Compliance with the Batho Pele principles in a Primary Health Care context

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DECLARATION

I, **IDAH DELIWE KHUMALO, student number** 12655619, declare that:

- **COMPLIANCE WITH THE BATHO PELE PRINCIPLES IN A PRIMARY HEALTH CARE CONTEXT** is my own work and that all sources that I have used or quoted have been indicated in the text and acknowledged in the bibliography.
- The study has been approved by the Ethics Committee of the Institutional Office of the North-West University (Potchefstroom Campus).
- This study complies with the research ethical standards of the North-West University (Potchefstroom Campus).

ID KHUMALO

November 2010

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SUMMARY

Compliance with the Batho Pele principles in a Primary Health Care context

In this study the focus is on Batho Pele (a Sotho translation for “people first”), an initiative to get people that work in the public services to be service orientated and to strive for excellence towards continuous service delivery improvement (SA, 2004a:8). Batho Pele consist of a framework with two primary functions that apply to this study; service delivery to people as the customers (patients in this study) and the possibility to hold individual public servants (health care personnel in this study) accountable for poor service delivery. This, in fact, implies that poor performance lead to poor service delivery; thus, compliance with the Batho Pele principles plays a pivotal role to improve quality health care service delivery.

The purpose of the study was to make recommendations to enhance the current compliance with the Batho Pele principles in a Primary Health Care (PHC) context that would positively improve quality care and patient satisfaction. A non-experimental, quantitative, descriptive study was undertaken within the philosophical framework of the Batho Pele principles as well as the Patients’ Right Charter. All participants completed a structured questionnaire to determine the level of compliance with the Batho Pele principles as experienced by the patients and viewed by the health care personnel in a PHC context. The data collected, was analysed using descriptive statistics. Four PHC clinics were involved, situated at Umzinyathi District Health in the Kwazulu Natal (KZN) Province of South Africa. The study included two patient-population samples, based on convenience; the participants that visited the clinics (n=132) and the participants visited by the researcher at home (n=101). Fifty- six (n=56) health care personnel who voluntary agreed to participate in the study were an all-inclusive sample.

The findings revealed that the patients in the study felt more secure to answer the questions on their experiences regarding compliances with the Batho Pele principles at home and this could be an important consideration when conducting patient satisfaction surveys. It was also clear that patients were more dissatisfied

than health care personnel in most questions asked regarding their experience on the compliance with the Batho Pele principles in a PHC context.

Recommendations were made in the light of what was contained in the study that can serve as a starting point to address identified shortcomings in nursing practice, nursing education and nursing research.

[Key concepts: Batho Pele principles, Primary Health Care Context, compliance, health care personnel, quality care, descriptive**]**

OPSOMMING

Die fokus in hierdie studie, Batho Pele (‘n Sotho verduideliking vir “mense eerste”), is ‘n inisiatief om mense wat binne openbare dienste werk sover te kry om diens-georiënteerd te wees en na uitnemendheid te strewe binne volgehoue verbetering in dienslewering (SA, 2004a:8). Batho Pele beskik oor ‘n raamwerk met twee primêre funksies van toepassing op die studie; dienslewering aan mense wat as die kliënte hanteer word (die pasiënte in die studie) en die moontlikheid om individuele openbare amptenare (gesondheidspersoneel in die studie) verantwoordelik te hou vir swak dienslewering. Genoemde beteken dat swak werkverrigting lei tot swak dienslewering en daarom dus speel die voldoening aan die Batho Pele beginsels ‘n deurslaggewende rol in die verbetering van gehalte gesondheidsorgdienslewering.

Die doel met hierdie studie was om aanbevelings te maak ten einde die huidige nakoming van die Batho Pele beginsels te verhoog binne ‘n primêre gesondheidsorg konteks wat positiewe verbetering vir kwaliteit sorg inhou sowel as vir pasiënte tevredenheid. ‘n Nie-eksperimentele, kwantitatiewe, beskrywende studie was onderneem binne die filosofiese raamwerk van die Batho Pele beginsels sowel as die Handves vir Mense Regte. Al die deelnemers het ‘n gestruktureerde vraelys voltooi om die vlak van nakoming van die Batho Pele beginsels soos ondervind deur die pasiënte en beskou deur die gesondheidspersoneel binne ‘n primêre gesondheidsorg konteks te bepaal. Die ingesamelde data, is geanaliseer deur die gebruik van beskrywende statistieke. Vier primêre gesondheidsorg klinieke was ingesluit in die studie, geleë binne die Umzinyathi Distrik Gesondheid in die KZN Provinsie van Suid-Afrika. Die studie behels twee pasiënt populasie steekproewe gebaseer op beskikbaarheid; die deelnemers wat die klinieke besoek het (n=132) en die deelnemers wat tuis besoek is deur die navorser (n=101). Ses-en-vyftig (n=56) gesondheidspersoneel wat ingestem het tot vrywillig deelname in die studie was ‘n alles-insluitende steekproef.

Die bevindings het getoon dat die pasiënte ingesluit in hierdie studie sekuriteit en veiligheid ervaar het om die vrae te beantwoord oor hul belewenis aangaande die

nakoming van die Batho Pele beginsels. Hierdie is ‘n belangrike aspek om in gedagte te hou wanneer verdere pasiënt tevredenheid opnames gedoen word. Dit was ook duidelik dat pasiënte groter ontevredenheid ervaar het met betrekking tot nakoming van die Batho Pele beginsels as die gesondheidspersoneel binne ‘n primêre gesondheidsorg konteks.

Aanbevelings is gemaak met betrekking tot die bevindings saamgevat in die studie wat dien as vertrekpunt om tekortkominge binne die verpleegpraktyk, verpleegonderrig asook verpleegnavorsing aan te spreek.

[Sleutelterme: Batho Pele beginsels, konteks van Primêre Gesondheidsorgdienste, nakoming van, gesondheidsorg personeel, kwaliteit sorg, beskrywend**]**

ABBREVIATIONS

ANC	African National Congress
ART	Anti- Retro Viral Therapy
BPP	Batho Pele Principles
CBO	Community Based Organization
CHC	Community Health Center
COHSASA	Council for health service accreditation of Southern Africa
DHS	District Health System
DOH	Department of Health
DPSA	Department of Public Service and Administration
ETQA	Education and Training Quality Assurance Body
EDP	Essential Drug Programme
FBO	Faith Based Organization
GEAR	Growth, Employment and Redistribution
HIV/AIDS	Human Immune Deficiency Virus/ Auto Immune Deficiency Syndrome
KZN	Kwazulu Natal
KZN-DOH	Kwazulu Natal Department of Health
MDG's	Millennium Development Goals
NGO	Non-governmental Organization
NHS	National Health System
NWU	North-West University
OSD	Occupational Specific Dispensation
PHC	Primary Health Care
RDP	Reconstruction and Development Programme
SA	South Africa
SANC	South African Nursing Council
SAS	Statistical Analysis System
TB	Tuberculosis
UN	United nations
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WPTPS	White Paper on Transforming Public Service (1995)
WPTPSD	White Paper on Transforming Public Service Delivery (1997)

TABLE OF CONTENTS

DECLARATION		I
ACKNOWLEDGEMENTS		Ii
SUMMARY		Iv
OPSOMMING		Vi
ABBREVIATIONS		Viii

CHAPTER 1: OVERVIEW OF THE RESEARCH

1.1	**INTRODUCTION AND BACKGROUND TO THE STUDY**	1
1.2	**RESEARCH PROBLEM**	9
1.3	**PURPOSE AND OBJECTIVES OF THE STUDY**	10
1.4	**PARADIGMATIC PERSPECTIVE**	10
1.4.1	META-THEORETICAL STATEMENT	10
1.4.1.1	Man	11
1.4.1.2	Health	11
1.4.1.3	Environment	12
1.4.1.4	Nursing	12
1.4.2	THEORETICAL ASSUMPTIONS	12
1.4.3	METHODOLOGICAL ASSUMPTIONS	13
1.4.4	CONCEPTUAL DEFINITIONS	14
1.4.5	LITERATURE REVIEW	16
1.5	**METHODOLOGY**	17
1.5.1	RESEARCH DESIGN	17

1.5.2 RESEARCH METHOD 17

1.6 ROLE OF RESEARCHER 20

1.7 RELIABILITY AND VALIDITY OF RESEARCH PROCESS 21

1.7.1 RELIABILITY 21

1.7.2 VALIDITY 21

1.8 ETHICAL CONSIDERATIONS 22

1.9 RESULTS 25

1.10 RESEARCH REPORT LAYOUT 25

1.11 CHAPTER CONCLUSION 26

CHAPTER 2: LITERATURE REVIEW

2.1	**INTRODUCTION**	27
2.2	**INTERNATIONAL AND NATIONAL INFLUENCES ON BATHO PELE**	29
2.2.1	ROLE OF THE WORLD HEALTH ORGANISATION (WHO)	30
2.2.2	ROLE OF THE NATIONAL GOVERNMENT IN THE HEALTH CARE SYSTEM	31
2.2.3	DEVELOPMENT OF THE DISTRICT HEALTH SYSTEM	32
2.2.4	PATIENTS' RIGHTS CHARTER AND BATHO PELE	34
2.2.5	THE RATIONALE TO FORMULATE BATHO PELE PRINCIPLES IN SOUTH AFRICA	35
2.3	**BATHO PELE WITHIN THE LEGISLATIVE FRAMEWORK**	36
2.4	**BATHO PELE AND PUBLIC SERVICES**	43
2.5	**SERVICE DELIVERY IN TERMS OF BATHO PELE PRINCIPLES**	43
2.6	**PRIMARY HEALTH CARE APPROACH**	45
2.6.1	ACCESS	45
2.6.2	AFFORDABILITY	46
2.6.3	ACCEPTABILITY	46
2.6.4	COMMUNITY PARTICIPATION AND INTERSECTORAL COLLABORATION	46

2.7	**QUALITY CARE AS PART OF PRIMARY HEALTH CARE PRINCIPLES**	47
2.7.1	ACCREDITATION AS AN EXTERNAL MECHANISM FOR CONTROLLING QUALITY HEALTH CARE	48
2.7.2	QUALITY CONTROL AT THE PHC CLINIC	50
2.7.3	QUALITY MEASUREMENT	51
2.7.3.1	Structure standard	51
2.7.3.2	Process standard	52
2.7.3.3	Outcome standard	52
2.8	**QUALITY ASSESSMENT STRATEGIES**	52
2.8.1	AUDITING	53
2.8.2	PATIENT SATISFACTION	53
2.9	**GENERAL OBSTACLES IN THE HEALTH CARE DELIVERY SYSTEMS**	54
2.10	**CHAPTER CONCLUSION**	

CHAPTER 3: RESEARCH METHODOLOGY

3.1	**INTRODUCTION**	57
3.2	**RESEARCH DESIGN**	57
3.2.1	QUANTITATIVE	59
3.2.2	DESCRIPTIVE	59
3.2.3	CONTEXTUAL	59
3.3	**POPULATION AND SAMPLING**	62
3.3.1	POPULATION	62
3.3.2	SAMPLING METHOD	63
3.3.3	PATIENTS AS POPULATION	63
3.3.3.1	Sampling method	64
3.3.3.2	Sample size	66
3.3.4	HEALTH CARE PERSONNEL AS POPULATION	66
3.3.4.1	Sampling method	66
3.3.4.2	Sampling size	67
3.4	**DATA COLLECTION**	67
3.4.1	PILOT STUDY	68
3.4.2	DATA COLLECTION PROCESS	68
3.4.3	DATA COLLECTION INSTRUMENT	69
3.5	**DATA ANALYSIS**	71
3.6	**RELIABILITY AND VALIDITY OF THE RESEARCH PROCESS**	73
3.6.1	RELIABILITY	73

3.6.2 VALIDITY 74

3.6.2.1 Face and Content Validity 74

3.6.2.2 External Validity 75

3.7 ETHICAL CONSIDERATIONS 75

3.8 CHAPTER SUMMARY 77

CHAPTER 4: RESEARCH RESULTS

4.1	**INTRODUCTION**	79
4.2	**REALISATION OF DATA COLLECTION**	80
4.2.1	QUESTIONNAIRE AS DATA COLLECTION INSTRUMENT	80
4.2.2	DATA COLLECTION INVOLVING PATIENTS	81
4.2.3	PRELIMINARY DATA ANALYSIS OF PATIENTS-PARTICIPANTS	82
4.2.4	DATA COLLECTION INVOLVING HEALTH CARE PERSONNEL	86
4.3	**RESULTS**	87
4.3.1	PATIENT-PARTICIPANTS	87
4.3.1.1	Demographic data of patient-participants	88
4.3.1.2	Patients' experiences regarding compliance with the Batho Pele principles	89
4.3.2	HEALTH CARE PERSONNEL PARTICIPANTS	98
4.3.2.1	Demographic data of health care personnel	98
4.3.2.2	Health care personnel's views on the level of compliance with the Batho Pele principles as in a PHC context	101
4.4	**CHAPTER SUMMARY**	110

CHAPTER 5: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS OF THE STUDY

5.1	**INTRODUCTION**	112
5.2	**REVIEW OF THE STUDY**	112
5.3	**SUMMARY OF CONCLUSION STATEMENTS**	114
5.4	**SIGNIFICANCE OF THE STUDY**	116
5.5	**LIMITATIONS OF THE STUDY**	117
5.6	**RECOMMENDATIONS**	118
5.6.1	RECOMMENDATIONS FOR NURSING PRACTICE	118
5.6.2	RECOMMENDATIONS FOR NURSING EDUCATION	120
5.6.3.	RECOMMENDATIONS FOR FURTHER RESEARCH	120
5.7	**CHAPTER SUMMARY**	121
BIBLIOGRAPHY		122

APPENDICES

APPENDIX A	Request for permission to conduct research at Umzinyati Health District	132
APPENDIX B	Informed consent for patient and health care personnel	134
APPENDIX C	Ethical approval	137
APPENDIX D	Permission granted Umzinyathi Health District	138
APPENDIX E	Permission granted Health KwaZulu Natal	139
APPENDIX F	Interview schedule and framework for patients as participants	140
APPENDIX G	Interview schedule and framework for health care personnel as participants	145

LIST OF TABLES

Table 1.1	The eight Batho Pele Principles according to the Batho Pele White Paper	6
Table 1.2	Overview of the research method	18
Table 1.3	Ethical aspects as applied to this study	23
Table 2.1	Objectives of the study	28
Table 2.2	Batho Pele principles applied to the study	39
Table 3.1	Objectives of the study	57
Table 3.2	Patients' demographic distribution according to clinics and municipalities	65
Table 3.3	The categories of participants per clinic	67
Table 4.1	Objectives of the study	79
Table 4.2	Summary of internal consistency regarding Batho Pele principles questionnaire	81
Table 4.3	Preliminary statistical analysis of data collected from patients at the clinics and at home	84
Table 4.4	Participants' age in years (n =101)	88
Table 4.5	Level of compliance with Consultation as experienced by patients, expressed as a percentage	89
Table 4.6	Level of compliance with Service Standards as experienced by the patients	91
Table 4.7	Level of compliance with Access as experienced by the patients	92
Table 4.8	Level of compliance with Courtesy as experienced by the patients	93
Table 4.9	Level of compliance with Information as experienced by the patients	94

Table 4.10	Level of compliance with Openness and Transparency as experienced by the patients	95
Table 4.11	Level of compliance with Redress as experienced by the patients	96
Table 4.12	Level of compliance with Value for Money as experienced by the patients	97
Table 4.13	Age distributions of health care personnel participants	98
Table 4.14	Health care personnel participants according to highest qualification	99
Table 4.15	Designations of the health care personnel participants	100
Table 4.16	Years working at the PHC clinic	100
Table 4.17	Level of compliance with Consultation as viewed by the health care personnel	102
Table 4.18	Level of compliance with Service Standards as viewed by the health care personnel	103
Table 4.19	Level of compliance with Access as viewed by the health care personnel	104
Table 4.20	Level of compliance with Courtesy as viewed by the health care personnel	105
Table 4.21	Level of compliance with Information as viewed by the health care personnel	106
Table 4.22	Level of compliance with Openness and Transparency as viewed by the health care personnel	107
Table 4.23	Level of compliance with Redress as viewed by the health care personnel	108
Table 4.24	Level of compliance with Value for Money as viewed by the health care personnel	109
Table 5.1	Objectives of the study	112

LIST OF FIGURES

Figure 2.1	Illustration of the research process to reach the overall purpose	29
Figure 2.2	The Batho Pele principles in the context of the study	44
Figure 3.1	Map of Umzinyathi District Municipality	61
Figure 3.2	Sampling of patients and health care personnel in PHC clinics, Umzinyathi Health District	63
Figure 4.1	Systematic selection process of patient-participants	82
Figure 4.2	Systematic process to explain the selection of health care personnel	86

CHAPTER 1: OVERVIEW OF THE RESEARCH

1.1 INTRODUCTION AND BACKGROUND TO THE STUDY

The Batho Pele principles, which means to put “people first”, has been in use for more than a decade since the inception of democratic government in South Africa. These principles have led to several governmental challenges, the most important of which might be transformation (Kuye & Ile, 2007:87) of public services. The then Minister for Public Services and Administration, the honourable Fraser-Moloketi, stated in the preface of the Batho Pele Handbook that to reach the key objective; namely creating, implementing and sustaining a better life for all; would call on dedication from all public servants (SA, **s.a.**:137). Public servants obviously also include health care personnel in Primary Health Care (PHC), who deliver services that are deemed essential, as part of public health service delivery.

PHC services are the point of entry into the health system in South Africa (Dennill *et al.*, 1999:3) and often forms the basis on which all health services are perceived and judged by patients. In addition to the honourable Fraser-Moloketi, the ANC (1994a:21) and Lawn *et al*. (2008:1001) state that the key to health for all South Africans is a national development strategy that incorporates PHC. The functioning of the PHC services is but one component of public services in South Africa that will be judged by one criterion above all; namely, that the services delivered should be so effective that it meets the basic needs of all South African citizens (SA, 1997:9).

Undeniably, with the advent of the Alma-Ata declaration more than thirty years ago, as well as the renewal of the PHC values “to put people at the centre of health care”, the PHC cadre was introduced worldwide and in South Africa (WHO, 2008:xii; Stanhope & Lancaster, 2008:72). The focus of PHC — to achieve principles such as equity, effectiveness, efficiency, quality, social justice, health promotion, and intersectoral collaboration — is also applicable in South Africa, in an attempt to meet the needs of the community (Dennill *et al.*, 1999:3, ANC, 1994a:21, Lawn *et al*., 2008:1001). Moreover, the Alma-Ata declaration entails key aspects underlining the

PHC approach; namely, to achieve the wider goal of universal access to essential health care through acceptability, accessibility, appropriateness and affordability (ANC, 1994a:20; WHO, 1978:409; Lawn *et al*., 2008:1001). The Batho Pele principles also add weight to the achievement of three explicitly health-related Millennium Development Goals (MDGs): improving children survival rates; improving maternal health; and to fight the scourge of Human Immune Deficiency Virus (HIV), Tuberculosis (TB), Malaria and other diseases (UN, 2010).

In addition to the above information, a variety of aspects, however, play a role in the functioning of PHC services at district level (Couper *et al.,* 2007:124). Although the World Health Organisation (WHO) and United Nations Children's Fund (UNICEF) advocate that community members should become involved in all aspects of their health care services (Stanhope & Lancaster, 2008:73), patients as well as health workers do not always understand how this should be achieved. Some of these health aspects are embedded in the everyday functioning of PHC services where patients seek help according to their needs from health care workers. When patients have a clear understanding of different aspects, like service standards pertaining to the functioning of PHC services, it can lead to a balance between their expectations and their experiences (Eiriz & Figuerero, 2005:404). Both PHC personnel and patients may or may not be aware of these aspects, for example the standards by which service delivery should be measured, how complaints about services should be addressed, that patients are entitled to information, and the type of services available (SA, 1997:14).

It is self-evident that in order for the patients who make use of PHC services to experience efficient and effective health care as "a service to the people" (SA, 1997:9), transformation of public services was necessary. Therefore, one of the government's most important tasks was to build a public service capable of meeting the challenges of improving service delivery to the citizens of South Africa (Van Rensburg & Pelser, 2004:119). The South African government's role is, thus, to ensure that health services become accessible and affordable to all the citizens of South Africa. Furthermore, the National Government, with the assistance of the

WHO and UNICEF, introduced a National Health System (NHS) that would strongly influence post-apartheid health policy to provide health services with the PHC clinic as first-line health care service delivery facility (Foster, 2005:245, WHO, 2008:45). Equally important is that the national health system should function as a single comprehensive, equitable and integrated health structure that deals with health, based on national guidelines, priorities and standards (ANC, 1994a:10).

In order to achieve such transformation, several governmental policy and program changes were required. One such strategy, that was developed to address the nature and quality of service delivery in South Africa, is the Batho Pele principles (Kuye & Ile, 2007:87). The White Paper on Transforming Public Service Delivery (WPTPSD) (referred to as the Batho Pele White Paper in the study) advocates the use of appropriate instruments and tools (like the Batho Pele principles) to enhance and measure performance against standards (SA, 1997:17). Therefore, National Government coordinates all aspects of public and private health care service delivery, it is accountable to the citizens of South Africa, and should encourage the community members to utilise the free of charge PHC services (ANC, 1994a:19).

Consequently, to meet the government's objective (as mentioned in the introductory paragraph of the study) — namely, creating, implementing and sustaining a better life for all (SA, **s.a**.:139) — the Batho Pele White Paper was launched in 1997 to provide a policy framework and practical implementation strategies for this transformation. This was introduced with the ultimate goal to improve service delivery (SA, 1997:9) and the Batho Pele principles were developed to put the people at the centre of public service delivery (ANC, 1994b:10; SA, 1997:13; SA, **s.a**.:8; Mkhabela, 2003:15; SA, 2004a:35; Foster, 2005:245; WHO, 2008:45; Arries & Newman, 2008:41-54).

Batho Pele — a Sotho translation for "people first"— aims to place the patient at the centre of health care service delivery. It is an initiative to encourage public servants to be more service-orientated, to strive for excellence and continuous service delivery improvement. Expanding on this explanation, the Batho Pele initiative is a

simple and transparent mechanism, which allows citizens to hold public servants accountable for the type of service they deliver (SA, **s.a**.:8). In order to examine this principle, the study will also focus on how patients hold health care personnel accountable for the PHC they do deliver.

As mentioned earlier, the Batho Pele White Paper calls on all national and provincial departments to make service delivery a priority (SA, **s.a**.:28). The Batho Pele White Paper provides a framework for public servants in all departments to develop service delivery strategies. The public servants in every public organisation are, thus, responsible to improve the efficiency and effectiveness of service delivery (SA, 1997:9) and are expected to put the eight national principles, referred to as the Batho Pele principles, into practice.

The Batho Pele White Paper of 1997 is also in line with Chapter 2 and specifically Article 10 of the South African Constitution (1996), which states: "Everyone has inherent dignity and the right to have their dignity respected and protected". The Batho Pele White Paper gives effect to the right to human dignity and contributes towards the positive transformation of society, a transformation that will be influenced not only by the Batho Pele principles, but indeed also strengthened by the Patients' Rights Charter (Van Rensburg & Pelser, 2004:113). Furthermore, a guide to revitalise Batho Pele (SA, 2004:6) made it clear that public servants have a greater responsibility in ensuring that citizens receive quality services. Since quality improvement is embedded in the Batho Pele principles and has become essential in all health sectors today, it justifies the conclusion that a clear understanding of the Batho Pele principles contributes to effective and quality PHC services. The principles also provide for an action plan, as stipulated in Chapter 10, Article 195(1) of the Constitution (1996), to achieve excellence in service delivery in an accountable, equitable, efficient, effective, fairly, equitably, and corruption free manner in order to address the needs of the community.

