

**PERCEPTIONS OF TB AND HIV CO-INFECTED
PATIENTS REGARDING QUALITY OF CARE PROVIDED AT
PRIMARY HEALTH CARE FACILITIES IN THE CHRIS HANI DISTRICT,
EASTERN CAPE PROVINCE,
SOUTH AFRICA**

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**A full thesis submitted in fulfilment of the requirements for the degree of Masters in
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ABSTRACT

As early as 1993, the World Health Organisation declared Tuberculosis (TB) a global emergency and the South African Department of Health confirmed that TB was a national emergency. The primary cause of the rise in TB cases has been attributed to co-infection with HIV. TB is the leading opportunistic infection worldwide and the primary cause of mortality among people living with Human Immunodeficiency Virus (HIV). TB and HIV are two of the highest health threats globally and in South Africa. Tuberculosis and HIV combined are responsible for the deaths of over 4 million people annually. More than 65% of individuals diagnosed with TB in South Africa are co-infected with HIV.

The importance of providing quality health services is a human right and non-negotiable. Better quality of health care is fundamental in improving South Africa's poor health outcomes and in restoring patient and staff confidence in the public and private health system. In 1996, the South African Department of Health introduced the topic of quality to raise its awareness and to make it an inherent part of the health care system. The South African health care consumers (patients) are increasingly becoming aware of their rights as patients and the gap between the actual and ideal health practices. They have broad knowledge and great expectations with regard to available care including effectiveness of service and treatment. Patients have desires for quality services when visiting a health care facility, and these desires are directly linked to the success of the healthcare system. If the desires are not met, they can negatively influence the outcome of healthcare processes such as treatment adherence and retention of patients on the system. This could possibly further escalate the TB/HIV co-infection rate in South Africa.

The need to address TB and HIV together in the light of quality care is urgent so as to improve the provision of quality health services rendered to people co-infected with TB and

HIV. The Institute of Medicine developed a framework that could guide on healthcare dimensions that need to be met for quality of care to be achieved and it is the underpinning theoretical framework for this study. The patients play a critical role in the healthcare system as they are the customers and therefore, the opinions of the patients need to be recognised to ensure that strategies and programmes that are developed are relevant.

The purpose of this research was to explore and describe the perceptions of patients co-infected with TB and HIV regarding the quality of care at the Primary Health Care facilities, in the Chris Hani District. A qualitative, explorative and descriptive design was used which enabled the researcher to understand the perceptions of TB and HIV co-infected patients regarding quality of care. The population studied in this research consisted of TB and HIV co-infected patients attending the Primary Health Care facilities at the Lukhanji Sub-district within the Chris Hani District. Purposive sampling was used to select participants with the assistance of nurses working at the selected facilities. The sample size was determined by data saturation, which was reached after 18 semi-structured interviews were conducted.

Data analysis was carried out simultaneously with data collection. In consensus discussions, the researcher and the co-coder reached an agreement on the main theme, sub-theme and sub-categories. From the research findings, two main themes were identified namely; satisfaction with delivered services and impediments to quality of care. These were further divided in sub themes and categories.

The conclusion that could be made on the quality of care provided to the TB and HIV co-infected patients in this study is that the nurses in the facilities aim to provide four of the six IOM aims of quality of care to the TB and HIV co-infected patients namely: equitable, effective, efficient and patient-centred domains. Therefore, the quality of care provided to

these patients is partial as they are not provided with all the six aims that are needed to achieve quality of care.

Recommendations are made for the field of community health nursing practice and nursing research on how to improve quality of care provided to TB and HIV co-infected patients at Primary Health Care facilities.

Keywords: Perceptions, Primary Health Care, Quality of care, TB and HIV co-infection



DECLARATION

I declare that this study; ‘Perceptions of TB and HIV co-infected patients regarding quality of care provided at Primary Health Care facilities in the Chris Hani District, Eastern Cape Province in South Africa’ is my own work, and that it has not been submitted for any degree at any University, and that all sources of information used or quoted have been indicated and acknowledged appropriately as complete references.

Siphokazi Mngcozelo

15 August 2016

Signed:



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Sing praises to the LORD, you His godly ones, and give thanks to His holy name. For His anger is but for a moment, His favour is for a lifetime; Weeping may last for the night, but a shout of joy comes in the morning.

To the most incredible gift in my life, my daughter Lukhanyo, for the unconditional love that I receive from you every hour. The beautiful smile that you had even when you could not spend enough time with me as I was committed to my studies and work.

My parents and siblings for their support and taking care of my daughter when I was busy with my studies.

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Last but not least, the National Research Foundation for their financial support.

DEDICATION

This study is dedicated to all my friends and colleagues that I have lost to HIV and TB, those who are living with the conditions and those that are directly affected and had to take responsibility for everything in their families.

I am grateful and thank the Almighty God for the willingness of the participants to take part in this study, giving a voice to millions of those who remain silent on the issues of quality of care at the health facilities.



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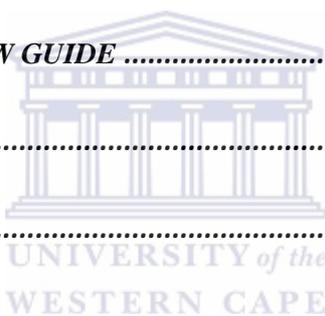


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LIST OF ABBREVIATIONS:

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
DoH	Department of Health
HIV	Human Immunodeficiency Virus
IOM	Institute of Medicine
MDG	Millennium Development Goal
NDoH	National Department of Health
NSP	National Strategic Plan
PHC	Primary Health Care
SA	South Africa
STI	Sexually Transmitted Infection
TB	Tuberculosis
WHO	World Health Organisation



CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

One hundred and eleven years after Mycobacterium Tuberculosis was identified, the World Health Organisation (WHO) declared that Tuberculosis (TB) represented a “Global Emergency.” Dr Kochi who was the manager of the WHO TB programme emphasized in a speech in 1993 that TB was humanity’s greatest killer and that the disease was out of control in many parts of the world (WHO, 2013). To date, TB remains a major global health problem. In 2014, it was estimated that 9.6 million people had fallen ill of TB and 12% of the 9.6 million of those new TB cases were HIV infected (WHO, 2015). In 2014, 6 million new cases of TB were reported to WHO, fewer than the two-thirds (63%) of the 9.6 million people estimated to have fallen sick with the disease. This means that worldwide, 37% of the new cases either went undiagnosed or were not reported. Due to its vast public health implications, TB is one of the three communicable diseases that were specifically mentioned in the Millennium Development Goals (MDGs) (Stats SA, 2015).

HIV is a strong risk factor for TB and contributes to the development of active TB from latent TB (Lawn & Bekker, 2009). The two epidemics are inextricably connected through biological, epidemiological and social pathways (WHO, 2015). TB and HIV co-infection has a negative impact on the TB control programme because it increases the case load due to excess incidences attributable to HIV infection. The combination of the two epidemics has a major impact on the global TB state and contributes to the increase of TB in countries with a high prevalence of both diseases, including South Africa which comes third after China and India (WHO, 2015). The diseases accelerate each other’s progression and perpetuate

synergistic rates of morbidity and mortality. Globally, people living with HIV are 26 times more likely to develop TB than those who are HIV-negative (WHO, 2015).

Around the globe, an estimated 1.2 million (12%) of the 9.6 million people who developed TB worldwide were HIV-positive and the African region accounted for 74% of these cases (WHO, 2015). HIV is the strongest risk factor for the development of TB disease and TB is the leading opportunistic infection and AIDS-defining condition among people living with HIV (UNAIDS, 2012). In 2014, there were an estimated 1.5 million deaths around the world from TB and 390 000 deaths among people who were HIV positive. Globally, TB ranks alongside HIV which accounted for 1.2 million deaths in 2014, including 390 000 TB deaths among HIV-positive people as a leading cause of death (WHO, 2015). Trends in the new adult infections differ among the six World Health Organisation (WHO) regions of America, Africa, Europe, Eastern Mediterranean, Southern Asia and the Western Pacific with a significant greater burden of the disease in the global south (WHO, 2013).

In the African continent, TB was acknowledged to be an emergency at the WHO African Region Committee meeting held in Maputo in 2005 (WHO, 2005). Nonetheless more than a decade later, the dual epidemics are still pervasive and HIV has been the most important factor contributing to the escalating incidence of TB.

South Africa contributes 0.7% to the global population yet it is home to approximately 6.19 million (more than 10% of the global population) people with HIV. TB cases have been escalating resulting to South Africa being declared one of the countries with a high TB burden in the world (WHO, 2015). In 2014, of the country's 295 136 TB cases with known HIV status, 179 756 were also living with HIV (WHO, 2015). Meaning currently, the TB and HIV co-infection rate in South Africa is currently at 61% (WHO, 2015). The majority of these patients are seen at the Primary Health Care (PHC) facilities.

The South African government chose the Primary Health Care (PHC) approach as a source of health care and therefore in most instances, the PHC facilities are the first contact and main treatment centres for the TB and HIV co-infected patients. The PHC approach was first introduced and endorsed at the international conference on Primary Health Care in Alma Ata, Kazakhstan in 1978 so as to achieve ‘health for all’ (WHO, 2008). However, the aim of the Alma Ata declaration seems to be challenging in South Africa as indicated through poor health outcomes such as TB cure rate, TB smear conversion, and high defaulter rates on TB and HIV which often lead to increased death rates.

In 2008, three decades post the Alma Ata Declaration, it was pointed out that the MDGs were complementary to PHC and it was recommended that emphasis should be on quality of care at primary, secondary and tertiary level. The MDGs’ targets set for achievement in 2015 were not met in South Africa hence there were sub-standard patient health outcomes (Stats SA, 2015). Nonetheless, the tide can change if all aspects of care such as expertise and training of healthcare providers, who will then provide quality of care, are taken into account when planning for health care in South Africa.

The Institute of Medicine (2001) describes quality of care as the extent to which health services provided to individuals and the populations improve health outcomes (WHO, 2015). The care should provide technical quality where patients receive services that ensure desired health outcomes exceed the health risks; for example, conducting the correct procedures, providing the correct diagnostic tests and treatment. The care should also ensure that all patients are treated in a culturally respectful manner and are allowed to participate in decisions about their treatment.

There are several systemic issues that contribute to poor health outcomes namely; unskilled health care workers providing TB and HIV services, attitudes of staff members and

fragmentation of services. Loveday, Scott, McLoughlin, Amin and Zweigenthal (2011) conducted a study in one of the rural districts in the KwaZulu-Natal Province and found that in some of the facilities, some of the staff members were not adequately trained in HIV, TB and Sexually Transmitted Infections (STI) services. The authors further stated that inability of staff members to manage such services through inability to manage side effects and ignoring patients' complaints regarding adverse effects of the medication, may lead to non-compliance with treatment which may eventually lead to poor health outcomes. The knowledge, attitudes and perceptions regarding TB and HIV play a very important role in the correct diagnosis and quality of care provided to patients diagnosed with the co-epidemic. Obtaining better health outcomes is greatly influenced by the level of knowledge and how care is delivered to the patients. Currently, the majority of PHC facilities are delivering TB and HIV as vertical disease specific programmes. Uyei, Coetzee and Macinko (2011) on their systematic review on "integrated delivery of HIV and TB services in Sub Saharan Africa", found that the vertical response to the TB and HIV epidemics is ineffective and inefficient. In 2011, Uyei, Coetzee and Macinko (*ibid*) conducted another study in Cape Town in an effort to examine how integrating TB and HIV services impacted on health outcomes. The findings from the study suggested that at the facilities where TB and HIV care were provided by one clinical team, the risk of death of the co-infected patients was lowered by about 50 to 60%. Therefore factors that impact on the provision of quality of care have an impact on the health outcomes of TB and HIV co-infected patients.

As much as patients have a right to quality of care and better health outcomes, they also have a responsibility to their health and therefore there are also patient-driven issues that also contribute to poor health outcomes. One of the major setbacks to the success of the TB control programme is stigma experienced by patients (Dodor & Kelly, 2009). Self-Stigma associated with HIV or TB has significant negative consequences on the uptake and

effectiveness of clinical and operational interventions that target their control thus associated with poor adherence and retention in HIV care (Mbonu, van den Borne & de Vries, 2009). Stigma can be aggravated by having insufficient knowledge about a disease. In a qualitative study conducted at Nyanga Clinic in Cape Town, Shasha (2010) found that community members lacked knowledge about TB and could not differentiate between TB and HIV. The two factors had caused the participants to refuse to take their treatment thus becoming non-compliant to their treatment. This meant that health education given to patients was not effective thereby contributing to poor quality of care and health outcomes.

Attempts have been made at scientific and policy level to improve health outcomes. However, patients have not been given an opportunity to be involved in decisions regarding their health where they are able to express their views and perceptions on quality of care responsive to their needs for better health outcomes. In order to reduce the incidence of TB and HIV co-infection in South Africa, both the health system and patient driven contributors need to be addressed so as to improve the quality of care rendered to the patients. Therefore, while the health system contributors are key in addressing the problem, it is also necessary to understand the perceptions of co-infected patients regarding quality of care rendered in the PHC facilities.

1.2. PROBLEM STATEMENT

South Africa has a high infectious disease burden with concomitant HIV and TB epidemics. The country has experienced a rapid increase in TB infections from 1990 to date and the primary cause is the co-infection with HIV (UNAIDS, 2013). The two epidemics have placed an enormous strain on the South African health care system, and are interlinked with 330 000 of the country's estimated 520 000 TB cases in 2011, which patients are also living with HIV (UNAIDS, 2013). In an attempt to integrate and improve the quality of TB and HIV

care, the National Department of Health (NDoH) launched the National Strategic Plan (NSP) for the period 2012-2016 (NDoH, 2012) with the aim to address the drivers of the co-epidemics and also sustain the health and wellness of already infected patients. Despite this intervention at policy level and medical interventions to overcome the burden, treatment outcomes are still not improving (WHO, 2015). With the treatment success rate for all HIV infected TB patients standing at 73% in 2013, far from the WHO target of more than 85% success rate (WHO, 2015), this raises questions on the quality of care provided at the PHC facilities where the majority of co-infected patients are managed. These questions are more so important in the study context (Chris Hani District) where the TB case findings dropped to 707.9 in 2014 from 841 in 2012; and the years of life lost (YLL) stood at 31.9 in 2013 as compared to the national average of 27.9 in the same year (Massyn, Peer, Padarath, Barron & Day, 2015).

