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THE PERCEPTION OF COMMUNITY MEMBERS OF THE QUALITY OF CARE RENDERED IN LIMPOPO, IN TERMS OF THE *BATHO PELE* PRINCIPLES.

by

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DEDICATION

To my mother, **Augoster Maledile Marokane**,

who instilled a sense of responsibility and hard work in me and

motivated me to become the person I am today.

Thank you, Ma.

Student number: 571-757-4

DECLARATION

I declare *that* ***The perception of community member of the quality of care rendered in Limpopo, in terms of the Batho Pele principles*** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

…….. ……..
Elizabeth Mmalehu Legodi Date

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The Sotho have a saying, *Motho ke motho ka batho babangwe* ("A person is a person because of others"). The same can be said of a dissertation because many hands and hearts touch it in its conception and production. Therefore my grateful thanks and appreciation to

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ABSTRACT

The purpose of the study was to describe and explore the provision of quality care in the primary health care clinics of Limpopo within the framework of the *Batho Pele* principles' service standards by determining the level of implementation of these principles. The aim was to improve compliance with the Batho Pele principles. The researcher conducted a quantitative, exploratory and descriptive study in four selected primary health care clinics. Data collection was done using structured questionnaires for interviews and observation. Two groups of respondents participated in the study, namely patients (n=185) and nurses (n=21). The study highlighted the level of implementation of the *Batho Pele* principles in four primary health care clinics in the Capricorn District, Limpopo. The findings revealed that the *Batho Pele* principles were regarded as important criteria to assess quality care. Recommendations were made to improve the level of implementation of some of the principles.

KEY CONCEPTS
Primary health care clinics; patients; nurses; *Batho Pele* principles; perceptions; quality care

CHAPTER 1

Orientation to the study

1.1. INTRODUCTION

Quality of care is a primary concern for health care providers and consumers. Measuring quality care has become an essential goal to justify organisations' existence. Customers are increasingly demanding quality care in the knowledge that they have a right to receive health services that are satisfactory (Al-Ahmadi & Roland, 2005; Leon, 2003; Williams, Schutte-Aine & le Roux, 2002).

Quality improvement has become essential in all health sectors today. Health institutions are required to have domain-specific standards and ensure that they are effectively implemented, in an attempt to improve quality and meet client's needs. Specialised health services are increasingly becoming an expensive commodity, which has a direct bearing on government health expenditure. This commodity has become almost unaffordable for the majority of South Africans and makes primary health care (PHC) services more relevant in that services are offered free of charge (Blackie, Appleby & Orr 2000:6).

The Government's role is to ensure that health services become accessible and affordable to all citizens of South Africa. Accordingly, the Government introduced a National Health System (NHS) for the provision of health services with the PHC clinic as first-line entry to service delivery (ANC 1994:10). In PHC, community members are encouraged to take charge of their health. PHC services are offered free of charge and community members are encouraged to utilize them (Blackie, Appleby & Orr 2000:6).

In 1997, in an effort to improve the quality and accessibility of all public services, including health care 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 Department of Health (DOH) introduced the White Paper for the Transformation of the Health System in South Africa. In 1999, the Patients' Rights Charter was adopted (DOH 2000:33). The question is whether PHC services have been transformed to a level that provides quality care as defined by these policies and have also become more accessible and acceptable to community members. Accordingly, the researcher wished to determine the level of implementation of the *Batho Pele* principles in the PHC clinics in Limpopo.

1.2 **BACKGROUND TO THE STUDY**

The *Batho Pele* principles (Sotho for "Putting people first") were introduced as part of public policy in 1997 (DPSA 1997:13). The aim was to transform public service delivery so as to provide quality service and care. The implementation of the *Batho Pele* service standards was made mandatory in all public service institutions in order to deliver quality service in the public sector (DPSA 1997:13).

The *Batho Pele* initiative was driven by the fact that public services were characterised by a lack of access to services, transparency, openness, accurate and simple information on services and standards, and responsiveness, together with insensitivity to clients and poor service standards. PHC was no exception to this problem. The aim of the *Batho Pele* approach was to introduce standards that put pressure on delivery systems, to change attitudes and behaviours within the public service to be more client oriented, and to improve the quality of service delivery. It was also intended to re-orientate the public service in customer favour, an approach which puts people first (DPSA 1997:13).

Since the introduction of the *Batho Pele* principles, monitoring strategies to determine the levels of implementation and the effect of these principles have not been established. In health services, in particular, it would be valuable to assess the implementation of these principles.

1.3. **THE BATHO PELE PRINCIPLES**

The *Batho Pele* ("Putting people first") principles, developed in the Department of Public Service and Administration to improve service delivery in the public sector, were used as a theoretical framework for the study. These principles were published in the White Paper on Transforming Public Service Delivery, also known as the *Batho Pele* document, and provide policy guidelines and implementation strategies for the transformation of public service delivery (DPSA 1997:1). The *Batho Pele* document complements the Constitution of South Africa, 1996, the Medicines and Related Substances Control Amendment Act,1997, the Patients' Rights Charter,1999, the Public Finance Management Act,1999 , the Choice on Termination of Pregnancy Act, 1996 and the National Health Bill, 2000.

In the context of this study, quality of care refers to meeting customers' needs or expectations stated or implied by consistently applying or adhering to the *Batho Pele* principles in all activities carried out by PHC service providers. These principles, therefore, guide health workers' activities to establish a satisfied health consumer community.

The *Batho Pele* principles cover consultation, service standards, accessibility, courtesy, information, openness and transparency, redress, and giving value for money (DPSA 1997:5).

1.3.1. **Consultation**

Consultation requires all PHC nurses to consult clients/customers about their needs and how these needs could be met. Customers know their needs and expectations best and should be included, consulted and informed throughout service delivery. Consulting with clients implies that sufficient time should be available to listen to, inform, verify and communicate with clients.

1.3.2. **Service standards**

Service standards provide criteria against which the quality of service can be measured. Standards should be realistic, attainable with the available resources, and utilized at regular intervals in PHC clinics to determine and improve the quality of service delivery. Service standards further serve to create realistic expectations for customers.

1.3.3. **Accessibility**

Accessibility of services in PHC clinics includes the distance that clients have to travel for the services, availability of the services in terms of times of day, availability of necessary equipment and supplies, access to information in terms of public servants who can converse in their own language, and accessibility of buildings, toilets and public areas to people with special needs such as disabilities.

1.3.4. **Courtesy**

Courtesy incorporates basic social values, such as being friendly, polite and helpful, and treating everyone with dignity and respect, no matter who they are. Nurses in PHC clinics are expected to display a code of conduct that commits service

providers to these values and rules. All PHC nurses should be continuously sensitised to these values. Strategies should be established for peers and clients to assess the level of adherence to these values.

1.3.5. **Information**

The principle of information includes the intention to provide clients with the necessary information to make informed decisions about their own needs, information about the nature and extent of service provision, and information about their own roles, rights and responsibilities to establish service delivery of high levels of quality and satisfaction. Information could be conveyed through face-to-face communication, telephonically or electronically, posters, leaflets, newspapers and newsletters, as well as radio and television. Information should be provided in a language that the customers can understand and at a level that is easily understood.

1.3.6. **Openness and transparency**

PHC nurses should be open and honest about what they do and how they work. They should tell customers what the resources are, how money is spent and how well the work is done. PHC nurses should be honest about positive and negative aspects and how they plan to improve services in the future. Open days, information brochures and openly displayed statistics contribute to openness and transparency.

1.3.7. **Redress**

"Redress" or righting the wrongs creates an opportunity for growth, development and improvement. This implies that strategies should be in place in PHC clinics for individuals and groups to complain, make suggestions, and contribute to a better

understanding of both needs and expectations. Through their attitude and service, PHC nurses should create an atmosphere that makes it easy for customers to tell them what they are not happy with and how they can improve. It is crucial to create two-way communication in this regard; complaints should be addressed as soon as possible and suggestions acknowledged and followed up.

1.3.8. **Giving value**

Giving value for money is about giving customers the best service in the most efficient way. PHC nurses should avoid wasting resources and eliminate fraud and corruption. Money can be saved by doing things right the first time as well as by forming partnerships with other service providers. Working together as a team helps to make sure the best possible service and value for money is given.

1.4 PROBLEM STATEMENT

The philosophy underpinning the *Batho Pele* service delivery principles is based on active community involvement and client satisfaction. The implementation of these principles impacts on the quality of care provided and the level of client satisfaction.

1.5 PURPOSE OF THE STUDY

The purpose of the study was to explore and describe community members' perceptions of the level of implementation of the *Batho Pele* principles in PHC settings in Limpopo. The aim was to improve compliance with these principles, which would positively improve quality of care, accessibility, acceptability and utilization of the PHC services.

1.6. **OBJECTIVES**

The objectives of the study were to

Explore and describe the extent to which the *Batho Pele* principles have been implemented in four clinics in the Capricorn Health District, Limpopo.
Determine the level of importance of the *Batho Pele* principles to nurses and health care consumers, respectively.

1.7 **RESEARCH QUESTIONS**

In order to achieve the objectives, the following questions guided the study:

To what extent have the *Batho Pele* principles been implemented in the four selected PHC clinics in the Capricorn Health District?
How important are these principles to nurses and clients, respectively?

1.8 **SIGNIFICANCE OF THE STUDY**

The findings would indicate the extent to which the *Batho Pele* principles had been implemented in the Capricorn Health District as well as their importance to patients and patient satisfaction. In addition, community members would have an opportunity to evaluate the level of quality care provided in the clinics in terms of the *Batho Pele* principles.

1.9 RESEARCH DESIGN AND METHODOLOGY

The researcher adopted a quantitative approach, using an exploratory and descriptive design (see chapter 3 for methodology).

The study was conducted in the Capricorn District of Limpopo, a province in the northern part of South Africa. Limpopo has a population of about 5, 4 million people (Limpopo News 2004:2). Limpopo is demarcated into five districts namely Capricorn, Waterberg, Mopane, Vhembe and Sekhukhune. Capricorn District consists of five (5) sub-districts also known as municipalities, namely Aganang, Blouberg, Lepelle-Nkumpi, Molemole and Polokwane. There are seventy-seven (77) clinics and two (2) health care centres.

For the purpose of this study, four clinics were randomly selected: one from Molemole sub-district, one from Lepelle-Nkumpi sub-district, and two from Polokwane sub-district. For purposes of comparison, two of the clinics were in rural areas and two were in urban areas.

1.9.1 **Population and sample**

The study population for this study consisted of clients utilising the services of the selected clinics in the Capricorn health district and nurses providing the PHC services in these clinics.

A census population of nurses on duty on the day of data collection was included in the study and a non-probability convenience sample of clients was selected (see chapter 3 for sampling).

1.9.2 **Data collection**

Data was collected mainly through structured interviews with nurses and patients. The data was verified by observation of the interaction between nurses and patients. An observation guide was used to record these observations. Field notes based on informal discussions with both clients and nurses complemented the data. The researcher visited each of the four clinics three times on separate days to obtain data, by observing the nurses, and interviewing the clients and the nurses. The researcher interviewed the nurses on the first visit and the clients on the second visit, and observed the interaction between nurses and clients on the third visit.

1.9.3 **Data analysis**

Data analysis is "the process of bringing order, structure and meaning to the mass of collected data" (Marshall & Rossman 1995:111). Data analysis usually begins when data collection begins. Data analysis is conducted to reduce, organise and give meaning to the data. In this study, descriptive and inferential analysis techniques were used. The analysis techniques implemented are determined primarily by the research objectives, questions or hypothesis (Burns & Grove 1999:43). A statistician analysed the data, using the Statistical Package for Social Sciences (SPSS) version 15 program.

1.10. **RELIABILITY AND VALIDITY**

The quality of a research instrument is determined by its validity and reliability.

Validity is the degree to which an instrument measures what it is supposed to be

measuring (Uys & Basson 1995:80). Validity was ensured by

- Requesting professional nurses working in PHC clinics not included in the study to assess the construct validity of the instruments.
- Testing the interview guide with student nurses at Mankweng Hospital to determine the clarity and specificity of questions.
- Constructing the questionnaire according to the objectives of the study and organising it according to the literature review.
- Giving the questionnaire to the supervisor for review.
- Using the services of a statistician to check whether the questionnaire was in line with the objectives of the study.

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).

Brink (1990:157) describes reliability as the extent to which measures are consistent or repeatable over time.

1.11 **ETHICAL CONSIDERATIONS**

Ethics deals with matters of right and wrong. Collins English Dictionary (1991:533) defines ethics as "a social, religious, or civil code of behaviour considered correct, esp. that of a particular group, profession, or individual". In this study, the researcher respected the respondents' right to

Self-determination

Privacy

Anonymity

Confidentiality

Fair treatment and protection from harm and discomfort.

1.11.1. **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).

Explaining the purpose of the study, potential benefits, and potential risks, if any, to the participants, ensured the right to self-determination. The researcher also informed them that participation was voluntary, 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.

1.11.2 **Privacy**

Privacy is the freedom an individual has to determine the time, extent and general circumstances under which private information will be shared with or withheld from others (Burns & Grove1999:158).

Respondents' privacy is protected if informed consent to participate is given and signed voluntarily before sharing private information. Respondents' private conduct or thoughts should not later be misused to embarrass or humiliate them. The researcher only collected data absolutely necessary for achieving the objectives of the study.

The respondents' self-respect and dignity was maintained by not obtaining information of a private nature that was not related to the study.

1.11.3 **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 1990:51).

To ensure the respondents' anonymity, they were not asked to provide their names on the questionnaire. Instead, the researcher numbered the questionnaires.

The researcher emphasised that all information would be treated as strictly confidential and that respondents were allowed to share personal information to the extent they wished.

1.11.4 **Fair treatment**

The right to fair treatment is based on the ethical principle of justice. This principle requires that people be treated fairly and receive what is owed or due to them. The researcher ensured that the respondents were selected and treated fairly during the study.

The selection of the respondents was not based on cultural, racial, social and sexual biases but on relevance of the study. The researcher and the respondents had an agreement regarding the participation and the role of the researcher in the study.