With the above expectations in mind, it is worth mentioning that a review conducted by the Department of Health (DOH) for the period 1999-2004 reported many

successes. Clinical audits and client satisfaction surveys conducted revealed that most provinces have instituted programs monitoring the quality of care. The Department of Health also reported that South Africa received a number of health rewards during the period under review (SA, 2004:5-15). In contradiction to the above report, Ehrat (2001:36) observes that the demands of first level preventative measures (see the explanation of PHC in this study) demonstrate problems of its own: like a brain drain and health care personnel who are faced with ethical and cultural dilemmas and are often expected to make decisions based on complex or incomplete information. The same author states that this reality results in health care personnel who react to, ignore or even postpone the problems that arise at first level health care (see PHC in this study).

However, with the mentioned successes and challenges taken into consideration, the researcher also takes note of the vision of the Department of Health's strategic priorities for the National Health System for 2004-2009. The aim is to provide "an accessible, caring and high quality health system" with a mission "…to consistently improve the health care delivery system by focusing on access, equity, efficiency, quality and sustainability" (SA, 2004b:4; ANC, 1994a:19). It is, therefore, clear that the vision and mission of the Department of Health correlates with the existing Batho Pele principles and one should hope that the required paradigm shift has taken place in PHC services.

In a study by Gary (2002:33), it is observed that the understanding and implementation of professional models like Batho Pele could result in growth, autonomy, education and collaboration between health care practitioners. The Batho Pele White Paper (SA, 1997) is, thus, also a drive from National Government towards transformation to alter a system which is characterised by a lack of access to services, transparency and responsiveness to complaints; inaccuracy in giving information; together with insensitivity to clients and poor service standards (Crous, 2006:400). All of the above begs the question whether, after the government's efforts to transform public service delivery, the services provided now are accessible

and affordable to the community and to determine the level of compliance with the Batho Pele principles in a PHC context (Legodi, 2008:2).

The following eight Batho Pele principles, that health personnel should comply with, are aimed at the transformation of public service delivery (see Table 1.1). These principles were developed to serve as accepted policy that should continue to guide government departments (in all three spheres of government) in their effort to deliver sustainable services. It also serves as a legislative framework regarding service delivery as indicated in the Batho Pele White Paper (SA, 1997:15-24; SA, 2004:7-14). The principles will be explained and discussed in detail in Chapter 2.

Table 1.1: The eight Batho Pele Principles according to the Batho Pele White Paper (SA, 1997:7-15)

Consultation	Citizens should be consulted about the level and quality of the public services they receive and wherever possible should be given a choice about the services they are offered.
Service Standards	Citizens should be told what level and quality of the public services they will receive so that they are aware of what to expect.
Access	All citizens should have equal access to the services to which they are entitled.
Courtesy	Citizens should be treated with courtesy and consideration.
Information	Citizens should be given full, accurate information about the public services they are entitled to receive.
Openness and Transparency	Citizens should be told how National and Provincial departments are run, how much they costs, and who are in charge.
Redress	If the promised standard of service is not delivered, citizens should be offered an apology, a full explanation and speedy and effective remedy; and when complaints are made, citizens should receive a sympathetic positive response.
Value for money	Public services should be provided economically and efficiently in order to give citizens the best value for money.

With the above mentioned principles in mind, it should be clear that quality assurance and improvement is inherent to the Batho Pele principles. This, therefore, implies that a formal program to monitor, measure and evaluate the quality of services delivered should be in operation, opportunities for improvement of services should be identified, and a mechanism should be provided to take remedial

actions in order to maintain improvement and bring about change and transformation (Booyens, 2002:597; Crous, 2006:403). The approach of quality improvement focuses on client satisfaction, which fit within the principles and the spirit of the Batho Pele White Paper (SA, 1997:15). With regard to the health services, quality care that results in patient satisfaction is an integral part of the before mentioned Batho Pele White Paper that refers to professional standards, guidelines and codes. For various reasons all health care providers, also in the PHC context, should pay attention to the "quality issue" (Booyens, 2002:595) and evaluate quality care and standards, identify areas that could be improved and subsequently identify limitations to the achievement of excellence in health care (Idvall *et al.*, 2002:327-334).

According to the strategic priorities of the National Health System for 2004-2009 (SA, 2004:7), progress has been made to improve quality of care at all levels of the health system, but much more remains to be done. Batho Pele is, therefore, everybody's business: it is considered the right of all patients and it is the responsibility of all health care workers (Crous, 2006:402). In all nursing situations, determination and observance of the standards remains an integral aspect of responsibility for patient care, and ultimately of accountability with regard to that care (Searle, 2000:72). Moreover, the importance of these principles are strengthened by the Patients' Rights Charter that was launched in November 1999, which clearly outlines the rights of patients and a complaints mechanism should patients not be satisfied with the quality of care they receive (Van Rensburg & Pelser, 2004:119).

Over and above the rights of the patient, nurses in a PHC context have further obligations and work within a professional, ethical, and legal framework as their responsibilities and accountability is outlined in Chapter 2 of the Nursing Act (33/2005). It also became necessary for all countries, including South Africa, to develop national medication policies in order to make safe medicines available at a lower cost (Lawn *et al*., 2008:921). Therefore, PHC nurses are expected to provide clinical assessment and management of common illnesses within the ambit of the Essential Drug Programme (EDP) and to refer patients when appropriate (SA, 2001a:14-15). In other words, the nurse working in a comprehensive PHC context

should provide a wide range of basic services to the community members, on a daily basis, in the most desirable and efficient way possible (Reagon *et al*., 2004:9).

PHC nurses are also expected to function independently as frontline providers of clinical PHC services within public health facilities, as mentioned in the policy document "Restructuring the National System for Universal PHC" (SA, 1996b:18). Equally important for better understanding, the reader should note that nurses take a pledge to put patients first when they enter practice, thus, nurses enter into a verbal agreement with the community to provide quality care (Muller, 2006:5). Further pressure on performance is also exerted by political leaders as is depicted in the national address by President Thabo Mbeki (2004:2) who said that: "We must be impatient with those in the public service who see themselves as pen-pushers and guardians of rubber stamps, thieves intent on self-enrichment, bureaucrats who think they have the right to ignore the vision of Batho Pele, who come to work as late as possible, work as little as possible and knock off as early as possible". It is unlikely, however, and unthinkable that the health worker's responsible to serve the health needs and expectations of patients (Carr-Hill *In* Almeida & Adejumo, 2004:3) will share the mentality mentioned in the statement of the President Thabo Mbeki.

Concerning the type of PHC services provided, it is noteworthy to mention that a comprehensive supermarket approach was created so that the users (community members as patients) can attend one facility and obtain several different services, rather than having to travel from one facility to another, possibly over several days. Some health facilities, however, provide only a narrow range of PHC services and only within prescribed or limited hours, which limit adequate access to quality health care. Thus, the aim of the District Health System (DHS) to provide a comprehensive, equitable, integrated and sustainable health service, based on the PHC approach, is defeated (SA, 2004:46; Petersen, 2000:332).

In line with the governmental policies and its emphasis on excellence in health care, one of the long-term objectives of PHC is to conduct periodic assessments to determine to what degree the needs and expectations of the community are met. The Batho Pele White Paper that puts the "people first", places pressure on health

care managers to create an environment which supports and enhances the capacity of staff to provide quality care and re-orientates staff members to become more customer-orientated (SA, 1997:6).

Since all health care providers are concerned with negative perceptions that community members have regarding service delivery and the quality of the care they receive, a need to train health care workers on the implementation of the Batho Pele principles was identified. A number of PHC workers were trained to ensure that the aim of the government, that is to implement quality service delivery, is achieved. Therefore, the National Department of Health Policy (SA, 2007:2) that aims to improve quality health care, involves measuring the gaps and working out ways to close the gaps between the implementation of and compliance with the Batho Pele principles in the health care system.

1.2 RESEARCH PROBLEM

Based on the discussion above and the experience of the researcher; who works as a nursing manager at two of the four targeted PHC clinics; it is clear that health personnel fail to comply with the implementation of the Batho Pele principles, which aim to improve and transform service delivery as required by the Batho Pele White Paper (SA, 1997:9). The ultimate goal of government to improve the quality of health care, thus, is not achieved and the vision and mission of the Department of Health, referred to earlier in the introduction, shall not crystallise in the PHC services context.

Patients that utilise PHC services have certain experiences by which they judge the quality of care they receive, and to what degree it satisfies their needs. The researcher, however, is concerned with the gaps pertaining to compliance with the Batho Pele principles. These gaps give rise to an important question within the research area; namely, “What possible recommendations can be made to strengthen current compliance with the Batho Pele principles in order to improve the quality of care and patient satisfaction in a PHC context?” In order to answer the question, **the following research questions were formulated:**

- To what level do patients experience compliance with the Batho Pele principles in a PHC context?
- To what level do health care personnel comply with the Batho Pele principles in a PHC context?

1.3 PURPOSE AND OBJECTIVES OF THE STUDY

The overall purpose of the study is to make recommendations that will strengthen current compliance with the Batho Pele principles in a PHC context, and in so doing will improve the quality of care and patient satisfaction.

To achieve this purpose, the following objectives should be met:

- To describe the level of compliance with the Batho Pele principles, as experienced by patients in a PHC context.
- To describe the level of compliance with the Batho Pele principles as viewed by the health care personnel in a PHC context.

1.4 PARADIGMATIC PERSPECTIVE

The following meta-theoretical, theoretical assumptions and methodological statements define the paradigmatic perspective of the researcher.

1.4.1 META-THEORETICAL STATEMENT

The assumptions of the researcher, as discussed in the paragraphs hereafter, were influenced by her Christian worldview regarding patient satisfaction. The researcher's interaction with health care personnel, who strive to comply with the Batho Pele principles in order to ensure that quality service is rendered in a PHC context, also influenced her assumptions. Therefore, the Nursing Theory of the Whole Person, Oral Roberts University: Anna Vaughn School of Nursing (1990:136-142) is still applicable and forms the framework of the paradigmatic perspective of this research.

1.4.1.1 Man

For the purpose of this research, man refers to both the patients and health care personnel in this study who are unique human beings created in the image of God. They are human beings who function in an integrated bio-psychosocial manner in their search for satisfaction, as would be the case when in search of care at a PHC facility that could lead to wholeness. The researcher regards the patient that visits the PHC clinic as someone who desires wholeness through acceptance, support and care that stems from the interaction process with the health care personnel, who in turn are also striving towards wholeness.

The patients and the health care personnel at the targeted PHC clinics/facilities interact as a whole, that is, in body, mind and soul with their external environment, during which the health care personnel take care of the patients seeking support and care, as well as the community at large.

1.4.1.2 Health

The health of a patient is a dynamic process that changes all the time and health in this study refers to a balance between the spiritual, mental and physical dimensions of a patient visiting the PHC clinic. The interaction between patients seeking support and care, and the health care personnel rendering quality health care to these patients, plays a pivotal role regarding where the patients will find themselves on the health continuum. This interaction with their external environment at PHC clinics/facilities enables the patients to cope with internal stimuli, i.e., biophysical diseases, stress and anxiety, as well as other socio-economical challenges.

As mentioned before, when visiting a PHC clinic/facility patients are searching for wholeness in their interaction with the health care personnel. Such wholeness can be achieved when these interactions lead to the patients being committed to, and taking responsibility for, their own health needs through the development of coping mechanism, and in doing so a state of equilibrium can be maintained.

1.4.1.3 Environment

This concept includes the internal and external environment of the patients and the health care personnel. God created them with a body, mind and soul as the internal environment, whereas, the external environment consists of the physical, social and spiritual dimensions. The focus is on the interaction between patients seeking support and care and the health care personnel rendering the support and care in a PHC clinic/facility. This type of interaction forms part of the external environment.

1.4.1.4 Nursing

The term implies a goal and authentic commitment directed toward service; provided to individuals, families and communities in order to promote, maintain and restore health. Nursing will be viewed as the comprehensive PHC services provided to individuals, families and communities within a Primary Health Care Package for South Africa in order to meet the physical, psychological, social, and spiritual needs of patients.

1.4.2 THEORETICAL ASSUMPTIONS

The theoretical perspective of this research is based on the following two philosophical value-driven frameworks as point of departure:

- The Batho Pele principles (SA, 1997)
- The Patients' Rights Charter (SA, 1996)

An explanation and integration of both frameworks will be expanded upon throughout the study, and will be discussed further in Chapter 2. In the following paragraphs, the central theoretical argument and the conceptual definitions of core concepts, applicable to the research, will be discussed.

1.4.3 METHODOLOGICAL ASSUMPTIONS

The study does not only focus on a better understanding of the phenomenon of PHC service delivery, but also to generate valid and reliable results (Klingenberg, 2008:13) concerning the experiences of patients and health care personnel regarding compliance with the Batho Pele principles in a PHC context. The purpose of the study is to make recommendations to strengthen current compliance with the Batho Pele principles, which will lead to improved quality of care and patient satisfaction in the PHC clinics of the Endumeni and Nquthu sub-districts of the Umzinyathi Health District in the KwaZulu-Natal Province.

The researcher is of the opinion that this study will provide a framework within which PHC personnel will be able to generate and organise new ideas to improve the quality of care in order to satisfy the needs of patients. The explanation this study provides, concerning the experiences regarding compliance with the Batho Pele principles, will help the authorities to take appropriate and effective action towards directing transformation and providing health care services that will best contribute to improved quality care and patient satisfaction in PHC settings.

According to Burns and Grove (2005:39), the philosophical framework of a study (Batho Pele principles and the Patients' Rights Charter in this study) enhances methodological assumptions. In addition, assumptions are also the basic principles that we accept and assume to be true without proof or verification (Burns & Grove, 2005:39, Brink *et al*., 2006:25). Since the purpose of this study is to make recommendations to strengthen current compliance with the Batho Pele principles in a PHC context, the researcher will be able to generate new knowledge about concepts in the study by using a descriptive study design. This would increase the understanding of the theoretical concepts that a variable presents (Burns & Grove, 2005:39) in order to achieve the purpose of the study.

In the following section, the main concepts that form part of the study will be defined.

1.4.4 CONCEPTUAL DEFINITIONS

Quality care

The characteristics or features associated with excellence in rendering services to the community are: when the right decision is made at the right time to satisfy the community's needs and expectations in a cost-effective manner, without compromising the services by undue restrictions on time and distance (Booyens, 2008:596-597). In the context of this study, quality care takes place when the needs or expectations of patients are met by consistently adhering to the Batho Pele principles when rendering comprehensive PHC services.

Standards

Standards refer to in this study to the desired level of performance. It contains the characteristics associated with excellence, and for measuring and evaluating actual performance or service delivery. A standard is an approved statement of something against which measurements can be made, and it serves as a basis for comparison (Booyens, 2008:206).

According to the Batho Pele White Paper (SA, 1997:7), existing service standards should progressively be raised and monitored; and working standards, in terms of service delivery in all spheres of government, should be implemented. In addition to the above explanation, a standard is described as a specific quantitative measure of degree or frequency that specifies what is desired and achievable when aspiring to excellence in performance (Donabedian, 2003:46; Bezuidenhoudt, 2005:76).

Patient satisfaction

Patient satisfaction is a multi-dimensional concept that is rooted in human experience; individuals judge it subjectively. It results from the patient's understanding and acceptance of her or his health status, the actual logistics of care, and the perception that the treatment has resulted or will result in improved

health (Lindsey *et al.*, 1997:31). Patient satisfaction is one of several criteria to measure the quality and acceptability of health services provided to patients (Knudtson, 2000:405). Conducting a facility-based patient satisfaction survey is one of the Department of Health's initiatives to improve service quality (SA, 2004:50).

Batho Pele principles

This is a government initiative to encourage public servants to become more service orientated, to strive for excellence in service delivery, and to commit to continuous service delivery improvement (SA, 2007:8). In this study, the Batho Pele principles form the motivational force for PHC personnel to return to quality care, excellence, commitment, and responsibility in terms of service delivery to meet the needs of customers (patients, families and citizens).

Primary Health Care (PHC)

PHC is essential health care that is based on practical, scientifically sound and socially acceptable methods and technology. The care and technology used should be accessible to individuals and families in the community. Families and individuals should participate in their own health care at every stage and patients' self-reliance and self-determination, in regards to their health, should be encouraged. Actions taken in the PHC context should be such that PHC services remain affordable to the community and the country and, thus, be sustainable (ANC, 1994a:20, WHO, 1978:409, Lawn *et al*., 2008:1001). In this study, PHC also encompasses community participation in the planning, provision, control, and monitoring of health care services in the spirit of Batho Pele.

Health Care Personnel

This term involves the individuals employed by the health sector to render PHC services to the patients in the PHC clinics within the community. In this study, the focus will be the individual categories of personnel who are employed in public PHC facilities and PHC municipality clinics. These individuals do not only include

health care personnel registered or enrolled with the South African Nursing Council (SANC), but also include general assistants, clinic support officers, and HIV-lay counsellors. Furthermore, in the PHC services targeted in this study all general assistants, clinic support officers and HIV-lay counsellors received short training on basic health care as well as on how a PHC service functions.

Compliance

Compliance refers to the processes that ensure that standards are met (Stanhope & Lancaster, 2008:233). It also encompasses conforming to guidelines, specifications or legislation. The health personnel in PHC clinics are expected to comply with the Batho Pele principles in order to ensure effectiveness in delivering health care services and satisfying the health needs of all the patients visiting the PHC services.

1.4.5 LITERATURE REVIEW

For the purpose of this dissertation relevant books, e-reference works, articles, journals, newspaper reports, government publications, thesis and dissertations, as well as the internet were used as sources. The Batho Pele White Paper (1997) and the Constitution (1996) was some of the legislation used to serve as the rationale behind the importance of compliance with the Batho Pele principles in public service. As stated before, the aim of these principles is to improve service delivery and put the public at the centre of public service delivery.

The following databases from the Library Services at the North-West University (NWU) were used*:* Academic Search Premier, A-Z journal list, RefWorks, ScienceDirect, EbscoHost, Medline, and Google Scholar.

The questionnaire used to collect data from patients and health care personnel, who served as participants in the study, was developed from themes identified in the literature review (see chapter 2 for the detailed literature review).

1.5 METHODOLOGY

1.5.1 RESEARCH DESIGN

The design of a study is described by De Vos (2001:281) as a logical strategy to gather evidence about desired knowledge and is, thus, the blueprint for conducting a study (Burns & Grove, 2009:219). To meet the purpose and the objectives of this study, a quantitative study design was utilised. This type of design was selected so that the researcher could gain an overall picture of the phenomenon by using research strategies that are descriptive and contextual in nature (Burns and Grove, 2005:44; Creswell, 2003:144; Mouton, 2006:102, 103 & 133). This enabled the researcher to attain a clear understanding of the experiences of the patients and the views of health care personnel a PHC context, as well as the level of compliance with the Batho Pele principles in order to identify the possible gaps and challenges to current implementation practices.

1.5.2 RESEARCH METHOD

The researcher followed two clearly defined steps (each step represents an objective of the study) in conducting the research (see Table 1.2 below for an overview of the research method). The summary of the research method, as contained in the table, refers to the sampling method, population size, data collection, context of the study, and data analysis. The research method will be described in more detail in Chapter 3.

Table1.2: Overview of the research method

Objective 1	To describe the level of compliance with the Batho Pele principles experienced by the patients in a Primary Health Care context		
Population and sampling	**Data collection**	**Context**	**Data analysis**
Population All patients who utilise the four PHC clinics: Two from Endumeni sub-district and two from Nquthu sub-district in the Umzinyathi Health District in the KwaZulu- Natal Province. **Sampling method** A non-probability, convenience, voluntary sampling method (Burns & Grove, 2005:350-351) was used to select two patient-samples who regularly visit the PHC clinics. All patients older than eighteen (18) years, who visited all the four clinics for longer than one year, participated. Patients that visit the clinic **(n=132)**. Patients visited at home **(n=101)** **Sampling size** The sample size was determined by the availability and voluntary participation of the patients.	**Method** Data was gathered by conducting face-to-face straightforward interviews using a structured questionnaire (Maree & Pietersen, 2007:8). The questionnaire focused on certain components, applicable to the objectives, in order to describe the experiences of patients regarding compliance with the Batho Pele principles in a PHC context. The interview process was explained beforehand and only commenced after participants gave voluntary consent. Interviews lasted approximately 20-30 minutes. **Pilot study** A pilot study was conducted (n=5) prior to the research project, using the same inclusion criteria as the actual research project, a similar setting, the same data collection instrument (questionnaire), and analysis techniques (Burns & Grove, 2005:42).	The study was conducted in a public PHC context in Umzinyathi Health District in the KwaZulu-Natal Province, where patients visit PHC clinics with various health needs to receive help from health care personnel.	Descriptive statistics was used and preparation of the data for analysis was done with the assistance of Statistical Services, NWU, Potchefstroom Campus. Internal reliability (internal consistency) testing of the measurements (instruments) was estimated by using Chronbach's Alpha co-efficient (Pietersen & Maree, 2007:216). The t-test was used to determine statistically significant differences between measurements of the two patient populations (Bruce, Pope, Stanistreet, 2008:222, Burns & Grove, 2009:502).

Table1.2: Overview of the research method (continued)

Objective 2	To describe the level to which health care personnel comply with Batho Pele principles in a Primary Health Care context		
Population and sampling	**Data collection**	**Context**	**Data analysis**
Population All health care personnel who render PHC services to meet the needs of the community of the Endumeni and Nquthu sub-districts of the Umzinyathi Health District in the KwaZulu-Natal province. At the time of the study, the health care personnel selected were employed for a period longer than six months by the KZN DOH and the Endumeni Municipality. **Sampling method** An all inclusive sampling method was used (Burns & Grove, 2005:343) to select participants who meet the inclusion criteria. The criteria determined that participating PHC personnel should have worked in the clinic for at least six months, should speak either English or Zulu, and be willing to participate in the study. **Sample size** The sample size was determined by the availability and willingness of the health care personnel to participate. **(n=56)**	**Method** The same data collection method was used as for objective 1, but was adapted to the objective 2 to describe the views of health care personnel regarding compliance with the Batho Pele principles in a PHC context. The structured interview process was explained beforehand and only commenced after the participants gave voluntary consent. Interviews lasted approximately 20-30 minutes. **Pilot study** A pilot study was conducted on health care personnel that were not part of the final study (n=3), using the same inclusion criteria as the actual research project, a similar setting, the same data collection instrument (questionnaire), and analysis techniques (Burns & Grove, 2005:42).	The study was conducted in a public PHC context as well as in their homes in Umzinyathi Health District in the KwaZulu-Natal Province, where patients visit PHC clinics with various health needs to receive help from health care personnel.	Descriptive statistics was used and preparation of the data for analysis was done with the assistance of Statistical Services, NWU, Potchefstroom Campus. Internal reliability (internal consistency) testing of the measurements (instruments) was estimated by using Chronbach's Alpha co-efficient (Pietersen & Maree, 2007:216). The same process as described for objective 1.

To achieve the overall purpose of the study — namely, to make recommendations to strengthen current compliance with the Batho Pele principles that would improve quality care and patient satisfaction — the researcher used data obtained from objective 1 and 2. Subsequently, the role of the researcher will be highlighted.