Over the past number of years, research has been conducted to determine the medical, clinical and health system's obstacles for improving health outcomes for the two epidemics and the quality of care provided to patients has been measured using professional standards (Uyei *et al.*, 2011). However, little attention has been given to TB and HIV co-infected patients' contribution to health outcomes which implies that their perceptions of quality of care have been ignored. These gaps have called for a study to be conducted to explore and describe the perceptions of these patients with regard to the quality of care provided at the PHC facilities where they receive their treatment and care. Understanding these perceptions can contribute to the development of interventions that are patient centred which in turn can improve the provision of quality of care to these recipients.

1.3 AIM OF THE STUDY AND THE RESEARCH QUESTION

The study aims to explore and describe the perceptions of TB and HIV co-infected patients regarding quality of care provided at the PHC facilities at the Lukhanji Sub-district located within the Chris Hani District in the Eastern Cape. To achieve the study aim, the following research question was posed:

- What are the perceptions of TB and HIV co-infected patients regarding quality of care provided at the PHC facilities at the Lukhanji Sub-district located within the Chris Hani District in the Eastern Cape?

1.4 SIGNIFICANCE OF THE STUDY

The South African government has made tremendous medical interventions in an effort to provide quality of care to TB and HIV co-infected patients with the aim of improving patient outcomes for TB and HIV programmes. This study's findings will assist policy makers with useful information from patients' view on what they perceive to be quality of care and how it should be rendered to them by the healthcare workers as compared to the current practices. Consequently, this information will be useful to the Professional Nurses in rendering an effective quality service to all co-infected patients which may be transmitted to the entire nursing fraternity. In addition, this study's findings can be used as a baseline to future research in the field.

1.5 PARADIGMATIC PERSPECTIVE

Babbie and Mouton (2011) define a paradigm as a model or framework for observation and understanding, which shapes both what we see and how we understand it. According to De Vos, Strydom, Fouche and Delpont (2011), the paradigmatic perspective describes the manner in which the researcher views and explains the research material. For this to be understood,

the researcher's meta-theoretical, theoretical and methodological assumptions will be unpacked.

1.5.1 Meta-theoretical statements

The researcher's meta-theoretical assumptions are founded on the social justice in health and include the following meta-theoretical statements as defined within the researcher's view of health, human being, environment, and nursing. The researcher's assumptions are as follows:

1.5.1.1 Health

The researcher shares the same sentiments with the World Health Organization's (1978) definition of health, which refers to it as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity (WHO, 1978). In this study, health refers to the provision and availability of services in the form of human resource and equipment for one to achieve a state of personal wellbeing.

1.5.1.2 Human being

Human beings are created as complex and unique in that they are made up of three components namely; the body, mind and soul. It is from this meta-theoretical view that TB and HIV co-infected patients in this research require caring, support and being treated equally and holistically such that their physical, mental and spiritual health is addressed to create harmony.

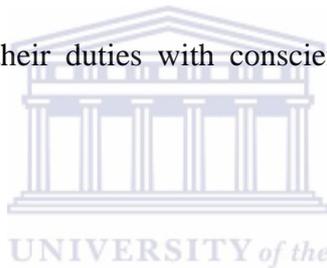
1.5.1.3 Environment

The environment is the sphere and surrounding in which human beings can live and share with fellow human beings. The environment where the TB and HIV co-infected patients receive care is at the PHC facilities in the Lukhanji Sub-district within the Chris Hani District.

The researcher believes that all patients have a right to be treated equally in the environment in which they seek healthcare and that no one should be denied the possibility to be healthy or feel discriminated due to being labelled according to a disease or condition they have. Therefore, PHC facilities in the Lukhanji Sub-district within the Chris Hani District are health environments where patients co-infected with TB and HIV should receive adequate care that is of excellent quality irrespective of their social standing.

1.5.1.4 Nursing

In this study, nursing means care, support and services offered to the patients in order to promote health, prevent and cure illness and assist patients to manage chronic illnesses. In providing services to patients, the nurses act as advocates for those under their care. Therefore, nurses should carry their duties with conscience and dignity and also respect human life.



1.5.2. Theoretical statements

In this section, the theoretical framework and central theoretical statement are discussed below.

1.5.2.1 Theoretical Framework

A theoretical framework is the structure that can hold or support a research's study source. It also introduces and describes the theory which explains the research problem under which the study exists (Swanson, 2013). This study is grounded on the Institute of Medicines' (IOM) model of quality (WHO, 2015) which states that for quality of care to be achieved, the following healthcare dimensions must be met:

Safe: Avoiding injuries to patients from the care that is intended to help them.

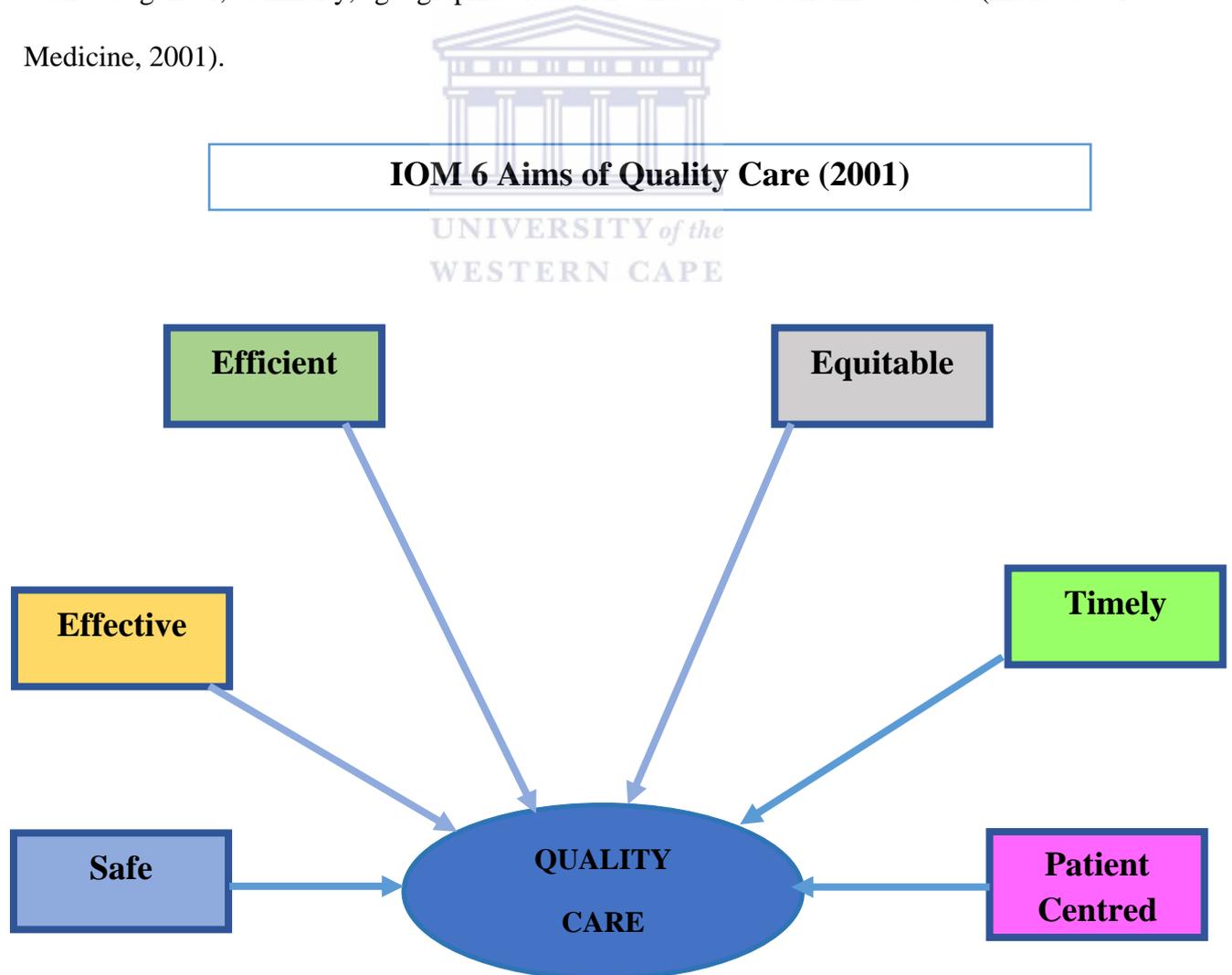
Effective: Delivering health care that adheres to an evidence based practice and results in improved health outcomes for individuals and communities based on need.

Efficient: Delivering health care in a manner that maximises resource use and avoids waste.

Patient-centred: Providing care that is respectful of and responsive to individual patient preferences, needs and values; and ensuring that patient values guide all clinical decisions.

Timely: Reducing waiting and sometimes harmful delays for both those who receive and provide care.

Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status (Institute of Medicine, 2001).



The framework argues that a health care system that achieves major gains in these six areas would be far better at meeting patient needs. Patients would experience care that is safer, more reliable, and patient-centred such that patients' views are listened and responded to. In return, patients would work with health workers to manage their own care and this may improve the outcomes of their health and ultimately the outcomes of the health of the community at large (WHO, 2015).

When applied to TB and HIV co-infected patients in this study, the model suggests that for these patients to recognise that they are receiving quality of care, they need to be treated in a safe facility such that they are not afraid to disclose their health status and they are not afraid of being harmed through illegal disclosure that may lead to them defaulting their clinic visits. The facility needs to have healthcare workers that are knowledgeable in the management of TB and HIV co-infection and follow the evidence-based guidelines in managing the co-infection through ensuring that the necessary drugs are available. The facility also needs to have an environment where patients are able to talk to the healthcare workers and be listened to regarding their problems with their treatment and any other problems that may be linked to treatment.

1.5.2.2 Central theoretical statement

Exploring and describing the perceptions of TB and HIV co-infected patients regarding quality of care in Primary Health Care facilities in Lukhanji Sub-district within the Chris Hani District would enable what patients perceive as quality of care to be known. It would further contribute to the formulation of recommendations to enable the Primary Health Care health workers to provide patient-centred quality of care.

1.5.2.3 Conceptual definitions

Tuberculosis: Is an infectious airborne disease caused by mycobacterium which usually affects the lungs and is an opportunistic infection to immune compromised individuals, especially HIV infected patients.

Human Immunodeficiency Virus: Is a virus that attacks and weakens the human immune system such that it makes one's body vulnerable to opportunistic infections such as Tuberculosis (TB).

Co-infection: Is when one is infected with more than one disease at the same time which may require that care of both diseases is integrated. In this study, co-infection means a person who has both Tuberculosis and HIV simultaneously and takes treatment for both.

Quality of care: Is the ability to access effective care responsive to patients' needs on an efficient and equitable basis for the optimisation of health benefit or wellbeing for the whole population (Mosimah & Battle-Fisher, 2015). In this study, this means that a patient must be able to access and receive care that is effective, efficient, equitable, timely and patient centred

Perception: Is the way in which something is regarded, understood or interpreted by an individual (Bratton, Landreth & Lin, 2010). In this study, perceptions denote how patients see and interpret the care they receive from the facilities they receive treatment from.

Primary Health Care: Is essential healthcare based on practical, scientifically sound and socially acceptable methods and technology; universally accessible to all in the community through their full participation at an affordable cost and geared towards self-determination (WHO, 2015). For this study, primary health care means a community based clinic where TB and HIV co-infected patients receive treatment and care from nurses.

1.5.3 Methodological statement

The study focused on a better understanding of the perceptions of TB and HIV co-infected patients regarding quality of care provided at the PHC facilities through the generation of new knowledge in the lived world of the TB and HIV patients in Lukhanji Sub-district in the Chris Hani District.

The researcher believes that the study will provide a framework within which the healthcare workers will be able to generate new ideas to improve quality of care in order to satisfy the needs of the TB and HIV co-infected patients.

According to Burns and Grove (2013), the theoretical framework of a study (IOMs 6 AIMS of quality care) enhances the methodological assumptions. In addition, “assumptions are also the basic principles that we accept and assume to be true without proof or verification” (Burns & Grove, 2013). Since the main objective of the study was to gain knowledge about the perceptions of TB and HIV co-infected patients regarding quality of care in the Chris Hani District and how these could be used to make recommendations, the researcher was able to generate new knowledge about concepts in the study by using a qualitative, explorative and descriptive study design. This increases the understanding of the theoretical concepts that a variable presents (Burns & Grove, 2013) in order to achieve the purpose of the study.

1.6 RESEARCH METHODOLOGY

Research methodology refers to the process or plan for conducting the specific steps of the study (Burns & Grove, 2013). In this chapter, the research design and method are discussed briefly and a more detailed discussion will follow in Chapter 2.

1.6.1 Research design

A research design is used to plan and structure the research project in such a way that the eventual validity of the research findings is maximised through minimising or, where possible, eliminating potential error (Mouton, 2009).

The researcher adopted a qualitative approach with explorative, descriptive and contextual design to explore and describe the perceptions of TB and HIV co-infected patients regarding quality of care provided at Primary Health Care facilities in the Lukhanji Sub-district within the Chris Hani District in the Eastern Cape.

1.6.1.1. Qualitative Approach

Qualitative research is a systematic subjective approach used to describe life experiences and situations to give them meaning (Burns & Grove, 2013). It focuses on the experiences of people as well as stressing uniqueness of the individual (Parahoo, 2014). The approach allows study of things in their natural settings in order to make sense of phenomena in terms of the meanings people bring to them. This approach was therefore chosen because it assisted the researcher to be successful in her quest to explore and describe the perceptions of TB and HIV co-infected patients regarding quality of care provided at Primary Health Care (PHC) facilities in the Chris Hani District.

1.6.1.2. Exploratory Design

Explorative studies are undertaken when a new area is being investigated or when little is known about an area of interest (Polit & Beck, 2010). The researcher chose the exploratory design with an intention to gain more insight on the perceptions of TB and HIV co-infected patients regarding the quality of care provide at PHC facilities. Although research has been conducted on quality of care provided to TB and HIV co-infected patients, little is known about the patients' perceptions of quality of care in the study context.

1.6.1.3. Descriptive Design

Descriptive research accurately describes the characteristics of persons, situations, or groups and the frequency within which certain phenomena occur (Polit & Beck, 2010). The researcher chose the descriptive design to be able to accurately describe how TB and HIV co-infected patients perceive quality of care at the PHC facilities in the Chris Hani District.