Respondents were treated with respect and fairly.

1.11.5 **Protection from discomfort and harm**

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.

1.11.6. **Rights of the institution**

The rights of the institution were safeguarded by obtaining permission from the Research Committee of the Department of Health and Social Development in Limpopo (see annexure 1). The researcher also obtained permission from the institutions where the study was conducted (see annexure 2). The researcher ensured that

- Staff members would not be kept from doing their work during data collection, but would be interviewed during their lunch break.
- Confidentiality of data was maintained at all times.
- The research results would be made available to the Department at the end of the study.
- Information would be made available to all stakeholders without disclosing details of a particular clinic or respondent.

1.12 DEFINITION OF KEY TERMS

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

Perceptions

Collins English Dictionary (1991:1156) defines perception as "the act or the effect of perceiving; insight or intuition gained by perceiving; way of perceiving; awareness or consciousness; view".

In this study, perceptions refer to the respondents' beliefs and values regarding PHC services in terms of the *Batho Pele* principles.

Primary Health Care (PHC)

Primary Health Care (PHC) services refer to "an essential health care service, which is based on practical, scientifically sound and socially acceptable methods and technically made universally accessible to individuals and families in the community through their full participation and at the cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination" (ANC 1994:20).

In this study, PHC services refer to services rendered in the selected clinics in the Capricorn District where the study was conducted.

Community

A community refers to "the people living in one locality; a group of people having

cultural, religious, ethnic, or other characteristics in common; the public in general; society" (Collins English Dictionary 1991:327).

In this study, community refers to the clients utilising the PHC services provided in the Capricorn health district.

Health care providers

Health care providers refer to all professionals who are involved in the provision of health care to patients/clients and have a health background.
In this study, health care providers refer to the nurses in the selected PHC clinics only.

1.13 OUTLINE OF THE STUDY

Chapter 1 introduces the problem and outlines the purpose, objectives and significance of the study.
Chapter 2 discusses the literature review conducted for the study.
Chapter 3 describes the research design and methodology.
Chapter 4 covers the data analysis and interpretation.
Chapter 5 concludes the study, briefly discusses its limitations, and makes recommendations for practice and further research.

1.14 CONCLUSION

The level of implementation of the Batho Pele principles in PHC services plays a significant role in improving the quality and provision of care. This chapter provided an overview of the study, including the purpose, objectives and significance of the study; research design and methodology; population and sample;

data collection and analysis; validity and reliability, and ethical considerations.

Chapter 2 discusses the literature review undertaken by the researcher.

CHAPTER 2

Literature review

2.1 INTRODUCTION

The ultimate goal of the public service transformation programme is improving service delivery. This goal calls for new ways of working that put the needs of the public first and are more responsive to public needs than conventional bureaucratic systems, processes and attitudes (van Rensburg 2004:118).

Access to decent public services is not a privilege to be enjoyed by a few, but the rightful expectation of all citizens, especially those previously disadvantaged, hence the guiding principles of public transformation and reform, namely "Service to the people" (DPSA 1997:1). The Patients' Rights Charter states that patients have the right to access to health care, provision of health information, choice of health service provider or health facility, referral for second opinion, and to complain about health services (van Rensburg 2004:119). The Bill of Rights in Chapter 2, section 27 of the Constitution of South Africa, stipulates that everyone has the right to health care services including reproductive health care (South Africa 1996:13).

The aim of the *Batho Pele* principles is to progressively raise standards of service delivery, especially for those whose access to public services was previously limited and whose needs are greatest.

The transformation of Health Services is to be judged by the practical difference customers see in their everyday lives and in their interaction with health providers

(DPSA 1997:2).

Transformation of health services should be seen from various perspectives. Booyens (1993:580) states that quality is viewed from different perspectives. Patients view quality from the perspective of the care they receive and place a high premium on the provision of their immediate health requirements; professional practitioners view it in terms of the knowledge and skills involved in professional practice, while management attaches a financial value to quality. All these aspects need to be seriously taken into consideration if quality service is to be provided. In this study, the provision of quality services was evaluated according to the patients' and nurses' perceptions.

The researcher therefore conducted a literature review on the progress in the improvement of service delivery in the health system in South Africa with special reference to the PHC services in Limpopo since the adoption of the service delivery transformation and other policies aimed at transforming health services. The review covered the background to financing the PHC services in Limpopo as this directly affects provision of quality services; strategies to improve quality, and the evaluation of health service delivery.

2.2 HEALTH CARE SYSTEM IN SOUTH AFRICA

Health care systems refer to the organization and distribution of resources allocated for the delivery of health services (Stanhope & Lancaster 1993:23). In 1994, the African National Congress (ANC) introduced a single comprehensive, equitable and integrated National Health System into South Africa. A single government structure deals with health, based on national guidelines, priorities and standards. Government coordinates all aspects of public and private health care delivery, and is accountable to the people of South Africa (ANC 1994:19). The

provision of health care services is coordinated at local, district, provincial and national level. Authority, responsibility and control over funds is decentralized to the lowest level possible that is compatible with rational planning and the maintenance of quality care (ANC 1994:19).

Prior to 1994 the South African health system was built on apartheid ideology and characterized by racial and geographic disparities, fragmentation, duplication and hospi-centricism with lip service paid to the PHC approach. There were fourteen (14) departments of health, each with its own objectives. Access to health care for rural communities and those classified as Black was difficult. Besides the lack of facilities, the financial burden on funding facilities and payments for health services acted as barriers to access to care. Many rural hospitals had very limited access to medical doctors, and medicines were expensive and not always available at public health facilities (DOH 2004:3). The public services, including health services, were characterized by a lack of access to services, transparency, openness, accurate and simple information on services and standards, responsiveness and insensitivity to clients, and poor service standards (DPSA 1997:13).

After 1994 the government embarked on a process of transformation, building a culture of quality and efficiency throughout the health care system (DOH 2004::4).The *Batho Pele* principles were introduced as one of the strategies to transform public service delivery to build a culture of quality.

In 1994 the Government introduced the District Health System (DHS) through which the delivery of PHC was decentralized and managed. The DHS provided the health sector with a management framework that could deliver health care in a cost-effective and integrated manner (van Rensburg 2004:150).

There is a high level of unemployment in South Africa and the majority of South Africans depend on the public health system. The public health budget accounts for approximately 11% of the overall Government budget. South Africa spends about 8, 5% of its Gross Domestic Product (GDP) on health care services (DOH 2004:9).

In its effort to improve quality in the public health sector, the Government, transformed the public health system from a fragmented, racially divided, hospital-centred service with the emphasis on urban health needs, into an integrated, comprehensive national service driven by the need to redress historical inequities and give priority to disadvantaged people, especially those residing in the rural areas. Health care services changed from a curative to a preventative approach. Four hundred and ninety-five new clinics were built; 2 298 existing clinics received new equipment and were upgraded; 124 new visiting points were built and 125 new mobile clinics were purchased **(**DOH 2005:7-9).

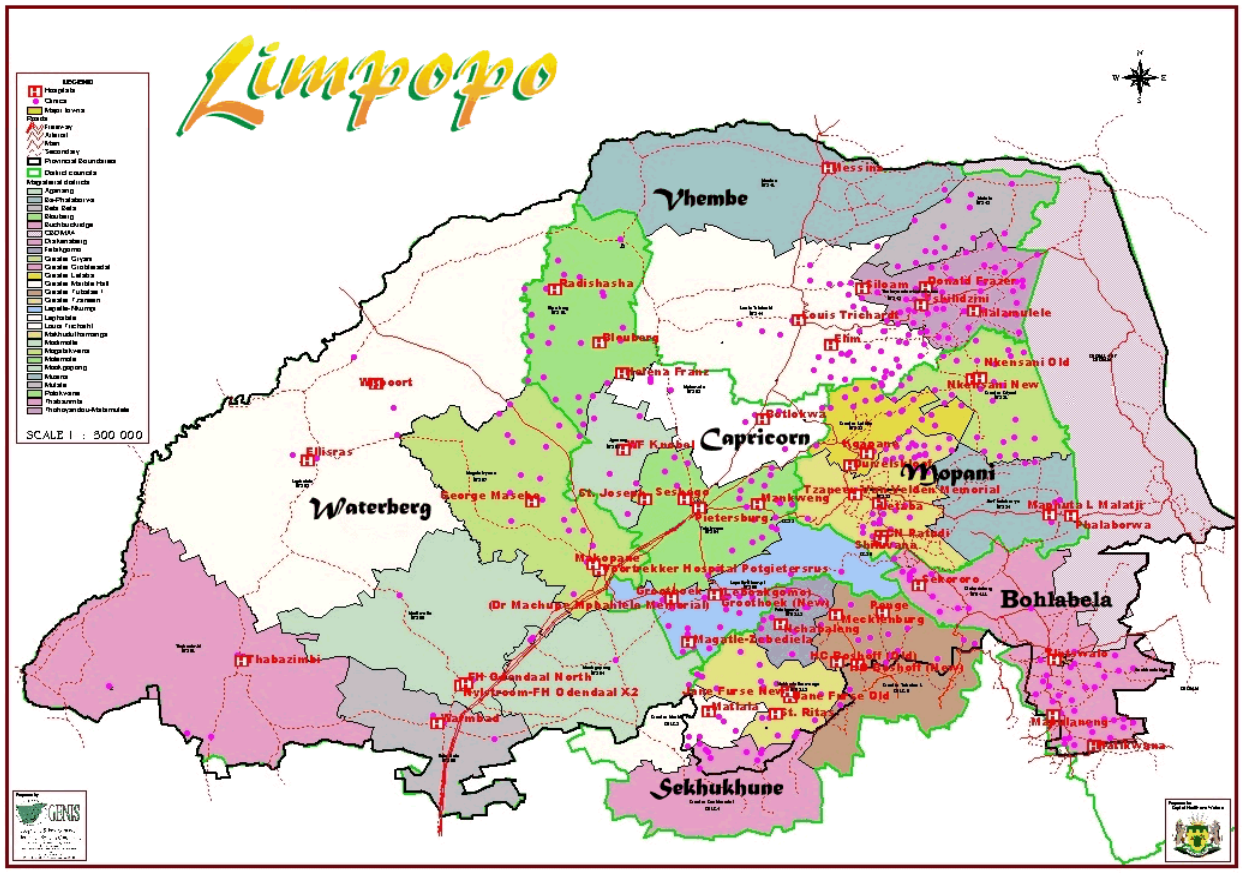
2.3 PHC SERVICES IN LIMPOPO

In 1978, the WHO defined PHC at the Alma Ata Conference as "an essential health care service based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at the cost that the community and the country can afford to maintain at every stage of their development in the spirit of self reliance and self-determination" (ANC 1994a:20).

Limpopo is a province situated in the northern part of South Africa and shares its borders with Mozambique in the east, Zimbabwe in the north and Botswana in the northwest (see figure 2.1**) (***www.doh.gov.za: 2008)*. Limpopo has a population of about 5, 4 million with unemployment rate of above 50% and is considered one of the poorest of the provinces, but is at the same time, one of the provinces with a

fast growing economy (*Limpopo News* 2004:2). The population of Limpopo consists of several ethnic groups distinguished by culture, language and race.

Figure 2.1 Map of Limpopo



Obtained from the Dept. of Health & Social Development Official Website: www.doh.gov.za.

Limpopo has had an average economic growth rate of more than five percent during the past eight years and contributes approximately 7% to national production. Limpopo's competitive advantage lies in agriculture, mining and tourism. Job creation has not increased at the same rate as economic growth and capital investment. Surveys indicated that the Province recently created approximately 5 000 new jobs in the formal sector, but that 20 000 persons enter the labour market each year. The unemployment situation is therefore deteriorating from its

already serious level of almost 50% (*Limpopo Financial Footprint* 2004:4).

The economic conditions in Limpopo make PHC services essential as more than 50% of the people are unemployed and depend entirely on free health care services provided in the PHC services **(***Limpopo Financial Footprint 2004:4).*

Limpopo is divided into five municipal districts, namely Capricorn, Waterberg, Sekhukhune, Mopane, and Vhembe, and further subdivided into twenty-five local municipalities also known as sub-districts. By late 2004, Limpopo had two hundred and eighty (280) PHC clinics, four new hospitals and twenty-seven new health centres. Sixty-three clinics had undergone large-scale upgrading, and many had been turned into 24-hour facilities (*Limpopo News* 2004:2).

In his 2005 budget speech, the MEC for Health and Social Development (DOHSD 2005:2) emphasised that PHC services remained "one of the crucial mandates the Department had to carry out in the past decade and it is with pride that 177 clinics were built and upgraded at a cost of R143 million between 1994 and 2004. One hundred and nine (109) of these were newly built and fitted with the required technologies that included computers, faxes and radios." Furthermore, the Department had managed to substantially increase the number of clinics rendering 24-hour services from 163 in 1994 to 292 in 2004 as well as 24-hour security to 355 clinics as a sign of commitment to increase accessibility of services (DOHSD 2005:2).

During the 2003/2004 financial year, the Limpopo local government implemented a fact-finding initiative of consulting communities to determine the impact of service delivery so as to inform the authorities of the state of health care

provision within the province. *Imbizos* ("mass meetings") and road shows enabled the local DOHSD to assess the level and impact of health care provided while also assisting them to focus on existing problems and to plan properly, putting funds and resources to the best possible use (*Limpopo News* 2004:2).

In 2005, the Department (DOHSD 2005:3) embarked on a comprehensive electrification audit at 203 clinics across the province, allocating an amount of R13.5 million for electrification and the provision of a reliable water supply. The water supply had previously had a negative impact on the delivery of health care with many clinics being without water. Presently, more than half have access to water and sanitation. R10 million is currently being put to use in providing the remaining clinics with access to water (*Limpopo News* 2004:2).

According to the Department (2004:2), the Limpopo health care system is well funded, with over R30 million having been injected into the provincial health facilities. The money has been earmarked primarily for the opening of more care centres so that citizens have improved access to quality health services. Funds will also be set aside to upgrade the overall quality of care received through the provision of more modern equipment and extra training for staff.
Approximately R43 million has been allocated for the maintenance and repair of medical equipment and buildings, and many hospitals are being generally upgraded.