1.6 ROLE OF RESEARCHER

The researcher was responsible for planning the whole research process. Permission was obtained from the Provincial Research Directorate of the KwaZulu-Natal Department of Health (see appendix E) to conduct the research after ethical clearance was obtained from the NWU, Potchefstroom Campus (see appendix C). The research was also blessed by a letter of support from the Umzinyathi Health District (see appendix D). The researcher negotiated access to the participants in the PHC clinics targeted, as described in the methodology, and conducted interviews personally while noting down participants responses to the questionnaire; the primary instrument for data collection and data analysis. Recruitment for participation of the health care personnel and appointments to complete the questionnaires were arranged by the researcher.

The researcher attended to ethical issues as described in paragraph 1.8 throughout the research process. Aspects like time and space was considered by the researcher to ensure comfort, privacy and confidentiality. The participants were offered a comfortable chair to sit in and the researcher offered them something to drink. Questionnaires were completed with the patient-participants after consultation, and patients who were acutely ill or had any kind of distress, were excluded.

The research took place in the Umzinyathi Health District that is divided into four sub-districts with four clinics. Two clinics are under the jurisdiction of the local municipality and the other two clinics fall under the authority of the KZN Department of Health.

1.7 RELIABILITY AND VALIDITY OF RESEARCH PROCESS

In order to ensure reliability and validity, the researcher took care to be as objective and honest as possible throughout the study, and to avoid any bias so that personal preferences would not influence the interpretation of the findings. Face-to-face structured interviews to complete the questionnaires were used, making the results less prone to different interpretations and opinions.

1.7.1 RELIABILITY

Reliability is the consistency and dependability demonstrated by a research instrument (questionnaire in this study) when it is used to measure the variable or attribute which it was designed to measure (Brink, 2000:213-214). The reliability of an instrument is high when it gives the same results when the research is repeated on the same sample (Maree & Pietersen, 2007:147). In this study, internal consistency of the questions, as one of the types of reliability, was estimated through Chronbach's alpha coefficient (Burns & Grove, 2005:376; Brink *et al*., 2002:164; Pietersen & Maree, 2007:216) that assesses items to determine their congruency.

1.7.2 VALIDITY

Validity can be obtained when the instrument (questionnaire) used in the research measures what it is supposed to measure (Maree & Pietersen, 2007:147). In this study the experiences of the patients and the health care personnel regarding compliance with the Batho Pele principles was meassured.

The researcher ensured **internal validity** by complying with the precision standards during the data collection process. Data was recorded fully, maintaining principles of neutrality and ensuring competence of both the researcher and the research assistant in data collecting technique by thoroughly orientating the research assistant regarding the data collecting process (Rossouw, 2005:178-179).

Face validity was ensured when the appearance of the questionnaire was evaluated on the "look" thereof (Pietersen & Maree, 2007:216-217) by the Statistical Services of the NWU, Potchefstroom Campus. The questionnaire was also scrutinised by two nursing managers known to the researcher.

Content validity was determined by the appropriateness of the questions contained in the questionnaires and whether the questions correspond with the study objectives (Polit *et al.,* 2001:309). The instrument covered all the aspects that needed to be explored regarding compliance with Batho Pele principles, provision of quality health care, and patient satisfaction. Experts at Statistical Services, NWU, Potchefstroom Campus evaluated the questionnaire to ensure face and content validity.

External validity is concerned with the extent to which study findings can be generalised beyond the sample used in the study (Burns & Grove, 2005:218). The external validity of this study was determined by comparing findings from the patients' experiences and the health care personnel's views with the reviewed literature and with findings from similar related studies conducted in different settings (Brink, 2002:124). Because the study was done in a certain context, it is not the intention to generalise the findings. In addition, sufficient data was collected to allow the researcher to become familiar with participants.

1.8 ETHICAL CONSIDERATIONS

A proposal was submitted for approval to the Research Committee, as well as the Ethics Committee of the NWU, Potchefstroom Campus (NWU-0071-08-A1) (also see appendix C) prior to the commencement of the study. After institutional approval was granted, a letter was submitted to the Department of Health's Provincial Research Directorate (see appendix E), requesting permission to undertake a research project along with the letter of support obtained from Umzinyathi Health District (see appendix A). Permission was also obtained from the study participants who participated in the study on a voluntary basis (see appendix B). The purpose and importance of the research was explained in the request for permission.

The ethical principles, as adapted from Burns & Grove (2005:181-230), were maintained throughout the research, in order to ensure that human rights were protected during the study. These ethical considerations are provided and discussed in detail in Chapter 3. Ethical aspects that the researcher adhered to during the study include the protection of human rights, anonymity and confidentiality, protection from harm and discomfort, benefits, fair treatment, informed consent, voluntary consent and competency to give consent, as well as danger/risks and precautions (also see Chapter 3).

Table 1.3: Ethical aspects as applied to this study

ETHICAL ASPECT/ PRINCIPLE	APPLICATION TO THIS STUDY
Protection of human rights	As a nurse manager working in the PHC facilities and a supervisor of two of the facilities under study, the researcher was already familiar with the protection of human rights as stipulated in Chapter 2 of the Constitution (1996), and was able to respect to these rights throughout the study.
Anonymity and Confidentiality	The researcher treated all the information as confidential and numbers were used to identify the questionnaires. The participants' names do not appear anywhere in the research findings. Questionnaires were kept in a safe place until publication of the final research report.
Protection from harm and discomfort	The researcher foresaw no psychological or physical detrimental effects. During this study, the researcher continued to manage this aspect to prevent any harm and the participants were not kept longer than necessary. The researcher conducted the interviews in a private room in the

	clinics where the participants felt comfortable or at the homes of patient-participants.
Benefits	Benefits derived from the study were communicated with participants and authorities; the purpose of the study being the formulation of recommendations to strengthen compliance with the Batho Pele principles in order to improve the quality of health care service delivery and patient satisfaction.
Fair treatment	All participants had an equal opportunity to be selected and to participate in the study and they were treated fairly. In the context of the study, the researcher accepted responsibility to treat all participants in the same manner.
Informed Consent	Informed consent was obtained from each participant after a full and thorough explanation of the aim of the study and the potential benefits of participating in the study. The said information was provided to the participants (patients and health care personnel) verbally and in writing.
Voluntary consent & competency to give consent	The aspect of voluntary consent was clarified to the participants and the participants had the right to decline the opportunity to participate. If the participants were not competent in reading or illiterate, the researcher obtained verbal consent.
Danger/risks and precautions	There were no dangers and risks foreseen in this study, because interviews were conducted at a time and venue that was convenient to the

participants and conducive to open communication. Personal research interviews took approximately twenty to thirty minutes each, using structured questionnaires. Data was recorded and analysed. The data was locked away in a safe place and the final report could not be traced back to any participant. The researcher planned the interviews in such a manner that all participants felt comfortable. Each participant gave informed voluntary consent to participate.

The researcher was safe as she is familiar with the area where the research was conducted and all the interviews were held in the PHC clinics or in the homes of patient-participants.

1.9 RESULTS

The results of the study will be communicated to the Umzinyathi Health District so that decision-makers may be influenced to implement the study recommendations in order to strengthen current compliance with the Batho Pele principles in a PHC context. The results will also be published in a scientific journal.

1.10 RESEARCH REPORT LAYOUT

The research report will adhere to the following structure:

Chapter 1: Overview of the research

Chapter 2: Literature Review

Chapter 3: Research Methodology

Chapter 4: Results, presentation and discussions

Chapter 5: Evaluation of the study, limitations, recommendations for practice, education and further research

1.11 CHAPTER CONCLUSION

The realisation of the government's objective of "putting the people first", i.e. Batho Pele, will create a better life for all South African citizens: as it aims to provide effective, efficient and cost-effective service delivery mechanisms. As the researcher has shown during the introduction and background to the study, health care providers are not sure whether community members feel positive about service delivery and the quality of care they receive. Furthermore, it became evident that gaps may exist between implementation and compliance with the Batho Pele principles in the health care system (SA, 2007:2).

This chapter provided an orientation to the study, with the aim to prepare the reader for the subsequent chapters. The introduction and the background of the study was described, thereafter the problem statement was outlined. The research aim and research objectives formulated from the research questions were also depicted. A summary of the research design and method were provided in table format in order to give a short overview of the research method in relation to the two objectives.

In Chapter 2, the researcher will review the literature pertaining to the Batho Pele principle

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

In Chapter 1, an overview of the study was given, which included the introduction and problem statement, the research problem, aims and objectives, paradigmatic perspective, research methodology, as well as rigour and ethical considerations of this study.

In this chapter, the literature from all the relevant sources (see paragraph 1.4.5) was reviewed. Sources included books, articles, the internet, government reports, government policy documents, and legislation. Since the White Paper on Transforming Public Service Delivery (referred to as the Batho Pele White Paper in the study) (SA, 1997) and the South African Constitution (1996) served as the rationale behind the application of the Batho Pele principles in all three spheres of government, namely, national, provincial and local level, these were studied in depth. In addition to the above available sources, the researcher believed it was imperative to also investigate the Reconstruction and Development Programme (ANC, 1994b), which stipulates government objectives in terms of service delivery.

Burns and Grove (2009:38) state that the purpose of a literature review is to "critically appraise, generate and synthesise the current state of knowledge relating to the topic under investigation as a means of identifying gaps in the knowledge". Consequently, the purpose of this chapter is to provide a holistic overview of what Batho Pele within a primary health care situation entails.

By doing this, the researcher was able to confirm the research problem and its relevance, but more importantly to integrate the knowledge gained through the literature review and current standardised questionnaires to develop an instrument applicable and suitable to the context of this study.

Table 2.1: Objectives of the study

Objective 1	Objective 2
To describe the level of compliance with the Batho Pele principles as experienced by patients in a PHC context	To describe the level of compliance with the Batho Pele principles as viewed by the health care personnel in a PHC context

Thus, an in-depth literature review was required to achieve the objectives and overall purpose, that is, to make recommendations to strengthen current compliance with the Batho Pele principles in a PHC context in the Umzinyathi Health District in the KwaZulu- Natal Province.

The schematic outlay as illustrated in figure 2.1 explains the research process of exploration, description and deductive reasoning, including the integration of the literature review and the results of both objectives, in order to enable the researcher to make recommendations regarding compliance with Batho Pele principles in the PHC context.

In order to gain a clear understanding of the Batho Pele principles, its development and how it forms part of the comprehensive health services in South Africa, a discussion followed in the subsequent paragraphs that include the role of PHC from an international point of view, the integral role played by the WHO and the South African health system on national, provincial, district and community level. The researcher also took cognisance of the influences of the Patients' Rights Charter, the Millennium Development Goals, legislative framework, and service delivery applicable to the Batho Pele principles, as well as quality care.

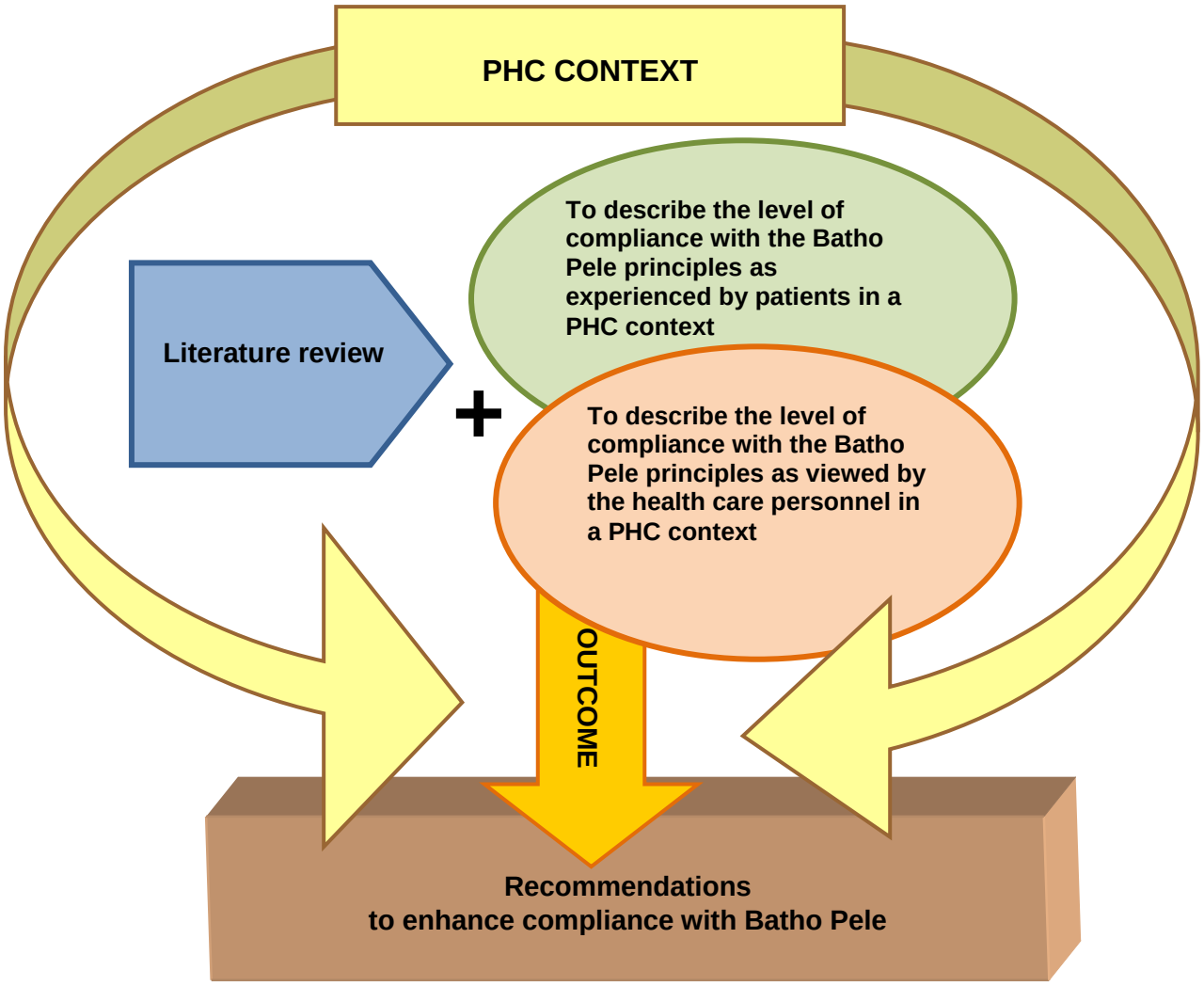

Figure 2.1: **Illustration of the research process to reach the overall purpose**

2.2 INTERNATIONAL AND NATIONAL INFLUENCES ON BATHO PELE

In the 1970's health care was in turmoil. Health care systems were fragmented and few people were given treatment, let alone preventive and promotive health care, and basic health care for all. In response to the inadequate level of health care internationally, the WHO (WHO and UNICEF jointly sponsored an International

Conference on PHC held at Alma-Ata in the USSR on 6-12 September 1978. The aim was to attain "health for all by year 2000" (Dennill *et al.*, 1999:2-3; ANC, 1994a:21; Lawn *et al*., 2008:1001). Kuye and Ile (2007:82) also indicated that the adoption of the Nigerians' Service Compact (Servicom) and the Batho Pele values was a sign that there is a realisation that the public service could do better and deliver adequate services to the people.

The view of health care systems in this research is based on the role of the WHO in health services, the role of the National Government, the development of the District Health system, and the formulation of the Batho Pele principles.

2.2.1 ROLE OF THE WORLD HEALTH ORGANISATION (WHO)

In 1945, international diplomats met in San Francisco to form the United Nations (UN). One of the first issues they discussed was to set up a global health organisation, hence the WHO came into being on 7 April 1948. Thirty years ago at Alma Ata, PHC was defined as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination" (ANC, 1994a:20; WHO, 1978:409; Dennill *et al.*, 1999:2). Therefore, according to this definition, PHC encompasses community participation in the planning, provision, control and monitoring of health care services, which correlate with the spirit of Batho Pele.

The WHO declared PHC as "essential health care provided at the first level of contact (community), that is at a PHC facility which constitutes the first element of contact in a continued health care process" (ANC, 1994a:10; Foster, 2005:245; WHO, 2008:45). Essential health care addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services; including provision of appropriate treatment of common diseases and injuries as well as providing essential drugs (WHO, 1978:410).

This international influence was clearly visible in the endeavours of Dr Beukes, a PHC cadre, at Chris Hani Baragwanath Hospital in the South Western Township (SOWETO). Dr Beukes started to train registered nurses in Primary Health Care officially on 27th July 1976, under the auspices of Professor Lucy Wagstaff. The goal was to equip registered nurses with knowledge and skills in patient assessment, diagnosis, treatment and care, and to expand the independent role of registered nurses (Beukes, 1993:2; SA, 1994b:18; SA, 2001b:23) in the absence of a medical practitioner. This training programme was instituted about two years prior to the WHO declaration on the global PHC approach at Alma-Ata, USSR in 1978 (WHO, 1978:410; Lawn *et al*., 2008:917).

As discussed before, during 2008 the WHO embarked on a PHC approach of 'putting people first', more than ever before (ANC, 1994b:10; SA, 1997:13; SA, **s.a.**:8; Mkhabela, 2003:15; SA, 2004:35; Foster, 2005:245; WHO, 2008:45; Arries & Newman, 2008:41-54). Thus, the focus in health care shifted to a service delivery approach; that is person-centred, comprehensive, integrated with continuity of care to give balanced consideration to health, well being, as well as values and capacities of the population and health care workers (WHO, 2008:41-48). Moreover, commitment of health care personnel is essential and the WHO works with countries to assist them with the planning, education and management of health care workforces. Assistance includes advice on policies to recruit and retain people working in health, as one way to address the critical shortage of health workers (also see paragraph 1.1).

2.2.2 ROLE OF THE NATIONAL GOVERNMENT IN THE HEALTH CARE SYSTEM

Prior to 1994, the South African health system was built on an apartheid ideology and was characterised by racial and geographic disparities, fragmentation, duplication and hospital-centred care, with only lip service being paid to the PHC approach (Legodi, 2008:19; SA, 1999:5). The current government of South Africa accepted the PHC approach as defined by the WHO and, therefore, government's role is to ensure that health services become accessible and affordable to all the citizens of South Africa. Achievement of this goal calls for the restructuring of the health care system in such a

manner that it reduces inequalities in access to health services, especially in rural areas and deprived communities (ANC, 1994a:20).

Accordingly, the government introduced a National Health System (NHS) for the provision of health services with the PHC clinic as the first-line provider for health care service delivery (ANC, 1994a:10; Van Rensburg, 2004:414) (see paragraph 2.2.1). The NHS is a single comprehensive, equitable and integrated health structure that deals with health; based on national guidelines, priorities and standards (SA, 1996b:3; SA, 2004:5). According to the guiding principles outlined by the African National Congress (ANC) in their vision for health in South Africa, government ought to coordinate all aspects of public and private health care service delivery, and is accountable to the citizens of South Africa (ANC, 1994a:19). Community members are encouraged to utilise the PHC services that are offered free of charge, so that they would become accountable and responsible for their own health, and the health care personnel are expected to render quality care to meet the health needs of South African citizens (SA, 1997:16).

2.2.3 DEVELOPMENT OF THE DISTRICT HEALTH SYSTEM

The District Health System (DHS) is a self-contained segment of the NHS and is based on the PHC principles like access, affordability, accessibility, and community participation. The DHS comprises of a well-defined population within a clearly delineated administrative and geographical area, whether rural or urban. It includes all institutions and individuals providing health care services in a specific district, whether governmental or non-governmental, private or traditional. The DHS, therefore, consists of a large variety of interrelated elements that contribute to health in the community, schools, workplaces and homes. It includes self-care and involves health workers and facilities such as hospitals, laboratories, and other diagnostic and logistic support services (ANC, 1994a:62).

The DHS provides the health sector with a management framework that can deliver health care in a cost-effective and integrated manner (Hattingh *et al*., 2006:72). Every part of every province falls within the geographical boundaries of a health

district, the size of each district varies according to local conditions. Each health district usually contains one or more than one district hospital, a Community Health Centre (CHC), PHC clinics, and smaller facilities such as mobile units and service points (Van Rensburg, 2004:414).

At the PHC level, the DHS is responsible for the overall management and control of the PHC budget and the provision and/or purchase of a full range of comprehensive PHC services within its jurisdiction. Effective referral network systems are ensured through the cooperation with other health districts. Services are rendered in collaboration with relevant role players (Hattingh *et al.,* 2006:151) in other sectors; namely, education, social development, transport, water and sanitation, agriculture, housing and so forth. At this level, the responsibilities of the DHS include health care, administrative, financial and support services, as well as planning and human resources development.

Over and above the aforementioned responsibilities and duties, the Umzinyathi Health District plays a pivotal role in the dissemination and implementation of the national health guidelines, priorities and standards of health care in the health care facilities within the district. The Umzinyathi Health District is also involved in the planning, provision, control and monitoring of services rendered to the community within its jurisdiction, as well as ensuring that health care services adhere to the objectives of the Batho Pele programme as stipulated in the Batho Pele White Paper (SA, 1997:15-24). Objectives; such as the development of service delivery activities, development of a comprehensive and integrated service delivery strategy, promotion of equity, the proper utilisation of services, and to ensure availability of financial resources to execute service delivery programmes, also form part of the Umzinyathi Health District's responsibilities.

2.2.4 PATIENTS' RIGHTS CHARTER AND BATHO PELE

The purpose and the expected outcome of the Patients' Rights Charter are to rectify service delivery problems (SA, 2001b:11). The effective implementation thereof will lead to the improvement of quality care and raise awareness of rights and responsibilities. The Strategic Priorities for the National Health System 2004-2009 (SA, 2004:8) states that the Patients' Right Charter is an advocacy tool for the improvement of quality care, and that the community must be empowered regarding their rights. It will not only raise expectations, but also bring about change of attitudes and strengthen the relationship between patients and health care personnel (SA, 2001b:11).

Davids *et al*., (2005:44) makes the remarkable statement that citizens are aware of their fundamental right of access to health care services, as stipulated in Article 27(1) of the Constitution (1996), a right that has been denied citizens for many years before 1994. The Department of Health has since been committed to uphold, promote and protect this right and, therefore, claim it as a common standard to be upheld in all health services (SA, 2001b:11).

The Patients' Rights Charter refers to a healthy and safe environment, participation in decision-making, access to health care, knowledge of one's health, insurance/medical aid scheme, choice of health services, treatment by a named health care provider, confidentiality and privacy, informed consent, refusal of treatment, a second opinion, continuity of care, and complaints about health services (SA, 1999; Van Rensburg & Pelser, 2004:119; Hattingh *et al*., 2006:67).

The Batho Pele principles respect and protect the patients' rights to have equal access to any public health facility and receive the quality services they are entitled to, as stipulated in the Constitution (1996). Therefore, an attitude like "BUYA NGENYANGA EZAYO MAMA", "COME BACK NEXT MONTH, MAMA" (Hatang, 2004:5) cannot be entertained or tolerated.

In the following section, the rationale behind the formulation of the Batho Pele principles will be discussed.