1.6.1.4 Contextual Design

The research took place within the context of the Chris Hani District in the province of the Eastern Cape. The researcher intended to explore the phenomenon under the context of the PHC facilities in the district. The research findings will not be generalised but contextualised within the parameters of the studied phenomenon.

1.6.2 Research setting

The study was conducted in the Lukhanji Sub District which is one of the eight local municipalities in the Chris Hani District Municipality in the Eastern Cape. It is the largest sub district in the district making up 24% of the district's population. This area was chosen because it was identified as one of the areas that have a high TB burden, (National Health Laboratory Services, 2014) and has the second highest HIV positivity rate of 9.7% amongst the other sub districts in the Chris Hani District (Chris Hani District Municipality, 2012). Another reason is that the area is a combination of urban, semi-urban and rural and therefore gave a different view for each of the areas in the sub district. A more detailed description of the setting is provided in Chapter 2.

1.6.3 Population

Brink (2009) describes population as “the entire group of persons or objects that are of interest to the researcher, or that meet the criteria the researcher is interested in studying”.

The target population in this study were patients who met the following inclusion criteria at the time the study was conducted:

- TB and HIV co-infected,
- On treatment for at least two months for both infections at the time of interview at the study setting,
- Fairly well and able to speak without difficulty ,
- Eighteen years of age and older.

1.6.4 Sampling technique and size

According to Burns and Grove (2013) sampling is a process of selecting a group of people, events or behaviour of the population being studied.

1.6.4.1 Sampling Technique

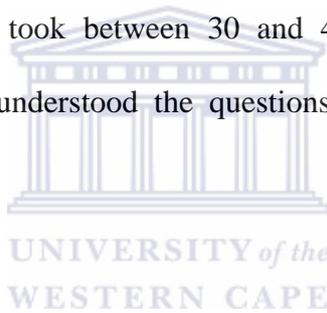
In this study, the sampling was non-probable and purposive in nature. In non-probability sampling, researchers use their judgment to select the subjects to be included in the study based on their knowledge of the phenomenon (Parahoo, 2014). This technique was used to seek the perceptions of TB and HIV co-infected patients regarding the quality of care provided at PHC facilities which they gave from their experiences. Only TB and HIV co-infected patients who met the set criteria were purposively chosen to participate in this study.

1.6.4.2 Sample size

For the purpose of this study, the sampling to redundancy technique was employed, meaning that the researcher did not know what the sample size was. However, the researcher had an estimation of 30 participants as the sample size. According to Burns and Grove (2013), saturation of information is reached when the researcher begins to hear the same information repeatedly being reported and no longer learning anything new, therefore, sufficient depth of information was collected from the participants until saturation was reached.

1.6.5 Data collection

Data collection is a precise, systematic gathering of information relevant to the research purpose or the specific objectives and questions of a study (Burns & Grove, 2013). Data collection was carried out in a private room in the PHC facilities by the researcher after informed consent forms signed by the participants were obtained from them. To ensure that the perceptions were explored, the researcher conducted interviews using a semi-structured interview guide (Annexure C). The interviews were conducted in isiXhosa and English as most participants in the study setting speak English and/or isiXhosa; the researcher also speaks both. The guide was developed using this study's theoretical framework; however this did not limit the responses of the participants as context driven information evolved. Interviews were conducted and took between 30 and 45 minutes each. The researcher confirmed that the participants understood the questions. Full details of this section are presented in Chapter 2.



1.6.6 Data analysis

Raw data was given to a co-coder who worked independently to analyse them as indicated by Brink (2009). A consensus discussion was held between the researcher and the co-coder. Data was reduced or broken into themes or categories.

1.7 TRUSTWORTHINESS

The goal of rigour in qualitative research is to accurately report study participants' experiences (Speziale & Carpenter, 2011). According to Creswell (2009), the suggested four criteria for developing the trustworthiness of a qualitative inquiry are: credibility, conformability, transferability and dependability. This chapter provides a brief discussion on trustworthiness and a detailed description of how this factor was ensured is described in Chapter 2.

1.7.1 Credibility

To enhance credibility of the study, the researcher consulted with the research supervisor throughout the study to evaluate the research process and outcomes. Member checking was conducted by taking the analysis of the data and summary of the findings back to the study participants for affirmation and validation of the findings.

1.7.2 Conformability

The researcher consulted with an experienced researcher in checking the research process, manual transcription of the audio recordings and independent coding so as to compare the transcription and coding with that of the researcher. The recommendations and conclusions made in this study were drawn from the collected data.

1.7.3 Transferability

To ensure transferability in the study, data collection was guided by the theoretical framework used. Data analysis was guided by both the theoretical framework, thick descriptions of the research process and the power of argument. The aim was not to generalise the study findings, as only the participants in the target population at the study setting were included. Therefore, transferability was enhanced by recruiting participants in the target population.

1.7.4 Dependability

According to Creswell (2009), dependability refers to the techniques to show that, if the study were to be repeated in the same context, same methods and with the same participants, similar findings would be obtained. Dependability was ensured through strategies such as peer evaluation and submission of the transcribed audio recordings to the study supervisor for scrutinising the coded data.

1.8 ETHICS

Permission to implement research was sought from the Research Ethics Committee of the University of the Western Cape (Annexure D), from the Eastern Cape Research and Surveillance Department (Annexure E) and from each participant who was involved and audio recorded in the study. Each participant was given an information sheet explaining what the study is about, the purpose, procedure, benefits and risks as well as the expectations of both the researcher and the participants (Annexure A). Participants were informed of their rights and that if there were any problems with the researcher; they could notify the researcher's supervisors. The supervisors' telephone numbers were provided. The researcher adhered to the following principles:

1.8.1 Privacy and confidentiality

Interviews were conducted in a private area to ensure that participants were free from interference by others and the permission to use such areas was requested from the managers of the selected facilities. The data gained from the participants was only available to the researcher and the supervisor and all the data on the voice recorder was deleted after transcription. Coding was used to identify the participants, and the information collected was protected from unauthorised access, use, disclosure, loss and theft by being kept under lock and key. The data, after transcription, was then kept at the supervisor's university office and will be destroyed within five years after the completion of the study.

1.8.2 Informed consent

Information such as aims of the study, duration of the interview, benefits and the dissemination of the findings and the right to withdraw from the study were explained to the participants in simple terms and in a language that they understood (Annexure B).

1.9 CHAPTER OUTLINE

Chapter 1: Overview of the study including the background, aims, objectives and methodology.

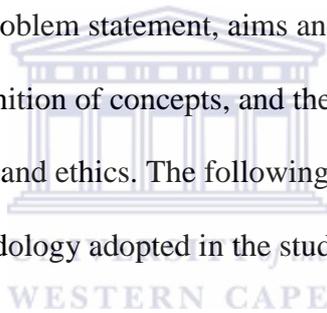
Chapter 2: Research Methodology of the study.

Chapter 3: Data analysis and discussions of the results and literature integration

Chapter 4: Recommendations, conclusions and study limitations

1.10 CONCLUSION

This chapter introduced the scientific foundation of the study which gave a brief description of the background of the study, problem statement, aims and research question of the study, the significance of the study, definition of concepts, and the theoretical framework employed, the methodology, trustworthiness and ethics. The following chapter will give a full description of the research methodology adopted in the study.



CHAPTER 2

RESEARCH METHODOLOGY

2.1 INTRODUCTION

This chapter outlines and gives a broader discussion on the research methodology applied in this study which includes research design, the study population, the sampling procedure, data collection methods, ethics, data analysis and study rigour. Table 2.1 below provides a summary of the study methodology.



Table 1: Summary of the study methodology

Table 1: Study Aim: To explore and describe the perceptions of TB and HIV co-infected patients regarding quality of care provided at the PHC facilities at the Lukhanji Sub district located within the Chris Hani District in the Eastern Cape.				
Population	Sampling technique and size	Data Collection	Data Analysis	Trustworthiness
TB and HIV co-infected patients	-Purposive sampling technique -18 interviews conducted	Semi structured interviews  UNIVERSITY of the WESTERN CAPE	Thematic Analysis	-Member checking -Independent coding -Audit trail -Verification of research process -Peer evaluation

2.2 RESEARCH DESIGN AND METHODS

This section will discuss the approach and design that was followed in this study and the methods that were used to collect, analyse and interpret data.

2.2.1 Research design

A research design is the overall plan that gives the exact instructions or guidelines on how to address the research problem or answers to the research question (Terreblanche, Durrheim & Painter, 2007). This research project was planned and structured in such a manner that the findings were maximised. Logical steps were used to answer the research question. In this study, a qualitative approach which is explorative, descriptive and contextual in nature was used; to explore and describe the perceptions of TB and HIV co-infected patients regarding quality of care at Primary Health Care (PHC) facilities at the Chris Hani District.

2.2.1.1 Qualitative Research

Guest, MacQueen and Namey (2011) explain qualitative research as a type of scientific research which sets out to answer questions using predefined systems or procedures. Furthermore, these authors define this approach as a flexible, iterative, text-rich, semi-structured and more aligned to describing and explaining relationships and experiences as they occur in particular research settings. The flexibility of this approach allows the use of semi-structured data collection tools which then permit the researcher to adapt the questions and the flow of the data collection tools according to the research participants' responses. Qualitative research also gives the investigator an opportunity to interact with the individuals whose experiences the researcher wants to understand. In view of the above, this approach was chosen for this study as it availed an opportunity of interaction with participants while they shared their experiences and the flexibility to use the most appropriate tools in the researcher's quest to explore and describe TB and HIV co-infected patients' perceptions of

the quality of care provided at the PHC facilities. Another reason for opting for qualitative research was to give the participants an opportunity to express their views regarding quality of care at the PHC facilities. The following are the characteristics of qualitative research as described by Patton (2011).

- Qualitative research examines the attitudes, perceptions and behaviours of the participants and therefore data collection should occur in a natural setting. In this study, the researcher collected data in a natural setting, that is, at the PHC facilities in Lukhanji Sub-district which was the participants' choice.
- Qualitative research acknowledges participation of the researcher in the study whilst being seen as the main instrument in the research process. In this study, the investigator was the primary instrument for data collection and analysis. Since qualitative research involves fieldwork, the researcher had to go to the people, settings and sites so as to observe their behaviour in their natural setting.
- This approach is designed to unleash what can be learned about a phenomenon where people are informants. In this study, semi-structured interviews were used and this provided an opportunity for the questions to be adjusted in reaction to the participants' responses so that their perceptions regarding quality of care at PHC facilities could be understood.

2.2.1.2 Exploratory Design

Exploratory designs are useful when there is limited information available and there are wishes to have the flexibility for future exploration of research areas (Polonsky & Waller, 2010). According to Polit and Beck (2010), this design is used to investigate the full nature of the phenomenon and other factors related to it. This design was chosen as it was more appropriate for this study with the aim to broadly explore more about and have a better

understanding of the perceptions of TB and HIV co-infected patients regarding quality of care provided at PHC facilities.

2.2.1.3 Descriptive Design

Burns and Grove (2013) describe the descriptive design as a systemic, subjective approach used to describe life experiences and give meaning. It is a way of gaining insight through discovering meanings. Descriptive design has as its main objective the comprehensive accurate portrayal of the characteristics of persons, situations, groups or the frequency within which the phenomenon occurs (Polit & Beck, 2010). In this study, a descriptive design was used because it allowed the researcher to describe and give meaning to the perceptions of TB and HIV co-infected patients as they narrate them from their lived experiences.

2.2.1.4 Contextual Design

According to Babbie and Mouton (2011), the aim of qualitative research is to describe and understand events within the concrete and natural contexts in which they occur. These authors also pointed out that research can be described as contextual as the study is made of occurrences in the participants' immediate environment or context; where context refers to the conditions and situations of an event. This study was focused on the perceptions of TB and HIV co-infected patients regarding the quality of care provided at PHC facilities in the Lukhanji Sub-district within the Chris Hani District in the Eastern Cape.

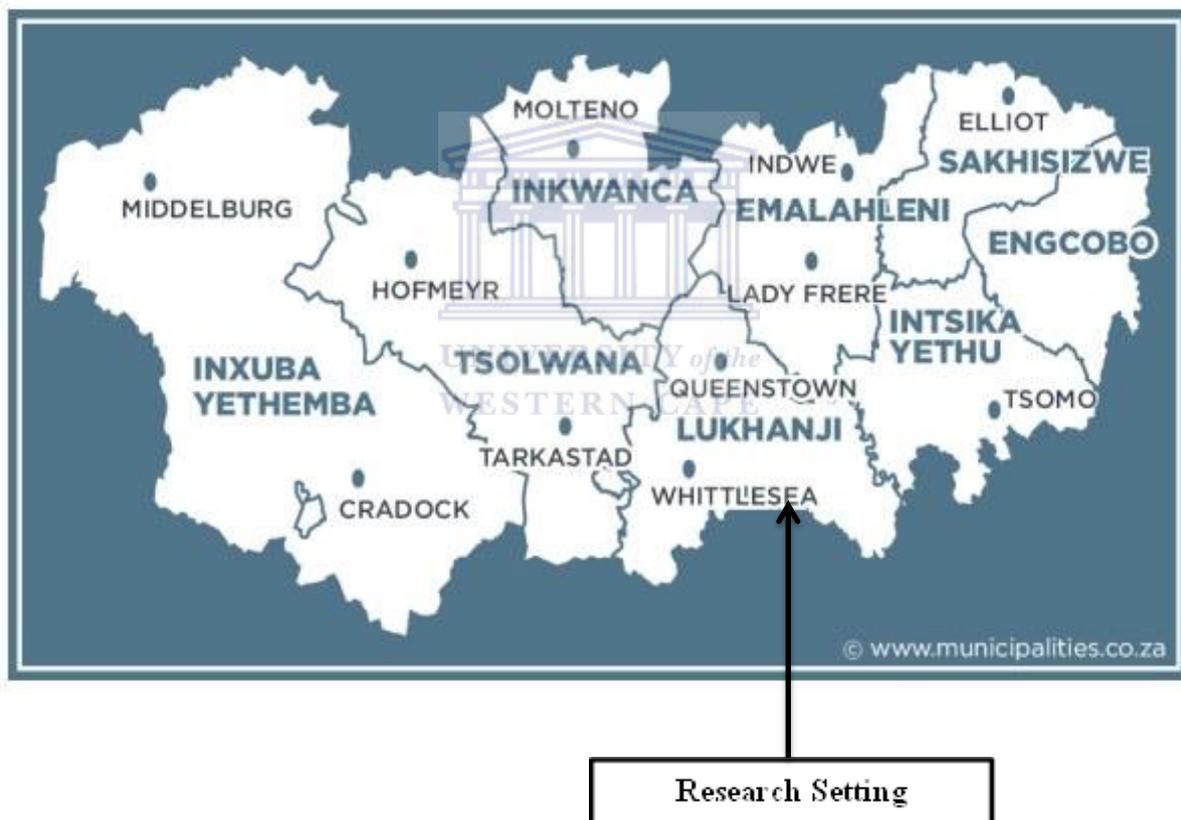
2.2.2. Research methods

This includes population and sampling, study setting, data collection, data analysis, trustworthiness and ethics.