Health for the elderly is a priority in Limpopo and PHC services have been introduced at pension pay points in Vhembe and Mopane Districts. These services will be rolled-out province wide (*Limpopo News* 2004:2).

Limpopo remains committed to its innovative HIV/AIDS projects, at hundreds of sites around the province, with access to voluntary HIV counselling and testing (VCT). Over 900 trained counsellors and rapid test kits are available and strategies

are in place to prevent mother-to-child transmission of HIV and AIDS (*Limpopo News* 2004:2).

2.4 THE CONTEXT OF THE STUDY

For the purpose of this study, three local municipalities in Capricorn District were randomly selected, namely Polokwane, Lepelle-Nkumpi and Molemole. One clinic each was selected from Lepelle-Nkumpi and Molemole and two clinics from Polokwane. For comparison purposes, two clinics were selected in Polokwane, which is situated in an urban area, while Lepelle-Nkumpi and Molemole are situated in the rural areas.

2.4.1 Buite Clinic

The Buite Clinic is situated in the city of Polokwane and serves communities from Westenburg, Rainbow Park, Ivy Park, Penina Park, Nirvana and Bo-dorp. The clinic has a staff complement of eight (8) registered nurses including the supervisor; no enrolled nurses and nursing assistants; two (2) cleaners and four (4) security guards. The clinic operates from Monday to Friday from 07h00 to 16h00. The average number of patients seen per day is 264 (Capricorn Health District 2007:10**)**

The clinic provides the following services: maternal and child health care; nutrition; immunization; reproductive health care; sexually transmitted illnesses (STI) treament; prevention of mother-to-child transmission (PMTCT) care; voluntary counselling and testing (VCT); mental health care; HIV/AIDS care and management; TB control; chronic disease management, such as asthma, arthritis, epilepsy, hypertension, diabetes mellitus, and chronic obstructive airway diseases, as well as treatment for all minor ailments. Ailments, which cannot be managed at

the clinic, are referred to the Pietersburg Hospital (Capricorn Health District 2007:14).

2.4.2 Rethabile Clinic

The Rethabile Clinic is situated in the city of Polokwane next to the Pietersburg Hospital and caters for all the suburbs in town. The clinic has a staff complement of 10 registered nurses and 4 enrolled nurses, 3 cleaners and 1 gardener.

The clinic provides the following services: maternal and child health care; nutrition; immunization; reproductive health care; sexually transmitted illnesses (STI) treatment; prevention of mother-to-child transmission (PMTCT) care; voluntary counselling and testing (VCT); mental health care; HIV/AIDS care and management; TB control; chronic disease management, such as asthma, arthritis, epilepsy, hypertension, diabetes mellitus, and chronic obstructive airway diseases, as well as all minor ailments. Ailments, which cannot be managed at the clinic, are referred to the Pietersburg Hospital. The clinic provides 24-hour services (Capricorn Health District 2007:12).

2.4.3 Unit R Clinic

The Unit R Clinic is situated in the Lebowa-kgomo Township, about 55 kilometres from Polokwane, and provides health services to all sections in Lebowa-kgomo as well as the nearby villages. The clinic has a staff complement of 7 registered nurses, 3 enrolled nurses and 2 nursing assistants. The clinic operates from Monday to Friday from 07h00 to 16h00,

and provides the following services: maternal and child health care; nutrition; immunization; reproductive health care; sexually transmitted illnesses (STI) treatment; prevention of mother-to-child transmission (PMTCT) care; voluntary

counselling and testing (VCT); mental health care; HIV/AIDS care and management; TB control; chronic disease management, such as asthma, arthritis, epilepsy, hypertension, diabetes mellitus, and chronic obstructive airway diseases, as well as all minor ailments. Ailments, which cannot be managed at the clinic, are referred to the Lebowa-Kgomo Hospital.

2.4.4 Ramokgopa Clinic

The Ramokgopa Clinic is situated in Ramokgopa village in Botlokwa, about 65 kilometres from Polokwane, and caters for the community in Ramokgopa village. The clinic has a staff complement of 6 registered nurses and 2 enrolled nurses.

The clinic provides the following services: maternal and child health care; nutrition; immunization; reproductive health care; sexually transmitted illnesses (STI) treatment; prevention of mother-to-child transmission (PMTCT) care; voluntary counselling and testing (VCT); mental health care; HIV/AIDS care and management; TB control; chronic disease management, such as asthma, arthritis, epilepsy, hypertension, diabetes mellitus, and chronic obstructive airway diseases, as well as all minor ailments. Ailments, which cannot be managed at the clinic, are referred to the Botlokwa Hospital

2.5 THE CONCEPT OF QUALITY

Health care professionals and organizations are committed to quality improvement. The establishment of specific quality assurance units in government organizations is an indication of the commitment to quality improvement (DOH 2001:50). Quality improvement programmes aimed at improving the provision of health care and ensuring the implementation of set standards as set out in the *Batho Pele* policy framework have been developed.

Schroeder (1994:ix) maintains that quality improvement has the potential to create a new paradigm for health care delivery. Furthermore, quality improvement is a powerful tool to positively change care and service, yet it is not fast, not foolproof, and not without a need for major investment in people and other resources. Schroeder (1994:ix) emphasises that quality improvement must be considered a science and a process that requires personal and organizational commitment, continuous critical thinking and a willingness to create change to meet the needs of patients, families and other customers.

The *Batho Pele* service standards are another strategy aimed at quality improvement that also require the commitment of the management and the willingness of the frontline service providers to implement change so as to improve quality. In this study, quality refers to meeting the patients' needs or expectations stated or implied by consistently applying or adhering to the *Batho Pele* principles in all the activities carried out by the service providers in the PHC services.

Collins English Dictionary (1991:1268) defines quality as "a distinguishing characteristic, property, or attribute; degree or standard of excellence, esp. a high standard". McCloskey and Grace (1990:243) describe quality as a degree of conformance to present standards.

Oakland (2000:4) defines quality as

- Fitness for purpose
- The totality of features and characteristics of a product or service that bear on its ability to satisfy stated or implied needs.
- Conformance to requirements
- Quality should be aimed at the needs of the consumers, present and future.

- The total composite product and service characteristics of marketing, engineering, manufacture and maintenance through which the products and service in use meet the customers' expectations.

Baker and Lee (1997:10) refer to Crosby's definition of quality as conformance to requirements, adding further that a quality service is not one that meets all customers' wishes at any cost. For example, patients in hospital might want their own room, complete with private television and telephone. However, patients in public service institutions do not pay directly for the service therefore managers would probably decide whether the cost would justify the service.

The International Standards Organization (ISO) (Baker & Lee 1997:10) defines quality as "the totality of features and characteristics of a product or service that bears on its ability to satisfy stated or implied needs". The ISO adds that when customers come to a health service they simply want to get better as quickly and as painlessly as possible although they might not always know the exact treatment they need. Therefore, to meet the customers' needs one would need to tease out what exactly the customers' implied or stated needs are.

Spradley and Allender (1996:618) describe quality as "a relative term that defines something with high merits or excellence. Quality must be measured according to some standard or norm, and quality care means that services provided match the needs of the population, are technically correct, and achieve beneficial results."

Oakland (2000:4) emphasises that quality is the ability of the product or service to continue to meet the customers' requirements and reliability ranks with quality in importance in that it is the ability of the product or service to continue to meet their requirements.

Most of the above definitions refer to meeting customers' stated or implied needs. The main aim of quality improvement is to meet customers' expectations. The *Batho Pele* principles are the blueprint for the improvement of quality. If implemented correctly and consistently, they will ensure that customers take part in designing the quality they want within the achievable costs. In this study, the *Batho Pele* principles were used as norms to evaluate quality in order to find out from the clients what value they attached to each of the principles so as to define quality.

Blackie, Appleby and Orr (2000:202) define the nature of quality in PHC according to four dimensions that should characterise the service, namely effectiveness, equity, humanity and efficiency. Furthermore, these categories blend the perspective of the professional with that of patient or client and encompass social issues. According to Blackie et al (2000:202), professionals are largely, but not exclusively, concerned with clinical effectiveness as a measure of quality. Clients/patients view this from a different perspective and are concerned with the way care is carried out as well as outcomes.

Maxwell and Shaw (cited in Blackie et al 2000:204) state that quality in health care, whether at population or individual level, can be considered in terms of appropriateness, equity, accessibility, effectiveness, acceptability and efficiency.

The *Batho Pele* principles provide moral guidelines to regulate how public servants should do their work to provide service to the satisfaction of their customers. Proper implementation of these principles would improve service delivery and promote equity, accessibility, acceptability, effectiveness and efficiency.

2.6 QUALITY IMPROVEMENT

Quality improvement is the commitment and approach used to continuously improve every process in every part of an organization, with the intention of meeting and exceeding customers' expectations and outcomes. It stimulates individuals and teams to look at the way they deliver care and service, to identify the root causes of problems in the system, and then to innovate to make improvements. Quality improvement integrates strategic leadership, an empowered workforce, and a data-driven effort to refine one's product and service constantly. It is a long-term approach, established through incremental steps, which must be tailored to the organization's setting, service, people and customers (Schroeder 1994:3).

Booyens (1993:582) refers to quality assurance as a process for monitoring and improving the quality of patient care. Quality assurance "implies a guarantee of knowledge and competence by the practitioner, and an adequate service that provides value for money in accordance with the characteristics associated with excellence. Assurance further implies that certain formal quality control systems are in place. These systems are used to strictly monitor and assess the way in which standards are maintained, and to take remedial steps, if necessary. Quality assurance is therefore a formal system that assures that the patient will receive service of a certain quality" (Booyens 1993:582).

Deming (1993) believes that health services should shift their focus from quality assurance to quality improvement. Quality improvement refers to a system in which the quality of health service is formally monitored and assessed. It is, therefore, a planned programme in which the quality of service is objectively monitored and evaluated, opportunities for improvement are identified, and a mechanism is provided for taking remedial steps to bring about and maintain improvements (Booyens 1993:581).

Booyens (1993:581) states that quality also refers to specific criteria, which a service has to measure up to, and these criteria should be formulated according to the perspectives of the patient, the professional practitioner and the management.

The Joint Commission on Accreditation of Health Care Organizations has a slogan that says, "Do the right things right". Doing the right things means identifying customers' needs, converting them into agreed upon requirements, and aligning the work process so that the requirements are met. To do things right means executing the work process in a way that meets the requirements (Booyens 1993:581).

2.6.1 Major concepts of quality improvement

The main concepts of quality improvement, irrespective of the model, include organizational mission, continuous improvement, empowerment, customer orientation, leadership commitment, collaboration/crossing boundaries, focus on processes, and data and statistical thinking.

2.6.1.1 Organizational mission

Quality requires consistent efforts to achieve the organization's mission. The mission of any organization is its basic purpose and reason for being. If the mission is to be achieved, it must be articulated in the mission statement, understood by all members of the organization, valued, visible, and used consistently to guide all plans, goals and actions. Measurable quality goals linked to the mission must be identified in job descriptions, performance plans and departmental expectations. The alignment of people and efforts will move the organization in a consistent and positive direction (Schroeder 1994:5).

Incorporation of the *Batho Pele* principles into the PHC mission ensures commitment to quality improvement. They can be used as a vehicle to align the mission of PHC clinics as well as to articulate the mission to the workforce and customers through consultation, and information sharing to promote ownership.

2.6.1.2 Continuous improvement

Continuous improvement is grounded in the premise that every plan, every effort, every process can always be made better. Continuous improvement requires deep valuing of the customers, both internal and external. It also creates a different organization, replacing the traditional protection of the status quo with willingness even eagerness to change. Quality is not a destination but an ongoing journey (Schroeder 1994:6).

The *Batho Pele* principle of redress outlines how complaints should be dealt with. Customers' complaints and comments should be used to correct wrongs and improve service delivery in order to meet their expectations. The principles emphasise customer care and careful ongoing implementation, monitoring and evaluation will ensure continuous improvement in PHC clinics.

2.6.1.3 Empowerment

The rendering of quality care to patients necessitates the training of skilled health workers as well as establishing a culture that values lifelong learning and recognizes its role in improving quality (DOH 2001:40).

Quality improvement is grounded in the concept that people on the front line of the production or service delivery know their production and customers better

than anyone else. Empowerment may be viewed as placing decision-making as close as possible to the frontline of service, or helping others to use the personal, professional or situational power that they already possess. The key to improvement is to empower people through infrastructure that promotes increased participation and shared authority (Schroeder 1994:7).

Authorities in charge of PHC services should make sure that all health providers in PHC clinics are trained in the implementation of the *Batho Pele* principles. Training should be continuous and consistent, ongoing monitoring and evaluation done to ensure compliance. Health providers in PHC services should be conversant with the *Batho Pele* principles and all policies that support quality improvements.

2.6.1.4 Customer orientation

Quality is defined as meeting and exceeding customers' expectations. This involves a dramatic shift for health care, which previously defined quality solely from professional perspectives. All quality improvement initiatives emphasise identification of customers and their unique needs (Schroeder 1994:6).

Customers in the PHC services should be informed about the level of service provided. Realistic standards that are attainable with the available resources should be set after identifying customers' needs. Customers should be informed of the clinic standards, how the clinic functions, the resources available, and how to lodge complaints if their needs are not met. Customers should also be informed of their rights and responsibilities. Waiting times at the clinics should be clearly displayed for patients to know how long to wait.

2.6.1.5 Leadership commitment

The personal commitment and long-term involvement of senior managers in quality improvement is essential to emphasise the value and importance of quality, establishment of a pervasive commitment to quality that runs through all levels of the organization and allocation of resources and support for quality (Schroeder 1994:6)

PHC services need to be resourced adequately to enable the health care providers to adhere to the *Batho Pele* principles. Resources include adequate personnel, medicines, equipment and supplies. Leadership commitment has a significant impact on staff performance and adherence to the *Batho Pele* principles.