2.2.5 THE RATIONALE TO FORMULATE BATHO PELE PRINCIPLES IN SOUTH AFRICA

As indicated in the introductory chapter, the programme that focuses on the Batho Pele principles is a National Government initiative aimed at improving public service delivery (see paragraph 1.1), and was designed to support initiatives in all three spheres of government (Arries & Newman, 2008:41-54). According to Van der Walt & Du Toit (2002:100), principles are normative guidelines, societal value systems, or established legal rules. When the Government of National Unity came into being in 1994, it was determined that public services are not a privilege in a civilized and democratic society, but rather a legitimate expectation (SA, 1997:10). Meeting the basic needs of the community was one of the priorities of the government (ANC, 1994a:14) and it was believed possible to achieve this by implementing the Reconstruction and Development Programme (RDP) and the government's macro economic framework, namely, Growth, Employment and Redistribution (GEAR) (SA, 1997:10; SA, 2004:7).

The Constitution (1996), through the Bill of Rights, gave citizens recourse to take action against the government if they believe their constitutional rights have been violated (SA, 1997:10). Article 195(1) in Chapter 10 of the Constitution (1996) also refers to the principles that public administration should adhere to; including the maintenance of high professional standards; services to be provided equitably, fairly and without bias; and resources to be utilised efficiently, economically and effectively.

In line with Batho Pele principles, the Batho Pele White Paper (1997) required all national and provincial departments to make service delivery a priority (SA, **s.a.** 28), to outline their specific short, medium and long-term goals for service provision, and that they will be required to provide annual reports (SA, 1997:17).

Consequently, the development of the Batho Pele principles to transform service delivery will be discussed within the applicable legislative framework.

2.3 BATHO PELE WITHIN THE LEGISLATIVE FRAMEWORK

In line with the declaration by the WHO, as stated in Chapter 1, that "all governments should formulate national policies, strategies and plans of action to launch and sustain PHC as part of a comprehensive national health system in collaboration with other sectors" (Dennill *et al*., 1999:2; Van Rensburg, 2004:412), the Batho Pele White Paper (1997) was introduced with the ultimate goal to improve service delivery. Accordingly, the Batho Pele principles were developed to put the people at the centre of public service delivery (SA, 1997:9). Although the Batho Pele principles were not exclusively developed with PHC in mind, as part of a comprehensive national health system, it is unquestioningly important for and part of the functioning of all PHC clinics, also the clinics targeted in this study.

Apartheid in South Africa created racial segregation and language barriers in nursing and the health care system. Because of this, the new political dispensation led to changes and previously adhered to principles and rules were questioned. The Batho Pele document complements the Constitution (1996), the Nursing Act (33/2005), the Medicine and the Related Substances Control Act (101/1965), and the Patients' Rights Charter (1999).

It should of course be noted that it is over fifteen years since the inception of our democratic government, whose key objectives; namely, to create, implement and sustain a better life for all in South Africa; is stated in the Batho Pele Handbook (SA, **s.a.**:8). The introduction of policies, such as the White Paper on the Transformation of Public Service of 1995 and the Batho Pele White Paper of 1997, is a clear indication of the government's resolve to provide a better life for all the citizens of South Africa and to attain the crucial goal of the public service transformation programme: to improve service delivery.

The Constitution (1996) not only states that everyone has the right to human dignity, in Articles 7 and 10, but also provides for the universal right of access to information in Article 32. The public service is there for the people and should, therefore, be accessible, transparent, accountable, efficient and free of corruption, as stipulated in

the RDP of 1994 (ANC, 1994b:42-51). The RDP also specified the necessity of public participation and involvement in the implementation thereof. One of the objectives of the RDP — to address income inequalities that characterised the South African economy (ANC, 1994b:43) — led to the provision of free medical health care services to pregnant women and children five years old or younger (Dennill *et al*., 1999:7). Moreover, these persons should never be denied access to decent health care services, services that they are entitled to.

Furthermore, a guide to revitalise the Batho Pele principles (SA, 2004:6) made it clear that public servants have a greater responsibility in ensuring that the citizens receive the quality services they deserve. PHC facilities deliver public services and are vehicles employed by the government to ensure that services are indeed delivered to the people. This has resulted in the Batho Pele Revitalisation Programme and projects that fall within its ambit are categorised according to the following four key strategic priorities, as approved by the South African Cabinet (SA, 2004:29-30):

- *"to take public services to the people to enhance access initiatives in terms of service delivery."* Applied to this study it could refer to the extension of clinic hours, putting up clear and informative signage, use of nametags, and using languages that are predominant and understandable to the specific area where the service is delivered.

- *"to know your Service Rights and Responsibilities Campaign that calls for patient awareness and education on citizens' rights"* in relation to services they are entitled to and health care personnel must know their rights and responsibilities in order to enable them to provide quality care services.

- *"to put people really first"* mean that this Revitalisation Programme would re-enforce Batho Pele and improve health care personnel capabilities of managing client related matters in a systematic way, by putting patients at the centre of the health care services. In order to monitor the level of service delivery, the Revitalisation Programme also makes provision for unannounced visits in the form of Ministerial Service Delivery Visits, the PHC service

inspectorate, and the SMS Service Delivery Challenge (Khaedu). This will also give health care service providers working outside the area of PHC an opportunity to experience first-hand the challenges experienced at the coalface of service delivery (SA, 2004:37-39).

- *"to mainstream and institutionalize Batho Pele"* which involves using human resources, systems and other regulations as a key lever for implementing Batho Pele and service delivery in general.

Because of the above, once again, even greater pressure was exerted on the health care system to hold health care personnel accountable and responsible for quality service delivery. This extra pressure constitutes a demand to take the implementation of the Batho Pele principles to a higher, more effective level, and to adhere to the rights enshrined in the Bill of Rights of the Constitution (1996).

The Batho Pele White Paper (1997) provides a very clear policy framework and implementation strategy for the transformation of Public Service Delivery. As mentioned in the previous chapter, the central component of the strategy is the eight Batho Pele principles. These principles are explained and applied to the study in Table 2.2.

Table 2.2: Batho Pele principles applied to the study

Consultation: Citizens should be consulted about the level and quality of the public services they receive and wherever possible should be given a choice about the services they are offered (SA, 1997:16).	
Explanation: Consultation refers to the involvement of the clients in expressing their views about the existing public services and the provision of new basic services that require adequate facilitative mechanisms to be effective.	**Application to the study**: At a PHC level, communities are consulted in groups about service delivery in the form of meetings, road shows, izimbizo's (community gatherings), interviews during client-satisfaction surveys, and holding meetings with representative bodies like clinic committees, Non-Governmental Organisations (NGOs), Community-Based Organisations (CBOs) and Faith-Based Organisations (FBOs).
Service Standards: Citizens should be told what level and quality of the public services they would receive so that they are aware what to expect (SA, 1997:16).	
Explanation: Service standards refer to existing and progressively raised and monitored working standards in all three spheres of government. This principle reinforces the need to constantly measure the extent to which communities are satisfied with the services they receive. The public's level of satisfaction with the services is the main indicator used for service standards. Patients should be well informed about the services that they should expect so that they have realistic expectations of the services provided (SA, 2004:13).	**Application to the study:** The clients should be involved in the development of service standards and policies on how the health care providers should respond and manage complaints. In a PHC context, set standards are being reviewed quarterly to ensure that the standards of care are met. This is done in order to confirm the gaps identified in the delivery of service and to remedy the situation.

Access: All citizens should have equal access to the services to which they are entitled (SA, 1997:18).	
Explanation: Increasing access means that the facilities where services are rendered should be easy to get to and within reach of community members. This is aimed at rectifying the inequalities in the distribution of existing services. Based on the development priorities for PHC to improve quality, access includes provision of comprehensive health care services on a daily basis, provision of 24hr services, extension of clinic hours and clinics being open on weekends as well as a on-call system (SA, 2004:12). The availability of a complaints mechanism should be in place and should create value for money as it reduces unnecessary expenditure for the community.	**Application to the study:** The health care facilities under study should provide comprehensive services and access to these services has several dimensions; namely, geographic, cultural and economic. Access to health care services is the fundamental right of every citizen in South Africa, as specified in Article 27 of the Constitution (1996) (SA, 1996). Therefore, it is essential to include views of the previously marginalised, those who have previously been denied access to public services, the illiterate, and the disabled in the consultation process.
Courtesy: Citizens should be treated with courtesy and consideration (SA, 1997:18).	
Explanation: Courtesy refers to establishing a code of conduct that values the principle of transforming service delivery and set standards for the treatment of the public. Health care providers are required to treat clients with empathy, dignity and respect, as they would like to be treated themselves.	**Application to the study:** Health care personnel should have the right attitude towards patients and respond to their queries in the spirit of Batho Pele. Customers should be treated with consideration and respect (SA, 2004:28). The courtesy people perceive in health care services is reflected in their view of corruption regarding the services, particularly in their conception thereof. There is a commonly held belief that, for example, misbehaviour and bad service represent corruption (Andersson *et al*., 2004:386).

<table>
<tr><td colspan="2">Information: Citizens should be given full, accurate information about the public services they are entitled to receive (SA, 1997:19).</td></tr>
<tr><td>Explanation: This principle refers to accurate and up to date facts about services that clients are entitled to. Information about service delivery is readily available to the PHC staff and the clients in the form of guidelines, procedures manuals, in-service training, pamphlets, and so on.</td><td>Application to the study: Pamphlets and posters are the most common method of informing people about new policies and programmes available at health care facilities. This is also a possible method to improve access to the facility.

Patients should know whom to contact in case of emergency, they should be informed about services offered, and a help desk should be provided.</td></tr>
<tr><td colspan="2">Openness and Transparency: Citizens should be told how National and Provincial departments are run, how much they costs, and who are in charge (SA, 1997:20).</td></tr>
<tr><td>Explanation: The community has a right to be informed and should know how national and provincial services are operated. This principle is crucial to promote values of openness and transparency, values that are essential in service delivery and deepening democracy. The community will be able to make suggestions regarding the improvement of service delivery mechanisms and become involved in decision-making (especially as members of the community clinic committees) to ensure the smooth running of the facility.</td><td>Application to the study: This clearly indicates that the public should know and be familiar with the sister-in-charge of the health care facility and this serves as the key indicator of this principle. The main reason is so that the public would know whom to address complaints and problems about the health care facility to, or in case of emergency who to contact as well as who to contact when more information is required.</td></tr>
</table>

Redress: If the appropriate standard of service is not delivered, citizens should be offered an apology, a full explanation and speedy and effective remedy; and when complaints are made, citizens should receive a sympathetic positive response. (SA, 1997:20).	
Explanation: The redress principle refers to mechanisms for recording any public dissatisfaction. Public servants must be willing to receive complaints from citizens with a sympathetic ear and respond positively (Van der Walt & Du Toit, 2002:109).	**Application to the study:** Patients should be encouraged to utilise the suggestion boxes to lodge their complaints so that the weaknesses in the system can easily be rectified for the good of the community. Making use of suggestion boxes may, however, discriminate against the illiterate, blind, frail and very old people. Therefore, the above-mentioned people should be encouraged to utilise any accessible complaint procedure.
Value for money: Public services should be provided economically and efficiently in order to give citizens the best value for money (SA, 1997:22).	
Explanation: Improvements that communities expect require no additional resources and sometimes even reduce costs. Citizens pay income tax, VAT and other taxes to finance the administration of the country. They have a right to insist that their money be utilised properly.	**Application to the study:** Health care patients should have full access to information about budget allocations and free services so that they can be responsible for their own health. Therefore, the health care personnel need to give sufficient explanations when questioned so that procedures would be done correctly and give best value for money. Health care facilities should offer proof that efficient savings programmes and improved service delivery are in the pipeline. Bringing health care closer to the people; rather than the fragmentation of health care services, for example, to transfer patients to the next level of health care; will result in lower overall health care costs for similar outcomes and greater patient satisfaction (WHO, 2008:53).

2.4 BATHO PELE AND PUBLIC SERVICES

According to the Batho Pele Handbook (SA, **s.a.**:8) that is a service delivery improvement guide, Batho Pele is a government initiative to encourage public servants to become service-orientated, to strive for excellence in service delivery, and commit to continuous service delivery improvement. It is a simple and transparent mechanism and provides a framework for the transformation of public service delivery, thus "putting people first" (ANC, 1994a:10; SA, 1997:13; SA, **s.a.**:8; Mkhabela, 2003:15; SA, 2004:35; Foster, 2005:245; WHO, 2008:45; Arries & Newman, 2008:41-54) and to hold public servants accountable for the level of services they deliver. The aim of the Batho Pele principles is to gradually raise the standards of service delivery, especially in marginalised communities whose needs are the greatest (SA, 1997:10 & 18).

2.5 SERVICE DELIVERY IN TERMS OF BATHO PELE PRINCIPLES

Batho Pele is about service delivery to the public. On the other hand, is it clear that to create a good life for all South African citizens will remain a challenge to all public servants within the three spheres of government; and in particularly the sub-districts or at local level as they are the closest to the people and they interact more closely with the community. Service delivery, therefore, should encompass the ability to provide users with the basic services needed or demanded, including a sense of redress, and services should raise the standard of living of the majority, especially the vulnerable and marginalised community (Hemson & Owusu-Ampomah, 2005:512).

According to Mbanga (2006:vi), the Batho Pele awareness campaigns were successful, since employees and customers are aware of the principles. However, Batho Pele is not a quick fix or a miracle cure for poor service delivery, it is an attitude and approach to service delivery that needs to be woven into the very very fabric of public service delivery (SA, **s.a.**:43). The departments are, therefore, expected to develop a Service Delivery Charter; a statement of the commitment that a department

(thus also health care personnel) makes towards service delivery; and it also illustrates the links to legislation and the Batho Pele White Paper (SA, **s.a.**:82).

Thus, the purpose of the Batho Pele White Paper (1997) is to provide a policy framework on "how" services are provided, rather than on "which" services are provided (SA, **s.a.**:23), with the ultimate goal to improve effective and efficient service delivery. In conclusion, does this mean that public servants (in this study all health care personnel) should comply with this code of conduct?; namely, for the public to come first and have powers of redress (SA, **s.a.**:22; Mkhabela, 2003). In the light of the discussed legislative framework, most certainly it does.

Before the discussion continues on the PHC approach, the researcher wants to draw the attention of the reader to a schematic presentation explaining the Batho Pele principles in the context of the study (see Figure 2.2).

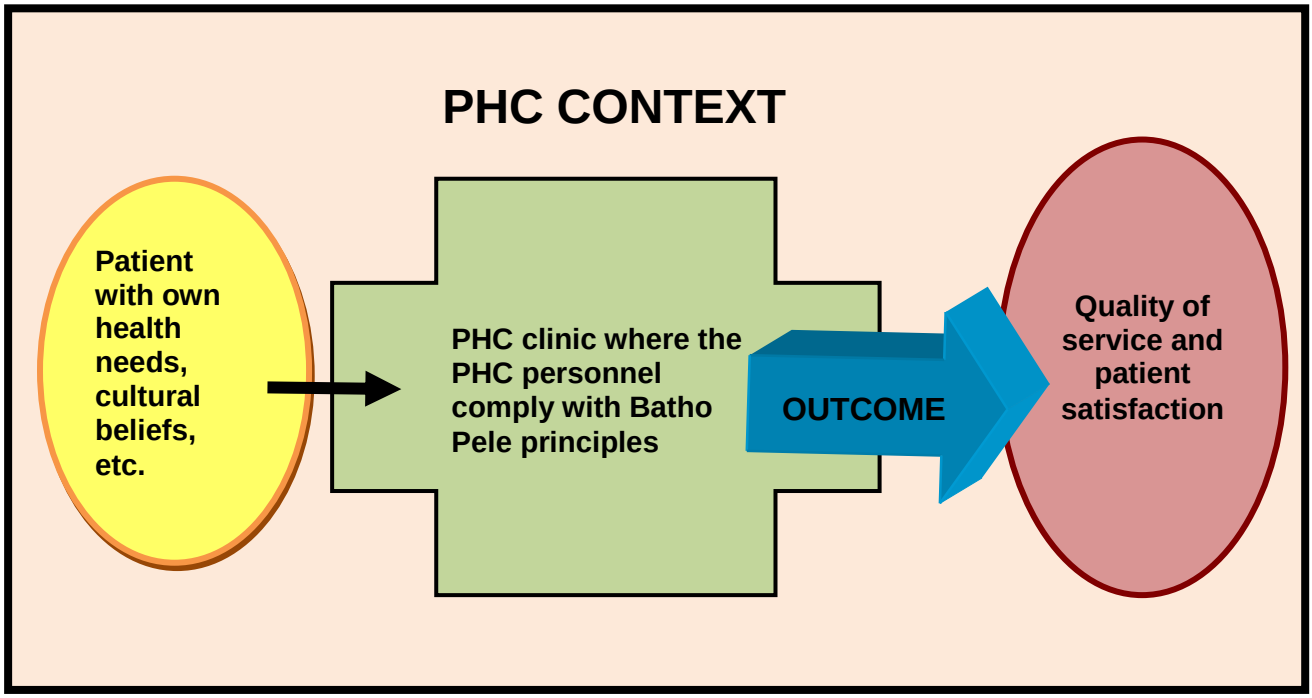

FIGURE 2.2: The Batho Pele principles in the context of the study

2.6 PRIMARY HEALTH CARE APPROACH

The reader should refer to paragraph 1.4.4 of Chapter 1 on the conceptualisation of PHC (ANC, 1994a:20; WHO, 1978:409; Lawn *et al*., 2008:1001). In brief, as stated by Naude and Setswe (2000:2-3), PHC is often the first care that a person receives, it should be ongoing care that is affordable and based on the specific physical, mental and social needs of the community. PHC should be provided by members of a multi-disciplinary team and include community development and empowerment.

PHC services in South Africa are mainly provided by the public health sector in an equitable, effective and efficient manner. Health care facilities provide a comprehensive service that includes a wide range of daily basic services; also called the supermarket approach to health care. This type of health care is more efficient because the patients can attend one health clinic to obtain several services, rather than travelling from one clinic to another (Reagon *et al*., 2004:1 & 9). It is consequently important to discuss some aspects of the primary health care approach and how these aspects are integrated with the Batho Pele principles.

2.6.1 ACCESS

Services should be geographically, financially and functionally accessible to all people in South Africa, regardless of colour, age, ethnicity, creed or social status (Dennill *et al*., 1999:6). Mr Makgato confirmed this in his speech at the 7th Batho Pele Learning Network held on 10-12 November 2008, when he stated that Zola Skweyiya (the then Minister for the Public Service and Administration) rightly captured the reason for the implementation of Batho Pele in the foreword of the Batho Pele White Paper that reads “access to decent public services is no longer a privilege to be enjoyed by a few, but it is now a rightful expectation of all the citizens especially those previously disadvantaged” (Makgato, 2008). Clearly this means that Batho Pele is about continuous service delivery and customer care with the cultural values of *ubuntu/botho* (SA, 2004:13; Mapadimeng, 2007:257) and a change of attitude in service delivery towards respecting and serving all community members.

The current President, His Excellency Jacob Zuma, also supports this viewpoint, as is clear from his inauguration speech on 10 May 2009 when he stated that: “There is no place for complacency, no place for cynicism and no place for excuses. Everything we do must contribute in a direct and meaningful way to the improvement of the lives of our people” (Zuma, 2009). In the same vein, the Minister of the Department of Social Development stated (at the Africa Public Service Day Celebrations during 2009), that the driving force to ensure sustainable machinery of government is to ensure high level of compliance with the Batho Pele principles. Such machinery of government should be geared towards facilitating access to quality service and by taking services to the people and, thus, truly putting them first (SA, 1997:13; SA; **s.a.**:22; SA, 2004:29; WHO, 2008:41; Dlamini, 2001).

2.6.2 AFFORDABILITY

It is imperative to foresee that no person should be denied access to health care services merely because they cannot pay for it (Dennill *et al*., 1999:6; Hattingh *et al*., 2006:64). In South Africa, PHC services are provided free of charge to pregnant women, children five years old or younger, and all community members that do not belong to a medical fund. The Public Service Commission stated, in their survey on citizen satisfaction, that they will also ensure the delivery of affordable and sustainable quality services by making use of research (SA, 2007:i).

2.6.3 ACCEPTABILITY

Factors that determine acceptability are: cultural factors, type of services offered, costs of services, travelling distance, and the attitude towards health and health care providers (Dennill *et al*., 1999:6). Thus, it is clear that in a country like South Africa, known as the “Rainbow Nation”, health care personnel should be highly aware of the mentioned aspects that can contribute to acceptability.

2.6.4 COMMUNITY PARTICIPATION AND INTERSECTORAL COLLABORATION

It is not only community members that should become active participants in their own health care; all possible stakeholders should become part of the process. Such

stakeholders may include community members with different health needs, local health government, local political leaders, non-governmental organisations (NGOs), community-based organisations (CBOs), faith-based organisations (FBOs), as well as the private business sector. Traditional leaders (amakhosi, izinduna), traditional and spiritual healers, ministers' fraternity and prominent figures in the community (including the governance structures in decision-making) should also be included. All these role players should become active partners in health care (Dennill *et al*., 1999:6-10; Watson, 2008:8).

2.7 QUALITY CARE AS PART OF PRIMARY HEALTH CARE PRINCIPLES

Quality care refers to the characteristics or features associated with excellence in rendering services to the community when the right decision is made (efficiency) at the right time (effective) to satisfy their needs and expectations in a cost-effective manner, without compromising the services by undue restrictions in time and distance (Booyens, 2008:596). In the context of this study, quality care refers to meeting the needs and/or expectations of patients by consistently adhering to the Batho Pele principles in rendering all PHC services.

According to Crouse (2006:399), the primary objective of quality care is to create and maintain a system of practices and procedures that will assure that the institution's services satisfy the needs of its customers (patients in this study). The same author states that users judge the quality of services according to outcomes achieved, or whether services are delivered in ways that empower them (Crouse, 2006:397). It is interesting that a professional practitioner sees quality in terms of performance, whereas clients regard accessible services, compassion and availability of medicines as quality. Managers regard quality as the attainment of effectiveness, efficiency and financial stability. Crouse (2006:399) further observes that services should also be the means to an end; the end being better quality of care.

On the other hand, Gilbert (2004:7) defines quality as the totality of features and characteristics of a product or service have a bearing on its ability to satisfy stated or

implied needs. Therefore, health services should shift their focus from quality assurance to quality improvement. Quality improvement refers to a system in which quality of service is formally monitored and assessed. It is, therefore, a planned programme in which quality of service is objectively monitored and evaluated, opportunities for improvement are identified, and a mechanism is provided for taking remedial action to bring about and maintain improvements (Booyens, 2002:582). Spradley and Allender (1996:618) describe quality as a relative term that defines something with high merit or excellence, which simply means that quality can be measured according to norms and standards, and services should be provided according to the needs and expectations of the community, as is confirmed by Oakland (2002:4).

In conclusion, for the purpose this study, quality care is perceived as a combination of the above factors. This means that health care personnel, especially the nurses and doctors working in PHC clinics, should know how to take a patient's history, diagnose, treat (cure) the condition, and take care of the sick. They should be able to look holistically at all patients in order to prevent illnesses, promote health, manage possible emergencies, and appropriately refer patients to needed, relevant services which they can still afford. These services should be provided in the spirit of the Batho Pele principles, thus, the Batho Pele principles are a blueprint for quality improvement.

In the following sections some aspects on quality health care; like accreditation, quality control at PHC clinics, and quality measurements as standards, will be highlighted.