2.2.2.1. Study Setting

The study was conducted at 12 Primary Health Care (PHC) facilities located at the Lukhanji Sub-district in the Chris Hani District. The Lukhanji Sub-district is comprised of two towns namely; Queenstown and Whittlesea. Queenstown is more urban while Whittlesea is semi-urban. Queenstown may be urban in character but it also has townships that are semi-urban and rural. On the other hand, Whittlesea is mostly made up of rural areas with a small portion of the area being semi-urban.

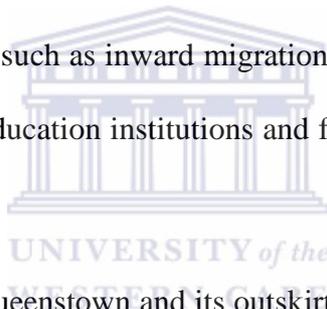
Map of the Chris Hani District



Source: Chris Hani District Municipality Web

Chris Hani District is one of the eight (8) districts in the Eastern Cape Province of South Africa. The seat of Chris Hani is Queenstown. This district is land-locked and situated in the centre of the Eastern Cape hinterland; between the Eastern Cape coastline and the Drakensberg Mountains. It incorporates both the Karoo in the west, as well as the former Transkei areas in the east; making it a district of varied physical conditions. The district comprises of eight (8) local municipalities namely; Inxuba Yethemba, Tsolwana, Inkwanca, **Lukhanji**, Intsika Yethu, Engcobo, Sakhisizwe and Emalahleni (Chris Hani District Municipality, 2012).

The greatest number of people within the district is concentrated in the Lukhanji Municipal area with a total population of 190 723 (Chris Hani District Municipality, 2012). This can be attributed to a number of reasons such as inward migration as a result of perceived economic and employment opportunities, education institutions and facilities; generally a perception of better living conditions.



Nine facilities were selected in Queenstown and its outskirts; with two being urban, two rural and five semi-urban. In Whittlesea, one facility was rural while the other two were semi-urban. The choice of more clinics in semi-urban areas was driven by the number of facilities at those areas and the higher numbers of TB and HIV co-infected patients around such areas in the sub district. All the 12 PHC facilities that were selected in the Lukhanji Sub-district open for eight hours per day; between 07h30 and 16h30. All the PHC facilities are led by facility managers referred to as operational managers, who ensure the smooth running of each facility. Each of the facilities has a professional nurse who runs the TB programme and also manages TB patients that are co-infected with HIV simultaneously. All TB and HIV co-infected patients are managed by this one professional nurse responsible for the programme in each facility and receiving both anti-TB drugs and Antiretroviral treatment in the same consulting room.

2.2.2.2. Population

A population is a group of subjects that meet the designated set of criteria. The target population becomes the population of interest from whom the data can potentially be collected (Parahoo, 2014). The target population in this study were patients who were:

- TB and HIV co-infected,
- On treatment for at least two months for both infections at the time of interview at the study setting,
- Fairly well and able to speak without difficulty ,
- Eighteen years of age and older.

Burns and Grove (2013) define sampling as a process of selecting a group of people, events, behaviours or other elements that are representative of the population being studied. According to Brink (2009), exploratory design calls for small samples that are chosen through a deliberate process to represent the desired population.

For the purpose of this study, a non-probability purposive sampling technique was used because it involves the selection of people who represent the desired population. The researcher consciously and deliberately selected subjects that met the criteria so as to obtain rich information regarding the phenomenon under investigation.

- **Sample size**

A sample size is the number of participants, determined by the depth of information needed to gain insight into the phenomenon (Burns & Grove, 2013). In a qualitative research, the focus is on the quality of information obtained from participants rather than the size of the sample (Burns & Grove, 2013). The goal of the qualitative approach is not to generalise the findings and therefore it is difficult to set a sample size. According to Brink (2009), data

saturation is the point at which new data no longer emerges during the collection process. In this study, the sampling to redundancy technique was employed and therefore there was no determined sample size. However, the researcher had an estimated sample size of 30 participants; data saturation occurred after 18 participants were interviewed.

2.3 DATA COLLECTION

This section gives a full account on the role of the researcher, the method of data collection and data analysis.

2.3.1 The role of the researcher

The researcher submitted a research proposal, consent form (**Appendix B**) and information sheet (**Annexure A**) to the Research Ethics Committee of the University of the Western Cape for the study's approval (**Annexure D**). Permission was also requested from the Eastern Cape Research and Surveillance Department (**Annexure E**) to conduct the study. After receiving the approval from the Eastern Cape Research and Surveillance Department, the researcher called the operational managers of the selected facilities to make an appointment for explanation of the background and aim of the study. Additionally, she requested access to a private room where the interviews would be conducted. The clinic nurses selected the patients who were eligible and the researcher personally called the patients with the assistance of the clinic personnel to make appointments as they have a trust relationship with the patients. The patients chose to be interviewed at the facilities where they collect treatment since the interviews coincided with their treatment collection days.

The eligible participants were given a detailed explanation of the background, purpose and aim of the study as written in the information sheet. They were then requested to volunteer participation. Each participant was requested to sign a consent form before being interviewed to show that they understood and agreed with the terms and conditions of participating in the

study. The questions were written in English, however, the researcher asked them in isiXhosa where a participant requested as isiXhosa is her mother tongue. All the ethical aspects pertaining to procedures that ensured privacy and confidentiality were explained to the participants. The researcher also made the participants aware that an audio recorder would be used to record the interviews. It was further explained that codes rather than their real names would be used for each recorded interview. The data was collected between mid-July 2015 and mid-September 2015.

The researcher was employed by a Non-Governmental Organisation in the Joe Gqabi District at the time of data collection and the study was conducted at the Primary Health Care facilities in the Lukhanji Sub-district which is under the Chris Hani District health department. Therefore, the researcher is not directly involved with the TB and HIV co-infected patients, thus preventing bias.

2.3.2 Data gathering

According to Welman, Kruger and Mitchell (2007), semi-structured interviews are a method where the researcher has specific questions but may add additional questions to obtain more information and also gain a detailed picture of a person's perceptions. Such interviews give the researcher and participants' flexibility by permitting the researcher to follow up interesting avenues that emerge during the interview; whilst the participant is given an opportunity to give a fuller picture. According to Burns and Grove (2013), the following are advantages of using semi-structured interviews as a data collection tool:

- Questions can be rephrased to increase understanding. In this study, questions were formulated then rephrased when a participant did not understand them.
- Ideas and views can be explored in depth and clarified when necessary. In this study, the questions were adjusted in reaction to the participants' answers as this allowed

for exploration of their perceptions of quality of care. The researcher went back to conduct interviews with some of the participants that were interviewed initially, so as to obtain in depth exploration and clarity on some of the responses that were given.

Therefore this study employed semi-structured interviews using an interview guide (**Appendix C**) to solicit information from the study participants.

An audio recorder was used to record and collect data from the interviews. According to Lincoln and Guba (1985) cited in Creswell (2009), data recording is a process that involves the recording of information using an interview guide which is a list of questions. An interview guide to be used for the semi-structured interviews was developed based on the objectives and the theoretical framework of the study. The interviews were held in a private room at the Primary Health Care facilities where the participants obtain their treatment for both TB and HIV. The interviews were recorded using an audio recorder with permission from the participants, ensuring that all the data was captured accurately.

The following steps were taken for data collection:

- An appointment was secured with each participant with the assistance of the TB nurses at the study sites.
- The operational managers of the facilities were asked to provide a private room which would be conducive to conduct interviews.
- Tables and chairs were arranged to suit face-to-face interviewing.
- A digital audio recorder was prepared and;
- The consent forms were signed before conducting each interview.

The researcher conducted the interviews herself and followed the communication techniques as described by De Vos, Strydom, Fouche and Delport (2011) to facilitate the interviews. The techniques used are as follows:

- **Clarifying:** This technique was used to clarify unclear statements; for instance “I wonder what you meant exactly by ...”
- **Probing:** Open-ended questions were asked to encourage the participants to give more information; for example “Tell me more about that.”
- **Minimal verbal responses:** Were used by the researcher such as ‘mm-mm, yes, I see’, to show the participant that she was listening and understood what the participant was saying.
- **Listening:** The researcher used listening skills.

2.3.3 Field notes

Field notes are the researcher’s description of the observations during the interview. They are a record of the research experience, personal reflections, and physical description of the setting (De Vos *et.al.*, 2011). In this study, a voice recorder and hand written notes prepared immediately after the interview became useful. According to Creswell (2009) field notes include:

Descriptive notes: These are the reports on the descriptions of the participants, the context, and the activities that took place during the interviews.

Demographic notes: This described information with regard to the time, place and date of the physical setting where the interviews took place.

Reflective notes: These gave a record of personal thoughts such as speculation of incidents, feelings, ideas generated during the process, hunches, impressions and prejudices (**See Annexure F**).

2.4. DATA ANALYSIS

Data analysis involves organising, providing structure and eliciting meaning to the data that has been collected in the study. Analysis of data in a qualitative research is an active and interactive process (Polit & Beck, 2010). The steps include identification of themes, verification of the themes through reflection of the data and discussion with other researchers or experts in the area, categorising the themes and recording of support data for the categories. However, in this study, the researcher used Tesch's (1990) proposed data analysis steps as outlined in Creswell (2009). The data analysis was guided by the following steps:

- All the transcriptions were read carefully to get a general impression by writing notes as thoughts and ideas that came to mind.
- The most interesting interview was selected and read to try to get meaning in the information.
- Similar topics were arranged in groups by forming columns, labelled major topics, unique topics and leftovers.
- The topics were abbreviated as codes and the codes were written next to the appropriate segment of the text. Data organisation was also observed to check whether new categories or codes emerged.
- The total list of categories was reduced by clustering topics that relate to each other to form a list of categories.
- A final decision was made on the abbreviation of each category and the codes were arranged alphabetically.

- All the data material belonging to each category was put together in one place and a preliminary analysis was performed.

An independent co-coder was appointed to analyse the data. All the transcripts were sent to the co-coder. The co-coder and the researcher independently analysed the data which was followed by a discussion. Thereafter, a consensus was reached on the categories that emerged from the analysed data.

2.5 TRUSTWORTHINESS OF THE STUDY

Brink (2009) states that “trustworthiness of a study has to do with the consistency, stability and repeatability of the informants’ accounts as well as the investigator’s ability to collect and record information”. Qualitative research requires special criteria to establish trustworthiness. Lincoln and Guba (1985) as cited in Creswell (2009) propose four criteria for judging the soundness of the study and they include: credibility, conformability, transferability and dependability. For the purpose of this study, the model of Lincoln and Guba (1985) was employed to ensure its trustworthiness. Table 2.2 below gives a summary of how these criteria were used.

Table 2: Strategies to ensure trustworthiness

STRATEGY	CRITERIA	APPLICATION
Credibility	Reflexivity	The co-coder and the researcher analysed data concurrently and later reached a consensus.
Transferability	Selected sample	Purposive sampling by use of clinic nurses who have a trust relationship with participants to ensure a representative sample of the TB and HIV co-infected patients
	Thick description	Dense information concerning the participants and research context was provided.
Dependability	Coding and re-coding	The researcher and a co-coder coded the data independently and consensus discussions were held on the coding themes and data analysis.
Conformability	Conformability Audit	Verification of the entire research process was done.
	Reflexivity	The co-coder and the researcher analysed data concurrently and there was later a consensus discussion.

2.5.1 Credibility

Credibility is an act of conducting an inquiry in such a manner as to ensure that participants were identified and described for the study to show that the inquiry is credible to the constructors of the original multiple realities (Marshall & Rossman, 2011).

The following strategies were used to ensure the credibility of collected data and data interpretation:

- Purposive sampling that is non-probable in nature was used to ensure that participants were selected on personal judgment in order to include the most informative ones in the study (Polit & Beck, 2010). Therefore, the targeted participants to meet the inclusion criteria had to be patients who were older than 18 years of age at the time of data collection, fairly well, co-infected with TB and HIV and on treatment for both diseases at least for two months and who could speak about their perceptions regarding quality of care.
- According to Polit and Beck (2010), member checking is a method of validating the credibility of data through discussions with the informants. The researcher conducted member checking by providing some of the participants with the analysis of the data and summary of the findings for affirmation and validation of the study findings. Data of the participants was checked throughout the study and the researcher asked the participants whether the interpretation was a true and fair reflection of their perspectives.
- Peer evaluation refers to exposing the researcher's analysis and conclusion to an experienced researcher on a continuous basis for the development of both design and analysis of the study (Wilkins, Shin & Ainsworth, 2009). In this study, a co-coder was given transcripts to independently analyse. The researcher and the co-coder discussed

the developed categories to reach a consensus to ensure that the data was correctly interpreted. The researcher liaised with the research supervisors throughout the study regarding the data collection, data analysis and outcomes.

2.5.2 Conformability

Conformability is a criterion for evaluating data quality. According to Polit and Beck (2010), conformability occurs when two or more independent people agree that the data is similar; meaning that the findings are free from bias. A number of strategies exist for enhancing conformability in qualitative studies. For the purpose of this study, the researcher consulted an experienced researcher in verifying the research process; manual and verbatim transcription of the audio recordings and independent coding to compare the transcription and coding with that of the researcher with the aim of reaching a consensus on the identified themes, codes and sub-themes. An audit trail was made available to ensure that conclusions and interpretations can be traced to their sources and to confirm that the findings are supported by their sources (Babbie & Mouton, 2011).