2.6.1 6 Collaboration/Crossing boundaries

A hallmark of quality improvement is the use of collaborative (multidisciplinary) teams to analyse and improve functions and processes. These teams, representing diverse disciplines, functions and viewpoints are able to identify different and at times simultaneous strategies necessary to improve (Schroeder 1994:7).

PHC services cannot function in isolation if they are committed to providing quality care. To succeed and be effective, they must form partnerships with other departments/services essential to the provision of quality services, such as the Departments of Water Affairs (provision of water), Public Transport (maintenance of roads), Eskom (provision of electricity), and Telkom (telephones/communication). Collaboration with other departments will enable PHC services to function effectively.

2.6.1.7 Focus on processes

Failure in quality commonly results from faulty processes. Processes are a series or set of actions carried out to achieve a certain result. Processes are usually complex, and linked to what preceded and what follows specific actions. Actions are rarely isolated; they first are related to inputs (Schroeder 1994:7).

Since 1997 all government departments are required to set service standards which will serve as national baselines and institutions may set standards which should serve as minimum norms and publish them. These standards should cover processes, such as length of time to answer a telephone, maximum time a patient should wait at a PHC clinic before being seen and others. The standards must be precise and measurable so that users can judge for themselves (DPSA 1997:17).

Adherence to the *Batho Pele* principles will ensure that customers' stated or implied needs are met. Processes designed to guide health care providers to perform their duties should be simple and clear to facilitate delivery.

2.6.1.8 Data and statistical thinking

There is a need for data to improve quality for three reasons (Schroeder 1994:8):

- Data is essential to identify and describe process variation. Until one is able to clearly understand the process and make it consistent, there is little hope for improvement.
- Data must be accurate and put into proper context in order to be useful.
- One must take care not to depend on statistical methods alone to address quality.

Quality improvement requires continuous measurement of the most significant aspects of processes in an effort to gauge and improve people's performance and find ways to improve results. Measurement enables people to control and improve processes. But measurement cannot be considered an end in itself. The analysis and use of critical and statistical thinking provides opportunity for improvement. Care must be taken to consider data and statistical tools as a strategy to tailor actions, rather than as the desired outcome (Schroeder 1994:9).

Institutions are required to measure performance against set standards and results published at least once a year and more frequently where appropriate. These are essential tools to track improvement in services from year to year, and to inform subsequent decisions about the level to which standards should be raised in future (DPSA 1997:17). Data and statistical tools are used for this purpose.

PHC clinics are required to compile a statistical report on how well they are doing to see whether the services are efficient; that is, making any impact on the lives of the community members. Statistics include the number of patients seen, services provided, patients referred to the second level of care, cure rate of certain diseases, and the number of births and deaths.

2.7 APPLICATION OF QUALITY IMPROVEMENT TO HEALTH CARE

Health care management struggles to integrate its conflicting demands and move towards a more effective and efficient care delivery system. Quality improvement may be the vehicle needed to do so (Schroeder 1994:9). Components of the quality function include standards and guidelines; performance appraisal; interdisciplinary assessment and improvement; interdisciplinary quality improvement teams;

interdisciplinary quality improvement teams; organizational culture, and interorganizational benchmarking.

2.7.1 Standards and guidelines

Standards and guidelines are "tools that reflect the vision, values and context for care and service. They are needed to establish consistent expectations and pattern for practice, to articulate what we do, both when we are talking with colleagues and when we are talking with consumers, serve as a framework against which we measure, with intent to constantly improve" (Schroeder 1994:10).

Standards and guidelines should be available in all PHC clinics to serve as a guide on how the service should be managed. The standards and guidelines should articulate what should be done, how and by whom in the PHC clinics, and also guide the implementation of the *Batho Pele* principles as well as the code of conduct.

2.7.2 Individual performance appraisal

Performance appraisal methods must include self-assessment, peer and leader feedback, data reflecting quality performance, and an action plan for further development (Schroeder 1994:10).

Implementation of *Batho Pele* principles should form part of the key performance areas of all health care providers in the PHC services. This would improve compliance with the implementation of the principles. Appraisals are done on a quarterly basis and both the supervisor and the supervisees should discuss performance. If positive results are not achieved, targets should be set for the next evaluation. People should receive feedback on their performance.

2.7.3 Interdisciplinary assessment and improvement

There will always be a need for groups to assess, analyse and improve their own performance (Schroeder 1994:10). There are many unit-and-departmental-specific systems that greatly influence care and service. Every department has quality issues that can be most efficiently addressed internally. Unit base quality improvement teams should focus on and coordinate the department's quality efforts to use the best measures, tools and techniques to analyse and improve care and/or service (Schroeder 1994:10).

PHC services would benefit from joint assessment by all health care providers, including nurses, doctors, social workers, pharmacists and others involved in the provision of health care services. This would ensure a coordinated effort in the implementation of the *Batho Pele* principles. The performance of one group of professionals in the organization affects the performance of another group thereby affecting the overall quality provision. Consequently, it is important for all health care providers in the PHC services to be concerned about the performance of their co-workers.

2.7.4 Interdisciplinary quality improvement teams

Interdisciplinary quality improvements project teams are the hallmark of quality improvement initiatives. They are based on the premise that much of health care is interdependent and requires collaboration across departmental boundaries to analyse and improve. Interdisciplinary groups are formed to share perspectives and views, analyse cross-functional processes of care and service, and innovate to find better approaches to meet customer needs (Schroeder 1994:10).

Service providers from various departments should form teams to assess the provision of quality care in PHC services. This should include the departments of health, social development, finance, education, transport, and water affairs at local level, as their functions are interrelated. The performance of these departments would enable PHC health care providers to implement the *Batho Pele* principles effectively.

2.7.5 Organizational culture

Organizational culture, that is, the values, beliefs and norms of the organization that shape its behaviour, is a key variable affecting the capacity of any organization to improve its performance. Because improvement requires change, organizations that support innovation and are risk-taking are more likely to be able to undertake successful quality improvement efforts (Schroeder 1994:10).

Quality is not the result of a task, regulation or a committee, but of a synergy of people, values, behaviour and structures that are integrated and focused on the common goal. The establishment of a pervasive quality culture differentiates the winning organizations from the mediocre ones. Quality improvement in its truest sense requires a culture that links quality-related tasks, functions and structures with all people, elements and strategies of the organization (Schroeder 1994:10).

The organizational culture in PHC plays a major role in determining and attaining quality care. The organizational culture in PHC services should shape the behaviour of the health care providers to better understand the reason for the existence of the organization as well as the needs of the customers. The organizational culture in the PHC should be based on the implementation of the *Batho Pele* principles.

2.7.6 Interorganizational benchmarking

Striving for excellence requires organizations to do more than look within themselves to improve. They need to look beyond their walls, to other organizations that have created excellence in care and service. Benchmarking is the continuous process of measuring products, services and practices against the company's toughest competitors and against the companies recognized as industry leaders. Benchmarking allows one to gain realistic views of the highest achievements in service or care. It has been found to be an approach most effective in high performing organizations (Schroeder 1994:10).

PHC services should visit other organizations, then, to copy good practices especially those with a good reputation and good practices. This should be an ongoing activity measure the attainment of goals.

2.8 MEASUREMENT OF QUALITY

McCloskey and Grace (1990:243) refer to Macmillan, who views customer satisfaction as "an essential component in the measurement of quality health care. Universally the measurement of quality examines the attainment of predetermined norms and standards of health care."

Health care consumers and providers are the most important stakeholders in the measurement of quality service. Oakland (2000:5) states that the most critical stakeholders in the organization are health care consumers. The first concern of a company should be the happiness of people who are connected with it. If people do not feel happy and cannot be made happy, that company does not deserve to exist.

The first order of the business is to pay employees an adequate income. Their humanity must be respected, and they must be given the opportunity to enjoy their work and lead a happy life. In this study, both health care consumers and providers were used to measure quality in the PHC services. The *Batho Pele* principles were used as norms to determine the community's perception of the quality of care provided. The norms included the structure of the clinic, processes used in the clinic as well as the outcome of the treatment or service provided.

According to Donabedian's framework for the measurement of quality, quality of health care can be measured in three ways, namely structure standard, process standard and outcome standard (McCloskey & Grace 1990:243). These three are complementary and should be used in combination (McCloskey & Grace 1990:243; Ajavi 2005:32-33).

2.8.1 Structure standard

A standard is a description of the characteristics associated with excellence. Structure standard describes the composition of and the resources in a health service that makes the provision of service possible. Structure standard is concerned with the adequacy of facilities and equipment, the number, qualifications and experience of nursing personnel, the administrative structure and operations of a facility, and staff welfare, motivation and development. The assumption is that given the proper setting and instruments, quality care will follow.

2.8.2 Process standard

Process standard applies to the way in which a task should be executed. It involves those aspects or factors of the actual way the practice is conducted. In clinical nursing, a process standard usually follows a scientific approach to nursing, namely assessment, planning, implementation and evaluation. The process standard therefore implicitly describes the 'what' and 'how' of clinical practice.

2.8.3 Outcome or product standard

Outcome or product standard refers to the results that have to be achieved, for example health changes in a patient, such as control of pain among other things. The outcomes of nursing care in terms of recovery, restoration of function, and survival are frequently used as indicators of quality nursing care. Outcomes remain the ultimate indicators of the effectiveness and quality of nursing care. However, a number of considerations limit the use of outcomes as measures of quality of care in nursing. Many factors other than nursing care might influence the outcome and precaution must be taken to hold all significant variables other than nursing care if valid conclusions are to be drawn.

Various methods can be utilized to measure quality of service. These tools, namely direct observation, self-evaluation, auditing, peer group evaluation, incident monitoring, patient satisfaction level, development of evaluation instruments including the gathering, analysis and interpretation of data from, say, a complaint system, can be used to measure different aspects of quality in an organization.

In this study, provision of quality service was evaluated in the PHC services by measuring compliance with the *Batho Pele* principles. Different methods were used

to measure adherence to the principles. Using more than one method enhances the validity of data (Polit & Hungler 1997:54; Burns & Grove 1999.231). In this study, the researcher collected data by means of direct observation, interviews with both patients and nurses, and field notes to enhance validity (see chapter 3).

2.9 ASSESSMENT STRATEGIES

Quality can also be measured by means of auditing, self-evaluation, peer group evaluation, incident monitoring, patient satisfaction, development of evaluation instruments, gathering data and analysis and interpretation of data and a complaint system. Although these methods were not used in this study because of time and financial constraints, they are nevertheless briefly described.

2.9.1 Auditing

Auditing is an evaluation method for assessing the quality of nursing as reflected in hospital documents. There are two methods of auditing: continuous and retrospective auditing. Continuous auditing is carried out on a daily basis while retrospective auditing is carried out formally on completion of the patient's health treatment (Booyens 1993:603).

Auditing in PHC services has become inevitable due to increased awareness of quality issues as well as customers' demands for human rights and better services. Primary health care services are vested with the responsibility of providing holistic care at all times. Therefore continuous evaluation of the effectiveness of the services provided will ensure compliance with the implementation of the Batho Pele principles and that customers receive the agreed level of care.

2.9.2 Self-evaluation

Evaluation refers to the formal way in which information is gathered and assessed in relation to set standards and criteria. Evaluation requires measurement and measurement requires instruments (Booyens 1993:601).

Self-evaluation is the way in which nursing professionals determine their own level of competence. The effectiveness of this evaluation depends on individuals' personal goals, their self-perception and self-confidence, and their assessment abilities. Self-evaluation is a personal matter used for personal and professional development (Booyens 1993:601).

Self-evaluation should also form part of service evaluation in PHC services. Health professionals in PHC services should evaluate their effectiveness for personal growth that will benefit the organization as the skills will be used to provide quality care.

2.9.3 Peer group evaluation

Peer group evaluation is a process in which people's job performance is evaluated by members of the professional group to which they belong. The evaluation consists of critical debate and is informal. It provides direct feedback and the focus is on performance and not on personalities (Booyens 1993: 602).

Peer group evaluation should be used in the PHC services to evaluate the performance of all service providers. This could be an internal or external arrangement. The performance of individual service providers has an impact on the overall performance of the service. If the performance of all PHC service

providers is continuously evaluated and improved, the provision of quality care will be ensured.

2.9.4 Incident monitoring

Incident monitoring involves monitoring and evaluating negative incidents that are harmful to the quality of nursing. Incidents such as administration of wrong medication or incorrect identification and treatment of patients are recorded and assessed according to a stipulated policy and specific system (Booyens 1993:603). A record of negative incidents is compiled for evaluation by a risk team within the institution. The team should put forward proposals or recommendations to correct the situation.

Incident reporting in PHC services would assist in the evaluation of compliance with the *Batho Pele* principles. All negative incidents that compromise quality service delivery should be reported and corrected at the earliest possible time. A record of all incidents should be kept and should reflect how the incident was dealt with as well as the time it took to resolve the matter, as this has an impact on quality.

2.9.5 Client satisfaction

Conducting facility-based patient satisfaction surveys is one of the initiatives introduced by the DOH (2001:50) to improve quality.

Booyens (1993:603) defines client satisfaction as an instrumental component in monitoring the quality of health care in relation to costs and services. Furthermore, providers of health care must demonstrate that they deliver quality care at a reasonable price. Quality of care is the best assurance of a client's allegiance and health institutions must work hard to maintain a good reputation and

high community awareness.

Client satisfaction can be done through a survey or continuously during informal rounds or through direct communication with the client during health care or treatment (Booyens 1993:603).

2.10 PERCEPTION OF QUALITY

Baker and Lee (1997:22) refer to Berry's (1997) finding that consumers' perception of service quality results from a comparison of their expectations before they receive service to their actual experience of the service. Customers judge quality by comparing their perception of what they receive to their expectations of what they receive. Berry (1997) emphasises that quality of service or product is not just determined by customers' reaction to it, but also depends on customers' expectations (Baker & Lee 1997:22).

Quality perceptions are derived from the service process as well as the service outcome. For example, a woman who is admitted to a maternity unit will be happy to go back home with a healthy baby. Most importantly, however, she will remember for the rest of her life how she was treated throughout her stay in the unit.

