A PROGRAMME TO FACILITATE QUALITY CLIENT-CENTRED CARE IN PRIMARY HEALTH CARE CLINICS OF THE RURAL WEST COAST DISTRICT

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KEYWORDS

Programme

Facilitate

Quality

Client-centred care (patient-centred care or person-centred care or individualised care)

Rural

Primary Health Care

Clinic

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ABSTRACT

A programme to facilitate quality client-centred care in Primary Health Care clinics of the rural West Coast District

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Introduction

The overall aim of this study was to develop a programme to facilitate quality client-centred care in Primary Health Care clinics of the rural West Coast District. This aim is accomplished through the formulation of the subsequent objectives:

Phase 1: Situational analysis (Quantitative)

- Objective 1: To explore and describe the current status of quality client-centred care by conducting an extensive literature review.
- Objective 2: To assess the clients' perceptions about quality client-centred care.
- Objective 3: To determine the clinical nurse practitioners' perceptions on quality client-centred care.

Phase 2: Situational analysis (Qualitative)

- Objective 4: To explore and describe managers and allied health professionals' perceptions about quality client-centred care.

Phase 3: Programme development

- Objective 5: To develop a programme to facilitate quality client-centred care in Primary Health Care clinics of the rural, West Coast District.

Research design and -method

Both quantitative and qualitative methods were applied for this study .

Phase 1, a situational analysis collected and analysed quantitative data from the perspective of clients and clinical nurse practitioners via structured questionnaires. The population included all clients 18 years and older (N=137 991) of the fixed clinics (N=25) in the five subdistricts

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of the West Coast District. According to the Cochran formula a sample of (n=383) should be adequate to represent the population. Non-proportional sampling was applied to estimate the number of participants per clinic. An all-inclusive sample of (n=64) clinical nurse practitioners participated in the study.

Phase 2, the qualitative part of the situational analysis, applied five focus group discussions to explore and describe the managers and allied health professionals' perceptions about quality client-centred care. A semi-structured interview schedule was compiled to guide the focus group discussions. An all-inclusive sample was utilised to include all the managers and allied health professionals of the five subdistricts (N=43).

Phase 3 included the development of the programme based on the study findings and literature.

Quantitative results

The analysis revealed the following quality client-centred care challenges, namely: Patient Rights (*Domain 1*) were not always respected and adhered to as these were characterised by: language (statistical $p<0.001$ and practical significant with a large effect size $d=0.74$); Satisfaction and Safety (statistical $p<0.001$ and practical significant with a medium effect size $d=0.55$); Referral Procedures (statistical significant $p<0.001$); Waiting Times (statistical $p<0.001$ and practical significant with a medium effect size $d=0.47$) and Confidentiality difficulties (statistical $p<0.001$ and practical significant with a medium effect size $d=0.68$). The *Domain 2*, Clinical Governance, Care and Safety showed shortcomings as highlighted by the Client and his/her Family (statistical $p<0.001$ and practical significant with a large effect size $d=0.77$). Clinical Support Services, *Domain 3*, revealed inadequacies regarding the continuous availability of medication (statistical significant $p<0.008$) and the reporting of side-effects (statistical significant $p<0.001$). Furthermore, Public Health *Domain 4*, showed that clients identified community health promotion and disease prevention events (statistical $p<0.01$ and practical significant with a large effect size $d=0.79$), and home visits by the community healthcare workers (statistical $p<0.001$ and practical significant with a large effect size $d=1.09$) as both a "problem" and a "gap". Leadership and Corporate Governance, *Domain 5* was characterised by the lack of: visible organograms (clients mean 2.40), community communication (clients mean 2.12 & clinical nurse practitioners mean 2.36), visibility of goals, values and future plans of the Western Cape Department of Health (statistical $p<0.001$ and practical significant with a medium effect size $d=0.59$) and role and function of the clinic committees (statistical significant $p<0.008$). Moreover, *Domain 6*, Operational Management

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was challenged by inadequate staffing levels (statistical significant p<0.003). Lastly, *Domain 7*: Infrastructure was characterised by the lack of drinking water in the waiting areas (clients mean 2.08 & clinical nurse practitioners mean 2.02), inadequate clinic space (clients mean 2.10 & clinical nurse practitioners 2.23); maintenance not up-to-date (statistical significant p<0.002); physical appearance of the clinic (statistically significant p<0.001) did not have a positive effect on staff morale and evacuation plans (statistical p<0.001 and practical significant with a medium effect size d=0.54) were not visible. In addition, correlations between the domains showed that the domains are not in silos, but are interdependent on another.

Qualitative results

The qualitative, thematic data analysis revealed various inadequacies regarding quality client-centred care. *Theme One* about the Patient Rights revealed that patients were not always treated with the necessary respect and dignity. *Theme Two* concerning Patient Care, revealed that focus group participants were well-informed on what the concept client-centred care entailed. However, patients and or clients did not always experience their care as client-centred. *Theme* Three about the Clinical Support Services, indicated shortages of medication and medical equipment; long waiting time for specialists and rehabilitation referral appointments. *Theme Four*, referring to the Public Health confirmed that health promotion and prevention activities are limited, due to various organizational factors and community healthcare workers' activities which are limited to home-based care activities. *Theme Five*, Corporate Governance and Leadership matters were characterised by too many processes or "red tape" resulting in inefficient procurement processes, inadequate staffing and inactive health committees. *Theme Six*, Operational Management highlighted the severe pressure under which the operational managers have to work, resulting from their twofold role of being the clinic manager and at the same time operate as a clinical nurse practitioner. *Theme Seven* refers to Infrastructure and Facilities and is characterised by inadequate maintenance and lack of space according to the number of clients and package of care.

To summarise:

The situational analysis revealed 81 problems. These problems form the evidence base for the development of the programme to facilitate quality client-centred care in primary helth care clinics of the rural West Coast District. The findings of this study suggest that

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Recommendations:

The researcher recommends various workshops and in-service training to address the identified problems and familiarise staff on all the relevant policies, protocols and guidelines. Furthermore, the researcher recommends that training institutions provide training in line with Healthcare 2030, where the Western Cape Department of Health envisions to move away from an all-consuming curative paradigm of treating illness to one of prevention, promotion and wellness. Lastly, the researcher suggests that the South African National Department of Health should provide opportunities to develop proactive leadership, health policy capacity and skills development among Primary Health Care nurses, and involve them in health policy development.

Limitation:

The study was limited to: the public health sector, one rural district, fixed clinics and clinical nurse practitioners of the selected fixed clinics.

Date 8 August 2018

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DECLARATION

I declare that "*A programme to facilitate quality client-centred care in Primary Health Care clinics of the rural West Coast District"* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Johanna Elizabeth (Elsa) Eygelaar August 2018

Signed ……………………………………………

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ACRONYMS

A

AIDS	Acquired Immune Deficiency Syndrome
ANOVA	Analysis of variance
ART	Anti-retroviral therapy

C

CCAIIRR	Caring, competence, accountability, integrity, innovative, respect and responsive
CDC	Community Day Centre
CINAHL	Cumulative Index of Nursing and Allied Health Literature
CVI	Content validity index

D

DoH	Department of Health
DPSA	Department of Public Service Administration

E

EBSCOhost	Elton B. Stephens Company host
ERIC	Education Resource Information Centre
EFA	Exploratory factor analysis

H

HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa

I

ICAS	Independent counselling and advisory services
ICN	International Council of Nurses
ICSM	Integrated Clinical Services Management
I-CVI	Individualised items Content Validity Index
IOM	Institute Of Medicine

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K

KMO	Kaiser-Meyer-Olkin

M

MDG	Millennium development goal
M	Mean

N

NCD	Non-communicable disease
NCS	National Core Standards
NDoH	National Department of Health
NHI	National Health Insurance
NSDA	Negotiated Service Delivery Agreement

O

OHSC	Office of Health Standards Compliance

P

PACK	Practical approach to care kit
PHC	Primary Health Care

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S

SANDoH	South African National Department of Health
S-CVI	Scale content validity index
SDG	Sustainable developmental goal
SE	Standard Error
SA	South Africa

T

TB	Tuberculosis

U

UNICEF	United Nations Children's Fund

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W

WCDoH	Western Cape Department of Health
WHO	World Health Organization
WISN	Workload Indicators Staffing Needs

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CHAPTER ONE:
ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Globally, research has shown that client-centred care has the potential to improve quality and outcomes in health care (Jayadevappa & Chhatre, 2011; Solberg, Asche, Fontaine, Flottemesch & Anderson, 2011). Furthermore, according to Bertakis and Azari (2011) client-centred care could diminish symptom severity, improve proper usage of health resources, and could lower health-care expenditures. Donaldson, Rutter and Henderson (2014) emphasise the importance of placing patients at the forefront of health care. According to these authors, the most important goal of health care should always be to optimise patient experiences, outcomes, treatment and safety. However, health systems around the world struggle to achieve this ideal.

Despite the challenge of client-centred care, quality of healthcare services fluctuates widely around the world, especially low-resource countries struggle to achieve this ideal. Donaldson *et al.* (2014) also highlight the extensive variation of care standards within countries. Basics such as cleanliness and infection are often neglected; evidence-based best practice being adopted slowly and inconsistently; avoidable risks of care are too high; periodic instances of serious failures in standards of care are observed and many patients experience disrespect, bad communication and poor coordination of care.

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Low-resource countries are confronted with high rates of mortality, life-threatening diseases and very low life expectancy. Therefore, the United Nations member states, including South Africa (SA) prioritised the following health-related millennium development goals (MDGs), namely: 4 (reduce child mortality rates), 5 (improve maternal health) and 6 (combat the Human Immunodeficiency Virus (HIV), AIDS, malaria and other infectious diseases) by the end of 2015 (Ruelas, Gomez-Dantes, Leatherman, Fortune & Gay-Molina, 2012). However, despite significant progress, much work remains to be done. To build on these successes, the WHO replaced the MDGs with 17 sustainable developmental goals (SDGs) during 2016 of which goal number three explicitly prioritises wellness for all towards 2030 (World Health Organization, 2015; Mohammed & Ghebreyesus, 2018).

Furthermore, the World Health Report (World Health Organization, 2008) stated that the establishment and maintenance of high quality primary health care (PHC) services seemed to

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be a major challenge for countries (El-Jardali, Hemadeh, Jaafar, Sagherian, El-Skaff, Mdeihly, Jamal & Ataya, 2014). The World Health Organization (2018) confirmed that PHC has the potential to improve health outcomes, e.g. improve population health in terms of life expectancy, health system efficiency (PHC can reduce the number of avoidable hospitalizations) and health equity (PHC can improve equitable access to health care and equitable health outcomes).

From the above, it is evident that both client-centred care and quality of healthcare services are a challenge. However, according to the WHO (2018), PHC has the potential to improve health outcomes, system efficiency and health equity. Therefore, this study aims to develop a programme to facilitate quality client-centred care in PHC clinics of the rural West Coast District. Terminology such as: patient-centred, client-centred, individualised and person-centred care will be used interchangeably. The following paragraphs provide the background and rationale for the study.

1.2 BACKGROUND AND RATIONALE FOR THE STUDY

The following sections provide a short overview about the current quality client-centred care status in the South African and the Western Cape, which contextualise the study.

1.2.1 South African context

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In recent years the South African National Department of Health (SANDoH) has shown strong commitment to improve the quality of health care. The vision, mission and 10 Point Plan as indicated in the Strategic Plan of 2010/11 to 2012/13, as well as the Negotiated Service Delivery Agreement 2010 to 2014, prioritise quality healthcare service delivery (South African National Department of Health, 2010; South African National Department of Health, 2013).

In addition, health system strengthening strategies, such as PHC re-engineering and National Health Insurance (NHI), mandate continuous monitoring of healthcare quality (Gray, Vawda & Jack, 2013). Subsequently, the Office of Health Standards Compliance (OHSC) develops the National Core Standards (NCSs) to create a benchmark for quality care, and aims to provide a framework for obtaining national accreditation of health establishments (South African National Department of Health, 2011; Lourens, 2012). The NCSs prioritise quality improvement in the following seven areas: patient rights; patient safety, clinical governance and care; clinical support services; public health; leadership and corporate governance; operational management; and facilities and infrastructure.

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Despite the aforementioned health system strengthening strategies, the national, baseline audit throughout SA (2011/2012) obtained poor results. PHC services obtained low scores in the areas of staff attitudes (25%); safety (30%); infection prevention and control (47%); cleanliness (48%); availability of medicines (47%) and waiting times (66%) (Health Systems Trust, 2013). For that reason, the SANDoH (South African National Department of Health, 2011) prioritizes the following six areas for fast tracking or immediate improvement of namely: patient rights (i.e. values and attitudes, waiting times, cleanliness); clinical governance and care (i.e. patient safety, infection prevention and control) and clinical support services (i.e. availability of medicines and supplies). Some of the challenges as related to the South African context will be highlighted.

The Patient Rights Charter (Health Professions Council of South Africa, 2008) and Batho Pele White Paper (Republic of South Africa, 1997) stipulate that citizens should be treated with courtesy, human dignity, patience, empathy and tolerance. However, *negative staff attitudes* seem to be a general phenomenon (Barnett, Patten, Kerschberger, Conradie, Garone, Van Cutsem & Colvin, 2013). It is for that reason that the study findings of Masango-Makgobela, Govender and Ndimande (2013) confirm that clients dodge their nearest clinic due to the impoliteness of staff.

The Health Professions Council of South Africa (HPCSA) also demands that clients and patients have the right to be treated in a setting which is hygienic, as well as clean (Health Professions Council of South Africa, 2008). However, Chimbindi, Barnighausen and Newell (2014) did exit interviews with HIV (N=300) and tuberculosis (TB) (N=300) patients at a PHC clinic in one of the rural areas of KwaZulu-Natal. Study findings revealed that a significant percentage (above 21%) of these patients were not satisfied with the cleanliness of the waiting rooms and toilets. Dirty, untidy and unhygienic facilities may be the result of staff who do not care about, or respect their patients or colleagues. The SANDoH (South African National Department of Health, 2011) confirms that *lack of cleanliness* is one of the most common complaints raised by healthcare users.

According to the HPCSA (Health Professions Council of South Africa, 2008) patients and clients should be protected against infections. Nevertheless, various South African studies have highlighted *serious inadequacies regarding infection control*. Naidoo, Seevnarain and Nordstrom (2012) reported that only 11(22%) of 51 PHC clinics had infection control policies. Similarly, the cross-sectional survey of Engelbrecht and Van Rensburg (2013) at 127 PHC

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facilities in the Eastern Cape, SA, indicated the lack of an infection control committee at 43.3% of selected clinics. Furthermore, 40.9% of these clinics did not have a clinic-specific infection control plan. Only a third of the professional nurses, one in ten community health workers were trained on infection control practices.

Medication shortages seem to be another concern at PHC clinics. Medication shortages could pose a threat to the continuity of care. The qualitative study findings of Visagie and Schneider (2014) reported episodic stock outs of chronic disease medication in the Northern Cape. Unavailability of medication at clinics was cited as a reason for patients being unwilling to attend their nearest clinic in Pretoria North (Masango-Makgobela *et al.*, 2013) and the ordering and delivery systems, payment and insufficient storehouse stock were highlighted as challenges. Study results of Macha, Harris, Garshong, Ataguba, Akazili, Kuwawenaruwa, and Borghi (2012) identified Ghana, Tanzania and SA as countries where drugs were more likely to be out of stock in public, rather than private facilities. The SANDoH confirmed that shortage of medicines has become the “norm” across South Africa. Patients, who are unable to get their medication on the day of their clinic visit, usually experience inconvenience, additional costs and possibly also deterioration of their condition (South African National Department of Health, 2011).

1.2.2 Western Cape scenario

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The Western Cape Department of Health (WCDoH) strategic frameworks, “Healthcare 2020” and “Healthcare 2030” (Western Cape Department of Health, 2011; Western Cape Department of Health, 2014) prioritise quality care characterised by means of positive patient experience or patient-centred service. However, the baseline, NCSs audit (2011/2012) revealed poor outcomes for staff attitudes (37%); safety (39%); infection prevention/control (50%); cleanliness (50%); obtainability of medicines (60%) and waiting times (69%) for the Western Cape PHC clinics and hospitals (Health Systems Trust, 2013).

Furthermore, clients should have the opportunity to schedule appointments for visiting health facilities (unless it is an emergency), and should be greeted by staff members who are friendly, helpful, empathetic and caring (Western Cape Deaprtment). Benjamin and De la Harpe (2011) conducted a study at 33 community clinics in the Western Cape. The study findings confirmed that some clinics have introduced appointment systems, but it was almost impossible to run according to schedule due to the large number of patients and inadequate staff capacity.

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The WCDoH (Western Cape Department of Health, 2011) also indicates that a client who needs health services and has been allocated an appointment, should not have to wait long, since their files should be available. However, according to Benjamin and De la Harpe (2011) patients at PHC clinics across the Western Cape, were exposed to long waiting times in order to receive treatment and medication. During the first four hours of the morning, reception areas are heavily overcrowded with patients who are expected to wait for many hours in long queues. Similarly, Stellenberg (2015) revealed that more than half (n=79; 52.7%) of participants in the Cape Metropolitan areas, complained about long waiting times, which averaged 10 hours. When too many patients showed up at the clinic on a specific day, they were often requested to come back the following day. Patients confirmed that the long waiting times were a discouragement for clinic attendance. They often spent a whole day at the clinic in order to see a healthcare provider for an appointment that would last only a few minutes (Kagee, Nothling & Coetzee, 2012).

In addition, the inspection conducted by the Public Service Commission (Republic of South Africa, 2010), indicated that staff members at PHC delivery sites in the Western Cape were not always able to utilise computers as a tool to enhance effective and efficient service delivery due to computer unavailability. Benjamin and De la Harpe (2011) reported that although the PHC Information System had been introduced to community clinics in the Western Cape during 2006, the service was only used for capturing demographic information and printing patient details, and labels for medication.

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To conclude: As indicated by the evidence provided above, health care throughout South Africa was compromised amongst others by: negative staff attitudes; facilities that showed a lack of cleanliness, inadequate infection control measures and medication shortages. Similarly, health care in the Western Cape was also compromised by long waiting times due to inadequate staff capacity and computer inadequacies at PHC facilities. Furthermore, the poor outcome of the baseline audit (2011/2012) throughout South Africa, including the Western Cape confirmed that patients and clients do not always receive quality, neither client-centred care. Based on the aforementioned, the problem statement and research questions are presented in the next section.

1.3 PROBLEM STATEMENT

Providing client-centred care of high quality is a central aim for national healthcare services in SA. However, previous studies and the poor results obtained in the national, baseline NCS's audit (2011/2012) as discussed above, confirmed that quality client-centred care in PHC was

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challenged amongst others by: negative staff attitudes, unhygienic and untidy clinics, safety risks, infection prevention/control risks, medication shortages and long waiting times.

The researcher herself can relate with the abovementioned quality client-centred care challenges as experienced and observed in the PHC milieu where she is employed as a PHC manager. However, no studies had been conducted on a programme to facilitate quality client-centred care in PHC clinics of the rural West Coast District.

The following questions are derived from the problem statement:

1) What is the current status of quality client-centred care according to the literature?
2) What are the clients' perceptions of quality client-centred care?
3) What are the clinical nurse practitioners' perceptions about quality client-centred care?
4) What are the managers and allied health professionals' perceptions about quality client-centred care?
5) How can a programme be described that will improve quality client-centred care?

1.4 RESEARCH AIM AND OBJECTIVES

The overall aim of this study is to develop a programme to facilitate quality client-centred care in PHC clinics of the rural West Coast District. This aim is accomplished through the formulation of the subsequent objectives:

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1.4.1 Phase 1: Situational analysis (Quantitative)

- Objective 1: To explore and describe the current status of quality client-centred care by conducting an extensive literature review.
- Objective 2: To assess the clients' perceptions about quality client-centred care.
- Objective 3: To determine the clinical nurse practitioners' perceptions on quality client-centred care.

1.4.2 Phase 2: Situational analysis (Qualitative)

Objective 4: To explore and describe managers and allied health professionals' perceptions about quality client-centred care.

1.4.3 Phase 3: Programme development

Objective 5: To develop a programme to facilitate quality client-centred care in PHC clinics of the rural, West Coast District.

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1.5 CENTRAL THEORETICAL STATEMENT

In conducting a situational analysis, the current status of quality client-centred care was determined through an analyses of the literature, perceptions of clients, clinical nurse practitioners, managers and allied health professionals to set the basis for the development of a programme to facilitate quality, client-centred care in PHC clinics of the rural West Coast District.

1.6 RESEARCHER'S ASSUMPTIONS

Assumptions are statements or sets of beliefs accepted to be true, even though they have not been scientifically examined (Grove, Burns & Gray, 2012; Polit & Beck, 2012). According to Creswell (2014), all researchers bring certain assumptions to their research, whether they make it clear or not. Creswell and Plano Clark (2010) emphasized that researchers should be aware of their philosophical assumptions and should clarify it in their studies. These assumptions shape the research process and the inquiry conduction.

The researcher's assumptions are discussed with regard to the meta-theoretical, theoretical; and methodological assumptions of this study.

1.6.1 Meta-theoretical assumptions

According to Klopper (2008) meta-theoretical assumptions or statements express the beliefs of the researcher about the human being, environment, health and nursing. The researcher aligned to the metaparadigm of Chinn and Kramer (2014) to convey the related meta-theoretical assumptions of the researcher. The meta-theoretical assumptions in the context of PHC nursing, are as follow:

1.6.1.1 View of the human being

In this study human being refers to the PHC "client" inclusive of various categories of persons: clients (persons accessing PHC services for preventive services, e.g. family planning, immunisation or screening programmes); patients (persons with a disease, injury or under medical treatment); individuals (persons significant to clients, e.g. family and friends); and care providers (clinical nurse practitioners, managers and allied health professionals).

Chinn and Kramer (2014) highlighted the dimension of wholism. The researcher also believes that clients (categories as mentioned in the previous paragraph) should be viewed holistically in order to render quality client-centred care.

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1.6.1.2 View of the environment

The researcher, as Chinn and Kramer (2014) is of the belief that healthcare providers should manage patients holistically, by considering them as part of a family and living in a specific community within a specific culture. In order to deliver quality client-centred care within the PHC milieu, healthcare workers should take into consideration the physical surroundings, as well as the the local, regional, national and worldwide cultural, social, political and economic conditions that can impact on the health of individuals.

1.6.1.3 Health

The researcher agrees with the WHO's definition of health which defines health as not only the absence of disease, but a complete state of physical, mental and social well-being (World Health Organization, 1948). This definition synchronised with Chinn and Kramer (2014) who accentuated the importance that the focus should be on the totality of the individual rather than typical parameters that have come to be commonly known as health. The researcher is of the belief that when individuals are viewed in totality, quality clent-centred care will result.

1.6.1.4 Nursing

The researcher adheres to the definition of the International Council of Nurses (ICN) which defines nursing as "autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key roles" (International Council of Nurses, 2010:1).

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The researcher is of the belief that the implementation of the ICN's nursing definition in the PHC setting, within the context of this study will promote wholeness of the individual as highlighted by Chinn and Kramer (2014) and will enable the goal of quality client-centred care.

1.6.2 Theoretical assumptions

Theoretical assumptions are the researcher's opinion about what is true or valid knowledge concerning the research subject (Botes, 1995). Theoretical assumptions are testable and result in a better understanding of the research problem (Botes, 1995). The concepts and theoretical framework (Figure 1.1) applicable to this study will be clarified in the paragraphs below.

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1.6.2.1 Primary Health Care

The WHO defined PHC as: "a vital health care service; grounded on a practical, scientifically sound and socially appropriate method, and technology; generally accessible to all in the community through their full involvement; at a reasonable cost; and geared towards self-reliance and self-determination" (World Health Organization, 1978:16).

Furthermore, PHC is regarded as the first point of contact for individuals, families and communities with the national health system. The intention is to bring health care as close as possible to where people live and work, and set up the first element of a continuing healthcare process. PHC services address the foremost health problems in the community, including promotive, preventive, curative and rehabilitative services (World Health Organization, 1978).

1.6.2.2 Fixed clinics

A PHC "fixed" clinic is a properly permanently equipped facility where comprehensive (e.g. preventive, promotive, curative and rehabilitative) services are delivered (Western Cape Department of Health, 2014).

Fixed clinics for the purpose of this study included PHC clinics which were operational for five days a week (Monday to Friday), from 07:30 to 16:30.

1.6.2.3 Clinical Nurse Practitioner

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The clinical nurse practitioner is a professional nurse registered by the South African Nursing Council (under the provisions of the Nursing Act, 2005) with an additional qualification (R48 diploma). The clinical nurse practitioner is an independent nurse specialist who functions independently to render the first level of nursing care, i.e. physical assessment, diagnosed illnesses, prescribes treatment, provides direct care and refers patients for further treatment (South African Nursing Council, 2014).

1.6.2.4 National Core Standards

NCSs can be defined as a set of national standards developed by the OHSC for health institutions to establish a benchmark for quality care against which delivery of services can be monitored and to provide a framework for obtaining national accreditation of health establishments. The NCSs prioritise quality improvement in the following seven areas: patient rights; patient safety, clinical governance and care; clinical support services; public health; leadership and corporate governance; operational management; and facilities and infrastructure (South African National Department of Health, 2011; Lourens, 2012).

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1.6.2.5 Donabedian's Quality Triad

Donabedian's Quality Triad (structure-process- outcome) model assess quality as a balance of structure (i.e. the tools and resources available to providers and their physical and organizational settings), process (the normative behaviours of providers and the interactions between them and their patients), and outcome (i.e. "changes in a patient's current and future status") (Donabedian, 1988:1743).

For the purpose of this study, the researcher applied Donabedian's model in order to categorize the identified problems or gaps in the current status of quality client-centred care with regard to the structure (organizational), process (actions and interventions) and outcome (results).

1.6.2.6 Quality

For the purpose of this study, the researcher adheres to the definition of quality as provided by the Institute Of Medicine (IOM) where quality is defined as care which is: effective, client-centred, timely, efficient, safe and equal to all who are in need of PHC service (Institute Of Medicine, 2001).

1.6.2.7 Client-centred care

The researcher also adheres to the Picker's definition of client-centred care, as care which adheres to the following eight principles, namely: respect for patients' values, preferences and expressed needs; coordination and integration of care, information, communication and education; physical comfort; emotional support and alleviation of fear and anxiety; involvement of family and friends; transition and continuity of care and access to care (Gerteis, Edgman-Levitan, Daley & Delbanco, 1993).

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1.6.2.8 Rural

The Western Cape is divided into the following districts namely: Cape Town, Cape Winelands, Central Karoo, Eden, Overberg and West Coast. For the context of this study Cape Town is defined as a metropolitan district (big town or city), while the other five districts outside Cape Town are the rural districts (farming and/or agricultural areas).

1.6.2.9 Quality improvement programme

According to the United States Department of Health and Human Services Health Resources and Services Administration (2011), a quality improvement programme involves systematic activities that are organized and implemented by an organization to monitor, assess and improve its quality of health care. The activities are cyclical so that an organization continues

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to seek higher levels of performance to optimize its care for patients it serves, while striving for continuous improvement.

The aim of this study is to develop a programme to facilitate quality client-centred care in PHC clinics of the rural West Coast District. Uys and Gwele's (2005) curriculum development method was utilised for the development of a programme to facilitate quality client-centred care in PHC clinics of the rural West Coast District. *Step One*, the situational analysis revealed *81 problems*. *Step Two*, seven programme goals were developed (deductively) and prioritised on the basis of the data analysis process. *Step Three*, proposed objectives were determined to reach these goals. *Step Four*, actions were developed from the objectives by using inductive logic. *Step Five*, implementation of the programme.

When implemented, this programme will enable managers and staff at the PHC clinics to monitor, assess, plan and improve their quality client-centred care in a continuous way. The quality improvement programme applicable to this study will be discussed in detail in Chapter 6.

1.6.2.10 Managers

Managers of the five subdistricts in the West Coast District, include the assistant PHC managers, infectious disease coordinators, CBS coordinators, assistant directors of finance and assistant directors of human resources. The PHC managers are excluded from the study, as the researcher is one of the three PHC employed in the West Coast District.

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1.6.2.11 Allied health professionals

Allied health professionals for the purpose of this study include pharmacists, occupational therapists, physiotherapists, dieticians, speech therapists, clinical psychologists, doctors, dentists and oral hygienists.

1.6.2.12 Theoretical framework applicable for this study

The researcher applied the seven domains of the NCSs as the framework to develop two individual questionnaires to determine the current status of quality client-centred from the perceptions of clients and clinical nurse practitioners working in the PHC clinics of the rural West Coast District. Donabedian's structure-process-outcome model, the IOMs (2001) six dimensions of quality and the eight Picker Institute's client-centred care principles (1993) were applied as a measure to identify quality client-centred problems and to determine whether the identified problems or gaps were structure, process or outcomes based (see Figure 1.1).

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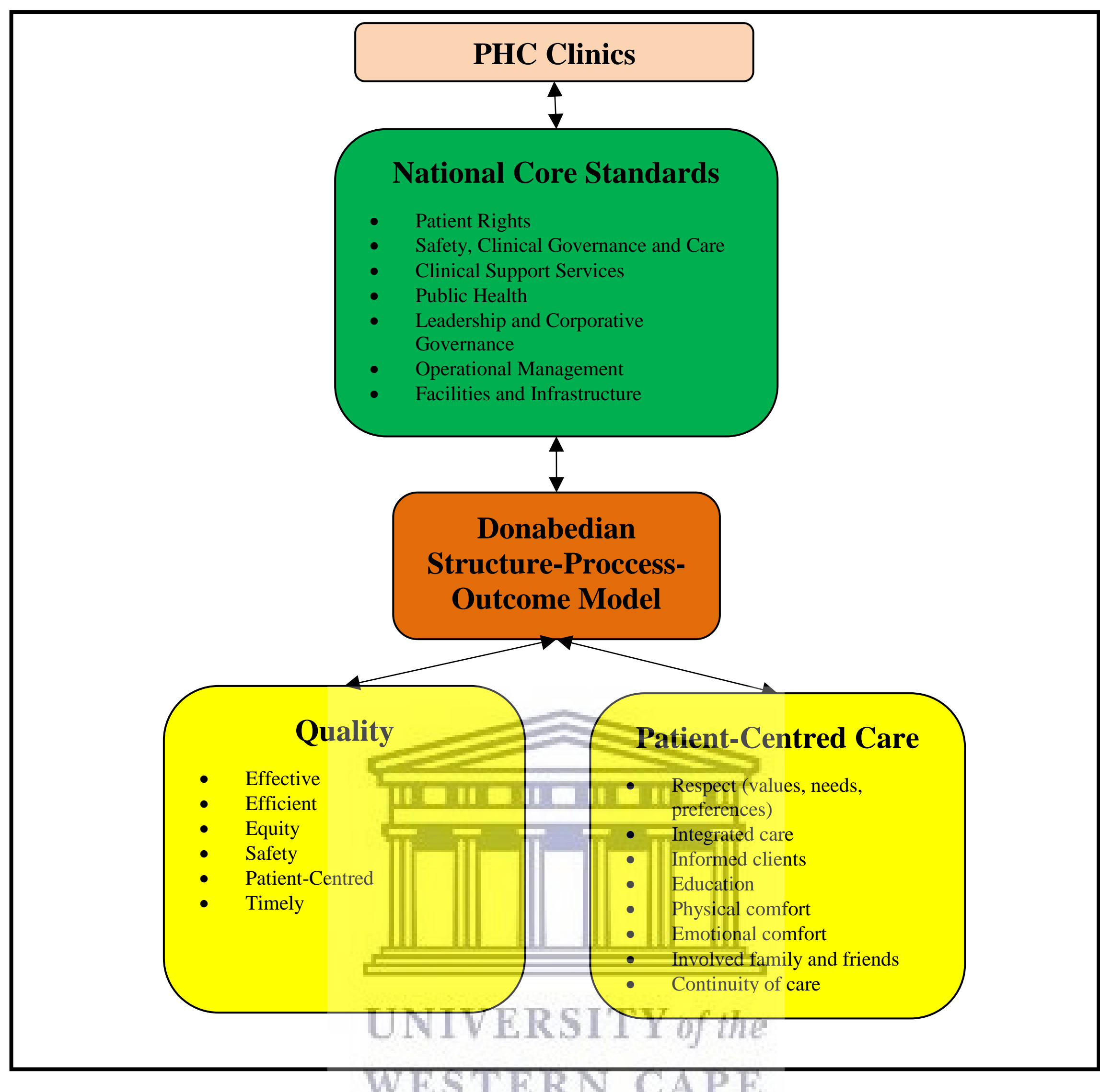

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Figure 1.1: Theoretical framework for quality client-centred care

1.6.3 Methodological assumptions

Methodological assumptions are the researcher's comprehension about the research process and the most appropriate methods to direct the research design (Mouton, 1996). These assumptions have their origin in science-philosophy and deal with the purpose, methods and criteria of the research validity. Polit and Hungler (1997) stated that methodological assumptions address the manner in which researchers obtain knowledge through the process of inquiry and conduct research within the research paradigm.

The research questions guided the methodology (process of research) of the study. The first two research questions, dealing with the clients and clinical nurse practitioners (see Section 1.4) called for a quantitative approach, while the third question (inclusive of the managers and the allied health professionals) lends itself to an in-depth, qualitative approach. The researcher

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believes that the combination of quantitative and qualitative approaches in the methodology of this study would result in a better understanding of the research problem and contribute to the most valid findings.

1.7 RESEARCH DESIGN

Both quantitative and qualitative approaches (Creswell, 2014) were applied to explore, describe and explain quality client-centred care in the context of PHC clinics in the rural West Coast District. These approaches were applied in a parallel (convergent) manner to gain a better understanding of the research problem (Creswell, 2014) and to set the basis for the situational analysis provided the data for the development of the programme to improve quality client-centred care (Objective 5) in phase 3.

1.7.1 Quantitative inquiry

The quantitative inquiry represents a firm, structured and predetermined technique to explore a phenomenon under investigation and aims to quantify the extent of variation (coded data into numerical forms); puts emphasis on the measurement of variables and objectivity (statistical analyses); proves evidence on the basis of a larger sample size; emphasises validity and reliability of findings; and communicates findings in an analytical and comprehensive way, drawing conclusions based on evidence that can be generalised (Kumar, 2013; Grove, Gray & Burns, 2014; Gliner, Morgan & Leech, 2010).

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Phase 1 of this study applied a quantitative design to explain and describe the clients' perceptions of quality client-centred care (Objective 2) and to determine the clinical nurse practitioners' reported status on quality client-centred care (Objective 3).

1.7.2 Qualitative inquiry

The qualitative inquiry is based on an open, flexible and semi-structured approach. Qualitative research aims to explore diversity; emphasises description and narration of feelings, perceptions and experiences; and communicates findings in a descriptive and narrative way, assigning no or less prominence on generalisations (Kumar, 2013; Grove *et al.*, 2012; Polit & Beck, 2015). The nature of qualitative research is explorative, descriptive and contextual (Leedy & Ormrod, 2015; Creswell, 2012; Fouche & Delport, 2013).

As such, the qualitative inquiry of this study deems to be appropriate for complementing the quantitative approach of phase 1. The qualitative approach is applied in phase 2, to explore

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and describe the experiences of the managers and allied health professionals regarding quality client-centred care.

1.7.3 Exploratory

Fouche and De Vos (2013) stated that exploratory studies provide insight or new insight on areas where there is a lack of basic information e.g. new, unknown areas, to test the feasibility of a more in-depth research study or to refine the methods for a more comprehensive study. The managers' and allied health professionals were involved in focus groups to explore and describe their perceptions regarding quality client-centred care.

1.7.4 Descriptive

According to Polit and Beck (2012) descriptive research aims to describe people's characteristics or circumstances and/or the frequency with which certain phenomena occur accurately.

Both phases of this study (quantitative and qualitative) provide an accurate portrayal of the clients and clinical nurse practitioners (Objective 2 and 3), as well as managers and allied health professionals (Objective 4) reported status on quality client-centred care.

1.7.5 Explanatory

According to Babbie (2013) one of the purposes of social science is to provide explanations to answer the what, where, when, how and why.

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Study findings of this study (both phases) provide valuable answers about what study participants regard as quality client-centred care and reasons for underperformance in this area.

1.7.6 Context

This study aimed to explore, describe and explain quality client-centred care from the viewpoint of clients, clinical nurse practitioners, managers and allied health professionals within the PHC context of the West Coast District in the Western Cape Province (Figure 1.2). In order to highlight the specific context of this research the following section elaborates on the research setting.

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Figure 1.2: Provinces of SA (Pinterest, 2012)

1.7.7 Research setting

The West Coast District (see Figure 1.3) is divided into the following five subdistricts, namely: Matzikama, Cederberg, Swartland, Bergrivier and Saldanha Bay (Massyn, 2014:606). Census 2011, estimated the population numbers as, Matzikama: 67 147; Cederberg: 49 768; Swartland: 113 752; Bergriver: 61 886 and Saldanha Bay: 99 170 (Lehohla, 2012). The majority of the population groups in the West Coast District comprise: Coloureds (67.1%) followed by Africans (16.5%), Whites (15.8%) and then Indians (0.6%) (Western Cape Government Provincial Treasury, 2013). Only 29.1% of the West Coast population, aged 20 years and older, had matric and 7.6% have higher education. Those with no schooling comprises 3.8%. The unemployment rate is 14.6% of which the youth unemployment rate (15 to 34 years) is 19.9%. Only 16.3% of the citizens have access to a medical scheme (Massyn, Padarath, Peer & Day, 2017). The main economic sectors of the West Coast District according to Massyn (2014) are: agriculture, fishing, mining, manufacturing, retail, trade and tourism.

The majority of the West Coast population (83.7%) have to rely on public health services, including PHC services. The PHC services (i.e. fixed clinics, satellites and mobile clinics) is

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the first contact for the patient within the public health service for preventive, promotive, curative and rehabilitative services (Table 1.1). These PHC services are supported and strengthened by the acute (district hospitals) and specialised (secondary) referral hospitals, as well as community-based services (Western Cape Department of Health, 2013).

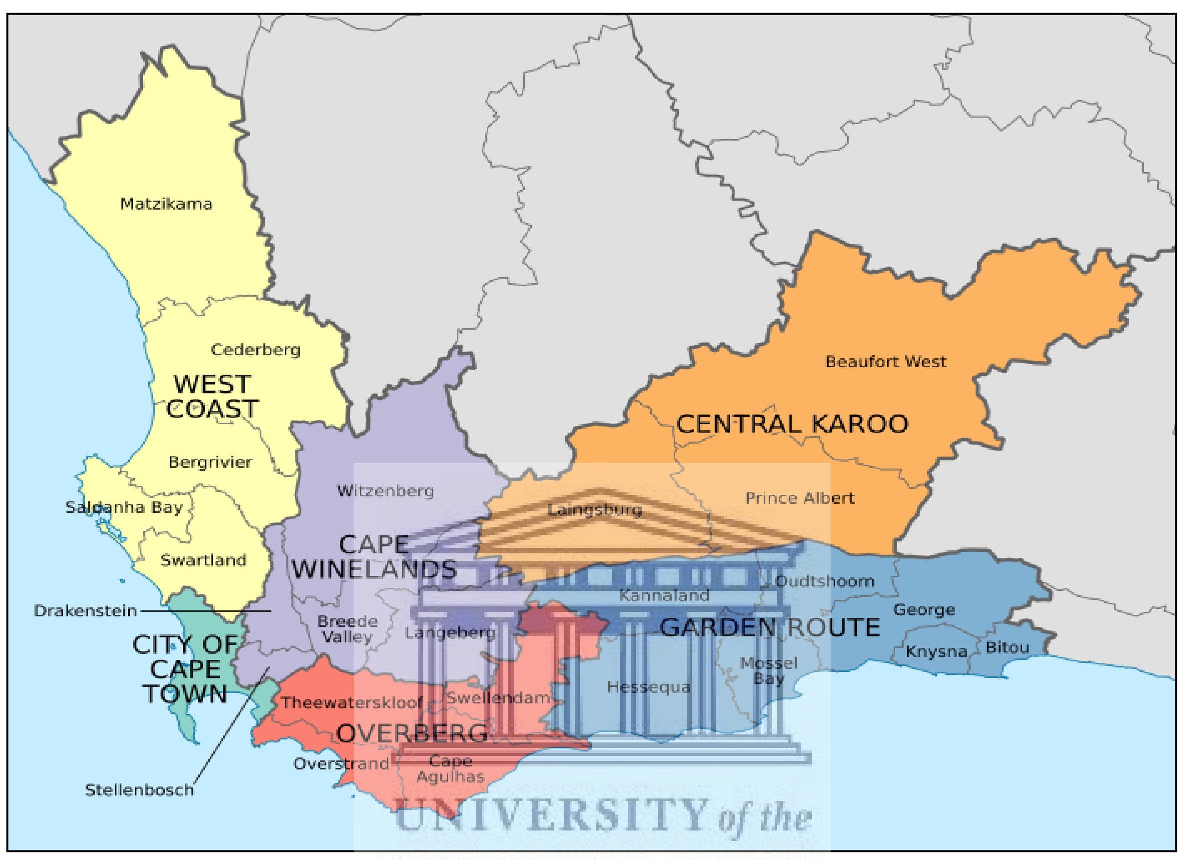

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Figure 1.3: Districts of the Western Cape Province

(Municipalities Demarcation Board, 2016)

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Table 1.1: Number of public health facilities in the five subdistricts of the West Coast District (Western Cape Department of Health, 2013)

SUBDISTRICTS	COMMUNITY DAY CENTRE	CLINICS	SATELLITES	MOBILES	DISTRICT HOSPITALS
Cederberg	None	1. Citrusdal 2. Clanwilliam 3. Elands Bay 4. Graafwater 5. Lambert's Bay	1. Wuppertal	1. Citrusdal 2. Clanwilliam 3. Graafwater 4. Leipoldtville	1. Citrusdal 2. Clanwilliam
Bergriver	None	1. Piketberg 2. Porterville 3. Veldrif	1. Aurora 2. Eendekuil 3. Goedverwacht 4. Redelinghuys 5. Wittewater	1. Piketberg Mobile 1 2. Piketberg Mobile 2 3. Piketberg Mobile 5 4. Porterville	1. Radie Kotze (Piketberg)
Matzikama	None	1. Klawer 2. Lutzville 3. Van Rhynsdorp 4. Vredendal Central 5. Vredendal North	1. Bitterfontein 2. Doringbaai 3. Ebenaezer 4. Kliprand 5. Koekenaap 6. Molsvlei 7. Nuwerus 8. Rietpoort 9. Stofkraal	1. Klawer 2. Lutzville 3. Vanrhynsdorp 4. Vredendal	1. Vredendal
Saldanha	None	1. Diazville 2. Saldanha 3. Vredenburg 4. Hanna Coetzee 5. Louwville 6. Lalie Cleophas 7. Langebaan 8. Laingville	1. Paternoster 2. Sandy Point	1. Hopefield 2. Vredenburg	1. Vredenburg
Swartland	1. Malmesbury	1. Darling 2. Moorreesburg 3. Riebeeck Kasteel 4. Riebeeck West	1. Abbotsdale 2. Chatsworth 3. Kalbaskraal 4. Koringberg 5. Riverlands 6. Yzerfontein	1. Darling 2. Malmesbury Mobile 1 3. Malmesbury Mobile 2 4. Moorreesburg	1. Malmesbury

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The West Coast District prioritizes the achievement of the SDGs. The SDGs followed and expanded on the MDGs, which have expired at the end of 2015. SDG number three focuses on wellness for all (World Health Organization, 2015). Therefore, the West Coast District aims to reduce child mortality, improve maternal health outcomes and combat HIV/AIDS.

According to Groenewald, Berteler, Bradshaw, Coetzee, Cornelius, Daniels, Evans, Jacobs, Neethling, Msemburi, Matzopoulus, Naledi, Shand, Thompson and Vismer (2013), the leading causes of premature mortality for the West Coast District (2010) are: HIV/AIDS (10.7%), TB (10.4%), violence (7.1%), ischaemic heart disease (6.3%), cerebrovascular disease (5.7%), road injuries (5.6%), diabetes mellitus (4.6%), lower respiratory infections (4.4%), trachea/ bronchi/ lung (3.8%) and chronic obstructive pulmonary disease (3.6%). Whereas, Massyn *et al.* (2017:765) categorised deaths into the following four groups, namely: injuries, non-communicable diseases (NCD), HIV and TB, and infectious diseases together with maternal,

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perinatal and nutritional conditions. See Table 1.2 for the percentages of deaths by broad cause and leading causes for 2010 to 2015.

Table 1.2: West Coast District percentages of deaths by broad cause and leading causes 2010 to 2015 (Massyn et al., 2017:765)

	FEMALE				MALE			
Age	**Injury**	**NCD**	**HIV/TB**	**Infectious diseases maternal, perinatal & nutritional**	**Injury**	**NCD**	**HIV/TB**	**Infectious diseases maternal, perinatal & nutritional**
Under 5	**9%**	**17%**	**4%**	**70%**	**7%**	**15%**	**6%**	**73%**
5-14	**46%**	**23%**	**11%**	**20%**	**60%**	**14%**	**9%**	**17%**
15-24	**29%**	**16%**	**45%**	**10%**	**75%**	**7%**	**13%**	**5%**
25-64	**8%**	**55%**	**32%**	**6%**	**19%**	**48%**	**29%**	**4%**
Above 65	**2%**	**89%**	**13%**	**6%**	**3%**	**86%**	**6%**	**5%**
Total	**6%**	**67%**	**17%**	**9%**	**16%**	**57%**	**20%**	**8%**

The aforementioned discussion provides the context of the study, as well as a description of the demographics and health status of the West Coast District. A detailed description of the three different population groups included in this study, follows below.

1.7.8 Population

This study included three different populations:

- **Population for Objective 1: an extensive literature review to explore and describe quality client-centred care**
  Ebscho Host was utilised to cover multiple databases (see Table 1.4).
- **Population for Objective 2: clients' perceptions about quality client-centred care**
  The target population comprise clients 18 years and older (N= 137 991) of the (N=25) rural, fixed PHC clinics in the West Coast District. The Community Day Centre, satellite clinics and mobile clinics are excluded (see Table 1.3).
- **Population for Objective 3: clinical nurse practitioners' reported status on quality client-centred care**
  This population include all clinical nurse practitioners (N= 64) employed at the (N=25) rural, fixed PHC clinics (see Table 1.3).

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- **Population for Objective 4: managers and allied health professionals' perceptions of quality, client-centred care**

  The target population include all managers (N=30) and allied health professionals (N= 43) (see Table 1.3). The researcher, one of the three PHC managers, is directly involved in the study and is therefore excluded from the study. The other two PHC managers are also excluded from the study to keep the groups homogenous.

Table 1.3: Target population of the fixed PHC clinics in the five subdistricts of the West Coast District

FIXED PHC CLINIC	MANAGEMENT + ALLIED HEALTH PROFESSIONALS	CLIENTS ↑18 YEARS	CLINICAL NURSE PRACTITIONERS
Cederberg subdistrict	**15**	**17365**	**13**
1. Citrusdal		5044	04
2. Clanwilliam		5382	04
3. Elands Bay		1047	01
4. Graafwater		1536	01
5. Lambert's Bay		4356	03
Bergriver subdistrict	13	**21125**	**06**
1. Piketberg		8252	02
2. Porterville		4859	02
3. Veldrif		8014	02
Matzikama subdistrict	14	**24376**	**14**
1. Klawer		4155	02
2. Lutzville		3426	04
3. Van Rhynsdorp		4355	02
4. Vredendal South			03
5. Vredendal North		12440	03
Saldanha subdistrict	15	**64864**	**20**
1. Diazville +		19716	03
2. Saldanha			02
3. Vredenburg +		26461	03
4. Hanna Coetzee +			02
5. Louwville			02
6. Lalie Cleophas (Hopefield)		4515	02
7. Langebaan		6245	02
8. Laingville (St Helena Bay)		7927	04
Swartland subdistrict	**16**	**10261**	**11**
1. Darling		879	03
2. Moorreesburg		5596	05
3. Riebeeck Kasteel		847	01
4. Riebeeck West		2939	02

1.8 RESEARCH METHOD

The research method refers to the processes and strategies to obtain, organise and analyse data (Polit & Beck, 2012). Table 1.4 presents a brief overview of the methods followed to obtain, organise and analyse the data.

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Table 1.4: Research methods followed to develop a programme to facilitate the quality client-centred care for PHC clinics

PHASE ONE: SITUATIONAL ANALYSIS (QUANTITATIVE)					
OBJECTIVE	**DATA COLLECTION**	**POPULATION AND SAMPLE**	**DATA ANALYSIS**	**RIGOUR**	**METHODS DISCUSSED IN MORE DETAIL**
OBJECTIVE 1					
To explore and describe quality client-centred, care by conducting an extensive literature review.	Available national and international sources	**Population**: EBSCHOhost to include multiple databases: • Academic Search Complete (multi-disciplinary journals) • CINAHL (journals for nursing & allied health professionals) • ERIC (Education literature and research) • Health Source: Nursing/Academic Edition (journals on various medical disciplines) • MEDLINE (information on medicine, nursing, health systems.) • Psych ARTICLES (psychology related full text articles) • Google Scholar search engine (scholarly literature across various disciplines) **Sampling**: Purposive sampling determined by the inclusion criteria i.e.: • Phenomenon of interest: PHC AND quality AND client-centred care (and synonyms). • Outcomes: Improved quality, client-centred care in a PHC milieu. • Time: Literature between 2010 and 2018 were included. • Language: English.	Content analysis (Strydom & Delport, 2013; Babbie, 2013).	Deductive reasoning (Grove *et al*. 2012).	Chapter 3

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PHASE ONE: SITUATIONAL ANALYSIS (QUANTITATIVE)					
OBJECTIVE	**DATA COLLECTION**	**POPULATION AND SAMPLE**	**DATA ANALYSIS**	**RIGOUR**	**METHODS DISCUSSED IN MORE DETAIL**
OBJECTIVE 2					
To assess the clients' experiences about quality client-centred, care.	A structured questionnaire	**Population**: All clients 18 years and older (N = 137 991) of all the fixed clinics (N = 25) in the five subdistricts of the West Coast District (Census 2011). **Sampling**: • Cochran formula calculated that a random sample of (n=383) was adequate to represent the population. • Non-proportional sampling was applied to estimate the number of participants (clients) per clinic. • Purposive sampling was done at the selected clinic.	• Descriptive statistics • Exploratory factor analysis.(EFA) • Correlations • GAP analysis.	**Validity:** • Construct validity • Content validity • Inferential validity • Theoretical validity **Reliability:** • Exploratory Factor Analysis • Cronbach's Alpha	Chapter 4
OBJECTIVE 3					
To determine the clinical nurse practitioners' reported status on quality client-centred care	A structured questionnaire	**Population**: Consisted of all the clinical nurse practitioners (N=64). **Sampling**: An all-inclusive sample was utilised to include all the clinical nurse practitioners (n=64).	• Descriptive statistics. • Explorative factor analysis (EFA) • Correlations • GAP analysis.	• Construct validity • Content validity • Inferential validity • Theoretical validity **Reliability:** • EFA • Cronbach's Alpha	Chapter 4

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OBJECTIVE	DATA COLLECTION	POPULATION AND SAMPLE	DATA ANALYSIS	RIGOUR	METHODS DISCUSSED IN MORE DETAIL
OBJECTIVE 4					
To explore and describe managers and allied health professionals' perceptions about quality client-centred care.	Focus group interviews	**Population**: Consisted of all the managers and allied health professionals of the five subdistricts (N = 43). **Sampling**: An all-inclusive sample was utilised to include all the managers and allied health professionals (n=43).	Tesch's (1990) Open Coding – manually (Creswell, 2013). (qualitative data analysis)	• Credibility • Transferability • Dependability • Confirmability (Klopper & Knobloch, 2010; Klopper & Knobloch, 2018)	Chapter 5
PHASE THREE: PROGRAMME DEVELOPMENT					
OBJECTIVE	**DATA COLLECTION**	**POPULATION AND SAMPLE**	**DATA ANALYSIS**	**RIGOUR**	**METHODS DISCUSSED IN MORE DETAIL**
OBJECTIVE 5					
To develop a programme to facilitate quality client-centred care in PHC clinics of the rural, West Coast District.	Evidence from Phase One (Objective 1, 2 and 3) and Phase Two (Objective 4) – Situational Analysis	Evidence from Phase One (Objective 1, 2 and 3) and Phase Two (Objective 4) – Situational Analysis	Deductive and inductive reasoning: • Vision • Mission • Values • Assumptions • Problems identified • Goals • Interventions • Actions (See Chapter 6, Section 6.3)	Evaluation of the programme after implementation thereof (Not conducted as part of this study)	Chapter 6

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1.9 ETHICAL CONSIDERATIONS

Polit and Beck (2015) defined ethical considerations as the adherence to the moral values in terms of professional, legal and social obligations to the participants.

The underneath paragraphs describe the ethical principles applied in this study, namely: permission to conduct the study, voluntary informed consent, beneficence, respect, justice, anonymity, confidentiality and reflexivity.

1.9.1 Permission to conduct the study

The Senate Research Committee of the University of the Western Cape approved the methodology and ethics of this research project on 18 June 2013 (registration number: 13/5/25, see Annexure A.). The WCDoH granted approval on 31 July 2013 (see Annexure B). The West Coast District office and the researcher informed the PHC managers, Chief Executive Officers or Medical Superintendents, as well as the Operational Managers of the proposed study in the five subdistricts of the West Coast District. A copy of the proposal summary was e-mailed to the relevant role players.

1.9.2 Voluntary informed consent

The study was explained in Afrikaans and English to the proposed participants (i.e. procedures, purpose, risks and benefits). Voluntary participation and declining at any time were emphasized. Participants were informed that they could withdraw at any time during the study. Written consent (Annexure D) was obtained from those who were willing to participate.

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According to the Belmont Report, the present research emphasized the following three ethical principles namely, beneficence, respect for human dignity, and justice (Grove *et al.*, 2012).

1.9.3 Beneficence

Beneficence is the ethical principle that strives to do "good" and prevent harm to study participants. Participants were informed about the benefits of the study. It was stressed that no risks or harm was foreseen (refer to Annexure C). However, participants would have been referred to a clinical psychologist should it have been necessary. An opportunity was granted to participants to ask any questions in the language of their choice.

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1.9.4 Respect

Participants had the freedom to participate or not to participate. Participants could decline at any stage without any prejudgment, which was in accordance with the principle of respect for persons.

1.9.5 Justice

The Belmont Report emphasises that all participants are entitled to equal treatment and privacy (Polit & Beck, 2015). All participants were given a fair chance to participate in the study. Participants were allowed to complete the questionnaires in their own time in the privacy of their homes and to return it in a closed envelope. The focus groups were conducted in venues conducive to privacy.

1.9.6 Anonymity and confidentiality

All participants have the right of anonymity and confidentiality (Grove *et al.*, 2014). Participants of this study were assured that their names would not be disclosed. Pseudonyms could be chosen to protect their identification. Participants were requested to keep information confidential and assurance was given of the anonymity of their contributions. The researcher will safely store all collected data, including the voice recordings until data collection is completed. The data will be destroyed 5 years after publication of the study results.

1.9.7 Reflexivity

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Leedy and Ormrod (2015), as well as Creswell (2013) emphasised the importance of the researcher's reflection about his or her personal background, culture, and experiences as it might influence the qualitative data collection and interpretation. Therefore, the researcher has to take steps in order to acknowledge such influences.

The researcher graduated as a registered nurse (1986) and is currently the PHC manager (since 2011) of the Matzikama and Cederberg subdistricts in the West Coast District. The researcher is very passionate about quality client-centred care and is very interested in identifying the factors which could have an influence on quality client-centred care. The topic of her Master's Degree (2009) also dealt with quality, namely *"An investigation into factors influencing the quality of nursing care in district hospitals in the previous West Coast Winelands Region, now the West Coast District of the Western Cape*" (Eygelaar, 2009:ii).

The Western Cape, like the rest of SA's PHC establishments is currently not performing "good" regarding quality client-centred care. As aforementioned, the NCSs audit conducted by Health

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Systems Trust during 2012, revealed poor scores in several areas. These poor outcomes motivated the researcher to conduct this study in order to develop a programme to facilitate quality client-centred care in PHC clinics. The researcher is well known to the Matzikama and Cederberg managers and allied health professionals. Her presence in the focus group discussions might have influenced the responses of these participants. In order to promote objectivity, the researcher recruited an external moderator for the focus groups. The moderator was a former social worker, an expert researcher and retired lecturer from the Nelson Mandela University. The researcher was responsible for the logistics such as the scheduling of the dates for the five focus groups, the arrangement of the venues, the welcoming, the introduction of the moderator, minutes and voice recording of each focus group.

The moderator obtained permission for the presence of the researcher in the venue and explained that the researcher was responsible for the field notes and the voice recordings, and there were no objections from the participants. The researcher did not participate in the focus group discussions. At the end of each focus group discussion the researcher read the summary of the discussion to the group in order to check for accuracy and completeness. This provided the opportunity for reflection The sound files were sent to an independent transcriber for verbatim transcriptions. The researcher used these transcriptions for the open-coding of the data, whereafter it was sent to an independent co-coder to reach consensus.

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1.10 OUTLINE OF THE RESEARCH REPORT

The thesis comprises the following chapters:

Chapter 1: Orientation to the study

Chapter 2: Research design and methods

Chapter 3: Literature review

Chapter 4: Results and discussion of the quantitative studies

Chapter 5: Results and discussion of the qualitative study

Chapter 6: Programme to facilitate quality client-centred care in PHC clinics of the rural West Coast District

Chapter 7: Summary, conclusion, limitations, and recommendations.

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1.11 SUMMARY

Chapter 1 provides an orientation about the scientific grounding for the development of a programme to facilitate the quality of client-centred care in the PHC facilities of the rural West Coast District. This chapter presents the background and rationale, problem statement, overall aim and objectives of the proposed study. The central theoretical statement and the researcher's philosophical assumptions are described, followed by a summary of the research design and methods. A detailed discussion of the research method for each of the objectives is discussed in the relevant chapters. The applied ethical principles and outline of the study chapters conclude Chapter 1. The research design and methods are discussed in Chapter 2.

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CHAPTER TWO:
RESEARCH DESIGN AND METHODS

2.1 INTRODUCTION

Chapter 1 provided an orientation to the study. Chapter 2 is organised around the research design, population, data collection, data analysis and rigour. This chapter includes the research design and research methods of Phase 1 (Objective 2 and 3) and Phase 2 (Objective 4), to develop a programme to facilitate quality client-centred care. Table 3.1 provides an overview of the study phases and objectives.

Table 2.1: Overview of the study phases and objectives

PHASE 1: SITUATIONAL ANALYSIS (QUANTITATIVE)	PHASE 3: PROGRAMME DEVELOPMENT
Objective 1 To explore and describe the current status of quality client-centred care by conducting an extensive literature review.	**Objective 5** To develop a programme to facilitate quality client-centred care in PHC clinics of the rural West Coast District.
Objective 2 To assess the clients' perceptions about quality client-centred care.	
Objective 3 To determine the clinical nurse practitioners' perceptions on quality client-centred care.	
PHASE 2: SITUATIONAL ANALYSIS (QUALITATIVE)	
Objective 4 To explore and describe managers and allied health professionals' perceptions about quality client-centred care.	

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2.2 RESEARCH DESIGN

The research design is considered as the overall plan to incorporate the different components of the study in a coherent and logical way, ensuring that the research problem is addressed. In addition, the research design directs the selection of a population, sampling process, methods of measurement, and a plan for data collection and analysis (Polit & Beck, 2013; Grove *et al*., 2012; Creswell, 2013).

The literature review and the following research questions guided the selection of the appropriate research design:

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1) What are the clients' perceptions of quality client-centred care?
2) What are the clinical nurse practitioners' perceptions about quality client-centred care?
3) What are the managers and allied health professionals' perceptions about quality client-centred care?

Questions 1 and 2 are directed towards a quantitative approach, while question 3 requires a more in-depth exploration of perceptions through a qualitative approach (see Figure 2.1). Three data sets were independently collected, namely: two sets of quantitative data (clients and clinical nurse practitioners) and one set of qualitative data (management and allied health professionals). Each of these data sets was analysed and interpreted separately. Qualitative and quantitative data were considered for the overall conclusions and interpretation.

Both qualitative and quantitative approaches seemed appropriate to develop an improved understanding of the research problem (Curry & Nunez-Smith, 2014; Creswell 2014).

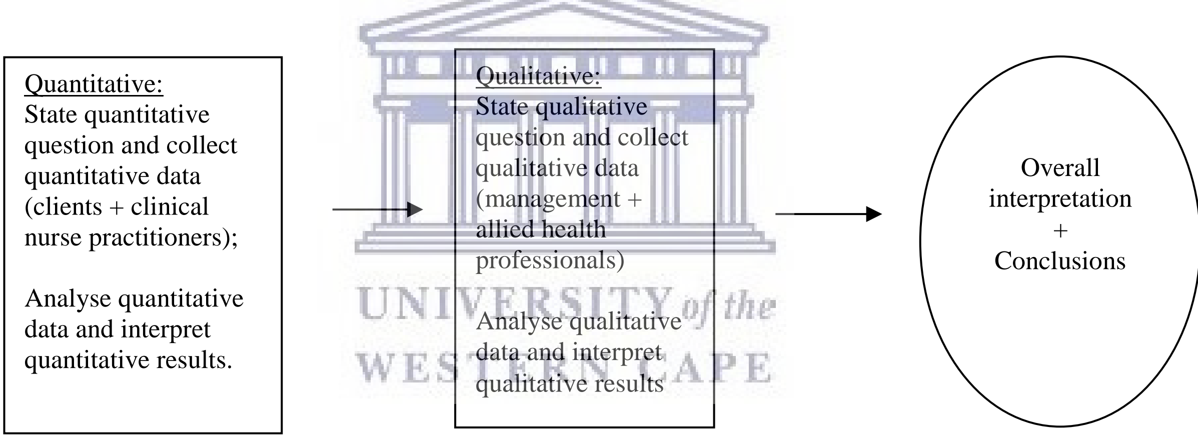

Figure 2.1: Quantitative and qualitative approaches

2.3 PHASE 1: SITUATIONAL ANALYSIS (QUANTITATIVE APPROACH)

Phase 1 (Objective 2 and 3) is part of the situational analysis to explore, describe and assess the current status of quality client-centred care from the viewpoints of clients and clinical nurse practitioners. This data are utilised to develop a programme to facilitate quality client-centred care in PHC clinics of the rural West Coast District.

2.3.1 Research methods

Research methods refer to all the techniques, procedures and tools to systematically structure a study, collect and analyse data (Polit & Beck, 2012). The population and sampling

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(population A and B), development of the data collection instrument, pilot test, data collection, analysis of data and rigour are discussed in the following paragraphs.

2.3.1.1 Population and sampling

A population (N) includes all elements compliant to the sample criteria of the defined group to be included in the study (Grove *et al*., 2012; Uys & Puttergill, 2012). Whereas, the sample (n) is a portion of the population that is designated to represent the population (Nieswiadomy, 2011; Grove *et al.*, 2012).

a) Population A

Population A comprised all the clients above the age of 18 years (N= 137 991) from the 5 subdistricts of the West Coast District (Lehohla, 2012). The University of the Western Cape statistician applied the Cochran formula to determine that random sample size of (n=383) clients should be adequate to be representative of this population. Non-proportional quota sampling was applied by the statistician to determine the number of participants per clinic (see Table 2.1). Non-proportional sampling is any technique in which samples are selected in some way not suggested by probability theory and include reliance on available subjects, as well as purposive (judgmental, quota and snowball) sampling (Babbie, 2013). Recruitment of the predetermined number of participants, were done at the clinic on the day of the survey. Participants complying with the selection criteria were recruited from the patients in the waiting room until the desired sample size was met using purposive sampling.

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The selection criteria for participants were:

- Above the age of 18 years.
- Attended the clinic for at least three times in the past 12 months.
- Literate in Afrikaans or English.
- Willing to participate.

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Table 2.2: Population of clients above 18 years – non-proportional sampling

CLINICS	POPULATION	PROPORTIONAL SAMPLING	NON-PROPORTIONAL SAMPLING	WEIGHTS
Cederberg subdistrict				
1. Citrusdal	5044	13	13	1
2. Clanwilliam	5382	14	14	1
3. Elands Bay	1047	3	8	0.35011336
4. Graafwater	1536	4	8	0.513633354
5. Lambert's Bay	4356	12	12	1
Bergrivier su district				
1. Piketberg	8252	22	22	1
2. Porterville	4859	13	13	1
3. Velddrift	8014	21	21	1
Matzikama subdistrict				
1. Klawer	4155	17	17	1
2. Lutzville	3426	14	14	1
3. Vanrhynsdorp	4355	17	17	1
4. Vredendal South + 5. Vredendal North	12440	49	40	1.215
Saldanha subdistrict				
1. Diazville + 2. Saldanha	19716	53	45	1.172
3. Vredenburg + 4. Hanna Coetzee + 5. Louwville	26461	71	50	1.416
6. Lallie Cleophas	4515	12	12	1
7. Langebaan	6245	17	17	1
8. Laingville	7927	21	21	1
Swartland subdistrict				
1. Darling	879	2	8	0.293934712
2. Moorreesburg	5596	15	15	1
3. Riebeeck Kasteel	847	2	8	0.283234018
4. Riebeeck West	2939	8	8	1
	137 991	400	383	

b) Population B

Population B included all the clinical nurse practitioners (N=64) employed at the fixed clinics (N=25) of the 5 subdistricts of the West Coast District.

The selection criteria were:

- Professional nurses in possession of the clinical nurse practitioner's qualification (i.e. a R48 diploma).
- Employed at the fixed clinics of the West Coast District.
- Willing to participate.

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2.3.1.2 Questionnaire as an instrument for data collection

Quantitative data was collected by utilising self-administered questionnaires. A self-administered questionnaire is considered as a formal written document with appropriate questions to obtain the needed information. Questionnaires seemed to be appropriate as the researcher could predetermine in advance, exactly what needs to be known and structure appropriate questions accordingly (Polit, Beck, Loiselle & Profetto-McGrath, 2010).

The researcher compiled two self-administered questionnaires, adapted from the content of the seven domains of the NCSs' framework of SANDoH (South African National Department of Health, 2011). The seven domains are considered as the benchmark for quality care (content validity) in SA (see Table 2.3). Questionnaire A was utilised to assess the clients' perceptions regarding quality client-centred care (Annexure E). Questionnaire B was utilised to determine the clinical nurse practitioners' reported status on quality client-centred care (Annexure F).

Both questionnaires consist of close-ended, pre-specified options questions (also called fixed-alternative questions). Close-ended questions provide a greater uniformity of responses and are more easily being processed than open-ended questions (Gray, 2014; Rubin & Babbie, 2016). Four point Likert scales were applied to both questionnaires. Likert scales are used in research where respondents express attitudes or other responses in terms of ordinal level categories that are ranked along a continuum (Delport & Roestenburg, 2013; Leedy & Ormrod, 2015). In this study the Likert scales encompass a number of declarative statements with a scale (1, 2, 3 and 4) after each statement that measured the respondents' views on the issues that were explored.

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a) Benefits and limitations of questionnaires

Questionnaires as research instrument have various strengths and weaknesses (Nieswiadomy, 2011; Gray, 2014; Moule & Goodman, 2014). In this study, the researcher experienced the following benefits and limitations as identified by the indicated authors.

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Table 2.3: Benefits and limitations of questionnaires

BENEFITS	LIMITATIONS
Questionnaires make large samples feasible (Babbie, 2013:286; Nieswiadomy, 2011). The researcher utilised questionnaires to collect data from (N=25) clinics over vast distances in five subdistricts. Furthermore, (N=383) clients and (N=64) clinical nurse practitioners were included.	The researcher experienced the utilisation of questionnaires as an expensive process. For this study, two fieldworkers had to be remunerated per questionnaire, per kilometre travelled, including meals and accommodation. Furthermore, courier costs had to be paid for the collection of the clinical nurse practitioners' questionnaires at the selected clinics.
The completion of questionnaires were less time-consuming. The completion of one questionnaire took at most 15 to 20 minutes, compared to the lengthy duration (1-2 hours) of a focus group (Nieswiadomy, 2011).	Clients must have the intellectual (literate) and physical ability for completion of the questionnaires, e.g. clients should be able to read. During the pilot test the researcher identified clients who did not have the literacy ability to read, as well as participants with poor visual sight.
It was not necessary for the researcher to do the data collection. The researcher trained two fieldworkers beforehand.	Respondents may provide socially acceptable answers.
Two fieldworkers collected data simultaneously. One fieldworker was employed for the Saldanha, Bergriver and Swartland subdistricts, while the second fieldworker collected data for the Matzikama and Cederberg subdistricts. The fieldworkers succeeded to cover one clinic daily, starting at 09:00 with the recruitment of participants and information sessions. At about 13:00 the predetermined number of questionnaires for one clinic was completed.	
Both questionnaires could be distributed simultaneously (clients as well as clinical nurse practitioners).	Respondents may fail to answer some of the items.
The training of the two fieldworkers ensured standardisation of the data collection (Babbie, 2013).	
The fieldworkers were present while the clients completed the self-administered questionnaires. They were able to support clients when needed (in a neutral way). After completion the fieldworkers collected each questionnaires in a sealed envelope.	Fieldworkers might be biased.
Clinical nurse practitioners could complete their questionnaires in their own time. Five days were allowed for completion.	The researcher spent time by means of follow-up telephonic calls to ensure and motivate everybody to complete their questionnaires. However, it was time well spent as all the clinical nurse practitioners (N=64) completed and returned their questionnaires.
Anonymity was guaranteed as the questionnaires did not contain any personal information of participants (Nieswiadomy, 2011; Polit & Beck, 2012). After completion it was placed in a sealed envelope.	

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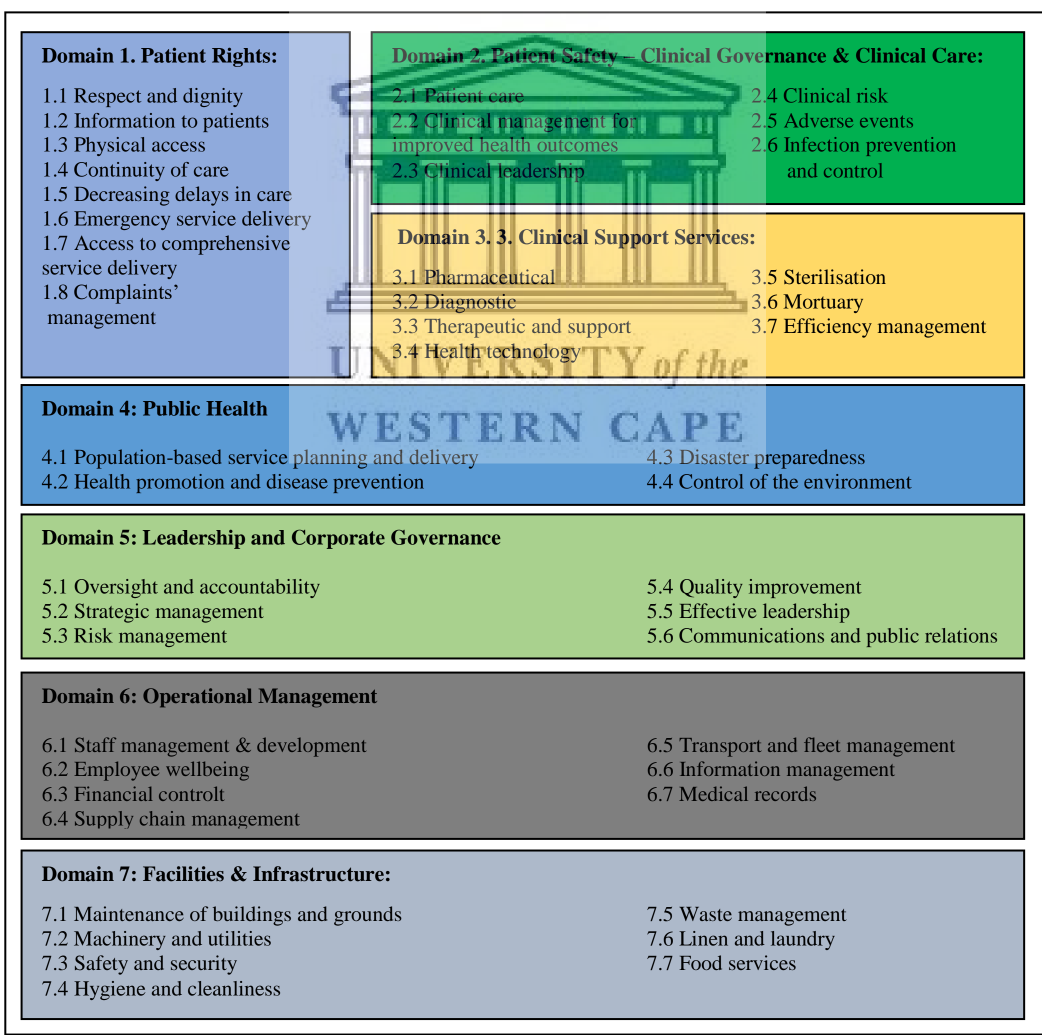
b) Development of the questionnaires

Two distinctive questionnaires were compiled, one for the clients and one for the clinical nurse practitioners. Questionnaires were compiled according to the NCSs' framework for Health Establishments in SA (see Table 2.3), which serves as a benchmark for assessing quality client-centred care in clinics or hospitals in SA (South African National Department of Health, 2011). The NCSs' framework covers seven domains regarding service delivery where quality or safety could be a risk namely: patient rights, patient safety, clinical governance, clinical support services, public health, leadership and corporate governance, operational management and facilities, and infrastructure. Each of these seven domains includes subdomains (critical areas) with specific standards and indicators to measure quality.

Table 2.4: Seven Domains of the NCSs (South African National Department of Health, 2011)



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- **Clients' questionnaire**

  The clients' questionnaire comprises of 77 items. This questionnaire is divided into three sections. Section A consists of 59 (numbers 1-59) "general" questions. The same questions are asked for both clients and clinical nurse practitioners. Section B comprises of 11 "specific" clients' questions (numbers 60 – 66). These questions are specifically formulated to be answered by the clients. Section C comprises of 11 questions (numbers 67 – 77) "about you" and refers to the biographical details of the client. Question 77 is an open question to collect data about "the reason for your visit today" (refers to Table 2.4).

- **Clinical nurse practitioners' questionnaire**

  This questionnaire contains a total of 76 items. The questionnaire is divided into three sections. Section A comprises of 59 (numbers 1-59) "general" questions. The same questions are asked for both the clinical nurse practitioners and clients. Section B comprises of 11 "specific" questions (numbers 60 – 70). These questions are related to the scope of practice of the clinical nurse practitioners. In other words these questions are outside the competency of a client. Section C comprises of 6 questions (numbers 71 – 76) "about you" (biographic questions) and refers to the gender, race, age, years of experience, qualifications and years of employment (see Table 2.4).

Table 2.5: Structure of the questionnaires

CLIENTS	CLINICAL NURSE PRACTITIONERS	
Section A (question 1-59) General Questions	**Section A** (question 1-59) General questions	The same questions asked for both clients and clinical nurse practitioners.
Section B (questions 60 – 66) Client specific questions	**Section B** (questions 60-70) Clinical nurse practitioners' specific questions.	Questions unique to clients. Questions unique to clinical nurse practitioners.
Section C (questions 67-77) "About you"	**Section C** (questions 71-76) "About you"	Biographic-related information.

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c) Construction of the questionnaire

The researcher adhered to the general principles of questionnaire compilation as described by Nieswiadomy (2011) and Brace (2013), namely:

- Each questionnaire was accompanied by an information letter to introduce the study and to motivate for participation. The information letter was also utilised by the fieldworkers as a guideline to provide standardised information sessions at the selected clinics.
- The name of the University of the Western Cape and the university's logo, address, telephone number and fax number are displayed on the questionnaires to enhance a professional appearance.
- The first section of the questionnaire reiterates that: there are no right or wrong answers; each response has to be marked by placing a (X) in the appropriate box; the scale is explained, e.g. 1= never, 2= sometimes, 3= frequently and 4 = always; the information will be treated as confidential and that participants should not write their name anywhere in order to ensure anonymity.
- Each question is provided with a number. Number 1 to 76 is used for the clinical nurse practitioners and numbers 1 to 77 for the clients. The researcher avoided lengthy questionnaires to prevent that too much time was spent on completion, resulting in boredom or response fatigue.
- The researcher tried to keep questions clear, unambiguous and as short as possible.
- The clients' questionnaires are available in Afrikaans and English in order to accommodate non-Afrikaans speaking clients (e.g. Xhosa). The clinical nurse practitioners' questionnaires are in English.
- Questions are phrased in everyday language to which the respondents could relate.
- Every question contains only one thought e.g. "staff members wear name tags to show their names".
- Every question is relevant (NCSs are utilised as a framework) to the purpose of the questionnaire.
- The completed questionnaires were sealed in envelopes in order to promote confidentiality and anonymity.
- "Thank you" was included at the end of the questionnaire thanking participants for participation.

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2.3.1.3 Pilot test

According to Delport and Roestenburg (2013) a pilot test is essential for a newly constructed questionnaire, so that errors of whatever nature can be rectified. The pilot test is also supported by Gliner *et al*. (2010), who emphasize that all good research should begin with a pilot test to ensure that the design and instruments are appropriate and will work to answer the research questions.

The first pilot test was conducted between 11 April 2014 and 14 April 2014. The clinical nurse practitioners' questionnaire was tested by eight professional nurses. They were excluded from the main study. The clients' questionnaire was tested on 20 clients (five clients from each of Rietpoort, Nuwerus, Vredendal North and Clanwilliam clinics). These clients were also excluded from the main study. In addition, both questionnaires (clients and clinical nurse practitioners) were submitted to the promoter and co-promoter, both experts in nursing research, and a statistician. The recommendations below were made and incorporated:

- Original questionnaires were too long – consisted of too many items which could result in "response fatigue".
- Language editing was advised – both questionnaires were sent to a professional editor for language editing.
- Some of the sentences were too long - these sentences were revised and were condensed.
- A few questions were repetitive - these questions were removed.
- Some of the sentences did not contain a verb – these questions were reconstructed to include a verb.
- Some of the questions were removed as it might not have been on the cognitive level of the participants.
- Words such as "adequate" and "timeously" were removed.
- The initial headings and subheadings were removed (seven domains of the NCSs –these were considered not to be explicit enough).
- Additional space for recommendations was provided under each of the headings, were removed, as the headings and subheadings were deleted.
- The Likert Scale was adjusted from 5 to 4 (as "frequently" and "most of the time" could have been confusing).

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The relevant recommendations were accepted and changes were incorporated. A second pilot test was done between 15 September 2014 and 19 September 2014. The questionnaire for the clinical nurse practitioners was tested on eight professional nurses, excluded from the main study; whereas the clients' questionnaire was tested on 20 clients (five clients each from Ebenaezer, Lutzville, Vredendal North and Clanwilliam clinics). These clients were excluded from the main study. No further adaptations to the questionnaires were necessary.

2.3.1.4 Data collection

The researcher trained two fieldworkers in the data collection procedure. The following aspects were covered during the training, namely:

- Background of the study.
- The content of the questionnaires.
- Ethical principles of respect, beneficence and justice.
- Selection criteria.
- Recruitment of participants.
- How to get informed consent.
- Support to participants in a neutral way, should they need any assistance (e.g. clarity).

An incentive was paid to both of them. Fieldworker A collected the data in the Matzikama and Cederberg subdistricts, while Fieldworker B collected the data in the Bergrivier, Swartland and Saldanha subdistricts. The operational managers were notified in advance about the data collection dates.

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The clinical nurse practitioners completed their self-administered questionnaires in their own time. The completed questionnaires were placed in a sealed envelope and were collected by a courier service after five working days. A unique number was provided for these questionnaires. Data collection was done during November and December 2014.

The clients had to complete the questionnaires on the day of the survey. The questionnaires were self-administered. On average 15 to 20 minutes were spent on the completion per questionnaire. Completed questionnaires were returned in closed envelopes. Each questionnaire was provided with a distinct identification number to keep the participant anonymous. A fieldworker was available at the clinic to render support should it be necessary.

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2.3.1.5 Analysis of data

Collected quantitative data of the clinical nurse practitioners and clients were captured by the researcher on individual Excel spreadsheets as prepared by the statistician. The captured data were sent to the Statistical Consultancy Services Department of the North West University for analysis by a statistical expert. Various statistical procedures were performed, namely: analysis of the clinical nurse practitioners' biographical data; analysis of the clients' biographical data; hierarchical linear modelling; an EFA; Spearman's rank order correlations, analysis of variance (ANOVA), and t-tests. Lastly, a GAP analysis was done referring to the mean, standard deviations and hierarchical linear modelling. The following paragraphs include a discussion of each of these mentioned statistical procedures.

a) Descriptive statistics

The analysis of the clinical nurse practitioners and clients' data was done by using the SAS programme, which provided descriptive statistics (SPSS 22). Data were reported in frequencies, percentages, mean and standard error. According to Pastor (Hancock & Mueller, 2010) descriptive statistics are particularly useful, because they convey information about the variables for the overall sample.

Biographical data of the clinical nurse practitioners (namely: gender, race, age range, years of experience after registration as a professional nurse, qualifications and years of employment at this clinic), as well as the biographical data of the clients (namely: gender, race, age range, educational level, employment status, distance to the clinic, way of getting to the clinic, average number of clinic visits, average number of traditional healer visits and average number of private doctor visits over the last 12 months) were reported as descriptive statistics (percentages and frequencies). Pie charts, a circular chart divided into sectors, each sector to show the relative size of each value were created to present the biographical data in a visual format (Chapter 4: Figures 4.1 to 4.16).

Since these results are inter-correlated per clinic, hierarchical linear models were used to take this into account. Table 4.2 presents the descriptive statistics of the clinical nurse practitioners and Table 4.3 the descriptive statistics of the clients, in the format of percentages, mean and standard error under the headings of the NCSs' seven domains. Percentages included the response rate according to the 4-point Likert Scale, where 1= never; 2= sometimes; 3= frequently and 4 = always. Table 4.18 presents the descriptive statistics of the clients in the same format as the clinical nurse practitioners.

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When people are clustered within naturally occurring organizational units (e.g. schools, classrooms, hospitals, companies), the responses of people from the same cluster are likely to exhibit some degree of relatedness with one another, given that they are sampled from the same organizational unit. In multilevel analyses, the extent of relatedness of observations within the same cluster, is unambiguously estimated and modelled, thereby correctly estimating the standard errors and eliminating the problem of inflated Type 1 error rates. These types of models are often referred to as hierarchical linear models, multilevel models, mixed models or random effect models. Multilevel analyses allow for exploitation of the information contained in cluster samples to clarify both the between and within cluster variability of an outcome of interest (Mc Coach, 2010).

b) Explorative factor analysis

According to Flick (2015) and Polit *et al*. (2010), a factor analysis is considered as a form of statistical analysis, focusing on identifying a limited number of basic factors, summarizing the original data in order to explain the relations in a field. Furthermore, an EFA determines whether a scale actually measures the concepts that it is intended to measure (LoBiondo-Wood & Haber, 2013). An EFA through principal component analysis and Oblim rotation was done according to each of the seven domains (Section A, questions 1 to 59 answered by both clinical nurse practitioners and clients). Chapter 4, Tables 4.4 to 4. 12 present the outcomes of the EFA as conducted on each of the seven domains.

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c) Correlations

Spearman's rank-order correlations were performed to determine associations between the seven domains of the NCSs (Table 4.13). Spearman's rank-order correlation (Spearman's rho), specifies the extent of a relationship between variables measured on the ordinal scale (Polit & Beck, 2012). Correlations vary between -1 and 1. Correlation values of 0.1 is considered as small, 0.3 as medium and 0.5 as large and of practical importance (Cohen, 1988).

Furthermore, correlations, analysis of variance (ANOVA) and t-tests were performed to establish the associations between the domains and biographical data of the clinical nurse practitioners (Table 4.14). Correlations, ANOVA and t-tests were also performed to determine associations between the domains with the biographical data of the clients (Table 4.15).

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d) Gap analysis

A gap analysis was performed on the seven domains (Section A, questions 1- 59) to indicate the differences between the clinical nurse practitioners and clients by referring to the differences in mean, statistical significances and the strength of the effect sizes (Tables 4.16 to 4.29).

Statistical significance is considered when the result from an analysis is unlikely to have been caused by chance, at a specified level of probability (Polit & Beck, 2012). A small *p*-value (less than 0.05) is considered as adequate evidence that the result is statistically significant (Grove *et al*., 2014).

Effect size is defined as a statistical expression of the magnitude of the relationship between two variables, or the magnitude of the difference between groups or an attribute of interest (Polit & Beck, 2012). Ellis and Steyn (2003) refer to Cohen (1988) for the interpretation of the effect sizes: small effect: p = 0.1; medium effect: p = 0.3 and large effect: p = 0.5.

Descriptive statistics regarding the clinical nurse practitioners (questions B60 - B70) were reported in mean and standard error of the mean (Table 4.30) and descriptive statistics about the clients (questions B60 - B66) were reported in mean and standard error of the mean (Table 4.31). A mean value smaller than 2.5 was interpreted as a gap.

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2.4 RIGOUR OF THE QUANTITATIVE PHASE

Grove *et al*. (2012) define rigour as the disciplined and meticulous attentions to detail and accuracy. Quantitative studies are considered rigorous when the procedures are prescribed prior to data collection, the sample is large enough to represent the population, and researchers tightly control the collection and analysis of data. The following strategies were implemented to ensure rigour in the quantitative phase:

- Testing the validity of the questionnaires.
- Testing the reliability of the questionnaires.

2.4.1 Validity of the questionnaires

Validity of instruments refer to the extent to which it accurately reflects or is able to measure the construct being examined in order to ensure that the conclusions and interpretations are accurate and well founded (Grove *et al.*, 2014; Polit & Beck, 2013; Creswell, 2013). Validity is discussed with regard to the construct and content of the questionnaires.

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2.4.1.1 *Construct validity*

According to Grove *et al*. (2012) construct validity examines the fit between the conceptual definitions and operational definitions of variables. Construct validity is important to determine whether the instrument actually measures the theoretical construct it purports to measure. Creswell (2013) states that construct validity occurs when researchers provide adequate definitions and measures of variables. The following was applied to ensure construct validity, namely:

Empirical evidence of the major constructs i.e. quality client-centred care, Primary Health Care, rural and programme were examined in order to clarify and interpret these constructs. Furthermore, the content of the questionnaires was adapted from the NCSs for Health Establishments in SA (see Table 2.2), which is the benchmark for the assessment of quality care in South African hospitals and clinics (National Department of Health, 2011). The NCSs' framework covers seven domains regarding service delivery where quality or safety could be a risk. Each of these seven domains has subdomains (critical areas) and are provided with specific standards and indicators to measure quality.

Moreover, an EFA identified and grouped together the different measures of the questionnaires into a unitary scale based on how participants reacted to the items, rather than based on the researcher's preconceptions (Polit & Beck, 2013; Grove *et al*., 2012). Factorial evidence was provided through an EFA, supporting the grouping of the theory-based items (Gliner *et al.*, 2010).

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2.4.1.2 *Content validity*

Content validity refers to the degree to which items in an instrument sufficiently represent the universe of content for the concept being measured (Polit & Beck, 2013). Klopper and Knobloch (2010) describe content validity as truth value, internal validity or measurement validity in order to ensure that the conclusions from the research findings are valid scientific knowledge.

The final questionnaires of both clinical nurse practitioners (Annexure I) and clients (Annexure H) were reviewed by four distinctive experts in the field, academics at the University of the Western Cape. In addition, four distinctive members of the public (Annexure G) were requested to review the content of the clients' questionnaire.

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These experts were requested to score each item on the clinical nurse practitioners and clients' questionnaire for relevance (1= item not relevant; 2= somewhat relevant, needs major revisions; 3= relevant, needs minor revisions; 4= use as is) and to give an indication about the clarity of each item (Y= yes; N= no). Thereafter, the content validity index (CVI) was calculated for both the individualised items (I-CVI) and for the overall scale (S-CVI) of the two questionnaires. CVI is a measure to estimate expert agreement. Polit and Beck (2013) suggest a CVI value of 0.90 or higher as the standard to ensure excellence in a scale's content validity. Nine items (Annexure H & I) measured 0.75 (thus below the suggested 0.90). Therefore, the wording of these items was adjusted, based on the comments received from the experts. The S-CVI obtained 0.88. Polit and Beck (2012) suggest a value of 0.90 for establishing excellent content validity.

The same procedure was followed with four members of the community with regard to content validity for the clients' questionnaire. Three questions (Annexure G) scored I-CVI of 0.75. These sentences were adjusted according to the feedback received from these community members.

2.4.2 Reliability of the questionnaires

Grove *et al.* (2012) describe reliability as the accuracy and consistency of the measuring instrument to prevent measurement error. Likewise, Creswell (2012) considers reliability as whether the scores to items on an instrument are internally consistent (i.e. are the item responses consistent across constructs?), stable over time (test-retest correlations), and whether there is consistency in test administration and scoring.

Reliability of this study is assured by adapting the seven domains of the NCSs (refer to Table 2.2), the recognised benchmark for quality of the SANDoH in the development for both questionnaires (South African National Department of Health, 2011). Cronbach's Alpha (coefficient alpha) was calculated for each of the seven domains in order to evaluate the internal consistency (Polit & Beck, 2013). Furthermore, an EFA was performed on the seven domains, except for Domain 6 (Operational Management). Domain 6, compromised of only two questions (items 35 and 41) applicable on both clinical nurse practitioners and clients. Therefore, a factor analysis could not be conducted on this domain. Also item A1 did not load at all, therefore a factor analysis was not done.

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Polit and Beck (2012) indicated that the normal range of values for Cronbach alpha, reliability index is between 0.00 to +1.00. Higher coefficient values, reveal better internal consistency, especially above the value of 0.80. However, Kline (1999) in Field (2009) indicates that although the usually accepted value of 0.8 is suitable for cognitive tests such as intelligence tests; for ability tests the cut-off point of 0.7 is more appropriate. However, according to Kline when dealing with psychological constructs, values below 0.7 can realistically be normal, due to the diversity of the constructs being measured. All the Cronbach alpha values are higher than 0.55 and according to the statistician are reliable (see Tables 2.11 to 2.16).

Table 2.6: Cronbach alpha values per domain

	Cronbach alpha
Domain 1: Patient Rights	
Waiting	0.71
Confidentiality/Privacy	0.55
Satisfaction/Safety	0.61
Referral	0.53
Reception	0.64
Domain 2: Clinical Governance/Care/Safety	
Myself/Family	0.74
Staff	0.60
Domain 3: Clinical Support	
Equipment/Consumables	0.69
Medicine/Assistive devices	0.56
Domain 4: Public Health	
Public Health	0.62
Domain 5: Leadership/Corporate Governance	
Leadership/Corporate Governance	0.70
Domain 7: Infrastructure/Facilities	
Infrastructure/Facilities	0.69

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2.4.3 Theoretical validity

According to Klopper and Knobloch (2010) and Klopper and Knobloch (2018) theoretical validity defines the theoretical meaning of a concept. The researcher defined the key concepts of this study in order to specify what is meant when particular terms are utilised.

2.5 PHASE 2: SITUATIONAL ANALYSIS (QUALITATIVE APPROACH)

In this section, the research methods of Phase 2 (Objective 4) of the study are discussed, referring to: population and sampling, focus group discussions as a method for data collection, pre-testing of the semi-structured interview schedule, data collection, qualitative data analysis and rigour.

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2.5.1 Research methods

This section describes the research methods for the qualitative approach applied in Phase 2 of the research. The following paragraphs describe the population and sampling, data collection process applied in the qualitative part of the study.

2.5.1.1 Population and sampling

The population of Phase 2 included the managers and allied health professionals in the five subdistricts of the West Coast District. In order to prevent bias, the researcher who is one of the three PHC managers of the West Coast District did not participate in this study and therefore excluded the other two PHC managers as well.

Grove *et al*. (2012) and Nieswiadomy (2011) defined a sample as a subgroup of the population selected for a study. Sampling involves the selection of the specific research participants from the entire population, and is conducted in different ways according to the type of study (Polit & Beck, 2013). Due to the small number of subdistricts in the West Coast, an all-inclusive sample was applied for this study by including all five management teams and allied health professionals.

2.5.1.2 Data collection through focus group discussions

Focus group discussions were conducted to collect qualitative data. According to Morgan (2013) and Krueger and Casey (2014), a focus group discussion is considered as a group interview facilitated by a well-trained moderator according to a pre-determined schedule with six to eight participants from a similar background, in order to understand the topic of interest. The feedback of the participants during their discussions are considered as the essential data of the focus groups.

a) Benefits and limitations of focus groups

Table 2.6 summarises the strengths and limitations experienced in this study.

Table 2.7: Benefits and limitations of focus groups

STRENGTHS	LIMITATIONS
The focus group discussions facilitated interaction between participants to explore and investigate the topic under discussion (Morgan, 2013). They also generated their own interpretations of the topics that came up in their discussions.	Barbour (2008) indicated that one of the most common myths is that focus groups are quicker and cheaper than other methods. Barbour emphasised additional costs such as travel, room hire, refreshments and transcription. The researcher could relate to the high cost effect.

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STRENGTHS	LIMITATIONS
The focus groups interactions allowed for rich dialogue – the open format provided an opportunity to obtain large and rich amounts of data in the participants' own words (Stewart & Shamdasani, 2014; Polit & Beck, 2012). According to Mertens (2012) one of the strengths of focus group research is the additional insight gained from the interaction of ideas among the group participants. The group dynamics resulted in bringing out aspects of the topics that would not have emerged from interviews (Babbie, 2013). The researcher could experience how participants responded to what was said by fellow participants, resulting in intensed expressions of opinion.	There may be further costs in terms of the researcher's time spent telephoning participants to ensure that they are to attend and simply dealing with the logistics of matching the required characteristics for group composition and availability of potential participants (Barbour, 2008; Morgan, 2013). The researcher spent a lot of time on the logistics (as the five focus groups were conducted in five different geographical subdistricts) including: the organizing of accommodation, meals, travelling, recruitment of participants, follow-up reminder telephone calls, arranging for venues and refreshments. Also the transcription and analysis of data were time-consuming tasks.
The researcher experienced the focus groups as resource effective – a wide range of information, insight and ideas of many people were obtained in a short time (Stewart & Shamdasani, 2014; Polit & Beck, 2013; Babbie, 2013). In this study, (N=42) participants were interviewed in five focus groups, instead of 73 one-on-one interviews.	One or two participants could sometimes dominate the conversation (Babbie, 2013:321) or on the contrary some people are uncomfortable or reluctant about expressing their views in front of a group (Polit & Beck, 2012, Nieswiadomy, 2011; Stewart & Shamdasani, 2014). The researcher experienced the domination of one member and the reluctance of another participant to express his/her views in front of the group. However, the moderator could manage these two scenarios.
The interaction of the moderator allowed for flexibility and opportunities for the clarification of responses, for follow-up questions, and for the probing of responses.	An experienced moderator is pivotal in order to get useful data from the focus groups. The moderator requires special skills. The skill of the moderator can have a tremendous impact on the success of the group (Babbie, 2013; Morgan, 2013).
	The moderator was an experienced researcher. She was originally trained as a social worker and was also an experienced researcher. Currently, she is a retired lecturer of the Nelson Mandela University, still guiding postgraduate students.
The researcher was granted approval by the participants to be present during the focus group discussions. Therefore, had the opportunity to observe some nonverbal gestures, smiles, and frowns and could even hear the intensity of the discussion. Nonverbal gestures may carry information that supplements and on occasion even contradict the verbal responses (Stewart & Shamdasani, 2014).	According to Babbie (2013) it could be difficult to bring groups together. The researcher experienced that it was challenging to find a time suitable for all participants. The date of the last focus group had to be changed three times due to other operational issues (30 April 2014, 9 May and 23 May 2014).

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STRENGTHS	LIMITATIONS
The researcher could easily understand and clarify most of the participants' responses. This is not always the case with more sophisticated survey research that employs complex statistical analyses (Stewart & Shamdasani, 2014).	The setting and conditions must be conducive to discussion – individuals must feel secure and confident within the group (Babbie, 2013). Two of the focus groups were conducted in the private rooms of a coffee shop and a guesthouse (neutral places). The researcher experienced that the participants were relaxed, responsive and confident. At the end of one of the session's one of the participants spontaneously reacted with the following: "We have to thank you, for the opportunity. For me personally, it was a pleasant experience to talk to somebody who is completely … who is not at all part of the organisation, who is totally objective …"
The focus group discussions ensured detailed discussions and clarity of the content. According to Babbie (2013) focus groups allow for high face validity (Babbie, 2013).	The open-ended nature of responses obtained in focus groups often makes summarization and interpretation of results difficult (Stewart & Shamdasani, 2014).
	However, the 28 years' experience of the researcher in the field of rural PHC helped with the summarization and interpretation of the results.

b) Research instrument: semi-structured interview schedule

A semi-structured interview schedule (Annexure J) was compiled to guide the focus group discussions. An interview schedule is the formal instrument, used in structured self-report studies, that specifies the wording of all questions to be asked (Polit & Beck, 2012; Nieswiadomy, 2011). The interview schedule comprised open-ended questions focused on the understanding of the study's topic of interest (Creswell, 2012).

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The interview schedule included five open-ended questions to explore and describe the managers and allied health professionals' perceptions on structures, processes and outcomes related to quality client-centred care at the PHC clinics of the rural West Coast District. The interview guide was validated by the study promoters and the ethical committee of the Western Cape University.

2.5.1.3 Pre-testing of the semi-structured interview schedule

Polit and Beck (2012) and Grove *et al*. (2012) stated that a pilot test is a small-scale version, or trial run in order to develop or refine the methodology in preparation for the main study. Stewart and Shamdasani (2014) highlighted that there should be some degree of pre-testing. Likewise, Morgan (2013) also advises the pre-testing of questions before the execution of the study. Pre-testing could provide an indication of how challenging the analysis will be and also provide an indication of the resources required for the analysis.

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The researcher arranged a focus group discussion with three willing operational managers from the Overberg, a district outside the West Coast District, to pre-test the interview guide. The researcher experienced an overwhelming exchange of thoughts, making it difficult to direct and observe simultaneously and therefore identified the need for an experienced moderator to facilitate the focus group discussions.

2.5.1.4 Data collection

Data collection is the accurate, organised collection of evidence applicable to the purpose, objectives and questions of the study (Grove *et al.*, 2012; Polit *et al.*, 2010). Five focus groups were conducted between 29 April 2014 and 23 May 2014. One focus group was conducted in each of the five subdistricts of the West Coast. Repetitive patterns were characterised after the third focus group discussion. However, the moderator and researcher decided to include all five subdistricts. According to Moule and Goodman (2014), saturation is a "matter of degree" and should be more concerned with reaching the point where there is no need to collect more data, since it is not going to necessarily add anything to the narrative, model, theory, or framework. Morgan (2013) confirmed that most projects require three to five groups assuming that the participants are only moderately diverse and that the topic is only moderately complex.

The moderator utilised the predetermined interview guide to ensure that the same procedure is followed for each of the five focus groups. Probing or additional questions were used at the discretion of the moderator to guide the focus groups (Nieswiadomy, 2011; Babbie, 2013).

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After every focus group discussion, the researcher provided a summary feedback of the discussion to the participants to ensure that the content of the discussion is correct and that participants agree (member checking). This is known as member checking (Rubin & Babbie, 2016).

a) The moderator or interviewer

The researcher contracted an external moderator for the focus groups. The moderator was a former social worker, an expert researcher and retired lecturer from the Nelson Mandela University.

b) Role of the researcher

The researcher was responsible for the logistics such as the scheduling of the five focus group discussions and for the arrangement of the venues. Proposed dates were communicated to the assistant managers and PHC managers of the five subdistricts and they supported with the

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recruitment of the participants. The assistant managers confirmed via e-mail about the attendance of the participants (three weeks in advance). The researcher sent a follow-up e-mail, one week before the proposed dates to ensure attendance.

c) Venues

Polit and Beck (2012) emphasized that the environment should be neutral, comfortable, accessible, easy to find and acoustically amenable to audiotape recording. Furthermore, according to Babbie (2013) privacy is important.

The researcher arranged the following venues, namely a private room in a coffee shop and guesthouse, a boardroom at one of the PHC subdistrict offices, as well as the boardroom in two of district hospitals to ensure easy access for the participants and to enhance a relaxing ambience. Refreshments were served after completion of the focus group discussions.

d) Duration of the focus groups

The duration of each focus group discussion ranged from 90 to 120 minutes.

e) Size of the focus groups

The size of the focus groups varied between six and eleven members (11, 10, 6, 6 and 10).

f) Language

Questions were posed in English; however participants were allowed to answer in Afrikaans or English. Communication was primarily in Afrikaans, as it is the dominant language in the West Coast District. The recordings were transcribed verbatim (Afrikaans and English). Thereafter, a language editor transcribed the final transcriptions into English.

g) The focus group process

The researcher did the welcoming of the participants and introduced the interviewer to the participants. The moderator put everyone at ease. She explained that the focus group discussion is not a performance appraisal, but about interacting with one another. The background and purpose of the study were discussed. Voluntary participation, confidentiality and anonymity were emphasized. Every participant had the opportunity to choose a pseudonym to enhance confidentiality. Written informed consent was obtained for participation as well as for the voice recordings (Annexure K). The interviewer obtained permission for the presence of the researcher and explained that the researcher is responsible for the field notes and the voice recordings - there were no objections. Field notes include sketches or descriptions of

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participants, impressions related to the discussions, or observations related to the group dynamics (Shaha, Wenzel & Hill, 2011; Polit & Beck, 2013).

2.5.1.5 Qualitative data analysis

Qualitative data analysis is a method of examining and interpreting data in order to gain understanding, and develop empirical knowledge (Grove *et al.* 2012). According to Creswell (2012), Polit and Beck (2012) qualitative data analysis involves the management of raw data, validation of the information, organising and preparing of data for analysis, coding, identification of themes and interpretation to give meaning (see Figure 2.2). These steps are described in the following paragraphs.

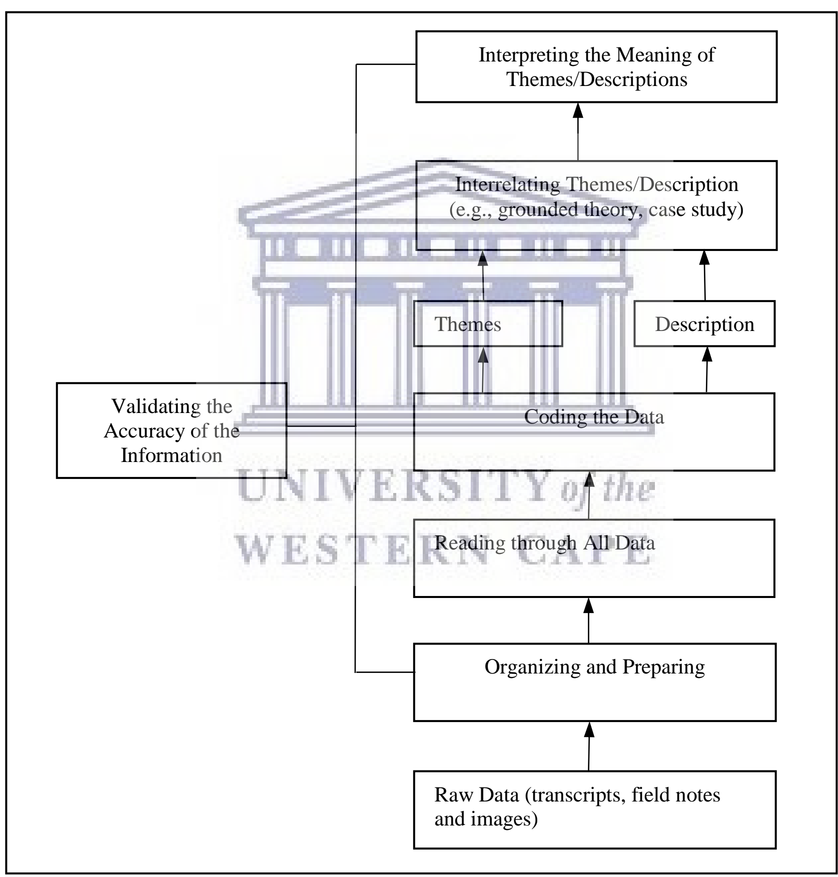

Figure 2.2: General data analysis in qualitative research (Creswell, 2013)

a) Raw data

The five audio-recorded focus group discussions were downloaded on the computer (MP3 audio/sound files) and sent to an independent, professional transcriber. The transcriptions were

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translated to English (see Annexure L). The data analysis process is described according to Figure 2.2.

b) Validating the accuracy of the information

The researcher validated the transcribed data. The audio-recorded data was cross checked with the transcribed data and the necessary corrections were done.

c) Organising and preparing data for analysis

The five transcribed folders, one for each of the five subdistricts (A001; A002; A003; A004; A007) were saved in a Word format.

d) Coding of the data

Creswell (2013) defined coding as the process of organizing the data by bracketing chunks and writing a word representing a category in the margin (called an in vivo term). Coding in qualitative research, in its simplest sense, is a way of "tagging" text with codes, of indexing it, in order to facilitate later retrieval. Naming a concept or topic aids organization of data and assists analytical thinking (Bazeley & Jackson, 2013).

The researcher read through all the transcriptions to become familiarised with the data and could visualise codes, categories, sub-themes and themes. The researcher recognised that these data could be analysed according to the seven domains of the NCSs (themes); the sub-domains (categories) and standards (codes) (Annexure N).

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The researcher started coding the first focus group's discussion (A001). The researcher went through every line and codes were assigned to the selected chunks of data (evidence), (see Table 2.12). Similar codes (1) were clustered and assigned to an appropriate category or sub-theme (2; sub-domain). Lastly, categories belonging together were clustered to represent one of the seven themes (3).

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Table 2.8: Codes, sub-themes and themes that emerged from the data

THEMES (3)	SUB-THEMES(2)	CODES (1)	EVIDENCE
Patient Rights	Respect and dignity	Patient satisfaction	"The patient should be satisfied with the service that I have provided" (A001: 178).
			"I do think that um… um… one gets the um… one does get patients who are satisfied" (A003:353)
			"The patient should be satisfied "I feel satisfied"; meaning he didn't wait too long for the service, he was received in a friendly way, and um… that what he had wanted he received. So, he… *ja*, his satisfaction matches his expectations (A004:176).

Data analysis was initially conducted by the researcher and reviewed by an independent co-coder to enhance the overall validity (Creswell, 2013).

e) Interpreting the meaning of the themes

The final step in data analysis involved the interpretation or meaning of the coded data. The results and interpretation of the qualitative analysis are described in: chapter 5.

2.6 RIGOUR OF THE QUALITATIVE PHASE

Moule and Goodman (2014) defined rigour as the accuracy and consistency of a research design that provides an indication of its quality. According to Creswell (2012) a rigorous approach entails extensive data collection and several levels of data analysis. The data analysis moved from the narrow codes or themes to broader themes of more abstract dimensions. Lincoln and Guba (1985) included the following four components with regard to the trustworthiness of qualitative research namely: credibility, dependability, confirmability and transferability. These four criteria are discussed in the following paragraphs.

2.6.1 Credibility

Credibility is comparable to internal validity in quantitative research and is concerned with the aspect of truth, believability and trust of the study findings (Lincoln & Guba, 1985). In this study triangulation, member checking and prolonged engagement were applied to ensure credibility.

2.6.1.1 Triangulation

Remler and Van Ryzin (2014) described triangulation as the use of multiple methods or analyses to confirm a finding. Triangulation is generally considered to be one of the best ways

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of enhancing validity and reliability in qualitative research (Klopper & Knobloch, 2010; Klopper & Knobloch, 2018).

Triangulation in this study was assured by collecting both quantitative and qualitative data from various data sources. Quantitative data was generated through two distinctive surveys (clients and clinical nurse practitioners), while focus group discussions were utilised to generate qualitative data from the managers and allied health professionals. Multiple methods of data analysis were applied (Section 2.3.1.5 & 2.5.1.5).

2.6.1.2 Member checking

Member checking is a method of validating the credibility of qualitative data through debriefings and discussions with informants (Polit & Beck, 2012; Mertens, 2012). After every focus group, the researcher presented a summary to the participants to verify the accuracy of the content (see Annexure M). Participants had an opportunity to add information or rectify or clarify any information, if it became necessary.

2.6.1.3 Prolonged engagement

Polit and Beck (2012) described prolonged engagement as the investment of adequate time for data collection to have an in-depth understanding of the group or phenomenon under study. Focus groups were conducted over a five-week period (29 April 2014 to 23 May 2014). Repetitive patterns were identified after the third focus group discussions. However, the researcher and facilitator decided to include all five subdistricts of the West Coast District. Therefore, another two focus groups were conducted to ensure that sufficient time was spent on data collection, to gain a thorough understanding of the topic of interest.

2.6.2 Transferability

Transferability is the extent to which the study findings of one study can be applied to other contexts and settings, or applied more widely to bigger populations (Lincoln & Guba, 1985). Mertens (2012) described transferability as the parallel concept that enables readers of the research to make judgements based on similarities and differences when comparing the research situation to their own. Transferability was ensured through the following:

2.6.2.1 Thick description

A thick description is considered as an extensive and detailed description of the research setting, referring to time, place, context and culture (Mertens, 2012; Polit & Beck, 2012). A thorough and detailed description enabled a decision of whether the findings of the research could be applied to other contexts.

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The research context and the way in which the research was executed were decribed in detail to ensure that other researchers could make a decision about the generalizability. However, transferability was not the intention of this study.

2.6.2.2 Saturation of data

Saturation of data occurs when the collection of qualitative data is to the point where a sense of closure is attained, because new data yield redundant information (Polit & Beck, 2012; Grove *et al*., 2012).

Five focus group discussions, one in each of the five subdistricts were conducted. Repetitive patterns were identified after the third focus group discussion. However, the researcher and moderator proceeded in order to include all five subdistricts of the West Coast District.

2.6.3 Dependability

Dependability of qualitative data refers to the stability of data over time and conditions (Klopper & Knobloch, 2010). According to Lincoln and Guba (1985) (also compare Knobloch & Klopper, 2010; Klopper & Knobloch, 2018) dependability can be ensured in an indirect way by applying the measures of credibility (triangulation, member checking and prolonged engagement) and direct ways, such as step-by-step repetition and an enquiry audit. These were discussed in previous pages. With regard to this, refer to triangulation (2.6.1.1), member checking (2.6.1.2) and prolonged engagement (2.6.1.3).

2.6.3.1 Inquiry audit

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An inquiry audit is defined as the appraisal of the data collection proccess and analysis by an outside assessor (Klopper & Knobloch, 2010; Klopper & Knobloch, 2018). A formal inquiry audit was not conducted. However, the researcher kept all data (voice recordings, transcriptions, and interview notes) and analysis products (coding) if an evaluator or auditor should require it. The study supervisors checked the total process of data collection and analysis to ensure the truth value thereof.

2.6.4 Confirmability

Confirmability refers to the degree of objectivity or neutrality in the research proccess to exclude personal biases, interests or perspectives (Polit & Beck, 2012). Confirmability of the data was ensured through triangulation and by an independent coder for crosschecking. Triangulation was discussed previously (see Section 2.6.1.1).

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2.6.4.1 Facilitator to conduct focus groups

The researcher contracted an experienced researcher and skilled as facilitator of focus group interviews, to conduct the focus group discussions so that the researcher could remain impartial and unbiased.

2.6.4.2 Independent coder

The researcher coded the data and contracted an independent coder to conduct an analysis simultaneously with the researcher. After this was completed, the researcher and independent coder met, to discuss the analysis and reach consensus on the themes.

2.7 PHASE 3: PROGRAMME DEVELOPMENT

The overall aim (Objective 5) of this study was to develop a programme to facilitate quality client-centred care in PHC clinics of the rural West Coast District. The following paragraphs presented the method to develop the programme.

2.7.1 Method to develop a programme to facilitate quality client-centred care in PHC clinics of the rural West Coast District

The aim of this study was to develop a program to facilitate quality client-centred care in the PHC clinics of the rural West Coast District. The researcher used the five steps of curriculum development as suggested by Uys and Gwele (2005) to formulate the program. Uys and Gwele (2005) provide a framework for the development of a programme and ensures a logical approach. The method is applicable to any type of programme development. Table 2.9 summarises the five steps as applied in this study.

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Table 2.9: Method to develop the programme to improve quality client-centred care

CURRICULUM DEVELOPMENT METHOD	METHOD APPLIED IN THIS RESEARCH STUDY
Situational analysis	Situational analysis to identify problems
Identify the outcomes or objectives	Identification of objectives according to problems identified
Develop a macro-content	Objectives and proposed interventions (broad)
Develop a micro-content	Objectives, proposed interventions and actions (specific)
Implementation and evaluation	Implementation (evaluation not part of this study)

(Uys&Gwele, 2005)

Each of the five steps are discussed in detail:

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2.7.1.1 Step 1: Problem identification

A situational analysis was conducted during Phase 1 and 2 of this study. Problems were identified through an extensive literature review (Objective 1); the empirical research findings of the clients (Objective 2); clinical nurse practitioners (Objective 3); managers and allied health professionals (Objective 4). The situational analysis revealed *81 problems* (see Table 6.2). Problem identification was done by using *deductive logic*. In a deductive argument, true premises necessarily lead to true conclusions. Using a deductive approach meant that the problems flow logically from the results of Objectives 2 to 4, i.e. the supporting evidence is linked to the conclusions (81 problems), thus providing deductive validity to the content of the programme (Mouton & Marais, 1996).

2.7.1.2 Step 2: Formulation of the programme goal and objectives

Uys and Gwele (2005) state that outcomes or goals should be formulated to guide the programme development. The overall goal of this study was to develop a programme to facilitate quality client-centred care in the PHC clinics of the rural West Cost District. This goal was achieved through the development of seven programme objectives (deductively) (see Table 6.3).

2.7.1.3 Step 3: Suggested broad interventions

After formulation of the seven objectives the researcher provided the proposed interventions in broad to reach these objectives (see Table 6. 4).

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2.7.1.4 Step 4: Suggested specific actions

Specific actions were developed for each of the proposed interventions by using *inductive logic* (see Table 6.5). In an inductive argument genuine supporting evidence can only lead to highly probable conclusions – therefore the conclusions is probably true (Mouton & Marais, 1996). We can however safely state that the proposed interventions have been inductively inferred from the problems identified.

2.7.1.5 Step 5: Implementation and evaluation of the programme

Uys and Gwele (2005) highlighted the importance of monitoring to what extent the programme is actually experienced by the participants. Therefore, it is also important to monitor the planned and unplanned results of the programme. The table below provides a visual illustration of the method applied in the development of the programme to facilitate quality client-centred care in PHC clinics of the rural West Coast District. Evaluation does not form part of this programme.