2.5.3 Transferability

Transferability is a process of demonstrating the applicability of one set of findings to another context (Marshall & Rossman, 2011). In this study, generalisation is not the aim of the findings as only TB and HIV co-infected patients that are fairly well, able to speak and have been on treatment for at least two months at the PHC facilities in the Lukhanji Sub-district were interviewed. Transferability was enhanced using the following strategies:

- Purposive sampling was used so that only the sample in the target population was recruited into the study. They population was chosen because of representativeness of the population on which conclusions were made.

- Data collection was guided by the theoretical framework that has been used in the study.
- The process of analysing data was guided by both the theoretical framework and the power of argument.

2.5.4 Dependability

In qualitative research, dependability refers to the stability of data over time and over conditions (Polit & Beck, 2010). It is a technique used to show whether the findings would be consistent if the study were to be repeated in the same setting, same methodology and with the same participants (Krefting, 1991). The following strategies were used to ensure stability of data in the study:

- All participants were interviewed using the interview guide (Annexure F).
- The transcribed data was given to a co-coder who acted as an independent reviewer.
- All the data obtained in the study was submitted to the study supervisor for examining the findings, interpretations and recommendations in order to attest that they are supported by data.
- The data collected during interviews was kept for audit trail purposes.

2.6. ETHICS

According to Terreblanche, Durrheim and Painter, (2007), ethics is a study of moral standards and how they affect conduct. Ethics relate to moral standards that a researcher should consider in all stages of the research process and the rights of the humans participating in the study. According to Mouton (2009), ethical measures include providing the participants with adequate information regarding the research and giving them assurances of privacy, anonymity, confidentiality, informed consent, dignity, and feedback. In addition, it is the

assurance that none of the participants will be psychologically or physically harmed. In this study, the following procedures and principles were adhered to:

2.6.1 Review by the ethics committee

The researcher submitted the research proposal to the ethics committee of the University of the Western Cape at the Bellville Campus, the Eastern Cape Research and Surveillance Department and the Chris Hani District Health Department for permission to conduct the study. The proposal that was submitted clearly indicated the purpose and objectives of the study, as well as the research design and the ethical principles that the researcher would adhere to.

2.6.2 Principles of ethics

The researcher adhered to the following ethical principles:

2.6.2.1 Privacy and confidentiality

Anonymity occurs when the researcher cannot link the information with the informants and to ensure this, coding was used to identify the participants; for example, participant 1 is P1 instead of using their real names. All interviews were conducted in a private room in the PHC facility after obtaining permission from the facility manager. In this study, confidentiality was ensured by using the following precautions:

- The researcher informed the participants before interviewing them who would have access to the information after completion of the study namely; the researcher's supervisor and the co-supervisor.
- The list of participants' names and transcriptions is kept at a safe place in the supervisor's office at the University of the Western Cape.
- Data on the voice recorder was transcribed and it is to be destroyed within five years after the completion of the study.

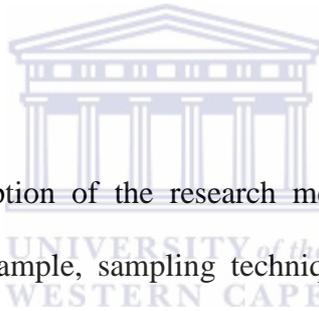
- Interviews will not be published and only the relevant units will be used in data presentation.

2.6.2.2 Informed consent

Informed consent involves giving participants adequate information regarding the research to enable them to comprehend the information, and have the power of free choice, enabling them to voluntarily consent to or decline participation (Polit & Beck, 2010). In this study, the researcher informed the participants about the purpose and aims of the study, duration of the interview, benefits and the dissemination of the findings and their right to withdraw from the study was emphasised. Both verbal and written informed consent was obtained from the study participants before they were interviewed by the researcher.

2.7 CONCLUSION

This chapter gave a full description of the research methodology used in this study. It discussed the research design, sample, sampling technique, data collection, data analysis trustworthiness of the study and ethics. The next chapter will deal with research findings, analysis and the study's discussions.



CHAPTER 3

RESEARCH FINDINGS, DISCUSSION AND LITERATURE INTEGRATION

3.1 INTRODUCTION

In the previous chapter, a detailed description of the research design and methods was discussed. In this chapter, the research findings and interpretation in response to the research objectives are presented pertaining to the exploration and the description of the perceptions of TB and HIV co-infected patients regarding the quality of care provided at the PHC facilities in the Chris Hani District, Eastern Cape in South Africa. The interviews were transcribed verbatim and checked for accuracy by the researcher.

Examples of direct quotations from the interviews augmented these findings, which the investigator compared and confirmed with existing literature pertaining to perceptions of TB and HIV co-infected patients regarding quality of care provided at Primary Health Care (PHC) facilities. Findings that are unique to this study are indicated.

3.2 RESEARCH FINDINGS AND LITERATURE INTEGRATION

Wood and Ross- Kerr (2006) argue that organising unstructured research data in trying to understand interview narratives requires extreme creativity and skill. A theme is defined as “the essence or the main idea” of research data, that occurs over and over again during data analysis. A theme is the basic topic of what the research data is about. Sub-themes are that “what” of the research data and are used to identify relationships in smaller units of research data. Categories are the smallest units of data that determine relationships in research data (*ibid*).

In analysing the collected data, the researcher presented the words, clusters, or segments from the transcripts of the individual interviews into themes, sub-themes and categories. The

researcher interrogated the data using questions from the interview guide which were followed by further relevant probing, clarification, and sub-questions aimed at achieving enhanced clarification and richness of the descriptions and explanations. The interviews were transcribed verbatim and checked for accuracy by the researcher. Direct quotations from the interviews have been written in bolded italics.

A consensus between the researcher and the co-coder resulted in two themes for perceptions of TB and HIV co-infected patients regarding quality of care provided at the PHC facilities namely satisfaction with delivered services and impediments to quality of care. These themes were further divided into sub-themes and categories as displayed in **Table 3** below.

Table 3: Summary of TB and HIV co-infected patients' views on quality of care

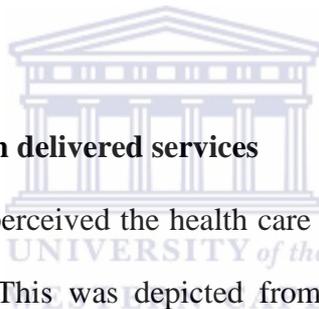
Themes	Subthemes	Categories
1. Satisfaction with delivered services	1.1 Positive nurse-patient relationship	Nurses are supportive
		Nurses are caring beings
		Nurses listen to patients
	1.2 Non-discrimination	Nurses' positive attitude
	1.3 Health promotion	Education role played by nurses in patient health literacy
	1.4 Availability of resources	Continuous availability of medication
Provisional planning		
2. Impediments to quality of care	2.1 Lack of privacy and confidentiality	The number of nurses in a consulting room

	2.2 Prolonged waiting time	Delayed attention to patients
		Tendency to ignore patients

3.3 FINDINGS AND DISCUSSIONS

Discussions of the findings regarding the perceptions of TB and HIV co-infected patients included the two themes identified as highlighted in Table 3.1.

- ✓ **Satisfaction with delivered services.**
- ✓ **Impediments to quality of care.**



3.3.1. Theme 1: Satisfaction with delivered services

The majority of the participants perceived the health care services rendered to them as those of a fairly satisfactory quality. This was depicted from the responses that demonstrated satisfaction with the services based on the positive nurse-patient relationship, non-discrimination, health promotion and availability of resources.

3.3.1.1. Sub-Theme1: Positive nurse-patient relationship

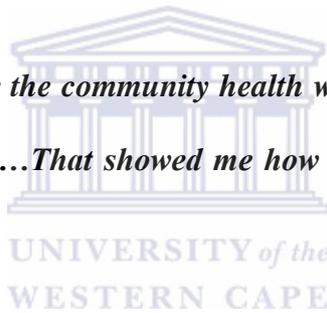
A number of participants in this study perceived the relationship that they have with nurses as an important factor that facilitates good quality of care. A culture of positive nurse-patient relationship was reportedly forged and was perceived from the participants observing nurses' behaviour as supportive and caring in addition to the ability to listen to patients.

- **Nurses are supportive**

From the findings of this study, a number of patients reported the supportive nature of nurses based on the behaviours they displayed towards the patients. Therefore, it was clear and evident that the nurses are supportive to the patients. This was perceived to be an important gesture that promotes good quality of care. The following are some of the responses from the participants:

“They give me a lot of support and there is a woman staying closer to my home who works here in the clinic at the TB side. She is the one who is really supportive and looks after me all the time...She assists me in taking my treatment at the right time.” (P 10)

“When I was too sick, you know the community health workers that work with the nurses brought my medication at home...That showed me how supportive they are of my health my sister.”(P 9)



“Oh they are very supporting... they are always there to give you the pat on the shoulder... A pat on the shoulder that ...ehh, the drugs are there and we also here to help you.”(P 16)

“There is a short man here in this clinic, he is really supportive and encouraging me not to stop taking the pills” (P 7)

From the findings of this study, a number of participants indicated that the nurses were supportive such that they were always reminding them of the times of taking the treatment, asking how they were feeling and even going the extra mile of providing treatment to them when they were unable to go to the facility to fetch it. One of the participants mentioned that nurses asked the community health workers to bring medication at home since he was very

sick to go to the clinic to fetch it. This is evident that the nurses were not only interested in the physical health of the patients but also in the emotional and psychological health of each patient as they were interested to know how they were “feeling” and that the patients had the freedom of sharing their feelings with them. This echoes findings from a study by Carlsson, Johansson, Eale and Kaboru (2014) which reports that nurses spoke about loving TB and HIV co-infected patients, getting closer to them and treating them as any human being. This is despite the commonly held perception about nurses having negative attitudes towards patients thus offering poor quality services. The support that the patients received from nurses in this study might be due to the communal ties found in non-urban areas whereby sympathy is displayed for fellow human beings and emotional support is deemed as important in improving their well-being. According to Scharff (2006), nurses working in rural settings tend to develop close community ties and relationships with their patients such that they have in-depth knowledge about their needs and give support according to those needs.

McQueen (2004) defined emotional support as one of the cornerstones of nursing practice and is often the reason a person chooses nursing as a career. From the findings of this study, it is evident that the nurses at these facilities show and possess this special characteristic. This behaviour echoes what Hogan (2004) raises regarding the fact that nursing has valued emotional support as a critical part of the role of the nurse in providing holistic care and healing. A study of diabetic patients in China who were experiencing anxiety found that emotional support was actually valued above practical knowledge. While requesting genuine concern and understanding one patient stated, *“Giving me medicine, you are treating 30 per cent of my illness; if you could treat my heart, you could have treated 70 per cent”* (Shiu & Wong, 2002). The researchers discovered that patients desired emotional support from healthcare providers and rated it high on their list of needs (Shiu & Wong, 2002). According to Lee (2009), if a patient feels that an intervention will help only in the physical sense, he or

she may continue to do it for a while, but if he or she believes it will help him or her emotionally and socially, spiritually and psychologically as well, he or she is much more likely to persevere with it. It is evident from this study that the nurses have been providing this highly desired intervention to the patients, which helps them deal with the disease process and also continue adhering to the treatment rules, helping in controlling the disease and improving the prognosis. Having used old and new literature (Hagan, 2004 & Lee, 2009) in an effort to examine the trends, it is evident that nurses have a responsibility to see to it that patients are provided with support to enhance their well-being.

- **Nurses are caring beings**

When the participants were probed about the behaviour of the nurses that influenced quality of care, it became evident that nurses were seen as caring towards them, and interacted well with them. One of the patients perceived nurses as treating them with delicacy. This behaviour was perceived to aid good quality of care. The following are responses that were given from the probing of the participants:

“I am well cared for...They are very caring...We as patients push them away but they are always willing to help.” (P 10)

“My sister, I do not want to lie, they treat a person with delicacy here, especially if you have these two diseases...They treat me well”(P 8)

“As you enter the door, they talk to you in a well-mannered way to make you feel welcome before you even tell them what you are here for.”(P 6)

From the findings of this study, it is apparent that the patients experienced a positive interaction with the nurses such that some of them indicated that they felt at liberty and trusted the nurses enough to share what they regarded as secrets with the nurses. This is contrary to the findings by Phetlhu (2011) where TB and HIV co-infected patients reported that healthcare workers do not care for their well-being even though they are in the healthcare service to care. Although literature confirms that nurses show care for the patients, the caring behaviour of nurses towards TB and HIV co-infected patients is unique to this study. This could be an indication that there has been a positive shift over the years in how nurses behave towards TB and HIV co-infected patients. This may be attributed to the continuous education provided to nurses in an effort to enhance knowledge and understanding of the two conditions.

- **Nurses listen to patients**

From the findings of this study, the majority of participants reported that nurses were able to listen to them when they came with their problems, seeking assistance and longing for a listening ear. It was evident that this skill was perceived by the participants as a critical factor that promotes good quality of care.

“I talk to them and they listen to me...When I tell them about my problems, they listen and advise me on how to deal with the problem I have.” (P 10)

“I am able to verbalise everything to them...I disclose everything” (P 11)

“I don’t have a problem with them, we get along well...They listen to me when I have a problem especially the Sister who does HIV.” (P 15)

“They do their utmost best to try and be of assistance to us. They listen, they listen to us” (P 16)

From this study's findings, a majority of the patients reported that they were grateful that the nurses took a moment to listen to their concerns and provided them with the health resources they needed, especially when in need of advice for other problems and ailments they might have. The findings that were reported by Campbell, Scott, Madanhire, Nyamukapa and Gregson (2011) were of HIV infected patients expressing their appreciation for nurses taking an interest in their lives by showing the patient centred approach through knowing them individually; this resonates with the findings in this study.

On the contrary, in a study conducted by Chimbindi, Bärnighausen and Newell (2014) it was found that TB and HIV co-infected patients found it difficult to report when they had missed taking their tablets. In the same study, it was also highlighted that TB and HIV patients found health care workers to be too busy to listen to their problems.

Listening to patients promotes a patient-centred approach where nurses and patients work collaboratively in problem solving and achieving better health outcomes. Research has found that active listening assists clinicians in understanding the client's perception of illness and increases patient satisfaction (Fassaert, Dulmen, Schellevis & Bensing, 2007). In another study conducted by Hayes (2009) it is reported that client satisfaction with nurses was enhanced when nurses listened to the views the patients had regarding the need for medication. This means that patients regard communication and being listened to as a need and as a nurse's responsibility that in return assists in the improvement of their health.