There are two types of service quality, namely normal and exceptional. Quality begins with pleasing the customers. Customers must get what they want when and how they want it. An organization strives not only to satisfy customers' expectations but also to please them by giving them more than they imagined possible (Baker & Lee 1997:22).

Wallace, Robertson, Miller and Frisch (1999:1144) found that quality and quantity of care are classified into competence and environment.

2.10.1 Competence

Clients and families view quality care as care that is delivered by competent staff. One aspect of competence is the ability to deliver coordinated and continuous care. Wallace, Robertson, Miller & Frisch (1999:1144) found that being treated by the same physician was the most frequent comment made about the coordination and continuity of care.

Wallace et al (1999:1144) pointed out that patients evaluated professional competence by the use of medications, as well as the discharge planning. Families and clients viewed discharge planning as a preparatory exercise to a successful transition into the community. Competence related to the ability of the care team to plan and co-ordinate the discharge (Wallace et al 1999:1144).

In this study, competence referred to the service providers' adherence to the implementation of the *Batho Pele* principles. Competent service providers are conversant with the *Batho Pele* service standards and apply its principles continuously and consistently. They further coordinate their services to ensure continuity of care.

2.10.2 Environment

Environment is an important component in the process of recovery. A dirty, dark, depressing and bland environment with a lack of privacy, broken toilets and showers does not promote recovery (Wallace et al 1999:1153).

In this study, environment was categorized into physical, psychological and social environment. The physical environment was the same as described above and the

psychological environment included the courtesy the service providers displayed, the emotional support they provided, and the empathy they displayed. The social environment included aspects such as the service providers' interpersonal relationship, level of maturity, approach and courtesy to customers, and dress code. All these aspects are vital to customers' recovery.

In a study on user perceptions of health care delivery in selected rural and urban areas of three Central American countries, namely Honduras, Costa Rica and Panama, Leon (2003:67-71) found both positive and negative responses. The negative responses, mainly in Honduras, included long waiting periods to obtain appointments; high transportation costs to the centres; low quality and non-dignifying attention, especially to low socio-economic patients; over-crowding and loss of vital information; patients, especially female patients, having to share beds in hospitals, and patients' histories getting lost when referred to regional hospitals. The polyclinics in Costa Rica and Panama were well regarded, however, due to the presence of specialists and the perceived advanced technology. The major complaint about the quality of care in Costa Rica was lack of access to the services, especially hospital admission, because patients had to be critically ill before being considered for admission (Leon 2003:67-71).

Regarding users' expectations, Leon (2003:67-71) found that they wished to have increased attention from health care providers and improved personal attention from physicians; shorter waiting times; to receive medication timeously and to have specialist appointments. Measures recommended to improve quality in those areas included access to a doctor that the users could trust; improved information and education, which would promote better use of services; reduction of insecurity and anxiety; improved doctor-patient relations, and improving response to treatment and medication, which would lead to better prognosis (Leon 2003:67-71).

In a study on the quality of PHC services in Saudi Arabia in order to identify factors impeding the achievement of quality and determine how quality of PHC in Saudi Arabia could be improved, Al-Ahmad and Roland (2005:331-346) described the quality of PHC in terms of access to and effectiveness of care, including both clinical and interpersonal aspects of care. With regard to access, patients indicated dissatisfaction with waiting time, waiting areas and the physical environment; lack of medical facilities, language and cultural barriers, lack of information, high staff turnover, and obstacles to community participation (Al-Ahmad & Roland 2005:331)

Regarding effectiveness, the respondents expressed dissatisfaction with poor professional skills reflected in misdiagnosis or mismanagement of major chronic conditions, over prescribing because medications were provided free of charge, use of inappropriate medication in certain cases, overlooking of drug interactions, as well as prescriptions often lacking complete information such as dosage, strength, and duration of treatment (Al-Ahmad & Roland 2005:331).

Al-Ahmad and Roland (2005:331-346) found six barriers to quality of PHC in Saudi Arabia:

- **Management factors**, including scant information available on management functions at health centres; lack of managerial training of supervisors; high staff turnover; lack of independent decision making by supervisors; poor information; unclear lines of accountability; lack of qualified supervisors, and stressful working conditions

- **Organizational factors**, including poor information system; high staff turnover, and stressful work conditions.

- **Implementation of evidence-based medicine**, including poor dissemination of guidelines; limited access of physicians to the Internet; inappropriate clinical decisions, and unsafe prescribing patterns.

- **Interface with secondary care**, including illegible handwritten referral letters, and poor exchange of information between primary and secondary care providers. At the same time, however, the referral system in Saudi Arabia established in 1986 had improved coordination between PHC centres and hospitals and reduced the number of patient referrals to hospital.

- **Organizational culture**, including a need to reinforce a spirit of teamwork and support/promote positive attitudes among staff.

- **Professional development strategies**, including inadequate professional development strategies in PHC; lack of access to journals by physicians, and few physicians with post-graduate qualifications.

2.11 CONCLUSION

The promotion of quality remains an integral part of PHC nationally and internationally. Continuous assessment of community and consumer perceptions of the quality of care provided in the PHC services remains relevant if organizations are serious about promotion of quality care. Quality improvement in PHC services requires the support and commitment of all stakeholders. This involves the provision of adequate facilities, adequate staffing, proper skill mix, proper and functional equipment and instruments, good management skills, skilled service providers, as well as availability of standards and protocols.

This chapter discussed the literature review, which covered the provision and

financing of health care services in South Africa; definitions of quality; strategies to measure quality; quality improvement in health care today; the *Batho Pele* principles in relation to quality; assessment of quality, and barriers to quality PHC provision.

Chapter 3 describes the research design and methodology.

CHAPTER 3

Research design and methodology

3.1 INTRODUCTION

This chapter discusses the research design and methodology, including the population, sample, data collection and analysis, and the data-collection instruments.

3.2 PURPOSE

The purpose of the study was to explore and describe community members' perceptions of the level of implementation of the *Batho Pele* principles in PHC settings in Limpopo. The aim was to improve compliance with these principles, which would positively improve quality of care, accessibility, acceptability and utilization of the PHC services.

3.3 RESEARCH DESIGN AND METHODOLOGY

The researcher adopted a quantitative approach, using an exploratory and descriptive design in four selected PHC clinics in the Capricorn District of Limpopo.

3.3.1 Quantitative

Quantitative research is a vigorous, systematic process for generating information about the world. Quantitative research is conducted to describe new situations, events or concepts, to describe relationships among concepts or ideas, and to

determine the effectiveness of treatment on the health of families (Burns & Grove 1999:23). Quantitative research requires that data collected be expressed in numbers; that is, quantified (Struwig & Stead 2001:7).

3.3.2 Descriptive

Descriptive studies attempt to provide a complete and accurate description of a situation. They describe things such as the demographic characteristics of the users of a given product and the degree to which product use varies with income, age, sex (Struwig & Stead 2001:8).

This study attempted to determine community members' perceptions of the quality of PHC provided in terms of the *Batho Pele* principles.

3.3.3 Exploratory

Neuman (2000:510) describes exploratory research as "research into an area that has not been studied and in which a researcher wants to develop initial ideas and a more focused research question. During the exploratory research stage the researcher investigates a problem about which little is known. The major purpose of exploratory research is the development and clarification of ideas and the formulation of questions and hypotheses for more precise investigations later. This type of research involves gathering a great deal of information from a small sample."

The researcher conducted interviews with both clients and nurses to obtain information on the adherence to the *Batho Pele* principles and also observed the nurses during their interaction with patients in the selected clinics.

3.4 POPULATION AND SAMPLE

The population for this study consisted of *clients* utilising the services of the selected clinics in the Capricorn health district and *nurses* providing the PHC services in these clinics.

Sampling is "the process of selecting a portion of the population to represent the entire population" (Polit & Hungler 1995:278). A convenient sample was chosen of all the nurses working at the selected clinics as well as clients from the age of 18 years who visited the clinics and were willing to participate.

This study used convenience or non-probability, purposive sampling. Non-probability sampling has the potential to obtain high quality data. In non-probability sampling, the researcher objectively judges a likely starting point and decides on the direction the sampling will take as the study progresses (Brink 1996:125). This sampling method was selected because it was not possible to determine who would visit the clinic the following day. The sample size was one quarter (25%) of the total number of clients seen at each clinic. Brink and Wood (1998:131) point out that convenience or non-probability sampling may or may not accurately represent the population.

3.5 DATA COLLECTION AND DATA-COLLECTION INSTRUMENTS

Data was collected mainly through structured interviews with nurses and patients. The data was verified by observation of the interaction between nurses and patients. An observation guide was used to record these observations. Field notes based on informal discussions with both clients and nurses complemented the data.

The researcher selected observation and interviewing as data-collection instruments to measure the implementation of the *Batho Pele* principles as accurately as possible. The researcher observed the nurses treating and interacting with the patients, and conducted interviews with both nurses and patients, using a structured interview guide (questionnaire).

All four clinics were visited three times. During the first visit, all the nurses were interviewed in order to determine their perceptions of the importance and level of implementation of the *Batho Pele* principles. On the second visit, the researcher interviewed the clients, and on the last visit observation of the interaction between nurses and clients was done to verify the findings from the interviews.

3.5.1 Observation

Observation is a method of collecting descriptive behavioural data and is extremely useful in nursing studies because one can observe behaviour as it occurs. Observation has stopped being a normal part of life of everyday life and becomes a research method if it is systematically planned and recorded and if both observation and recordings are checked for their validity and reliability (Brink & Wood 1988:139).

Brink and Wood (1988:139) go on to say that observation "may be the only way to gather some kinds of data if information required cannot be obtained by asking questions, through other available records or by directly measuring some quality of subjects. Studying the behaviour of infants, psychiatric patients, and dying patients; examining the verbal or non-verbal interaction between individuals or within groups; looking to see if people behave as they say they will – all these are well suited to observation."

In nursing studies observation can provide a rich source of data that describes patient responses. Observation can be used alone or in combination with other methods, and will assist in interpreting the results obtained through other methods. For example, observation can be used in conjunction with interviewing to validate self-report information. In some instances, observation has been used when questionnaires or interviews could not be used because the subjects were not able to respond to questions such as infants, brain damaged people as well as foreigners who do not speak any of the local languages (Brink & Wood 1988:139).

Ajayi (2005:35) points out that while observation can generate considerable information because of its intensity, it also has serious limitations. The main limitation of participative or non-participative observation is the changes that are likely to occur in the usual practice of nurses who know that they are being observed. Furthermore, the observer's objectivity might constitute a threat to the technique. Using standardized checklists where possible could enhance such objectivity.

Observation can either be structured or unstructured. Unstructured observation can be used to describe the behaviour of nurses following an event or incident such as a patient's death. Such an observation would involve a complete description of everything the nurse says or does at that time, which would be virtually impossible.

Selectivity is bound to occur. This fact should be recognized if unstructured observation is used. Of particular value is the combination of both structured and unstructured observation (Brink & Wood 1988:145).

Structured observation can take several forms, but the most common is the checklist. The checklist allows the researcher to record whether or not a given behaviour occurs. In this study, observation was used to observe the ways in which nurses in the selected clinics implemented the *Batho Pele* principles.
Observation has the following limitations:

- If people are aware that their actions are being observed, they tend to behave differently.
- It may be very costly in that it is time consuming.
- It may also be perceived as an invasion of privacy.

The nurses were observed during their interactions with clients, using a checklist. This observational method of data collection was used to measure the level of implementation of principles such as consultation, courtesy, and provision of information, accessibility and value for money. The observation was direct and conducted in a natural environment. A checklist was used to enhance the objectivity of the data collected.

3.5.2 Questionnaire and interview

A structured data-collection approach was adopted, using an interview schedule or questionnaire (see annexure 4 and 5). The structured approach was chosen because it "yields data that is easy to analyse and does not require much effort from the respondents" (Polit & Hungler 1993:202).

A questionnaire is "a formal, written document in which respondents complete the instrument themselves in a paper-and-pencil format. When the same questions are asked orally in a face-to-face or telephone format, it is called an interview" (Polit & Hungler 1993:202).

Brink and Wood (1988:146) state that questionnaires and interviews are "the easiest and most effective methods when the objective of the study is to find out what people believe or think. The purpose of asking questions is to find out what is going on in people's heads; that is, their perceptions, attitudes, beliefs, feelings, motives, plans, and past events."

The main difference between questionnaires and interviews is the presence of an interviewer. In questionnaires, responses are limited to answers to predetermined questions while in interviews the interviewer is present with the subject and there is an opportunity to collect nonverbal data as well and to clarify the meaning of questions if subjects do not understand (Brink & Wood 1988:146).

The researcher conducted face-to-face interviews with both nurses and patients, using structured questionnaires as a tool for data collection. Structured interview schedules, consisting mainly of closed questions, were considered a suitable tool. Two interview guides were used: one to evaluate the nurses' knowledge of and compliance with the *Batho Pele* principles, and one to determine the patients' perceptions of the acceptable level of quality of care provided in the clinics as well as to determine acceptable norms. Field notes were also taken.

The researcher chose interviews for the following reasons (Polit & Hungler 1995:205; Babbie & Mouton 2001:258; Brink 1996:153):

- Interviews yield a high response rate.

- Interviews are feasible with most people.
- In face-to-face interviews respondents are less reluctant to refuse to participate while it is easy to ignore a mailed questionnaire.
- Respondents are less prone to misinterpret questions because the interviewer is present to determine whether questions have been misunderstood.
- Respondents do not have to be literate and researchers can explain and clarify questions for them.
- They are easy to administer and analyse.
- They yield a high degree of consistency for comparative purposes.
- The same information is collected from all respondents.

3.6. **RELIABILITY AND VALIDITY**

The quality of research and research instruments is determined by their validity and reliability. In this study, the researcher adhered to the principles of reliability and validity.

3.6.1. **Validity and reliability of the study**

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". Validity provides the chief basis for making decisions about which findings are useful.

The researcher ensured the validity and reliability of the study by means of the following (Polit & Hungler 1995:31, 246):

- Undertaking an extensive literature review.