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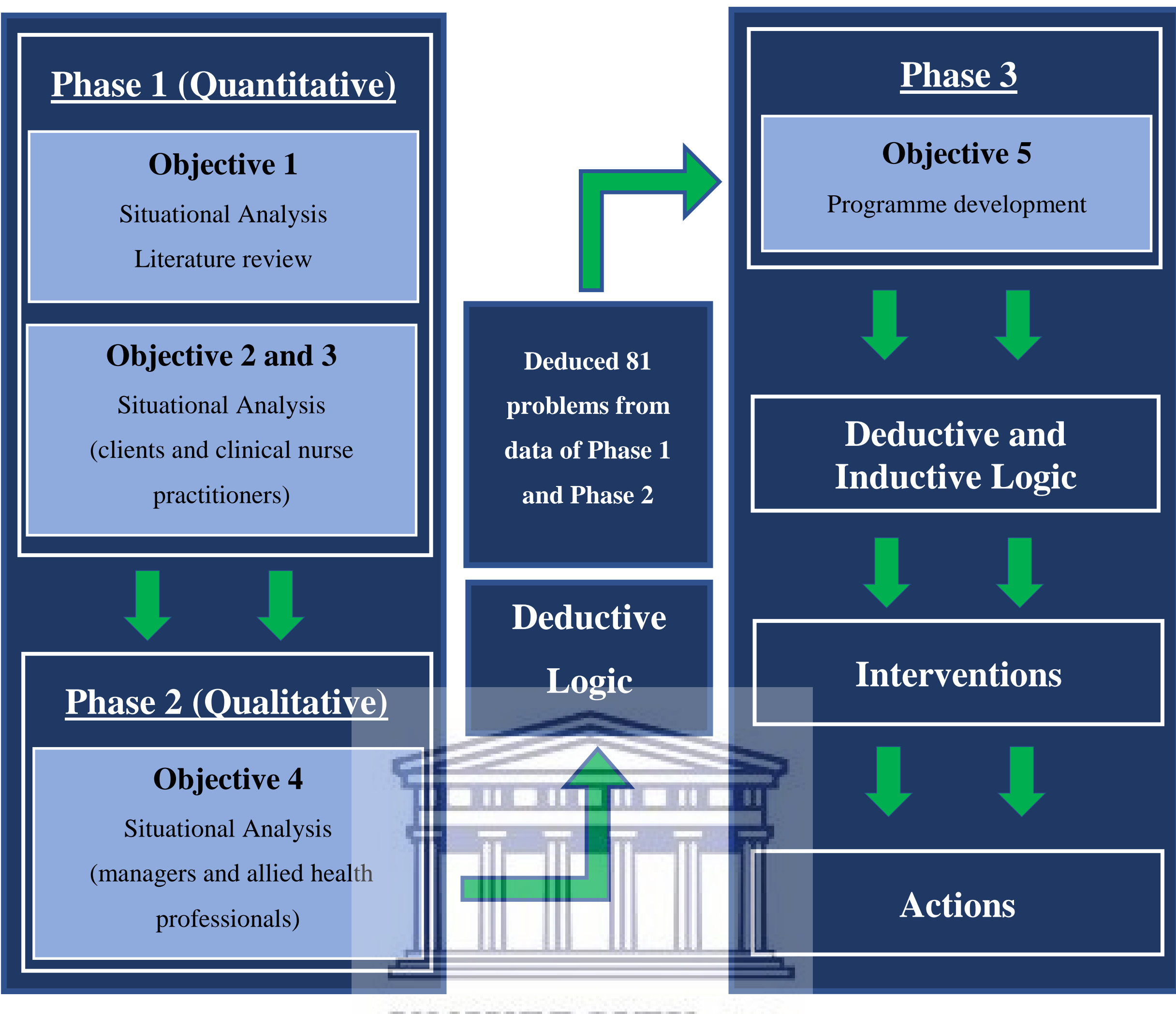

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Figure 2.3: Method applied in the development of the programme to improve quality client-centred care

2.8 SUMMARY

In this chapter, the research design in accordance with the aim and objectives, and the research methodology were described in relation to Phase 1 (Situational Analysis - Quantitative), Phase 2 (Situational Analysis - Qualitative), as well as Phase 3 (Programme development). Phase 1 and 2 were discussed with regard to the research instrument, study population, sampling method, pilot test, data collection and analysis and programme developing. The rigour of the study was included. Subsequently, chapter three explores and describes quality client-centred care through a literature review.

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CHAPTER THREE:
LITERATURE REVIEW

3.1 INTRODUCTION

Chapter 1 is an outline of the study and comprises: the research problem, objectives, paradigmatic perspective, research design, method and ethical considerations. Chapter 2 presented an exhaustive description of the research design and methods. Phase 1 (situational analysis - quantitative) of this study comprises three objectives. Chapter 3 (Objective 1), aims to explore and describe quality client-centred care by conducting an extensive literature review (see Table 3.1). The literature review provides the researcher with a comprehensive background about the phenomenon under study, identifies gaps in the existing body of knowledge and helps to motivate the importance of the proposed study (Fouche & Delport, 2013; Samuel, 2017).

Table 3.1: Overview of the study phases and objectives

PHASE 1: SITUATIONAL ANALYSIS (QUANTITATIVE)	**PHASE 3: PROGRAMME DEVELOPMENT**
Objective 1 To explore and describe the current status of quality client-centred care by conducting an extensive literature review	Objective 5 To develop a programme to facilitate quality client-centred care in PHC clinics of the rural West Coast District
Objective 2 To assess the clients' perceptions regarding quality client-centred care	
Objective 3 To determine the clinical nurse practitioners' perceptions on quality client-centred care	
PHASE 2: SITUATIONAL ANALYSIS (QUALITATIVE)	
Objective 4 To explore and describe the managers and allied health professionals' perceptions about quality client-centred care	

A search strategy was applied to identify and select relevant literature.

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3.2 SEARCH STRATEGY

The search strategy included the following:

3.2.1 Electronic databases

The researcher liaised with the librarian of the University of the Western Cape to select appropriate electronic bibliographic databases. Table 3.2 is a summary of the selected electronic databases.

Table 3.2: Electronic databases

Name of Database	Database Content
EBSCOhost (Elton B. Stephens Company host) – the following databases were included to ensure a multiple search:	These databases include full-text articles from scholarly journals, magazines and newspapers (Grove *et al.*, 2014; LoBiondo-Wood & Haber, 2013; Polit & Beck, 2015)
• Academic Search Complete	
• Cumulative Index of Nursing and Allied Health Literature (CINAHL)	
• Education Resource Information Centre (ERIC)	
• Health Source: Nursing/Academic Edition	
• MEDLINE	
• PsycARTICLES	

3.2.2 Inclusion and exclusion criteria

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Table 3.3 presents the inclusion and exclusion criteria as applied for this study.

Table 3.3: Inclusion and exclusion criteria

PICO format	Inclusion criteria	Exclusion criteria
Phenomenon of interest	PHC AND quality AND client-centred care (and synonyms)	Documents or studies in other contexts than the PHC milieu
Intervention	A programme OR measure OR strategy to improve quality client-centred (and synonyms) care	
Comparative intervention	The current status quo	
Outcomes	Improved quality client-centred care in a PHC milieu	
PICO format	**Inclusion criteria**	**Exclusion criteria**
Time	Empirical literature between 2010 and 2018 are included	Studies before 2010
Language	English	Literature in other languages
Types of studies	All research methods and non-research documents (e.g. expert opinions, policies and guidelines)	Documents and studies irrelevant to the research or review question

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3.2.3 Identification of key words

"PHC, client-centred care and quality" are selected as the leading key words for this study. Synonyms, Boolean operators (OR, AND) and the wild card (?) were applied to combine keywords and to accommodate different spellings (Bettany-Saltikov, 2012; Polit & Beck, 2015). Annexure O, provided an overview of the various searches.

3.2.4 Searching the literature

The first section of the literature review concentrates on the definitions and dimensions of the theoretical concepts as stated in the theoretical framework for quality client-centred care (Figure 1.1 in Chapter 1) of this study.

The second section of the literature review explores and describes the empirical literature guided by the seven domains of the NCSs (South African National Department of Health, 2011). Table 3.4 presents the search strategy.

3.2.5 Search strategy

All titles and abstracts of research articles were screened. Thereafter, full texts compliant with the inclusion criteria were retrieved to be finally included or excluded. Unobtainable records, duplicates and full-text articles based on exclusion criteria were removed. Where appropriate, additional studies were selected from reference lists and manual Google Scholar searches (Annexure O).

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3.3 THEORETICAL LITERATURE

The following sections describe the leading theoretical concepts, namely: quality, client-centred care, PHC, NCSs and Donabedian's (structure-process-outcome) framework.

3.3.1 Quality

Retrieved literature showed that there is no single or perfect definition for quality. Quality is a concept with various definitions and dimensions.

3.3.1.1 Quality definitions

According to the literature, quality is a broad and diverse concept. Table 3.4 summarises some of the quality definitions as provided by various authors and organizations.

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Table 3.4: Quality definitions

Author/Organisation	Quality Definitions	Cited by:
Donabedian (1966)	Maximum patient wellbeing after considering the expected gains and losses regarding the total care process (Donabedian, 1966)	Opinion paper: Mills and Bacthelor (2011) Expert Panel on effective ways of investigating Health; Final report on Future European Union Agenda on quality of health care with a special emphasis on patient safety (2014); Elfgren, Grodzinsky and Tornvall (2013)
Donabedian (1980)	Care conforming to medical science and technology (Donabedian, 1980)	Mosadeghrad (2012)
Parasuraman, Zeithaml, Berry (1985)	The similarity between a client's expectation and his/her perception of services received (Parasuraman, Zeithaml, Berry, 1985)	Papanikolaou and Zygiaris (2012) Aikins, Ahmed and Adzimah (2014)
Institute Of Medicine (1990)	" Quality of care is the degree to which health services increase the likelihood of desired health outcomes and are consistent with current professional knowledge, and meet the expectations of healthcare users" (Institute Of Medicine, 1990:21)	Joshi, Russell, Cheng, Kay, Pottie, Alston, Smith, Chan, Vasi, Lo, Wahidi and Harris (2013) Mills and Batchelor (2011) Gavin, Moskosky, Carter, Curtis, Glass, Godfrey, Marcell, Mautone-Smith, Pazol, Tepper and Zapata (2014)
Ǿvretveit (1992)	Highest possible health outcomes with the available resources (Ǿvretveit, 2009)	
World Health Organization (2000)	The extent to which the health system accomplishes essential health improvement targets and meets the expectations of the general public (World Health Organization, 2000)	
South African National Department of Health (2007)	Attainments of the best results given available resources (South African National Department of Health, 2007a)	
Whittaker, Shaw, Spieker & Linegar (2011)	The extent to which an organisation complies with the needs and expectations of clients (Whittaker *et al.*, 2011)	

For the purpose of this study, the researcher defined quality care as care compliant with the IOMs (2001) quality dimensions as described in paragraph 3.3.1.2.

3.3.1.2 Quality dimensions

Mosadeghrad (2012) and Davies, Wye, Horrocks, Salisbury and Sharp (2011) also confirmed that quality is a multidimensional concept, where different stakeholders could emphasize different aspects of quality. The IOM (Institute Of Medicine, 2001) embraced the following

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six quality dimensions, namely: safety, effective, patient-centred, timely, efficient and equitable. These dimensions were recognised internationally as one of the most influential frameworks (Goodrich & Cornwell, 2008). Various studies emphasized these aforementioned quality dimensions (Gavin *et al.*, 2014; Jayadevappa & Chhatre, 2011). The researcher integrated these six dimensions for the proposed study as it provided a good indication of what quality care comprised. Table 3.5 summarises and describes the six quality dimensions (Institute Of Medicine, 2001).

Table 3.5: Institute Of Medicine's quality dimensions

Quality dimensions	
Safety	Avoidance of preventable harm, risk or injuries
Effective	Care grounded on scientific knowledge resulting in desired outcomes, i.e. a positive change in health status of the individual or communities. Refraining from overuse, underuse and misuse have to be avoided
Patient-centred care	Care respectful and responsive to the needs, preferences and values of the individual
Timely	Care received timely, characterised by the minimising of time lags and possible harmful delays in getting health care
Efficient	Optimal use of scarce resources such as time, cost, energy, equipment, supplies and ideas at the lowest cost and to minimise waste
Equity	Care provided with no difference in quality due to gender, race, ethnicity, socio-economic status or geographical location

The focus of this study is quality client-centred care in a PHC context. Client-centred care will be discussed in the following paragraphs.

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3.3.2 Client-centred care

The IOM included patient-centred care as one of the six quality attributes (Institute Of Medicine, 2001). For this study, the researcher applied the term "client-centred care" to include not only those with a disease, but also those accessing PHC for other services, e.g. family planning, immunisations and other screening services. See Table 3.6 for client-centred and other interchangeable terminology.

3.3.2.1 Client-centred care and interchangeable terminology

Client-, patient-, person-, people- and family-centred care, as well as individualised care are used interchangeably in the literature (refer to Table 3.6). All of these terminology aimed to put the patient at the focus of care (Dewi, Evans, Bradley & Ullrich, 2014; Kogan, Wilber & Mosqueda, 2016; Thorarinsdottir & Kristjansson, 2014; McCance, McCormack & Dewing, 2011).

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Table 3.6: Client-centred care and other interchangeable terminology

Author/Organisation	Client-centred care and interchangeable terminology	Cited by
Patient-centred care	Care characterised by respect and responsiveness to individual patient preferences, needs and values (Institute Of Medicine, 2001)	Health Foundation (2014) DNV GL/Sustania (2014) Verjee and Robertson-Malt (2013) Storm and Edwards (2013) Greene, Tuzzio and Cherkin (2012) Kupfer and Bond (2012) Barry and Edgman-Levitan (2012) Jayadevappa and Chhatre (2011) Drach-Zahavy (2009) Mead and Bower (2000) (Gerteis *et al.*, 1993)
People-centred care	Humane and holistic care prioritising health needs and expectations of healthcare users (individuals, families and communities) rather than diseases (World Health Organization, (2015; 2016)	
Individualised care	Care delivery considering patients' individual characteristics and preferences encouraging patient participation and decision-making (Suhonen, Stolt, Puro & Leino-Kilpi, 2011)	
Family-centred care	Care planned around the whole family - a way of caring for children and their relatives (Shields, Pratt & Hunter, 2006)	
Person-centred care	Care aiming to treat patients holistically and as individuals. Care characterised by treating patients with dignity and respect, providing patients with adequate information on their level of understanding, and enabling the patient to make choices regarding treatment options (Western Cape Department of Health, 2014)	Health Foundation (2014) Dewi et al. (2014) DNV GL/Sustania, 2014) McCormack, Dewing, Breslin, Tobin, Manning, Coyne-Nevin, Kennedy and Peelo-Kilroe (2010)
Client-centred care	An approach to service that is based on the principles of respect and forming of a partnership with people receiving health care (Jormfeldt, Arthur-Brunt & Svedberg, 2013)	

According to Table 3.6 the IOMs (2001) "patient-centred care" definition, was most often referenced in studies. Irrespective, of whether referred to as patient-centred, client-centred, person-centred, and people-centred or individualised care, various dimensions seemed to be repetitive. For this study, the researcher defined client-centred care as care compliant with the eight Picker Institute's dimensions (as described in section 3.3.2.2) and applied it as such throughout this study.

3.3.2.2 Client-centred care dimensions

As mentioned, patient-, client-, people-, person-centred and individualised care are used interchangeably. The variation seemed to depend on the context in which care is provided, e.g.

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patient-centred care is most commonly used when care refers to illness or disease. Person-centred care was frequently used as the umbrella term for patient-centred and client-centred care (Thorarinsdottir & Kristjansson, 2014).

Client-centred care is a multi-dimensional concept. According to the retrieved literature, the Picker Institute's dimensions were most frequently cited. These dimensions included:

- Respect for an individual's values, preferences and expressed needs
- Coordination and integration of care among providers and healthcare institutions
- Information, communication and education (tailored to individual needs)
- Physical comfort (especially freedom from pain)
- Emotional comfort and alleviation of fear and anxiety
- Involvement of family and friends in care giving and decision making
- Planning for transition and continuity (Gerteis *et al.*, 1993).

The context of this study is the PHC milieu. Therefore, the subsequent sections defines and describes the principles of PHC as applicable for the context of this study.

3.3.3 Primary Health Care

The WHO (1974) in Djukanovic and Mach (1975) described PHC as a fundamental part of the healthcare system intended to integrate all the elements in the community required for an impact on the health status of the society. However, in the course of the Alma Ata Conference (1978) the PHC concept was redefined (see Table 3.7).

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3.3.3.1 PHC definition

Table 3.7 shows the PHC definition as defined by the WHO (World Health Organization, 1978), the Australian and Chinese governments.

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Table 3.7: Definitions of PHC

Author/Organisation	PHC Definitions	Cited
WHO (World Health Organization, 1978)	PHC is basic health care, based on practical, scientifically and socially appropriate methods and technology, universally accessible to everyone in the community through their full participation at an affordable cost geared toward self-reliance and self-determination. PHC is to provide health care as near to where people live and work and is regarded as the first contact with the healthcare service	Ruano, Sebastian & Hurtig (2011) Bath and Wakerman (2012) Alzaied and Alshammari (2016) Alameddine, Saleh and Natafgi (2015) Papanikolaou and Zygiaris (2012) Makaula, Bloch, Banda, Mbera, Mangani, de Sousa, Nkhono, Jemu and Muula, 2012) Business for Development Pathfinder, (2012) Ndateba, Mtshali and Mthembu, (2015) Kooienga and Carryer (2015) Xaba, Peu and Phiri (2012)
Australian PHC Research institute in Tilton and Thomas (2011)	PHC is defined as socially applicable, universally accessible, scientifically sound first level of care provided by appropriate trained staff supported by integrated referral systems to prioritize those who are most in need, maximises community and individual self-reliance and participation and involves partnership with other sectors. PHC comprises health promotion, illness prevention, care of the sick, advocacy and community development	Bailie, Si, Shannon, Semmens, Rowley, Scrimgeour, Nagel, Anderson, Connors, Weeramanthri, Thompson, McDermott, Burke, Moore, Leon, Weston, Grogan, Stanley and Gardner (2010)
Wong, Yin, Bhattachharyya, Wang, Liu and Chen (2010)	PHC in China, is defined as the first contact of an individual or family with comprehensive, continuous, and convenient health care services.	

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The three versions of PHC definitions as illustrated in Table 3.7 show some repetitive terminology: "socially appropriate, universally accessible and scientifically sound first level of care". PHC, similar to quality client-centred care is also a multidimensional concept. However, for the purpose of this study, the researcher applied the PHC definition as provided by the WHO (1978).

3.3.3.2 PHC dimensions

PHC has sixteen dimensions as summarised in Table 3.8. First contact, accessible health care, equity, appropriate technology, health promotion, cultural sensitivity, inter-sectoral collaboration, community participation, affordability, availability, effectiveness, efficiency, comprehensive, coordination, continuity and family focus are dimensions synonymous with PHC.

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Table 3.8: PHC Dimensions

First contact	PHC is the entry point, i.e. the first level of contact with the health system in non-emergency situation (Mosquera, Hernandez, Vega, Martinez & Sebastian, 2013; Starfield, 2012)
Accessible health care	PHC services should be available when needed, irrespective of geographical, financial or organisational barriers (Dennill, King & Swanepoel, 2010:6; Mosquera *et al.*, 2013; Van Deventer & Mash 2014)
Equity	Everyone should be equal and must be treated fairly and in an unbiased way. The least advantaged people in a community must receive equal opportunity, education, care and service to those who are advantaged by virtue of both tangible (finance) and intangible (knowledge) resources (McMurray & Clendon, 2014; Starfield, 2012; Van Deventer & Mash, 2014)
Appropriate technology	The implementation and adaptation of health services, interventions, technology and PHC providers must be in line with the needs and conditions of the community, while remaining scientifically sound (Banfield & Jardine, 2013; Sanders, Baum, Benos & Legge, 2011). McMurray and Clendon (2014) emphasized effective and efficient care, i.e. the right care has to be provided to the right people by the right provider in the right context and using the most suitable and effective technology
Health promotion	Health information should be continuously shared with the community to control and improve their own health (Banfield & Jardine, 2013; Visagie & Schneider, 2014; Sanders *et al.* (2011). Health promotion is essentially a political, ecological and capacity building process, aimed at arranging the social and structural determinants of health in a way that facilitates health (McMurray & Clendon, 2014)
Cultural sensitivity	PHC providers should be aware of their own and others' cultural beliefs, values and knowledge and how these shape health and health decisions (McMurray & Clendon, 2013)
Inter-sectoral collaboration	Inter-sectoral partnership is essential between different stakeholders of the community, including (but not limited to) those managing health, education, social services, housing, transportation, environmental planning and local government to respond to all the social facors that have an influence on the health status of people (McMurray & Clendon, 2014; Banfield & Jardine, 2013)
Community participation	Community members should be engaged in making decisions regarding their health and wellbeing through reciprocal dialogue (McMurray & Clendon, 2014; Banfield & Jardine, 2013; Mosquera *et al.*, 2013)
Affordability	Not a single person should be deprived of health care because of the failure to pay (Dennill *et al.*, 2010)
Availability	There should be sufficient and appropriate services to meet the specific PHC needs of each community (Dennill *et al.*, 2010)
Effectiveness	PHC services should be justifiable in terms of total cost (Dennill *et al.*, 2010)
Efficiency	The results attained in PHC should be proportionate to the input, in terms of effort expended, money spent, resources used and time utilised (Dennill *et al*., 2010)
Comprehensive	Van Deventer and Mash (2014); Mosquera *et al.* (2013) and Starfield (2012) stated that comprehensiveness is the extent to which PHC facilities cater for all important health services needed for the majority of the population's health
Coordination	PHC services should organize PHC care between different levels and with other important social services and sectoral roleplayers (Mosquera *et al.*, 2013; Pavlic, Sever, Klemenc-Ketis & Svab, 2015). There should be coordination between the community and the clinic or health centre and between the clinic and the referral hospital (Van Deventer & Mash, 2014)
Continuity	Informational, relational and management continuity are important in the PHC milieu (Pavlic *et al.,* 2015). Organisation of care should be characterised by the retaining of information between visits and over time, as well as some prolonged continuity with the same PHC providers (Van Deventer & Mash, 2014)
Family focus	PHC has to consider the patient within the wider context, which includes the family environment, and the encouragement of the participation and support of the family (Mosquera *et al.*, 2013)

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Both quality and PHC as concepts highlight “efficiency, effectiveness and equity”. Whereas client-centred care emphasises “respect for values”, corresponding to “cultural sensitivity” in PHC. Furthermore, “information, communication and education” dimensions of client-centred care are similar to “health promotion” in PHC. Moreover, “involvement in decision making” of client-centred care speaks to “community participation” and “inter- sectoral collaboration” of PHC.

3.3.4 Donabedian’s quality assessment

According to Donabedian (1988), Mills and Batchelor (2011) and Robinson and Botha (2013), quality assessment comprises measuring of “structure, process and outcome”. *Structure* refers to the qualities of the PHC settings in which care is delivered. This includes material resources (e.g. facilities, equipment and budget), human resources (e.g. number and qualifications of staff members), and the organisational structure. *Process* focuses on what is actually done in giving and receiving PHC, including the patients’ or clients’ activities in seeking care and carrying it out, as well as the PHC providers’ activities in making a diagnosis and recommending or implementing treatment. *Outcome* represents the effects on the health status of PHC patients, e.g. improvement in the patient’s knowledge, constructive changes in the patient’s behaviour and the degree of the patient’s satisfaction with care. Donabedian (1988) and Schaeuble, Haglund and Vukovich (2010) indicated that good structure supports the probability of good process, and good process supports the prospect of good outcomes.

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The researcher applied the Donabedian structure-process-outcome model throughout this study in order to categorise the gaps as identified in the situational analysis (Phase 1 and 2 of this study) as either structure-process or outcomes based. In order to support the quality improvement initiatives.

3.3.5 National Core Standards

Spending more money on health than any other African country, SA’s health outcomes are worse than those in many lower income countries. SA, including the the Western Cape Province, is challenged by a quadruple burden of disease (i.e. HIV & AIDS, TB; chronic diseases; injuries; maternal and child mortality) contributing to a low life expectancy (Versteeg, Du Toit & Couper, 2013; Perez, Ayo-Yusuf, Hofman, Maker, Mokonoto, Morojele, Naidoo, Parry, Rendall-Mkosi & Saloojee, 2013; Mash, Fairall, Adejayan, Ikpefan, Kumari, Mathee, Okun & Yogolelo, 2012). Significant improvements in a number of areas in SA were falling short of achieving the health MDGs at the end of 2015, i.e. MDG 4: to reduce the mortality

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rate of children under five by two-thirds; MDG 5: to reduce the maternal mortality rate by three quarters and MDG 6: to combat HIV/AIDS, Malaria and TB (United Nations, 2015). The SDGs (2016 to 2030) aim to strengthen the efforts to complete of what was not achieved by the MDGs (World Health Organization, 2015). These poor health outcomes obliged the South African Government to embark on a total transformation of the health system.

The NDoHs' Strategic Plan (2010/11 to 2012/13) indicated the vision of the department as "...an accessible, caring and high quality health system" and mission "...to improve health status through prevention of illness and the promotion of healthy lifestyles and to consistently improve the healthcare delivery system by focusing on access, equity, efficiency, quality and sustainability" (South African National Department of Health, 2010:10).

The Strategic Plan, is in line with the the objectives of the 10-Point Plan and the strategic outputs according to the Negotiated Service Delivery Agreement (NSDA) with prominence given to the strengthening the effectiveness of the health system through improved patient care and satisfaction, as well as accreditation of health facilities (South African National Department of Health, 2010; Whittaker *et al.*, 2011). Strengthening of the effectiveness of the health system comprises re-engineering of PHC, reinforcement of manpower, and improvement and standardisation of quality of care through the accreditation of health facilities for compliance (South African National Department of Health, 2010; Moleko, Msibi & Marshall, 2013).

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The National Health Act (No. 61 of 2003) as amended by the Amendment Act (12 of 2013), provided the governmental framework and mechanism for the development of the NCSs as a quality framework and came into being by the OHSC to set a standard for quality care, and to provide a framework, for the accreditation of hospitals and clinics (South African National Department of Health, 2017a; Lourens, 2012).

Complimentary to the NCSs, the SANDoH implemented the Ideal Clinic strategy (2013) to transform all PHC facilities to align with the OHSCs, norms and standards, and to lay a strong basis for the successful implementation of the NHI guaranteeing universal access to appropriate, efficient and quality health services (Fryatt, Hunter & Matsoso, 2013; Fryatt & Hunter, 2015; Naidoo, 2012). An "Ideal Clinic" is defined as a clinic with proper infrastructure, conducive staffing levels, sufficient medicine and supplies, good administrative processes and an adequate amount of bulk supplies, appropriate clinical policies, protocols, guidelines as well

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as partner and stakeholder support, to ensure the provision of quality health services to the community (South African National Department of Health, 2015; Fryatt & Hunter, 2015).

The overall aim of this study was to develop a programme to facilitate quality client-centred care in PHC clinics of the rural West Coast District. Quantitative data were collected by means of two structured questionnaires (one for clients and one for clinical nurse practitioners) and qualitative data were collected through five semi-structured focus group discussions with managers and allied health professionals. The surveys were guided by the seven domains of the NCSs as a framework and focus group discussions were guided by Donabedian's structure-process-outcome model. This situational analysis allowed for the generation of baseline data to identify the shortcomings or gaps regarding the current quality client-centred care in the PHC context and was utilised to develop a programme to facilitate quality client-centred care.

The seven domains of the SANCS's (South African National Core Standards, 2011) guided the empirical section of the literature review.

3.4 EMPIRICAL LITERATURE

The NCSs are structured in seven cross-cutting domains (see Table 2.3), areas where quality care or safety of patients could be exposed to danger. Domain 1: Patient Rights; Domain 2: Patient Safety, Clinical Governance and Care; Domain 3: Clinical Support Services; Domain 4: Public Health; Domain 5: Leadership and Corporate Governance; Domain 6: Operational Management and Domain 7: Facilities and Infrastructure (South African National Department of Health, 2011; Lourens, 2012; Moleko *et al.*, 2013). The SANDoH (South African National Department of Health, 2011) identified the first three domains for fast track improvement.

The literature review is structured according to the seven domains and subdomains of the NCSs. Findings are summarised at the end of each subdomain.

3.4.1 Domain 1: Patient Rights

The Constitution of South Africa, Act 108 of 1996 (Republic of South Africa, 1996), National Patient Rights Charter (South African National Department of Health, 1999), White Paper on Transforming Public Service Delivery (Republic of South Africa, 1997) and the National Health Act 61 of 2003 (Republic of South Africa, 2003) are legal frameworks highlighting Patient Rights when accessing healthcare services. Complimentary to the aforementioned, the HPCSA (Health Profession's Council of South Africa, 2008) and National Patient Rights

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Charter provides health care professionals with guidelines to respect, promote, protect and deliver health care accordingly to the rights of health care users.

Domain 1 of the NCSs focuses on Patient Rights and includes the sub-domains of: respect and dignity, patient information, physical access, continuity of care, decreasing delays, emergency care, access to package of service and management of complaints (Box 3.1) (South African National Department of Health, 2011; Moleko *et al.*, 2013).

Box 3.1: Domain 1: Patient Rights

- Respect and dignity
- Access to information
- Physical access
- Continuity of care
- Reducing delays in care
- Access to package of services
- Complaints' management

The Patient Rights sub-domains (Box 3.1) are discussed in the following paragraphs.

3.4.1.1 Respect and dignity

The WCDoH's vision towards 2030 emphasises a value-driven approach supporting the values of caring, competence, accountability, integrity, responsiveness, respect and innovation (CCAIRR)(Western Cape Department of Health, 2011; Western Cape Department of Health, 2014; Govender, Isaacs, De Sa & Schlemmer, 2013).

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The aforementioned legal frameworks emphasise that every health care user should be treated with respect and dignity. However, according to various studies, respect and dignity are violated by: negative staff attitudes; lack of privacy and confidentiality; environments that are neither healthy nor safe and the lack of security at PHC facilities.

a) Negative staff attitudes

Young adults in the United Kingdom perceived doctors as unfriendly, insensitive and sceptical (Davey, Carter & Campbell, 2013). On the contrary, in Brisbane diabetes patients experienced healthcare providers as friendly (Hepworth, Askew, Jackson & Russell, 2013). While, in Barbados clients showed to have mixed perceptions. Some staff were experienced as helpful, while others were perceived as perceiving that they are almighty (Adams & Carter, 2011).

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In Africa, Zimbabwean staff were perceived as overwhelmingly positive (27 out of 28 study participants) as they were experienced as friendly and approachable (Chindedza, Mutseyekwa and Chideme-Mundawafa, 2013).

However, in SA, eThekweni, KwaZulu-Natal 37% (25/66) of young women experienced PHC staff as rude, unfriendly, loud and vulgar. (O'Reilly & Washington, 2012). Another eThekweni study reported staff attitudes as both negative and positive. Some patients experienced PHC staff as not treating patients well, while others were satisfied with the positive staff attitudes (Sokhela, Makhanya, Sibiya & Nokes, 2013). An Eastern Cape study revealed that some staff members took their frustrations out on patients. Moreover, the staff attitudes are often driven by stigmas. There seems to be a general stigma among health professionals regarding teenage pregnancy and HIV (Tsawe & Susuman, 2015). In the Western Cape PHC staff are perceived as impatient, abrupt, disrespectful, rude and unsympathetic (Murphy, Chuma, Mathews, Steyn & Levitt, 2015; Kagee *et al.*, 2012; Stellenberg, 2015; Black Sash, 2010). However, the study of Scheffler, Visagie and Schneider (2015) in the Western Cape shows both positive (caring, committed and professional) and negative (disrespectful, rude and rushed) staff attitudes. The researcher can relate to negative staff attitudes in the West Coast PHC milieu, especially when staff are challenged by a high workload and inadequate staffing. Negative staff attitudes are perceived as a general reason for complaints (Western Cape Department of Health, 2011).

b) Lack of privacy and confidentiality

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Various research studies found that confidentiality and privacy seemed to be a global concern and were challenged through several inadequate structures and processes of health systems.

Davey *et al.* (2013) and Johnston, Harvey, Matich, Page, Jukka, Hollins and Larkins (2015) reported that young people in the United Kingdom and Australia respectively, feared that their confidentiality could be compromised when consulting a health professional regarding a sexual health problem. Adolescents in the United States of America also, did not trust the confidentiality commitment of the healthcare provider even if they said they would. Teens were concerned that providers would inform their parents without their knowledge or against their wishes and would share their health information with other clinic staff (Schaeuble *et al.*, 2010).

Likewise, according to Project Empower researchers, nineteen of the 66 (28%) young women of eThekweni, Durban in SA reported that they heard clinic staff talking about patients' health.

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Breaches of confidentiality were among the most significant reasons why patients did not attend their nearest clinics (O'Reilly & Washington, 2012).

In addition, Barron, Holterman, Shipster, Batson and Alam (2010) explored the awareness and experiences of interpreting provision services for people whose first language is not English in relation to accessing PHC in the United Kingdom. This study points out that privacy is a concern when friends, children or husbands are used to interpret, as there could be some sensitive and confidential matters that they do not want anyone to know about.

Similarly, as reported by Barron *et al.* (2010) migrants or refugees in KwaZulu-Natal and Mpumalanga, SA also face intimidation to sustain confidentiality of medical information. Due to the lack of interpreters, healthcare staff have sometimes to rely on companions to interpret information about HIV counselling and testing during antenatal care. Consequently, these companions could become cognisant of their partner's HIV status, and healthcare staff have no control about how this information is transferred (Amnesty International, 2014).

The West Coast District which is the focus of this study, also does not have access to translators, but is fortunate to have access to a telephonic language translating service. Where translation for thirty- two languages are offered, comprising all of SA's 11 official languages, together with other languages spoken by immigrants from the rest of Africa, such as Shona (Zimbabwe), Swahili (Kenya) and Yoruba (Nigeria). Even Russian and Chinese are offered.

Furthermore, in the United States of America, Hodgson, Mendenhall and Lamson (2013) highlighted that confidentiality could also be challenged by poorly built infrastructure (i.e. inadequate space, thin walls and lack of waiting room seating), as well as poor layout of clinics.

Similarly, in SA Amnesty International (2014), an organisation working to end human rights' abuses, pointed out that infrastructure of some clinics in KwaZulu-Natal and Mpumalanga often challenged privacy and confidentiality. The following practices were highlighted as posing threats to patients' confidentiality, namely: patients had to walk through communal areas with their records, possibly identifying their HIV status; small and overcrowded rooms, making it almost impossible to protect confidentiality; stickers on doors instructing doors to be open for better air circulation to reduce the risk of TB; patients were queued up in crowded conditions outside, within hearing distance of private discussions and the shortage of consultation rooms made it impossible to take the blood tests of women alone in a room.

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Moreover, Project Empower researchers identified that health system procedures and practices in KwaZulu-Natal and Mpumalanga clinics compromised patient privacy and confidentiality, e.g.: distinct queues and waiting areas for people with HIV; a specific room being used for HIV counselling and testing; antenatal care available daily, while Friday was the day for antenatal care for pregnant HIV patients and HIV patients have special files to track their medication and associated tests. These were distinguishing, some were yellow; others had particular patterns on them. Doing the blood tests is another concern; women who are HIV negative have only one vial of blood taken, while women who are HIV positive have two taken. Doing the blood test openly means patients can tell a person's status, depending on the number of vials taken. A specific nurse deals with antiretroviral treatment, consequently, anyone seen going to that nurse is anticipated to be living with HIV (Amnesty International, 2014). Chimbindi *et al.* (2014) conducted patient-exit interviews with HIV and TB patients at a PHC clinic in rural KwaZulu-Natal. Study results revealed that 16% of the 300 HIV patients and 11% of 300 TB patients included, indicated that they could only now and then or by no means have the opportunity to talk to their healthcare providers in privacy. However, 96% of the 300 HIV patients and 94% of the 300 TB patients confirmed that patient information was confidential. Black Sash, a human rights organisation assessed and gave feedback on the quality of service delivery in 74 clinics (n=360 respondents) across SA, also found that most patients (79%) felt that they had ample privacy when seen by healthcare providers. Almost 90% of patients reported being consulted in private. (Black Sash, 2011).

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Likewise, according to the elderly in Omusati and Tsandi, rural areas in Namibia, confidentiality is secured as consultations were done in private rooms and confidentiality is ensured as only one person at a time comes into the consultation room. However, in Kabbe and Zambezi, also rural areas in Namibia, participants reported that confidentiality and privacy were breached as procedures are just done in front of other people (Van Rooy, Mufune & Amadhila, 2015). Moreover, in-depth interviews with healthcare providers in Kenya revealed that the integration of health services resulted in enhanced privacy and confidentiality, as more clients became willing to be tested for HIV while visiting the reproductive health clinic (Mutemwa, Mayhew, Colombini, Busza, Kivunaga & Ndwiga, 2013).

c) A healthy and safe environment

All healthcare users are entitled to be treated in a healthy and safe environment. A healthy and safe environment comprises cleanliness, available water, proper sanitation and safe waste

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disposal. Though, several studies confirmed that PHC environments, national and internationally are not always healthy nor safe.

A national household survey in Iraq showed that 43.7% (N=1256) households experienced that clinics were not clean (Burnham Hoe, Hung, Perati, Dyer, Hifi, Aboud & Hasoon, 2011). Similarly, Shabila, Al-Tawil, Al-Hadithi, Sondorp and Vaughan (2012) explored the challenges which could have an influence on the provision of primary care services in Kurdistan, Iraq. Participants emphasized the poor sanitary situation due to the lack of sufficient cleaning staff. Ahmed Elnour, Yousif, Farah, Akasha, Osman and Abasaeed (2013) reported that toilet facilities were present in 11/13 (84.6%) Bangladesh clinics. However, the sanitation condition of most toilettes was not satisfactory in 7/13 (63.6%) cases.

On the contrary, a descriptive cross-sectional study measuring satisfaction among PHC patients in Johannesburg, SA showed that almost 80% (N=9 965) of patients in 80 clinics were satisfied with the cleanliness. Twenty percent (N=1 992 patients) were neutral or strongly disagreed regarding the cleanliness of the clinics (Zambia, 2014). However, the Eastern Cape Province in SA also experienced sanitation challenges. Pit latrines at the Pilane Clinic was indicated as being full and filthy (Mbatha, 2013). The descriptive, cross-sectional study of Stellenberg (2015) at six PHC clinics in the Cape Town Metropole too, revealed that 150 (N=353) respondents experienced the service to be inaccessible. Eleven percent participants highlighted that conditions were unhygienic (e.g. unhygienic toilets), making the long waiting hours unpleasant.

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In addition, the availability of water seems to be also a challenge in some of the PHC clinics. The cross-sectional study of Ahmed *et al.* (2013) aimed to assess the quality of antenatal care in PHC centres of Bangladesh, showed that running water was not available in 6 (46.2%) of clinics. Correspondingly, in KwaZulu-Natal, SA evidence from patient-exit interviews, also identified the unavailability of water dispensers and containers for drinking from as a source of dissatisfaction (Chimbindi *et al.*, 2014). According to the Ideal Clinic standards, it is essential that toilets in PHC clinics should have access to running or piped water, toilet paper, liquefied hand wash soap and throwaway hand towels. Furthermore, general sanitary and healthcare waste disposal bins, with inside liners and functional lids should be available. Moreover, all toilets should be clean and functional (South African National Department of Health, 2017b).

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Inadequate waste management seems to be another hazard for the safety and cleanliness of PHC clinics. The cross-sectional survey of Kyabayinze, Achan, Nakanjako, Mpeka, Mawejje, Mugizi, Kalyango, D'Alessandro, Talisuna, Van Geertruyden and Jean-Pierre (2012) assessed the malaria diagnosis capacity of (N=125) Uganda's facilities. Results showed that various facilities did not have the prescribed equipment for infection control and procedures for the safe disposal of biological waste were not followed.

Moreover, Gyawali, Rathore, Bhuvan and Shankar's (2013) mixed methods study conducted at ten PHC clinics in Nepal, also indicated that waste disposal guidelines were unavailable, staff members disposed medical waste without applying any safety precautionary procedures and neither had received any official training in waste management. Likewise, a cross-sectional study on injection safety, in the Jazan Region, Saudi Arabia showed that: syringes in the clinics were not reusable (100%), separately packed (92%) and available at all volumes (98%). Methods of safe discardin of needles and sharps were also operated through contracting with professional companies in 84.8% of instances. However, continuous training programmes on infection control were present in only 60% of clinics (Ismail, Mahfouz & Makeen, 2014). Moreover, a cross-sectional study among 30 midwives and 27 nursing staff members to evaluate safe injection practices in PHC settings of Naxalbari Block, Darjeeling District, and West Bengal findings showed that only 13.33% PHC settings had at least one puncture resistant leak proof container (Chaudhuri & Ray, 2016).

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In the Western Cape, medical waste should be managed according to the Western Cape Health Care Waste Management Amendment Act 6 of 2010 (Western Cape Government, 2010). This legislation requires that waste should be properly segregated, stored in an accessed controlled room at the health facility until removed by an accredited service provider. In addition, Ideal Clinic standards require a signed contract between the DoH and service provider (South African National Department of Health, 2017b). The West Coast District has a service level agreement with Solid Waste Technologies SA (Pty) Ltd for the removal of medical waste.

d) Security measures at PHC facilities

Security measures should be available to ensure a safe environment for healthcare users and staff at PHC facilities. Ideal Clinic standards (South African National Department of Health, 2017b) require that perimeter fencing, a lockable pedestrian entrance, staff parking on the grounds and a security room should be available. A signed contract between the security

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company and the provincial DoH should be available. Several study findings confirmed that security at various PHC facilities is at risk.

The cross-sectional study of Munyewende, Rispel and Chirwa (2014) conducting at PHC facilities (N=111) in the Gauteng and Free State Provinces in SA revealed that security at clinics seemed to be a big concern. Managers experienced their workplace as unsafe as the majority of clinics did not have an alarm system or security guard on the premises. Managers also confirmed several burglaries where clinic equipment and medication were stolen or broken. In addition, the study of Kagee *et al.* (2012) emphasised the issue of personal safety. Patients reported that they often have to walk to the clinic in the dark and were worried about their safety, given the high crime rate in SA. Findings confirmed that challenges regarding transport, long distances and inadequate security caused barriers to clinic attendance.

According to the Constitution of South Africa, Act 108 of 1996 (Republic of South Africa, 1996), the National Patient Rights Charter (South African National Department of Health, 1999), Batho Pele principles (Republic of South Africa, 1997), the National Health Act 61 of 2003 (Republic of South Africa, 2003), Patient Rights Charter (Health Profession's Council of South Africa, 2008), all healthcare users are entitled to be treated with respect and dignity. However, according to the abovementioned studies quality client-centred care is challenged by: staff with negative and inappropriate attitudes, lack of privacy and confidentiality, health care environments that are not always healthy and safe, as well as inadequate security measures at PHC clinics.

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The findings of the aforementioned studies confirmed that quality that care was characterised by staff with negative attitudes, inadequate privacy and confidentiality, health environments which were neither safe nor clean and inadequate security for patients and staff.

Box 3.2: Respect and dignity

- Negative staff attitudes
- Inadequate privacy and confidentiality
- Health environments that are neither clean nor safe
- Inadequate security for patients and staff

3.4.1.2 Information to patients

According to the aforementioned legal frameworks every healthcare user has the right to be informed about the availability of services and how to utelise them. In addition, healthcare

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users are also entitled to access information about medical care in order to make informed choices.

a) Information about the facility and services

Ideal Clinic standards (South African National Department of Health, 2017b) require that all staff should wear identification tags while on duty. O'Reilly and Washington (2012) emphasized that it is difficult to lodge a complaint when the healthcare worker involved is not identifiable. Young women from informal settlements being interviewed to report on their experiences of accessing sexual and reproductive and other health services from clinics in Durban, reported numerous instances of healthcare workers not wearing name tags.

Ideal Clinic standards (South African National Department of Health, 2017b) expect that external signage should be visible at the entrance of the facility to inform the users about the name of the facility, physical address, contact details, service hours, and service package. Furthermore, all service areas within the facility should be signposted by clear way finding signage to ease healthcare users' journey through the facility (South African National Department of Health, 2017b). The following should also be visibly posted, namely: the NO WEAPONS, SMOKING, ANIMALS, LITTERING and HAWKERS signs, the vision, mission and values of the DOH, the staff organogram and the National Patient Rights poster (South African National Department of Health, 2017b). Despite clear Ideal Clinic standards, the West Coast District PHC clinics are currently not compliant regarding information about the facility (external signage) and internal way finding signage.

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Likewise, a descriptive cross-sectional study of 15 randomly selected PHC facilities in Riyadh, Saudi Arabia to evaluate the ease of access for older adults, found that signage was in general good, except for the unavailability of Braille signage. Seven centres (n=15) had a name board that included all staff and job titles, including that of the receptionist. All centres made staff easily identifiable by name badges or name boards (Alhamdan, Alshammari, Al-Amoud, Hameed, Al-Muammar, Bindawas, Al-Orf, Mohamed, Al-Ghandi, Calder, 2015:1094). Whereas, the study to determine the quality of antenatal services in Bangladesh PHC centres showed that a signboard was present in 10 (76.9%) centres, but the board showing the time schedule of delivering antenatal care was absent in 8 (61.5%) centres (Mansur, Rezaul, Mahmudul & Chowdhury, 2014). A comparative analysis of the Maximising Access to Quality instrument supplemented by non-participant observation as a way of evaluating the quality of nursing care in four primary care clinics in the north-eastern Badia of Jordan revealed that there

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were no signs displaying the clinic working hours and special services such as immunisation days were unavailable (Hasna, Hundt, Al-Samairan & Alzaroo, 2010).

Furthermore, Ideal Clinic standards necessitate that information about evacuation should be displayed to be prepared for emergency evacuation at all times (South African National Department of Health, 2017b). The Waterberg District Municipality, Limpopo, SA occupational and safety policy included emergency evacuation where an accredited service provider had been contracted to draw an emergency evacuation plan, which is displayed where visible. All exit and evacuation routes signs are visible, emergency exits and evacuations routes should not be blocked by any means, and emergency drills are performed every six months (Waterberg District Municipality, 2015).

b) Access to medical information

In line with the aforementioned legal frameworks, every healthcare user is entitled to receive the necessary medical information, in order to make an informed choice.

However, according to Project Empower researchers eighteen out of 66 (27%) female participants from informal settlements in Durban, SA reported instances where they had been enforced to obtain HIV tests before receiving treatment for any medical condition (O'Reilly & Washington, 2012). Similarly, focus group discussions and interviews conducted by Amnesty International officials, revealed that pregnant women and adolescent girls perceived HIV testing to be obligatory, fearing that they will be deprived of other antenatal care services, should they decline an HIV test (Amnesty International, 2014).

In the West Coast District, the researcher experiences that healthcare providers are pressurised to chase statistics to obtain predetermined targets resulting in the "forcing" of HIV testing on patients. The 90-90-90 Strategy is adopted globally, including by the NDoH in SA to improve performance in curbing the AIDS epidemic. This strategy aims to test 90% of people for HIV, treat 90% of positive clients on sustained antiretroviral therapy and to ensure that 90% of clients on antiretroviral therapy are virally suppressed (Health Systems Trust, 2016).

However, the thematic analysis of a qualitative study, which included three PHC clinics in Cape Town, SA revealed that patients would like to have more information and counselling. Participants also indicated that staff did not spend adequate time with them, neither had good communication skills to provide information on the cause and nature of their disease or to guide

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them on controlling their disease. These lack of information left many patients feeling shocked and confused (Murphy *et al*. 2015).

Furthermore, according to the qualitative study findings of Tsawe and Susuman (2015), the lack of information could pose a serious barrier to the utilization of maternal health services in the Eastern Cape, SA. The study pointed out that most health professionals and patients were not aware of available maternal health services, resulting in underutilization of these services. Moreover, healthcare staff do not always refer pregnant women for antenatal services, and when those women have delivered, they were not referred for postnatal care either, which then resulted in less frequent use of maternal health services. Sometimes women do not return to clinics for check-ups after they had delivered, they see no need to do so, unless problems arise. This then contributes to the low numbers of those seeking postnatal care.

The aforementioned studies confirm that patients did not allways received adequate information about the facility and about available health services. Furthermore, patients do not always receive sufficient information to make an informed decision regarding treatment and testing.

Box 3.3: Information to patients

- Inadequate information about the facility and services
- Not enough information to make informed decisions about testing and treatment

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3.4.1.3 Physical access

PHC services should be accessible to all people in the country. However, the West Coast District, like other rural districts include sparsely populated areas, which are not always within walking distance to the nearest PHC, neither accessible for those with disabilities.

a) Geographical distances

Focus group discussions and individual interviews with 78 caretakers and 10 adults with a disability in rural New South Wales showed that due to the non-existense of local services, people with a disability and their caretakers have to travel long distances to receive a medical service (Dew, Bulkeley, Veich, Gallego, Lincoln, Brentnall & Griffiths, 2013). Study results of Wojuade and Fadare (2014) showed that more than 30% (n= 791) Ibadan residents in Nigeria have to travel 5 km or less and 70% more than 5 km for their medical needs. It took the majority of respondents 2 hours. Likewise in SA, McLaren, Ardington and Leibbrandt (2013) highlighted that 90% of residents live within 7 km of the nearest public clinic, and two-thirds

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live less than 2 km away. However, 15% of Black African adults live more than 5 km from the nearest facility, in contrast to only 7% of "coloured" and 4% of "whites".

b) Access for people with disabilities

Ideal Clinic standards require that PHC infrastructure should be wheelchair friendly, i.e. a smooth terrain, ramps at the entrance, lowered reception counter, one toilet should allow access for a wheelchair and should have handrails installed, as well as elbow taps and door handles at the height of the wheelchair (South African National Department of Health, 2017a).

Alhamdan *et al.*, (2015) conducted a descriptive cross-sectional study to assess healthcare services provided for older adults in 15 randomly selected PHC centres in Riyadh. Results confirmed that only 5/15 clinics had dedicated parking areas for the disabled and older adults. Fourteen centres had steps at the entrance, with the number varying from 2-5. There were centres that had steps, as well as a ramp at the entrance. The centres without steps had a ramp in place. Ramps were all gently sloping. Fourteen of the centres were accessible to wheelchairs users. The entrances of all centres were >900 mm wide; in most cases being 1500 mm wide. Nine centres occupied the ground floor only, while 6 had more than one floor: none of these had a lift. The reception area was easily identifiable in all centres. Most centres were well laid out, with wheelchair accessible corridors. Only one centre did not have a toilet in the waiting area. Stairs in those centres with more than one floor were accessible and had handrails or grab bars.

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On the contrary, Booysen and Schlemmer (2015) utilised interviews and focus groups to determine why diabetes patients at Bishop Lavis Community Health Centre, SA were non-adherent. Findings revealed that not all government facilities were wheelchair-friendly, neither friendly for people who have to walk with crutches. In addition, Vergunst, Swartz, Mji, MacLachlan and Mannan (2015) conducted 26 semi-structured interviews with health care providers, community leaders and health service users in Madwaleni, Eastern Cape focusing on disability and access to health care. These authors identified that health facilities were not strategically placed as people living in the hills and valleys are often not accessible. The terrain was also an issue in that the wheelchair users had to deal with "mud", "gravel" and "uneven roads" making it difficult to access the nearest health clinic. Compounding these difficulties of distances and transport to health centres, patients encounter also physical barriers in the form of poorly designed buildings. The layout of the establishments are not always being perceived as wheelchair friendly.

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According to the WHO's (World Health Organization, 1978) definition, PHC services should be universally accessible to all citizens, nearby to where people live. The aforementioned empirical studies confirm that vast geographical distances, especially in the rural and remote areas are indeed barriers to access PHC services when needed. In addition, PHC infrastructure seems to be not always accessible to disabled patients.

Box 3.4: Physical access

- Vast geographical travelling distances
- Infrastructure of PHC facilities is not always accessible for disabled patients

3.4.1.4 Continuity of care

Both client-centred care and PHC concepts, emphasised the importance of co-ordination, integration, planning for transition and continuity of care (Gerteis *et al.*, 1993). Van Deventer and Mash (2014) referred to the importance of co-ordination between the community and the clinic, and the referral hospital. In addition, Pavlic *et al.* (2015) gave prominence to informational, relational and management continuity.

The West Coast District has the following referral pathways to ensure continuity of care: Upward, i.e. patient referral from a lower to a higher level of health care. Horizontal referring, i.e. patient referral to a healthcare setting with a similar scope. Downward, patients could also be referred between organisations and government departments. To enhance continuity of care, a standardised referral letter has to accompany each patient to the referred service provider and a written referral feedback must come back to the PHC (South African National Department of Health, 2017a). An effective referral process has the potential benefit of reducing hospital admissions and to empower patients with useful information for self-care (Western Cape Department of Health, 2014). Coordination and integration between providers and services are requirements for client-centred care, which are challenged by various referral challenges.

a) Long waiting times

A qualitative study on the perceptions of clients, caregivers and healthcare providers in Canada revealed that lengthy waiting times and confusing referral systems were significant barriers to care, especially for those attempting to access specialist services. Participants experienced challenges to get hold of specialist appointments at a convenient time (Lafortune, Huson, Santi & Stolee, 2015). In addition, those in need of cataract surgery, reported not only long waiting times, but also high cost of surgery, complexity of the steps involved in treatment, lack of

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surgical (specialists) capacity and low awareness of regional eye health needs (Boudville, Anjou & Taylor, 2013).

Moreover, Reid, Mash, Downing and Moosa (2011) found that besides the lack of resources (i.e. shortages of qualified staff, equipment, medication) in Africa, referral of patients to higher levels of care was considered as a demanding task, and required practitioners to constantly upgrade their skills as they were often forced to manage clinical problems beyond their scope of practice.

On the contrary, Phaswana-Mafuya, Davids, Senekal and Munyaka (2011) conducted a cross-sectional descriptive design study to determine patient satisfaction in twelve PHC facilities in the Eastern Cape, SA. Study results revealed that more than three quarters of women (N=503; 75.4%) confirmed that if they could not be helped at the clinic, they were referred to the nearest hospital or doctor. This also confirmed that nurses in this facility called an ambulance when a client was very sick. Furthermore, nurses in that facility asked patients to return (N=628; 66.9%) to determine their situation or progress.

b) Lack of referral letters

A qualitative, descriptive cross-sectional design study by Chindedza *et al.* (2013) highlighted the barriers of ART patients with the referral system when they had to travel outside their catchment area in Zimbabwe. One participant reported that the nurses refused to resupply his treatment unless he showed a referral letter. In the end this patient had to travel 80 km back to Bonda to get a referral letter. Likewise, focus group discussions with 47 caretakers, utilizing services at rural PHC facilities in Tanzania reported their dissatisfaction regarding the referral of children. Caretakers indicated that they were only given verbal referrals in stead of written referrals. A referral letter could avoid unnecessary delays in the provision of appropriate care (Kahabuka, Moland, Kvale & Hinderaker, 2012). In addition, the mixed-methods study of Nnebue, Ebenebe, Duru, Egenti, Emelumadu and Ibeh (2016) to assess the availability and continuity of care for maternal health services in four randomly selected public PHC centres in Nnewi, Nigeria revealed that none of the centres had evidence in terms of printed referral forms or registers to confirm referral, though they claimed referrals were done to secondary or tertiary institutions. Thus, there was no two-way referral system in place. Furthermore, none of the health facilities had transport facilities for referring women to the next level of care.

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Locally, Dube and Uys (2015) conducted a mixed-methods study in one of the rural districts of KwaZulu-Natal, SA to determine PHC nurses' management practices of most familiar health conditions. The study findings revealed that referral criteria and routes were not obtainable in the clinics where the study was conducted and it was therefore not certain what procedures were followed when PHC nurses referred patients to the next level of care.

c) Inappropriate referrals

An exploratory descriptive study was conducted with lower urgency community-dwellings where patients average aged ≥82 years (n=100) who attended a tertiary metropolitan Melbourne public hospital's emergency department. Seventy three percent attended during business hours (on week days between 09:00 and 17:00). Exploration of responses why the emergency department was chosen revealed problems with access to PHC (21%), referral by a third party (22%), patient or family's first choice for care (24%) or fast-track access to specialist care (33%). A participant mentioned that: "My General Practitioner said let's try going to the emergency department and see if that speeds it up … and it did!" (Lowthian, Smith, Stoelwinder, Smit, McNeil & Cameron, 2012:59). Also, a cross-sectional retrospective cohort study revealed that Spanish physicians and patients frequently use the emergency department to avoid the time-consuming process of PHC referrals to a specialist or for diagnostic tests; potentially contributing to emergency department overcrowding and increased hospital admissions (Bosch, Escoda, Nicolas, Coloma, Fernandez, Coca & Lopz-Soto, 2014).

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The WCDoH (Western Cape Department of Health, 2014) highlighted that continuity of care should result into a seamless care in an uninterrupted way. However, according to the aforementioned studies, long waiting times for specialists' appointments and confusing referral systems, lack of referral letters and inappropriate referrals pose a threat to continuity of care and could impact negatively on quality client-centred care in the PHC milieu.

Box 3.5: Continuity of care challenges

- Long waiting times for specialists appointments
- Unavailability of referral letters
- Confusing referral systems
- Inappropriate referrals

3.4.1.5 Reducing delays in care

Quality health care requires that healthcare delivery should be delivered timely, without avoidable delays. The WCDoH (Western Cape Department of Health, 2011) and SANDoH

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(South African National Department of Health, 2017a) stated that "a client (i.e. those with a stabilised chronic condition or those for the mother, child, and women's health prevention programmes) visited a health facility with an appointment. The client with an appointment should not wait long; as the folders of scheduled patients should be retrieved at least 24 hours in advance of the appointment. However, various countries, including the West Coast District experience challenges with the management of waiting times and implemented various strategies to curb the effect of long waiting times.

a) Long waiting times

Adams and Carter (2011) conducted focus group discussions to explore the barriers reported by patients receiving diabetes and hypertension PHC. Study findings revealed that long waiting times were experienced. This was a problem especially for working persons. Likewise, a national survey in Iraq including 1 256 households, about the perceptions and utilization of PHC services, showed that more than half of the respondents perceived the waiting time too long; this was similar to that of public and private health facilities (Burnham *et al.*, 2011).

In addition, Van Rooy *et al.* (2015) applied a qualitative approach to assess the perceptions of healthcare delivery held by older adults living in rural Namibia. Participants reported that in Tsandi/Omusati the waiting time is too lengthy, especially on Mondays and Fridays. The older adults reported that the registration process was too time-consuming, even when there were not many patients.

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In SA (Mathibe, Hendricks & Bergh, 2015) long waiting times across three large facilities in Tswane were also reported. Despite having arrived early, clients have to wait the whole day just to collect medicine or are requested to return the next day for a due consultation. However, the systematic review of Basu, Andrews, Kishore, Panjaby and Stuckler (2012) revealed that waiting times were shorter at private healthcare services compared to public healthcare services (Basu, Andrews, Kishore, Panjaby & Stuckler, 2012).

b) Quantification of waiting times

Qualitative study findings by Chindedza *et al.* (2013) reported that the average waiting time at Bonda clinic in Zimbabwe was 59 minutes (median = 30 minutes; mode=30 minutes). One nurse confirmed that patients wait longer on days when they drew blood for CD4 cell count. However, the study results of Mbirimtengerenji, Jere, Lengu, Maluwa (2013) study's results showed that in Uganda the shortest waiting time was 7 hours and maximum 10 hours and the

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average was 8 hours 36 minutes. According to one of the participants they did not wait as long for services as they waited to collect their prescribed drugs at the pharmacies, together with the rest of the clients accessing services other than for opportunistic anti-retroviral therapy (ART).

Similarly, the cross-sectional, non-experimental quantitative approach study, conducted by Stellenberg (2015) in the Western Cape showed that respondents (n=79, 79.52%) also complained about waiting times as too long, which averaged 10 hours. Respondents required to be at the clinic by 06:00. If they arrived at 07:00, it might be too late to be attended to on that specific day.

d) Inadequate staffing

Visagie and Schneider (2014) conducted a descriptive qualitative study in the rural Northern Cape Province, SA to determine the degree to which PHCprinciples were applied. One of the participants revealed that there was only one sister and they have to wait for that sister. Patients went in the morning and waited the whole day. Then were told to go away and come return in the afternoon. On Mondays they dispensed medication, Wednesdays were set aside for the doctor. Then they could not visit the clinic at all, because they would not have been helped. On Fridays people from the farms were prioritised, then the other patients have to sit till late before they were being helped. The qualitative study about maternal health care utilization in the Eastern Cape, SA also revealed long waiting times due to staff shortages. Moreover, this leads to a decline in the utilization of health services (Tsawe & Susuman, 2015).

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e) Effect of long waiting times

In Malawi and in Ugandan settings, long waiting times were reported as being influencing ART adherence among women (Mbirimtengerenji *et al.*, 2013; Kunihira, Nuwaha, Mayanja, & Petersen, 2010). The semi-structured interviews conducted with 10 Western Cape Black South Africans, on the anti-retroviral treatment programme also reported that the long waiting times at clinics were a discouragement for clinic attendance. Patients stated that they often spent a full day at the clinic in order to see the doctor or nurse for only a short time (Kagee *et al.*, 2012). One participant commented that: “Waiting makes people fed up and the can leave before they are attended to, and end up falling pregnant because maybe you are rushing to work, you can’t get fired for late coming. Therefore one may decide to leave if the queue is not fast” (Sokhela *et al.* 2013:4). Tsawe and Susuman (2015) also reported that women from the Eastern Cape, who waited a long time at maternal health clinics before attended to, perhaps going home

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not looked after, might see no necessity to return to the clinic and might even search medical attention from privately paid doctors as opposed to waiting for hours at public clinics.

f) Interventions to decrease waiting times

An evaluative, cross-sectional, ex post facto study that included a control group was carried out at 25 PHC clinics in Salvador, Bahia and Brazil. The results showed that better accessibility was found in clinics where the following interventions were developed: a) a system for scheduling appointments b) a telephone appointment scheduling system c) a waiting list for elective appointments d) work group on humanisation (i.e. respecting the different subjects involved in the process of providing health care users: users, workers and managers) to support implementation of the project in the clinics (Vieira-da-Silva, Chaves, Esperidiao & Lopes-Martinho, 2010). Telecommunication applications have been introduced to improve delivery of healthcare services in developed countries.

However, public-funded healthcare systems in developing countries like Nigeria are mostly unfamiliar with the use of aforementioned technologies for improving healthcare access. Adedokun, Idris and Odujoko (2016) proposed a short text message system-based appointment scheduling system to consenting patients at an outpatient clinic and explored their preparedness to utilize and pay for the service. A total of 500 consecutively recruited patients participated in clinics where waiting times ranged from 1 – 7.5 hours. Ownership of cell phones was confirmed by 96.4% (n=482) subjects. Nearly all preferred the proposed appointment scheduling system (n=486, 97.2%). The majority of patients who preferred the system were willing to pay for the service (n=484, 99.6%).

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In SA, Cape Town the following interventions were piloted to reduce waiting times at specialist clinics of the New Somerset Hospital, namely: new X-ray forms which enable pre-ordering; signage on the windows of the admission office, arrows on the ground, and placards providing clear direction to patients were installed; patients were provided with numbered stickers in order of arrival; and staggered appointments were scheduled. All patients were informed of their appointment time via telephone. Preliminary results showed a 39.4% decrease in waiting times. At three months follow-up, a 18.2% decrease in waiting time had been continued. Qualitative data showed that both patients and staff were more satisfied with the service delivery (Price, 2014).

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The descriptive qualitative study of Scheffler *et al.* (2015) described various service organisational strategies implemented by Gugulethu, Cape Town PHC to improve service delivery. The following strategies were implemented, namely: an appointment system and 6-monthly prescripts for stable chronic patients; after hours clinics and outreach services; triage system to screen and prioritise unbooked patients; preferential services to the elderly and patients with disabilities and implementation of scheduled clinics for patients with chronic diseases, e.g. diabetes and hypertension.

A descriptive qualitative survey using content analysis to explore the experiences of Fast Queue service in eThekweni, SA, reported that fast queues enables quick attendance to a degree that permits healthcare users to keep to their normal daily routine. Long waiting was mainly experienced during the process of registration. In the fast queue waiting was minimal (Sokhela *et al.*, 2013).

The qualitative data analysis of Mutemwa *et al.* (2013) regarding the integration of HIV and reproductive health services revealed that clients no longer had to queue three or four times at different healthcare providers per visit; and that the majority of clients were now receiving more than just the one service. On the contrary, participants reported increased waiting time where HIV and reproductive health services were integrated. Consultation times were longer. This has much more to do with ART patients e.g. ongoing counselling; these patients' needs and their long term emotional status (Mathibe *et al.*, 2015; Mutemwa *et al.*, 2013).

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Previously PHC users were helped on a first come, first serve basis, which resulted in long waiting times and people arriving in the early hours of the morning before opening time. This has been changed with clinic triage systems to screen and prioritise unbooked healthcare users. The elderly and persons with disabilities receive special treatment (Scheffler *et al.* 2015).

Quality client-centred care requires service delivery on time. According to the aforementioned studies, delays in care seem to be a global challenge in spite of various interventions. Long waiting times were experienced as a hindrance for clinic visits and could have impacted negatively on the health status of those who were dependent on uninterrupted treatment.

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Box 3.6: Reducing delays in care

- Patients experience long waiting times at PHC facilities
- Inadequate staffing
- Long waiting time is a disincentive for clinic attendance
- Long waiting time has a negative influence on treatment adherence

3.4.1.6 Access to a package of services

PHC in SA is the first contact of the individual with the health system, and provides basic services for the majority of healthcare needs. The PHC package includes CBS, PHC clinics for prevention, curative and rehabilitative services, as well as intermediate care. PHC services are nurse driven and build on CBS for prevention, diagnosis, treatment and recovery. Where possible, the following health professionals should be available at PHC clinics namely: doctors, registered nurses for mental health and maternity. The nurse practitioner and doctors in PHC will be supported by physiotherapists, speech therapists, occupational therapists, audiologists and dieticians (Western Cape Department of Health, 2014). In some of the PHC facilities, quality client-centred care is compromised by inadequate access to the full package of care, as well as inadequate clinic hours.

a) Inadequate access to the full package of care

The thematic content analysis of the descriptive qualitative study conducted by Scheffler *et al.* (2015), including the community health centre and two clinics in Gugulethu, Cape Town revealed that healthcare users were dissatisfied as they did not have access to the full package of care. Emergency and rehabilitation services were limited to the bigger community health centre and limited to the treatment of acute conditions on a weekly, twice monthly or monthly basis. Availability of sessions was often determined by time constraints, which is rather the norm for specific conditions (Scheffler *et al.*, 2015).

b) The lack of extended hours

Globally, various authors highlighted the lack of extended hours as a barrier for accessing PHC. Banks and Baker (2013) highlighted that due to the lack of extended clinic hours employed men were not receiving adequately effective prevention and screening services or diagnosing and treating potentially serious conditions soon enough. This is not just a United Kingdom problem, it affects Europe, and indeed, most of the world. Employed men tend to have less flexible working hours and had to sacrifice their pay if they take time off to attend the clinic. In addition, the mixed-methods study of Johnston *et al.* (2015) on increasing access to sexual health care for rural and regional young people of Queensland, Australia indicated that school

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and working youth perceived the clinic operational hours as a huge barrier for accessing reproductive health care. One service provider indicated that the once-weekly after hour clinics that were available, filled quickly with working youth.

In SA, the qualitative study of Xaba *et al.* (2012) aimed to explore and describe factors influencing service delivery at two subdistricts in Tswane, PHC settings. Results indicated that the lack of extended hours for some programmes, e.g. TB and ART, and the unavailability of family planning services after hours were indicated as disabling factors. The participants indicated that some of the priority programmes were not accessible to all clients, including learners, despite the fact that the service hours had been extended. Clients who came after hours or over weekends requesting TB or ART services were turned away and given another time for an appointment. In addition, people who work office hours had no access to public PHC services, as PHC services are only available during office hours.

In addition, the descriptive, retrospective study of Van Wyk and Jenkins (2014), found that 47% of 2 560 after hours triaged patients at George Provincial Hospital emergency centre in SA, could be managed at the PHC clinic. These results indicate a need for the availability of PHC extended clinic hours. Such PHC services could either be separate from the hospital, or incorporated with the emergency centre. The study of Weimann and Stuttaford (2014) asked suggestions from participants on how they would like health care services in their communities to be improved through the National Health Insurance. The extension of clinic opening hours was also one of the suggestions on how to improve service delivery.

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According to the aforementioned studies quality client-centred care at PHC clinics were compromised due to inadequate access to the full package of care at all PHC clinics. Especially, rehabilitation and emergency services were limited to bigger community health centres. Furthermore, due to the lack of extended hours a variety of clients do not have access to basic PHC services.

Box 3.7: Access to a package of services

- Inadequate access to the full package of care
- Unavailability of extended hours at PHC facilities

3.4.1.7 Complaints management

According to the National Patient Rights Charter (South African National Department of Health, 1999), every healthcare user are entitled to complain about healthcare services.

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Complaints have to be investigated and feedback on such an investigation should be provided (Health Professions Council of South Africa, 2008). Furthermore, the National Policy to Manage Complaints, Compliments and Suggestions in the Public Health Sector of SA provides guidance about the management of complaints, compliments and suggestions by ensuring that standards and measures as set out by the OHSC, the Department of Planning, Monitoring and Evaluation in the Presidency and SA DPSA are adhered to (South African National Department of Health, 2017a). According to this policy all healthcare users should have a chance to complain, compliment or make a suggestion at the health facility.

Complaints boxes should be visible at all clinic entrances. Official forms and pens should be available and also a poster to describe the process to lodge a complaint. The Ideal Clinic Manual, Version 17 requires that 90% of complaints should be settled within 25 working days (South African National Department of Health, 2017a). However, it seems that not all healthcare users are aware of the process to lodge a complaint.

a) Poor awareness about the complaint procedure

Gurung, Derrett, Gauld and Hill (2017) conducted a mixed-methods study aimed to explore why service users from Nepal's PHC system did not complain. Data were generated through interviews, focus group discussions and questionnaires. Patients, clients, staff and service providers of 22 PHC facilities were included. Results showed that, in spite of having a reason to complain, users did not complain regularly: only 9% (n=20) lodged complaints about the PHC services. The study results highlighted that healthcare users were not always aware of their right to complain when not satisfied, official complaint procedures were not always available and healthcare users were not aware of the procedure how to lodge a complaint.

In SA, a content, thematic analysis of interviews conducted by O'Reilly and Washington (2012) with many of the young women accessing sexual and reproductive and other services in Durban PHC facilities, indicated that they did not understand the complaint process or had difficulties with it. Information about the complaint system was often not accessible and most young women were unaware of how to lodge a complaint. Similarly, the patient satisfaction survey in the Kouga subdistrict, Eastern Cape, SA revealed that only: 42.8% (n=799) respondents knew where and to whom to raise complaints; 43.2% (n=796) were aware of how to use the suggestion box and 31.2% (n=796) received feedback after lodging a complaint (Munyaka, Senekal, Phaswana-Mafuya & Davids, 2010). In addition, Human Rights Watch officials visited sixteen health facilities in the Eastern Cape, 157 women receiving maternal

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health services were interviewed, individually or in small groups. The findings revealed that the majority of clinics had posters about the complaint procedure, however some are not placed in strategic places where patients can see them. Furthermore, some healthcare users are illiterate, or may not have time to read the posters as they are often confronted by long queues. According to Human Rights Watch, low awareness of rights and complaints mechanisms discourage healthcare users from lodging complaints about poor treatment (Human Rights' Watch, 2011).

Black Sash, a human rights organisation visited 74 clinics across SA to evaluate and report on the quality of service delivery. One of the questions dealt with complaints, namely: "Do you know that you have the right to complain/comment about healthcare service you receive and that it should be examined and you should receive feedback from the manager?" (Black Sash, 2011:17). The findings showed that exactly 70% of patients were cognisant of their right to complain, with 30% of patients uninformed (Black Sash, 2011).

According to the National Patient Rights Charter (South African National Department of Health, 1999) everyone is entitled to complain about inadequate healthcare services. However, the complaint procedure is not known by everyone.

Box 3.8: Complaints management

• Unfamiliarity about the complaints procedure

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To summarise: quality client-centred care in Domain 1: Patients Rights are compromised by a lack of respect and dignity; inadequate information about the facility or health service; physical access barriers; continuity of care challenges; delays in care; poor awareness of the complaints mechanism and inadequate access to the full package of care.

3.4.2 Domain 2: Patient Safety, Clinical Governance and Clinical Care

Domain 2 of the NCSs focuses on maintaining and improving quality patient care. Quality care refers to: client-centred care (nursing and clinical); clinical governance and clinical risk identification (South African National Department of Health, 2011). These aspects are described in the following paragraphs.

3.4.2.1 Quality client-centred care

"Quality, person-centred care" is the vision of the WCDoH (Western Cape Department of Health, 2014:i). This vision is closely linked to the nursing philosophy of caring and

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compassion. Nurses are pivotal for the provision of quality person-centred care in order to achieve the Healthcare 2030 priorities, including the sustainable developmental goals (Western Cape Department of Health, 2014). Numerous research articles highlighted patients and or clients expectations, and factors influencing quality client-centred care.

a) Care expectations of clients and patients

Focus group discussions conducted by Papp, Borbas, Dobos, Bredehorst, Jaruseviciene, Venko and Balogh (2014) to explore the perceptions of patients in Estonia, Finland, Germany, Hungary, Italy, Lithuania and Spain about quality in PHC revealed several expectations about "quality" care. Expectations such as empathy, friendliness, attention and sympathy; a partnership instead of a patriarchal connection; to be listened to; healthcare providers to spend more time on the consultation and examination; information should be communicated in an understandable and clear manner were highlighted.

Furthermore, the exploratory study of Hepworth *et al.* (2013) regarding an improved type 2 diabetes-management in a new model of integrated primary/secondary care in Brisbane also highlighted several patient perceptions regarding quality client-centred care. Participants in this study emphasised the following dimensions as important, namely:

- easy service access
- a positive care environment
- clear and supportive interpersonal communication
- patients being part of the team-based care
- friendliness and respect
- multi-professional teamwork
- immediate referrals among the team
- effective communication between the service and participants' regular healthcare provider and
- empowered patients, where patients had a clear sense of their role in improving diabetes management
- the team as a motivating factor for them to do well,
- patients felt engaged.

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Likewise, Jeon, Jowsey, Yen, Glasgow, Essue, Kljakovic, Pearce-Brown, Mirzaei, Usherwood, Jan, Kraus and Aspin (2010) stated that patients desired healthcare staff who were not only

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well-informed, but also good communicators, demonstrating kind-heartedness, respect and engagement with the particular needs of the individual. According to participants, this empathetic and holistic approach would result in better self-management. Furthermore, continuity regarding healthcare staff and continuity of information between various services were appreciated by participants. There was a strong sense that patients want access to easy and ongoing education and information. Patients put emphasised on the importance of psychological and emotional support through which they felt reassured, comforted by having someone to talk to, and empowered to sustain social activities and act on lifestyle risk factors.

Moreover, Askew, Togni, Shluter, Rogers, Egen, Potter, Hayman, Cass and Brown (2016) in a mixed-methods exploratory study found that patients who became more involved in their PHC, their rates of depression decreased from around two thirds to one third ($p= 0.03$) and significant improvements in systolic blood pressure ($p< 0.001$) and diabetes control ($p=0.05$) were achieved.

b) Factors influencing quality care

However, various studies highlighted barriers to quality client-centred care. Kuzma, Solomom, Masono, Manari, Hopping, Pasum, Yvia and Tenge (2012) conducted a semi-structured qualitative interview study with 265 participants across nine rural sites in Papua New Guinea to classify the factors that have an impact on the quality of healthcare services of rural populations. The majority of participants reported that they were turned away at least once due to the absence of staff (n=172; 65%), lack of drugs (n= 162; 61%) or inadequate equipment (n=127; 48%). In addition, Sufiyan, Umar and Shugaba (2013) conducted a cross-sectional descriptive study at Kaduna State, Nigeria in PHC centres among 234 women attending antenatal services. Findings revealed that privacy and confidentiality (77.4%) as well as waiting times (48.0%) were of concern.

Moreover, Adams and Carter (2011) explored the barriers reported by patients receiving diabetes and hypertension PHC in Barbados. The following aspects were highlighted as factors that hindered quality client-centred care, namely: not considering the “whole person”; not showing enough respect, and long waiting times in PHC clinics. Jeon *et al.* (2010) conducted semi-structured interviews with 52 patients and fourteen caretakers in Western Sydney, Australia to have an in-depth understanding of the experience of patients and family caretakers affected by chronic diseases. The study revealed that participants were seriously hindered by fragmented services, difficulty in navigating health services, relationships with healthcare staff

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and others, and co-morbidity. Most participants reported difficulties and the way in which healthcare staff provided care. Participants identified negative encounters when healthcare staff seemed rushed or showed little consideration for their individual needs. Participants agreed that such encounters failed to result in realistic self-management plans. Extended waiting times for some health facilities and difficulties in changing appointment times were major sources of anxiety for participants.

Lastly, a qualitative study was conducted to explore the experiences of care and motivation of diabetic and hypertensive patients for effective self-management at a PHC clinic in Cape Town, SA. Patients indicated that they received inadequate information, counselling or autonomy support. The study findings showed that patients experienced many barriers to effective self-management and behavioural changes. Patients indicated that they received inadequate information, counselling or autonomy support. According to the study results, the recent approach to chronic care was unsuccessful to meet patients' motivational needs. Several patients were concerned about their health and were not satisfied with the quality of their care. It is evident that patients need better assistance and support. (Murphy *et al.*, 2015).

The aforementioned studies confirm that patients or clients have expectations to be treated in line with client-centred principles, namely: empathy, sympathy, friendliness, to be listened to and that more time should be spend on consultations. However, several researchers highlighted that client-centred care was negatively influenced by: being turning away, lack of drugs and equipment, inadequate privacy, long waiting times and rushed healthcare workers.

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Box 3.9: Quality client-centred care

- Patients or clients did not experience client-centred principles, e.g. empathy and sympathy .
- Client-centred care is negatively influenced by various structures and processes, inadequacies, e.g. lack of drugs, rushed healthcare workers.

3.4.2.2 Clinical management for desired health outcomes

As previously stated, quality client-centred care is pivotal in the vision of Healthcare 2030 and to be compliant with the sustainable SDGs for maternal and child health, HIV and TB. As emphasized by Donabedian (1988), "*structures*" need to be in place to enhance or enable "*processes*" in order to achieve the desired "*outcomes*". National clinical guidelines are essential "structures" to make sure that quality clinical care is delivered in a standardized way to patients in the PHC milieu.

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a) *Adherence to programme guidelines*

According to the Ideal Clinic Manual Version 17 (South African National Department of Health, 2017a), the guidelines and protocols about Integrated Clinical Services Management (ICSM) should be available in every consultation room and at least 80% of professional nurses and at least one doctor of each PHC clinic should be trained on this package. The ICSM package includes: the Practical Approach to Care Kit (PACK). PACK adult is a comprehensive clinical practice guideline which aims to equip nurses and other clinicians to diagnose and manage common adult conditions at PHC level. Conditions include infectious diseases, chronic respiratory diseases, cardiovascular risk, hypertension and diabetes, mental health conditions, musculoskeletal disorders, epilepsy and women's health. Besides PACK adult, the Standard Treatment Guidelines and Essential Medicine List for PHC and Integrated Management of Childhood Illness Chart Booklet should be available in every consultation room. Additionally, the doctors' consultation rooms the Standard Treatment Guidelines and Essential Medicine List for Hospital level of Adults and the Paediatrics version, as well as Newborn Care Charts Management of Sick and Small Newborns in Hospital should be available.

Furthermore, Mkele (2010) emphasized that the South African National TB Programme is based on standardised chemo-therapy schedules and proper case management to ensure successful completion of treatment and cure. These schedules are detailed in the most recent edition of the Standard Treatment Guidelines and Essential Medicines List. In order to ensure effective implementation, healthcare staff should follow the programme guidelines and only use the suggested anti-TB treatment regimen medication combinations and dosages. The development of drug resistance may result from incorrect choice of drugs, incorrect dosage and period of treatment.

b) *Unfamiliarity with policy guidelines*

The study of Maseko, Chirwa and Muula (2015) explored and documented the reasons why the cervical cancer prevention programme outcomes in Malawi were not good. Findings revealed that staff in the majority of health facilities were unaware of the policy on cervical screening. Furthermore, cervical cancer screening guidelines and standards were unavailable. Similarly, a quantitative cross-sectional study was conducted in Tzaneen, SA to assess clinical nurse practitioners (n=145) knowledge about notification of notifiable diseases according to the Health Act (Act No. 61 of 2003). The study results indicated that clinical nurse practitioners have poor knowledge as only (2%) knew the act. Furthermore, a high proportion (85%) of the clinical nurse practitioners shows no insight of the functions of GW 17 forms. In addition, to

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support lack of knowledge, when asked to identify conditions requiring to be reported within 24 hours, the clinical nurse practitioners still demonstrated poor knowledge (Lowane, Mamabolo & Mashau, 2014).

Quality client-centred care necessitates appropriate "structures" to ensure that clinical care is delivered in a standardised way to patients in the PHC milieu. Ideal Clinic standards (2017) highlight the importance that all the relevant clinical guidelines and protocols should be available in each PHC consultation room to guide the services being offered. Furthermore, all staff should receive the necessary training to be familiar with the utilisation of these protocols and guidelines. However, empirical studies revealed that staff were not always trained or familiar with these protocols and guidelines, which could impact negatively on quality client-centred care.

Box 3.10: Clinical management for improved health outcomes

- Staff are unfamiliar with protocols and guidelines

3.4.2.3 Clinical leadership

According to Healthcare 2030 (Western Cape Department of Health, 2014) clinical leadership is essential for clinical governance. Clinical leadership ensures clinical liability by: the implementation of professional standards; teamwork; inter-disciplinary co-operation; comprehensive service care packages; evidence-based clinical interventions; constant monitoring and improvement of clinical risks and continuous professional development.

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In the West Coast District clinical governance is enhanced by the employment of family physicians. Currently, only two family physicians, one for the Swartland and one for the Saldanha subdistricts are employed. These two family physicians are the custodians for clinical governance in these two subdistricts. The other three subdistricts, without family physicians, are supported with monthly outreaches of the following specialists, namely: an internist, a surgeon, a paediatrician, a gynaecologist and a psychiatrist.

Von Pressentin (2015) stated that the family physician is considered as the champion of clinical governance; community-oriented care and capacity building towards quality improvement with person-centred care fundamental to this approach.

A qualitative study including sixteen interviews with academic and government leaders was conducted across SA. Thematic analysis identified the following important roles for family

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physicians, namely: to reduce referrals at district hospitals; to improve clinical quality and to provide support for community-oriented care (Moosa, Mash, Derese & Peersman, 2014). In line with the aforementioned authors, Pasio, Mash and Naledi (2014), family physicians add value in the following ways: role examples for an evidence-based, holistic and patient-centred approach; promoting a collaborative and multi-disciplinary approach to patient care; being champions of clinical governance and constantly trying to improve quality of care (effectiveness); decreasing referrals to higher levels of care by seeing more complex patients and being available for consultation; developing preventative and promotive activities; making a reasonable contribution to the training of interns, medical students and registrars; and forming a culture of learning and innovation; having a vision for community-oriented primary care and making some advancement in the realisation of this through strengthening CBS, boosting health promotion and engaging with local non-governmental organisations and resources. According to the aforementioned studies family physicians are vital for ensuring quality client-centred care through various quality improvement strategies, role models for evidence-based care, fostering of the multi-disciplinary approach and promotion of community-orientated primary care.

Box 3.11: Clinical leadership

- Inadequate number of family physicians employed in the West Coast District

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3.4.2.4 Clinical risk identification

Ideal Clinic standards (2017) oblige the availability of the National Policy for Patient Safety Incident Reporting and Learning in all PHC facilities of SA. This policy requires that all patient safety incidents should be reported on an adverse incident form and documented in a dedicated register in order to identify recurrent, reversible factors impacting on patient care (South African National Department of Health, 2017a). Studies highlighted several areas of safety risks, including adverse events and healthcare associated infections.

a) Adverse events

Findings of a cross-sectional study among 30 auxiliary nurse midwives and 27 nursing staff members assessing safe injection practices in PHC settings of Naxalbari Block, Darjeeling District, and West Bengal, showed that 53.3% of the auxiliary nurse midwives and all the nursing staff members were practising non-recapping of needles. Only 13.33% PHC settings had at least one puncture resistant leak proof container and 86.7% PHC settings are free from loose needles (Chaudhuri & Ray, 2016).

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In addition, Khoo, Lee, Saraks, Samad, Liew, Cheong, Ibrahim, Su, Hanafiah, Maskon, Ismail and Hamid (2012) evaluated 1 753 PHC medical records in Malaysia. The following medical errors were identified: diagnostic errors in 3.6% (95% CI: 2.2, 5.0) and management errors in 53.2% (95% CI: 46.3, 60.2) of the selected medical records. For management errors, medication errors existed in 41.1% (95% CI: 10.8, 18.2) of the selected medical records. Overall, 39.9% (95% CI: 33.1, 46.7) of these errors had the potential to cause severe harm. Problems of documentation, including illegal handwriting were found in 98.0% (95% CI: 97.0, 99.1) of records. Nearly all errors (93.5%) identified were considered avoidable.

Furthermore, a cross-sectional survey at 70 PHC centres and two clinical laboratories with 317 respondents (a response rate of 94%) showed that instructions for venous blood collection were not followed in the surveyed PHC centres. Fifty four percent (54%) of PHC staff reported that they always identified the patient by name and identification number, as compared with 95% of laboratory staff ($p<0.001$). In the surveyed PHC centres there are clinically risks for misidentification of patients and erroneous test results, with consequences for the diagnosis and treatment of patients (Soderberg, Wallin, Grankvist & Brulin, 2010).

A team of specialists' in the Thames Valley area confirmed that, of the 4 301 enquiries, 158 (3.7%) were documented as vaccine errors. The greatest frequency of errors, 145 (92.9%) were concerned immunisations administered in PHC settings. Errors occurred during selection and preparation of vaccines (n=80, 51%) and evaluating the patients' history and/or schedule (n=64, 41%), together included 92% of reported errors. Overall, 65.3% of all errors happened to children under the age of five years. Incidence of errors by type and immunisation course (n=158) comprised: incorrect vaccine (n=52, 33.3%); extra dosage (n=30, 19.2%); shortened intervals (n=28, 18%); wrong dose (n=17, 10.8%); expired vaccine (n=9, 5.8%); leakage (n=7, 4.5%); contra-indication (n= 4, 2.5%) , documentation error (n=3, 1.8%) and other (n=6, 3.8%). The majority of errors could be avoided by increasing attention to detail (Lang, Ford, John, Pollard & McCarthy, 2014).

Besides, Elkalmi, Hassali, Al-lela, Ihsan, Awadh, Al-Sham and Jamshed (2013) explored the knowledge of the general population towards adverse drug reactions. Interviews using a structured questionnaire (reliability coefficient of 0.71) showed that 77.2% of participants got their information about the side-effects of drugs from doctors, followed by pharmacists (44.6%). More than half of the participants reported unfamiliarity about the existence of adverse drug reactions. Participants reflected insufficient knowledge on adverse drug-reaction

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reporting. Strategies were needed to inform patients about how to report adverse drug reactions and committees to which these adverse drug reactions are reported.

The aforementioned study findings were in line with previous studies. Healthcare professionals and patients were not only unsure about reporting, but did not have any prior information about the reporting centres in their region. The burden of adverse drug reactions on patient care has been a global concern and is particular high in SA. Metha (2011) highlighted that according to the meta-analysis of 69 prospective and retrospective studies conducted by Wiffen, Gill, Edwards and Moore (2002) in various regions of the world, approximately 6.7% of all hospitalizations were as a result of adverse drug reactions. Metha also referred to the study Metha, Durrheim, Blockman, Kredo, Gounden and Barnes (2008) in a secondary hospital in the Western Cape which indicated that 6.3% hospitalised patients were admitted as a direct consequence of an adverse drug reaction. More than half of the adverse drug reactions were considered to be avoidable with enhanced prescribing administration, monitoring and adherence.

Blockman and Cohen (2011) also confirmed that adverse drug reactions and medication errors are an important cause of preventable harm in patients. Encouraging a culture of non-punitive reporting of adverse events in the medical community is essential to increase awareness of harm by drugs and introduce strategies to minimise such harm.

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Focus group discussions were conducted with 32 healtcare staff of the Eastern Cape, Province, SA. Study results revealed that due to the lack of training they did not have sufficient knowledge to decide whether a health problem was a possible adverse drug reaction or not, nor did they have the neccessary knowledge to treat adverse drug reactions. Furthermore, they did not receive training about how to complete a formal adverse drug reaction form, nor were they aware of the existence of the adverse drug reaction recording form. In addition, healthcare staff highlighted that some patients would refuse to bedin or carry on with ART due to anxiety of adverse drug reactions, indicating the necessity to educate patients about adverse drug reactions (Ruud, Srinivas & Toverud, 2012).

b) Infection prevention and control

Ideal Clinic standards (2017) require that the SANDoH's Policy on Infection Prevention and Control should be obtainable. Moreover, each health facility should have a dedicated person assigned for infection prevention and control. Appropriate protective clothing, e.g. gloves and

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masks should be readily available (South African National Department of Health, 2017a). Overall, research evidence highlighted various inadequacies regarding infection prevention and control at PHC facilities.

Interviews at 28 PHC centres in the Western Development Region, Nepal were carried out to identify the infection control knowledge and practice of basic health workers. Of 100 basic health workers, only 22 had correct knowledge of universal precautions and 73% said they followed universal precaution guidelines. A total of 62% reported that they regularly used protective gloves, while handling patients and 72% reported they never used high-level disinfection to eliminate all microorganisms from instruments and other items that would come into contact with broken skin or intact mucous membranes. Reasons for non-compliance included irregular supply of materials (31%); lack of autoclave and other high-level disinfection equipment (50%); lack of knowledge and insufficient technical skills regarding universal precaution procedures (20%) (Timilshina, Ansari & Dayal, 2011).

Moreover, a cross-sectional survey in Kuwait where anonymous self-administered questionnaires were distributed to 152 physicians showed that most of the participants were aware that healthcare workers can acquire health care-associated infections from a patient, but fewer than 60% recognised that healthcare staff can spread these infections to a patient. Only 59.4% of participants believed that hands hygiene after removing gloves is a control measure, while 84.6% believed that changing face masks before going to another patient is a health care-associated measure, and 70.2% believed that wearing gloves, face masks and protective eye-wear are health care-associated control procedures. However, only 62.7% always wore gloves every time when they have direct contact with a patient and 64.6% confirmed that they changed gloves at all times after working with each patient, while 51.0% and 64.3% always performed hands hygiene procedures before and after wearing gloves respectively. A total of 67.8% and 62.5% of participants always performed hands hygiene before beginning the working activity and before going to another patient correspondingly. Placing needles in sharp's containers were performed by 67.8%, while other protective measures were encountered in lower percentages as wearing protective eye-wear (20.5%) or face masks (31.5%) when in contact with a patient, recapping needles after usage (36.8%), using syringes with retractable needles (38.5%), use syringes with protective shields (44.8%), and using intravenous cannulation with retractable needles (36.6%) (Alnoumas, Enezi, Isaeed, Makboul & El-Shazly, 2012).

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In SA, Engelbrecht and Van Rensburg (2013) conducted a cross-sectional survey to explore the extent of TB and infection control measures at 127 PHC clinics across SA. The study identified that not all clinics have infection control committees, neither specific infection control plans. In terms of administrative controls, 94.5% of clinics did not have the TB sign and symptoms screening tool, 48.8% did not separate coughing patients from other patients and only 35.4% provided coughing patients with masks or tissues. An open window register was available at only 18.9% of the selected clinics. There was a shortage of N95 respirators. Moreover, an infection control audit in ten PHC facilities in the Western Cape was done by applying a cross-sectional descriptive study. Findings revealed that only a small number of the professional nurses and community health workers were trained on infection control practices. Infection control seems to be inadequate, as only two of the ten facilities had infection control plans. The analysis also showed that there was adequate protective equipment (respirators) in eight of the ten facilities. Only five of the ten facilities had a designated infection control officer on site (Mphalele, Tudor, Van der Walt & Farley, 2012).

Similarly, in KwaZulu-Natal, a descriptive study assessing adherence to suggested infection control policies in 51 PHC clinics in eThekweni, Kwa-Zulu-Natal showed that of the 51 clinics, only 11 (22%) had infection control policies, 13 (26%) isolated or fast line coughing patients and 16 (31%) had a devoted nurse and a dedicated consulting room for treating TB patients. Only eleven (22%) of the 51 clinics had N95 masks available for staff use (Naidoo *et al.*, 2012). In addition, Malangu and Mngomezulu (2015:1) conducted a cross-sectional study at PHC clinics in KwaZulu-Natalwas to evaluate TB infection control measures. Results revealed that in general, some 48.6% (18 out of 37) of aspects of TB- infection control encompassing administrative, environmental, clinical and occupational health measures were compliant with specific standards by at least 80% of selected clinics. The unfortunate outcome of this inadequate compliance was that 23 and 12 cases of nosocomial TB had been diagnosed among staff members respectively in Ugu and Uthungulu districts. It appears that at facilities surveyed, less than 50% of TB-infection control measures were complied with.

The Health Systems Trust (2013) reported on Adeleke's study about the barriers regarding TB Infection Control as experienced by staff members of two PHC clinics in Khayelitsha, SA. The following barriers were highlighted during this study, namely: trouble with breathing - uncomfortable respirators, discomfort and suffocating. Non-proactive use of respirators – healthcare workers use respirators only after they had determined the TB status of a patient.

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Non-responsive compensation policy – TB is a disease for which compensation can be obtained through the Compensation for Occupational Injuries and Diseases Act (Act 130 of 1993). However, because of all the governmental processes and delays healthcare workers view TB as a "personal" problem and not an official problem. Other disincentive factors were the disrespect and non-compliant behaviour of patients. Patients often rebel against the use of face masks. Healthcare workers perceive TB-infection control as distinct from their routine tasks. They feel they are too busy to comply completely with TB-infection control measures. Furthermore, most staff had not received more training in TB-infection control. Insufficient air circulation was highlighted as a barrier to effective TB-infection control in clinics. Although all interviewed staff knew about the infection control committee, they seemed to be unacquainted with the actual committee activities.

Above-mentioned studies confirm inadequate adverse incident and infection control prevention and control measures as "structures" and "processes" that are not always in place to ensure quality client-centred care.

Box 3.12: Clinical risk identification

- Inadequate adverse event control
- Inadequate infection prevention and control measures

To summarise: according to the aforementioned studies, quality client-centred care in Domain 2: Patient Safety, Clinical Governance and Clinical Care were compromised by the following: patients and clients did not experience their care as client-centred care, clinical management was identified as high risk, as staff did not adhere to treatment guidelines and or were unfamiliar with the content of these guidelines and protocols. Furthermore, clinical governance was compromised by an inadequate number of family physicians being employed in the West Coast District.

3.4.3 Domain 3: Clinical Support Services

Domain 3 of the NCSs focuses on essential services required for the provision of clinical care which include: pharmaceutical, diagnostic, therapeutic, and health technology (South African National Department of Health, 2011).

3.4.3.1 Pharmaceutical services

According to the Ideal Clinic standards every clinic has to ensure for the continuous accessibility of essential PHC medicines. The South African Essential Medicine List for PHC

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facilities should be available in every PHC clinic, as well as 90% of essential medicines. Essential medicine is regarded as medicine that should be available for the most general diseases and health needs within a specific setting (South African National Department of Health, 2017a). In addition, the NCSs require that medicines are prescribed according to treatment guidelines and patients have to be educated to understand how and when to take their medicines and to report reactions or severe side-effects (South African National Department of Health, 2011).

a) Availability of medicines

Unavailability of essential medicine seems to be a general phenomenon as emphasized by numerous studies. A cross-sectional study was done including 85 doctors in PHC clinics and healthcare centres in Madhya Pradesh, India in order to assess their readiness for cardiovascular diseases. The study showed discordance with the obtainability of recommended class drugs. Hypertension beta blockers are widely available, but Thiazide diuretics are not. The accesability of Aspirin and Lipid lowering drugs was low, despite both of these drugs being useful in the primary prevention of diabetes mellitus (primary prevention) or in those who already have had an earlier event (secondary prevention) (Pakhare, Kumar, Goyal & Joshi, 2015).

The systematic review of Joshi, Alim, Kengne, Jan, Maulik, Peiris and Patel (2014) about task shifting for non-communicable disease management in low and middle income countries revealed that the task shifting was challenged by the unavailability of algorithms, restriction on prescribing medications, irregular drug supply and availability of equipment. Correspondingly, Mendis, Al Bashir, Dissanayake, Varghese, Fadhill, Marhe, Sambo, Mehta, Elsayad, Sow, Algoe, Tennakoon, Truong, Lan, Huiuinato, Hewageegana, Fahal, Mebrhatu, Tshering and Chestnov (2012), conducted a cross-sectional survey in eight low- and middle-income countries (Benin, Bhutan, Eritrea, Sri Lanka, Sudan, Suriname, Syria and Vietnam) in 90 randomly selected facilities to assess the ability of PHC facilities to implement elementary interventions for prevention and management of the foremost non-communicable diseases. The results revealed that glyceryl trinitrate, isosorbide, dinitrate, insulin, glibenclamide, ipratropium bromide, and morphine injection were not available in any PHC facility. None of the countries had all the selected essential medicines in all PHC facilities. Only one country had glyceryl trinitrate, insulin, and beclomethasone inhaler available in more than half the primary care clinics. In 34% of primary care clinics, there were no stock or logbooks that kept

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an up-to-date account of available medicine stocks. The survey of Maiti, Bhatia, Padhy and Hota (2015) on the availability of essential medicines at 36 PHC facilities in 12 districts of Maharashtra, India showed that the availability of medication was a huge challenge. Thirteen percent of facilities did not have the essential medicines and 75% facilities did have adequate stock. It has been projected that 50-80% of the Indian population were unable to access the needed medicines.

An explorative qualitative study with an imbedded quantitative stand was conducted in a rural district of Sindh, Pakistan to determine the barriers hindering the implementation of integrated management of childhood illnesses. Survey findings showed that not one of the 16 included facilities had 100% stock of essential supplies and medication. Only one facility had 75% of the total supplies, while 4 had 56% of the required drug stock. The average availability of drugs fluctuated between 45.8 and 56.7% (Pradhan, Rizvi, Sami & Gul, 2013).

In SA, semi-structured interviews with 36 nurses, pharmacy personnel and doctors from six PHC Community Health Centres, in both rural and urban settings of the Eastern Cape revealed that medication stock-outs were a major challenge specifically in the rural clinics. These stock outs forced providers to either refer patients to other facilities or gave them another appointment. Stock-outs and perceived quality of services were amongst the reasons for not attending the nearest clinic (Magadzire, Budden, Ward, Jeffery & Sanders, 2014).

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b) Patient education

Various studies showed that patient education and counselling about medication and side-effects result in improved understanding and knowledge about the disease, medication, side-effects, as well as adherence.

A multi-centre prospective intervention clinical trial was performed at 10 PHC clinics in the Western Provinces of Sudan. Three hundred (n=300, 85.7%) participants successfully completed the study. The intervention plan was in the form of behavioural interventions. Educational interventions involved teaching the patients about the medications and diseases. Results showed that the scores improved significantly in four screens (pre- and post-interventions): regimen [4.6 ±0.2 to 1.8 ±0.1: p=0.001], belief [1.6 ±0.3 to 0.3 ± 0.3: p=0.07], recall [1.7 ±0.2 to 0.6 ± 0.2: p=0.043] and access screens [1.8 ± 0.1 to 0.4 ± 0.1: p=0.005]; which have indicated an enhanced patients' adherence to drugs. The percentage of subjects reaching the target of postprandial blood glucose have improved from 28.0% to 49.3% [p=0.02]

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post interventions. Postprandial blood glucose values have lessened considerably [11.1 ± 0.6 mmol/L to 8.1 ±0.8 mmol/L; p=0.001]. The percentage of subjects with improved blood pressure control have increased significantly [50.3% to 89.0%; p=0.001] (Ahmed *et al.*, 2013:701–702). Likewise, an intervention study to evaluate the influence of counselling on the medication knowledge of (n=151) hypertension and cholesterol patients of Johannesburg showed that patients' medication knowledge have significantly improved with 14.6% after counselling. After counselling patients demonstrated improved knowledge of why they have to use medication (14.9%), the size of a dose (5.9%), correct time to take the medication (4.6%), benefits (19%), side-effects (14.1%) and awareness about the medication strength (26.9%) (Marais, Schellack & Meyer, 2014).Similarly, a cross-sectional study conducted in the Congo at Kinshasa PHC network facilities, including 395 hypertensive patients showed that patient education improves the patient's understanding of diseases, lifestyle change and medication. Patients who admitted to benefitting from education and who had good knowledge of hypertension and its complications respectively were twice more likely to be treatment adherent (Lulebo, Mutombo, Mapatano, Mafuta, Kayembe, Ntimba, Mayindu & Coppieters, 2015).

On the contrary, a mixed-methods survey was conducted amongst nurses working in several PHC clinics in one of the rural districts in KwaZulu-Natal in order to determine their practices in the management of psychiatric patients. The findings revealed that in five sites (83.3%) treatments were not reviewed every six months, there were no local protocols on the administration of psychiatric emergency drugs, and none of the study sites provided psychiatric patients with education on their medication and its possible side-effects (Dube & Uys, 2015).

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Likewise, the results of a qualitative study on hypertensive care behaviour in Malaysian PHC clinics showed that the majority (N=19/25) of the hypertensive patients being interviewed felt the explanation of medication side-effects, the importance of exercise and diet should be discussed more thoroughly. Only five participants were of opinion that the doctor informed them about some side-effects (Shima, Farizah & Majid, 2014).

In addition, Mkele (2010) did a review on the role of the pharmacist in TB management. This review highlighted that pharmacists have a significant role in the management and prevention of TB, especially in aspects related to improve the obtainability and accessibility of drug medication, thereby improving adherence to treatment and educating patients about the illness. Health education either on an individual basis or by the provision of health information

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pamphlets targeted at the public, are some of the ways in which pharmacists can help control the spread of TB. Informaton about the side effects, as well as the interaction profile of anti-TB medicine can help the pharmacist when providing counselling services for the patient. According to Steyn and Goldstuck (2013) there are a number of effective contraceptive options that may be used safely by women during the postpartum period. It is important to supply women with written information on contraceptives, including advice about possible side-effects and the availability of emergency contraception if needed. A follow-up appointment or referral to a family planning facility should be arranged before the women are discharged after a delivery. Sankal, Krishna, Reddy, Mahebdiran, Hussan and Parthasarathy (2015) also emphasized the vital role of patient information leaflets, preferably pictograms or pictures to explain the use of the medicine clearly and simply. Unfortunately, there are very few patient information leaflets available. So until such time as they become available, and probably even after that, we need everyone who deals directly with consumers to make sure that enough information is given and that the consumer understands the information.

Moreover, a qualitative study was conducted to examine patients' adherence to ART in the Limpopo Province. The qualitative data analysis revealed how ART patients perceived challenges regarding medication adherence, interactions of antiretroviral drugs with food and available support offered when on antiretroviral treatment. The study recommended that healthcare professionals should implement a patient-centred approach to educate patients about the side-effects of ART. Dieticians and community health workers should be involved in the care of ART patients. The patients must be encouraged to join support groups and become educated about interactions between ARSs and nutrition (Lekhuleni, Mothiba, Maputle & Jali, 2013).

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A descriptive, qualitative study with ten female participants attending an ART clinic at a KwaZulu-Natal showed that adherence could be influenced by patient, disease, treatment and staff associated factors. Patient-related factors included difficulties with acceptance of the disease, to disclose their status, willpower and support of their family. While disease-related and treatment-related factors were linked to symptoms of the disease and improvement on ART. Healthcare staff-related factors were associated with relationships. Adherence counselling support participants with an improved understanding of the disease, the reasons for taking medications, awareness of side-effects and to correct misinterpretations about HIV (Ross, Aung, Campbell & Ogunbanjo, 2011).

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Numerous studies confirmed that continuous availability of medication ("structure") seems to be a global challenge. Whereas patient education ("process") about medication seems to have a positive effect on quality client-centred care, characterised by increased knowledge about diseases, side-effects and resulting into improved adherence ("outcomes").

Box 3.13: Pharmaceutical services

- Unavailability of medication

3.4.3.2 Diagnostic services

According to the Ideal Clinic standards it is essential that all PHC clinics should have the PHC Laboratory Handbook as provided by the National Health Laboratory Service (South African National Department of Health, 2017a). The PHC Handbook provides a standardized guidance for PHC clinics regarding the selection of appropriate laboratory tests, specimen collection and its preservation, storage, recording and courier services. Furthermore, Ideal Clinic standards require that all functional diagnostic equipment and consumables e.g. Haemoglobin meter, glass slides, blood glucose strips, rapid HIV tests, and specimen collection material and stationery should be available in all clinics. Furthermore, laboratory results should be available within the specified turnaround times (South African National Department of Health, 2017b).

All over, studies showed numerous inadequacies about the available laboratory services.

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The cross-sectional study of Mendis *et al.* (2012) which included 90 health facilities outside SA, revealed that vital urine and blood tests were unavailable and patients had to be referred to a higher of care or a private service provider for these tests.

In addition, Hailegiorgis, Girma, Melaku, Teshi, Demeke, Gebresellasie, Yadeta, Tibesso, Whitehurst, Yamo, Carter and Reithinger (2010) assessed 69 Ethiopian laboratory facilities to determine their diagnostic capacity. Only 24% of the 159 staff members had been trained on Malaria, and 72% of the facilities had a functional microscope. The levels of equipment, supplies and biosafety procedures for the diagnosis of malaria were variable. Quality assurance/quality control protocols were unavailable in all of these facilities.

Similarly, Kyabayinze *et al.* (2012) assessed PHC facilities in 11 districts of Uganda to determine if they have the required tools, skills, staff, infrastructure and systems to diagnose for malaria. Only 30% of the larger health facilities provided laboratory services. Standardized internal and external quality control policies were unavailable. Limited quality control

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proccesses were practised at only 7/18 (38%) of facilities, but not one of the facilities had ever taken part in any outside quality assurance accreditation. Consistent reagent change as a means of quality control was reported at only 3 (17%) facilities.

Crowley and Stellenberg (2014) did a quantitative descriptive study to determine if PHC clinics in KwaZulu-Natal, SA have the capacity to provide integrated HIV services. According to the findings of this study, laboratory services were accessible in more than fifty percent (n=15; 75%) of the clinics. However, turn-around time of less than two weeks on certain blood samples were restricted to only eight (40%) of the clinics. Furthermore no clinic had access to a computerised laboratory system.

Numerous studies confirmed inadequate availability of "structures" regarding laboratory services. Shortages of laboratory tests, inadequate number of microbiologists, lack of quality control protocols and electronic systems were highlighted. In addition, turn-around times ("process") seem to be a further challenge which could pose a risk for quality client-centred care as it could result in late initiation of the relevant treatment.

Box 3.14: Diagnostic services

- Shortage of laboratory tests
- Inadequate number of microbiologists
- Lack of quality control protocols
- Long turn-around times of specimens

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3.4.3.3 Therapeutic and support services

Ideal Clinic standards require that all patients should have access to a comprehensive range of professionals which include: a medical practitioner, oral health services, occupational therapy, physiotherapy, dietetic, social worker, radiography, ophthalmic, mental health, speech and hearing, and pharmacy services (South African National Department of Health, 2017a). However, several studies revealed the unavailability of medical, mental health and allied health practitioners.

The cross-sectional questionnaire-based study of Pakhare *et al.* (2015) to assess the preparedness to manage and treat non-communicable diseases at PHC clinics and centres at Madhya Pradesh, India indicated that nutritionists and physiotherapists were mostly unavailable. In addition, a cross-sectional study using an interview schedule was conducted to assess the availability of oral health in health centres Taluk, India. The results showed that

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among 23 health centres of Mangalore Taluk, dental services were offered at only six health centres (23%) – two community health centres and four PHC centres. Mouth mirrors, dental explorers, and extraction instruments were obtainable at six health centres, two community health centres (100%) and four clinics (19%). Not one health centres provided orthodontic tooth correction, removal of impacted teeth and oral biopsies, and fabrication of removable dentures. Thus, the accessability of dental services was limited in the health centres, and a vast majority of the rural population in Mangalore Taluk did not have access to dental care (Simon, Rao, Rajesh, Shenoy & Pai, 2014).

Quality client-centred care could be negatively influenced as aforementioned studies highlighted that nutritionists, physiotherapist and dentists ("structure") were not everywhere available.

Box 3.15: Therapeutic and support services

- Shortages of therapeutic staff categories such as: nutritionists, physiotherapists, and dentists.

3.4.3.4 Health technology services

All consultation rooms should have sufficient furniture, e.g. a desk, chairs and examination coach, as well as essential equipment for safe and efficient patient care (South African National Department of Health, 2017b). All staff members should receive training in the correct use of medical equipment. However, study findings revealed that overall, PHC facilities are lacking some essential equipment and all staff members were not adequately trained in the usage of medical equipment.

Rao, Naftar, Baliga and Unnikrishnana (2012) conducted a cross-sectional study at 70 PHC clinics in South Coastal India to determine the knowledge and practices regarding cold chain management. Results indicated that ice- line refrigerators and deep freezers were available in 69 (98.6%) and 67 (95.8%) of the clinics. Dial thermometers were available in all of the clinics. Cold boxes, frozen packs and automatic voltage stabilizers were available in 68 (97.2%) clinics. However, inappropriate vaccine storage was observed in 7 (10%) of clinics. Knowledge on correct practices in fields like equipment, polio-drops administration, and vaccines requiring diluents were adequate. However, only 47 (61.8%) medical officers had correct practices of defrosting the deep freezers. In addition, Pakhare *et al.* (2015) did an assessment to determine preparedness of PHC centres for cardiac disease in Madhya Pradesh, India. Vital tools such as a blood pressure measurement device, measuring tape, weighing

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machine, glucometer, urinary protein and ketone testing strips have to be readily available. However, except for a blood pressure measurement device, these basic technologies were unavailable in many PHC facilities of Madhya Pradesh, India. Additional complex technologies to be added when resources permit, include a facility to measure serum creatinine, lipids, and electrocardiography that were mostly not available. Average availability of these necessary drugs and technologies reported in the enrolled health-centres ranged between 11 and 55% in PHC clinics, and 37 to 80% in community health centres. Likewise, Saxena, Kumar, Kumari, Nath and Pal (2015) assessed the availability of health services at 24 villages in Uttarakhand, India. Results showed that blood pressure measurements for ante-natal patients were done at only 11 (45.83%) and weight at 13 (54.17%) sites. Blood pressure instruments and adult scales were unavailable at 45.83% and 41.66% sites, respectively. Furthermore, none of the facilities were providing all the required services, though immunization was provided mostly. Centres were lacking availability of various essential instruments and equipment. Mendis *et al.* (2012) conducted a cross-sectional study to evaluate the capability of PHC facilities to implement basic interventions for prevention and management of major non-communicable diseases in eight low- and middle-income countries. Study findings revealed that all facilities had at least one functional blood pressure meter. Automatic devices were available in only 10% of all facilities. Facilities that used aneroid sphygmomanometers were using them without ever calibrating them. Weighing scales were available in just about 99% of the clinics and measuring tapes in 63%. Ambu- bags, oxygen masks, nebulizers, electrocardiographs, peak expiratory flow meters and pulse oximeters were available in 61%, 44%, 37%, 28%, 20%, and 2% of primary care facilities respectively.

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Furthermore, the qualitative study of Xaba *et al.* (2012) to explore and describe the perceptions of registered nurses about factors influencing service delivery in expanding programmes in a Tswane, South African PHC setting indicated that equipment, such as examination lights were inadequate. Furthermore, the maintenance of equipment was also below standard.

Salam, Alshekteria, Alhadi, Ahmed and Mohammed (2010) conducted a survey to examine PHC quality in Benghazi, Libya. Results indicated that most of the health centres and polyclinics were functioning with a large number of staff according to the patient load at each facility and all of these facilities were equipped modern diagnostic and treatment equipment, including X-ray and ultrasound machines, Electro Cardio Graphs, dental chairs, centrifugal pumps, dental sterilizers, blood analysis and laboratory equipment. However, there were biases

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as to availability of equipment and some were not on par with requirements or even availability to professionals leading to poor maintenance of equipment, as well as careless handling. Outdated equipment was also found, but at negligibly less number of facilities.

The above studies highlighted several shortfalls regarding organisational "*structures*" and referred to: unavailability of essential medication, equipment, laboratory inadequacies, inaccessibility to the full spectrum of allied health professionals and lack of maintenance of medical equipment. These shortfalls of organisational "structures" could impact negatively on the care "*processes*", e.g. unavailability of essential medicines could result in non-adherence or non-compliance; lack of essential equipment or lack of maintenance of equipment could result into serious adverse events or safety risks for a patient. The "*outcome*" of quality client-centred care could be challenged by insufficiencies in "*structures*" and "*processes*" at facility level.

Box 3.16: Health technology services

- Inadequate equipment
- Lack of training about the utilisation of equipment
- Poor maintenance of equipment

To summarise: quality client-centred care in Domain 3: Clinical Support Services were compromised by the following inadequacies namely: pharmaceutical services experienced unavailability of medication; diagnostic services were hampered by shortages of laboratory tests, inadequate number of microbiologists, lack of quality control protocols and long turn-around times of specimens; therapeutic support services were threatened by shortages of certain staff categories and health technology was challenged by inadequate equipment, lack of training on the utilisation of equipment and poor maintenance of equipment.

3.4.4 Domain 4: Public Health

The IOM defined public health as the application of scientific and technical knowledge to prevent disease and promote health in a community (Institute Of Medicine, 1988). The first strategic goal of the WCDoH (2014/15 to 2019/20) emphasises health promotion and wellness in order to increase life expectancy (Western Cape Department of Health, 2015). The SADoH envisions to diverge from the curative paradigm to focus more on wellness (Western Cape Department of Health, 2014).

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The leading causes of premature mortality (2013) for the West Coast District include: TB (11.2%); HIV/AIDS (10.8%); ischaemic heart disease (7.3%); interpersonal violence (6%); chronic obstructive pulmonary disease (5.8%); Diabetes mellitus (5.3%); cerebrovascular disease (5.2%); road injuries (5%); trachea/bronchi/lung cancer (4.1%) and lower respiratory infections (4%) (Morden, Groenewald, Zinyakatira, Neethhling, Msemburi, Daniels, Vismer, Coetzee, Bradshaw& Evans, 2016). Almost all of these diseases are preventable. Therefore, the importance of health promotion and disease prevention should be emphasised at clinic level and in the community.

3.4.4.1 Facility level health promotion and disease prevention

Health promotion and disease prevention at PHC clinics are influenced by: organisational factors, unmet support and inadequate information to patients, inadequate knowledge of patients and information not considered as useful and relevant.

a) Organisational challenges

Findings of an integrative review (1998-2011) indicated that nurses were considered as general health promoters, with their health promotion activities based on sound knowledge, and giving information to patients. However, nurses were confronted by several barriers within the organizations, i.e.: lack of resources, time, equipment and health education material (Kemppainen, Tossavainen & Turunen, 2012). Similarly, Brobeck, Odencrants, Bergh and Hildingh's (2013) qualitative study revealed that Swedish nurses also experienced that they did not have the time for health promotion as they must prioritise their time for the sick and for those in need of medical care.

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In line with the aforementioned studies, the findings of a cross-sectional study at 30 PHC facilities in Cape Town, SA interviewing patients (n=580) with non-communicable diseases, also showed that the lack of resources were a barrier for effective health promotion. Inadequate time, space and equipment; staff shortages, high staff turnover; high patient load and patient non-compliance were highlighted (Parker, Steyn, Levitt & Lombard, 2012). Furthermore, Kolisa's (2016) cross-sectional study to assess the oral health promotion services in Pretoria, SA identified also similar constraints, namely: shortage of dental education resources (43%), limited time (48%) and lack of staff training (52%).

In addition, Malan, Mash and Everett-Murphy's (2015) situational analysis of training for behavioural change counselling for primary care providers identified that trainers did not have

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faith in the effectiveness of the counselling, neither in the training methods. Furthermore, trainers experienced barriers such as: limited training time, counselling not integrated through the training course, emphasis of training on theory rather than on practice and the lack of formative, and summative assessments. Training was also restricted by the unavailability of education resources, inadequate care continuity and documentation, contradictory daily living messages and an uncooperative managerial culture.

b) Unmet support and information

Collected data from 768 patients from six PHC centres in central Ethiopa showed that the majority of patients (n=624; 81.3%) experienced the consultations shorter than expected. Almost fifty percent of the patients (47.1%) were not informed about their illness was. Moreover, 62.6% of the respondents confirmed that their disease had not been explained to them. Only 33.3% of the respondents received advice on prevention of the disease. Of those who had received advice, 98.1% reported that they would adhere to the guidance offered. More than fifty percent of the patients (56%) were not motivated to come back for follow-up visits. This lack of information may be a risk for quality client-centred care as information, communication and education are considered as important (Birhanu, Woldie, Assefa & Morankar, 2011).

Similarly, semi-structured qualitative interviews conducted in three United Kingdom locations – Luton, West London and Leicester exploring quality improvements in diabetes care reported that twenty one out of 47 (45%) participants experienced unmet support and information needs at diagnosis, i.e. diet detail, risk and complications explained; what monitoring to expect (Wilkinson, Randhawa & Singh, 2014). Moreover, the focus groups of Onwudiwe, Mullins, Winston, Shaya, Pradel, Laird and Saunders (2014) to explore patients' perceptions about barriers to self-management of diabetes revealed that a number of participants found some of the health information received on diabetes difficult to understand. Doctors are not helpful with information relating to diabetes. An absence of awareness of target blood glucose and blood pressure goal was recognised by the majority of participants. The key to successful diabetes management is heavily dependent upon the education, knowledge and diabetes self-management skills of each individual.