2.7.1 ACCREDITATION AS AN EXTERNAL MECHANISM FOR CONTROLLING QUALITY HEALTH CARE

Accreditation can be seen as one of the external mechanisms for controlling the quality of health care (UNISA, 2000:70). The Joint Commission on Accreditation of Health Care Organisations has a slogan that states "Do the right things right". This entails identifying customer needs, converting them to agreed upon requirements,

and aligning the work process so that these requirements are met. To do things right means executing the work process in a way that meets the requirements (Booyens, 2002:581). In order to ensure the safety of patients, the PHC package for South Africa stipulates “No member of staff including PHC nurses should undertake tasks unless they are competent to do so” (SA, 2001b:7). Bearing in mind the above expectations for health care, the South African Nursing Council (SANC) is a statutory body entrusted to set and maintain the standards and qualifications for nursing in South Africa (SA, 2005:7).

The extended independent function of a registered nurse was recognised and is now regulated by SANC through the Nursing Act, (33/2005). SANC has fulfilled this accreditation function since 20 November 2000 as an Education and Training Quality Assurance Body (ETQA) in terms of Section 5(1)(a)(ii) of the South African Qualifications Authority Act (58/1995). SANC remains the responsible body for monitoring and auditing achievements in terms of the national quality standards (SA, 2001a). Each category of nurse is an independent practitioner in accordance with the scope of practice, level of training, and competence attained (SA, 2004:7). Nurses should be registered and work under the conditions set by the rules and regulations of SANC and ultimately adhere to SANC’s objectives (SA, 2001a), namely:

- to serve and protect the public in matters involving health services generally and nursing services in particular;
- perform its functions in the best interests of the public and in accordance with national health policy as determined by the Minister;
- promote the provision of nursing services to the inhabitants of the Republic that complies with universal norms and values;
- establish, improve, control conditions, standards and quality of nursing education and training within the ambit of this Act and any other applicable laws;

- maintain professional conduct and practice standards for practitioners within the ambit of any applicable law;
- promote and maintain liaison and communication with all stakeholders regarding nursing standards, and in particular standards of nursing education and training and professional conduct and practice both in and outside the Republic;
- advise the Minister on the amendment or adaptation of this Act regarding matters pertaining to nursing;
- be transparent and accountable to the public in achieving its objectives and in performing its functions;
- uphold and maintain professional and ethical standards within nursing; and
- promote the strategic objectives of the Council.

In this study, the other categories of health care personnel working in a PHC clinic serve as support personnel for registered nurses.

In conclusion, with accreditation as an external mechanism to support health facilities in controlling the quality of health care, the Council for Health Service Accreditation of Southern Africa (COHSASA) is a registered non-profit organisation that has been dealing with quality improvement in South African's health care institutions since 1995. COHSASA aims to assist health care facilities (including PHC services) with the process of continuous quality management and to improve service delivery leading to an improved standard of compliance with the Batho Pele principles (COHSASA, 2005).

2.7.2 QUALITY CONTROL AT THE PHC CLINIC

In the context of this study, quality care refers to the creation and maintenance of a system of practice and procedures that will ensure that the PHC clinic satisfies the stated or implied needs and/or expectations of patients by consistently applying or

adhering to the Batho Pele principles in all activities carried out by PHC service providers. These principles, therefore, guide health care personnel activities so that health care users and communities are satisfied with the quality of care provided.

Interdisciplinary quality improvement project-teams are the hallmark of quality improvement initiatives. Such collaborations are based on the argument that mostly health care is interdependent and interdisciplinary in nature, and collaboration across departmental boundaries is required to analyse and improve the quality of health care. Interdisciplinary quality improvement groups are formed to share perspectives and services, to innovate, and to find better approaches to meet customer needs (Schroeder, 1994:10).

The physical and staff structures, the management of the clinics, services rendered, the community profile (catchment area), and the infrastructure (telephones, electricity, water, sanitation, refuse disposal) are some of the aspects that are evaluated in terms of quality control (SA, 2001b:1).

2.7.3 QUALITY MEASUREMENT

According to Donabedian (2003:46), the American father of quality control, there are three categories that should be considered when the quality of health services is evaluated; namely, structure, process and outcome (mortality, recovery and patient satisfaction in the health care context). Therefore, the researcher adhered to Donabedian's framework (2003:46-60), which was used in Chapter 5.8.2 as an aid to achieve the purpose of this study in relation to nursing practice.

2.7.3.1 Structure standard

Structure standard describes the composition of, and the resources available, in a health service that makes the provision of the service possible. Furthermore, the structure standard is concerned with the adequacy of facilities and equipment; the number, skills, qualifications, and the experience of the health care personnel; administrative structure and operations of the facility; and employees' welfare, training and development (Booyens, 2008:267).

2.7.3.2 Process standard

Process standard applies to the manner in which tasks should be executed. It involves the actual way the practice is conducted and aspects that form part of this process. In clinical nursing, a process standard usually follows a scientific approach; namely, assessment, planning, implementation and evaluation. The process standard, therefore, implicitly describes the "what" and "how" of clinical practice. (SA, 2001b: 7). It furthermore also refers to the interaction between patients and health care personnel in the PHC setting.

2.7.3.3 Outcome standard

Outcome standard refers to the results that have been achieved, for example, treating minor ailments and care for chronically ill patients. The outcomes of nursing care, described in terms of recovery, restoration of function and survival, are frequently used as indicators of the quality of nursing care. Furthermore, outcome standard also refers to how skilfully care was rendered and it denotes the end results of health care functions.

These above components are interdependent and interrelated when rendering effective health care services. When one of these components is inadequate, service delivery is compromised, leading to higher mortality and morbidity rates with a negative impact on the outcome component.

2.8 QUALITY ASSESSMENT STRATEGIES

Various measurements can be used to measure quality care; namely, auditing, patient satisfaction surveys, complaints mechanism, and data interpretation (SA, 2001b:11). In this study, auditing and patient satisfaction surveys were employed. The other methods were not used due to financial constraints and because they are so time consuming.

2.8.1 AUDITING

In the PHC setting, clinical auditing is essential to patient care as it promotes education through the implementation of clinical guidelines (SA, 2007:21) and it is one of the methods used to measure quality care, as is reflected in hospital documents. Over and above this purpose, auditing in PHC services has become inevitable due to increased awareness of quality issues and customer demands for human rights and a better life for all. PHC services are vested with the responsibility of providing comprehensive health care services to all South Africans. Therefore, continuous assessment, monitoring and evaluation of how cost-effective, efficient and effective provided services are would ensure compliance with the Batho Pele principles. This will ultimately guarantee that patients receive the quality care they are entitled to as citizens of South Africa.

2.8.2 PATIENT SATISFACTION

Patient satisfaction is a multi-dimensional concept that is rooted in human experience and individuals judge it subjectively. Patient satisfaction furthermore results from the patient's understanding and acceptance of his or her health status, the actual logistics of care, and the perception that the treatment has resulted, or will result, in improved health care (Lindsey *et al.*, 1997:31). Booyens (1998:603) defines patient satisfaction as an instrumental component in monitoring the quality of health care in relation to costs and services. Therefore, health care personnel must demonstrate that they deliver quality care at a reasonable price, according to the value for money principle.

According to Legodi (2008:46), quality care is the best assurance of a clients' allegiance, therefore, health institutions must work hard to maintain a good reputation and a high community awareness. In agreement with the above statement, Knudtson (2000:405) indicates that client satisfaction is one of several criteria used to measure health outcomes and the quality of health services provided to the patient. In line with the government policies (which all stress the importance of service delivery), one of the long-term objectives of PHC services is to conduct a periodic customer satisfaction survey. This is also one of the initiatives introduced by the Department of

Health as a means to assess how well the public service is doing in terms of commitment to the needs and expectations of citizens, and to measure and improve the quality of care (SA, 2007:21). Such a survey is being conducted at least twice a year in some of the facilities investigated in this study.

2.9 GENERAL OBSTACLES IN THE HEALTH CARE DELIVERY SYSTEMS

The improvement of health care service delivery is one of the ultimate goals of public service transformation, as previously discussed (see paragraph 1.1). Several obstacles stand in the way of quality care. Some of these, as identified during meetings, personal discussions and in the literature, are listed below.

- Rapid changes outside the PHC context, like political changes, lead to the implementation of several different programmes, causing a lack of coordination and collaboration.

- The introduction of rural and scarce skills allowances in May 2003 and the eventual implementation thereof in March 2004 (Reid, 2004:3), as well as the implementation of the Occupation Specific Dispensation (OSD) in 2008, resulted in higher salaries for nursing health professionals actively engaged in clinical studies (SA, 2008:1). The drawback to this, though, is that is also led to nurses being less dedicated to their jobs as they are more concerned with their pay cheques than service delivery.

- Financial constraints within the health care system caused the Department of Health to freeze some posts leading to a lack of human resources and work overload (SA, 2010b:1). Health care personnel often suffer of burnout, this leads to dissatisfaction, absenteeism, poor service delivery, negative attitudes towards the patients and the profession, low productivity, as well as abuse of patients' rights. Health care services in South Africa are faced with severely limited human resources, specifically in reference to inadequate staff levels. Human resource allocation is unrealistic; this results in health care personnel who have to cope with an increase in workload and demands from the public.

- Limited staff numbers result in less time spent with patients. Health care personnel try to manage only the critical aspects of nursing care, like curative services, obviously thus being able to spend less time on preventive and health promotion projects.

- There is growing evidence of a lack of crucial technical/clinical skills, which are most pronounced in the rapidly expanding area of TB management, and HIV/AIDS prevention, treatment and care. To address this requires massive training programmes/strategies and continuous support of PHC services and personnel, even more so in the light of the planned anti-retro viral therapy (ART) programme announced by the State President JG Zuma on 5 December 2009. This planned programme involves the initiation of ART to HIV positive children and pregnant women with CD4 counts below 350, as well as the integration of TB/HIV and AIDS management (Zuma, 2009). How is this objective to be achieved when there are already huge financial constraints and an enormous lack of human resources in the various health departments?

- Over and above the increased number of services rendered at the clinics under study, there is a shortage of infrastructure; namely, telephones, electricity, water, sanitation, refuse disposal, accommodation and HIV counselling space, all of which denies access to health care services.

- On top of all the mentioned challenges facing clinics and the shortcomings identified, a moratorium was placed on posts by the Department of Health Kwazulu-Natal (SA, 2010a:1). This decision even further demotivated and lowered the morale of health care personnel, resulting in a further setback to the achievement of the Batho Pele principles.

In addition to the above, Dennill *et al*. (1999:6) highlights additional factors that hinder access to PHC clinics. These include: long waiting times; systems-related limited resources; free services that exacerbate patients expectations for medicine; ignorance of the importance of counselling and health education (that can be linked to socio-economical status); distance and travelling-time (distance should be within 5 km

radius); lack of resources as a geographical related aspect; patients and their families have their own cultural system and beliefs; limitations to communication and lack of infrastructure (for example telephones are unavailable, inability to use two-way radios and to utilise a complaints mechanism); and attitudinal problems of health care personnel (especially negative attitude towards patients and resistance to change can lead to misunderstandings and an escalation in complaints).

2.10 CHAPTER CONCLUSION

It is clear that the application of and adherence to the Batho Pele principles are imperative within PHC service delivery. The fundamental rights enshrined in the Bill of Rights of the Constitution (1996), i.e., equality, human dignity and freedom, should be adhered to. In addition, the central tenets of the Batho Pele principles signify that patients are entitled to be treated justly, with respect, and ought to have access to information and services.

Measuring compliance with the Batho Pele principles is a means of improving service delivery to the public. It is not a method to judge individual performance, but to develop a service delivery culture in all health care facilities. These principles underline the importance of commitment, the cultural values of *ubuntu botho*, i.e., humanity (SA, 2004:13; Mapadimeng, 2007:259), and a change in attitude by actually putting people first. In order to achieve quality service delivery, the values and ethos of Batho Pele need to be shared across all spheres of government, including PHC services.

In the following chapter, the research methodology is introduced, and the experiences of the patients and the health care personnel regarding compliance with the Batho Pele principle in a PHC context, are described.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

The previous chapter consisted of a literature review within the research framework, during which compliance with the Batho Pele principles was examined. The purpose of this chapter is to explain, in detail, the methodology employed in this study and special attention will be paid to the research design, research method, data analysis, reliability measures, as well as the ethical considerations.

The overall purpose of the study is to make recommendations that will strengthen compliance with the Batho Pele principles in the PHC context by identifying possible gaps in the current implementation of these principles. In order to achieve this, a quantitative study design was used and data was collected by directly questioning the sample of participants using a structured questionnaire (Polit *et al.*, 2001:472; Burns & Grove, 2005:398). To enable the researcher to make purposeful recommendations and in so doing improve the quality of care and patient satisfaction, the following objectives applied to the study (see table 3.1):

Table 3.1: Objectives of the study

Objective 1	Objective 2
To describe the level of compliance with the Batho Pele principles as experienced by patients in a PHC context	To describe the level of compliance with the Batho Pele principles as viewed by the health care personnel in a PHC context

3.2 RESEARCH DESIGN

This study is quantitative, non-experimental, descriptive, and contextual in nature. The research design forms the blueprint, or the overall plan, of the study (Blaike, 2004:35). A specific research design is employed to achieve greater control and improve the validity of the study when examining the research problem (Burns & Grove, 2005:231). The main purpose of this study was to determine the level of compliance with the Batho Pele principles to make recommendations that will

strengthen current compliance with the Batho Pele principles and in so doing improve the quality of care and patient satisfaction in a PHC context.

On order to achieve the research objectives, as stated in table 3.1, a non-experimental, quantitative, descriptive and contextual research design was selected. The study focussed on the experiences of individuals (patients and health care personnel) regarding a specific topic (compliance with the Batho Pele principles) being examined (Mouton, 2006:55). A quantitative, descriptive approach was used for the following reasons:

- Descriptive statistics were used to describe and summarise data (Brink *et al.,* 2006:171) and examine the significance of the experiences of the patients and health care personnel, in order to identify problems with current practices (Burns & Grove, 2005:232) in PHC clinics. This enabled the researcher to achieve objectives 1 and 2 (see Table 1.2).

- Information regarding the level of compliance with the Batho Pele principles was obtained by determining the experiences of patients and the viewpoints of health care personnel involved in this study.

- This quantitative design provided the researcher with new insights (by making use of statistical data) regarding compliance with Batho Pele principles in a PHC context. This enabled the researcher to make recommendations to enhance current compliance with the Batho Pele principles in a PHC context.

According to Brink *et al*. (2006:113), making use of a quantitative, descriptive research design is more appropriate when the viewpoints of research participants, based on their experiences in a particular context, are examined. A discussion of the design concepts follows.

3.2.1 QUANTITATIVE

According to Burns & Grove (2005:24), quantitative research is a formal, objective and systematic process during which numerical data is used to describe variables, examine relationships between the variables and thus obtain information about the lived world (in this study, compliance with the Batho Pele principles as experienced by patients and viewed by health care personnel in a PHC clinic). Moreover, a quantitative research design is compatible with the purpose of the study and as well as the resources available, such as time, money and sources of information (Brink *et al.*, 2006:92).

3.2.2 DESCRIPTIVE

A descriptive research design was elected because it provides a complete picture of the phenomenon, as it exists (Brink *et al.*, 2006:104) and as it is experienced by the participants. Using a descriptive study design also allowed the researcher to examine and describe the situation more clearly, based on the various perspectives of the participants (Burns & Grove, 2009:359).

3.2.3 CONTEXTUAL

The study is contextual in nature because the findings are valid in, and applicable to, a specific situation (Burns & Grove, 2005:170; Brink *et al.*, 2006:64) where the population was identified, the sample selected, the data collection method designated, and the method for analysing the results established. This study was conducted in PHC clinics and includes the patients attending the clinics on a regular basis, as well as the PHC personnel rendering health care services to these patients of the Endumeni and Nquthu sub-districts of the Umzinyathi Health District in the KwaZulu-Natal Province.

When describing the geographical boundaries and the area where the targeted PHC clinics are situated, an explanation of the District Health System (also see paragraph 2.2.3) and the Umzinyathi District Municipality is essential. The Umzinyathi Health District falls under the auspices of the Umzinyathi District Municipality, devided into

four local municipalities (sub-districts in this study), Endumeni, Nquthu, Msinga and Umvoti Municipalities. The demographics of the residents were obtained from Umzinyathi District Municipality. The total population was estimated to be 495 748 in 2007, consisting of 104 535 households with an average family size of 5.5 persons per household. Out of the total estimated population (495 748), 54 440 people live in Endumeni and 164 888 in Nquthu. The average income is less than R1 200 per household and a further 10.4% of the population earn less than R800.00 per month, with an approximate unemployment rate of 46%. These statistics indicate that the majority of the residents of the Umzinyathi District Municipality fall within the low-income group, with an extremely high unemployment rate. This means that most of these residents have to utilise the free of charge PHC services (Umzinyathi District Municipality, 2010:2).

According to the same Umzinyathi District Municipality summary report for the 2010/2011 financial year, there is a service backlog in terms of telecommunication; about 60% households are without any telephone connection to their dwellings. Furthermore, more than 75% of households do not have electricity, 21% are without proper sanitation, 36% without a portable water supply and 80% without waste removal. This lack of essential basic services can expose the Umzinyathi District Municipality community to communicable diseases such as HIV/AIDS, TB, diarrhoea, measles, malaria, bilharzia, maternal and child mortality, as well as other chronic diseases. Some of these mentioned diseases fall under three explicitly health-related Millennium Development Goals (also refer to paragraph 1.1). Prevention of child mortality (MDG 4), improving maternal health (MDG 5), and the eradication of HIV, tuberculosis, malaria and other chronic diseases (MDG 6) are goals that the WHO and the UN regard as high mortality emergencies (Lawn *et al*., 2008:917).

This study focuses on the Endumeni and Nquthu sub-districts that are rendering health care services to the communities within and outside their overlapping boundaries. For the sake of clarity on the geographical boundaries, figure 3.1 contains a map of the district.

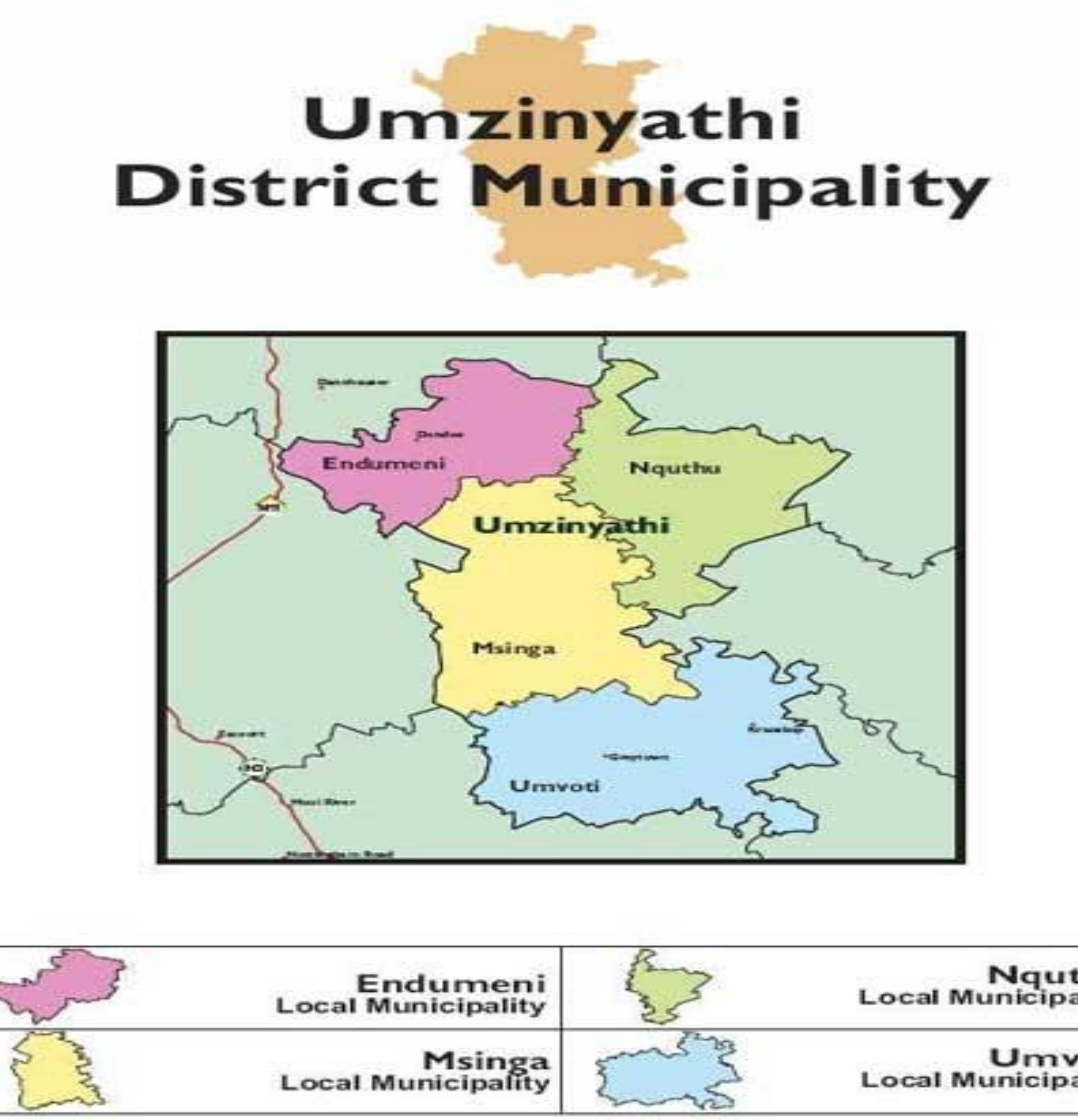

Figure 3.1: **Map of Umzinyathi District Municipality**
(Source: http://www.umzinyathi.gov.zarefrence)

The four-selected health clinics included in this study are PHC facilities situated in the two sub-districts Endumeni and Nquthu of the Umzinyathi District Health in the Kwazulu- Natal Province. The targeted clinics are referring facilities to the two district hospitals. Two of the four clinics included in the study operate from 7h30 –16h25 on weekdays. The other two clinics operate from 7h00–18h00 during the week, including weekends and holidays and operate on an on-call system.

These study sites were selected because the researcher, as a PHC manager, is more familiar with these PHC facilities specifically.

- As part of her normal duties, the researcher has to conduct support and supervisory visits at two of the four targeted facilities on a weekly and /or monthly basis.

- The researcher is involved in the Quality Assurance Quarterly Review Assessments of the other two clinics.

- These four clinics are the busiest PHC facilities in the area with a PHC headcount of above 2000 per month, per clinic. These clinics suffer under the burden of severe staff shortages (see staff categories in Table 3.2).

- A working relationship already exists between the researcher and the health care personnel working in the clinics.

3.3 POPULATION AND SAMPLING

For the purpose of this research, two populations groups were used; namely, the patients that visit the PHC clinics and the health care personnel rendering health services at these PHC clinics.

3.3.1 POPULATION

According to Burns and Grove (2009:343), a population includes all the individuals who comply with the research sampling criteria, whereas LoBiondo-Wood and Haber (2006:291) describe a population as a well-defined set that has certain specified properties. In this study, the population comprised of two groups; firstly the patients who attend the PHC clinics on a regular basis; and secondly, the health care personnel working in the PHC clinics. The population of health care personnel have been employed by the KZN-DOH or the Endumeni Municipality for more than six months, and render health services to the patients of the Endumeni and Nquthu sub-district of the Umzinyathi Health District in the KwaZulu-Natal Province.

In the subsequent paragraphs the samples, sampling method and sampling criteria are discussed.

3.3.2 SAMPLING METHOD

Sampling in this study involved the selection of a group of people from a population within which the study was conducted (Burns & Grove, 2009:343). The sampling method was applied to both the patients and the health care personnel, as illustrated in Figure 3.2 and discussed thereafter.