3.3.1.2. Sub-Theme2: Non-discrimination

From the findings of this study, a number of participants perceived the condition of the environment where they receive care as an important indicator of good quality of care. The patients viewed the environment as conducive and safe as they are treated equally by the nurses and not according to the disease or condition they have and regarded that as being

treated equally as any other member of the community. This non-discriminatory environment was depicted by positive nurses' attitude experienced and seen by TB and HIV co-infected patients.

- **Nurses' positive attitude**

Another finding that emerged from the study was that the participants saw the nurses as not demonstrating unequal treatment or disgust in that all patients are treated the same in the clinic and the attitude showed towards them was positive and non-discriminatory. The following quotes give evidence of their perceptions:

“We are the same. We are the same, there is no difference...They do not discriminate us”
(P 10)

“I would be lying, we are the same here...They treat us the same way...Everybody here is treated the same way.” (P 13)

“We all sit there ready to be called in...There is no discrimination” (P11)

The logo of the University of the Western Cape, featuring a classical building facade with columns and a pediment, with the text 'UNIVERSITY of the WESTERN CAPE' below it.

The findings from this study show that a majority of the patients experienced a positive attitude and behaviour from the nurses as they felt that all the patients visiting the facilities were treated equally and with respect. This echoes findings from a study conducted by Chimbindi *et al.*, (2014) where TB and HIV positive patients reported that they were treated with respect by the health care workers. Contradictory findings were reported by Cremers, de Laar, Kapata, Gerrets, Klipstein-Grobusch and Grobusch (2015) where patients felt disrespected as a result of negative attitude by nurses; where they were shouted at and all coughing patients suspected of having TB redirected to the “TB corner”.

Looking at the previous literature, there is still room to find out more on how nurses' behaviour towards TB and HIV co-infected patients could be improved so that these patients feel respected.

3.3.1.3. Sub-Theme3: Health promotion

From this study's findings, it also emerged that a number of participants perceive promotion of health as an important indicator for provision of good quality of care. This was depicted by the information impacted by nurses on the condition and the treatment patients were on including side effects.

- **Education role played by nurses in patients' health literacy**

From the responses the participants provided, it was evident that the nurses are perceived to be providing the patients with empowering information regarding their condition, treatment and the side effects they may experience from taking double treatment of the two conditions. The following statements give evidence of their perceptions:

"...The last time was when they told me how to take my treatment and what are the side effects of the tablets that they gave me." (P 18)

Yes my sister I can say so because it was explained to me how I should take the treatment," (P 17)

The researcher could not find literature supporting the fact that TB and HIV patients are provided with health education to empower them such that they understand their condition and know how to manage it. On the contrary, in a study conducted by Gebremariam, Bjune and Frich (2010), it was reported that TB and HIV co-infected patients were not educated on

TB treatment but only on Antiretroviral Therapy (ART) and its side-effects at the ART sites. However, findings similar to those of this study were reported where it was mentioned that TB patients are informed and educated about the disease, how to behave and how to prevent transmission of the disease to other people (Carlsson, Johansson, Eale & Kaboru, 2014). It was also reported that the nurses educate patients about side effects and that they should not mix medication with substances such as alcohol or other drugs (*ibid*)

In another study conducted by Dean, Young, Elley and Bruton (2008), the health professionals felt that informing patients about how to manage their condition was a duty that came with their role and also believed that health education was worthwhile. The association between health education and health outcomes was examined in a four-year longitudinal, observational study of 2125 adult patients with chronic medical conditions. Patient compliance after health education was associated with improvement in health outcomes in this study (*ibid*). Having used older literature to show trends and changes over time, none confirms that health education provision to HIV and TB co-infected patients is provided as in this research. Therefore, this means that this aspect is a unique finding, thus needs further research.

3.3.1.4. Sub-Theme 4: Resources available

This sub-theme is associated with the availability of the necessary patients' resources, including medication. A number of participants perceived the availability of resources at the facility, especially medication, to be a critical dimension that indicates good quality of care. It was evident that the patients viewed the alternative provision of medication as an acceptable indicator of quality of care. The categories that emerged are the continuous availability of medication and the provisional plans made when there are challenges.

- **Continuous availability of medication**

From this study's findings, a majority of the participants have never experienced problems with not receiving the lifelong medication including any other medication that has been prescribed for them at the facilities where they receive care. The following illustrate this:

“I always get my treatment, I'm on Rifinah and ARVs, and I'm also taking pyridoxine and also Bactrim. There has never been a time whereby I didn't get my treatment” (P 16)

I would be lying if I say there was a time I didn't get my medicines here...I always get my medication. I even get panado for headache. I get all of them, TB treatment and ARVs”

I always get my treatment when I come here.” (P 17)

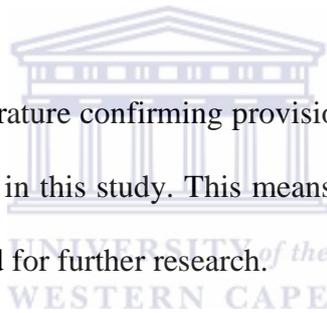
Contradictory incidents were reported in a study conducted by Muture, Keraka, Kimuu, Kabiru, Ombeka and Oguya (2011), where TB and HIV co-infected patients and TB patients experienced periods of drug unavailability on all the scheduled clinic appointment days. This led to patients not adhering to treatment. In another study conducted by the government of Uganda's Ministry of Health in 2008, 72% of governmental health facilities had monthly stock-outs of any indicator medicine and key essential medicines were only partially available (46%) during an assessment of the pharmaceutical situation (Ministry of Health, 2008). The findings from this study show that a number of patients are satisfied with the level of efficiency shown by the clinics and nurses as all TB and HIV co-infected patients always get their medication at the time they are supposed to get it. Therefore, this means that the nurses have knowledge and understanding of the supply chain management and are able to order the supply according to the demand.

- **Provisional planning**

It was highlighted that at times there are no drugs due to challenges with delivery of the medicine to the facility at the rural area. However, it was pointed out that the nurses make provisions for the patients in cases where there are drug stock outs by referring them to the hospital nearby where they are provided with their medicines. This was the response to the probing:

“Medicine is available...Sometimes it is because the truck didn’t deliver the medicines. They then write referral letters for us to go and collect the medication from the hospital.”
(P 10)

The researcher could not find literature confirming provisional planning of the availability of medication by health facilities as in this study. This means that this finding is unique to this study and therefore there is a need for further research.



3.3.2 Theme 2: Impediments to quality of care

The second main theme identified by patients infected with both TB and HIV deals with impediments to quality care. The purpose of this theme is to describe the difficulties that patients face when receiving care at the facilities which they perceived as obstacles to them receiving good quality of care. Two subthemes were identified in this theme with further categories. Following, is a detailed discussion of these subthemes and further categories:

3.3.2.1. Sub-Theme1: Lack of privacy and confidentiality

The first subtheme that emerged was that a number of patients raised their concerns about the lack of privacy and disclosure of their health information to those that are not supposed to have access to it. The participants perceived the protection and safety of their information as

one the most important facilitators of good quality of care. The categories that emerged from this sub-theme are the disclosure of patients' information in the presence of others and nurses' lack of discretion.

- **Disclosure of patients' information in the presence of other patients**

When the participants were probed about the environment in which they receive treatment and care, some communicated that nurses were not keeping patients' information safe from being disclosed to other patients. They perceived the lack of trustworthiness of the nurses regarding confidentiality as prohibiting good quality of care as they felt unsafe with their information. These are the quotations from the probing:

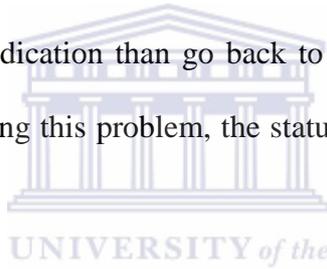
“Yes though, the nurses interact with people with TB and HIV... they are still disclosing peoples statuses with other people, and they are talking about other people that’s why some people they don’t want to come to this clinic... it’s not necessary for other people to know, but now the people at the clinic who are supposed to keep it confidential are telling other people, it’s just, it’s just totally wrong... I know a lot of people who defaulted their treatment because they know if you go to Room X, you will be discussed” (P 14)

“They can give you medicine in the presence of other people. For an example, if I have high blood pressure, they say that in the midst of other people. I feel that they are disclosing people’s disease in the presence of others”(P 18)

Breach of patients' confidentiality is both illegal and unethical as one would feel that their right to privacy has been violated. Some literature confirms that there is a problem with nurses regarding breach of confidentiality. According to the findings by Greeff, Phetlhu,

Makoae, Dlamini, Holzemer, Naidoo, Kohi, Uys and Chirwa (2008), the TB and HIV co-infected patients reported that they did not feel at ease with the nurses regarding their confidential information as they feared that they would disclose their health status without their consent.

Similar incidences are found in this study as a number of participants highlighted that the issue of discussing people's health statuses leads to patients defaulting their treatment as they get discouraged by the nurses disclosing their statuses in the presence of other patients. It is evident that the patients become reluctant to seek medical attention as they fear their health information could be disclosed. The reluctance to seek medical assistance posed as unsafe to the health of the patients as mentioned by one participant that some patients highlighted that they would rather be without medication than go back to the clinic. This, therefore, means that even after years of highlighting this problem, the status quo seems to have remained the same.



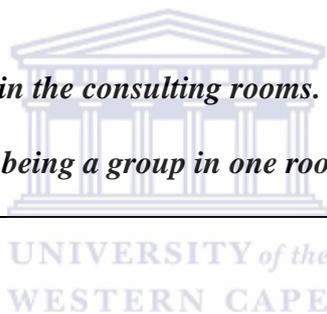
According to the South African National Patient Rights Charter, all information pertaining to the health and treatment of a patient may only be disclosed with informed consent from the patient, unless it is done under an order of the court. Patients' privacy during examinations and interviews should be protected (HPCSA, 2008). The American Hospital Association developed guidelines that state that, "Patient information should not be discussed where others can overhear the conversation (in hallways, on elevators, in the cafeteria, in restaurants, and more). The National Health Act No. 61 of 2003 states that all patients have a right to confidentiality and this is consistent with the right to privacy in the South African Constitution's Act No. 108 of 1996 (HPCSA, 2008). Therefore, this means that even after years of highlighting this problem, the status quo seems to have remained the same.

- **Nurses' lack of discretion**

Participants experienced lack of privacy where the nurses did not close the door when patient consultation took place and that there were too many nurses in one room whereas only one patient was being consulted. These are some of the responses:

“They don’t lock the doors or they don’t close the door... they like to sit a lot of nurses, like in one room. They won’t excuse themselves to their department where they are working and they are sitting there... I mean, why are they sitting there? They have their own rooms where they are working but now they are sitting there when you must draw blood and hear that you are HIV positive” (P 14)

“They are having conversations in the consulting rooms. Whilst helping me, the others are having a conversation. They like being a group in one room” (P15)



Literature confirms this aspect as indicated in the findings of a study conducted by Chimbindi *et al.*, (2014) where patients indicated that they had either sometimes or never been able to talk in private to their doctors and nurses in their past clinic visits; meaning privacy is still a challenge in the health care facilities.

3.3.2.2 Sub-Theme 2: Prolonged waiting time

The participants in this study experienced lengthy waiting times before receiving health care services at the facilities. They perceived waiting time as an indicator of good quality of care. The experience they had regarding waiting time at the facilities proved to be a constraint to the provision of quality of care as depicted from the categories that emerged which are delayed attention to patients and the tendency to ignore patients.

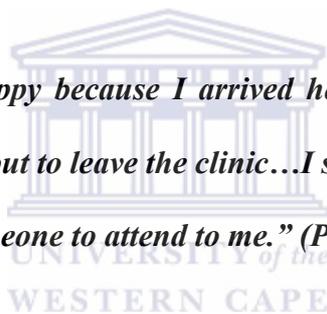
- **Delayed attention to patients**

The majority of patients expressed their discontent with the way the nurses delayed giving them attention in the health services. From the findings in this study, it became evident that the patients perceived the waiting time as being too long as they reported that they spend long hours waiting for someone to attend to them. The following are their responses.

“They don’t attend to you promptly...You arrive here in the morning before the clinic opens at 7...At 10, you’ll still not be attended to when they go for tea break, they’ll attend to you at that time...You see even now I arrived at 8:30, last time I left the clinic at 12...”

(P 15)

“You see my sister, I’m not happy because I arrived here after 8 and you see now it’s around 11 to 12 and am only about to leave the clinic...I sat for about one and half hour in the waiting area, waiting for someone to attend to me.”

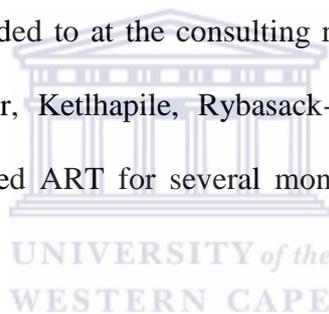


“...you come in here maybe at 7 o’ clock, you queue outside. The gates open at 07h45 to 8 o’clock. They start with prayer. Sometimes you wait until closure time 16h30 and then you are told to come back tomorrow.”

“Sometimes I find myself sitting for 3-4 hours”

From the findings of this study, it is clear that the participants were not satisfied with the nurses pertaining to the delay in providing them with services as they highlighted that they felt neglected because the nurses start the day by having conversations amongst each other before doing their job of serving the patients. Some of the patients complained that the delays

had a direct impact on other aspects of their lives such as missing other appointments like picking their children from school at the appropriate time. It was also brought forward that the time they had to wait between arrival and leaving the facilities was too long and no one informed them of the reasons for the long waiting times, highlighting that it would be better if they were informed of such reasons so that they could be aware. It was also raised that the long waiting times lead to them being at the health facilities for extended periods only to be sent back home due to closing times, without getting the service they came to the facility for. Although the researcher could not find literature confirming a delay for provision of attention to TB and HIV co-infected patients, some literature confirms that similar incidents have been reported where it was mentioned that a patient who came to fetch HIV treatment had to wait for two hours before being attended to at the consulting rooms (Mahlangu, 2014). Another incident was reported by Miller, Ketlhapile, Rybasack-Smith and Rosen (2010) where patients cited that they abandoned ART for several months due to long queues and long waiting times at the facilities.