Likewise, a Cape Town, SA qualitative study, including 22 individual interviews with diabetic and hypertensive patients to determine their experiences of care and motivation. Inadequate information, counselling or support for autonomy were highlighted as a common theme. Only

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nine patients received a few words of advice from the healthcare staff on some aspects of self-care; ten of these patients were provided with a small pamphlet or diet sheet and only one patient was referred to a dietician. The researcher of this study identified an overall lack of education materials at the 3 clinics under study. Education materials were restricted to some placards containing messages about the symptoms of diabetes, foot care and diet. This study highlighted that unless healthcare staff did not determine their diabetes and hypertension patients' existing knowledge or beliefs about their illness, problematic misconceptions about the causes of their disease will prevail (Murphy *et al.*, 2015). Also, a qualitative study, conducting focus groups and in-depth interviews with patients attending Bishop Lavis PHC centre in Cape Town, SA showed these negatively influenced adherence to diabetes care, namely: poor knowledge, inadequate education and counselling – overloaded PHCservices resulted into inadequate time for individual education and counselling; dietary barriers – patients might not be aware of the importance to follow a diabetic diet (Booysen & Schlemmer, 2015).

c) Knowledge of patients

Various studies confirmed that patients have inadequate knowledge of their disease or illness. A quantitative, descriptive, correlative research design study was done at a community health centre in Cape Town, SA to assess the knowledge of patients with regard to HIV and ART. A sample of 200 respondents was selected from a population of 2 349. Results revealed various misconceptions regarding HIV and ART and 80% seemed to have poor knowledge. Inadequate knowledge may result in non-compliance of treatment, drug resistance, and the disease could develop to an advanced stage and increased expenditure with regard to the treatment of such patients. Patient education should receive more attention. Healthcare staff and HIV counsellors must take up the role of a supportive-educative medium for the patient, by educating the patients and equipping them to make informed decisions built on what they know and understand. Patients need to be knowledgeable, motivated and prepared to convey information and to create time for patient education using the available resources (Stellenberg & Terblanche, 2014).

Correspondingly, a survey to assess the knowledge and acceptability of TB infection control measures in a rural South African community, indicated that the majority of participants (75%) were knowledgeable about the cause of TB, but only 25% of participants were aware of the bacterial aetiology. An overwhelming majority of participants (98%) accepted the basic cough

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hygiene and (89%) of participants were willing to make use of face masks when they were in clinics, but only 42% of TB suspects and 66% of TB patients (p=0.016) agreed to wear face masks at home. Only 68% of participants acknowledged to be isolated in the clinics and refrained from sleeping with uninfected house members. At the end of treatment, TB patients revealed improved knowledge of TB and increased tolerabilty of certain household infection control methods (Gonzalez-Angulo, Geldenhuys, Van As, Buckerfield, Shea, Mahomed, Hanekom & Hatherill, 2013).

In line with the aforementioned studies, Khohomela and Maluleke's (2010) quantitative cross-sectional design study in the Thulamela Municipality in Limpopo Province to evaluate the knowledge of diabetes mellitus patients concerning eye complications associated with diabetes, also found that diabetes mellitus patients have poor knowledge about their disease and its effects on the eyes. Therefore, health professionals have a big responsibility to support patients to obtain essential knowledge and skills about the prevention of eye problems and self-care.

d) Relevance and usefulness of health information

Patients do not consider all health information as relevant and useful. A cross-sectional study was done with patients (N=580) to assess their preferences for health promotion methods. Study results revealed that individual counselling was the preferred health education method of choice for the majority of patients. Sixty four percent of patients indicated chronic clubs, however only a third indicated it as their first choice. The least preferred methods included pamphlets (9%), posters (12%) and group counselling sessions (11%) (Parker *et al.*, 2012). Similarly, Wright, Biya and Chokwe (2014) explored whether a pamphlet about healthy lifestyle choices and preventive healthcare in order to promote the health of the pregnant mother and child improved the knowledge of young female adults with regard to maintaining their health and preventing complications during pregnancy, and whether the literacy level of the young female had an effect on the effectiveness of the English pamphlet on pregnancy. The findings confirmed that prior knowledge was almost non-existent and that the pamphlet on pregnancy did not increase their knowledge.

In addition, Mirzaei, Aspin, Essue, Jeon, Dugdale, Usherwood and Leeder (2013) interviewed patients (N=52), carers (N=14) and health care staff (N=63) about the challenges encountered by people living with complicated diabetes, chronic heart failure or chronic obstructive pulmonary disease. Participants were selected from the Australian Capital Territory and

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Sydney West, New South Wales. They had difficulties in understanding the material and advice that they were given and this often resulted into non-compliance.

e) Support groups and or group education

The study findings of Adams and Carter's (2011) focus groups to explore the barriers reported by patients receiving diabetes and hypertension PHC in Barbados, recommended education for patients during sessions and while waiting in the clinic, and also by means of support and education groups, including the general public through the schools, mass media and bill boards.

Furthermore, Payne (2013) assessed a diabetes support group programme for Nywaigi women, facilitated by non-indigenous allied health clinicians which covered eight-weekly sessions. The intervention included: self-management strategies; a grief and loss component; health ownership and concepts of shared knowledge; and diet and exercise. Results revealed critical success factors, e.g. confidentiality, personal safety, trust and knowledgeable facilitators. Likewise, Johnston, Irving, Mill, Rowan and Liddy (2012) did an exploratory study to assess the value of a group self-management support programme. A change in physical activity patterns was the most noticeable behavioural change by over 50% of the participants. Other recurrent effects included an improved sense of social connection and better coping skills. Barriers to self-management were experienced by almost all participants with several dominant themes emerging, including problems with the health system and patient-doctor interaction. Participants reported a wide variety of resources used in their self-management, and in some cases, an increase in the use of some resources.

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In addition, Mo and Coulson (2012) performed an internet search to examine the mechanism through which online participation of support groups may encourage patient empowerment for individuals living with HIV/AIDS individuals. A total of 340 online support participants completed the online review. Results revealed that greater use of online support groups were linked to more frequent occurrence of the empowering processes as measured by receiving useful information, receiving social support, finding positive meaning and helping others. Results suggested that online support group involvement may offer some assistance for those HIV/AIDS individuals.

Moreover, Fort, Murillo, Lopez, Dengo, Alvarado-Molina, De Beausset, Castro, Liz-Pena, Ramirez-Zea and Martinez (2015) described the impact of lifestyle group education for hypertension and diabetes patients at three PHC centres in Mexico. Six group intervention

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sessions were provided and participants were monitored for 8 months. In Costa Rica intervention group participants showed significant improvements in systolic and diastolic blood pressure and marginal significant improvement for fasting glucose, and significant improvement in the stages-of-change measure compared to the comparison group. In Chiapas, the intervention group revealed significant improvement in the stages-of-change measure. However, no improvements were observed for knowledge, self-efficacy, dietary behaviour or physical activity. Only in Chiapas, a significant dose-response relationship was detected for blood pressure. In conclusion, group education interventions can improve stage-of-change initiation, and may also improve medical outcomes.

Likewise, Serfontein and Mash (2013) did a qualitative assessment on the value of diabetes group education sessions at a community health centre of Cape Town Metro District. Results showed that these group education sessions increased diabetes patients' knowledge about self-management.

The aforementioned studies highlighted various facility challenges regarding health promotion and disease prevention. Organisational "structures" included challenges, such as inadequate staffing levels, lack of time, space and equipment. Furthermore, according to previous study findings, patients and clients were of the opinion that they did not receive adequate information and counselling regarding their disease and treatment. Moreover, patients did not consider all information as useful and appropriate. However, support group and group education seem to be effective for increasing patients' knowledge about their disease and the management thereof.

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Box 3.17: Facility level health promotion and prevention

- Organisational challenges, e.g. inadequate staffing and a lack of time.
- Unmet support and inadequate information about disease and treatment
- Inadequate patient knowledge about their disease and illness
- Health information not always relevant and useful

3.4.4.2 Community health promotion and disease prevention

Stellenberg and Terblanche (2014) reiterated that leaders in the community should be equipped with the knowledge and skills required to support and motivate members of the community with regard to HIV and AIDS, drug resistant TB and should strengthen and expand the coverage of outreach, and health promotion programmes to every corner in the entire community.

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In addition, the participation of people living with drug resistant TB, HIV and AIDS in the campaigns provides community members the chance to interact and get first-hand information from lived experiences. The use of patients could intensify community awareness about drug resistant TB, HIV and AIDS. The health educators could involve community leaders and volunteers for the distribution of TB, HIV and AIDS information (Fana, Mayekiso & Gwanure, 2013).

Furthermore, the descriptive qualitative study of McCreary, Kaponda, Davis, Kalengamaliro and Norr (2013) highlighted the value of community leaders trained in HIV. Trained community leaders of Malawi networked with community members at church and community meetings about HIV prevention. The community recognised them as HIV change agents and reliable mentors (McCreary *et al.*, 2013).

It is evident from the above studies that health promotion and disease prevention should occur everywhere, at the clinic while waiting, at schools, churches, workplaces and community meetings. Community leaders and patients should be empowered with the knowledge and skills required to support and motivate members of the community members about HIV/AIDS and TB.

Box 3.18: Community health promotion and disease prevention

- Availability of health promotion and prevention activities everywhere in the community
- Community leaders and patients knowledge and skills

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3.4.4.3 Health promotion and community health workers

The qualitative study of Tsolekile, Puoane, Schneider, Levitt and Steyn (2014) explored the current roles of community health workers in Cape Town, SA and revealed that in spite of acting as support group facilitator and educator, health education also occurred at homes in the community. However, health education during home visits was in response to questions of clients, rather than in depth as done in support groups.

In addition, Sips, Mazanderani, Schneider, Greeff, Barten and Moshabela (2014) explored the referral trends and practices of community care workers in the rural Bushbuckridge in Mpumalanga, SA and found that referrals from clinics and hospitals to home-based care services occurred occasionally. There were more referrals from community care workers to health care facilities than from healthcare facilities. Community care workers are crucial for

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connecting clients to clinics and hospitals to encourage the appropriate use of medical services, although this effort requires depletion of their own personal resources.

In addition, Jack, Jenkins and Enslin (2010) from the Department of Family Medicine in the George Complex, regularly joined the home-base carers on their morning visits in Thembalethu community. They found that the work of carers was controlled by looking after patients with HIV and TB, and facing up to the issues of adherence. Their ability to engage in health promotion and case seeking was inadequate. These researchers suggested that given the difficulty of the community care worker's job and the challenges encountered by carers, they feel that training must be improved. Supporting the carers is crucial. Home-base care is the basis of the South African Government's policy in fighting HIV and TB. It intuitively seems like a positive development, but there is certainly a dearth of data as to whether it has an influence on outcomes, such as a default rate of TB medication.

Similarly, Schneider, Schaay, Dudley, Goliath and Qukula (2015) described the roles of community health workers as activities limited to home-based care activities and community-based follow up of chronic lifelong conditions. Children, reproductive health and young adults' activities were not included. Preventive and promotive roles were limited to periodic community drives.

Stakeholders in general were in favour of a reviewed definition of roles for community health workers in line with Healthcare 2030, and believed that CBS has potential for addressing disease burdens. Senior managers suggested a comprehensively trained community health worker with a stronger emphasis on prevention and promotion, more strongly rooted within the PHC system and in collaboration with other sectors (Maphula & Mudhovozi, 2012b).

According to the above studies community care workers have a vital role of linking clients to the clinics. However, currently their role seems to be overwhelmed by home- based care, e.g. by looking after those with chronic lifelong diseases, such as TB and HIV/AIDS, doing pill counts, instead of health prevention and promotion.

Box 3.19: Health promotion and community health workers

- Community care workers are overwhelmed by home-based care activities, e.g. looking after patients with chronic lifelong diseases instead of doing health promotion and prevention activities in the communities

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To summarise: quality client-centred care in Domain 4: Public Health was compromised on facility level by: organisational challenges such staff shortages, lack of time; inadequate information of disease treatment, inadequate knowledge of patients about their disease and patients who did not find health promotion information always relevant and useful. Furthermore, community health promotion was challenged by the inadequate number of health promotion activities in the community and community leaders, and patients who did not have adequate knowledge nor skills to enhance health promotion. While community healthcare workers were overwhelmed with community-based activities which hamperered their involvement in health-promotion activities.

3.4.5 Domain 5: Leadership and Corporate Governance

Good governance and value- driven leadership through integrated healthcare services and person-centred care is the second strategic goal of the WCDoH for 2015 to 2019 (Western Cape Department of Health, 2015). Good governance requires amongst other compliance to the Public Finance Management Act, 1 of 1999; National Health Act, 61 of 2003; National Health Amendment Act, 2013; Western Cape Health Facility Boards Amendment Act, 2012 (Act No. 7 of 2012) and the Western Cape Health Facilities and Committees Act, 2016 (Act No. 4 of 2016). Transparency, responsiveness and information sharing are imperative for good governance (Western Cape Department of Health, 2014).

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Western Cape leadership and governance occur at three levels: macro (provincial – policy development and macro coordination); meso (districts – co-ordination of integrated service delivery) and micro (institutions – implementation of person-centred care and population interventions; individuals – communities in the drainage areas). These three levels are supported by the following central support functions, namely: finance and supply chain management; people management; strategy and health support (information management and information technology; pharmacy management; professional support services); infrastructure and technology management (infrastructure planning, infrastructure delivery, health technology, engineering and maintenance); health programmes.

3.4.5.1 Vision and values towards 2030

The 2030 vision for the WCDoH is: Access to "person-centred", quality care (Western Cape Department of Health, 2014). The WCDoH embraces the CCAIRR values (Western Cape Department of Health 2014).

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Although there is a strong emphasis to live these mentioned values, employees are challenged by various organisational aspects. Mash, Govender, Isaacs, De Sa and Schlemmer (2013) provided feedback about the Barrett Value Survey, including (N=154) staff members from five community health divisions in Cape Town, SA. Survey results revealed that the current organisation was experienced as inflexible and limiting. Furthermore, the organisation was characterised by confusion, long hours, power, hierarchy and control. Relationships were demoralised by a culture of blame and manipulation. Desired organisational values suggest the need for a shift towards a different organisational culture that is characterised by improved communication, shared decision-making, accountability, staff acknowledgement, leadership and competence.

From the above it is evident that the WCDoH envisioned a "person-centred", quality care approach towards 2030. However, according to the Barrett Value survey, there should be a shift towards a different organisational culture, characterised by open communication, shared decision making, accountability, staff recognition, leadership development and professionalism.

Box 3.20: Vision and values towards 2030 challenges

- Rigid and restricting internal structures, e.g. management styles characterised by power, hierarchy and control, and a culture of blame and manipulation

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3.4.5.2 Role and function of the clinic committee

The WCDoH agrees to undertake a greater effort to communicate to communities, in a more user-friendly format (Western Cape Department of Health, 2014). The Ideal Clinic standards also require community engagement, therefore functional clinic committees have to be put in place (South African National DoH, 2017a).

Various studies indicated the lack of clarity regarding the role and functions of health committees. According to Loewenson, Machingura and Kaim (2014) and Haricharan (2014) health committees are currently more involved in the day-to-day operational tasks, instead of strengthening governance which could result into an improved health system. The oversight role of the health committees was described, as monitoring and ensuring that plans have been implemented in a manner responsive to the community; providing feedback to the community and discussing plans with communities and health workers on how to make improvements, in a cycle that again identifies new needs to feed into planning. These roles could have a positive impact on advancing the right to health, to improve the performance of PHC systems, the

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satisfaction and retention of health personnel at primary level and the satisfaction of communities with their services.

Moreover, Goodman, Opwora, Kabare and Molyneux (2011) explored managerial engagement of health facility committees in Kenya. Results showed a lack of trust between the health facility committee and health staff, and between the health facility committee and the community. Uncertainty about the roles of the health facility committee's were identified. The authors of this study recommended training for health committees, explanation of their roles, and better engagement with the wider community.

Likewise, a survey including managers (n=248), committee members (n=464) and healthcare users (n=698) of Kenya, emphasised the need for more focus on finance training, supervisory support, and community awareness and involvement (Waweru, Opwora, Toda, Fegan, Edwards, Goodman, Molyneux, 2013).

In addition, Xaba *et al.* (2012) explored and described the perceptions of registered nurses regarding factors influencing service delivery in expanding programmes in a PHC setting of two Tswane, South African subdistricts. One of the emerging themes of this study highlighted the important role of clinic committee members to educate the community on health service operational issues and create awareness of available services.

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Moreover, Ranthiti's (2014) qualitative study, using three focus group discussions with community members in Free State, SA on the perceptions of community members regarding community participation, revealed that community participation can improve quality of care through sharing of information and concerns, community members can greatly contribute to the early detection of lost/or new cases. This will not only be essential for reducing morbidity and mortality, but will contribute to reducing the workload of the primary healthcare services as the informed community will apply preventative measures leading to healthier outcomes.

Various studies indicated the lack of clarity regarding the role and functions of health committees. According to abovementioned studies, current health committees are more involved in the daily operations, rather than the strengthening of governance and quality improvement aspects.

Box 3.21: Role and functions of the clinic committee

- Lack of clarity regarding the role and functions

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3.4.5.3 Community communication, education and outreach

The systematic review of Nunan and Duke (2011) assessed the effectiveness of pharmaceutical system interventions at PHC clinics in Cameroon, Uganda and Nigeria. Communities were involved in meetings with health services to decide about dates of interventions; product and the appointment of community “implementers”, who were responsible for supervision of the community’s participation, monitoring and feedback to health services. The results showed that availability of drugs was higher and patient coverage went beyond control sites.

On the contrary, Owusu (2014) followed an exploratory, qualitative approach to establish whether community participation in malaria control is evident in Ghana. Study findings confirmed that community participation and dialogues were non-existent. Communities had inadequate chances to air their opinions in the planning processes. The study’s findings, therefore view their opinions in the planning processes. The study findings therefore raise concerns over the effectiveness of the policy strategy of the national control programme to improve community participation.

In addition, Aibinuomo (2011) conducted a needs assessment in the following Nigerian states, namely: Delta, Ogun, Ondo, Osun, and Oyo. Findings showed that 70% of Nigeria’s wards had at least one PHC centre, but did not have a doctor in any local government area and midwives were in top of that in short supply. Only 2.5% of the surveyed facilities had more than 75% essential equipment; medication availability was especially poor; and nearby half of health facilities had not received any medication supplies in the last 2 years. Furthermore, antenatal delivery, children and postnatal experiences usually take place in communities, rather than in health facilities. Plans for improvement should include the community to any facility-based intervention. PHC is the foundation to achieving the SDGs and healthcare workers have to diverge from the normal practice and include community mobilizers for effective behavioural change.

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Moreover, Kotze, Seedat, Suffla and Kramer (2013) conducted focus group discussions to have an improved understanding of the community conversation progress and its community engagement value. Results showed that community dialogues increased community members’ awareness of community resources and allowed them to voice their shared concerns and discuss matters that they deem to be important in their community. The conversations were considered to have created a participative environment in which community members and external stakeholders could debate potential solutions to identified problems, thereby laying a basis for

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future action. Additionally, the conversations were interpreted as promotive of relationship-building and partnership opportunities among community members and external stakeholders.

In line with the abovementioned study, is the qualitative study of Kunihira, Nuwaha, Mayanja and Peterson (2010) on the barriers influencing the adherence to antiretroviral drugs in Rakai district of Uganda. Results also emphasized the importance of community education. Absence of sensitization was reported by 258 (67%) of people living with HIV, by 30 out of 38 (87%) of the key informants. These authors suggested that community education regarding ART should be prioritised. More community leaders should take part in community education. Furthermore, Namatovu, Ndoboli, Kulle and Besigye (2014) applied focus group discussions to determine the availability of community participation in health services and to ascertain support mechanisms in the Wakiso and Gulu districts. Study results confirmed community mobilisation and health centre attempts to encourage community participation. However, community involvement was restricted by a lack of belief and poor communication with healthcare providers.

The Andhra Pradesh Eye Disease Study provided a comprehensive evaluation for the prevalence and causes of blindness. It also highlighted that uptake of services was a concern, primarily among lower-socioeconomic groups, women and rural populations. Awareness is important for the uptake of healthcare services, particularly in the context of eye care services, as they rank low. As a result, community outreach drives are required to generate awareness of both eye conditions and the obtainability of a service provider to treat them (Rao, Khanna, Athota, Rajshekar & Rani, 2012).

On the contrary, Visagie and Schneider (2014) explored the degree to which PHC principles are being applied in the rural, Northern Cape Province, SA. Study results revealed that the community was not included in service management and individual clients were not adequately involved in their healthcare. The researcher recommends the introduction of a community-health forum through which community members can voice their pleasure, frustration and hopes for health care.

The aforementioned studies emphasised the importance of community involvement, engagement, participation and conversation.

Box 3.22: Community communication, education and outreach

- Inadequate opportunities for community involvement, engagement, participation and conversation

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To summarise: quality client-centred care in Domain 5: Leadership and Corporate Governance were hampered by: rigid and restricting internal structures e.g. management styles, the lack of clarity about the roles and functions of clinic committee members and inadequate opportunity for community involvement, engagement and participation.

3.4.6 Domain 6: Operational Management

Operational management refers to the everyday responsibilities and activities of the PHC clinic to support and ensure safe patient care. Operational management requires daily access to computer technology, conducive staffing levels, staff satisfaction, training opportunities, and access to an employee assistance programme, availability of supervisory support and staff attendance of morbidity and mortality meetings.

3.4.6.1 Access to computer technology

The Ideal Clinic standards require that all PHC facilities should have access to a functional computer system (National DoH, 2017b). However, study findings showed that not all employees of PHC clinics abroad or in SA have always access to computerised technology.

A cross-sectional survey to evaluate the capacity of PHC facilities in eight low- and middle-income countries revealed major deficits in health financing, access to basic technologies and medications, information systems, and the healthcare staff. According to the results, there were no computers available for record-keeping in any of the PHC facilities. In 85% of facilities, paper- based records were saved. In 58% of facilities the information was captured into an everyday attendance register. In the other 42% different reports were prepared for individual patients, and in half of them records were recovered and used for follow-up visits (Mendis *et al.*, 2012).

Correspondingly, in SA, Cape Town, Bimerew, Korpela, and Adejumo (2014) explored facility managers' (n=14) perspectives of mental health information processing and application at PHC level. Content analysis identified fragmented information processing systems which was inadequate to utilise for decision-making, and it was not known how to use mental health information. Unavailability of computers for information processing was highlighted as a challenge. "There is no computer here for everybody... unfortunately because of financial constraints we can't give everybody a computer and e-mail address, even the doctors don't have access to a computer" (Bimerew *et al.*, 2014:459).

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On the contrary, Ridgway, Mitchell and Sheean (2011) sought to describe Victorian Maternal and Child Health Nurses' use of information communication technology to establish baseline information on the current level of information communication technology resources available to them. Data by means of a questionnaire was collected from 1 007 staff members of the mother-child health service programme. Results showed that nearly all respondents (98.8%) had access to a desktop or laptop computer however nearly half (48.2%) of these computers lacked a compact disc or digital versatile disc. Over half the respondents had both printer and fax access (57.4%) however a small proportion only (8.6%) had neither. Electronic diaries were used by a large number of nurses (79%), although fewer than (41%) in rural areas. A small number (7%) used both paper and electronic diaries. The majority had either onsite or remote information communication technology assistance; however, it is remarable that 12.2% specified that they received no support. Over 85% of nurses have high self-confidence using computer hardware, email, Internet and electronic health records. Despite the majority (84.4%) had received training in the use of computers or electronic resources, including the Internet, there were those who had not (15.6%) or had received it informally, suggesting the equipment might have been used without adequate training.

According to aforesaid, not all PHC clinics abroad or in SA have always access to computerised technology.

Box 3.23: Access to computer technology

- Not all clinics have adequate access to computer technology

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3.4.6.2 Conducive staffing levels

Numerous research studies emphasised inadequate staffing levels, stating the unequal distribution of staff between rural and poorer districts, staff challenges in the HIV programme and the consequences of insufficient staffing on the quality of care.

a) Inadequate staffing levels in rural and poor districts

Willcox, Peersman, Daou, Diakite, Bajunirwe, Mubangizi, Mahmoud, Moosa, Phaladze, Nkomazana, Khogali, Diallo de Maeseneer and Mant (2015) conducted a review of published and unpublished "grey" literature on human resources which showed that staff numbers have increased gradually since 2000 in SA and Botswana, but had not extensively increased progressively since 2004 in Sudan, Mali and Uganda which reveal serious shortages. In all five countries a minority of doctors, nurses and midwives are working in PHC and a shortages of

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qualified staff seem to be the highest in rural areas. SA perceives a shortage of doctors in PHC in the lower resource districts. Likewise, Van Rensburg (2014) emphasizes that although SA has strongly developed health professions, large numbers of professional and mid-level workers, and also well-established training institutions, it is experiencing serious workforce deficiencies, resulting from imbalanced distribution of health workers, between the well-resourced private sector over the poorly-resourced public sector, as well as from distributional inequalities between urban and rural areas.

In addition, Gaede and Versteeg (2011) explored the achievements and restraints in terms of the right to access health care in rural areas in SA. They also highlighted the shortage of health professionals as a significant barrier to the right to health care in rural SA. North West and Limpopo provinces have the lowest access to health professionals of different categories, while Gauteng and Western Cape residents are in a better position.

Correspondingly, Uwinmana, Jackson, Hausler and Zarowsky (2012) conducted in-depth interviews to assess the barriers related to the implementation of collaborative TB/HIV activities in KwaZulu-Natal. The study results highlighted that the majority of facilities are understaffed and cannot cope with the high patient load and need healthcare staff with special skills and training, while staff retaining is difficult in rural areas.

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On the contrary, structured discussions with facility administrators, key staff and systematic observations comprising PHC centres and polyclinics in Benghazi, Libya showed that the majority of facilities were functioning with a great number of staff in both medical (medical and paramedical) and non-medical fields, which was equivalent to the patient load at each facility. In health centre No. 1 - 50 staff attend to 70 patients a day. A polyclinic, Facility No. 14 -180 staff attend to 150 patients in a day. While Facility No. 7, a health centre functioning with 52 staff have to service 250 patients a day (Salam *et al.*, 2010).

b) Staff inadequacies in the HIV programme

Sibanda, Hatzold, Mugurungi, Ncube, Dupwa, Siraha, Madyira, Mangwiro, Bhattacharya and Cowan (2012) assessed sixteen PHC institutions in Zimbabwe regarding provider initiated HIV testing and counselling programme. Study results showed that shortages of staff trained in provider initiated testing and counselling, HIV rapid testing and counselling prevented optimum implementation. Likewise, Stellenberg and Crowley (2015) evaluated the adequacy of pharmaceutical services for ART in PHC clinics of KwaZulu-Natal. Analysis showed that

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professional nurses were responsible for the administration of drug supply, prescribing and dispensing medication as pharmacists or pharmacist's assistants were unavailable. The study results of Uebel, Guise, Georgeu, Colvin and Lewin's (2013) also indicated that the integration of HIV care is negatively influenced by the unavailability of support staff. In PHC clinics with no pharmacist assistants, nurses often stored all the packets in one consultation room and issued drugs to all patients on ART.

c) Consequences of inadequate staffing levels

Several studies pointed out that inadequate staffing levels resulted into high work pressure for staff and compromised the quality of care. A descriptive cross-sectional, qualitative study was conducted by Chindedza *et al.* (2013), to investigate the perceived barriers in a convenience sample of 28 HIV patients accessing services and 3 nurses employed in the ART clinic at a rural mission hospital in Zimbabwe. This study highlighted that only a limited number of nurses have knowledge of managing patients on ART and as such a small number of nurses have to carry the burden of caring for patients on ART. One nurse indicated that inadequate staffing compromised quality of care, as the focus would rather be on dispensing of medications than on attending to the holistic needs of patients and also working under pressure was likely to predispose nurses to breakdown.

Furthermore, Kunihira *et al.* (2010) interviewed 38 key informants and 384 HIV patients in the Rakai district of Uganda about the barriers of using antiretroviral drugs. Findings revealed that health care system barriers included overcrowding in HIV/AIDS health units, while staff numbers who can manage ART were inadequate. As a result staff members were overworked and patients have to wait long before being helped. Similarly, a cross-sectional survey was conducted to assess Uganda's health system's ability (n=125) to provide parasite-based malaria diagnosis which also revealed also a deficiency of qualified health staff. Only 1 out of 5 (20%) of the critical positions were filled.

In addition, the quality of leadership was influenced due by the inadequate staffing levels. Only 15% of the health facilities had suitably trained leaders. Due to a shortage of trained health workers, nurses and nursing aides have to deliver a broad range of services under minimal supervision (Kyabayinze *et al.,* 2012).

In SA Kagee *et al.* (2012) conducted a qualitative study, including interviews with a sample of 10 ART patients in SA. Study results indicated that inadequate funds were available for the

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recruitment of adequate staff. A large number of patients and insufficient staffing lead to too long waiting times, which was regarded as a disincentive for clinic attendance and could result in potential non-adherence. High patient volume could be a reason for staff burnout.

Likewise, the descriptive, cross-sectional study of Stellenberg (2015) to explore and describe accessibility, affordability of health care in six suburban areas of the Northern and Eastern regions of the Cape Metropolitan area in the Western Cape, SA also revealed that (17.3% of 353) participants indicated that the clinics were overcrowded, because there is a staff shortage.

Weimann and Stuttaford (2014) did a Mxit mobile phone-based survey to motivate remarks on the proposed NHI and to raise awareness among South Africans about their rights to free and quality health care. Data were collected by means of public e-consultation, and by following a qualitative approach. The significance of waiting times for the healthcare consumers was emphasised by the following two quotes: "in public sector patients wait over 12 hours", and "I never spend less than 4 hours in a clinic". Diverse explanations were given for long waiting times: "long waiting time due to break time for staff", and "the waiting time is too long because the shortage of staff", and "long waiting time because everything is free" (Weiman & Stuttaford, 2014:1). Furthermore, Reid *et al.* (2011) conducted a qualitative study to elicit perspectives on key principles of generalist medical practice in public service in sub-Saharan Africa. An overall lack of resources to cope with the burden of illness in Africa occurred as a small number of who do fill the post. Frustration and exhaustion contribute to the fast turnover of staff.

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In addition, Munyewende *et al.*, (2014) conducted a cross-sectional study, surveyed 111 PHC nursing managers in two South African provinces to determine overall job satisfaction. The findings identified that job satisfaction was negatively influenced by work stress, aggravated by shortages of health professionals and support staff. Especially, the clinic manager experienced tremendous work stress as she has to fulfill various roles, e.g. for when the cleaner is absent she must clean the clinic, when the pharmacy assistant is not available she must dispense medication.

Staff shortages, trained staff in the HIV programme and pharmacists were revealed by various studies. Consequences of inadequate staffing seem to be high work pressure and burnout for staff and long waiting times for patients. Long waiting time was highlighted as a disincentive

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for clinic attendance and could result into defaulting, therefore compromising quality client-centred care.

Box 3.24: Conduciveness of staffing levels

- Inadequate staffing levels in rural and poor districts
- Shortages of staff trained in the HIV programme
- High work pressure compromise quality client-centred care

3.4.6.3 Personal accomplishment in the work situation

The Ideal Clinic Manual (South African National Department of Health, 2017a) states that staff should work in a conducive working environment. A staff satisfaction survey should be conducted every year and outcomes should be used for improving the work environment. However, various studies reported on low job satisfaction and unfavourable working conditions which negatively influenced staff's work life and patient care. Community appreciation and Lean Management showed to have a positive influence on staff satisfaction.

a) Unfavourable working conditions

A total of 508 PHC nurses in the Jazan Region, Saudi-Arabia completed the Brooks' survey of Nursing Work Life, the Anticipated Turnover Scale and demographic data. Findings of this survey suggested that respondents were dissatisfied with their work life, with almost 40% indicating a turnover intention from their current PHC centres. The researchers highlighted the importance to create and maintain a healthy work life for PHC nurses to improve their work satisfaction, reduce turnover, enhance productivity and improve nursing care outcomes (Almalki, FitzGerald & Clark, 2012).

In addition, Alhassan, Spieker, Van Ostenberg, Ogink, Nketiah-Amponsah and De Wit (2013) did a survey of health workers (n=324) in 64 PHC facilities in two regions in Ghana. Results revealed that the quality care situation in health facilities was in general low. As in the previous study, staff motivation seemed to be overall low. However, staff members in the private sector experience better working conditions compared to staff members in the public sector ($p<0.05$). Positive associations were identified between staff satisfaction levels with working conditions and the facility's attempt towards quality improvement and patient safety ($p<0.05$). Comprehensive actions to improve staff motivations should be implemented at public health facilities where working conditions are regarded as poor.

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Kumar, Khan, Inder and Mehra (2014) highlight that job satisfaction contributes enormously to performance in the working milieu. The findings of their comparative study showed that job satisfaction among both permanent and contract PHC staff members (n=333) in Delhi, India seemed to be relatively low. According to these authors, privileges, interpersonal relations, working-environment, patient relationship, the organization's facilities, career development, and the scarcity of human resources have an influence on the satisfaction level.

Furthermore, a South African cross-sectional study to determine the overall job satisfaction of PHC nursing managers and the predictors of their job satisfaction reported that nursing managers were influenced by challenging working conditions, such as: the lack of clinic maintenance; the poor infrastructure; and the unavailability of basic equipment. Respondents emphasised the need for a conducive working environment (Munyewende *et al.*, 2014).

On the other hand, the study findings of Mutemwa *et al*. (2013) revealed that integration of HIV and reproductive health services in Kenya lead to improved job satisfaction for staff as they received more regular positive feedback from clients. Furthermore staff were of opinion that integration improved service delivery to clients, as it promoted holistic care, where every detail of the patient was captured and all problems were attended to.

In addition, Jayasuriya, Whittaker, Halim and Matineau (2012) examined job satisfaction among 344 rural PHC nurses of Papua New Guinea. The study results showed that nurses working for church facilities experienced more job satisfaction, compared to those working for government facilities ($p<0.01$). Ownership of facility, work climate, supervisory support and a community support predicted 35% of the variation in job satisfaction. Work climate (17%) and supervisory support (10%) seemed to have the biggest impact on job satisfaction. These findings highlight that the provision of a conducive environment requires attention to human relations aspects. This is very important as this critical cadre provides the frontline of PHC for more than 70% of the population of the country. Prytherch, Kagone, Aninanya, Williams, Kakoko, Leshabari, Ye, Marx and Sauerborn (2013) did in-depth interviews with 25 maternal and neonatal healthcare providers of rural Burkina Faso, Ghana and Tanzania to explore their vision about motivation and incentives at PHC level. Results showed that health workers were motivated. However, the motivation to remain at a rural facility was far less. Job satisfaction was good, and was particularly associated with community recognition. The implementation of financial and non-financial encouragements were motivated to enhance job satisfaction.

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Moreover, Naidoo and Fields (2015) determined the results of Lean on staff morale in a rural district hospital in KwaZulu-Natal. The sample consisted of all service nodes and employees of a rural district hospital outpatients department. A pre- and post-intervention assessment of staff morale was conducted. Results highlighted that the implementation of Lean had a positive impact on the number of staff satisfied with their jobs (increased from 21.1% to 77.8%; $p<0.0001$) and those that felt inspired (increased from 15.8% to 77.8%; $p<0.0001$). The proportion of staff who felt that things were getting better in their department, improved from 21.1% to 83.3% ($p<0.0001$). Pre- and post-intervention scores for communication strength ($p=0.0003$) and staff attitude toward teamwork ($p=0.002$) significantly improved. The application of Lean has a positive effect for staff morale improvement across similar hospitals.

Various studies indicated that staff motivation and job satisfaction seemed to be low. Working conditions were not always conducive and were characterised by lack of clinic maintenance, poor infrastructure, and unavailability of basic equipment. Integrated HIV and reproductive health services seem to result into improved job satisfaction. Higher satisfaction was also reported by nurses employed by church facilities where working conditions seemed to be conducive, supervisory support and community support were available. There seems to be a significant positive association between staff satisfaction and effort towards quality improvement. Therefore, staff with low job satisfaction could have a negative effect on quality client-centred care.

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Box 3.25: Personal accomplishment of the work situation

- Unfavourable working conditions

3.4.6.4 Attendance of mortality and morbidity meetings

The attendance of mortality and morbidity meetings is very important as it allows for: professional learning, identification of errors, failures or missed opportunities regarding quality client-centred care. Furthermore, mortality and morbidity meetings could be regarded as an opportunity for the development of quality improvement initiatives.

Higginson, Walters and Fulop (2012) stated that mortality and morbidity meetings showed a considerable variation in the way deaths were reviewed. Clinicians supported its inclusion into mortality and morbidity meetings and managers saw that a standardised trust-wide process offered greater levels of assurance. (Higginson *et al.*, 2012).

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Moreover, Clarke, Furlong, Laing, Aldous and Thompson (2013) of the Edenvale Hospital in Pietermaritzburg, SA developed a structured template to analyse mortality and morbidity, in order to classify deaths as expected/unexpected; unpreventable/ preventable. Cases were then investigated by using a combination of error classifications. During the period June-December 2011, a total of 20 morbidity and mortality meetings were held at which 30 patients were discussed at mortality meetings. A total of 43 errors were identified. These errors comprised: 33 assessment failures, 5 logistical failures, 5 resuscitation failures, 16 errors of execution and 27 errors of planning. Seven patients experienced a number of errors, of whom 5 died. Error theory identified the contribution of error to adverse events in this institution. Converting this insight into effective strategies to decrease the incidence of error remains a challenge. Utilising the examples of error identified at the mortality meetings as educational cases may help with initiatives that directly target human error.

Correspondingly, Von Pressentin (2015) highlighted mortality and morbidity meetings as opportunities for an exchange of ideas between participants of the multi-disciplinary team. The clinical cases and facility statistics provide opportunity for the acknowledgement of health system problems which could be the foundation of quality improvement initiatives. Mortality and morbidity meetings should be an open discussion, in which learning experiences can be shared in a safe and blame-free atmosphere.

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Studies confirmed that mortality and morbidity meetings allow for identification of errors, failures and missed opportunities and serve as opportunity for quality improvement initiatives.

Box 3.26: Attendance of mortality and morbidity meetings

- Mortality and morbidity meetings are an opportunity for quality improvement initiatives

3.4.6.5 Training priorities

Various studies indicated the benefits of training, prioritizing integration of HIV, mental health and eye care, to enhance a care continuum of comprehensive quality care, instead of functioning in separate silos. In addition, pharmaceutical management training for PHC staff is regarded as beneficial to enhance the quality of care in resource poor areas.

a) Integrated HIV care

Integration of health services in Kenya (Mutemwa *et al.,* 2013) showed to improve the skills of healthcare staff through training and clinical experience. Providing more than one service not only expanded their skills but also improved their awareness about other health problems.

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Also in Kenya, Odeny, Penner, Lewis-Kulzer, Leslie, Shade, Adero, Kioko, Cohen and Bukusi (2013) conducted an evaluation at three health facilities in the Suba District to assess the effect of HIV integration on patient satisfaction and stigma. Before integration, only staff working in the HIV clinic receive training. After integration, all staff received training for HIV-related and non-HIV-related topics. This study is a step in the direction of developing a care model that integrated HIV care in resource-limited settings. Given the potential positive aspects, it is of value to explore integration as one inventive way of improving PHC services.

b) Integrated mental health care

Winer, Morris-Patterson, Smart, Bijan and Katz (2013) assessed the knowledge and attitudes of primary care providers in an Eastern Caribbean country towards mental illness. Results showed that primary care providers have basic, but insufficient knowledge of mental illness diagnosis and treatment. Providers were interested and felt that mental health should be prioritised and were enthusiastic to have further training. Strengthening of clinic resources, staff training, yearly mental health screening, and weekly mental health clinics were suggested.

In order to reduce the huge treatment gap in mental health, the WHO has called for the integration of mental health into PHC. The purposes of this study were to provide a training course to improve the community health staff's knowledge of mental health and reduce stigma related to mental illness, as well as to evaluate the impact of this training on knowledge and stigma. The training intervention was a one-day course for community mental health staff in Guangzhou. Stigma was assessed by the Mental Illness Clinician's Attitude Scale and the Reported and Intended Behaviour Scale. A total of 99 community mental health staff from eight regions were selected for the study. The training course did not lead to a significant improvement of participants' level of mental health knowledge. However, the results showed that the training course is an effective way to enhance community mental health staff's attitude towards people with mental illness in the short term, as well as to lessen the social distance between staff and people with mental illness (Li, Li, Huang & Thornicroft, 2014).

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c) Integrated eye care

Mafwiri, Kisenge and Gilbert (2014) emphasise that a lot of blinding eye conditions in developing countries are avoidable or curable. However, primary eye care for children is poorly developed, resulting in unnecessary visual loss. Fifteen Clinical Officers and 15 nurses received training in Dar-Es-Salaam, Tanzania. Before training staff had inadequated knowledge about the management of eye diseases. After training the implementation of

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prophylaxis treatment improved from 83.7% to 100%, and all staff included eye conditions in health educating sessions. After one year, trained staff could still accurately describe, diagnose and treat conjunctivitis. The study results emphasized that primary eye care for children in Dar-Es-Salaam was insufficient, but training of staff improved knowledge in the short term and changed practices. Continuous supportive supervision was recommended to keep up the knowledge and practices.

Moreover, Mafwiri, Jolley, Hunter, Gilbert and Schmidt (2016) evaluated the effectiveness of a four-day training programme of PHC workers in primary eye care conducted in Morogoro, Tanzania. A mixed-methods study was conducted using pre- and immediate post-training knowledge assessment of 60 trainees and in-depth interviews with 20 PHC staff, and 8 service managers 2 to 3 years after the training. Pre- and immediate post-training assessments indicated enhancement in health workers' knowledge about eye care in the short term. Qualitative investigations 2 to 3 years after the training showed that although staff could make the correct management decisions when presented with eye-health problems, they often could not make an accurate diagnosis. Theoretic teaching was appreciated by most participants, however almost all recommended that time spent on acquiring skills must be increased. Acquired skills and knowledge were used for identification, referral of patients and for eye-health promotion.

Likewise, in SA uncorrected refractive error and low vision, have not received the needed attention. The Giving Sight to KwaZulu-Natal project trained 1004 PHC nurses over a four year period (2007 to 2011). Results highlighted that the total number of clinics offering primary eye care increased from 96 (10%) to 748 (76%). Consequently a decrease of 51.08% was also seen in the number of patients seeking services at higher levels of care, thus reforming eye-health service delivery (Naidoo, Naidoo, Maharaj, Ramson, Wallace & Dabideen, 2013).

d) Pharmaceutical management skills

Nunan and Duke (2011) conducted a systematic review to evaluate the effectiveness of pharmacological system interventions to improve the availability of essential medicines at PHC level. Two of the seventeen studies were relevant to staff training and continuing education. In Nepal, PHC workers received training on stock management, basic computer skills and the principles of a new supply system. Over three years, stock-outs of child health medicines fell from 23% to 9% and on family planning commodities from 85 to 4%. The Dekhi Programme in India, integrated training of healthcare staff in a new Essential Medicines policy, from 1994

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onwards. Results confirmed that drug availability improved from <50% to an average availability of >80%.

According to the abovementioned studies, HIV integration, mental health integration and the integration of eye care in PHC could contribute to quality client-centred care. Staff were equipped with broadened skills and patients were holistically managed. Furthermore, pharmaceutical management skills training also seemed to result into improvement of drug availability.

Box 3.27: Training priorities

- Integrated HIV care
- Integrated mental health care
- Integrated eye care
- Pharmaceutical management skills training

3.4.6.6 Staff access to employment assistance programmes

The WCDoH, utilises an integrated approach to acknowledge the significance of employees' individual health, wellness, safety and social factors and its influence on organisational wellness and production. According to the Independent Counselling and Advisory Services Report of 2014/15 supervisors and managers referred a total of 208 employees officially to the Employee Health and Wellness Programme for support of which 17.54% employees were referred for absenteeism and 9.84% for stress. During 2015/15, 6.2% of WCDoH staff members experienced problems that had a very great influence on their work performance.

The researcher accessed a few studies covering employee wellness aspects. Studies revealed different reasons for implementing wellness programmes for employees (Western Cape Department of Health, 2016a).

Results from the case study of Van der Veen, Van Pietersom, Cardozo, Rushiti, Ymerhalili and Agani (2015) showed that in Kosovo the level of stress level amongst PHC professionals were high, because health professionals who are part of the population are extremely affected by war conflict. The need to support staff and look after their well-being were acknowledged by the Director of the Centre for Development of Family Medicine, resulting in the implementation of an integrated psycho-social capability building programme for PHC professionals. Awareness was raised on staff well-being and stress management, as well as strengthening their knowledge of and skills in anxiety management. Findings revealed that offering structured

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support, entailing the opportunity to discuss work-related problems and providing mechanisms to deal with stress related to work or personal life help staff to carry on with their professional tasks under perplexing conditions.

The qualitative study of Mutemwa *et al.* (2013) explored the experiences of frontline health about integrated HIV and reproductive health services in Kenya. The authors highlighted the unavailability of psychosocial support for staff to support them to be able to deal with occupational stressors. Staff have to deal with HIV/AIDS, severe poverty, and domestic violence. At some health facilities supervisors organized sporadic calm down staff meetings for staff; most services did not have any method of psychosocial support.

In addition, Sieberhagen, Pienaar and Els (2011) used a cross-sectional design, consisting of quantitative and qualitative questions to describe employee wellness in SA by investigating the types, foci and perceived successes of employee wellness programmes. The study results showed that service providers and labour unions define employee wellness in a different way and that these role players give different reasons for introducing employee wellness programmes, e.g.: Organisations introduce wellness programmes for high occurrence of sick leave, high rates of non-attendance, social responsibility, anxiety, needs for services because of human relations incidents and high number of people who work overtime. Whereas, service providers introduced wellness programmes to become employers of choice and compliance with Occupational and Health Safety Law. Labour unions introduced wellness programmes to make their employees more productive, more socially responsible, and more compliant with Occupational Health Safety Law and also retain employees. However, almost fifty percent of the participating organisations have no point of departure with which to relate the effectiveness of their wellness programmes. Generally all the organisations present the results of their programmes reasonably (10 of the organisations rated their programme as 70% successful, or higher, three rated their programme as 60% successful and two of the organisations gave their rating of only 50%. One organisation indicated that it could not rate its programme yet. However, the programmes involve little overall expenditure to the organisations. Activities on which organisations spend their budgets, included: HIV and health services, EAP providers, wellness services and counselling.

From the above it becomes clear that employee assistance programmes were not everywhere available. However, according to the WCDoH it has benefits, such as reducing medical

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expenses, less absenteeism and results into higher staff productivity and morale (Western Cape Department of Health, 2018).

Box 3.28: Staff access to employment assistance programmes

• Unavailability of employee assistance programmes everywhere

3.4.6.7 Availability of supervisory support

The United Nations Children's Fund (2013) defined supportive supervision as a collaborative effort of guiding, helping, training and encouraging staff members to improve performance continuously in order to provide high quality health services. Supportive supervision implies concentrating on performance monitoring towards targets, using statistical data for decision making and depends on consistent follow-up with staff members to ensure that new tasks are being implemented appropriately. Supportive supervision promotes sustainable and efficient programme management through interactive communication, as well as performance planning and monitoring. Several studies highlighted several inadequacies regarding supervisory support.

a) Inadequate supervisory support

Kyabayinze *et al.* (2012) assessed Uganda's health system ability to absorb parasite-based malaria diagnosis at PHC clinics. Study results revealed that less than fifty percent (n=55/42%) of the healthcare staff were supervised on the administration of malaria in the previous six months. Supervision was irregular with no clear line of accountability given to the direct supervisors. Moreover, Jenkins, Othieno, Okeyo, Aruwa, Kingora and Jenkins (2013) explored 20 Kenian PHC workers' perceptions mental health integration into PHC. The study results identified the absence of supervision as a weakness – supervisors did not offer much support as they were more interested in meeting strategic goals for other programmes, such as malaria, HIV and immunization.

On the other hand, the explorative study of Scott, Mathews and Gilson (2011) about the implementation of an equity-driven staff restructuring strategy showed that the nursing staff considered this approach as a risk for quality care: "We want to render quality, but the managers don't want that" (Scott *et al.*, 2011:143). Nurses perceived the managers to be predominantly interested in headcount-based workload calculations, which could be a concern for quality of care. Some nurses experienced district managers as being reserved and having a different agenda to the nursing staff on the ground. Supervision is regarded as important for performance

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and motivation, but is often experienced as episodic inspection and control, rather than support and feedback to increase performance. Semi-structured interviews were conducted on the perceptions of district health management teams in Tanzania and Malawi on their role as supervisors and on the challenges to effective supervision. In both countries facility level performance measurements governed. Furthermore, the unavailability of standards to evaluate individual health worker performance was considered as a challenge.

Shortage of staff, at both district and facility level was described as a major barrier for carrying out regular supervisory visits. Other challenges included conflicting and multiple responsibilities of district health team staff and financial constraints. Supervision needed to be sufficiently resourced and assisted in order to ensure improved performance and retention at the district level (Bradley, Kamwendo, Masanja, De Pinho, Waxman, Boostrom & McAuliffe, 2013).

Clinic managers (N=111) of two provinces in SA reported that job satisfaction was negatively influenced by being excluded from the decision making proccess, particularly those linked to financial management. Furthermore, managers were of opinion that they did not have the power to manage their clinics (Munyewende *et al.*, 2014). Ramathuba and Davhna-Maselesele (2013) did a qualitative study to explore the current staffing resource capacity in nursing and described the challenges HIV/AIDS poses on the nursing workforce in rural health settings in Vhembe District, Limpopo Province, SA. The open-coding analysis revealed a stressful workforce due to shortages of human and material resources and overfull units. The staff also indicated that they received very limited supervisory support. The effects of all these aggravated to a stressed and burnout workforce that is unfavourable to quality client-centred care.

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In addition, the explorative study of Scott *et al.* (2011) about the implementation of an equity-driven staff reallocation strategy showed that the nurses considered this strategy as a risk for quality care. Respondents perceived the managers to be primarily interested in headcount-based workload calculations, and considered this to contradict concern for quality of care. Some nurses characterised district managers as being distant and having a different agenda to the nurses on the ground.

On the contrary, Ngxongo and Sibiya's (2013) descriptive, quantitative study on the factors influencing the successful implementation of the basic antenatal care approach revealed that midwives were getting support from their managers as they were doing supervisory visits.

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The above studies confirmed that supervisory support was challenged by various inadequacies, such as: irregular, weak and with no distinct line of accountability to the direct supervisors. PHC staff experienced supervisors as distant as they were more interested in meeting goals, targets and counting headcounts, than supporting with problem-solving to improve performance.

Box 3.29: Availability of supervisory support

- Inadequate supervisory support

To summarise: quality client-centred care in Domain 6: Operational Management was compromised by clinics not always having adequate access to computer technology, inadequate staffing numbers, inadequate numbers of staff trained in the HIV programme and staff working under high work pressure. Furthermore, staff did not always have the opportunity to attend morbidity and mortality meetings, neither employment assistance programmes to their availability and lacked supervisory support.

3.4.7 Domain 7: Facilities and Infrastructure

Ideal Clinic standards require that the infrastructure of PHC clinics should be in a properly maintained condition with adequate spaces for service delivery (Fryatt & Hunter, 2015). According to the WCDoH (Western Cape Department of Health, 2014), infrastructure should have a positive impact on the healing process and should improve staff efficiency and morale, promote a conducive working environment, and should allow for future changes regarding service delivery. However, studies highlighted serious infrastructural inefficiencies about maintenance and small and limited spaces for service delivery.

3.4.7.1 Maintenance of clinic buildings

Scholz, Ngoli and Flessa (2015) pilot tested a rapid assessment tool for infrastructure at seven PHC clinics in Tanzania. Findings identified several areas of major concern, namely: inadequate standards for power and water supply; roof leaks and unavailability of plinth protection; insufficient rain water drainage. Furthermore, clinics were not organised for consistent maintenance of technical medical equipment. All clinics did not have functional burners and distinct disposal systems for contagious medical waste. Maintenance of clinics and equipment were recognised, but the clinics did not have adequate skilled personnel, space for workshops and maintenance equipment.

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In addition, Schoeman, Smuts, Faber, Van Stuijvenberg, Oelofse, Laubscher, Benade and Dhansay (2010) conducted a cross-sectional design study in the rural districts of the Eastern Cape (EC) and Umkhanyakude and Zululand in KwaZulu-Natal (KZN), SA to evaluate PHC clinics' infrastructure. Of the 40 PHC clinics in the aforementioned two provinces, eight in the Eastern Cape and six in KwaZulu-Natal had been built or repaired after 1994 and about half were graded as being in a poor condition. The following were determined: access to safe drinking water (Eastern Cape: 20%; KwaZulu-Natal: 25%); electricity (Eastern Cape: 45%; KwaZulu-Natal: 85%); flush toilets (Eastern Cape: 40%; KwaZulu-Natal: 75%); and functional telephones (Eastern Cape: 20%; KwaZulu-Natal: 5%). More than 80% of the nurses confirmed infrastructural challenges, inadequate resources (telephone, water and electricity supplies and staff shortages). The study findings of Makaula *et al.* (2012) in rural Malawi also showed that the infrastructure in the majority of health clinics were not maintained.

Box 3.30: Maintenance of clinic buildings

- Inadequate maintenance of clinic buildings

3.4.7.2 Inadequate clinic space

A qualitative study comprising 40 PHC centres in the Kurdistan revealed that most facilities were old, small and did not have enough space to provide health services. These facilities were built in 1987 when the area had a small population. Since then, the area has developed considerably, but the facilities remained the same (Shabila *et al.*, 2012).

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In line with the above, Sibanda *et al.* (2012) conducted an assessment of the Zimbabwe ministry of health and child welfare provider which initiated a HIV testing and counselling programme. Results also pointed out that in ten sites, spaces were inadequate to provide confidential counselling. Similarly, the qualitative assessment of Makaula *et al.* (2012) in rural Malawi to explore the relevance of the community-directed interventions approach showed that inadequate space identified in most of the health facilities. Furthermore, a qualitative study was conducted by Mutemwa *et al.* (2013) to explore the experiences of frontline health workers regarding the integration of HIV and reproductive health services in Kenya. The majority of respondents reported infrastructural insufficiencies, e.g. inadequate room space. Staff members have to move with the client from one room to another, mostly because of limited room space and equipment that could not be delivered in one room.

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On the other hand, Crowley and Stellenberg (2014) conducted a qualitative study in selected PHC clinics in KwaZulu-Natal, SA to assess capacity of clinics to deliver integrated HIV services. Study findings highlighted that only six (30%) clinics had adequate storage space for dietetic products and medication. In 10 (50%) clinics the number of consultation rooms were not enough for service delivery. Consultation rooms have to be shared between service providers, posing threats to the privacy of clients. Clinics providing ART services appeared to have more consultation rooms, compared to clinics not providing ART ($p < 0.01$). Opinions of professional nurses regarding factors influencing service delivery in expanding programmes in a PHC setting of the Tshwane District, SA also identified that lack of space for the different programmes grossly affected the quality service delivery (Xaba *et al.*, 2012). Moreover, Goeiman and Labadarios (2011) in their qualitative study identified that clinic dieticians in the Western Cape also experienced inadequate consultation space. Subsequently, Vawda and Variawa (2012) emphasized that the lack of space in many ARV clinics in SA, resulted in the sharing of consultation rooms by a variety of disciplines, violating the patient's constitutional right to privacy. In addition, the unavailability of space resulted in overcrowding of waiting areas, which could have resulted in patients with infectious diseases passing the disease on to other immune-compromised patients. Davies, Homfray and Venables (2013) conducted a qualitative study on the perceptions of nurse-initiated ART. Limited space was perceived for the increasing numbers of patients, additional stock and extra services. These infrastructural constraints impacted on staff morale, compromised staff health and affected clinic efficiency. Poor infrastructure also undermined the staff capacities to safeguard patient confidentiality.

Amnesty International (2014) conducted research within a human rights framework, to respect, defend and achieve the rights of all healthcare users. Amnesty International also highlighted small and overcrowded rooms in the clinics of Mpumulanga, SA they visited. Amnesty International also pointed out how these poor environments posed serious threats to the health care of staff to become infected with communicable diseases, as well as infringing the patients' right to privacy. The report of Mbatha, (2013) indicated challenges at health care facilities in the Eastern Cape Province with regard to insufficient space for the number of patients visiting the Cwill, Mathomela, Machibini and Zola clinics This meant that there could not have been enough space for private consultations with patients to take place and also resulted in problems with medication storage.

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The aforementioned studies confirmed that quality client-centred care was compromised by lack of maintenance and inadequate space of PHC clinics.

Box 3.31: Availability of clinic space

• Inadequate clinic space, e.g. insufficient storage space and number of consultation rooms

To summarise: Quality client-centred care in Domain 7: Facilitities and Infrastructure were confronted with inadequate maintenance of clinic buildings, inadequate space for storage, as well as inadequate number of consultation rooms.

3.8 SUMMARY

Objective 1 (Phase 1), aimed to explore and describe quality client-centred care by conducting an extensive literature review in order to gain a broad overview of the most recent and currently published literature. The first part of the review described the leading theoretical concepts, namely quality client-centred care, PHC, NCSs and the Donabedian framework. The second section was structured according the findings of empirical studies as structured around the seven domains of the NCSs as a framework.

3.9 CONCLUSION

The findings of this extensive literature review confirmed that quality client-centred care was at risk in all seven domains due to various structure-process-outcome inadequacies. The researcher could not find any studies utilising the NCSs as a framework to improve quality client-centred care in the PHC milieu. This gap, confirmed the need for the current study in order to develop a programme to facilitate quality client-centred care in PHC clinics of the rural West Coast District. Chapter four provides the results of the quantitative data.

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CHAPTER FOUR:
RESULTS AND DISCUSSIONS OF THE QUANTITATIVE STUDIES

4.1 INTRODUCTION

In this chapter, results and discussion of the quantitative data of Phase 1 (Objectives 2 and 3) are presented (Table 4.1). Various data analysis techniques were applied, namely: descriptive statistics (frequencies, percentages, mean and standard deviation); EFA, reliability and inferential statistics (Spearman's rank order correlations, ANOVA test and t-tests) were conducted to establish the relationship between the seven domains of the NCSs; and between the NCSs domains and the biographical data. In conclusion: a gap analysis (effect sizes) was calculated between the perceptions of the clinical nurse practitioners and the clients. Hierarchical linear modelling with the clinic as primary unit of measurement was used for this purpose, as clinical nurse practitioners and clients in a clinic are not independent, and are reporting on the same environment. An integrated discussion concludes the chapter.

Table 4.1: Overview of the study phases and objectives

PHASE 1: SITUATIONAL ANALYSIS (QUANTITATIVE)	**PHASE 3: PROGRAMME DEVELOPMENT**
Objective 1 To explore and describe the current status of quality client-centred care by conducting an extensive literature review	**Objective 5** To develop a programme to facilitate quality client-centred care in PHC clinics of the rural West Coast District
Objective 2 To assess the clients' perceptions about quality client-centred care	
Objective 3 To determine the clinical nurse practitioners' perceptions on quality client-centred care	
PHASE 2: SITUATIONAL ANALYSIS (QUALITATIVE)	
Objective 4 To explore and describe the managers and allied health professionals' perceptions about quality client-centred care	

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4.2 REALISATION OF THE DATA

Phase 1 of this study envisioned to collect quantitative data on quality client-centred care from the perspective of the clinical nurse practitioners and the clients from selected rural, PHC clinics of the West Coast District. Two self-administered questionnaires (one for the clinical nurse practitioners and one for the clients) based on the seven domains of the NCSs (2011) were developed. These seven domains referred to: Patient Rights; Clinical Governance, Care

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and Safety; Clinical Support; Public Health; Leadership and Corporate Governance; Operational Management; Facilities and Infrastructure.

The populations included the clinical nurse practitioners (N=64) and clients (N= 137 991) above the age of 18 years. According to the Cochran formula, a random sample size of (n=383) clients should be adequate to represent the population. An all-inclusive sample was used for the clinical nurse practitioners (n=64). The statistician used non-proportional sampling to predetermine the number of clients for each of the (N=25) clinics. Purposive sampling was done at the clinic. Participants complying with the selection criteria were recruited in the waiting room, until the predetermined number of questionnaires per clinic were completed. The response rate of 100% was obtained for both clinical nurse practitioners and clients. This ensured valid, reliable and representative findings.

4.3 CLINICAL NURSE PRACTITIONERS' BIOGRAPHICAL DATA

This section provides the analysis and interpretation of the demographical data of the clinical nurse practitioners. Gender, race, age range, years of experience after registration as a professional nurse, qualifications and years of employment at this clinic are presented in the section that follows (see Figure 4.1 to Figure 4.6). Problems are highlighted in Box 4.1 and Box 4.2. Results are discussed in Section 4.9.

4.3.1 Gender of clinical nurse practitioners

This section of the research indicates the gender of the clinical nurse practitioners. Sixty three clinical nurse practitioners (98.44%) were female and only one (1.56%) clinical nurse practitioner was male.

According to Reinecke (2014) male nurses attribute to a minority status within the nursing profession, with only 6.8% currently registered with the South African Nursing Council. However, this is also a global phenomenon. Duman (2012), Ten Hoeve, Jansen and Roodbol (2013) confirmed that nursing is a profession dominated by women. Although the number of males entering the nursing profession is on the increase, there has not been a remarkable increase of males entering the nursing profession. In Canada and the United States, only 5% of nurses are men (Zamanzadeh, Valizadeh, Negrarandeh, Monadi & Azadi, 2013).

The findings of the study show that the West Coast District's clinical nurse practitioners are predominantly females. This female domination is similar to international and national trends.

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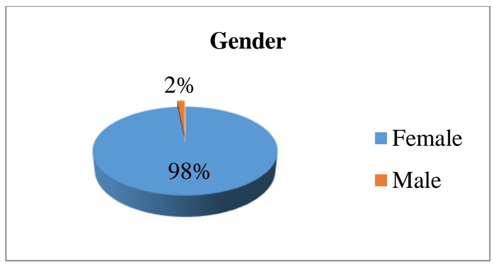

Figure 4.1: Gender of clinical nurse practitioners (n=64)

4.3.2 Race distribution of clinical nurse practitioners

Figure 4.2 portrays the racial composition of the West Coast clinical nurse practitioners. According to this figure, 34 (53.13%) of the clinical nurse practitioners are “Coloured” and 30 (46.87%) are “White”.

The Western Cape Government Department of Agriculture (2014) indicated the demographic profile of the Western Cape as (52%) Coloured, (29%) African, (18%) White and 1% other population groups.

The racial composition of the West Coast District’s clinical nurse practitioners is restricted to Coloured n=34 (53.13%) and White n=30 (46.87%). Therefore, the racial composition of this district is not representative of the Western Cape demographic profile, as no African, Asian or “other” clinical nurse practitioners are employed.

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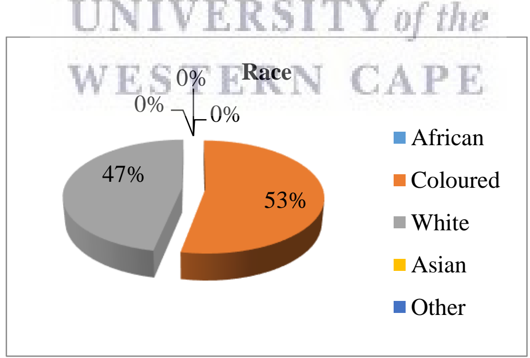

Figure 4.2: Race distribution of the clinical nurse practitioners (n=64)

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Box 4.1: Race distribution of clinical nurse practitioners

- The racial composition of the clinical nurse practitioners employed in the West Coast District is not representative of the demographical profile of the Western Cape Province

4.3.3 Age distribution of the clinical nurse practitioners

Figure 4.3 indicates the age range of the clinical nurse practitioners. Most of the of clinical nurse practitioners, n=27 (42.19%) are in the age group 41-50, followed by n=19 (29.69%) in the age group 51-60, and n=14 (21.88%) in the age group 31-40. Only n=2 (3.12%) clinical nurse practitioners are in the age group above 60 and only n=2 (3.12%) are in the age group 25-30.

The South African Nursing Council (2016) stated that 75% of registered nurses are 40 years and older. Therefore, the study findings correspond with the findings of the South African Nursing Council, as the majority of clinical nurse practitioners n= 48 (75 %) are in the age range of 41 and older. These findings showed that the clinical nurse practitioners' workforce, as in the rest of SA shows signs of an ageing nurse population. The study findings of Munyewende *et al.* (2014) also emphasized the ageing nursing workforce as a significant number of nurses were between the age of 41 and 50 years.

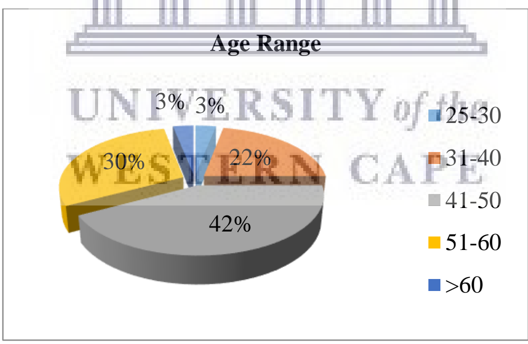

Figure 4.3: Age range of the clinical nurse practitioners (n=64)

Box 4.2: Clinical nurse practitioners' Age-range

- The clinical nurse practitioners' workforce of the West Coast District are indicative of an ageing nurse population

4.3.4 Years of experience after registration as professional nurse

Figure 4.4 reports on the years of experience of the clinical nurse practitioners after registration as a professional nurse. The majority of clinical nurse practitioners, this is n=33 (51.56%) have

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more than twenty years of work experience. According to these findings, the West Coast District has an experienced PHC workforce.

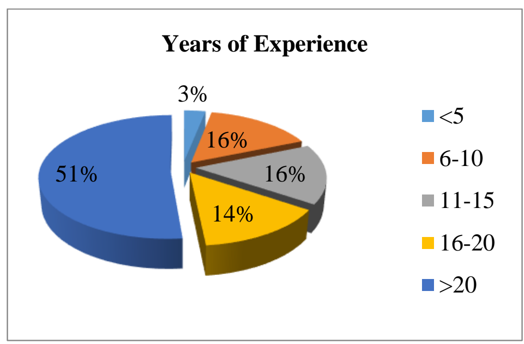

Figure 4.4: Years of experience after registration as a professional nurse (n=64)

4.3.5 Qualifications of the clinical nurse practitioners

Figure 4.5 presents the qualifications of the clinical nurse practitioners. According to this figure, n=58 (90.63%) clinical nurse practitioners are in possession of the R48 post basic diploma. Only n=1 (1.56%) clinical nurse practitioner is in possession of the qualification in community health, n=4 (6.25%) in possession of the midwifery qualification and n=1 (1.56%) in possession of the qualification in psychiatry.

The postbasic Diploma in Clinical Nursing Science, Health Assessment, Treatment and Care, as stipulated in the South African Nursing Act No 50 of 1978, as amended by Regulation 48 of 22 January 1982 is an essential qualification for practising as a clinical nurse practitioner. Figure 4.5 shows that the most of the participants, n=58 (90.63%) are qualified as clinical nurse practitioners. Two of the clinical nurse practitioners are not in possession of the R48 postbasic diploma. They obtained the certificate (R1444) which was the initial training in PHC, before 2007.

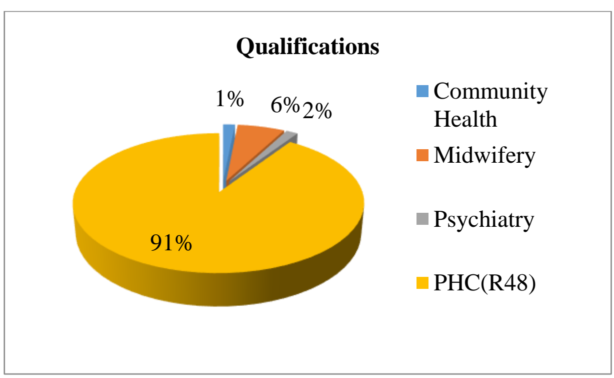

Figure 4.5: Qualifications of the clinical nurse practitioners (n=64)

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4.3.6 Years of employment at this clinic

Figure 4.6 portrays the years of employment at a certain clinic. The findings show that the majority of clinical nurse practitioners n=49 (76.56%) are working more than 5 years at their respective clinics. These results are evident of a stable workforce.

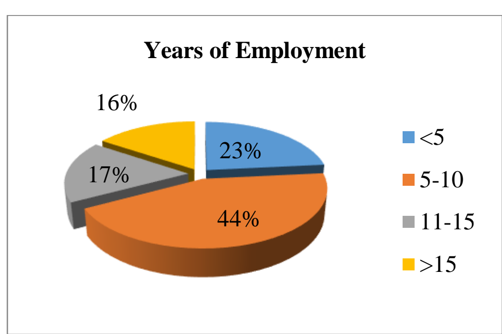

Figure 4.6: Years of employment at this clinic (n=64)

4.4 CLIENTS' BIOGRAPHICAL DATA

This section presents the analysis and interpretation of the biographical data of the clients who participated in this study. Gender, race, age range, educational level, employment status, distance to the clinic, way of getting to the clinic, average number of clinic visits, average number of traditional healer visits, average number of private doctor visits over the last 12 months are presented (see Figures 4.7 to 4.16) and discussed. Problems are highlighted in Boxes 4.4 to 4.11. Results are discussed in section 4.9.

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4.4.1 Gender of clients

According to Figure 4.7, the majority n=297 (77.55%) clients were female and only n=86 (22.45%) clients were male.

The Western Cape Government Provincial Treasury (2013) reported that in 2011, the male portion of the population decreased slightly to 49.7%, whilst the female portion increased to 50.3%. The study findings of Nteta, Mokgatle-Nthabu and Oguntibeju (2010); Okoronkwo, Onwujekwe and Ani (2014) also reported that the majority of clients who visited PHC clinics in SA and Nigeria were female. Most probably PHC services are more female orientated, e.g. antenatal care, family planning, cervical screening and immunizations are more female orientated. While specialized male services, such as urology services are not always available.

The findings of this study reveal that the majority of clients visiting the West Coast, rural clinics are females and males are underrepresented.

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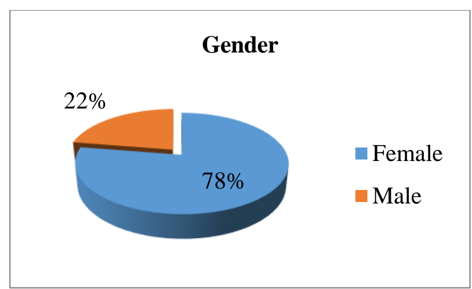

Figure 4.7: Gender of clients (n=383)

Box 4.3: Gender of clients

- Male clients underutilize PHC services

4.4.2 Race of clients

Figure 4.8 portrays the racial composition of the clients. The overwhelming n=302 (78.85%) number of clients were Coloured, n=54 (14.10%) African, n=24 (6.27%) White and n=3 (0.78%) presented "other" population groups.

According to the Western Cape Government Department of Agriculture (2014) the demographic profile of the Western Cape comprises: (52%) Coloured, (29%) African, (18%) White and (1%) Asians and "other" racial groups.

The percentages of the study findings correspond with the Western Cape Race profile, where the majority of the population is Coloured, followed by Africans and then Whites. However, the percentage of Coloureds in the West Coast is remarkably higher, Africans remarkably lower and Asians more or less the same as in the Western Cape.

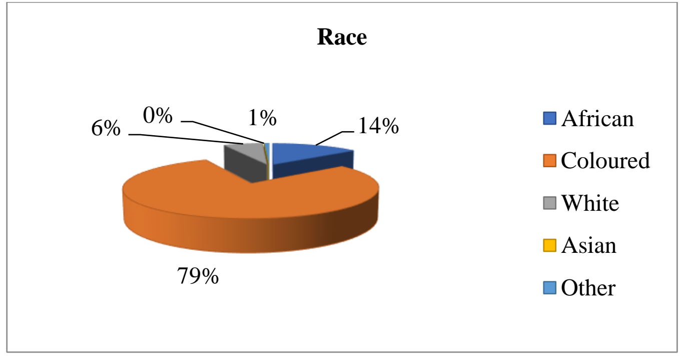

Figure 4.8: Race of clients (n=383)

4.4.3 Age of clients

Figure 4.9 shows the age range of the clients. The age ranges of the clients comprised: n=139 (36.29%) between 18 to 29; n=90 (23.50%) between 30 and 39; n=77 (20.10%) between 40 to

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49; n=54 (14.10%) between 50 and 59; n=17 (4.44%) between 60 and 69; n=5 (1.31%) between 70 and 79 and only n=1 (0.26%) over the age of 80.

According to the Western Cape Government Department of Agriculture (2014), the age demographical categories for the Western Cape population are as follows, namely: 33.93% (15-34 years), 34.29% (35-64) years and 5.7% (65 years and older).

Both the Western Cape profile and West Coast District, show the "working age" for clients who are utilising the clinics. Possible reasons for clinic visits could be family planning methods, antenatal care, postnatal care, cervical screening, bringing children for immunizations and minor ailments. From 60 years onwards clinic visits are remarkably lower.

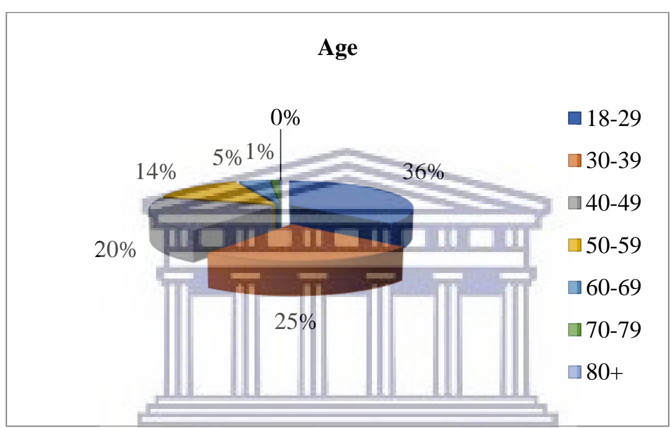

Figure 4.9: Age of clients (n=383)

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4.4.4 Educational level of the clients

Figure 4.10 presents the educational level of the client participants. The results show that n=5 (1.31%) participants had no schooling, while n=85 (22.19%) obtained Grade 7. The majority of participants n=156 (40.73%) were educated on a level of Grade 10 (Standard 8), n=118 (30.81%) obtained Grade 12 and only n=19 (4.96%) have a degree or diploma.

According to Census 2011 (Statistics South Africa, 2012), 2.7% persons have no schooling at all, 28.6% persons obtained Grade 12 and 14.1% have higher qualifications.

The Western Cape has a higher percentage of people with higher qualifications. Furthermore, the rest of the educational levels are more or less the same. Important to consider, is that there are still people with no schooling at all or a low level of schooling (Grade 7).

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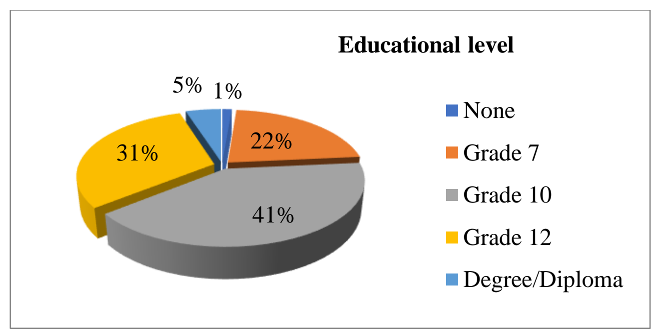

Figure 4.10: Educational level of clients (n=383)

Box 4.4: Educational level of clients

- There are clients with a low educational level (Grade seven and lower)

4.4.5 Employment status of clients

Figure 4.11 presents the employment status of the clients. Slightly more than half, n=206 participants (53.79%) were unemployed, while n=170 (46.21%) were employed.

The 2011 census indicated the unemployment rate of the Western Cape Province as 21.4% (Statistics South Africa, 2012).

A high number of clients visiting the PHC clinics are unemployed.

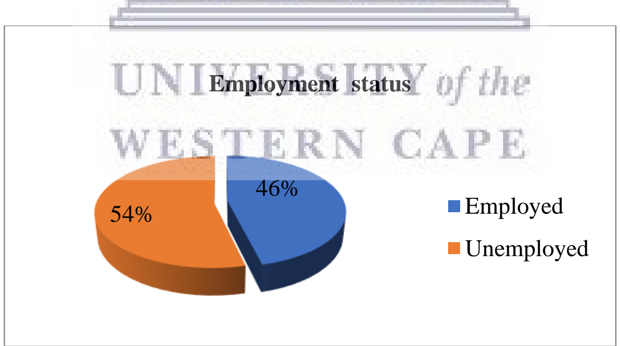

Figure 4.11: Employment status of clients (n=376)

Box 4.5: Employment status of clients

- A high number of clients visiting the PHC clinics are unemployed

4.4.6 Travelling distance from home to clinic

Figure 4.12 shows the results of the travelling distances to the clinics (less than 5 km, and more than 5 km). The majority of the clients that is n=275 (71.99%) were within 5 km, while n=107 (28.01%) clients have to travel more than 5 km.

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Clinics are geographically accessible for the majority of participants. However, a high number of clients have to travel more than 5 km to the nearest clinic.

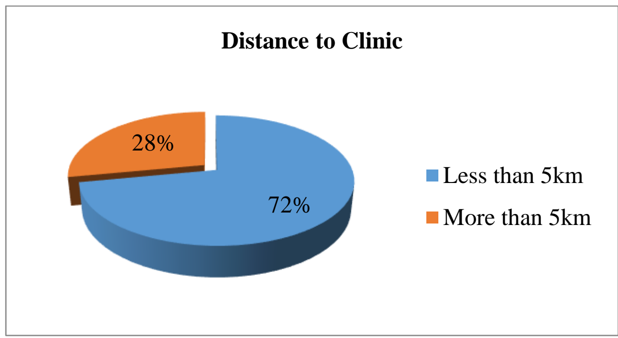

Figure 4.12: Travelling distance from home to clinic (n=382)

Box 4.6: Travelling distance from home to clinic

- Not all clients are within 5 km or walking distance from the clinics

4.4.7 Way of access to the clinic

The findings of getting to the clinic are described in Figure 4.13. The majority of clients, n=311 (81.20%) walk to the clinic. While n=40 (10.44%) make use of taxis and n=32 (8.36%) have their own transport to reach the clinic.

Some patients make use of taxis and own transport to access clinics.

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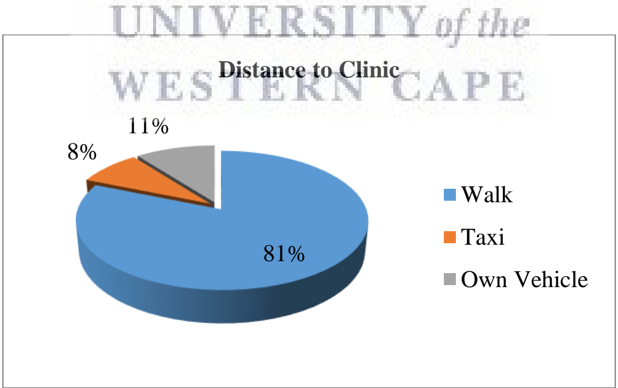

Figure 4.13: Way of access to the clinic (n=383)

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Box 4.7: Way of access to the clinic

- Some patients make use of taxis and own transport to reach the clinic

4.4.8 Average number of clinic visits in the past 12 months?

Figure 4.14 provides the average number of clinic visits over the past 12 months, namely: 1-3 times: n=93 (24.28%), 4-6 times: n=126 (32.90%), 7-9 times: n=56 (14.62%), 10+: n=108 (28.20%).

Day, Barron, Massyn, Padarath and English (2012) indicated an average of 3.5 PHC visits per person as the target for the South African public health sector. However, most of the West Coast clients n=290 (75.72%) visited the clinic more than 4 times over the past 12 months. This high utilisation could be due to the high incidence of HIV and TB; child and maternal, chronic disease and violence shin the Western Cape (Western Cape Department of Health, 2013).

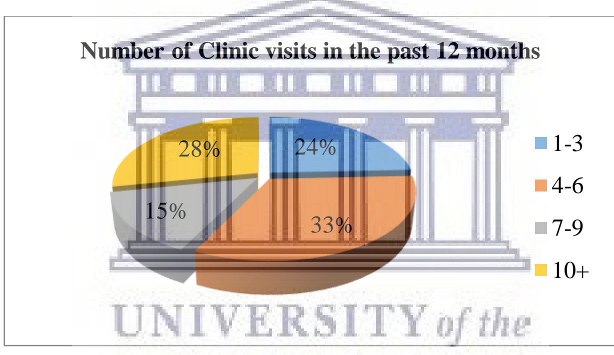

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Figure 4.14: Average number of clinic visits in the past 12 months (n=383)

Box 4.8: Average number of clinic visits in the past 12 months

- The clients of the West Coast reflected a high PHC utilisation rate

4.4.9 Average number of traditional healer visits in the past 12 months

Figure 4.15 reports the average number of traditional healer visits for the past 12 months. The majority n=281 (73.37%) clients did not visit a traditional healer, while n=63 (16.45%) visited a traditional healer one to three times, and n=39 (10.18%) visited more than four times the past 12 months. Thus, n=102 (26.63%) clients of the West Coast has consulted a traditional healer.

Learmonth, Van Vuuren and De Abreu (2014) reported that up to 80% of SA's population consult traditional healers prior to PHC consultations. According to Price, Ndom, Attenguena, Nouemssi and Ryder (2012) 80% of Africans use traditional healers. Thus, the West Coast

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population visits to traditional healers are much lower than the rest of the South African population.

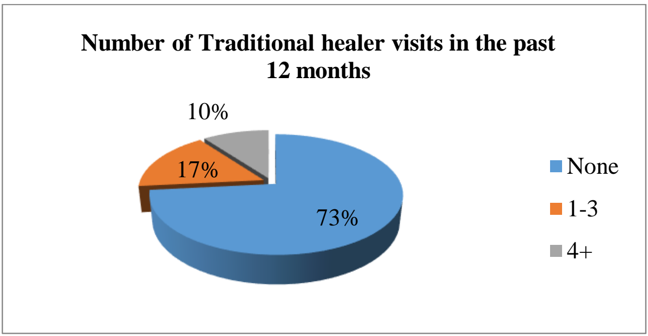

Figure 4.15: Average number of traditional healer visits in the past 12 months (n=383)

Box 4.9: Average number of traditional healer visits in the past 12 months

- A remarkable number of patients consulted traditional healers.

4.4.10 Number of private doctor visits in the past 12 months

Figure 4.16 provides the findings about the number of private doctor visits of the clients in the past 12 months. Just over half of clients n=207 (54.33%) did not visit a private doctor. However, n=138 (36.22%) clients visited the private doctor one to four times and n=36 (9.44%) clients were visiting the private doctor more than five times during the past 12 months. Private doctor visits could be unaffordable, as the majority of South Africans are not covered by medical insurance or medical aid. According to Statistics South Africa (2017), the general Household Survey of 2016 showed that 72.7% of the White population are covered by medical insurance, while merely 49.5% of the Indian/Asian population and less than 105% of Black Africans are covered by medical aid. Private doctor visits have to be considered in the treatment plan of a patient.

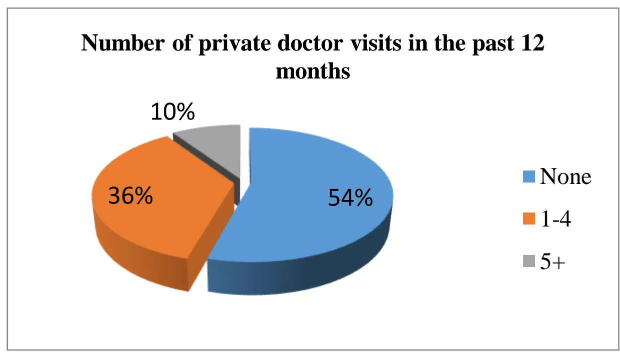

Figure 4.16: Number of private doctor visits in the past 12 months (n=381)

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Box 4.10: Number of private doctor visits in the past 12 months

- A significant number of patients (n=174) are utilising both PHC services and private doctors

4.5 DESCRIPTIVE STATISTICS

Since these results are inter-correlated per clinic, hierarchical linear models were used to take this inter-dependence into account. In this section the descriptive statistics are reported in the form of percentages (%), mean (M) and Standard Error (SE) under the headings of the seven domains. Percentages included the response rate according to the 4-point Likert Scale, where 1= never, 2= sometimes, 3= frequently and 4= always. A mean less than 2.5 could be considered as a "problem" with regard to quality, client-centred care. The descriptive statistics from the perspective of the clinical nurse practitioners are presented and followed by the descriptive statistics of the clients:

4.5.1 Descriptive statistics of the clinical nurse practitioners

Table 4.2 represents the descriptive statistics of the clinical nurse practitioners and is followed by the descriptive statistics of the clients. Items with a mean lower than 2.5 indicated a problem area. Problems are highlighted in Box 4.12 and are discussed in section 4.9.

Table 4.2: Descriptive statistics of the clinical nurse practitioners (n=64)

		Percentages (%)				Mean	SE
		1 Never	2 Sometimes	3 Frequently	4 Always		
Domain 1: Patient Rights							
1	Information boards are available	14.06	15.63	26.57	43.75	3.00	0.10
2	Clerks at reception are helpful	3.13	21.88	29.69	45.31	3.17	0.10
3	Staff members wear name tags to show their identity	9.38	20.31	31.25	39.06	3.00	0.08
4	Staff members treat patients with respect	0	12.5	51.56	35.94	3.23	0.08
5	Patients are addressed in a language that they understand	0	25.00	45.31	29.69	3.05	0.07
6	Patients may schedule appointments according to their needs or preferences	4.69	40.63	37.50	17.19	2.67	0.09
7	Patients have the opportunity to choose a staff member they prefer for health service delivery	17.19	48.44	21.88	12.50	2.30	0.12
8	Patient folders are retrieved timely at reception	3.13	39.06	39.06	18.75	2.73	0.08
9	Patients are kept informed about how long they would have to wait before someone attends to them	7.81	42.19	37.50	12.50	2.55	0.10
10	Patients are triaged to ensure that patients with more urgent health problems receive care before those with minor problems	14.06	14.06	20.31	51.56	3.09	0.11

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		Percentages (%)				Mean	SE
		1	2	3	4		
		Never	Sometimes	Frequently	Always		
Domain 1: Patient Rights (continued)							
11	Waiting times are monitored to prevent long waiting periods	26.56	37.50	25.00	10.94	2.20	0.10
12	Waiting time is acceptable	28.13	23.44	35.94	12.50	2.33	0.10
13	Patients are kept busy while they have to wait	23.44	46.88	21.88	7.81	2.14	7.81
14	Patients are treated during the scheduled clinic hours	1.56	29.69	40.63	28.13	2.95	0.08
15	Patients are made aware of the process of how they may lodge a complaint	4.69	6.25	26.56	62.50	3.47	0.10
16	Patients are made aware about the "Patient Rights Charter"	1.57	15.63	37.50	45.31	3.27	0.10
17	Clean drinking water and disposable cups are available for patients in the waiting areas	43.75	28.13	7.81	20.31	2.05	0.11
18	Privacy of patients are respected during consultation or treatment	0	1.56	12.50	85.94	3.84	0.05
19	Personal information of patients are kept confidential	1.56	0	12.50	85.94	3.83	0.06
20	Referral appointments are available within two weeks, when needed	7.81	34.38	28.13	29.69	2.80	0.12
21	A patient receives a referral letter for the referred service	3.13	3.13	10.94	82.81	3.73	0.09
22	Patients have access to transport, when needed	4.69	25.00	39.07	31.25	2.97	0.10
23	Patients are encouraged to ask questions	1.56	10.94	26.56	60.94	3.47	0.09
24	The clinic is accessible to patients with disabilities or the aged	6.25	7.81	15.63	70.31	3.50	0.10
25	Patients have had the opportunity annually to participate in a patient satisfaction survey	29.69	25.00	14.06	31.25	2.47	0.14
26	Security services are available	67.19	9.38	10.94	12.50	1.69	0.12
27	The clinic is clean	1.56	12.50	50.00	35.94	3.20	0.08
Domain 2: Clinical Governance, Care and Safety							
28	An integrated approach is used to treat a patient for all their problems or needs during one visit	0	17.19	37.50	45.31	3.28	0.09
29	Time spent with a patient	1.56	18.75	32.81	46.88	3.25	0.09
30	The results of the diagnostic tests are explained to patients in an understandable manner	1.56	7.81	26.56	64.06	3.53	0.09
31	Patients are asked to repeat information in order to confirm whether they understood	4.69	23.44	43.75	28.13	2.95	0.09
32	Written information about the relevant health problem or medication is provided to patients	10.94	45.31	23.44	20.31	2.53	0.09
33	Advice on how to improve wellness is provided	1.56	9.38	32.81	56.25	3.44	0.09
34	Patients are advised to come back	1.56	0	7.81	90.63	3.88	0.05
35	Patients are involved in decisions about their health care	0	6.25	20.31	73.44	3.67	0.08
36	Family or friends (when appropriate) involved in a patient's health care	0	20.31	31.25	48.44	3.28	0.10
37	Staff members are focused to provide a person-centred care service	2.13	6.25	31.25	59.38	3.47	0.10
38	Patients are encouraged to report any adverse event	1.56	6.25	18.75	73.44	3.64	0.09
39	Infection control measures are practised by the staff	1.56	7.81	34.38	56.25	3.45	0.10
40	I attend training courses	18.75	28.13	32.81	20.31	2.55	0.11

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		Percentages (%)				Mean	SE
		1 Never	2 Sometimes	3 Frequently	4 Always		
Domain 2: Clinical Governance, Care and Safety (continued)							
41	Staff members deliver quality care to patients	1.56	7.81	35.94	54.69	3.44	0.09
42	I am provided with the relevant clinical guidelines or policies to provide quality care	0	4.69	28.13	67.19	3.63	0.07
43	I attend mortality and morbidity meetings	53.13	25.00	12.50	9.38	1.78	0.10
Domain 3: Clinical Support							
44	Medicines are in stock when needed	1.56	21.88	51.56	25.00	3.00	0.09
45	Reasons for taking medication are explained to patients	1.56	3.13	26.56	68.75	3.63	0.08
46	Patients are encourage to report any medication side-effects	4.69	6.25	25.00	64.06	3.48	0.10
47	Patients have access to assistive devices when needed	6.25	37.50	32.81	23.44	2.43	0.10
48	Equipment is available as required for service delivery	1.56	7.81	21.88	68.75	3.58	0.09
49	Medical equipment is in a working condition	1.56	7.81	35.94	54.69	3.44	0.09
50	Consumables or supplies are in stock	0	9.38	40.63	50.00	3.41	0.08
Domain 4: Public Health							
51	Health promotion or disease prevention events are organised in the community	3.13	18.75	43.75	34.38	3.09	0.09
52	Patient support groups are organised at the clinic or in the community	12.50	20.31	28.13	39.06	2.94	0.12
53	Community-based service teams visit families at home between clinic appointments	1.56	4.69	40.63	53.13	3.45	0.07
54	An evacuation plan is visible	18.75	10.94	18.75	51.56	3.03	0.11
Domain 5: Leadership and Corporate Governance							
55	An organogram with the names or pictures of all the staff members is visible in the clinic	37.50	7.81	10.94	43.75	2.61	0.16
56	Community communication events are organised by the DoH to inform the community about health system aspects	23.44	32.81	26.56	17.19	2.38	0.12
57	The future plans, goals, values and focus areas of the WCDoH are visible in the clinic	6.25	18.75	25.00	50.00	3.19	0.11
58	The role and function of the clinic committee is visible in the clinic	48.44	25.00	7.81	18.75	1.97	0.13
Domain 6: Operational Management							
59	Staff utilises computer technology	12.50	21.88	32.81	32.81	2.86	0.10
60	Staffing levels are conducive for quality service delivery	14.06	20.31	28.12	37.50	2.89	0.11
61	My work situation gives me a feeling of personal accomplishment	4.69	21.88	40.63	32.81	3.02	0.10
62	The employee assistance programme enables me to cope with the daily demands of the working milieu	37.50	32.81	20.31	9.38	2.02	0.11
63	Supervisory support is available to me	6.25	23.44	31.25	39.06	3.03	0.11
64	The clinic manager has the capacity to function as an operational manager and clinical nurse practitioner	7.81	15.63	17.19	59.38	3.28	0.11
65	The current staff appraisal system helps me to improve my work performance	20.31	25.00	35.94	18.75	2.53	0.12

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		Percentages (%)				Mean	SE
		1	2	3	4		
		Never	Sometimes	Frequently	Always		
Domain 7: Facilities and Infrastructure							
66	The clinic has adequate space available for the number of patients	37.50	23.44	17.19	21.88	2.23	0.11
67	Maintenance of the building is up to date	7.81	42.19	35.94	14.13	2.56	0.70
68	The physical appearance of the clinic has a positive effect on the staff morale	26.56	29.69	34.38	9.38	2.27	0.09
69	The grounds outside the clinic are maintained	10.94	35.94	31.25	21.88	2.64	0.10
70	Medical waste is managed in a safe way	4.69	3.13	15.63	76.56	3.64	0.08

According to Table 4.2, the clinical nurse practitioners identified the following items in *Domain 1*: Patient Rights as "problems" (mean ‹2.5), namely: opportunity for patients to choose staff members they prefer for health service delivery (item 7: mean 2.30); the monitoring of waiting time to prevent long waiting periods (item 11: mean 2.20), acceptability of waiting time (item 12: mean 2.33) and patients being kept busy while waiting (item 13: mean 2.14); availability of clean drinking water and disposable cups in the waiting area (item 17: mean 2.05); the opportunity to participate in a patient satisfaction survey (item 25: mean 2.47) and the availability of security services (item 26: mean 1.69). Compared with the Likert Scale, these rights were only "sometimes" adhered to.

Analysis of *Domain 2:* Clinical Governance, Care and Safety showed that attendance of mortality and morbidity meetings were considered as a "problem" (item 43: mean=1.78). According to the Likert scale, these meetings were only "sometimes" being attended.

The mean of item 47 (patients have access to assistive devices when needed) in *Domain 3:* scored 2.43. According to the clinical nurse practitioners this could be considered as a "problem", meaning that patients have only "sometimes" access to assistive devices.

Table 4.2 revealed that the mean of two variables in *Domain 5* (Leadership and Corporate Governance) scored below 2.5, therefore could be considered as "problems", namely: the organisation of community communication events by the DoH to inform the community about health system aspects (item 56: mean 2.38) and the visibility of the role and function of the clinic committee in the clinic (item 58: mean 1.97). These activities rated as only "sometimes" on the Likert Scale.

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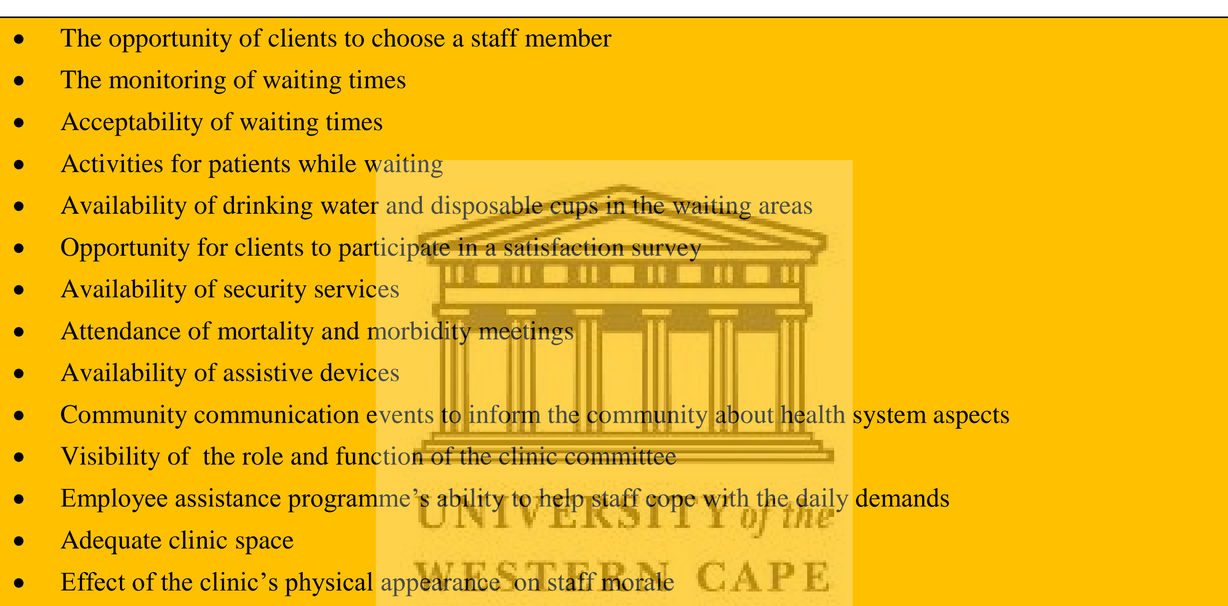
According to *Domain 6:* Operational Management, the clinical nurse practitioners considered item (item 62: mean 2.02), the employee assistance programme enables the clinical nurse practitioners to cope with the daily demand of the working milieu, as a "problem".

Analysis of *Domain 7* (Facilities and Infrastructure) shows that the clinical nurse practitioners, only "sometimes" perceive space as adequate for the number of patients (item 66: mean 2.23) and the physical appearance of the clinic, has only "sometimes" a positive effect on staff morale (item 68: mean 2.27).

Box 4.11: Problems as indicated by the descriptive statistics of the clinical nurse practitioners (mean less than 2.5)



- The opportunity of clients to choose a staff member
- The monitoring of waiting times
- Acceptability of waiting times
- Activities for patients while waiting
- Availability of drinking water and disposable cups in the waiting areas
- Opportunity for clients to participate in a satisfaction survey
- Availability of security services
- Attendance of mortality and morbidity meetings
- Availability of assistive devices
- Community communication events to inform the community about health system aspects
- Visibility of the role and function of the clinic committee
- Employee assistance programme's ability to help staff cope with the daily demands
- Adequate clinic space
- Effect of the clinic's physical appearance on staff morale

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4.5.2 Descriptive statistics of the clients

Table 4.3 represented the descriptive statistics of the clients and problem areas (mean lower than 2.5) are highlighted in Box 4.13.

Table 4.3: Descriptive statistics of the clients (n=383)

		Percentages (%)				Mean	SE
		1 Never	2 Sometimes	3 Frequently	4 Always		
Domain 1: Patient Rights							
1	Information boards are visible	10.18	10.71	12.53	66.58	3.36	0.05
2	Clerks at reception are helpful	8.09	28.46	17.76	45.69	3.01	0.05
3	Staff members wear name tags to show their identity	18.32	16.50	10.21	54.98	3.02	0.06
4	Staff members treat me with respect	6.81	24.35	19.37	49.48	3.12	0.05

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		Percentages (%)				Mean	SE
		1 Never	2 Sometimes	3 Frequently	4 Always		
Domain 1: Patient Rights (continued)							
5	I am addressed in a language that I understand	6.00	5.22	6.01	82.77	3.66	0.04
6	I can make an appointments according to my needs or preferences	23.50	22.72	14.36	39.43	2.70	0.06
7	I have the opportunity to choose a staff member I prefer for health service delivery	54.86	13.12	14.17	17.85	1.95	0.06
8	My folder is retrieved timely at reception	11.23	25.07	18.02	45.79	2.98	0.05
9	I am kept informed about how long I would have to wait before someone sees me	54.31	19.58	9.14	16.97	1.89	0.06
10	Patients with more urgent health problems receive care before those with minor problems	20.37	27.94	15.40	36.29	2.68	0.06
11	Waiting times are monitored to prevent long waiting periods	46.48	22.19	15.93	15.40	2.00	0.06
12	Waiting time is acceptable	47.26	22.98	12.53	17.23	2.00	0.06
13	I am kept busy while I have to wait	54.83	21.15	7.83	16.19	1.85	0.05
14	I am treated on the day of my clinic visit	9.14	20.10	13.58	57.18	3.19	0.05
15	I am made aware of the process how to lodge a complaint	36.03	13.05	13.84	37.08	2.52	0.07
16	I am made aware about the "Patient Rights Charter"	26.37	17.75	16.19	39.69	2.70	0.06
17	Clean drinking water and disposable cups are available to me in the waiting areas	50.65	14.62	7.83	26.90	2.11	0.06
18	My privacy is respected during consultation or treatment	6.28	11.26	13.09	69.37	3.46	0.05
19	My personal information is kept confidential	6.27	9.14	12.79	71.80	3.50	0.05
20	Referral appointments are available within two weeks, when needed	9.65	17.68	19.29	53.38	3.16	0.06
21	I am provided with a referral letter when referred	6.85	7.44	11.61	74.11	3.53	0.05
22	I have access to transport, when needed	10.75	14.63	12.84	61.79	3.26	0.06
23	I am encouraged to ask questions	24.67	17.32	17.32	40.68	2.74	0.06
24	The clinic is accessible to patients with disabilities or the aged	13.87	10.99	14.92	60.20	3.21	0.05
25	I have had the opportunity to participate in a patient satisfaction survey	58.75	12.27	14.62	14.36	1.85	0.06
26	Systems are in place to ensure my safety	51.70	14.88	10.18	23.23	2.04	0.06
27	The clinic is clean	14.43	20.21	20.47	44.88	2.96	0.05
28	I feel welcome at the clinic	16.19	21.93	15.14	46.74	2.92	0.06
29	Staff members act as role models	28.80	26.44	18.59	26.18	2.42	0.06
30	Health care service delivery is free	8.36	6.01	7.31	78.33	3.56	0.05

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		Percentages (%)				Mean	SE
		1	2	3	4		
		Never	Sometimes	Frequently	Always		
Domain 2: Clinical Governance, Care and Safety							
31	All my problems or needs are addressed during one visit	19.90	22.51	17.54	40.05	2.78	0.06
32	Staff spends time with me	17.75	19.06	15.14	48.04	2.93	0.06
33	The results of my diagnostic tests are explained to me in an understandable manner	12.30	12.30	12.30	63.09	3.26	0.06
34	I am asked to repeat information to the staff in order to confirm whether I understood the information they had given me	32.46	21.47	17.28	28.80	2.42	0.06
35	I receive written information about my health problem or medication	38.48	16.49	17.28	27.75	2.34	0.06
36	I receive advice about what I can do to improve my wellness	21.05	18.68	14.47	45.79	2.85	0.06
37	I am advised to come back	8.62	8.36	14.88	68.15	3.43	0.05
38	Staff involves me in decisions about my health care	18.63	16.16	14.79	50.41	2.97	0.06
39	Staff involves my family or friends (when appropriate) in my health care needs	24.51	14.23	29.64	31.62	2.68	0.07
40	I am encouraged to report any adverse event	22.98	14.88	17.23	44.91	2.84	0.06
41	Infection control measures are practised by the staff	19.06	12.53	13.84	54.57	3.04	0.06
42	I receive personalised health care	15.71	18.85	19.37	46.07	2.96	0.06
43	I understand more about my health after my clinic visit	12.01	19.58	19.32	49.09	3.05	0.05
44	My basic health needs are met	11.75	21.41	19.32	47.52	3.03	0.05
45	I will recommend the service to my family or friends	19.84	20.89	16.71	42.56	2.82	0.06
Domain 3: Clinical Support							
46	Medicines are in stock and available when needed	4.70	18.28	18.02	59.00	3.31	0.05
47	Reasons for taking medication are explained to me	6.79	10.97	11.22	71.02	3.46	0.05
48	I am encouraged to report any medication side-effects	17.50	16.45	14.62	51.44	3.00	0.06
49	I have access to assistive devices when needed	30.96	15.90	15.90	37.24	2.59	0.08
50	The necessary equipment is available as required for my treatment	4.70	7.31	7.83	80.16	3.63	0.04
51	Medical equipment that is required for my needs is in a working condition	5.22	7.05	13.05	74.67	3.57	0.04
52	Consumables or supplies are in stock	3.66	5.22	15.93	75.20	3.63	0.04
Domain 4: Public Health							
53	Health promotion or disease prevention events are organised in the community	31.85	22.19	18.28	27.68	2.42	0.06
54	Patient support groups are organised at the clinic or in the community	25.95	13.05	16.97	43.86	2.80	0.06
55	The community-based service team visits my family at home between clinic appointments	48.83	13.84	12.27	25.07	2.14	0.06
56	An evacuation plan is visible	40.99	15.67	12.27	31.07	2.33	0.07
Domain 5: Leadership and Corporate Governance							
57	The structure with the names or pictures of all the staff members is visible in the clinic	43.42	11.58	9.47	35.53	2.37	0.06
58	Community communication events are organised by the WCDoH to inform the community about health system aspects	44.91	19.06	14.62	21.41	2.13	0.06
59	Goals, values, future plans and focus areas of the WCDoH are visible in the clinic	39.79	11.52	14.66	34.03	2.43	0.06
60	The role and function of the clinic committee is visible in the clinic	40.99	9.92	15.14	33.94	2.42	0.07

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		Percentages (%)				Mean	SE
		1	2	3	4		
		Never	Sometimes	Frequently	Always		
Domain 6: Operational Management							
61	Staff utilises computer technology during my visit	26.63	11.23	12.53	49.61	2.85	0.06
62	Staffing levels are conducive to quality service delivery	32.72	22.25	15.97	29.06	2.41	0.06
Domain 7: Facilities and Infrastructure							
63	The clinic has enough space for the number of patients	48.43	17.02	11.78	22.25	2.09	0.06
64	Maintenance of the building is up-to-date	17.75	15.14	15.14	51.96	3.01	0.06
65	The physical appearance of the clinic has a positive effect on my staff morale	20.79	20.53	23.95	34.74	2.73	0.06
66	The grounds outside the clinic are maintained	12.30	22.51	21.20	43.98	2.97	0.05

According to Table 4.3, the “problems” as perceived by the clients about the adherence to some of the Patient Rights (*Domain 1*) correspond with these of the clinical nurse practitioners, namely: opportunity for patients to choose staff members they prefer for health service delivery (item 7: mean 1.95); the monitoring of waiting time to prevent long waiting periods (item 11: mean 2.00), acceptability of waiting time (item 12: mean 2.00) and patients being kept busy while waiting (item 13: mean 1.85); availability of clean drinking water and disposable cups in the waiting area (item 17: mean 2.11); the opportunity to participate in a patient satisfaction survey (item 25: mean 1.85) and the availability of security services (item 26: mean 2.05). However, the mean of the clients for these activities scored lower than that of the clinical nurse practitioners except for the availability of clean drinking water and disposable cups in the waiting area (clinical nurse practitioners’ mean: 2.05; clients’ mean: 2.11) and for the availability of security services (clinical nurse practitioners’ mean: 1.69; clients’ mean: 2.05), showing that clients were more convinced than the clinical nurse practitioners about the non-adherence of these Patient Rights. The clinical nurse practitioners’ rated item 9, “I am kept informed about how long I have to wait before someone sees me” as borderline (mean 2.55), while the clients (mean 1.89) showed that patients were only “sometimes” informed about how long they would have to wait before someone can see them. Lastly, item 29,“staff members act as role models” (mean 2.42) shows that staff members ocassionally act as role models. Clinical nurse practitioners were not tested on this variable.

Analysis of *Domain 2:* Clinical Governance, Care and Safety shows that clients perceived the following as “problems”, namely: patients were only “now and then” asked to repeat information in order to confirm whether they understood the information they were given (item 34: mean 2.42), and only “at times” they received information about their health problem or medication (item 35: mean 2.34).

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Clients revealed that health promotion or disease prevention (*Domain 4:* Public Health) events are only “occasionally” organised in the community (item 53: mean 2.42). Furthermore, the community-based serviced teams did not always visit their families at home between their clinic visits (item 55: mean 2.42). In addition, according to the clients an evacuation plan is only “sometimes” visible in the clinic (item 56: mean 2.33). As all of these activities scored a mean less than 2.5 this could be considered as “problems” perceived by the clients.

Table 4.3 indicates that the mean of all the *Domain 5* (Leadership and Corporate Governance) variables scored below 2.5. Thus, clients were only “sometimes” convinced about the following leadership and governance aspects, namely: the visibility of the structure with the names or pictures of all the staff members (item 57: mean 2.37); community communication events by the DoH to inform the community about health system aspects (item 58: mean 2.13); the visibility of the goals, values, future plans and focus areas of the DoH (item 59: mean 2.43) and the visibility of the role and function of the clinic committee in the clinic (item 60: mean 2.42). Therefore, these activities could be considered as “problems”.

The clinical nurse practitioners and the clients’ analysis about “the organisation of community communication events organised by the DoH (clinical nurse practitioners’ mean: 2.38 and clients’ mean: 2.13) and “the visibility of the role and function of the clinic committee” (clinical nurse practitioners’; mean: 1.97 and clients’ mean: 2.42) correspond with each other, as both perceived these activities as “problems”.

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The analysis about Operational Management (*Domain 6*) variables indicate that clients only “sometimes” agree on the adequacy of conducive staffing levels for quality service delivery (item 62: mean 2.41).

Lastly, the analysis of *Domain 7* (Facilities and Infrastructure) shows that both clients and clinical nurse practitioners, perceive the adequacy of space for the number of patients (item 63: mean 2.09) only “at times”.

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Box 4.12: Problems as identified by the descriptive statistics of the clients (mean less than 2.5)

- Clients' opportunity to choose a staff member for health service delivery
- Information to clients of how long they would have to wait
- Monitoring of waiting periods
- Acceptability of waiting time
- Activities for clients while waiting
- Availability of clean drinking water and disposable cups in the waiting areas
- Clients' opportunity to participate in a satisfaction survey
- Clients' safety systems
- Staff members as role models
- Confirmation of whether clients understood the information they had received
- Written information to clients about their health problem or medication
- Health promotion or disease prevention in the community
- Home visits of community-based service teams
- Visibility of the evacuation plan in the clinic
- Visibility of the structure in the clinic with the names or pictures of all the staff members (organogram)
- Community communication events to inform the community about health system aspects
- Visibility of the goals, values, future plans and focus areas of the Western Cape Department in the clinic
- Visibility of the role and function of the clinic committee
- Conduciveness of staffing levels to provide quality service
- Adequate clinic space

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4.6 FACTOR ANALYSIS AND RELIABILITY

In both the questionnaires, the headings (of the seven domains) were removed and the sequence of questions slightly changed. Both questionnaires comprised: Section A (general questions), B (clinical nurse practitioner specific or client specific questions) and Section C (biographical data).

Section A (questions 1 to 59) posed identical questions to both clinical nurse practitioners and clients. While Section B differs, as it is specific for the clinical nurse practitioners (questions 60 -70) and specific for clients (questions 60 - 66), Section C also differs as it is related to biographical data of clinical nurse practitioners and biographical data of clients.

An EFA, through principal component analysis and Oblim rotation was done according to each of the seven domains (Section A, questions 1 to 59, answered by both clinical nurse practitioners and clients). Internal consistency was measured by calculating coefficient alpha (also called Cronbach's alpha). According to Flick (2015) and Polit *et al.* (2010), a factor

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analysis is a form of statistical analysis, focusing on identifying a limited number of basic factors summarizing the original data so that they can explain the relationships in a field. Furthermore, an EFA determines whether a scale actually measured the concepts that it is meant to measure (LoBiondo-Wood & Haber, 2013). Polit and Beck (2012) emphasized that the normal range of values for Cronbach alpha, reliability index is from .00 to +1.00. The higher the coefficient, the more internal consistent the measure. However, Kline in Field (2009), stated that although the usually accepted value of 0.8 is suitable for cognitive tests such as intelligence tests, for ability tests the cut-off point of 0.7 is more appropriate. Furthermore, when dealing with psychological constructs, values less than 0.7 can realistically, be expected, because of the multiplicity of the constructs being measured.

The paragraphs to follow present the outcomes of the EFA as conducted on each of the seven domains (Table 4.4 to Table 4.12).

4.6.1 Domain 1: Patient Rights

Table 4.4 presents the EFA regarding Domain 1: Patient Rights and refers to waiting, confidentiality and privacy, satisfaction and safety, referral and reception.

Table 4.4: Domain 1: Patient Rights

	PATIENT RIGHTS	Waiting	Confidentiality/ privacy	Satisfaction/ safety	Referral	Reception
		1	2	3	4	5
A 13	I am kept informed about how long I would have to wait before someone attends to me	0.758				
A 14	Waiting time is acceptable	0.725				
A 12	Waiting times are monitored to prevent long waiting periods	0.679				
A 9	I have the opportunity to choose a staff member I prefer for health service delivery	0.587				
A 15	I am kept busy while I have to wait for service delivery	0.566				
A 8	I can make an appointment according to my needs or preferences	0.414				
A 11	Patients with more urgent health problems receive care before those with minor problems	0.369				0.259
A 37	My personal information is kept confidential		0.727			
A 36	My privacy is respected during consultation or treatment		0.667			
A 30	I am encouraged to ask questions	0.208	0.497			

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	PATIENT RIGHTS	Waiting	Confidentiality/ privacy	Satisfaction/ safety	Referral	Reception
		1	2	3	4	5
A 28	I am provided with a referral letter when referred		0.390		0.351	
A 44	I am made aware of the process how to lodge a complaint			0.746		
A 40	I am made aware about the "Patient Rights Charter"			0.683		
A 46	Systems are in place to ensure my safety		-0.200	0.596		0.215
A 45	I have had the opportunity to participate in a patient satisfaction survey	0.214		0.537	-0.241	
A 27	Referral appointments are available within two weeks, when needed				0.744	
A 29	I have access to transport, when needed				0.678	
A 4	I am addressed in a language that I understand					0.676
A 3	My folder is retrieved timely at reception				-0.219	0.582
A 10	I am treated on the day of my clinic visit					0.551
A 2	Clerks at reception are helpful		0.37		-0.261	0.472
A 7	Staff members treat me with respect		0.411			0.458
A 5	Staff members wear name tags to show their identity			0.211		0.376
A 48	The clinic is clean	0.244				0.282

The researcher in consultation with the statistician and promoters did an EFA on the Patient Rights domain which yielded five factors. The KMO (Kaiser-Meyer-Olkin) value of the Patient Rights domain was 0.808, the total percentage of variance explained by the five factors was 44.05% and the Bartlett p-value was < 0.001, which indicates that factor analysis was an appropriate analysis.

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Table 4.5 showed that factor 4 referral has a low Cronbach Alpha (0.53) as this construct contained only three items. However, the inter-item correlation is 0.27, which is acceptable.

With the five factor analysis the following were included in each factor:

Factor 1 *(waiting)* – 7 items: 8, 9, 11, 12, 13, 14 and 15

Factor 2 *(confidentiality/privacy)* – 3 items: 30, 36 and 37

Factor 3 (*satisfaction/safety*) – 4 items: 40, 44, 45 and 46

Factor 4 *(referral*) – 3 items: 27, 28 and 29

Factor 5 (*reception*) – 7 items: 2, 3, 4, 5, 7, 10 and 48

During the analysis item number 1 (information boards are visible) did not load on any of the factors and was removed from the factor analysis and it was decided to use it as a unique factor.

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Table 4.5: Cronbach of the Patient Rights subscales

	Cronbach alpha
Factor 1 (waiting)	0.71
Factor 2 (confidentiality/privacy)	0.55
Factor 3 (satisfaction/safety)	0.61
EFA	0.53
Factor 5 (reception)	0.64

4.6.2 Domain 2: Clinical Governance, Care and Safety

Domain 2: Clinical Governance, Care and Safety EFA is provided in Table 4.6 and refers to "Myself", Family and Staff.

Table 4.6: Domain 2: Clinical Governance, Care and Safety

	CLINICAL GOVERNANCE/CARE/SAFETY	**Myself/Family**	**Staff**
		1	**2**
A38	Staff involves me in decisions about my health care	.720	
A43	I am encouraged to report any adverse event	.714	
A24	I receive written information about my health problem or medication	.684	
A39	Staff involves my family or friends (when appropriate)	.661	
A25	I receive advice about what I can do to improve my wellness	.550	
A20	I am asked to repeat information received, to the staff to evaluate whether I understood the information they had given me	.539	
A47	Infection control measures are practised by the staff	.223	.220
A17	All my problems or needs are addressed during one visit		.787
A18	Staff spends time with me		.710
A19	The results of my investigation tests are explained to me in an understandable manner		.671
A31	I am advised to come back	.307	.409

Domain 2 was labelled Clinical Governance, Care and Safety. Two factors explaining 42.30% of the total variance were extracted. The KMO value of this sub-scale was .832. The Bartlett p-value was < 0.001, which indicates that the factor analysis was appropriate.