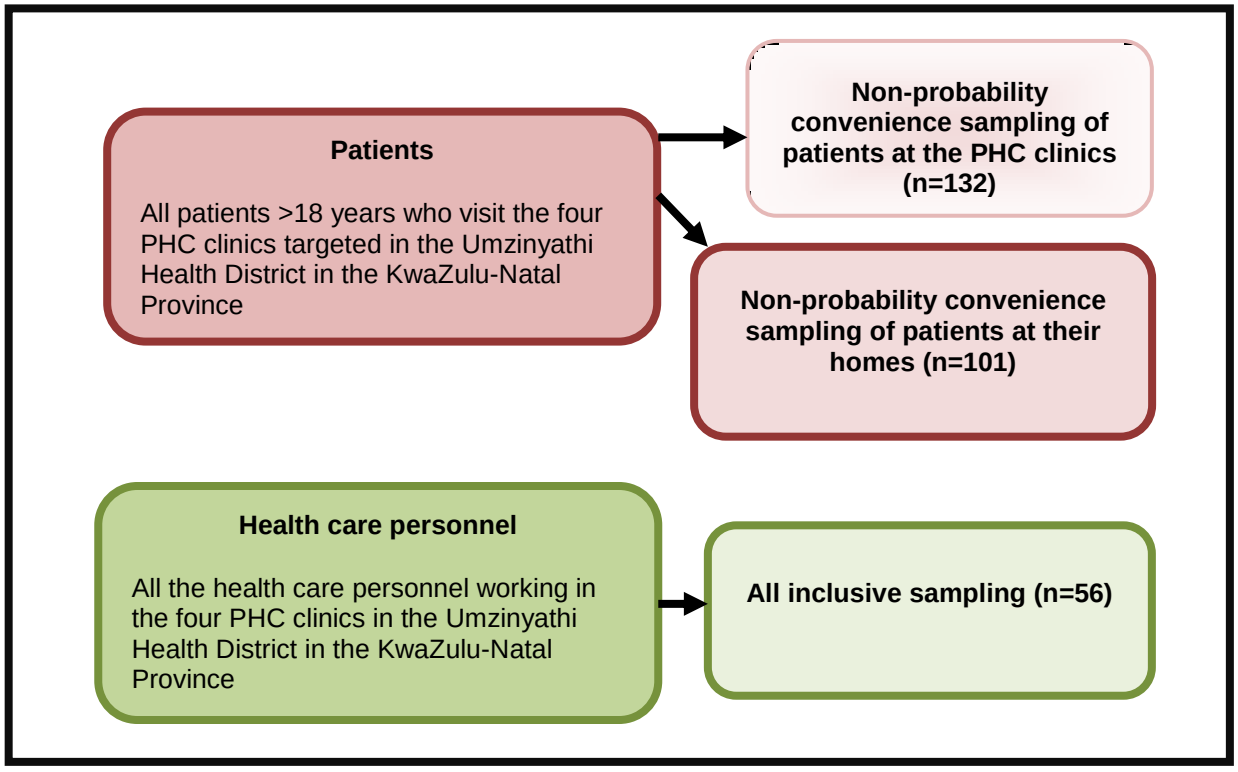

Figure 3.2: Sampling of patients and health care personnel in PHC clinics, Umzinyathi Health District

3.3.3 PATIENTS AS POPULATION

This population consisted of all patients utilising the four PHC clinics. According to Burns and Grove (2005:343), sampling criteria are those characteristics that a subject must possess to be part of the target population. The sampling criteria for the target population (patients) were:

- voluntary participation;
- willingness to be interviewed using a structured questionnaire;

- patients visiting the PHC clinics under study on a regular basis (at least more than five times a year);
- able to communicate in English or Zulu;
- the participant should be older than 18 years.

3.3.3.1 Sampling method

A non-probability, convenience sampling method was used to select patients. Non-probability sampling means that not all persons who form part of the population had an equal opportunity to be included in the sample (Burns & Grove, 2009:353; Brink *et al*, 2006:132). Because of the sampling technique used, the findings and conclusions of this study regarding compliance with Batho Pele principles, cannot be generalised. A convenience sampling method was used because it refers to the inclusion of participants (patients) that happen to be in the right place (one of the four PHC clinics) at the right time. This sampling method was also selected because of the accessibility of the clinics and in an attempt to save money and time (Burns & Grove, 2009:354).

All patients who attended the clinic on a chosen day, who had the time to answer the questionnaire, and who were willing to participate and did not leave while the researcher was busy interviewing someone else, were included in the study (Bruce *et al.*, 2008:139). A sample of one hundred-and-thirty two (n=132) patients completed the questionnaire.

However, during the completion of the structured questionnaires the researcher observed that the patients seemed reluctant and possibly felt threatened when interviewed at the clinics. Thus, the researcher concluded that the patients were either withholding information or they were not honest due to fear of intimidation.

At this stage in the study, there was a clear need to select a further sample from the population, bearing in mind the possible problem of intimidation or reluctance to be honest, and still based on the purpose of the study (Babbie, 2007:18). Therefore,

after consulting the Statistical Consultation Services of the NWU, Potchefstroom Campus, the researcher was advised to collect another data set from the patient-participants that adhere to the same sampling criteria (see paragraph 3.3.3). This time, however, the interview took place **in their homes,** within the same catchment area, and focused on the same issue; their experiences of compliance with the Batho Pele principles by the health care personnel working at the PHC clinics they visit.

A non-probability, convenience sampling method was used to collect data from patients available and willing to allow the researcher to conduct a home visit and complete the structured questionnaire. This led to a second sample of one hundred and one (n=101) patient-participants interviewed during home visits (see Chapter 4.2.1 on the systematic selection process followed).

Hence, during data analysis, the results (discussed in detail in Chapter 4) of the two different patient samples (see Figure 3.1) were compared to determine whether there was a significant difference between the means (average of all the data values) and the standard deviation (spread of data around the average) (Burns & Grove, 2005: 502; Pietersen & Maree, 2007:187-188). See Table 3.1 for an overview of the included patients' demographic distribution.

Table 3.2 Patients' demographic distribution according to clinics and municipalities

Clinic	**Municipality**	**Participants at clinics**	**Home visits**
Clinic A	Endumeni	25	25
Clinic B	Endumeni	25	24
Clinic C	Nquthu	41	25
Clinic D	Nquthu	41	27
N	**4**	**132**	**101**

3.3.3.2 Sample size

Large sample sizes are difficult to obtain in nursing studies; it would require long data-collection periods and are costly. However, because this is a descriptive study that was not intended to be generalised, a smaller sample was acceptable (Burns & Grove, 2009:357-359). The sample size was influenced by the availability of patients visiting the four PHC clinics, time for data collection, and the research instrument that was used. The researcher interviewed one hundred and thirty-two (n=132) patients at the clinics, who's completed questionnaires could be used. Some patients were interested in participating and signed informed consent, though they did not really want to participate and their questionnaires were incomplete and therefore could not be used. One hundred and one (n=101) participants were interviewed during home visits (see chapter 4, paragraph 4.2.2).

3.3.4 HEALTH CARE PERSONNEL AS POPULATION

Included in the population were all health care personnel who render PHC services on a continuous basis to meet the needs of the community in the Endumeni and Nquthu sub-districts of the Umzinyathi Health District in the KwaZulu-Natal Province. The following sampling criteria were used to select health care personnel:

- Available participants should have worked in a PHC clinic for at least six months;
- Should be able to communicate in English or Zulu;
- Should be willing to participate and be interviewed by the researcher using a structured questionnaire.

3.3.4.1 Sampling method

An all-inclusive sampling approach (Burns & Grove, 2005: 343) was used to select the participants, because all the health care personnel working at the four PHC clinics, fifty-six (n=56), were included. Participants have knowledge of the phenomenon (in this study the Batho Pele principles) being studied (Brink *et al.*,

2006:134). The PHC clinics included in the study were visited on a day randomly selected (Minnie, 2010:147) and the health care personnel, who volunteered to participate and complied with the sampling criteria, were interviewed.

3.3.4.2 Sampling size

The sample size was determined by the availability of the participants (Burns & Grove, 2005:355). All the PHC personnel available (n=56) were included and voluntarily participated in the study. The health care personnel included in this study were not all professional nurses, but also included other categories of support personnel (see Table 3.3) who work in the selected PHC clinics.

Table 3.3: The categories of participants per clinic

Category	Clinic (A)	Clinic (B)	Clinic (C)	Clinic (D)
Professional nurse	3	5	6	4
Enrolled nurse	1	1	4	5
Enrolled nurse assistant	0	0	0	0
Clinic supporter	1	1	1	1
HIV/AIDS counsellor	1	5	2	4
General Assistant	2	2	3	4
n = 56	**n=8**	**n=14**	**n=16**	**n=18**

3.4 DATA COLLECTION

Data collection is the process of gathering data from the participants (Burns & Grove, 2005:430) in order to achieve the purpose of the study. The study employed a structured data collection approach (Legodi, 2008:62) by distributing two similar questionnaires to the sample groups of patients and health care personnel with the aim of collecting systematic and unbiased data on the experiences and views of the participants. A questionnaire was selected as the data-collecting instrument for this descriptive study so that wide-ranging information on compliance with the Batho Pele principles in four PHC clinics could be gathered. The items in the questionnaire were

formulated in the most understandable possible way to be answered on a 4-point Likert-based rating scale (see Appendices G and H).

3.4.1 PILOT STUDY

According to Burns and Grove (2005:42), a pilot study is defined as a minor study that is based on a proposed study to improve or refine the research method before a major study is initiated. Burns and Grove (2005:219) state that the elements of a good research design include suitability with the purpose of the study, feasibility, and reducing threats to validity. In this research, a pilot study was conducted in a familiar PHC context without any disturbances at the time of the interview sessions. The researcher adhered to the principle of similarity and chose participants with the same sample inclusion criteria and within the same context as the main study. The same data collection and data analysis methods were also used.

The questionnaire was pre-tested in two clinics, both located in rural areas, one in each sub-district. A total of five patient questionnaires and three health care personnel questionnaires were completed. Based on the findings of the pilot study, questions that were not interpreted correctly were changed to avoid ambiguity and improve appropriateness.

3.4.2 DATA COLLECTION PROCESS

The researcher and an identified research assistant distributed the research instruments (questionnaires) to both participant groups. Before handing out the questionnaires, the researcher trained the research assistant on the different questions so that she could explain the questions to the participants, where needed, thus ensuring that the questionnaires were completed correctly. The main categories outlined in the questionnaire addressed the level of compliance with the Batho Pele principles in a PHC context. It was a 32 question, 4-point -based rating scale instrument, which had been tested for internal reliability at the NWU, Potchefstroom Campus, Statistical Consultation Services (see paragraph 3.6.1). The questionnaire

used for the health care personnel was slightly adapted for appropriateness, but also consisted of 32 questions (see appendix G).

After informed consent was signed (see appendix B), the researcher asked for permission to interview the participant. After consultation and during exit at the clinic the patients completed the questionnaire with the help of the researcher and the research assistant.

As mentioned earlier (see paragraph 3.3.3.1), the patient-participants were reluctant to answer some of the questions in a clear and honest manner when the interview was conducted at the clinic. According to Burns and Grove (2005:738), the Hawthorn effect is a psychological response and causes participants to alter their behaviour, simply because they are being observed. The researcher realised this and thought this was due to the patients' fear that the health care personnel may observe their participation in the study and victimise them afterwards. It was clear that the patient-participants were not at ease when interviewed at the clinics and that this could possibly influence their responses to the different questions.

The interviews lasted 15-20 minutes each, depending on the willingness of the participant. One hundred-and-thirty two (n=132) questionnaires were completed by patients at the four clinics, and one hundred-and-one (n=101) questionnaires were completed by patients at their homes. Fifty-six (n=56) questionnaires were completed by the health care personnel included in the study.

3.4.3 DATA COLLECTION INSTRUMENT

A structured interview schedule (questionnaire), descriptive in nature, was designed to address aspects regarding compliance with the Batho Pele principles in a PHC context. The questionnaire was adapted from the studies conducted by Legodi (2008:99) and Mbanga (2006:102), and partly from the surveys conducted by the Dundee Hospital on quality assurance and patient satisfaction (2009). These studies were used as a guideline to design a data collection tool (see Appendices G and H).

The Statistical Consultation Services of the NWU, Potchefstroom Campus, assisted in determining whether the questionnaire could be applied to this study. Small adaptations to the initial questionnaire were suggested, which were noted and implemented by the researcher. According to Brink (2006:149), closed-ended questions limit the answers to the options provided. However, based on an in-depth literature review on the Batho Pele principles, as well as previous studies conducted by Legodi (2008) and Mbanga (2006), simple, short and to the point formulated questions were deemed more appropriate for this study.

A questionnaire should be a natural and ready-to-use instrument to gather information (Maree & Pietersen, 2007:9). Questions in a questionnaire are called items and the items are supposed to measure a certain construct (Rabie, 2009:92). In this study, the construct measured was the eight Batho Pele principles with four items under each principle. Questions concerning client satisfaction and quality care were also included. The participants were asked to score their feelings, attitudes, thoughts, experiences, some facts, and views about the phenomenon (Batho Pele principles) being studied.

The researcher was aware that most participants would only be able to express themselves freely if the interviews were conducted in their mother tongue. Also in the light of the language and cultural rights conferred by Article 6, 30 and 31 of the Constitution (1996), questions were orally translated to Zulu during the structured interview, to ensure that the data obtained was valid and reliable. This oral translation process was effortless to the researcher and the research assistant because they are also fluent Zulu speakers. Any areas of disagreement regarding the possible translation of the questions were resolved before the onset of the structured interviews, by means of discussions between the researcher and research assistant.

As already stated, a 4-point Likert-based rating scale questionnaire was used to examine the experiences and views of the participants. Each item in the questionnaire linked to the main category or topic (the eight Batho Pele principles) and were scored using four possible responses: ‘strongly agree’, ‘agree’, ‘disagree’

and ‘strongly disagree’. Demographic questions were asked concerning gender and age in case of the patient-participants. Gender, age, highest education level, designation, and years of service (experience) were included in the questionnaires in case of the health care personnel.

One hundred and thirty-two (n=132) patients who visited the four different PHC clinics, one hundred and one (n=101) patients in their homes, and fifty-six (n=56) health care personnel participants completed the questionnaires. Although the data collection process was time consuming and costly, the researcher preferred to be involved personally and in doing so ensured that language barriers and any uncertainties were attended to.

3.5 DATA ANALYSIS

Data analysis is the process when all the raw data, collected with the data collection tools, are organised, managed and reduced. There should be a plan to summarise, categorise and order the data so that it can be understood and provide answers to the research questions under investigation (Van der Walt & Van Rensburg, 2006:170).

Statistical analysis of the data was done with the assistance of the Statistical Consultation Services of the NWU, Potchefstroom Campus. Descriptive statistical strategies were employed and comparative means as well as standard deviations were determined. Statistical Analysis System (SAS Institute Inc. 2007), a comprehensive mainframe software package that uses linearization methods to estimate variances of nonlinear statistics (Lohr, 2009:393; Burns & Grove, 2005:455), was used to compute and interpret the data. This allowed for easier data entry and analysis for hierarchical regression. A backup system was made each time more data was entered to reduce errors.

As recognised in paragraph 3.3.3.2, the sample size influences the reliability of the study, i.e., the way in which the study can detect differences or relationships between the population and the sample selected for the study (Burns & Grove, 2009:361). The researcher strived towards precision in measurement to enhance the reliability of the

study. Reliability is the consistency and dependability demonstrated by a research instrument when it is used to measure the variable or attribute that it was designed to measure (Brink, 2002:213-214). Internal reliability, also known as internal consistency, was also determined in this study. A questionnaire was used as measuring instrument and a pilot study was conducted before the data collection process commenced.

A descriptive data analysis approach employs a measure of central tendency; namely, mean and measures of dispersion, i.e., the standard deviation, which is the most widely used measure of variability and of relationship (Burns & Grove, 2005:462-463; Brink *et al.*, 2006:178). The t-test was used to demonstrate that the difference between the two means of the two patient-participant populations (the patients interviewed at the PHC clinics and the patients interviewed at home in the same catchment area) were significant (Burns & Grove, 2005:502; Ellis & Steyn, 2003:51; Brink *et al.*, 2006:182). The level of statistical significance was defined at a probability value of $p=<0.05$, signifying a significant difference, and $p=<0.01$, signifying a highly significant difference.

For the purposes of the study, effect sizes were calculated to determine the practical significance of the findings and the results focused on the p-values calculated. Even if a study does not have statistically significant results, the results can still be applied to clinical practise and may be considered to be of practical importance (Ellis & Steyn, 2003:52, Burns & Grove, 2005:355; Pietersen & Maree, 2007:211).

Descriptive statistical methods were employed to describe and summarise the collected data (Brink *et al.*, 2006:171). It allowed the researcher to organise data obtained from the completed questionnaires in ways that give meaning and facilitate insight into, and examine, a phenomenon (compliance with the Batho Pele principles) from a variety of angles (Burns & Grove, 2005:461). The data was grouped and interpreted mainly by means of frequency percentage distribution (Burns & Grove, 2009:470).

Data was printed and checked for accuracy. The completeness of the data collection instrument (questionnaire) was also examined, as in some cases subjects may be excluded from data analysis because of missing essential data (Burns & Grove, 2005:453). For the sake of clarity, the data was summarised and visually presented in table and/or graphic format (Van der Walt & Van Rensburg, 2006:171). The researcher aimed at providing a clear, complete picture through a summarised description of the data collected from the two samples; data obtained from the patients and, secondly, the health care personnel.

3.6 RELIABILITY AND VALIDITY OF THE RESEARCH PROCESS

3.6.1 RELIABILITY

Burns & Grove (2005:374) believe that reliability is an indication of the extent of random error in the measurement method. Reliability tells you how repeatable your measures are on a retest. Because this study was conducted in a specific context, it should be noted that the results are only applicable to the Umzinyathi Health District. Errors might occur when collecting data, therefore, reliability should be ensured with the aim to achieve more accurate results (Burns & Grove 2009:377). Reliability was maintained by ensuring consistency in data collection by closely adhering to the data collection tool. Internal consistency was estimated through Chronbach's alpha coefficient (Burns & Grove, 2005:376; Brink *et al.*, 2006:164; Pietersen & Maree, 2007:216) that assesses items to determine their congruency (see paragraph 4.2.1). Stability was ensured through the pilot study by administering the same questionnaire to another sample of patients and health care personnel (see paragraph 3.4.1) to determine if similar scores were obtained.

As stated by Burns and Grove (2009:307), reliability can be influenced by motivational (health seeking behaviour), social (language) and environmental factors (the clinic or the home). Realising that conducting patient interviews in the PHC clinics might influence the reliability of the data collected, the researcher acted judiciously after consulting with the Statistical Consultation Services of the NWU, Potchefstroom Campus, and collected a second set of data from the patients in another social

environment, i.e., their own home (see chapter 3, paragraph 3.4.2 and 3.3.3.1). No language barriers could influence the reliability of the study because the researcher as well as the research assistant speaks Zulu fluently, the language of the participants (see chapter 3, paragraph 3.4.2).

3.6.2 VALIDITY

Validity refers to the degree to which the measuring instrument measures what is supposed to measure (Rossouw, 2005:123; Lobiondo-Wood & Haber, 2006:368; Creswell, 2003:152). To ensure validity, the researcher took care to be as objective and honest as possible throughout the study, and to avoid any bias in order to exclude systematic errors in sampling or measurements that could lead to an incorrect conclusion (Bruce *et al*., 2008:134). Following this approach also ensured that personal preferences would not influence the interpretation of the findings. A well-designed and structured questionnaire was used, making it less prone to different interpretations and changes. A pilot study was conducted to improve or refine the research questionnaire before the actual study was initiated (see chapter 3, paragraph 3.4.1). The research assistant was briefed beforehand about the purpose and the contents of the questionnaire and how to administer it.

Data was recorded fully, maintaining principles of neutrality and ensuring competence of both the researcher and the research assistant in data collecting techniques by thoroughly orientating the research assistant on the data collecting process (Rossouw, 2005:178-179). The findings are a true reflection of the level of compliance with the Batho Pele principles.

3.6.2.1 Face and Content Validity

Face and content validity was ensured by determining the appropriateness of the questionnaire and whether the questions correspond with the study objectives (Polit *et al.,* 2001:309). This was done with the help of a professional statistician in order to ensure that the instrument covered all the aspects to be examined about the relationship between the Batho Pele principles, quality health care, and patient

satisfaction. Questions that were likely to be interpreted incorrectly were changed or left out to avoid ambiguity and the remaining questions were relevant, reasonable and clear.

3.6.2.2 External Validity

According to Rossouw (2005:182) and Burns & Grove (2005:218), external validity is concerned with the extent to which study findings can be generalised beyond the sample used in the study and applied to the target population. In this study, the findings were specific to the chosen sub-districts of the Umzinyathi Health District in the KZN Province and cannot be generalised (see chapter 1, paragraph 1.9).

Making use of non-probability, convenience sampling has implications for external validity, namely, biased. However, in this study, a relatively large sample of (n=132) was obtained and the sampling criteria was later re-defined to improve the representativeness of the sample (Burns & Grove, 2005:350). This was done to accommodate the additional one hundred and one (n=101) patient-participants interviewed at home, and the fifty-six (n=56) health care personnel as participants. Thus, a fairly big sample was obtained in order to overcome this obstacle.

3.7 ETHICAL CONSIDERATIONS

Mouton (2006:238) states that for a researcher to conduct scientific research, certain generally accepted norms and values should be adhered to. The ethical principles, as identified by Burns & Grove (2005:181-230) and Creswell (2003:11-12), guided the researcher to carefully consider and refrain from ethical dilemmas that might occur during the study. These ethical principles were applied in order to ensure the safety of the participants and to prevent any violation of human rights.

The ethical considerations that were addressed during the study are summarised below:

Permission to conduct a study

Ethical approval: **NWU-0071-08-A1** from the Research Committee of NWU, Potchefstroom Campus was granted before the study commenced (see appendix C). Further permission and support to access the facilities and conduct the study were obtained from Umzinyathi Health District (PHC Cadre) before data collection commenced (see appendix D). Written approval to undertake a research project was also given by the KZN Department of Health Research Unit (see appendix E). Participation in the study was gained through informed consent and on a voluntary basis (see appendix B). Permission to conduct the research was also obtained from the participants after the purpose and importance of the research were explained (see appendices F and G).

Informed consent (written consent)

The research activities were introduced and explained to the participants. Participants were given the freedom to withdraw from the study, or not to participate at all, if they were not willing to do so, without being coerced. Informed consent was obtained from each participant after a full and thorough explanation of the aim and the potential benefits of the study.

	A copy of the signed informed consent was also included in each participant's file.
Anonymity and Confidentiality	The researcher treated all information as confidential and numbers were used to identify the questionnaires. The participants' names do not appear anywhere in the research findings. Questionnaires were kept in a safe place under lock and key.
Protection from Harm and Discomfort	There were no risks or discomfort involved because all the questionnaires were completed in a setting safe and familiar to the participants, they were completed in a private room in the PHC clinic or in the privacy of the participant's home where there were no distractions. With the permission of the participants, the interviews was completed that lasted fifteen to twenty (15-20) minutes. Participants' needs were respected and they were treated with sensitivity, especially when entering their homes care was taken not to trespass on their privacy.