- Giving operational definitions of concepts, which are specifications of the operations that the researcher must perform to collect the required information.
- Ensuring congruency between the research questions, objectives, investigations, findings and recommendations.

3.6.2 **Reliability of the research instrument**

Reliability is "the extent to which measures are consistent or repeatable over time" (Brink 1990:157). 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).

Asking more than one person the same questions and obtaining the same answers will ensure reliability. An interview guide was used to obtain information from all the respondents to make sure that the same questions were asked.

To ensure reliability, the researcher developed the questionnaire in consultation with the supervisor. Questions regarded as not clear by the supervisor were then corrected accordingly. The researcher pre-tested the interview schedule in a pilot study with student nurses from Limpopo University, Turfloop Campus at Mankweng Hospital, during their clinical learning experience. These nurses were not part of the main study. The researcher personally conducted all observations and interviews, which ensured that the same questions were asked in the same way. This enhanced reliability.

3.6.3. **Validity of the research instrument**

Validity is "the degree to which an instrument measures what it is supposed to be measuring" (Uys & Basson 1995:80). Internal validity refers to the extent to which it is possible to establish that the independent variable truly influences the dependent variable and the relationship is not false. External validity is achieved when results can be generalized to situations outside the specific research setting (Polit & Hungler 1995:277).

The questionnaire was considered valid for the following reasons:

- The questionnaire was constructed according to the objectives of the study and organised according to the literature review.
- Content and face validity was ensured giving the questionnaire to the supervisor for review and subsequently making corrections as recommended.
- The professional nurses working in the PHC clinics who were not included in the study were also asked to assess the construct validity of the instrument.
- The interview guide was tested with student nurses at Mankweng Hospital to determine the clarity and specificity of the questions.
- The service of a statistician was used to check if the instruments were in line with the objectives of the study. Having the content of the questionnaire reviewed by the statistician enhanced their validity.

3.7 **DATA ANALYSIS**

Data analysis is the process of bringing order, structure and meaning to the mass of collected data (Marshall & Rossman 1995:111). Data analysis usually begins when data collection begins. Data analysis is conducted to reduce, organise and give

meaning to the data.

In quantitative research, analysis techniques include descriptive and inferential analysis. The analysis techniques implemented are determined primarily by the research objectives, questions or hypothesis (Burns & Grove 1999:43). Descriptive statistics are used to describe and summarise data. Descriptive statistics convert and condense a collection of data into an organised, visual representation of data (a picture) in a variety of ways so that the data have some meaning for the reader. A descriptive approach employs measures of central tendency and dispersion or variability and measures of relationship (Brink 1990:179). Inferential statistics use sample data to make an inference about the population. Inferential statistics help researchers to determine whether the difference found between two groups is real or only a difference that occurred because a non-representative sample was chosen from the population (Brink 1990:179).

Exploratory, confirmatory and post hoc analysis is performed. A complete picture of the sample and frequencies of descriptive variables related to the sample are obtained. Estimates of central tendency (mean) and dispersion of variables relevant to the sample are calculated (Burns & Grove 1999:295).

In research, researchers must become as familiar as possible with the nature of the data obtained on variables that will be used to test research questions and objectives. Data on the variables are examined using measures of central tendency and dispersion to determine the nature of variation in the data to identify outliers (outliers are subjects with extreme values that seem unlike the rest of the sample). Relationships among variables and differences between groups are explored using statistical procedures (Burns & Grove 1999:296). Expectations

regarding the data that are expressed as questions or objectives are confirmed. Findings are generalised from the sample to the population using inferential statistics (Burns & Grove 1999:297). Chi-square analysis and analysis of variance are used to test for differences among groups in the study. The chi-square test is used to compare two or more samples (Burns & Grove 1999:297).

The data was analysed as follows (Burns & Grove 1999:295):

- All the responses were collected and counted.
- Data was presented with the use of descriptive statistics.
- A comparison of the outcome for all the clinics was done.
- Data was entered on computer using the Statistical Package for Social Sciences (SPSS) version 15 program.
- Errors such as missing data, and spelling were reduced by using a systematic plan.
- After every entry data was cleaned; that is, data on the printout was crosschecked with the original data for accuracy.
- Data on the printout was crosschecked with the original data for accuracy.
- All identified errors were corrected.
- Missing data points were identified and entered into the data file.

3.8. **ETHICAL CONSIDERATIONS**

Ethics deals with matters of right and wrong. *Collins English Dictionary* (1991:533) 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, confidentiality, fair treatment, and protection from harm and discomfort.

3.8.1. **Permission and approval**

Approval was sought and obtained in writing from the Research Committee of the Department of Health and Social Development in Limpopo (see annexure 1). Permission was also obtained from the institutions where the study was conducted (see annexure 2). The researcher undertook to ensure that

- Staff members were not kept away from their work during the collection of data.
- Confidentiality of data was maintained at all times.
- The research results would be made available to the Department of Health and social development as well as participating institutions at the end of the study.
- Information would be made available to all stakeholders without disclosing information of a particular clinic or respondents.

3.8.2. **Right to self-determination**

The right to self-determination is based on the ethical principle of 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 respondents' right to self-determination was ensured by explaining the purpose, significance and potential benefits of the study to them; obtaining their informed consent, and emphasising that participation was free and voluntary, and that they had the right to withdraw from the study at any time without penalty.

3.8.3. **Privacy**

Privacy is the freedom an individual has to determine the time, extent and general circumstances under which private information will be shared with or withheld from others (Burns & Grove1999: 158).

To protect the respondents' privacy, the researcher obtained informed consent from them to participate voluntarily (see annexure 7). They were assured that their private conduct or thoughts would not be misused to embarrass or humiliate them. Only data absolutely necessary for achieving the objectives of the study would be obtained.

3.8.4. **Anonymity and confidentiality**

Using numbers instead of their names ensured the respondents' anonymity. Anonymity therefore means that the researcher cannot trace the data to specific subjects (Brink 1990:51). Confidentiality entails that information provided by respondents will not be divulged or made available to any other person.

The researcher ensured the respondents' confidentiality by:

- Allowing them to share personal information to the extent they wished.
- Information shared by them would be (and was) kept confidential.

3.8.5. **Fair treatment and selection**

The right to fair treatment is based on the ethical principle of justice. This principle requires that people be treated fairly and receive what they are owed or is due to them. The research report needs to indicate that the selection of

subjects and their treatment during the study were fair. All the respondents were given the right to choose to participate in the study. They were allowed to give answers to questions, which they felt comfortable answering.

The respondents were selected fairly on relevance to the study and not according to cultural, racial, social and sexual bias. They were treated with respect and fairly throughout the study.

3.8.6. **Protection from discomfort and harm**

The right to protection from discomfort and harm from the study 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 research there was no risk of exposing the respondents to discomfort or harm.

3.9. **LIMITATIONS OF THE STUDY**

Only clinics in the Capricorn District of Limpopo were involved in the study therefore the results cannot be generalized to other districts and provinces.

3.10. **CONCLUSION**

The chapter described the research design and methodology, including sampling, data collection and analysis, and ethical considerations.

Chapter 4 discusses the data analysis and interpretation.

CHAPTER 4

Data analysis and interpretation

4.1 INTRODUCTION

Data collected during the study will be presented, analysed and interpreted in this chapter. The purpose of the study was to explore and describe community members' perception of the level of implementation of the *Batho Pele* principles in PHC settings in Limpopo. This was done with the aim of improving compliance with the *Batho Pele* principles, which would have a positive impact on improving quality of care, accessibility, acceptability and utilization of PHC services.

Observation and interviews were used for data collection. The researcher designed an observation tool for observing the interaction between nurses and clients (see annexure 3). Structured interview guides (questionnaires) were used during interviews with both nurses and clients (see annexure 4 and 5).

The purpose, significance and benefits of the study and ethical principles were explained to all participants and their informed consent obtained (see annexure 7).

4.2 DATA ANALYSIS

Data analysis was based on quantitative principles and is presented as descriptive statistics. Data was mainly obtained from the interview guides and verified with observations and informal discussions by the researcher (see annexure 3, 4 and 5).

The researcher explored and determined all the respondents' knowledge of and perception of the importance of the *Batho Pele* principles by means of the interviews. A Likert scale was used to indicate the responses with intervals of 0 (most negative response) to 2 (most positive response).

The observation guide addressed each of *Batho Pele* principles that lend themselves to observation, namely consultation, accessibility of services, courtesy and provision of information. Implementation of standards such as openness and transparency about the functioning of the clinic, redress of specific complaints and challenges in the service delivery, and value for money were not observed during the face-to-face interaction between nurses and clients.

4.3 RESPONDENTS' DEMOGRAPHIC PROFILE

To contextualise the findings, it is necessary to give an overview of the demographic profile of the nurses and the clients involved in the study.

4.3.1 Nurses' profile

During the explanation about the research, the nurses positively identified with the purpose and therefore willingly participated in the study. They verbalized that the study would assist them in dealing with the challenges they faced in delivering health service of a high quality.

A total of twenty-one (21) nurses from the four selected clinics in the Capricorn district participated in the study. Twenty (20) were females and only one (1) was a male.

4.3.1.1 Geographical distribution

All the nurses on duty on the day of data collection participated in the study. Of the respondents, five (5) were from Unit R Clinic in Lebowa Kgomo Township in Lepelle Nkumpi municipality; four (4) were from Ramokgopa Clinic in Botlokwa village in Molemole district; six (6) were from Rethabile Clinic in Polokwane city in Polokwane municipality, and six (6) were from Buite Clinic in Polokwane city in Polokwane municipality.

4.3.1.2 Professional categories

Of the respondents, sixteen (16) were registered nurses (RN), four (4) were enrolled nurses (EN) and one (1) was a nursing assistant (see table 4.1).

Table 4.1 Respondents' categories per clinic

Category	**Unit R Clinic (rural)**	**Ramakgopa Clinic (rural)**	**Rethabile Clinic (urban)**	**Buite Clinic (urban)**
Professional nurse	4	3	5	6
Enrolled nurse	0	1	1	0
Nursing assistant	1	0	0	0
Total	5	4	6	6

The high percentage of Registered nurses in the clinics can be attributed to the fact that registered nurses, especially those with an additional qualification in health assessment, treatment and care, are often responsible for the delivery of

health care at PHC level in the absence of a medical doctor. Enrolled nurses and nursing assistants provide support to the registered nurses.

4.3.2 Patients'/Clients' profile

4.3.2.1 Geographical distribution

A total sample of one hundred and eighty-five (N=185) clients was obtained from the four clinics. Of the respondents, thirty (30) were from Unit R Clinic; twenty-nine (29) were from Ramokgopa Clinic; sixty (60) were from Rethabile Clinic, and sixty-six (66) were from Buite Clinic (see table 4.2).

Table 4.2 Patients' geographical distribution according to clinics and municipalities

Clinic	Municipality	Total	Percentage of sample
Unit R	Lepelle-Nkumpi	30	16,2%
Ramokgopa	Molemole	29	15,7%
Rethabile	Polokwane	60	32.4%
Buite Clinic	Polokwane	66	35.7%
TOTAL		**185**	**100%**

4.3.2.2 Respondents' age and gender

The respondents were interviewed when they were leaving the clinic after consultation with the nurse. To participate in the study, the respondents had to be 18 years of age or older. Of the respondents, 73% (N=135) were younger than 40; 38% (N=70) were between 31 and 40; 14% (N=25) were between 41 and 50; 11% (N=20) were between 51 and 60, and 3% (N=5) were older than 60 (see table 4.3).

Table 4.3 Respondents' age (N=185)

Age in years	**Number per age group**	**Percentage**
18-19	17	9%
20-30	48	26%
31-40	70	38%
41-50	25	14%
51-60	20	11%
61-70	5	3%
Total	**185**	**100%**

Of the respondents, 65.9% (N=122) were females. This is representative of the total population in Limpopo where males often seek employment in the bigger cities of Gauteng, while the women, children and older people are left in their traditional environment. The respondents' ages also reflect the nature of services provided in the clinics, which mainly address the needs of the women of reproductive age and small children. The following factors could also have an influence on the client profile:

- *Times of service delivery (07:00-16:00)*. People who are employed would find these times inconvenient. Children go to school during these hours and may not be able to attend the health facility.
- *The nature of services delivered*. According to existing policy, clinics should not offer services in silos, but services should be comprehensive, providing a one-stop service. For example, specific days for immunization or antenatal care should not be the norm. A mother should therefore be able to receive her own family planning tablets, have one child immunised and have an older child's cough attended to during a single visit to the clinic.

- *The needs of the health care consumer*. Mother and child services, including antenatal, immunization and reproductive services, treatment of minor ailments, follow-up services for chronic illnesses, and health assessment for schoolchildren should be available for all the relevant age groups.

4.4 RESPONDENTS' PERCEPTION OF THE IMPORTANCE OF THE *BATHO PELE* PRINCIPLES

One of the objectives of the study was to determine how important the *Batho Pele* principles were to both clients and nurses as indicative of quality services.

4.4.1 Nurses' perception of the importance of the *Batho Pele* principles

During the interviews, the professional nurses displayed a good knowledge of the meaning of the *Batho Pele* principles. The enrolled nurses and nursing assistants, however, did not reveal the same level of understanding of these principles. During observation of the interaction between nurses and clients, it was evident that the nurses in general (all categories) treated clients with respect and dignity. They suggested rather than imposed treatment modalities for clients; did not rush clients to leave the consulting room due to long waiting lines, but gave them time to discuss their health problems. In addition, information about health problems was given to clients throughout the consultation.

All the nurses indicated that the *Batho Pele* principles were very important for improving quality service (see section B of annexure 4 and table 4.4). These positive perceptions clearly influenced their attitude towards the implementation of the *Batho Pele* principles. Their positive perceptions also indicated the respondents' commitment to implementing policies for quality improvement.