During loading of the items (items 17, 18, 19, 20, 24, 25, 31, 38, 39, 43 and 47) on this specific sub-scale, the items split and loaded differently. Items 17, 18, 19, 31 and 47 clustered together under the sub-scale named "staff". While items 20, 24, 25, 38, 39 and 43 clustered together under the factor named "Myself/Family".

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Items 17, 18, 19, 31 and 47 focused more on the "staff" activities towards the client, e.g. practising of infection control measures, addressing all the problems in one visit, explaining the investigation results, spending adequate time with the patient and advising the patient to come back when necessary.

Whereas, items 20, 24, 25, 38, 39 and 43 clustered together, because they focused more on what the client and his/her family (when appropriate) received. Aspects included e.g. "staff involves me in decisions", "I am encouraged to report any adverse event", "I receive written information about my health or medication", "staff involves my family or friends (when appropriate)", "I receive advice about what I can do to improve my wellness", "I am asked to repeat information received to the staff to evaluate whether I understood".

These items had an acceptable Cronbach's alpha of .0.60 ("staff") and 0.74 ("Myself/Family)".

4.6.3 Domain 3: Clinical Support

Table 4.7 presents the factor analysis about Domain 3: Clinical Support refers to equipment and consumables, medicine and assistive devices.

Table 4.7: Domain 3: Clinical Support

	CLINICAL SUPPORT	Equipment/ Consumables	Medicine/ Assistive devices
		1	2
A33	Medical equipment that is required for my needs is in a working condition	.883	
A32	The necessary equipment is available as required for my treatment	.764	
A34	Consumables and supplies are in stock	.674	
A23	I am encouraged to report any medication side-effects		.823
A22	Reasons for taking medication are explained to me		.652
A26	I have access to assistive devices when needed		.572
A21	Medicines are in stock and available when needed		.476

The Domain 3 is named Clinical Support. Two factors explaining 51.42% of the total variance were extracted. The KMO value of this sub-scale was .706. The Bartlett p-value was < 0.001, which indicates that the factor analysis was appropriate.

The items that loaded on this sub-scale were items (21, 22, 23, 26, 32, 33 and 34). The items split and loaded differently, items (21, 22, 23 and 26) clustered together under the sub-scale named medicines/assistive devices and items (32, 33 and 34) clustered together under the factor named Equipment/Consumables.

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Items (21, 22, 23 and 26) focused more on medicines and assistive devices. These items focused more on the availability of medication, explanation of the reasons for taking medicines, reporting of medication side-effects and access to assistive devices when needed. Whereas items (32, 33 and 34) focused more on medical equipment, which is available and in a working condition, as well as the availability of consumables or stock.

These items had an acceptable Cronbach's alpha of .56 (medicines/assistive devices) and .69 (equipment/consumables).

4.6.4 Domain 4: Public Health

The factor analysis regarding Domain 4: Public Health is presented in Table 4.8.

Table 4.8: Domain 4: Public Health

	PUBLIC HEALTH	Public Health
		1
A49	Health promotion or disease prevention events are organised in the community	.808
A51	The community-based service team visits my family at home between clinic appointments	.768
A50	Patient support groups are organised at the clinic or in the community	.679

The Domain 4 is named Public Health. One factor explained 56.76% of the total variance was extracted. The KMO value of this sub-scale was .619. The Bartlett p-value was < 0.001, which indicates that the factor analysis was appropriate.

The items that loaded on this subscale were items 49, 50 and 51. These factors focused on the organisation of health promotion activities in the community, community-based team home visits between clinic visits and the organisation of patient support groups in the community or at the clinics.

This subscale had a moderate Cronbach's alpha of .62 (Taber, 2017).

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4.6.5 Domain 5: Leadership and Corporate Governance

Domain 5: Leadership and Corporate Governance factor analysis is presented in Table 4.9.

Table 4.9: Domain 5: Leadership and Corporate Governance

	LEADERSHIP AND CORPORATE GOVERNANCE	Leadership/ Corporate Governance
		1
A53	Goals, values, future plans and focus areas of the WCDoH are visible in the clinic	.842
A54	The role and function of the clinic committee is visible in the clinic	.801
A52	Community communication events are organised by the Department of Health to inform the community about health system aspects	.759
A6	The structure with the names or pictures of all the staff members is visible in the clinic (organogram)	.488

This sub-scale is labelled Leadership/Corporate Governance. One factor clarified that 54.14% of the total variance was extracted. The KMO value of this sub-scale was .704. Bartlett p-value was < 0.001, which indicates that the factor analysis was appropriate.

The items that loaded on this sub-scale were items 6, 52, 53 and 54. These items focused on the visibility of the organogram, role and function of the clinic committee, goals, values and future plans of the DoH and the organisation of communication events as organised by the DoH.

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This subscale had a moderate Cronbach's alpha of .70.

4.6.6 Domain 6: Operational Management

The EFA regarding Domain 6: Operational Management is shown in Table 4.10.

Table 4.10: Domain 6: Operational Management

	OPERATIONAL MANAGEMENT
A35	Staff utilises computer technology during my clinic visit
A41	Staffing levels are conducive for quality service delivery

Items 35 and 41 theoretically belong in the sub-scale Operational Management. These two questions could be answered merely by the clinical nurse practitioners and not by the clients. The Cronbach Alpha of these two items is 0.43. As the Cronbach Alpha is very low, these two items were kept separate.

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4.6.7 Domain 7: Infrastructure and Facilities

The EFA regarding Domain 7: Infrastructure and Facilities is presented in Table 4.11.

Table 4.11: Domain 7: Infrastructure/facilities

	INFRASTRUCTURE AND FACILITIES	
A57	The physical appearance of the clinic has a positive effect on my morale	.780
A56	Maintenance of the building is up-to-date	.717
A58	The grounds outside the clinic are maintained	.687
A55	The clinic has enough space for the number of patients	.610
A59	An evacuation plan is visible	.528
A16	Clean drinking water and disposable cups are available to me in the waiting areas	.416
A42	The clinic is accessible to patients with disabilities or the aged	.342

The Domain 7 was named Infrastructure and Facilities. One factor explained 36.24% of the total variance was extracted. The KMO value of this sub-scale was .779. The Bartlett p-value was < 0.001, which indicates that the factor analysis was appropriate.

The items that loaded on this subscale were items 16, 42, 55, 56, 57, 58 and 59. These items focused on the availability of clean drinking water in the waiting areas, accessibility of the clinic for the aged and disabled clients, adequate space for the number of clients, maintenance of the building is up-to-date, the physical appearance of the building has a positive effect on the morale, the grounds outside the clinic are maintained and that an evacuation plan is visible.

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This subscale had a moderate Cronbach's alpha of .69.

4.6.8 A1: Information Boards

A1 (information boards are visible) referring to Table 4.12, did not load at all – therefore factor analysis was not done.

Table 4.12: Information Boards

	INFORMATION BOARDS
A1	Information boards are visible

4.7 CORRELATIONS

Spearman's rank order correlations were performed to determine associations between the domains, followed by Spearman correlations with ordered biographical data were performed on the domains for both clinical nurse practitioners and biographical data of the clients.

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According to Nieswiadomy (2011) a correlation indicates the extent to which one variable is related to another variable. Correlations can be interpreted as follow, namely: Small: r = 0.1, medium: 0.3 and large: 0.4 and bigger.

4.7.1 Correlations between the domains

Table 4.13 summarises the results of the correlations between the domains and are discussed:

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Table 4.13: Correlations between the domains

Domains		Facilities/ Infrastructure	Leadership/ Corporate Governance	Public Health	Clinical Support: Medicine and Assistive Devices	Clinical Support: Equipment and Consumables	Clinical Governance/ Care: Staff	Clinical Governance/ Care: Myself and Family	Patient Rights: Referrals	Patient Rights: Reception	Patient Rights: Satisfaction	Patient Rights: Confidentiality	Patient Rights: Choice and Waiting
Facilities/ Infrastructure	Correlation Coefficient	1.000	.456**	.414**	.254**	.059	.376**	.470**	.148**	.422**	.337**	.284**	.420**
	N	447	447	447	447	447	447	447	424	447	447	447	447
Leadership/ Corporate Governance	Correlation Coefficient	.456**	1.000	.550**	.186**	-.033	.207**	.533**	-.045	.309**	.437**	.216**	.420**
	N	447	447	447	447	447	447	447	424	447	447	447	447
Public Health	Correlation Coefficient	.414**	.550**	1.000	.212**	.060	.307**	.554**	.058	.314**	.458**	.293**	.367**
	N	447	447	447	447	447	447	447	424	447	447	447	447
Clinical Support: Medicine and assistive devices	Correlation Coefficient	.254**	.186**	.212**	1.000	.342**	.497**	.399**	.406**	.408**	.243**	.432**	.285**
	N	447	447	447	447	447	447	447	424	447	447	447	447
Clinical Support: Equipment and consumables	Correlation Coefficient	.059	-.033	.060	.342**	1.000	.271**	.133**	.344**	.245**	.049	.261**	-.009
	N	447	447	447	447	447	447	447	424	447	447	447	447
Clinical Governance/ Care: staff	Correlation Coefficient	.376**	.207**	.307**	.497**	.271**	1.000	.507**	.264**	.485**	.329**	.541**	.419**
	N	447	447	447	447	447	447	447	424	447	447	447	447
Clinical Governance/ Care: me and family	Correlation Coefficient	.470**	.533**	.554**	.399**	.133**	.507**	1.000	.161**	.401**	.527**	.527**	.488**
	N	447	447	447	447	447	447	447	424	447	447	447	447
Patient Rights: referrals	Correlation Coefficient	.148**	-.045	.058	.406**	.344**	.264**	.161**	1.000	.240**	.036	.246**	.117*
	N	424	424	424	424	424	424	424	424	424	424	424	424
Domains		Facilities/ Infrastructure	Leadership/ Corporate Governance	Public Health	Clinical Support: Medicine and Assistive Devices	Clinical Support: Equipment and Consumables	Clinical Governance/ Care: Staff	Clinical Governance/Care: Myself and Family	Patients' Rghts: Referrals	Patient Rights: Reception	Patient Rights: Satisfaction	Patient Rights: Confidentiality	Patient Rights: Choice and Waiting
Patient Rights: reception	Correlation Coefficient	.422**	.309**	.314**	.408**	.245**	.485**	.401**	.240**	1.000	.285**	.418**	.353**
	N	447	447	447	447	447	447	447	424	447	447	447	447
Patient Rights: satisfaction	Correlation Coefficient	.337**	.437**	.458**	.243**	.049	.329**	.527**	.036	.285**	1.000	.308**	.336**
	N	447	447	447	447	447	447	447	424	447	447	447	447
Patients' rights: confidentiality	Correlation Coefficient	.284**	.216**	.293**	.432**	.261**	.541**	.527**	.246**	.418**	.308**	1.000	.339**
	N	447	447	447	447	447	447	447	424	447	447	447	447
Patient Rights: choice and waiting	Correlation Coefficient	.420**	.420**	.367**	.285**	-.009	.419**	.488**	.117*	.353**	.336**	.339**	1.000
	N	447	447	447	447	447	447	447	424	447	447	447	447

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Spearman's rho

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Table 4.13 shows that *Facilities/Infrastructure (Domain 7)* has large positive correlations with almost all the domains, namely: *Clinical Governance/Care/Safety: Myself/Family* (r=.470; p ‹0.001); *Leadership/Corporate Governance* (r=.456; p ‹0.001); *Patient Rights: Reception* (r= .422; p ‹0.001); *Patient Rights: Waiting time* (r= .420; p ‹0.001) and *Public Health* (r=.414, p ‹0.001). Furthermore, Facilities/Infrastructure has medium positive correlations with *Clinical Governance/Care/Safety: Staff* (r=.376; p ‹0.001) and *Patient Rights: Satisfaction/Safety* (r=.337; p ‹0.001).

Leadership/Corporate Governance (Domain 5) has large positive relationships with *Patient Rights, namely: Satisfaction Safety* (r= .437; p ‹0.001), *Waiting* (r= .420; p ‹0.001) and a medium correlation with *Patient Rights: Reception* (r= .309; p ‹0.001). Furthermore, *Leadership/Corporate Governance* shows a large, positive relationship with *Clinical Governance/Care and Safety: Myself/Family* (r= .533; p ‹0.001). In addition, *Leadership/Corporate Governance* has a large correlation with *Public Health* (r= .550; p ‹0.001).

Public Health (Domain 4) correlates with *Clinical Governance/Care/Safety. A large positive correlation is shown with Myself/Family* (r= .554; p ‹0.001) and a medium positive correlation with *Staff (r=.307;* p ‹0.001). Furthermore, Domain 4 correlates positive with Patient Rights, namely: a large correlation with *Satisfaction/Safety* (r=.458; p ‹0.001) and medium correlations with: *Waiting* (r=. 367; p ‹0.001) and *Reception* (r= .314; p ‹0.001).

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Domain 3, Clinical Support: Medicine/Assistive Devices has a medium positive correlation with *Clinical Support: Equipment/Consumables* (r= 342; p ‹0.001). Furthermore, this domain correlates with *Clinical Governance/Care/Safety, namely:* a large positive correlation (r= .497; p ‹0.001) with *Staff* and a medium correlation (r= .399; p ‹0.001) with *Myself/Family.*Moreover, Domain 3 has large positive correlations with Patient Rights, namely: *Confidentiality* (r= .432; p ‹0.001), *Reception* (r= .408; p ‹0.001) and *Referral* (r= .406; p ‹0.001).

The second part of *Domain 3* namely, *Clinical Support: Equipment/Consumables* has a medium positive correlation with *Patient Rights: Referral* (r= .344; p ‹0.001).

Domain 2, Clinical Governance/Care/Safety: Staff shows a large positive correlation with *Clinical Governance/Care/Safety: Myself/Family* (r= .507; p ‹0.001). Furthermore, *Domain 2* has correlations with Patient Rights, namely: a large positive correlation with *Confidentiality*

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(r= .541; p ‹0.001); *Reception* (r=. 485; p ‹0.001) and *Waiting* (r=. 419; p ‹0.001) and a medium positive correlation with *Satisfaction* (r= .329; p ‹0.001).

The second part of *Domain 2*, namely *Clinical Governance/Care/Safety: Myself/Family* has large positive correlations with Patient Rights, namely: *Satisfaction* (r= .527; p ‹0.001); *Confidentiality* (r= .527; p ‹0.001); *Waiting* (r= .488; p ‹0.001) and *Reception* (r= .401; p ‹0.001).

Domain 1, Patient Rights, comprises of the following subdomains, namely: Referrals, Reception, Satisfaction, Confidentiality and Waiting/Choice. There is a large positive correlation with Patient Rights: Reception and Confidentiality (r=. 418; p ‹0.001) and a medium correlation with Waiting (r= .353; p ‹0.001).

Domain 1, Patient Rights: Satisfaction has a positive medium correlation with Waiting (r= .336; p ‹0.001) and Confidentiality (r= .308; p ‹0.001).

Domain 1, Patient Rights: Confidentiality has a medium positive correlation with Waiting (r= .339; p ‹0.001).

From the above it is clear that the domains are not in isolation, but interwoven or dependent on each other. For example, when the infrastructure is experienced as poor, it could result in both negative patient perceptions of the quality of care they are probably to receive at the facility and unhappiness amongst health care workers with regard to their working conditions (Vawda & Variawa, 2012). Furthermore, the study of Davies *et al.* (2013) confirmed that infrastructural constraints impacted morale, compromised staff health and influenced clinic efficiency. The study of Xaba *et al.* (2012) emphasised that inadequate infrastructure in some clinics hampered service delivery, specifically the lack of space grossly affected the quality of care. Some clinics are not intended for the provision of a PHC package of care, especially those that were built before 1994. Thus, poor infrastructure could hamper clinical care, pose safety risks, and could negatively influence Patient Rights (satisfaction, privacy and waiting).

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4.7.2 Correlations between the domains and the biographical data of the clinical nurse practitioners

Spearman correlations were conducted on the age range, years of experience after registration as a professional nurse and years of employment at this clinic and is presented in Table 4.14.

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Table 4.14: Spearman correlations between the domains and clinical nurse practitioners' biographical data (n=64)

Domains	Age	Years of experience after registration	Years of employment at this clinic
Infrastructure	.442**	.216	.292*
Leadership/Corporate Governance	.069	.120	.062
Public Health	.192	.212	.095
Clinical Support: Medicine and assistive devices	.324**	.279*	.134
Clinical Support: Equipment and consumables	.078	.054	.023
Clinical Governance/ Care: staff	.131	.060	.140
Clinical Governance/ Care: me and family	.208	.080	.183
Patient Rights: referrals	.309*	.377**	.104
Patient Rights: reception	.375**	.267*	.130
Patient Rights: satisfaction	-.079	-.094	.058
Patients' rights: confidentiality	.191	.099	.088
Patient Rights: choice and waiting	.438**	.438**	.297*

A large positive correlation is shown between infrastructure and the age of the clinical nurse practitioners (r=.442; p ‹0.001) and a medium correlation with years of employment at this clinic (r= .292; p= 0.019). The perceptions of the clinical nurse practitioners will intensify as they become older and the longer (more years of employment) they work.

There is a medium positive correlation between clinical support: medicines/assistive devices and the age of the clinical nurse practitioners (r= . 324; p=0.009). The impact on the clinical nurse practitioners' perceptions (positive or negative as per their experience or exposure) about medicines and assistive devices will intensify, the longer they are employed.

According to Table 4.14 there is a medium correlation between Patient Rights: referrals and the age range of the clinical nurse practitioners (r=.309; p = 0.013) and a medium correlation, with statistical significance with years of experience after registration as a professional nurse (r=.377; p= 0.002). The perception (whether positive or negative) of the clinical nurse practitioners regarding referrals will intensify as they grow older, and as the years after registration advance.

There is a medium correlation between Patient Rights: Reception and the age range of the clinical nurse practitioners (r = .375; p = 0.002). The perceptions of the clinical nurse practitioners regarding Patient Rights: Reception will intensify as the clinical nurse gets older.

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According to Table 4.14, there is a large correlation between Patient Rights: Waiting and the age range of the clinical nurse practitioners (r= .438; p= ‹0.001), also a large relation, with years of experience after registration (r= .438; p ‹0.001). The clinical nurse practitioners' viewpoint regarding Patient Rights: waiting will intensify as they get older also with more years of experience after registration.

4.7.3 Correlations between the domains and the clients' biographical data

Correlations were performed between biographical data of the clients with the domains, referring to: age; educational level; average number of clinic visits in the past 12 months; average number of traditional healer visits in the past 12 months; average number of private doctor visits during the past 12 months. These correlations are presented in Table 4.15.

Table 4.15: Correlations between the domains and clients' biographical data (n=383)

Domains	Age	Education	Clinic visits	Traditional healer visits	Private doctor visits
Infrastructure	-.040	.131*	-.093	.052	.089
Leadership/Corporate Governance	-.138**	.159**	-.038	.226**	.190**
Public Health	-.035	.107*	-.044	.138**	.104*
Clinical Support: Medicine and assistive devices	.021	-.002	-.004	-.064	-.049
Clinical Support: Equipment and consumables	.048	-.111*	.045	-.105*	-.066
Clinical Governance/ Care: staff	.076	-.019	-.006	-.030	-.045
Clinical Governance/ Care: me and family	-.010	.099	-.081	.150**	.108*
Patient Rights: referrals	.096	-.109*	.053	-.138**	-.122*
Patient Rights: reception	.124*	-.064	.007	.017	-.010
Patient Rights: satisfaction	-.018	.035	-.075	.094	.040
Patients' rights: confidentiality	.062	-.011	-.057	-.008	.002
Patient Rights: choice and waiting	.017	-.006	-.010	.139**	-.006

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed)

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Table 4.15 shows low correlations between the domains and clients' biographical data.

ANOVA and t-tests revealed no statistical significances.

4.8 GAP ANALYSIS (MEAN, STANDARD ERROR, EFFECT SIZE, HIERARCHICAL LINEAR MODELLING)

A four-point Likert scale was utilised during the study, (1= never; 2= sometimes, 3= frequently and 4= always). The differences between the clients and clinical nurse practitioners were indicated by way of mean (M), Standard Error (SE), Effect Size and Hierarchical Linear Modelling. These analyses were performed on the clinic level and an unstructured covariance structure was used when comparisons between different groups were made. The utilisation of the standardised difference is one method to report on practical significance. Effect Sizes are introduced, which not only makes the difference independent of units and sample size, but relates it also with the spread of the data (Ellis & Steyn, 2003). Cohen (1988) in Ellis and Steyn (2003) gives the following guidelines for the interpretation of the *Effect Sizes*, namely: *small effect: d=0.2; medium effect: d=0.5 and large effect: d=0.8.* A *mean value smaller than 2.5* on the 4-point Likert scale is considered as a "*problem*", while medium to large differences between perceptions of clinical nurse practitioners and clients represent a "*gap*".

The *gaps/problems* (see Tables 4.16 to 4.31) are identified referring to the difference in mean between the clients and clinical nurse practitioners, statistical significances and strength of the effect sizes. Boxes 4.14 to 4.27 highlighted the identified problems and or gaps.

Table 4.16: Patient Rights - Reception (mean, p value and effect size)

		Mean			Clinic		
		Clients	Nurses	MSE	Variance	P value	Effect Size
	PATIENT RIGHTS: RECEPTION	3.14	3.06	0.309	0.230	0.243	0.15
A2	Clerks at reception are helpful	3.02	3.17	0.945	0.090	0.270	0.14
A3	My folder is retrieved timely at reception	2.99	2.74	1.051	0.350	0.068	0.24
A4	I am addressed in a language that I understand	3.65	3.05	0.665	0.008	‹0.001	0.74
A5	Staff members wear name tags to show their identity	3.07	3.06	1.227	0.175	0.930	0.01
A7	Staff members treat me with respect	3.12	3.24	0.892	0.031	0.378	0.12
A10	I am treated on the day of my clinic visit	3.19	2.96	1.006	0.037	0.088	0.23
A48	The clinic is clean	2.96	3.19	1.021	0.120	0.095	0.22

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According to Table 4.16 both clinical nurse practitioners and clients are persuasive about Patient Rights: reception issues.

Question A4 (I am addressed in a language that I understand), is statistically (p ‹ 0.001) and practically significant with a large effect size (d=0.74). Therefore, language could be considered as an area where there is a "gap" between the perception of the clinical nurse practitioners and clients.

Box 4.13: Gap regarding Patient Rights - Reception (mean, p value and effect size)

- Addressing clients in a language they understand

Table 4.17: Patient Rights – Satisfaction and Safety (mean, p value and effect size)

		Mean			Clinic		
		Clients	Nurses	MSE	Variance	P Value	Effect Size
	PATIENT RIGHTS: SATISFACTION/SAFETY	2.28	2.72	0.642	0.031	<0.001	0.55
A40	I am made aware about the "Patient Rights Charter"	2.70	3.27	1.370	0.040	<0.001	0.48
A44	I am made aware of the process how to lodge a complaint	2.53	3.49	1.516	0.056	<0.001	0.76
A45	I have had the opportunity to participate in a patient satisfaction survey	1.83	2.44	1.240	0.083	<0.001	0.53
A46	Systems are in place to ensure my safety	2.04	1.68	1.373	0.144	0.026	0.29

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Table 4.17 shows that clients (mean <2.5) are less convinced, than the clinical nurse practitioners about Patient Rights: Satisfaction/Safety. Furthermore, Patient Rights: Satisfaction/Safety is statistically (p<0.001) and practically significant with a medium effect size (d=0.55). Patient Rights: Satisfaction/Safety domain could be considered as a "problem" for clients, as well as an area where there is a gap between perception of clinical nurse practitioners and clients.

Item A40 (I am made aware about the "Patient Rights Charter"), is statistically (p<0.001) and practical significant with a medium effect size (d=0.48). The awareness about the Patient Rights Charter could be considered as a "gap" between the perception of clinical nurse practitioners and clients.

Item A44 (I am made aware of the process how to lodge a complaint), is statistically (p< 0.001) and practical significant with a medium effect size (d= 0.76). Clients (mean=2.53) are less convinced that they are aware of how to lodge a complaint. This could be considered as a

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"problem" for clients, as well a gap between perception of clinical nurse practitioners and clients.

Item A45 (I have the opportunity to participate in a patient satisfaction survey), is statistically ($p<0,001$) and practical significant, with a medium effect size ($d= 0.53$). Both clinical nurse practitioners and clients (mean <2.5) are not persuasive about the opportunity to participate in a patient satisfaction survey. This is a "problem" for both clinical nurse practitioners and clients, as well as a gap between perceptions of clinical nurse practitioners and clients.

A46 (systems are in place to ensure my safety), shows statistical significance ($p = 0.026$). Both clinical nurse practitioners and clients (mean <2.5) are not convinced that systems are in place to ensure their safety. This is a "problem" for both the clinical nurse practitioners and clients, as well a gap between perceptions of clinical nurse practitioners and clients.

Box 4.14: Problems and gaps regarding Patient Rights – Satisfaction/Safety (mean, p value and effect size)

- Clients' awareness of the "Patient Rights Charter"
- Clients' awareness about the process of how to lodge a complaint
- Clients' opportunity to participate in a patient satisfaction survey
- Availability of systems to ensure clients' safety

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Table 4.18: Patient Rights – Referrals (mean, p value and effect size)

		Mean			Clinic		
		Clients	**Nurses**	**MSE**	**Variance**	**P value**	**Effect Size**
	PATIENT RIGHTS: REFERRALS	3.35	3.17	0.496	0.028	0.062	0.25
A27	Referral appointments are available within two weeks, when needed	3.17	2.81	1.021	0.027	0.010	0.35
A28	I am provided with a referral letter when referred	3.55	3.73	0.676	0.089	0.106	0.21
A29	I have access to transport, when needed	3.26	2.96	1.019	0.054	0.030	0.25

Table 4.18 shows that both clinical nurse practitioners and clients are convinced about Patient Rights: Referrals.

Item A27 (referral appointments are available within two weeks, when needed), is statistically significant ($p=0.0010$) where clients tended to be more satisfied with referral appointments than nurses' perceptions.

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A29 (I have access to transport, when needed), is statistically significant (p=0.030), where clients tended to be more satisfied with transport than nurses' perceptions.

Box 4.15: Gaps about Patient Rights – Referrals (mean, p value and effect size)

- Availability of referral appointments within two weeks

Table 4.19: Patient Rights -Waiting (mean, p value and effect size)

		Mean			Clinic		
		Clients	Nurses	MSE	Variance	P value	Effect Size
	PATIENT RIGHTS: WAITING	2.15	2.47	0.443	0.018	‹0.001	0.47
A8	I can make an appointment according to my needs or preferences	2.69	2.67	1.333	0.028	0.894	0.02
A9	I have the opportunity to choose a staff member I prefer for health service delivery	1.94	2.28	1.291	0.032	0.027	0.30
A11	Patients with more urgent health problems receive care before those with minor problems	2.68	3.10	1.334	0.004	0.008	0.36
A12	Waiting times are monitored to prevent long waiting periods	2.00	2.20	1.184	0.015	0.175	0.18
A13	I am kept informed about how long I would have to wait before someone attends to me	1.89	2.55	1.214	0.000	‹0.001	0.60
A14	Waiting time is acceptable	1.99	2.32	1.215	0.045	0.025	0.30
A15	I am kept busy while I have to wait for service delivery	1.86	2.17	1.029	0.162	0.024	0.29

According to Table 4.19 Patient Rights: Waiting is statistically (p‹0,001) and practical significant with a medium effect size (d= 0.47). Both clinical nurse practitioners and clients (mean ‹2.5) are not persuasive about Patient Rights: Waiting. Patient Rights: Waiting could be considered as a "problem" for both clinical nurse practitioners and clients, as well as an area where there is a "gap" between perception of clinical nurse practitioners and clients.

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Item A9 (I have the opportunity to choose a staff member I prefer for health service delivery), is statistically significant (p= 0.027) although not important in practice. Both clinical nurse practitioners and clients (mean ‹2.5) are not convinced about the opportunity for clients to choose a staff member for service delivery. This could be considered as a "problem" for both clinical nurse practitioners and clients. A11 (patients with more urgent health problems receive care before those with minor problems), is statistically (p=0.008) and practical significant (effect size d=0.36). The clients are less convinced that patients with more urgent health problems receive care before those with minor problems. However, the clients' mean are low (2.68) and this could become a "problem".

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A12 (Waiting times are monitored to prevent long waiting). Both clinical nurse practitioners and clients (mean ‹2.5) were not convinced about the monitoring of waiting times. This could be considered as a problem for both clinical nurse practitioners and clients.

A13 (I am kept informed how long I would have to wait before someone attends to me), is statistically (p‹0.001) and practical significant with a medium effect size of (d=0.60). The clients (mean ‹2.5) are less convinced that they were cognisant of how long they would have to wait. This is a problem for the clients, as well as a gap between perception of clinical nurse practitioners and clients.

A14 (waiting time is acceptable), is statistically significant (p=0.025) although not important in practice. Both clinical nurse practitioners and clients (mean ‹2.5) are persuasive about the acceptability of waiting times. This is a "problem" for both clinical nurse practitioners and clients.

A15 (I am kept busy while I have to wait for service delivery), is statistically significant (p=0.024) although not important in practice. Both the clinical nurse practitioners and clients (mean ‹2.5) are not convinced that clients are kept busy while waiting. This could be considered as a problem for both clinical nurse practitioners and clients.

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Box 4.16: Gaps and problems about Patient Rights - Waiting (mean, p value and effect size)

- Opportunity for clients to choose a staff member
- Patients with urgent problems to receive care before those with minor ailments
- Monitoring of waiting times
- Informing patients about how long they have to wait
- Acceptability of waiting times
- Keeping clients busy while waiting

Table 4.20: Patient Rights – Confidentiality (mean, p value and effect size)

		Mean			Clinic		
		Clients	Nurses	MSE	Variance	P value	Effect Size
	PATIENT RIGHTS: CONFIDENTIALITY	3.24	3.72	0.464	0.028	‹0.001	0.68
A30	I am encouraged to ask questions	2.75	3.48	1.307	0.070	‹0.001	0.62
A36	My privacy is respected during consultation or treatment	3.47	3.86	0.707	0.488	0.001	0.45
A37	My personal information is kept confidential	3.51	3.83	0.715	0.016	0.006	0.37

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According to Table 4.20 Patient Rights: Confidentiality is statistically (p‹ 0.001) and practical significant, with a medium effect size (d= 0.68). Both clinical nurse practitioners and clients are convinced about Patient Rights: Confidentiality but clients to a lesser degree than clinical nurse practitioners and this can be considered as a "gap".

A30 (I am encouraged to ask questions), is statistically (p‹0.001) and practical significant, with a medium effect size (d=0.68). The clients are less convinced about the opportunity to ask questions than clinical nurse practitioners and this can be considered as a "gap".

A36 (my privacy is respected during consultation or treatment), is statistically (p=0.001) and practical significant with a medium effect size (d=0.45). The clients are less convinced about privacy than clinical nurse practitioners and this can be considered as a "gap".

A37 (my personal information is kept confidential), is statistically (p=0.006) and practical significant (medium effect size d=0.37)). The clients are less convinced about personal information being kept confidential than clinical nurse practitioners' and this can be considered as a "gap".

Box 4.17: Gaps about Patient Rights – Confidentiality (mean, p value and effect size)

- Opportunity for clients to ask questions
- Respect for clients' privacy
- Confidentiality of clients' personal information

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Table 4.21: Clinical Governance, Care and Safety – Staff (mean, p value and effect size)

		Mean			Clinic		
		Clients	Nurses	MSE	Variance	P value	Effect Size
	CLINICAL GOVERNANCE, CARE AND SAFETY: STAFF	3.09	3.47	0.417	0.021	‹0.001	0.57
A17	All my problems or needs are addressed during one visit	2.80	3.29	1.182	0.083	0.001	0.44
A18	Staff spends time with me	2.93	3.21	1.160	0.138	0.060	0.24
A19	The results of my investigation tests are explained to me in an understandable manner	3.26	3.53	1.086	0.000	0.056	0.26
A31	I am advised to come back	3.43	3.87	0.807	0.023	‹0.001	0.49
A47	Infection control measures are practised by the staff	3.04	3.45	1.304	0.000	0.008	0.36

According to Table 4.21 Clinical Governance, Care and Safety: Staff, is statistically (p‹0.001) and practical significant, with a medium effect size (d=0.57). Both clinical nurse practitioners

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and clients are convinced about Clinical Governance/Care/Safety: Staff, but clients to a lesser degree than clinical nurse practitioners and be considered as a "gap".

A17 (all my problems or needs are addressed during one visit, is statistically (p=0.001) and practical significant, with a medium effect size (d = 0.44) with clients to a lesser degree satisfied than clinical nurse practitioners and can be considered as a "gap".

A31 (I am encouraged to come back) is statistically (p‹ 0.001) and practical significant, with a medium effect size= 0.49) with clients to a lesser degree satisfied than clinical nurse practitioners and can be considered as a "gap" between perception of clinical nurse practitioners and clients.

A47 (infection control measures are practised by the staff) is statistically (p=0.008) and practical significant (medium effect size d=0.36).

Box 4.18: Gaps about Clinical Governance, Care and Safety: Staff (mean, p value and effect size)

- Addressing of clients' problems or needs during one visit
- Advising clients to come back
- Staff practising infection control measures

Table 4.22: Clinical Governance, Care and Safety (mean, p value and effect size)

		Mean			Clinic		
		Clients	Nurses	MSE	Variance	P value	Effect Size
	CLINICAL GOVERNANCE, CARE AND SAFETY: MYSELF AND FAMILY	2.67	3.25	0.565	0.008	‹0.001	0.77
A20	I am asked to repeat information received to the staff to evaluate whether I understood the information they had given me	2.42	2.96	1.352	0.014	0.001	0.45
A24	I receive written information about my health problem or medication	2.34	2.53	1.460	0.000	0.249	0.16
A25	I receive advice about what I can do to improve my wellness	2.87	3.40	1.294	0.043	‹0.001	0.50
A38	Staff involves me in decisions about my health care	2.97	3.67	1.210	0.049	‹0.001	0.62
A39	Staff involves my family or friends (when appropriate)	2.69	3.29	1.157	0.046	‹0.001	0.54
A43	I am encouraged to report any adverse event	2.84	3.64	1.348	0.001	‹0.001	0.69

Table 4.22 shows that Clinical Governance, Care and Safety: Myself and Family are statistically (p‹0.001) and practical significant, with a large effect size (d=0.77). Clients (mean=2.67) are not very persuasive about Clinical Governance/Care/Safety: Myself: Family.

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This can be considered as a “gap” between the perception of clinical nurse practitioners and clients and could become a “problem” for the clients.

A20 (I am asked to repeat information received to the staff to evaluate whether I understood the information they had given me) is statistically significant (p=0.001) and practical significant with a small effect size (d=0.45). The clients (mean ‹2.5) are less convinced about this statement. This is a “problem” for the clients, as well as a “gap” between perception of clinical nurse practitioners and clients.

Item A24 (I receive written information about my health problem or medication), shows that both clinical nurse practitioners and clients (mean ‹2.5) are not convinced about the provision of written information about the clients’ health problem or medication. This could be considered as a “problem” for both clinical nurse practitioners and clients.

A25 (I receive advice about what I can do to improve my wellness), is statistically and practical significant, with a medium effect size (d= 0.50). This can be considered as a “gap” between perception of clinical nurse practitioners and clients.

A38 (staff involves me in decisions about my health care), is statistically (p‹0.001) and practical significant with a medium effect size (d=0.62). This can be considered as a “gap” between perception of clinical nurse practitioners and clients.

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A39 (staff involves my family or friends, when appropriate), is statistically (p‹ 0.001) and practical significant, with a medium effect size (0.54). This can be considered as a “gap” between perception of clinical nurse practitioners and clients.

A43 (I am encouraged to report any adverse events), is statistically (p‹0.001) and practical significant with a medium effect size (d= 0.69). This can be considered as a “gap” between perception of clinical nurse practitioners and clients.

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Box 4.19: Problems and gaps about Clinical Governance, Care and Safety: Myself and Family (mean, p value and effect size)

- Clients' repetition of information to evaluate whether they understood
- Written advice to clients about their health problem or medication
- Written advice to clients to improve their wellness
- Involvements of clients in decision making about their health care
- Involvement of clients' family or friends (when appropriate)
- Clients' reporting of adverse events

Table 4.23: Clinical Support: Medicines and Assistive Devices (mean, p value and effect size)

		Mean			Clinic		
		Clients	Nurses	MSE	Variance	P value	Effect Size
	CLINICAL SUPPORT: MEDICINE AND ASSISTIVE DEVICES	3.17	3.21	0.455	0.029	0.651	0.06
A21	Medicines are in stock and available when needed	3.32	3.00	0.784	0.037	0.008	0.37
A22	Reasons for taking medication are explained to me	3.47	3.62	0.796	0.014	0.207	0.17
A23	I am encouraged to report any medication side-effects	3.01	3.50	1.223	0.063	0.001	0.42
A26	I have access to assistive devices when needed	2.61	2.74	1.311	0.137	0.439	0.11

According to Table 4.23 Clinical Support: Medicine and Assistive Devices, both clinical nurse practitioners and clients are convinced about Clinical Support: Medicine/Assistive Devices.

A21 (medicines are in stock and available when needed), is statistically (p=0.008) and practical significant (medium effect size d=0.37) with clients perceived more satisfied than clinical nurse practitioners.

A23 (I am encouraged to report any medication side-effects), is statistically (p=0.001), and practical significant with a medium effect size (0.42), with clients being perceived as less satisfied than nurses. This can be considered as a "gap" between perception of clinical nurse practitioners and clients.

Box 4.20: Gaps about Clinical Support: Medicines and Assistive Devices (mean, p value and effect size)

- Availability of medicines
- Report of medication side-effects

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Table 4.24: Clinical Support: Equipment and Consumables (mean, p value and effect size)

		Mean			Clinic		
		Clients	Nurses	MSE	Variance	P value	Effect Size
	CLINICAL SUPPORT: EQUIPMENT AND CONSUMABLES	3.62	3.47	0.374	0.009	0.080	0.24
A32	The necessary equipment is available as required for my treatment	3.64	3.58	0.631	0.009	0.583	0.07
A33	Medical equipment that is required for my needs is in a working condition	3.58	3.43	0.655	0.019	0.172	0.18
A34	Consumables or supplies are in stock	3.63	3.40	0.538	0.004	0.025	0.30

Table 4.24 reveals that both clinical nurse practitioners and clients are persuasive about clinical support: equipment and consumables.

A34 (consumables are in stock), is statistically significant (p=0.025) although not important in practice. Clients are more positive than the clinical nurse practitioners with Clinical Support: Equipment/Consumables.

Table 4.25: Public Health (mean, p value and effect size)

		Mean			Clinic		
		Clients	Nurses	MSE	Variance	P value	Effect Size
	PUBLIC HEALTH	2.45	3.16	0.761	0.033	‹0.001	0.79
A49	Health promotion or disease prevention events are organised in the community	2.42	3.09	1.272	0.057	‹0.001	0.58
A50	Patient support groups are organised at the clinic or in the community	2.80	2.93	1.370	0.152	0.417	0.10
A51	The community-based service team visits my family at home between clinic appointments	2.13	3.44	1.395	0.042	‹0.001	1.09

Table 4.25 states that public health, is statistically (p‹0.001), and practical significant with a large effect size (d=0.79). Clients are less convinced (mean ‹2.5) about the Public Health aspects. This could be regarded as a "problem" for the clients, as well as a 'gap" between perception of clinical nurse practitioners and clients.

A49 (health promotion or disease prevention events are organised in the community), is statistically (p‹0.001) and practical significant with a medium effect size (d= 0.58). Clients (mean ‹2.5) are less convinced that health promotion and disease prevention events are

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organised in the community. This could be regarded as a "problem" for the clients, as well as a "gap" between perception of clinical nurse practitioners and clients.

A51 (the community-based service team visits my family at home between clinic appointments), is statistically (p‹0.001), and practical significant with a large effect size (d=1.09). Clients (mean ‹2.5) are less convinced that community-based service team home visits do between clinic appointments. This could be regard as a "problem" for the clients, as well as a gap between perception of clinical nurse practitioners and clients.

Box 4.21: Gaps and problems about Public Health (mean, p value and effect size)

- Health promotion or disease prevention events in the community
- Home visits by community-based service teams

Table 4.26: Leadership and Corporate Governance (mean, p value and effect size)

		Mean			Clinic		
		Clients	Nurses	MSE	Variance	P values	Effect Size
	LEADERSHIP AND CORPORATE GOVERNANCE	2.35	2.53	0.778	0.100	0.118	0.20
A6	The structure with the names or pictures of all the staff members is visible in the clinic (organogram)	2.40	2.64	1.568	0.277	0.146	0.18
A52	Community communication events are organised by the DeoH to inform the community about health system aspects	2.12	2.36	1.290	0.100	0.124	0.20
A53	Goals, values, future plans and focus areas of the WCDoH are visible in the clinic	2.43	3.18	1.499	0.127	‹0.001	0.59
A54	The role and function of the clinic committee is visible in the clinic	2.43	1.97	1.629	0.061	0.008	0.36

According to Table 4.26 both clinical nurse practitioners and clients (mean ‹2.5) are dissatisfied with leadership/governance aspects. This is a "problem" for both clinical nurse practitioners and clients.

A6 (the structure with the names or pictures of all the staff members is visible in the clinic). The clients (mean ‹2.5) are less convinced about the visibility of the organogram in the clinic. The clinical nurse practitioners (mean=2.64) are not very persuasive about the visibility of the organogram. The visibility of the organogram could become a "problem" for the clinical nurse practitioners, as well as for the clients.

A52 (community communication events are organised by the DoH to inform the community about health system aspects). Both clinical nurse practitioners and clients (mean ‹2.5) are not

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convinced about the organisation of community communication events in the community. Therefore, this aspect is a "problem" for both the clinical nurse practitioners and clients, as well as a "gap" between perception of clinical nurse practitioners and clients.

A53 (goals, values, future plans and focus areas of the WCDoH are visible in the clinic) is statistically (p‹0.001) and practical significant, with a medium effect size (d=0.59). The clients (mean ‹2.5) are less convinced about the visibility of the goals, values and future plans of the WCDoH. A53 could be considered as a "problem" for the clients, as well as a "gap" between perception of clinical nurse practitioners and clients.

A54 (the role and function of the clinic committee is visible in the clinic), is statistically (p= 0.008) and practical significant (medium effect size d= 0.36). Both clinical nurse practitioners and clients (mean ‹2.5) are not convinced about the visibility of the role and functions of the clinic committee. Therefore, this aspect could be considered as a 'problem" for both clinical nurse practitioners and clients, as well as a "gap" between perception of clinical nurse practitioners and clients.

Box 4.22: Gaps and problems about Leadership and Corporate Governance (mean, p value and effect size)

- Structures with the names or pictures of all the staff members (organograms)
- Community communication events by the DoH
- Visibility of the WCDoH's goals, values, future plans and focus areas
- Visibility of the clinic committee's role and function

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Table 4.27: Infrastructure (mean, p value and effect size)

		Mean			Clinic		
		Clients	**Nurses**	**MSE**	**Variance**	**P value**	**Effect Size**
	INFRASTRUCTURE	2.64	2.60	0.414	0.071	0.716	0.05
A16	Clean drinking water and disposable cups are available to me in the waiting areas	2.08	2.02	1.374	0.243	0.726	0.04
A42	The clinic is accessible to patients with disabilities or the aged	3.21	3.51	1.118	0.052	0.036	0.28
A55	The clinic has enough space for the number of patients	2.10	2.23	1.290	0.235	0.394	0.11
A56	Maintenance of the building is up-to-date	3.02	3.56	1.175	0.124	0.002	0.41
A57	The physical appearance of the clinic has a positive effect on my morale	2.75	2.25	1.145	0.122	0.001	0.44
A58	The grounds outside the clinic are maintained	2.97	2.65	1.088	0.037	0.023	0.30
A59	An evacuation plan is visible	2.33	3.02	1.601	0.023	‹0.001	0.54

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According to Table 4.27, both clinical nurse practitioners and clients are not very persuasive about the adequacy of the infrastructure. This could become a “problem” for both the clinical nurse practitioners and clients.

A16 (clean drinking water and disposable cups are available in the waiting area). Both clinical nurse practitioners and clients (mean ‹2.5) are not convinced about the availability of clean drinking water and cups in the waiting areas. Therefore, this is a “problem” for both clinical nurse practitioners and clients.

A42 (the clinic is accessible to patients with disabilities or the aged), is statistically significant (p=0.036) but not important in practice.

A55 (the clinic has enough space for the number of patients). Both clinical nurse practitioners and clients (mean ‹2.5) were not convinced about adequate space for the number of patients. Therefore, this aspect could be considered as a “problem’ for both clinical nurse practitioners and clients.

A56 (maintenance of the building is up-to-date), is statistically (p=0.002), and practical significant with a medium effect size (d=0.41) with clients less satisfied than clinical nurse practitioners, indicating a “gap” between the perceptions of clients and that of clinical nurse practitioners.

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A57 (the physical appearance of the clinic has a positive effect on my morale), is statistically significant (p=0.001) with a medium effect size (d=0.44) with clients more satisfied than clinical nurse practitioners. The clinical nurse practitioners (mean ‹2.5) are not convinced about this statement. Also, the clients (mean=2.75) are not very convinced. Therefore, the physical appearance of the clinic could be considered as a “problem” for the clinical nurse practitioners and could become a “problem” for the clients.

A58 (the grounds outside the clinic are maintained), is statistical significant (p=0.023) although not important in practice. The maintenance of the grounds could become a problem for the clinical nurse practitioners’ as the mean is low (2.65).

A59 (an evacuation plan is visible), is statistically (p‹ 0.001), and practical significant with a medium effect size (d=0.54), indicating a “gap” between perceptions of clinical nurse

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practitioners and clients. The clients (mean ‹2.5) are not aware of an evacuation plan. The lack of the evacuation plan is a "problem" to be considered for the clients.

Box 4.23: Gaps and problems about Infrastructure (mean, p value and effect size)

- Availability of clean drinking water and cups for clients in the waiting area
- Accessibility for clients with disabilities
- Adequacy of clinic space
- Up-to-date clinic maintenance
- Effect of the clinic's physical appearance on staff morale
- Maintenance of the clinic's outside ground
- Visibility of the clinic's evacuation plan

Table 4.28: Information boards are visible (mean, p value and effect size)

		Mean			Clinic		
		Clients	Nurses	MSE	Variance	P value	Effect Size
A1	Information boards are visible	3.38	3.01	1.037	0.040	0.008	0.36

A1 (information boards are visible), is statistically (p=0.008) and practical significant (medium effect size d=0.36). Both clinical nurse practitioners and clients are convinced about the visibility of the information boards.

Box 4.24: Gap about Information boards are visible (mean, p value and effect size)

- Visibility of information boards

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Table 4.29: Operational Management (mean, p value and effect size)

		Mean			Clinic		
		Clients	Nurses	MSE	Variance	P value	Effect Size
	OPERATIONAL MANAGEMENT		N/A	N/A			N/A
A35	Staff utilises computer technology during my clinic visit	2.83	2.83	1.409	0.173	0.997	0.00
A41	Staffing levels are conducive for quality service delivery	2.40	2.88	1.366	0.073	0.003	0.40

Table 4.29 shows that A41 (staffing levels are conducive for quality service delivery), is statistically (p=0.003), and practical significant with a medium effect size (d=0.40) indicating a "gap" between perception of clinical nurse practitioners and clients. Clients (mean ‹2.5) were less convinced about the adequacy of the staffing levels. Therefore, staffing levels could be considered as a "problem" according to the clients.

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Box 4.25: Gap and problem about Operational Management (mean, p value and effect size)

- Conduciveness of staffing levels

Table 4.30: Descriptive statistics regarding the clinical nurse specific questions (B60-B70) (n=64)

		Mean	Standard Error of Mean	95% CL for Mean	
B60	Medical waste is managed in a safe way	3.63	0.08	3.48	3.80
B61	Staff members deliver quality care to patients	3.44	0.09	3.26	3.61
B62	Staff members are focused to provide person-centred services	3.47	0.10	3.27	3.66
B63	My work situation gives me a feeling of personal accomplishment	3.02	0.10	2.80	3.23
B64	I am provided with the relevant clinical guidelines or policies to provide quality care	3.63	0.07	3.49	3.76
B65	I attend meetings about mortality and morbidity	1.78	0.10	1.57	1.99
B66	I attend training courses	2.55	0.11	2.31	2.78
B67	The employee assistance programme enables me to cope with the daily demands of the working milieu	2.02	0.11	1.79	2.24
B68	Supervisory support is available for me	3.03	0.11	2.80	3.26
B69	The manager of the clinic has the capacity to function as both operational manager and as a clinical nurse practitioner	3.28	0.11	3.07	3.49
B70	The current staff appraisal helps me to improve my work performance	2.53	0.12	2.29	2.77

B65 (I attend meetings about mortality and morbidity), mean is ‹2.5. This could be considered as clinical nurse practitioners not persuasive about the attending of mortality and morbidity meetings. Therefore, this could be considered as a "problem" for the clinical nurse practitioners.

B66 (I attend training courses) have a low score (mean 2.55) indicating that the clinical nurse practitioners were not very persuasive about the attending of training courses. This could be considered as a "problem" regarding the clinical nurse practitioners.

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B67 (the employee assistance programme enables me to cope with the daily demands of the working milieu), has a low mean (mean ‹2.5) and could be identified as a “problem” to be considered for the clinical nurse practitioners.

The mean of B70 (the current staff appraisal system helps me to improve my work performance) scores 2.53, this could be considered as a “problem” for the clinical nurse practitioners.

Box 4.26: Problems identified by the descriptive statistics regarding the clinical nurse specific questions (B60-B70)

- Attendance of mortality and morbidity meetings
- Employee assistance programme’s ability to help staff coping with daily demands

Table 4.31: Descriptive statistics about the client specific questions (B60-B66) (n=383)

		Mean	Standard Error of Mean	95% CL for Mean	
B60	I feel welcome at this clinic	2.92	0.06	2.81	3.04
B61	Staff members act as role models	2.42	0.06	2.31	2.54
B62	I receive personalised health care	2.96	0.06	2.85	3.07
B63	I understand more about my health after my clinic visit	3.05	0.05	2.95	3.16
B64	My basic health needs are met	3.03	0.05	2.92	3.13
B65	I will recommend the service to my family or friends	2.82	0.06	2.70	2.94
B66	Health care service is free	3.56	0.05	3.46	3.65

According to Table 4.31, B61 (staff members act as role models) mean is ‹2.5. Therefore, this could be considered as a “problem” for the clients.

Box 4.27: Problem identified by the descriptive statistics about the client specific questions (B60-B66) (n=383)

- Staff acting as role models

4.9 DISCUSSION OF RESULTS

The quantitative data analysis of this study revealed numerous “gaps” or/and “problems”, as indicated by clinical nurse practitioners and clients. These identified “gaps” and “problems” could pose a threat towards quality client-centred care of PHC clinics in the West Coast District. These “gaps” or/and “problems” are discussed in the following section, according to

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the clinical nurse practitioners' biographical data, clients' biographical data, seven domains (structured according to the GAP analysis), information boards, clinical nurse specific problems and clients' specific problems.

4.9.1 Clinical nurse practitioners' biographical data

The racial composition of the West Coast is currently restricted to Coloured and White clinical nurse practitioners, while the demographic profile of the Western Cape include: 52% Coloureds, 29% Africans, 18% Whites and 1% "other" population groups (Western Cape Government Department of Agriculture, 2014). The context of this study is rural and Afrikaans is the language of the day. African and "other races" could experience language barriers which may possibly pose a barrier to quality client-centred care as it can result in communication barriers between the health care providers and clients. Fernandez, Rossouw, Marcus, Smit, Reinbrecht-Schutte, Smit, Kinkel, Memon and Hugo (2014), Williams, Petersen, Sorsdahl, Matthews, Everitt-Murphy and Parry (2015) confirmed that language barriers may cause a problem to health care staff in understanding their clients' complaints or desires and clients in turn, may not always understand the information provided by the of the healthcare workers.

Moreover, the current workforce, as in many countries around the world (Uthaman, Chua & Ang, 2015; Sherman, Chiang-Hanisko & Koszalinski, 2013), shows signs of ageing as 75% (n=48) clinical nurse practitioners were above the age of 41 years. When this age group retires, the West Coast District will experience a serious shortage of clinical nurse practitioners as only 3.12% (n=2) clinical nurse practitioners were in the age group between 25 and 30.

4.9.2 Clients' biographical data

An interesting, though not unique finding was the low percentage of male clients n=86 (22.45%), compared to females n=297 (77.55%) visiting the PHC clinics. According to Banks and Baker (2013) PHC until now are not providing men with adequate and effective prevention and screening services, or diagnosing and treating potentially severe conditions quickly enough. This is not only a United Kingdom problem – it affects Europe and, indeed most of the world.

Another threat to quality client-centred care, are the clients with no schooling or clients with marginal education levels (Grade 7 and below). Low literacy levels could compromise quality client-centred care as it is associated with poor understanding of information, poor self-management skills, worse self-reported health status, and greater likelihood of hospitalisation

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(Taylor & McDermott, 2010; Javadzade, Sharifirad, Radjati, Mosttafavi & Hasanzade, 2012). Furthermore, low literacy levels could influence active engagement in the management of health and to make a wide range of health decisions (Ishikawa & Kiuchi, 2010).

In addition, the study findings indicated a significant percentage of unemployed clients n=206 (53.79%) which could pose another threat to quality client-centred care. The relationship between unemployment and poorer physical and mental health are well-described (Driscoll & Bernstein, 2012; Romppainen, Saloniemi, Kinnunen, Liukkonen & Virtanen, 2014). Concurrently, Pharr, Moonie and Bungum (2012) also confirmed that unemployed clients were more prone to experience higher levels of mental health conditions, e.g. depression, anxiety and stress, as well as higher levels of mental health admissions, chronic disease (cardiovascular disease, hypertension and musculoskeletal disorders), and premature mortality.

The study findings also highlighted that not all clients were within 5 km or walking distance from the nearest clinic. According to Gaede and Versteeg (2011), 15% rural households live more than an hour away from the nearest clinic. This study, also in the rural context n=107 (28.01%) participants indicated that they have to travel more than 5 km to the nearest clinic. Dennill *et al.* (2010) stated that according to the WHO, clinics must be within 5 to 10 km in order to be geographically accessible. Furthermore, n=72 (18.80%) participants indicated that they have to make use of transport to access the nearest clinic. Unfortunately, the West Coast clients do not have access to free transport services, therefore they have to pay for transport compromising the "free" health services.

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In addition, this study revealed a high PHC clinic utilisation rate. The majority of clients n=290 (75.72%) visited the clinics more than 4 times over the past 12 months. According to the WCDoH (Western Cape Department of Health, 2013), the national target for 2014/15 was estimated at 3.5 visits per person per annum. This higher utilization rate could be as a consequence of the burden of disease of the West Coast District, comprising HIV, and TB, child and maternal diseases, non-communicable diseases and injuries.

Besides PHC clinic visits, a remarkable number n=102 (26.63%) of clients, also consulted traditional healers. This is not a unique finding as Learmonth *et al.* (2014) confirmed that 80% of South Africans are consulting with traditional healers. Likewise, Mukolo, Cooil and Victor (2015) stated that a remarkable number of people in rural Mozambique are consulting both traditional and biomedical health care providers. The improvement in health education, general

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education and acculturation/modernization support increased the utilisation of biomedicine care, while the let-down to adequately prioritize and address people's satisfaction with care and expectancy of meaningful relief from illness, is likely to undermine these public health initiatives. However, Hughes, Aboyade, Clark and Puoane (2013) emphasised that health care workers should be aware of, and question traditional health medication, in order to counsel patients on the probability of herb-drug interaction and possible side effects.

Furthermore, n=174 (45.66%) clients indicated that besides clinic visits, they also utilize the services of private doctors. Therefore, to ensure quality client-centred care traditional healer visits and private doctor visits have to be considered in treatment plans.

4.9.3 Domain 1: Patient Rights

The Consitution of the Republic of South Africa (Act 108 of 1996), the National Health Act (Act 61 of 2003), the National Patient Rights Charter (South African National Department of Health, 1999) and Batho Pele principles (Republic of South Africa, 1997) acknowledge and emphasize the rights of all people and affirm the values of human dignity, equality and freedom. In spite of this legislation and these policies, the study findings showed numerous "problems" and/or "gaps" relating to the Patient Rights domain. The Patient Rights domain included the following subdomains, namely: Reception; Satisfaction/Safety; Referral; Waiting and Confidentiality.

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4.9.3.1 Patient Rights: Reception

Patient Rights: Reception (Table 4.1), identified the ability to understand language as a "gap". According to the National Patient Rights Charter (South African National Department of Health, 1999; Health Professions Council of South Africa, 2008) health information should be in an understandable language. The study findings showed that language understandability was identified as a "gap" and is consistent with international and national study findings. Priebe, Sandhu, Dias, Gaddini, Greacen, Loannidis, Kluge, Krasnik, Lamkaddem, Lorant, Riera, Sarvary, Soares, Stankunas, Straβmayr, Wahlbeck, Welbel and Bogic (2011) confirmed that language difficulties pose a challenge for accessible, equitable and good quality health services. Likewise, the qualitative study of Williams *et al.* (2015) in Cape Town, SA showed that facilities increasingly see more foreigners with large diversities of languages. These language barriers pose challenges for quality client-centered care, since the aim to overcome cultural and socioeconomic differences, improve communication and develop meaningful client-clinician relationships were compromised.

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In addition, this subdomain, correlates positively with the following subdomains, namely: Patient Rights: confidentiality; Patient Rights: Waiting and also positively correlates with the age of the clinical nurse practitioners.

4.9.3.2 Patient Rights: Satisfaction/Safety

According to the study findings, the sub-domain Patient Rights: Satisfaction/Safety (Table 4.17) revealed the following problems/gaps, namely: the process about how to lodge a complaint, the opportunity to participate in patient satisfaction campaigns and the availability of systems to ensure clients' safety. According to the National Patient Rights Charter (South African National Department of Health, 1999 & Health Professions Council of South Africa, 2008), all people are entitled to complain about health care services.

This study findings were in line with the focus group discussions of O'Reilly and Washington (2012) confirming that most of the participants (young women from informal Durban settlements) were unaware of the process how to lodge a complaint. On the contrary, when Black Sash (2011) monitored 74 SA clinics in the Western Cape, Northern Cape, Eastern Cape, Mpumalanga, Limpopo, Gauteng, North West and KwaZulu Natal, they found that 70% of patients, were knowledgeable of their right to complain.

Furthermore, awareness of the Patient Rights Charter, was identified as a "gap" in this study. Similarly, the study findings of a cross-sectional study on the awareness of Patient Rights in Sari, Iran also showed that the majority of participants (63.4%) were not aware of the bill of Patient Rights, (Yaghobian, Kaheni, Danesh & Abhari, 2014). On the other hand, the patient satisfaction survey in the Eastern Cape (2009) showed that more than half (n=562;59.9%) participants confirmed the visibility of the Patient Rights posters (Phaswana-Mafuya, Davids, Senekal & Munyaka, 2011).

Safety and security seemed to be also a problem as indicated by both clinical nurse practitioners and clients. These findings are contradictory to the proposed NHI for SA which stated that "fundamental health support services such as ... safety and security must be available on a continuous and uninterrupted basis" (Republic of South Africa, 2015). Similarly, the National Health Care Facilities Baseline Audit of 2011 (Health Systems Trust, 2013) showed poor outcomes regarding safety and security at health facilities throughout SA (including PHC clinics) referring to: Eastern Cape (34%), Free State (37%), Gauteng (50%), KwaZulu-Natal (38%), Limpopo (31%), Mpumulanga (27%), Northern Cape (23%), North West (30%) and

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Western Cape (39%). These poor outcomes about safety and security correspond with the results of the cross-sectional study of Munyewende *et al*. (2014) confirming that security in the clinics of Gauteng and Free State was a big challenge for nursing managers. Most of these clinics did not have alarms or guards to safekeep the premises. On the contrary, Zambia (2014) did a case study in the city of Johannesburg and almost 75% of participants were satisfied regarding safety and security aspects.

Furthermore, both clinical nurse practitioners and clients identified the opportunity to participate in patient satisfaction surveys as a “problem” and as a”gap”. According to the Ideal Clnic Standards (South African National Department of Health, 2017a) “the outcomes of the annual patient experience of care survey should be visibly posted ”. This is supported by De Almeida, Bourliataux-Lajoinie and Martins (2015) who stated that patient experience and satisfaction are a measure of quality care. Furthermore, patient satisfaction surveys provide the opportunity for managers and policy makers with an improved understanding of patient views and perceptions, and the extent of their participation in improving the quality of care and services (Al-Abri & Al-Balushi, 2014).

This domain also showed to correlate with the following Patient Rights domains, namely Confidentiality and Choice/Waiting.

4.9.3.3 Patient Rights: Referrals

The HPCSA (Health Professions Council of South Africa, 2008) and Patient Rights Charter (South African National Department of Health, 1999) stated that everyone has the right to be referred for a second opinion to a health provider of one’s choice. This study identified the availability of a referral appointment within two weeks as a “gap” (Table 4.18). Clients tended to be more convinced with their referral appointments within two weeks and were more satisfied with access to transport than the clinical nurse practitioners.

According to the literature, waiting time for an referral appointment could be long. According to the study findings of Price *et al.* (2012) breast cancer, Kaposi sarcoma and lymphoma patients of Cameroon waited more than 6 months to consult with a health care provider after the initial sign of their cancer. The rural mental health workforce assessment of Thomas, MacDowell and Glasser (2012) in the United States of America, similarly as in the rural areas of SA, confirmed that referral centres were too far and showed serious inadequacies of certain categories of healthcare providers, e.g. psychiatric nurses, social workers and therapists

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resulting in long waiting times for appointments. More than 30 days or travelling more than one hour for care were reported. Dew *et al.* (2012) study results also showed that due to the shortage of therapists in the rural areas of New South Wales, many disabled people experienced difficulties to access therapeutic services.

Despite the challenge of getting a referral appointment, transport to the referral services seemed to be nationally and internationally a challenge. Transport was repeatedly identified as a barrier for access to community-based PHC in Ontario, particurlarly in the rural areas (Lafortune *et al.*, 2015). In line with this study, Gaede and Versteeg (2011) also expressed their concern with access to referral services for rural communities in SA due to long travelling distances, time and cost.

4.9.3.4 Patient Rights: Waiting

Various problems and gaps related to Patient Rights: Waiting as a subdomain was highlighted by this study's findings (Table 4.19).

According to Oche and Adamu (2013) the IOM recommends that 90% of patients should be attended to within 30 minutes of their appointment. However, the current findings of the studt showed that both clinical nurse practitioners and clients experienced this sub-domain as a "problem" and a "gap". Clients were more convinced that waiting time subdomain was a problem.

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Several studies highlighted long waiting times as a concern. Van Rooy *et al.* (2015) identified that especially on Mondays and Fridays waiting times were extremely lengthy in Sarantakos, Namibia. Sokhela *et al.* (2013) also identified Mondays as having extremely lengthy waiting times at eThekwini District, SA, due to admissions from hospitals. Furthermore, the study results of Stellenberg (2015) also showed that n=28 (51.9%) of participants indicated that long waiting times at community health clinics prohibited them from using their clinic services. Clients were required to be at the clinic at 06:00 and when they pitched at 07:00, it might be too late to be attended to on that specific day. Moreover, Miller, Ketlhapile, Rybasack-Smith and Rosen (2010) reported the abandoning of treatment because of long waiting times.

The WCDoH (Western Cape Department of Health, 2014) emphasized the importance of patient triaging to ensure prioritising of patients with acute conditions or those with limited mobility. However, this study finding showed that clinical nurse practitioners and clients differed on their perceptions about the triaging of patients.

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Moreover, another area of concern is that clients were more convinced than clinical nurse practitioners of not being informed about how long they would have to wait. Sokhela *et al.* (2013) confirmed that when clients were informed about how long they would have to wait, they showed understanding and acceptance. Whereas, a lack of communication about waiting times were perceived as poor staff attitude and was associated with dissatisfaction.

In addition, the National Patient Rights Charter (South African National Department of Health, 1999 & Health Professions Council of South Africa, 2008) highlighted that everyone is entitled to choose a specific health care provider. However, both clinical nurse practitioners and clients confirmed that the opportunity to choose a staff member for service delivery was a problem.

Furthermore, this study's findings showed that waiting times are not monitored. Sastry, Long, De Sa, Salie, Topp and Van Niekerk's (2015) study findings showed that it was worthwhile to monitor waiting times to plan for quality improvement. This action research resulted in the decreasing of waiting times in two busy PHC clinics in the Western Cape. Waiting times in the pharmacy reduced by 27 minutes and for acute patients, the average waiting time decreased from 197 to 171 minutes. Moreover, a reduction in patient time spent at the clinic was shown, a 79 minute, or a 295 descent in mean time from arrival to departure.

In addition, clients who were kept busy while waiting was perceived as a problem by both clients and clinical nurse practitioners. On the other hand, Oche and Adamu's (2013) study results showed that while waiting n=63/96 (65.6%) respondents were engaged in chatting with each other, while a few (7.3%) were reading newspapers or magazines. However, among the participants, n=42/96 would have desired listening to health talks, while n=32/96 (33.3%) would have preferred watching television if available.

Patient Rights: waiting correlates positively with age and years of experience of the clinical nurse practitioners.

4.9.3.5 Patient Rights: Confidentiality

The SANDoH's Patient Rights Charter (South African National Department of Health, 1999) and HPCSA (Health Professions Council of South Africa, 2008) are very specific that information about a person's health and or information about treatment may only be exposed with informed consent. However, according to this study the clinical nurse practitioners and clients differed about their perceptions on the sub-domain of Patient Rights: Confidentiality

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(Table 4.35). "Gaps" were identified, about: clients encouraged to ask questions, respect of privacy during consultations or treatment and confidentiality of personal information.

On the contrary, study results of Sufiyan *et al.* (2013) showed 88.9% of the staff motivate clients to ask questions concerning their various health conditions and 86.3% of the clients had their questions answered fully. Similarly, Aggarwal and Hutchison (2012:17) reported that Canadian patients (85%) confirmed that they have always or often have an opportunity to ask questions about recommended treatment, compared to New Zealand (92%).

However, as in this study, Amnesty International (2014) went to 16 PHC clinics in KwaZulu-Natal and health care staff confirmed that fears of confidentiality were justified. Patients confirmed that the lack of confidentiality was the main reason for their unwillingness to visit the clinics – and was often their justification for postponing antenatal care.

Furthermore, Van Rooy *et al.* (2015) emphasised that some clinics were accommodated in a house with small rooms. When these rooms become overcrowded, it was almost impossible to protect patients' privacy. A 79 year old Kabbe/Zambesi pensioner reported that "things are just done in front of other people".

Patient Rights: Confidentiality showed a positive correlation with the subdomain Patient Rights: Choice and Waiting.

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4.9.4 Domain 2: Clinical Governance

Clinical Governance refers to the subdomains of Clinical Governance, Care and Safety of Staff (Table 4.21) and Clinical Governance, Care and Safety of the Client, and his Family (Table 4.22).

4.9.4.1 Clinical Governance, Care and Safety: Staff

The study findings revealed that the subdomain Clinical Governance, Care and Safety: Staff was considered as a "gap". Furthermore, both problems or needs are addressed during one visit, and clients are advised to come back, are to be considered as "gaps". While infection control measures, practised by the staff seemed to be statistically and practical significant.

Likewise, Visagie and Schneider's (2014) study results higlighted the impact of inadequate staffing, e.g. when only one sister was on duty it could result in very long waiting times and patients who pitched during the morning could be told to come back later the afternoon. In addition, service delivery seemed to be fragmented. Mondays were scheduled for the handout

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of medication, Wednesdays were prioritised as doctor's day and on Fridays patients from the farms received preference. On these days other patients could not visit the clinic as they would not receive care and have to return on another day. The study of Ngxongo and Sibiya (2013) showed that basic antenatal services were available every day of the week in 17 (94%) facilities, except for one (5.6%) where basic antenatal services were provided twice a week. When basic antenatal services are available on a daily basis, it will prevent clients from either being turned away or asked to return on another day. Moreover, Vergunst *et al.* (2015) identified that unreliable levels of resources could result in visiting the clinic more than once, in order to receive complete treatment. Also, the study of Stellenberg (2015) revealed that when too many patients attended the clinic on a specific day, rapid screening was performed by the registered nurse, and even if the patient was there at 06:00, he or she could be told to return the following day.

Moreover, the study findings indicated gaps between the perceptions of the clinical nurse practitioners and clients about "I am advised to come back".

On the other hand, Jama and Tshotsho's (2013) study confirmed the various efforts of clinical nurse practitioners to get hold of defaulting patients, namely: phoning the clients or the nearest clinic, home visits, collaboration with other stakeholders, assistance through family members or partners. Nevertheless, Nzaumvila and Mabuza's (2015) study identified various reasons why patients dit not pitch for their follow-up visits. According to the participants they were not informed about the prevention of mother-to-child transmission, poor service delivery, unprofessional behaviour of healthcare staff, unavailability of drugs, fear of stigma and poor patient socioeconomic circumstances. Poor socioeconomic conditions were concurrent with numerous other studies, namely: Steyl and Phillips (2014); Eloff, Forsyth, Finestone, Ebersohn, Visser, Ferreira, Boeving and Sikkema (2011) and Mulondo, Khoza and Maputle (2014). In addition, Padtfield (2013), a community psychologist experienced that 35% of patients scheduled for appointments did not pitch. Unattended appointments were due to: family crises, physical illness, long waiting times, stigma and helplessness. In addition, "gaps" were identified between the perception of the clinical nurse practitioners and clients about the practising of infection control measures.

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As in this study, various studies highlighted various inadequacies about the practice of infection control. According to Bhebhe, Van Rooyen and Steinberg (2014), 89.2% of healthcare workers had proper knowledge of TB. However, only 22% knew the correct method

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of sputum collection. Furthermore, 36.4% reported poor infection control practices. Only 38.8% reported the usage of the N95 respirator. Engelbrecht and Van Rensburg's (2013) study in three districts in SA revealed that 48.8% of clinic staff did not isolate coughing patients from other patients. Only 35.4% provided coughing patients with face masks or tissues. Furthermore, only 18.9% of the clinics had an open-window register. There was a serious shortage of N95 masks and only 10 community health workers received training on infection control practices.

Clinical governance, care and safety: staff showed positive correlations with the following subdomains, namely: clinical governance/care and safety: myself and family, as well as with the following Patient Rights subdomains, namely: reception, satisfaction, confidentiality, choice and waiting.

4.9.4.2 Clinical Governance, Care and Safety: Myself and Family

As with the previous subdomain, Clinical Governance, Care and Safety: Myself and Family, as subdomain was also identified as a "gap" (Table 4.22). Almost all the variables were identified as "gaps" by the clinical nurse practitioners and clients.

Clients were more convinced that they were not asked to repeat information to the healthcare providers in order to evaluate whether they understood the information.

Howarth (2014) emphasized the importance to verify a patient's understanding of the options available, the risks involved and the consequences of the decision made. Moreover, health care staff should encourage patients to make sure they understood the information. Mabuza, Omole, Govender and Ndimande's (2014) study showed that not all patients seek clarity.

Similar to this study, clients were not convincing about having received written information about their health problem or medication. Written information to patients seemed to be important for some researchers and debatable for others. Steyn and Golstuck (2013) emphasized the importance of providing women with written information on contraceptives, including advice about possible side-effects and the availability of emergency contraception if needed. On the other hand, Wright, Biya and Chokwe's (2014) study results showed that a leaflet in English on pregnancy promoting health and increasing health literacy about pregnancy in Tswane, SA did not improve knowledge but exposed the low level of knowledge regarding health in pregnancy. On the other hand, the study findings of Court and Austin (2015) showed that 95% of participants in Wales, found an information leaflet about glaucoma extremely useful as they understood their condition very well (95%) and correctly identified

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their diagnosis as glaucoma, 83% as ocular hypertension and 78% suspected eye problems. On the other hand, findings of Mirzaei *et al.* (2013) revealed that almost half of the Australian participants have difficulties in understanding the material and advice they recieved about their health conditions and this often led to non-compliance. Effective assessment of patients' literacy levels will support healthcare staff to provide education on an suitable level to improve patients' health literacy (Wasserman, Maja & Wright, 2010). In addition, according to Black (2012), patient information pamphlets, with well-tested pictograms or pictures explaining the use of medicine clearly and simply could add value. Unfortunately, there are very few pictograms available.

In addition, clinical nurse practitioners and clients differed about the provision of advice to improve wellness. Clients were less convinced about receiving advice on how to improve wellness. All patients should be afforded the time and interest of their health care provider so that they may assist their patients in making well-informed choices with respect to their lifesyle (eg. excercise training, dietary modifications and psychosocial interventions) to promote health and manage diseases (Derman, Whitesman, Dreyer, Patel, Nossel & Schwellnus, 2010). However, overcrowded public health facilities resulted in inadequate time for individual patient education and counselling sessions. The study results of Fernandez *et al*. (2014) confirmed that a third of patients (N=447) in selected PHC clinics (N=22) in Tshwane, SA could not recall whether they received information regarding lifestyle changes or diet modifications. Comprehension of information was linked with three or more doctor's consultations; communication in the same or similar language; patient participation; and opinion that the doctor had explained their disease to them. In addition, patients experienced group education as valuable and indicated that they gained new knowledge and a change in their behaviour was confirmed (Serfontein & Mash, 2013).

"Gaps" were shown with regard to the involvement of clients and family. The South African Constitution (Act No. 108 of 1996) and National Health Act (Act No. 61 of 2003) higlighted the importance of a patient's right for self-determination and the doctrine of informed consent. Furthermore, shared decision making where the patient is placed at the centre of care, is considered as the most important aspect of client-centred care. Patients can engage with the healthcare process as they are motivated to take into account the options available to treat or manage the condition (and the likely benefits and harms of each) so that they can communicate their preferences and help choose the best course of action (Manyonga, Howarth, Dinwoodle,

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Nisselle and Whitehouse, 2014). As in this study, partcipants in the study of Marshall, Kitson and Zeitz (2012) were less convinced about involvement in decision making and showed a need for better communication, creating a sense of being actively involved in their care rather, than being a passive receiver. Similarly, Diab (2013) also valued the inclusion of patients in decision making to ensure optimum care, satisfied patients, a decrease in litigation risk and an overall more satisfying experience for both the health care provider and patient. It is widely believed that patients are more prone to take their medicines effectively when they have agreed to their prescription and felt involved in the decision making (Hawley, 2012).

In addition, the study findings showed "gaps" in the perceptions of clients who have been encouraged to report adverse events. Research has indicated that a large number of adverse events were preventable and related to human behaviour (Jansma, Zwart, Leistikov, Kalkman & Binjen, 2010). However, various barriers were experienced with the reporting of adverse events, namely: limited time , difficult reporting systems, no perceived benefits, ignorance, no motivation from the facility, inadequate feedback on medical events reports, threats to one's career and personal reputation, and a lack of knowledge of what to report. Oosthuizen and Van Deventer (2010) emphasized the importance of the physician-patient relationship and patient-centredness in quality care. Patient participation should be considered in the management of adverse events and quality improvement programmes. Metha (2011) confirmed that ongoing and routine monitoring of patients for adverse events were neglected. While actively encouraging patients to immediately report any adverse effects or intolerance to the medication throughout the course of treatment could ensure that adherence or harmful effects aremanaged efficiently. Blockman and Cohen (2011) also emphasized a culture of non-punitive reporting of adverse events in the medical community to ensure awareness of harm caused by drugs and introduce strategies to minimise harm.

Importantly, Clinical Governance, Care and Safety: Myself and Family showed positive correlations or interrelatedness with Patient Rights (Reception, Satisfaction, Confidentiality, Choice and Waiting).

4.9.5 Domain 3: Clinical Support: Medicines and Assistive devices

Clinical Support Services Domain 3 refers to the subdomains of Clinical Support: Medicines and Assistive Devices (Table 4.23) and Clinical Support: Equipment and Consumables (Table 4.39).

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4.9.5.1 Clinical Support: Medicines and Assistive devices

The subdomain Clinical Support: Medicines and Assistive devices revealed a “gap” about the availability of medicines when needed. The clinical nurse practitioners were less convinced that medicines were in stock when needed.

The WHO estimates that nearly two billion people are not receiving regularly all medicines they need (Paniz, Fassa, Maia, Domingues & Bertoldi, 2010). Various studies reported medication stock-outs, namely: Macha *et al.* (2012); Magadzire *et al.* (2014); Wood, Viljoen, Van der Merwe and Mash (2015); Marais and Petersen (2015) and Masango- Makgobela *et al.* (2013). Likewise, Bansal and Purohit (2013) revealed that fifty to eighty percent of the Indian population have limited access to basic medicines. This resulted in patients being either forced to go without or buy medicines from the private sector where generic medicines cost on average six times more than their international reference price. Moreover, the study of Visagie and Schneider (2014) emphasized the negative influence of medication shortages on contiunuity of care in rural and remote areas of SA. The reasons for these medication shortages were not known, but seemed to be linked to the ordering and delivery systems, as well as payment and inadequate stock in the warehouses. However, the unavailability of medication can cause complications and permanent impairments and poses a threat to quality client-centered care.

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Furthermore, clinical nurse practitioners and clients differed about the reporting of medication side-effects. The clinical nurse practitioners were more convinced tha clients were encouraged to report medication side-effects. On the contrary, study findings of Elkalmi *et al.* (2013) revealed that in Penang, Malaysia 77.2% of participants indicated that they received information on medication side-effects from the doctor and 44.6% from the pharmacist. However, it was not stated that they were encouraged to report side-effects. On the other hand, Mkele (2010) emphasized the role of the pharmacist to inform patients about common medication side-effects and advising patients to report these symptoms. Moreover, according to Van Zyl (2011) information leaflets are very clear about possible side-effects and patients were advised to report these side-effects to their doctor. Similarly, study findings of Ross *et al.* (2011) showed that respondents attending adherence classes in KwaZulu-Natal learnt what the medication side-effects were, and to report it to their doctor.

Clinical Support: Medicines and Assistive devices show positive correlations with the following domains and subdomains, namely: Clinical Support: Equipment and Consumables,

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Clinical Governance, Care and Safety: Staff and Myself and Family; Patient Rights: Referrals, Reception, Confidentiality. Positive correlations are also showed with the age of clinical nurse practitioners.

4.9.5.2 Clinical Support: Equipment and Consumables

The subdomain: Clinical Support: Equipment and Consumables (Table 4.24) showed a statistical significance, though not important in practice. Both clinical nurse practitioners and clients did not experience a "problem" with consumables and equipment.

On the contrary, the study of Crowley and Stellenberg (2014) reported that in 10% of the PHC clinics in uMgunglovu District, KwaZulu-Natal, essential equipment, e.g.: otoscopes, thermometres, blood pressure monitors, and jugs for mixing and measuring paediatric medication were unavailable or not in a working condition. Simirlarly, Scheffler *et al.* (2015) identified periodic shortages of equipment and resources, eg. gloves and oxygen masks in urban PHC settings, SA. Furthermore, equipment has to be shared between consultation rooms of the clinics, resulting to time wasted searching for it. Shortages of equipment and consumables are not restricted to the South African setting, as indicated by the study of Aikins *et al.*, (2014). Ghana also experienced shortages in equipment and consumable supplies which resulted in mistrust and alienation of health care users.

Clinical support: equipment and consumables showed a positive correlation Patient Rights: referrals.

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4.9.6 Domain 4: Public Health

The Domain of Public Health (Table 4.25) revealed a "gap" between clinical nurse practitioners and clients. Clients in this study, identified this domain as a "problem".

This is in line with Bam, Marcus, Kinkel, Hugo and Kinkel (2013) who described PHC as a passive, low quality and episodic service to patients in clinics, whilst hospitals were burdened excessively with referrals and patients seeking help. Therefore, Dr Aaron Motsolaledi, the Minister of Health emphasized the re-engineering of PHC towards proactive household and community-based interventions. Re-engineering of PHC incudes promotion of healthy living, disease prevention, early detection, treatment of illness, community-based management and rehabilitation (Le Roux & Couper, 2015).

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However, according to this study's findings clients' health promotion events in the community seemed to be a challenge. The study findings of Samson-Akpan, Edet, Akpablo and Asuquo (2013) confirmed that nurses experienced a lack of knowledge regarding health promotion, as well as a lack of the practical prescriptions as to what constitutes health promotion activity and how it is to be applied in nursing practice. Kemppainen *et al.* (2012) also emphasized that nurses still do not always understand health promotion activities. Furthermore, Brobeck *et al.* (2013) stated that Swedish nurses indicated that they required more time and resources to design successful health promotion activities.

To address the health promotion challenge, Ramathuba, Mashau and Tugli (2015) identified that community healthcare workers at the most basic level in the communities are in a better position to focus on health promotion activities and programmes, thus easing the workload burden of nurses in the public health sector, because they are unable to intensify health education programmes. Clients in this study, identified home visits by the community healthcare workers as a challenge. While Mthobeni and Peu (2013) higlighted the good results of door-to-door or home visits and drives where health information pamphlets and health education were provided to families with good outcomes. The study of Maphula and Mudhovozi (2012); Jack *et al.* (2010) and Mthobeni and Peu (2013) emphasized the following services of home-based carers, namely: to support and counsel those with physical disabilities, medication and adherence support to those with chronic disease, including TB and HIV/AIDS. Furthermore, home-based carers visit selected households in the community on a daily basis to render physical care, emotional support, training of family members on how to care for their family member, refer patients when needed to the nearest clinic, hospital or hospice.

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Public Health showed positive correlations with the following domains and subdomains, namely: Clinical Governance, Care and Safety: Staff and Myself and Family, Patient Rights: Reception, Satisfaction, Choice and Waiting.

4.9.7 Domain 5: Leadership and Corporate Governance

Both clinical nurse practitioners and clients identified the Domain of Leadership and Corporate Governance as a "problem" (Table 4.26). Clients experienced problems about the visibility of staff names or pictures (organograms). The researcher could not identify any other studies where patients have a "problem" with the visibility of staff names or organograms. However, the Ideal Clinic Standards (2017a) require the visibility of organograms with photographs of the facility staff and contact details of the facility manager.

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Moreover, according to the WCDoH (Western Cape Department of Health, 2014) public participation and community involvement are inherent to the PHC philosophy, with effective communication and information sharing capacity as integral parts. However, both clients and clinical nurse practitioners are not convinced about the organisation of community communication events. This is similar to the study findings of Namatovu *et al.* (2014) stating that community involvement activities in both Namayumba and Bobi, Uganda were low. Lack of trust and poor communication amongst community members, health workers and local leaders were stated as reasons. On the contrary, the study of Kotze *et al.* (2013) showed the benefits of community communication, namely: increasing knowledge about community resources and allowed community members to communicate their shared concerns and discuss matters that they deem to be most important in their community. Additionally, the dialogues were interpreted as promotive of relationship-building and collaboration opportunities among community members and between community members and external stakeholders. Furthermore, Abinuomo (2011) emphasized that the strengthening of the link between community and services can only be accomplished through the participation and effective empowerment of the community in the management of the services. This will help to create knowledge, stimulate demand, help persuade those that are difficult to reach and lastly, encourage community participation.

The vision of the WCDoH (Western Cape Department of Health, 2014) for 2030 encompasses access to person-centred quality care and the CCAIRR values. This study findings revealed that the visibility of the goals, values, future plans and focus areas of the DoH showed to be a "gap" and a "problem" between the perceptions of the clinical nurse practitioners and clients. It is of the utmost importance that these aspects should be visible to keep clients, community and staff informed of what they could expect from the WCDoH. The researcher could not identify any studies where these aspects were highlighted as a "problem".

In addition, the visibility of the role and functions of the clinic committee were considered as a "gap", as well as a "problem" by both the clinical nurse practitioners and clients. Similarly, Goodman *et al.* (2011) also identified that over fifty percent of exit interviewees in their study, were unaware of the clinic committee. Women and less-educated repondents were specifically unlikely to know about the clinic committee. However, clinic committees could have a positive impact on promoting the right to health, improving the performance of PHC systems, the satisfaction and permanency of healthcare staff and the satisfaction of communities with

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service delivery. Furthermore, clinic committees could enhance communication and the solving of conflict between communities and healthcare staff and mobilising resources for health activities and services. However, the role of clinic committee members are less well defined, damaging their legitimacy and functioning (Haricharan, 2014).

Leadership and Corporate Governance showed positive correlations with the Domains of Public Health; Clinical Governance: Myself and Family and Patient Rights: Reception, Satisfaction, Choice and Waiting.

4.9.8 Domain 6: Operational Management

The Operational Management domain (Table 4.29) revealed that the adequacy of staffing levels was considered as a "gap". Clients considered staffing levels as a problem in providing quality service.

According to Munyewende *et al*. (2014) many countries experience a health staff shortage. In addition, the WHO (World Health Organization, 2013) projected a shortfall of 12.9 million healthcare staff by 2035. More than four million health workers are needed to address the health workers' shortage in sub-Saharan Africa, with 11% of the world's population and only 3% of health workers.

In SA, since democracy (1994), PHC services expanded to a comprehensive range of services free at the point of contact. Before 1994, the focus was on health prevention and health promotion. PHC comprehensive services pose a big challenge for additional staff with special training. Furthermore, the re-engineering of PHC services poses an additional challenge for more nurses with special skills. According to the National Health Insurance Green Paper towards universal health coverage, PHC is regarded as a nurse-driven service, supported by doctors'. In addition, SA is confronted by a changing profile of diseases, maldistribution of resources between hospitals and clinics, and escalating community expectations. These challenges are made worse by inadequate preparation and training of nurses for community-based work (Munyewende *et al*. (2014).

Nevertheless, according to Bain and Kasangaki (2014) well-trained health care workers is a global shortage, emphasizing staffing levels as low as 50% in Uganda, especially for the hard-to-reach rural areas. Kenya is also challenged by health care workers shortages, particularly in hard-to-reach areas (Ojakaa, Olango & Jarvis, 2014).

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4.9.9 Domain 7: Infrastructure and Facilities

The Domain Infrastructure revealed numerous "problems" and "gaps' (Table 4.27). The availability of clean drinking water and disposable cups in the waiting areas was a "problem" for both the clinical nurse practitioners and clients. This was also highlighted as a "problem" in the study of Chimbindi *et al.* (2014), assessing patients' satisfaction with HIV and TB treatment in public health services in rural KwaZulu-Natal.

Furthermore, a statistical significance was shown between infrastructure and the access of clinics for the disabled or aged client. This is consistent with the findings of Booysen and Schlemmer (2015) where participants indicated that the community health centre of Bishop Lavis, Cape Town is neither wheelchair-friendly nor friendly for those who have to walk with crutches.

Another "problem", identified by both clinical nurse practitioners and clients, was the lack of adequate clinic space for the number of patients. Simarly, Goeiman and Labadarios (2011) also identified the unavailability of space with regard to the nutrition work force in the Western Cape. Makaula *et al.* (2012) also identified limited space as a challenge for rural PHC delivery in Malawi. Also, described in an assessment of the Zimbabwe ministry of health and child welfare provider, a HIV testing and counselling programme was initiated, where the shortage of appropriate counselling space was emphasised as the main challenge which prevented optimum implementation , as the majority of the clinics were built before the HIV epidemic (Sibanda *et al.*, 2012).

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Besides, the lack of adequate clinic space, the lack of maintenance of the buildings as a domain was identified as a "gap" influencing the quality client-centered care. Lack of maintenance was also highlighted by other studies in the PHC context, namely: Makaula *et al*. (2012) in rural Malawi, Scholz *et al.*, (2015) in Tanzania referring to roof leaks and unavailability of plinth protection, including inadequate rain water drainage.

Moreover, clinical nurse practitioners have a "problem" with the effect of the physical appearance of the clinics on their morale, which was also indicated as a "gap". Totman, Hundt, Wearn, Paul and Johnson's (2011) qualitative study revealed that a comfortable and attractive working environment was beneficial for a positive staff morale, especially where staff have access to open-air spaces. Improvements to the working environment were also regarded as

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positive for staff morale, as staff felt valued. Furthermore, a statistical significance between infrastructure and the maintenance of the outside grounds was shown.

The researcher could not find studies revealing the outcomes about the maintenance of clinic outside grounds.

In addition, the visibility of an emergency plan was experienced as a "problem" by the clients and was also highlighted as a "gap". The NCSs criteria for a safe and secure environment require the availability of an evacuation plan to show that patient well-being is always protected (South African National Department of Health, 2011). The Waterberg District Municipality in SA is complying with the NCSs criteria, as they have appointed an accredited service provider to draw an emergency evacuation plan of their buildings. These plans with all exit and evacuation routes and signs are displayed displayed (Waterberg District Municipality, 2015).

Infrastructure and Facilities have shown positive correlations with the following domains, namely: Leadership and Corporate Governance; Public Health; Clinical Governance Care: Staff and Myself and Family; Patient Rights: Reception, Satisfaction, Choice and Waiting.

4.9.10 Information Boards

The visibility of Information Boards (Table 4.28) did not load at all, therefore a factor analysis was not done. However, both clinical nurse practitioners and clients differ on their perceptions about the visibility of information boards, therefore considered to be a "gap".

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The study of Leonard, Verster and Coetzee (2014) emphasized the importance of signage as a contributor to a client-centred environment. Clear signage could support clients in way finding, decrease stress and anxiety levels and increase satisfaction. Furthermore, adequate signage could ease the staff burden, as staff members spend additional time redirecting patients. Ideal Clinic Standards (South African National Department of Health, 2017a) require that the following signage and notices should be visible, namely: road signs to inform clients about the location of the facility; a prominent board indicating the facility name, service hours, physical address, contact details and service package details at the entrance of the facility; gun free, no smoking, no animal notices; visible board to indicate disclaimer searches; photos of political leadership, mission, vision, belief and goals of the health facility; staff organogram with contact details of the managers displayed and all services including the identification and direction of the reception and toilets within the facility.

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4.9.11 Clinical nurse specific problems

In this current study, clinical nurse practitioners (Table 4.30) revealed the attendance of mortality and morbidity meetings as a "problem". However, according to the Clinical Excellence Commission (2014) participation in mortality and morbidity review meetings should be considered as a "core" activity for all clinicians. Clinicians from all relevant specialties and professional backgrounds (i.e. medical, nursing, allied health) have to attend mortality and morbidity meetings. The clinical cases and facility statistics should be the foundation of quality improvement initiatives (Von Pressentin, 2015).

In the descriptive findings, specific to the clinical nurse practitioners, the employee assistance programme (to enable them to cope with the daily demands of the working milieu) was identified as a "problem". Similarly, the study of Mugari, Mtapuri and Rangongo (2014) dealing with employee assistance programme of a local municipality in SA, also showed that the employee assistance programme was not comprehensive enough to meet the needs of the employees.

4.9.12 Client specific problems

Clients (Table 4.31) revealed "staff members acting as role models" as a "problem". This is in line with the baseline audit of the Health Systems Trust (2013) showing that "positive and caring attitudes", one of the six departmental priority areas for patient-centred care obtained the lowest score (30%). Also, Mannava, Durrant, Fisher, Chersich and Luchters' (2015) systematic review confirmed that attitudes and behaviours of maternal staff influence health care seeking and quality of care. Fifty-eight studies covered only negative attitudes or behaviours, with a minority describing positive provider behaviours, such as being caring, respectful, sympathetic and helpful. Negative attitudes and behaviours commonly included verbal abuse (n=45), rudeness such as ignoring or ridiculing patients (n=35) or neglect (n=32). Studies also documented physical abuse towards women, absenteeism or unavailability of staff, corruption, and lack of respect for privacy, poor communication, unwillingness to accommodate traditional practices and authoritarian or frightening attitudes.

4.10 SUMMARY AND CONCLUSION

This chapter represented the clients and clinical nurse practitioners' reported status about quality client-centred care (Objective 2 and 3). Quality client-centred care was analysed by utilising several statistical techniques (biographical analysis; descriptive; factor analysis, correlations and GAP analysis) and was interpreted against the seven domains of the NCSs.

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In conclusion, the analysis indicated that both clients (Objective 2) and clinical nurse practitioners (Objective 3) reported that quality client-centred care was compromised as evident from the clinical nurse practitioners and clients' biographical data and according to each of the seven domains as discussed in the following paragraphs.

The biographical data revealed that clinical nurse practitioners are currently limited by employing only Coloureds and Whites and their ages (above 40 years) contributed to an ageing effect which could result into a shortage of clinical nurse practitioners. The clients' biographical data revealed the following risks for quality client-centred care, namely: males and those above 60 years are underutilising the PHC services; Africans and other races are visiting the clinics, while the staff component is limited to Coloured and Whites only; low educational levels and these unemployed; those not within walking distance and have to make use of taxis or own transport; overutilization by those who attend the clinic more than four times a year and clients consulting both traditional healers and private doctors.

In addition, according to the seven domains the analysis revealed the following quality client-centred care challenges, namely: Patient Rights (*Domain 1*) was not always respected and adhered as it was characterised by: language; satisfaction and safety; referral procedures; waiting times and confidentiality difficulties. The *Domain 2*, Clinical Governance, Care and Safety showed shortcomings as highlighted by the Staff, the Client and his Family. Clinical Support Services, *Domain 3*, revealed inadequacies regarding the continuous availability of medication and the reporting of side-effects. Furthermore, *Domain 4*, the Public Health Domain showed that clients identified community health promotion and disease prevention events, and home visits by the CBS as both a "problem" and a "gap". Leadership and Corporate Governance, *Domain 5* was characterised by the lack of: visible organograms, community communication, visibility of goals, values and future plans of the DoH and role and function of the clinic committees. Moreover, *Domain 6*, Operational Management was challenged by inadequate staffing levels. Lastly, *Domain 7*: Infrastructure was characterised by the lack of drinking water in the waiting areas, inadequate clinic space; maintenance not up-to-date; physical appearance of the clinic did not have a positive effect on staff morale and evacuation plans were not visible.

In addition, correlations between the domains showed that the domains are not in silos but interdependent on each other. Furthermore, the positive correlations between the domains and the biographical data of the clinical nurse practitioners revealed that as the clinical nurse

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practitioners grow older and have more years of experience, problems regarding the relevant domains will intensify.

The results from the quantitative data analysis provided valuable information to be used in the development of the programme to improve quality client-centred care in the PHC facilities of the rural West Coast District.

Chapter five reports on the qualitative data as analysed from the perspective of the managers and allied health professionals.

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CHAPTER FIVE:
RESULTS AND DISCUSSION OF THE QUALITATIVE STUDY

5.1 INTRODUCTION

Chapter 4 provides the quantitative analysis and interpretation of Phase 1 (Objective 2 and 3) - to assess the clients' perceptions and to determine the clinical nurse practitioners' perceptions on quality client-centred care. Chapter 5 presents the qualitative results and discussion of Phase 2 (Objective 4) - to explore and describe the managers and allied health professionals' perceptions about client-centred care. Table 5.1 provides an orientation about the study phases and objectives.

Table 5.1: Overview of the study phases and objectives

PHASE 1: SITUATIONAL ANALYSIS	PHASE 2: PROGRAMME DEVELOPMENT
Objective 1 To explore and describe the current status of quality client-centred care by conducting an extensive literature review	**Objective 5** To develop a programme to facilitate quality client-centred care in PHC clinics of the rural West Coast District
Objective 2 To assess the clients' perceptions regarding quality client-centred care	
Objective 3 To determine the clinical nurse practitioners' perceptions on quality client-centred care	
Objective 4 To explore and describe the managers and allied health professionals' perceptions about quality client-centred care	

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5.2 REALISATION OF THE DATA

A semi-structured interview schedule (Annexure J) was compiled for the focus group discussions. The interview schedule comprises the following five open-ended questions, namely:

- What is your perception of client-centred care at the clinics?
- What inputs are needed to enhance quality client-centred care to clients?
- Which processes must be used to enhance quality client-centred care to the clients?
- What is your perception on the output of a quality client-centred care delivered to clients?
- How can a programme be described that will improve quality client-centred care?

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The target population (N = 43) for this study included the managers and allied health professionals of the five subdistricts. The five subdistricts were coded as: A001; A002; A003; A004 and A007 to enhance confidentiality. The managers of the subdistricts included the PHC Assistant Managers, Co-ordinators of the Infectious Disease programme and Co-ordinators of the CBS programme, Assistant Directors of Human Resources, Finance and Supply Chain. While the allied health professionals included medical officers, dentists, dental chair assistants, pharmacists, dieticians, physiotherapists, occupational therapists, speech therapists and clinical psychologists. An all-inclusive sample was applied. A001 (n =11 participants); A002 (n = 10 participants); A003 (n = 6 participants); A004 (n = 6) and A007 (n = 10 participants).

The researcher conducted a mock focus group discussion in Caledon (situated in the Overberg District) on 12 September 2013, to pre-test the interview schedule. Data generated from this discussion was not included for this study. The researcher identified the need for an external moderator to facilitate the focus group discussions of the main study. Five focus groups, one in each of the five subdistricts were conducted between 29 April and 23 May 2014. The researcher attended each focus group discussion and kept verbatim minutes of each discussion (see Annexures M).

The five audio-recorded focus group discussions were downloaded (MP3 audio/sound files) and sent to an independent professional transcriber. The transcriptions were translated word for word to English. The researcher reviewed the transcribed data and made corrections where appropriate.

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Tesch's open-coding method (1990) was used to analyse data as described in Creswell (2013). The researcher studied all the transcriptions to become familiar with the content. Transcript A001 was picked to commence with and the researcher read through the content and made notes and wrote topics in the margin. The same procedure was followed for transcripts A002, A003, A004 and A007. This review provided the researcher with a general overview of the information and the researcher identified that the data were in line with the seven domains of the NCSs – the theoretical framework of this study. A list of topics were made. These topics were converted into codes. Coding is the process where categories are assigned to portions of the text (Creswell, 2014). All codes were provided with an individual number, e.g. A001: 178 and colour coded to locate where this code was derived from, in order to leave an audit trail. Similar codes were clustered together to form categories, similar categories were clustered

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together to form sub-themes and similar sub-themes were clustered together to form different themes.

The coding/analysis process of this study was a bottom-up process (general to specific) where codes, categories, subthemes and themes were identified. Different colour codes were utilised to differentiate between the seven domains of the NCSs (see Annexure N). The standards of the NCSs guided the researcher to identify relevant "categories" and "sub-themes" from the collected data. Whereas, the seven domains of the NCSs were applied as the seven "themes" for the qualitative data.

The data were revisited to make sure that all data were covered. This data analysis was reviewed by an independent research consultant to ensure consensus about themes, sub-themes, categories and codes. The write-up process follows a top-down process. The researcher starts with the themes and ends with discussing the quotations (see Annexure N). The themes, sub-themes, categories and codes emerging from the focus group discussions are presented as follows.

5.3 THEMES

The subsequent sections presented the findings of the qualitative data as reported by the respective five focus groups. Table 5.2 provided an overview about the emerging themes and sub-themes and Boxes 5.1 to 5.43, present the verbatim, word-for-word quotes. A001, A002, A003, A004 and A007 refer to the five sub-districts and the number on the right e.g. A001: 178 refers to the number of the quote as it was written up. Similar quotes were clustered together, e.g. see example quotation

"Satisfaction with the service" (A001: 178 & A004: 176). This mean that both A001: 178 and A004: 176 shared the same view:

"The patient should be satisfied with the service. Meaning he didn't wait too long for the service, he was received in a friendly way, and um… that what he had wanted he received. So, he… *ja*, his satisfaction matches his expectations" (A001: 178; A004:176).

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Table 5.2: Overview of emerging themes and sub-themes

THEMES	SUB-THEMES
Theme 1: Patient Rights	Respect and dignity
	Access to information
	Reducing delays in care
	The right to complain
	Scheduling of appointments
	Continuity of care
Theme 2: Quality client-centred care	The concept client-centred care
	Self-determination incapability
	Involvement of family, friends and those who matter/are important
	Well-informed healthcare providers
	Quality service delivery
THEMES	**SUB-THEMES**
Theme 3: Clinical Support Services	Medication unavailability
	Patient education about medication usage
	Inadequacy of referral resources
	Inadequate budget
	Benefits of specialists' outreaches
	Inadequate medical equipment
Theme 4: Public Health	Importance of patient education
	Importance of health promotion and prevention
	Organizational health promotion constraints
	Various health promotion and prevention methods
	Importance of community involvement
	Availability of CBS
Theme 5: Corporate Governance and Leadership	Enormous changes within the health system
	Too many procurement processes
	Incorrect budget allocation
	Inadequate staff allocation and use
	Incompetence and unaccountability
Theme 6: Operational Management	Challenges around compulsory community service
	Comprehensive human resource development
	Understaffing on the operational level
	High workload
	Unnecessary duplication of tasks
	Staff satisfaction with the working environment
	Procurement and supply chain challenges
	Overemphasising of statistics
Theme 7: Infrastructure and Facilities	Lack of infrastructure maintenance
	Inadequate physical space
	Not enough consultation rooms
	Lack of security

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5.3.1 Theme 1: Patient Rights

Theme 1, dealt with the "Patient Rights" aspects of care. Sub-themes referred to the following: respect and dignity, access to information, long waiting times, the right to complain, scheduled appointments and continuity of care.

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5.3.1.1 Sub-theme: Respect and dignity

According to the Patient Rights Charter every healthcare user is entitled be treated with the necessary respect and dignity, i.e.: courtesy, patience, empathy and tolerance (South African National Department of Health, 1999).

The focus group discussions highlighted patient satisfaction; positive staff attitude; confidentiality, privacy and a clean, hygienic environment as ways to promote respect and dignity.

a) Category: The client should be satisfied

The NCSs (South African National Department of Health, 2011), as well as Ideal Clinic Standards (South African National Department of Health, 2017a) required that a twelve-monthly patient satisfaction survey should be conducted. Quality improvements should be based on these patient satisfaction surveys.

Two focus groups stated that the patient should be satisfied. Patient satisfaction meant that: waiting time was not too long, friendly staff and patient expectations were met.

Box 5.1: Satisfaction with the service

"The patient should be satisfied with the service. Meaning he didn't wait too long for the service, he was received in a friendly way, and um… that what he had wanted he received. So, he… *ja*, his satisfaction matches his expectations" (A001: 178; A004:176).

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Participants emphasised that the healthcare user should be satisfied with service delivery. Satisfaction relates to: waiting times not too long, friendly staff and patient expectations being met. These identified attributes will most definitely enhance client-centred care.

b) Category: Positive staff attitude

Client-centred care requires that each staff member should have a positive attitude towards patients or clients. In other words, healthcare providers should treat clients with the necessary friendliness, courtesy, care and respect. The WCDoH (Western Cape Department of Health, 2011) embraces the following values: caring, competence, accountability, integrity, responsiveness, respect and innovation. It is expected that each staff member should make these values a living reality.

Various focus groups pointed out that patients should be treated with respect. Participants related respect with friendliness, courtesy, listening and addressing patients by their names.

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They highlighted that there seemed to be an instant connection when someone was addressed by his or her name. Unfortunately, the dignity of patients was challenged when staff treated them as numbers or as statistics. Furthermore, one focus group acknowledged that some staff members have a "state's" mentality, where it was acceptable for patients to wait or where they must make do with what they got, as staff were not willing to walk the extra mile. Three focus groups reported that they experienced patients as angry and livid, as they were screaming at staff, did not show any understanding and taking their frustrations out on the staff.

Box 5.2: Positive staff attitude

"The client should be treated with respect from the time he enters the clinic" (A001:445; A002:311; A002: 332; A002:333; A004:396).
"When one addresses somebody else by his name then it's almost as if an instant connection of mutual respect is created…" (A004:100; A004:68; A004:101).
"Many times, patients are called by numbers at the clinics. Yes, it sort of takes away one's dignity, I think. One has to..." (A002: 293; A007:442).
"I am trying my best to what I have at my disposal. One is not going to try and do that extra [thing] because what difference does it make?" (A001:159 & 263).
"When they get to the clinic and it is not a good encounter, then the patient sits there with that anger and sometimes, it happened before. And then, they take it out on the first person that they see" (A002:170; A002:334 & 180; A003:343; A007:179 & A007:400 & 441).

According to the feedback, various focus groups agreed that in order to ensure client-centred care, patients should be treated with the necessary respect. However, patients were challenged by staff members who were not willing to go the extra mile and patients had to wait. In addition, various participants confirmed that some patients took their frustrations out on them.

c) Category: Confidentiality and privacy

The Patient Rights Charter (South African National Department of Health, 1999) stated that patients and clients' information should be treated as confidential and their privacy should also be respected. According to the SANDoH (South African National Department of Health, 1999) and HPCSA (Health Professions Council of South Africa, 2008) information about a patient's health, including information about a patient's treatment may only go public with informed consent, with the exception of when required by the law or the court.

However, focus groups indicated that confidentiality, privacy and trust were compromised by poorly built infrastructure at some of the PHC facilities in the West Coast. The physical layout of some clinics were also inappropriate, e.g. the counselling room is situated in the middle of the clinic, or the clinic has only one waiting area and all patients have to utilise this area.

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Confidentiality and privacy were compromised as everybody could see and hear, e.g. who enters, exits or who is being called for counselling and treatment. These privacy and confidentiality challenges could make patients feel uncomfortable and could result in patients who would not return for follow-up visits.

Box 5.3: Confidentiality and privacy

"In some of our clinics, the counselling room is literally situated in… in the centre of the… of the clinic. Patients are able to see who enters and who exits, as well as how they appear when they exit the door "(A001:237; A002:297; 300 & 171; A004:370). "And the whole issue of confidentiality as well. Somebody might hear something that was meant for the practitioner. So, patients – sometimes are even too scared to open up" (A002: 169 & A002:303). "And then, when a patient feels he cannot trust or he feels he's uncomfortable to talk to somebody about his condition, he would not return" (A007:412 & A007: 401).

Several participants indicated that confidentiality, privacy and trust were compromised by the inadequate layout and infrastructure of some PHC facilities in the West Coast. Patients' privacy were compromised as patients were exposed to one another, their information was not always kept confidential. Patients lost their trust in the staff and as a result did not pitch again.

d) Category: Hygienic and clean environment

A healthy and safe environment comprise a clean environment, available water supply, proper sanitation and safe waste disposal. According to the (Health Professions Council of South Africa, 2008) everybody should be treated in a healthy and safe environment. One focus group highlighted the importance of cleanliness.

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Box 5.4: Hygienic and clean environment

"So, cleanliness is very important" (A007:119).

Cleanliness of PHC facilities seemed to be important. All facilities should have a proper water supply, sanitation and waste disposal system to ensure that patients are treated in a healthy and safe environment.

5.3.1.2 Sub-theme: Access to information

According to the Patient Rights Charter, all healthcare users should have access to health information. That is to receive information regarding their diagnosis, their treatment and the accessibility of health services at the facility and how to make the best use of it (South African National Department of Health, 1999).

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The focus group discussions pointed out that patients are ordinary people. Not all healthcare users know their diagnosis or were familiar with the role and function of the allied health professionals. Focus groups emphasised the importance of informing healthcare users about their diagnosis and treatment, what they can expect from the service and what the healthcare provider expects from them. Importantly, this information has to be provided on the level of the patient or in a language that would be understood by the patient.

Box 5.5: Access to information

“The client should get the necessary information about his diagnosis, as well as the treatment he needs to receive” (A001:25, 35, 65, 231; A002:331 & A004:57. “You must know the procedure to be able to tell them from the beginning. Take them through. They must know what you’re expecting from them and what they can expect from you” (A002:312, 314, 328 & A001: 26). “Patients have the right to know what they get at the clinic” (A007:172 & 426; A001:229). “We are working with ordinary people, né. They… they do not know these things. They do not know about a concept like occupational therapy and never mind even what that occupational therapist does, or the psychologist” (A002:315, 187, 188; A003:352 & A007:428). “We should step down and move towards them. Talk their language. In order to reach him” (A002: 60; A001:275; A004:59 & 58).

The focus group results confirmed that patients were not always familiar with their diagnosis, the role and function of the allied health professionals or even of what they can expect from the clinic. Therefore, staff members have to step down to the patient’s level to provide them with the relevant information. Client-centred care requires that relevant information should be communicated to the clients.

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5.3.1.3 Sub-theme: Long waiting times

No patient or client should wait longer than necessary for service delivery. Waiting times should be monitored and any delays should be communicated to the healthcare user. Waiting times and the managing of queues are prioritised as one of the six priority areas for quality improvement (South African National Department of Health, 2011). Moreover, timely care is one of the six quality attributes (Institute Of Medicine, 2001).

Waiting times were highlighted as one of the most pressing problems at PHC facilities. Participants indicated that healthcare workers did not communicate with patients about waiting times. Furthermore, one of the focus groups emphasised that staff could make it worthwhile for patients while waiting, e.g. by providing talks on prevention.

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Box 5.6: Long waiting times

"We know the most pressing problem is the waiting times of the patients" (A004:359; A001: 269). "Waiting times. We fall short is communication with the patients" (A001: 64, 230, 287, 288; A004: 109; A002:62, 67; A007:61, 63, 427). "At least, makes it worthwhile to wait, conduct sessions - talk about something preventive" (A001: 289; A001:290).

Participants acknowledged that long waiting times were a serious problem. Patients or clients were not informed about how long they had to wait. This lack of communication is not favourable to client-centred care. Furthermore, quality care requires that patients should receive care within a reasonable time. Moreover, patients should be kept busy while waiting. Waiting times can be seen as an opportunity for clients to do health prevention activities.

5.3.1.4 Sub-theme: The right to complain

According to the Ideal Clinic Standards (South African National Department of Health, 2017a) posters should be visible in all facilities to make patients aware of the complaint and compliment procedure. According to the HPCSA (2008) every healthcare user may complain when not satisfied with his or her service delivery. Complaints should be investigated and complainants have to receive response on such investigation. Ideal Clinic Standards (South African National Department of Health, 2017a) require that patients should be provided the chance to lay a complaint.

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According to the focus group feedback, patients were made aware about the process to lodge a complaint. Healthcare users were advised to write a letter to complain when they were not satisfied with the service, complaints/compliment boxes were available at the facilities and complaints were investigated. Furthermore, patients could complain directly to the Western Cape Minister of Health. Unfortunately, participants pointed out that many complaints and a small number of compliments were received. An interesting, but shocking finding was, "when the patient is known as a constant complainer, the complaint might not be taken seriously".

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Box 5.7: The right to complain

"You as patient could write a letter to whomever and complain that we are unable to provide the services" (A004:174 &391).
"The clinics have such post boxes and then, every week the post boxes are… are opened and examined to see whether they are complaints or compliments" (A004:394).
"Nowadays, the patients phone the Minister of Health and demand to get an answer within a limited period of time why you have turned the patients away" (A004:395).
"Yes, the compliments and then the clinics are actually getting very few" (A004:392; A003:354).
"...because most of the time it's complaints" (A004:393).
"The patients are known. So, if you know the patient is a constant complainer, then you might not take his complaints seriously" (A007:439).

According to the aforementioned feedback, participants were well informed regarding the management of complaints and how to make patients aware of their right to complain. However, of concern was that more complaints were received than compliments. Also alarming, was that when it was a known complainer, complaints might not be taken seriously.

5.3.1.5 Sub-theme: Scheduled appointments

Healthcare users should have access to an appointment system according to their needs and preferences. According to the WCDoH (Western Cape Department of Health, 2011), a client should make an appointment to visit the health facility, except in the case of an emergency.

Various focus groups confirmed that appointments at PHC facilities work. Appointments lead to improved organization, smaller groups of patients, patients do not have to sit at the clinic for an extended time and patients are provided with follow-up dates. However, one focus group pointed out that some patients were not willing to wait, they bypassed the clinic and went straight to the emergency department of the hospital.

Box 5.8: Scheduled appointments

"I'm attempting a project of using appointments that will help a lot. Um… it works. Now, the clinic is more relaxed." (A001: 248; A007:201; A002:15; A007:11; A007:16; A007:12).
"…the patient's mentality is sometimes also a problem because they… they… they know that they are going to wait at the clinic, then they go to emergencies at the hospital, understand?" (A001:270).

Various participants were positive about the benefits of appointments. However, of concern was that some patients were not willing to wait and would bypass the clinic, and head straight for the hospital's emergency department.

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5.3.1.6 Sub-theme: Continuity of care challenges

Client-centred care is characterised by care which is coordinated and integrated between various healthcare providers and healthcare institutions (Gerteis *et al*., 1993).

The WCDoH (Western Cape Department of Health, 2014) emphasises continuity of care processes in order to provide an uninterruptive service as if care is provided by the same staff member throughout the care trail to co-operatively provide the patient's desired health outcomes.

According to various focus groups' feedback, continuity of care was challenged by: a client seen today, has to come back tomorrow and the day after tomorrow; a communication gap between the nursing staff and the allied health professionals; lack of written feedback from physiotherapist referrals; the annual replacement of community service allied health professionals.

Box: 5.9: Continuity of care challenges

"The client is seen today, has to come back tomorrow and come back the day after tomorrow and come back again a day after that. Pay attention to and to complete one client" (A002: 48).
"Clearly, there is a communication gap between the sister and us (rehab team) because the sister want to give us patients who…" (A001: 67).
"The sister who to the… who refers the guy to the um… physiotherapist. The physiotherapist could post a note in the programme to say, that is what I have found and… and" (A001: 271).
"Yes, continuity. Incidentally, for the patients it's going to because now it's somebody new again and they still have to establish a relationship with you. Especially, with us at rehab, one needs to establish a reasonable relationship. Firstly, they first have to trust you and then… have to convince them that you would be able to assist them and after that you leave and somebody new arrives. So…" (A004:69).
"Consistency of the service because with the rolling in "comserves", it takes us a while to um... also get into it and then we lose patients like that. Because they're waiting for an appointment or they don't even know..." (A007:437).

Participants identified a lack in continuity of care as a thread for client-centred care. According to the participants not all patients were sorted out completely within one visit so they have to visit the clinic again. Furthermore, communication was inadequate between the clinic staff and the allied health professionals. The lack of written referral feedback was highlighted. The annual replacement of community service allied health professionals was also identified as a thread for the continuity of care, as new relationships had to be established with patients and it took a while before trust could be established.

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5.3.2 Theme 2: Quality client-centred care

Theme 2 focuses on the analysis and interpretation of the "quality client-centred" aspects of care and dealt with the following aspects, namely: the concept of quality client-centred care, self-determination, involvement of family and friends and those who are important, well-informed healthcare providers and quality service delivery.

Goodrich and Cornwell (2008:19); Gavin *et al*. (2014) and Jayadevappa and Chhatre (2011) acknowledged the IOM's (Institute Of Medicine, 2001) six quality attributes: safety, effective, patient-centred, timely, efficiency and equity. Patient-centred care is one of the aforesaid quality attributes.

This study switched between client-centred, patient-centred and person-centred terminology, depending on the setting of care. However, person-centred care is recognised as the umbrella term to include: patient-centred, client-centred, individualised care and people-centred care (Thorarinsdottir & Kristjansson, 2014). Person-centred care is described by McCormack *et al*. (2010) as the therapeutic relationship between patients, clients, healthcare providers and those important to them. This relationship is embedded by values of mutual respect for persons, individual right to self-determination and understanding. It is enabled by cultures of empowerment that promote continuous approaches to practice development.

Gerteis *et al*. (1993) emphasised the following client-centred dimensions: respect for individual values, preferences and needs; coordination and integration of care among providers; information, communication and education adapted to the needs of the individual; physical and emotional comfort; participation of family and friends where appropriate; planning for transition and integration. The sections which follow analysed and interpreted the respective categories of quality client-centred care as reported by the focus groups.

5.3.2.1 Sub-theme: The concept client-centred care

Every healthcare user should be recognised and treated as an individual with unique biological, social, psychological and spiritual needs. According to Morgan and Yoder (2011) person-centred care requires a holistic approach, where the individual is viewed as a "whole" person comprising of biological, social, psychological and spiritual dimensions. Similarly, Mead and Bower (2000) confirm that illness or disease has an impact on the whole person. According to Suhonen, Valmaki and Katajisto (2000) care focusing only on biological aspects without bearing in mind the psychological or social aspects impedes healing and contribute to poor

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outcomes. In addition, McCance (2003) reiterated that the healthcare provider has to consider the unique needs and the particular health concerns of the individual to tailor interventions accordingly. Suhonen *et al*. (2000) also emphasized care according to individual needs and preferences, instead of "one size fits all".

Focus groups summarised client-centred care as: viewing someone in totality; seeing someone holistically and focusing on the individual.