Long waiting times are a persistent challenge facing healthcare systems across Africa, and have been linked to a variety of undesirable outcomes (Miller, Ketlhapile, Rybasack-Smith and Rosen, 2010). The TB and HIV co-infected patients in this study were no different as they also expressed the challenges they have experienced in the Primary Health Care (PHC) facilities where they have to wait for a long time before they receive the required services. Oluwagbenga and Mora (2012) found that patients who had long waiting times were not satisfied with the services. In another study conducted by Tabler, Scammon, Kim, Farrell and Tomoia-Cotisel (2014), experiencing long waiting times by patients negatively shaped their perceptions of the quality of the relationship with their healthcare providers. This echoes the findings in this study as the majority of the participants were unhappy with long waiting times and the impact it has on their lives. Looking at the previous literature and trends over

the years, despite the effort of conducting patient waiting times surveys at the facilities, long waiting times remain a challenge and this leads to a negative impact on the patients' personal lives.

- **Tendency to ignore patients**

Another finding in this study demonstrates that patients were sometimes ignored and not assisted timeously and this was perceived as nurses not providing and meeting the needs of the patients. The participants perceived this as being a hindering factor to the provision of quality of care. The following are the quotations from the interviews:

“You’ll find the nurses going up and down or find them in one of the rooms...You don’t even know what is happening, we are sitting and the queue is not moving” (P 17)

“...the nurses are sitting in one room and they have conversations about their stuff.” (P 15)

“When you arrive, they are having a conversation, in those rooms they are talking to each other...You are waiting, they neglect you whilst you are there” (P 4)

Similar incidences were reported in a study conducted by Mahlangu (2014) in Tshwane where patients complained of waiting for more than five hours because nurses were laughing and gossiping without informing them of what was happening.

3.4. CONCLUSION

The findings of the research regarding the perceptions of TB and HIV co-infected patients at Primary Health Care facilities were discussed, interpreted and compared with existing literature in this chapter. Findings that are unique to the study were also highlighted.

In the next chapter, the limitations and conclusions drawn by the researcher will be discussed.

The researcher will also highlight recommendations for the nurses at PHC facilities so as to provide quality of care to TB and HIV co-infected patients.



CHAPTER 4

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS FOR NURSING RESEARCH AND NURSING PRACTICE.

4.1. INTRODUCTION

In the previous chapter, the research findings were discussed. The findings were supported by direct quotations from the interview participants presented in italics, and confirmation was also made through reference to relevant literature. In this chapter, the conclusions and the study's shortcomings will be discussed. Recommendations will be made for nursing research and nursing practice with special reference to the nurses on how to provide quality of care to TB and HIV co-infected patients who are accessing care at the Primary Health Care (PHC) facilities.

4.2. CONCLUSIONS ON THE RESEARCH FINDINGS

The conclusions derived from the study are based on the findings yielded from interviews that were conducted with the aim to discover the perceptions of TB and HIV co-infected patients regarding quality of care provided at PHC facilities in the Chris Hani District, Eastern Cape Province in South Africa. Data analysis by the researcher and the co-coder resulted in two themes namely satisfaction with delivered services and impediments to quality of care and therefore the conclusions pertaining to these themes are discussed below.

4.2.1. Conclusions pertaining to the satisfaction with delivered services

The presented findings indicated that the participants' perceptions regarding the quality of service that they received in the PHC facilities in the study setting was highly associated with their perceptions of the nurses behaviour. This is an indication of the role the nurses' play in ensuring a positive image of the facility which in turn contributes to the patients' use of the

services. In addition to the nurses' behaviour, the systemic dynamics were also seen as contributors to the quality of care.

A conclusion that can be deduced from the findings is that the TB and HIV co-infected patients are satisfied with the services that are provided at the facilities from where they seek healthcare. It is apparent that the satisfaction is due to the supportive and caring nature that nurses show towards each patient. The satisfaction was apparently also caused by the ability of the nurses to listen and interact with each individual patient showing that nurses respect each patient. Previous studies report that some nurses do not care about the wellbeing of the TB and HIV co-infected patients. However, the researcher can conclude that the nurses in this study are committed to their work and care about the patients as they treat them with respect and compassion.

It is notable that the nurses ensured that they build relationships with their patients and that they showed patience such that each patient was given the support and care that was unique and responsive to their individual needs. This is shown by the patients feeling at liberty to share the most sensitive and confidential information with the nurses so that they can be cleared of any queries regarding their conditions and possibly resolve the problem and set goals for managing their conditions. It can be concluded that the nurses are respectful and responsive to the individual patients' needs and therefore able to provide patient-centred care to the patients.

Additionally, it can be concluded that the TB and HIV patients are treated equally as any other patient with another condition different from theirs. It is apparent that there are neither special rooms nor specialised nurses that are dedicated to the TB and HIV co-infected patients because, when the patients visit the facilities, they all sit in the same waiting area as other patients and wait to be called into the consulting room which makes the patients

comfortable and not identifiable to the rest of the community. In previous studies, TB and HIV co-infected patients indicated that they were treated differently due to the conditions they have. However in this study, patients were not discriminated and were treated equally. This shift could be related to sufficient knowledge and understanding that nurses have acquired in relation to the spread of these two diseases.

It can, therefore, be concluded that the health care provided to the patients does not vary according to the condition or disease one has. The patients did not experience any form of discrimination and therefore equitable treatment correlated to the IOM framework was provided.

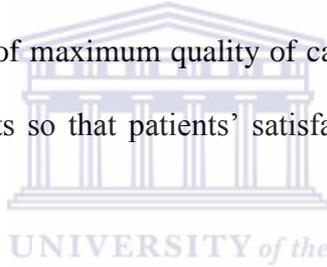
The investigator made a further conclusion that the TB and HIV co-infected patients were provided with effective care. The majority of the patients were empowered through health promotion to effectively take care of themselves at home so that their health could be improved and eventually improve the health outcomes of TB and HIV. The nurses ensured that the patients received health education on the conditions they have and were also given information on the medication together with the side effects thereof. In other studies, it is reported that TB and HIV co-infected patients were not educated on the treatment for their condition. However, from the findings of this study, it is evident that nurses understood that part of their duty is to provide health education to patients. Therefore it can be concluded that the nurses are knowledgeable on TB and HIV co-infection and patients were given sufficient and evidence-based information that assisted in the effectiveness and safety of the medication that could assist in improved health outcomes which concurs with one of the IOM dimension that requires care to be effective

From this study's findings, it can be concluded that medication, which is one of the resources that are necessary to ensure delivery of health care, was always available. Unlike in previous

studies where there were reports of drug stock outs leading to forced non adherence to treatment, in this study it is clear that patients always had medication on their scheduled treatment pickup dates. In the facilities that had incidences of drug stock-outs, necessary provisions were made for the patients who could not access the medication at that particular period by referring them to the nearest facility with stock. It can then be concluded that the nurses have knowledge and an understanding of efficient use of the available resources that are necessary for the management of the patients' conditions, which is crucial for the effective and efficient patient healthcare provision.

4.2.2 Conclusions pertaining to impediments to quality of care

Contrary to the reported satisfaction regarding delivered services, the participants described the aspects that impede delivery of maximum quality of care. This aspect highlight the need to improve on the lacking aspects so that patients' satisfaction level can be increased thus their perceived quality of care.



It is clear that patients' personal information and the medication they were on was disclosed in the presence of other patients compromising the principles of privacy and confidentiality. This lead to patients losing trust in the nurses and the health care system that is supposed to provide them with care and protection. Consequently, the majority of the patients felt discouraged and intimidated to go to the healthcare facilities considering that they had to bare the pain of having their information exposed to others even if they were not ready to disclose their TB and HIV status.

It can, therefore, be concluded that the patients were given care in an unsafe environment that did not protect their private information from individuals that were not supposed to have access to it. This contributed to patients becoming hesitant to seek medical assistance from such facilities that pose a danger to their psychological wellbeing.

Furthermore, the prolonged periods that patients had to wait for treatment and medication have a negative impact on the quality of care as patients have to forfeit and change their daily arrangements because they had to wait at the facility longer than anticipated. This lack of immediate assistance after arriving at the facility and the potential of being turned away without being attended to by the nurses was seen to have a negative impact on the quality of care. This is imperative to highlight because the patients' perceptions that they are not receiving the care and consideration from nurses could be harmful to their health as some would potentially not return to the PHC facilities.

This study highlights the silent message sent by health workers, in this case nurses when they do not communicate their intentions. The patients felt ignored and not attended to timeously because the nurses were sitting in one room chatting and not even informing the patients of the reasons for the delays. This was subsequently perceived as disrespect to the patients because the nurses did not see it necessary to inform them of their delay challenges, if any. The conclusion that can be made is that patients wait for prolonged periods and the care they are given at the facilities is not timely. These unnecessary delays could pose harm to the health of the patients as some patients may leave the facility without being attended to and never come back for medical assistance or treatment and this may be a risk to their health. Therefore, it is important to communicate with the patients when there are delays that could result in them staying for prolonged periods at the PHC facilities.

4.2.3 Conclusion of the results in relation to the IOM six domains of quality of care as the theoretical framework.

As indicated in chapter one, this study was grounded on the IOM as a theoretical framework which makes an assumption that for quality of care to be rendered, the patients need to perceive that it is efficient, effective, equitable, timely, safe and patient-centered. Table 4

below demonstrate what the perceptions of the participants in this study places the service they receive in their PHC facilities on this continuum.

Table 4: Summary of results in relation to the IOM six domains of quality of care as the theoretical framework.

IOM domains	Study findings (Elements)	Achievement measure
Efficiency	Availability of resources	✓
Effectiveness	Health promotion	✓
Equitable	Non discrimination	✓
Timely	Prolonged waiting periods	X
Safe	Lack of privacy	X
Patient-centered	Positive nurse-patient relationship	✓

✓ = Achieved X = Not achieved

Four elements from the findings of the results namely availability of resources, health promotion, positive nurse-patient relationship and non-discrimination, could be well aligned with the domains of the IOM framework which indicate that the service rendered at the PHC facilities in the Chris Hani District in the Eastern Cape Province in South Africa meet the criteria set by the IOM to some extent. However it can be noted that two of the IOM domains namely, safe and timely were not aligned to the findings. This implies that the quality of care rendered to the patients co-infected with TB and HIV in the PHC facilities in the Chris Hani District is not of the standard expected by the IOM. Therefore it is imperative to ensure that the areas that were found lacking be addressed if the quality of care that the patients are so deserving need to be met.

4.3. SHORTCOMINGS OF THE RESEARCH

The following are the shortcomings of the research as observed by the researcher.

The researcher discovered that the nurses who served as mediators did not give the participants full explanation regarding the purpose of the study. This resulted in the participants being uncomfortable to discuss the issues around HIV and TB as it is a sensitive topic. In addition, the fact that the researcher was a stranger made the participants a bit reluctant to participate in the study at first. Therefore it took the researcher more time to explain the purpose of the research so as to gain the participants' trust, confidence and their written consent. The researcher had to probe first before they could open up. After the researcher had probed, the participants were co-operative and participated fully thus rich data was ultimately gathered.

Another shortcoming to the study was that the study was conducted in 12 out of the 33 PHC facilities in the Lukhanji Sub-district due to resource restraints and the scope of the academic project (Masters level). This study could have been richer if more than one sub-district was used to fully explore the Chris Hani district.. Thus further studies are required to enrich the data from the overall district. Nonetheless, these findings highlight the limitation of the quality of care rendered to TB and HIV co-infected patients.

4.4. RECOMMENDATIONS FOR NURSING RESEARCH AND NURSING PRACTICE

In this section, recommendations for nursing research and nursing practice will be discussed. Reference will be made to this research's data, and to the conclusions that were made.

4.4.1 Recommendations for nursing research

Based on the research findings, literature and conclusions drawn from this research, it is evident that there is potential for further research in the field of TB and HIV co-infection as research on quality of care recommends the following possible areas:

4.4.1.1. The knowledge level of the nurses regarding patients' rights with specific reference to privacy and confidentiality.

4.4.1.2. An exploration of the perceptions of healthcare workers regarding quality of care provided to patients.

4.4.2 Recommendations for nursing practice

Based on the study's findings, the following recommendations for nursing practice are made:

4.4.2.1. The nurses need to develop strategies to ensure an environment that is conducive to the patients co-infected with TB and HIV such that their medical information is kept private and confidential. This can be done by giving refresher courses in ethics so that they are continuously updated on ethical issues and patient rights.

4.4.2.2. The nurses should educate other healthcare workers at the facilities regarding the right of TB and HIV co-infected patients to privacy and confidentiality.

4.4.2.3. The nurses need to develop strategies that will continuously assist them in reducing the patient waiting times at the facilities. This should be done by regular analysis of waiting time and bottlenecks with the assistance of the quality assurance managers followed by the development of improvement plans to remove the bottlenecks and thereby reducing waiting times.

4.4.2.4. Healthcare managers in the Lukhanji Sub district within the Chris Hani District need to be informed on the findings of the research for possible implementation of sustainable

quality improvement plans that can assist to improve the quality of services provided at the facilities.

4.4.2.5. The findings and recommendations should be included in the in-service training programmes in the public health sector, the private sectors and Non-Governmental Organizations (NGOs) to empower all levels of nurses who deal with patients co-infected with TB and HIV. These in-service training programmes should also be presented to lay counsellors and community health workers including other categories such as data capturers, administration clerks and the members of the Ward-Based Outreach Teams as they often come into contact with patients co-infected with TB and HIV.

4.5 CONCLUDING REMARKS

The aim of this research was achieved which mainly was to explore and describe the perceptions TB and HIV co-infected patients regarding quality of care provided at Primary Health Care (PHC) facilities and to make recommendations that will assist to improve quality of care provided at the PHC facilities.

The researcher performed data collection using semi-structured questions, and analysis was conducted with the assistance of an independent co-coder. The findings of this research clearly describe the perceptions of TB and HIV co-infected patients regarding quality of care provided at the PHC facilities. Literature from the electronic database was used to confirm these findings. Unique findings in this research were highlighted and reported in the form of recommendations.

The conclusion that could be made on the quality of care provided to TB and HIV co-infected patients in this study is that the nurses in the facilities achieved four of the six IOM aims of quality of care namely: equitable, effective, efficient and patient-centred dimensions.

Therefore, the quality of care provided to these patients was partial as they were not provided with all the six aims that are needed for optimum quality of care.

Recommendations in this study are made for nursing research and nursing practice with the intension to facilitate the improvement of quality of care provided at the PHC facilities.



