

**PATIENT SATISFACTION WITH PUBLIC
PRIMARY HEALTH CARE SERVICE DELIVERY
IN KHOMAS REGION, WINDHOEK DISTRICT
NAMIBIA**

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A mini-thesis submitted in partial fulfillment of the requirements for the
degree of Masters in Public Health at the School of Public Health,

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The logo of the University of the Western Cape, featuring a stylized building with columns and the text "UNIVERSITY of the WESTERN CAPE" below it.

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ABSTRACT

Primary Health Care (PHC) services in Namibia are based on the principles of equity, availability, accessibility, affordability of services, and community participation and empowerment. According to the Namibian Constitution and the National Health Policy, all Namibians should have equal access to public health services at no cost to the patient. The government places a high premium on the involvement of communities in PHC through communication, consultation and respectful interaction between health workers and patients and communities in the interests of quality service delivery. Services provided at PHC facilities include immunisations, antenatal care, post-natal care, family planning, health education, tuberculosis and malaria treatment, outreach services, anti-retroviral treatment (ART), and the Prevention of Mother to Child Transmission (PMTCT) programme.

Numerous complaints have been received from patients relating to patients' admissions at clinics, long waiting hours, over-crowded facilities, poor communication between patients and nurses, and non-availability of some medications and medical officers at some of the PHC facilities.

This study investigated patient satisfaction and the reasons for reported poor nurse-patient relations at PHC facilities in Khomas region in Namibia. The objectives of the study were to describe patient's perceptions concerning quality of service delivery at PHC clinics, to explore factors related to the clinic environment that might influence perceived quality of care and to describe the nature of nurse-patient relations.

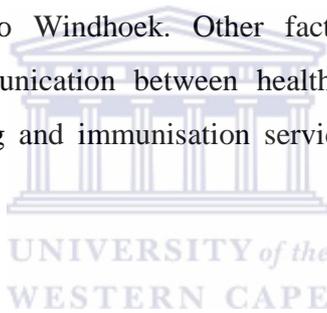
Methodology

A descriptive, qualitative study was conducted among randomly selected patients (15) and registered nurses (5) at five purposively selected PHC clinics in Khomas region, in the Windhoek district. Five sisters-in-charge from the designated facilities were interviewed as key informants.

Data was collected through key informant interviews and focused interviews with nurses and patients, respectively. Data on the participants' experiences and perceptions of using the health services, as well as factors influencing nurse-patient relations and patient satisfaction was collected. Interview data was recorded on audiotape and transcribed verbatim. Data from key informants was captured in field notes. Thematic analysis of transcribed data was conducted.

Results

Low patient satisfaction with services was confirmed as a key problem facing four out of the five health facilities visited in Khomas region. Patient dissatisfaction was mostly related to the long waiting times, which in turn, was caused by increased patient numbers as a result of the escalating HIV/AIDS and tuberculosis (TB) epidemics, ART roll out and increased immigration to Windhoek. Other factors attributed to low patient satisfaction were poor communication between health providers and patients, non-availability of family planning and immunisation services, and frequent stock-outs of some prescribed medicines.



Conclusions

The findings of this study support the need to rethink nurse-patient relations for greater patient satisfaction and quality of service delivery in the public Primary Health Care facilities in Khomas region. Greater care should be taken to inform patients about service days and the staffing limitations at health facilities, and to educate and empower patients for self-care. Communication strategies should target negative perceptions about service delivery at PHC clinics in the communities. In-service training in areas like case management, different PHC disciplines and communication skills are needed to improve the competency of nurses. In addition, motivation of nurses needs to be addressed through recognition and appreciation from management in order to avoid frustrations and negative attitudes towards patients. Motivation of nurses can be improved by paying attention to their work environment and the physical structure of health facilities.

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CHAPTER 1

INTRODUCTION

1.1 OVERVIEW OF PRIMARY HEALTH CARE

The World Health Organization (WHO) defines Primary Health Care (PHC) as “*essential health care made accessible at a cost a country and community can afford, with practical, scientifically sound and socially acceptable methods*” (WHO, 1998: 39). The WHO developed key principles to improve the quality of primary health care by making services available, accessible and affordable, through service integration, community participation and empowerment. It is argued that if services are brought closer to the client, health care becomes more affordable and accessible. This would aid efficiency in service delivery as preventative and curative programs could run simultaneously. Such a strategy would enhance the delivery of comprehensive, quality care, and improve disease prevention, treatment and rehabilitation.

The International Council of Nurses (ICN) (1999) propagates that equity and access to primary health care services, particularly nursing services, are key elements to improving the health and well being of all people. Together with its member associations, the ICN advocates for the right of all people to equitable and effective health care services, and endorses the Alma Ata Declaration on primary health care (WHO, 1978) as a means of attaining a level of health that will permit people to lead a socially and economically productive life. The ICN and its members collaborate with governments and non-governmental organisations for more effective implementation of primary health care. In planning and implementing PHC services, the ICN urges a multi-sectoral approach and adherence to the PHC principles of equity, accessibility, affordability, illness prevention, treatment and rehabilitation, health promotion, health education, and community participation in service planning (ICN, 1999). In addition to this, the World Health Report reflects a widespread and growing demand for primary health care from its member states (WHO, 2008).

This demand is demonstrated by a growing interest among policy makers for knowledge related to how the health system can become more equitable, inclusive and fair (WHO, 2008). The report also reflects more fundamentally the need to revitalize and renew the primary health care system. Globally, people are becoming impatient with the inability of health services to deliver levels of national coverage that meet population demands and changing needs, in addition to the failure to provide services in ways that correspond to their expectations. Member states agree that health systems need to respond better and faster to the challenges of a changing world and believe that PHC can achieve that.

According to Tollman, Doherty and Mulligan (2006), improvement of primary health care service delivery is needed in developing countries, particularly in the poorest countries, where limited versions of the minimum package of care are available. The minimum package consists of prevention of diseases, general treatment, rehabilitation and health promotion. They further state that the limitations of primary health care service delivery, such as shortages of skilled health personnel, lack of medicine and medical supplies and lack of physical infrastructure could be attributed to lack of government commitment to primary care and inadequate financing. In addition, the HIV/AIDS epidemic and the increase in cardiovascular diseases have also increased demands for these services. Tollman *et al.* note that the quality of primary care can be improved by:

- 1) developing and strengthening health management teams at district levels through a decentralised health care system;
- 2) re-prioritising activities and budgets in order to allocate more financial resources to primary health care services;
- 3) improving the skills and competencies of primary health care workers;
- 4) addressing problems of understaffing, low motivation, lack of incentives and support to health care workers; and
- 5) developing the skills of health managers in order to improve on health planning and setting health priorities which are community-oriented and based on the local disease burden.

Primary Health Care (PHC) in Namibia

In March 1990, after independence, the Namibian Ministry of Health and Social Services (MOHSS) developed a National Health Policy with a policy statement entitled “*Towards Achieving Health for All Namibians*”. In this policy, the government committed itself to provide access to health services for all Namibians by the year 2000, through the adoption of the primary health care approach and principles. The Namibian health care policy is driven by the PHC principles of equity, accessibility, affordability, community participation and empowerment, multi-sectoral collaboration, and the provision of quality health care services. The National Health Policy was reviewed in 1997 (Ministry of Health, National Policy, 1997) resulting in current policy that re-emphasizes the primary health care approach as the best strategy to address the citizens’ health care needs.

The Namibian health care policy is driven by the following principles:

- 1) Ensuring equity of access to health care services by all people with special emphasis on the vulnerable groups and those most affected by inequalities such as those in poor rural areas, women and children.
- 2) Promoting community involvement and participation in decision-making.
- 3) Providing affordable health care services by strengthening the health care system to be sustainable and cost-effective.
- 4) Facilitating inter-sectoral cooperation with all stakeholders in the provision of health care.
- 5) Ensuring the development of human resources for the different health delivery systems.
- 6) Providing quality health care services.

The Republic of Namibia, being a member state of the World Health Organization (WHO) and of the international community, has adopted and incorporated the same PHC principles of the Alma Ata Declaration in the Namibian National Health Policy. This was done as part of the country’s commitment towards addressing community needs and achieving health for all Namibians.

1.2 PROBLEM STATEMENT

During the period of 2006 and 2007, the regional health management became aware of several problems that affected the delivery of PHC services at the clinics in Windhoek. Councillors and patients were complaining about the health service delivery directly and through the national radio. These complaints were received both telephonically at the office of the accounting officer or through written complaints, and channeled to the Khomas regional office for investigation. Complaints about overcrowding of the health facilities and ill treatment of patients were most frequently reported. It was also reported that nurses leave the workplace earlier than the scheduled closing times. This contributed to the patients' dissatisfaction.

Although there is anecdotal evidence of poor nurse-patient relations and dissatisfaction among patients with the quality of services received in PHC facilities in Windhoek district, no systematic investigation into the nature and extent of these complaints has been conducted. Information concerning alleged poor nurse-patient relations and low patient satisfaction in the clinics is needed to formulate adequate programmatic responses from district, regional and perhaps national levels to improve PHC service delivery.

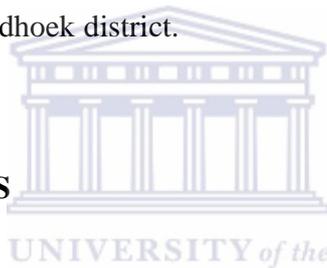
1.3 DESCRIPTION OF STUDY SETTING

Khomas region is situated in the centre of Namibia and includes the capital city, Windhoek (Windhoek district). Khomas region is one of 13 political and administrative regions of the Republic of Namibia. The population of the region according to the 2007 census is estimated at 280 181 (Khomas Region, 2007). Eighty-eight percent of the region's population lives in the urban areas, with the remaining 12% in the surrounding rural areas. According to the last Resident's Survey Report published by Windhoek municipality, the estimated number of people migrating into the city of Windhoek was at that time reaching up to 600 per month (Windhoek Municipality, 1999).

The Municipality estimated that the population of Windhoek was increasing at a rate of 5.4% per year. Most of the migrants are in the 20-34 year age groups, with high levels of unemployment in Windhoek reaching up to 22% (Ministry of Health Demographic & Health Survey, 2007). .

1.4 PURPOSE OF THE STUDY

The purpose of this study was therefore to investigate factors that influence patient-satisfaction and perceived quality of care at selected PHC facilities in Windhoek district and the reasons behind poor nurse-patient relations. It was envisaged that the results of this research could contribute towards improving patient satisfaction with PHC services in urban areas in the urban Windhoek district.



1.5 AIM AND OBJECTIVES

The aim of the study is to investigate low patient satisfaction and reasons behind poor nurse-patient relations.

The objectives of the study are:

- 1) To describe patients' perceptions about quality of services received (delivered) at PHC clinics.
- 2) To explore factors related to the clinic environment that influence perceived quality of care.
- 3) To describe the nature of nurse-patient relations.
- 4) To explore factors that influence nurse-patient relations.

1.6 OUTLINE OF THE THESIS

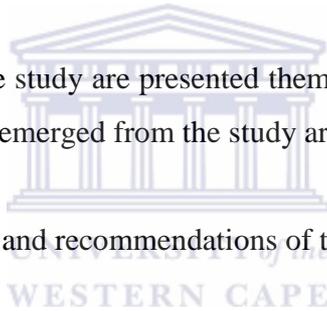
Chapter 1 provides a brief introduction to the research study, the research aim, objectives and settings.