Box: 5.10:The concept client-centred care

"When the patient walks in we have to view him in his totality. Um… not only the sore knee but um… engage with the patient: slightly more comprehensively" (A001: 73, 74, 75 & 226; A003:262).
"For me it is to see someone as a whole; not only a knee or something" (A002: 92 &190; A003:71 & 83; A004:70 & 91).
"Every person likes to feel important. From the moment he enters the door, he should realise for that moment he is number one and also for that moment the attention is focused on him. All the attention is focused on you" (A002: 78 & 82; A003:76, 77, 79, 80, 81, 85 & 339).

Focus groups emphasised that in order to render client-centred care, patients should be viewed in totality, holistically and as an individual. Their response confirmed that they have a good understanding of the concept client-centred. Participants also highlighted that the patient or client should be treated as "number one", meaning that the patient should be the focus of care which is in line with client-centred care.

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5.3.2.2 Sub-theme Self-determination incapability

Healthcare users should be allowed to make informed decisions about their care. The WCDoH (Western Cape Department of Health, 2014) defined person-centred care as an approach to treat individuals holistically, with dignity and respect, providing them with information on their level of understanding, involve and empower them to make informed choices regarding treatment options. Likewise, Pulvirenti, McMillan and Lawn (2011) also emphasised the participation of patients in the decision-making process regarding their treatment options. This involvement has the potential for patients to take possession with self-confidence, autonomy, self-determination and could contribute to their own care, performing various types of self-treatment.

However, focus group discussions, pointed out that it was difficult to convince patients to change when they are not ready for change. According to these participants, some patients have unrealistic expectations, e.g. they expect to receive medication in spite of no indication or need.

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Box: 5.11: Self-determination incapability

"Important for me is what... is where the patient is in terms of their stage of change. If they're not ready to make the change, it's very hard for me to convince them" (A002:190; A003:191, 192 & 193). "The client arrives with certain expectations – out of ignorance – of what we are not able to meet" (A001:228, 271; A002:185 & A004:186). "The patient expects to get a tablet. But often the patient does not need that tablet because the patient might have another condition" (A004:183, 184 & 357).

According to the aforementioned, healthcare providers found it difficult to convince change when the patients were not ready for change. In addition, patients showed unrealistic expectations regarding service delivery.

5.3.2.3 Sub-theme: Involvement of family, friends and those of importance

Client-centred care required that family, friends or those of importance should be included in the care of patients. The Picker Institute also emphasised the importance of involving family or friends in care giving and decision making of the individual (Gerteis *et al*., 1993). One of the focus groups also indicated the importance of focusing on the client, as well as the family or those who could have an influence on a better outcome for the individual.

Box: 5.12: Involvement of family, friends and those appropriate

"Not only focus on the client but also the family because the family also has a big influence" (A002: 190). "And also, to involve everyone who could have an influence on the patient in order to provide him with a better outcome" (A002: 98).

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Participants were of the opinion that client-centred care requires the involvement of family, friends or those important as they could contribute to the care of the patient to have more effective outcomes.

5.3.2.4 Sub-theme: Well-informed healthcare providers

All healthcare providers should be well informed about all the processes and procedures as required for integrated, co-ordinated and seamless service delivery. The Picker's Institute highlighted the importance of co-ordination and integration of care among providers as one of the principles of patient-centred care (Gerteis *et al*., 1993). One of the focus groups also valued the importance of knowing the processes and procedures in the health system.

Box: 5.13: Well-informed healthcare providers

"Yes! Must know every process, procedure of how a patient needs to... how it works through that system" (A002:222 & 223).

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Participants acknowledged the importance to be well-informed about all the processes and procedures of the health system.

5.3.2.5 Sub-theme: Quality service delivery

Healthcare users come to PHC facilities with specific needs and expectations. Patients perceived the service as quality when these expectations or needs were met. The IOM (Institute Of Medicine, 1990:21) emphasized "desired health outcomes" and "meeting expectations" of healthcare users as essential to derive at quality care. Furthermore, the IOM (Institute Of Medicine, 2001) prioritized the following quality dimensions, namely: safety, effective, efficient, patient-centred and timely. Focus groups confirmed that clients are inclined to return to facilities where they receive quality service.

Box: 5.14: Quality service delivery

"People are inclined to return to places where they know they will receive a quality service" (A003:211, 212 & A007:214).

According to the experience of the participants, clients are prone to return to facilities where they received quality service.

5.3.3 Theme 3: Clinical support services

Clinical support services refer to the availability of medicines, patient education about medication usage, inadequacy of referral resources, inadequate budget, benefits of specialsts outreaches and as well as inadequate medical equipment. Subsequently, the data analysis and interpretation regarding clinical support services are presented.

5.3.3.1 Sub-theme: Medication unavailability

Medicines and medical supplies should always be available. According to Ideal Clinic Standards at least 90% of tracer medicines should always be available (South African National Department of Health, 2017a). Moreover, medicines should be prescribed according to standardised treatment guidelines and patients should be informed about how and when to take medicines (South African National Department of Health, 2017a). Side-effects should be reported and patients should be properly managed.

Focus groups reported critical low stock levels at the end of March, which is the last month of the financial year. Moreover, facilities have to wait for the delivery of medicines. This could result in the patient having to go without medication.

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Box: 5.15: Medication unavailability

"Yes, the financial year is the switch over of the tenders and then the new tenders take time. Actually, this time of the year is always a crisis because then the wholesaler has very little stock" (A007:138).
"Now… now, you wait another week for… for stock to be delivered from… from… from the distributors" (A001: 260).
"The patient doesn't get his medication. So… yes. So, his health suffers" (A007:398).

According to the above, medication stock levels could become very low at the end of the financial year. Furthermore, providers could take long to deliver medication and medication could be unavailable for patient care. Medication unavailability is a serious threat for quality care as it has the potential to influence the effective outcome of care. A patient's condition could deteriorate while waiting for medication.

5.3.3.2 Sub-theme: Patient education about medication usage

Patients should be educated about how and when to use medication. In addition, reactions to medication and side-effects should be reported and patients should be properly managed accordingly.

One of the five focus groups highlighted the importance of explaining medication usage to patients. Furthermore, the patients should come back when the medication makes them feel worse.

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Box: 5.16: Patient education about medication usage

"Explain to the guy what medication he is getting and how he should be taking it" (A001: 27 & 232).
"If the tablets make you feel worse, come back to see the doctor that he could re-evaluate you" (A007:434).

Participants acknowledged that educating patients and information are client-centred requirements. Therefore, patients should be informed and educated about the use of medication and the importance to return should they experience any side-effects. Education and information about medication-side effects could enhance quality care as it will ensure an effective outcome.

5.3.3.3 Sub-theme: Inadequacy of referral resources

Ideal Clinic Standards require that patients should have access to comprehensive health services at the facility or through appropriate referral (South African National Department of Health, 2017a). Comprehensive PHC delivery includes preventive, promotive, curative and rehabilitation aspects of care, allows for continuity of care by ensuring early diagnosis, management, and referral to secondary and tertiary care (Dizon, Grimmer, Machingaidze,

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McLaren & Louw, 2016). Furthermore, an integrated referral system in the rural and remote areas is important to enable a continuum of care; access to health professionals with specific and sophisticated biomedical- and social skills; adequate resources; and a client-centred approach (Visagie & Schneider, 2014).

Several focus groups recognised that quality service required referral of patients to the doctor, physiotherapist, social worker, psychologist and referral hospitals, e.g. Red Cross, Conradie and Lentegeur hospitals. One of the focus groups revealed that the number of referral hospitals seemed to be inadequate. Specifically eye care and ear, nose and throat specialised services were highlighted as challenging. In addition, various focus groups reported long waiting times before getting a referral appointment. Moreover, one of the focus groups reported a surprising low referral rate of patients to the occupational therapist. Whereas another focus group emphasised that the occupational therapist conducted awareness talks in the waiting rooms to make patients aware of the occupational therapist services. Indicating that the respective communities are still not aware of the role and function of the allied health professionals.

Box: 5.17: Inadequacy of referral resources

"Refer [him] to the *physio*, doctor, social worker or to the psychologist. We are never just one profession and that allows us to provide quality service" (A003: 90, 97, 286 & 345; A004:361, 364; A002:86).

"Refer them. Red Cross, Conradie and Lentegeur in Mitchells Plain" (A004:88; A004:358).

"I have several… various resources where I could refer him to…" (A004:360).

"There are not enough hospitals to refer to" (A007:420; A007:444; A007:415; A007:419; A007:419).

"That patient has to wait long before she would get an appointment" (A003:346; A007:199; A007:442; A007:416; A007:110; A007:198; A007:102; A007:103).

"I am the only occupational therapist in the entire sub district. I have not yet received even five referrals for the entire year" (A001: 280; A001:278).

"I wouldn't say that it is really in place but what I usually do at the clinics, I would speak in the waiting room and then I would only talk about the kind of patients whom I see. You are aware already that they go out and, for example, um… your child cannot walk yet at one year and three months" (A004:14).

Quality client-centred care requires continuity of care. However, participants differed on the availability of referral resources. One focus group indicated that they have access to enough referral resources, while another focus group indicated that referral resources seemed to be inadequate for the needs of the West Coast District population and patients have to wait long for an appointment. In order to provide quality care, patients should have access to care resources within a reasonable time span. Furthermore, not all patients were aware of the role

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and function of the occupational therapist. Awareness talks in the waiting rooms seemed to be a good idea to clarify the roles and functions of the allied health professionals.

5.3.3.4 Sub-theme: Inadequate budget

An adequate budget should be available to accommodate the various activities and resources needed for quality client-centred care. According to Miji, Rhoda, Statham and Joseph (2017), the National South African Rehabilitation Policy (2000) aimed to improve accessibility of rehabilitation services, the facilitation of appropriate allocation of resources, and encouraged optimal utilisation. Various focus groups highlighted an extensive waiting list for wheelchairs due to budgetary constraints.

Box 5.18: Inadequate budget

“Then one is simply going to wait longer because the budget does not allow for a more expensive chair to be delivered, not in time, so…” (A003:344; A001: 240). “We have a list of people who need wheelchairs. Who is already waiting for two, three, four years to get a wheelchair” (A001: 241; A003:41, 128; A007:135).

According to the feedback, budgetary constraints resulted in a backlog of wheelchairs. Participants highlighted that some patients waited very long, three to four years to get a wheelchair. Therefore, an inadequate budget does compromise quality client-centred care as patients in need of assistive devices such as wheelchairs experience emotional and physical discomfort and are exposed to safety risks due to their physical limitations.

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5.3.5.5 Sub-theme: Benefits of the specialists outreaches

The subdistricts of the West Coast, which is within the context of this study are visited on a monthly basis by the following specialists, namely: a gynaecologist, paediatrician, anaesthetist and an internist. The National Service Delivery Agreement (South African National Department of Health, 2010:4) “for a Long Healthy Life for All South Africans”, has the following strategic objectives, namely: to expand life expectancy; lower maternal and child mortality; reduce HIV and AIDS and decrease TB and strengthen healthsystem effectiveness. Consequently, PHC re-engineering, a district-based service model was implemented as the vehicle to address the abovementioned priorities. PHC re-engineering includes the following three streams: school health services, municipal ward-based community services and clinical specialists outreach teams to support the aforementioned priority health programmes (South African National Department of Health, 2011; Schaay, Sanders & Kruger, 2011). The role of the district clinical specialist teams is to: improve the quality of clinical care; arrange for

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clinical training and monitoring and evaluation; assist district level organisational activities; support health systems and logistics; promote teamwork, communication and reporting, and teaching and research actions (South African National Department of Health, 2014b).

One of the focus groups indicated that specialists outreach programmes could be beneficial, e.g. to address the cataract problems of the rural areas. Participants also mentioned the possibility of the "Wellness Bus" outreach programme from Cape Town, including eye screening and oral health services.

Box: 5.19: Benefits of the specialists outreaches

"I think it would be a solution if they could only think of an outreach programme, for instance, to come and do cataracts in the rural areas" (A007:421). "That's the bus that is parked in the Cape for a while? Bus or wheels? So, the bus would start its rounds in the month of September? So, he is going to provide a package of services; such as eye screening, teeth, and…" (A007:422).

One focus group acknowledged that specialist outreaches have the potential to enhance quality client-centred care, as these specialists can transfer their knowledge and skills to empower rural staff. Eye care and oral health needs were prioritised as needs which could be addressed by outreach services.

5.3.5.6 Sub-theme: Inadequate medical equipment

According to Ideal Clinic standards, all PHC facilities should have the essential equipment and all staff should be trained on the utilisation thereof (South African National Department of Health, 2017a).

According to the focus groups, some of the subdistricts experienced maintenance challenges, e.g. there was no one to repair the broken extractor fans and wheelchairs. Concerning, two focus groups pointed out that staff has to make do with what is available. A shortage of dental chairs, televisions and digital video disc machines was highlighted. Moreover, inadequate computerised systems were also highlighted. Several focus groups emphasised the importance of the needed equipment, in order to deliver a holistic service. On the other hand, three of the five focus groups were of opinion that all basic equipment is available in the facilities.

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Box 5.20: Inadequate medical equipment

"… There is no one to service it, the equipment" (A001: 243a &243b).
"At the moment, the dentist working on an ordinary chair and it should not be like that because it hampers me to provide my most basic services to the patients" (A001: 245a; A002:309).
"You must like just go on with what you have" (A002:308 & A004:156).
"So, all the clinics must be fully equipped. It comes down to everything. Must be fully equipped to do a holistic service to a certain patient" (A002: 108 &295; A004:132 & A001:131).
"Not all the clinics are equipped TVs or DVDs" (A002:39; A004:390).
"All have their… their diagnostic stuff" (A002:306; A004:372; A004:373).
"I think when one… if one takes that into account, we are living in a modern era and why then are these Systems not yet computerised or um…" (A001: 265).
"I mean, everything has to be handwritten on these packets filled with tablets. One cannot even read the guy's name because…" (A001: 266).

Participants emphasised that in order to provide quality client-centred care, clinics should be fully equipped. However, the feedback revealed several medical equipment inadequacies, namely: insufficient number of dental chairs; lack of televisions, digital video disc players and computerised systems. Maintenance of broken equipment seemed to be another challenge. Inadequate medical equipment, just as poorly maintained equipment are a risk for quality care as it could negatively influence the effective outcome of treatment. Furthermore, it is a safety risk as previously stated, the disease of patients could deteriorate due to the lack of equipment. Inadequate and poorly maintained equipment are not client-centred as it can influence patient care negatively, e.g. needs of patients cannot be addressed, continuity of care is at risk, e.g. patients cannot receive their follow-up treatment when there is a lack of equipment or when the equipment is not in a working condition.

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5.3.4 Theme 4: Public Health

Public health refers to health promotion and disease prevention and includes collaboration with NGOs and other appropriate healthcare providers. The underneath sub-themes referred to: importance of patient education, importance of health promotion and prevention, organizational health promotion constraints, various health promotion and prevention methods, community involvement and the availability of community based services.

5.3.4.1 Sub-theme: Importance of patient education

Focus group participants emphasized the importance of educating patients regarding service demands, what to expect and how to manage it. Various focus groups referred to the daily health promotion and prevention talks at clinics in Cape Town where health promotion officers

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were employed. According to the participants community healthcare workers should communicate to the community about the availability of services.

Box: 5.21: Importance of patient education

“We would also have to educate our people. I don’t want to mean it negatively, about what a service demands. What they could expect. How they have to handle it. Uh… I cannot go to my doctor and curse and swear at him. I cannot come to my doctor with all sorts of demands. Uh… I have to make an appointment” (A002:305 & 316). “The health promotion officer, like in the Cape. Every clinic has a health promotion officer who talks to the people every morning or during the day about medical problems” (A002: 317; A004:388 &70 & A001:291). “Yes, it boils down to communication. Those instances… I don’t know whether processes were put in place for the carers to… communicate with the community and to explain to them, listen these are the service that are promised. This is what is available to you” (A001: 272 & 291).

Focus group participants acknowledged the importance to educate patients about service demands, what they could expect and how they should manage it. Various participants referred to the availability of health promoters in the urban clinics providing daily talks in the clinics. Unfortunately, only one health promoter is currently employed in the West Coast District. In addition, participants pointed out that community care workers should inform communities about the available services. Quality client-centred care requires patient education, information and communication. However, these requirements seem to be sacrificed due to the scarcity of health promoters.

5.3.4.2 Sub-theme: Importance of health promotion and prevention

The WCDoH emphasises that healthcare providers should diverge their curative paradigm to a focus of wellness. The third strategic goal for the WCDoH (2015 - 2019) is to promote wellness and tackle social ills in order to increase life expectancy (Western Cape Department of Health, 2015).

Participants described the importance of health promotion and prevention. The following prevention and promotion topics were highlighted, namely: diabetes-related illnesses; advantages of breastfeeding, effects of alcohol, smoking effects on the foetus, postnatal support for mothers; community education to prevent teeth extractions.

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Box: 5.22: Importance of health promotion and prevention

"I think, when we have a look at Health Care 2030 health promotion, prevention promotion, those are the ones that could improve the most" (A007:432 & 435).
"Oh, I mean one could facilitate talks about all the stuff. The diabetes, um… al the illnesses. One could even talk about the dynamics of mother and father's relation… or children, parents" (A002:31).
"I want to get more involved with um... especially in the Mother Baby Friendly Hospital Initiative with breastfeeding and clinical care. Making mother more aware of the actual affect that alcohol has [mumbles] on the foetus, smoking on the foetus. Um... providing proper support for mothers postnatal to ensure that our breastfeeding statistics go up, decrease of illness, the whole [mumbles] that it has. Um... trauma care, especially" (A007:431).
"And the education of patients in the community on more preventative strategies to prevent teeth extraction" (A007:439).

Participants were well aware that client-centred care necessitated patient education, communication and information sharing with clients. They could identify a variety of appropriate topics, e.g. diabetes-related illnesses, promotion of breastfeeding, effects of alcohol, effects of smoking on the foetus, postnatal support for mothers, and community education to prevent teeth extractions. One focus group indicated that they want to get more involved in health promotion and prevention as prioritised by the 2030 Health Care Initiative.

5.3.4.3 Sub-theme: Organizational health promotion constraints

Health promotion and prevention are very important, but could be hindered by various organizational constraints.

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One of the focus groups pointed out that nurses do not always prioritise health promotion and health education, resulting from nurse training which was focused primarily on clinical aspects. Shortage of human resources and lack of time are provided as reasons for health prevention and promotion not being accomplished. On the other hand, one focus group indicated that patients were "closed" for health promotion, as they were more interested in the collection of their medication.

Box: 5.23: Organizational health promotion constraints

"But we... from the day we go to study, we are taught to help someone clinical. So, we... the focus is what type of pill, what type of thing... So, we are not really focused on health promotion, health education" (A003:348).
"The shortage of human resources. Anyway, I can… there's no point, I'm simply carry on like that, in circles. So, um… health promotion does not get done" (A003:350 & A007: 429).
"Yes, yes, yes it's a time problem, it's a... But the thing is, we can do health promotion, health education until it comes out of our ears but a lot of patients are very closed off to it. They're just there to come collect their medication" (A003:351).

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Participants disclosed that during nurse training, more emphasis was put on clinical aspects, than health promotion and health education. Furthermore, according to them client-centred care was hampered, as health promotion and prevention activities were not priorities, due to organizational barriers, e.g. inadequate staff and lack of time.. An interesting fact is that patients prioritised the collection of medicines as more important and were not necessarily interested in health promotion or education.

5.3.4.4 Sub-theme: Various health promotion and prevention methods

Healthcare providers could utilise various health promotion and prevention methods. Participants emphasised the following health promotion and prevention methods, namely: health talks and demonstrations, pictures and small group interactions, information posted in bathrooms, pamphlets, wellness days, newspaper articles and multidisciplinary outreaches to crèches and schools. However, some focus groups were unsure of whether patients do read the pamphlets.

Box: 5.24: Various health promotion and prevention methods

"To act preventively means one has to talk extensively to ensure that the patient understands what one is telling him, demonstration. The patient then needs to demonstrate to you again" (A003:349).
"Yes, pictures do help but it's about interaction. Personal interaction, even when is with small groups. I think, when one wants to do it at clinics, one could… We always tell the people with the AIDS and stuff but let us form small groups" (A002: 30).
"But then, I'd almost say um… when I look further. Say, for example, in practice to provide information in the bathrooms. The information that is disseminated to crowds of people…" (A004:28).
"I… I think we do not have a reading community. That I want to state clearly. Pamphlets, yes" (A002: 336).
"But now, the point is… is whether they ever use the condoms or read the pamphlets; that I cannot say" (A004:389 & 29).
"So, we have these wellness days and what we do then; then it is like a gift… gift parcel that we are giving to the people. It's filled with pamphlets, condoms and say, for instance, a bottle of water or a packet of chips or whatever and then they are very excited" (A004:33).
"Should one not perhaps use the example the example that she just has used to say, we have local newspapers – the Courant and the Gazette – and to once a month perhaps place an article in one of these" (A004:22).
"Where we usually go to schools as a multidisciplinary group. The dentistry, the rehab, the sister. Multidisciplinary group going out to the schools or to the crèches or something like that" (A001: 277).

The focus groups confirmed the availability of various methods for health prevention and promotion. They highlighted the importance that information should be provided on the level of the patient to make sure that the patient understood the diagnosis and medication they needed to take. However, it was interesting that some participants doubted whether patients read the pamphlets at all.

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5.3.4.5 *Sub-theme: Importance of community involvement*

Community involvement and community-based education is pivotal for the promotion of wellness and prevention of diseases. The Western Cape Provincial Strategic Plan (2014-2019) prioritised community health promotion and safety, prevention of lifestyle diseases (Western Cape Government Department of the Premier, 2015). The WCDoH (Western Cape Department of Health, 2014), in line with Healthcare 2030, encourages public participation and community participation to enhance the health status of the population. This could range from an active role in governance to encouraging communities about healthy lifestyles.

Focus groups recognised the importance of community involvement and community awareness. In addition, the role of the health committee to educate people in the community was pointed out by one of the focus groups.

Box: 5.25: Importance of community involvement

"It's very important to get the community more involved. Make them aware (A009:430)".
"And get them more involved in the community as well. Because currently there are so many sick people that just want to stay at home and everybody comes for disability grants because I can't move my hand or I... my back is sore" (A007:436).
"And the health committees are going to the people and educate them. So, they have been of great assistance. Here, we don't have health committees but one could plan it" (A002: 335).

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According to the aforesaid, it was evident that participants were well aware about the importance of community involvement. Only one participant referred to the educating role of the health committee. Currently, health committees are not active in the West Coast District, which is the context of this study.

5.3.4.6 *Sub-theme: Availability of community-based services*

CBS focus on community health promotion and disease prevention and include support to those with long-term conditions. Rehabilitative and palliative care are added to improve the comprehensiveness of CBS (Western Cape Department of Health, 2014; Austin-Evelyn, Rabkin, Macheka, Mutiti, Mwansa-Kambafwile, Dlamini & El-Sadi, 2017).

Focus group participants of this study, indicated CBS as the link between the home (community) and the clinic. They mentioned a number of functions or roles of the community healthcare workers, i.e. to check on patients; assist or look after the frail patients; clipping patients' nails; checking the TB patient who has to take tablets daily; ensuring that patients are taking their tablets correctly; when needed deliver a patient's tablets at home and keeping

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patients informed; deliver medical supplies to bedridden patients and request the ambulance when necessary. However, one focus group highlighted that community-based co-ordinators experience a shortage of petrol money.

Box: 5.26: Availability of community-based services

“Or then she would – let’s say – say but perhaps the home-based carer needs to check on the patient. Then has to complete a referral form and then it has to go to the home-based carers. So, there is… “(A004:111).
“So, what… what the clinic would do, when they need more assistance – say, for instance, it’s a frail patient who has to be cared for at home – then they would refer the person. Or, for example, the TB patients who have to take tablets every day, then they would refer that person. Those kinds of people are referred to the home-based carers and then um… they look after… “(A004: 380).
“Just the fact that somebody is going to say, “Good Morning”. The mere fact that the health care worker has check that the tablets are taken correctly, this elderly woman gets better care. There’s someone who is clipping her nails. Even the circumstances of the home in relation to this…” (A003:42).
“ Even with home-based care, it is incredible to see the sisters who are willing on a daily basis to the X-rays um… to take steps that would keep the patient informed; who would even go and deliver the packet of tablets at home, in the small towns” (A003:218).
“And to add to what she is saying: say, for instance, it’s the old man who is bedridden for two years, there should be a… there should be a community-based health service… um… This patient is getting totally isolated, he becomes dependent on the service that the home-based carer provides. He needs a tremendous amount of stock” (A003: 43).
“That is still not really practicable but eventually it influences the service delivery to the whole patient. He does not receive the medication. The sister has to prescribe the medication according to what the family says. When the patient is that ill, they phone… could call out the ambulance, come pick him up and take him to the hospital” (A003:130).
“They… the… the home-based carers have coordinators at the NGO and then I’m the intermediary between the DoH and the… and the coordinators. So, basically I am the link between the clinics and the… so, when… when there is a problem at the clinics and the sister – let’s just say – picks that up… so and so complains that the health carer never visits them. Then they contact me and then I go and investigate” (A004:112).
“We have a limited amount of petrol money available. The members could visit this small place twice a month. For the rest, one relies on the um… service of the home carers that… that is provided in the town” (A003:139).

The feedback above, showed that client-centred care was at risk. Participants recognised CBS as the link for continuity between the community and clinic, however it was lacking. The other risk factor was that community health workers’ output is currently limited to physical caring and supporting of activities. The health prevention and promotion activities seemed to be non-existent.

5.3.5 Theme 5: Corporate governance and leadership

The strategic direction provided by senior management on national, provincial and district level is discussed under the theme, corporate governance and leadership. Sub-themes about

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corporate governanace and leadership analysis included the following, namely: enormous challenges within the health system, too many procurement processes, the budget allocation process, inadequate staff allocation and use, competency and accountability.

5.3.5.1 Sub-theme: Enormous changes within the health system

The National Development Plan prioritised enormous changes for the SANDoH towards 2030. The South African health sector is currently confronted by a multifaceted burden of disease, severe distresses about the quality of care, an ineffective and inefficient health system and an escalation in healthcare costs. The National Development Plan 2030 envisions to: expand the life years of South Africans to a minimum of 70 years; increase TB prevention and cure; decrease maternal, infant and child mortality; lessen the prevalence of non-communicable diseases and injury, accidents and violence by 50% compared to the outcomes of 2010; finalise health system reform; implementation of PHC teams to provide care to families and communities; universal health care coverage; fand appoint competent staff (Republic of South Africa, 2016).

In line with the aforementioned, one of the focus groups highlighted tremendous changes all the time. However, no change management processes were implemented within the organisation.

Box: 5.27: Enormous changes within the health system

"There are tremendous changes in the organisations all the time. Um… there are new protocols and stuff but from an organisational perspective there is no change management that is implemented. But organisationally, nowhere are there processes in this organisation for change management" (A003: 340).

Feedback confirmed that employees experienced continuous and remarkable changes within the PHC milieu. However, they did not experience the implementation of change management processes within the organisation.

5.3.5.2 Sub-theme: Too many procurement processes

The Australian DoH (Australian Department of Health, 2015) implemented an efficiency alignment process to eliminate unnecessary processes and "red tape" and included the removing of ineffective regulation, simplifying existing processes and reduced duplication.

However, focus group participants reported various delaying, "red tape" aspects regarding the procurement process. Currently, anything more than R30 000 has to be advertised for a quotation on Trade World's website to find an appropriate supplier. Procurement policies

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required compulsory registration on the Western Cape Database for prospective suppliers wanting to do business with the government. This requires lots of paperwork to be completed. All of these processes could result in long waiting times for the end user, e.g. for a stable door. Only one focus group pointed out that the reason of all of these processes is to prevent corruption.

Box: 5.28: Too many procurement processes

"Somehow, for me it is similar to protocols and systems. There are such a lot of red tape and paper pushers" (A007:403).
"Anything that costs more than R 30 000 has to go through Trade World" (A007:406).
"Precisely! Then, nobody applies on Trade World because the people who should be applying on Trade World are not prepared to do all that paperwork to be part of Trade World. So, then one gets… then, at the end of the day one is stuck for nine months and one still does not have a stable door" (A007:407 & 405).
"Yes, but to do that one actually has to address corruption. Because I think that is what it's all about that they should eliminate corruption to for all" (A007:408).

Quality client-centred care was challenged by too many processes involved in the procurement process, which resulted in long waiting times for the end user, which is the patient. However, it was indicated that corruption is the underlying problem of all of these processes.

5.3.5.3 Sub-theme: Budget allocation process

The SADoH's budgetary processes are not known to all healthcare providers, especially those working in the clinical areas. The WCDoH (Western Cape Department of Health, 2014) has a three-year budgeting cycle. The budgeting process is an integrated process in alliance with various other programmes, e.g. strategic planning, information management and health impact assessment (Western Cape Department of Health, 2014). The DoH allocated R68 509 billion over the 2017 Medium Term Expenditure Framework for the prioritization of Provincial Strategic Goal 3: To increase wellness and safety, and to address social diseases (Western Cape Government, 2017).

One of the focus groups perceived the budget allocation as not being correct**,** because it is projected by the expenditure of the previous financial year, plus the inflator and did not consider the ongoing accumulation of services. Furthermore, there is no annual review of the increase in population numbers to make the necessary budget adjustments.

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Box: 5.29: Budget allocation process

"Um… firstly, I think the allocation of our… of our funds [sic] is incorrectly handled at our head office. Um… because every year extra services are added um… and… and basically how they are allocating it, is basically just to look at what you had spent last year and then they only add inflation" (A001: 24). "Yes, apart from that. Uh… uh… there is also not an annual review of the population. There might be – if it is indeed the case – a review every five years to consider the population and to make adjustments accordingly. The last couple of years it was only the inflator" (A001: 238).

The feedback of the participants seemed to be evident of employees who were not well informed about what the budgeting process entails. According to the participants the budget was based on the history of the previous year and added services and growing populations were not taken into consideration. However, an inadequate budget is a huge risk for quality client-centred care. Financial shortages could result in an ineffective outcome of patient care; safety of patients are put at risk and patients have to wait long for service delivery – maybe for a new financial year to address their individual needs and bear the emotional and physical consequences.

5.3.5.4 Sub-theme: Inadequate staff allocation and use

An Ideal Clinic is defined as a clinic with sufficient staff and appropriate staff categories with the correct skills to deliver quality client-centred care (South African National Department of Health, 2017b). Bheekie and Bradley (2016) emphasised PHC re-engineering as an approach to improve the health status of the South Africans by focusing on prevention through the introduction of the following three streams: ward-based level community and home-based care, school health and outreach district-specialists teams. A strong element of PHC re-engineering's success is dependent on the availability of the right categories of staff. However, the District Health Expenditure Review (2010-2011) showed a non-optimal skills mix with lack of support, clinical, pharmaceutical and administrative support leading to a high workload for professional nurses affecting the quality of care (South African National Department of Health & Medical Research Council, 2012). Mosadeghrad (2014) accentuated that healthcare quality can be enhanced by leadership, planning, training, accessibililty and management of resources.

Focus group discussions, identified several "head office" (i.e. senior management or higher level) hampering issues, namely: Staffing numbers are determined or allocated by "head office", staff capacity problems also results from "top" management, and only senior management can influence change. "Head office" does not always consider population growth or the shift in the burden of disease to determine the need for more staff or categories of staff.

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With the integration of TB, HIV or the combination of both, staff indicated that they have to spend more time on patients than before. Staff members are frequently informed by "head office" that the statistics did not indicate the need for more staff. Interestingly, one focus group, indicated that statistics would not really increase when staffing numbers remain the same. However, despite the plea for more staff, the availability of money is a determining factor for "head office" for appointing more staff.

Box: 5.30: Inadequate staff allocation and use

"Basically, the staff members are sort of allocated by head office. They do not keep track of the population growth" (A001: 251 & 254).
"…but one doesn't have the time… one doesn't have the capacity to do that. Therefore, um… one needs to go back to where the real problem lies and we need to look at the setup at the top and one would notice things that indicate what the hospital should be getting" (A001: 255).
"I think so. And then it goes back to bigger things like the personnel and that's a senior manager… a management issue. It's only the senior manager that can actually… actually affect the change there" (A002: 330).
"As a matter of fact, it is not only about growth in population. It also includes… the shift in various diseases" (A001: 252).
"With HIV and TB and the combination of the two. One spends far more time on one's… on one's patients than before" (A001: 253).
"We hear it very regularly, straight from our HOD of Health. Your statistics do not indicate that you need more staff" (A001: 256; 257).
"So… so, the population grows around you but your statistics are not going to indicate more because person can only do that much. Therefore, your statistics would not really go up simply because the population has increased because you are… you are the… the personnel board remains as small as it has always been" (A001:258).
"When there is only one… one clinical nurse practitioner there and the need is… is for another… another clinical nurse practitioner and now we send, for example, a trust [sic] to the office. The first question they ask, do… do you have the finances?" (A001:261; A007:21 & 124).

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The focus group discussions emphasised that quality client-centred care was threatened due to leadership and governing failures which resulted into inadequate numbers and categories of staff. According to various participants, provincial office officials did not consider the growth in population, the shift in the disease burden and that more time was spent on patients due to new programmes being implemented, to determine the staffing numbers.

5.3.5.5 Sub-theme: Competence and accountability

Competence and accountability are two of the six CCAIRR values that the Western Cape have adopted (Western Cape Department of Health, 2011).

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One of the focus groups accentuated incompetence of employees who should do certain activities. Participants emphasised that management should appoint competent and accountable human resources. According to participants employees were not held accountable for their mistakes, but stayed in their positions.

Box: 5.31: Competence and accountability

"I think the human resources… it's the incompetence of the people who have to have to do that" (A007:410).
"I think perhaps those higher up in corporate governance should perhaps observe the core values, né. For example, care because one obviously needs to care about one's personnel and competent people need to be appointed. There at the top there should be people who know specifically how to negotiate. And then… they should be accountable for what needs to be done" (A007:17).
"But people are not held accountable. He simply carries on making the same mistakes and he remains in the post" (A007:116).

According to the participants of this study, employees were not held accountable for their actions, as those who made mistakes were still in their positions. Quality client-centred care necessitates the importance to employ competent staff. Otherwise, the individual needs of patients will not be addressed or managed in an effective and efficient manner.

5.3.6 Theme 6: Operational Management

The sub-themes of operational management analysis for the context of this study referred to the following challenges: compulsory community service, comprehensive human resource development, understaffing on the operational level, high workload, uneccessary duplication of tasks, staff should be satisfied with their working environment, procurement and supply chain challenges and overemphasising of statistics.

5.3.6.1 Sub-theme: Challenges around compulsory community service

The subdistricts in the West Coast District have to accommodate a number of newly graduated community service professionals every year, e.g. nurses, occupational therapists, physiotherapists for compulsory community service.

Participants of this study perceived formal training programmes as not always in line with current service needs. Moreover, one focus group emphasised that newly qualified nurses are not up to date with what is happening in the TB programme or what rural practice entailed. Unfortunately, these newly qualified community service professionals were perceived as either "lazy" or "brilliant". The brilliant community service professionals were eager to work things out. Furthermore, these community service professionals were replaced every year with new

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community service professionals, so they had scarcely found their feet and knew how things work then they had to leave again.

Box: 5.32: Challenges around compulsory community service

"The result of training. We are experiencing that newly qualified nurses do not really know the basics about TB. At the beginning, they do not really have an idea about what is happening in the programme" (A001: 282, 8 & A002: 337).

"I think, one gets "*comserves* "who are working and one gets people who are lazy, okay? Then one gets youngsters who really are brilliant, they are eager and they work things out and they come and surprise you with new ideas how to entertain people and new advice to the patients and pamphlets and lots of stuff" (A002: 19).

"Every year there are new "comserves" No relationship gets established. By the time that the "comserve" has found his feet and knows how things work, two months are left before he leaves again. Then, somebody new comes" (A004:378).

"I realise that it is influenced by the amount of guidance one is getting, the "pregrad," because it is the amount of guidance expected postgrad and like I'm saying, it differs from institution to institution. Often, it stems from the curriculum and one's exposure to one's rural… to one's rural communities and… because that is going to… Health promotion campaign rural is going to be completely different from metro" (A002: 338).

According to the participants, formal training programmes at nursing colleges and universities were not always aligned to the service needs. In addition, community service professionals could be perceived as either "lazy" or "brilliant". According to the researcher it could be either "coping" or "not coping" with the rural circumstances, especially when they were not exposed to rural practice during their training. Furthermore, annual replacement of community service workers could influence quality client-centred care in a negative way, as service sustainability and continuity are put at risk.

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5.3.6.2 Sub-theme: Comprehensive human resource development

Ideal Clinic Standards (South African National Department of Health, 2017a) require a programme for staff training and continuing professional development. Furthermore, staff should receive continuing in-service education according to their individual job desriptions and performans plans.

Focus groups highlighted the importance of qualified and competent staff, e.g. not anybody can work in the pharmacy, and the staff member should be trained to work with medication. However, a focus group reported that cleaners were contracted from outsourced cleaning agencies to replace the cleaner of the clinic during sick leave or vacation. Unfortunately, these cleaners usually did not have the appropriate skills as required for the cleaning of a clinic. In addition, participants from nearly all focus groups, agreed about the importance of sending

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staff members for training. Moreover, participants also stressed the importance of regular updates. One of the focus groups pointed out a unique finding, i.e. the further training of community health workers increase their opportunities to apply for better posts. The researcher could identify with this, as the current practice of NGOs is to employ community health workers for only four and a half hours a day, whereas a well- trained community health worker has the capacity to apply for a full-time post, e.g. at an old age home, subacute facilities and private hospitals.

Box: 5.33: Comprehensive human resource development

"And also… your personnel should also be qualified and competent for the task "(A001: 20 & A004:18).
"And now, I do... do get um... freelance cleaners [sic] from the agency. They cannot clean our clinics. So, I need to get somebody that they can teach how to do this and this" (A002: 326).
"There should be an available person who has the training. Especially because there is such … not simply anybody could go and work in the pharmacy. It should be a person who has been trained to work with medication" (A007:4).
"Send as many of them as possible for training because it opens up their worlds" (A001:5; A003:3; A002: 313 & A004:7).
"Another thing is um … adequate training because only when one is skilled and trained and one goes for regular updates; it goes hand in hand with quality" (A003:1; A004:6).
"When they also on training – with the broadening of training – is actually nearly I said of an open heart. It is difficult for the coordinators. Difficult for the organisation but that community health workers apply for a better post" (A003:356).

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Participants highlighted the importance of qualified and competent staff. The majority of participants considered training and updates as very important. A unique finding is that one participant pointed out that the further training of the community healthcare workers will equip them for better and full-time jobs.

5.3.6.3 Sub-theme: Understaffing on the operational level

An Ideal Clinic, according to the Ideal Clinic standards (South African National Department of Health, 2017b) is a clinic with adequate staff to enable quality client-centred care.

However, several focus groups revealed that understaffing on the operational level is a huge challenge. Participants working in the district hospital also experienced severe understaffing. Consequently, this study revealed several challenges due to inadequate staff, namely: could not always attend to all patients; quality of care decreased; longer waiting times; health promotion is not done and training lagged behind.

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Box: 5.34: Understaffing on the operational level

"I have a huge issue with our staffing. It is totally understaffed and it makes a huge difference" (A002: 299; A001:234; A002:165; A002:294; A002:324; A003:153; A003:168; A003:347; A007:161).

"I… I would say there are many but the most important for me is simply time. We do not have time because we are only a few. So, I have to go through the patients and that's when the quality decreases" (A003: 155; A001:150; A003:154).

"Waiting times, as a matter of fact, plays a big role. Um… and I think sometimes it boils… it boils down to… to the shortage of staff "(A001: 162; A002:321).

"The shortage of human resources. So, um… health promotion does not get done" (A003:350)."

"It goes hand in hand with human resources. When one doesn't have somebody to send for training then one does not have somebody. And it always remains in abeyance; that continual clinical training or the updates remain in abeyance" (A003: 2).

"The files need to be retrieved again with the result that there are too many files that need to be retrieved in relation to the number of available clerks" (A004:164, 374, 376 & A002:45).

"We do get it. The thing is um… the… the shortage of coordinators or the coordinators… It sounds good to say the coordinator has been appointed to supervise twelve carers who then… then they could perhaps oversee an area like a third of the Berg River" (A003:167).

Several focus groups revealed that understaffing on the operational level was a huge challenge for quality client-centred care in the PHC milieu. Staff shortages resulted amongst others into long waiting times, health promotion that is neglected and staff who could not be sent for training.

5.3.6.4 Sub-theme: High workload

The shortage of nurses with the consequently high workloads in the healthcare facilities in South Africa is well known. However, finding ground-breaking solutions to this problem remains a priority. Igumbor, Davids, Nieuwoudt, Lee and Roomaney (2016) study findings showed that clinical nurse practitioners in the rural, Western Cape fixed clinics spend a median time of about 13 minutes with each patient. The median number of patients seen per day per observed nurse was 34 (interquartile range: 23-40 patients). The most frequently performed activity in fixed clinics is medication dispensing (21.90%), followed by curative consultations (20.28%), documentation of clinical care (12.99%) and interruptions (10.71%). Interruptions, refer to breaks during consultations resulting from either phone calls, someone else entering the room or for reasons unrelated to the care of the particular patient.

Concurrent with the above study, two focus groups also indicated the severe workload with which staff at PHC clinics have to cope and compared it with a sausage machine and a conveyor band. They emphasised that due to these large numbers of patients quality of care is

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compromised. In addition, participants accentuated the severe pressure, due to the dual role of the operational manager, i.e. she is the clinic's manager and at the same time has to operate as a clinical nurse practitioner. The clinic manager experiences severe work pressure, amongst others she has to manage the staff, complete the statistics, manage the stock and equipment.

Box: 5.35: High workload

"All of that are at the clinics but there is simply so much pressure in terms of numbers that the quality suffers as a result of pressure, as a result of time and at the end of the day it becomes like a sausage machine or conveyor belt "(A002:292, 310, 203, 322; A004: 385 & 13). "Especially from the operational managers. At a clinic they are under so much pressure and, yes "(A002:206). "To manage because managing... she has to manage her stock, her staff, her equipment, and her stats. That is a full-time job and being a clinical nurse practitioner in itself is a full-time job. So, that's two jobs in one. I think that's a big burden" (A002: 209; A002:208; A002: 210; A003: 205).

Participants indicated that staff members of PHC clinics have to cope with huge workloads. They emphasised that due to these large numbers of patients, quality care was compromised as they did not have time to attend to patients' needs. In addition, focus groups also accentuated the severe pressure under which the operational managers have to work. Operational managers have a dual role of clinic manager and at the same time have to operate as a clinical nurse practitioner. The clinic manager amongst others has also to manage the staff, complete the statistics, manage the stock and equipment.

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5.3.6.5 Sub-theme: Unnecessary duplication of tasks

Healthcare staff members have to complete multiple registers and books for various services during a visit of a patient to a health professional. Shihundla, Lebese and Maputle (2016) confirmed the documentation of information on numerous documents at PHC facilities in Vhembe, Limpopo Province aggregating professional nurses' responsibilities and workload. Several registers and books have to be completed, e.g. antenatal patients attending the first visit must be recorded in the following documents: Prevention of Mother-to-Child Transmission register; consent form for HIV and AIDS testing; HIV Counselling and Testing register, if tested positive for HIV and AIDS then this must be recorded in the ART wellness register; ART file with a supplementary single file, completion of which is time consuming; TB suspects register; blood specimen register; maternity-case record book and Basic Antenatal Care checklist. The findings of these studies showed that nurses find it challenging to cope with the increased workload, related to the documentation of patient information on the many records that are utilised at PHC facilities, leading to incomplete information.

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Focus groups of this study also emphasised these duplications of information and the necessity to reduce the duplication of recorded information. According to one focus group, operational managers were working already under pressure. Moreover, participants also pointed out the duplication of information regarding the under-five child, namely documentation in the file, as well as on the Road-to-Health booklet. However, according to the experience of the researcher there is also a tick sheet, immunisation register, and Integrated Management of Childhood Illness checklist to be completed. In addition, when these children are diagnosed as malnourished, the Nutritional Therapy Programme register should also be completed. One of the participants highlighted the time-consuming aspect to complete all of these multiple documents, resulting in longer waiting times for patients.

Box 5.36: Unnecessary duplication of tasks

"We are busy to duplicate so many things, meaning at… think about the poor clinical nurse. She has to do forms, she has to [attend] to the things of the occupational therapist, and she has to do this, do this, do that. And how much of that information is duplication" (A004:381, 382, 383 & 384).

"We need to get something to reduce this duplication. It could be anything" (A004:40).

"Especially from the operational managers. At a clinic they are under so much pressure and, yes" (A002:206).

"Documents that we are busy writing. The maternity side. It's there. It's there. This is the file, it's the [mumbles]. This is the file, this is the record of [mumbles]. Goodness knows what else. So, um… like breastfeeding. We have a tick sheet [sic] that we have to do. Once more, the same information is provided by the PMTCT [sic], the councillors also who do the breastfeeding. We are so busy duplicating constantly "(A004:382).

"The little one gets weighed, the length is taken, the head-in-place gets done, and the immunisations are done. It gets recorded in the file. Most of that information also needs to be recorded in the Road to Health booklet "(A004:383 & 384).

"As a result of this duplication, where she could have seen a patient in twenty minutes it then becomes forty minutes. In other words, we are not mindful of patients who are waiting longer" (A004:151).

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Focus group participants emphasised the high workload resulting from duplication of recorded information to multiple tick sheets and registers, and requested the decrease thereof. Duplicating these are time consuming and result in longer waiting times for patients.

5.3.6.6 Sub-theme: Staff should be satisfied with their working environment

The Ideal Clinic Standards emphasised that staff should work in a conducive environment. Furthermore, an annual staff satisfaction survey should be conducted (South African National Department of Health, 2017a). According to these results a quality improvement plan should be developed to improve the working environment.

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The participants of this study acknowledged that staff satisfaction has an influence on service delivery. One of the focus groups indicated that unhappy staff will not provide a quality service. Moreover, they confirmed that quality care will not be provided when a patient did not show appreciation for care received. In addition, focus groups emphasised that satisfied staff is needed for the delivery of quality care. Participants confirmed that when a staff member is happy at work, he or she will put in additional service delivery efforts. Moreover, it was reported that it was very satisfying when a patient returned to compliment staff on service delivery. Various focus groups participants experienced staff as: physically and emotionally neglected; demotivated; burnt out; near breaking-point; low morale; despondent and without courage. On the contrary, only focus group participants perceived the staff morale as actually good. Lastly, one focus group mentioned that only staff of their subdistrict, one of the five rural districts, did not receive a rural allowance. This was a concern and could be a threat to staff recruitment and satisfaction.

The focus groups identified the following staffing needs: organisational support, personal support, and care for the carers, as well as professional support training. However, as mentioned by one of the focus groups, the WCDoH adopted the caring, competency, accountability, integrity, innovation, respect and responsive value-driven approach to address restrictive values, such as: bureaucracy, hierarchy, control, long hours and confusion (Western Cape Department of Health, 2014).

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In addition, as confirmed by one of the participants, the WCDoH contracted the independent counselling and advisory services (ICAS) to support individual wellness (physically and psycho-socially); organisational wellness; and work-life balance (Western Cape Department of Health, 2015). Moreover, participants suggested team building activities to improve staff morale.

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Box: 5.37: Staff should be satisfied with their working environment

"When the members of staff in the final analysis are not happy, then they wouldn't really provide a quality service" (A001: 227; A007: 181).
"I would also like to see that the personnel are satisfied because the… one needs um… a satisfied member of staff to provide an outstanding service" (A004:363; A007: 417; A007:433 & A001: 264).
"That… that does not always happen but it is very satisfying when a patient returns and confirms that they actually are doing it and it works" (A001: 264).
"Once a week, I work in the clinics as… as psychologist. Then, once a year I pay all the facilities in the district a visit and I see every member of staff. I can only say, those people are extremely neglected. One cannot believe the high prevalence of high blood pressure, all the sugars, all the lifestyle illnesses. They are all overweight and I think it is a release valve to... to eat. In other words, they are physically and emotionally neglected (A002: 197; A002: 324; A001: 182; A007: 194; A007: 195 & A007: 202).
"But, once again, I could not… I could also not be happy and my morale would also not be high when I go through all the trouble and when I arrive there on the day and then nothing is happening there" (A001: 279, A003: 219, A004: 377, A002: 221 & A003: 355).
"Actually, the people's morale is actually very good. Despite everything – I think – the people's morale is fantastic" (A002: 320).
"Yes, what I tell myself personally, is every day when I walk in, I have to tell myself – even when I'm tired, even when one becomes despondent with the system – now one has to focus on the patient. And one does not always succeed" (A003: 81 & A003:200).
"When you walk in that morning, a whole crowd of people are sitting there. I always say, if I have to work the everyday, my courage will disappear when I think I have to attend to these hundred people by this afternoon" (A001: 304).
"Um… perhaps I am thinking about the morale of the nursing staff. For example, uh… a team competition or anything else assists. For argument sake, to have a team building once a quarter or every six months just to boost the morale; simply to do something pleasant" (A001: 283, A001:284 & A001:175).
"We have um… the… the values of the department are "CCAIRR". They started doing this because they had realised that there were um… a patient satisfaction and a staff satisfaction. The results in both cases were bad" (A001: 285 & A001:227).
"The department launches training programme[s] to… to ensure that every member of staff… the quality… or quality service… and then there is also ICAS for employee assistance programme" (A001: 227, A002: 44; A002: 323 & A003: 46).
"And that one often does not find the emotional maturity or we also do not assist these people organisationally to… "(A003:47).

According to the aforementioned, staff showed inadequate staff satisfaction. As mentioned by some participants, these low levels of satisfaction could compromise quality client-centred care. In spite of the adopted values approach and ICAS for employee wellness, participants highlighted the need for personal and professional support.

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5.3.6.7 Sub-theme: Procurement and supply chain challenges

Ideal Clinic Standards (South African National Department of Health, 2017a) required a committed budget for each facility and standard operating procedures for procurement of consumables and supplies. Furthermore, monitoring should be done to ensure a reliable supply chain management system, as well as the obtainability of funds neccessary for optimal service delivery.

Various participants pointed out that the necessary resources, i.e. sufficient stock necessary to deliver quality care, however was compromised by constant stock shortages. Several items seemed to be out of stock, namely: web calls; needles; bandages and injections. In addition, various participants indicated that too many procurement processes have to be followed. However, one focus group indicated that procurement has to comply with the prescribed directives as determined by the Public Finance Management Act (Act No. 1 of 1999). In addition, several participants identified the lack of communication, i.e. no feedback to the end users or no follow-up as another challenge in the procurement process. At the end of the day, the patient has to compromise due to the various procurement inefficiencies. Due to the long waiting for stock delivery, staff members are forced to buy their own stationary. Lastly, one focus group highlighted the importance to stay within the budget.

Box: 5.38: Procurement and supply chain challenges

"One cannot provide quality service when one does not have the equipment and sufficient stock. The correct stock" (A001: 131).
"You could have done more… if you only had the resources" (A001:230).
"One can't. One can't. So, that is what creates quite huge gaps for us at the moment – is the constant stock shortages that we are experiencing" (A001: 133; 136; 249 & 134).
"I especially refer to the logistics in terms of stock. I think that there is not always an understanding of which processes are in place. We simply have too many processes. There are too many people who have to rubber stamp and there are too many… "(A001: 50; A007:404).
"…a delay caused in the clinical processes. And I really don't think it is in… in the hands of the finances at the hospital to do something about it. They have directives they need to follow. They simply cannot get around it "(A001: 49).
"I think communication is still a huge problem because um... say for instance back to the ordering. If I order something um... and say for instance it has never been ordered before. So, now it needs obviously a different process to follow" (A007:127; 126 & 412; 413).
"Then, one goes for – I nearly said – a cheaper option or whatever is available and then the patient gets at the end of the day only that" (A007:160).
"Yes, a simple thing such as a [mumbles], one's Pritt or one's [mumbles] or stationery. Something simply like stationery that one says, oh! I'd rather buy it myself because one cannot wait that long" (A007:412).
"One has to always stay within the budget" (A007:443).

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The feedback identified frequent stock shortages and unclear ordering procedures, poor communication, and long waiting times for the obtaining of supplies, as major challenges for quality client-centred care. These challenges do have a negative influence on the staff, as well as quality client-centred care.

5.3.6.8 Sub-theme: Overemphasising of statistics

According to Ideal Clinic Standards (South African National Department of Health, 2017a) facilities should produce and record accurate information for their own use and submission to district, provincial and national levels. Therefore, the National District Health Information Management System policy should be accessible. Facility staff and data capturers should receive training about the Standard Operating Guidelines for data management. Relevant District Health Information System registers should be available and have to be updated. Facilities should submit their data timeously on subdistrict level, and monthly data should be taken to the next level (district and provincial levels). A functional computerised patient information system should be in place.

However, according to one of the focus groups data capturing was incomplete, as not all data, e.g. Vitamin A and deworming were always captured. Various participants confirmed that statistics were not correct. In addition, it was confirmed that no data was kept regarding the number of patients who were turned away, i.e. patients who did not receive service. However, participants confirmed that they, for their own purpose started to record the number of patients who were turned away. Moreover, one of the focus groups indicated that the number of patients being turned away could be used as a motivation for more staff. Participants also reported that the data elements have expanded and accentuated the importance of everyone to document the relevant data. Recognition was acknowledged regarding the appointment of the appropriate data information clerks, to ensure correct and accurate data capturing.

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Box: 5.39: Overemphasising of statistics

“That they have seen forty, fifty children today. One knows every child has walked out of there and received his vitamin A and his deworming and his immunisation but it has not been entered on the Jimmy tool (A002: 325). “Just look at the statistics that you are saying is not accurate. It is not accurate. I know. There are heads that are lost” (A004:387). “So, we are not keeping statistics about the people whom we are sending away. So, that is why the statistics are going to remain the same because we only submit the ones whom the sister has seen” (A004:38). “We have no idea about how many are turned away and how many simply leave the clinic because [mumbles]. One should keep record” (A001:281). “That’s the problem. We have started to um… at some of the places where we know what problem is they have record the patients who couldn’t be seen. He has to come back tomorrow, né. So, now they are keeping a diary of that. But… but… no… nowhere do we report, does it get regulated” (A004:36a). “So the motivate… when we have to write a motivation to the district office for more um… um… um… for another nurse practitioner, then we are going to attach those statistics to say that’s what…” (A004:36b). “The info… the information expanded quite a lot. Everyone has to complete a tally sheet. Um… it’s keeping your wits. So, when there is a clerk it would make the task so much better… go… make” (A004:375). “Then people were also appointed whose specific duty it is. Then they physically go to the heads… to yesterday’s page and they check. Have all hundred people been captured? So, I think the clinics have a reasonable system in place at the moment to… “(A004: 386).

According to the feedback, the current data capturing was not always complete or accurate as not all data were captured. According to the researcher, it was a concern that there was no official data for the number of patients who were turned away, as these numbers could be used as motivation for the recruitment of more staff to enhance quality client-centred care. However, according to the feedback, data quality was compromised by incompleteness and inaccuracy.

5.3.7 Theme 7: Infrastructure and facilities

The facilities and infrastructure domain necessitates a clean, safe and secure physical infrastructure and effective waste management. Furthermore, it is required that infrastructure of clinics should be maintained to ensure conducive health service delivery. Infrastructure of PHC facilities has to comply with safety regulations. The sub-themes of infrastructure and facilities, referred to: lack of infrastructure maintenance, inadequate physical space, not enough consultation rooms and lack of security.

5.3.7.1 Sub-theme: Lack of infrastructure maintenance

However, participants mentioned that the walls, roofs and tiles of some clinics were not in a good shape. According to focus groups money and human resources, and capacity were always insufficient for infrastructure maintenance, upgrading or expansion. It could take years before maintenance aspects receive attention. This could result that infrastructure goes to wrack and

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ruin and has to be rebuilt from scratch. The following comment was disturbing: "when your place of work appears scruffy then you wouldn't be bothered about how you treat the patients who enter". This comment implicates that the appearance of infrastructure has a direct impact on quality of client-centred care.

Box: 5.40: Lack of infrastructure maintenance

"Some of the [mumbles] clinics are no longer in a proper condition; such as the roofs, the walls, the tiles "(A007:118 & 125).
"When we address the infrastructure, there's never money to upgrade and maintain the infrastructure" (A007:22).
"Infrastructure needs a lot of money but there are not the human resources to either expand the service or to provide the services" (A007:409).
The department of public works has um… priority lists. And then, sometimes it takes three to ten years for your project to be really attended to" (A001: 268).
"The maintenance, yes. I think at the moment the attitude of the state , the leave a place to completely go to wrack and ruin [sic] and then it costs an awful lot of money the rebuild it from scratch" (A007:124).
"When it is a place where you are going every day, certainly you would like to go and work at a respectable place. Because when your place of work appears scruffy then you wouldn't be bothered about how you treat the patients who enter" (A007:120).

The aforementioned feedback indicated that the maintenance of clinics in the West Coast District was not up to date and that this lack of maintenance could affect patient care and staff satisfaction in a negative way.

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5.3.7.2 Sub-theme: Inadequate physical space

Ideal Clinic Standards (South African National Department of Health, 2017a) emphasised that clinic space should be favourable for service delivery.

Various allied health professionals highlighted the lack of adequate space to perform their rehabilitation services. The lack of space impacted negatively on patient care as some patients have to be sent home due to the lack of space. The following space inadequacies were identified, namely: the occupational therapists, physiotherapist, additional services, e.g. medical male circumcisions, and the pharmacist needs more storage space for bulk supplies. In addition, participants also indicated that the waiting room should be large enough. Especially on the day when more than one allied health professional visited the clinic, e.g. the dentist and the occupational therapist, then the waiting room did not have adequate space to accommodate everyone and resulted in patients having to wait outside.

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Box: 5.41: Inadequate physical space

"Firstly, we simply do not have space to provide her with a good rehabilitation service. We send her home" (A003:145). "Yes. And we have um… especially with occupational therapy, especially with the paediatric population, then one needs more space" (A004:371; 146 & A003:141 & 142). "Well, I can say from the point of view of a physiotherapist um… I see an incredible amount of backache. I think one can present a back session instead of seeing patients individually, but we are also faced with the space as problem (A001: 274). "On top of that the medical male circumcisions were added and had to be fit in during certain times and there was no space" (A004:366)". "The pharmacy only have a small storage space which means I need to order more often. So, you end up ordering stock every two weeks for the clinic where you could have done it once" (A001:259; A007:121 & 122). "It should definitely uh… the… the um… waiting room should be large enough to accommodate the patients" (A002: 29 & A001: 247).

The feedback from almost all the focus groups pointed out that space was currently inadequate for service delivery. Therapists, e.g. occupational and physiotherapists need physical space to accommodate activities like walking, jumping, stretching of individuals, as well as group classes. As indicated by the participants, all clinics were in need of storage space, e.g. pharmacy for bulk supplies and equipment, e.g. mats and plinths.

5.3.7.3 Sub-theme: Not enough consultation rooms

Ideal Clinic Standards (South African National Department of Health, 2017a), also required that the number of consultation rooms should be compatible according to the services and staff.

It was pointed out that before the implementation of PHC (1994), no allied health professionals were employed at clinics. Currently, various allied health professions are employed, though the infrastructure is still unchanged or inadequate. Therefore, various allied health professionals highlighted the shortage of consultation rooms. Consequently, patients have to be accommodated in inappropriate rooms, e.g. the: kitchen, store room, waiting room, nearby hall or library. Sometimes more than one allied health professional have to share one room compromising the privacy of patients. In addition, participants also identified that the absence of a tea or rest room in some clinics was demoralising. Not even all operational managers have the necessary office space. In addition, the allied health professionals also pointed out that they also lacked the necessary lock-up space or dedicated rooms to store their equipment. The speech therapist also indicated the challenge of doing a hearing screening in a room next to a kitchen where there is supposed to be silence. The lack of adequate consultation rooms also

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challenged the privacy and confidentiality of patients as illustrated by the following scenarios: intermittent movement, interruption or disturbance, e.g. when the kitchen has to be utilised, lack of privacy and confidentiality when within hearing distance of other patients, e.g. in the waiting room, one can hear everything when there is only a dry wall between two consultation rooms or when two therapists have to share one room, privacy and confidentiality are also challenged. However, therapists make do with what they have. They make plans, e.g. responsibility is transferred to the patient who has to maintain his treatment at home.

Box: 5.42: Not enough consultation rooms

"I don't think in those days there were occupational therapists and dieticians. Yet, the infrastructure still looks the same" (A004:367).

"There aren't uh... enough consultation rooms available on certain days. Obviously that directly impacts quality of care. I mean, it infringes on Patient Rights um... to... to confidentiality and that. Um... and *ja*. Batho Pele principles. It's not fair on the patients to accept having a consultation in a waiting room where there are other patients" (A003:141 & A002: 301).

"We can sit talking in any space with a table but there is a problem. It is the intermittent movement of personnel that causes constant interruption. We are currently talking about patient-centred. How would a person feel when we are sitting in the kitchen during a consultation?" (A004:144; 368; A002: 196 & A002: 296).

"We are working in two small rooms. It's the store room. It's the storeroom. It's the tea room. It's the treatment room. Everything gets done in those two small rooms. The sterilising gets done there, the works. In comparison with what it should be, there need to be a room for everything, like for the one who works with that patient and for those patients. Why is everything pushed into one room?" (A002: 298; A002: 301; A004: 369; A001: 235 & A001: 236).

"The waiting space. In the clinics there are no um… restrooms. There is not a small space for the personnel to have some tea for ten minutes. So… so, it really is, it really does something to the morale" (A003:341 & A002: 303).

"One had to walk through the consultation rooms to get to the toilet" (A004:123 & A004: 365).

"I think when one has one's own lock up space, then one would have the opportunity to keep a few better things there" (A002:307).

"So, I'm stuck with that little problem. There is not a specific room that I can take and say that it my room" (A001: 246 & A002: 296).

"I think where space affects us is with the um… hearing screening. When one is in the room next to the kitchen and there is supposed to be silence. It is somewhat of a… problem" (A004:143).

"The issue of limited space remains. They are trying to accommodate me in terms of privacy. For instance, a dry wall are this sliding door in between. One can hear everything that the person next door is saying" (A003:148).

"We make a plan when there is a shortage like when there is not enough space that we need, then we make it work. Therefore, what I do, I have to transfer the responsibility to the shoulders of the patient by saying, okay. This is what one can do at home to maintain your own treatment" (A001: 158 & A002: 157).

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According to the aforementioned feedback, various clinics have inadequate number of consultation rooms. This impacted negatively on staff morale, as well as on the quality of client-centred care.

5.3.7.4 Sub-theme: Lack of security

Patient and staff safety should be ensured at all times. Ideal Clinic Standards (South African National Department of Health, 2017b) required the availability of a safety and security standard operating procedure, perimeter fencing, a security guard on duty or an alarm system linked to armed response.

However, security seems to be a challenge specifically for the clinics of participants from the focus groups. Participants confirmed that there was no security at their clinics. They also reported on the risk of theft.

Box: 5.43: Lack of security

"But the televisions and stuff are stolen every other week" (A002: 53).
"No, we do not have security" (A002: 56).
"And the patients are sitting there and they observe how it is working and tomorrow morning when one notices, then they had broken in and removed all those things. Then, one has nothing. It is an enormous problem" (A002: 56).
"We erected a building here behind us; nice prefab and whatever. They came… they came and stole the complete windows" (A002:318).
"They need to use the security to guard those things. Now we get this. Today, it's still here, then afterwards they would come and steal everything" (A002: 54).
"Every morning when one reports for duty, then one has to hear the stuff is no longer there" (A002: 319).
"Now, just think how that makes the staff feel? Here one arrives and now all your stuff has been stolen" (A002: 55).

Security systems were lacking at various clinics and theft seemed to be a huge safety risk for both staff and clients. Quality client-centred care demands a safe environment for staff and patients.

5.4 DISCUSSION OF RESULTS

Phase 2 (Objective 4) of this study included five focus group discussions to explore and describe the managers and the allied health professionals' perception about quality client-centred care. Seven themes, according to the seven domains of the NCSs emerged and are discussed below.

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5.4.1 Theme 1: Patient Rights

Theme 1 prioritised Patient Rights aspects of care and referred to: respect and dignity, access to information, long waiting times, the right to complain, scheduled appointments and continuity of care.

Focus groups put emphasis on the patient who should be satisfied with service delivery. In line with patient satisfaction, the WHO (World Health Organization, 2015; 2016) emphasised that people-centred care has to consider the expectations of individuals, families and communities.

Various studies confirmed that satisfied healthcare users were more likely to adhere to treatment, return for follow-up visits and ultimately, achieved better health outcomes (Mohamed, Sami, Alotaibi, Alfarag, Almutairi & Alanzi, 2015; Kabatooro, Ndoboli & Namatovu, 2016; Ali, Nikoloski & Reka, 2015).

Participants of the current study, linked patient satisfaction with waiting times that are not too long, friendly staff and meeting of patient expectations. Similarly, Nunu and Munyewende (2017) reported that patients' satisfaction were indeed influenced by the length of waiting time, nurses listening to patients, patients being informed regarding their condition and being treated politely.

In addition, the study results revealed that some staff members showed a negative attitude towards patients. These staff members were not willing to go the extra mile and it was good enough for patients to wait. Similarly, several studies reported that patients experienced staff as disrespectful, e.g. rude, unfriendly, impatient and unsympathetic (O'Reilly & Washington, 2012; Tsawe & Susuman, 2015; Murphy *et al.*, 2015; Kagee *et al.*, 2012). Nevertheless, Verjee and Robertson-Malt (2013), Storm and Edwards (2013), and Greene *et al*. (2012) stated that patient-centred care should be characterised by respect and responsiveness to specific patient likings, desires and standards.

Moreover, Hepworth *et al*. (2013) pointed out that patients were happy, when they experienced healthcare providers as friendly. Though, the systematic review of Mannava *et al*. (2015) about attitudes and behaviours of maternal healthcare staff, reported that negative patient relations dominated the positive ones. In the Western Cape, an exploration of patient complaints acknowledged that waiting times and negative staff attitudes were major challenges (Western Cape Department of Health, 2014).

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Moreover, the current findings of this study indicated that confidentiality and privacy were compromised by poorly built and inadequate layout of some PHC facilities. The same was reported by the study of Hodgson *et al*. (2013) confirming that infrastructure of poor quality, e.g. limited space, thin walls, as well as inadequate layout of facilities could result in a breach of privacy and confidentiality. Lack of confidentiality, privacy and trust seem to be a global challenge. Especially young people, teens or adolescents were reluctant to share personal information with healthcare providers as they did not trust the providers. These young people were concerned that providers would share their information with other providers or their parents (Davey *et al*., 2013; Johnston *et al*., 2015; Schaeuble *et al*., 2010).

One focus group specifically emphasised the importance of cleanliness. Several studies reported on the lack of cleanliness at PHC facilities. Shabila *et al*. (2012) highlighted the poor sanitary situation in Kurdistan, Iraq, due to insufficient numbers of cleaning staff. Likewise, Stellenberg (2015) stated the unhygienic conditions of PHC clinics in Cape Town, South Africa. On the contrary, PHC users in Johannesburg, South Africa, revealed that 80% (n=9 965 patients) in 80 health facilities were satisfied with the cleanliness of the clinics (Zambia, 2014).

Furthermore, results from the focus groups of this study, found that patients were not always familiar with their diagnosis, the role and function of the allied health professionals or available services. Kabatooro *et al*. (2016) urged healthcare providers to spend enough time to inform the patient about his or her diagnosis, provide an acceptable explanation and provide correct information on the management of their disease. Information to patients regarding their expectations and their illness have been associated to higher patient satisfaction, compliance with health advice and improved health outcomes.

Access to information, communication and education, tailored to individual needs is one of the seven dimensions of client-centred care (Gerteis *et al*, 1993). Patients looked for a relationship of respect and trust with the healthcare staff who included them in two-way flow of consultations, and decision making in medical diagnosis and treatment (Van de Ven, 2014).

What is more, the focus groups of this study identified long waiting time as one of the most pressing problems at PHC facilities. Various participants indicated that there was a lack in communication when delays were experienced. This was concurrent with the study findings of Bamidele, Hoque and Van der Heever (2011) who recognised that there was a negative association between waiting time and overall satisfaction. Longer waiting times were related

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with decreased patient satisfaction. Unfortunately, waiting time is a cause of dissatisfaction for patients and remain a challenge for quality client-centred care and services in clinics. Several studies confirmed that patients experienced too long waiting times (Adams & Carter, 2011; Burnham *et al*., 2011; Van Rooy *et al*., 2015; Mathibe *et al*., 2015; Basu *et al*., 2012).

Focus group feedback showed that participants were well informed regarding the management of complaints and the process to make patients aware of their right to complain. As a concern, more complaints were received than compliments. Also alarming, when it was a known complainer, complaints might not be taken seriously.

On the contrary, study findings of Gurung *et al*. (2017) indicated that patients or clients did not complain due to the non-existence of complaint channels, inadequate knowledge, no opportunity to choose alternative providers, lack of recognised culture of complaining and a deficiency of responsiveness to complaints. Furthermore, O'Reilly and Washington's (2012) study findings revealed that not all patients understood the complaint process or had difficulties with it. Information of the complaint procedure was often not accessible and most patients were unaware of the complaint procedure. On the other hand, Munyaka *et al*. (2010) confirmed that the majority of respondents in their study were aware of where and to whom to lodge complaints. Black Sash (2011) monitored 74 clinics all over South Africa, also found that the majority of patients (70%), were aware of their right to complain.

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Various participants of the current study were positive about appointments. Of concern, was that some patients did not want to wait and then side-stepped the clinic and went straight to the emergency department of the district hospital. The bypassing of PHC clinics to access emergency departments at the nearest hospital is an interesting, but not a unique finding. Kraaijvanger, Van Leeuwen, Rijpsma and Edwards' (2016) systematic review reported that self-referral to emergency departments in several Western countries was increasing. This was consistent with the study findings of Ntleko (2011) who reported that the main reasons for bypassing the KwaZulu-Natal PHC level were the unavailability of mobile clinics for that day, the hospital was closer, patients were used to coming to the hospital and were doing things in town and decided to combine this visit with the hospital visit. Mojaki, Basu, Letskokgohka, & Govender (2011) also reported that patients perceived the hospital services as superior, a better resource availability, desired to be seen by a doctor, and the hospital might be the nearest facility. Other reasons were that after-hour clinic services were unavailable, PHC facilities

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dysfunctional, absence of public transport, and lack of information about the referral system among patients and healthcare providers.

Besides, this study results identified that continuity of care was lacking: not all patients were completely sorted out on the day of their visit and had to return to the clinic; inadequate communication between the clinic staff and the allied health workers; lack of written referral feedback and lack of consistency due to the annual replacement of community service health professionals. However, lack of the continuity in care seemed to be a common occurrence. Legodi and Wolvaardt's (2015) study showed that only 5.4% (n=46) of 858 referrals received written feedback. A high percentage of feedback letters (41.8%; n=19) appeared to be incomplete as contact details were unavailable. Furthermore the majority of referral letters did not refer to the signs and symptoms (87%; n=40). Chindedza *et al*. (2013) reported about patients from Zimbabwe who had to travel outside their catchment area without referral letters. Furthermore, Kahabuka *et al*. (2012) also revealed that children under five from Tanzania were referred with verbal referrals and no written documents to the referral hospital. In addition, PHC centres in Nigeria revealed that none of the centres had evidence of in terms of printed referral forms or registers to confirm referrals (Nnebue *et al*., 2016).

5.4.2 Theme 2: Quality Client-Centred care

The second theme of this study discussed the results related to the quality client-centred aspects as viewed by the managers and allied health professionals of the West Coast District. These results included categories of client-centred care, self-determination, and involvement of family and those important, well-informed healthcare providers and quality service delivery.

Focus groups discussions confirmed that a patient has to be viewed in totality, holistically and as an individual. These findings were in line with interpretations of Paparella (2016); Health Foundation (2014); Dewi *et al*. (2014); DNV GL/Sustania (2014); McCormack *et al*. (2010) about person-centred care.

In addition, the study results showed that, healthcare providers found it sometimes difficult to convince patients of change when they were not ready for change. Moreover, sometimes patients have unrealistic expectations. According to Pretorius, Van Rooyen and Reinbrecht-Schutte (2010) change is driven by the perceived gap between current performance and important personal goals or values. When patients realised that they were compromising their personal goals or values by persisting with the behaviour, it might motivate them to change.

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Client-centred care should meet patients "where they are" and support them to achieve the necessary skills, abilities, information and confidence to take an active role (Foot, Gilburt, Dunn, Jabbal, Seale, Goodrich, Buck & Taylor, 2014).

As indicated in this study, Greene *et al*. (2012); Foot *et al*. (2014), confirmed the importance to involve those who were important in their lives, e.g. patient's friends, family, and/or caregivers to support the patient in order to achieve the expected health outcomes. This is supported by Foot *et al.* (2014) who emphasised the following important roles of family and carers: emotional, social and financial care; household assistance; observing health and wellbeing; supporting with basic health and personal care; assisting with information about the individual; advocating for individuals and proactively seeking out care and treatment options.

Of note is that managers and allied health professionals acknowledged that quality client-centred care requires employees to be well-informed about the processes and procedures of the health system. In support, Pulvirenti *et al*. (2011) confirmed that knowledge of all the processes and procedures in the health system could result in the facilitation and integration of multidisciplinary care across services, settings and sectors.

According to the Australian Medical Association (2016) coordination between all healthcare providers ensures that all services continue as seamlessly as possible.

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Furthermore, focus groups confirmed that clients were inclined to return to facilities where they received quality service. On the contrary, Leonard (2014); Visser, Marincowitz, Govender & Ogunbanjo (2015), indicated that healthcare users were frequently bypassing their nearest clinic in order to receive better quality care. Masango-Makgobela *et al*. (2013) concluded that most of the patients refused to return to their nearby clinics, due to: lengthy waiting time (88; 25.1%); long queues (84; 24%); impolite staff (60; 17%); and unavailability of medication (39; 11.1%).

However, study results of Kahabuka *et al*. (2011) confirmed that 59% (206/348) of caretakers did not use their nearest clinic, due to: lack of diagnostic services (42.2%), lack of medication (15.5%), closed clinics (10.2%), poor services (9.7%) and unavailability of skilled staff (3.4%).

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5.4.3 Theme 3: Clinical Support

Theme 3 of this study speaks to the clinical support aspects and refers to the availability of medication, patient education about medication usage, availability of referral resources, budgetary constraints, specialists outreach teams and availability of medical equipment.

According to the qualitative results of this study, medication stock levels are usually very low towards the end of the financial year. Facilities then have to wait long for the delivery of medication which could compromise quality client-centred care, due to possible stock-outs.

In line with the aforementioned, the National Health Care Facilities Baseline Audit (Health Systems Trust, 2013) also confirmed that health establishments throughout South Africa showed a high percentage failure regarding the availability of medicines.

Participants confirmed that patients were informed about the use of medication. However, only one focus group emphasised that patients should return when they experienced any side-effects. Various studies emphasised the importance of patient education and counselling about the use of medication and information about possible side-effects (Ahmed *et al*., 2013; Marais *et al*., 2014; Lulebo *et al*., 2015; Mkele, 2010; Steyn & Goldstuck, 2013; Lekhuleni *et al*., 2013; Ross *et al*, 2011). On the contrary, the study of Dube and Uys (2015) revealed that none of their study sites provided patients with medication information and its possible side-effects.

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According to this study, referral resources seemed to be inadequate for the needs of the West Coast District. Correspondingly, several other studies indicated a global shortage of allied health professionals working in rural areas (Keane, Lincoln & Smith, 2012; Roots & Li, 2013; Jesus, Landry, Dussault and Fronteira, 2017). The National Health Care Facilities Baseline Audit (South African National Department of Health, 2013b) also confirmed the low availability of audiology (6%); dietetic (16%); psychology and speech therapy (10%) services at South African PHC facilities. In addition, Sherry (2014) pointed out that even the Western Cape Province, revealed huge unmet needs regarding referral for rehabilitation services. Similarly, Scheffler *et al*. (2015) indicated that many referral services had long backlogs.

According to the focus groups results there was a backlog of wheelchairs due to budgetary constraints. Correspondingly, according to various authors, budgetary constraints seemed to be the main reason for the long waiting times and delayed provision of assistive devices (Sherry, 2014; Visagie & Schneider, 2014).

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Participants of this study acknowledged that outreach services could be of value for specifically addressing eye care and oral health needs. The researcher supports this, as there is currently a backlog in the West Coast regarding eye care and oral health services. Likewise, according to Schoevers and Jenkins (2015) outreach specialists were essential, as it improved access to specialised healthcare services, effectiveness, efficiency and relationships between the different levels of healthcare.

Moreover, according to the managers and allied health professionals clinics should be fully equipped. However, the feedback revealed insufficient number of dental chairs; TVs and DVDs and the lack of computerised systems. The challenge regarding maintenance of broken equipment was also pointed out. The aforesaid findings were not unique. The researcher retrieved several studies indicating shortfall about maintenance and unavailability of the necessary equipment (Pakhare *et al*., 2015; Saxena *et al*., 2015; Mendis *et al*., 2012; Xaba *et al*., 2012).

5.4.4 Theme 4: Public Health

The public health theme refers to: patient education, health prevention and promotion, organizational constraints, various health prevention and promotion methods, importance of community involvement and CBS.

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Focus group participants acknowledged the importance of educating patients regarding what they can expect and what the service demanded from them. Furthermore, the feedback also confirmed that managers and allied health professionals were aware of the importance of health promotion and prevention. In line with the aforementioned, the National Health Promotion Policy and Strategy (2015-2019) also emphasised prevention and promotion programmes (South African Department of Health, 2014c).

However, patients prioritised the collection of medicines as more important and were not necessarily interested in health promotion or education activities. Moreover, various studies (Kemppainen *et al*., 2012; Brobeck *et al*., 2013; Parker *et al*., 2012; Malan *et al*., 2015; Asiri, Bawazir & Jradi,2013; Kolisa, 2016) pointed out that, "lack of time" was indeed indicated as a barrier for providing health promotion and prevention activities. Likewise, Swedish district nurses also felt that they must prioritise their time for the sick and for individuals in need of medical care, instead of health prevention and health promotion (Brobeck *et al*., 2013).

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The focus groups participants were well informed about the various methods for health prevention and promotion. However, the study of Parker *et al*. (2012) emphasized that individual counselling was the number one choice as a health education method for most of the patients, while pamphlets, posters and group counselling were the least desired. Furthermore, Wright's *et al*. (2014) study findings revealed that a health information pamphlet about pregnancy did not expand patients' knowledge to a level where they would be informed and educated about their health during pregnancy. On the other hand, Mirzaei *et al*. (2013) pointed out that patients have difficulties to understand the information and advice and this could often lead to non-adherence.

The feedback from the focus groups of this study were evident of participants who were well aware about the importance of community involvement. Only one focus group referred to the educating role of the health committee. Currently, health committees are not active in the West Coast District, the context of this study. Interestingly, surveys of Haricharan (2014) and Loewenson *et al*. (2014) reported that health committees are currently involved primarily in activities with limited influence and decision-making, e.g. supporting the clinic in the day-to-day running (29%), projects and health awareness drives (28%), auxiliary community social worker. While a greater role in governance overview was important for effective and meaningful health committees.

Haricharan (2014) confirmed that community participation has the potential to strengthen the PHC system when involved in governance and overview, i.e. active involvement in identifying problems, finding solutions and taking part in decision making. Supported by Iyanda and Akinyemi (2017) also emphasised that community participation was important for the implementation of PHC and the realisation of universal health care. Furthermore, community participation was a prerequisite for the successful acceptance of health services in communities. Community members have a role to play in the conducting of needs assessments, mobilization and dissemination of information within their communities. Moreover, Maimela, Van Geertruyden, Alberts, Modjadji, Meulemans, Fraeyman and Bastiaens (2015) also reported that health committees were not always functional in rural South Africa. Kilewo and Frumence (2015) highlighted the following hindering factors regarding community participation in Tanzania, namely: lack of awareness, poor communication and information sharing, unstipulated roles and responsibilities, lack of management capacity and lack of financial resources to implement activities.

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In addition, participants recognised community health care workers as the link between the community and clinic. Likewise, Rachlis, Naanyu, Wachira, Genberg, Koech, Kamene, Akinyi and Braitstein (2016) plus Tsolekile *et al*. (2014) in line with the findings of this study, also acknowledged community healthcare workers as the link between the communities and health services.

Tsolekile *et al*. (2014) and Schneider *et al*. (2015) emphasised the multiple roles of community health workers, namely: preventive, promotive, care and rehabilitation. Furthermore, community health workers also screen patients for complications of illness and assist community members in navigating the health system.

However, according to the qualitative results of this study, community health workers' output was currently limited to physical caring and supporting activities. The health prevention and promotion activities seemed to be non-existent. In addition, lack of petrol money was limiting their community-based activities. Moreover, in line with the findings of this study, shortage of money for fuel was also highlighted by McCollum, Otiso, Mirehu, Theobald, De Koning, Hussein and Thaegtmeyer (2016), as well as by Ndima *et al*. (2015) influencing supervision and household visits in rural Kenya, Mozambique respectively.

5.4.5 Theme 5: Corporate Governance and Leadership

Theme 5 spoke to corporate governance and leadership aspects and refer to the enormous changes within the health system, too many procurement processes, budget allocations, staff allocation and use, and competence and accountability.

According to the study findings, managers and allied health professionals perceived remarkable changes within the PHC working milieu. However, they did not experience the implementation of processes for change management. Likewise, Healthcare 2030, emphasised consistent flexibility and adjustments to allow for changes in demography and socio-economic causes for disease. Healthcare 2030 prioritises further changes as evident with the implementation of the SDGS, the National Development Plan, the NHI and provincial planned objectives. In addition, the NCSs' baseline assessment identified several quality gaps which necessitated several changes to ensure quality improvement. The Barrett staff surveys also showed that a remarkable number of staff did not feel involved within the organisation. Constant improvement in patient experience of quality health care are pivotal to address the escalating disease burden and to reach wellness (Western Cape Department of Health, 2014).

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Moreover, according to the focus group discussions there were too many limitation processes involved in the procurement process, which resulted in long waiting times for the end user. One focus group pointed out that corruption necessitated all these limitation processes. These "too many" processes were not unique to South Africa. The Australian Health Department demonstrated a cultural change towards a lighter regulatory touch by government, where regulations should only be imposed where absolutely necessary. The Australian government is dedicated to decrease the "red tape" burden on individuals, businesses and community organisations by one billion dollars annually. During 2014 the Australian health department testified the following key reforms, namely: eliminating ineffective regulation, streamlining existing processes and systems, and reducing duplication (Australian Department of Health, 2015).

In addition, budget allocation is an integrated process considering much more than the previous year's expenditure, inflator and population numbers. According to this study feedback it seemed that employees were not well informed about all the budget processes or what budgeting all entails. According to the budgetary summary of the Western Cape Government (2017) budget prioritization is according to the priorities as set out in the Annual Strategic Plan. "Wellness", is the current focus. Therefore, the Department implements various interventions to address unhealthy lifestyles. These interventions include the First 1 000 Days initiative, the Western Cape on Wellness project; the Integrated Service Delivery Model and the Community-Oriented-Primary Care (Western Cape Government, 2017).

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Moreover, according to the focus group discussions leadership and governing failures resulted into inadequate numbers and categories of staff for the current PHC service delivery. Various participants highlighted that the following were not taken into consideration for determination of staffing numbers: the growth in population, the shift in the disease burden, more time is spent on patients due to certain programmes being implemented, and statistics showed no escalation. Rispel (2016) highlights the following deficiencies as the reasons for the poor performance of the South African health systems, namely: acceptance of incompetence and poor leadership, management and governance disappointments, lack of a fully efficient district health system; and an inability to deal with the health staff catastrophe. Consequently, patients have to take the consequences for these failures in their often negative experience of the public health sector and the poor quality of care received. However, healthcare providers who seem to be on the "frontline" find it challenging to sustain their professional Code of Ethics and to

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provide good quality of care in the face of an unsupportive management milieu. Furthermore, Van Rensburg (2014) highlighted that the introduction of free-health policies, the district health system and the prioritisation of PHC resulted in more equal distribution of the workforce, as well as greater access to services for disadvantaged groups. However, the HIV/AIDS epidemic brought about enormous demands for care and huge patient loads in the public sector. Although South Africa has strongly developed health professionals, large numbers of professional and mid-level workers, and also well-established training institutions, it is experiencing severe staff shortages and access constraints. According to Operation Phakisa (South African National Department of Health, 2014a), the staff shortages is likely to increase given: a higher demand from the requirements of the Ideal Clinic delivery model, low numbers of health and clinical studies graduates.

Furthermore, results of the focus groups of this study indicated that management should employ competent people and has to hold employees accountable for their actions. Unfortunately, employees were not always held accountable for their actions, as those who made mistakes were still in their positions. In line with above findings, Rispel (2016) also highlighted ineffective management due to incompetence and failure of leadership and authority all over, aggravated by a general lack of responsibility. The National Development Plan 2030 (Republic of South Africa, 2016) stated that the current health system is challenged by poor authority, lacking accountability, marginalisation of clinicians, and low staff morale hindering PHC and the district health system to function effectively. Nursing managers have been identified as being crucial for the reform of the South African public health sector into a more efficient, effective, and responsive system. However, the research of Pillay (2011) revealed an absence of nursing management capacity. The study findings showed that the skills gap was the biggest for legal and ethical issues (-1.0135), followed by organizing (-0.977), controlling (-0.862), delivering of health care (-0.857), and leading (-0.856). The skills gap for planning (-0.68) and self-management (-0.532) was relatively smaller. This deficiency of management capabilities could hamper service delivery and the transformation of the public sector from developing into a more efficient and effective service. In line with the aforementioned, Munyewende, Levin & Rispel (2016) concluded their study by stating that although the socio-demographic characteristics of PHC nursing managers show that they have extensive experience in the health sector, they are lacking finance management competencies.

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5.4.6 Theme 6: Operational management

Theme 6 covered the following operational management aspects, namely: clinical placement of community service health workers, human resource development, understaffing at operational level, high workload, limitations due to duplication, staff satisfaction, procurement and supply chain challenges and overemphasising of statistics.

According to participants of this study, formal training programmes at nursing colleges and universities were not always in line with service needs. In addition, community service professionals were perceived as either “lazy” or “brilliant”, where the brilliant ones were eager to work things out. Annual replacement of community health workers could influence service sustainability and continuity as required for quality client-centred care.

In line with the above findings, Van Graan, Williams and Koen (2016) acknowledged that newly qualified nurses do not meet or do not always feel adequately prepared for their new role expectations. In addition, Magano (2016) emphasised that after training, the newly qualified professionals need support or guidance, to allow them to move smoothly into their new roles of nurse practitioners. According to Rispel and Bruce (2015) nursing education reform through appropriate training is essential. Training should accentuate ethical value systems and social accountability, acceptable staffing levels and conducive working environments.

Furthermore, focus groups participants, highlighted the importance of qualified and competent staff. Therefore, the majority of participants considered training and updates as very important. A unique finding, was where one focus group pointed out that further training provided to community health workers opportunities to apply for better posts, e.g. full time jobs at an old age home, subacute facilities and private hospitals. In line with above Sooruth, Sibaya and Sokhela (2015); Xaba *et al*. (2012) also put emphasis on the importance of regular or continuous in-service education of qualified staff to strengthen and update their knowledge and skills. Letlape, Koen, Coetzee and Koen (2014) explored service-education needs of psychiatric nurses, stressed that new research findings, modifications in legislation and the use of information technology in nursing neccessitates constant in-service training to enable staff to reflect on and adapt their clinical practice based on developing knowledge. According to Letlape *et al*. (2014); Fentahuin and Molla (2012), similarly as reported by the participants, many international studies confirmed that in-service training increases the quality of nursing care.

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In addition, several focus groups revealed that understaffing on the operational level was a huge challenge for PHC clinics, as well as for the district hospital. Participants pointed out various challenges, due to inadequate staff, namely: other patients could not be attended to; quality of care decreased; longer waiting times; health promotion was not done and training stayed in abeyance. Inadequacies in various staff categories were experienced, namely: clerks; community-based service coordinators; dental assistant; physiotherapist; handyman and lack of courier-service staff. Interesting, but alarming, participants reported that due to the shortage of pharmacy staff, cleaners dispensed medication to patients. Understaffing as revealed by the current study is concurrent with numerous studies in a lot of countries facing a health staff shortage, characterized by inadequate production, suboptimal recruitment, poor retention and staff management (Munyewende *et al*., 2014; Bain & Kasangaki, 2014; Ojakaa *et al*., 2014; Maniyisa & Van Aswegen, 2017).

Furthermore, according to Operation Phakiza (South African National Department of Health, 2014a) the personnel shortage of both clinical and non-clinical PHC staff in South Africa range between 3% and 84%. At that stage there were 46 000 vacancies in the human resources nationwide. In spite of a shortage of staff numbers, participants also highlighted staff shortages in various staff categories. According to SANDoH and Medical Research Council (South African National Department of Health & Medical Research Council, 2012) PHC Re-engineering's success is dependent on the availability of the right categories of staff. The District Health Expenditure Review (2010-2011) like this current study, showed a non-optimal skills mix with lack of support, clinical, pharmaceutical and administrative support leading to a high workload for professional nurses affecting the quality of care.

Participants indicated the severe workload with which staff at PHC clinics have to cope with. They emphasised that due to these large numbers of patients quality of care was compromised as there was not adequate time. In addition, they also accentuated the severe pressure under which the operational managers have to work. Operational managers have a dual role that of clinic manager and at the same time has to operate as a clinical nurse practitioner. The clinic manager amongst others has to manage the staff, complete the statistics, manage the stock and equipment. McQuide, Kolehmainen-Aitken and Forster's (2013) study applied the workload indicators to determine staffing needs (WISN) in Namiba. The WISN method is a programmatic approach to determine staffing norms and appropriate skills mix according to the workload of a facility. The West Coast District, the context for this study, does not apply

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WISN to measure workload or to accurately measure the real staff shortage. This is a gap and a concern for the researcher.

Furthermore, focus group participants emphasised the high workload contributed by duplication of recorded information to multiple tick sheets and registers and requested the decrease thereof. The completion of all of these tick sheets and registers were regarded as time consuming and results in longer waiting times for patients. Similarly to the current study, Uebel *et al*. (2013), also indicated that integrated care at the PHC level is negatively influenced by the superfluity of medical records, registers and monthly reports, the deficiency of support staff and inadequate infrastructure.

According to the aforementioned focus group discussions, including managers and allied health professionals, staff showed signs of inadequate staff satisfaction. Quotes like: “demotivated, burnout, low morale, cracks, despondent” characterised a lack of staff satisfaction. “Burnout” and “low morale” were repetitively voiced. As mentioned by some participants, these low levels of satisfaction could have a negative influence on quality client-centred care. Despite departmental values and ICAS for employee wellness, participants highlighted the need for personal and professional support. Congruently with the current study, Bhaga (2010) and Matsaung (2014) also confirmed that morale problems could impact negatively on the quality of service delivery. Decreased productivity could result from low staff morale. Khamisa, Oldenburg, Peltzer and Ilic (2015), similarly found that low staff morale has a negative influence on productivity and performance and quality of patient care. In addition, Janicijevic, Seke, Djokovic and Filipovic (2013), as well as Asegid, Belachew and Yimam (2014) confirmed that healthcare worker satisfaction does impact patient satisfaction, as there is a strong correlation between patient satisfaction and employee satisfaction.

Another concern, highlighted by the focus groups of this study was the frequent stock shortages and unclear ordering procedures, poor communication, and long waiting times for the obtaining of supplies. These challenges do have a negative influence on the staff, as well as quality client-centred care. Study results of Scheffler *et al*. (2015) also reported on periodic shortages of equipment and resources, e.g. gloves, oxygen, bandages, catheters and stoma bags Western Cape facilities. In addition, Wasswa, Nalwadda, Buregyeya, Gitta, Anguzu and Nuwaha (2015) from an Ugandian context, also confirmed that all government health facilities reported to routinely experience some form of scarcity of supplies, e.g. gloves, disinfectants and soap. Concurrent with these findings, Operation Phakisa – Supply Chain Management of Medical

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and Non-medical supplies, confirmed regular unavailability of services and medical and non-medical standard supplies (e.g. cleaning materials and stationary) at clinics, impacting on the quality of care (South African National Department of Health, 2014a). Whereas non-standard supplies such as maintenance supplies can take months to requisition and receive; a process that forms a significant work burden for the facility management. According to Fryatt and Hunter (2015), supply chain administration should be enhanced to ensure the availability of medicine, consumables and equipment in PHC facilities.

What is more, according to the study results, data capturing were not always complete or accurate as not all data were captured. According to the researcher, it was a concern that there was no official data for the number of patients who were turned away from PHC facilities, as these numbers could be used as motivation for the recruitment and appointment of more staff. Kagasi, Zungu and Hogue (2013) and Mlambo, Pettzer and Koivu (2014) emphasised the importance of accurate, valid complete and timely data. Data quality gaps were not limited to the West Coast District, the context for this study. Nicol, Dudley and Bradshaw (2016) assessed the quality of routine statistics for prevention of mother-to-child transmission of HIV in the Western Cape and KwaZulu-Natal and identified serious data inaccuracies that start with errors in data transfer within facilities, suggesting that the data might not be reliable for planning or monitoring purposes. In Eastern Ethiopia the data quality was also found to be below national expectation level (Teklegiorgis Tadesse, Mirutse, & Terefe, 2016).

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5.4.7 Theme 7: Infrastructure and facilities

Theme 7 dealt with infrastructure and facility aspects and included: lack of maintenance, inadequate physical space, not enough consultation rooms and lack of security services at the various clinics.

The feedback as received from focus groups indicated that the maintenance of our clinics in the West Coast District was not up to date and that this lack of maintenance could affect patient care and staff satisfaction in a negative way. The study of Schoeman, Smuts, Faber, Van Stuyjvenberg, Oelofse, Laubscher, Benade and Dhansay (2010) assessed PHC infrastructure in the Eastern Cape and KwaZulu-Natal. Of the 40 PHC facilities, eight in the Eastern Cape and six in KwaZulu-Natal had been built or refurbished after 1994 and about half were graded as being in a bad condition. Whereas, Scholz *et al*. (2015) assessed PHC infrastructure in Tanzania, like the results of this study, clinics also showed to have inadequate infrastructural quality. Roof leaks and lack of plinth shields, including inadequate rain water drainage were

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major areas of concern. The need for maintenance was evident but the facilities lacked the capacity to deliver.

Furthermore, the feedback from almost all the focus groups pointed out that space is currently inadequate for service delivery. Therapists, e.g. occupational and physiotherapists need physical space to accommodate activities like walking, jumping, and stretching for individuals, as well as group classes. They also need lockup space to accommodate their equipment, e.g. mats, plinths, and balls. As indicated by the participants all clinics were in need of storage space, e.g. pharmacy for bulk supplies. However, various studies all over the country showed that PHC facilities were in need of adequate space. Most facilities in the Kurdistan lacked enough space to provide health services. These facilities were built in 1987 when the area had a small population. Since then, the area has developed considerably, but the facilities remained the same (Shabila *et al*., 2012). In Zimbabwe, Sibanda *et al*. (2012) of the Zimbabwe PHC infrastructure also pointed out that spaces were inadequate to provide confidential counselling. In rural Malawi, Makaula *et al*. (2012) identified inadequate space again in most of the PHC facilities. Likewise, Mutemwa *et al*. (2013) in Kenya, respondents also reported insufficient physical room space.

According to the current feedback of this study, various clinics showed inadequate number of consultation rooms. This impacted negatively on staff morale, as well as on the quality of client-centred care. Crowley and Stellenberg's (2014) study, highlighted that 10 (50%) of the PHC clinics under study in KwaZulu-Natal, South Africa revealed that the number of consultation rooms were inadequate for service delivery. Subsequentlyly, Vawda and Variawa (2012) emphasized that the limited space in many ARV clinics in South Africa, resulted in the sharing of consultation rooms by a variety of disciplines, violating the patient's constitutional right to privacy. In addition, the lack of space resulted in overfilling of waiting rooms, which can result in the patients with infectious diseases infecting other immune-compromised patients. According to Davies, Homfray and Venables (2013) similarly, as in the current study, these infrastructural constraints impacted negatively on staff morale.

Study results revealed that security services were lacking at various clinics of the West Coast District and theft seemed to be a big risk. Similarly, to the current study the cross-sectional study of Munyewende *et al*. (2014), PHC facilities in the Gauteng and Free State Provinces in South Africa also revealed that security at clinics was a huge challenge. Managers were of the opnion that their workplace was insecure, as the majority of clinics did not have any alarm

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systems or security guards on the grounds. Managers reported that there were several break-ins where equipment and medication were stolen or broken. Furthermore, elementary security measures, such as fencing or the availability of phones in event of emergency were asked for and thought to be vital to ensure job satisfaction.

5.5 SUMMARY/CONCLUSIONS

Phase 2 (Objective 4) of this study, applied five focus group discussions to explore and describe the managers and the allied health professionals' perception about quality client-centred care. Donabedian emphasised that "*structures*" and "*processes*" need to be in place to result into desired "*outcomes"*, i.e. quality client-centred care, the focus of this study.

To conclude: the qualitative data results revealed various "*structure*" and "*process*" inadequacies which could negatively influence the "*outcome*" of quality client-centred care.

The overall goal of this study is to address these inadequacies with the development of a programme to facilitate quality client-centred care in PHC clinics of the rural West Coast District (Objective 5). The structure-process-outcome inadequacies are summarised below according to the appropriate themes.

Theme *One* about the Patient Rights revealed that patients were not always treated with the necessary respect and dignity.

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Theme *Two* concerning patient care, revealed that focus group participants were well-informed on what the concept client-centred care entailed. However, patients and or clients did not always experience their care as client-centred.

Theme *Three* about the clinical support services, indicated shortages of medication and medical equipment; long waiting time for specialists and rehabilitation referral appointments.

Theme *Four*, referring to the public health confirmed that health promotion and prevention activities are limited due to various organizational factors and community health care workers' activities which are limited to home-based care activities.

Theme *Five*, corporate governance and leadership matters were characterised by too many processes or "red tape" resulting in inefficient procurement processes, inadequate staffing and inactive health committees.

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Theme *Six* speaks to operational management which highlighted the severe pressure under which the operational managers have to work resulting from their twofold role of being the clinic manager and at the same time has to operate as a clinical nurse practitioner.

Theme *Seven* refers to infrastructure and facilities and is characterised by inadequate maintenance and lack of space according to the number of clients and package of care.

Chapter 6 is about the programme to facilitate quality client-centred care in the PHC facilities of the rural West Coast District.

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CHAPTER SIX:
A PROGRAMME TO FACILITATE QUALITY CLIENT-CENTRED CARE IN PHC CLINICS OF THE RURAL WEST COAST DISTRICT

6.1 INTRODUCTION

Chapter 5 explored and described the managers and allied health professionals' perceptions about quality client-centred care (Phase 2: Objective 4), while Chapter 6 provides a detailed discussion about the development of a programme to facilitate quality client-centred care in PHC clinics of the rural West Coast District. This chapter includes, the process applied for the development of the programme, the vision, mission, values, assumptions, goals, objectives, actions and implementation of the proposed programme. Table 6.1 is a summary of the phases and objectives of this study.

Table 6.1: Overview of the study phases and objectives

PHASE 1: SITUATIONAL ANALYSIS (QUANTITATIVE)	PHASE 3: PROGRAMME DEVELOPMENT
Objective 1 To explore and describe the current status of quality client-centred care by conducting an extensive literature review	**Objective 5** To develop a programme to facilitate quality client-centred care in PHC clinics of the rural West Coast District
Objective 2 To assess the clients' perceptions regarding quality client-centred care	
PHASE 2: SITUATIONAL ANALYSIS (QUALITATIVE)	
Objective 3 To determine the clinical nurse practitioners' perceptions on quality client-centred care	
Objective 4 To explore and describe the managers and allied health professionals' perceptions about quality client-centred care	

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6.2 THE PROCESS APPLIED FOR THE DEVELOPMENT OF THE PROGRAMME TO IMPROVE QUALITY CLIENT-CENTRED CARE IN PHC CLINICS

Phases 1 (quantitative) and 2 (qualitative) comprise a situational analysis to determine the current status of quality client-centred care. Data were generated by means of an extensive literature review (Objective 1); the empirical research findings of the clients (Objective 2); clinical nurse practitioners (Objective 3); managers and allied health professionals (Objective 4). These data were compared against the seven domains of the NCSs, which is the quality benchmark for South Africa's health establishments. The situational analysis revealed *81 problems* that have to be included in the programme. See Table 6.2 for a summary of identified

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problems. The research method applied for the programme development is discussed in Chapter 2 section 2.7.1.

6.3 A PROGRAMME TO FACILITATE QUALITY CLIENT-CENTRED CARE IN PHC CLINICS OF THE RURAL WEST COAST DISTRICT

As indicated in Section 2.7, the five steps of curriculum development as suggested by Uys and Gwele (2005) were applied for the development of the programme to improve quality client-centred care. The first section of the programme deals with the formulation of the vision, mission, values and assumptions. Thereafter, the problems for intervention were identified, followed by the determination of the goals, objectives and actions. Lastly, the programme needs to go through the process of implementation. Evaluation does not form part of this study.

6.3.1 Vision

The vision statement focuses on an organization's future, considering the current status, and is used to provide direction for the organization (McCoy & Anema, 2012). The situational analysis revealed that PHC clients and patients of the rural West Coast District did not always receive quality client-centred care. The theoretical framework (Figure 1.1) guides the formulation of the vision as it indicates what is required to ensure quality client-centred care. The vision for this programme is stated as follows, namely: "access to quality client-centred care compliant with NCSs".

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6.3.2 Mission

According to McCoy and Anema (2012) a mission statement defines what an organization does, why it exists, and its reason for being. The mission for this programme is formulated as follows: "the PHC clinics of the West Coast District undertakes to provide quality client-centred care as determined by the NCSs, through a process of continuous quality improvement".

6.3.3 Values

The researcher integrates the CCAIRR values as endorsed by the WCDoH (Western Cape Department of Health, 2014; 2011) for this study. The values are as follows:

- Caring: to show sincere concern for the well-being of healthcare users and colleagues
- Competence: to be eager to learn in order to enhance skills and capacity
- Accountability: to retain ownership for decisions and not shifting responsibility
- Integrity: to be truthful and doing what is expected

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- Responsiveness: quick and efficient response to matters and needs of colleagues and healthcare users
- Respect: to treat healthcare users and colleagues with dignity, embrace diversity, value other's strengths and empower them
- Innovation: to be flexible for new ideas and to have the ability of developing creative solutions to challenges.

6.3.4 Assumptions

Assumptions are the point of departure or identified elements assumed to be in place for carrying out the suggested activities (Goeschel, Weiss & Pronovost, 2012; Hayes, Parchman & Howard, 2011). The following assumptions are integral to the programme and serve as a point of departure, namely:

- The IOM's quality attributes in Section 3.3.1.2 (see Table 3.5)
- Client-centred care attributes in Section 3.3.2.2
- PHC definition and dimensions in Sections 3.3.3.1 and 3.3.3.2 (see Table 3.8)
- NCSs in Section 3.3.4 (see Table 2.3)
- Donabedian's quality assessment in Section 3.3.4.

6.3.5 Problems identified

The situational analysis as described in section 6.2, *81 problems* were inductively deduced, which form the evidence base (the what) for the development of the programme to facilitate quality client-centred care in the PHC facilities of the rural West Coast District. Table 6.2 summarises the problems as indicated by the literature review, clients (quantitative), clinical nurse practitioners (quantitative), managers and allied health professionals (qualitative). Identified problems are categorised according to the seven domains and subdomains of the NCSs.

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Table 6.2: Problems identified for intervention

Domain 1: Patient Rights	CHAPTER THREE Literature Review	CHAPTER FOUR Clients	CHAPTER FOUR Clinical Nurse Practitioners	CHAPTER FIVE Managers and Allied Health Professionals
Respect and dignity				
1. Clients do not always have an opportunity to choose a staff member		√	√	
2. Unavailability of clean drinking water and disposable cups in the waiting areas		√	√	
3. Clients do not always have the opportunity to participate in a client-satisfaction survey		√	√	
4. Unavailability of security systems		√	√	√
5. Staff are not always acting as role models		√		
6. Negative staff attitudes	√			√
7. Lack of privacy and confidentiality	√			√
8. Health environments are neither clean nor safe	√			√
9. Inadequate information about the facility	√			
10. Inadequate information for patients to make informed decisions about testing and treatment	√			
Physical access				
11. Vast geographical distances	√			
12. Infrastructure has inadequate access for disabled people	√			
Continuity of care				
13. Long waiting times for specialists' appointments	√			√
14. Lack of referral letters	√			
15. Lack of referral feedback				√
16. Inappropriate referrals	√			
17. Inadequate referral resources				√
18. Confusing referral systems	√			
19. Patients are not always sorted out on the day of their visit				√
Delays in care				
20. Lack of information about how long patients would have to wait before seen		√		
21. Lack in communication about service delays				√
22. Waiting times are not always monitored		√	√	
23. Waiting time length is not always acceptable	√	√	√	√
24. Unavailability of activities to keep clients busy while waiting		√	√	
Access to full package of care				
25. Lack of extended clinic hours	√			
26. Rehabilitation services are limited to bigger clinics	√			
Complaints management				
27. Clients are unfamiliar with the process of how to lodge a complaint	√			

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Domain 2: Patient Safety, Clinical Governance and Clinical Care	Literature Review	Clients	Clinical Nurse Practitioners	Managers and Allied Health Professionals
Client- centred care				
28. Clients do not always experience client-centred care	√			√
29. Clients are not always asked to repeat information in order to confirm whether they understood information		√		
30. Clients do not always receive written information about health problems or medication		√		
Clinical Management				
31. Unfamiliarity with policy guidelines and protocols	√			
32. Employment of inadequate number of family physicians	√			
Clinical risk				
33. Inadequate infection prevention and control	√			
34. Inadequate adverse events control	√			
35. Mortality and morbidity meetings not always attended			√	
Domain 3: Clinical Support				
Pharmaceutical support				
36. Unavailability of medication	√			√
Diagnostic services				
37. Long turnaround time for laboratory results	√			
38. Shortages of laboratory tests	√			
39. Inadequate number of microbiologists	√			
40. Unavailability of quality control protocols	√			
Therapeutic and support services				
41. Shortages of certain categories of allied health professionals, e.g. nutritionists, dentists and physiotherapists.	√			√
42. Annual replacement of community services allied health professionals				√
43. Unavailability of assistive devices			√	√
Health technology				
44. Insufficient equipment	√			
45. Poor maintenance of equipment	√			√
46. Inadequate training regarding the utilisation of equipment	√			
Domain 4: Public Health				
Health promotion/disease prevention at the facility				
47. Organizational challenges, e.g. staff shortages and lack of time	√			√
48. Unmet support to clients and inadequate information to clients about disease and treatment	√			
49. Inadequate patient knowledge about their disease and illness	√			
50. Health information is not always relevant and useful	√			
Health promotion and disease prevention in the community				
51. Lack of health promotion and disease prevention in the community	√	√		
52. Inadequate knowledge and skills of community leaders and patients	√			
Community health workers and health promotion				
53. Overwhelmed by home-based care activities	√			√
54. Limited health promotion activities in the community	√			
55. Lack of home visits between clinic appointments		√		

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Domain 5: Leadership and Corporate Governance	Literature Review	Clients	Clinical Nurse Practitioners	Managers and Allied Health Professional
Communication and public relations				
56. Unavailability of departmental communication events in the community	√	√	√	
57. Visibility of the goals, values, future plans and focus areas of the department		√		
58. Visibility of the role and function of the clinic committee		√	√	√
Strategic management				
59. Limited by rigid and restricting internal structures, e.g. management styles, hierarchy, power manipulation	√			√
60. Employees do not always experience change management processes				√
61. Organogram with the name or pictures of staff members are not always visible		√		
Domain 6: Operational Management				
Human resource management and development				
62. OPMs experience high work pressure				√
63. Inadequate staffing levels	√	√		√
64. Formal training course does not always meet the service needs				√
65. Newly trained staff are not always prepared for their roles				√
66. High work pressure compromises quality client-centred care	√			
Employee wellness				
67. Unavailability of an employee-wellness programme to support staff with daily demands in the work place				√
68. Inadequate staff satisfaction	√			
69. Inadequate supervisory support	√			
70. Unfavourable working conditions	√			
Supply chain				
71. Staff are uninformed about the budget process				√
72. Procurement has too many processes (red tape)				√
73. Unclear ordering procurement processes				√
74. Stock outs of consumables				√
75. Long waiting times for ordered items				√
Information management				
76. Statistics not always of good quality				√
Domain 7: Infrastructure and facilities				
Maintenance				
77. Demoralising effect of the clinics' physical appearance			√	
78. Inadequate maintenance of infrastructure				√
Inadequate space				
79. Inadequate number of consultation rooms	√	√	√	√
80. Inadequate space according to the number of patients and storage spaces				√
Emergency planning				
81. Unavailability of an evacuation plan		√		

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6.3.6 Intervention programme goal and objectives

Uys and Gwele (2005) emphasise that the outcomes or goals of a programme should be identified. An outcome can be described as a set of defined goals that is expected to be achieved as the end result (Oxford University Press, 2010). The overall goal for this programme is to facilitate quality client-centred in PHC clinics of the rural West Coast District. This goal is achieved through compliance with the seven domains of the NCSs (objectives) in order to receive accreditation from the OHSC. Therefore, the objectives of this programme were prioritised (deductively) according to the *81 identified problems* in Table 6.2 and were in line with the vision, mission, values and assumptions to facilitate quality client-centred care in the PHC clinics of the rural West Coast District. The seven objectives (the seven domains of the NCSs) to faciliate quality client-centred care are presented in Table 6.3. Each objective (domain) is stated, with the corresponding problems.

Table 6.3: Objectives and problems identified

OBJECTIVES	PROBLEMS IDENTIFIED FOR INTERVENTION
1. To ensure that Patient Rights are respected	Items 1 to 27
2. To strengthen Clinical Governance and Patient Care	Items 28 to 35
3. To ensure the availability of Clinical Support Services	Items 36 to 46
4. To prioritise Health Promotion and Disease Prevention	Items 47 to 55
5. To strengthen Leadership and Strategic Management	Items 56 to 61
6. To ensure Operational Management	Items 62 to 76
7. To ensure that patients and clients receive care in proper and maintained Infrastructure and Facilities	Items 77 to 81

6.3.7 Proposed interventions

An intervention is described as an action or process of intervening (Oxford Press University, 2010). The proposed interventions (Table 6.4) for this study were developed from the intervention programme objectives (see Table 6.3), which were based on the problems identified. Table 6.4 summarises the objectives and proposed interventions for this programme. The interventions are further applied to the seven domains of the NCS which is the theoretical framework of the study (see Figure 1.1) and Table 2.3.

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Table 6.4: Objectives and proposed interventions

OBJECTIVES	SUGGESTED INTERVENTIONS	THEORETICAL FRAMEWORK (NCS APPLIED)
1. Ensure that Patient Rights are respected	1.1 Ensure that patients are treated with respect and dignity (Items 1 to 10) 1.2 Enhance physical access (Items 11 to 12) 1.3 Promote continuity of care (Items 13 to 19) 1.4 Minimise delays in care (Items 20 to 24) 1.5 Ensure access to the full package of care (Items 25 to 26) 1.6 Manage complaints effectively (Item 27)	Domain 1
2. Strengthen clinical governance and patient care	2.1 Implement quality and client-centred care attributes (Items 28 to 30) 2.2 Enhance clinical management (Items (31 to 32) 2.3 Manage and prevent clinical risks (Items 33 to 35)	Domain 2
3. Ensure the availability of clinical support services	3.1 Ensure pharmaceutical support (Item 36) 3.2 Ensure adequate diagnostic services (Items 37 to 40) 3.3 Enhance therapeutic and support services (Items 41 to 43) 3.4 Ascertain the availability of the required health technology (Items 44 to 46)	Domain 3
4. Prioritise health promotion and disease prevention	4.1 Encourage facility health promotion and disease prevention activities (Items 47 to 50) 4.2 Motivate community health promotion and disease prevention (Items 51 to 52) 4.3 Prioritise health promotion and disease prevention by community healthcare workers in the community (Items 53 to 55)	Domain 4

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OBJECTIVES	SUGGESTED INTERVENTIONS	THEORETICAL FRAMEWORK (NCS APPLIED)
5. Strengthen leadership and strategic management	5.1 Promote community events to communicate the DoH's goals, values and future plans (Items 56 to 57) 5.2 Establish clinic committees (Item 58) 5.2 Strenthen strategic management (Items 59 to 61)	Domain 5
6. Ensure operational management	6.1 Enhance human resource management and development (Items 62 to 66) 6.2 Promote employee assistance (Items 67 to 70) 6.3 Manage supply chain processes (Items 71 to 75) 6.4 Improve information processes to ensure better quality of statistical data (Item 76)	Domain 6
7. Ensure that patients and clients receive care in proper and maintained infrastructure and facilities	7.1 Maintain the infrastructure (Items 77 to 78) 7.2 Create more space (Items 79 to 80) 7.3 Check that evacuation plans are visible (Item 81)	Domain 7

6.3.8 Proposed actions

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The Oxford University Press (2010) describes an action as the process of doing something to achieve. In this study actions were developed to implement the proposed intervention. Table 6.5 presents the proposed actions to facilitate client-centred care in the PHC clinics of the rural West Coast District.