Table 4.4 Respondents' perception of the importance of the *Batho Pele* principles

Norms	Clinics															
	Urban									Rural						
	Rethabile: n=6				Buite: n=6					Unit R: n=4			Ramokgopa: n=5			
	Not important	Not really	Important	Very important	Not important	Not really	Important	Very important	Not important	Not really	Important	Very Important	Not important	Not really	Important	Very important
Principles																
Consultation			100				100				100				100	
Access				100				100			100				70	30
Service standards			100				20	80				100				100
Information			100				100				100				100	
Courtesy				100				100				100			18	82
Openness and transparency			80	10			100				100				100	
Redress				100			100				100				100	
Value for money			100				100				100				100	

4.4.1.1 Consultation

During interaction between nurses and clients it was evident that rather than being imposed on clients, treatment interventions were suggested and discussed with them, in line with the *Batho Pele* principle of consultation.

At all four clinics, all the respondents indicated that consultation was important. The respondents' positive perception of the principle of consultation should result in a high level of client satisfaction and contribute to the perception of receiving quality service. The respondents gave the clients the opportunity to express their concerns and discuss their condition and treatment strategies thereby enabling them to make informed choices.

4.4.1.2 Access

In all the clinics the respondents perceived the access of services to clients to be important (see table 4.4). It should be noted that only Rethabile Clinic provided 24-hour service. The reason that the other clinics only offered services between 07:00 and 16:00 on weekdays was a shortage of nurses.

Accessibility of services was measured in terms of availability of medications in the clinics during the time of the study and whether cultural and language barriers existed between nurses and clients. In the rural clinics, all the necessary medications were not available on the day of the study. This could seriously influence the perceived quality of care and should be regarded as a priority in service delivery.

During observation, the researcher found no evidence of language or cultural barriers (see tables 4.6, 4.7 and 4.8). It was clear that there was a trust relationship between nurses and clients and that conversation flowed freely. This was also confirmed by the clients' responses where 100% indicated that they did not experience any cultural and language problems (see table 4.7). The availability of medications appeared to be a challenge, however, especially in the rural clinics (see tables 4.7 and 4.8).

4.4.1.3 Service standards

In all the clinics the respondents perceived the principle of service standards to be important (see table 4.4). During observation, however, it became clear that service standards were not openly displayed in service areas. The researcher also found a difference in the clients' responses in the different clinics. It was noted that the rural clinics performed better than the urban clinics in terms of the clients' perceptions (see table 4.7).

The level of implementation of service standards was measured in terms of waiting time. Eighty percent (80%) of the clients attending the Buite Clinic indicated that they had to wait too long to be attended (see table 4.7). It should be noted that it could be difficult and challenging to balance the number of staff available, the number of clients, time spent with each client, and waiting times.

4.4.1.4 Information

Sharing of information was measured in terms of the relevance and appropriateness of health education provided to clients during consultation as well as additional health-related information made available to clients in terms of pamphlets, posters, videos and pictures. All the respondents indicated that this was an important aspect of quality service delivery (see table 4.4). Yet the implementation of this principle was not evident in all the clinics. Only 60% of the clients in Unit R Clinic and 50% of those in Ramokgopa Clinic were given health education during the consultation (see table 4.6). No additional health-related pamphlets were available either. The level of literacy of clients could have influenced this observation, but the importance of information to clients cannot be underestimated and should receive the necessary attention.

4.4.1.5 Courtesy

Courtesy was important to all the respondents (see table 4.4). This was also confirmed by the majority of the clients, who were satisfied with the manner in which nurses generally interacted with them (see table 4.7). During observation of nurse-client interaction, the researcher found that the nurses generally displayed a friendly attitude towards clients (see table 4.6). Clients were addressed with dignity and respect as Mr, Mrs or Ms. Privacy was maintained at all times.

4.4.1.6 Openness and transparency

The respondents in all the clinics perceived openness and transparency to be important (see table 4.4.) Openness and transparency was measured in terms of the clients' knowledge of how the clinic operates, who the person in charge of the clinic was, and the general performance of the clinic. The level of implementation of this principle was the lowest in the urban clinics (see table 4.7).

4.4.1.7 Redress

At all the clinics all the respondents perceived redress to be important (see table 4.4). The level of implementation of this principle was measured in terms of the availability of suggestion boxes and established strategies to manage incidents, complaints and compliments.

Contrary to the respondents' positive perceptions of this principle, however, it was observed that none of the clinics kept an incidence or complaints register (see table 4.5). Suggestion boxes were available except in Buite Clinic (see table 4.7). The analysis and understanding of incidents, complaints and compliments clients

can be a valuable source of information to improve the quality of service delivery and client satisfaction.

4.4.1.8 Value for money

At all the clinics all the respondents perceived the principle of "value for money" as important (see table 4.4.) The level of implementation of this principle was measured in terms of availability of equipment in a working condition and the systems in place to maintain and replace equipment and supplies. It was observed that rural clinics only had 50% of the necessary equipment in working order (see table 4.8). Buite Clinic had adequate equipment in functional order at the time of the study and none of the clinics had maintenance or service registers in place to maintain and replace necessary equipment (see table 4.8).

4.4.2 Clients' perception of the importance of the *Batho Pele* principles

Clients' knowledge of the *Batho Pele* principles is an integral part of the philosophy behind the principles. If people are "put first" in addressing their needs as cost-effectively as possible, community members should be actively involved in service delivery and in taking responsibility for their own (as well as others') health.

During the interviews, the respondents (clients) appeared to have a good understanding and knowledge of the value of the *Batho Pele* principles. Knowledge and understanding of these principles will guide clients to know their own rights (and responsibilities) and to have realistic expectations of PHC services.

With regard to the importance of the *Batho Pele* principles, it was evident that, with a few exceptions about *service standards* in Buite Clinic (3%), *openness and*

transparency in Rethabile Clinic (10%) and Ramokgopa Clinic (5%), the respondents perceived them as important (see table 4.5).

Table 4.5 Clients' perception of the importance of the *Batho Pele* principles

Norms	Clinics															
	Urban								Rural							
	Rethabile: n=60				Buite: n=66				Unit R: n=30				Ramokgopa: n=29			
	Not important	Not really important	Important	Very important	Not important	Not really	Important	Very important	Not important	Not really	Important	Very Important	Not important	Not really	Important	Very important
Principles																
Consultation			100				70	30			100				100	
Access				100			100				100				40	60
Service standards			100			3		97				100				100
Information			100				100				100					100
Courtesy				100				100				100			100	
Openness and transparency		10	80				60	40			10	80		5	80	15
Redress			100				100				100				100	
Value for money			100				100				100				100	

The fact that clients regard service standards as important can contribute to more active involvement by community members in the planning and developing of

health services. In so doing, community members become watchdogs for quality service delivery thereby leading to optimal utilisation of health services.

During the interviews, the researcher took the approach of trying to determine how upset the respondents would have been or how negative the implications would be if the specific principle were not present or effectively implemented in the specific clinic.

The respondents' perception of the *Batho Pele* principles was found to be generally positive (see table 4.5). Clients' positive perception will have a positive impact on the utilisation and acceptability of the services.

4.4.2.1 Consultation

The respondents perceived consultation to be important (see table 4.5). The level of implementation of this principle was measured in terms of time spent with clients during consultation to discuss their health problems and information regarding their illnesses given to them as well as answering questions about their health problems. The respondents were mostly satisfied and perceived that all their questions about their health problems were answered (see table 4.7). At the same time, however, their perceptions and experiences of additional health-related information being made available were negative (see table 4.7).

4.4.2.2 Service standards

The respondents rated service standards as either important or very important (Table 4.5). The level of implementation of service standards was measured in terms of waiting time and accessibility of services in terms of language and

culture. Table 4.5 reflects that the respondents were not satisfied with the time they had to wait before they were attended to.

4.4.2.3 Access

The respondents perceived access to services as important (see table 4.5). This concurred with the nurses' responses that access of services to the community was very important (see table 4.4). During the interviews, the respondents stated that they did not experience any language or cultural barriers at the clinics (see table 4.7). Access to services also includes the availability of medication and supplies, equipment and instruments for provision of services, opening times of the clinics as well as waiting time. The respondents did not find all these aspects satisfactory (see table 4.5).

4.4.2.4 Courtesy

The respondents perceived courtesy as important and indicated a high level of satisfaction with the nurses' courtesy (see table 4.7). This was also confirmed by the researcher's observation of the nurses during their interaction with clients (see table 4.6).

4.4.2.5 Information

Although the respondents regarded health information as important to them, they were not satisfied with the implementation of this principle, especially in the rural clinics (see tables 4.5 and 4.7). Information sharing has a positive impact on community health and service utilization.

4.4.2.6 Openness and transparency

The respondents regarded the principle of openness and transparency as very important (see table 4.5). It was evident that the implementation of this principle in all the clinics could be improved. None of the respondents who visited the Buite and Rethabile Clinics were informed how the clinics operated and performed, or who the person in charge of the clinic was (see table 4.7). The implication of not implementing this principle well is that the community is not sufficiently informed of what is happening in the clinic and can therefore not actively participate in improving the service.

4.4.2.7 Redress

Although the respondents viewed this principle as important, its application in all the clinics could improve. Suggestion boxes were available in three clinics, but did not see to be fully utilized. Buite Clinic did not have a suggestion box (Table 4.7). Observations made by the researcher during data collection were that even though the suggestion boxes were available, pens and paper were not provided for the use of patients. None of the clinics had a complaints register. The implication of non-compliance with this principle is that nurses will not know what the patients are dissatisfied with or areas that need to be improved. Continued unresolved complaints or concerns of patients will affect utilization and acceptability of services.

4.4.2.8 Value for money

Availability of equipment was found to be a challenge in the rural clinics. Buite Clinic complied with this principle and equipment seemed to be functional at the

time of the study (see table 4.6). Unavailability of and dysfunctional equipment will have a negative impact on the accessibility of services as well as a direct impact on the patients' waiting time.

4.4.3 Perceptions of the implementation of the *Batho Pele* principles

The researcher conducted the interviews with the nurses and clients without the assistance of research assistants (see annexure 4). All the nurses present at the clinic on the day of data collection were interviewed after they had given informed consent (see annexure 5).

Interviews with clients were conducted after they had been attended to by nurses. The researcher explained the purpose of the interview and if the client was willing to participate, informed consent for the interview was obtained.

The interviews focused on the implementation of the *Batho Pele* principles, namely effective consultation; accessibility of services; courtesy, value for money and provision of information. The same criteria to determine the level of implementation were used in all the interviews with all the respondents (see tables 4.6 and 4.7).

Table 4.6 Nurses' perceptions of the implementation of the *Batho Pele* principles

Principles		Clinics			
		Urban		Rural	
		Rethabile n=6	Buite n=6	Unit R n=5	Ramokgopa n=4
Consultation	Have enough time discuss clients' health problems during consultation	100%	100%	100%	100%
	Answered clients' questions about their health problems and treatment	100%	100%	100%	100%
Accessibility of services	Medications available and adequate at all times	100%	100%	70%	60%
	Clients experienced no language problem during consultation	100%	100%	100%	100%
	You found no cultural barriers between you and the clients	100%	100%	100%	100%
Clients treated with dignity and respect (courtesy)	Friendly to patients at all times	100%	100%	100%	100%
	Treat clients with dignity and respect	100%	100%	100%	100%
	Privacy maintained during consultation	100%	100%	100%	100%
Value for money	Equipment available and adequate for provision of services	60%	100%	50%	50%
	Equipment functional	70%	100%	40%	55%

Table 4.7 Clients' perception of levels of implementation of the *Batho Pele* principles

Principles		Clinics			
		Urban		Rural	
		Rethabile n=60	Buite n=66	Unit R n=30	Ramokgo pa=29
Consultation	Given enough time by nurse to discuss his/her health problems during consultation	100%	100%	100%	100%
	Questions about his/her health problems and treatment answered by the nurse	100%	100%	100%	100%
	Information related the health of the client.	80%	97%	78%	83%
Accessibility of services	Medication prescribed is available and given to clients	100%	100%	50%	69%
	Experienced language problem with the nurse	100%	100%	100%	100%
	Experienced cultural barriers	100%	100%	100%	100%
Service standards	Wait for a long time before being attended to	70%	80%	73%	69%
Clients treated with dignity and respect (courtesy)	Nurse was friendly and helpful	100%	100%	100%	100%
	Treated with dignity and respect by nurses	100%	100%	100%	100%
	Privacy maintained during consultation	100%	100%	100%	100%
Provision of information	Health education given to you with regard to your illness	83	100	60	50
	Information(pamphlets/ booklets) Given to you on any aspect of health	34	50	0	0
Operation of the clinic	Given information on how the clinic operates	40%	50%	80%	100%

	Know who is in charge of the clinic	0	0	70%	100%
	Informed about clinic performance	0	0	78%	100%
Procedure for dealing with complaints is available	Suggestion box available	60%	0	70%	90%
	Have any of your complaints/compliments been acknowledged and/or addressed	0	0	0	0

4.4.3.1 Consultation

The nurses were of the opinion that sufficient time was allowed during consultations to communicate with clients and that the questions about their health problems were answered satisfactorily (see table 4.6). The clients, however, maintained that they did not receive sufficient information about their particular health problems (see table 4.7).

4.4.3.2 Accessibility of services

Three criteria were formulated to evaluate the accessibility of services to clients, namely the availability of medications, barriers in terms of language, and evidence of cultural sensitivity. Both the nurses and the clients reported that medication was not always available. This limitation was especially experienced in the rural clinics (see tables 4.6 and 4.7). All the respondents were of the opinion that sufficient attention was given to language and cultural issues.

4.4.3.3 Service standards

The clients reported long waiting times before they could consult the nurses (see table 4.7). The nurses, however, argued that they needed time to attend to patients.

4.4.3.4 Courtesy

Three questions were designed under this principle to evaluate the nurses' attitude towards patients: whether the nurses were friendly to clients at all times, treated clients with dignity and respect, and privacy was maintained during consultation with clients. All the respondents seemed satisfied with the level of implementation of this principle (see table 4.6 and 4.7). The clients reported that the nurses treated them with dignity and respect and were friendly and approachable at all times. Privacy was maintained throughout the consultation.