Chapter 2 presents a review of literature on the quality of primary health care services and its assessment, patient satisfaction and nurse-patient relations in a primary health care setting. The chapter provides an overview of similar studies, which have been conducted in different countries on patient satisfaction and nurse-patient relations.

In Chapter 3 the research methodology is outlined. Details about and justification for the study design, sampling, data collection and data analysis are provided.

In Chapter 4 the findings of the study are presented thematically, and detailed discussion of the analysis and themes that emerged from the study are provided.

Chapter 5 presents conclusions and recommendations of the research study.



CHAPTER 2

LITERATURE REVIEW

In this chapter the researcher explores the role and functions of PHC in the national health system as described in the literature as well as reviewing the concept of “*quality of care*”, and approaches for assessing quality of care.

2.1 IMPROVING PRIMARY HEALTH CARE SERVICES

2.1.1 Benefits of Primary Health Care (PHC) services

Not only are PHC services underpinned by principles such as equity, accessibility and affordability, they also are intended to have direct value to the population they serve. In developing countries, PHC services offer cost-effective services and reduce the financial burden on governments, because most of the rehabilitative and preventative measures can be achieved at primary care level (Doherty and Govender, 2004). The authors add that PHC improves access to health care for communities, because PHC facilities bring services closer to patients’ homes, being situated in the reach of communities. In this way, PHC services provide an added benefit for communities by eliminating the transport costs of visiting hospitals and paying hospital fees. The authors also add that PHC facilities in developing countries usually offer a broad range of services including prenatal care, immunisations and family planning.

2.1.2 Challenges to Primary Health Care (PHC) services

Although governments are increasingly recognising that adequate delivery of PHC services is fundamental to the effective functioning of health care systems, coverage and effectiveness of primary care services are limited by insufficient resources and staff, erratic drug supplies and faulty equipment (Doherty and Govender, 2004). The WHO (2008) has considered the challenges that lie ahead for developing PHC systems, and identified major avenues to narrow the gaps between aspiration and implementation.

These are defined as four sets of reforms that reflect a convergence between the values of primary health care, the expectations of people and the common health performance challenges. They include:

- 1) Universal coverage reforms to improve health equity and social justice;
- 2) Service delivery reforms to make health systems more people centered i.e. focused on people's needs and expectations;
- 3) Public policy reforms to promote and protect the health of communities; and
- 4) Leadership reforms to make health authorities more reliable.

Implementing these sets of reforms should have a positive impact on the quality of primary health care service delivery.

2.2 INDICATORS OF QUALITY OF CARE

Within the PHC environment, it is quality of care which is ultimately the goal of reform. Quality of care is defined as “the degree to which health services for individuals and the population increase the likelihood of desired health outcomes that are consistent with the current professional knowledge” (Lohr, cited in Sheik, 1998: 59). Expanding the scope of this definition, Benbasset and Taragin (1998) suggest that quality health care should address the following dimensions:

- 1) *outcomes* - which are the “end results” or the improved health condition of individuals after treatment;
- 2) *provider-patient relations* - which entail patients' perceptions and experiences of receiving health care; this in turn, would provide indications of patient satisfaction with service delivery, and
- 3) *community needs* - with regard to issues such as community knowledge, community self-help and reliance, community awareness and satisfaction with the services provided and treatment offered in the context of the local disease burden of a specific community.

These indicators provide a basis for exploring the quality of care in any district or regional setting.

2.3 FRAMEWORKS FOR ASSESSING QUALITY OF CARE

Various techniques have been developed to measure or describe aspects of quality of health care. These techniques vary from investigations of complaints to routine audits (Fooks, Rachilis and Kushner, 1990). In their review of quality assessment in primary care, Longo and Daugird (1994) found that most assessments of care that took place from the 1950s through to the 1980s, originated from observations of medical records which comprised a retrospective view of medical care. From the 1990s however, the authors noted advances in the assessment of primary care through the use of patient perception data relative to health status and satisfaction. This was done by enquiring about the patients' medical history in order to determine the suitability of the medical intervention and treatment. This measurement was initiated in developed countries and done through the use of computerised systems by developing an electronic database to record the patients' general information, also termed the health information system database.

A range of frameworks has been advanced to assess quality of care in primary care settings. Donabedian (1988) suggested three frameworks for assessment: provider-focused; structure, process and outcome-focused; and client-focused assessments. These will be discussed further. This coincides with Gadallah, Zaki, Rady, Anwar and Sallam (2002) who suggest that quality of care can be assessed from three perspectives: client's views of quality; professional quality; and management quality. Client quality is the dimension that receives most attention in discussions of quality of health care, and is based on to what extent patients are satisfied with services provided at the health facility. Professional quality is the perspective which addresses issues such as the skills, knowledge and experience of health workers, the efficacy of human resource management and development, capacity building and continuous education and training. Management quality is the dimension addressing health care infrastructure in terms of

facilities, personnel and providing the necessary support to health workers. The researcher will explore the three frameworks suggested by Donabedian (1988).

2.3.1 Provider-focused assessment

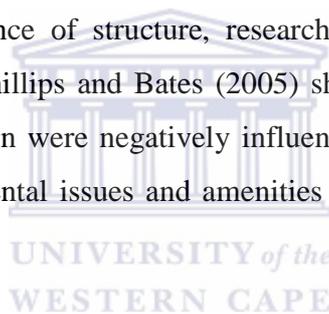
In provider-focused assessments, the assessment of quality of care is based on an audit of clinical skills, and of the knowledge and experience health workers acquire over the years. This is done through the use of Clinical Practice Guidelines (CPGs), which are of utmost importance to health workers, because the CPGs outline predetermined standards of practice to ensure quality patient care. The use of CPGs is particularly appropriate for primary care settings, because they assist health care workers at primary level in making decisions about appropriate treatment for a specific clinical condition (Worrall, Chauk and Freake, 1997). In addition, a growing number of health practitioners are making use of CPGs, due to rapid expansion of scientific knowledge, practice variations and expanding commitment to quality of care. Therefore, application of CPGs has become a frequent component of provider-focused assessment of quality (Benbassat and Taragin, 1998; Walters and Morgan, 1995). However, while there is a general belief that compliance to CPGs produces better outcomes for patients, not all researchers agree with this. According to Worrall, Chauk and Freake (1997), there is little evidence that the use of CPGs improves patient treatment in primary care level. This is because their effects may be short term or insignificant in that CPGs are often quite narrow in their focus. However, the study conducted in Estonia by Polluste, Kalda and Lember (2000) pointed out other factors like competence of the staff, knowledge and experience, and the comprehensibility of the explanations provided to patients that may significantly influence the quality of service delivery and subsequently patient satisfaction.

2.3.2 Outcome-, structure- and process-focused assessment

Outcome-, structure- and process-focused assessment constitutes a three-pronged framework for assessing quality of care (Donabedian, 1988). In other words, the assessment of care takes place either directly through the examination of processes or indirectly through the examination of structures and outcomes. The concept, *outcome*, describes the effects of care on the health of individuals. Measuring outcomes can include

mortality rate, complications, physical functioning, physiological functions, knowledge and sense of well-being. *Process* refers to all aspects of providing or receiving care, whether treatment or counselling, and includes interpersonal communication between patients and health care providers. *Structure* refers to the characteristics of the health care setting regarding PHC services available, physical structures of PHC facilities, the surrounding environment, and availability of skilled health personnel, medical doctors and medical supplies.

According to Donabedian (1988), good structures increase the likelihood of good processes, and good processes, in turn, increase the likelihood of good outcomes. The author further adds that the relationship of structure to quality of care is indirect and increases or decreases the probability of good performance or delivery of quality care. Further supporting the influence of structure, research done by Weingart, Pagovich, Sands, Li, Aronson, Davis, Phillips and Bates (2005) shows that the quality of service delivery and patient satisfaction were negatively influenced by service deficiencies like problems related to environmental issues and amenities of the services, cleanliness and comfort of health facilities.



Donabedian (1988) elaborated on the two dimensions for assessing the *process* of care as it relates to the health worker performance or delivery of quality care. The first dimension is technical care, and the second dimension is interpersonal care.

Technical care refers to the application of scientific and technological knowledge to select the most appropriate strategy for treatment intervention and the appropriate use of the range of medical equipment available for diagnosis. A study that was conducted in Riyadh, Saudi Arabia by Ahlam and Al-Osimy (1993) illustrates the aspect of technical care, emphasising the importance of continuous education and training to sensitise health workers to the different aspects of and new techniques in primary health care. They argue that improving the knowledge and skills of health workers through continuous training programmes on new treatment interventions should have a positive impact on the quality of service provision in the PHC clinics and subsequently on patient satisfaction.

The second dimension, interpersonal care, refers to the process of communication between health care provider (doctor or nurse) and the patient. It is argued that interpersonal care must meet individual and social expectations and standards of privacy, confidentiality, informed choice and honesty (Donabedian, 1988). Bearing out this assertion, the result of the study conducted in Kuwait city by Al-Doghaiter, Abdelrhman and Wahid Saeed (2000) suggests the need for continuous educational programmes to inform patients of the objectives and limits of primary health care service delivery.

2.3.3 Client-focused assessment

Accessibility to health services when needed, successful medical interventions and quality of care provided are considered the key principles of the primary health care approach (Jatulis, Bundek and Legorreta, 1997). Client-focused assessments involve assessing the quality of staff-patient relations in terms of qualities such as respectful treatment, the dignity of the patient and competent care (Laine and Davidoff, 1996). The terms client-focused and customer-focused are used interchangeably. According to these authors, competent care and continuity of service provision are also important aspects of these assessments.

Since the 1990s, consumer satisfaction has gained widespread recognition as a measure of service quality in health care systems (Yildiz and Erdogmus, 2004). Patients' perceptions about health care systems seem to have been largely ignored by health managers in developing countries, but are now deemed to be an important outcome measure for the quality of health services provided (Yildiz and Erdogmus, 2004).

From a management perspective, it is argued by Dansky and Miles (1997) that client-satisfaction is an important measure of service quality in health care organisations for the following reasons. A satisfied patient is likely to maintain a consistent relationship with a specific health worker at the frequently visited clinic. This is beneficial to the patient because he/she can obtain a better quality of service as a result of good nurse-patient relations. Furthermore, by knowing the reasons for patient dissatisfaction, management can address these issues in their health facilities. Elsewhere it is argued that client

satisfaction is also important in health care, because satisfied patients are more likely to follow specific prescribed medical regimes and treatment plans leading to better health outcomes (Wartman, 1983). Wartman also argues that patient satisfaction measurements add important information to system performance, thus contributing to an organisation's total quality management.

The patients' satisfaction with medical outcomes is considered a very important measure of the quality of health care. Jatulis, Bundeck and Legorreta (1997) argue that the most important predictors of satisfaction of quality of care are the outcomes of the health care experience itself. That is, the patient's levels of satisfaction with the medical outcomes and access to care when needed are considered as measures of quality of care.