Table 6.5: Proposed objectives, interventions and actions

DOMAIN 1: PATIENT RIGHTS		
OBJECTIVES	INTERVENTIONS (WHAT)	ACTIONS (HOW)
1.1 Ensure that patients are treated with respect and dignity (Items 1 to 10)	1.1.1 Provide clients the opportunity to have a choice	1.1.1.1 Reception clerks should allow clients to choose a preferred staff member
	1.1.2 Ensure that clients have access to clean drinking water and disposable cups in the waiting areas	1.1.2.1 Cleaners should check the waiting areas every day for the availability of clean drinking water and disposable cups
	1.1.3 Organise annual client-satisfaction surveys	1.1.3.1 The Operational Manager should organise in-service training for all clinic staff regarding the National Patient Experience of Care Guideline. Include this training in the orientation programme of newly appointed staff

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OBJECTIVES	INTERVENTIONS (HOW)	ACTIONS (HOW)
		1.1.3.2 Operational managers should organise with reception clerks to conduct an annual client-satisfaction survey during the month of September
		1.1.3.3 Operational managers should analyse the results of the client-satisfaction survey and involve all clinic staff to plan, implement and monitor quality improvement activities
	1.1.4 Implementation of security systems to ensure the safety of staff and patients	1.1.4.1 The PHC managers should schedule monthly PHC meetings with all Operational Managers. Security aspects should be a standing point on the agenda to ensure that managers are informed about the relevant safety and security standard operating procedures
		1.1.4.2 Operational managers should monitor that all security incidences are continuously documented in a security register, completed and monthly statistics sent to the PHC manager
		1.1.4.3 Operational managers should involve all clinic staff to identify security needs on a continuous basis. All security needs should be reported to the PHC manager at sub-district level. The PHC manager must report security needs at the monthly management meeting at the District Hospital to ensure that needs will be attended to by the relevant support staff
		1.1.4.4 PHC managers should motivate and budget for security guards or an alarm system at high-risk clinics.
	1.1.5 Emphasize the importance that staff should act as role models	1.1.5.1 PHC managers should arrange with the training officials at district level to arrange training for all categories of staff about the Patient Rights Charter; Batho Pele Principles and the endorsed values of the WCDoH on an annual basis
	1.1.6 Emphasize positive staff attitudes	1.1.6.1 Operational managers should apply the disciplinary procedure when necessary to ensure that staff act in a professional manner
	1.1.7 Ensure that clients are treated in privacy and that their information is kept confidential	1.1.7.1 PHC managers should observe or interview clients to monitor clients' privacy and confidentiality during consultations, examinations and counselling during their monthly support visits
	1.1.8 Ensure cleanliness of the clinics	1.1.8.1 Operational managers should organise annual training for all cleaners on cleaning and hygiene standards
		1.1.8.2 Operational managers should implement daily, weekly and monthly cleaning schedules (tick sheets) for all areas in the clinic
		1.1.8.3 Tick sheets to be signed off and verified by the operational managers or designated staff members on a daily basis
		1.1.8.4 Operational managers should check that all required disinfectants, cleaning materials and equipment are available for cleaning purposes

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OBJECTIVES	INTERVENTIONS (HOW)	ACTIONS (WHAT)
	1.1.9 Ensure adequate information about the facility and services	1.1.9.1 Operational managers should ensure that information-display boards are available at the entrance of the clinic
		1.1.9.2 Operational managers should ensure that internal wayfinding signage is visible inside the clinic to ensure Direction for patients within the clinic
		1.1.9.3 Operational managers should check on a daily basis that staff members wear their identification tags
		1.1.9.4 Operational managers should monitor that the organogram with all the staff names is visible in the waiting rooms
		1.1.9.5 Operational managers should ensure on a daily basis that the helpdesk/reception is provided with clerks to support patients with needed information
	1.1.10 To ensure adequate patient information to make informed decisions about testing, treatment and procedures	1.1.10.1 Sub-district co-ordinators should conduct monthly folder audits to make sure that patients received adequate information to be able to make informed decisions regarding treatment, testing and procedures
		1.1.10.2 PHC managers can interview five clients during their monthly support visit to make sure that they receive adequate information to make informed decisions
1.2 Promote physical access (Items 11 to 12)	1.2.1 Ensure that clients living in the vast and remote geographical areas have access to clinics	1.2.1.1 District managers should budget annually for subsidised patient transport for patients in the remote areas
		1.2.1.2 Operational managers should liaise with HealthNet for the availability of patient transport where possible.
		1.2.1.3 District managers should attend multi-sectoral meetings in order to improve public transport availability
	1.2.2 Ensure that disabled persons have access to clinics, e.g. wheelchair friendly.	1.2.2.1 The Operational Manager should monitor that the outside terrain is compacted and smooth
		1.2.2.2 The Operational Manager should ensure that handrails are available for people with impairments.
		1.2.2.3 The Operational Manager should ensure that ramps are available for persons in wheelchairs
		1.2.2.4 The Operational Manager should ensure that elbowtaps are available for persons in wheelchairs
		1.2.2.5 The Operational Manager should ensure that doorhandles are at the height of a wheelchair in the toilet with access to persons in wheelchairs
		1.2.2.6 The Operational Manager should plan for at least one toilet available for those in wheelchairs
		1.2.2.7 The Operational Manager should ensure for the availability of a functional wheelchair at the clinic
1.3 Enhance continuity of care (Items 13 to 19)	1.3.1 Address long waiting times for specialists' consultations.	1.3.1.1 Sub-district medical managers should motivate for rural specialists' outreaches
		1.3.1.2 Sub-district medical managers should attend the quarterly Geographical Service Areas meetings to communicate the needs of those living in rural and remote areas
		1.3.1.3 Sub-district medical managers should motivate for the employment of more family physicians to reduce referrals to specialists

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OBJECTIVES	INTERVENTIONS (HOW)	ACTIONS (WHAT)
	1.3.2 Effective and timeous management of referrals	1.3.2.1 District Human Resource Development staff should conduct annual training sessions to make relevant staff aware of the National Referral Policy (referral letters, written feedback, referral criteria, and referral resources)
		1.3.2.2 The sub-district Medical Manager should communicate referral needs to the specialists attending the Geographical Service Areas meetings
	1.3.3 Sort patients out on the day of their initial clinic visit	1.3.3.1 Reception clerks should keep daily statistics about the numbers of patients who are not sorted out on the day of their initial clinic visit
		1.3.3.2 Information clerks should analyse this data monthly to identify the root cause
		1.3.3.4 The Operational Manager with the involvement of all relevant staff should develop a quality improvement plan to address this challenge
		1.3.3.5 The trainer at the District Office should provide training on a quarterly basis about integrated service delivery to capacitate staff with the necessary skills and knowledge to manage patients comprehensively within one visit
1.4 Manage delays in care	1.4.1 Provide information to patients about how long they have to wait before attended to	1.4.1.1 The trainer at the District Office should conduct quarterly training sessions with staff to make them aware of the National Policy for the Management of Waiting Times.
		1.4.1.2 Reception clerks should monitor hourly that a patient should not wait more than three hours
	1.4.2 Communicate with patients when delays occur	1.4.2.1 The PHC Manager should ask five patients during her monthly support visit whether they have been informed about delays
	1.4.3 Monitor waiting time	1.4.3.1 The Operational Manager should conduct quarterly waiting-time audits
		1.4.3.2 The Operational Manager and the Information Clerk could analyse the data and with the involvement of all relevant staff, develop quality improvement plans
	1.4.4 Keep the length of waiting time acceptable	1.4.4.1 The Operational Manager should make a staff member responsible for the daily monitoring of waiting times
		1.4.4.2 The Operational Manager should encourage clients daily to make staff attend to unacceptable long waiting times
	1.4.5 Provide activities for patients to keep them occupied while waiting for service delivery	1.4.5.1 Operational managers must motivate annually for televisions, video machines and educational material at all clinics

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OBJECTIVES	INTERVENTIONS (HOW)	ACTIONS (WHAT)
		1.4.5.2 Counsellors should provide a monthly planning schedule to the Operational Manager to inform her about activities for patients while waiting
1.5 Ensure that clients have access to a full package of care	1.5.1 Motivate for extended clinic hours	1.5.1.1 The PHC Manager should establish the need for extended service hours, e.g. include in client-satisfaction survey
		1.5.1.2 The PHC Manager should motivate the need for extended hours at a higher level, e.g. district office
		1.5.1.3 The PHC Manager should get the buy in of the clinic committee to support the motivation about extended clinic hours
	1.5.2 Ensure the availability of rehabilitation services at all clinics	1.5.2.1 The PHC Manager should review the monthly planning rosters of all allied health professionals to ensure that they outreach to all the clinics
		1.5.2.2 The PHC Manager should review the monthly bookings of the allied health professionals at the clinics to monitor their availability or needs
1.6 Ensure effective management of complaints	1.6.1 Familiarise clients with the process how to lodge a complaint	1.6.1.1 The Operational Manager should conduct monthly staff meetings to share the content of the National Guideline to Manage Complaints/Compliments/Suggestions
		1.6.1.2 The Operational Manager should ensure for the availability of complaints/compliments/suggestions boxes at the clinic
		1.6.1.3 The Operational Manager should observe daily that official complaints/compliments/suggestion forms and pens are available
		1.6.1.4 The Operational Manager should ensure for the visibility of the poster on how to lodge a complaint
		1.6.1.5 The Operational Manager should review the complaints/compliments/suggestions register monthly to ensure that all complaints are acknowledged, investigated and feedback provided and solved within 25 working days

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DOMAIN 2: QUALITY CLIENT-CENTRED CLINICAL CARE		
OBJECTIVES	**INTERVENTIONS (HOW)**	**ACTIONS (WHAT)**
2.1 Improve quality client-centred care	2.1.1. Re-emphasise the importance of a positive client-centred care experience	2.1.1.1 The Operational Manager should arrange annual training sessions with the Human Development Staff at the District Office to refresh staff on the quality client-centred care attributes
		2.1.1.2 The Operational Manager should monitor that all consultation rooms are provided with a National Patient Experience of Care Guideline
		2.1.1.3 The Information Clerk at the clinic should analyse data monthly about complaints annually for waiting-time audits, and patient-satisfaction surveys to identify gap

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OBJECTIVES	INTERVENTIONS (HOW)	ACTIONS (WHAT)
		2.1.1.4 The Operational Manager should involve all staff to support her/him with the development and implementation of quality improvement plans
		2.1.1.5 The Operational Manager should provide feedback on the monthly clinic staff meetings
	2.1.2 Make sure that clients understand the information they receive	2.1.2.1 The PHC Manager should interview five patients during the monthly support visit to determine whether staff spend adequate time with patients
		2.1.2.2 The Operational Manager should assess all nursing staff quarterly to determine whether they explain to patients their disease or health information with pictograms or models to enhance understanding
		2.1.2.3 The Operational Manager should assess all nursing staff quarterly to determine whether they provide patients the opportunity to explain in their own words or to repeat what you have explained to them
	2.1.3 Provide patients with written information about health problems and medication	2.1.3.1 The PHC Manager should ensure during the monthly support visit that all clinics have adequate reading material or pictograms about health problems and medications
2.2 Strengthen clinical management activities	2.2.1 Familiarise staff with clinical guidelines and protocols	2.2.1.1 The PHC Manager should monitor during the monthly supervisory visit that all the the relevant clinical guidelines and protocols are available in each clinic
		2.2.1.2 Sub-district programme co-ordinators should conduct monthly folder audits to monitor the correct implementation of protocols and guidelines
		2.2.1.3 The Operational Manager should arrange monthly clinic staff meetings to refresh or update staff on the latest protocols and guidelines
	2.2.2 Employ an adequate number of family physicians	2.2.2.1 The sub-district medical managers should motivate to the District Human Resource Department for the appointment of a family physician in each of the five sub-districts to strengthen clinical management
2.3 Manage and prevent clinical risks	2.3.1 Ensure infection prevention and control measures	2.3.1.1 The sub-district Quality Assurance Co-ordinator should schedule quarterly meetings to share information with staff regarding the National Policy on Infection Prevention and Control
		2.3.1.2 The sub-district quality Assurance Co-ordinator should allocate a dedicated staff member in each clinic to take responsibility for infection prevention and control
		2.3.1.3 The sub-district Quality Assurance Quality Co-ordinator should develop Standard Operating Procedures on infection control standard precautions for all clinics
		2.3.1.4 The sub-district Quality Co-ordinator should organise quarterly training for all staff on infection prevention and control

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OBJECTIVES	INTERVENTIONS (HOW)	ACTIONS (WHAT)
		2.3.1.5 The sub-district Quality Co-ordinator should conduct annual risk assessment at every clinic for infection prevention and control compliance
	2.3.2 Improve adverse events control	2.3.2.1 The Quality Assurance Co-ordinator should share information at the monthly sub-district PHC meeting about the National Guidelines for Patient Safety Incident Reporting and Learning
		2.3.2.2 The sub-district Quality Assurance Co-ordinator should provide quarterly training to all staff on the Standard Operating Procedure for Patient Safety Incidents Reporting and Learning
		2.3.2.3 The sub-district Quality Assurance Co-ordinator should encourage all staff at the monthly PHC meeting to complete Patient Incident Management forms for all safety risk incidents
		2.3.2.4 The PHC Manager should monitor during the monthly supervisory visit for the availability of the safety risk-incident register
		2.3.2.5 The clinic Information Clerk should collect and analyse data on safety incidents on a monthly basis
		2.3.2.6 The Operational Manager should involve all staff to support the development of quality improvement plans to prevent safety risk incidents
	2.3.3 Encourage the attendance of mortality and morbidity meetings	2.3.3.1 The sub-district medical managers should schedule quarterly mortality and morbidity meetings
		2.3.3.2 Operational managers should provide clinical nurse practitioners the opportunity to attend these meetings
		2.3.3.3 The sub-district medical managers should ensure the availability of agenda and minutes
		2.3.3.4 The Operational Manager should include this information to develop quality improvement plans where indicated

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DOMAIN 3: CLINICAL SUPPORT SERVICES		
OBJECTIVES	**INTERVENTIONS (HOW)**	**ACTIONS (WHAT)**
3.1 Ensure pharmaceutical support	3.1.1 Ascertain the availability of medicines and supplies	3.1.1.1 The sub-district Pharmacy Supervisor should develop a Standard Operating Procedure for all clinics about the management and safe administration of medicines
		3.1.1.2 The sub-district Pharmacy Supervisor should review the effective utilisation of the electronic network system regarding the availability of medicines on an annual basis.
		3.1.1.3 The sub-district Pharmacy Supervisor should do monthly supervisory visits to clinic pharmacies to make sure that 90% of the medicines on the tracer medicine list are always available

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OBJECTIVES	INTERVENTIONS (HOW)	ACTIONS (WHAT)
		3.1.1.4 The Pharmacy Supervisor should support the Pharmacy Assistant at the clinics to determine minimum/maximum re-ordering stock levels for each item on the district/facility formulary
		3.1.1.5 The Pharmacy Supervisor should ask staff during the monthly visits about the adequacy of medical supplies (consumables)
3.2 Strengthen diagnostic services	3.2.1 Manage long turnaround times for laboratory specimens	3.2.1.1 Operational managers should monitor turnaround times on a monthly basis for laboratory specimens
		3.2.1.2 The PHC Manager should attend quarterly meetings with the laboratory supervisor to address any shortcomings
		3.2.1.3 The PHC Manager should keep written minutes of this meeting
	3.2.2 Ensure adequate laboratory tests	3.2.2.1 The Laboratory Supervisor should familiarise staff with the correct stock levels and procurement processes
		3.2.2.2 Operational managers should report and address any stock outs to the relevant laboratory supervisor continuously
	3.2.3 Ensure adequate number of microbiologists	3.2.3.1 The laboratory supervisors should organise a meeting with the District Office Human Resource Department to report any problems regarding an inadequate number of microbiologists
	3.2.4 Ensure the availability of the relevant quality control protocols	3.2.4.1 The Laboratory Supervisor should monitor for the availability of the necessary quality control protocols and measures at the sub-district laboratory and clinics
		3.2.4.2 The Laboratory Supervisor should facilitate the necessary training for clinic staff should there be a need
3.3 Enhance therapeutic and support services	3.3.1 Ensure patient access to a comprehensive range of allied health professionals	3.3.1.1 The PHC Manager should motivate for the recruitment and appointment of a comprehensive team of allied health professionals for the sub-district
	3.3.2 Strengthening of the current community service allied health professional teams	3.3.2.1 The PHC Manager should motivate for the recruitment and appointment of full-time allied health professionals, in addition to the community service allied health professionals to keep the service sustainable
	3.3.3 Ensure access to assistive devices	3.3.3.1 The sub-district Occupational Therapist should conduct an annual situational analysis to determine the need for assistive devices
		3.3.3.2 The sub-district Occupational Therapist should utilise the data of the annual situational analysis to motivate for an adequate budget for the procurement of assistive devices
3.4 Ensure availability of needed health technology	3.4.1 Ensure adequate and appropriate equipment in all consultation rooms	3.4.1.1 The Operational Manager should compile a master checklist to ensure the availability of essential equipment for all consultation rooms
		3.4.1.2 The Operational Manager should budget annually for additional equipment or replacement of equipment

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OBJECTIVES	INTERVENTIONS (HOW)	ACTIONS (WHAT)
		3.4.1.3 The Asset Clerk at the District Hospital should compile an electronic asset register for all equipment at all clinics
		3.4.1.4 The Asset Clerk at the District Hospital should conduct quarterly stock taking to ensure that all equipment is available
		3.4.1.5 The Operational Manager should monitor that no longer needed and non-functional equipment are taken away from the clinic
	3.4.2 Ensure proper maintenance of equipment	3.4.2.1 The sub-district Quality Assurance Co-ordinator should provide every clinic with a Standard Operating Procedure for the maintenance of equipment
		3.4.2.2 The Operational Manager should monitor monthly that all medical equipment are in a working condition
		3.4.2.3 The sub-district Quality Co-ordinator should provide every clinic with a Standard Operating Procedure for decontamination of medical equipment
	3.4.3 Ensure that staff have the skills for the correct utilisation of equipment	3.4.3.1 The Operational Manager should organise annual staff training on the use of all equipment

DOMAIN 4: PUBLIC HEALTH		
OBJECTIVES	**INTERVENTIONS (HOW)**	**ACTIONS (WHAT)**
4.1 Encourage health promotion and disease prevention at the facility	4.1.1 Manage organizational challenges preventing health promotion and disease prevention activities	4.1.1.1 The Operational Manager should motivate continuously for more staff, should they experience that staff shortages hamper health promotion and disease prevention activities
		4.1.1.2 Operational managers should ensure adequate equipment and education material for health promotion and disease prevention
	4.1.2 Ensure adequate support and information to clients about disease and treatment	4.1.2.1 Operational managers should ensure that health promotion and disease prevention activities are daily available
		4.1.2.2 Sub-district programme co-ordinators should conduct quarterly folder audits to evaluate the quality of health promotion and disease prevention information
		4.1.2.3. Sub-district programme co-ordinators should arrange quarterly training to address unmet support and inadequate information to clients
		4.1.2.4 Counsellors at the clinic should report weekly to the Operational Manager about all health promotion and disease activities
	4.1.3 Provide patients with adequate knowledge about disease and health	4.1.3.1 Operational managers should ensure daily availability of health promotion and disease prevention activities
		4.1.3.2 Clinic counsellors should conduct before and after tests quarterly to evaluate the adequacy of their health promotion and disease prevention activities

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OBJECTIVES	INTERVENTIONS (HOW)	ACTIONS (WHAT)
	4.1.4 Ensure that health promotion and disease prevention activities are relevant and useful	4.1.4.1 Counsellors should do annual mini surveys to evaluate the usefulness and relevancy of their health promotion and disease prevention activities
		4.1.4.2 Counsellors should ask clients about their preferences about health promotion and prevention activities within the clinic
		4.1.4.3 Health promotion and prevention activities should be adjusted accordingly
4.2 Support health promotion and disease prevention in the community	4.2.1 Promote health promotion and disease prevention activities in the community	4.2.1.1 The sub-district Community Base Service Co-ordinator should plan and organise quarterly health awareness campaigns in the community in collaboration with community healthcare workers
		4.2.1.2 Community healthcare workers should participate in social marketing at sport and religious events to raise awareness about health and diseases
		4.2.1.3 The sub-district Community Base Service co-ordinators and community healthcare workers should provide monthly screening services at strategic points in the community to identify asymptomatic patients and identify individuals at risk
		4.2.1.4 The sub-district Community Base Service Co-ordinator should establish local partnerships or inter-sectoral groups to address health issues
		4.2.1.5 Community healthcare workers should participate quarterly in the school health teams to provide health education and awareness campaigns at school level and provide screening services to assist with the early detection of chronic diseases and the appropriate referral of these high-risk clients
		4.2.1.6 The sub-district Community Base Service Co-ordinator should involve clinic committees in health promotion and disease activities
	4.2.2 Address inadequate knowledge and skills of community leaders and patients	4.2.2.1 The sub-district Community Base Co-ordinator should encourage community healthcare workers to do community health promotion and disease prevention
		4.2.2.2 The sub-district Community Base Co-ordinator should organise annually community communication events to engage with community leaders and patients
4.3 Prioritise health promotion and disease prevention by community healthcare workers	4.3.1 Encourage community healthcare workers to be actively involved in community health promotion and disease prevention activities	4.3.1.1 The sub-district Community Base Service Co-ordinator should limit the home-based care activities of community healthcare workers and empahasise the health promotion and prevention activities
		4.3.1.2 The sub-district Community Base Service Co-ordinator should motivate community healthcare workers to do home visits between clinic visits

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DOMAIN 5: STRATEGIC DIRECTION AND LEADERSHIP BY SENIOR MANAGEMENT		
OBJECTIONS	**ITERVENTIONS (HOW)**	**ACTIONS (WHAT)**
5.1 Promote community communication events in the community	5.1.1 Communicate the goals, values and future plans of the WCDoH	5.1.1.1 The Operational Manager should ensure the visibility of the WCDoH's goals, values and future plan in all clinics
		5.1.1.2 The Clinic Committee should arrange annual community meetings to inform the community of the goals, values and future plans of the WCDoH
5.2 Establish the formation of clinic committees	5.2.1 Include the community in planning of the services and taking ownership of their PHC clinics and its functioning	5.2.1.1 The Community Base Service Co-ordinator should arrange for quarterly meetings to share with clinic staff the National Clinic Committee Guideline in order to understand the roles, responsibilities and activities of the clinic committee
		5.2.1.2 The sub-district Community Base Service Co-ordinator should render support with the establishment of the clinic committees
		5.2.1.3 The Operational Manager should display the names and contact details of the committee members in the clinics
		5.2.1.4 The Operatioanl Manager should develop a schedule of monthly meetings in collaboration with the members of the clinic committee
		5.2.1.5 The sub-district Community Base Service Co-ordinator should organise training for the members of the clinic committees to clarify their role and function
		5.2.1.6 The sub-district Community Base Service Co-ordinator should encourage the clinics' operational members to attend the clinic committees meetings
		5.2.1.7 The Operational Manager should make the chair of the respective clinic committees responsible for the monthly meeting's agenda, attendance register and minutes
		5.2.1.8 Operational managers should follow up on the actions arising out of the monthly clinic committee meetings
5.3 Strengthen strategic management processes	5.3.1 Prevention of rigid managerial structures	5.3.1.1 The PHC Manager should encourage all staff members to participate in the Barrett survey every two years to voice their opinions
	5.3.2 Involvement of employees in change management processes	5.3.2.1 The PHC Manager should keep employees continuously informed about change management processes
	5.3.3 Make staff structures visible	5.3.3.1 Operational managers should make staff organograms visible in the clinic to identify the name and position of service providers

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DOMAIN 6: OPERATIONAL MANAGEMENT		
OBJECTIVES	**INTERVENTIONS (HOW)**	**ACTIONS (WHAT)**
6.1 Strengthen human resource management and development	6.1.1 Manage high work pressure of operational managers	6.1.1.1 The PHC Manager should motivate for dedicated operational managers at the fixed PHC clinics (currently the operational manager has a dual function of operational manager and clinical nurse practitioner)
		6.1.1.2 Otherwise, the Operational Manager should provide a split of 80% management and 20% clinical for facilities with a head count above 170 patients per day
		6.1.1.3 Operational managers should provide a split of 60% management and 40% clinical for facilities less than 170 patients per day
		6.1.1.4 PHC managers should make sure that these 60/80 per cent management and 40/20 percent clinical work principles are included in the job description of the Operational Manager
		6.1.1.5 The PHC managers should motivate management training for the operational managers in order to strengthen their management skills
	6.1.2 Address the inadequate staffing levels	6.1.2.1 The District Human Resource Department should arrange for the determination of staffing needs according to the Workload Indicators of Staffing Needs
		6.1.2.2 PHC managers should motivate that staffing numbers and skills mix to be in line with the Workload Indicator Needs
	6.1.3 Ensure that formal training meets service requirements	6.1.3.1 The PHC Manager should attend sub-district training meetings to discuss training needs
	6.1.4 Ensure that newly trained staff are prepared for their roles	6.1.4.1 The sub-district Human Resource officials should ensure that newly trained staff have access to orientation and induction
		6.1.4.2 Operational managers should develop annually an individual development plan for all staff members
		6.1.4.3 Operational managers should arrange for in-service-training in line with the development plans of staff
		6.1.4.4 Operational managers should arrange for refresher course training if indicated as a need
		6.1.4.5 Operatinal managers should document all training provided in the training registers
	6.1.5 Manage high work pressure	6.1.5.1 Operational managers should do root cause analysis to identify reasons for high work pressure
		6.1.5.2 Operational managers should develop a quality improvement plan to address high work pressure

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OBJECTIVES	INTERVENTIONS (HOW)	ACTIONS (WHAT)
6.2 Promote employee wellness	6.2.1 Make sure that an employee-wellness programme is available to help staff cope with the daily demands	6.2.1.1 Operational managers should make their staff aware of ICAS activities
		6.2.1.2 The PHC Manager should prepare a Standard Operational Procedure about the process and criteria for ICAS referrals
		6.2.1.3 The PHC Manager should promote six-monthly teambuilding activities in the working environment
	6.2.2 Promote staff satisfaction	6.2.1.1 The Operational Manager should encourage staff to participate in the staff-satisfaction surveys every two years
		6.2.1.2 The Information Clerk should analyse the outcomes of the staff-satisfaction surveys
		6.2.1.3 The PHC Manager should utilise the staff-satisfaction data to plan for quality improvement activities to address staff-satisfaction issues
	6.2.3 Provide adequate supervisory support	6.2.3.1 PHC managers should do monthly support supervisory visits at all clinics
		6.2.3.2 PHC managers should schedule the monthly support visits
		6.2.3.3 Operational managers should be available for staff when needed
	6.2.4 Improve working conditions	6.2.4.1 The PHC Manager should utilise the staff-satisfaction data to plan for quality improvement activities to improve working conditions
6.3 Ensure an effective and efficient supply chain functioning	6.3.1 Make staff aware of the budgeting processes	6.3.1.1 The PHC Manager should arrange for a workshop or two to make all staff categories aware of the budgeting processes
		6.3.1.2 The PHC Manager should arrange for a workshop or two to inform all categories of staff regarding the legal requirement of all the processes
	6.3.2 Make staff aware of all the procurement processes	6.3.2.1 The procurement clerks should explain to the Operational Manager the ordering process in detail (when, how, who and where.)
		6.3.2.2 The procurement clerks should explain to the Operational Manager about stock outs and how to deal with stockouts
		6.3.2.3 The procurement clerks should explain to Operational Manager about waiting times and how to prevent or deal with waiting times
6.4 Promote good data management	6.4.1 Ensure that data is always of good quality	6.4.1.1 The PHC Manager should motivate for the appointment of trained data management clerks at all fixed clinics

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OBJECTIVES	INTERVENTIONS (HOW)	ACTIONS (WHAT)
		6.4.1.2 Information clerks should capture monthly data on a daily basis
		6.4.1.3 Information clerks should validate data daily, weekly and monthly to ensure correct and accurate data

DOMAIN 7: INFRASTRUCTURE AND FACILITIES		
OBJECTIVES	**INTERVENTIONS (HOW)**	**ACTIONS (WHAT)**
7.1 Ensure maintained and updated infrastructure to prevent demoralised staff	7.1.1 Make sure that the infrastructure of the facility is maintained and upgraded when necessary	7.1.1.1 Operational managers should compile annually a maintenance plan for infrastructure repairs and additional needs, e.g. more space and more consultation rooms needed
		7.1.1.2 Operational managers should log a request to the sub-district PHC manager to have the repairs and/or additional needs onto the district's annual infrastructure plan
		7.1.1.3 The Operational Manager should keep records of orders submitted and track progress
		7.1.1.4 The Operational Manager should obtain the certificates from the district office that are required to ensure that the facility is compliant with all safety regulations
7.2 Address inadequate space at PHC clinic	7.2.1 Ensure that clinics have adequate space to render the full package of service	7.2.1.1 Operational managers should do an annual needs analysis with regard to the number of consultation rooms, storage space and waiting areas needed
		7.2.1.2 Operational managers should provide a written motivation for the extension of the clinic via the West Coast District office for attention of Public Works Department in order to be prioritised and budgeted
OBJECTIVES	**INTERVENTIONS (HOW)**	**ACTIONS (WHAT)**
7.3 Ensure that the clinics are prepared to handle emergency evacuations	7.3.1 Ensure that the evacuation plan in times of emergency is visible in the clinic	7.3.1.1 Operational managers must ensure for the visibility of the evacuation plan in all clinics

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6.4 PROCESS FOR IMPLEMENTATION

The process for implementation of the programme to facilitate quality client-centred in PHC clinics of the rural West Coast District will include the following:

6.4.1 Development of an audit checklist

The information of table 6.5 (proposed objectives, interventions [what] and actions [how] will be utilised to compile an audit checklist which will be used in a programme to facilitate quality client-centred care in the PHC clinics of the rural West Coast District.

This programme showed the following potential for future research, namely that it could be used in a larger study to include all five rural districts, as well as the Metropolitan District. The

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findings can then be generalised to the Western Cape Province. It should also be very interesting to repeat this study to include both the public health sector and private health sector. Several best practices will be identified. A repeat study in the West Coast can be undertaken to include all clinics (i.e. fixed, satellite and mobile clinics) and also to include all categories of staff and not only the clinical nurse practitioners as in the current study. Lastly, a follow-up study three years after implementation of this programme to evaluate the performance and to measure the impact of the programme to facilitate quality client-centred care in PHC clinics of the rural West Coast District.

6.4.2 Informing the District Management of the audit checklist

The researcher will schedule a meeting with the District Management Team of the West Coast District to discuss the study findings and specifically the *81 problems* as identified. The researcher will present the preliminary version of the proposed audit checklist which was developed according to the identified problems. The management team should evaluate the content of the proposed audit checklist. Permission will be asked to pilot this checklist in the Matzikama sub-district.

6.4.3 Informing the Sub-District Management about the audit checklist

The researcher will meet with the Matzikama sub-district managers, allied health professionals and operational managers of the five fixed clinics, at a scheduled monthly PHC meeting to share with them the 81 problems as identified in this study. The proposed audit checklist will be presented to them. The possibility to pilot the audit checklist in the five fixed clinics of the Matzikama sub-district will be discussed.

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6.4.4 Piloting of the audit checklist in the fixed PHC clinics of Matzikama sub-district

The researcher will organise staff meetings at the five fixed clinics to dicuss the detail about piloting of the proposed audit checklist. The researcher will present a detailed discussion about the audit checklist. Each operational manager has to arrange for a baseline evaluation within three months to determine which aspects of the audit checklist are already present and to identify problem areas within each clinic. The focus will then be to focus on reinforcing the actions that are already in place in the clinics and from there provide intervention ideas about the problem areas identified. The researcher will train clinic staff on the Shewart, plan-do-study-act cycle (Deming, 2000), to facilitate quality client-centred care improvement . Figure 6.2 is a visual presentation of the plan-do-study-act cycle.

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The plan-do-study-act cycle emphasises quality improvement as a continuous process comprising various cycles of:

- Planning: Operational managers should do a baseline assessment by utilising the audit checklist (as prepared by the researcher) for identifying problem areas and to determine what actions according the NCSs (as the benchmark) are needed.
- Do: All staff members should be involved to implement the quality improvement activities (action plans). Staff members will be informed about who does what.
- Study: The Operational Manager has to do the quarterly assessment and analyse the collected data.
- Act: The Operational Manager should arrange a team meeting to determine what further changes or corrective actions should be made that will result in improvement. He/she will keep trying and apply changes based on results.

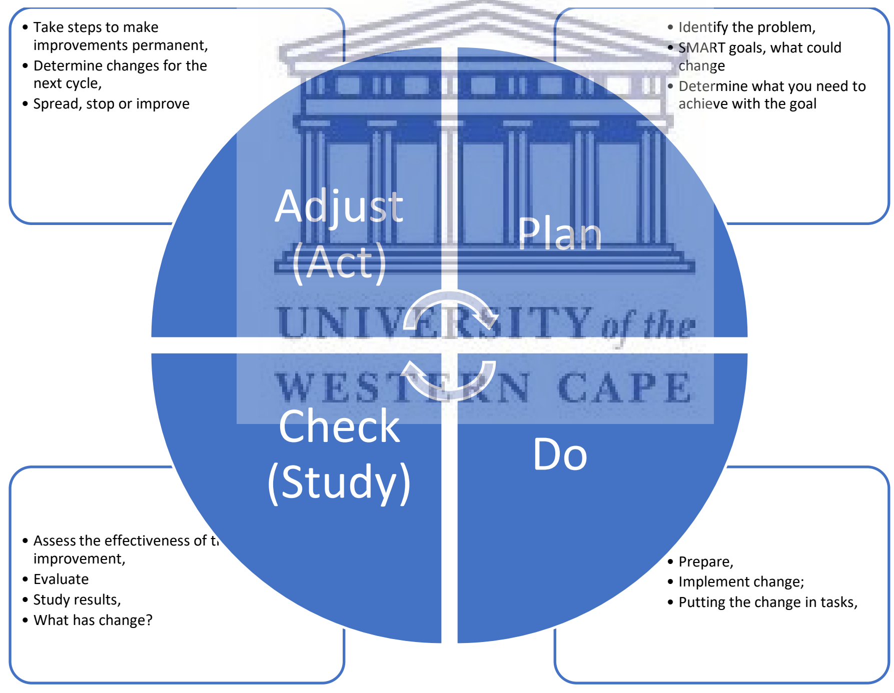

Figure 6.1: Continuous plan-do-act-study cycle

By repeating the plan-do-study-act cycles, the respective clinics will get structures and processes in place and become compliant with the NCSs as required by the OHSC to achieve accreditation status.

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6.4.5 Evaluation of the programme

Programme evaluation is not part of this study. However, the researcher recommends a follow-up study three years after implementation of the proposed programme to evaluate the programme and to measure the impact of the programme.

6.5 SUMMARY

The aim of the study was to develop a programme to facilitate quality client-centred care in the PHC clinics of the rural West Coast District. Chapter 6 described this programme, including the vision, mission, assumptions, problems, goals, objectives, actions as well as the implementation of the programme. Chapter 7 will address the evaluation of the study, limitations and recommendations for practice, research, education and policy.

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CHAPTER SEVEN:
EVALUATION OF THE STUDY, LIMITATIONS AND RECOMMENDATIONS FOR PRACTICE, RESEARCH AND POLICY

7.1 OVERVIEW OF THIS CHAPTER

Chapter 7, the final chapter of this thesis provides a summary of the study with regard to the achievement of the objectives, describes the limitations and concludes with the recommendations for practice, education and research.

7.2 INTRODUCTION

The overall aim of this study was to develop a programme to facilitate quality client-centred care in the PHC clinics of the rural West Coast District in the Western Cape Province. This aim was achieved through inductive and deductive reasoning to achieve the following five objectives:

7.2.1 Phase 1: Situational analysis (quantitative method)

Objective 1: A literature review to gain a comprehensive background and an improved understanding about quality client-centred care in the PHC context.

Objective 2: To assess the clients' experiences about quality client-centred care.

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Objective 3: To determine the clinical nurse practitioners' reported status on quality client-centred care.

7.2.2 Phase 2: Situational analysis (qualitative method)

Objective 4: To explore and describe the managers and allied health professionals' perceptions about quality client-centred care.

7.2.3 Phase 3: Programme development

Objective 5: To develop a programme to facilitate quality client-centred care in the PHC clinics of the rural West Coast District of the Western Cape Province.

7.3 EVALUATION OF THE STUDY

The following sections provided the evaluation of this study with regard to the achievement of the five objectives as outlined in Table 7.1.

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7.3.1 Evaluation: achievement of objectives

Table 7.1 summarises the different objectives required for the development of a programme to facilitate quality client-centred care in the PHC clinics of the rural West Coast District. Phase 1 included Objectives 1 to 3. Objective I (Chapter 3) involved a literature review to gain a comprehensive overview and an improved understanding about quality client-centred care in the PHC context. Objective 2 and 3 (Chapter 4) collected and analysed data from the viewpoint of the clients and clinical nurse practitioners' experiences about quality client-centred care. For Phase 2, Objective 4 (Chapter 5) data was collected and analysed to explore and describe the managers and allied health professionals' perceptions about quality client-centred care. The data analysis of Phase 1 and 2 (Objectives 1 to 4) identified 81 problems about the current quality client-centred care and provided the foundation for the development of the programme to improve quality client-centred care in the PHC clinics of the rural West Coast District (Phase 3). Objective 5, the development of the programme is described in Chapter 6.

Table 7.1: Phases and objectives of the research study

PHASE 1: SITUATIONAL ANALYSIS (QUANTITATIVE)	PHASE 3: PROGRAMME DEVELOPMENT
Objective 1 To explore and the describe the current quality client-centred care by conducting an extensive literature review	**Objective 5** To develop a programme to facilitate quality client-centred care in PHC clinics of the rural West Coast District
Objective 2 To assess the clients' perceptions about quality client-centred care	
Objective 3 To determine the clinical nurse practitioners' perceptions on quality client-centred care	
PHASE 2: SITUATIONAL ANALYSIS (QUALITATIVE)	
Objective 4 To explore and describe the managers and allied health professionals' perceptions about quality client-centred care	

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7.3.1.1 Phase 1: Objectives 1 to 3

Objective 1 of this study involved an extensive literature review. The theoretical concepts as stated in the theoretical framework guided the study throughout and provides a golden thread. By means of the literature review the theoretical concepts, could be defined and clarified (see Figure 1.1 - Theoretical Framework) and recent national and international studies, guided by the seven domains of the NCSs, the benchmark for quality in South African Health Establishments (see Table 2.3) could be explored and described. The literature review

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confirmed that quality client-centred care was at risk in all seven domains of the NCSs due to various structure-process-outcome inadequacies. The researcher could not find any empirical studies exploring and describing the status of quality client-centred care in the PHC milieu through a literature review, and from the perspective of clients, clinical nurse practitioners, managers and allied health professionals who provided the data in order to develop a programme to facilitate quality client-centred care. This gap confirmed the need for this current study.

Objectives 2 and 3 were achieved through the use of two self-administered questionnaires (see Annexure D – Clients Questionnaire and see Annexure E – Clinical Nurse Practitioners Questionnaire) developed by the researcher, based on the seven domains of the NCSs. These instruments allowed the researcher to assess the clients experience and to determine the clinical nurse practitioners report on the status of quality client-centred care. Chapter 4 discussed the quantitative results of Objectives 2 and 3.

7.3.1.2 Phase 2: Objective 4

Objective 4 (Phase 2) was achieved by exploring and describing the managers and allied health professionals' perceptions about client-centred care through focus group discussions (see Annexure J – Focus Group Discussion Schedule). These focus group discussions allowed the researcher to explore and describe the managers and allied health professionals' perceptions about quality client-centred care. Chapter 5 discussed the qualitative results of Objective 4.

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7.3.1.3 Phase 3: Objective 5

Phase 3, Objective 5 involved the development of the programme to improve quality client-centred care through deductive and inductive reasoning (refer to Figure 2.14). This objective is presented in Chapter 6. To be able to develop the programme, the researcher firstly formulated a vision, a mission, values and assumptions prior to the formulation of the 82 problems identified for the intervention programme (see Table 6.2). From all the problems identified, seven goals for the programme were developed (see Table 6.3). These goals were expanded as proposed interventions (see Table 6.4), which then formed the basis for the development as proposed actions (see Table 6.5). The proposed interventions were also developed in accordance with the seven domains of the NCSs which provided the theoretical framework for the research study.

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The researcher succeeded in meeting the five research goals, in that the literature review provided a comprehensive overview about the current status of quality client-centred care in the PHC context. Through the literature review, it was confirmed that quality client-centred care against the background of the seven domains of the NCSs was compromised, due to several structure-process-outcome inadequacies, thereby supporting the rationale for this study. Objectives 2, 3 and 4 also revealed that quality client-centred care was compromised, due to several structure-process-outcome inadequacies. In reaching Objectives 1 to 4, Objective 5 could be met and an intervention programme to increase quality client-centred care could be developed.

The development of this programme was innovative and makes a unique contribution to the body of science. Furthermore, the central theoretical statement was fulfilled. This was the first empirical study to explore and describe the current status about quality client-centred care in the PHC milieu through a literature review, from the perspective of clients, clinical nurse practitioners, managers and allied health professionals. This situational analysis provided the data to develop a programme to facilitate quality client-centred care in PHC clinics of the rural West Coast District.

7.4 LIMITATIONS OF THE STUDY

Limitations are described as constraints or problems in a study that may decrease the generalisability of the results (Grove *et al*., 2012). The study revealed the following limitations:

- The study was limited to the public health sector of the West Cast District, thus limited the findings to the public sector. The private sector was excluded.
- The Western Cape comprises six districts, five rural districts and one metropolitan district. However, only one rural district was included for this study. Therefore, the study findings were only applicable to the West Coast District.
- Only fixed clinics of the West Coast District were selected for this study. As a result, the study findings could not be generalised to satellite and mobile clinics.
- The study participants were limited to clinical nurse practitioners of the PHC clinics. While professional nurses, staff nurses, administrative clerks, data clerks and counsellors were excluded. They could be a rich source of information regarding quality client-centred care. For that reason the study finding could only be generalizable to the clinical nurse practitioners.

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Despite the aforementioned limitations, the study aim was achieved, “to develop a programme to facilitate quality client-centred care in PHC clinics of the rural West Coast District”.

7.5 RECOMMENDATIONS

Based on the study findings it has been established that the PHC clinics of the West Coast District showed various quality client-centred care challenges. The following recommendations made for practice, research, education and policy are discussed:

7.5.1 Recommendations for practice

The study findings of this study indicated the following threads for quality client-centred care, namely:

7.5.1.1 Domain 1: Patient Rights

Study findings indicated various “gaps or problems” regarding Patient Rights, namely: inadequate respect and dignity; insufficient access to information; lack of continuity of care; long waiting times and inadequate complaint management.

Policies and guidelines are available in clinics, however staff were not always familiar with the content thereof.

Workshops and in-service training should be organised on the National Patient Rights Charter, Standard Operating Procedure for referrals and referral pathways, National Policy on Management of Patients Waiting and National Guideline to Manage Complaints and Suggestions in the Health Sector of South Africa. Furthermore, the SANDoH should also ensure the availability of leaflets to inform patients of their rights and what they could expect at PHC clinics.

7.5.1.2 Domain 2: Patient Safety and Care

According to the study findings “quality” and “client-centred” care according to the quality and client-centred care attributes were not always evident in service delivery, patient safety was compromised by inadequate infection control measures and were under reporting on adverse events.

Currently, there are no guidelines or training material available for PHC staff about the theoretical aspects and implementation of “quality” and “client/patient or person-centred care”.

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Furthermore, the current National Infection Control Prevention and Control Policy and Strategy of SANDoH is outdated (South African National Department of Health, 2007b).

The researcher recommends that the SANDoH should prepare training material or guidelines regarding the implementation of "quality" and "client/patient/person-centred care" for PHC staff. Furthermore, workshops and in-service training should be scheduled about the utilisation and implementation of the quality improvement cycle, patient safety incident reporting and learning in the health sector of SA and the infection control prevention and control. It is also suggested that the SANDoH should provide an upgraded National Infection Control Prevention Policy.

7.5.1.3 Domain 3: Clinical Support Services

Study findings highlighted that medicines and supplies were not always available. Furthermore, patients do not always have access to assistive devices. PHC clinics do not always have the basic medical equipment, neither have the capacity for the maintenance thereof.

Currently, the fixed PHC clinics are staffed with Post Basic Pharmacist Assistants and are supported by community service pharmacist's visits. However, these visits seemed to be inadequate and infrequent. Therefore, it is suggested that a dedicated, permanent pharmacist should be employed in each of the five subdistricts to enhance sustainable support to the Post Basic Pharmacist Assistants, to enhance the management of stock levels and supplies.

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Access to assistive devices and availability of medical equipment are challenged by budgetary constraints. The researcher recommends that the occupational therapists and operational managers should prepare a complete database regarding the needs for assistive devices and medical equipment respectively and keep it updated. This updated database could be used to prioritise and motivate for a bigger portion of the budget.

Maintenance of equipment is challenged by limited workshop capacity. Therefore, the researcher suggests that a mobile outreach workshop team visit the five subdistricts on a regular basis to repair the defaulted equipment on site.

7.5.1.4 Domain 4: Public Health

Study participants reported that health promotion and disease prevention at facility level are challenged by: inadequate staffing levels, heavy patient loads, lack of space, equipment and

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education materials. Furthermore, the community healthcare workers' contribution to promotion and prevention activities are currently very limited.

The Provincial Strategic Plan 2014 to 2019 (Western Cape Government Department of the Premier, 2015) sets out five strategic goals, namely enabling environments for better economic growth and more jobs, better-quality education, increased wellness, safety and addressing of social ills, ensuring better living environments for communities and promoting good governance and integrated service delivery through collaboration and spatial alignment.

The aforementioned emphasised the importance of health promotion and disease prevention activities to improve wellness by empowering individuals and inspiring people to take responsibility for their health and wellbeing. However, PHC clinics are challenged by the lack of health promoters and inadequate number of counsellors. The researcher suggests that health promoters be employed in all PHC clinics and the number of counsellors be revised. In addition, SANDoH should ensure the availability of the needed education materials.Currently, the health promotion and prevention activities of community healthcare workers are limited in the community. They work only four-and-a-half hours per day. The researcher recommends that the community healthcare workers be employed eight hours per day. Furthermore, there is currently not a good linkage between the facilities and the community healthcare workers. The community healthcare workers are employed by Non-Governmental Organisations. The researcher advises that community healthcare workers be employed by the WCDoH, in order to render an integrated and sustainable service.

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7.5.1.5 Domain 5: Corporate Governance

The study findings revealed that the WCDoH communication to the community about future plans, visions, values and change management was inadequate. In addition, clinic committees are currently not active to enhance community communication.

Furthermore, participants indicated that the government administrative and procurement processes have too much "red tape" and determination of staff allocation levels were insufficient.

The WCDoH should organise community communication events in order to share information with the community about the health system including: vision 2030, future plans and changes. Furthermore, clinic committees should be established to enhance communication between the facilities and the community.

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The researcher identified that PHC staff are not familiar with the government processes such as budgeting, procurement and staff allocation. Therefore, it is recommended that guidelines and training sessions be developed by SANDoH to familiarise PHC staff on these processes.

7.5.1.6 Domain 6: Operational Management

This study highlighted several operational management barriers, namely: inadequate staffing numbers, operational managers expected to manage the clinics have to execute clinical functions, duplication of tasks, supply chain processes are not always clear and result in frequent stock outs, statistics are overemphasised, and data capturing seems to be incomplete. These barriers contribute to high workload and lack of staff satisfaction.

WISN method is a human resource management tool, to support managers in determining how many staff of a particular type is necessary to cope with the workload of a particular facility and also measure the workload pressure of a given facility (World Health Organization, 2010). It is recommended that WISN be conducted at each PHC facility to shed light on staffing needs and workloads.

In addition, the role and function of the Operational Manager should be standardised. It is not beneficial for quality healthcare delivery that Operational Managers manage facilities and perform clinical functions as well. According to the researcher, this is one of the reasons for poor quality client-centred care at PHC facilities.

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Moreover, NDoH should conduct audits in PHC facilities to identify and eliminate unnecessary duplication. Supply chain and procurement processes should be made clear to PHC staff. The researcher recommends that Standard Operating Procedures be compiled to ensure standardised processes. Furthermore, it is recommended that the collection of data in PHC clinics be revised, streamlined, computerised and minimised. According to the researcher, too much data are collected.

7.5.1.7 Domain 7: Facilities and infrastructure

Infrastructure is characterised by insufficient space and number of consultation rooms, lack of maintenance and lack of the necessary security systems at PHC clinics.

The current PHC facilities were built before 1994, when the focus was on preventative service delivery. However, after 1994 the service changed to prevention, promotion, curative and rehabilitative delivery. Categories of staff expanded, e.g. operational managers, clinical nurse

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practitioners, professional nurses, staff nurses, administrative clerks, data capturers, counsellors, dentists, dental chair assistants, oral hygienists, clinical psychologists, speech therapists, occupational therapists, physiotherapists, dieticians and doctors. resulting in inadequate number of consultation rooms, waiting-room space, storage space, folder space, therapy space.

Infrastructure upgrading and expansions are also challenged by budgetary constraints. The researcher recommends that the SANDoH and Department of Public Works work closer, and determine infrastructural needs as required by NCSs.

In addition, a safe environment is a right, however security systems are non-existent at most of the clinics. Therefore, the researcher recommends that security systems and or alarm systems be implemented at all PHC clinics.

7.5.2 Recommendations for research

As discussed earlier, this research study showed some limitations. The following recommendations for future research are made, namely:

- A larger study should be conducted by including the five rural districts and the metropolitan district of the Western Cape, to assess quality client-centred care in the public health sector. The findings could then be generalised to the whole Western Cape Province.
- It should also be very interesting to conduct a study on quality client-centred care by including the public health sector and private health sector. The researcher is convinced that several best practices will be identified.
- This study could also be repeated in the West Coast District, but should then include all the clinics, i.e. fixed clinics, satellite clinics and mobile clinics. Also, all staff categories (clinical nurse practitioners, professional nurses, staff nurses, administrative clerks and counsellors) should be included.
- Lastly, the researcher recommends a follow-up study three years after implementation of the proposed programme, to evaluate the programme and to measure the impact of this programme.

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7.5.3 Recommendations for education

These study findings indicated that formal training programmes did not always spend adequate time on preparing students to deal with diseases as experienced in the rural areas of the Western Cape.

The researcher recommends that training institutions provide training (retraining of educators and students) in line with Healthcare 2030 where the WCDoH envisions to diverge from a curative paradigm to a focus of wellness (SDGs). The priority areas for intervention should include: reducing infectious diseases such as TB/HIV, improving healthy lifestyles, preventing injuries and violence, improving maternal and child health, strengthening women's health and improving Mental Health, striving for patient-centred quality of care and commitment to the PHC philosophy (Western Cape Department of Health, 2016a). In addition, it is recommended that students spend more time during their training by rotating through the rural areas.

7.5.4 Recommendations for policy

The researcher identified that the National Policy on Quality in Health Care for South Africa, (South African National Department of Health, 2007a), as well as The National Infection Prevention and Control Policy and Strategy, (South African National Department of Health, 2007b), are due for upgraded versions.

PHC clinics are in process to achieve quality accreditation and are aware of numerous policies, but are not familiar with the content thereof. The researcher recommends that operational managers provide feedback to all relevant staff regarding policies influencing their service delivery. Policies should be a standing item on the agenda for staff meetings.

Lastly, Ditlopo, Blaauw, Penn-Kekana and Rispel (2014) indicated that there is evidence of the benefits to the healthcare system, patients, and the nursing profession when nurses are involved in health policy development. The South African health system presents major opportunities for nurses to influence and direct policies that affect them. Therefore, the researcher recommends that the SANDoH provide opportunities to develop proactive leadership, health policy capacity and skills development among PHC nurses and involve them in health policy development.

7.6 PERSONAL REFLECTION

This study encompassed a journey of six years with many ups and downs. However, the researcher showed perseverance and kept going with the support of Professors Hester Klopper

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and Karien Jooste. As a PHC manager, the researcher is convinced that the implementation of this programme could improve quality client-centred care at the rural PHC clinics of the West Coast District.

7.7 SUMMARY

Chapter 7 provided an overview of the aim and objectives of the study and confirmed that the five objectives were accomplished. This chapter concluded with recommendations for practice, education, research and policy.

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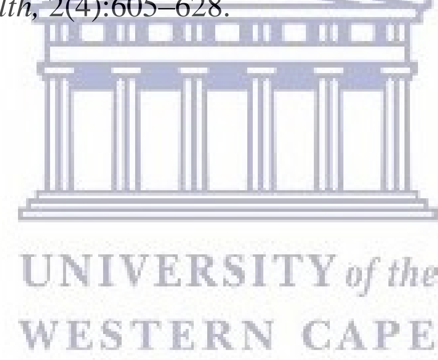
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ANNEXURES

Annexure A: Ethical approval

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OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

18 June 2013

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and ethics of the following research project by: Mrs JE Eygelaar (School of Nursing)

Research Project:	A programme to improve the quality of client-centred care in fixed rural primary health clinics in the West Coast.
Registration no:	13/5/25

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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.

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

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Annexure B: WC approval letter

HEALTH IMPACT ASSESSMENT
HEALTH RESEARCH SUB DIRECTORATE
Health.Research@westerncape.gov.za
tel: +27 21 483 0866: fax. +27 21 483 9895
5th Floor, Norton Rose House,, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: WC_201802_008
ENQUIRIES: Dr Sabela Petros

University of The Western Cape

Robert Sobukwe Road

Bellville

Cape Town

7505

For attention: Mrs Johanna Eygelaar

Re: A programme to improve the quality of client-centred care in fixed rural primary health care clinics in the West Coast.

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact **Dr Danie Schoeman on 022 487 9333** to assist you with any further enquiries in accessing the following sites:

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Citrusdal Clinic

Clanwilliam Clinic

Diazville Clinic

Elandsbaai Clinic

Graafwater Clinic

Hanna Coetzee Clinic

Klawer Clinic

Laingville Clinic

Lalie Cleophas Clinic

http://etd.uwc.ac.za/

Lamberts Bay Clinic

Louwville Clinic

Lutzville Clinic

Moorreesburg Clinic

Piketberg Clinic

Redelinghuys Satellite Clinic

Riebeeck West Clinic

Saldanha Clinic

Van Rhynsdorp Clinic

Vredenburg Clinic

Vredendal Central Clinic

Vredendal North Clinic

Wittewater Satellite Clinic

Yzerfontein Satellite Clinic

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

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4. The reference number above should be quoted in all future correspondence.

Yours sincerely

AT HAWKRIDGE

DR A HAWKRIDGE

DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 8 | 2 | 2018

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Annexure C: Information sheet

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9592274, Fax: 27 21-9592271

INFORMATION SHEET

Project Title: A programme to facilitate the quality of client-centred care in rural primary health clinics.

What is this study about?

This is a research project conducted by Mrs J.E. Eygelaar at the University of the Western Cape. We are inviting you to participate in this research project because you are a client, a clinical nurse practitioner or a member of the sub-district management of rural Primary Health Care. The purpose of this research project is to develop a programme to facilitate the quality of client-centred care for rural primary health clinics in the Western Coast district.

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

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The clients and clinical nurse practitioners will be asked to complete a questionnaire whereas the members of the sub-districts management (including allied health professionals) will be invited to take part in a focus group discussion. The study will be conducted at your clinic and at the sub-districts offices for the sub-districts management teams. The completion of the questionnaires will take approximately 20 to 30 minutes and, where applicable, the group discussion will last approximately 60 minutes. Questions will cover the following aspects:

- Patient Rights;
- Patient Safety, Clinical Governance and Care;
- Clinical Support Services;
- Public Health;
- Leadership and Corporate Governance;
- Operational Management;
- Facilities and Infrastructure.

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Would my participation in this study be kept confidential?

We will take the following measures to keep your personal information confidential. Your name will not be included on the questionnaires or transcribed audiotapes, and a code will be placed on the survey and other collected data. Through the use of identification keys, only the researcher will be able to link your survey to your identity; and only the researcher will have access to the identification key. The collected data will be stored in a locked filing cabinet and the researcher will make use of password protected computer files. If we write a report or article about this research project, your identity will thus be protected to the maximum extent possible.

What are the risks of this research?

As the information is not sensitive by nature, no known risks are foreseen during the project. As such, you will be protected from any possible psychological harm and where necessary, you would be referred to appropriate psychological services.

What are the benefits of this research?

The results of the survey may help the investigator to learn more about the quality of client-centred care. We hope that in future, other people might benefit from this study through an improved understanding of what quality client-centred care entails, in order to improve the quality of client-centred care at rural primary health clinics.

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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 penalised or lose any benefits to which you otherwise qualify.

What if I have questions?

This research is being conducted by Mrs J.E. Eygelaar at the School of Nursing at the University of the Western Cape.

If you have any questions about the research study itself, please contact:

http://etd.uwc.ac.za/

Researcher: Elsa Eygelaar
University of the Western Cape
Private Bag X17, Bellville 7535
Telephone: (021) 959 2258
Cell: 083 6301 376
Email: elsaeygelaar@telkomsa.net

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:

Research Supervisors:
Prof H. Klopper and Prof K. Jooste
University of the Western Cape
Private Bag X17, Bellville 7535
Telephone: (021) 959 2271;
Email: klopperhc@gmail.com or kjooste@uwc.ac.za

Dean of the Faculty of Community and Health Sciences
Prof Jose Frantz 021 9592631
Email: jfrantz@uwc.ac.za
University of the Western Cape
Private Bag X17
Bellville 7535

This research has been approved by the Senate Research Committee and Ethics Committee of the University of the Western Cape.

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Annexure D: Written informed consent: Survey

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Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9592274, Fax: 27 21-9592271

WRITTEN INFORMED CONSENT

Letter of request to participate in the study

Project Title: A programme to facilitate the quality of client-centred care in rural primary health clinics.

The study has been explained to me in a language that I understand and I hereby voluntary agree to participate in this research study. All my questions have been answered and sufficiently clarified. I understand that my identity will not be disclosed and that I may withdraw from the study at any stage without giving any reason.

Participants name: ....

Participants signature: ....

Witness: ....

Date: ....

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

Researcher: Elsa Eygelaar

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: (021) 959 2258

Cell: 083 6301 376

Email: elsaeygelaar@telkomsa.net;

Research Supervisors: Prof H. Klopper or Prof K. Jooste

University of the Western Cape

Private Bag X17, Bellville 7535

http://etd.uwc.ac.za/

Telephone: (021) 959 2271

Email: klopperhc@gmail.com or kjooste@uwc.ac.za

Dean of the Faculty of Community and Health Sciences

Prof Jose Frantz   021 9592631

Email: jfrantz@uwc.ac.za

University of the Western Cape

Private Bag X17

Bellville 7535

http://etd.uwc.ac.za/

Annexure E: Instrument – Clients

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville, 7535, South Africa

Tel: +27 21 959 2274, Fax: +27 21 959 2271

There are no right or wrong answers to the statements in this questionnaire.

Indicate your response to each question by placing a cross (X) in the appropriate box.

Use the following scale: 1 = Never; 2 = Sometimes; 3 = Frequently; 4 = Always.

The information in this form will be treated confidentially.

Do not write your name anywhere on this form.

A. GENERAL QUESTIONS

Scale: 1 = Never; 2 = Sometimes; 3 = Frequently; 4 = Always	**1**	**2**	**3**	**4**
1. Information boards are visible (e.g. about available services, times when the various services are offered, and clear directions to the various service areas in the clinic).				
2. Clerks at reception are helpful (e.g. assisting or supporting me where needed).				
3. My folder is retrieved timely at reception (e.g. there is no delay in finding my folder).				
4. I am addressed in a language that I understand.				
5. Staff members wear name tags to show their identity.				
6. The structure with the names or pictures of all the staff members is visible in the clinic (organogram).				
7. Staff members treat me with respect (e.g. polite, caring, tolerant, and empathetic).				
8. I can make an appointment according to my needs or preferences.				
9. I have the opportunity to choose a staff member I prefer for health service delivery.				
10. I am treated on the day of my clinic visit (e.g. I am not turned away).				

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Scale: 1 = Never; 2 = Sometimes; 3 = Frequently; 4 = Always	1	2	3	4
11. Patients with more urgent health problems receive care before those with minor problems.				
12. Waiting times are monitored to prevent long waiting periods (e.g. by dedicated staff or queue marshals).				
13. I am kept informed about how long I would have to wait before someone attends to me.				
14. Waiting time is acceptable (e.g. I am not waiting too long for service delivery).				
15. I am kept busy while I have to wait for service delivery (e.g. watching videos or listening to health talks).				
16. Clean drinking water and disposable cups are available to me in the waiting areas.				
17. All my problems or needs are addressed during one visit (e.g. care is provided without allocating specific days for specific services).				
18. Staff spends time with me (e.g. listens to me, discusses and explains my health problem, and treatment while allowing time to ask questions).				
19. The results of my investigation tests are explained to me in an understandable manner (e.g. blood tests, X-ray, and sonar).				
20. I am asked to repeat information received to the staff to evaluate whether I understood the information they had given me.				
21. Medicines are in stock and available when needed.				
22. Reasons for taking medication are explained to me.				
23. I am encouraged to report any medication side-effects.				
24. I receive written information about my health problem or medication (e.g. a pamphlet or pictorial material).				
25. I receive advice about what I can do to improve my wellness (e.g. about diet, exercises, smoking, drinking, and emotional wellbeing).				

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		N/A	1	2	3	4
26.	I have access to assistive devices when needed (e.g. crutches, walking aids, wheel chairs, spectacles, dentures, and hearing aids).					
27.	Referral appointments are available within two weeks, when needed (e.g. councillors, doctors, specialists, and allied health workers).					
28.	I am provided with a referral letter when referred.					
29.	I have access to transport, when needed (e.g. to the nearest hospital or referral service).					
30.	I am encouraged to ask questions.					
31.	I am advised to come back (e.g. follow-up date or earlier should my condition not improve).					
32.	The necessary equipment is available as required for my treatment (e.g. scales, blood sugar meters, blood pressure apparatuses).					
33.	Medical equipment that is required for my needs is in a working condition (e.g. scales, blood sugar meters, blood pressure apparatuses).					
34.	Consumables or supplies are in stock (e.g. needles, syringes, bandages, and plasters).					
35.	Staff utilises computer technology during my clinic visit (e.g. to access my medical information or tests results, to transmit my prescription to the pharmacy, or showing my X-ray images to me).					
36.	My privacy is respected during consultation or treatment (e.g. closed doors, screens, or curtains).					
37.	My personal information is kept confidential.					
38.	Staff involves me in decisions about my health care.					

		N/A	1	2	3	4
39.	Staff involves my family or friends (when appropriate) in my health care needs (e.g. care planning, training and decision making).					
40.	I am made aware about the "Patient Rights Charter" (e.g. poster or pamphlets).					
41.	Staffing levels are conducive for quality service delivery (e.g. doctors, nursing staff, pharmacists, pharmacy assistants, and administrative staff).					

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42.	The clinic is accessible to patients with disabilities or the aged (e.g. wide enough door entrances, ramps, rails, and wheelchairs).				
43.	I am encouraged to report any adverse event (e.g. any negative effect or injury resulting from care delivery)				
44.	I am made aware of the process how to lodge a complaint (e.g. poster explaining the procedure is posted on the walls of the clinic or pamphlets are available).				
45.	I have had the opportunity to participate in a patient satisfaction survey.				
46.	Systems are in place to ensure my safety (e.g. security guards, closed circuit television, or alarm system).				
47.	Infection control measures are practised by the staff (e.g. safe handling of needles, masks, hand wash facilities, open windows, and coughing patients are separated from other patients).				
48.	The clinic is clean (e.g. the entrance, waiting areas, consultation rooms, and toilets).				
49.	Health promotion or disease prevention events are organised in the community (e.g. door-to-door campaigns or in the multi-purpose community halls, crèches, and schools).				
50.	Patient support groups are organised at the clinic or in the community (e.g. for patients with TB, HIV, and chronic diseases).				
51.	The community-based service team visits my family at home between clinic appointments (e.g. health promotion and prevention, detection of disease, treatment support, and rehabilitation).				
52.	Community communication events are organised by the Department of Health to inform the community about health system aspects (e.g. how to utilise the Primary Health Care services and explanation of the appointment system).				
53.	Goals, values, future plans, and focus areas of the Western Cape Department of Health are visible in the clinic (e.g. posters are posted on the walls of the clinic).				

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54.	The role and function of the clinic committee is visible in the clinic (e.g. poster).				
55.	The clinic has enough space for the number of patients (e.g. waiting areas, consultation rooms).				
56.	Maintenance of the building is up-to-date (e.g. no broken windows, leaking ceilings, faulty air conditioners, and out of order toilets).				
57.	The physical appearance of the clinic has a positive effect on my morale (e.g. feeling psychologically better).				
58.	The grounds outside the clinic are maintained (e.g. clean and neat).				
59.	An evacuation plan is visible (e.g. showing the evacuation procedure should there be an emergency).				

B. PATIENT SPECIFIC QUESTIONS

60.	I feel welcome at the clinic.				
61.	Staff members act as role models (e.g. they inspire and motivate me).				
62.	I receive personalised health care (e.g. individualised care, respected my rights and building a trusting relationship).				
63.	I understand more about my health after my clinic visit.				
64.	My basic health needs are met.				
65.	I will recommend the service to my family or friends.				
66.	Health care service is free (e.g. no out of pocket payments for transport or anything else).				

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C. ABOUT YOU

67. What is your gender?

Female 1 Male 2

68. What is your race?

African	1
Coloured	2
White	3
Asian	4
Other	5

69. What is your age?

18-29	1
30-39	2
40-49	3
50-59	4
60-69	5
70-79	6
80+	7

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70. What is your educational level?

None	1
Finished Grade 7 (Standard 5)	2
Finished Grade 10 (Standard 8)	3
Finished Grade 12 (Standard 10)	4
Finished Degree or Diploma	5

71. Indicate your employment status

Employed	1
Unemployed	2

72. What is the distance from your home to the clinic?

Less than 5 km (e.g. within walking distance)	1
More than 5 km (not within walking distance)	2

73. How do you get to the clinic?

walk	1
taxi	2
own vehicle	3

74. Indicate your average number of clinic visits in the past 12 months.

1-3	1
4-6	2
7-9	3
10+	4

75. Indicate your average number of traditional healer visits in the past 12 months.

None	1
1-3	2
4+	3

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76. Indicate the average number of private doctor visits during the past 12 months.

None	1
1-4	2
5+	3

77. What is the reason for your visit today?

………

………

………

………

………

Thank you

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Annexure F: Instrument – Clinical nurse practitioners

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville, 7535, South Africa

Tel: +27 21 959 2274, Fax: +27 21 959 2271

There are no right or wrong answers to the statements in this questionnaire.

Indicate your response to each question by placing a cross (X) in the appropriate box.

Use the following scale: 1 = Never; 2 = Sometimes; 3 = Frequently; 4 = Always.

The information in this form will be treated confidentially.

Do not write your name anywhere on this form.

D. GENERAL QUESTIONS

Scale: 1 = Never; 2 = Sometimes; 3 = Frequently; 4 = Always	1	2	3	4
78. Signage boards with information about the clinic is visible (e.g. available services, times when the various services are offered and clear directions to the various service areas in the clinic).				
79. Clerks at reception are helpful (e.g. assisting and supporting patients where needed).				
80. Patient folders are retrieved timely at reception (e.g. there is no delay in finding a patient's folder).				
81. Patients are addressed in a language they understand.				
82. Staff members wear name tags to show their names and staff categories.				
83. An organogram with the names and pictures of all the staff members and their post descriptions is visible in the clinic.				
84. Staff members treat patients with respect (e.g. polite, caring, tolerant, and empathetic).				
85. Patients can schedule appointments according to their needs or preferences.				
86. Patients have the opportunity to choose a staff member they prefer for health service delivery.				

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Scale: 1 = Never; 2 = Sometimes; 3 = Frequently; 4 = Always	1	2	3	4
87. All patients are treated in the scheduled clinic time (e.g. no patients are turned away or no quota system is followed).				
88. Patients are triaged to ensure that those with urgent health problems receive immediate attention.				
89. Waiting times are monitored to prevent long waiting periods (e.g. dedicated staff or queue marshals).				
90. Patients are kept informed about how long they would have to wait before someone sees them.				
91. Waiting times are acceptable for patients (e.g. as indicated by the number of oral or written complaints received).				
92. Patients are kept busy while they have to wait (e.g. watch videos or listen to health talks).				
93. Drinking water and disposable cups are available for patients in the waiting area (e.g. clean or distilled water)				
94. An integrated approach is used to treat a patient holistically during one visit (e.g. care is provided without allocating specific days for specific services).				
95. Adequate time is spent with a patient (e.g. to discuss and explain the diagnosis and treatment plan, listen to the patient's concerns and allowing time for questions).				
96. The results of the diagnostic tests are explained to patients in an understandable manner (e.g. according to the literacy level of the patient).				
97. Patients are asked to explain back to staff, in order to evaluate whether they understood what was explained.				
98. Medicines are in stock and available when needed.				
99. Reasons for taking medication are explained to patients.				
100. Patients are encouraged to report any medication side-effects.				
101. Literature about the relevant health problem or medication is provided to patients (e.g. a pamphlet or pictorial material).				

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Scale: 1 = Never; 2 = Sometimes; 3 = Frequently; 4 = Always	1	2	3	4
102. Advice on how to improve wellness is provided (e.g. about diet, exercises, smoking, drinking, drugs, and emotional wellbeing).				
103. Patients have access to assistive devices when needed (e.g. crutches, walking aids, wheel chairs, spectacles, and dentures).				
104. Referral appointments are available within two weeks when needed (e.g. councillors, doctors, specialists, and allied health workers).				
105. A referral letter is accompanying the patient to the referred service.				
106. Patients have access to transport when needed (e.g. to the nearest hospital or referral service).				
107. Patients are encouraged to ask questions.				
108. Patients are advised to return when needed (e.g. follow-up date or earlier should their condition not improve).				
109. The necessary equipment is available as required for service delivery.				
110. Maintenance of medical equipment is done as per policy guidelines (e.g. is in a working condition).				
111. Consumables or supplies are in stock and available (e.g. needles, syringes, bandages, and plasters).				
112. Staff has access to computerised technology (e.g. computers, printers, e-mail, and Internet).				
113. Privacy of patients are respected during consultation or treatment (e.g. closed doors, screens, or curtains).				
114. Personal information of patients are kept confidential.				
115. Patients are involved in decisions about their health care.				
116. Family or friends, as appropriate are involved in a patient's health care, should it be necessary(e.g. for care planning, training or having a voice on care decisions)				
117. Patients are made aware about the "Patient Rights Charter" (e.g. poster or pamphlets).				

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Scale: 1 = Never; 2 = Sometimes; 3 = Frequently; 4 = Always	1	2	3	4
118. Staffing levels are conducive for quality service delivery (e.g. doctors, nursing staff, pharmacist, pharmacy assistants, and administrative staff).				
119. The clinic is accessible to patients with disabilities or the aged (e.g. wide enough door entrances, ramps, and rails).				
120. Patients are encouraged to report any adverse event t (e.g. any negative effect related to care).				
121. Patients are informed of the process how they can lodge a complaint (e.g. procedure is posted on the wall of the clinic or pamphlets are available).				
122. Patients have the opportunity annually to participate in a patient satisfaction survey.				
123. Security services are available (e.g. security guards, closed circuit television, or alarm system).				
124. Infection control measures are practised by the staff (e.g. safety principles regarding the handling of sharps, masks, hand washing facilities, open windows, extractor fans, and coughing patients are separated from other patients).				
125. The clinic is clean (e.g. the entrance, waiting areas, consultation rooms, toilets).				
126. Health promotion or disease prevention events are organised in the community (e.g. door-to-door campaigns or in the multi-purpose halls, crèches, schools).				
127. Patient support groups are organised at the clinic or in the community (e.g. for TB, HIV, and chronic diseases).				
128. Community-based service teams visit families at home between clinic appointments (e.g. health promotion and prevention, detection of disease, treatment support, and rehabilitation).				
129. Community communication events are organised by the Department of Health (e.g. to provide information about health systems aspects, e.g. the implementation of an appointment system or how to utilise Primary Health Care services).				

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Scale: 1 = Never; 2 = Sometimes; 3 = Frequently; 4 = Always	1	2	3	4
130. The strategy of the Western Cape Department of Health is visible in the clinic (e.g. posters or pamphlets identifying the future plans, goals, values, focus areas).				
131. Patients are made aware about the activities of the clinic committee (e.g. a poster identifying the role and function of the clinic committee is visible in the clinic).				
132. The clinic has adequate space available for the number of patients (e.g. waiting areas, consultation rooms).				
133. Maintenance of the infrastructure is up to date (e.g. no broken windows, leaking ceilings, faulty air conditioners, mechanical ventilation systems and out of order toilets).				
134. The physical appearance of the clinic has a positive effect on the staff morale.				
135. The grounds outside the clinic are maintained (e.g. clean and neat).				
136. An emergency evacuation plan is visible (e.g. showing the evacuation procedure should there be an emergency).				

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E. CLINICAL NURSE PRACTITIONER SPECIFIC QUESTIONS

137. Medical waste is managed in a safe way (e.g. safely handled, stored, and disposed).				
138. Staff members deliver quality care to patients.				
139. Staff members are focused to provide a patient-centred care service (e.g. treating patients as individuals, respecting their rights, building mutual trust and developing therapeutic relations).				
140. My work situation gives me a feeling of personal accomplishment.				
141. I am provided with the relevant clinical guidelines or policies to provide quality care.				
142. I attend meetings about mortality and morbidity.				
143. I attend training courses (e.g. infection control and quality improvement).				

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Scale: 1 = Never; 2 = Sometimes; 3 = Frequently; 4 = Always	1	2	3	4
144. The employee assistance programme enables me to cope with the daily demands of the working milieu (e.g. debriefing and staff motivation sessions).				
145. Supervisory support or guidance is available to me.				
146. The clinic manager has the capacity to function as operational manager and clinical nurse practitioner.				
147. The current staff appraisal system helps me to improve my work performance.				

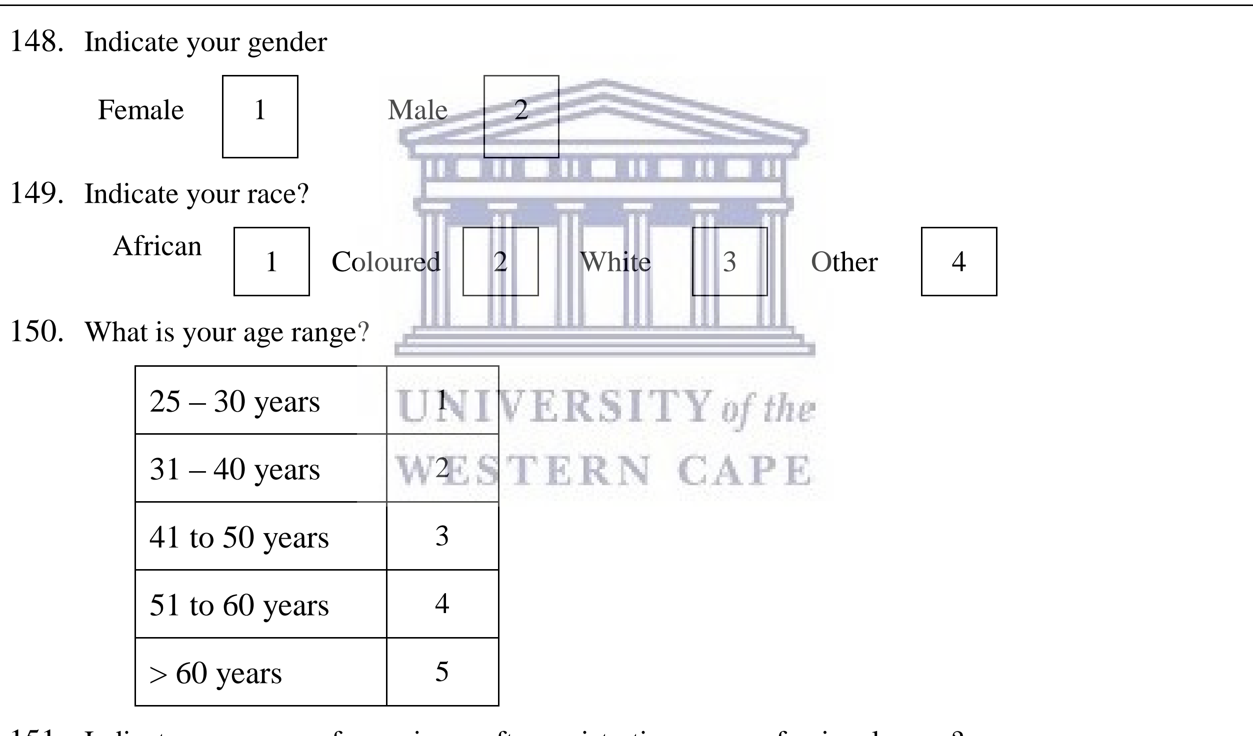
F. ABOUT YOU:

148. Indicate your gender

Female	1	Male	2

149. Indicate your race?

African	1	Coloured	2	White	3	Other	4



150. What is your age range?

Age range	Code
25 – 30 years	1
31 – 40 years	2
41 to 50 years	3
51 to 60 years	4
> 60 years	5

151. Indicate your years of experience after registration as a professional nurse?

Experience	Code
Less than 5 years	1
6 – 10 years	2
11 – 15 years	3
16 – 20 years	4
> 20 years	5

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152. Indicate your qualifications

Community health	1
Midwifery	2
Psychiatry	3
Primary Health Care (R48)	4

153. Indicate your years of employment at this clinic

Less than 5 years	1
5 to 10 years	2
11 to 15 years	3
More than 15 years	4

Thank you!

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Annexure: G: Content validity item index (I-CVI) clients (as received from the 4 members of the public)

I-CVI													
									Best questions				
Item	Expert 1 (E 1)	Clarity	Expert 2 (E 2)	Clarity	Expert 3 (E 3)	Clarity	Expert 4 (E 4)	Clarity	E 1	E 2	E 3	E 4	Total I I-CVI
Subscale 1													
1	4	Y	4	Y	4	Y	4	Y					1.00
2	4	Y	4	Y	4	Y	4	Y					1.00
3	4	Y	4	Y	4	Y	3	Y					1.00
4	4	Y	4	Y	4	Y	4	Y					1.00
5	4	Y	3	Y	4	Y	4	Y					1.00
6	3	Y	3	Y	4	Y	4	Y					1.00
7	4	Y	4	Y	4	Y	4	Y					1.00
8	4	Y	4	Y	4	Y	4	Y					1.00
9	4	Y	4	Y	2	N	4	Y					0.75
10	4	Y	4	Y	4	Y	4	Y					1.00
11	4	Y	3	Y	4	Y	4	Y					1.00
12	4	Y	4	Y	3	Y	4	Y					1.00
13	4	Y	4	Y	3	Y	4	Y					1.00
14	4	Y	4	Y	4	Y	4	Y					1.00
15	3	Y	4	Y	4	Y	4	Y					1.00
16	4	Y	4	Y	4	Y	4	Y					1.00
17	4	Y	4	Y	4	Y	4	Y					1.00
18	4	Y	4	Y	4	Y	4	Y					1.00
19	4	Y	4	Y	4	Y	4	Y					1.00
20	4	Y	4	Y	4	Y	4	Y					1.00
21	4	Y	4	Y	4	Y	4	Y					1.00
22	4	Y	4	Y	4	Y	4	Y					1.00
23	4	Y	4	Y	4	Y	3	Y					1.00
24	4	Y	4	Y	4	Y	4	Y					1.00
25	4	Y	4	Y	4	Y	4	Y					1.00
26	4	Y	4	Y	3	Y	4	Y					1.00
27	4	Y	4	Y	4	Y	4	Y					1.00
28	4	Y	4	Y	3	Y	4	Y					1.00
29	4	Y	4	Y	3	Y	4	Y					1.00
30	4	Y	4	Y	4	Y	4	Y					1.00
31	4	Y	4	Y	4	Y	4	Y					1.00
32	4	Y	4	Y	4	Y	4	Y					1.00
33	3	Y	4	Y	4	Y	4	Y					1.00
34	4	Y	4	Y	2	N	4	Y					0.75
35	4	Y	4	Y	4	Y	4	Y					1.00
36	4	Y	4	Y	4	Y	4	Y					1.00
37	4	Y	4	Y	4	Y	4	Y					1.00
38	3	Y	4	Y	4	Y	4	Y					1.00
39	4	Y	4	Y	4	Y	4	Y					1.00
40	3	Y	4	Y	4	Y	4	Y					1.00
41	3	Y	4	Y	4	Y	4	Y					1.00
42	4	Y	4	Y	4	Y	4	Y					1.00
43	4	Y	4	Y	4	Y	4	Y					1.00
44	4	Y	4	Y	2	N	4	Y					0.75
45	4	Y	4	Y	4	Y	4	Y					1.00
46	4	Y	4	Y	4	Y	4	Y					1.00

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47	4	Y	4	Y	4	Y	4	Y					1.00
48	4	Y	4	Y	4	Y	4	Y					1.00
49	4	Y	4	Y	4	Y	4	Y					1.00
50	4	Y	4	Y	4	Y	4	Y					1.00
51	4	Y	4	Y	4	Y	4	Y					1.00
52	4	Y	4	Y	4	Y	4	Y					1.00
53	4	Y	4	Y	4	Y	4	Y					1.00
54	4	Y	4	Y	4	Y	4	Y					1.00
55	4	Y	4	Y	4	Y	4	Y					1.00
56	4	Y	4	Y	4	Y	4	Y					1.00
57	4	Y	4	Y	4	Y	4	Y					1.00
58	4	Y	4	Y	4	Y	4	Y					1.00
Subscale 2													
59	4	Y	4	Y	4	Y	4	Y					1.00
60	4	Y	4	Y	4	Y	4	Y					1.00
61	4	Y	4	Y	4	Y	4	Y					1.00
62	4	Y	4	Y	4	Y	4	Y					1.00
63	4	Y	4	Y	4	Y	4	Y					1.00
64	4	Y	4	Y	4	Y	4	Y					1.00
65	4	Y	4	Y	4	Y	4	Y					1.00
66	4	Y	4	Y	4	Y	4	Y					1.00
67	4	Y	4	Y	4	Y	4	Y					1.00
68	4	Y	4	Y	4	Y	4	Y					1.00
69	4	Y	4	Y	4	Y	4	Y					1.00
Subscale 3													
70	4	Y	4	Y	4	Y	4	Y					1.00
71	4	Y	4	Y	4	Y	4	Y					1.00
72	4	Y	4	Y	4	Y	4	Y					1.00
73	4	Y	4	Y	4	Y	4	Y					1.00
74	4	Y	4	Y	4	Y	4	Y					1.00
75	4	Y	4	Y	4	Y	4	Y					1.00
76		Y		Y		Y		Y					

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Table 4.4: Content validity scale index (S-CVI)

S-CVI						
Item	Expert 1	Expert 2	Expert 3	Expert 4	Number in agreement	I-CVI
Subscale 1						
1	X	X	X	X	4	
2	X	X	X	X	4	
3	X	X	X	X	4	
4	X	X	X	X	4	
5	X	X	X	X	4	
6	X	X	X	X	4	
7	X	X	X	X	4	
8	X	X	X	X	4	
9	X	X		X	3	0.75
10	X	X	X	X	4	
11	X	X	X	X	4	
12	X	X	X	X	4	
13	X	X	X	X	4	
14	X	X	X	X	4	
15	X	X	X	X	4	
16	X	X	X	X	4	
17	X	X	X	X	4	
18	X	X	X	X	4	
19	X	X	X	X	4	
20	X	X	X	X	4	
21	X	X	X	X	4	
22	X	X	X	X	4	
23	X	X	X	X	4	
24	X	X	X	X	4	
25	X	X	X	X	4	
26	X	X	X	X	4	
27	X	X	X	X	4	
28	X	X	X	X	4	
29	X	X	X	X	4	
30	X	X	X	X	4	
31	X	X	X	X	4	
32	X	X	X	X	4	
33	X	X	X	X	4	
34	X	X		X	3	0.75
35	X	X	X	X	4	
36	X	X	X	X	4	
37	X	X	X	X	4	
38	X	X	X	X	4	
39	X	X	X	X	4	
40	X	X	X	X	4	
41	X	X	X	X	4	
42	X	X	X	X	4	
43	X	X	X	X	4	
44	X	X		X	3	0.75
45	X	X	X	X	4	
46	X	X	X	X	4	
47	X	X	X	X	4	
48	X	X	X	X	4	
49	X	X	X	X	4	

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50	X	X	X	X	4	
51	X	X	X	X	4	
52	X	X	X	X	4	
53	X	X	X	X	4	
54	X	X	X	X	4	
55	X	X	X	X	4	
56	X	X	X	X	4	
57	X	X	X	X	4	
58	X	X	X	X	4	
Subscale 2						
59	X	X	X	X	4	
60	X	X	X	X	4	
61	X	X	X	X	4	
62	X	X	X	X	4	
63	X	X	X	X	4	
64	X	X	X	X	4	
65	X	X	X	X	4	
Subscale 3						
66	X	X	X	X	4	
67	X	X	X	X	4	
68	X	X	X	X	4	
69	X	X	X	X	4	
70	X	X	X	X	4	
71	X	X	X	X	4	
72	X	X	X	X	4	
73	X	X	X	X	4	
74	X	X	X	X	4	
75	X	X	X	X	4	
76	X	X	X	X	4	
TOTAL: 0.99						

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Annexure: H: Content validity item index (I-CVI) clients (feedback from experts at university)

I-CVI														
									Best questions					
Item	Expert 1 (E 1)	Clarity	Expert 2 (E 2)	Clarity	Expert 3 (E 3)	Clarity	Expert 4 (E 4)	Clarity	E 1	E 2	E 3	E 4	Total I I-CVI
Subscale 1													
1	4	Y	4	Y	4	Y	4	Y					1.00
2	4	Y			4	Y							0.50
3	4	Y	4	Y	4	Y	4	Y					1.00
4	4	Y	4	Y	4	Y	4	Y					1.00
5	4	Y	4	Y	4	Y	4	Y					1.00
6	4	Y			4	Y	4	Y					0.75
7	4	Y	4	Y	4	Y	4	Y					1.00
8	4	Y	4	Y	4	Y	4	Y					1.00
9	4	Y	4	Y	4	Y		Y					0.75
10	4	Y	4	Y	4	Y	4	Y					1.00
11	3	N			3	Y		Y					0.50
12	4	Y	4	Y	4	Y		Y					0.75
13	4	Y	4	Y	4	Y	4	Y					1.00
14	4	Y	4	Y	4	Y		Y					0.75
15	4	Y	4	Y	4	Y	3	N					1.00
16	4	Y			4	Y	4	Y					0.75
17	4	Y	4	Y	4	Y	4	Y					1.00
18	4	Y			4	Y	3	Y					0.75
19	4	Y	4	Y	4	Y	4	Y					1.00
20	4	Y	4	Y	4	Y	4	Y					1.00
21	4	Y	4	Y	4	Y	4	Y					1.00
22	4	Y	4	Y	4	Y	4	Y					1.00
23	4	Y	4	Y	4	Y	3	N					1.00
24	4	Y	4	Y	4	Y	3	Y					1.00
25	4	Y	4	Y	4	Y	3	Y					1.00
26	4	Y	4	Y	4	Y	3	Y					1.00
27	4	Y	4	Y	4	Y	3	Y					1.00
28	4	Y	4	Y	4	Y	3	Y					1.00
29	4	Y	4	Y	4	Y	4	Y					1.00
30	4	Y	4	Y	4	Y	4	Y					1.00
31	3	N	4	Y	4	Y	4	Y					1.00
32	4	Y	4	Y	4	Y	4	Y					1.00
33	4	Y	4	Y	4	Y	4	Y					1.00
34	4	Y	4	Y	4	Y	3	Y					1.00
35	4	Y	4	Y	4	Y	4	Y					1.00
36	4	Y	4	Y	4	Y	4	Y					1.00
37	4	Y	4	Y	4	Y	4	Y					1.00
38	3	N	4	Y	4	Y	4	Y					1.00
39	4	Y	4	Y	4	Y	3	Y					1.00
40	4	Y	4	Y	4	Y	4	Y					1.00
41	4	Y	4	Y	4	Y	4	Y					1.00
42	4	Y	4	Y	4	Y	4	Y					1.00
43	3	N	4	Y	4	Y	4	Y					1.00
44	4	Y			4	Y	4	Y					0.75
45	4	Y	4	Y	4	Y	4	Y					1.00
46	4	Y	4	Y	4	Y	4	Y					1.00

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47	4	Y	4	Y	4	Y	4	Y					1.00
48	4	Y	4	Y	4	Y	4	Y					1.00
49	4	Y	4	Y	4	Y	4	Y					1.00
50	4	Y	4	Y	4	Y	4	Y					1.00
51	4	Y	4	Y	4	Y	4	Y					1.00
52	4	Y	4	Y	4	Y	4	Y					1.00
53	4	Y	4	Y	4	Y	3	Y					1.00
54	4	Y	4	Y	4	Y	4	Y					1.00
55	4	Y	4	Y	4	Y	4	Y					1.00
56	4	Y	4	Y	4	Y	4	Y					1.00
57	4	Y	4	Y	4	Y	4	Y					1.00
58	4	Y	4	Y	4	Y	4	Y					1.00
Subscale 2													
59	4	Y	4	Y	4	Y	4	Y					1.00
60	4	Y	4	Y	4	Y	4	Y					1.00
61	4	Y	4	Y	4	Y	4	Y					1.00
62	4	Y	4	Y	4	Y	4	Y					1.00
63	4	Y	4	Y	3	Y	4	Y					1.00
64	4	Y	4	Y	4	Y	4	Y					1.00
65	4	Y	4	Y	4	Y	4	Y					1.00
66	4	Y	4	Y	4	Y	4	Y					1.00
67	3	N	4	Y	4	Y	4	Y					1.00
68	4	Y	4	Y	4	Y	4	Y					1.00
69	4	Y	4	Y	4	Y	4	Y					1.00
Subscale 3													
70	3	N	4	Y	4	Y	4	Y					1.00
71	4	Y	4	Y	4	Y	4	Y					1.00
72	4	Y	4	Y	4	Y	4	Y					1.00
73	3	N	4	Y	4	Y	4	Y					1.00
74	4	Y	4	Y	4	Y	4	Y					1.00
75	4	Y	4	Y	4	Y	4	Y					1.00
76		Y		Y		Y		Y					

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Content validity scale index (S-CVI)

S-CVI						
Item	**Expert 1**	**Expert 2**	**Expert 3**	**Expert 4**	**Number in agreement**	**I-CVI**
Subscale 1						
1	X	X	X	X	4	
2	X	X	X		2	0.50
3	X	X	X	X	4	
4	X	X	X	X	4	
5	X	X	X	X	4	
6	X		X	X	3	0.75
7	X	X	X	X	4	
8	X	X	X	X	4	
9	X	X		X	3	0.75
10	X	X	X	X	4	
11	X		X		3	0.50
12	X	X	X		3	0.75
13	X	X	X	X	4	
14	X	X	X		3	0.75

15	X	X	X	X	4	
16	X		X	X	3	0.75
17	X	X	X	X	4	
18	X		X	X	3	0.75
19	X	X	X	X	4	
20	X	X	X	X	4	
21	X	X	X	X	4	
22	X	X	X	X	4	
23	X	X	X	X	4	
24	X	X	X	X	4	
25	X	X	X	X	4	
26	X	X	X	X	4	
27	X	X	X	X	4	
28	X	X	X	X	4	
29	X	X	X	X	4	
30	X	X	X	X	4	
31	X	X	X	X	4	
32	X	X	X	X	4	
33	X	X	X	X	4	
34	X	X	X	X	4	
35	X	X	X	X	4	
36	X	X	X	X	4	
37	X	X	X	X	4	
38	X	X	X	X	4	
39	X	X	X	X	4	
40	X	X	X	X	4	
41	X	X	X	X	4	
42	X	X	X	X	4	
43	X	X	X	X	4	
44	X		X	X	3	0.75
45	X	X	X	X	4	
46	X	X	X	X	4	
47	X	X	X	X	4	
48	X	X	X	X	4	
49	X	X	X	X	4	
50	X	X	X	X	4	
51	X	X	X	X	4	
52	X	X	X	X	4	
53	X	X	X	X	4	
54	X	X	X	X	4	
55	X	X	X	X	4	
56	X	X	X	X	4	
57	X	X	X	X	4	
58	X	X	X	X	4	

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Subscale 2						
59	X	X	X	X	4	
60	X	X	X	X	4	
61	X	X	X	X	4	
62	X	X	X	X	4	
63	X	X	X	X	4	
64	X	X	X	X	4	
65	X	X	X	X	4	
Subscale 3						
66	X	X	X	X	4	
67	X	X	X	X	4	
68	X	X	X	X	4	
69	X	X	X	X	4	
70	X	X	X	X	4	
71	X	X	X	X	4	
72	X	X	X	X	4	
73	X	X	X	X	4	
74	X	X	X	X	4	
75	X	X	X	X	4	
76	X	X	X	X	4	
			TOTAL:	0.88		

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Annexure: I: Content validity item index (I-CVI) clinical nurse practitioners (experts from university feedback)

Item	Expert 1 (E 1)	Clarity	Expert 2 (E 2)	Clarity	Expert 3 (E 3)	Clarity	Expert 4 (E 4)	Clarity	E 1	E 2	E 3	E 4	Total I-CVI
I-CVI													
									Best questions				
Subscale 1													
1	4	Y	4	Y	4	Y	3	Y					1.00
2	4	Y		N	4	Y	4	Y					0.75
3	4	Y	3	N	4	Y	4	Y					1.00
4	4	Y	4	Y	4	Y	4	Y					1.00
5	4	Y	4	Y	4	Y	4	Y					1.00
6	4	Y	3	Y	4	Y	4	Y					1.00
7	4	Y	4	Y	4	Y		Y					0.75
8	4	Y	4	Y	4	Y	3	Y					1.00
9	4	Y	3	N	4	Y							0.75
10	4	Y	3	N	4	Y	4	Y					1.00
11	4	Y	4	Y	4	Y	4	Y					1.00
12	4	Y	4	Y	4	Y	4	Y					1.00
13	4	Y	4	Y	4	Y	4	Y					1.00
14	4	Y	3	N	4	Y							0.75
15	4	Y	4	Y	4	Y	3	Y					1.00
16	4	Y	3	N	4	Y	4	Y					1.00
17	4	Y	3	N	4	Y	4	Y					1.00
18	4	Y	3	N	4	Y	3	Y					1.00
19	4	Y	4	Y	4	Y	4	Y					1.00
20	4	Y	4	Y	4	Y	4	Y					1.00
21	4	Y	4	Y	4	Y	4	Y					1.00
22	3	N	4	Y	4	Y	4	Y					1.00
23	4	Y	4	Y	4	Y	3	Y					1.00
24	4	Y	3	N	4	Y	3	Y					1.00
25	4	Y	3	N	4	Y	3	Y					1.00
26	4	Y	3	N	4	Y	3	Y					1.00
27	4	Y	4	Y	4	Y	3	Y					1.00
28	4	Y	4	Y	4	Y	3	Y					1.00
29	4	Y	4	Y	4	Y	4	Y					1.00
30	4	Y	4	Y	4	Y	4	Y					1.00
31	3	N	4	Y	4	Y	4	Y					1.00
32	4	Y	3	N	4	Y	4	Y					1.00
33	3	Y	4	Y	4	Y	4	Y					1.00
34	3	N	4	Y	4	Y	3	Y					1.00
35	4	Y	4	Y	4	Y	4	Y					1.00
36	4	Y	4	Y	4	Y	4	Y					1.00
37	4	Y	4	Y	4	Y	4	Y					1.00
38	4	Y	3	N	4	Y		Y					0.75
39	3	N	4	Y	4	Y	3	Y					1.00
40	4	Y	4	Y	4	Y	4	Y					1.00
41	4	Y	4	Y	4	Y	4	Y					1.00
42	4	Y		N	4	Y	4	Y					0.75
43	4	Y	4	Y	4	Y	4	Y					1.00
44	4	Y	4	Y	4	N	4	Y					1.00
45	4	Y	4	Y	4	Y	4	Y					1.00
46	4	Y	3	N	4	Y	4	Y					1.00

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47	4	Y	4	Y	4	Y	4	Y					1.00
48	4	Y	4	Y	4	Y	4	Y					1.00
49	4	Y	4	Y	4	Y	4	Y					1.00
50	4	Y	4	Y	4	Y	4	Y					1.00
51	4	Y	3	N	4	Y		Y					0.75
52	4	Y	4	Y	4	Y	3	Y					1.00
53	4	Y	3	N	4	Y		Y					0.75
54	4	Y	4	Y	4	Y	4	Y					1.00
55	4	Y	3	N	4	Y	4	Y					1.00
56	4	Y	4	Y	4	Y	4	Y					1.00
57	4	Y	4	Y	4	Y	4	Y					1.00
58	4	Y	4	Y	4	Y	4	Y					1.00
Subscale 2													
59	4	Y	4	N	4	Y	4	Y					1.00
60	4	Y		N	3	Y	4	Y					0.75
61	4	Y	3	N	3	Y	4	Y					1.00
62	4	Y	4	Y	4	Y	4	Y					1.00
63	4	Y	4	Y	4	Y	4	Y					1.00
64	4	Y	4	Y	4	Y	4	Y					1.00
65	4	Y	4	Y	4	Y	4	Y					1.00
66	4	Y	4	Y	4	Y	4	Y					1.00
67	4	Y	4	Y	4	Y	4	Y					1.00
68	4	Y	4	Y	4	Y	4	Y					1.00
69	4	Y	4	Y	4	Y	4	Y					1.00
Subscale 3													
70	4	Y	4	Y	4	Y	4	Y					1.00
71	4	Y	4	Y	4	Y	4	Y					1.00
72	4	Y	4	Y	4	Y	4	Y					1.00
73	4	Y	4	Y	4	Y	4	Y					1.00
74	4	Y	4	Y	4	Y	4	Y					1.00
75	4	Y	4	Y	4	Y	4	Y					1.00
76		Y		Y		Y		Y					

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Content validity scale index (S-CVI)

S-CVI						
Item	**Expert 1**	**Expert 2**	**Expert 3**	**Expert 4**	**Number in agreement**	**I-CVI**
Subscale 1						
1	X	X	X	X	4	
2	X		X	X	3	0.75
3	X	X	X	X	4	
4	X	X	X	X	4	
5	X	X	X	X	4	
6	X	X	X	X	4	
7	X	X	X			0.75
8	X	X	X	X	4	
9	X	X	X		3	0.75
10	X	X	X	X	4	
11	X	X	X	X	4	
12	X	X	X	X	4	
13	X	X	X	X	4	
14	X	X	X		3	0.75
15	X	X	X	X	4	
16	X	X	X	X	4	
17	X	X	X	X	4	
18	X	X	X	X	4	
19	X	X	X	X	4	
20	X	X	X	X	4	
21	X	X	X	X	4	
22	X	X	X	X	4	
23	X	X	X	X	4	
24	X	X	X	X	4	
25	X	X	X	X	4	
26	X	X	X	X	4	
27	X	X	X	X	4	
28	X	X	X	X	4	
29	X	X	X	X	4	
30	X	X	X	X	4	
31	X	X	X	X	4	
32	X	X	X	X	4	
33	X	X	X	X	4	
34	X	X	X	X	4	
35	X	X	X	X	4	
36	X	X	X	X	4	
37	X	X	X	X	4	
38	X	X	X		3	0.75
39	X	X	X	X	4	
40	X	X	X	X	4	
41	X	X	X	X	4	
42	X	X	X		3	0.75
43	X	X	X	X	4	
44	X	X	X	X	4	
45	X	X	X	X	4	
46	X	X	X	X	4	
47	X	X	X	X	4	
48	X	X	X	X	4	
49	X	X	X	X	4	

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50	X	X	X	X	4	
51	X	X	X		3	0.75
52	X	X	X	X	4	
53	X	X	X		3	0.75
54	X	X	X	X	4	
55	X	X	X	X	4	
56	X	X	X	X	4	
57	X	X	X	X	4	
58	X	X	X	X	4	
Subscale 2						
59	X	X	X	X	4	
60	X	X	X		3	0.75
61	X	X	X	X	4	
62	X	X	X	X	4	
63	X	X	X	X	4	
64	X	X	X	X	4	
65	X	X	X	X	4	
Subscale 3						
66	X	X	X	X	4	
67	X	X	X	X	4	
68	X	X	X	X	4	
69	X	X	X	X	4	
70	X	X	X	X	4	
71	X	X	X	X	4	
72	X	X	X	X	4	
73	X	X	X	X	4	
74	X	X	X	X	4	
75	X	X	X	X	4	
76	X	X	X	X	4	
TOTAL: 0.88						

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Annexure J: Interview schedule: Management, including allied health professionals

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1. What is your perception on quality, client-centred care at the clinics?
2. What inputs are needed to enhance the quality, client-centred care to clients?
3. Which processes must be used to enhance the quality, client-centred delivered to clients?
4. What is your perception of the output of a quality, client-centred care delivered to clients?
5. How can a programme be described that will improve quality, client-centred care to clients?

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Annexure K: Written informed consent: Focus group

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FOCUS GROUP CONFIDENTIALITY BINDING FORM

Title of Research Project: A programme to facilitate the quality of client-centred care in rural primary health clinics.

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. I also agree not to disclose any information that was discussed during the group discussion.

Participant's name……………………………………….

Participant's signature………………………………….

I agree to be audio-taped during my participation in the study

Participant's name……………………………………….

Participant's signature………………………………….

I agree that field notes will be taken

Participant's name……………………………………….

Participant's signature………………………………….

Witness's name…………………………………………..

Witness's signature……………………………………….

Date………………………………

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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 coordinators:

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Annexure L: Matzikama focus group transcript

Transcript of Sound File DVT_A001_140429_0913

Facilitator: F

Researcher: R

Participants: P ?

F: And you may converse in you preferred language. Those who want to speak English, welcome. You who would like to speak Afrikaans, welcome.

[Paper shuffling. Background conversation. Laughter. Thumping in the background.]

F: Okay. Um… It is unspeakably pleasant for me to be here. Um… I visited [Name of town] years ago and I assisted um… many *ERB* [sic] students and at this point it is a pleasant experience to sit on the outside. I am not part of this study; therefore, you may speak openly. I requested [Researcher] to leave the room because I first wanted to ask you how honestly you will express your opinions in her presence?

[Background discussion.]

F: Would you? You are comfortable that she would not expose your contribution due to her position? Um… Anyway, you would not consent voluntarily to participate if you really don't feel like participating? I mean, you would feel obliged to participate on emotional grounds or due to the fact you are working at the same institution?

[Answer in the background.]

F: Not? Is it okay?

P ?: Yes.

P ?: How much time are we going to spend on this exercise?

F: We cannot carry on beyond eleven o'clock.

P ?: And is this a once-off exercise?

F: It is a once-off exercise. Unless you are of the opinion that there are a lot of things you would still like to express. And I think, under circumstances that would make a second meeting impossible, you should not hesitate to submit your thoughts in writing. It might be possible that you would like to take these questions, these issues

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that we are going to talk about, and to either add additional thoughts in writing or to express any thoughts that you were not comfortable expressing during the focus group. Then I would inform the researcher about that. But you are um… okay to talk in one another's company? About these issues?

[Affirmative background answers.]

F: Okay, I think we are making progress.

[Background discussion.]

F: I would just like to confirm everything the researcher told you about confidentiality and that the research results would be published, however, your names would not appear in any publication. I'm um… an old lady who is well versed in research. Therefore, I am very sensitive to the fact that no one should feel obliged to participate. You should feel comfortable to keep quiet if you wish not to say anything about this theme.

[Researcher], we are no longer talking about you. Okay. You may enter. Um… I also would like to… I overheard while you were introducing yourselves that you are working in different disciplines. Therefore, once we start the conversation, I would very much like everyone to express their opinions from their own perspective, you own context. After that, you are free to express your thoughts about additional issues that you might have observed in another context. Because a focus group aims at treating everyone – the doctor and the assistant nurse alike – the same, since it is not part of a performance appraisal. Also, it is not a regional meeting; it is a research group. Therefore, you are really at liberty to share whatever you want and to express your view about anything. Um… and the whole idea is [clears throat] that you should not be talking to me but to one another. There should be interaction; you may either agree or disagree with somebody else's point of view. In order to have a conversation, you are also welcome to elaborate on any point of view.

Um… I don't think there should be a feeling that um… the one has a bigger say and that's why I have found in focus groups before where people from different levels are present that one might feel it inappropriate to speak, since the manager has expressed his opinion already. So, this focus group has nothing to do with the work… it depends on what you seek to finally achieve because it is not um… it is not a job adjudication in the context of a group discussion. Otherwise, I… we… have a maximum of um… of… until eleven o'clock and we would like to look at four um… [mumbles]. We would like to discuss four themes. And the first um… something that we are

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wondering about in relation to this research project, if it deals… with um… Do you still have a piece of paper? Then we can write down some names.

[Background discussion and lots of laughter.]

P ?: This is [Name and Surname], he is the [jobdiscription].

F: Oh, a warm welcome! We dearly would like to hear about your opinion.

[Laughter.]

F: Very dearly. The [business process] is always in deep trouble. What else?

[Laughter and bantering.]

F: Okay. I said, let… let us try and grasp what your understanding is or what your perception is about quality client-centred service? And it's not an academic question. It is about the ideal that you would perhaps like to see… how should it be realised in your job? So, what does this word, this concept mean to you: Quality client-centred service? Um… and, yes. I um… I also have a keen interest in this. Um… in my business, I was actually a social worker and we often talked about… our customer service. What would we like to do that is client-centred? And if we firstly… because as I have said, you come from different perspectives. For instance, what does it mean to you [mumbles]? What does client-focused… service mean to you, [Name], from a [business process] perspective or the doctor, from his perspective? Or whatever. The nurse practitioner, whoever it is in our midst. So, how do you view this? Who would like tot start?

[Pause.]

F: Yes, do tell.

P ?: Um… [mumbles] often says I'm difficult in the community. Patient-centred focus usually is… I also have to be the patient. Yes, and sometimes I also feel that it is more about totals and statistics and we do not necessarily focus on the patient. Sometimes, we forget what it really is about. I think… I think, initially the patient had been the focus but later on it became statistics, statistics and then we loose the focus of [mumbles]. Somehow we have to return to the patient and… but… if I can make an example… can provide…

[Laughter.]

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P ?: …um… Clients who we come across in the community who… who… who do not… they are not necessarily aware of their condition. They do not know their diagnosis but we do hand out pamphlets. Pamphlets because we have to and out [mumbles]. We also had to see the patients. But one has patients who still do not know what's wrong with them and how they can restore their health. In that case, the whole idea of client-centred is totally mis… understood.

F: I hear you saying that if the service is client-centred, the client has the right to know his diagnosis and how the information in the pamphlet relates to my diagnosis. He should be informed properly and I should not provide quality by means of a mere piece of paper. He has the right to know about himself and and to understand the content of the pamphlet. Well, I would like to hear what… what are you thinking about what she says?

P ?: I… I agree… I agree with um… [Name]. I… I… If we only look at… facilities…

F: Yes?

P ?: …um… I feel that when the patient walks in we have to view him in his totality. Um… not only the sore knee but um… engage with the patient: "Do you know your HIV status? Is there perhaps somebody in your household who is on TB treatment?" Because there is such a TB hotspot in our area. Um… "When last did you do family planning? When last did you have a pap smear? Um… you know, slight… slightly more comprehensively but um… because we see such a large number of patients with a relatively small staff corps um… I think at the moment our circumstances are such that we process masses and we cannot always consider the patient in totality. There… therefore, I think if we were to – in my opinion – offer a more um… a better quality service, then we should start putting strategies into place that afford us the opportunity to create the space and to provide them with that quality service… not only processing the masses.

F: In a while, I would like you to return to this story of… of the facilities but for now, I understand that you are saying that a quality client-centred service means that I should see a client in his totality and to not only… only treat the symptom at that moment. Is that… or would you like to add something?

P ?: No, that's fine.

F: Um… somebody else who directly um…

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P ?: Yes. I think, when one returns to the… to the roots of it all… Then, it is basically – in my opinion – to… or to the client or the patient should be satisfied with the service that I have provided… And I should also be satisfied by the service I have provided, basically. Understand?

F: So, the quality service will realise once you see that the client is satisfied with what he had received form you and you feel that you had enough time to assist him properly. Right?

P ?: That's correct.

F: …or had the expertise to assist him?

P ?: I think um… when… when the client… patient… when… when he… the moment he enter – whether it is the hospital or the clinic – directly until the end that he collects is medication, he should have [mumbles]. Um… um, I mean during the entire thing… waiting times, as a matter of fact, plays a big role. Um… and I think sometimes it boils… it boils down to… to the shortage of staff because now that there are pharmacists and assistant pharmacists everywhere to… to… have the capacity to handle the clients… to… to assist…to assist them but then… then a nurse needs to step in or a… a sister needs to and um… and assists the patient themselves. Um… and on top of that, it usually takes a long time to see a patient as well.

F: Yes, it sort of sounds to me that you say when one… when one really… wants to respect the respectability of the client… the… the dignity of the client, then one needs to assist him from the moment he walks in until he leaves. And throughout he should feel that he gets treated with dignity, accept that he has received the correct treatment and… It feels to me that you would like to say something? Yes?

P ?: Like what he just said about the waiting times. That is where some of my staff members usually… I think it contributes greatly to patients using waiting times um… where [mumbles] encompasses it. And… and where we fall short is communication with the patients – especially time wise – is really not up to standard. I think it is… it is quite poor at most of the institutions. Um… perhaps people should try and focus on um… a few issues. The… the… the quality thereof… improve and provide to your patient because an informed patient is a more satisfied client and the moment that the patients…

F: …yes, you feel that in a quality-centred service there is time for communication with the patient?

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P ?: …very badly informed. Yes, yes.

F: [Name], what are you saying? How do you experience… what… what is your… let's assume in your head you have this concept that you can take with you and say I have a quality service… means to me… if you have to express it in a sentence or two. What would you say it is?

P ?: The client should be treated with respect from the time he enters the clinic. He should be observed in totality and should be treated accordingly. And um… should get the necessary information about his diagnosis, as well as the treatment he needs to receive. And um… the aftercare should also be explained to him and as a satisfied patient, he should get [mumbles].

F: Fine. Would anybody like to add to the main concepts that she is busy writing down? What you just heard – you don't have to look that way now – but what you had heard from the others. What can still be added by somebody? Because I'm highly interested in what the… what the HR members who are present… What – from your perspective and work situation – what do you think in your field – when you view it from that perspective – is quality-centred service? From your HR perspective?

P ?: What the clients… are basically – and when the staff members – when the members of staff in the final analysis are not happy, then they wouldn't really provide a quality service. And… and… and most of the time, that… those requirements are complemented by respect [sic]. And then you hand it… you hand it over to the personnel. Your personnel might be busy with… with a campaign and in many instances it interferes with what they are busy with because at a higher level it is said, this is the deadline and… and then… then we loose in many respects then… also the quality of the service. Where it could have been ninety per cent, then it is fifty.

F: Do you think that… that… that whatchamacallit… in other words, it is an aspect of… when you seek to deliver quality-centred service, your personnel should be relatively happy in order to deliver that service? The other aspect that I would like to ask you, do you think they are capable of delivering a quality service?

P ?: Yes.

[Background noise and discussion.]

F: I'm not talking about the people around this table…

P ?: No, I…

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F: …I'm talking about… about… about the… um… Do you want to tell me that whether they go there or not does not matter? The people who go out to the clinics and the hospitals should be in a position to and should feel that they are capable of doing what is expected of them?

P ?: Yes… yes. For instance, I do think that people are in… in a position… to… to um… do it. [Pause.] And the reason why I am saying that um… the department launches training programme[s] to… to ensure that every member of staff… the quality… or quality service… and then there is also ICASS [sic] for employee assistance programmes… pers… personnel who… more… about circumstances… like prices increase… the financial role.

F: Yes. Yes… where we are also involved. Yes, I… I have great respect for what you are saying because it seems to me that this region performs relatively well. But I dearly would like to know whether the other people agree with him because I… I am also aware that between the HR perception and the people in practice… is… often there are two perspectives. In an academic environment it is the same. So, yes…

[Laughter and group discussion.]

F: …but wait… You can't… hope you haven't… you should have signed that you are not going to put it in their files.

P ?: …yes, not putting it in their files

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[Laughter and group discussion.]

F: You are prohibited from… and you are prohibited from telling anybody in the corridors, "That woman said…"

[Laughter and group discussion.]

P ?: I would also just like to add that one cannot provide quality service when one does not have the equipment and sufficient stock. The correct stock.

F: Well yes, that's the way the cookie crumbles…

P ?: …and also… your personnel should also be qualified and competent for the task.

F: Do you… do you think that we… we get students who – how does one put it? – who, for example, who are incompetent to do that? We are deviating a little now from the… but I think… now that is what I am wondering about when… when it happens in an academic environment what one would…

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P ?: It might be similar but there are training programmes. Therefore, when you you identify the person as unfit to perform the task then they have to be sent for training.

F: Hmmm. All right… Well then, because it is… I would like to go back to what you have said earlier… would you like to add or do you agree with everything? Who would like… Would you like to add something?

P ?: I would like to say from a communication point of view um… the patient is critical [mumbles] because he expects the standard of service that is being provided. But then, the client expects certain skills from you. How… how… how does it become a good quality when your assistance is not there while the patient or the client particularly focuses on the existing gaps? They are aware that the assistance does not exist. They know exactly what it is and they keep on harping on it. Therefore, the woman who is there, it requires continual adjustment. And adjust in order to provide your service. Otherwise, afterwards he could say that has been good quality but at present, the patient is too focused on the service…

F: Hmmm… and…

P ?: …and for us it is very difficult. I… I think…

F: Hmmm… In other words, you feel that you are trying to provide a quality-centred service with the means at your disposal but… but the clients know what to expect and then they are not satisfied, or what? Is that what you are saying? Or not?

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P ?: Some of them… or the majority know everything about the service and what they can get out of it. Therefore, sometimes people probably just [mumbles] but at other instances, it is about basic things that we cannot provide. Then we have to make adjustments to take it to a level that would satisfy them. And afterwards you sort of know…

F: Hmmm…

P ?: …you could have done more… if you only had the resources.

F: [Name]?

[Giggling.]

F: You're not [Name].

P ?: Um… I think at… from my point of view it is about… or what I have observed over the years, communication to ultimately ensure the satisfaction of your patients. When

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that patient enters, you have to explain to him that it is um… public prices. This is what I can offer you. I can try to offer you a little more but then you have to… You know, you have to explain to the patient exactly what you can offer him and also what the private sector can provide him with.

F: Hmmm…

P ?: In the event of his arrival, firstly he knows about the doctor or the um… sister can assist me in this way but she would not be able to assist me any further. Therefore, he knows already. He could not expect that [a service]. He cannot expect that big [mumbles] but at least here we can communicate… communicate. Because you communicate that patient feels dignified. Not simply saying: "Sit. Where does it hurt? Okay, here's your packet of tablets. Off you go". You know, that is simply looking at that one specific problem of the patient.

P ?: I am inclined to support the principle. Um… um… Mentality of personnel as far as the state is concerned. Many… I don't want to…

F: Do tell.

P ?: I do not want to tread on toes and that type of thing but sometimes one feels that… that some members of staff say, "Ah, well. It's the state. People just have to wait. Anyway, they do not have a clue what is happening here".

P ?: I have to support [Name] um… about…

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P ?: Um… yes and then… Yes, communication. That… that the patients at least know where… why wait… why… why… what medication is he using because sometimes I feel that there is no competence of… of… of sisters because they do not have the knowledge about medication, amongst other things. That is why people do not know why… why… why do I have to take this tablet? Why?

F: They only receive the packet of tablets? At the clinic and…

P ?: Yes, they just ignore it and do not take their medication because they do not know what the medication is supposed to do. They do not know…

F: Hmmm. In other words, you are saying with them… en what um… what [Name] said and what you… what you said that… one has to [provide] a client quality service to the client within the context of what you are doing; it implies that you need communication to tell him what to do. This [medication] you take for that [condition].

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This is what I can provide you with; more than that I cannot do. Or do we have to tell the client, this is the ultimate?

P ?: Yes, but I also think that the… the personnel should personally take responsibility and… and say but – I mean – everybody in the health services – that's the way I feel – they should take an oath to declare, "I would do everything for my fellow human beings. Um…

F: His attitude… there should be an attitude?

P ?: Yes. There should be a positive attitude towards the patients for the patients to…

F: Okay. I get the message. You are saying that the attitude one would like to see in a professional care giver – who goes and works in the public service – need to go with dedication; the same as someone who is going to work in the private [sector]. You want the best for your clients. You should not say, I'm just working for the state and you are simply a number…

P ?: Yes, I do not get the income of the person who is getting something from me but – I mean – it remains a patient.

F: Okay.

P ?: It more or less goes…

F: Yes?

P ?: Sister, perhaps I can mention in this context, I do not think that the people are incompetent. Um… that is not what it is about. Time is extremely tight. Um… it's one nurse and one sister in the entire clinic and forty, fifty clients and patients are seated outside to whom she has to attend. Therefore, there is not always time or it might not be clear; you simply say this is your condition and this is what the medication does. Diet is only talked about in general. You have to take your tablets – the adherence – but there is not always time to have an in-depth discussion. I think that is where the problem lies.

F: In other words you are saying… you are saying a client… quality of client service suffers – with this overload – and if we want to provide a quality-centred service at all, we have to have more human resources?

P ?: Yes.

F: Okay.

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P ?: And feet.

P ?: And feet with a purpose.

[Laughter.]

F: Yes… [while laughing]. Feet to do that. Okay, in conjunction with that is my… the second theme that we want to discuss, what is needed – externally – in the organisational context for a quality-centred service? In other words, which inputs that we have little control over – from the bigger context of our work – is the organisation of the structure. What do we need? What structural stuff do I need in order to provide a quality-centred service? Do you understand what I'm asking?

[Laughter.]

F: Um… what should the organisation… what… um… I mean, like he said, there is an inner responsibility that I should get from within myself. Now we have to ask – we will talk about it again when are going to talk about the processes that we have to execute – but for now we would like to know, for such a service, which support services and facilities do I need from the organisation and the structure in order to provide that service? To provide a quality-centred service? And I think the best why to start talking about it is to think what do I actually need? What does not exist? What… what is the expectation? So, if one starts there, then one can say, okay. If this is in place, the service would run more smoothly. Are there any gaps like that?

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P ?: Firstly, the infrastructure should be there.

F: Tell us, what problem with the infrastructure?

P ?: Infrastructure means that there should be adequate space for um… clients to wait. There… there should be enough consulting rooms and that applies to the whole… the whole structure. The pharmacy should be in order. If… There should be enough storage space because otherwise everything is in a mess with the result that you keep looking for things and it delays your service… the work and there is no storage space.

F: So, infrastructure refers to physical infrastructure? Is… yes. Okay. Who else? Yes?

P ?: I have to agree there… um… often a lot of people see their patients simultaneously in the same room due to the shortage of consulting rooms and to top it all, that one room is not even a proper consulting room. Sometimes, we see patients in the library. And from my point of view, to see a patient under such circumstances I am not as effective as I would like to be. A proper consulting room with a plinth [sic], with equipment.

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F: Hmmm…

P ?: Now, look. At some clinics there are too few consulting rooms. It implies that she sees a patient. She sees a patient. I see a patient. She sees a patient. I see a patient. Like that…

F: You can't work simultaneously?

P ?: There is no space.

P ?: There is no space. Therefore, time… our time… is too short. So… um… I feel that I have to agree. If we only could… um…

F: I mean, space is a very important priority. Does everybody agree? How does it influence the services of the HIV clinics?