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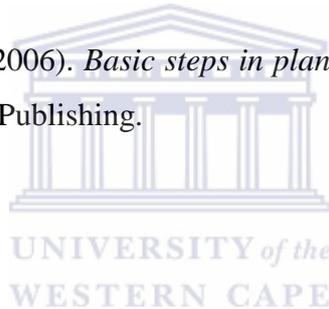
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Project Title: Perceptions of TB and HIV co-infected patients regarding quality of care provided at Primary Health Care facilities in the Chris Hani District, Eastern Cape Province in South Africa

What is this study about?

This is a research project being conducted by Siphokazi Mngcozelo at the University of the Western Cape. We are inviting you to participate in this research project because you are older than 18 years old, are fairly well in health, infected with both HIV and TB and getting the treatment for both at this facility. The purpose of this research project is to explore and describe the perceptions of TB and HIV co-infected patients regarding quality of care provided at the PHC facilities at the Lukhanji sub district located within the Chris Hani District in the Eastern Cape.

What will I be asked to do if I agree to participate?

You will be asked to answer questions that are relating to TB and HIV, the environment at which you are receiving the treatment, the behaviour and your relationship with the healthcare workers at the facility. The interview may take 90 minutes to complete. The answers that you will give, will be recorded with an audio recorder. The study does not involve a follow up and therefore, this interview will be the only one.

Would my participation in this study be kept confidential?

We will do our best to keep your personal information confidential. To help protect your confidentiality, your name will not be used and only codes will be used as an identity. All the information that has been collected will be kept under lock and key and only the researcher and the supervisor will have access to the information.

If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

What are the risks of this research?

There may be some risks from participating in this research study where you may have fear in describing the experience you had in the health care facility where you are receiving the health service

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about the perceptions of the patients that are infected with TB and HIV regarding the quality of care provided at the Primary Health care clinics. We hope that, in the future, other people might benefit from this study through improved understanding of the quality of care that TB and HIV co-infected patients at Primary Health care need.

Describe the anticipated benefits to science or society expected from the research, if any

The information from the study will be useful for the nurses in providing an effective quality service to all TB and HIV co-infected patients which may be transmitted to the entire nursing field.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

Is any assistance available if I am negatively affected by participating in this study?

The researcher will by all means assist you in getting the relevant assistance at the facility or if need be, refer for relevant help, for example, counselling

What if I have questions?

This research is being conducted by **Siphokazi Mngcozelo**, being supervised by **Professor Rene Phetlhu** from the School of Nursing at the University of the Western Cape. If you have any questions about the research study itself, please contact Siphokazi Mngcozelo at: The Faculty of Community and Health Sciences, School of Nursing, The University of the Western Cape, Bellville 7535. The contact number is 0834442343

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department:

Professor Karien Jooste (+27)219592274

Email: kjooste@uwc.ac.za

Dean of the Faculty of Community and Health Sciences:
University of the Western Cape
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This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

APPENDIX B – PARTICIPANTS INFORMED CONSENT FORM



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Title of Research Project: Perceptions of TB and HIV co-infected patients regarding quality of care provided at Primary Health Care facilities in the Chris Hani District, Eastern Cape Province in South Africa

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's name.....

Participant's signature.....

Witness.....

Date.....

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Siphokazi Mngcozelo

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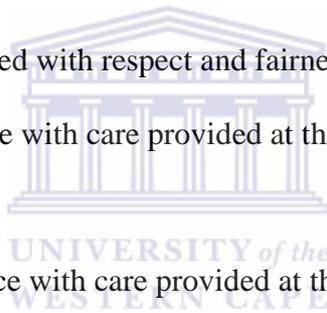
Email: 3419332@myuwc.ac.za

A handwritten signature in black ink, appearing to read 'Hugo', with a stylized flourish at the end.

APPENDIX C

SEMI-STRUCTURED INTERVIEW GUIDE

1. Tell me how you became a patient at this facility.
2. Tell me what you know about the relationship between TB and HIV
3. Do you think you are getting adequate information about the diseases you have and the treatment? Please explain.
4. What measures you think can be used to prevent TB and HIV?
5. Tell me about the environment in which you receive treatment and care
6. What sort of behaviour do healthcare workers have towards patients who have TB and HIV? Please explain
7. Do you think you are treated with respect and fairness? Please explain
8. Tell me on your experience with care provided at the facility with regards to waiting time
9. Tell me on your experience with care provided at the facility with regards to availability of medicine
10. Tell me about your relationship with healthcare workers and what support you receive from the facility.
11. Is there anything you want to add?



APPENDIX D

UNIVERSITY APPROVAL



OFFICE OF **THE DEAN**
DEPARTMENT OF RESEARCH DEVELOPMENT

18 May 2015

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by:
Ms S Mngcozelo (School of Nursing)

Research Project: Perceptions of TB and HIV co-infected patients regarding quality of care provide at Primary Health Care facilities in the Chris Hani District, Eastern Cape Provinces in South Africa.

Registration no: 15/3/23

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

UNIVERSITY of the
WESTERN CAPE

A handwritten signature in black ink, appearing to read 'Patricia Josias'.

*Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape*

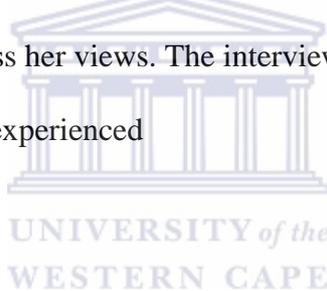
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A place of quality,
a place to grow, from hope
to action through knowledge

APPENDIX F
FIELD NOTES

Descriptive notes:

A young woman in her youth, who have been living with HIV since 2012 and have been on TB treatment for the past six (6) months. The patient looked well and very willing to partake in the study. She was willing to talk about both her conditions and was excited that she was about to finish her TB treatment period. The interviewer did not struggle to get the patient to talk and she was relaxed throughout the interview. Probes were used to encourage the patient to talk as well as the non-verbal communication. Most of the time the patient volunteered information and enjoyed to express her views. The interview was held in a private room in the clinic. No interruptions were experienced



Demographic notes:

The interview was held at about **11h00** on the **20th August 2015** at the clinic. It lasted for **45 minutes** as the patient wanted to express herself and the researcher allowed her to do so without putting any restraint on time.

Reflective notes:

The patient was very passionate about the topic. She seemed to have insight into her condition and even knew that treatment she was on is for managing HIV and what bloods show whether the treatment is working or not. She appeared to have accepted both her TB and HIV status. She showed real enthusiasm when she spoke of the nurses of the facility where she receives healthcare from and appeared to have a very good trust relationship with the nurses working there.

APPENDIX G

TRANSCRIPTION OF AN INTERVIEW

R: Can we start?

P: Ja

R: Ok

R: The first question my dear is, just tell me how you became a patient in this facility, what, what happened?

P: Ok, I was diagnosed Eh!..., positive in the hospital, so they told me to start treatment, I have to start at this facility

R: So the hospital was it the hospital here in this town?

P: Ja, in this town, at X hospital

R: Alright, alright! Okay, so what made you, or what prompted you to do an HIV test, were you sick or what was happening?

P: No, I started to lose weight, and because I heard, the person I slept with was positive, I stressed, and it started to give me peptic ulcer, so I went to the Hospital and asked them to....to look for anything, anything, that may be wrong HIV anything, so they diagnosed me with the peptic ulcer because of the stress and they also diagnosed me HIV positive,

R: Ok, Alright, ok, the second question is tell me, in you your own words in your own understanding, what the relationship is between TB and HIV?

P: Ok, My own words, I don't know much about TB because I had TB of the hip, HIV.. it's just you have to look after, if you to look after yourself and you use your treatment correctly if you use it maybe 8 o' clock like for me for instance I'm using it every 8:30 at night, then you don't have a problem, don't drink, just look after yourself, eat healthy, then there'll be nothing wrong, still the same person and you still healthy

R: Ok. The third question is, what do you think can be done or used to prevent TB and HIV, from, from infecting those that are not infected yet?

P: Like, ehh....maybe...if they can use a vaccine or something, for the people that are infected already, that would be nice.. the nurses should give the people a vaccine not to get infected, but also educate the people , because I think the people out there still need a lot of education about HIV and TB

R: So if you were to be asked to give them education yourself what would you say to them?

P: Ja..like, Ja...I would, I would tell them to use more condoms and not to interact with other peoples blood, although they know maybe know that person is HIV negative, but just to be on a safe side use gloves at all times

R: Ok, alright, ehh.... the next question is, tell me about this clinic, in terms of environment, How is it?

P: Eh this clinic, I don't want to make even any exception, I want to tell the truth, Yes though, the nurses interact with people with TB and HIV, Still!.. they are still disclosing peoples statuses with other people, and they are talking about other people that's why some people they don't want to come to this clinic. Maybe like for

instance, I took my treatment and my friend comes just after for testing, then she will know, by later come to me , hey X, I heard everything that you are like this, I mean it's your personal, It's your personal, its personal you don't want other people to know your status. For instance me, it's only my family that know, and I keep it like that ,because it's not necessary for other people to know, but now the people at the clinic who are supposed to keep it confidential are telling other people, it's just, it's just totally wrong , and I would also like it if, there's no room only for HIV people, because if everybody goes to that room maybe you are not infected, you are just going for testing, maybe you are already diagnosed by people. So,if they can use all the rooms and educate all the nurses to help with those that are HIV positive. And then, the other thing is, they are so, I don't know, what can I say; they are not up to standard because there are people who are very weak to come to the clinic. Those people should not come to the clinic but whereby those who are so sick are forced to come to the clinic to come and get the treatment. Whereby I say the department or something, there are health carers, they are people that work in the community, they are working here in the clinic. We can use those people to go to that person and go and give them treatment but they don't do it like that. You must come from your house very sick. Some people come in wheelbarrows. There are people who don't have money to pay for taxis. Some people must hire cars to come because they are too weak to come.

R: Ok, I think you might have mentioned this but let me ask you this question. What sort of behaviour do the nurses have towards people who have TB and HIV?

P: Ok, for me they know, I'm a very strict person when it comes to my HIV status, So, the nurses don't know anything about confidentiality because they don't lock the doors or they don't close the door. Like for instance, when you are coming to draw

bloods and stuff, they don't tell the other people, like; they like to sit a lot of nurses, like in one room. They won't excuse themselves to their departments where they are working and they are sitting there and you don't want people to disclose your status. I mean, why are they sitting there? They have their own rooms where they are working but now they are sitting there when you must draw blood and hear that you are HIV positive or they can just make it more confidential.

R: So, has it ever happened that if they are together as nurses in one room that you have more than one patient in that one room or it's just one patient but so many nurses in one room?

P: Most of the time it's only one patient with a lot of nurses and they discuss the people's HIV status ... In front of you. And it happened to me

R: In front of you?

P: In front of you. And it happened to me.

R: Do you ever feel that, they are treating people with HIV or people with TB differently from other people with other diseases?

P: I, what, what I saw, ehh... not the HIV but there is only one. I even want to mention her name. There is one sister who really satisfies when coming to HIV patient is Sr. X. If all the nurses can be like her, then people wouldn't be afraid to come in, come and take their treatment; because I know a lot of people who defaulted their treatment because they know if you go to Room X, you will be discussed. But Sr X is very, very confidential.. If all the nurses could be like her in this clinic, it would be nice. Only the thing that I saw ehh, I can see is the MDR people, they are very strict like they are so afraid of getting TB and wear masks

R: Ok, ok. Emh. Tell me in your own experience; what have you experienced in terms of waiting time in the clinic and in terms of availability of medicine. What has happened?

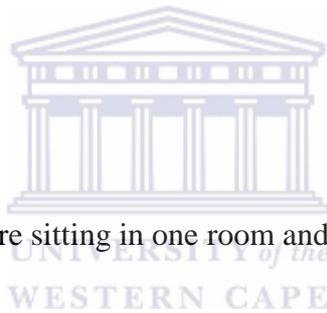
P. The only thing is what I'm telling you is, you come in and be here maybe at 7 o'clock, you queue outside. The gates open at 07h45 to 8 o'clock. They start with prayer. Sometimes you wait until closure time.

R: What's the closure time?

P: Ja, it's 16h30 and sometimes they tell you, yhooo!!! We are short now you must go back home and you must come back tomorrow even though you came by in the morning

R: Why?

P.: Because why, the nurses are sitting in one room and they have conversations about their stuff.



R: Medication is always available ?

P: I never had a problem with medicine. There was only ehh, because they told me I'm one of the patients that are regular on my dates for my treatment and now they are giving me two months regimen and , they also told me other patients whereas there is only one pill they have difficulty with this because when they come they still have a lot of pills so that means they are defaulting. Otherwise I never had a problem.

R: So, even other medication like panado, you have never been told it's out of stock?

P: There were sometimes they told us, especially rub stuff, panado

R: But never for ART or TB?

P: No. there was never for ART and TB

R: Just tell me about your relationship with the people that are working here in this, clinic and what sort of support do they give you?

P: Ok. Support, I never a problem because as I told you, I know I'm sick nhe, but my relationship is ok because they know I know the channels and I tell them, eh, sometimes when I come in the room and there's people; I tell the sister that I want my confidentiality, I want to be with you, if you can please close the door. I'm like that, so they know if they interact with me they get into the room and I want to be with that sister. But sometimes, because the people know me, I'm in the situation I'm positive, I don't mind but I know it's not right, I wish they could rectify that.

R: Ok, ahh. What do you think the facility can do to improve ahh, the services that they are providing? Is there something that you feel needs to be improved?

P: Ja, there are, there are a lot. If they can only...if they start at 8 o'clock, do their work and then afterwards they chat when the clinic is empty. And then mostly is what I told you before. These people know these and they don't want to come to the clinic because people talk. Some people are in denial, they don't even wanna know they are positive. But now they come to the clinic because they want they want to live. But now when going to that room, all the people are like, that person is positive, so that is why I'm asking, if the department can do it like this, all the nurses interact with HIV positive and get your treatment and your ARTs, that would be nice.

R: Ok, alright. Then emh, the last question I have for you, is there anything that you need to add that I might have left that I might have left in this conversation that we had,

just anything that you can think of. I know you have said a lot of stuff in the beginning but if you want to just add anything else, I'll appreciate it.

P: Ja, ahh...ahh...the thing I would like to add is, you have to educate people not to be afraid to know their status because its better knowing your status than not to know it because at the end of the day, you'll die or you'll get to interact with ART when it's too late. So please educate people. Living here at this facility, educate people. Everyday maybe when they open, please people test, test. It's a better, it's better to know than not to know.

R: Wow thank you