This linkage between patient satisfaction and systems improvement is emphasised by a study conducted in Egypt by Gadallah, Zaki, Rady, Anwar and Sallam (2002) to measure the quality of service delivery and patient satisfaction in PHC facilities in two districts. The findings of the study in Egypt showed that patients were satisfied with the health care infrastructure in terms of health facilities and personnel. However, the real challenge noted was to improve the staff performance in order to minimise wasted effort, wastage of medical resources, delay and costs involved. Underpinning this approach is the intention that understandings gained through assessment would enable health care providers to give clients what they need and facilitate continuous improvement in the efficiency and effectiveness of health services provided (Berwick, 1997). A study conducted by Haddad, Fournier, Machouf and Yatara (1998) demonstrated the importance of client-focused assessment through examining lay people's perceptions (both individual and community) of health care services provided at health facilities. They found that quality of health care based on lay people's perceptions includes three dimensions, each with sub-dimensions:

- 1) *personal* dimension - which includes sub-dimensions related to the technical competence, attitude and conduct of the health worker;
- 2) *health facilities* dimension - which includes sub-dimensions related to the availability and adequacy of resources and services and accessibility; and

- 3) *health care outcomes* dimension - which includes the sub-dimension related to the effectiveness of health care delivery.

2.4. FACTORS THAT INFLUENCE PATIENT SATISFACTION

Factors that influence patient satisfaction are the focus of this study and therefore the literature on patient satisfaction is of particular interest. During the past 10 years patient satisfaction has gained widespread recognition as a measure of service quality in health care systems (Yildiz and Erdogmus, 2004). Patient satisfaction is measured by soliciting the experiences and perceptions of patients and the community. Patients' perceptions about health care systems seem to have been largely ignored by health managers in developing countries, but are now deemed to be an important outcome measure for the quality of health services provided. From a management perspective, client satisfaction is important because a satisfied patient is likely to maintain a consistent relationship with a specific health worker at the frequently visited clinic. This is beneficial to the patient because he/she can obtain better quality of service as a result of good nurse-patient relations (Dansky and Miles, 1997). Furthermore, by knowing the reasons for patient dissatisfaction, management can address these aspects in their health facilities.

A number of studies have been conducted in different countries exploring reasons that may lead to patient satisfaction or dissatisfaction with the quality of health service delivery in PHC facilities. A study was conducted in Kuwait city to assess patient satisfaction with respect to physicians' services in primary health care centers and to determine the association of patients' socio-demographic variables on their satisfaction level (Al-Doghaither, Abdelrhman and Wahid Saeed, 2000). The data was collected through individual interviews with 301 patients from five different PHC centers representing various geographic areas, using a structured questionnaire. The results showed that the overall mean satisfaction with physician services was 2.2 points out of a maximum of five points. The results also indicated that gender, marital status, occupation and income are the most important predictors, with females, married, labourers and

higher income levels having the highest mean satisfaction score. The findings of the study indicate that communication between health care workers and patients play a major role in enhancing patient satisfaction and suggest the need for educational programmes to inform patients of the objectives and limits of primary health care services. The study demonstrates that opening communication channels between health care workers and clients, designing educational programmes and conducting regular educational sessions will enhance patient satisfaction; offer ways of optimising health status; and help in the reduction of wastage of medical resources.

A similar study of satisfaction with the services provided was conducted among primary health care patients in Riyadh, Saudi Arabia (Ahlam and Al-Osimy, 1993). Researchers recommended the study of patient satisfaction as a way of evaluating primary health care. The results show that the patients were moderately satisfied with the services. They were mostly satisfied with the effectiveness of health care delivered and the human aspects of care provided by the health workers in PHC facilities, and less satisfied with the thoroughness of care owing to overcrowded facilities and the continuity of care due to the non-availability of their physician at times. The study also emphasised the importance of enhancing communication between the Ministry of Health and its staff by developing programmes of continuous education in order to train health workers on the different aspects of primary health care services. The study suggests that improving knowledge and skills of health workers through continuous training programmes on the principles and practices of PHC should have a positive impact on the quality of service provision in the PHC clinics and in turn on patient satisfaction.

A study was conducted in Egypt in 2002 to explore patient satisfaction with primary health care services and to identify factors associated with patient satisfaction in two health districts, one from Upper and the other from Lower Egypt, where a project for upgrading the PHC services had been running for three years (Gadallah, Zaki, Rady, Anwar and Sallam, 2002). An exit interview was conducted with 1108 patients using a structured questionnaire. The results revealed that most clients using PHC services were females. Patient satisfaction was high for accessibility, because the clinics are close to

home and workplaces. They also appreciated the condition of the waiting areas with regard to size, cleanliness and tidiness, comfort level and ventilation as well as the performance of nurses and doctors in terms of technical knowledge and skills, competence, attitudes and conduct. The main complaints centered on the number of prescribed drugs (at least four to five items prescribed) and the availability of prescribed drugs because most of the items are not available at the pharmacy as a result of frequency of prescription. This resulted in patients having to buy items from a private pharmacy at their own cost. In addition, patients had to visit a private laboratory at their own cost because most of the laboratory tests and analysis were unavailable at the primary health care facilities. There was also dissatisfaction with the level of privacy in the consultation room because of overcrowded facilities and lack of organisation at the clinics. There was no association between overall patient satisfaction and age, gender, education level (socio-economic variables) or the type of service provided.

Similar findings were presented by Shikiar and Rentz (2004) who confirmed that patient satisfaction with their medication has been of increasing interest by patients. This could be a reflection of the rise of the patient as consumer. Medication satisfaction is a type of patient-reported outcome, but differs from other patient-reported outcomes that are health related. In addition, the finding is consistent with the need to focus on patients' beliefs and values concerning the impact of taking his/her medication. Although the beliefs will differ according to the specific drug-disease combination, the beliefs can also be classified in several domains of satisfaction with medications: availability, symptoms relief/efficacy, side effects, ease and convenience and impact on health (Shikiar and Rentz, 2004).

Weingart, Pagovich, Sands, Li, Aronson, Davis, Phillips and Bates (2005) found that patient satisfaction centered on service accessibility, the amenities of the services and the health worker-patient relations. An analysis of the incidents in a medical service unit in the United States enumerated a wider range of factors seen as service deficiencies, such as waiting time, queues and delays, problems in communication between staff and patients and problems related to environmental issues and amenities.

These results are in line with patient satisfaction study conducted in Estonia (Polluste, Kalda and Lember, 2000) which showed that patients consider the relations between the staff and the patient as the most relevant for their satisfaction, while the quality of the amenities of the primary health care centre were judged as less relevant. Generally this study pointed to three factors: competence of the staff, the comprehensibility of the explanations given by staff; and the comfort and the cleanliness of the primary health care centre which significantly influenced the degree of patient satisfaction.

A study conducted by Lambrew, Defreeze, Carey, Ricketts and Biddle (1996) to assess continuity of care, meaning the effects of having a regular doctor accessible in primary health care facilities, is also of interest. The results suggest that individuals with any type of regular source of care had better access to primary health care than those with a regular site but no regular doctor. However, the apparent advantage of having a regular doctor over a regular site was less relevant when only those individuals reporting a physician's office, clinic or health maintenance organisation as their regular source of care were compared. These results suggest that promoting the doctor-patient relations will increase access, although the gains may be negligible for individuals who use mainstream primary care sites (physician's office, clinic or health maintenance organisation) versus sites such as walk-in clinics or emergency rooms.

According to Pawar (2005), health workers (nurses and physicians) can learn some key lessons to improve health worker-patient relations by examining what works in other fields, such as sales. The author adds that to get patients to change their behavior, there is an element of selling that is required of the physician/nurse. In other words, the physician/nurse has to recognise the opportunity for intervention, reframe communication in a way that makes it meaningful to the patient and generate a sufficient sense of urgency to compel the patient to take action. At the same time, the physician/nurse has to maintain a partnership with the patient, based on trust and understanding. These key lessons would have the potential to strengthen physician/nurse-patient relations and to consequently improve patient satisfaction and enhance patient compliance with their treatment. Key to this argument is improving nurse-patient relations as the first and most

important step in primary health care settings because nurses are usually the first encounter for patients. Pawar (2005) notes that this can be achieved by:

- 1) establishing a sense of trust between nurse and patient: when patients trust their doctors or nurses, they are more likely to adhere to treatment plans and follow advice. Effective listening and inquiry from nurses will help the health worker to uncover the patient's real needs and goals;
- 2) nurses being able to uncover the patients' actual needs: this requires the health worker to have the skills of inquiry, asking questions with a spirit of curiosity and a smiling face, to be friendly and sympathise with clients;
- 3) nurses thinking dialogue and not monologue, making a connection with the patient, establishing a two way discussion and conversation, digging deeper and finding out how patients' problems affect their day to day lives;
- 4) nurses not forcing "the close". The close is the phase of interaction during which the nurse obtains a commitment from the client to close the deal and proceed to the following step. The timing of this step is critical for success: nurses should be able to assess how and when a patient is ready for commitment and should invite negotiations; and
- 5) nurses making follow-ups, asking the patients to report back by phone or by visiting in a week's time to see how the treatment plan is working and whether things are progressing or not, and if necessary, making another appointment.

These guidelines could go along way to generating trusting nurse-patient relations and improve patient satisfaction when visiting health facilities. They can also lead to a greater understanding of patients' needs and increase levels of compliance to treatment advice (Pawar, 2005).

These findings were consistent with the results of several studies, such as the patient satisfaction study conducted in Estonia (Polluste, Kalda and Lember, 2000). The result showed that patients consider the relations between the staff and the patient as the most relevant for their satisfaction. The study conducted in Kuwait also indicated that the most important aspect is communication between health care workers and patients. Finally, the

study in Riyadh, Saudi Arabia by Ahlam and Al-Osimy (1993) showed that the patients were moderately satisfied with the services, but they were mostly satisfied with the effectiveness and the human aspects of care provided by health workers.

2.5 SUMMARY

The literature reviewed suggests several indicators of quality of primary health care services, namely: availability, accessibility, affordability, competence and community empowerment. These are also the key principles of the primary health care approach. However, Benbasset and Taragin (1998) suggest that quality health care should address the following critical dimensions: the outcomes (which are the end results), provider-patient relations, and the community's needs.

Different frameworks for assessing the quality of care are suggested. Donabedian (1988) suggests three frameworks for assessment, namely: provider-focused assessment; structure-, process- and outcome-focused assessment; and client-focused assessment. On the other hand, Gadallah, Zaki, Rady, Anwar and Sallam (2002) suggest that quality of care can be assessed from three perspectives: client's views of quality, professional quality and management quality.

CHAPTER 3

METHODOLOGY

This chapter describes the research methodology used in this study. It details the study design and methods (data collection and analysis), the setting, characteristics of the participants and the sampling procedure. Steps taken to improve the rigour of the study, as well as ethical considerations, are also described.