P ?: No, the administration does not really affect… where… where our problem lies, is with the TB programme because we do not necessarily have TB room that uh… does not have its own entrance and all the facilities. As a result, it is a problem to some of the patients that these patients have to physically move amongst them to fetch their medication. Um… so… so, yes. There is not really the same kind of problem with the HIV programme as… as… I think the layout of our… of our… of our clinics is not always, let's say, not that counselling-friendly. In some of our clinics, the… the… counselling room is literally situated in… in the centre of the… of the clinic. As a result, patients are able to see who enters and who exits, as well as how they appear when they exit the door. At some of the clinics, it sometimes put patients off to the extent that they are reluctant to test for HIV because um… sometimes they do know what the results would be and they… they also realise but when I exit through that door, when I remain in that room for too long, then they people are immediately going to put a board [label] around my neck. Um… and also in relation to our current ARV services, we have a separate ARV clinic inside another clinic. So, the people know that when one enters that door, one is going to see the ARV sister. In other words, that person has to be HIV-positive and there is…

F: In other words, the confidentiality of the… and the respect for the client… the confidentiality of the client… I have heard before there in the Eastern Cape that people… the carers told me that… um… there is no chance. They… they share… five of them shared one office. So…

P ?: Yes.

P ?: Yes.

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F: …I don't know, what do you think? What – apart from space – what other organisational structure, facilities would improve qualified client service?

P ?: May I… may I say something? Um… what is not… not necessarily space. But I think in our area what a gap according to me…is

F: Yes?

P ?: …is um… For instance, in Vredendal we have the Hoop [sic] Pharmacy and now a patient is sitting there and um… smoking reed [sic] that, for instance, um… who now… say for example now he needs an antidote for [mumbles] but the… the hospital is situated in Vredendal and we do not have like a courier service that commutes daily to deliver stock, to deliver medication and to… and to deliver everything… everything to the clinics. Sometimes, it can be somewhat of a crisis when people um… need medical stock from Vredendal [coughing] and we cannot get to the clinics. We have to [wait] for the next distribution to that place… And sometimes, it is possible that one waits for a couple of days and…

F: And someone might be critically ill?

P ?: Therefore… therefore, it is somewhat… We… we try and be creative about this [matter] to… to solve the problem but I think it really is a need in our area that we do not have [clears throat] an effective courier service and I understand where it comes from because if our finances that… there.. there are no finances for that. Therefore, we cannot… we cannot proceed by saying: "Oh, wait! Appoint the courier". So, one has no choice other that being creative about it but it surely causes a gap in our… in our exposure.

F: But um… I'm now wondering – from a financial aspect – what do you anticipate um… what are people asking for that cannot be supplied which um… is critical for a quality patient service?

P ?: Um… what is happening there um… are incidents in our um… that are impracticable and one cannot… Perhaps we need to talk about finances in a broader sense.

F: Hmmm.

P ?: Um… firstly, I think the allocation of our… of our funds [sic] is incorrectly handled at our head office. Um… because every year extra services are added um… and… and basically how they are allocating it, is basically just to look at what you had spent last year and then they only add inflation. Um… now we might have these wonderful AEP plans that we would like to implement… um… and we go and sit down to do our

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planning. Um… but it should actually happen earlier in order for me to submit a request according to my services and… and then to budget accordingly. It simply doesn't work that way. In other words, one is given one's budget and then one has to work within that budget. Um…

F: Apart from the fact that the… the number of patients increases or… or…

P ?: Yes, apart from that. Uh… uh… there is also not an annual review of the population. There might be – if it is indeed the case – a review every five years to consider the population and to make adjustments accordingly. The last couple of years it was only the inflator [sic]. Um… so, what you as… or… or as hospital management then has to do is basically to go and establish what are your immediate needs for that year and then to um… distribute your money accordingly. It even got to the stage that they um… you… you know, that you don't even have um… that planning and oversight role any longer. Now it even gets divided into item levels for you. You only have the ability to make slight adjustments between the item levels. In other words, you don't really have an opportunity to plan and to manage…

F: …not according to your priorities?

P ?: One can't. One can't. So, that is what creates quite huge gaps for us at the moment. Um… and then… and… and another thing – that all of them would confirm – is the constant stock shortages that we are experiencing. Um… it is the logistics in the finance component, as well as um… the shortage of staff. Um…

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F: What kind of stock are you thinking about?

P ?: Basic things like bandages, injections. These are standard things that people should have access to. A large percentage of this um… stock is um… is delivered to us by the central KMB. Um… and if the state cannot supply it, there is no other way of… of acquiring it.

F: How do the clients feel when they consult you and you say but [desperate laughter]…

P ?: That's the problem… that's the problem that they have to…

F: You know, what causes… what happens.

[Laughter.]

P ?: They are not laughing.

[Professional laughter.]

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P ?: They are not like that.

F: They are not laughing? Of course not.

P ?: And then, what is also happening; the people at grassroots level have the alternatives. In other ways, it's also like they've said um… you are… from day to day you are busy moving the goal posts and implementing changes simply to cope with delivering a service.

P ?: I'm going to… another aspect. From the point of view of a novice, the password is resources. Therefore, the current stance of the group is the same story over and over… about wheelchairs and resources like [mumbles] and the like. Wheelchairs are a big, big headache to the members because we are not receiving stock and we put time aside for maintaining the peace to try and assess more people out there in order to establish what they need. But that is not how it is. We know exactly what they would like to have but there are not finances to buy that stock.

F: Hmmm.

P ?: For instance, somewhere shortages are identified in relation to finances. It's probably like… gaps.

P ?: But it goes unnoticed because wheelchairs are not such a major priority. Therefore, I feel that it is better internationally but it brings us back to the point where it becomes a priority. So, when a person needs a chair we cannot… we really can't offer a chair. Then, what is the quality?

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[Many group members confirm what has been said.]

P ?: We are not their goal.

F: Yes.

P ?: We have a list of people, patients who need wheel… who, for example, need wheelchairs and um… the list is actually so extensive that when one goes back and the person who actually gets a wheelchair is grateful; then one goes back to the person at the top of the list and often the people… had passed on or… whatever the… the situation is. And now, one has to go down [the list] and it causes the entire system… It does not help, here we get to the new patient, a young patient, but the patient who needs it more is the person who is already waiting for two, three, four years to get a wheelchair. Therefore, that… the existing system…

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P ?: Um… what I… perhaps I can also say about infrastructures, we um… we are very happy for um… when… when we get new um… when we get alterations and additions at our clinics. For instance, one or two clinics converted the garage into a TB area…

F: Um...

P ?: …um… with extractor fans and the like but there is no one to service it [the equipment].

P ?: To do what?

P ?: To service it. So, now the extractor fans are unserviceable.

[Someone is laughing.]

P ?: …but there is no one to maintain it.

F: In other words, when it breaks, that's it?

P ?: And I think it is also the same thing with the wheelchairs. We do not have people who can service them. Therefore, when it is broken, who fixes it?

F: So, once again it is an HR issue?

P ?: It… Yes, I think…

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F: Is it a financial issue?

P ?: …but I think…

[Chattering.]

F: Hmmm, a financial issue. Hmmm.

P ?: But I also have to… When… when you really… you… you can't really appoint someone who only fixes wheelchairs because our workload is not of such a nature that it would justify that guy's salary.

F: Hmmm.... hmmm...

P ?: So, I think it really is a dilemma that goes both ways.

F: How does it affect the medical services providers, from the dentist and the doctor?

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P ?: If I can [refer] to infrastructure um… also add a little something. My… in my… from the point of view of my opinion [sic], when I go to my clinic then I have to book it for a time that I there will not be another… like the rehabilitation team will not be there. There will be no other team there. At the moment, I am working on an ordinary chair and it should not be like that because it hampers me to provide my most basic services to the patients. It hampers me because there are particular procedures that I cannot perform on such a chair. But, on the other hand, the station is sort of… I… I am able to um… luckily I am still fortunate enough that um… for me a plan can me made. I don't know. It is perhaps because the visit by dentistry is longer than that of rehabilitation. It is… I… that's what it boils down to. Like I'm able to um… a… I'm able to get a dental chair for the remote clinics but it… it literally has to be fixed… to the floor.

F: Hmmm...

P ?: So, there I consider space again because what other member of staff would be able to work in that space when I visit only once a month.

F: Hmmm...

P ?: So, I'm stuck with that little problem. There is not a specific room that I can take and say that it my room.

F: So, it would appear to me um… that teeth are not a priority.

P ?: At the… breakfast it is a sight to behold.

[Group discussion.]

P ?: …from you… How can I put it? Not entirely isolated but um… but um… in terms of space at some clinics, when a dentist is present, then all the personnel are abuzz due to the large crowd of patients outside but, in the meantime, most of them are my patients. That's why I think many people… and I'm not a person who would… I want my forty files and I want them now. I want them immediately because I want to start right now.

F: Hmmm...

P ?: Therefore, many of the… of the… perhaps the reception they now have to go through all those patients. Added to that… also the patients of the regular personnel at the clinic. Therefore, for them to do all that work during an hour in the morning, say from an hour or two before I start, puts a little… puts them under more stress and then

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perhaps it gets transferred to the patients. Like, just put down your [medical] card! I would just like to quickly… look up the file for the sister, understand? Therefore, once again it comes to… the patient and… and that the personnel do not provide you with a proper um… How can I put it? Not providing an image to the… to the um… to the patient personally. But fortunately now, we are busy with um.. [a] project or I'm attempting a project of using appointments that will help a lot. Um… some of the personnel will not admit it but um… um… it works because only that particular patient is present and the first patient of my shift is there. Now, the clinic is more relaxed. At that stage, there is not a massive group of patients standing there. All of them will say um… it works and are glad that you have implemented. On the other hand, some arrive because you find patients who are not used to it and then they do not turn up for the appointment. As a result, where I perhaps should have seen fifteen there are only ten. Now they sit watching, but you have these patients today but those patients are not coming today because then it's not my fault. Do you understand? Now, that's the patient. We are endeavouring to provide him with a quality service… to enable him… I always tell them that… I always tell the patients endearingly you can finish the washing and other chores and then only come and consult with me instead of waiting until… Like that, understand? I always explain to them it is all about them. That we offer them a better experience at the clinic.

F: The appointment system?

P ?: Yes?

F: [Name], how does it work for you?

P ?: Yes. Look, now there is…

F: What are the infrastructural issues that… that complicate things for you?

P ?: It's basically… Yes, stock. Basically, it is – like he knows – the web calls in the hospital. We have to… understand? It is those kinds of expenses, the swabs and other stuff.

F: Yes. In other words, it is the basic stock for the…

P ?: So, the basic things… basic stuff. If I want to be punctual for a period of eleven hours, then I need to seek assistance for that [mumbles], understand? There are no needles. Um…

F: But should the pharmacy not order that?

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P ?: No, it is…

[Enthusiastic group discussion.]

P ?: And then, I think I'm going to… Yes, like they say, it's a [mumbles] time. Personnel. Personnel, guys, bodies who are there to… to do the work, understand? Like at the moment… we would like to…

F: How many of the clients, what do you thing? How do the medical services work with… for you: the *physios*, the doctors, nurse, the whatever. Um… how extensive is the problem?

P ?: It's a big problem, because um… the point I would like to make just to… is there… We… we have a women's ward, a general ward and a maternity ward that are basically one room and there's one sister to basically… handle and manage. And sometimes it is just a tad…

F: Chaos?

P ?: I have seen already, understand? The maternity ward keeps one occupied. One cannot attend to the other patients too. That is why it is a problem. Um… I know that people are perhaps not applying for the posts. Maybe, no posts are advertised, that kind of thing.

F: I mean, what are you doing that there are not enough people? What is the problem?

P ?: Look, there…

F: Is that… May I ask, is this a general problem? In all the professions?

P ?: Yes.

F: You too?

P ?: Yes.

P ?: Hmmm.

F: Um… yes, but now some people would say… um… how big is the prob… I don't know? What I mean, there are shortages but how serious is the problem where you function?

P ?: Basically, the staff members are sort of allocated by head office and, in turn, head office says, "Oh!" Right, the size of the hospital only justifies, for instance, twenty

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four PENs [sic] or fourteen SNs [sic], but… but they do not keep track of the population growth.

F: No growth. Hmmm.

P ?: Yes.

P ?: As a matter of fact, it is not only about growth in population. It also includes… the shift in various diseases.

F: The shift of?

P ?: The shift in various diseases.

F: Oh, okay.

P ?: With HIV and TB and the combination of the two. One spends far more time on one's… on one's patients than before.

F: So, it also causes an accumulation?

P ?: It's actually still the same that…

F: [Name?]

P ?: [Name] has said.

[Enthusiastic laughter.]

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F: Yes.

P ?: Because at the end of the day, we can take all the time in the world to discuss the issues that… but actually the dilemmas come from the side of the province because there is a precise number of sisters that one needs. But when we look at the reality, it simply doesn't work. There cannot be only one sister for every ward. She works at causalities and she works in the ward. So, it simply does not make sense in cold practice. I am from a private hospital. And when I started working at this hospital, I couldn't believe my eyes because I had… for me… it simply does not make sense. You are at a private… and if they now take that statement that you have made we should now provide the same quality that the private… personnel or staff members are providing at hospitals, that cannot realise.

F: It can't materialise.

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P ?: Because it does not make sense because you really want to… You present a certain idea, I dearly want to, because that is my attitude. And one wants to write the reports and one wants to do it differently like it ought to be.

F: Hmmm.

P ?: …but one doesn't have the time… one doesn't have the capacity to do that. Therefore, um… one needs to go back to where the real problem lies and we need to look at the setup at the top and one would notice things that indicate what the hospital should be getting.

F: What is the… what the capacity is… I beg your pardon? What are the capacity problems? The doctors, the nurse, the pharmacists, or the *physio*? Where is the biggest capacity problem? That you are experiencing?

[Group discussion.]

F: Okay, you would like to say?

P ?: Now, I would like to return to the comment that [Name] has started with…

F: Hmmm.

P ?: …that is now the quality programmes and we hear that when we… when we are at the [mumbles] are at the regional office um… and even province, we hear it very regularly. Straight from our HOD of Health. Your statistics do not indicate that you need more staff.

F: Hmmm.

P ?: Like… like for them… I… I think that the impression I personally get of the decision makers is that they go and look at your population and what statistics you have submitted.

F: Hmmm.

P ?: And according to that they establish what personnel you get.

F: Yes.

P ?: Unfortunately, the reality at grass roots level [clears throat] is that when you are one sister at a clinic and a new RDP house development starts and your… and the

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population of you town rapidly increases by four hundred RDP houses or more um… overnight you are not going to…

F: Four hundred...

P ?: …not able to see four hundred more each month because you are only one person.

F: Hmmm.

P ?: So… so, the population grows around you but your statistics are not going to indicate more because person can only do that much. Whether you… it doesn't matter what staff complement you have, you don't have ten people around you. Therefore, your statistics would not really go up simply because the population has increased because you are… you are the… the personnel board remains as small as it has always been. Therefore… um. Therefore, I think it… that is why we are now emphasising statistics.

F: Hmmm.

P ?: Because… because we sort of feel that we need to do something at district office…

F: Yes.

P ?: …to improve it. So, we keep on harping passionately on statistics and that I think is…

F: …is a burden.

P ?: …we are chasing numbers. Is there nothing else that can be counted?

F: I hear it from the people who are assisting us with the board enquiry also that… that… but they again say – I mean, I have said that before – they say the problem is that nurse practitioners do not have a support system with data capturing. For that reason, the stuff is seriously incorrect. Sometimes, it is incomplete and at other times, it simply has not been done at all. And because you have to choose what you are doing, you leave that kind of stuff [for later]. So, I want to… actually look at [Name]. I think um… there's a very big need in this regard. Support personnel, not only the nurse practitioners. Okay, yes. What would you like to say?

P ?: I have listened carefully to what everybody is saying. The pharmacist – I am inclined to agree with all the points. I mean, like space you have mentioned – um… um… What I'm trying to say is when you look around, there's no space to… to… for bulk storage. For example, let's assume there is a terrible outbreak of a stomach virus. Everybody starts vomiting. Then, there is no medication for nausea for the people who…

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F: …are ill?

P ?: …what now… One usually plans for just enough for the next month and now, if something unforeseen happens, then there is not… there is not… Now… now, you wait another week for… for stock to be delivered from… from… from the distributors. That type of story. Um, I feel… we have now introduced a new thing that delivers [mumbles] medication from a depot that they pre… pre-prepare. Um…what I mean, it does not drive to the clients. Now, the stuff is stuck there at… at um… at Vanrijnsdorp. Vanrijnsdorp then takes it to Bitterfontein. At Bitterfontein it is kept in the deserted kitchen of the courier company and there is no *aircon*. The… the medication is not looked after properly and, understand? It's all that kind of niggling little problems that need to be examined if one [interruption] that… would like to bear that in mind. Um… and then staff um… numbers. I think… I think at every… like operational clinics that… that… that handle large… large numbers um… um… need uh… need a post-basic dispensary system. Um… not only… not only to… not only to work in order to alleviate the load of… of… of sisters and nurses um… that they don't need to go and dispense and that kind of thing but also to… to check whether what they are doing is correct. I mean, then they have a basic knowledge of… of medication and of dispensing…

F: [Researcher], perhaps you would like to throw a question into the mix?

[Babbling.]

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R: Now I want to play devil's advocate. If you have these infrastructure problems, what are you doing about it? For instance, when you have personnel problems, are you doing something about it?

F: They have to…

R: If one does not ask, one would not get. Have you asked before?

P ?: Y… yes, for example, the other day I arrived at a member of staff um – what a – when I ask for an example – ask where it [mumbles] would… would… The population in… in… increases um… when there is only one… one CNP there and the need is… is for another… another CNP and now we send, for example, a trust [sic] to the office. The first question they ask, do… do you have a [mumbles]?

[Affirmative group reaction.]

F: Okay. Um… so, we are quickly going to through in a last question in relation to recommendations. Then, you have to give your minds free reign but I do hear what

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you are saying. There is a financial um… boundaries to your work. But I also do hear what [Researcher] is asking. What does one do within those financial boundaries that… one's clinic or with whatever one has? What is there that one can do nothing about? We ask, what do we have… what input… inputs do we need from the organisation to… to provide excellent service and you are currently busy to accumulate all those things and eventually, we would like to think, okay. When you have to provide recommendations at the moment, where should we start first? What is the priority. Say, for instance, one only has ten rands, hoe is one going to distribute the ten rands amongst all these space problems and whatever else or whatever else? What are the strategies that we need to think about? I would like to move on to the next theme. Now, we have talked very pleasantly… you have very thoroughly discussed the things that are not there that should come from the structures, from the infrastructures, and from the organisation. I think, now we need to look at the third theme about a peek um… a peek at ourselves and… where you work, what are the processes? What are the strategies? What is… how does it look… is… what happens on a day to day basis that I can control? In other words, what are the clinical interventions, procedures? What needs to happen in order to provide a client-centred service? Currently, we know there are… there are gaps on the peripheries. So, how do… how do the processes of a quality-centred service look? If I now… if you now have to think um… think critically in terms of what happens at a clinic on a day to day basis that you can control? Internal matter that can improve? Or, what should it look like? Let me rather ask, how should it… to provide a client quality service? What should really happen? What is my ideal where I work? This role that I am fulfilling every day? Besides the fact that there is a lack of space. What happens clinically that… where I notice that there should… what… what should be more client-centred? [Pause. Somebody clears throat.] Tell us, [Name].

P ?: I think it is very important while it remains a long process to put all these things in place, before the infrastructure is available, the personnel remain demotivated.

F: Okay. The morale is low? In other words, you are saying that a client-centred is – like he has said a while ago – I need the desire to, even when I am in the street, there ought to be some motivation…

P ?: …internal motivation…

F: …an internal motivation to provide a quality service despite… But you are saying, when someone… people do not hear that you are calling them… people's morale decreases?

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P ?: After a long period, when one's circumstances remain the same, one adjusts to those circumstances.

F: Hmmm.

P ?: And one goes like, "Oh well, what shall be…

F: … shall be."

P ?: So, I just keep on doing what I am doing, trying my best to what I have at my disposal. One is not going to try and do that extra [thing] because what difference does it make?

F: So, an attitude that…

P ?: That attitude… and.. and then it's easier to convert an attitude in clients because he will just have to make do with what he is getting.

F: Hmmm.

P ?: And even when I do not do it on my own volition but one becomes in that proses and one becomes used to it and then it becomes a matter of expressing an internal thing. Now, somewhere we have to go and try revitalising the inner [self] in order to get the quality that we are able to get outside.

F: That morale and motivation? I hear… I would dearly like to hear from the others.

P ?: I have to state that I have started this year. In other words, I haven't been here for long. Um… what I am saying, there is a sister and we are in the first year team [ice jingles in a glass] and we make a plan when there is a shortage like when there is not enough space that we need, then we make it work. Or, for instance, um… once a month I can – perhaps twice a month – go to a clinic for a patient who um… has an acute or… or a chronic problem actually has to see a physiotherapist more than once a month for the treatment to be effective. And for me, to provide hands-on treatment, one session, one half an hour session once a month does not work [coughing] as effectively. Therefore, what I do, I have to transfer the responsibility to the shoulders of the patient by saying, okay. This is what one can do at home to maintain your own treatment.

F: Hmmm...

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P ?: Often, I try and convey the message of the importance to continue doing it because I think the patients do not always understand. They simply expect to come in and you have to fix it there and then, however, it is a chronic problem.

F: Hmmm. I want to add to what she has said because one says one can easily slip into that morale of one is simply providing a service once a month because that is the only thing one can do. I am simply going to keep the wheel turning, or one could try to improve the process, to improve the strategy by providing the people with certain movements, certain exercises, certain whatever that they should go and do. Therefore, you say some of these processes to provide client-qualified… pardon, to provide quality with what you have at your disposal, you have to make a plan?

P ?: But one does not experience it as very satisfying.

P ?: That… that does not always happen but it is very satisfying when a patient returns and confirms that they actually are doing it and it works.

F: Okay.

P ?: It makes a difference. Therefore, it cuts both ways but it is in the hands of the patient whether he wants to do it or not.

F: Okay, what do the processes at a hospital look like, at a clinic that is client-centred? What… what has to happen? What can improve? What are the qualities that…

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P ?: Um...

F: What do the processes at a pharmacy look like? To me, those appear to be a nightmare. When I take somebody there, the lady who works for me and so on. Therefore, I… I am just wondering what should happen with strategies in relation to this discussion about the infrastructure um… what kind of processes do I have control over? How does it look like to be quality-centred?

P ?: I think when one… if one takes that into account, we are living in a modern era and why then are these systems not yet computerised or um…

F: Don't tell me that.

P ?: Or why one… Understand? Everything should – especially in the public sector – I mean, everything has to be handwritten on these packets filled with tablets. One cannot even read the guy's name because…

P ?: Don't look at me.

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F: Do you not have a system that prints it out? Or stick it on?

P ?: No. No. It is all handwritten. Um… I think when one – and it goes right to the top – I mean, at university I had to prepare an assignment about what I thought could improve the services at… at… at state level um… services can improve and it is… it was… I mean, even to decrease the load on… on… on sister level and on nursing staff. The statistics are definitely going to decline because, I mean, everything is entered electronically and from… from when the appointment is made right through to the… where the patient is attended to, through to the pharmacy until the patient is discharged. That entire process um… and I mean… I mean it's… it's… is something that I can propose.

F: And what I think, that… the electronic programs could be implemented to a greater extent to provide a quality service within these processes at our hospital?

P ?: Yes, definitely.

F: And people should have access? Why do you look somewhat um… [Name], somewhat despondent about this?

P ?: No, I am just writing down something.

[Everybody laughs.]

F: No, um… um… [Name], what do you think?

P ?: Um… sometimes, one can also become more positive. One is inclined to think – how shall I put it now? – about the negativity. Like, when one considers some of the qualities they… they are a clean place, a clean hospital, a clean clinic are fairly important and it's something that one could achieve with some ease.

F: Can one?

P ?: Yes.

P ?: Yes.

F: I don't know how… do you have the ability to um… the capacity to manage that, the processes? In other words, are you saying the… what… what about a clean… what does a clean hospital have to do with quality client service?

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P ?: I think anybody who walks into a clean place would already have a smile on the face in contrast with when he would enter a dirty place. And, therefore, it would influence him to be more positive. Perhaps, it would also the waiting time somewhat…

[Some group members are trying to complete the sentence on behalf of the participant.]

P ?: Yes, would make it more pleasant when it looks lovely and it's clean. Um…

F: [Name], do you have money to get the passage of a hospital painted? Not? Oh, you… you… Oh, so you don't have anything to do with the passages? You only deal with the people?

P ?: Not really. Um… all of that is part of project… the… the… there again, there are processes that we have. Um… one… nowadays, we could not – in the case of projects – we could do on our own at the hospital. For the rest, everything has to be at the top… has to be done by the department of public works.

F: And what is the communication like with them?

P ?: The… the communication, it's reasonably good but the department of public works has um… priority lists. In other words, one submits a request um… then it gets entered on a priority list and, for example, then you have to grin and bear with the frustration because one continues regardless for three years um… then it is… for instance, they would say that you are on the list to be attended to during this year. Then, there is something – as an example – there is something at the psychiatric hospital or… A higher priority than yours. You move down. And then, sometimes it takes three to ten years for your project to be really attended to.

F: In other words… in other words, it… when the passages are filthy and the clients are ill already and one's morale is low, may I mobilise a group of volunteers to come and paint the passage or is that not allowed?

P ?: Yes, may… for example, you may mobilise volunteers or businesses to get involved.

F: Oh, you may.

P ?: You may.

F: How does it work um… how does it work um… not exactly but for now I would like to ask: Processes at the hospital. What… what is it like? What does it look like? What does a quality-centred clinical process at a hospital look like? What is the ideal?

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P ?: Yes, basically the ideal is merely um… look, yes. The one thing that people… that everybody has raised is the issue about the existence of waiting times. To continue, there is um… there is a triage system in place allows for patients to be classified according to a colour code. For example, green patients – now those are patients whose… everything is stable – he could wait for up to six hours. Understand? Yellow patients, for instance, could wait about two hours and then, orange and red need to be seen like immediately, understand? So, um… some…

F: Does it have anything to do with an HR problem?

P ?: I… I think not necessarily an HR problem. Perhaps. Perhaps in terms of…

F: Why…

P ?: …of personnel and then… then sometimes the numbers are also an added problem, especially… the patient's mentality is sometimes also a problem because they… they… they know that they are going to wait at the clinic, then they go to emergencies at the hospital, understand?

F: Hmmm.

P ?: And… and… and according to… I am aware the guidelines and protocol we are supposed to say, okay. But you are a green patient, therefore, you need to go to the clinic. However, since the patient is there already… Yes, at that stage I feel too embarrassed to say, "Sir, please leave" or whatever.

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F: Hmmm.

P ?: Understand? It takes… it takes only five minutes simply to say, okay. Is this the problem? Establish whether everything is hunky dory and whether the patient is in a position to leave. It takes five minutes to say in a scolding manner, "Go to the clinic", understand? So, there goes the patient already. Um… yes, and then also our stock… it's a matter of… understand…

F: Where… Yes, pardon me. Where at the hospital… where at the hospital is clinical intervention urgently um… a to… a problem with quality in relation to clinical processes and strategies and interventions. What… what is it that – when you look from the outside – what would you really like to see improving? I still want to hear about this. We have spoken a lot about the structures.

P ?: I think… I think for me from the point of view external to the hospital um… at sub-district level, we are not physically present in the clinics but I… The frustration that

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we are picking up during our clinic visits, I don't think… I don't think it is a decision. I think it is a… a… sort of a… let's call it the ignorance of the personnel who do not understand the processes.

F: Like what? What…

P ?: And especially… and I especially refer to the logistics in terms of stock because… because… in… they… they realise their clinic needs a coat of paint and they cannot understand why it… Why can't a hospital simply come and paint it? But are there people in the… in the repair shop? Um… I… I think that there is not always an understanding of which processes are in place and what… and… and even I do not always understand um… I need milk for my HIV-positive babies or moms with babies. Um… but it is a… is a process to get hold of it. Um… for me, it is not only about the completion of a form or the pressing of a button and the milk appears. In other words, um… it is even up to the patient's level. But sister, you told me two weeks ago there is no milk. Now I'm back and am still not here. Why is it not here? It's bad service that one gets. Um… but… but the comprehension the entire processes… and I think us… we simply have too many processes. There are too many people who have to rubber stamp and the are too many…

F: Logistical processes?

P ?: Logistical processes. Um… that uh… sort of a delay in the whole…

F: …a delay caused in the clinical processes.

P ?: …a delay caused in the clinical processes. And I really don't think it is in… in the hands of the finances at the hospital to do something about it. They have directives they need to follow. They simply cannot get around it.

F: Well, I… I still want to go back. When we… you still wanted to say something?

P ?: I will do so later…

F: Oh! Because the clinical – what I want to ask you – the clinical aspect that I'm wondering about. The… the daily intervention at a clinical level um… Okay, you… you now want… you want facilities, your um… - I don't always know what the correct words are – but you want milk, you want bandages, you want whatever is needed. It needs to be there. It is a basic requirement, but in terms of the… What do you call the clinical interventions where there is a nurse practitioner, from pharmacists, from… from… the doctor and the um… everybody who is involved in the… in the day to day clinical interventions?

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P ?: I… I think it still boils down to what I have said a while ago about um… we do not want to treat the symptoms only but want to consider the patient in totality. Uh… and… and I think… I… for me personally it is our… our… um… our entire support system is… is not client friendly. It's mass processing. Um… for instance, the s-sister [sic] sees the patients and doctor visits the clinic for an hour session only to attend to those patients who are really ill and who sister couldn't sort out. In other words, we lapse into a process of um… sister stands next to doctor and when [Name] enters, sister says, "Doctor, I think [Name] has cellulitis". Then doctor… or then he looks again. Yes it is cellulitis. Go to hospital. There is not… physically, there is no time to treat that patient in totality to establish what really the source of the cellulitis is. When he is in hospital, then things start to be sorted out and to be unravelled um… to perhaps establish where it originates but… but that – let us call it mass processing or whatever – is… is a… we are on…

F: Is a process problem.

P ?: … and it is an issue of a process we are supposed to have… The… the waiting rooms and our clinics are processing… really are processing multitudes. I don't know where we are going to get time to also…

F: You are saying that the quality of clinical services is prejudiced by this mass processing?

P ?: Yes.

F: The quality services? You wanted to say something?

P ?: Is… is exactly what I wanted to say and you um… I think when… especially when somebody is ill or when only one person is working, then um… the services really suffer as a result of that. Out of the group, you barely have attended to five people properly and you… you… you are almost too scared to look into the waiting room to see how many there still are because actually you don't want to know how many still need to be attended to.

P ?: What I'm also thinking – from the perspective of rehabilitation – um… we get a referral from the clinic or from the street and then we attend to the patient to the best of our ability. We do a home visit. We go and see the patient at the clinic. Um… and how it then works, once we have done what we could have then we are through with the patient. As a result, we don't want to get there the next week and simply attend to the same patient because we already did what was possible. In other words, another patient who really needs assistance could have been seen instead of that same patient.

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F: Hmmm. Then, how…

P ?: Clearly, there is simply a communication gap between the sister and us because the sister want to give us patients who…

F: …who have been attended to...

P ?: …who have been attended to already but when it is not possible to do anything else, then it would not be necessary to see al those multitudes…

F: Yes.

P ?: Um… then more have the opportunity to come and…

F: When… when the system of the communication – whether by means of um… a program or something of one-to-one communication – then you have to harness this interprofessional… cooperation communication…

P ?: I… I think when one has a program that… let's take something like the… the um… the sister who to the… who refers the guy to the um… physiotherapist. The physiotherapist could post a not in the program to say, listen but this and this and this. That is what I have found and… and things like that…

F: He was threated that month already?

P ?: He received his treatment for that month and…

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F: ...urgent...

P ?: I think that's why… why, I hear what they are saying that we would like the patients to relax after the treatment but the crowds that are what's limiting the nursing. The patient comes in and is seen by the sister. The sister tries to view him in his totality, okay. Just complete there for his chest but have a look whether his application is going through [mumbles].

F: Hmmm. Hmmm.

P ?: But the referral never really gets done because there are so many other things that need to be done. So, eventually they come to use for some reason or another. We attend to him… notes if you want to… and when… comes back and want to know what you have done. But then you have written there clearly: "Discharged. Hold exercise programme". Now comes the…

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F: Is it in a program inside a file?

P ?: It is in their file because by then we have scratched it out on our own notes. Then you you record it at the clinic then you know exactly. You know, all the other people can also see it. All the other professions but I don't think it gets read.

F: I think… I think that… that's his argument. When you open it in a computer program then everyone has to pay attention to it. Understand? But if you want to… you can push a file to one side but when you want to make an entry you should be able to see everything at a glance. So, I hear what you are saying. There's a delay, there's a relation you know. The processes do not run smoothly and he thinks that a program could assist. You wanted to say?

P ?: Perhaps I could just add, the question was what we could do. Are there small things that we could do? Firstly, what I think is lacking is… I think the people… the mentality of the community is one of receiving. They just want to receive. Therefore, somewhere along the line one should also try and change their mentality – especially at the hospitals – they come and sit down. They want that specific service… they want… they expect that service. But in reality, we cannot provide them with that service. But their mentality is, I want that service because I'm entitled to it.

F: I'm entitled to it and I want it?

P ?: In other words, somehow we have to try and change the mentality because even with the carers. They want the carers to take to them. They can roam around. Then can… they are act… active. They are able to do their own stuff but since there is a process in place, I expect that process to pay me a visit. Therefore, the mentality of the community could… is not something that we can… perhaps… maybe some other people could go to them.

P?: Yes, it boils down to communication. Those instances… I don't know whether processes were put in place for the carers to… communicate with the community and to explain to them, listen these are the service that are promised. This is what is available to you. This is…

P ?: It is like that. That mentality still continues. We… we are in this area. We are suffering and I want and you have to give it to me.

F: Yes. I hear… I hear you saying that this process… the processes are disadvantaged by this mentality of receiving. Um… but [Name] is saying um… perhaps when we um… I am a carer. I am able to this for you but those things you have to do on your own. In

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social work, when we… we try saying that this dependence by contractual things, okay. This is what I am able to do. That is what you have to do and… and attempt… It doesn't always work, but I mean, but he says there… there should… that communication portion should facilitate the processes amongst the patients and… Somebody else? Something else? Um… I am… I am very scared of [Name] who is sitting so quietly but I am going but I am going to give him a question in a short while.

[Laughter.]

F: He is sitting and listening very carefully. Um… now he is going to assist us… No, I still wanted to ask about the… about the… um… manpower quality but you are telling me your quality… it is good? What I mean, the processes, the intervention strategies, the clinical interventions with people whom you are working with in your region, is it relatively good?

[Pause.]

P ?: I don't know, I only receive half of the stuff. I simply don't get a grip [smiles] and also, I think your understanding is deeper than the question but…

F: Yes.

P ?: …but I'm simply going to… because it sits on my shoulders the whole time and all. I'm simply going to say it.

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F: No, tell if you want to say something.

P ?: Then, you might as well on your own… Like in my case, *né*. In dentistry, we have like uh… you have a conservative and then you have a preventative.

F: *Yes*.

P ?: Like, um… I'm a dentist. Therefore, I'm *gonna* do preventative and I'm *gonna* do um… conservative. But to do my preventive… is where you do all your hygiene education and all those other small things, *né*. It has to be done because um… the people have the mentality that the state only extracts teeth, only extract teeth, only extract teeth. Then they visit me, then I say, no but we can do this for you… we can do this…

F: Yes.

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P ?: …so, all that hygiene education is meant for one's children and for one's adults. In other words, eventually we would like to prevent people from wanting to only extract teeth. We want them to watch and develop the mentality that your father is brushing his teeth. You can do it too. Um… like, it has to be done. Conservative, where I currently do my fillings and the cleaning. This is what I – how can I put it? – went to get educated for… But now it happens, when I… when CDS approaches me to go and give a talk – which I do lovingly because I would like the mentality of the people to change – then I go and present the talk. But then I neglect… I neglect my conservative when I go to present a talk, it takes the whole morning, or it's at least the whole day, um… because I'm going to present the talk and one also wants to collect inputs and… and questions from… to get feedback from the community. Therefore, it takes the whole day. In other words, I loose a clinic or I loose a communica… um… conservative… those fillings and cleaning I could have done. And that's where the personnel play a role who um… at the moment the dental team consists of… it's only the dental assistant and I. If I at least could get an oral hygienist but that she entirely… her training is entirely um… um…

F: Prevention?

P ?: …prevention. You know, if… if one can get that person, then there would be no need for me to go out. It is not that I would not like to go out but then I can concentrate on the conservative and my dental that I actually went to get… to get trained for, understand? The physical aspect of dentistry I could concentrate on. There is… In other words, in the final analyses at the end of the day it boils down to…

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F: ...to the supporting personnel?

P ?: Yes. Yes.

F: And I wonder the finances, or pharmacy, or whatever; whether you can get hold of supporting personnel to reduce your load or whatever. You who… are there processes in your hospital or in your region um… What is the role of supporting personnel? And, for example, pharmacist assistants, or um… data capturers, or people who assist you with statements? Are there… what are the processes that we of a quality from other people – up to now I have a lot – she has… up to now we have spoken a lot about morale and mind-set of patients. Would somebody still like to add something?

[Complete silence.]

F: Okay. Let us ask… let me ask you this. Say, for instance, I say, here is um… What would the clinic look like, or the region look like, or service look like where there

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um… excellent quality client-centred service listens [sic]? In other words, let us try to… to combine the two of when I am providing a client-orientated service, then the outputs would be. And this would be my recommendation for those outputs. Actually, something that…

R: …it is like the categories that you are telling me about what you need to give a quality service…

F: Yes.

R: ...Personnel who are not there.

F: Yes. What... what...

R: …if I only could get this, if I only could get this.

F: That... that within the...

R: …if only it had been in place.

F: Yes. That within this… what… how does ideal client-centred services at a clinic look like? Apart from the fact that I would more facilities… but let us look at the positive. Let us look in a positive way, what should it look like? What are the… outputs… what would the outputs be of excellent client-centred quality service? Excellent quality service. What is in your head? What… what do you consider as ideal? How would you like to summarise that? [Pause.] [Name], what is it going to look like?

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P ?: Oh, a very lovely big clinic with enough…

[Laughter.]

P ?: …consultation rooms for the occupational [therapist], for the physio-[therapist], dentist. For everybody who…

F: These are going to make your service easier, but what is the… what is the quality of your client-centred service going to look like? What are the outputs that you would be able to improve when you have such [a] service? When you have all your facilities.

P ?: If… if you also have enough personnel there and you are going to… they would have enough time to pay attention to… to that patient properly. You are going to regard them in totality and at the end of the day your patient will also return less frequently. In other words, you are now going to sort out all his aches and pains and his treatment during one visit and later on, he will return less and less frequently.

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[Pause.]

F: Um… let us think about that. We are living in South Africa. There are a very limited number of people who pay tax and there are masses of people who need services. Despite this, how are we going to manage providing client-qualified [sic] in the confines of the budget and the basic structure? What… How could we work creatively, you guys? What do we have to do in order to get the ball rolling with getting a better service? What do we have to do proactively and decisively?

P ?: We have to ensure that the care programme is available.

[Someone speaks inaudibly.]

F: Just repeat that?

P ?: For instance, preventive information…

F: Yes?

P ?: …to reduce the prevalence of disease.

F: Yes. Do you think there… should it um… Who – in your opinion – who should be doing this to support this limited number of people? What is your view about… how do you view it creatively? How could one this preventive service except… she is now going to need [mumbles] around here. How could one… use limited sources to provide an improved uh… a better quality service?

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P ?: Well, I can say from the point of view of a physiotherapist um… I see an incredible amount of backache. It probably is the issue that I'm dealing with most and a lot of them have chronic backache and many of the um… causes of backache are simply… they did not prevent… they did not prevent the backache. Therefore, many treatments of backache are very similar. That's why I think one can present a back session instead of seeing patients individually, but we are also faced with the space as problem.

F: Hmmm.

P ?: Then, it also is fewer patients whom we are able to see. More patients and more sessions.

F: In other words, you are agreeing with her that in that instance one could provide preventive services on one could provide group um… interventions but then one needs space. For the group interventions?

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P ?: Yes.

P ?: Then one gets there and one finds all one's patients at one…

P ?: …one place, yes.

P ?: …one space.

P ?: I can actually do that at the clinic but…

F: So, you can gather all of yours? I would like from the other people.

[Everybody speaks simultaneously.]

P ?: About that um… prevention section, one point that we also have a problem with is that we receive pamphlets but the pamphlets are in English. In other words, we are not looking at the basic need of the community. Nobody here is reading Engels and things like that. Are all basically Afrikaans [speaking]. You do not speak to the people. You don't simply hand out a sheet that they are in any case going to read. Therefore… therefore, the level that we are moving towards is not on the level of the client.

F: I think… I think you are mentioning an extremely important issue in conjunction with everybody else but I think it relates to a customer orientation. Am I conversing in the language of the people? And… and when one wants to have preventive services or one wants more information about an illness. Um… I had a student there in the Cape… a nursing student – an M student – and it was about asthma and I gave that pamphlet one look and I told her, who were going to [read] this pam… because she was very upset that the mothers would not do what they had been told to do when a child became asthmatic. The next day he would once again return with the packet… and the pamphlet was um… um… professionally very correct. I'm only a layman. I am not a nurse but the languages…

P ?: Another thing I wanted to say a short while ago, the pamphlets are neatly provided with the tablets in the small containers. On top of that, there is this… this very small handwriting…

F: And then, it is not possible to understand anything.

P ?: …because many of our patients, one anticipates problems and it is such a technical language that no patient would by able to understand [mumbles].

P ?: But that's why I am saying when… when one has somebody with a basic under…

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[Group tries to assist the speaker with finding the correct word.]

P ?: Wisdom?

P ?: Yes, to have an assistant who… who basically…

P ?: ...has the time to...

P ?: …has time for the patient.

P ?: …has time to… to… even when they do not have the… the… the… basic knowledge about the medication but at least they understand the information in that pamphlet.

P ?: Yes, because one does not have that kind of time.

F: Who would that person be whom one needs? An assistant pharmacist?

P ?: Post-basic, yes.

F: Post-basic assistant pharmacist. Like, yes?

P ?: I would just like to go back because such issues should actually go to the province because at the end of the day, I really want to – because I am in the community – I really would like to translate the thing because I obviously understand what the people would like to hear but you're also not allowed to do that because it needs to go higher up. Then it takes ten years before it is available at your level. Therefore, at the end of the day, one is not able to conduct prevention.

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F: It is not even possible to translate that during a conversation?

P ?: No, you are not allowed to. Therefore, the process…

F: And one also does not have the time to see each one individually, yes. Yes, okay. I hear. Okay, we are talking about processes how… how… we are talking about outcomes. What is the clinic going to look like where there could be within… within the limits of certain finances and structures um… What are we able to do with what we have?

P ?: Have we perhaps um… obtained something positive from it already? I am still trying to ask the other participants. Where we usually go to schools as a multidisciplinary group. The dentistry, the *rehab*, the sister. Um… from my side, I had because um… youngsters ident… we see them all in one mass production but, you understand? We examine all of them, go through all of the personnel um… and one could not simply

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identify there and then whom one really needs and especially for our less privileged people who are not interested in bringing children to the clinic. Therefore, one has that opportunity at the school to um… to be able to say, "Grab!" Now, he did not want to listen to them or to stand in for their work because then it would also be something that we could tackle, the multidisciplinary group going out to the schools or to the crèches or something like that.

F: Hmmm.

[There is a lot of noise and the next participant does not speak clearly.]

P ?: …the idea of having the administration in the district is *nice*. But now, if it goes back to the… how many referrals I get from a hospital or the clinic sister specifically, it is minimal. Therefore, I am a big opponent [sic] to solicit my own referrals. It's not only that it is a problem to me but something more rudimentary like may they come and ask about the four months. And when everybody [mumbles], what is going to happen to the four months?

F: Hmmm.

P ?: When one returns after four months: no patients. [Mumbles] we share two, three patients. Then I put a whole day aside for a project. Everybody knows. I timely send out a timetable, then only four people show up, understand? Then, it is time that gets wasted which I could have used for a home visit. But are there going to arrive more people?

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F: Hmmm. How could we improve that?

P ?: How could we improve that? At the moment, I am like somebody who constantly tells the same story over and over at every clinic. Send the referrals even when it is not a proper referral in terms of written letters. Simply send the name and I will start addressing the issue immediately. But, once again, I could not… I could also not be happy and my morale would also not be high when I go through all the trouble and when I arrive there on the day and then nothing is happening there.

F: Now, listen um… the nurse practitioners very carefully because they… they do not have that problem of searching for people whom they have to help. Um, yes…

P ?: And it is, I am the only occupational therapist in the entire district because then… How do I explain the huge population, the massive needs that exist in terms of the few referrals at the clinic. Now, we have sometimes had because from the hospital I have not yet received even five referrals for the entire year.

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F: Wow!

P ?: In other words, how could one deal with an acute person? Now, one expects after three months that I should on my one the patient… when I am standing here… he could refuse. Then he could not at all…

F: But, [Name], one could not now say that there could no longer be an occupational therapist at… at the…

[Everybody finds the statement funny and laughs.]

P ?: …are referrals and then I arrive there and, at that stage, I am so low already. Mrs [Surname] does not regard it as an acute priority because I am there and so on and then the form that we write. Then they say, no we cannot be there. There is not a budget. But if one is going to have a look at the form, nothing is written about the *OT* or *physio*, understand? At the time that the form is being completed, it is not at all taken into account but it sounds like a limited approach according to the [mumbles].

F: Hmmm. What do you think she should be doing, [Name]?

P ?: Some of… of… of us as… from the question, it has been the first time that it gets handled further at managerial level.

[Agreement.]

F: I… may we just spend the last few minutes to… to ask [Researcher] to say, if she now has to write a programme with recommendations or with guidelines. How… for instance, you have a piece of paper in front of you. We talked about infrastructure and processes and… and what you would like it to look like. But, for instance, she has to write a programme but this like should be implementable. What would you like to tell [Researcher], what should this… where should it start? How should it progress? How should the… for instance, the model be drawn up? How should it progress in order for the patient… there is a better quality of the client service? Where should I start? And who should become involved? And what activities should be built into this programme? Who can think? Who can offer some advice? Even if each one offers one idea only. For example, let's say you… you now have… you know have um… the privilege of advising on a programme um… to improve the quality services to clients in this region, how would you approach this? What would you include?

P ?: Firstly, um… my thing [sic] is to increase the personnel excluding the headcounts who are helping us already.

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F: Hmmm.

P ?: We have no idea about how many are turned away and how many simply leave the clinic because [mumbles]. One should keep record, also for one to establish how many have been seen but these parts should have been seen but have not been seen. Therefore…

F: In other words, she is saying that you say there should… there should be something in place that is… going to facilitate that capturing. One should have a good structure, or programme, or something in place and it looks to me that [Name] is eager to assist. He should… he'll have to assist [Researcher]. There should be a programme in place where one could capture data and where one could keep records that… not… that does not need an *IT* specialist. There needs to be a user-friendly way of keeping record of people who arrive and who leave and abscond, yes. More? We are still looking for ideas. That was an excellent contribution. It was an excellent idea.

P ?: I think… I think we should also um… find a way to… to in the thing… What I actually want to say it… it… it is the result of… it is the result of training. Um… we are experiencing that the… the [mumbles] sisters arrive. They do not really know the basics about *TB*. At the beginning, they do not really have an idea about what is happening… about what is happening in the programme. Um… therefore, to me it feels that… whether it is in terms of training, yes, does everyone only receive basic information like all of us received, but a section should be incorporated that… what are the different programmes and how does it… it work in the programmes. What is the um… what… what… I take it from my point of view. While I was busy training, I worked at a clinic for a short while and we were in the *TB*…

P ?: …you might not know what is happening in a TB programme until you have not physically started working there.

P ?: Now, I am not saying that it is impossible for you to teach the people everything in three days but… but I have a feeling that when people get here they are clueless.

F: Is… is that a problem with the training of students or is it the people who are coming here from the city?

P ?: Yip, I think it is a problem with the training of students. We are actually getting students from all quarters… of people who are coming here to work who are coming from all other places…

F: Hmmm.

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P ?: …not simply necessarily… But we're all in the same programme. But I feel that we have to instil from day one – let us say in nursing – that idea in personnel to approach a patient in his totality in order to provide a quality service. Therefore, whether you are at a hospital or whether you are at a clinic, your focus should be that at the moment you are working in surgery. In other words, now you are focusing only on the postoperative dressing of wounds.

F: Like what the doctors do when they chop off your leg and then you cannot walk, *ja*.

P ?: Therefore, your point should be to…

[The group grasp the humour a tad late and then start laughing.]

P ?: …regard the patient in totality so that when you walk into a hospital um… you should be able to ask that patient, what your HIV status is um… Have you been tested for TB symptoms, have you had a pap smear already? Um… is your family planning, are you? Because we experience that so many patients, for instance, go to a TB hospital and then they return pregnant. Nobody paid attention to family planning. Um… so, it is a case of you are sort of focusing only on your…

F: The portion that you are responsible for?

P ?: …portion where… and that… and that is only… Yes, I think that… I think that…

F: Is that uh… are you specifically addressing the nurse practitioners or what?

P ?: I am talking from the point of view of a nurse practitioner. I am talking.

F: Yes.

P ?: I… I feel that one has to um… that thing needs to be instilled in you.

F: Even when one is going to work in primary care?

P ?: Even when one is going to work wherever. From day one, one really has to regard the patient in his totality and within his context. And the reality is, the waiting room is a hotspot for TB. Therefore, you literally have to ask every person who is entering any facility about TB symptoms because we have people. In other words, it feels to me that should be made more sensitive to not only treat symptoms but to regard the patient in totality.

F: Okay, I am looking for more ideas for [Researcher].

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P ?: Um… perhaps I am thinking about the morale of the nursing staff. For example, uh… a team competition or anything else assists. For argument sake, to have a team building once a quarter or every six months just to boost the morale; simply to do something pleasant. That it should not always only be work-centred but – you know – in order for the people to become a little more positive and to boost the morale.

F: I… I… I am looking for your ideas to advise somebody?

P ?: No man, I first have to think.

[Laughter.]

F: …because it is still stuck in your cheek? Yes, I really would like to because you have touched on the morale, *né*. I am wondering um… in order not to get stuck in this cycle of these unbelievable [number] of patients, a few members of staff. Eventually, I don't care any longer. I am simply treading water. Um… and I'm wondering what one could do about that? What should a programme look like that… because one cannot provide a quali… um… a quality service when you are in that morale.

P ?: At the end of the day, one should really invest quality or time in one's personnel. Look, I also have given the guys each a birthday letter every month on their birthdays. Put a small… it's the small things that are going to make a difference at the end of the day. In other words, one does not need the finances to do these things because it simply requires the sharing of thoughts and saying thank you. Look, one knows that everyone goes through such difficulties from time to time which cause them not to be themselves on that particular day. We are… nobody is perfect. We are not always a hundred per cent where we should be but um… it's simply…

F: Does… does HR do something about it? Or is it our ward sisters and stuff?

[Group discussion.]

P ?: Oh!

F: It does not work?

P ?: But actually it is too paper intensive.

F: What kind… what kind of programme is that?

P ?: We have um… the… the values of the department are "CCAIRR". That's um… C squared where the… R squared… um… and basically it aims at them to… They

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started doing this because they had realised that there were um… a patient satisfaction and a staff satisfaction. The results in both cases were bad.

F: Yes.

P ?: Um… therefore, they then decided that they would implement the initiative in the department in order for both to improve because… because what clearly transpired was that the bad… uh… uh… patient satisfaction actually was the result of the satisfaction of the staff that had been so bad because the people's morale was so low an so forth. So, um… now there have been a few… a few hospitals selected where there are initiatives where we compete against one another. And there are specific little things that we should put in place. For instance, some things are absolutely that we are doing on a daily basis. Um… collecting statistics, um… patient um… forecasting we need to get in order for us to know that we have a clinic today. There are going to be more patients. We have to put more personnel… we have to um… put more on duty, for instance. In other words, these are actually planning issues that management or… or… or… um… yes, hospitals also fail in some ways to use things because when you… we… all of us could say that we have too few staff, we have too few staff but when one knows beforehand that one is going to have a high patient load today then one could adjust one's duty sheet for that week or for that month in order not to at that stage… not to overburden one's personnel. So, these are all such initiatives um… and then she arrives at the hospitals and starts… she's not entirely successful but she starts with the staff morale, for example. We had introduced um… a small school initiative where everyone of us… member of staff drew someone else's name and one had to on a weekly basis – any way you wanted – give a little note, give a little flower, give a small gift, anything you wanted simply to make that person feel but he was valued. Um… so, this is the initiative that the department is currently implementing but I think in the long run it could be very positive because it teaches us to think differently about our day to day approach to work. We have got stuck to such an extent that everything remains exactly the same. We are doing it like this for the past twenty years. Therefore, for the next twenty years we have to again… Now, since it is linked to a competition, we need to think out of the box in order to change.

F: All right. These are the elements?

P ?: These are the elements from that.

F: Yes. I… yes. I'm wondering um… what one could [do] with the other [mumbles]. [Name], what could one do in the pharmacies to improve the quality of the service to patients except to – I also heard what you have been saying since the beginning –

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but… but… um… what is one supposed to do when one walks into a hospital and a hundred people are seated while they are waiting for their tablets and everyone appears to be ill and the pharmacist does even look up. Then, um… then I simply loose heart. And I am wondering whether there is something one could do?

P ?: I think um… if only that patient could know what his position in the line is. Um… I don't know how one could achieve that, how one um… But I know that here in [Name] the [work]load is not terribly high and I had…I had… um… last year I worked in Gugulethu or at [mumbles] in Gugulethu um… and I mean there – where a pharmacy normally would handle about a hundred and fifty prescription per day – I had um… drawn four hundred, five hundred prescriptions per day. Um… how those people spat against the windows because they were tired of waiting. They were swearing and saying and going nuts. But… but when you, for instance, have a system of receiving a number or… or um… or like a… a TV screen where… When… when one hands in one's file, then your name appears there and then the next ten people could see who are next in line to be assisted. Um… that kind of thing. It's at a pharmacy… the people…

F: Hmmm. Not simply giving something but giving it in a client-centred manner?

P ?: Yes, and then that person also knows he is going to be assisted in a short while. Okay, I'm going to remain calm for the time being. So, that guy may as well spend two, three minutes to quickly explain to the guy what medication he is getting and how he should be taking it and so forth. Um… to sort of handle it.

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F: The services at the hospital?

[Controlled giggling.]

P ?: I think you would…

F: That's a dreadful…

P ?: Yes.

P ?: …exceptional admittance… because um… even one's admittance of one's causalities where people have to wait. If one… if one could implement a system.

[Enthusiastic group discussion.]

P ?: …like at the receiver [of revenue] or when one goes for one's passport, whatever. Then they tell you. It does not necessarily have to be a calling system and it's not

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something that is going to cost a lot of money. In other words, it's something one could plan for the following year.

P ?: That's a good idea.

F: And at the same time, we could casually make a couple of information messages.

[Group discussion.]

P ?: Like in Stellenbosch, where one has such a lot of seated patients who are waiting. At least, then one makes it worthwhile to wait. Try it for like four months because every patient is obviously not sitting at the clinic every day. And then… it's difficult. Everybody should be where… then you conduct sessions, half an hour sessions, where everyone at the clinic is afforded the opportunity to stand in front of the clinic to at least talk about something. Preventive or um…

F: Even when it is a volunteer?

P ?: Even when it is a volunteer, yes.

F: I wondered to what extent the hospital is using the… the structure of volunteers?

P ?: Yes, or what one normally does, one creates one poster and then one rotates it amongst the clinics and gets someone to tell about certain diseases or…

P ?: I think that is also where staff… staff appraisal – or whatever one wishes to call it – like it complicates the process a little. Um… that people, let's say like in a situation where one has a couple of nurse practitioners who are… who are… who are… working um… and… and everyone gets a turn to do something and then one could – I know it sounds tedious – but like give the people marks or… or… or to explain how they understand it or like a question that… that one completes. Um… and then… and then one could at… at the clinic also a type of… for example, [Name] and I or [Name] and I need to for the same – sorry – for the um… same… same week [we] could present lessons against each other for the people who are… who are waiting there. I mean, simply to provide them with information that addresses their concerns. I mean, diarrhoea… um. How mean children die of diarrhoea because… because parents do not have the necessary information how to perform a quick rehydration. Um… how to clean water. I mean, sometimes the water one finds in the rural areas is dirty. Um… how to quickly clean water when… when you are battling with diarrhoea. Such small kind of things.

F: Hmmm.

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P ?: And I don't know whether we could involve the home-based carers because…

P ?: Yes, they also have a basic…

P ?: …and to allow time for them at home…

F: The carer?

P ?: That is also why they now have the councillors tat the hospitals. The councillors could get involved by providing training. We also have [conducted] a little home… or we go out into the community because sometimes we do house visits but then, they only work for a certain number of hours. Therefore, one should actually at the facility – and the same at the clinics – they should have their councillors who have talks every day. Perhaps, the same visit could be conducted at the hospital in order for us to get the talks because the people are standing and waiting. So… could use it.

P ?: Eventually, it actually deals with prevention at the end. One's talks, because that's the only means at one's disposal, but at the end of the day one has to train somebody because we… we are covering such a huge area here. One can't – it would be utterly stupid – one can't remain in one spot for an entire week. Then the others go…

P ?: And it should also be a qualifying community. The standard that one currently has is the same standard of the hospital and also the department of health. Also, it cannot be any old layperson. It needs to be somebody who has received training to provide at the appropriate standard.

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F: Wow! But you are a pleasant group; actively talking. Um… I would like to understand to say what you are saying that – I don't know, that's my understanding – then you have to read it to them but when I could simply summarise it on a placard then it's done… right from the start a client-centred quali service... lity service is a person who takes a holistic view of the patient and who has a good communication with a patient. Those are the basics that a patient is entitled to. He has to have good communication with the service provider. And you are overburdened by numbers and you have a small number of support personnel… and when you do not have more clinical personnel then there are a few support personnel who could assist with um… assistance or with whatever. And that the infrastructure really – in terms of physical space – many restrictions on your service delivery, restrictions on a quality client-centred service delivery suffer and you keenly would like to see that um… within the limits of the financial or whatever that um… like she has said, the client still… No, let me rather say that the morale of the personnel should be addressed within this frightening roller coaster thing that people, patients have to get those support services

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or a programme that could assist the patients to observe that people are caring. Even when I could not assist him immediately, there should by a way for him to know that people are aware of me. I'm twelfth in the row. Um… people know about me. And that we have preventive services, need people with support knowledge. Even when they are not the highly professional in your occupation but the oral hygienist, the carers, or whoever. That those people should be assisted to disseminate messages to clients that are in an understandable language for the people.

But… but the financial people and the HR people um… I… I think what I have learnt over the years um… is that in the former apartheid era when people were discriminated against, we sort of expect that people should lift themselves by their boot straps. Therefore, there simply comes a time that one could not expect from people… from your personnel to really turn the system upside down. One could only do that much without burning out, without losing one's morale. And the infrastructural stuff in terms of supporting personnel and facilities, that actions should really start and keep going. And as long as we remain quiet and say, "Oh, it's okay. It's… it would never change. We are never going to change". Are we going to create the same thing that… that we observe in the patients? Now I'm simply going to sit down and allow things to take their own course even when they are going to assist me in three days' time.

Therefore, I think there is a very strong [message] I'm hearing that at some stage, assistance should also come from the outside. We would try our best but there should be assistance that comes from the outside.

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Wow! That was pleasant. Thank you very much. I have learnt so much. I have learnt a huge amount but now, the programme that needs to be written… at the moment, I have a pretty good idea that [half a name]… [Researcher] eventually would ask each one of you individually. Um… who are creative with ideas.

R: We will talk again. Once we have the results.

F: Yes, because uh… Yes, when one… when I the finance people and the HR people just get some control then one has to become very creative with a programme. Even when one has to put advocacy programmes in place but like…

R: I could only tell what would now be wonderful. The patients are also going to tell their story. Then the statistics would obviously indicate. Now it has been scientifically established. One's clinical nurse practitioners are also going to write something. And then one is going to look because I am absolutely sure one would then be able to connect all the dots. Patients are also going to complain about the infrastructure. They

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are also going to complain about stock outs. One's nurse practitioners are also going to complain. In other words, one is going to see um… with my M they also said, "Wow! Something must have happened for these people to be so negative". It probably during the SPMS, the staff appraisals. But when three groups, when one is able to connect the dots…

F: Then one has to listen, *né*. There should, somebody should at least see one time or another um… yes. So, I don't know um… It would be wonderful if perhaps creative ideas are surfacing but I think it should not cause the decision makers to feel, but okay. They are able to manage on their own. I think at least there is… I have a feeling that a message is emerging. I… I… yes. I don't know what is happening in the hospitals. Doctor is extremely quiet. So, I um…

[Group members laugh out loud.]

F: Thank you very much. Thank you very very much.

R: May I, at this point, express my deepest gratitude to everyone who has attended. [Name], you are one leave. [Name] would have liked to go on leave. [Name] is on leave. Um… all of you who had to reorganise your programmes to make every effort to attend. Without you I cannot do it. I am really dependent on you.

Now you can sit back and relax. I am just going to bring you the menus and we have mouth-watering tea, coffee, juice, water, something sweet, something salty. Just what you feel like.

[Commotion and enthusiastic communication.]

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Annexure M: Minutes Matzikama focus group

29 APRIL 2014 PROF SS TERBLANCHE AT MANUELLAS

Planning of focus groups: The study was approved by the UWC (higher education as well as ethical approval). Furthermore, the study was approved by the Western Cape Department of Health as well as by the West Coast District – Dr D. Schoeman granted access into the district. The three PHC managers was informed about the proposed for focus groups – one in each of the 5 sub districts. The proposed dates were given and the Assistant Managers were asked to organise the identified participants as well as a neutral venue (choice was given between a venue at a nearby guesthouse and any available venue conducive for a focus group). The Assistant Managers confirmed via e-mail the bookings of the chosen venues as well as the attendance of the participants (3 weeks in advance) – a follow-up e-mail was sent one week before the proposed dates to ensure attendance.

Welcome/ Introduction: Mrs Eygelaar welcome each of the participants. Mrs Eygelaar (the researcher) and explained the purpose of the study. Confidentiality, voluntary participation, as well as anonymity were discussed. Anonymity was ensured by allowing each of the participants to select a "fake" name. The role of the facilitator was explained. As well as the role of the researcher – to take field notes and to manage the voice recording. Prof Terblanche was putting everyone at ease, establishing rapport (trust) – it is not a performance appraisal or a district meeting. It is about interacting with each other. Mrs Eygelaar was asked to leave the room – Prof Terblanche asked for approval, from the group for the presence of the researcher. They have no objections.

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Participants: 11 Participants attended the Matzikama focus group (attendance register attached).

Informed Consent: Written, informed consent was obtained for participation, field notes as well as for the voice recording.

Venue: A *private room* in the Manuella's Coffee shop was booked for the focus group as it was easily accessible for all the participants. In order to serve refreshments to the participants after the focus group.

Moderator/ Interviewer/ Facilitator: Prof Susan Terblanche (an experienced researcher – with … years of experience). Prof Terblanche succeeded very well in establishing rapport and succeeded to include everyone around the table in the discussion – by way of probing.

Establishing rapport: Rapport can be defined as an open and trusting relationship (Babbie, 2013:316) "Identifying yourself as a researcher, explain the purpose of the research, say that

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you are here to learn about them and to understand them, not to judge them or cause any problems".

Duration of session: 09h00 to 11h00 (2 hours).

Semi-structured interview: 5 Questions in total was covered – moving from general to the specific (Polit & Beck, 2012: 538) (see attached).

Voice recorder: The interview was voice recorded.

Reflective: Good, spontaneous participation. Lots of laughter. Focus group was done in a positive spirit. **However,** Sr Laubscher and Mervin Julius were very quiet during the interview. Two of the participants arrived late and have a disruptive effect. Background music was disturbing – Mrs Eygelaar request for the elimination of it.

Post interview procedures: the voice recorded interview was listened to and it was checked for completeness as well as for audibility. The content of the voice recorded interview was downloaded on the PC – in a shared drop box and mailed to Andre Hills for transcribing of the interview (30/04/2014).

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FOCUS GROUP:

1. **What is your perception on quality, client-centred care at the clinics?**

   Wat beteken kwaliteit "client-centred"?

   Wat verstaan julle of wat is julle persepsie van pt gefokusde diens?

   Hoe sou jy dit graag gerealiseer sien? Wat beteken die konsep vir jou?

   Wat is 'n customer service?

   Kom ons praat daaroor?

- Bettie (CBS): "Pasient self": Fokus het verskuif bv. Na statistieke, getalle i.p.v die pasient self. Ons vergeet soms waaroor dit gaan.
- "In totaliteit": En nie net die "seer knie" nie (simptoom). Weet jy jou HIV status? TB, PAP smeer gehad ens.
  Ek klient in sy totaliteit moet sien en nie net simptoom van die oomblik behandel nie.
- Groot getalle/massas kniehalter ons;

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- Dr Ockhuis: Pasient moet tevrede wees: Ek wat die diens gelewer het moet tevrede wees met die diens wat gegee is – dan sal kwaliteit diens kom!
- Tiaan: (Apteek) Tevredenheid: Dwarsdeur die sisteem tevrede wees – tevrede wees met die wagtye – tekort aan staf – apteek asste!
- Respek en menswaardigheid van die mens – moet dwarsdeur behandel kan word!
- Johlene: Kommunikasie om kwaliteit te verbeter. Wagtye word gebruik om ontevredenheid te toon – beter kommunikasie met pasiente. Ingeligde pt is 'n meer tevrede pasient.
- Sarah: Pasient met respek behandel; in totaliteit; inligting gee t.o.v diagnose en behandeling, nasorg kry – tevrede wees!
- Mervin: Kliente is die personeel (HR) – as hulle nie gelukkig is nie, gaan hulle nie kwaliteit diens gee nie. Meeste van die tyd hoofkantoor/distrik kantoor met spertye kan 'n uitdaging wees – personeel moet relatief tevrede wees en in staat wees om te doen dit wat van hulle verwag word!
- Rita: Kwaliteit is afhanklik van: beskikbaarheid van toerusting en verbruikbare voorrade;
- Adele (OT): Pasient se perspektief, verwagtinge en tevredenheid – afhanklik van die hulpbronne wat nie daar is nie. Gedurig aanpassings maak.
- Antonya: Kommunikasie - Verduidelik aan pasient wat jy vir hom kan gee in die publieke opset, weet tot waar die pasient gehelp kan word – pasient is 'n MENS;
- Tiaan: Personeel se mentaliteit (houding) rondom die staat: "Ag dit is die staat, hulle kan maar wag"
- Kommunikasie: Hoekom moet die pasient wag, wat makeer jy, dit is wat ons jou kan bied – onbevoegdheid van Srs – hulle kry net die pakkie pille – hulle weet nie wat doen die medikasie! Positiewe houding teenoor die pt wees.
- Sonet: Personeel nie noodwendig onbevoeg nie! Kwaliteit is afhanklik van personeel getalle: Tyd is beperk, een CNP, nie altyd tyd om in diepte te gaan.
  Kwaliteit lei onder die oorlading – het meer HR – voete nodig!

2. What input is needed to enhance the quality, client-centred care to clients?

Watter insette?

Die organisasie?

Watter strukturele goed het ek nodig om 'n klient gesentreerde diens te lewer? Watter ondersteuning uit die organisasie?

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Wat het ek nodig? Wat bestaan nie? Dit gaan die diens beter laat verloop as dit in plek is?

- Rita: Infrastruktuur benodig (fisies): voldoende spasie; konsultasiekamers, stoorplek (organisasie) – anders is alles deurmekaar, bly 'n gesoek;
- Mineke: Infrastruktuur (rehab): OT + Fisio moet een konsultasiekamer gebruik, selfs die biblioteek gebruik – dus nie so effektief as wat ek kan wees nie; paar klinieke het te min konsultasiekamers; is nie spasie nie.
- Ina: TB Program: TB kamers het nie aparte uitgang: pte moet deur die hele kliniek beweeg – uitleg van die klinieke nie altyd pt vriendelik nie soos bv.
- Ina: Counselling: almal weet wie gaan vir berading (HIV) – konfidensialiteit gaan verlore;
- ARV klinieke is nog apart – dus pte weet as jy by Sr Ohna ingaan kry jy ARV meds.
- Ina: Courier diens leemte: voorraad verspreiding;
- Johlene: Voorrade "stock outs": verbande, inspuitings, KMD kan nie altyd voorsien;
- Johlene: Begroting: Word op hoer vlak bepaal, volgens wat verlede jaar spandeer is ten koste van APP doelwitte, populasie vermeerdering, indeling word ook op hoer vlak gedoen;
- Adele: Hulpmiddele: tekorte aan rolstoele, looprame – daar is nie finansies vir rehab nie; nie 'n prioriteit.
- Ina: Diens/nasorg/instandhouding: t.o.v. rolstoele, extractor fans ens.
- Antonya: Infrastruktuur: Mondgesondheidsdienste: gebrek aan ruimte vir die permanente plasing van 'n tandarts stoel – moet dus gebruik maak van gewone stoel vir die trek van tande;
- Antonya: Admin ondersteuning vir die trek van die tandarts se 40 leers is gebrekkig;
- Antonya: Afsprake werk;
- Dr Ockhuis: Verbruikbare voorrade: "Stock outs" bv Webcalls, LP Naalde;
- Dr Ockhuis; Hospitaal personeel tekorte: Kraamsaal is deel van die Vrouesaal en funksioneer met net een PN;
- Mervin: Diensstaat bepaal deur hoofkantoor vl die grootte van die hospital – hou nie tred met die populasiegroei;
- Rita: B.O.D. verander: meer personeel word benodig, spandeer meer tyd met die pte;
- Denise: Groot verskil tussen die Privaat Sektor en die Publieke Sektor;
- Ina: Statistieke wys nie altyd dat jy meer personeel benodig bv. Graafwater het net een CNP; 'n dag het net 8 ure – een CNP kan net soveel pte sien per dag dus sal haar stats. Nie voortdurende akkumuleer;
- Ina: Distrik/Provinsie soek stygende statistieke vir die aanstelling van meer personeel;

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- Tiaan: Apteek benodig spasie vir die stoor van "bulk" voorrade;
- Tiaan: vervoer van medikasie – pre-prepare UTI ry nie uit tot by die klinieke staan oor by ander klinieke – depos wat nie temperatuur gerguleer is. Post basic asste is nodig om werkslading te verlig maar ook om te kontroleer dat di twat gedoen word reg is.
- Mervin: Motiverings word deurgestuur na distrikkantoor vir die motivering van meer personeel – is nie fondse.

3. **Which processes should be in place to enhance the quality, client-centred care to clients?**

   Wat is die strategiee op dag tot dag basis, kliniese intervensies wat moet gebeur in die kliniese diens – waaroor ek beheer het, interne goed wat kan verbeter om klient kwaliteit diens te lewer?

- Bettie: Moraal/ gesindheid/ motivering van personeel is tans baie lag: a.g.v die langdurige tekorte;
- Mineke: Maak 'n plan – probeer kreatief wees – wat kan dalk by die huis gedoen word;
- Tiaan: Gerekenariseerde/ elektroniese sisteme vir die apteek bv. Vir die druk van plakkers, moet tans nog met die hand geskryf word;
- Brumilda: Personeel kan ook meer positief raak - Skoon kliniek – kan gedoen word, sal pasiente laat glimlag;
- Johlene: Dept Werke – prosesse strem ons: mag nie projekte bo R30 000 doen soos bv. Self verf nie; kom op 'n prioriteitslys van 3-4 jaar;
- Dr Ockhuis: Wagtye - Triage word gedoen – pte bypass die kliniek en gaan hospitaal toe;
- Dr Ockhuis: Voorraad!!!;
- Ina: Personeel verstaan nie die logistieke betreffende die voorrade, finansies: te veel prosesse; te veel voorskrifte;
- Ina: Dr sessies by die kliniek van een uur lank – nie pasiente vriendelik – nie tyd om pt in totaliteit te sien – massa produksie;
- Rita: Stem saam met Ina en voeg by: Personeel situasie is nog erger wanneer personeel siek is of afwesig is;
- Mineke/Adele: Kommunikasie leemtes tussen die kliniek en die rehab span – skriftelike verwysings ontbreek – prosesse loop nie glad nie – vertragings.

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- Gemeenskap se mentaliteit moet ook verander bv. Gemeenskap verwag dat die "carer" na hulle toe moet kom;
- Tiaan: Carers moet kommunikeer wat kan ons vir julle kan doen en dit is wat julle moet doen.
- Antonya: Mongesondheid: die behoefte aan mondhigienis – tandarts moet self die voorkomende diens doen ten koste van akute dienste wat gelewer moet word;

4. What are your perceptions on the output of a quality, client-centred care delivered to clients

Hoe gaan 'n diens lyk waar daar goeie kwaliteit gesentreerde diens is – dit gaan die uitsette wees?

Hoe lyk 'n ideale kliniek gesentreerde diens – positiewe uitsette van 'n baie goeie kwaliteit gesentreerde diens?

Binne die perke van finansies – wat kan ons maak met wat ons het?

- Sonet: Konsultasiekamers: Groter en meer vir die hele rehab span.
- Sonet: Genoeg personeel - pasiente kan dan in totaliteit gesien word, beter aandag gee aan pte;
- Rita:Voorkomende inligting om die siektetoestande te verminder.
- Mineke: Voorkomende klasse: Mees algemene klagte wat fisio sien is rugpyn – klasse aanbied, spasie is 'n probleem;
- Denise: Pamflette in Engels: is nie op die kliente se vlakke; praat ek die mense se taal – gekompliseerde proses om te vertaal – media beampte;
- Tiaan: Post Basic Asst is nodig om die medikasie aan pte te verduidelik;
- Antonya: Multi Dissiplinere Span uitreike na die skole/ chreches – identifiseer wie behoeftes het;
- Adele:Skriftelike verwysings doen na Multi Dissiplinere Span – kry tans minimale verwysings van bv. die hospitaal – party dae net vier verwysings.

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5. **How can a programme enhance the quality, client-centred care to clients?**

   Wat kan ons doen om die diens te verbeter vir pasiente?

- Rita: Personeel vermeerder: Meet hoeveel pasiente per kliniek weg gewys word of loop voordat hulle diens gekry het – omdat hulle te lank gewag het – data moet gecapture kan word – verbruikers vriendelike manier om hiervan boek te hou;
- Ina: "Comm Serve PNs": Moet gedurende opleiding voldoende onderrig ontvang betreffende TB sodat pasient in totaliteit gesien kan word (TB, FP, PAP smeer, borsondersoek, HIV ens) – hulle weet net die basiese van TB en weet nie wat regtig aangaan nie;
- Sonet: Moraal van persone - Spanbou;
- Denise: Spandeer tyd aan die personeel – bv as hulle verjaar – kaartjie – dankie se.
- Johlene" CCAIR program – pt satisfaction + staff satisfaction beide sleg uitgekom het, daarom die insentief. By die hospital begin met die "spokie" inisiatief – om person gewaardeerd te laat voel;
- Tiaan: Apteek: Nommer sisteem – nommer trek sisteem of naam verskyn op 'n TV skerm, pt aanduiding kan kry waar hy in die lyn is;
- Rita: inligting deurgee, kan sommer inligtingsboodskappies deurgee;
- Mineke: Health talks: solank pte wag kan praatjies gegee word;
- Tiaan: Staff appraisals - inligting sessies aan wagtende pte; deel take uit aan personeel – almal kry 'n beurt om iets te doen – punte gee/kompeteer bv Mineke en Tiaan oor diarree!
- Mineke: Maak Carers ook betrokke en of die
- Denise: Counsellors: voorkomende health talks.
- Opleidng gee betreffende die praatjies – standaard te handhaaf.

OPSOMMING:

- **Holistiese diens aan pte;**
- **Goeie Kommunikasie met pte;**
- **Tans is klinieke oorlaai met getalle van pasiente;**
- **Min ondersteuning personeel wat kan help met assistensie;**
- **Infrastruktuur – spasie tekort baie beperkend op 'n kwaliteits van diens;**
- **Lae moraal van personeel moet aangespreek word: moet ondersteuning kry/ program – pte moet weet dat al is ek 12de in die ry die personeel weet van my;**

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- **Voorkomende inligting moet in verstaanbare taal deurgegee word;**
- **HR/Finansies: Personeel kan nie die hele sisteem dra nie;**
- **Personeel kan net soveel doen;**
- **Hulp moet van buite kom!!**

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Annexure N: Qualitative data analysis

THEMES, CATEGORIES AND CODES THAT EMERGED FROM THE FOCUS GROUP DISCUSSIONS

Table 5.1 Codes, Categories and Themes that emerged from the data

Themes	Categories	Codes	Evidence
1. Patient Rights	• Respect and dignity	Patient satisfaction	"I think, when one returns to the …. To the roots of it all …. Then, it is basically – in my opinion – to … or to the client or the **patient should be satisfied with the service** that I have provided …. And I should also be satisfied by the service I have provided, basically. Understand? (A001: 178)".
			"Um… however, I do think that um… um… one gets the um… **one does get patients who are satisfied** (A003: 353).
			"I would say it is um… the patient should be **satisfied** with the service that he receives. For example, when he leaves the clinic he should say, "I feel **satisfied**"; meaning he didn't **wait too long** for the service, he was **received** in a **friendly** way, and um… that what he had wanted he received. For instance, let's assume he was ill and um… wanted medication. He gets examined and he walks out with medication. So, he… *ja*, his **satisfaction** matches his **expectations** (A004:176).
			"Um... I really would like to see that – like Sannie has said – the **patient** should be **satisfied** (A004:362)**.**
			"I think **the patient would be satisfied** and the community is going to proud of their clinic at the end of the day and I think subsequently they would also convey a good message… (A004:177).

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			"Proper buildings. And then, the people. They should also be there. And also the appearance of our clinics. Obviously, that is our face. And our society is included. Then I would say, when the patients visit the clinic he would like to have reception… proper reception that is the face of our services. He wants a system that would treat him holistically. So, he would like to have the competent staff, personnel inside the building or the clinics and **he should leave the clinic satisfied** after the personnel have attention to him (A007: 399). (move to infrastructure and OPM)
		Lack of dignity	"Many times, **patients** are **called** by **numbers** at the clinics. Yes, it sort of takes away one's **dignity**, I think. One has to... (A002: 293).
			"Yes, and sometimes I also feel that it is more about **totals** and **statistics and we do not necessarily focus on the patient.** Sometimes, we forget what it really is about. I think… I think, initially the patient had been the focus but later on it became **statistics**, **statistics** and then we lose the focus of [mumbles]. Somehow we have to **return to the patient** and… but… if I can make an example… can provide… (A001: 224)".
			"About people who can't be bothered. I think, since we are a **small community** it is a disadvantage in the sense that **one knows the people** but also because we are a small community, one knows the people and then **one does just that little extra**. While there (in the Metro), **one literally is a number. One's name doesn't exist. They… they do not know your name**. So, I think we are doing better than… in comparison with other places but not nearly what we are able to do (A007:442)
		To show respect and dignity in an "ideal clinic" situation	"I think I am going to walk in there and it is going to be **spotlessly clean**. There would not twenty thousand people sitting. I am going to the counter and I am going to say what my problem is. I would like to see somebody about my problem. She is going to answer in a **friendly** manner, "Good morning. Um… we are fully booked today. Will you **please** be patient? Unfortunately, the doctor is fully

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			booked. How ill are you? Um… we will get the sister to attend to you first" and tell the patient **courteously** and then the patient will be **happy** to sit down and wait, or will come back tomorrow to see the doctor. So, um… then the patient would walk down the very **clean** passage to the sister's office (A002: 332).
			"To be **welcomed** by the sister and examined… **listen** to the **complaints**. Examine the patient. Suggest recommendations. Um… ask the patient whether she is **satisfied** with what we are discussing and decide and then the **patient** is **happy**. The patient gets his medication from the very **friendly pharmacist** who gives it to her, not somebody else. And um… on the way out, the receptionist will greet the patient while saying, "All of the best. We um… hope everything will turn out well" (A002: 333).
		Respect	"That is client-centred to me. **To respect that person** and their understanding of their world and their problems [mumbles]. And quality… then would be to – whatever time one has to spend with a patient – really **try to give that person your full attention** and to feel that that person as person is valuable and that you would indeed try to give each person the same and not to advantage or disadvantage somebody because you might perhaps like them a lot more than the previous… than the other guy. And then, yes. Basically, to make available to a patient all the applicable **resources** that you have at your disposal. Whether it is something that is from you, whether it is something that comes from a referral. To simply work realistically within the clinic context and not to create false hope of… There are all these and those and those but you know in the end it would only be available to a handful. I also do not make empty promises (A003:96). (D2 Patient care)
			"To treat the patient with the necessary **respect and dignity** and not to force my own opinion onto the patient. But I am… I would also say, when I… walk into a clinic for the first time I look at the way the staff members are dressed (A004:95).

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			"The **client should be treated with respect** from the time he enters the clinic. He should be observed in totality and should be treated accordingly. And um… should get the necessary information about his diagnosis, as well as the treatment he needs to receive. And um… the aftercare should also be explained to him and as a satisfied patient, he should get [mumbles] (A001:445).
		Clients show respect to staff	"The **personnel** would feel better because people would **treat them… patient would also treat them respectfully** at the end of the day (A004:397).
		Staff are identifiable	"So, and often it is the same in the private sector. Look, they are always **neatly dressed and identified and they radiate that professionalism.** So, I think we need to also start in the public sector for everybody… (A004:101).
			"Yes because I always look at the **identification**. What is this one's name and then I know, okay. It is [Name Surname]. Then I also can address her accordingly. Like even in the shops when I buy at Shoprite or Checkers, "*Oompie*, thank you". And then [mumbles] the guy… And you know, they are always, "No, it's all right, Ma'am. Thank you". Because often when one addresses somebody else by his name then it's almost as if an instant connection of mutual **respect** is created… (A004:100).
			"Yes, I also have thought of establishing a very good personal relationship with the patients. As long as one… I do not that it takes a while getting to know them. One cannot know everybody but to remember that this one the previous time told me about her little daughter who is ill and to ask whether the little daughter recovered, to relate more on a personal level. And like you have said, **to address them by name that also… To really know the patients and to establish a relationship** with them… (A004:68).

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		Ethical responsibility of staff to do everything for their patients	Yes, but I also think that the… the **personnel** should **personally** take **responsibility** and… and say but – I mean – everybody in the health services – that's the way I feel – they should take **an oath to declare**, **"I would do everything for my fellow human beings**. Um… (A001: 233).
		Positive staff attitude	"One has to be **friendly**. One has to be **interested**. One has to be **caring** (A002:311).
			"A **positive attitude**. People would be more positive to visit the clinic (A004:396).
		Negative staff attitudes	"I do not want to tread on toes and that type of thing but sometimes one feels that… that some members of **staff** say, "**Ah, well. It's the state. People just have to wait**. Anyway, they do not have a clue what is happening here" (A001: 230)
			"So, I just keep on doing what I am doing, **t**rying my best to what I have at my disposal. **One is not going to try and do that extra [thing] because what difference does it make**? (A001:159).
			"That **attitude**… and... And then it's easier to convert an attitude in clients because he will just **have to make do with what he is getting** (A001: 263).
			"It also... sorry that I'm like that when I see a patient. It also seems that if... if like certain patients that are viewed as maybe **difficult patients** or they may be **psychiatric patients**, for other reasons or because the receptionist often knows the people in the community. There's... I think, there's quite a bit of **discrimination** in terms of the quality of service, the reception that... that they get (A007:440).
		Patients are angry and livid	"An appointment system, yes. I mean, when I am on medical aid I also have to wait for the doctor but I don't sit there for this morning eight o'clock until four o'clock this afternoon. I think it is demoralising for any patient. Then, when he gets to the sister, he is already worked up and he's **angry** and he's **livid** and all such words… (A002: 170).
			"I… I would like to add something. The uh… uh… I am not at all answering your question, I know. I also think the patients need to start taking ownership of their own health but

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			also for the clinic. **All of the patients arrive there. They are already angry** (A002: 334).
			"I am oversimplifying and I am exaggerating in what I am saying. But they arrive there and they are **already angry**. They have **no understanding** of the situation or show no understanding of the sit… So, I feel one should get to the point where they also take ownership, *né* (A002: 180).
			"Of course, and then one also get **patients**; patients who attack one **verbally** (A003: 343).
			"Can I possibly add there? I think also affects your dealing with a patient because if they aren't at the first point when they get to the clinic is not a good encounter, then the **patient sits there with that anger** and sometimes, it happened before. And then, **they take it out on the first person that they see** and if it's you, then it affects your attention [sic] that you end up giving to the patient. So, I think it's very important. Especially when they come for the first time and they don't know what to do. Your first encounter is I'm just there, pushed away or they're not speaking to me nicely or... I mean, I won't go into that clinic (A007:400).
			"I had a **patient** sit in front of me, **shouting at me, speaking not nice about the services we provide**, about the actual patient who was sitting there who happened to be a child. Um... you don't get anything done because they're so busy complaining. Then they threaten that they are not coming back. They think about this, they think about that. Now you sit there. You are worried: What is actually going on? And you have to provide this patient with a service. I don't want to – to be honest – I didn't want to provide that patient with a service (A007:179).
			"And then, all they actually say is keep quiet. I literally do not attend to them and then that escalate and the **person starts shouting at reception because there's forty sick people, or ill people sitting there.** And the situation becomes like type of unpleasant for everyone. Whereas if you went through the little bit of extra effort and telling that person, you might be very cross with them...

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			anxious... possibly hard... like on their way to become psychotic. That... There should be a reception that's tailored to the needs of that patient. I feel... and um... to make it easier on everybody – the patients and the staff members – um... to allow the service to flow (A007:441).
		Lack of confidentiality and privacy	"No, the administration does not really affect… where… where our problem lies, is with the TB programme because we do not necessarily have TB room that uh… does not have its own entrance and all the facilities. As a result, it is a problem to some of the patients that these patients have to physically move amongst them to fetch their medication. Um… so… so, yes. There is not really the same kind of problem with the **HIV programme** as… as… I think the **layout** of our… of our… of our **clinics** is not always, let's say, not that **counselling-friendly**. In some of our clinics, the… the… counselling room is literally situated in… in the centre of the… of the clinic. As a result, patients are able to **see who enters** and **who exits**, as well as **how they appear** when they exit the door. At some of the clinics, it sometimes put patients off to the extent that they are reluctant to test for HIV because um… sometimes they do know what the results would be and they… they also realise but when I exit through that door, when I remain in that room for too long, then they people are immediately going to put a board [**label**] **around my neck**. Um… and also in relation to our current ARV services, we have a separate ARV clinic inside another clinic. So, the people know that when one enters that door, one is going to see the ARV sister. In other words, that person has to be HIV-positive and there is…" (A001:237).
			"Yes… and, for instance, the very young girls who are coming for **family planning**. They have to sit there amongst those women who say, "*Kwit*!" The things that they are discussion with the girls are inappropriate. **One has to have different areas** (A002: 171).
			"No fine. I… I also think another thing, it removes the feeling of a crowd. I am one of a crowd. This… its small groups. Small… because you're still **completely exposed**. This I

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			want to say, like, for example, in that model one remains exposed. The people notice but you are **entering through one door and everybody sees where you are going**. Therefore, that issue of… of anonymity one is going to remove with great difficulty but I do think it eliminates that feeling that I am part of a crowd. I am part of a smaller group. Um… I… I… is more manageable. Um… oh! It's spacious. It's huge. It's sunny. It's… There's a green feeling… (A002: 297).
			"No, it has because one is once again… In the first place, we ***physios* undress our patients** because we have to look and we have to feel. Then, someone knocks on the door. It… in other words, **we do not undress the patients any longer because somebody else may enter at any time**. Number one, yes… And also when one… the funny thing is as soon as one touches a person then they start talking. Um… and now someone is knocking and that… that basically stops one's entire treatment. That… I don't know. It influences one's communication with one's patient and stuff (A002: 300).
			" I fully agree with what Nellie had said. I think that, for example, what Cupcake was saying about we need to undress the patient and here **someone comes in**. I think you disturb that connection between the client and the practitioner as well. Because now the whole mood shifts from what you were discussing or what you were doing with this person coming in. And the whole issue of **confidentiality** as well. **Somebody** might **hear something** that was meant for the practitioner. So, patients – I would say – sometimes are even too scared to open up because of that. (A002: 169).
			"But what happens often, one is busy with a patient and we as visiting outreach personnel are at an advantage because they do not know us that well. Um… where they have the same problem with the same sister every day, perhaps later on they become disenchanted. So, when one talks to a patient, you connect and they open up. And as soon as sister X enters the room and she says, "Sorry, Charmaine" or this and this and this. Or "Sorry, Inge"

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			that, that, that. What happens then um… the patient says, but okay. The two of you are in fact in cahoots with each other, therefore, I am not going to talk any further. So, there is absolutely a **confidentiality breach** that is happening there. Then it also makes it difficult when you add the staffing movies with personnel who are not there, then it happens that one knows that one has to get this service for this patient. One knows one has to make an appointment at the psychologist. One knows one has to also book this patient at the *physio* but there are now personnel. In other words, that opportunity does not exist. The sister has to immediately pay attention to this result of fever that one has discovered in one's patient a short while ago. One cannot handle it because the sister is too busy. Then, he has to return either tomorrow or the day thereafter for a sick appointment. So, the services, although let's assume it is the ideal, the service is not available due to staff [mumbles] (A002: 303).
			"Sometimes, **patients feel um… the personnel are discussing their diseases or um**… their files or whatever. So, that another thing that I think plays a part in the… in the… in the… (A007:401).
		Lack of privacy	"There is **no privacy**. Often there is no privacy (A004:370).
		Lack of trust	"And then, when a **patient feels he cannot trust** or he feels he's uncomfortable to talk to somebody about his condition, **he would not return**. Or he is going to the service… (A007:412).
		Confidentiality challenges in community based services	"Then it is once again a chasing out thing to do supervision, follow-up. We are talking about **lay workers**, how they are handling it, how they are bringing their own point of view to the service. We are talking about small satellite towns where perhaps the **HIV** sister would come to me and say um… there are rumours… are spread that the **carers feel that the names of everybody who are involved at an ARV clinic should be disclosed to protect the rest of the town**. So, one gets those situations (A003:342)

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	• Access to information for patients	Lack of information about treatment and care	"Clients who we come across in the community who… who… who do not… they are not necessarily aware of their condition. They **do not know their diagnosis but we do hand out pamphlets**. Pamphlets because we have to and out [mumbles]. We also had to see the patients. But one has patients who still **do not know what's wrong** with them and how they can restore their health. In that case, the whole idea of client-centred is totally mis… understood" (A001: 225).
			"The client should be treated with respect from the time he enters the clinic. He should be observed in totality and should be treated accordingly. And um… should get the necessary **information** about his **diagnosis**, as well as the **treatment** he needs to receive. And um… the aftercare should also be explained to him and as a satisfied patient, he should get" (A001:25).
			"I fully really agree with Nellie. I also feel for me the most important thing is education. You need the control cause your patient needs to be **informed** about their **diagnosis** or their **illness** or whatever is happening with them so that they can actually take responsibility and maintain their… their health (A002: 331).
			"One is going to **provide him with all the information he needs** but one is going to make it patient-centred in order to adapt to his needs (A004:57).
			"You must know the **procedure** to be able to **tell them** from the beginning. **Take them through**. They must know what you're expecting from them and what they can expect from you (A002:312).
			"Yes, **he's going to know exactly, this is what I have to do**. My date is in six months' time. I'm not going to visit before then. I will be able to use it at home as a home remedy and things like that and whatever. Therefore, his is going to a lot less… (A002: 328).
		Importance of communication	"In the event of his arrival, firstly he knows about the doctor or the um… sister can assist me in this way but she would **not be able** to **assist** me any further. Therefore, he knows already. He could not expect that [a service]. He cannot expect that big [mumbles] but at least here we can **communicate**… **communicate**. Because you communicate that patient feels **dignified**. Not simply saying: "Sit. Where does it hurt? Okay, here's your packet of tablets. Off you

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			go". You know, that is simply looking at that one specific problem of the patient (A001: 26).
			Um… yes and then… Yes, **communication**. That… that the patients at least know where… **why wait**… why… why… **what medication** is he using because sometimes I feel that there is no competence of… of… of sisters because they do not have the knowledge about medication, amongst other things. That is why **people do not know why**… why… why do I have to take this tablet? Why? (A001: 231).
			"Um… I think at… from my point of view it is about… or what I have observed over the years, **communication** to ultimately ensure the satisfaction of your patients. When that patient enters, you have to **explain** to him that it is um… public prices. This is what I can offer you. I can try to offer you a little more but then you have to… You know, you have to **explain** to the patient exactly **what you can offer him** and also what the private sector can provide him with (A001: 65)
			"Often, I try and **convey the message** of the importance to continue doing it because I think the patients do not always understand. They simply **expect** to come in and **you have** to **fix** it there and then, however, it is a chronic problem (A001: 35).
		Provide information about the services	"I would say very well. Number one is, for example, say at **reception**, *né*. There should… there we should have signs with the purpose of continually providing the patients with **information**. Which staff members, which services are provided today? (A007:426).
		Right to know what they can get at the clinic	"Patients have **the right to know what they get at the clinic**. Patients have the right to know what the treatment is going to cost. Um… the patient has the right to choose whether he wants the treatment (A007:172).
		Information about the available services	"I think, I one goes back, it is **every personnel member**, every supportive system, every person who is working there **who** has **contact** with a **patient**, with a client has a duty to contribute. When you as a diabetic walks in at the sister, you are [inaudible]. **That person should be able to tell you these, these, these are the steps that we are going to follow.** Are you still okay? In other words, client-centred service. Then you are going to walk in at

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			the sister. **Sister** is going to say, right. This medication is needed. So, you are going to see **doctor**. We are going to perform this test on you every six months. You are going [sic]… to you or ventilated [sic] down to you uh… to your support group. You are going to see the **dietician** because she has to assist you with your diet. You are going to see the ***physio*** for a lifestyle adjustment. At the support group you are going to get jobs [sic] and we are going to weigh you every time. Do you still have support? Perhaps there is an issue at home that causes you to be emotional. You have to see the **occupational therapist**. The sister. When you report to the clerk then you have to say that you are a diabetic. Then she is going to tell you, have you been to this [one]? Have you been to that [one] yet? Do you know about this already? Do you know about that? When you get to the occupational therapist then the occupational therapist needs to tell you, do you know about the dietician? Have you been to the *physio* yet? What do things at home look like and wouldn't you perhaps like to also go and see the **clinical psychologist**? (A002:314).
			"Some of them… or the majority **know everything about the service** and what **they can get out** of it. Therefore, sometimes people probably just [mumbles] but at other instances, it is about basic things that we cannot provide. Then we have to make adjustments to take it to a level that would satisfy them. And afterwards you sort of know… "(A001:229).
		Not all patients are aware of the available services	"I often experience that **patients do not know about the services that are available**" (A002: 187).
			"The problem lies at grassroots level. I… I think we once again have to compassionately say we are working with **ordinary people**, *né*. They… **they do not know these things**. They do not know about a concept like **occupational therapy** and never mind even what that occupational therapist does, or the **psychologist**. It's mad people who go to the psychologist. They… they do not have the… the broader concept and understanding of what it is – not what our role is – **but what work are we doing** (A002:315).

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			"A lot of patients just think I... I'm... as a **dietician**, I can only help them to lose weight. They **don't know about the other services** that I can also offer as a dietician. For OT and for *physio* it... it's the same. So, patients need to work with us as health professionals (A003:352).
			"May I quickly elaborate about what Japsnoet has said? It's true, everything he is saying. When the **people have toothache**, they do **not go** to the **dentist**. They are going to the **medical doctor** or the sister and… Or they say, yes. Then they have had a swelling. They simply wait until the swelling subsides. I agree with Japsnoet. It boils down to… the patients come but one could tell the patient, come to the dentist when you have trouble with your mouth. The run to the medical doctor. Then, I have to fork out money again to see the dentist. So, it's also a… (A002:188).
			"I think I should... I think another thing that we can do is when we pick up there's something that it seems the **people don't know about your particular field of practice**, like let's say that needs to be done at the hospital. That we need to **raise awareness** amongst each other about those things. So, um... that should be put under training, or the staff, or having forms where you communicate um... these sorts of things. Like the PMS can use it more because at the moment, it's not always attended by everyone. Maybe that should be communicated in a different way in a letter or something to the... (A007:428).
		Language not understood by the patient	"About that um… **prevention section**, one point that we also have a **problem** with is that we receive pamphlets but the **pamphlets are in English**. In other words, we are not looking at the basic need of the community. **Nobody here is reading Engels** and things like that. Are all basically Afrikaans [speaking]. You do not speak to the people. You don't simply hand out a sheet that they are in any case going to read. Therefore… therefore, the level that we are moving towards is not on the level of the client (A001: 275).
			"Another thing that I think we need to always realise – and I am saying it with great compassion – we are **working with ordinary people**. And uh… we should… we should step down from our little thrones and move towards them. **Talk their language**. On… on… on… I don't really

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			know how to express myself but one needs to really one's use of language, one's approach in order to reach him. Otherwise, one scares him and one does not get… unlock him" (A002: 60).
		Communicate on a level that the patient understands	"Look, from my frame of reference as **dietician**, I would say um… when that patient sit in front of you during consultation, then the **information** that he receives will certainly **be on a level that he understands** but that he should also be treated professionally and perhaps also to look at um… if I can put it this way, one needs to accompany that patient down the road (A004:59).
			"Yes, he has the **information and understands, understands** what I am trying to tell him and then his limited resources… for example, the bicycle [sic] at home and his financial situation will enable him to apply at home what I have told him (A004:58).
		Patient has the right to choose whether he want the treatment.	"Patients have the **right to know** what they get at the clinic. Patients have the right **to know** what the treatment is going to cost. Um… the **patient has the right to choose** whether he wants the treatment (A007:173).
	• Reducing delays in care	Communication about waiting times	"Like what he just said about the **waiting times**. That is where some of my staff members usually… I think it contributes greatly to patients using waiting times um… where [mumbles] encompasses it. And… and where we **fall short is communication with the patients – especially time wise – is really not up to standard**. I think it is… it is quite **poor** at most of the institutions. Um… perhaps people should try and focus on um… a few issues. The… the… the quality thereof… improve and provide to your patient because an **informed patient** is a more satisfied client and the moment that the patients… "(A001: 64).
			Um… yes and then… Yes, **communication**. That… that the patients at least know where… **why wait**…" (A001: 230).
			"I agree with Japsnoet on this point. Once again, the most important thing for me is how one receives that patient… receives that client. Not… one needs to receive him and allows him to experience that he has a hundred per cent

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			of your attention. He should never feel neglected. One has **to keep him informed** at all times. When perhaps there is a **delay** or something, one is going to say, he is perhaps **going to wait a little longer.** I think is simply going to… That's very important to me (A002: 67).
		Communicating with the patients	"I think lots of patients now understand – what I'm now going to confess – like when a patient comes to me, then I **say**, you know I can assist you but I really don't have the time. Because if I'm assisting you now, I have to do exactly the same for the next three as well and then I would never get to all my work. So, as it is at the moment, one doesn't get everything done. And then, perhaps a patient understands but then I say it's not my job. Go and see that one. It's that person's job and if you are not satisfied, take it further but I can't…it's not my job. I cannot assist you because I have crowds whom I have to attend to on my own. And if the patient says, no. He's not really happy with that but they do understand it to some extent (A007:61).
			"Especially when you, yes, **say** for instance I want to assist you but I can't. There is simply no way because otherwise I have to stay until late in the evenings (A002:62).
			"Yes, I would just like to add to that. Some people forget to **explain** why they can't actually help you. But like in you case, she literally couldn't. Someone else can help you but I can't at that time. But some other people are like, "I can't help you. Please leave." And then the patients become upset and they take it out on everyone else. So, it's just that **communication** with them why (A007:63).
			"...sometimes it could take six months before the system is in place. But I've learnt to **communicate** with the patients (A007:427).
		Waiting time is a problem	"But perhaps also, when I examine the clinic setting. To say, we often know the **most pressing problem is the waiting times of the patients**. And perhaps, it includes their lack of experience – how can I express it? – When they receive the information about the way in which processes at the clinic work (A004:359).

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			“I think – if I may interrupt – um… say, for instance, like on a day when there is only **one sister** the **statistics**, for example, need to be submitted on that day. Now, all the patients have to wait because the… the *admin* stuff has to be submitted first. So, um… um… perhaps… it could perhaps happen that the p**atient needs to wait a while longer.** Has to be a little more patient (A004:109).
		Awareness of the complaints procedure	“We asked at the previous hospital where I was working that… that the patients… that we say that, sorry. **We do not have hearing equipment but you as patient could write a letter to whomever and complain** that we are unable to provide the services. So, we have… (A004:174).
			“Yes. So, we started **telling our patients, but are you complaining? Are you writing letters to whomever**? Um… (A004:391).
		Few compliments received from patients	“Yes, the **compliments** and then the clinics are actually getting very **few** (A004:392).
			““It is a **few** but those patients who writes one a letter and the people and calls the people by name and **compliment** them on their service. I received a note from somebody who had written a letter to **compliment** me and the service from reception until she went out the door again (A003:354).
		Complaints are in majority	“ ...because **most** of the time it’s **complaints** (A004:393).
		Complaints not taken seriously	“The patients are known. So, **if you know the patient is a constant complainer, then you might not take his complaints seriously** (A007:439).
		Compliments and complaints	“Look, when one examines the **compliments** and the **complaints**. There are certainly compliments that arrive from the clinics and one could say **eighty per cent of the patients are happy with the service**. It becomes quite small the… the minority who might have a problem.(A007:402).

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		Availability of complaint-compliment boxes inside the clinics	"But it does get done here at the moment. It's that… the… the… The clinics have such **post boxes** and then, every week the post boxes are… are opened and examined to see whether they are **complaint** notes or **compliment** notes and then they get entered on Symfoni [sic]. So, it… it does get measured and… (A004:394).
		Patients complain at the MEC	"And it is like that. You are now talking about advocacy and the nurses. Now, I'm only talking about complaints. About **empowering** the **patients**. Nowadays, the patients **phone the Minister of Health** and the Minister of Health goes to that nurse manager and demand to get an answer within a limited period of time why you have turned the patients away. Because say, now here are four hundred people; here's only one CNP. So, she could only… So, then they have to be turned away. But there are not enough hands, but the Minister of Health still wants it clarified (A004:395).
		Makes it worth wile to wait	"Like in Stellenbosch, where one has such a lot of seated patients who are waiting. At least, then one **makes it worthwhile to wait**. Try it for like four months because every patient is obviously not sitting at the clinic every day. And then… it's difficult. Everybody should be where… then you **conduct sessions**, half an hour sessions, where everyone at the clinic is afforded the opportunity to stand in front of the clinic to at least talk about something. **Preventive** or um… (A001: 289).
			"I think that is also where staff… staff appraisal – or whatever one wishes to call it – like it complicates the process a little. Um… that people, let's say like in a situation where one has a couple of nurse practitioners who are… who are… who are… working um… and… and everyone gets a turn to do something and then one could – I know it sounds tedious – but like give the people marks or… or… or to explain how they understand it or like a question that… that one completes. Um… and then… and then one could at… at the clinic also a type of… for example, [Name] and I or [Name] and I need to for the same – sorry – for

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			the um… same… same week [we] could **present lessons** against each other for the people who are… who are **waiting** there. I mean, simply to provide them with **information** that addresses their concerns. I mean, diarrhoea… um. How mean **children** die of **diarrhoea** because… because parents do not have the necessary information how to perform a quick **rehydration**. Um… how to **clean water**. I mean, sometimes the water one finds in the rural areas is dirty. Um… how to quickly clean water when… when you are battling with diarrhoea. Such small kind of things (A001:290).
		Information about how long they will have to wait	"I think um… if only that **patient could know what his position in the line** is. Um… I don't know how one could achieve that, how one um… But I know that here in [Name] the [work] load is not terribly high and I had…I had… um… last year I worked in Gugulethu or at [mumbles] in Gugulethu um… and I mean there – where a pharmacy normally would handle about a hundred and fifty prescription per day – I had um… drawn four hundred, five hundred prescriptions per day. Um… how those people spat against the windows because they were tired of waiting. They were swearing and saying and going nuts. But… but when you, for instance, have a system of receiving a number or… or um… or like a… **a TV screen where… When… when one hands in one's file, then your name appears there and then the next ten people could see who are next in line to be assisted.** Um… that kind of thing. It's at a pharmacy… the people… (A001: 287)
			"Yes, and then that person also **knows** he is going to be **assisted** in a **short while**. Okay, I'm going to remain calm for the time being (A001:288).
		Appointment system	"But fortunately now, we are busy with um... [a] project or I'm attempting a project of **using appointments** that will help a lot. Um… some of the personnel will not admit it but um… um… **it works** because only that particular patient is present and the first patient of my shift is there. Now, the clinic is more relaxed. At that stage, there is not a massive group of patients standing there. All of them will

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			say um… it works and are glad that you have implemented" (A001: 248).
			"Um... I work in both the sub-districts and the Matzikama sub-districts and in my experience, the reception where they work with in... on an **appointment basis** it's a lot more **controlled**. So, the receptionist is not so overworked and they're more friendly because they know they... they don't have that much [sic] people to handle at one time. Whereas in... in this sub-district, they are **not** working on **appointments** yet and they do feel **overworked** and then... They can come across as a bit rude, if I can say (A007:201).
			"An **appointment system**, yes. I mean, when I am on medical aid I also have to wait for the doctor but I don't sit there for this morning eight o'clock until four o'clock this afternoon. I think it is demoralising for any patient. Then, when he gets to the sister, he is already worked up and he's angry and he's livid and all such words… (A002: 15).
			"**Appointment system** and they need to be given 'n regular date. So, don't give them a date for the fourteen week injection. Give them a date for a month letter so that the follow-up process can be better. And then also in the hospital, mothers are being discharged and are unable to breast feed. Um... staff within the hospital, before the mother is discharged, they should check that the baby is latching properly (A007:11).
			"Communication. And then, the **appointment system** with the known patients, like by now every patient has a… a clinic card, né, that has been neatly place inside a little plastic holder. So, then to record the appointments on his card so that the patient knows there is a little form for him. And to communicate with the patient to arrive on the date that appears on the card. And then, to honour the times that have been given to them (A007:12).
			"Before I see all my patients, just talk... you can just talk to them. It's not that difficult. I know it takes up of your time but

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			to stand in front of the clinic and just to have a discussion with them. But again, if you have the **appointment system**, we have a smaller load to lead. Now there are a lot of people that talk over you. But if you go to Matzikama, it's a small amount of people, very quiet and also, it's an experience for them. No one is shouting; they're sick. It's a small group of people and you can actually speak to them and they can respond because they can... they can actually listen to you (A007:16).
		A triage system to manage waiting times according to the seriousness of the patient	"Yes, basically the ideal is merely um… look, yes. The one thing that people… that everybody has raised is the issue about the existence of **waiting times**. To continue, there is um… **there is a triage system** in place allows for patients to be classified according to a colour code. For example, green patients – now those are patients whose… everything is stable – he could wait for up to six hours. Understand? Yellow patients, for instance, could wait about two hours and then, orange and red need to be seen like immediately, understand? So, um… some… (A001:269).
		Patients' have the attitude to bypass the clinic and go to the emergency at the hospital	"…of personnel and then… then sometimes the numbers are also an added problem, especially… the **patient's mentality** is sometimes also a problem because they… they… they know that they are going to **wait** at the clinic, **then they go to emergencies at the hospital**, understand? (A001:270)
	• Continuity of care	Come back tomorrow	"If I could join Japsnoet, what often happens is that the client is seen **today** but there are still two or three steps in the process that still need to be completed. Then, **come back tomorrow and come back the day after tomorrow and come back again a day after that**. Perhaps then we could have completed the whole situation instead of taking that chunk of time to pay attention to and to **complete one** client" (A002: 48).
			"Clearly, there is simply a **communication gap** between the **sister** and **us** (**rehab team**) because the sister want to give us patients who… (A001: 67).
			"I… I think when one has a program that… let's take something like the… the um… the sister who to the… who **refers** the guy to

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			the um… **physiotherapist**. The physiotherapist could **post** a **note** in the program **to say**, listen but this and this and this. That is **what I have found** and… and things like that… (A001: 271).
		Rolling in community service staff	"Yes, **continuity**. Incidentally, for the patients it's going to because now it's **somebody new again** and they still have to establish a relationship with you. Especially, with us at *rehab*, one needs to establish a reasonable relationship. Firstly, they first have to trust you and then… have to convince them that you would be able to assist them and after that you leave and somebody new arrives. So… (A004:69).
			"**Consistency** of the service because with the **rolling** in ***comserves***, it takes us a while to um... also get into it and then we **lose patients** like that. Because they're waiting for an appointment or they don't even know... (A007:437).
	• Right to be treated in a healthy and safe environment	The right to be attended in a clean area	"The only way I could answer, the patients have **the right to be attended to in a clean area**. So, cleanliness is very important to the patient. Especially when [mumbles]… (A007:119).
2. Patient Care, Clinical Governance and Safety	• Patient Care	View the patient in totality	"I feel that when the patient walks in we have **to view him in his totality**. Um… not only the sore knee but um… engage with the patient: "Do you know your HIV status? Is there perhaps somebody in your household who is on TB treatment?" Because there is such a TB hotspot in our area. Um… "When last did you do family planning? When last did you have a pap smear? Um… you know, slight… slightly more comprehensively" (A001: 75).
			"The client should be treated with **respect** from the time he enters the clinic. He should be observed in **totality** and should be treated accordingly. And um… should get the necessary information about his diagnosis, as well as the treatment he needs to receive. And um… the aftercare should also be explained to him and as a satisfied patient, he should get" (A001: 226).
			"…not simply necessarily… But we're all in the same programme. But I feel that we have to instil from day one – let us say in nursing – that idea in personnel to **approach a patient in his totality** in order to provide a quality service.