3.8 CHAPTER SUMMARY

In this chapter, each step of the research process was explained, from the grand plan or blueprint, to the smaller details of how each step was implemented. The researcher focused on the data collection method, population, sampling, as well as data analysis. A detailed discussion of the non-experimental, quantitative, typical descriptive as well as contextual study design was provided. This study design was selected in order to meet the objectives of this study to describe compliance with the Batho Pele

principles in a PHC context, as experienced by patients and viewed by health care personnel. The entire research process was well planed, the rights of the participants were protected throughout, and nothing relevant to the study was omitted.

In the following chapter, the results will be presented and discussed, as well as the conclusions drawn from the results.

CHAPTER 4: RESEARCH RESULTS

4.1 INTRODUCTION

The purpose of this chapter is to present the reader with a detailed description of the findings and the interpretation thereof. The results will be discussed and the chapter will end with a conclusion statement that will highlight the purpose of the study, namely to make recommendations to enhance compliance with the Batho Pele principles in a PHC context (see table 4.1 regarding the objectives of the study).

Table 4.1: Objectives of the study

Objective 1	Objective 2
To describe the level of compliance with the Batho Pele principles as experienced by patients in a PHC context	To describe the level of compliance with the Batho Pele principles as viewed by the health care personnel in a PHC context.

As stated in chapter 1, the theoretical perspective of the research was based on the philosophical framework of the Batho Pele principles (1997) as well as the Patient's Rights Charter (1999). This framework and its application to the study was discussed in detail in chapter 2.

The Department of Health's policy aims to improve the quality of health care. This process involves measuring the gaps and finding ways to close the gaps between the implementation of and compliance with the Batho Pele principles in the health care system (SA, 2007:2). This study supports this purpose and attempted to identify such gaps and make recommendations that will strengthen current compliance with the Batho Pele principles in a PHC context in the Umzinyathi Health District, KwaZulu-Natal Province. A non-experimental quantitative descriptive contextual research design was employed in order to reach the set objectives (see table 4.1). The literature review and the results from the empirical world (the patients and the health care personnel in a PHC context) formed the basis for the recommendations of the study. The data collection results will be presented in the following section, feedback on the process followed will also be

given (see figure 4.1) and the most outstanding and important actions that contributed to the precision of the study, will be highlighted.

4.2 REALISATION OF DATA COLLECTION

A quantitative and descriptive study design was followed and implemented according to a non-experimental decision path (LoBiondo-Wood & Haber, 2006:240). Subsequently, the questionnaire used as data collection tool, the data collection and preliminary data-analysis of the patient-participants' data, and the data collection from health care personnel, will be introduced.

4.2.1 QUESTIONNAIRE AS DATA COLLECTION INSTRUMENT

A structured interview schedule (questionnaire), descriptive in nature, was designed to measure compliance with the Batho Pele principles in a PHC context from the perspective of patients as well as health care personnel (see paragraph 3.4.3 and appendices G and H).

The Statistical Consultation Services of the NWU, Potchefstroom Campus, assisted in determining whether the questionnaire could be applied to this study. The statistician agreed that on face value the questionnaire could be used if small adaptations were made. The questionnaire consisted of thirty two questions that covered all eight Batho Pele principles as the main constructs, with four items under each principle. The internal consistency of the questionnaire was estimated by determining Chronbach's Alpha coefficient, based on the inter-item correlations (Burns & Grove, 2009:379). Chronbach's Alpha coefficient measures the inter-item correlation; if the items strongly correlate with each other and their internal consistency is high, the Alpha coefficient will be close to one. On the other hand, if questions are poorly formulated and do not correlate strongly, the Alpha coefficient will be close to zero.

Pietersen and Maree (2007:216) indicate that if the reliability estimates are 0.80 and above, the questionnaire is regarded as acceptable, but if the reliability estimates are below 0.60, reliability is unacceptable. However, Field (2005:668) states that in social sciences values below 0.70 and even lower are acceptable when measuring constructs, due to variability.

Of all the items measured in terms of the Batho Pele principles questionnaire, four of the principles showed an acceptable reliability with values of 0.60; 0.61; 0.62 and 0.66 (see table 4.2). The total count on similarity, was however, too low and a combination of the items could not be used to measure one common construct (each of the eight Batho Pele principles). For this reason, all thirty-two items (questions) were dealt with separately during data-analysis.

Table 4.2: Summary of internal consistency regarding Batho Pele principles questionnaire

CONSTRUCTS OF BATHO PELE PRINCIPLES	CRONBACH'S ALPHA
1. Compliance with Consultation	0.60
2. Compliance with Service Standards	0.34
3. Compliance with Access	0.17
4. Compliance with Courtesy	0.45
5. Compliance with Information	0.61
6. Compliance with Redress	0.45
7.Compliance with Openness and Transparency	0.62
8. Compliance with Value for Money	0.66

Although the values for internal reliability estimate that some of the questions do not correlate strongly, the questionnaire, in the context of social sciences, was found to have an acceptable level of reliability for the purpose of this study. Therefore, the data collection process continued with the patients as well as the health care personnel respectively. Although the Alpha coefficients of the other four Batho Pele principles were lower, in the light of Field's view and because the study falls within the ambit of the social sciences, the questionnaire was deemed an effective data collection instrument for this study.

4.2.2 DATA COLLECTION INVOLVING PATIENTS

During data collection, the selection of patients took place as an important part of the process, as illustrated by the systematic selection process below (figure 4.1), adapted from Minnie (2010:40 & 147).

Selection of the sub-districts in the Umzinyathi Health District in the KwaZulu-Natal Province

Two of the four sub-districts were randomly selected: Endumeni and Nquthu

Selection of the clinics in the sub-districts

Four clinics with adequate space convenient for interviewing the patients were selected randomly, using the operational manager as mediator

Selection of days on which data was collected

Days were randomly selected from Monday to Friday for each clinic to collect data from the patients over a period of four weeks

Selection of the patients as participant

(The reader should refer to paragraph 3.3.3.1 and figure 3.1 for clarity on the two patient populations)

Convenience sampling was employed; while the patients were waiting for their consultation, the researcher explained the study and invited them to participate. Exit interviews were conducted using a questionnaire as the data collection instrument.	Patients from the catchment area, and who attended the clinics regularly, were invited to volunteer as participants to complete the questionnaire at their homes.

Figure 4.1: Systematic selection process of patient-participants

Consideration was given to the fact that patients demonstrated participant bias when answering the questionnaire at the clinics (see paragraph 3.3.3.1); therefore, preliminary data-analysis was required at this stage of the study as part of the non-experimental decision path.

4.2.3 PRELIMINARY DATA ANALYSIS OF PATIENT-PARTICIPANTS

All patients older than18 years, who attend the PHC clinics at least three times per year (KZN-DOH and Endumeni Municipality), were included in the study (see

paragraph 3.3). A total sample of one hundred and thirty-two (n=132) patients from the four PHC clinics voluntary agreed to participate and completed the questionnaire at the four PHC clinics. (Please refer to chapter 3 (table 3.1) for the demographic distribution of patients according to clinics and municipalities.)

Participant bias was detected among the patients (n=132) interviewed at the PHC clinics. This compelled the researcher to consult with the Statistical Consultation Services at the NWU, Potchefstroom Campus, after which a decision was made to regard the current sample of patients as a sub-population (Ellis & Steyn, 2003). The degree to which the phenomenon is present in the population was examined, namely the effect size (Burns & Grove, 2009:698). A new sample of one hundred and one (n=101) patient-participants were identified within the catchment area of the selected PHC clinics, and the same questionnaire was completed in another setting; **in the patient-participants' homes**.

The data from both samples were analysed by both the researcher and a statistician from the Statistical Consultation Services, NWU, Potchefstroom Campus, after the completed questionnaires were captured and computed. The measures of central tendency, mean and standard deviation, were used to describe the differences in the data (Burns & Grove, 2005:463-465) from the two samples of patients, i.e., two independent samples taken from patients that visited the clinics and patients interviewed at home. The two sets of data, illustrated hereafter (see table 4.3), were not taken from the same sample and, therefore, the two scores are not related.

The t-test is used when comparing two independent samples; it is particularly useful in studies where it is difficult to obtain large samples. It is performed to determine the significant difference between statistical measures (Burns & Grove, 2009:502) of two samples. The level of significance for this study was defined at a probability value of p=<0.05; signifying a significant difference, and p=<0.01; signifying a highly significant difference. In addition to the statistical significance, effect sizes were calculated to determine the practical significance of the results. The best method to comment on the practical significance of this study was to use the difference between the two means of the two sets of data, divided by the estimate for standard deviation: which is the effect size.

Table 4.3: Preliminary statistical analysis of data collected from patients at the clinics and at home

CRITERIA	CLINIC		HOME			
1. COMPLIANCE WITH CONSULTATION	**Mean**	**SD**	**Mean**	**SD**	***t*-test p-value**	**ES**
1.1 Awareness of clinic services	2.06	0.24	2.59	0.56	0.0000	1.45
1.2 Manager decides on services	2.18	0.41	2.05	0.39	0.0204	1.26
1.3 Services provided at hours requested	2.43	0.49	2.56	0.49	0.0580	0.80
1.4 Informed by the clinic staff about the services provided	2.33	0.49	2.35	0.47	0.8267	0.80
2. COMPLIANCE WITH SERVICE STANDARDS						
2.1 Services are good	2.00	0.00	2.01	0.14	0.1066	0.35
2.2 Services according to expectations	2.28	0.45	2.80	0.44	0.0000	1.51
2.3 Extent services meet your needs	2.00	0.08	2.43	0.57	0.0000	0.34
2.4 Would you come back?	2.00	0.00	2.01	0.14	0.1053	0.67
3. COMPLIANCE WITH ACCESS						
3.1 Takes more than one hour	2.81	0.38	2.73	0.44	0.1187	1.89
3.2 Do visit other clinics	2.59	0.49	2.47	0.50	0.0616	1.30
3.3 Patients have equal access	2.21	0.41	2.85	0.35	0.0000	0.34
3.4 Satisfied with services provided	2.01	0.12	2.32	0.47	0.0000	-1.38
4. COMPLIANCE WITH COURTESY						
4.1 Patients treated with respect	2.03	0.17	2.00	0.00	0.0782	-1.68
4.2 Patients treated with dignity	2.05	0.22	2.00	0.00	0.0187	0.13
4.3 Satisfied with help received	2.05	0.22	2.56	0.49	0.0000	1.16
4.4 Recommend service to a friend?	2.00	0.00	2.11	0.32	0.0000	0.30
5. COMPLIANCE WITH INFORMATION						
5.1 Up-to-date information provided	2.01	0.12	2.25	0.43	0,0000	0.70
5.2 Available in one official language	2.00	0.00	2.04	0.21	0.0099	0.22
5.3 You know who to call in cases of emergency	2.78	0.41	3.01	0.14	0.0000	3.70
5.4 Community given information about services.	2.02	0.15	2.30	0.48	0.0000	-2.89
6. COMPLIANCE WITH OPENNESS AND TRANSPARENCY						
6.1 Know person-in-charge of the clinic.	2.17	0.38	2.42	0.49	0.0000	0.38
6.2 Free to ask about money spent on medicines	2.92	0.36	3.25	0.46	0.0000	2.66
6.3 Know the number of staff at this clinic	2.85	0.35	3.08	0.31	0.0000	0.72
6.4 Clinic staff wears name badges	1.81	0.85	2.56	0.62	0.0000	-1.81
7. COMPLIANCE WITH REDRESS						
7.1 Experience problems during your visit?	2.56	0.51	2.38	0.48	0.0066	1.87
7.2 Allowed to complain if not satisfied with services?	1.03	0.19	2.02	0.22	0.0000	0.34
7.3 To what extent do you receive feedback?	2.65	0.50	2.79	0.40	0.0457	-0.46
7.4 Has your complaint been dealt with satisfactory?	2.73	0.47	2.83	0.40	0.1390	-0.93
8. COMPLIANCE WITH VALUE FOR MONEY						
8.1 Have you been informed about the clinic budget?	3.00	0.18	3.52	0.50	0.0000	0.96
8.2This clinic saves costs	3.00	0.00	3.29	0.48	0.3911	0.76
8.3 Did the nurse explain your condition?	2.40	0.57	2.81	0.39	0.0000	2.26
8.4 Service helped you to deal with your problems?	1.99	0.15	2.04	0.32	0.0780	1.14

All *p*-values are <0.05 unless otherwise noted;
ES= effect size; SD= standard deviation

According to Burns and Grove (2005:580) and Ellis and Steyn (2003), results do not necessarily have to be statistically significant to have any importance to clinical practice, the practical significance of the results is important in nursing practice. The larger the effect sizes, the higher the practical significance. Guidelines by Cohen (1988) in Ellis and Steyn (2003), and Pietersen and Maree (2007:211) were followed (see chapter 3, paragraph 3.5). The effect size of eighteen of the questions asked of patient-participants were practically significant (>0.8), when looking at the mean differences. The mentioned eighteen questions included aspects of all eight Batho Pele principles (see table 4.3).

The low p-values on the t-tests, when comparing the results from the two independent samples (see table 4.3), indicate that patients who completed the questionnaire at home were statistically significantly more dissatisfied regarding most items than those who completed the questionnaire at the PHC clinics. These results confirmed the decision of the researcher, in consultation with an expert statistician, to exclude the set of data of the patient-participants who completed the questionnaire at PHC clinics and only consider data of patient-participants who completed the questionnaire in their homes.

Conclusion statements on the preliminary data-analysis

- The patients who completed the questionnaire at home had more freedom to express their experiences regarding compliance with the Batho Pele principles in a PHC context.
- The statistically significant difference between the results of the patients who completed the questionnaire at PHC clinics and those who completed the questionnaire at home is of importance to the body of knowledge that apply to community nursing. When investigating compliance with the Batho Pele principles, as experienced by the patients in a PHC context, the data collection and interviews should take place in a setting where participants will have no fear of discrimination or retaliation.

In the discussion that follows, the results obtained from the one hundred and one (n=101) patient-participants interviewed at home will be reported. Before the

discussion on the results continues, the realisation of data collection with regard to the health care personnel will be explained.

4.2.4 DATA COLLECTION INVOLVING THE HEALTH CARE PERSONNEL

The data collection involving the health care personnel working in the PHC clinics under study adhered to an all-inclusive sampling method. The process is also illustrated (see figure 4.2) in the systematic selection process adapted from Minnie (2010:40 & 147).

Selection of the sub-districts in the Umzinyathi Health District in the KwaZulu-Natal Province

Two of the four sub-districts were randomly selected: Endumeni and Nquthu

Selection of the clinics in the sub-districts

Four clinics with adequate space convenient for interviewing the health care personnel were randomly selected, using the operational manager as mediator

Selection of days on which data was collected

Days were randomly selected from Monday to Friday for each clinic to collect data from the health care personnel over a period of four weeks

Selection of the health care personnel as participants

The selection of health care personnel was based on an all-inclusive principle (n=56). The health care personnel completed the questionnaire on their own after the researcher explained the study and invited them to participate. The researcher and the research assistant were available to help if a question was not clearly understood.

Figure 4.2: Systematic process to explain the selection of health care personnel

Please refer back to paragraph 4.2.1 for a discussion on the questionnaire used as the data collection tool. The questions contained in the questionnaire used for the health care personnel were slightly adapted (see appendix G).

After the researcher explained the purpose of the research to the health care personnel, they positively identified with the research and were all, therefore,

willing to participate. They agreed that the study would improve commitment to service delivery, quality of care, accessibility, acceptability, and utilisation of PHC services. Thus, the recommendations based on the results of this study will also enable PHC personnel to deal with challenges that hinder service delivery (see chapter 2, paragraph 2.9).

4.3 RESULTS

The results obtained from data collected from patient-participants at their homes, and the health care personnel respectively, will be discussed hereafter. The data was analysed with the help of the Statistical Consultation Services of the NWU, Potchefstroom Campus, by making use of frequencies, percentages, means (average score), standard deviations (average difference/deviation of a score from the mean of the sample of the patients [n=101] and health care personnel [n=56]), and is presented in frequency tables and figures.

Although expert statistical consultants assisted in compiling the data collection instrument (questionnaire) and with the data analysis process, the researcher remained the content expert and final authority in interpreting the meaning of the analyses in terms of the discipline's (nursing) body of knowledge (Burns & Grove, 2005:456). Therefore, the researcher remains responsible and accountable for interpreting the statistical procedures when the results of the study are communicated.

In order to achieve the overall purpose and objectives one and two of the study, the researcher utilised a structured questionnaire to gather wide-ranging information from patients and health care personnel regarding compliance with the Batho Pele principles in the four PHC clinics targeted. The items in the questionnaire were formulated as statements that were answered on a 4-point Likert-based rating scale (see appendices G and H).

4.3.1 PATIENT-PARTICIPANTS

Contextually, it is pivotal to give an overview of the demographic profile of the patients and health care personnel involved in the study so that the extent of compliance with the Batho Pele principles can be viewed in context.

4.3.1.1 Demographic data of patient-participants

Demographic data, according to age and gender distribution, was collected from patient-participants. As indicated in table 4.4 below, the age of patients were recorded within certain parameters, and the percentage belonging to each category was calculated.

Table 4.4 Participants' age in years (n =101)

Age in years	n	Percentage (%)
>18-20	4	4
21- 30	17	16.8
31- 40	25	24.8
41- 50	21	20.8
51- 60	17	16.8
61- 70	12	11.8
71- 80	5	5
Total	101	100%

The results in table 4.4 reflect the age distribution of patient-participants. The ages ranged between 20 and 80, 4% of whom fell into the category >18-20 years of age, 16.8% between 21 and 30 years old, 45.6% between 31 and 50 years of age, 16.8% between 51 and 60 years,11.8% between 61 and 70 years, while only 5% were between 71-80 years of age.

Of the total one hundred and one (n=101) participants, two (2%) did not indicate their gender, forty-two participants (42%) were male and fifty-seven (56%) were female. The patients were predominantly Zulu speaking, previously disadvantaged blacks living in rural areas (refer to chapter 3, paragraph 3.2.3).

Conclusion statements on the patients' demographic data

- The PHC clinics in the study are utilised mostly by female patients.
- Of the patients who utilise the four PHC clinics in the Umzinyathi district, the majority are between 30 and 50 years of age, the so-called working group, of childbearing age and those in need of chronic care.

In the following section, the researcher will discuss the results of the data collected from the patient-participants regarding compliance with the Batho Pele principles.

4.3.1.2 Patients' experiences regarding compliance with the Batho Pele principles

In order to achieve objective one, criteria to ascertain the level of compliance with the Batho Pele principles were compiled in a 32 item questionnaire. Items were scored using a 4-point Likert-based rating scale (see appendix F and G) with the following ratings:

- strongly agree (sa)
- agree (a)
- disagree (d)
- strongly disagree (sd).

The mean and the standard deviation, as calculated for the data, are also indicated in the discussion of the results. The results will be discussed by referring separately to each Batho Pele principle under investigation.

- **Level of compliance with Consultation**

Compliance with this principle was measured by asking four questions on the individual sub-divisions; namely, patients' awareness of the services rendered, whether only the manager decides on the services provided, the hours services are rendered, as well as information provided by the clinic staff regarding services (see table 4.5 for the summarised results).

Table 4.5: Level of compliance with Consultation as experienced by patients, expressed as a percentage

CRITERIA	sa	a	d	sd	Missing values	Mean	SD
You are aware of the services rendered at this clinic.	_	44.7%	51.4%	3.9%	0%	2.59	0.56
Only the clinic manager decides on which services are to be provided.	3.9%	87.3%	7.9%	0.9%	0%	2.05	0.39
Services are provided at hours requested by the community.	_	43.6%	56.4%	_	0%	2.56	0.49
You have been informed by the clinic staff about the services provided at this clinic.	_	64.4%	34.7%	_	0.9%	2.35	0.47

SD=standard deviation; sa=strongly agree; a=agree; d=disagree; sd=strongly disagree

Of the participants involved in the study, 55.3% (51.4% + 3.9%) were not aware of the services rendered at the clinic. Furthermore, 56.4% were not of the opinion

that services are provided at hours requested by the community, and it appears that the majority of participants, 87.3%, felt that only the clinic manager decides on which services are to be provided. Against that 64.4% of the participants were of the opinion that they have been informed about the services provided by the clinic staff. Mean item scores for the four items ranged from 2.05 (agree) to 2.59 (agree towards disagree).

The ratings suggest that while the participants appreciate and understand a need to be consulted, this is not happening at the level of the real engagement. Although consultation can help to foster a more participative and co-operative relationship between the service providers and the users (SA, 1997:16), it seems that not enough is done to consult patients about their needs, as proper consultation will give patients an opportunity to influence decisions about the services provided.

Conclusion statement on the level of compliance with Consultation as experienced by patients

- The clinic manager is the only decision-maker and patients are excluded from participative decisions regarding the services provided and the hours when the services should be provided.

- **Level of compliance with Service Standards**

According to the Batho Pele White Paper (SA 1997:17), service standards must be displayed and communicated to potential users so that they can complain if they are not satisfied with the services provided. Service standards included in this principle refer to the quality of services, and to what degree it meets the needs and expectations of the patients.

Table 4.6: Level of compliance with Service Standards as experienced by the patients

CRITERIA	sa	a	d	sd	Mean	SD
The services are good at this clinic.	_	99.1%	0.9%	_	2.01	0.10
Services are rendered according to your expectations.	_	21.7%	76.4%	1.9%	2.80	0.44
To what extent have services received met your needs?	_	60.5%	35.6%	3.9%	2.43	0.57
Would you come back to this clinic if you were to seek help for the same reason again?	_	99.1%	0.9%	_	2.01	0.10

SD=standard deviation; sa=strongly agree; a=agree; d=disagree; sd=strongly disagree

The majority of the participants, 99.1%, confirmed that the health care personnel render good services at the clinics and 99.1% indicated that they would return to the clinic. These results directly contradict the opinion expressed by 76.4% of patients who indicated that the services are not provided according to their expectations, though 60.5% agreed that the services rendered met their needs. Mean total scores ranged between 2.01 (agree) and 2.80 (agree to disagree).

Conclusion statement on the level of compliance with Service Standards as experienced by the patients

- Although services are considered to be good at the PHC clinics and patients are willing to return to make use of the health services provided at the clinic, it does not mean that all patient expectations are met. This might indicate that although patients are not necessarily satisfied with services they do not have any real alternative when seeking health care.

- **Level of compliance with Access**

All people should have equal access to basic health care (Dennill *et al*., 1999:6) and simple measure of innovation make it possible to render services under circumstances where currently no services are available near the people in need thereof (SA, 1997:12). In this study, access refers to the time it takes to get to the clinic, equal access, utilisation of other clinics, as well as satisfaction with services.

Table 4.7: Level of compliance with Access as experienced by the patients

CRITERIA	sa	a	d	sd	Mean	SD
It takes more than one hour to get to this clinic.	_	26.7%	73.3%	_	2.73	0.44
You do visit other clinics.	_	52.5%	47.5%	_	2.47	0.50
Patients have equal access to all services rendered.	_	14.9%	85.1%	_	2.85	0.35
You are satisfied with the services provided at this clinic.	_	67.4%	32.6%	_	2.32	0.47

SD=standard deviation; sa=strongly agree; a=agree; d=disagree; sd=strongly disagree

The majority, 85.1%, of the patient-participants disagreed that they have equal access to the PHC services. Of the participants, 26.7% agreed that it takes them longer than one hour to get to the clinic, which could mean that the clinic is more than 5 km away. In spite of the 67.4% of participants who are satisfied with the services provided at the clinics, 52.5% of the participants do visit other clinics. Mean item scores for the four items ranged from 2.32 (agree) to 2.85 (agree to disagree).