3.1 STUDY DESIGN

This study used a qualitative approach. The researcher used a descriptive, qualitative study because it was appropriate for exploring patients' perceptions, experience and expectations of quality service and enabled the identification of unanticipated gaps in quality of care. Using a qualitative approach allowed the interviewees the space to describe the factors that influence the relations between nurses and patients in PHC. The flexible nature of qualitative research meant that the researcher was able to interview both nurses and patients who were of great value because it allowed participants to share their experiences, perceptions and expectations (Al- Doghaither, Abdelrhman and Wahid Saeed, 2000; Gadallah, Zaki, Rady, Anwar and Sallam, 2002). It also allowed the researcher to compare and contrast the information provided from both the patients and the nurses. This was helpful in uncovering new areas and ideas that were not anticipated by the researcher. That, in turn, provided the researcher with rich information about the participants' perceptions of the quality of service delivery and the staff-patient relations. Qualitative studies have been used previously in similar studies and produced in-depth results for the same phenomena under study (Al- Doghaither *et al.*, 2000; Gadallah *et al.*, 2002).

3.2 STUDY SITES AND DESCRIPTION OF THE STUDY SETTING

The research study was conducted in five purposively selected, urban PHC state facilities in Khomas region, Windhoek district. The five facilities were chosen because they are the busiest clinics in the district; in contrast to the rest of the clinics found in rural areas, which are much smaller and serve only local communities. The study included two study populations: (1) nursing staff working in the selected PHC facilities; and (2) patients who visited these PHC clinics during the study period.

Prior to the data collection process, during the month of October 2008, the researcher conducted familiarisation visits to the clinics. The aim of these visits was to meet the key informants and to introduce and discuss the study.

The following are brief descriptions of the study sites:

- **Katutura Clinic (A)**

This clinic has three medical officers although the staff establishment makes provision for six medical officer posts. The clinic has one principal registered nurse although the staff establishment makes provision for two principals. There are 12 filled registered nurse posts although the staff establishment makes provision for 13 registered nurses. Only eight enrolled nurses' posts are filled whereas the clinic makes provision for 18. The estimated catchments population for this clinic is 88 817 (Khomas region, 2007). The number of patients that visited the clinic in 2007 was 171 250 patients (Ministry of Health, 2007).

- **Khomasdal Clinic (B)**

This clinic's staff establishment makes provision for one medical officer post which is vacant. The staff establishment makes provision for one principal registered nurse which is filled. There are only four registered nurse posts, which are filled. The clinic's staff establishment makes provision for six enrolled nurses, but three are vacant. The estimated catchment population for this clinic is 29 721 (Khomas region, 2007). The estimated number of patients that visited the clinic in 2007 was 45 733 (Ministry of Health, 2007).

- **Robert Mugabe Clinic (C)**

The staff establishment makes provision for one medical officer post which is occupied as well as one principal registered nurse post which is also filled. There are three registered nurse posts filled although the staff establishment makes provision for four registered nurses. Only three enrolled nurse posts are filled out of an available six. The estimated target population for this clinic is 65 662 (Khomas region, 2007). The estimated number of patients that visited the clinic in 2007 was 35 646 (Ministry of Health, 2007). This clinic serves a mix of different cultures found in Namibia, because it is situated in the centre of Windhoek city where all the businesses and government offices are situated.

- **Okuryangava Clinic (D)**

This clinic is staffed by four registered nurse posts of which three are filled, and seven enrolled nurse posts of which only three are filled; no medical officer posts exists. The estimated target population for this clinic is 31 795 (Khomas region, 2007). The estimated number of patients that visited the clinic in 2007 was 49 413 (Ministry of Health, 2007).

- **Donkerhoek Clinic (E)**

This clinic is staffed by two registered nurse posts, both of which are filled and three enrolled nurse posts of which only one is filled. There is no provision for a medical officer. The estimated target population for this clinic is 29 721(Khomas region, 2007). The estimated number of patients that visited the clinic in 2007 was 34 828 (Ministry of Health, 2007).

3.3 DESCRIPTION OF SAMPLE AND SAMPLING PROCEDURES

The researcher interviewed the five sisters-in-charge (key informants) of the clinics prior to starting the interviews and data collection, all of whom were female. This was done in order to become familiar with the setting in which the PHC services are delivered. The purpose of these interviews was also to gain buy-in for the study, and to help the

researcher recruit experienced patients and nurse participants according to the set criteria developed for purposive sampling.

Purposive sampling was used in this research project, because it allowed the researcher to select participants who will provide rich experience relevant to the study questions (Rice and Ezzy, 1999). The use of purposive sampling strengthened the research project by providing some diversity in terms of perceptions and experiences.

One registered nurse from each clinic, who had been working for at least the past two years in the same clinic, was recruited for an interview. Two patients from each clinic were recruited for an interview from those who had visited the clinic at least once every two months at the time of data collection. These knowledgeable and experienced participants were able to provide rich information to facilitate investigation into nurse-patient relations and other factors related to patient-satisfaction and quality of care. The PHC nursing staff and regular patients were considered as experienced members and acted as rich sources of information, as they were able to provide valuable insights into the problems, and to provide views from all aspects - the staff as well as the patients.

The nurse participants were restricted to registered nurses who had been working at the selected clinic for more than two years; they were identified with the assistance of the human resources manager and sisters-in-charge. Nurse participants were randomly chosen from those that were present on the day of data collection and interviewed during their tea breaks. Five registered nurse participants were interviewed, one from each clinic. Of the five nurse participants, one was male and four were female.

Ten patient participants were interviewed, two from each clinic. Of the ten patient participants, three were male and seven were female. Participants, including the key informants, ranged in age between 25 and 55 years old. All participants were English speaking. Patients who visited the clinics at least once every two months were identified from their health passports, with the assistance of the sisters-in-charge. This was done on the day of data collection as the patients came into the clinics. Interviews with patient

participants were conducted at the clinic in a private room during their waiting time for service points. The researcher made sure that the above-mentioned selection criteria were strictly applied during the selection of participants.

3.4 DATA COLLECTION

The data collection method was semi-structured individual interviews. Individual interviews were conducted with the key role players: sisters-in-charge as key informants; PHC nursing staff; and patients visiting the clinics. The use of individual interviews encouraged participants to talk openly and freely and allowed for the information/data to be obtained directly from the respondents' perspective. It also enabled the researcher to probe the participants and make clarifications, if needed, to get more information.

3.4.1 Key informant interviews

Key informants refer to people in the community with specialised knowledge about the subject under study (Sankar, Golin, Simoni, Luborsky and Pearson, 2006). Key informants are considered a major source of information due to the fact that they are based within the setting under investigation. They have expert knowledge about the research subject and the study setting. In this study, the researcher recruited sisters-in-charge of the five selected health facilities as the key informant participants. The five sisters-in-charge have been managers for several years, and therefore have enough knowledge, skills and experience about their clinics and the surrounding communities to provide rich information and valuable insights about the research topic.

The key informant interviews were conducted during October 2008 at the clinics. The purpose of the interviews with key informants was to gain buy-in for the study and insight into their perceptions and problems they experience. The key informants were asked about their perceptions of nurse-patient relations and patient satisfaction within their operational setting and the quality of service delivery at their clinics. Information provided by the key informants was used to triangulate information obtained from nurse

and patient participants. Arrangements were made between the researcher and the key informants, regarding a convenient date, time and setting, to conduct the interviews. The researcher took field notes during the interviews.

3.4.2 Semi-structured individual interviews

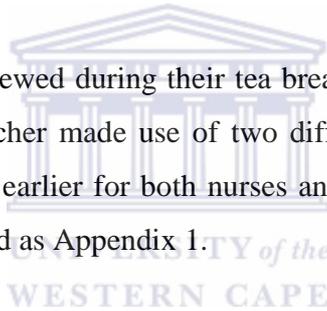
Individual interviews with patients and nurses were the main sources of data collection. The interviews were conducted at the clinics in the period of October to November 2008. Individual interviews are a good technique to use in research when seeking to learn about people's feelings, perceptions and experiences (Bowling, 2002). The individual interview encourages participants, particularly patients, to talk freely and to provide information about their experiences in visiting the clinics and their interactions with the nursing staff. It is also useful because it uncovers new areas and ideas that are not anticipated by the researcher at the outset (Pope and Mays, 1995).

According to Polit and Hungler (1999), the setting where the interviews take place can affect the behavior and feelings of participants and can also affect the way they respond to questions. Thus an appropriate and suitable place was negotiated in collaboration with the clinic staff. The interviews were conducted in a suitable, private and comfortable room, with adequate space for two people, well ventilated, no noise and minimal disruptions. Ordinarily, the rooms provided at the clinics are only used for staff meetings, staff offices or as a staff tearoom. The rooms were suitably furnished with a table and two chairs to allow face-to-face interaction between the participant and the researcher. The tape recorder was placed at a strategic point where it could easily be handled by the researcher to record the discussions, without being in direct view of the participant. The researcher ensured at all times that the participants were comfortable and at ease prior to and during the interviews. Probing was used to encourage participants to talk freely about their thoughts and experiences (Robson, 1993). Throughout the interview process, the researcher maintained an inquiring and non-judgmental attitude (Bowling, 2002). The interviews with participants were tape-recorded.

An interview guide was compiled and followed throughout the research in order to ensure uniformity and consistency across interviews with participants. The researcher endeavoured to establish rapport with the participants to encourage them to respond freely about their experiences during the interviews.

All interviews were tape recorded and transcribed in the same words of the participants. The researcher wrote a one-page summary for every interview at the end of each day. All interviews were conducted in English with patients and nurses that are conversant in English. Fluency to express themselves in English was checked by the researcher upon recruitment of participants, and again, prior to commencing the interviews. Interviews with patient participants were conducted in the morning, at the clinic in a private room during their waiting time at service points.

Nurse participants were interviewed during their tea breaks in the afternoon in a private room at the clinic. The researcher made use of two different sets of interview guiding questions that were developed earlier for both nurses and patients. The guide for these individual interviews is attached as Appendix 1.



3.5 RIGOUR

Rigour, or study quality, is of utmost importance when conducting qualitative research to ensure that results and interpretations are valid. *Credibility* refers to the process of demonstrating that the inquiry was conducted in a manner that ensures the accuracy of how subjects were identified and described (Marshall and Rossman, 1995). Choosing nurse participants who have been working in the clinic for more than two years and patient participants who visit at least once every two months enhanced credibility in this study. Triangulating the data obtained from patient participants, nurse participants and key informant participants also enhanced credibility.

Triangulation is a technique used in surveying and refers to the pin pointing of an object by viewing it from different angles and positions (Gifford, 1996). Gifford (1996) classified the triangulation methods into four types:

- 1) Data source triangulation: different kinds of data from different sources (nurses and patients) to address a certain research question.
- 2) Researcher triangulation: a number of different investigators involved in the data collection.
- 3) Method triangulation: individual interviews, focus groups or observations to investigate a research question.
- 4) Theory triangulation: involves trying to fit different theoretical frameworks to a set of data.

This research study used *data source triangulation*, which was achieved through interviews with different categories of participants as key informants, for example: patients; PHC nursing staff; and nurses in charge of clinics.

During interviews the researcher probed participants to provide more information. In this way the researcher could explore the lived experiences of participants and gather rich data. Furthermore, by exploring their experiences, the researcher was able to derive rich descriptions, which, when analysed, yielded explanations of possible factors that influence nurse-patient relations, patient satisfaction and perceptions of quality of service delivery in the PHC clinics.