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			Therefore, whether you are at a hospital or whether you are at a clinic, your focus should be that at the moment you are working in surgery. In other words, now you are focusing only on the postoperative dressing of wounds (A001:74).
			"Regard the patient in **totality** so that when you walk into a hospital um… you should be able to ask that patient, what your HIV status is um… Have you been tested for TB symptoms, have you had a pap smear already? Um… is your family planning, are you? Because we experience that so many patients, for instance, go to a TB hospital and then they return pregnant. Nobody paid attention to family planning. Um… so, it is a case of you are sort of focusing only on you… (A001:75).
			"I agree with her whole-heartedly because every patient is an individual and [it] does not make… and to almost say pain is physiological, psychological; so many other things that could contribute to toothache. I'm moving away from backache completely but when you one is not really spending attention and time on that specific patient and problem and not observing him in his **totality** (A003: 262).
		No **time** to view the patient in totality	"I… I think it still boils down to what I have said a while ago about um… we do not want to treat the symptoms only but want to **consider** the **patient** in **totality**. Uh… and… and I think… I… for me personally it is our… our… um… our entire support system is… is not client friendly. It's mass processing. Um… for instance, the s-sister [sic] sees the patients and doctor visits the clinic for an hour session only to attend to those patients who are really ill and who sister couldn't sort out. In other words, we lapse into a process of um… sister stands next to doctor and when [Name] enters, sister says, "Doctor, I think [Name] has cellulitis". Then doctor… or then he looks again. Yes it is cellulitis. Go to hospital. There is not… physically, there is **no time to treat** that **patient** in **totality** to establish what really the source of the cellulitis is. When he is in hospital, then things start to be sorted out and to be unravelled um… to perhaps establish where it

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			originates but… but that – let us call it mass processing or whatever – is… is a… we are on… (A001: 73).
		See someone as a whole	"For me it is to see **someone** as a **whole**; not only a knee or something. And also, to involve everyone who could have an influence on the patient in order to provide him with a better outcome (A002: 92).
		Not seeing the patient as a whole	"For example, say that patient comes in with a **cough**. Um… Say, for example the patient has **TB** but this particular sister focuses on **pneumonia** or whatever that she misses the point completely and, therefore, she doesn't even screen the patient for TB and then the diagnosis is completely inappropriate (A004:93).
		Holistically	"If I could take Cupcake's idea further, I think she also talks about the accessibility of other people. Therefore, when a patient sits in front of you and you observe that he has not eaten **to call in the dietician in order to involve all the role-players**. How to approach the patient **holistically** in order to provide a quality service. In other words, you are not only going to do your small part and then to hand over. One should include those persons in order for you to approach it holistically and to also involve the **family** to provide the other services (A002: 190).
			"I think um… we are never one profession only. One specialises in one profession, like for example I am the OT but I am net just the OT only. Sometimes, I am the psychologist, the *physio*, and the nurse, and the dentist, and the dietician. However, I do not perform the entire duty of those professions. I refer further. Therefore, one needs to be aware what the person… let us call it **holistic**… **holistic view** and when you perceive holistically, only also looks at the patient as an individual like, for instance, if I may refer to backache. When a person has backache, sometimes it is more a psychological cause than biological. Then one needs to know, okay, one is going to treat it biologically because it is a symptom. In other words, one gives him a lot of things. One gives him exercises for the back and refer [him] to the *physio* when necessary and perhaps [to the] doctor for tablets and

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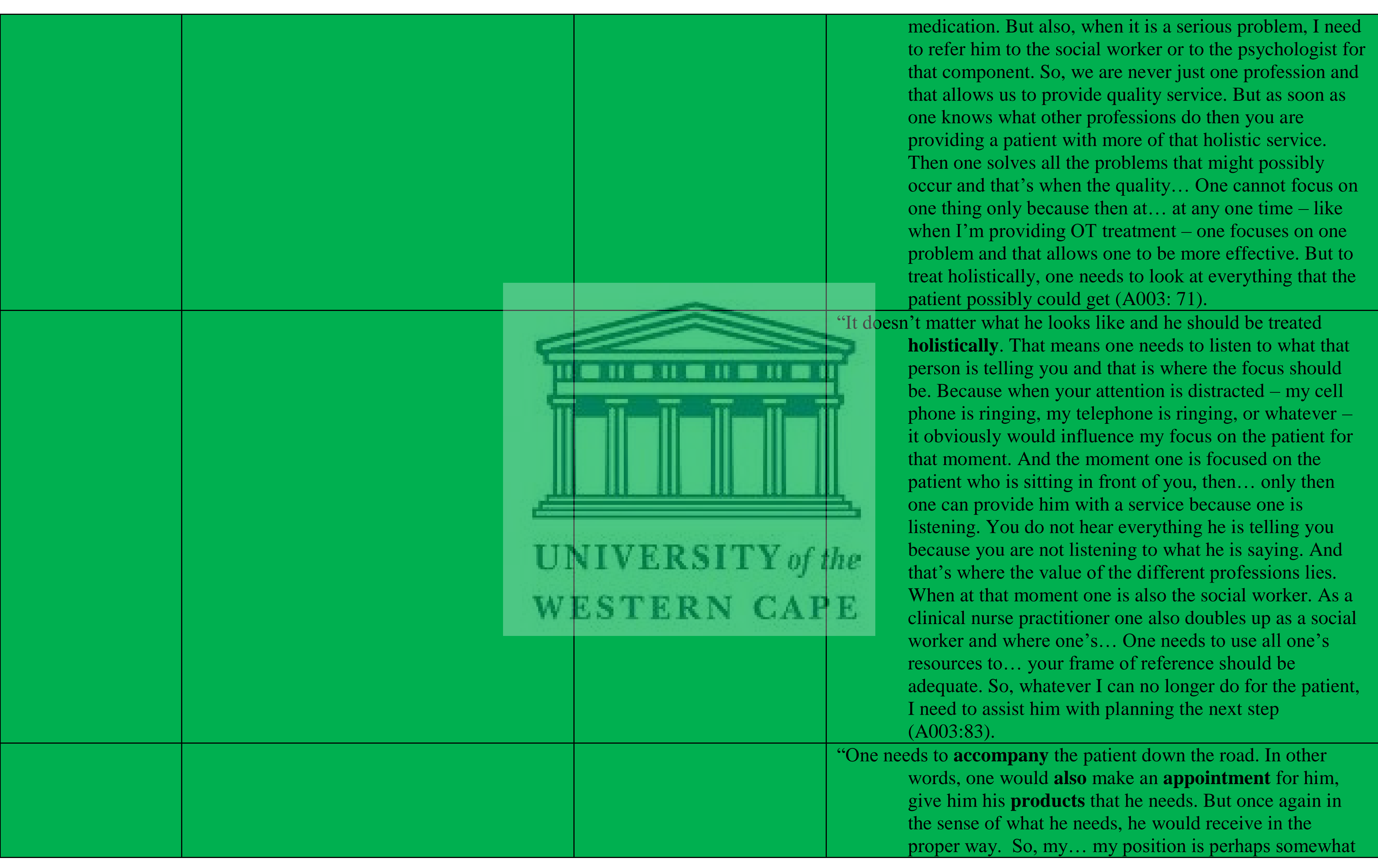

			medication. But also, when it is a serious problem, I need to refer him to the social worker or to the psychologist for that component. So, we are never just one profession and that allows us to provide quality service. But as soon as one knows what other professions do then you are providing a patient with more of that holistic service. Then one solves all the problems that might possibly occur and that's when the quality… One cannot focus on one thing only because then at… at any one time – like when I'm providing OT treatment – one focuses on one problem and that allows one to be more effective. But to treat holistically, one needs to look at everything that the patient possibly could get (A003: 71).
			"It doesn't matter what he looks like and he should be treated **holistically**. That means one needs to listen to what that person is telling you and that is where the focus should be. Because when your attention is distracted – my cell phone is ringing, my telephone is ringing, or whatever – it obviously would influence my focus on the patient for that moment. And the moment one is focused on the patient who is sitting in front of you, then… only then one can provide him with a service because one is listening. You do not hear everything he is telling you because you are not listening to what he is saying. And that's where the value of the different professions lies. When at that moment one is also the social worker. As a clinical nurse practitioner one also doubles up as a social worker and where one's… One needs to use all one's resources to… your frame of reference should be adequate. So, whatever I can no longer do for the patient, I need to assist him with planning the next step (A003:83).
			"One needs to **accompany** the patient down the road. In other words, one would **also** make an **appointment** for him, give him his **products** that he needs. But once again in the sense of what he needs, he would receive in the proper way. So, my… my position is perhaps somewhat

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			different to the way you would put it… (Patient Care – holistic care) (A004:70).
			"Nothing wrong – clinically – with the patient. So, one's history at the end of the day will also… one will also [have] more history, **one is also going to dig deeper in order to find the actual problem**. How I can [reach] beyond the surface… (A004:91).
		Individualisation	"I… I want to say, I think it is about the fact that **every person likes to feel important.** I think it… it is the important issue. It is about the patient. It does not matter what his problem is. From the moment he enters the door, I think it is important that he… that he should realise for that moment he is number one and also for that moment the attention is focused on him. I always say, we need to go and have a look, for… for instance, when one walks into a hotel, into a five star hotel. **All the attention is focused on you**. And it is not about money or no money. It is about the person. Uh… I say, we need to go and learn there, at that service delivery uh… how he is received, how we are talking to him, uh… how we are listening to him. I always say, when a patient comes to the clinic or goes to hospital, they do not know what gets done. They do not know what one does for this illness… it has to do with those bedside manners. When we are seeing the guy there, the bedside manners (A002: 78).
			"I agree with Japsnoet on this point. Once again, the most important thing for me is how one receives that patient… receives that client. Not… one needs to receive him and allows him to experience that he has **a hundred per cent of your attention**. He should never feel neglected. One has to keep him informed at all times. When perhaps there is a delay or something, one is going to say, he is perhaps going to wait a little longer. I think is simply going to… That's very important to me (A002: 82).
			"In other words, not to go by what one necessarily thinks is the problem but **to really pay attention to what the person is putting down in front of you**. Then, I think it is

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			somewhat different to the way the others think about it (A003:85).
			"I would say, that at the *physio* it's like… I get a lot of patients, say with back for instance, backache and it's easy to treat all patients the same because you are pressed for time or probably simply… could only provide basic treatment and so on **instead of regarding each patient as an individual and to specifically figure out what he or his problem is and to try and solve that** (A003: 80).
			"I agree with her whole-heartedly because every patient is an **individual** and [it] does not make… and to almost say pain is physiological, psychological; so many other things that could contribute to toothache. I'm moving away from backache completely but when you one is not really spending attention and time on that specific patient and problem and not observing him in his totality **(A003: 79).**
			"Situation. But when a patient… really use all our senses and… and almost I have said wisdom to treat the patient. It is only that… when we are talking about quality, I think it is… would… would come back to the concept of viewing him as an **individual** again (A003: 76).
		Focus on the client	"I… I agree with what Lovebug said in terms of quality um... and service of care and treating of patients in that way. For me, as a dietician, client-centred care is very important. Um... my goals for the patient might be very different to what their goals might be. Um... and it's very important for me to work with them in that way because I'm not going to be successful as dietician if... if they're not... if they can't see the importance of the lifestyle changes they need to make. Um... so, it's important that **I focus on the client in that way and helping from where they are**. And also in terms of um... at which stage of change they are in terms of making lifestyle changes and things. So, to help the clients as um... the focus and meet their goals, accept what their goals are, that's important for me to be successful and for us to as a... as a professional... like team. And that would ultimately determine quality of my care for them (A003: 339)

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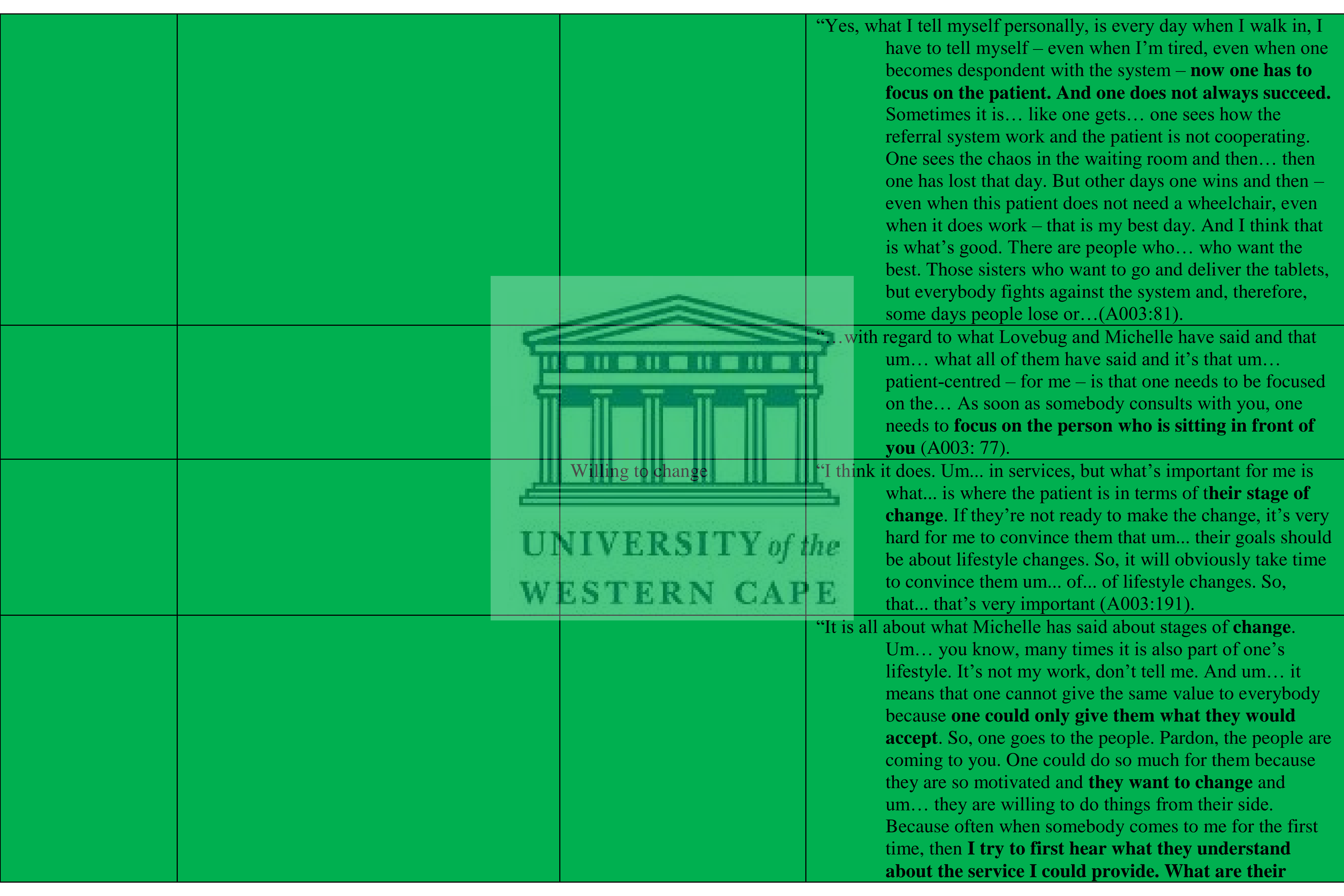

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			“Yes, what I tell myself personally, is every day when I walk in, I have to tell myself – even when I’m tired, even when one becomes despondent with the system – **now one has to focus on the patient. And one does not always succeed.** Sometimes it is… like one gets… one sees how the referral system work and the patient is not cooperating. One sees the chaos in the waiting room and then… then one has lost that day. But other days one wins and then – even when this patient does not need a wheelchair, even when it does work – that is my best day. And I think that is what’s good. There are people who… who want the best. Those sisters who want to go and deliver the tablets, but everybody fights against the system and, therefore, some days people lose or…(A003:81).
			“…with regard to what Lovebug and Michelle have said and that um… what all of them have said and it’s that um… patient-centred – for me – is that one needs to be focused on the… As soon as somebody consults with you, one needs to **focus on the person who is sitting in front of you** (A003: 77).
		Willing to change	“I think it does. Um... in services, but what’s important for me is what... is where the patient is in terms of t**heir stage of change**. If they’re not ready to make the change, it’s very hard for me to convince them that um... their goals should be about lifestyle changes. So, it will obviously take time to convince them um... of... of lifestyle changes. So, that... that’s very important (A003:191).
			“It is all about what Michelle has said about stages of **change**. Um… you know, many times it is also part of one’s lifestyle. It’s not my work, don’t tell me. And um… it means that one cannot give the same value to everybody because **one could only give them what they would accept**. So, one goes to the people. Pardon, the people are coming to you. One could do so much for them because they are so motivated and **they want to change** and um… they are willing to do things from their side. Because often when somebody comes to me for the first time, then **I try to first hear what they understand about the service I could provide. What are their**

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			expectations? And then, you know, to say, but I cannot do anything for you but I can assist you to help yourself (A003: 192).
			"Yes. We can only do so much. Like Michelle has said, for instance, one… one could… say, for instance, when a patient is **diabetic**, one could only **inform** him up to a point about the consequences of uncontrolled diabetes. One could tell him he might possibly get a **stroke**; one could do this, one could do that. One could explain to him what might happen until one is blue [in the face] but **when that patient is not going to take responsibility for taking his tablets, for healthy eating, for exercising, to look after himself, then it's all in vain** (A003:193).
		Involvement of the family	"I think it's also important to **not only focus on the client but also the family** because the family also has a big influence in how that client is perceived or what happens in the client's house (A002: 190).
		Involve everyone	"For me it is to see someone as a whole; not only a knee or something. And also, to **involve everyone** who could have an influence on the patient in order to provide him with a better outcome (A002: 98).
		Patient expectations	"I would like to say from a communication point of view um… the patient is critical [mumbles] because he **expects the standard of service** that is being provided. But then, the client expects certain **skills** from you. How… how… how does it become a good quality when your assistance is not there while the patient or the client particularly focuses on the existing gaps? They are aware that the assistance does not exist. They know exactly what it is and they keep on harping on it. Therefore, the woman who is there, it requires continual adjustment. And adjust in order to provide your service. Otherwise, afterwards he could say that has been good quality but at present, the patient is too focused on the service…" (A001: 228).
			"Perhaps I could just add, the question was what we could do. Are there small things that we could do? Firstly, what I think is lacking is… I think the people… the mentality of the community is one of receiving. They just want to receive.

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			Therefore, somewhere along the line one should also try and change their **mentality** – especially at the hospitals – they come and sit down. **They want that specific service**… they want… **they expect that service**. But in reality, we cannot provide them with that service. But their mentality is, I want that service because I'm entitled to it (A001: 271).
			"The problem that I anticipate, is the… our client is not familiar with the services. Uh, the client has no idea what a clinical psychologist does. Perhaps I also do not know what a clinical psychologist does. I have no idea but uh… what is a clinical psychologist? What is uh… an occupational therapist? What is a physiotherapist? What is a… what do we still… the dietician? So… so, we are talking of expectations. What are your **client's expectations** of us and what are we offering him? And I think often there is a discrepancy. **He arrives with certain expectations – out of ignorance – of what we are not able to meet** (A002:185).
			"It's not always the same because like she says, it's about medication. A patient could **expect** to receive **medication**… (A004:357).
			"Jo-Jo:but we have examined and found medication is not necessary and that's where **conflict** often originates (A004:183).
			"Then, often a patient has a complaint but then patient actually has another problem and like Sister [Surname] also has said that **the patient expects to get a tablet. But often the patient does not need that tablet because the patient might have another condition** but then he merely comes with a complaint of an ordinary ailment. And I also think that is where one's education and counselling [are]. And also, you opportunity [sic] of the patient is important (A004:184).
			"Understand? So, so… I would like to… I… I still do not know how we are going to arrive at both but… because there is

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			– like I have said – conflict because **the patient has an expectation that we cannot meet** (A004:186).
	• Patient care according to protocols	Staff must know the procedures	"The **procedures**, **you must know** if you; for diabetes, for TB. You must know from handling it. Everybody in you clinic must know; from the receptionist to the councillor to the cleaner... knows that **this is the procedure**. So, when somebody comes in and is coughing, they know that person needs to sit and wait there and there's going to be sputum... There must be... they must go through the whole procedure of what happens in that clinic and I think everybody must be aware of it (A002:222).
			"Yes! Must **know** every **process**, **procedure** of how a patient needs to... how it works through that system. (A002:223).
	• Ideal Clinic	Quality care in an "ideal clinic"	"The patient there at the clinic. Firstly, we spoke about the **infrastructure**. So, assume that the infrastructure is at its best and it's adequately **staffed**. So, you're getting your medicine from the **pharmacist** or the **pharmacist assistant**. You are likely to get all that **information**, then in terms of the things that upset patients or things that make patients unhappy, is either they are treated badly or things like waiting times are too long. So, yet everything in terms of **infrastructure**, **personnel**, **equipment**, **medication to be there**. Then, when you arrive there, then you need to be channelled through the system properly where this might be frustrating now. So, that's about **communication** and um… So, either the patient's **expectations** aren't met or haven't been modified or someone hasn't spoken to them and told them this is our facility. This, this, and this is available. This is **how long** it **will take** you to get out there. When you reach this person, they will… like I think you're bound to reach that person. When you get to the **occupational therapist**, for example, or the **dentist**, that person will take it further from there. And again, from that point onwards that's got to be clear. You will not get a wheelchair today or you might not be able to fit a denture for you ever or something. So, the services that are available must be clear to the patient. So, you need a **proper written protocol** in place to channel patients through the… through the system (Patient Care – quality care in an ideal clinic) (A002: 329).

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		Increasing in the number of patients when they receive good quality care	"If the **quality of services is very good**, I think, initially you will see a **large influx** because you will be picking up more cases. You will... um... you will be... you know, all the ones who fall through the cracks. Your... your services are very good, there will be – initially – a **large influx** of patients but if you can maintain that good standard of care for a long time, **then** you will **see** that **drop**: the burden of disease, the number of patients who are *gonna* die. But I think initially you will see a lot of patients that you haven't seen before (A003:211).
			"Yes, but in the **long run**, they are… they are… **People are inclined to return to places where they know they will receive a quality service**. So, I agree. Or let me say, I agree that the… We will not see that decrease immediately. The people are… they are going to carry on coming because they know here they receive a wonderful service. We might get fewer patients in the longer run… Due to the fact the quality is so good, the patient is not going to constantly, constantly, constantly come back. He is going to be sorted out during the first visit (A003:212).
			"So, they are… they are not continually going to come to the clinic. Then, with this problem… one problem that… say for instance – **does not require five or six visits to be sorted out. Possibly, they would sort it out during two visits.** So, and also um… at the end of the day, we are going to have a healthy community and then that is where the **burden** of **disease** a… could bring possible relief. On the other side, we could also say, possibly we're going **to get an increase in one's burden of disease due to the fact that we are going to be more alert and going to provide better quality service to the patient. So, you're going to, yes. One's health promotion is going to be wonderful. So, consequently one is going to get more people who would come to the fore with certain kinds of illnesses or possibly one is going to identify them sooner.** And it might possibly [cause] an increase of your burden of disease (A003:213).
			"But it happens like when you have provided a patient with **good service once**, then I think they are… is such an exceptional service. Doesn't say good service, exceptional service. Then, because they are not used to it, **they are returning all the time** (A007:214).

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			"Yes. Yes. And that is what's bad because they are getting so used to it and so… so… Yes, then **they come to you every time and then your burden becomes so much heavier and then this one patient** wants exceptional service while five others would then receive an average service because then I have to hurry my work for them. So, that's also why one needs to say, a standard for everybody [should be] the same. Witheverybody needs to [get] his part of… (A007:215).
Clinical Support Services	• Pharmaceutical services	Explain medication usage	"So, that guy may as well spend two, three minutes to quickly explain to the guy **what medication** he is getting and **how** he should be **taking** it and so forth. Um… to sort of handle it (A001: 27).
			"Um… yes and then… Yes, **communication**. That… that the **patients at least know where…** why wait… why… why… **what medication is he using** because sometimes I feel that there is no competence of… of… of sisters because they do not have the knowledge about medication, amongst other things. That is why people do not know why… why… why do I have to take this tablet? Why? (A001:232). I would also just like to add that one cannot provide quality service when **one does not havethe equipment and sufficient stock.** The correct stock √
		Inform the patient to come back when he experienced side-effects	"Now, when you tell him, "Take all your tablets because you are going to feel better. If the tablets make you feel worse, **come back** to see the doctor that he could re-evaluate you". Because he doesn't know that, understand. So, the stuff makes him feel worse but he doesn't take it but he still arrives every month to come and collect it (A007:434).
		Low stock levels	"Yes, the financial year is the switch over of the tenders and then the new tenders take time. Actually, **this time of the year is always a crisis because then the wholesaler has very little stock** (A007:138)
		Result of low stock levels	"**The patient doesn't get his medication**. So… yes. So, his health suffers. So, a health patient is eventually what we all are pursuing (A007:398).

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		Need for post-basic dispensary system	“”…what now… One usually plans for just enough for the next month and now, if something unforeseen happens, then there is not… there is not… Now… now, you **wait** another week for… for **stock** to be **delivered** from… from… from the **distributors**. That type of story. Um, I feel… we have now introduced a new thing that delivers [mumbles] medication from a **depot** that they pre… pre-prepare. Um…what I mean, it does not drive to the clients. Now, the stuff is stuck there at… at um… at Vanrijnsdorp. Vanrijnsdorp then takes it to Bitterfontein. At Bitterfontein it is kept in the **deserted kitchen of the courier company and there is no *aircon*. The… the medication is not looked after properly and, understand?** It’s all that kind of niggling little problems that need to be examined if one [interruption] that… would like to bear that in mind. Um… and then staff um… numbers. I think… I think at every… like operational clinics that… that… that handle large… large numbers um… um… **need uh… need a post-basic dispensary system**. Um… not only… not only to… not only to work in order to alleviate the load of… of… of sisters and nurses um… that they don’t need to go and dispense and that kind of thing but also to… to check whether what they are doing is correct. I mean, then they have a basic knowledge of… of medication and of dispensing…” (A001: 260).
	• Therapeutic and support services	Social support	“So, while we are healthy inside, there are many **social problems** also what are starting to affect this woman like her children. Who takes care of them? Is her husband going to stay with her? Does she have a husband for these two children? (A003:189).
			“There, I think we also have a tremendous shortage. Point number one. Further, there is um… um… kind of – even in a small town like Porterville – there’s a **Badisa** and there’s an **ACVV** and then there is uh… department of **social services**. One sends out one **referral** and, in the meantime, it should have gone to the ACVV Centre (Clinical Support Services - referrals) (A003:347).

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		Assistive devices – budget constraints	"Or to… okay. The… one could… one could order another **suitable chair**. Then one is simply going to wait longer because the **budget does not allow for a more expensive chair to be delivered,** not in time, so… (A003:344)
		Lack of assistive devices	"We have a list of people, patients who need wheel… who, for example, need **wheelchairs** and um… the list is actually so extensive that when one goes back and the person who actually gets a wheelchair is grateful; then one goes back to the person at the top of the list and often the people… had passed on or… whatever the… the situation is. And now, one has to go down [the list] and it causes the entire system… It does not help, here we get to the new patient, a young patient, but the patient who needs it more is the person who is already **waiting** for **two**, **three**, **four years** to **get** a **wheelchair**. Therefore, that… the existing system… (A001: 241).
			"But it goes unnoticed because wheelchairs are not such a major priority. Therefore, I feel that it is better internationally but it brings us back to the point where it becomes a priority. So, **when a person needs a chair we cannot… we really can't offer a chair**. Then, what is the quality?(A001:240)
			"But it goes unnoticed because **wheelchairs** are not such a major priority. Therefore, I feel that it is better internationally but it brings us back to the point where it becomes a priority. So, when a **person needs** a **chair** we **cannot**… we really can't **offer** a **chair**. Then, what is the quality? (A001: 239).
			"That's a **big problem. Especially the wheel chairs**. Wheel chairs! Wheel chairs! Wheel chairs! Um… when a patient comes to you, then it seems that the community thinks um… an old man of sixty years, for instance – if one can approach it practically – had a stroke, understand. It's okay. They would look after him until him really, really cannot get out of bed. Then they come with a wheel chair and unfortunately one has to measure a wheel chair, one orders it and one receives it – when you are lucky – **only in two years' time. I mean, by that time – if the man is lucky –**

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			he is still alive after two years when one really looks at the time in between, perhaps he is still alive after two years and the family is not going to make any effort with him. They are not going to move him. So, he gets worse, worse, worse. It is a bout not bringing the client… (A003:41).
			"Um… and then, one is stuck with the issue that give to… One can't give him a **broken wheel** chair that the clinic would have used to transport a patient… transport daily (A003:129).
			"Because he is not currently at the clinic. Now, one is scared that we might fall and hurt himself. So, one **waits two years to give a wheel chair to the old man who really needs it** (A003:128).
			"For example, the patient comes to me. Let me use the example of a **wheelchair**. Um… now, **we don't have wheelchairs in stock and he expects to leave with a wheelchair**. So, often… I can't his um… (A004:135).
		Limited with dentures	"Now, we are also **limited** with the **dentures** because that's… (A007:423).
			"Then, we're limited in that regard. We could only buy **one set per month** (A007: 424).
		Result of lacking dentures	"Because he **can't eat**. Then he goes to the **dietician** and he can't **speak** and then he goes to the **speech therapist** (A007:425).
	Referrals	Involve one's role players	"So, it is not about… Yes, one is going to **involve one's role-players**. Those… whom one can contact and those whom you can involve but often our clients are stuck with social problems. Therefore, it is about… **inter sectoral**… like one is not going to work in a silo with a patient and that is part of one's holistic approach. When that patient needs a social worker or uh… somebody in labour law, then one is also going to **involve that person** (A002: 86).
			"That is client-centred to me. To respect that person and their understanding of their world and their problems [mumbles]. And quality… then would be to – whatever

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			time one has to spend with a patient – really try to give that person your full attention and to feel that that person as person is valuable and that you would indeed try to give each person the same and not to advantage or disadvantage somebody because you might perhaps like them a lot more than the previous… than the other guy. And then, yes. Basically, **to make available to a patient all the applicable resources that you have at your disposal**. Whether it is something that is from you, whether it is something that comes from a referral. To simply work realistically within the clinic context and not to create false hope of… There are all these and those and those but you know in the end it would only be available to a handful. I also do not make empty promises (A003: 286).
			"It doesn't matter what he looks like and he should be treated holistically. That means one needs to listen to what that person is telling you and that is where the focus should be. Because when your attention is distracted – my cell phone is ringing, my telephone is ringing, or whatever – it obviously would influence my focus on the patient for that moment. And the moment one is focused on the patient who is sitting in front of you, then… only then one can provide him with a service because one is listening. You do not hear everything he is telling you because you are not listening to what he is saying. And that's where the value of the different professions lies. When at that moment one is also the social worker. As a clinical nurse practitioner one also doubles up as a social worker and where one's… **One needs to use all one's resources** to… your frame of reference should be adequate. So, whatever I can no longer do for the patient, I need to assist him with planning the next step (A003: 97).
			"…and I am going to **utilise my resources** (A004: 361).
		Refer	""I think um… we are never one profession only. One specialises in one profession, like for example I am the OT but I am not just the OT only. Sometimes, I am the psychologist, the *physio*, and the nurse, and the dentist, and the

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			dietician. However, I do not perform the entire duty of those professions. I refer further. Therefore, one needs to be aware what the person… let us call it holistic… holistic view and when you perceive holistically, only also looks at the patient as an individual like, for instance, if I may refer to backache. When a person has backache, sometimes it is more a psychological cause than biological. Then one needs to know, okay, one is going to treat it biologically because it is a symptom. In other words, one gives him a lot of things. One gives him exercises for the back and **refer** [him] to the *physio* when necessary and perhaps [to the] doctor for tablets and medication. But also, when it is a serious problem, I need to **refer** him to the social worker or to the psychologist for that component. So, we are never just one profession and that allows us to provide quality service. But as soon as one knows what other professions do then you are providing a patient with more of that holistic service. Then one solves all the problems that might possibly occur and that's when the quality… One cannot focus on one thing only because then at… at any one time – like when I'm providing OT treatment – one focuses on one problem and that allows one to be more effective. But to treat holistically, one needs to look at everything that the patient possibly could get (A003: 90)
			"…firstly, clinical service we should um… **a good referral path – that is available to her –** because clinically… oh, on paper and according to policy we have the rehabilitation centre where a woman could go for six months… oh, for six weeks where she would be getting *physio*, occupational therapy and speech therapy (A003:345).
			"When… when we talk about resources, then I can only add, one could also **refer** them. One is also specialised also in… public [health]. One's Red Cross, I'm only talking about CP that one can **refer** to the Red Cross. When one talks about orthopaedic, one could **refer** to Conradie. When one talks about spinal um… one could **refer** to Lentegeur in Mitchells Plain (A004:88).

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			"Can't satisfy his need. So, what I'm going to do, I'm going to put him on a **waiting list**. When our waiting list becomes too extensive, I can consider other alternatives and, for example, and **refer** him to **another hospital** where his need could be met (Clinical Support Service – refer) (A004:358).
			"During a given timeframe in order to [identify] the problem as soon as possible… Because I have several… various resources where I could **refer** him to… (A004:360).
			"And so, when one cannot handle the patient, rather **refer** to the next person (A004:364).
		Referral gets never done	"But the **referral never** really **gets done** because there are so many other things that need to be done. So, eventually they come to use for some reason or another. We attend to him… notes if you want to… and when… comes back and want to know what you have done. But then you have written there clearly: "Discharged. Hold exercise programme". Now comes the… (A001: 89).
		Not time to complete the form	"No, it does not go well. There are many patients whom we… whom could still be delegated but like Hildegard says, it's **a form that needs to be completed. So, she doesn't always get the time to complete the form.** So, then se sees the patient every time um… until she has the time to complete the form (A004: 149)
		Not enough referral facilities	"There are **not enough hospitals** to refer to (A007:420).
			"So, I just feel **we need more places to refer** or we need to put something in place where Cederberg gets this day and all our patients go on that day to see whoever we need (A007:444).
		Referral – long waiting time	"But when she sees the pat… this SVO patient and she **refers** her to me. That patient has to **wait – two months – before she would get an appointment with me.** So, it boils down to the… (A003:346).
			"They don't. It's like a circle effect. I have most of the previous years' speech therapist... **her referrals coming back to me**

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			again this year. And now, I've given her, someone a date for the 8th of December. So, next year's speech therapist is going to get that patient again (A007:199).
		Referral – long waiting time to get appointment with the specialist	"In terms of speech therapy um... from my side, I can say for what I can give, I'm giving quality but then the next step is, for example, when I do hearing screening, or you need to for a hearing evaluation or **we need to go to the ENT and they are booked up until the end of the year**. So, then it's not really quality because I'm not completing the full weight of the appointment (A007:110).
			"I... I think that from our perspective, we need either more hospitals to **refer** to or we need a specific day in the week or in the month at least for our patients to go. Because I have a patient who... whose mother had um... died of cancer of her ear and I can't... and she has chronic otitis media and I can't send her because **I can't get an appointment at ENT**. So, what's going to happen to that patient? (A007:415).
			"And in terms of quality care, you want them to get the care as soon as possible because otherwise he's going to get worse and worse and worse. And you want to prevent further chronic illnesses by getting them sorted out now but because **you are saying it's only the end of the year, it's going to get so much worse** (A007:198).
			"Um... Paarl ENT is **booked up until the end of the year.** So, really I can't get appointments here. **They're not taking appointments** (A007:442).
		Only Fridays for the referral of TB patients	"If one takes, a TB patient who is referred; say, for instance, the patient is referred on a **Monday**, then they tell you, yes. The patient could o**nly next Friday because Fridays are the days for TB patients** (A007: 416).
		Difficulty to refer eye patients	"It's like eye… **eye screening, *né*. There are no hospitals to refer the patients to**. So, we have the only… the only hospital is in Eerste River. But I mean, we could only see approximately four patients per month (A007:419).

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		Outreach program for cataracts	"I think it would be a **solution** if they could only think of an **outreach programme**, for instance, to come and do **cataracts** in the rural areas (A007:421).
		Health bus outreach for service delivery	"That's the bus that is parked in the Cape for a while? **Bus** or wheels? So, the bus would start its rounds in the month of September? So, he is going to provide a package of services; **such as eye screening, teeth, and…** (A007:422).
		Money is needed for the health bus service	"But it's not going to be here all the time. So, the service is not *gonna* be so… it's going to improve the health care but the **percentage** is a **fraction** of the **few people** but then the bus goes away. There's no facility to do what they do. So, it's always about the **money** to create a facility… (A007:23).
		Difficult to get a transport booking	"When you make an **appointment**, say for me WCOC [sic] and you get an appointment just for this day. But then, **if you want to book they're busy. The only place is in two months (A007: 102).**
			"I have to make **appointments** at the moment for **July** because that's when the bus is available (A007:103).
		Inadequate referrals from hospital or clinic to the occupational therapist	" …the idea of having the administration in the district is *nice*. But now, if it goes back to the… how many **referrals** I get from a **hospital** or the **clinic** sister specifically, it is **minimal**. Therefore, I am a big opponent [sic] to solicit my own referrals. It's not only that it is a problem to me but something more rudimentary like may they come and ask about the four months. And when everybody [mumbles], what is going to happen to the four months? (A001: 278).
			"And it is, I am the **only occupational therapist** in the entire district because then… How do I explain the huge population, the massive needs that exist in terms of the few referrals at the clinic? Now, we have sometimes had because from the hospital **I have not yet received even five referrals for the entire year** (A001: 280).

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		Occupational Therapist do awareness talks in the waiting room	" I wouldn't say that it is really in place but what I usually do at the clinics, **I would speak in the waiting room and then I would only talk about the kind of patients whom I see. You are aware already** that they go out and, for example, um… your child cannot walk yet at one year and three months. Then you sit with your neighbours and say, oh! My child is two years old already and my child cannot walk yet. Then the auntie who is sitting in the waiting room says, for example, could convey the message. But yesterday, I heard at the clinic that when you go there and make an appointment with the occupational therapist, then we could assist your child. So, that 's how I go about doing my work (A004:14).
	• Health technology	Lack of maintenance	"…um… with **extractor fans** and the like but there is **no one to service** it [the equipment]" (A001: 243a).
			"And I think it is also the same thing with the **wheelchairs**. We do **not** have **people** who can **service** them. Therefore, when it is broken, who fixes it?" (A001: 243b).
		Lack of equipment	"If I can [refer] to infrastructure um… also add a little something. My… in my… from the point of view of my opinion [sic], when I go to my clinic then I have to book it for a time that I there will not be another… like the rehabilitation team will not be there. There will be no other team there. At the moment, I am working **on an ordinary** chair and it **should not be** like that because **it hampers** me to provide my most basic services to the patients. It hampers me because there are particular procedures that I cannot perform on such a chair. But, on the other hand, the station is sort of… I… I am able to um… luckily I am still fortunate enough that um… for me a plan can be made. I don't know. It is perhaps because the visit by dentistry is longer than that of rehabilitation. It is… I… that's what it boils down to. Like I'm able to um… a… I'm able to get a dental chair for the remote clinics but it… it literally has to be fixed… to the floor (Clinical Support – lack of a dental chair) (a001: 245).

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			"If I can just add, everybody is simply talking about the experience and qualities but also, when **one does not have the people or the equipment to provide that service**. When I am speaking about what some people do when they need equipment, then one cannot [provide] that person or that patient with a quality service... One knows what to do but one cannot do it because one needs x to get to y. And, then one could not [treat] the patient... then one could only do the basic thing for the patient. One cannot assist him any further because it is not humanly possible to assist the patient any further" (A002: 295).
			"**One has to have a bed**. One cannot simply expect the guy to lie on the floor (A002: 302).
			"The same with us, the work that we do. I mean, flip. I've been used to do a lot more than that. Even... you [mumbles] do more but you can only do that and if you go out to a certain clinic, you are based at a certain clinic. That is where the two rooms are. But there we can do a little bit more. But if you go to the outlying clinics, you can only do that Mr [Surname]... Even if you say, okay. But I can do that, you cannot do it because then you must tell the patient, come back tomorrow. But then, the patient needs transport money and the patient doesn't have money. So, you can't do the things you want to do. So, **all the clinics must be fully equipped.** It comes down to everything. Must be fully equipped to do a holistic service to a certain patient (A002: 108).
			"We've got one clinic with **old equipment** and **no other equipment** at the outreach clinics which is all the other clinics, seven or eight clinics that we are doing in the sub-district. So, you've got to go and do your **dental work** with a **normal chair** or without any proper equipment (A002: 309).
			"To elaborate on what Cupcake has said, but am I going to, **not** all the **clinics** are **equipped** with those kind of **TVs** that could display that kind of stuff. We have a digital… I have… one cannot use it because there isn't… Um…

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			perhaps one would [like to play] a **DVD** or something but one cannot play it because there is not… (A002:39).
			"..any educational… even TB, the HIV. Then the **problem** was we had the CDs **but did not have the technology. In other words, we don't have CD players where there is a TV.** All of them are old TVs. There's not even a video machine or some of them have [a] video machine. So, one is stuck with all these ideas about technology that is advanced but it is not available at the clinic (A004:390).
		The basic equipment should be there	"Um... there should be no shortage of medication. Okay, that's medication. But **equipment**, **the basics should be there** like um… I don't want to wonder around looking for a stethoscope and a sphygmomanometer, an Hb meter. Those are basics. Yes, so it… (A004:132).
		Adequate diagnostic equipment	"I think it is all right. We are fine with that. **All have their**… their **diagnostic stuff** because it… it um… say, for instance, like level one. First clinic, therefore, we are only allowed to keep certain **equipment**. For instance, we can't… (A002:306).
			"I think so. Reasonably speaking, I think the **basic things are there** (A004:372).
			"…is clean and all. Yes, I think all the clinic have autoclave equipment and um… gloves and wash basins and all those things. So, **I think the equipment is reasonably… reasonably all right**. I don't know, she might be able to elaborate (A004:373).
		Adequate equipment and stock	"I would also just like to add that one cannot provide quality service when **one does not have the equipment and sufficient stock.** The correct stock (A001:131).
		Making do with what they have	"Nothing. Nothing. Nothing. Because these old things, **you must like just go on with what you have**. Now it is your turn to speak, Nellie (A002:308)
			"…but I do not have the um… **I only have the screening… I only have a screening machine**. Therefore, I can only do

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			screening. For an audiogram, it needs to be a soundproof…(A004:156).
		Systems not yet computerised	"I think when one… if one takes that into account, we are living in a modern era and why then are these **systems not yet computerised** or um… (A001: 265).
1. Public Health	• Population based planning and service delivery	Community Base Services (CBS) limited resources	"Yes, it is not negotiable but one also has um… we **have a limited amount of petrol money available**. The members could **visit** this **small** place twice a **month**. For the rest, one relies on the um… service of the home carers that… that is provided in the town (A003:139).
		Need for Community Based Services	"And to add to what she is saying: say, for instance, it's **the old man who is bedridden for two years**, there should be a… there **should be a community-based health service**… um… This patient is getting totally isolated, he becomes dependent on the service that the home-based carer provides. He needs a tremendous amount of stock. The family is in crisis and we are sitting for about… for years just to make a case for a policy that would allow an ambulance to take a category three patient to a clinic (A003: 43).
		Refer to Community Based Services	"So, what… what the clinic would do, for example, they would um… when they need more assistance – say, for instance, it's a **frail patient** who has to be cared for at home – then they would refer the person. Or, for example, the TB patients who have to take tablets every day, then they would **refer** that person. [Mumbles.] For example, something that they not every day… they could… sister cannot leave the clinic to attend to granny at **home** because those kinds of people are referred to the **home-based carers** and then um… they look after… (A004: 380).
		Process of referral to Community Based Services	"Look, the patient arrives at reception and then a file gets retrieved. Then… their observation… then they move to the following room or venue then their observations are done. Then they see the sister. Then the sister decides

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			whether they are seriously ill. Now they have to see the doctor or she gives them medication and they go home. Or then she would – let's say – say but perhaps the home-based carer needs to check on the patient. Then she has to complete a **referral form and then it has to go to the home-based carers**. So, there is… (A004:111).
		Community Based Services is the link with the clinic	"They… the… the home-based carers have coordinators at the NGO and then I'm the intermediary between the department of health and the… and the coordinators. So, basically **I am the link between the clinics and the… so, when… when there is a problem at the clinics and the sister** – let's just say – picks that up… so and so complains that the health carer never visits them. Then they contact me and then I go and investigate. They… the… the home-based carers have coordinators at the NGO and then I'm the intermediary between the department of health and the… and the coordinators. So, basically **I am the link between the clinics and the… so, when… when there is a problem at the clinics and the sister** – let's just say – picks that up… so and so complains that the health carer never visits them. Then they contact me and then I go and investigate (A004:112).
			"Sometimes it is shocking when we admit the patient and to see the elderly woman there and her circumstances and in the months that we only… just the fact that somebody is going to say, "Good Morning". The mere fact that the child has check that the tablets are taken correctly, this elderly woman gets better care. There's someone who is clipping her nails. Even the circumstances of the **home** in relation to this… (A003:42).
		Community Based Services hard working staff	"I would like to go back, agree that one the… the expectation is that it is a bad service or… or it's like that but even when there are outcomes and there… even with **home-based** care, it is **incredible** to see the **sisters who are willing on a daily basis to the X-rays um… to take steps that**

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			would keep the patient informed; who would even go and deliver the packet of tablets at home, in the small towns (A003:218).
		Community Based Services –limited resources	"That is still not really practicable but eventually it influences the service delivery to the whole patient. **He does not receive the medication**. The sister has to prescribe the medication according to what the family says. It is not for the um… In-house, when the patient is that ill, they phone… could call out the ambulance, come pick him up and take him to the hospital (A003:130).
	• Health Education	Educate patient them well	"Those people are sitting there from eight o'clock until four o'clock in that room. There is a **TV**. **Educate** them well! (A002: 316).
		Educate our people	"Yes, of course. And also the sister. And I don't want to say they are taking it out on each other because to a large extent there is patience. So, an appointment system should be introduced but I think we also have a responsibility at another level and I do not know that answer. We would also have to **educate** our people – and pardon my language – educate. I don't want to mean it negatively **about what a service demands. What they could expect. How they have to handle it**. Uh… I cannot go to my doctor and curse and swear at him. I cannot come to my doctor with all sorts of demands. Uh… I have to make an appointment. Therefore, we also have an educational responsibility and I know… (A002:305).
			"Oh, I mean one could **facilitate talks** about all the stuff. The **diabetes**, um… al the **illnesses**. One could even talk about the **dynamics** of **mother** and **father's relation**… or children, parents. Anecdotal stories. [Group giggles.] Everybody is sitting there, they could watch… (A002:31).
			"And the **education** of patients in the **community** on more **preventative** strategies to prevent extraction (A007:439).
		Health information method	"I… I think we **do not have a reading community**. That I want to state clearly. Pamphlets, yes (A002: 336).

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			"To act preventively means **one has to talk extensively to ensure that the patient understands** what one is telling him and like um… Lovebug has said, **demonstration**. The patient then needs to demonstrate to you again (A003:349)
			"Yes, **pictures** do help but it's **about interaction**. Personal interaction, even when is with **small groups**. I think, when one wants to do it at clinics, one could… We always tell the people with the AIDS and stuff but let us form small groups. Ten people. Let us talk to them about… about it (A002: 30).
			"But then, I'd almost say um… when I look further. Say, for example, in practice **to provide information in the bathrooms.** The information that is disseminated to crowds of people… (A004:28).
			"We are **spending so much money on pamphlets** and at the end of the day then one sees but [mumbles] (A004:29).
			"So, what we've done, we have these **wellness days** and what we do then; then it is like a gift… gift parcel that we are giving to the people. It's filled with **pamphlets**, condoms and say, for instance, a bottle of water or a packet of chips or whatever and then they are very excited. And then they come. They're very excited about that (A004:33).
			"Should one not perhaps use the example the example that she just has used to say, we have **local newspapers – the Courant and the Gazette – and to once a month perhaps place an article in one of these** (A004:22).
		Don't know if the patients were reading the pamphlets	"But now, the point is… is **whether they ever use the condoms or read the pamphlets; that I cannot say** (A004:389).
	• Health promotion and disease prevention	Outreaches to schools and crèches	"Have we perhaps um… obtained something positive from it already? I am still trying to ask the other participants. Where we usually **go to schools** as a **multidisciplinary group**. The dentistry, the *rehab*, the sister. Um… from my side, I had because um… youngsters' ident… we see

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			them all in one mass production but, you understand? We examine all of them, go through all of the personnel um… and one could not simply identify there and then whom one really needs and especially for our less privileged people who are not interested in bringing children to the clinic. Therefore, one has that opportunity at the school to um… to be able to say, "Grab!" Now, he did not want to listen to them or to stand in for their work because then it would also be something that we could tackle, the **multidisciplinary group going** out to the **schools or** to the **crèches** or something like that (A001: 277).
		Health Promotion Officer	"The **health promotion officer**, like in the cities here in the **Cape**. Every clinic has a health promotion officer who **talks** to the people every morning or during the day about medical problems" (A002: 317).
			"But perhaps I can add by saying **we have the health promoters**. What's it in Afrikaans? *Gesondheids*… (A004:388).
		Health talks by the health promotors	"Look, **they do talks. Often, they do preventive talks**. It's mainly what they are doing. When they arrive at a clinic then it's to provide counselling to the people while they are sitting in the waiting room (A004:70).
		Health promotion	"Not at all. Um... We... And I think it's coming um... **from a day of training** and it's also a mind-set change and we know from models outside our country like health promotion, health education, health prevention, promotion is... are key target areas. But we... from the day we go to study, we are taught to help someone clinical. So, we... **the focus is what type of pill, what type of thing... So, we are not really focused on health promotion, health education.** We might um... There also are even some devils [sic] (or levels?) that we are not even aware of. Interaction, or we will not advocate for we have the VAS [sic] problem. We have um... trauma units for our people with alcohol abuse but even we will not really advocate for stricter laws in the liquor law (A003:348).

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			"That's right. He has to understand what you are telling him with regard to it. What we don't have as a result of human… as a result of **the shortage of human resources**. Anyway, I can… there's no point, I'm simply carry on like that, in circles. So, um… health promotion does not get done (A003"350).
			"Yes, yes, yes. I... I agree with what she's saying and what I also want to add to that is that... um... it's very difficult um... to... to always or what Bokkie said, it's a **time** problem, it's a... It's just difficult to do multi-tasking all the time and you need every opportunity that you get um... But the thing is, **we can do health promotion, health education until it comes out of our ears but a lot of patients are very closed off to it**. They... they... they don't have um... or they don't know... they don't take enough responsibility for their own health, to seek the information and to be open to it. So, there are a lot of patients who, if you are doing health promotion in a waiting area, they'll put their earphones in. They're not interested. **They're just there to com collect their medication (A003:351).**
			"Like I say um... from my point of view, I want to get more involved with um... especially in the MBNI with **breastfeeding** and clinical care. Making mother more aware of the actual affect that **alcohol** has [mumbles] on the foetus, **smoking** on the foetus. Um... providing proper **support** for mothers **postnatal** to ensure that our breastfeeding statistics go up, decrease of illness, the whole [mumbles] that it has. Um... trauma care, especially. Um... (A007:431).
			"I also feel like if you had more **time**, you could do more **prevention** and **promotion** (A007:429).
			"I think, when we have a look at Health Care 2030 then there are three things they are addressing very clearly and then they start saying the CBS and then one goes to health care and then um… intermediate care that says health

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			promotion, **prevention** promotion. They say because those are the ones that could improve the most (A007:432).
			"Um... so, even just... even if you do **prevention** and **promotion** or you can target those people better, support them better and you can get to a stage where they don't need that support, where they maybe take less medication or no medication (A007:435).
		Community Involvement	"It's very important to get the **community** more **involved**. Make them aware (A009:430).
			"And get them more **involved** in the **community** as well. Because currently there are so many sick people that just want to stay at home and everybody comes for disability grants because I can't move my hand or I... my back is sore (A007:436).
		Councillors	"That is also why they now have the **councillors** at the hospitals. The councillors could get involved by **providing training**. We also have [conducted] a little home… or we **go** out **into** the **community** because sometimes we do **house visits** but then, they only work for a certain number of hours. Therefore, one should actually at the facility – and the same at the clinics – they should have their **councillors** who **have** talks **every day**. Perhaps, the same visit could be conducted at the hospital in order for us to get the talks because the people are standing and waiting. So… could use it (A001: 291)
	• Communication with the community	Carers communication with the community	"Yes, it boils down to **communication**. Those instances… I don't know whether processes were put in place for the **carers** to… **communicate with the community** and to explain to them, listen **these are the service** that are promised. This is what is available to you. This is… (A001: 272).
		Health Committees	"And the **health committees** are going to the people and **educate** them. So, they have been of great assistance. Here, we don't have health committees but one could plan it (A002: 335).
5. Leadership and Corporate Governance		Change management	"Even what we have discussed a while ago, um… there are tremendous changes in the organisations all the time. Um… there are new protocols and stuff but from an **organisational**

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			perspective there is no change management that is implemented. So, we expect um… a protocol today. We are giving training for an hour and tomorrow we will evaluate the same person; does he do his work or doesn't he? But organisationally, nowhere are there processes in this organisation for **change management** (A003: 340)
		Lot of red tape	""Somehow, for me it is similar to protocols and systems. There are **such a lot of red tape** and paper pushers… (A007:403)
			"Anything that costs **more than R 30 000 has to go through Tradeworld** (A007:406).
		Too many processes	"Precisely! Then, nobody applies on **Tradeworld** because the people who should be applying on Tradeworld are **not prepared to do all that paperwork to be part of Tradeworld**. So, then one gets… then, at the end of the day one is stuck for nine months and one still does not have a stable door (A007:407).
		Prevention of corruption	"Yes, but to do that one actually has to address **corruption**. Because I think that is what it's all about that they should eliminate corruption to for all… (A007:408).
	• Budget allocation	Allocation of funds incorrectly handled at head office	"Um… firstly, I think the **allocation** of our… of our **funds** [sic] is **incorrectly handled** at our **head office**. Um… because every year extra services are added um… and… and basically how they are allocating it, is basically just to look at what you had spent last year and then they only add inflation. Um… now we might have these wonderful APP plans that we would like to implement… um… and we go and sit down to do our planning. Um… but it should actually happen earlier in order for me to submit a request according to my services and… and then to budget accordingly. It simply doesn't work that way. In other words, one is given one's budget and then one has to work within that **budget**. Um… (A001: 24).
		No annual review of the population to make adjustments to the budget	"Yes, apart from that. Uh… uh… there is also **not** an **annual review** of the **population**. There might be – if it is indeed the case – a review every five years to consider the population and **to make adjustments accordingly**. The last couple of years it was only the **inflator** [sic]. Um… so, what you as… or… or as hospital management then

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			has to do is basically to go and establish what are your **immediate needs** for that year and then to um… distribute your money accordingly. It even got to the stage that they um… you… you know, that you don't even have um… that planning and oversight role any longer. Now it even gets divided into item levels for you. You only have the ability to make slight adjustments between the item levels. In other words, you don't really have an opportunity to plan and to manage…" (A001: 238)
	• Staff allocation	Staff numbers are allocated by head office	"Basically, the **staff members are sort of allocated by head office** and, in turn, head office says, "Oh!" Right, the size of the hospital only justifies, for instance, twenty four PENs [sic] or fourteen SNs [sic], but… but they **do not keep track of the population growth** (A001: 251).
			"Because at the end of the day, we can take all the time in the world to discuss the issues that… but actually the **dilemmas come from the side of the province because there is a precise number of sisters that one needs.** But when we look at the reality, it simply doesn't work. There cannot be only one sister for every ward. She works at causalities and she works in the ward. So, it simply does not make sense in cold practice. I am from a private hospital. And when I started working at this hospital, I couldn't believe my eyes because I had… for me… it simply does not make sense. You are at a private… and if they now take that statement that you have made we should now provide the same quality that the private… personnel or staff members are providing at hospitals that cannot realise (A001: 254).
			"…but one doesn't have the time… one doesn't have the capacity to do that. Therefore, um… one needs **to go back to where the real problem lies and we need to look at the setup at the top** and one would notice things that indicate what the hospital should be getting (A001: 255).
		Senior Managers and staffing	"I think so. And then it goes back to bigger things like the personnel and that's a **senior manager**… a management issue because everyone on the floor will complain that

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			they are understaffed. That they do not have someone to give out medicine. But they can't fix it. We can complain about it in this forum. It's only the senior manager that can actually… actually affect the **change there**. And it's the same with the protocols. The person in control… (A002: 330).
	• Need for bigger staff component	Shift in various diseases	"As a matter of fact, it is not only about growth in population. It also includes… the **shift** in **various diseases** (A001: 252).
		Spend more time on patients' than before	"With HIV and TB and the combination of the two. One **spends far more time on** one's… on one's **patients** than before (A001: 253).
		Statistics do not indicate that you need more staff	"…that is now the quality programmes and we hear that when we… when we are at the [mumbles] are at the **regional office** um… and even **province**, we hear it very regularly. Straight from our **HOD** of Health. Your **statistics** do not indicate that you need more staff (A001: 256).
			"Like… like for them… I… I think that the impression I personally get of the **decision makers** is that they go and look at your population and what **statistics** you have submitted (A001: 257).
			"So… so, the **population grows** around you but your **statistics** are not **going** to indicate more because person can only do that much. Whether you… it doesn't matter what staff complement you have, you don't have ten people around you. Therefore, **your statistics would not really go up simply because the population has increased because you are… you are the… the personnel board remains as small** as it has always been. Therefore… um. Therefore, I think it… that is why we are now emphasising statistics (A001:258).
	Budget	Do you have the finances to appoint more staff?	"Y… yes, for example, the other day I arrived at a member of staff um – what a – when I ask for an example – ask where it [mumbles] would… would… The **population** in… in… **increases** um… when there is **only** one… one **CNP** there and the **need** is… is for **another**… another CNP and now we send, for example, a trust [sic] to the office. The first

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			question they ask, do… **do you have the finances?**" (A001:261).
		Need more money for appointment of staff	"I'm talking from experience. When there is no **money** we cannot **appoint qualified peopl**e in the pharmacy (A007:21)
	• Stock supply	Central Cape Medical Depot cannot supply	"Basic things like bandages, injections. These are standard things that people should have access to. A **large percentage** of this um… stock is um… is delivered to us by the **central Cape Medical Depot**. Um… and if the state **cannot supply** it, there is no other way of… of acquiring it" (A001: 134).
	• Department of Public Works	It takes three to ten years for your project to be attended	"The… the communication, it's reasonably good but the **department of public works** has um… **priority lists**. In other words, one submits a request um… then it gets entered on a priority list and, for example, then you have to grin and bear with the frustration because one continues regardless for three years um… then it is… for instance, they would say that you are on the list to be attended to during this year. Then, there is something – as an example – there is something at the psychiatric hospital or… A higher priority than yours. You move down. And then, **sometimes it takes three to ten years for your project to be really attended to** (A001: 268).
			"...yes, to achieve the goal in the end. Um… when it is also for **infrastructure**. **First**, it has to… At first, one needs to see what it **costs**, then one needs to get the **quotations**. When it is more than a particular amount, then it has to be put on **Tradeworld**. Then one gets somebody who applies. Then, the entire process has to be repeated right from the start and then, along the way the guy falls out of the bus and in the meantime, we are watching walls that are peeling (A007:405)
		Incompetency of staff	"I think the human resources… it's the **incompetence** of the people who have to have to do that (A007:410).
			"I think perhaps those higher up in **corporate governance** should perhaps observe the core values, *né*. For example, **care** because one obviously needs to care about one's personnel. One needs to care for one's patients. And competency. **Competent people need to be appointed**,

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			especially in the area that we um… have spoken about such as infrastructure. There at the top there should be people who know specifically how to negotiate. And then… they should be accountable for what needs to be done. And that's also one's respect, one's integrity and what is the last one? (A007:17).
		People are not hold accountable	"But people are **not held accountable**. He simply carries on making the same mistakes and he remains in the post. He… he's been in the post for years and everybody goes, "Forget it! It doesn't even matter to speak to that guy because one doesn't get anywhere. Rather ask that other one"? (A007:116).
		Attitude of the state	"The maintenance, yes. I think at the moment **the attitude of the state** , the **leave a place to completely go to wrack** and ruin [sic] and then it costs an awful lot of money the rebuild it from scratch while… I mean, there are standards that prescribe every how many years should the outside of a building be painted and when a tile breaks to replace it. Only that one tile. One does not need to [do] the whole place… [faded speech] (A007:124).
		Never money for infrastructure	" Money would be giving us personnel. When we address the infrastructure, then money becomes an issue there because **there's never money to upgrade and maintain the infrastructure** (A007:22).
		Not enough staff	""I think perhaps a better system should be implemented. When one speaks about what is there, there's not really a budget. For example, when one looks at **infrastructure**. Infrastructure needs a lot of money but **there are not the human resources** to either expand the service or to provide the services (A007:409).
	• Values of the department	CCAIR values	"We have um… the… the **values** of the **department** are "**CCAIRR**". That's um… C squared where the… R squared… um… and basically it aims at them to… They started doing this because they had realised that there were um… a **patient satisfaction** and a **staff satisfaction**. **The results in both cases were bad (A001: 285).**

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	• Translation services	Translation of English pamphlets	"I would just like to go back because such issues should actually go to the **province** because at the end of the day, I really want to – because I am in the community – **I really would like to translate the thing** because I obviously understand what the people would like to hear but you're also not allowed to do that because it needs to go higher up. T**hen it takes ten years** before it is available at your level. Therefore, at the end of the day, one is not able to conduct prevention (A001: 276).
		Discrepancy between policy and available resources.	"Um… I also think our **referral resources** – and there it also goes back to people, it goes back to buildings – we have certain **policies** and there are things that have been implemented for quality. What… what… um… the availability thereof as a result of the **shortage** is… is… absolutely a big vacuum (A003:105)
6. Operational Management	• Human resources and development	Competent staff	"And also… your personnel should also be qualified and **competent** for the task" (A001: 20).
			"Um... the clinical nurse practitioner also has to um… be up to standard in her work, like to be **competent** (A004: 18).
		Disorganisation	"Um… for instance, when I have to walk into a place and… and it always troubles me to observe the **disorganisation** at a clinic (A003:107).
			"It appears that **there never is organisation**. It seems that everybody are running around like headless chickens instead of just taking a step back and just check simply to see, is there not something that I could do differently? Is there not something that I could do better but we are so inclined just to enter and to immediately start with the job that you totally forget simply to step back and observe from a distance? Is there not something that I can do better? Because it's chaos. It is absolute **chaos** (A003: 106).
		Excellent service delivery	"...after all, there are people who, despite this **messiness**, still provide **excellent service**… (A003:217).
		Result of training	"I think… I think we should also um… find a way to… to in the thing… What I actually want to say it… it… it is the result of… it is the **result of training**. Um… we are experiencing that the… the

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			[mumbles] sisters arrive. They do not really know the basics about *TB*. At the beginning, **they do not really have an idea about what is happening… about what is happening in the programme.** Um… therefore, to me it feels that… whether it is in terms of training, yes, does everyone only receive basic information like all of us received, but a section should be incorporated that… what are the different programmes and how does it… it work in the programmes. What is the um… what… what… I take it from my point of view. While I was busy training, I worked at a clinic for a short while and we were in the *TB*… (A001: 282).
			"That's a lot. Often, I find that your ***undergrad* education does not gel** with the requirements here on the outside but it differs from institution to institution (A002: 337).
			"I think, one gets people who are working and one gets people who are lazy, okay? Unfortunately, one also gets it in our careers where one finds people who are not… Then one gets youngsters who really are brilliant, they are eager and they work things out and they come and surprise you with new ideas how to entertain people and new advice to the patients and pamphlets and lots of stuff. But then, with the *comserves* also, one finds the same. One finds… one has no control over those… This is what a person is like. So, and… and… (A002: 19).
			"I realise that it is influenced by the amount of **guidance** one is getting, the *pregrad*, because it is the amount of **guidance** expected **postgrad** and like I'm saying, it differs from institution to institution. Often, it stems from the curriculum and one's exposure to one's rural… to one's rural communities and… because that is going to… Health promotion campaign **rural** is going to be completely different from **metro**. Um… therefore, often that training also differs (A002: 338).
			"Yip, I think it is a **problem** with **the training** of students. We are actually getting students from all quarters… of people who are coming here to work who are coming from all other places… (A001: 8).

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		Training	"It might be similar but there are **training programmes**. Therefore, when you identify the person as unfit to perform the task then they have to be sent for training" (A001: 5).
			"Other things that I feel are somewhat important, send as many of them as possible for **training** because it opens up their worlds (A003:3).
			"She needs to have the necessary **training** (A002: 313).
			"Another thing I want to say about the personnel is, we have eight clinics and two [mumbles]. But we sit with eight clinics. So, you see? And now, I do... do get um... freelancers [sic] from the **agency**. I quickly go and get it but they... they **cannot clean** our **clinics**. They just fumble [sic]. So, I need to get somebody that they can **teach** how to do this and this (A002: 326).
			"Um… yes. In… in the… I might as well concur with them. As far as personnel is concerned, it is a huge gap because one cannot provide one's patients with quality service because I need to be focused on the patient and need to listen to the patient. When one knows one is the only clinical nurse practitioner today and there are fifty seated people who still need to be seen. Then one is going to rush through the people and one cannot remain focused because one's attention is completely divided. So, one is not focused on the patient who is sitting in front of you. Another thing is um… **adequate training because only when one is skilled and trained and one goes for regular updates**; it goes hand in hand with quality. Then one could provide a quality services to one's patients (A003:1).
			"Competent. She… she… she has to um… she has the qualification but she also has to regularly go for **training** and for **upgrading** in order for her to know exactly when there are changes and how to handle the patients and the most important is, when one doesn't know, rather admit and refer to the next level (A004:6).
			"…patient. Um… so, if one didn't have the **training**, at least had done one's PALSA-plus um… then one wouldn't know how to handle the patient. So, one should have done that **training** um… and… if one hasn't done it, then know

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			okay. I am not sure. Then, rather refer to the sister next door or ask (A004:7).
			"Well, at the moment for me it's about… because we have struggled so much already, therefore, **there should be an available person who has the training**. Especially because there is such… not simply anybody could go and work in the pharmacy. It should be a person who has been trained to work with medication. Because we are a rural, one battles to attract those members of staff to the rural areas. So, that's the first thing. When nobody is available to provide the service, then it doesn't matter whether he knows what he is doing or not. The service disintegrates completely. One could have stock available um… yes. Availability of stock is also another matter but even when I do have the stock and I have nobody to give it to the patient, then the entire train de-wheels… derails (A007:4).
		Effect of training	"When they also on training – with the **broadening** of **training** – is actually nearly I said of an open heart. It is difficult for the coordinators. Difficult for the organisation but that **these people apply for a better post** (A003:356).
		Training is dependent on the human resources	" …and the um… once again, it goes hand in hand with human resources. When one doesn't have somebody to send for **training** then one does not have somebody. And it always remains in abeyance; that continual clinical **training** or the updates remain in abeyance (A003: 2).
		Staff shortages	"Um… um, I mean during the entire thing… **waiting times**, as a matter of fact, plays a big role. Um… and I think sometimes it boils… it **boils down** to… to the **shortage** of **staff** because now that there are pharmacists and assistant pharmacists everywhere to… to… have the capacity to handle the clients…" (A001: 162)
			"It's a **big problem**, because um… the point I would like to make just too… is there… We… we have a women's ward, a general ward and a maternity ward that are basically one room and **there's one sister to basically**… **handle and manage**. And sometimes it is just a tad… (A001: 250).

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			"I have seen already, understand? The maternity ward keeps one occupied. **One cannot attend** to the **other patients too**. That is why it is a problem. Um… I know that people are perhaps not applying for the posts. Maybe, no posts are advertised, that kind of thing (A001: 251).
			Sister, perhaps I can mention in this context, I do not think that the people are incompetent. Um… that is not what it is about. **Time** is extremely tight. Um… it's **one nurse** and **one sister in the entire clinic and forty, fifty clients and patients are seated outside to whom she has to attend.** Therefore, there is not always time or it might not be clear; you simply say this is your condition and this is what the medication does. Diet is only talked about in general. You have to take your tablets – the adherence – but there is not always time to have an in-depth discussion. I think that is where the problem lies (A001:234).
			"At this stage, I have a huge issue with our staffing. It is **totally understaffed** and it makes a huge difference (A002: 299).
			"When… I think, when ten is the ideal and one is totally, there's nothing, we are sitting at a four, five. It is um… demoralising for staff that certainly influences the quality of service. Um… I think not as much when it comes to allied health. Probably more where you are. **But definitely when one looks at one's CNPs, when one considers the professional nurses, when one considers the councillors, the crowds are simply too big** to say, right. This is your hour for the day. There's no opportunity while that's what the client needs. So, when one looks at it, it is perhaps not working harder but working smarter because there is most **certainly a staff shortage** (A002: 165).
			"If I can just add, everybody is simply talking about the experience and qualities but also, when **one does not have the people** or the equipment to provide that service. When I am speaking about what some people do when they need equipment, then one cannot [provide] that

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			person or that patient with a quality service... One knows what to do but one cannot do it because one needs x to get to y. And, then one could not [treat] the patient... then one could only do the basic thing for the patient. One cannot assist him any further because it is not humanly possible to assist the patient any further (A002: 294).
			"Is… is exactly what I wanted to say and you um… I think when… especially **when somebody** is **ill** or when **only one person is working**, then um… the services really suffer as a result of that. Out of the group, you barely have attended to five people properly and you… you… you are almost too scared to look into the waiting room to see how many there still are because actually you don't want to know how many still need to be attended to (A001:150)
			"May I just add something? I am responsible for paying the clinics a supervisory visit. When I walk into that big clinic this morning – or say around twelve o'clock – and **the operational manager stands in the waiting room while she is saying, "People, I am the only person who can attend to you. I am the only person. You simply have to wait until I get to you"**. Now, am I going to take her away for a supervisory visit? All I can do is to say, "What can I do? What can I do to assist?" That is how it is going at the clinics (A002: 321).
			"Well, I don't know how to put it into words, the following thing that I… We always say that we n**eed more personnel. That… that is true**. But when one listens to the nursing staff, it is the same people who come every day. They were here yesterday and they had been here the day before yesterday (A002: 324).
			"I… I would say there are many but the most important for me is simply **time**. We do not have time because **we are only a few.** So, I have to go through the patients and that's when the quality decreases (A003: 155).
			"So, one needs **time** with a patient. Obviously, I need stuff and all of that but for me it is… it boils down to time. **We are**

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			trying to pull too many people through the system… (A003: 154)
			"**More** pers… **personnel**. And that will provide one with more time. When I am only one who has to see the patients of the entire Berg River, time is limited and we are saying we need to remain focused on the provision of service to the patient. One cannot remain focused when one knows there are another then who need to be seen within an hour (A003: 153).
			"Um… yes. In… in the… I might as well concur with them. As far as **personnel** is concerned, it is a **huge gap** because one cannot provide one's patients with quality service because I need to be focused on the patient and need to listen to the patient. When one knows **one is the only clinical nurse practitioner** today and there are fifty seated people who still need to be seen. Then one is going to rush through the people and one cannot remain focused because one's attention is completely divided. So, one is not focused on the patient who is sitting in front of you. Another thing is um… adequate training because only when one is skilled and trained and one goes for regular updates; it goes hand in hand with quality. Then one could provide a quality services to one's patients (A003:168).
			"The **shortage** of **HR**. The process is there but the process doesn't work because there is no follow through (A003:347).
			"That's right. He has to understand what you are telling him with regard to it. What we don't have as a result of human… as a result of **the shortage of human resources**. Anyway, I can… there's no point, I'm simply carry on like that, in circles. So, um… health promotion does not get done (A003:350).
			"Such as when we walk into the theatre after we have seen eight patients. The doctor does not have a choice. He gets told by the anaesthetist that the teeth should be extracted while the patient already has [mumbles] or for cleaning and fillings and stuff. And the goes… Apparently, for them **at the end of the day it's all about time**. But I

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			actually have explained it to them previously that it's exactly the same time it would have taken us to do a filling. Then they would say, no. **We do not have the people.** When the message gets out there, even once, that fillings are done under anesthesia and they feel it's a luxury, filling and cleaning. Where it actually is a preventative… (A007:161).
		Number of clerks inadequate	"Um... what I mean by that is that we have many outreach service to certain clinics with the result that they have retrieve a lot of staff members' work the previous day already. I am talking about perhaps thirty patients per person or outreach service that is visiting. And… currently, the next day some other patients arrive. So, the files need to be retrieved again with the result that there are **too many files that need to be retrieved in relation to the number of available clerks**. So, perhaps… and we still need to take into account that the files need to be refiled the same day which makes it even more difficult for the clerks. And that is based on an assumption that the issuing services deems it necessary to have the files ready at that moment when one enters the clinic to provide one's services (A004:164)
			"Hey not that… that bad. Um…because, for instance, **there's like a clinic that does not have a clerk** (A004:374).
			"Yes, because like some of the smaller places – like I understand it – for instance, some of the **satellites**, for example, they visit twice a week. Then, **there is not a clerk to accompany them.** Now Loeloe… comes for example to provide a service. Then, either the sister or the staff nurse or the councillor as to stop doing what they are busy with. Retrieving files before they could carry on with their services. So, there definitely is a need for extra personnel, people who only do that. Because at the moment, they cannot do their work without the files and um…

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			somebody has to retrieve them. Somebody has to do it. Yes, so… (A004:376).
			"In front… definitely clerks. **Clerks** and then um… clinical nurse practitioners, um… the operational manager anyway is um… is… is a clinical nurse practitioner and she has to do her own… her own um… *admin* stuff. So, all those clinics have to um… facility manager essentially is somebody who should only do the *admin* and then there the… the… understand? (A004:376).
		Staffing should be according to population numbers	"Now, that clinic with the personnel, with the equipment is suitable for the current population. Now, out of the blue there are another four hundred people. So… and then, the **calculation was not done of the size of the clinic and staff complement**. So, like I actually – I would almost say – as the population increases, one should actually **expand the clinic and appoint personnel** in relation to the changing circumstances (A004:9).
		New Community Day Care Centre in Malmesbury	"But now, now they have, for instance, where the clinic was, they now also have to attend to the patients of the day hospital. So, now it's not only the personnel at the clinic. Now, it's also the personnel of the day hospital who got added. So, now they are also… Ah, patients. They… they've state of the art equipment, everything. **Now, the facility is ready but gained extra crowds of people and there is also a huge frustration for the personnel where one would still like to have extra personnel** like the people… And once again, the areas are expanding and expanding and houses and more people, more people. So, um… there they have the facility but there are still frustrations about… (A004:10).
		No rural allowance	"So, we in the Swartland sub-district are not… don't get rural. So, even if we do get people who are not complaining. So, we are battling. **We are the only sub-district in the West Coast that does not get a rural allowance** (A004: 379).
		CBS shortage co-ordinators	"We do get it. The thing is um… the… the **shortage** of **coordinators** or the coordinators… It sounds good to say

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			the coordinator has been appointed to supervise twelve carers who then… then they could perhaps oversee an area like a third of the Berg River (A003:167).
		High workload	"I think... I would perhaps like to add something as far as that is concerned. I think the qualities and the expertise and... All of that are at the clinics but there is simply **so much pressure** in terms of numbers that the quality suffers as a result of pressure, as a **result** of **time** and at the end of the day it becomes like a **sausage machine**. Not because the quality is not there, not because the expertise is not there. All those... I think we have wonderful qualities at the clinics but when... when one sees what a clinic looks like in the morning then one could not provide a quality service... service (A002:292).
			"It's like a ***wors machine*** [sausage machine]. You must just **go on** like doing it because you must do it (A002:310)
			"And also for the staff as well. If they want to give quality, it gets a little bit difficult. You just feel as if you are part of a **conveyor belt**, you know. And you have to move on because that can be **quite desponding** as well (A002: 203).
			"Oh, I think a trivial little thing – and while I am thinking, I want to say that it is common at **all the clinics** – for example, imagine your sisters are on their legs the whole day. **There's no such thing that they are sitting on the other side of a desk** while they are consulting. Fair enough, there are physical examinations that have to be conducted but the… the setting simply does not allow her to rest her legs for a short while. **She is on her feet the entire day** (A002: 322).
			"And there are some many people who are **waiting**, **patients**, and we… I as a member of staff **do not go home before five o'clock or half past five**; not before I have seen everybody because how could I expect a mother to return early the next morning? **When I stop at four o'clock or half past four. She has to come back the next day but the distance she has to walk from her home to the clinic is not… it's… it's not easy** for her **(A004:385).**

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			"At some places it does work like when um… Like the CDC with lots of space and everything… there are um… for instance, children. Nobody has been delegated to the children and she makes those appointments. So, it functions but inside another clinic what they should be doing. This **morning** the nurse has to do the **TBs** and **then** she has to do a couple of **observations** for the CNP. **Then** she has to see **children** and then she has to [do] **everything**… (A004:13).
		High work load - duplication	"I cannot provide an answer but I can say one thing; we are busy to **duplicate** so many things, meaning at… think about **the poor clinical nurse. She has to do forms, she has to [attend] to the things of the occupational therapist, and she has to do this, do this, do that. And how much of that information is duplication** of what has been there since the beginning? Shouldn't we get something to minimise everything? If you understand what I'm trying to say (A004:381).
			"If… if I can use an example. **Documents** that we are busy writing. The file of the patient. The um… the record on the **maternity side**. It's there. It's there. This is the file, it's the [mumbles]. This is the **file**, this is the record of [mumbles]. Goodness knows what else. So, um… like breastfeeding. We have a **tick sheet** [sic] that we have to do. Once more, **the same information** is provided by the PMTCT [sic], the **councillors** also who do the breastfeeding. So, what I'm trying to say, many documents that boil down to the same thing at the end of the day; we are **so busy duplicating** constantly and that is what takes time. That takes up most of the time (A004:382).
			"Yes, although I didn't know about such a system at all. So, but what was at the back of my mind is that we need to get something to reduce this **duplication**. It could be anything (A004:40).

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		Duplication of information	"A mother arrives with her baby [mumbles]. [Mumbles] arrives with the [mumbles]. And then, what get done; the little one gets **weighed**, the **length** is taken, the **head**-in-place gets done, the **immunisations** are done. All of that. **It gets recorded in the file**. There are still documents that I don't even know about and then, most of that information **also needs to be recorded in the Road to Health booklet** (A004:383).
			"So it takes that member of staff where she could have only done the Road to Health booklet or only the file, **now it is two documents that contain the same information** (A004:384).
		Duplication decrease the quality of service – patients have to wait longer	"Um… yes, in that respect one could view it in that way. What I actually mean, is the time. What you do for me as a clinical member of staff. Like the sister. For example, where **she could have seen a patient in twenty minutes it then becomes forty minutes. In other words, we are not mindful of patients who are waiting longer** (A004:151)
		Time	"Actually, I don't really have anything new to add except to say that I do not agree. Um… especially in my occupation **time** is of the essence because nobody is going to make them that vulnerable when they know in **five minutes** you are going to say, "Oops! Time's up." Now, come back next month again or whatever. Uh… it's not worth it. And um… about privacy and confidentiality, for me that's the highest priority. There, I do not need that much equipment (A003:152).
		OPM High work load	"I mean, also the **operational manager** has to **manage**, which is a full-time job in itself. Especially if you manage such a big clinic but she's **also** the **senior CNP** there... (A002: 208).
			"She should just be doing **admin**, **not seeing patients** (A002:210)
			"To manage because **managing**... she has to manage her **stock**, her **staff**, her **equipment**, and her **stats**. That is a full-time job and being a CNP in itself is a full-time job. So,

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			that's **two jobs** in one. I think that's a big burden (A002: 209).
			"We have but they… they have **shared responsibilities** and **they are clinical nurse practitioners and eighty per cent of them are operational. Eighty per cent have to see their patients**. The people walk home every evening with files to do their *admin* work (A003:205).
		Work pressure	"Especially from the operational managers. At a clinic they are under so much **pressure** and, yes. It seems like they are coping but when one asks them something, it's like quickly take time out for ten minutes. Take a breather and then we can carry on with the rest of the day. Often, that is what I experience during my infrequent visits to the clinics, you know. But one ignores some things. Um… die BHC [sic] manager sometimes ignores things because you know if you are going to be harsh on her about a *stats* book that has been completed until yesterday or until a week ago; you mention it because she needs to know. But you are not going to reprimand her there and then. There is a possibility that she would say, I **had enough** and she walks and then you are stuck… or she **cracks**… or she has a **nervous breakdown**. So, often ignores certain things (A002:206).
			"I would like to confirm – it adds to what Japsnoet and Nellie have said – often one sits with this person, nurse, because you know can only handle so much before she **cracks**. Therefore, often one ignores what one knows should change (A002: 324).
		Cleaners outside their scope of practice	"I cannot talk for long. I would like to mention – from a pharmacists [sic] – um… like we mention about the cleaners. It happens that the **cleaners** themselves **dispense** the **medication** (A002: 327)**.**
			"Because I know it's **wrong** and I am **closing** my **eye** but that's how they are managing. Otherwise, there is nothing they could do (A002: 328).
			"Anyway, to get back to what MJ has said about the **cleaners**? When that **patient** comes he specifically **looks** for the **cleaner**. Then they ask why? Yes, because they think that

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			when they are talking to the cleaner, the cleaner is going to um… understand the better and then **quickly fetches** the **medication** from the **shelf** (A002: 328)
		Lack of Oral Hygienist	"Um… **at the moment the dental team consists of… it's only the dental assistant and I. If I at least could get an oral hygienist** but that she entirely… her training is entirely um… um… (A001: 273).
		Lack of admin support	"Yes. Another thing that I am thinking about and there… for instance, there is **not** a **support system** in the **clinic**. There is not a support… I don't have… - oh, I make it to a clinic once a week – Theirs is nobody whom I can ask to **make** a **phone call** for me. Just **phone** the **hospital** for me and ask when I can get an appointment… not for the sister. I believe not even for the… one has to everything oneself ((A002: 45).
		Lack of maintenance person	"But I also have to… When… when you really… you… you **can't** really **appoint someone** who **only fixes wheelchairs** because our workload is not of such a nature that it would justify that guy's salary" (HR – employment of someone to maintenance the wheelchairs) (A001: 244).
		Lack of physiotherapist	"We do **not** have a ***physio*** at our CDC. Is only at the hospital that we have that (A004:397).
		Lack of courier service	"Therefore… therefore, it is somewhat… We… we try and be creative about this [matter] to… to solve the problem but I think it really is a need in our area that we **do not** have [clears throat] an **effective courier service** and I understand where it comes from because if our finances that… there. **There** are **no finances** for that. Therefore, we cannot… we cannot proceed by saying: "Oh, wait! Appoint the courier". So, one has no choice other than being creative about it but it surely causes a gap in our… in our exposure" (A001: 137)
			"…is um… For instance, in Vredendal we have the Hoop [sic] Pharmacy and now a patient is sitting there and um… smoking reed [sic] that, for instance, um… who now… say for example now he needs an antidote for [mumbles] but the… the hospital is situated in Vredendal and we **do not have** like a **courier service that commutes daily to deliver stock, to deliver medication and to… and to deliver everything…** everything to the clinics.

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			Sometimes, it can be somewhat of a crisis when people um… need medical stock from Vredendal [coughing] and we cannot get to the clinics. We have to [**wait**] for the **next distribution** to that place… And sometimes, it is possible that one waits for a couple of days and…" (A001: 238).
		New community service professionals annually	" But where it is like the *comserves*… Many of the clinics that I have… Thursday… what now? Tuesday spoke to a lot of them. Then, like ***comserves* and every year there are new *compserves***. So, then no relationship gets established. By the time that the *comserve* has found his feet and knows how things work, two months are left before he leaves again. Then, somebody new comes. So… (A004:378).
	• Staff welfare and employee wellness	"Staff not happy"	"When the members of **staff** in the final analysis are **not happy**, then **they wouldn't really provide a quality service**. And… and… and most of the time, that… those requirements are complemented by respect [sic]. And then you hand it… you hand it over to the personnel. Your personnel might be busy with… with a campaign and in many instances it interferes with what they are busy with because at a higher level it is said, this is the deadline and… and then… then we lose in many respects then… also the quality of the service. Where it could have been ninety per cent, then it is fifty (A001: 227).
		Staff satisfaction	"But I would also like to see that the other – I know we are now talking about patient satisfaction – but I would also like to see that the personnel are satisfied because the… **one needs um… a satisfied member of staff to provide an outstanding service** (A004:363).
			"When an **employee is satisfied and happy**, then a patient is also going to be satisfied and happy. It goes hand in hand (A007:417).
			"Because when one is **happy at one's work,** then one is **going to put in more effort** with one's patients and one is going to treat them better, to talk better to them and then the

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			patient is also… Because I mean, when one is going to explain to a patient in a clear logical manner why he has to take his medication every day instead of telling him, "Take your tablets!"(A007:433).
		Neglected staff	"Yes, I might be in a fortunate position. Once a week, I work in the clinics as… as **psychologist**. Then, once a year I pay all the facilities in the district a visit and I see every member of staff. I can only say, those people are extremely neglected. One cannot believe the high prevalence of high blood pressure, all the sugars, all the lifestyle illnesses. They are all overweight and I think it is a release valve to... to eat. In other words, **they are physically and emotionally neglected,** the personnel. And… and a project should be implemented to once again build that morale that… that… They are looking at other people carefully – I… I always draw the comparison – I say like a battery that has tremendous output but that battery never gets charged. And any… and eventually the lights go off and later on everything dies (A002: 197).
		Demotivated	"I think it is very important while it remains a long process to put all these things in place, before the infrastructure is available, the **personnel remain demotivated"** (A001:182).
		Patients demotivated staff	"And then your day is ruined as well. For you it's a... What's "*'n bose kringloop*?" Because the next patient... **This patient ruined your day**, so you think, oh! This patient is also going to do the same. So, I'm not giving this patient quality care because none of them appreciate what I'm doing. And then, *ja*. It goes around and round a circle (A007:181).
		Burnt out staff	"Or to… make it okay to live in the real world even if it is not how one thinks it could be. And it's got a lot to do with that belonging. There are people who… with "should"… "Should and musts" those are the things at **burn us out.** I… because **that's the stuff that one thinks one ought**

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			to do but one does not necessarily get there (A003:196).
			"Before, mean in terms of resource... a colleague of mine said um... I spoke earlier about um... yes, there is a clear lack of resources and long queues and stuff like that but your manner and um... treating someone with respect and real interest and stuff like that can still remain. But after a while, I think, **people start to burn out.** If a look at people at the clinics... (A007:195).
			"I think people feel a bit lost sometimes because in terms of their referral, they... I think there is a like of... less communication then. Less of go that extra mile. There... there's really under resourced and I don't think it's for... it's an intention. I think it's **just burn out** for a lot of people and they really... They have to take work home if they want to do it the same quality (A007:194).
		Staff is overworked	"...because they're so **overworked**. They start working more like in silence and only worry about their work because it's been jeopardised because it is so much that there... there's less energy to consider your... your... like the next staff member (A007:202).
		Morale would also not be high	"How could we improve that? At the moment, I am like somebody who constantly tells the same story over and over at every clinic. Send the referrals even when it is not a proper referral in terms of written letters. Simply send the name and I will start addressing the issue immediately. But, once again, I could not… I could also not be happy and **my morale would also not be high** when I go through all the trouble and when I arrive there on the day and then nothing is happening there (A001: 279).
		Activities to boost the morale	"Um… perhaps I am thinking about the **morale** of the **nursing staff**. For example, uh… a team competition or anything else assists. For argument sake, to have a **team building** once a quarter or every six months just to **boost** the **morale**; simply to do something pleasant. That it should not always only be work-centred but – you know – in order for the people to become a little more positive and to boost the morale (A001: 283).

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			"At the end of the day, one should really invest quality or time in one's personnel. Look, I also have given the guys each a **birthday letter every month on their birthdays**. Put a small… it's the small things that are going to make a difference at the end of the day. In other words, one does not need the finances to do these things because it simply requires the sharing of thoughts and saying thank you. Look, one knows that everyone goes through such **difficulties** from time to time which cause them not to be themselves on that particular day. We are… nobody is perfect. We are not always a hundred per cent where we should be but um… it's simply… (A001:284).
			"**Staff morale**, for example. We had **introduced** um… a small school initiative where everyone of us… member of staff drew someone else's name and one had to on a weekly basis – any way you wanted – **give a little note, give a little flower, give a small gift, anything you wanted simply to make that person feel but he was valued.** Um… so, this is the initiative that the department is currently implementing but I think in the long run it could be very positive (A001:175).
		Despondent	"Yes, what I tell myself personally, is every day when I walk in, I have to tell myself – even when I'm tired, even when one becomes **despondent** with the system – **now one has to focus on the patient. And one does not always succeed.** Sometimes it is… like one gets… one sees how the referral system work and the patient is not cooperating. One sees the chaos in the waiting room and then… then one has lost that day. But other days one wins and then – even when this patient does not need a wheelchair, even when it does work – that is my best day. And I think that is what's good. There are people who… who want the best. Those sisters who want to go and deliver the tablets, but everybody fights against the system and, therefore, some days people lose or… (A003: 81).
		My courage will disappear	"I do not think the inside personnel but I do think that management can control it. So… so, I… I… for me, I always say, okay. From the side of the **personnel**, I always say, I don't know whether you have been at a

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			clinic before? **When you walk in that morning, a whole crowd of people are sitting there. I always say, if I have to work the everyday, my courage will disappear when I think I have to attend to these hundred people by this afternoon.** Therefore, I think there should be a system introduced that spreads the people evenly (A001: 304).
		Morale is low	"And one wants to do things. I mean, he… we come such a long way in that, then he asks, how have you done this. Then we say, "Nellie, we simply carried on". Perhaps then Nellie says, "But it's not supposed to be like that". And perhaps then… and then you come and you try to do things but then he simply stops. Then they stop him "The equipment is too expensive. You must go on with it". And things like that. And after a while one does something simply because one has to do it. Not because one wants to do it any longer. It's one work that one has to do. **You are simply doing it. You are already as low** as… You are pressing ahead with the means you have… and to… like I have said (A002: 221).
			"What one also sometimes – I would almost say – becomes **despondent** because one… one… one questions what their exact core functions are (A003:200).
			"Um… morale. The… the… the fact that t**he morale is low** also has an influence on um… how they accept you. When one enters as… as manager – you know – it is that cold shoulder that one gets because they feel you as supervisor… (A003:219).
			"I think their **morale** becomes very **low** (A004:377).
		Morale is good	"Actually, the people's **morale is actually very good**. Despite everything – I think – the people's morale is fantastic (A002: 320).
		Employee assistance programmes	"Yes… yes. For instance, I do think that people are in… in a position… to… to um… do it. [Pause.] And the reason why I am saying that um… the department launches **training programme**[s] to… to ensure that every

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			member of staff… the quality… or quality service… and then there is also ICASS [sic] for **employee assistance programmes**… pers… personnel who… more… about circumstances… like prices increase… the financial role (A001: 227).
			"I take my hat off for them; how they cope and what they are doing. Perhaps I would like to put it slightly differently by saying that **there should be more care for the carer**. It needs to be implemented but we have great admire… I admire the people. I would not be able to work like that (A002: 44).
			"There are many um… **problems** with **morale** but I think it is from the beginning – I nearly said – is one wants one's point of view and also organisational. And many of these organisations – apart from what we give to the department of health – invests quite a lot in people like extra training, extra um… a care for the **carer day**, to indeed give them support (A003:355).
		Lack of debriefing	"I said on that point, it comes down to **personal support**. [Intercom announcement drowns part of Nellie's response.] Lack of effective support structure for staff um... to allow them to **debrief** and... (A002: 323).
		Need for professional support	"And then also um… I'm inclined to take it back to the university. I think we are stuck with a young and we are stuck with an old crowd – oh, perhaps I'm the oldest – is um… Also, no provision has been made and I don't think there are platforms where we are actually taught to… The most important thing that I've seen is my goals, the organisational goals, and the patient's goals… And that one often does not find the **emotional maturity** or we also do **not assist** these people organisationally to… (A003:47).
			"Train… training um…**more professional support** and that… and that not everything is directly aimed at clinical um… When we talk about clinical support because it's easy to say one needs to tell somebody he should not smoke (A003:46).

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		Satisfying when patients return and said it work	"That… that does not always happen but it is very **satisfying** when a **patient returns** and **confirms** that they actually are doing it and it **works** (A001: 264).
	• Supply chain and asset management	Lack of adequate stock	"I would also just like to add that one cannot provide quality service when one does not have the equipment and **sufficient stock**. The correct stock" (A001: 131).
			"You could have done more… if you only had the **resources**" (A001:230).
			"One can't. One can't. So, that is what creates quite huge gaps for us at the moment. Um… and then… and… and another thing – that all of them would confirm – is the **constant stock shortages** that we are experiencing. Um… it is the logistics in the finance component, as well as um… the shortage of staff. Um… "(HR – limited resources) (A001: 133).
			"It's basically… Yes, **stock**. Basically, it is – like he knows – the **web calls** in the hospital. We have to… understand? It is those kinds of expenses, the swabs and **other stuff** (A001: 136).
			"So, the basic things… **basic stuff**. If I want to be punctual for a period of eleven hours, then I need to seek assistance for that [mumbles], understand? There are **no needles**. Um…" (A001: 249).
		Too many processes	"And especially… and I especially refer to the **logistics** in terms of **stock** because… because… in… they… they realise their clinic needs a coat of **paint** and they cannot understand why it… Why can't a hospital simply come and paint it? But are there people in the… in the repair shop? Um… I… I think that there is **not always an understanding of which processes** are in place and what… and… and even I do not always understand um… I need **milk** for my **HIV-positive babies** or moms with babies. Um… but it is a… is a **process to get hold** of it. Um… for me, it is not only about the completion of a form or the pressing of a button and the milk appears. In other words, um… it is even up to the patient's level. But sister, you told me two weeks ago there is no milk. Now I'm back and am still not here. Why is it not here? It's bad service that one

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			gets. Um… but… but the comprehension the entire processes… and I think us… we simply have **too many processes**. There are **too many people** who have to **rubber stamp** and there are too many… (A001: 50).
			""…a delay caused in the clinical processes. And I really don't think it is in… in the hands of the **finances** at the **hospital** to do something about it. They have **directives they need** to **follow**. They simply cannot get around it (A001: 49).
			"**Supply chain** when it… let it be **distributed properly** and not **wait such a long time** for… it has to come from Vredendal after it has been ordered or otherwise not (A007:404).
			"I think if it was more accessible because to get stuff, one **needs to first get hold of people in Citrusdal or Vredendal** or... It's not where we are and, yes. It's just one call away but um... I'm clinical at the end of the day. So, I'm not always at the office and if I'm at the office, **they would be off or not there** or... So, it's always [mumbles.] (A007:117).
			"But even if you place a **phone call**, you need to **complete** this **form** and then you need to **fax** it and then they don't receive the fax (A007:411).
			"*Ja. Ja*, and then it's **not the correct form and then two weeks later, you're still waiting for the stock**. And then, you follow and then, no...(A007:114).
			" Yes, I think there are t**oo many levels in our hierarchy** I'm inclined to say because when I would like to apply a new coat of paint, for instance. And somewhere in all those steps, it simply gets lost. So, if they could perhaps say, okay. The budget remains important but that every institution has its own budget and allows the people who are working at that institution – and only the people who work at that institution – to take responsibility for that budget (A007:51).
			"Yes. Yes, certainly. Because I think like in… it would be easier when Leanne needs milk and that is part of the hospital budget. She goes directly to the people who work with

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			that and say, I want that. But at the moment, **she still needs to go to another person whom she needs to contact telephonically**. That, I nearly said… (A007:52).
		Complicated procurement processes in Cederberg	"Pardon me, here at Cederberg, I think, is a matter [sic] of the two hospitals that **complicates** it even more. As a result, there are two systems. One system works through Vredendal and then, the other system works through um… Citrusdal. Therefore, it makes the processes even more difficult (A007:414).
		Communication in procurement is a problem	"I think **communication** is still a huge problem because um... say for instance back to the ordering. If I order something um... and say for instance it has never been ordered before. So, now it needs obviously a different process to follow (A007:127).
			"Oh, no. Then the clinics start complaining. We don't have this and I then say, "Okay, **but I haven't heard anything.** I don't know what's going on". Um... but then also, just to mention space (A007:126).
			"**Nobody lets me know it's a new item.** You must do this. It will take this long, you know. (A007:413).
			"**There's no follow-up**. So, I mean, in six weeks you're like, "Oh, my word! I've ordered this thing" (A007:412).
		Making use of what is available	"Then, one goes for – I nearly said – a cheaper option or whatever is available and then **the patient gets at the end of the day only that** (A007:160).
		Staff buy Pritt themselves because of long waiting	"Yes, a simple thing such as a [mumbles], one's **Pritt** or one's [mumbles] or stationery. Something simply like stationery that one says, oh! **I'd rather buy it myself because one cannot wait that long (A007:412).**
		Log forms got lost	"You know, especially when that [mumbles]. It depends. One fills in a form, a log form. After two, three weeks then one enquires. Either t**he form got lost**, or… Then one has to complete a form once more (A007:115).
		Have to stay within the budget	"...and one has to always **stay within the budget** (A007:443).
	• Information management	Statistics not captured	"That they have seen forty, fifty children today. One knows every child has walked out of there and received his vitamin A and his deworming and his immunisation but it has **not** been **entered** on

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			the **Jimmy** tool [sic]. Therefore, one is going to say that and one knows what has happened and one could send somebody to retrieve it or to extract it because one knows when that child has been seen, they will fetch the booking, would be entered in the file but it's not on the Jimmy tool [sic]. So, one is going to mention that, but it would be excused because one knows in that regard one has had difficulties. At that point, you are not going to reprimand her (A002: 325).
			"So, **we are not keeping statistics about the people whom we are sending away**. So, that is why the statistics are going to remain the same because we only submit the ones whom the sister has seen (A004:38) (A004:38).
		Stats not accurate	"Just look at the **statistics that you are saying is not accurate.** It is not accurate. I know. There are heads that are lost (A004:387).
		Documentation of statistics	"Like um… um… also the *info*… the **information** expanded quite a lot, *né*. Initially, we only reported about a [mumbles] six. Now [it] is the um… I do not know, hundred and how many those… things that one… the nurse practitioner has to complete a tally sheet. **Everyone has to complete a tally sheet**. Um… it's keeping your wits. One really has to keep one's wits. So, when there is a clerk it would make the task so much better… go… make (A004:375).
			"That's the problem. We have **started** to um… at some of the places where we know what problem is t**hey have record the patients who couldn't be seen.** He has to come back tomorrow, *né*. So, now they are keeping a diary of that. But… but… no… nowhere do we report, does it get regulated (A004:36a).
			"Sarah: We have **no idea about how many are turned away and how many simply leave the clinic** because [mumbles]. One should keep **record**, also for one to establish how many have been seen but these parts should have been seen but have not been seen. Therefore… (A001:281)

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		Data capturers being appointed	"Look here, what we have done um… in… in the beginning with this new system and stuff it was to provide training to the people how to fill in the forms and so forth. And then, one also has… **then people were also appointed whose specific duty it is. Then they physically go to the heads… to yesterday's page and they check. Have all hundred people been captured?** Or, now there are hundred and twenty people. What are those twenty people now? So, I think the clinics have a reasonable system in place at the moment to… (A004: 386).
		Stats could be used to motivate for more staff	"So the motivate… when we have to write a **motivation** to the district office for **more** um… um… um… for another **nurse practitioner**, then we are going t**o attach those statistics to say** that's what… (A004:36b).
7. Facilities and Infrastructure	• Buildings and grounds	CBS Infrastructure	"Problems that are surrounding this woman. So, firstly we have her and then inside the home **we usually do not have the infrastructure** to really care for the woman (A003:113.)
	• Facility infrastructure	There should be adequate space	**Infrastructure** means that there should be **adequate space** for um… clients to **wait**. There… there should be **enough consulting rooms** and that applies to the whole… the whole structure. The **pharmacy** should be in order. If… There should be enough **storage space** because otherwise everything is in a mess with the result that you keep looking for things and it delays your service… the work and there is no **storage space" (A001: 122).**
		Appearance of the workplace influence patient care	"I would like to add to the personnel. When it is a place where you are going every day, certainly **you would like to go and work at a respectable place**. Because when your place of work **appears** scruffy then you wouldn't be bothered about how you treat the patients who enter. Because it's that scruffy. It's simply backward [sic] (A007:120).
		Inadequate space	"I have listened carefully to what everybody is saying. The pharmacist – I am inclined to agree with all the points. I mean, like **space** you have mentioned – um… um… What I'm trying to say is when you look around, there's **no space** to… to… for **bulk storage**. For example, let's assume there is a terrible outbreak of a stomach virus.

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			Everybody starts vomiting. Then, there is no medication for nausea for the people who…" (A001:
			"Yes, because say for instance [mumbles] you have a high patient, you know [mumbles] of patients is high and then patients are [mumbles] on supplements is high. They only have a **small storage space** which means I need to order more often. So, you end up ordering stock every two weeks for the clinic where you could have done it once (A007:121).
			"From you… How can I put it? Not entirely isolated but um… but um… in terms of **space at some clinics**, when a **dentist** is **present**, then all the personnel are abuzz due to the **large crowd** of **patients outside** but, in the meantime, most of them are my patients. That's why I think many people… and I'm not a person who would… I want my forty files and I want them now. I want them immediately because I want to start right now (A001: 247).
			"Well, I can say from the point of view of a **physiotherapist** um… I see an incredible amount of backache. It probably is the issue that I'm dealing with most and a lot of them have chronic backache and many of the um… causes of backache are simply… they did not prevent… they did not prevent the backache. Therefore, many treatments of backache are very similar. That's why I think one can present a **back session** instead of seeing patients individually, but we are also **faced** with the **space** as **problem (A001: ??)**
			"It should definitely uh… the… the um… **waiting** room should be **large enough** to accommodate the patients (A002: 29).
			"I think when one has one's **own lock up space**, then one would have the opportunity to keep a few better things there (A002:307).
			"The waiting **space**. For example, in… in the clinics there are **no** um… **restrooms**. There is not a small **space** for the personnel to have some **tea** for ten minutes. Or even, one just has had a very difficult patient who has drained one emotionally. There's **no space** in the clinics just to quickly catch one's breath before continuing, at least then one could be somewhat revived or something. So… so, it

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			really is, it really does something to the morale (A003:341)
			"I have a good example from yesterday. I had to go with a walk with a patient like gate [sic] re-education and there was no space in the room because it this big. So, then I had to do it in the corridor but the corridor is just as narrow. Then, nobody could pass me. So, other patients had to wait. So, their quality of service… they were sitting and waiting for a nurse who could not get past us. My patient could not turn around. So, it is **space** and **place**. I also have to say, those beds that are too high. There is no… (A003:142).
			"Firstly, we simply **do not have space** to provide her with a good rehabilitation service. We send her home. We expect of a lay worker and we expect of occupational therapists and physiotherapists who are available, who visit the town once a month to also relinquish time to go and assist the lay worker who could then educate the family. Then, inside that house processes need to be implemented because this forty year old woman suddenly has to be looked after by someone else (A003:145).
			"At that time, it was only prevention. Like your antenatal, you immunisation. PHC was never… and on top of that the MMCs were added because the MMCs had to fit in during certain times and **there was no space**. So… (A004:366).
			"Like, for instance, I can say um… at **occupational therapy** we need a fair amount of **space**. Especially for our paediatrics because when we would like to [do] motor… or to establish whether the child can run, can jump. Now, the small room that I sometimes get, it's not nearly suitable and one's bed is either in or out, the basin is in the corner, the cupboard is there. It is so **small** that one can do absolutely nothing. In summer it is okay because then I could go outside (A004:146).

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			"Yes, perhaps it's not difficult like it is in the case of the two of them. We can sit talking in any **space** with a table but there is a **problem**. It is the **intermittent movement of personnel that causes constant interruption**. And also, I have to say, we are currently talking about patient-centred. How would a person feel when we are sitting in at a table in the **kitchen** during a consultation? Certainly it's not… what one… (A004:144).
		Expand the size of the clinic according to the population	"Now, that clinic with the personnel, with the equipment is suitable for the current population. Now, out of the blue there are another four hundred people. So… and then, the **calculation was not done of the size of the clinic and staff complement**. So, like I actually – I would almost say – as the population increases, one should actually **expand the clinic and appoint personnel** in relation to the changing circumstances (A004:9).
		Space affected hearing screening	"I think where **space** affects us is with the um… **hearing screening**. When one is in the **room next** to the **kitchen** and there is supposed to be silence. It is somewhat of a… problem (A004:143).
			"Yes. And we have um… especially with occupational therapy, especially with the paediatric population, then **one needs more space**. Like an adult who stutters. Then we could go and sit down somewhere because we are mainly going to talk. But then, the paediatric population in terms of audiology when one also does **hearing screening** (A004:371).
		Space and privacy	"Uh… It… [sighs]. We are trying to coordinate that not too many people go the same clinic on any particular day. So, we are trying that but the issue of limited **space** remains. Some days, there are some problems but I have to say, they are trying to accommodate me in terms of **privacy**. For instance, a **dry wall** are this sliding door in between. There is no… one can hear everything that the person next door is saying. So…(A003:148)

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			"The… the… the patient sits in the s**mall waiting room; a small waiting room.** Um… for example, in one of our toilets, they say, the new cups are thrown into a bowl in the waiting room. Um… a previous clinic that we had where we had improved the infrastructure was um… **one had to walk through the consultation rooms to get to the toilet** and um… and often the toilet water rose. It was a carpet. Then, during the weekend the toilet had over… overflown with the result that on Monday, services could not be provided. It is… its things like that (A004:123).
			"...and I think, it has never been maintained, especially with the **infrastructure**, like with the service as the years went by. In those days, provision was never made for Primary Health Care. That is why the clinics are still **too** small and why the **waiting rooms** are **too tiny** and often one **has to go through the consultation room** (A004:365).
			"...but all of them have to visit the clinics and t**here is no space**. Ask them. Some of them have to see patients in the kitchen (A004:368).
			"Or [see] them **outside**, or **organising** a **hall** that is close to the facility where they can see them, the patients. That… yes (A004:369).
		Infrastructure do not fit the current services	"I don't think in those days there were occupational therapists and dieticians. Yet, **the infrastructure still looks the same**… (A004:367).
		Staff make it work with what they have	"I have to state that I have started this year. In other words, I haven't been here for long. Um… what I am saying, there is a sister and we are in the first year team [ice jingles in a glass] and we **make** a **plan** when there is a **shortage** like when there is **not enough space** that we need, **then we make it work**. Or, for instance, um… once a month I can – perhaps twice a month – go to a clinic for a patient who um… has an acute or… or a chronic problem actually has to see a physiotherapist more than once a month for the

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			treatment to be effective. And for me, to provide hands-on treatment, one session, one half an hour session once a month does not work [coughing] as effectively. Therefore, what I do, I have to transfer the responsibility to the shoulders of the patient by saying, okay. This is what one can do at home to maintain your own treatment (A001: 158).
		Shortage of rooms	"I have to agree there… um… often a lot of people see their patients simultaneously in the same room due to the **shortage** of **consulting rooms** and to top it all, that one room is not even a proper consulting room. Sometimes, we **see** patients in the **library**. And from my point of view, to see a patient under such circumstances I am not as effective as I would like to be. A proper consulting room with a plinth [sic], with equipment (A001: 235).
			"Now, look. At some clinics there are **too few consulting rooms**. It implies that she sees a patient. She sees a patient. I see a patient. She sees a patient. I see a patient. Like that… (A001: 236).
			"So, I'm stuck with that little problem. There is **not a specific room** that I can take and say that it **my room** (A001: 246).
			"From my perspective, I think um... all the **health professionals** will have their **own room** because it is not good if me come and disturb the other health professional and get things out of the cupboard or get the scale. And you're disturbing that patient's time with the health professional. Um... there's sometimes where **we as the allied health have to work in the pharmacy or in the kitchen because there's no room for us** (A002: 296).
			"We are working in **two small rooms**. It's the **storeroom**. It's the storeroom. It's the **tea room**. It's the **treatment room**. Everything gets done in those two small rooms. The **sterilising** gets **done** there, the works. In comparison with what it should be, there need to be a room for everything, like for the one who works with that patient and for those patients. **There needs to be a room where the sterilisation needs to be done. There needs to be a place where one could drink tea. There needs to be a**

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			place where one needs to do one's *admin*. Why is everything pushed into one room? When I want to work, then another professional person enters. He just needs to quickly print something on the computer. At that stage, I am busy with the patient but there's no other way. They need to enter and simply say sorry. Michelle, um… I need to quickly come and print that thing. No, its fine, Nellie. Do what you have to do (A002: 298).
			"**Infrastructure**, yes. And personnel as well. I think, if you look after your staff, it's you that's going to deliver a better duty. **Not one** of these sisters in charge has an **office**. They are stuck all over the world. Your office. **Some places don't even have a tearoom**. It's a dump. I won't even be sitting there. It's very bad (A002:303).
			"There should be **enough workrooms** because… And also, one cannot treat somebody when there is not a bed in the room. In other words, one cannot work in the **tea room** (A002: 301).
			"If I can add onto what Poppie just said now. For us as... as health professionals, sometimes there aren't uh... **enough consultation rooms** available on certain days. Um... um... and obviously that directly impacts quality of care. I mean, it infringes on Patient Rights um... to... to confidentiality and that. Um... and *ja*. Batho Pele principles are also not upheld and that is the organisation's um... issue. Because, I mean, we... we as health professionals can't really do anything about that and it's not fair on the patients to accept having a consultation in a waiting room where there are other patients. That's all (A003:141).
			"So, number one says tools or the equipment or to what extent one could do it in the organisation; what [is] your limit in terms of quality service. But also the space, like everybody says, because lots of times like with the OT one has to sit in this small empty room with nothing. And that is where they expect one to see people and it is not fair to the patient or to one's service. So, in terms of that also and we need space. We need a **room** (A003:141).

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		Infrastructure improvement	"Um… what I… perhaps I can also say about **infrastructures**, we um… we are very happy for um… when… when we get new um… when we get alterations and additions at our clinics. For instance, one or two clinics converted the garage into a TB area…" (A001: 242).
		Clinics are no longer in a proper condition	"Right now, it's like that at some of our clinics to get the load of our clinics accurate [sic]. Some of the [mumbles] **clinics are no longer in a proper condition**; such as the roofs, the walls, the tiles. Currently these things are meant to be restored but they have not yet received attention (A007:118).
		Infrastructure has to be neat	"It needs to be neat and something as simple as a new hue of **paint instead of pealing walls** and stuff like that (A007:125).
		Making a plan with what we have	"People, I would like to join Cupcake. One would be able to obtain what one wants at every facility that one could lock up. **But at this stage, we are so used to making a plan with what we have** that we can't actually think whether it would work. No, we are able to provide the service with what we have and we are so used to it that one not really… (A002: 157).
	• Hygiene and cleanliness	Clean place	"Um… sometimes, one can also become more positive. One is inclined to think – how shall I put it now? – About the **negativity**. Like, when one considers some of the qualities they… they are a **clean** place, a **clean** hospital, a **clean** clinic are fairly important and it's something that one could achieve with some ease (A001: 267a).
			"I think anybody who walks into a **clean place** would already have a **smile** on the **face** in contrast with when he would enter a dirty place. And, therefore, it would influence him to be more **positive**. Perhaps, it would also the waiting time somewhat… (A001: 267b).
	• Security	Lack of security services	"But the TVs and stuff are **stolen** every other week (A002: 53).
			"No, we **do not have security.** We only have the… we only have the… Um, what does one call those small things? (A002: 56).
			"And the patients are sitting there and they observe how it is working and tomorrow morning when one notices, then **they had broken in and removed all those things**. Then, one has nothing. It is an enormous problem (A002: 56)

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			"To now mention something like this. We erected a building here behind us; nice *prefab* and whatever. They came… they came and **stole the complete windows** (A002:318)
			"They need to use the **security** to **guard** those things. Now we get this. Today, it's still here, then afterwards they would come and **steal** everything. Then they would come for nothing. And one has not put down security in front of the door (A002: 54)
			"It's true. Every morning when one reports for duty, then **one has to hear the stuff is no longer there** (A002: 319).
			"Now, just think how that makes the staff feel? Here one arrives and now all your stuff has been stolen (A002: 55).

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Annexure O: Search strategy

Theoretical Concepts	
Primary Health Care AND **Donabedian** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **Donabedian** AND quality	3
Primary Health Care AND **Donabedian**	5
Primary Health Care AND **Donabedian structure-process-outcome model** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **Donabedian structure-process-outcome model** AND quality	1
Primary Health Care AND **Donabedian structure-process-outcome model** AND quality	1
Primary Health Care AND **programme to improve**, AND **quality** AND patient cent?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	6
Primary Health Care AND **patient cent?red care** OR **client cent?red care** OR **person cent?red care** OR **individuali?ed care** OR **self-directed care** OR **relationship cent?red care** OR **family cent?red care** AND quality	58
Primary Health Care AND **patient cent?red care** OR **client cent?red care** OR **person cent?red care** OR **individuali?ed care** OR **self-directed care** OR **relationship cent?red care** OR **family cent?red care**	148
Primary Health Care AND **client cent?red therapy** OR **person cent?red therapy**	22
Primary Health Care AND **primary healthcare system** AND quality AND patient cent?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **primary healthcare system** AND quality	31
Primary Health Care AND **primary healthcare system**	120
Primary Health Care AND **quality definition** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **quality definition** AND quality	3
Primary Health Care AND **quality definition**	3
Primary Health Care AND **quality improvement** AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	8

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Search terms	Results
Primary Health Care AND **quality improvement**	435
Primary Health Care AND **nursing** AND **quality** AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	17
Primary Health Care AND **nursing** AND **quality**	825
Primary Health Care AND **nursing**	3 071
Primary Health Care AND **Primary Health Care principles** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **Primary Health Care principles** AND quality	5
Primary Health Care AND **Primary Health Care principles**	23
Primary Health Care AND **quality indicators** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	159
Primary Health Care AND **quality indicators** AND quality	159
Primary Health Care AND **quality indicators**	
Primary Health Care AND **accreditation** in healthcare AND quality AND patient cent?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **accreditation** in healthcare AND quality	10
Primary Health Care AND **accreditation** in healthcare	14
Seven Domains of the National Core Standards	
Domain 1: Patient Rights	
Primary Health Care AND **Patient Rights** in healthcare AND quality AND patient cent?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **Patient Rights** in healthcare AND quality	0
Primary Health Care AND **Patient Rights** in healthcare	6
Primary Health Care AND **continuity** of **care** AND quality AND patient cent?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	20
Primary Health Care AND **continuity** of **care** AND **quality**	388
Primary Health Care AND **continuity** of **care**	957
Primary Health Care AND **triage** AND quality AND patient cent?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	4

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Primary Health Care AND **triage** AND Quality	82
Primary Health Care and **triage**	312
Primary Health Care AND **appointment scheduling** AND Quality AND patient cent?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	1
Primary Health Care AND **appointment scheduling** AND Quality	8
Primary Health Care AND **appointment scheduling**	12
Primary Health Care AND **waiting times** AND Quality AND patient cent?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	2
Primary Health Care AND **waiting time** quality	49
Primary Health Care AND **waiting time**	128
Primary Health Care AND **confidentiality** and **privacy** AND quality AND patient cent?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	1
Primary Health Care AND **confidentiality** and **privacy** AND **Quality**	17
Primary Health Care AND **confidentiality** and **privacy**	85
Primary Health Care AND **respect** and **dignity** AND quality AND patient cent?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **respect** and **dignity** AND Quality	2
Primary Health Care AND **respect** and **dignity**	12
Primary Health Care AND **access** and **information** AND quality AND patient cent?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	1
Primary Health Care AND **access** and **information** AND Quality AND Quality	14
Primary Health Care AND **access** and **information**	54
Primary Health Care AND **language barriers** AND quality AND patient cent?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	1
Primary Health Care AND **language barriers** AND quality	14
Primary Health Care AND **language barriers**	52
Primary Health Care AND **safety** and **security** AND quality AND patient cent?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	1
Primary Health Care AND **safety** and **security** AND quality	9
Primary Health Care AND **safety** and **security**	24

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Primary Health Care AND **cleanliness and hygiene** AND quality AND patient cent?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **cleanliness and hygiene** AND quality	2
Primary Health Care AND **cleanliness and hygiene**	11
Primary Health Care AND **complaints** AND quality AND patient cent?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR family cent?red care	1
Primary Health Care AND **complaints** AND quality	63
Primary Health Care AND **complaints**	235
Primary Health Care AND **patient satisfaction** survey AND quality AND patient cent?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	1
Primary Health Care AND **patient satisfaction** survey AND quality	7
Primary Health Care AND **patient satisfaction** survey	12
Domain 2: Patient Safety, Clinical Governance and Care	
Primary Health Care AND **clinical governance** AND quality AND (patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care)	0
Primary Health Care AND **clinical governance** AND quality	15
Primary Health Care AND **clinical governance**	23
Primary Health Care AND **adverse events** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **adverse events** AND quality	69
Primary Health Care AND **adverse events**	194
Primary Health Care AND **patients** OR **family** OR **friends** are **involved** in care AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	57
Primary Health Care AND **patients** OR **family** OR **friends** are **involved** in care AND quality	3 211
Primary Health Care AND **patients** OR **family** OR **friends** are **involved** in care	12 929
Primary Health Care AND **patient safety** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	1
Primary Health Care AND **patient safety** AND quality	153
Primary Health Care AND **patient safety**	282

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Primary Health Care AND **infection control** and **prevention** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **infection control** and **prevention** AND quality	65
Primary Health Care AND **infection control** and **prevention**	301
Domain 3: Clinical Support Services	
Primary Health Care AND **equipment availability** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care)	0
Primary Health Care AND **equipment availability** AND quality	2
Primary Health Care AND **equipment availability** AND	14
Primary Health Care AND **medication adherence** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	6
Primary Health Care AND **medication adherence** AND quality	48
Primary Health Care AND **medication adherence**	161
Primary Health Care AND **medicines availability** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **medicines availability** AND quality	5
Primary Health Care AND **medicines availability**	15
Primary Health Care AND **medication side effects** AND quality AND (patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **medication side effects** AND quality	13
Primary Health Care AND **medication side effects**	56
Primary Health Care AND **assistive devices** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **assistive devices** AND quality	3
Primary Health Care AND **assistive devices**	7
Domain 4: Public Health	
Primary Health Care AND **health promotion** and **disease prevention** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	2
Primary Health Care AND **health promotion** and **disease prevention** AND quality	65
Primary Health Care AND **health promotion** and **disease prevention**	301

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Primary Health Care AND **support groups** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **support groups** AND quality	34
Primary Health Care AND **support groups**	124
Primary Health Care AND **home visits** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care)	3
Primary Health Care AND **home visits** AND quality	30
Primary Health Care AND **home visits** AND	106
Domain 5: Leadership and Corporate Governance	
Primary Health Care AND **corporate governance definition** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **corporate governance definition** AND quality	0
Primary Health Care AND **corporate governance definition**	0
Primary Health Care AND **strategic goals** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **strategic goals** AND quality	1
Primary Health Care AND **strategic goals**	1
Primary Health Care AND **leadership and corporate governance** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **leadership and corporate governance** AND quality	1
Primary Health Care AND **leadership and corporate governance**	1
Primary Health Care AND **corporate governance** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **corporate governance** AND quality	4
Primary Health Care AND **corporate governance** AND	8
Primary Health Care AND **core values** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **core values** AND quality	4
Primary Health Care AND **core values**	8
Primary Health Care AND **clinic committees** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **clinic committees** AND quality	0
Primary Health Care AND **clinic committees**	0

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Primary Health Care AND **community communication** AND quality AND cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	1
Primary Health Care AND **community communication** AND quality	5
Primary Health Care AND **community communication**	17
Domain 6: Operational Management	
Primary Health Care AND **operational management** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **operational management** AND quality	4
Primary Health Care AND **operational management**	1
Primary Health Care AND **supervisory support** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **supervisory support** AND quality	2
Primary Health Care AND **supervisory support**	2
Primary Health Care AND **organogram** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **organogram** AND quality	0
Primary Health Care AND **organogram** AND quality	1
Primary Health Care AND **computer technology** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **computer technology** AND quality	7
Primary Health Care AND **computer technology**	23
Primary Health Care AND **performance appraisal** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	1
Primary Health Care AND **performance appraisal** AND quality	10
Primary Health Care AND **performance appraisal**	32
Primary Health Care AND **staff appraisal** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **staff appraisal** AND quality	2
Primary Health Care AND **staff appraisal**	6
Primary Health Care AND **staff evaluation** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **staff evaluation** AND quality	2
Primary Health Care AND **staff evaluation**	14

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Primary Health Care AND **staff satisfaction** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	1
Primary Health Care AND **staff satisfaction** AND quality	11
Primary Health Care AND **staff satisfaction**	21
Primary Health Care AND **employee assistance program** AND quality AND (patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **employee assistance program** AND quality	13
Primary Health Care AND **employee assistance program** AND quality	36
Primary Health Care AND **employee performance appraisal** AND quality AND (patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care)	0
Primary Health Care AND **employee performance appraisal** AND quality	1
Primary Health Care AND **employee performance appraisal**	2
Primary Health Care AND **staff training** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **staff training** AND quality	36
Primary Health Care AND **staff training**	87
Primary Health Care AND **staffing levels** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **staffing levels** AND quality	5
Primary Health Care AND **staffing levels**	12
Domain 7: Facilities and Infrastructure	
Primary Health Care AND **infrastructure** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **infrastructure** AND quality	67
Primary Health Care AND **infrastructure**	168
Primary Health Care AND **waste management** AND quality AND patient cen?red care OR client cent?red care OR person cent?red care OR individuali?ed care OR self-directed care OR relationship cent?red care OR family cent?red care	0
Primary Health Care AND **waste management** AND quality	1
Primary Health Care AND **waste management**	11

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Annexure P: Certificate of language editing

English/Afrikaans
Afrikaans/English

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* Translations * Editing * Proofreading
* Transcription of Historical Docs
* Transcription of Qualitative Research
* Preparation of Website Articles

TO WHOM IT MAY CONCERN

This letter serves to confirm that the undersigned

ILLONA ALTHAEA MEYER

has edited and proofread the doctoral thesis contained herein for language correctness.
Signed

Ms IA Meyer

26 July 2018

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FOR: THE PhD of ELSA EYGELAAR
TITLE: A PROGRAMME TO FACILITATE QUALITY CLIENT-CENTRED CARE IN PHC CLINICS OF THE RURAL WEST COAST DISTRICT

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Annexure Q: Certificate of technical formatting

To whom it may concern

This letter serves as confirmation that I, Lize Vorster, performed the technical formatting of Elsa Eygelaar's thesis entitled:

A programme to improve quality, client-centred care at rural Primary Health Care clinics of the West Coast District

Technical formatting entails complying with the University's technical requirements for theses and dissertations, or where relevant, the requirements of the department.

Yours sincerely

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Language Practitioner

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