the-counter-medication with prescribed medication.             | I1.15 | <input type="text"/> |
| 1.16 | Patients attend more than one clinic during the same visit to the PHC service. | I1.16 | <input type="text"/> |
| 1.17 | Patients threatening behaviour towards nurses.                                 | I1.17 | <input type="text"/> |

## 2 To what extent do you agree with the following statements?

Use the key that best describes the situation in your institution.

Key:	Always	=	1
	Often	=	2
	Seldom	=	3
	Never	=	4



- 2.1 Patients do not complain without reason about the service they receive. **I2.1**
- 2.2 The complaints of patients are immediately dealt with. **I2.2**
- 2.3 A survey of patient satisfaction is conducted. **I2.3**
- 2.4 Patients return to the clinic more than once for the same acute complaint before it is resolved. **I2.4**
- 2.5 The literacy rate of patient does make a difference to the prevalence rate of diseases in this community. **I2.5**
- 2.6 The policy of free health services cause patients to visit clinic without legitimate reasons. **I2.6**
- 2.7 Members of the community are invited to become involved in the activities of the PHC service. **I2.7**
- 2.8 Members of the community are actively involved in the activities of the PHC service. **I2.8**

**3 Indicate how many hours on average a patient has to wait to be seen by a health professional in your clinic.**

Key: Less than 1 hour = 1  
 Between 1-2 hours = 2  
 Between 2-3 hours = 3  
 Between 3-4 hours = 4  
 More than 4 hours = 5

**I3**

## **SECTION J – RATING OF THE SERIOUSNESS OF PROBLEMS IN THE PHC SERVICE**

**Please place the following problems that hinder the rendering of quality PHC service in order of seriousness. (1 most serious --- 8 less serious).**

<b>1</b>	<b>PERSONNEL RELATED ISSUES</b>	<b>J1</b>	<input type="text"/>
<b>2</b>	<b>MANAGERIAL ISSUES</b>	<b>J2</b>	<input type="text"/>
<b>3</b>	<b>SUPPLIES AND EQUIPMENT</b>	<b>J3</b>	<input type="text"/>
<b>4</b>	<b>INFRASTRUCTURE</b>	<b>J4</b>	<input type="text"/>
<b>5</b>	<b>REFERRAL SYSTEM</b>	<b>J5</b>	<input type="text"/>
<b>6</b>	<b>TRAINING ISSUES</b>	<b>J6</b>	<input type="text"/>
<b>7</b>	<b>MULTI-DISCIPLINARY TEAM</b>	<b>J7</b>	<input type="text"/>
<b>8</b>	<b>ISSUES RELATED TO THE PATIENTS</b>	<b>J8</b>	<input type="text"/>

**THANK YOU FOR YOUR TIME AND PARTICIPATION IN THIS RESEARCH.  
SHOULD YOU HAVE ANY OTHER COMMENTS OR RECOMMENDATIONS TO  
IMPROVE THE PROVISION OF PHC, PLEASE SHARE IT WITH THE  
RESEARCHER.**

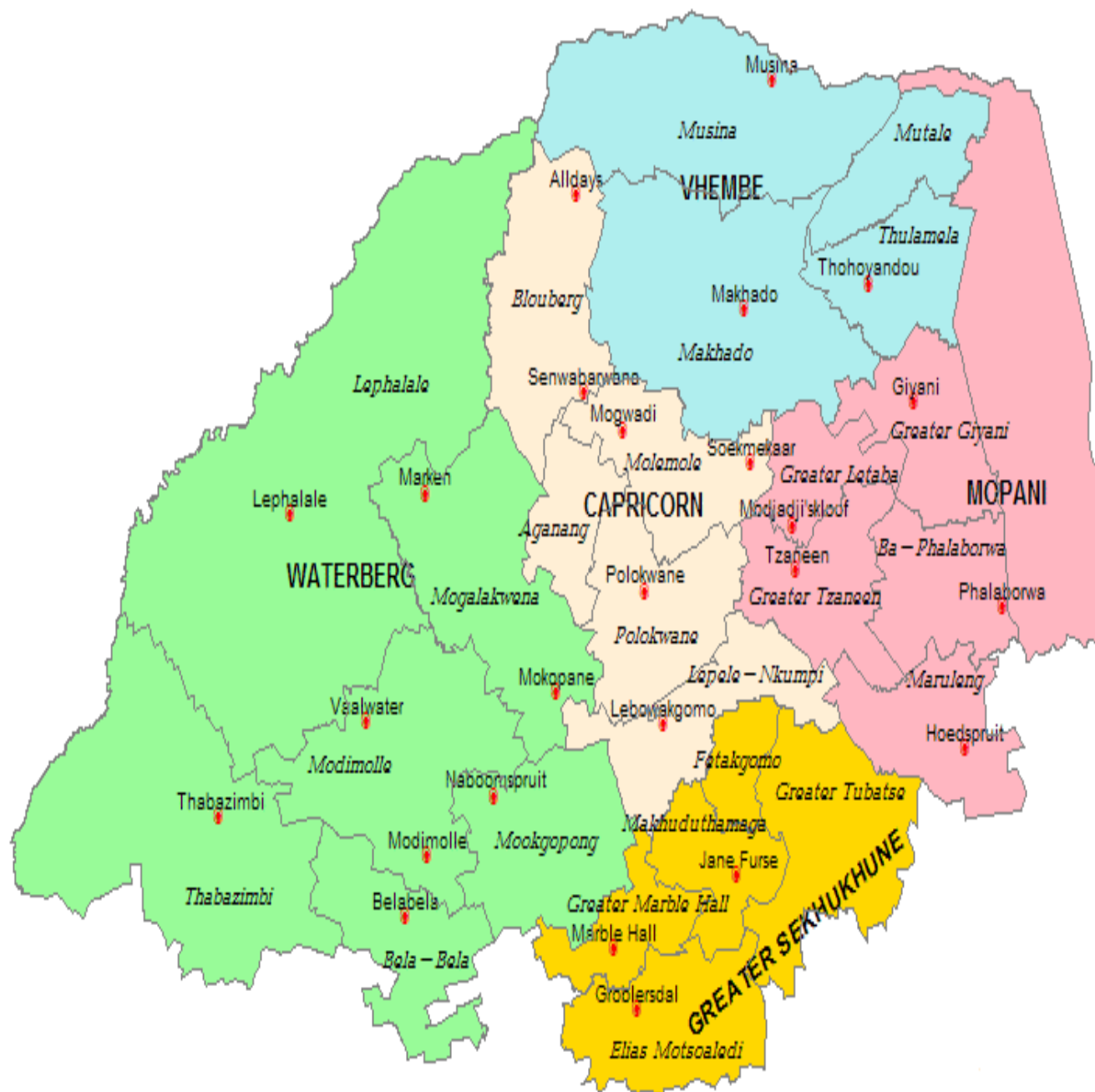
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# **ANNEXURE I**

## **MAPS**



**MAP OF SOUTH AFRICA**



**MAP OF THE DISTRICTS OF LIMPOPO PROVINCE**