Credibility (Marshall and Rossman, 1995) was achieved by sticking to the proposed research decisions, i.e. data collection, analysis and interpretation as outlined in the initial proposal. The researcher did not distort the data/information collected by including personal views and opinions. The questions were asked in a neutral, non-judgmental way, with unconditional acceptance of participants' responses.

Trustworthiness (Marshall and Rossman, 1995) was used as an approach to increase the research rigour. This means that the researcher remained true to the criteria specified for selecting participants. The researcher was transparent with his supervisor during the

entire process. This is also called transparency, and helped in providing a clear trail for audit-ability of the study.

Applicability was used to increase the study rigour. This entails that the researcher provides thick descriptions of the settings of the study, a description of the participants, which helps the application of the findings of the current study to similar settings and contexts (Marshall and Rossman, 1995).

Reflexivity was used in this research to increase the study rigour. Reflexivity refers to the practice of constantly taking stock of actions, assumptions and the role the researcher plays in research activities because he or she is the main research tool (Gifford, 1996). It is a form of self-critique which is considered to be the useful way of strengthening data in qualitative research studies. The researcher should make him/her self accountable to the study proceedings. This can be achieved through the use of logs, memos, testimonials, recording personal thoughts and feelings throughout the study to make the role of the researcher more transparent in his/her work (Gifford, 1996). The researcher, being the main tool of the study, made every effort to be self-aware and open-minded with the interviewees. During the procedure of the interviews, the researcher (who is a medical officer by profession) was aware of his position as a researcher at this point, not as a senior manager or a medical doctor. Therefore, the researcher dealt with participants not as if they were staff or ordinary patients, but rather as participants in his research. The interviews focused only on the factors that influence patient satisfaction at PHC facilities and the patients' perceptions of quality of service delivery.

The researcher avoided confrontational questions and rather approached the participants in a way that searched for a solution to improve the health care delivery. The researcher never lost patience and felt sympathetic towards the patients and nurses by giving full attention to their problems and constraints during the interviews. This eliminated the fear factor from the participants and allowed them to talk freely, discuss issues and provide full information. The researcher never showed a pessimistic attitude. The researcher kept a research journal, which is a diary of personal thoughts and feelings throughout the

study research for self-monitoring purposes. An extract from the field trip diary is attached in Appendix 2. In addition, the researcher had regular debriefing sessions with his supervisor and/or a colleague, which helped him to stay focused during the research process.

3.6 DATA ANALYSIS

Based on Marshall and Rossman (1995), data analysis is the process of bringing order, structure and meaning to the mass of data collected. Thematic analysis methods can be used for analysing data. Thematic analysis is the process of grouping data into themes; whereas content analysis is a more specific type of analytic approach that can be used once the general themes in a set of data have been identified (Marshall and Rossman, 1995).

In qualitative research the data collection and analysis is a parallel process, that is because qualitative research is usually inductive, and tries to uncover the meaning frameworks by bringing a mass of data into a coherent whole. In order to generate meaning for the research, as data collection proceeds, it is important to examine the data to see what kinds of issues are emerging (Gifford, undated). During data collection, one of the first things that is normally produced is what is called a thick description of the phenomena under study. A thick description is a very useful way for the researcher to initially approach the qualitative data (Gifford, undated).

In this research and before starting with the actual interviews, the researcher kept a research journal (field trip diary) recording what he was doing, how, where and when, and this provided a context for the analytic process. The researcher wrote down and tape-recorded that on a specific day, date and time he conducted the individual interviews with a registered nurse and two patients at a specific clinic in Windhoek.

In this study a thematic analysis approach was used. Recorded interviews were transcribed by the researcher. Data analysis occurred concurrently with data collection. The following process was followed in data analysis:

- 1) The interviews were conducted in the clinics; the official language used was English; the data was tape recorded and then transcribed. Verbatim transcripts were typed in MS Word. The researcher made field notes about what the participants were saying, and even though it was more work and time consuming for the researcher, it made the data transcription more accurate.
- 2) Each of the participants' responses was numbered according to the interview questions for easy referencing of quotations extracted from transcripts.
- 3) Data was read over many times and coded line by line.
- 4) Similar issues or topics were grouped and coded. The codes were categorised under themes. The themes were formulated to denote the relations between various coded categories.

The use of a transcription facilitated a check on data reliability because the researcher could read the transcripts while listening to the recordings (Terre Blanche, and Durrheim, 1999). Transcripts were read carefully and some significant words and phrases were noted down. The reading of transcripts while listening to the audio tape-recorded interview helped the researcher to correct what was incorrectly transcribed and note other omitted expressions in the interview. Similar topics were grouped and arranged into major topics. The most accurate and descriptive wording was found and turned into themes.

After conducting each of the individual interviews at each clinic, the researcher sifted through the data by writing a one-page summary of the main findings from each interview, either in the evening of the same day or early the next morning. The summary of each interview was sent to the supervisor via e-mail. These summaries were the first step to help the researcher towards developing themes for the research study.

Then the researcher started to code the data. *Code* is a descriptive name used as a marker for those perceptions expressed by the participants. The main aim of coding the data is to transform or extract meaning out of the participants' sentences and words. There are two ways for coding the data, either to highlight with a coloured pen all the important similar issues mentioned by the participants, or to cut and paste all similar sentences and words mentioned by participants on a separate sheet of paper. The researcher made use of the first-mentioned method in this study.

Finally, for coding the transcribed data it was necessary to go through the summarised data line by line and paragraph by paragraph, looking for significant statements and codes according to the topics addressed. The researcher compared the various codes based on differences and similarities and sorted them into categories; and finally the categories were formulated into themes.

Interpretation of data was undertaken and the final report was then drafted.



3.7 ETHICAL CONSIDERATIONS

Ethical approval for the study was obtained from the University of the Western Cape Senate Research Committee and the research protocol and consent forms were approved by the University of the Western Cape Senate Higher Degrees Committee. The study was conducted after approval had been granted from the National Health Authorities in Windhoek (Subdivision: Management Information and Research Unit). In addition, permission to conduct the interviews with nurses and patients at the selected clinics was obtained from Khomas Regional Director and Windhoek District Management.

All participants were informed of the aim, objectives and the purpose of the study through a participant information sheet. Written consent was obtained from all participants (nurses and patients) for interviews. Participants were informed that they were free to withdraw from the interview at any time if they wished to, or to decline to

answer any specific question without any consequences. Copies of the participant information sheet (Appendix 3) and informed consent forms for patients (Appendix 4) and for nurses (Appendix 5) are included.

The participants were assured that their refusal to be interviewed would not affect their future treatment at the clinics. Strict confidentiality, anonymity and privacy were maintained throughout the interviews.

3.8 LIMITATIONS

One of the limitations that were considered in this study was the sample size, because the researcher was not able to continue interviewing until saturation was reached, as is the norm for qualitative studies. The researcher pre-specified the number of individual interviews to be conducted as a time and resource consideration. The researcher also pre-specified the types of patients to be interviewed as English speaking patients only. The position of the researcher as a senior manager and as the Chief Medical Officer for Khomas Region may have had implications on the proceedings of the interviews; it may have raised some anxiety from the staff or caused them to be inhibited in their answers. In the same way, the range of views of patients may have been limited though it did not seem to have any major implications on the research procedures, because of the attempts made for the participants not to feel intimidated. In qualitative studies, the researchers are usually more interested in the nature or processes within a phenomenon or an experience rather than its distribution, therefore the researcher made use of purposive sampling, to deliberately recruit participants who have had exposure to the phenomenon under the study.

CHAPTER 4

RESULTS AND DISCUSSION

In this chapter, the researcher presents the findings of the study and discusses them. The discussion will elaborate on the possible factors that influence nurse-patient relations and patient satisfaction with the quality of service delivery at the clinics. The discussion will be linked to some of the experiences described in the literature on quality of care in other countries.

4.1 RESULTS FROM KEY INFORMANT INTERVIEWS

The key informant interviews were held in advance of the research and focused on their views on the state of nurse-patient relations and patient satisfaction in the public primary health care clinics (PHC). Their concerns covered a range: over-crowded PHC facilities; long queues and waiting time; lack of some prescribed medicines; no medical officer services at some of the clinics; and nurses' negative attitudes towards patients.

The five key informants agreed on one general concern: that the clinics are understaffed. As a result, the number of nurses is not sufficient to meet the demands of patients attending the clinics. They noted that the number of HIV/AIDS/TB patients is increasing, which has also contributed to the unfulfilled demands of the patients. The referrals from the smaller clinics where medical officers are not available, results in greater number of patients coming to the clinics where these services are offered, which increases the workload of nurses at the receiving clinics as well.

According to the key informants, the clinics experience a heavy flow of patients, especially between Mondays and Wednesdays. In addition, they receive patients coming for follow-up treatment and other patients coming for routine immunisations or family planning. They admitted that patients generally wait for a long time before being attended

to, mainly because nurses are busy with other patients, or nurses performing other tasks such as dispensing medicine and stabilising trauma patients. These have all contributed to the late attendance of nurses to patients, which is a source of patient dissatisfaction.

A recurring concern related to the working environment at the clinics, which is not conducive to the nursing staff delivering quality service or to patients visiting the facility, is that space at the clinics is too small to accommodate a large number of patients. As a result of inadequate space, patients with contagious diseases such as TB are brought into close contact with other patients. This could contribute to the transmission of TB to relatively healthy patients. There is no suitable waiting area for the great number of patients, the room space for screening services is undersized and observation rooms do not exist at some clinics. Because of the confined space, one room is often used to deliver two services.

Key informants expressed their concern that most of the nurses are stressed and show signs of burnout arising from the heavy workload. In addition, nurses are de-motivated because they feel their work is not appreciated and not recognised by senior management. They also noted that many nurses feel that they are under-paid. Hence they fail to focus and concentrate fully on their tasks and fail to communicate well with their clients.

4.2 RESULTS FROM INTERVIEWS WITH NURSES AND PATIENTS

The analyses of participants' interview transcripts are presented thematically according to the factors influencing nurse-patient relations and patient satisfaction in Windhoek clinics.

4.2.1 Work overload

This theme emerged from all nurses interviewed. Clinics are overcrowded and the number of patients is increasing as a result of the following factors: the HIV/AIDS and TB epidemics; the introduction of new services such as anti-retroviral treatment (ART);

no provision for extra nursing staff; and increased immigration to Windhoek. In the words of one of the participants:

Working environment is hectic for each and every nurse, all are overworked. Often one nurse is covering two services e.g. family planning and immunization. This is not fair for nurses. Reasons being increasing number of patients due to HIV/AIDS/TB epidemic, Namibian and non-Namibians migrate to Windhoek for greener pastures and shortage of medical officers at some clinics.
(Registered nurse, Clinic A)

Another participant noted that,

There is not enough staff. We are only two registered nurses working at the clinic. One is attending to parameters, family planning and immunization services. The second nurse is doing screening, treatment and dispensing of medicines.
(Registered nurse, Clinic E)

It is reported that one nurse is often required to cover two or three services simultaneously in different rooms, or perform two different services such as family planning and immunisation, in one room. This leads to delays in delivering the other two services. Consequently, all these have contributed to work overload amongst the nursing staff and extra waiting time for services.