4.4.3.5 Value for money

The implementation of the principle of value for money was determined by asking the respondents' opinion on the availability of necessary equipment. The nurses were asked to comment on the condition and functionality of equipment and whether some strategy was in place to manage and monitor the maintenance and replacement of equipment. Maintenance registers and/or service books are often used for this purpose. This principle did not appear to be implemented to a satisfactory level. Only Buite Clinic, a very busy clinic in an urban area, was doing very well with equipment availability and functionality (see table 4.6). In all the other clinics, services were delivered without some of the necessary equipment. None of the clinics had maintenance and/or service registers or any strategy to manage and monitor the servicing, repair or replacement of equipment.

4.5 VALIDATION OF FINDINGS THROUGH OBSERVATION

To validate some of the findings from the interviews, the researcher observed the interactions between nurses and clients, using an observation guide (see Annexure

3). The Hawthorne effect of research, which could influence behaviours during an "unnatural" research situation, was limited by creating a relationship of trust through friendly explanation that the observation was being done in an effort to learn and understand the actions at clinic level and with the aim of improving the quality and nature of service delivery.

The researcher observed, interpreted and rated the interactions, presenting them as a percentage (%) (see table 4.8). The observation was done in all four clinics. The researcher moved from consulting room to consulting room to ensure that all the nurses on duty on the day of the study were covered in these observations. The percentage indicated in table 4.8 reflects the number of interactions between nurses and clients that complied with the service standard principle. Only four of the *Batho Pele* principles were observed, namely consultation, access, courtesy and provision of information.

Table 4.8 Observed compliance with the *Batho Pele* principles

Principles		Clinics			
		Urban		Rural	
		Rethabile n=6	Buite n=6	R Unit n=5	Ramokgopa n=4
Effective consultation	Clients given time to discuss their health problems with the nurse	88%	90%	60%	98%
	Questions raised by clients about their health problems answered by the nurse	100%	100%	100%	100%
	Nurses obtain history from the clients	80%	86%	70%	60%
Accessibility of services	Clients experienced no language problem with the nurse during consultation	100%	100%	100%	100%
	No cultural barriers between nurse and clients observed	100%	100%	100%	100%
Clients treated with dignity (courtesy)	Nurse was friendly to the patient and helpful	100%	100%	100%	100%
	Privacy was maintained during consultation	100%	100%	100%	100%
Provision of information	Nurse gave clients health education with regard to their illness	83%	100%	60%	50%
	Additional information in the form of pamphlets/booklets given to clients on any aspect of health	50%	60%	0	0

4.5.1 Effective consultation

Three criteria were designed to measure the effective implementation of consultation in the clinics, namely whether clients were given enough time to discuss their health problems; whether questions raised by clients about their health problems were answered by nurses, and whether nurses obtained relevant history from the clients that would assist in diagnosis (see table 4.8).

The researcher observed that the nurses in all the clinics consulted the patients. The nurses gave clients enough time to discuss their health problems. The rating for compliance was as follows: Ramokgopa Clinic – 98%; Buite Clinic – 90%; Rethabile Clinic – 88%, and Unit R Clinic – 60%.

The nurses answered all questions raised by clients in all the clinics. With regard to history taking, the researcher observed that there was room for improvement in all the clinics. A possible reason for this observation was the number of activities they had to perform such as taking vital signs and examinations while other patients were waiting to be called. The clinics scored as follows: Buite Clinic – 86%; Rethabile Clinic – 80%; Unit R Clinic – 70%, and Ramokgopa Clinic – 60%.

4.5.2 Accessibility of services

Two criteria checked whether there were barriers that prevented patients from accessing services: whether cultural and/or language barriers existed between clients and nurses during consultation.

The researcher observed no cultural or language barriers between the nurses and the clients at any of the clinics.

4.5.3 Treating clients with dignity and respect (courtesy)

Two criteria were formulated to determine how the clinics performed with regard to the nurses' attitude towards patients: whether nurses were friendly and helpful to clients, and whether privacy was maintained throughout the consultation. All the nurses who participated in the study in all the clinics were observed to be friendly and helpful to clients and the provided privacy throughout the consultation. This observation was confirmed during interviews with clients (see table 4.7).

4.5.4 Provision of information

The criteria formulated to assess the provision of information to patients by the nurses included whether health education was given with regard to clients' illnesses as well as whether any additional health information was made available in the form of pamphlets and/or booklets The researcher scored the clinics as follow: Buite Clinic – 100%; Rethabile Clinic – 83%; Unit R – 60%, and Ramokgopa Clinic – 50%. With regard to the provision of additional health information, it was observed that there was room for improvement (see table 4.7). Possible reasons for the non-availability of health information are that the supply is smaller than the demand, and that delivery is sometimes late in the rural areas.

4.6 CONCLUSION

This chapter discussed the data analysis and interpretation and presented the data as descriptive statistics. It was found that all the respondents regarded the principles as important for quality service delivery. With regard to the levels of implementation, the study found that attention should be given to the availability of medications; waiting times for clients; provision of individualized health information as well as general health information; transparency about service

standards; the performance of clinics and the availability of equipment, and strategies to manage and control servicing, repairing and replacing equipment. Facilitating improved interaction between services and the community through better utilization of suggestion boxes and management of complaints and compliments would contribute to better-informed communities and higher levels of active community participation.

Chapter 5 concludes the study, presents the findings and makes recommendations for practice and further research.

CHAPTER 5

Conclusions, limitations and recommendations

5.1 INTRODUCTION

Quality of care is a primary concern for health care providers and consumers. Measuring quality care has become an essential goal to justify organisations' existence. Customers are increasingly demanding quality care in the knowledge that they have a right to receive health services that are satisfactory (Al-Ahmadi & Roland, 2005; Leon, 2003; Williams, Schutte-Aine & le Roux, 2002).

The *Batho Pele* ("Putting people first") principles were introduced in 1997 as part of public policy in an effort to increase the standards of service delivery (DPSA 1997:13). The implementation of the *Batho Pele* service standards was made mandatory in all public service institutions in order to deliver quality service in the public sector (DPSA 1997:13). With regard to standards of service delivery in health care, especially at PHC level, strategies to assess and monitor the implementation and effects of the *Batho Pele* principles have not been fully established. This motivated the researcher to conduct this study

The purpose of the study was to explore and describe community members' perceptions of the level of implementation of the *Batho Pele* principles in PHC settings in Limpopo. The aim was to improve compliance with these principles, which would positively improve quality of care, accessibility, acceptability and utilization of the PHC services.

The objectives of the study were to

- Explore and describe the extent to which the *Batho Pele* principles have been implemented in four clinics in the Capricorn Health District, Limpopo.
- Determine the level of importance of the *Batho Pele* principles to nurses and health care consumers, respectively.

The *Batho Pele* principles were used as a theoretical framework.

5.2 FINDINGS AND CONCLUSIONS

The data were obtained through

- interviews with the nurses
- interviews with the clients after they had been seen by the nurses
- Observation of the interaction between the nurses and the clients.

The findings are discussed within the framework of the two objectives of the study.

5.2.1 Explore and describe the extent to which the *Batho Pele* principles have been implemented in four clinics in the Capricorn Health District, Limpopo

Criteria were designed to assess the level of implementation of the *Batho Pele* principles. These criteria were applied to all the respondents (both nurses and clients) as well as during observation.

In most cases, the implementation of the *Batho Pele* principles was satisfactorily done. The rural clinics performed poorly in the implementation of the following

principles: nurses not taking comprehensive histories from clients; long waiting times; lack of provision of additional health information in the form of health information pamphlets; lack of strategies to improve client satisfaction by utilizing suggestion boxes and complaints registers, and the shortage of medication and functional equipment (see chapter 4, table 4.6 and 4.7). The principle best implemented in all four clinics was courtesy, with the patients indicating satisfaction with the friendly and helpful way in which they were treated at the clinics (see chapter 4, table 4.7).

The researcher's observation confirmed the findings from the interviews (see chapter 4, table 4.8).

5.2.2 Determine the level of importance of the *Batho Pele* principles to the nurses and the clients, respectively

To determine the respondents' perception of importance of the *Batho Pele* principles necessitates a thorough knowledge and understanding of them. During the interviews, the researcher adopted an approach of establishing how the respondents would react if a specific *Batho Pele* principle was not implemented. All the respondents (both nurses and clients) perceived the *Batho Pele* principles as very important in the provision of quality care (see chapter 4, table 4.4 and 4.5).

5.3 SIGNIFICANCE OF THE STUDY

The study highlighted the challenges faced by the clinics in Capricorn District, Limpopo in the provision of quality care according to the *Batho Pele* service standards, identified areas for improvement and made recommendations for practice and further research. The implementation of the recommendations would contribute to addressing the challenges and promote acceptability, accessibility

and utilization of the PHC services.

5.4 LIMITATIONS OF THE STUDY

Research limitations refer to "restrictions that may decrease the generalisability of findings" (Burns & Grove 1993:46). In this study, the research findings are relevant to Capricorn District, Limpopo only and cannot be generalised to the entire PHC services in Limpopo, other provinces, or the rest of the country.

5.5 RECOMMENDATIONS

Based on the findings and supported by the literature review, the researcher makes the following recommendations for practice and further research.

5.5.1 Practice

- **Provision of information**

There was a lack of provision of individual health information. The importance of giving health education to clients should be emphasised during in-service training sessions to develop and maintain skills to effectively convey relevant and appropriate information to clients. This will enable clients to make informed choices and take responsibility for their own and others' health.

A mentor should be appointed for all newly appointed nurses in the clinics to observe and follow guidance on providing health-related information, based on comprehensive and appropriate history taking and taking into consideration clients' level of understanding with sensitivity to language and cultural differences.

To improve quality in health care service delivery, information and education should be given to clients. Better-informed clients will result in better utilisation of health services, reduction of insecurities and anxiety, good doctor-patient relations, improved response to treatment and medication, and consequently better health (Leon 2003:67-71).

- **Provision and display of additional information on general health-related issues**

Although the level of literacy should be taken into consideration, the value of booklets, pamphlets, posters and pictures with information on general health issues should not be underestimated. Within the framework of "family literacy", written health information can reinforce health education given orally and serve as a source of reference when clients are at home.

- **Display of service standards**

Service standards should be clearly displayed in a user-friendly way in all service areas especially to inform clients about what they can expect from the service. Displayed service standards can add to transparency and accountability of the quality of service delivery.

The Department of Public Services and Administration (1997:17) advocates the use of appropriate tools and instruments to measure and enhance performance against set standards and the publication of outcomes at least once a year, and more frequently where appropriate, in the form of annual reports or progress reports. Schroeder (1994:6) concurs, emphasising that monitoring of standards is essential

to improve both quality of service and accountability to consumers and customers.

All quality improvement strategies should include the unique needs of clients and customers.

Standards and guidelines are tools that reflect the vision, values and context for care and service (Schroeder 1994:10). Transparency and display of service standards contribute to realistic expectations and patterns for practice. Clients are informed about the standards of service delivery and are able to contribute in an informed manner to the improvement of service delivery.

- **Suggestion boxes, complaints registers and incidence files**

Strategies to involve the community in planning, assessing and improving the quality of service delivery and to improve client satisfaction were not in place and optimally utilised.

Clients should be made aware of the availability and use of suggestion boxes and avenues to lodge complaints. Skills and methods should be developed to analyse trends in client inputs for the planning, assessing and improving of service delivery. Clinics should be empowered to respond to complaints in an effective and timely manner

Booyens (1993:603) emphasises the importance of effective and appropriate management of complaints. Risks should be identified and prioritised within a team approach. This risk team should establish strategies and design policies to prevent and address risks. Staff members should continuously be sensitised to risks. Clients' suggestions should be seriously considered and treated as important.

- **Informing patients about the operational activities of the clinic**

It was found that the clients were not informed about the operational activities of the clinics.

Clients should have easy access to information about the operations in the clinics, including times of operation; who to contact in an emergency when the clinics were not functional; names of personnel; expected waiting times, how to actively become involved in improving service standards, as well as how and where to complain.

Information should be written in local languages and strategies implemented to convey this information to people who cannot read and write. Information should be relevant and updated regularly.

- **Sufficient and effective equipment**

The lack of sufficient and effective equipment was a serious shortcoming.

Formalized systems to manage and account for servicing, repairing, maintaining and replacing equipment should be established. Nurses should be trained and assessed in the optimal and effective use and maintenance of equipment.

- **Medication and supplies**

The availability of medications appeared to be a challenge, especially in the rural clinics.
Keeping and using client records to determine the utilisation of the service and morbidity and mortality trends can assist in maintaining supply levels of medication

and other supplies. Effective auditing and inventory systems to manage and control medications and supplies should be implemented and continuously monitored and updated.

- **Value for money**

Booyens (1993:582) refers to quality assurance as a process for monitoring and improving the quality of patient care. Moreover, assurance implies a guarantee of knowledge and competence by the practitioner, and an adequate service that provides value for money in accordance with the characteristics associated with excellence. Assurance further implies that certain formal quality control systems are in place. These systems are used to strictly monitor and assess the way in which standards are maintained, and to take remedial steps if necessary. Quality assurance is therefore a formal system that assures that the patient will receive service of a certain quality. Functional equipment and sufficient supplies, adequate facilities, adequate staffing and proper skill mix are integral elements of service delivery that offers value for money to both the provider and the consumer **(**Leon 2003:67-71).

5.5.2 Further research

The researcher recommends that research be conducted into the following topics:

- Strategies to improve client participation in improving health services at PHC level.
- Strategies to monitor service standards levels of PHC on a continuous basis, especially in rural areas.

5.6. CONCLUSION

An exploratory and descriptive study was conducted with the aim of describing and comparing community members' perception of the level of implementation of the *Batho Pele* principles in PHC settings in Capricorn District, Limpopo. The study population included one hundred and eighty-five (185) patients and twenty-one (21) nurses. Interviews and observation were used to collect data.

Study findings indicated that PHC services in the Capricorn District were generally of a high standard when assessed within the framework of the *Batho Pele* principles. The majority of clients indicated that they were satisfied with the quality of service delivery. All the respondents perceived the *Batho Pele* principles positively and indicated that they play an important role in quality care. Recommendations were made to address those areas in need of improvement.

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