We need more nursing staff, allocation of medical officer and pharmacist assistant to the clinic in order to release nurses from these duties.
(Registered nurse, Clinic D)

The study conducted by Fogarty International Centre of the U.S. National Institute of Health and the World Health Organization (2007) in developing countries confirmed that the HIV/AIDS epidemic and the increase of non-communicable diseases in developing countries has increased demands on PHC services. This leads to a compromise of the other primary health care services; hence the quality of care is negatively affected.

4.2.2 Shortage of nursing staff

Most of the nurse participants reported that their clinics are suffering from shortages of nursing staff which is confirmed by current records of unfilled posts. There are not enough nurses to cater for the number of patients visiting the clinics. Some of the reasons for the reported shortages are that the clinics are experiencing vacant nursing positions. Katutura Clinic, for example, reported ten vacancies of enrolled nurse category out of eighteen posts available. Khomasdal clinic reported three vacancies out of six available posts. This is because school leavers are not interested in enrolling for the two year programme for enrolled nurses. These unfilled positions added to the severity of staff shortages. Nurse participants noted that,

My clinic is not yet fully staffed, there is shortage of staff.

(Key Informant, Clinic A)

No plans are made for extra nursing posts to cater for the new services. No measures were put in place to create new nursing positions for the rolling out of the anti-retroviral therapy (ART) to the clinic level.

(Registered nurse, Clinic A)

Nurses are not enough compared to the increasing number of patients.

(Registered nurse, Clinic A)

There is no enough staff, the clinic is operating with only two registered nurses today, one is attending to Para- meters, family planning and immunization services and second one is attending to screening, treatment and dispensing of medicines.

(Registered nurse, Clinic E)

The ART services could not be introduced at my clinic because we do not have enough staff.

(Registered nurse, Clinic D)

Nurse turnover was also noted as a factor, as was redeployment to do relief duties at the rural clinics. The rural clinics are operating with only two nursing staff: if one gets sick or goes on vacation leave, there will be a need to send relief staff. Nurses' tendency to resign or go on early retirement is adding to the problem of staff shortages.

Nurses are frustrated and stressed due to high workload, today two nurses resigned from the clinic; the other one was sent to relief duties, we are only two nurses working today.

(Key Informant, Clinic B)

A nurse who was supposed to deliver PHC services has been assigned to a pharmacy in place of a pharmacist assistant. This has also contributed to the shortage of staff at PHC clinics. One nurse noted:

There is no quality of service due to shortage of nurses, one nurse is permanently allocated to the pharmacy for dispensing of medicines; the other one is delivering two services at the same time.

(Registered nurse, Clinic C)

All these reasons have contributed to the shortage of nurses at the clinics. It was also noted that essential services like family planning and immunisation were not delivered in some clinics.

The concerns that were raised in this study have also been contributing factors to poor quality care as shown in a study conducted by the U.S. National Institute of Health and the WHO (2007).

4.2.3 Nurses' scope of practice

This theme emerged from four out of the five nurses interviewed. In the smaller facilities nurses dispense medicines on a weekly or monthly rotation basis. Nurses are in charge of the pharmacy at the smaller clinics because the staff establishment has not made

provision for pharmacist assistants' positions at these clinics. As a result, one nurse is often assigned full-time to the pharmacy.

Nurses at the clinics act as a doctor, pharmacist and nurse.

(Key Informant, Clinic D)

Where I work, there is a need to expand on the staff establishment of the clinic in order to make provision for extra nursing staff, medical officer and pharmacist assistant.

(Registered nurse, Clinic D and Clinic E)

Nurses working in the pharmacy are responsible for ordering items, stocktaking and dispensing medicines. This situation has led to the lack of some prescribed drugs especially those for diabetic, hypertensive and epileptic patients as nurses were not trained in ordering procedures or stocktaking for medications. This has contributed to dissatisfaction amongst patients who are visiting the clinics either for a first time diagnosis or for monthly follow-ups in order to obtain their anti-hypertensive or anti-diabetic medications.

In this study the non-availability of medications at the primary health care facilities was a big concern to most of the patients interviewed, particularly for non-communicable diseases. This resulted in many referrals to the next level, thus more waiting time and dissatisfaction among clients. This was unlike the study conducted by Shikair and Rentz (2004) where they found that patient satisfaction with their medication has increased over the past few years in relation to the quality of primary health care service delivery. They noticed that the main domain for patient satisfaction with the PHC service delivery was the availability of medication for a wide variety of diseases at PHC level.

Key informants noted with concern that the non-availability of medical officers at two study clinics has also burdened the staff. For example, during emergencies, nurses are forced to put up the intravenous drips and stabilise the patients before referring them to

the next level of health services where medical officers are available. This has led to a greater financial burden for patients to get to the next level of service delivery and has added more waiting time for patients.

*Doctor, patients wait for long time because nurses are performing other duties like putting up drips during emergencies and act as medical officers.
(Key Informant, Clinic D)*

The above-mentioned examples provide clear evidence that nurses working at PHC facilities are under pressure to perform non-nursing tasks and duties outside their scope of practice which adds to delays in attending to patients, therefore resulting in dissatisfaction amongst the waiting patients.

It was found by Lambrew, Defriese, Carey, Ricketts and Biddle (1996) that patients who have a regular doctor at the clinic have better access to primary health care facilities. However, this was not the case in this study. It was also indicated that the availability of a medical officer at the clinic will help to reduce the workload of the nursing staff and cut down on referrals to the next level of care.

4.2.4 Nurse-patient relations

This theme emerged from the nurses' interviews. Three nurses reported that relations with patients depend on the mood and attitude of individual nurses and patients. When the nurse is in a good mood she interacts with patients properly and shows empathy, but when the nurse is in a bad mood she is not willing to help and does not show any friendly attitude or sympathy to patients. This also applies to patients as they might have mood swings especially when they are in hurry to get the required service at the clinic and do not want to stand in queues and wait for a long time.

Relations with patients depend on individual nurses. You get nurses with bad attitude towards patients and you see some nurses who can talk and communicate nicely. (Registered nurse, Clinic A)

Some patients might be problematic; otherwise there is mutual understanding between nurses and patients at this clinic.

(Registered nurse, Clinic C)

Two other nurses reported that nurse-patient relations at their clinics are fairly good. This is because of faster service delivery and a well-organised clinic. As a result, patients from outside their catchment area are visiting these two clinics.

Relations with patients in this clinic are not bad at all, fairly good and the communication is okay as long as you inform patients in advance about the existing problem.

(Registered nurse, Clinic B)

However, all nurses interviewed reported that nurse-patient relations in general have deteriorated over time and tend to be negative. This is because patients lost trust in the nurses and health facilities, as a result of the poor quality of care provided to them as a result of staff shortages, which led to reluctance to deliver care on the side of the nurses.

Patients became much aware of their rights; when they demand these rights nurses would feel cornered, offended or challenged. There is an increasing demand from patients' side to health services. Nowadays you find patients shout, insult and even threaten nurses.

(Registered nurse, Clinic A and Clinic D)

Sometimes the bad attitude of the nurses provokes the patients. On the other hand you find patients who shout and quarrel, this leads to provocation of nurses.

(Registered nurse, Clinic E)

These relational problems make the nurses reluctant to help patients, and de-motivated and discouraged as their intent to help patients is not appreciated. This in turn leads to the provision of poor quality care which further augments patient dissatisfaction.

This concurs with the findings in the study in Estonia (Polluste, Kalda and Lember, 2000) which indicated that a trustful nurse-patient relationship led to patient satisfaction.

Zebiene, Razgauskas, Basys, Baubiniene, Gurevicius, Padalga and Svab (2004) found in their study in Lithuania that patient satisfaction was attained through provision of information by nurses concerning treatment, and understanding patients' problems rather than provocative actions that could damage relations, as was observed in this study.

4.2.5 Communication

All the nurses interviewed in this study supported community involvement in the clinic management and the holding of regular community meetings with the clinic staff. This is not taking place regularly due to organisational problems and time constraints. According to participants, this would be the platform to discuss all problems related to delivery of health services at the clinic, to convey health-related messages, and to educate communities on health matters. This, in turn, would enable the community to identify the shortcomings, assist the nurses to come up with solutions by making decisions together, which will ultimately strengthen nurse-patient relations.

Community meetings will be the forum to discuss problems related to the clinic, health-related issues such as diarrheal diseases, URTI, HIV/AIDS/TB etc.
(Registered nurse, Clinic E)

Community can take ownership of the clinic and both nurses and community can make decisions together. It will also be a platform to get volunteers to help during health campaigns and outbreaks.
(Registered nurse, Clinic D)

The communication issue between nurses and patients, which was raised as a concern by all participants, was also supported by the study done by Al-Doghaiter *et al.* (2000) in Kuwait city, where good communication between nurses and patients has brought improvement in their primary health care services.

4.2.6 Health worker motivation

Nurses reported feeling neglected. They felt their work and efforts are not appreciated by the senior management at MOHSS nor by patients. They tried to explain the source of their de-motivation as follows:

- 1) they feel that patients do not understand the demanding nature of their job, i.e. that nurses have multiple tasks to fulfill;
- 2) the senior officials at the ministry have failed to understand their workload, where they are covering the duties of others due to unfilled posts, or the available posts are insufficient. In addition to this, they have not received incentives for the good job they are performing.

De-motivation because of lack of acknowledgement was also observed in a study done by Ahlam Mansour and Muneera Al-Osimy (1993) in Riyadh, Saudi Arabia. They recommended that the Ministry of Health should develop continuous educational programmes to train and encourage its staff members to work in PHC facilities. The following are comments from nurse participants:

I expect more understanding of the nurses' nature of job and respect from patients' side.

(Registered nurse, Clinic A)

I would like to see the Minister or the Permanent Secretary visiting the nurses at the clinic, I do not know our PS.

(Registered nurse, Clinic D)

I would like to be motivated and recognised from higher authorities at MOHSS, get feedback and quick response from regional and national level.

(Registered nurse, Clinic C)

4.2.7. Patient-centered care

Reports by participants regarding the attitudes of health workers were mixed. Whilst some patient participants reported general satisfaction with the behaviour of the health

workers, others were completely dissatisfied with their attitudes. Five patients expressed their positive experiences with nurses that are conduct their work with a positive, pleasant attitude, greeting patients in a friendly manner. However, five patients expressed negative experiences as some nurses come to work with their own stresses; with no greeting and are unfriendly. On the other hand, while all nurses interviewed confirmed that nurse-patient relations have changed negatively over time, few nurses admitted that some nurses have negative attitudes towards patients. It would seem that in the past patients were more respectful to nurses but currently it is possible that patients will shout, insult and even threaten nurses. The following are some comments from participants:

Some nurses are good and helpful; some others are coming to work with their own stresses, do not talk to patients and some are very harsh on patients.

(Patient 1, Clinic E)

Nurses' attitude to patient is good, polite, nice and cooperative.

(Patient 2, Clinic E)



Often times the nurses shouted at me, however today I was not shouted at like last time.

(Patient 2, Clinic A)

Nurses' attitude towards patients depends much on individual nurses, timing, and the nurses' mood.

(Patient 2, Clinic D)

Doctor, some patients can be very problematic, they come with their own attitude and style of shouting and insulting nurses.

(Registered nurse, Clinic B)

Sometimes the way nurses talk to clients' leads to provoking patients not to behave nicely. On the other hand you find a patient that shouts and quarrels because the clinic is over- crowded. This provokes nurses not to behave well.
(Registered nurse, Clinic E)

The nurse-patient relations in this study showed that there is little mutual respect and dignity, both important aspects of primary health care service delivery, as suggested by Laine and Davidoff (1996).

4.2.8 Waiting and service time

This theme emerged from the majority of participants. All patients stated that they wait for long hours in queues before the nurse sees them: nurses attend late to patients and the average waiting time is 2-5 hours. From the nurses' point of view, the reasons for waiting long hours were: shortage of staff compared to the heavy flow of patients; and nurses are performing multiple non-nursing duties. From the patients' point of view, the reasons were: nurses are very slow in attending to patients; and nurses are wasting time talking to colleagues or on the telephone. However, two patients did not have problems with having to wait for a long time, as they understand that the reasons for a long queue would be shortage of nurses. The following quotes reflect different perspectives:

I have been waiting for very long, four hours; generally the service is very slow, nurses should be fast and quick.
(Patient 2, Clinic D)

I have been waiting for 2-3 hours before seen by the nurse; however I cannot complaint because there are not many nurses working in the clinic, other patients are also waiting, patients cannot rush nurses to do their work, and nurses must take their time to attend to patients properly.
(Patient 1, Clinic E)

We wait long periods for treatment because nurses are too slow.

(Patient 2, Clinic C)

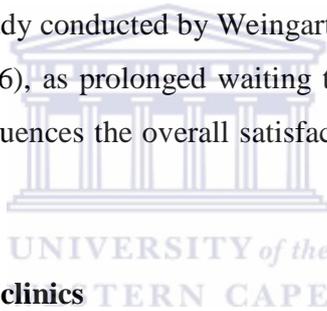
Patients wait for long time due to nurses performing non-nursing tasks, and some patients are in hurry to get the service.

(Registered nurse, Clinic E)

Shortage of staff at the clinic leads to patients waiting for a long time and late attendance to patients especially on Mondays to Wednesdays when the flow is heavy.

(Key Informant, Clinic A)

This was also noticed in the study conducted by Weingart, Pagovich, Sands, Li, Aronson, Davis, Phillips and Bates (2006), as prolonged waiting time, long queues and delays in service delivery negatively influences the overall satisfaction of patients to the care they receive.



4.2.9. Spatial arrangement of clinics

This theme emerged from both nurses and patients. Five nurses reported that there are space constraint at their facilities, due to the increasing number of patients, the introduction of new services, and the utilisation of rooms for dual services, for example, family planning and immunisation. One nurse reported that the queue extends outside the clinic building and patients are exposed to heat, rain or wind. Two nurses reported that the ART services could not be rolled out to their clinics because of the space problem; they further added that the TB room is very small and TB patients are mixing with other patients and staff. They felt that the lack of adequate space meant patients with communicable diseases mixed with patients whose immunity is diminished and staff members. This could negatively affect the quality of infection control and prevention as the ventilation in the rooms is poor. The following are some of the comments:

The working environment of the clinic is too small, no space for the screening services, the screening and Para-meters are done in the corridor, no observation room and one room is used for two services.

(Key Informant, Clinic D)

I only complained from the confusion at the waiting area, patients do not know where to go or where to wait after taking the Para-meters.

(Patient 1, Clinic C)

There is a need to extend the clinic.

(Patient 1, Clinic E)

Two patients' experiences in attending the clinics are summarised as follows:

- 1) not all clinics have signage for directing patients to different services;
- 2) nurses and security officers organise the queues and the waiting area and a first-come-first-served rule applies; and
- 3) there is order in these two clinics despite the space problem; however, order can not be maintained in the other clinics because of space constraints.

4.3 SUMMARY

The researcher developed a list of themes and codes related to factors that influence patient satisfaction and perceived quality of care. A summary of the themes and codes is stated in the following table:

Themes	Codes (meaning units)
Work overload	<ul style="list-style-type: none"> • Clinics are not yet fully staffed • One nurse is performing 2-3 services at the same time • Introduction of new services e.g. roll-out of ART services • Increased patient demand for medicine, care and treatment, particularly TB and ARTs.
Staff shortages	<ul style="list-style-type: none"> • Not all vacant nursing positions are filled • Non-availability of medical officers or pharmacist assistants positions at some clinics • Few nurses available compared to increasing number of patients • Some clinics are operating with two registered nurses only • No provision to appoint extra nursing staff
Confined space at the clinics	<ul style="list-style-type: none"> • Two services delivered from one room • No provision for observation room • Waiting area very small, screening is done in the corridors • Different patients are mixed together e.g. TB and flu patients
Nurses' scope of practice	<ul style="list-style-type: none"> • Nurses work full time at the pharmacy and dispensing medicines • Some medications are out of stock • Nurses acting as pharmacists' assistants • Nurses acting as medical officers particularly at smaller clinics • Nurses performing administrative duties
Nurse-patient relations	<ul style="list-style-type: none"> • Nurse-patient relations have deteriorated over the past few years • Nurse-patient relations depend on individual moods and attitudes of nurses and patients • Nurses expect cooperation and respect from patients • Patients became more demanding of health services

Long waiting and service time	<ul style="list-style-type: none"> • Patients have to stand in long queues for many hours • Nurses are slow in attending to patients • Patients are referred to other clinics/hospitals • Patients are not getting all required/desired services at the clinics
Nurses' attitude towards patients	<ul style="list-style-type: none"> • Some nurses are reluctant to help patients • Some nurses are moody • Some nurses provide attention and care • Some nurses have time to listen to patients' complaints and provide advice • Some nurses come to work with their own stresses
Communication breakdown between nurses, patients and community leaders	<ul style="list-style-type: none"> • Nurses support community involvement in the clinic management • Nurses support holding regular community meetings • Nurses encourage putting more emphasis on health education at community level • Time constraints hinder holding regular meetings and communication
Low health worker motivation	<ul style="list-style-type: none"> • Nurses feel neglected • Nurses' efforts are not appreciated by patients • Nurses' work is not recognised by senior management • Nurses do not have opportunities for career development • Nurses feel underpaid

The study focused on patients attending the PHC facilities in Khomas region, Windhoek district. A summary of patients' experiences, nurses' experiences and factors that influence patient satisfaction with the service delivery at the clinics are presented.

The current study found that only few patients are generally satisfied with the services received at the clinics. They cited reasons such as easy accessibility, i.e. clinic being

closer to their homes, and nurses being friendly to them as reasons for their satisfaction with services.

The results revealed that there were mixed feelings regarding nurse-patient relations. Although some nurses were supportive, helpful and displayed friendly attitudes towards patients, others were reporting to work with their own stresses, which made patients feel intimidated. On the other hand, some patients were impatient, often threatened nurses, and were rude towards nurses. A few patients did not have problems with the long queues and waiting time because they understood that the clinics are crowded and nurses are overwhelmed with work.

There are a number of major issues regarding factors that influence patient satisfaction that were identified in the literature review and were confirmed by the results of the current study with PHC service delivery in selected clinics in Khomas region, Windhoek district. Shortage of nursing staff, increased demands on services, and nurses' negative attitudes (such as unsympathetic and inconsiderate feelings towards patients), had a negative impact on patient satisfaction and perceptions of quality of service delivery at the clinics.

4.3.1 Staff-level factors

It was demonstrated that most nurses were frustrated and stressed due to high workloads. Nurses reported that shortage of staff, increased number of patients and the unregulated nursing scope of practice compromised the quality of service delivery at the clinics. Most of the nurses reported the noticeable changes in the nurse-patient relations which have deteriorated over the past few years. Of particular concern to nurses was the lack of support and appreciation from higher authorities at the MOHSS and lack of understanding and respect from patients.

4.3.2 Patient-level factors

The results show that patients had mixed experiences and perceptions of their satisfaction with the quality of service delivery and the nurse-patient relations at the PHC facilities in

Khomas region, Windhoek district. Of particular concern to most of the patients was the reported average waiting time at the clinics of 2-5 hours; the long patient queues; inconsiderate and rude attitudes towards patients of some of the nurses; and the fact that some of the essential services, such as immunisation and family planning, are not available at their clinic. However, a few patients were happy about easy accessibility and that they do not have to travel long distances to reach the services at the clinic.

4.3.3 Management-level factors

The study clearly highlighted that non-availability of full time medical officers and pharmacist assistants, particularly at the smaller clinics (four out of five clinics), resulted in low satisfaction among patients. This reported lack of satisfaction was related to patients being referred to the bigger clinics or to the hospital to be seen by the doctor or to get the medications that were not available at the smaller clinics. As a result, patients had to travel long distances to other health facilities and had to pay for transport when financial resources are limited. A second factor that negatively affected patient satisfaction was the lack of collective planning, decision making and communication that is supposed to take place between health care providers and patients at community level. This was due to the fact that community meetings with the health care providers were not taking place regularly. Patients and nurses were not able to incorporate this activity into their daily schedule due to time constraints.

4.3.4 Workplace-level factors

It was evident from this study that some participants are experiencing problems with the clinic environment. The spatial arrangements at the clinics are becoming a stressful issue for both nurses and patients. The waiting area is too small to accommodate the increasing number of patients; the number of rooms is insufficient to accommodate the existing or new services, such as ART treatment; patient queues are going beyond the clinic building; ordinary patients are mixed with TB patients; more than one service is delivered from one room; and the screening of patients in some clinics is done in the corridors. All these factors had a negative impact on the quality of service delivery and patient satisfaction.

In conclusion, the chapter discussed the results of the study and the implications of the results based on the interviews conducted. A list of themes and codes illustrating the possible factors that influence patient satisfaction was developed. Factors such as shortage of nurses, heavy workload, communication breakdown, nurses' attitude and conduct, long waiting time, low health worker motivation and workplace factors were identified as key factors that influence patient satisfaction and the delivery of quality health care services at PHC facilities in Windhoek.



CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 CONCLUSIONS

Patient satisfaction and nurse-patient relations are complex issues; and multi-dimensional approaches are required to address the problem. The study identified critical factors associated with low patient satisfaction and negative perceptions of the quality of health services delivery in selected public PHC facilities in Khomas region, Windhoek district. Factors that influence patient satisfaction were *staff-related*, i.e. shortage of nurses, and heavy workloads; *patient-related*, i.e. long waiting times, and negative nurses' attitudes; *management-relate*, i.e. lack of planning; and lack of communication at community level; and finally *workplace-related*, i.e. clinic environment. Efforts to improve the quality of care in health care services therefore require a comprehensive approach that involves patients, the community, health care providers and policy makers, and should focus on addressing environmental and structural constraints as well.

5.2 RECOMMENDATIONS

The recommendations of the study are based on various issues that emerged from the study findings and suggestions made by the key informants, registered nurses and patients interviewed.

1. The Ministry of Health needs to review the staff establishment of PHC facilities in Khomas region, Windhoek district. This should be addressed as a national priority in order to make provision for extra nursing staff, medical officers and pharmacist assistants.
2. The need to expand/renovate the physical structure of the existing facilities in order to cater for increasing number of patients and newly introduced services.

3. The introduction of continuous training of nursing staff on case management and all PHC disciplines in order to achieve and ensure more effective and efficient service delivery at the clinics.
4. Nurses should be released from duties that are outside their scope of practice in order to focus on nursing services. This should help to improve the quality of service delivery.
5. Nurses should undergo training on communication skills and refresher courses on nursing ethics in order to improve nurses' attitudes towards patients. Since nurses are the most important support system at the PHC facilities, they must strive to create and maintain an empathetic and respectful environment that can enhance the nurse-patient relations that is supportive of patients' treatment goals.
6. Strengthening the health education component of primary health care by conducting regular health education sessions at community level and not only at the clinic level. This should help to involve the communities in the planning and decision-making for issues regarding the service delivery in the clinics.
7. The Ministry of Health should put in place an incentive system (e.g. an award for best nursing practice, or best nurse attitude) and other innovative strategies to enhance the morale of nurses. This could serve as a token of appreciation and recognition from the authorities to the nurses' effort and for a job well done.

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APPENDIX 1: GUIDING QUESTIONS FOR INDIVIDUAL INTERVIEWS

Guiding questions for interviews with patients:

- For how long have you been coming to this clinic?
- What services do you mostly access the clinic for?
- What do you expect from the nursing staff/service at the clinic?
Prompt: Service provision, nurse attention, patient care, medicine dispensing etc.
- What was your experience in attending the services?
- Do you get all the care that you think you need at the clinic?
- How would you describe the nurses' attitudes towards you?
- For how long did you wait to be seen by the nurse?
- Do you access the hospital services as well?
- If yes, what services do you access at the hospital?
- How would you compare care received at a hospital to that of the clinic?
- Do you have any recommendations to improve the quality of care and service received in the clinic?

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Guiding questions for interviews with nurses:

- Can you describe your working experience in this clinic?
- What type of patients do you see at this clinic?
- How do you experience relations with the patients at your clinic?
- Do you think that nurse-patient relations have changed over time?
- What do you expect from patients or the community at large?
- Should the community be more involved in the clinic, would this help and how?
- What do you think can be done to improve the quality of care at the clinic?

APPENDIX 2: FIELD TRIP DIARY

The researcher started his journey with the study by obtaining permission from the research unit at the Ministry of Health, the regional director and Windhoek district management to conduct individual interviews with patients and nurses at the selected PHC facilities in Windhoek.

The researcher embarked on his visits to the clinics on the 27th of October 2008 to conduct the interviews first with the key informants (medical sisters-in-charge) to gain buy-in for the study and to get the sense of the environment in which nurses are working and PHC services are delivered. The key informants were already informed about the student visits to the selected clinics. The researcher conducted 2 interviews on 27th, 2 interviews on 28th and 1 interview on 29th of October 2008 with the key informants during their tea breaks at 10h00 in the morning and 15h00 in the afternoon. The researcher submitted a two-page summary of these interviews to his supervisor by 30th October 2008. During these interviews, arrangements were made with the sisters-in-charge to visit the clinics on any day between Wednesdays and Fridays of every week for five weeks (one clinic each week) to conduct the interviews with registered nurses and patients.

The first clinic was visited on Friday 31st October in the morning and two patients were interviewed during their waiting time. Patients were recruited on the day of the visit from those who visit the clinics at least once every two months and were identified from the health passports with the assistance of the sister in charge. Only English speaking patients or those who are able to express themselves fully in English were recruited for interviews. The same clinic was visited on 31st October in the afternoon to interview the registered nurse during the tea break. The nurse participants were restricted to registered nurses who have been working at the selected clinics for more than two years; those were identified by looking at HRM files with the assistance of the sister-in-charge. On the 2nd of November the researcher submitted a two-page summary of the three interviews conducted in the first clinic. The same procedures were followed in the rest of the clinics.

The second clinic was visited on 6th of November, the third clinic was visited on 12th November, the fourth on 20th November and the last one was visited on 26th November. Two-page summaries of each of the clinic interviews have been submitted to the supervisor.

Semi-structured individual interviews were conducted with patients and nurses using some guiding questions. All interviews were held in a private room. All interviews were conducted in English with patient and nurse participants. Fluency to express themselves in English was checked by the researcher upon recruitment and prior to commencing interviews. All interviews were recorded on audiotape and transcribed verbatim. Writing the summary of the main findings after each interview helped the researcher towards developing the themes for the mini-thesis.



APPENDIX 3: PARTICIPANT INFORMATION SHEET



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Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959 2809, Fax: 27 21-9592872
<http://www.uwc.ac.za/comhealth/soph>



PARTICIPANT INFORMATION SHEET

Factors that influence patient-satisfaction with public primary health care service delivery in Khomas Region, Windhoek District, Namibia.

August 2008

Dear participant

Thank you for your willingness to hear about this research. Allow me to explain the research project and your potential participation. This research study is being conducted for a mini-thesis. It is a requirement for the Masters in Public Health degree that I am studying towards at the University of the Western Cape. If there is anything that you do not understand or are unclear about, please do not hesitate to ask me. My contact details and those of my supervisor are included at the end of this letter.

This research study is aiming to understand the factors that influence patient-satisfaction at PHC clinics in Khomas region, Windhoek district. It is hoped with your assistance and participation, a better and clear understanding will be formulated of the factors that affect patient-satisfaction, its implications on the quality of service provision and suggestions for improvement. The research study will come up with a set of recommendations to strengthen and improve patient-satisfaction and the delivery of quality PHC services.

The study will include individual interviews with patients attending 5 PHC clinics in Windhoek, and PHC nurses from the same clinics. Questions about your experiences with nurses/patients at the clinics and the quality of service delivery at those clinics will guide the discussion and the interview that I will have with you.

Your name as a participant will be kept confidential at all times. I shall keep all records and information of your participation, including a signed consent form which I will need from you should you agree to participate in this study, locked away at all times and it will be destroyed after the research is finished.

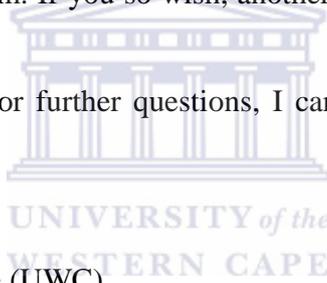
Your participation in this study is absolutely voluntary - that means you are free to decline to participate in the study. If you choose to take part in this study, you may withdraw at any time, even after consenting initially, without giving a reason for doing so. You also have the right not to answer any particular question/questions in the study as you wish. If there is anything that you would need to have clarified, or prefer not to discuss at all, please feel free to say so.

You as a participant may not get any direct benefit from this study. However, the information we learn from the participants in this study in understanding the factors that influence patient-satisfaction, may help to guide the clinics staff and the district management team for further strengthening and improvement. There are no cost implications for participating in this study other than the time you will spend in the interview.

Each participant will be asked to sign a consent form to participate in this study before I proceed with the interview. I have included the consent form with this information sheet so that you will be able to review the consent form and then decide whether you would like to participate in the study or not. Should you decide to participate in the study, I will ask you to sign the consent form. If you so wish, another person can sign on your behalf as a witness.

Should you have any queries or further questions, I can be contacted at the following address:

Dr. Hesham EL Sherif
Student Number: 2617124
University of the Western Cape (UWC)
Mobile: 0811244890



I am accountable to my supervisor at UWC.

His contact details are as follows:

Dr. Brian Van Wyk, at UWC: Tel.: +27 21 9592173; E-mail: bvanwyk@uwc.ac.za

APPENDIX 4: INFORMED CONSENT FOR PATIENTS



UNIVERSITY OF THE WESTERN CAPE
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INFORMED CONSENT FOR PATIENTS

Factors that influence patient-satisfaction with public primary health care service delivery in Khomas Region, Windhoek District, Namibia.

I have read the information about this research study on the *Participant Information Sheet*. I have had the opportunity to ask questions about it and all the questions have been answered to my satisfaction.

I understand that refusal to participate in the study will not adversely affect the care that I receive at the clinic now or in the future.

I consent voluntarily to be a participant in this study and understand that I have the right to end the interview at any time, and to choose not to answer particular questions that are asked in the study.

My signature says that I am willing to participate in this study.

Participant Name

Participant Signature

Consent Date

Researcher Name

Researcher Signature

Date

APPENDIX 5: INFORMED CONSENT FOR NURSES



UNIVERSITY OF THE WESTERN CAPE

SCHOOL OF PUBLIC HEALTH

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INFORMED CONSENT FOR NURSES

Factors that influence patient-satisfaction with public primary health care service delivery in Khomas Region, Windhoek District, Namibia.

I have read the information about this research study on the *Participant Information Sheet*. I have had the opportunity to ask questions about it and all the questions have been answered to my satisfaction.

I understand that refusal to participate in the study will not adversely affect the professional working relations between myself as a subordinate and my senior manager, now or in the future.

I consent voluntarily to be a participant in this study and understand that I have the right to end the interview at any time, to choose not to answer particular questions that are asked in the study, and that the information provided by myself is kept confidential and will never be used against me at any stage.

My signature says that I am willing to participate in this study.

Participant Name

Participant Signature

Consent Date

Researcher Name

Researcher Signature

Date

APPENDIX 6: HIGHER DEGREES COMMITTEE APPROVAL

Private Bag X17, Belville, 7535
South Africa
Tel: +27 (0) 21 959 2163
Fax: +27 (0) 21 959 2755
E-mail: csjohnson@uwc.ac.za

HIGHER DEGREES COMMITTEE

17 September 2008

TO WHOM IT MAY CONCERN

Dear Sir/Madam

Research Project of Dr Hesham El Sherif (Student Number: 2617124)

This letter confirms that Dr El Sherif is a registered student in the Faculty of Community and Health Sciences at the University of the Western Cape.

His research proposal entitled "*Factors that influence patient-satisfaction with public primary health care service delivery in Khomas Region, Namibia*" submitted in fulfilment of the requirements for Masters in Public Health has been examined by the Higher Degrees Committee and found to be of high scientific value, methodologically sound and ethical.

We fully support the research and kindly request that you allow her/him access to your organization.

Sincerely



DR GAVIN REAGON

Chairperson: Higher Degrees Committee

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APPENDIX 7: MINISTRY OF HEALTH APPROVAL



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REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198 Ministerial Building Tel: (061) 2032562
Windhoek Harvey Street Fax: (061) 272286
Namibia Windhoek E-mail: hilmanamgombe@yahoo.com
Enquiries: Ms. H Nangombe Ref.: 17/3/3/AP Date: 14 October 2008

OFFICE OF THE PERMANENT SECRETARY

Dr. H. Ali EL Sherif
CMO
Primary Health Care
MoHSS

Dear Dr. Ali EL Sherif,

Factors that influence patient-satisfaction with public primary health care service delivery in Khomas Region, Namibia.

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. Kindly be informed that approval has been granted under the following conditions:
 - 3.1 A quarterly progress report is to be submitted to the Ministry's Research Unit;
 - 3.2 Preliminary findings are to be submitted to the Ministry before the final report;
 - 3.3 Final report to be submitted upon completion of the study;
 - 3.4 Separate permission to be sought from the Ministry for the publication of the findings.

Wishing you success in your project

Your Sincerely


Mr. K. Kamure
PERMANENT SECRETARY



Forward with Health for all Namibians by the Year 2005!