The high percentage of patients who indicated that they do not have equal access to services rendered, support the recommendation in the Batho Pele White Paper (1997) that targets for increasing access should be set. Such targets could include extending clinic hours or even setting up mobile units (SA, 1997:18). Equal access implies that all PHC services should be provided comprehensively, that is a supermarket approach, to meet the needs of the community. Some of the clinics are still providing certain services only on certain days and this could be the reason why 52.5% of participants visit other clinics.

Conclusion statement on the level of compliance with Access as experienced by the patients

- Compliance with access needs attention for not only do patients visit other clinics, nor are they fully satisfied with current levels of access to the clinics. This could be due to several reasons that need to be explored further.

- **Level of compliance with Courtesy**

Citizens should be treated with courtesy and consideration. Compliance with this principle was measured with the questions whether patients are treated with respect and dignity, whether they are satisfied with the help they receive, and whether they will refer a friend to the services.

Table 4.8: Level of compliance with Courtesy as experienced by the patients

CRITERIA	sa	a	d	sd	Mean	SD
The staff treat all the patients with respect.	_	100%	_	_	2.00	0.00
Patients are treated with dignity in this clinic.	_	100%	_	_	2.00	0.00
You are satisfied with the amount of help received from this clinic.	_	43.6%	56.4%	_	2.56	0.49
If a friend were in need of similar help, would you recommend our services to him/her?	_	88.1%	11.9%	_	2.11	0.32

SD=standard deviation; sa=strongly agree; a=agree; d=disagree; sd=strongly disagree

Although 100% of the participants felt that the health care personnel are treating them with respect and dignity, 56.4% of the participants indicated that they are not satisfied with the amount of help received. On the other hand, 88.1% would recommend a friend to make use of the clinic's services, while only 11.8% of the participants would not recommend the services to a friend. Mean item scores for the four items ranged from 2.00 (agree) to 2.56 (agree to disagree).

Conclusion statements on the level of compliance with Courtesy as experienced by the patients

- All patients who visit the clinics in the Umzinyathi district feel that the health personnel comply well with the courtesy principle.
- There are gaps in the services, specifically with regard to the amount of help received.

- **Level of compliance with Information**

Good progress has been made regarding the provision of full, accurate information about the public services citizens are entitled to receive. This criterion of the Batho Pele principles was measured by ascertaining whether up-to-date

information is provided to patients and to members of the community about services, whether information is available in one official language, and whether the correct information is made available on who to call in case of emergency.

Table 4.9: Level of compliance with Information as experienced by the patients

CRITERIA	sa	a	d	sd	Mean	SD
Patients are provided with up-to-date information about the services they are entitled to.	_	74.3%	25.7%	_	2.25	0.43
Information is available in one official language.	_	95.1%	4.9%	_	2.04	0.21
You know whom to call in case of emergency.	_		98.1%	1.9%	3.01	0.14
Members of the community are given information about services.	_	70.4%	28.7%	0.9%	2.30	0.48

SD=standard deviation; sa=strongly agree; a=agree; d=disagree; sd=strongly disagree

The results indicate that the majority, 74.3%, of the participants are provided with up-to-date information and 70.4% agreed that information is also provided to the community. Furthermore, 95.1% of the participants indicated that the information is available in one official language. In contrast, though, 98.1% of participants do not know whom to call in case of emergency. Mean total scores ranged between 2.04 (agree) and 3.01 (disagree to strongly disagree).

Conclusion statement on the level of compliance with Information as experienced by the patients

- The health care personnel do not comply with patients' need to know who to contact in case of emergency or when they need assistance.

- **Level of compliance with Openness and Transparency**

According to this principle, patients should know who is in charge of the clinic, they should be informed about the budget, they should know who work where, and they should know that all the health care personnel ought to wear name badges.

Table 4.10: Level of compliance with Openness and Transparency as experienced by the patients

CRITERIA	sa	a	d	sd	Mean	SD
You know the person-in-charge of the clinic.	_	57.4%	42.6%	_	2.42	0.49
You feel free to ask about money spent on medicines.	_	0.9%	72.4%	26.7%	3.25	0.46
You know the number of staff working at this clinic.	_	0.9%	89.2%	9.9%	3.08	0.31
The clinic staff do wear name badges.	_	50.6%	42.5%	6.9%	2.56	0.62

SD=standard deviation; sa=strongly agree; a=agree; d=disagree; sd=strongly disagree

Rating in terms of compliance with openness and transparency indicated that most participants, 72.4%, did not feel free to ask about money spent on medicines and an even a higher percentage, 89.2%, did not know the number of staff working at the clinic, whereas 57.4% of participants knew the person-in-charge of the clinic. When questioned whether staff members wear name badges, 50.6% indicated that the staff members do, while 42.5% of the participants disagreed that this is the case. Mean item scores for the four items ranged from 2.42 (agree) to 3.25 (disagree to strongly disagree).

Conclusion statement on the level of compliance with Openness and Transparency as experienced by the patients

- A high percentage of patients, 99.1%, indicated that information about money spent at the clinic on medicines and the number of staff working at the clinic; thus resource allocation; is not provided to them and that compliance with openness and transparency remain a challenge.

- **Level of compliance with Redress**

There are complaints mechanisms in place, especially suggestion boxes and other means of expressing dissatisfaction verbally and telephonically (SA, 1997:21). Patients should also be assisted with complaints handling. To determine compliance with the Batho Pele principle of redress, participants were asked to

rate their experience regarding problems experienced during their visits to the PHC clinics, freedom to complain, feedback on complaints, and whether complaints were dealt with in a satisfactory manner.

Table 4.11: Level of compliance with Redress as experienced by the patients

CRITERIA	sa	a	d	sd	Mean	SD
Did you experience problems during your visit to this clinic?	_	61.4%	38.6%	_	2.38	0.48
Are you allowed to complain when you are not satisfied with the services provided?	0.9%	95.4%	3.7%	_	2.02	0.22
When you complain, to what extent do you receive feedback?	_	20.9%	79.1%	_	2.79	0.40
Has your complaint been dealt with satisfactory?	_	17.6%	81.5%	0.9%	2.83	0.40

SD=standard deviation; sa=strongly agree; a=agree; d=disagree; sd=strongly disagree

A rather large percentage, 61.4%, of participants did experience problems during their visit to the clinic, whilst the vast majority, 96.3% (0.9% + 95.4%), indicated that they were allowed to complain when they were not satisfied with the services. The 79.1% of patients who disagreed that they receive feedback after complaining correlates well with the 82.4% (81.5% + 0.9%) of patients who also disagreed that their complaints had been dealt with satisfactorily. Mean item scores for the four items ranged from 2.02 (agree) to 2.83 (agree to disagree).

Conclusion statement on the level of compliance with Redress as experienced by the patients

- It appears that patients do not receive feedback on their complaints and complaints are not dealt with effectively.

- **Level of compliance with Value for Money**

The Batho Pele principle, which determines that public services (in this study PHC clinics) should be provided economically and efficiently, was evaluated by rating whether information on the budget, saving of costs, explanation of conditions, and dealing with problems, is made available. Patients should be informed about money spent on resources. This aids health care personnel to adhere to the

stringent cost control measures; for example, effective use of medication, medical supplies, equipment and stationary; refraining from private use of clinic medical equipment, telephones and vehicles; as well as elimination of wasteful and inefficient procedures (SA, 1997:22).

Table 4.12: Level of compliance with Value for Money as experienced by the patients

CRITERIA	sa	a	d	sd	Missing values	Mean	SD
You have been informed about the clinic's budget.	_	_	47.6%	52.4%	_	3.52	0.50
This clinic saves costs.	_	0.99%	55.9%	26.3%	16.81%	3.29	0.48
Did the nurse explain your condition?	_	18.8%	81.2%	_	_	2.81	0.39
Did this service help you to deal with your problems?	2.9%	89.2%	7.9%	_	_	2.04	0.32

SD=standard deviation; sa=strongly agree; a=agree; d=disagree; sd=strongly disagree

Participants who disagreed that they have been informed on the clinic's budget add up to 100% of the sample, 47.6% disagreed and 52.4% strongly disagreed. While 55.9% of patients indicated the clinic does not save costs. Furthermore, the majority of the participants, 81.2%, indicated that the nurse did not explain their condition, although this opinion is contradicted by the 89.2% who indicated that they are of the opinion that the service did help them to deal with their problems.

Conclusion statements on the level of compliance with Value for Money as experienced by the patients

- Ratings in terms of compliance with value for money indicated that all the participants were unaware of the clinics' budget.
- Patients were not given information or an explanation about the condition they were diagnosed with.

The results with regard to compliance with the Batho Pele principles, as rated by patients as they experience it in the PHC clinics, reveal that there are still gaps in the implementation thereof. The health care personnel working in the Umzinyathi district should take cognisance of these gaps in implementation and the many challenges they are faced with in this regard.

The conclusion statements served as the foundation for the recommendations made by the researcher regarding nursing practice, research and education. In the following section, the results pertaining to how health care personnel view compliance with the Batho Pele principles in a PHC context will be discussed.

4.3.2 HEALTH CARE PERSONNEL PARTICIPANTS

It is essential to give an overview of the demographic profile of the health care personnel to gain insight into their backgrounds. Such insight will aid the researcher when interpreting their views regarding the level of compliance with the Batho Pele principles in a PHC context. Following the demographic data, the results from the questionnaires completed by the health care personnel, will also be reported. Conclusion statements and recommendations to enhance the quality of services in a PHC context will also be provided.

4.3.2.1 Demographic data of health care personnel

All the health care personnel on duty in the PHC clinic, on the day randomly selected for data collection, participated in the study (see Figure 4.2). Fifty-six (n=56) health care personnel from the four selected clinics in the Umzinyathi district took part in the study; eight (n=8) from Clinic A; fourteen (n=14) from Clinic B; sixteen (n=16) from Clinic C; and eighteen (n=18) from Clinic D. Data was collected by means of a structured questionnaire using a 4-point Likert-based rating scale (see Chapter 3, section 3.4.3).

The participating health care personnel were asked to indicate their age group, gender, highest qualification, designation, and years of service. The following section will report on the information obtained.

Table 4.13: Age distributions of health care personnel participants

Age	n	Percentage (%)
<30	10	17.8
31-40	15	26.7
41-50	14	25.0
51-60	13	23.5
>61	3	5.3
Missing	1	1.7
Total	**56**	**100%**

Of the fifty-six (n=56) health care personnel participants, 17.8% (n=10) were 30 years old and younger. Most participants, 52%, (n=29) were between the ages of 31-50, while 23.2% were between 51–60 years old, the smallest percentage, 5.3%, were 61 years or older. However, 1.7% did not indicate their age.

Considering the above results, there is a well-balanced distribution of health care personnel regarding age. Based on the distribution one may conclude that there is sufficient support from more experienced health care personnel regarding skills and knowledge, while the young and active staff can support and assist the experienced older staff in the smooth running of the clinics.

One hundred per cent (100%) of the participants who responded to the item on race were Black Africans. The South African Nursing Council's (2009:1) statistics on geographical distribution reflects that there are 41 992 female nurses and 4 191 male nurses working in KwaZulu-Natal. In this study, there was a striking predominance of female health care personnel among the participants. The majority of the health care personnel participants were female, i.e. 85% (n=48), with only 12.5% (n=7) male participants. The nursing field are usually female dominated, so these figures are not unexpected. However, 1.7% (n=1) of the participants did not indicate their gender.

Table 4.14 Health care personnel participants according to highest qualification

Highest qualification	Count (n)	Percentage (%)
Grade 12	20	36
Certificate	12	21
Diploma	23	41
Degree	0	0
Missing	1	2
Total	56	100 %

Of the fifty-six (n=56) participants included in the study, 36% (n=20) indicated that they have completed grade 12, 21% (n=12) possess a certificate in a number of different fields of training (from communication skills to HIV counselling), whereas the majority of participants, 41%, (n=23) have acquired nursing diplomas. One of the participants did not indicate the highest qualification she/he has obtained.

The highest percentage, 41%, of participants have acquired a nursing diploma, the required qualification for a professional nurse rendering health care services in PHC clinics. Even PHC personnel who only possess a grade 12 certificate, can be essential to the process of disseminating information on health-related matters to the community. Health care personnel should be encouraged to further their studies in order to acquire more skills and knowledge.

Table 4.15 Designations of the health care personnel participants

Designation	Count (n)	Percentage (%)
General assistants (cleaners and gardeners)	7	12.4
HIV/AIDS counsellors	5	9
Clinic supporter (admin)	12	21.6
Enrolled nurse	9	16
Professional nurse	23	41
Missing	0	0
Total	n=56	100%

General assistants (cleaners and gardeners) account for 12.4% of clinic personnel, whereas 9% were HIV/AIDS counsellors. Clinic supporters, mostly involved in administrative tasks, constituted 21.6% of staff members, while 16% were enrolled nurses and lastly, the majority of the participants, 41%, were professional nurses.

A relatively high percentage of personnel working in the PHC clinics do not fall within the designations of enrolled or professional nurse. This demonstrates that staff “categories other than nursing” can provide support to professional nurses to achieve common PHC universal goals and enhance compliance with the Batho Pele principles.

Table 4.16 Years working at the PHC clinic

Years of service	Count (n)	Percentage (%)
< 5years	19	33.9
6-10	7	12.5
11-20	11	19.6
21-30	8	14.4
>30	11	19.6
Total	56	100%

The largest group of participants (33.9%) indicated that they have been working in PHC services for less than 5 years, 12.5% have been appointed for between 6 to 10 years, while 19.6% have been working in PHC services for 11 to 20 years. Only 14.4% of the participants indicated between 21 to 30 years of service, whilst 19.6% participants indicated that they have worked in PHC services for longer than 31 years.

Conclusion statements on the demographic data gathered from the health care personnel

- The ages of the health care personnel in the four PHC clinics indicate that there are experienced health care personnel working in the clinics who can support the younger staff members with regard to skill and knowledge.
- The health care personnel working in the PHC clinics are predominantly female.
- The highest qualification of the health care personnel in the PHC clinics is a diploma, none have completed a degree.
- The professional nurse plays an important role in the PHC clinic; therefore, they make up the highest percentage of personnel working in the PHC clinics.
- The majority, 66.1%, of health care personnel working in the PHC clinics under study, have been working there for longer than 5 years. This indicates that there is stability within the personnel corps and low personnel turnover.

4.3.2.2 Health care personnel's views on the level of compliance with the Batho Pele principles as in a PHC context

As described in chapter 2 of this study, the Batho Pele principles are the basis for the transformation of public service delivery, according to the Batho Pele White Paper (SA, 1997:38). It advocates a more efficient, effective and equitable public service, which is accessible, transparent, accountable and free of corruption. It specifies the need for public participation and involvement in the health services rendered at the PHC clinics.

A questionnaire was used to collect data from the participating health care personnel (please refer to paragraph 4.2.1). The questionnaire focussed mainly

on effective consultation, minimum service standards and quality of services, increasing the accessibility of services, provision of information, courtesy, openness and transparency, handling of complaints (redress), as well as value for money. The results obtained from the questionnaires completed by the health care personnel are presented in the following section. In order to describe the level of compliance with the Batho Pele principles, as viewed by the health care personnel, criteria to ascertain their opinions were included in a 32 item questionnaire, using a 4-point Likert-based rating scale (see paragraph 4.3.1.2).

- **Level of compliance with Consultation**

According to the guide to revitalise Batho Pele (SA, 2004:11), health care personnel are required to consult with the clients (patients) on the level and quality of services to be provided. The results indicate that the health care personnel working at the clinics under study appreciate the need to comply with the Batho Pele principle of consultation.

Table 4.17: Level of compliance with Consultation as viewed by the health care personnel

CRITERIA	sa	a	d	sd	Missing values	Mean	SD
The services are good at this clinic.	23.3%	76.7%	_	_	0%	1.76	0.42
Only the clinic manager decides on which services are to be provided at this clinic.	57.1%	42.9%	_	_	0%	1.42	0.49
You are aware of the guidelines in this clinic that inform you on how services are to be conducted.	3.5%	66.2%	17.8%	_	12.5%	2.16	0.47
You have been orientated about the services provided at this clinic.	5.3%	92.8%	1.9%	_	0%	1.96	0.26

SD=standard deviation; sa=strongly agree; a=agree; d=disagree; sd=strongly disagree

All of the 56 participants (23.3% + 76.7%) confirmed that the services rendered at the clinic where they work are good, and all of the participants (57.1% + 42.9%) are also of the opinion that only the clinic manager decides on the services provided. Furthermore, 69.7% (3.5% + 66.2%) of the participants are aware of the guidelines, although 12.5% of the participants did not answer this question. The vast majority of participants, 98.1% (5.3% + 92.8%), affirmed that they have been orientated regarding the services provided at the clinic. Mean total scores ranged between 1.76 (strongly agree to agree) and 2.16 (agree), as shown in table 4.17,

which confirms that the health care personnel feel that they comply with the consultation principle to a high degree.

Conclusion statement on the level of compliance with Consultation as viewed by health care personnel

- In this study, it appears that only the clinic manager decides on which services are to be provided at the clinic. Providing information to patients forms part of consultation process, this requires participative decision-making to enable the patients to have a say in decisions affecting their health.

- **Level of compliance with Service Standards**

This Batho Pele principle reinforces the need to measure the extent to which communities are satisfied with the services they receive on a constant basis, e.g. quarterly. Patients should be well informed about the services they should expect and, thus, have realistic expectations of the services provided (SA, 2004:49).

Table 4.18: Level of compliance with Service Standards as viewed by the health care personnel

CRITERIA	sa	a	d	sd	Mean	SD
The services are good at this clinic.	7.2%	92.8%	_	_	1.92	0.25
Services rendered satisfy the expectations of patients.	_	87.5%	12.5%	_	2.12	0.33
To what extent have the services rendered met the community's needs?	1.9%	73.6%	22.8%	1.7%	2.24	0.51
Would you recommend the services provided at this clinic to another person?	28.6%	71.4%	_	_	1.71	0.45

SD=standard deviation; sa=strongly agree; a=agree; d=disagree; sd=strongly disagree

All of the participants involved in the study confirmed that good services are rendered, while 87.5% agreed that services are rendered according to the expectations of the patients. When asked to rate the level to which the services rendered met the needs of the community, 73.6% agreed and 1.9% strongly agreed that the services meet the community needs. All the participants indicated that they will recommend the services of the clinic to another person. Mean total scores ranged between 1.7 (strongly agree to agree) and 2.24 (agree), which

indicate that the health personnel on average strongly agreed that compliance with service standards have been achieved.

Conclusion statement on the level of compliance with Service Standards as viewed by health care personnel

- Health care personnel do comply with the service standards principle and the majority of health care personnel felt that services are rendered according to the expectations of the patients.

- **Level of compliance with Access**

Some of the barriers to equal access that should to be taken into account, are social, cultural, physical, communication and attitudinal in nature (SA, 1997:18) and can hinder access to PHC services.

Table 4.19: Level of compliance with Access as viewed by the health care personnel

CRITERIA	sa	a	d	sd	Missing values	Mean	SD
This clinic provides comprehensive (supermarket approach) services to the community.	30.4%	39.3%	3.6%	_	26.7%	1.63	0.58
The clinic caters for elderly citizens.	17.8%	82.2%	_	_	_	1.82	0.38
Patients have equal access to all services rendered at this clinic.	1.8%	28.6%	67.8%	_	1.8%	2.67	0.51
Operating hours are convenient to the users of this facility.	_	7.2%	85.7%	5.4%	1.7%	2.98	0.35

SD=standard deviation; sa=strongly agree; a=agree; d=disagree; sd=strongly disagree

Although 69.7% (30.4% + 39.3%) of the health care personnel participants agreed that the clinic provides a comprehensive service, more than a quarter (26.7%) of the health care personnel did not answer the question because of reasons unknown to the researcher. All the participants agreed and strongly agreed, respectively, that the clinic caters for elderly citizens. Patients do not have equal access to services according to 67.8% of the health care personnel, whereas the majority, 91%, are of the opinion that the operating hours are not convenient to the users. Mean total scores ranged between 1.63 (strongly agree) to 2.98 (agree to disagree).

Equal access is a problem in the opinion of the health care personnel. The refusal or forgetting to answer the question (26.7% of data missing) on the provision of comprehensive (supermarket approach) services to the community might indicate that they do not think that the clinic provides comprehensive care, but felt that they could not openly state this. Possible reasons for this might be explored in future.

Conclusion statements on the level of compliance with Access as viewed by health care personnel

- The results suggest that the health care personnel do not fully comply with the Batho Pele principle of access.
- Barriers may exist that hinder access and this must be taken into account to strengthen current compliance with the Batho Pele principles and improve the quality of service delivery.

- **Level of compliance with Courtesy**

Courtesy entails aspects like a fast queue for disabled patients, treating elderly patients with dignity, treating patients with respect, and the level of satisfaction with the care provided at the PHC clinics in the Umzinyathi district.

Table 4.20: Level of compliance with Courtesy as viewed by the health care personnel

CRITERIA	sa	a	d	sd	Missing values	Mean	SD
There is a fast queue for patients with disabilities.	1.7%	12.5%	73.3%	12.5%	_	2.96	0.57
Elderly patients are treated with dignity.	1.7%	98.3%	_	_	_	1.98	0.13
The staff members treat patients with respect.	1.7%	98.3%	_	_	_	1.98	0.13
To what extent are you satisfied with the level of care provided at this clinic?	_	96.6%	1.7%	_	1.7%	2.01	0.13

SD=standard deviation; sa=strongly agree; a=agree; d=disagree; sd=strongly disagree

Of the health care personnel, 73.2% did not agree and a further 12.5% strongly disagreed that there is a fast queue for patients with disabilities. This finding strongly contradicts their opinion (100%), that elderly patients are treated with dignity. This might indicate that the health care personnel do not consider elderly

patients to be disabled. All of the participants indicated that patients are treated with respect while 96.6% were satisfied with the level of care provided at the clinic. Mean total scores ranged between 1.98 (strongly agree) to 2.96 (agree to disagree).

Conclusion statement on the level of compliance with Courtesy as viewed by health care personnel

- It appears that patients with disabilities are afforded no special treatment and are not regarded as a priority.

- **Level of compliance with Information**

Health care personnel should always find out what patients need and want to know, and work out how, where and when the information could best be provided (SA, 1997:19).

Table 4.21: Level of compliance with Information as viewed by the health care personnel

CRITERIA	sa	A	d	sd	Missing values	Mean	SD
It is easy to find this clinic.	41,1%	42.8%	16,1%	_	_	1.75	0.71
The health education material is available in the local language.	_	100%	_	_	_	2.00	<0.001
During consultation, procedures are explained to the patients.	16%	71.4%	_	_	12.6%	1.81	0.39
Interpreting services are available and utilised.	_	1.7%	10.7%	46.6%	41%	3.75	0.50

SD=standard deviation; sa=strongly agree; a=agree; d=disagree; sd=strongly disagree

Most of the health care personnel indicated that it is easy to find the clinic (41.1% strongly agreed and 42.8% agreed). All of the participants confirmed that health education material is available in the local language, whereas 87.4% of the participants were of the opinion that consultation procedures are explained to the patients. In contrast with these findings, 57.3% (10.7% + 46.6%) of the participants disagreed that interpreting services are provided. Furthermore, 41% of participants elected not to answer this question. Therefore, it seems as if the overwhelming majority of health care personnel believe that interpreting services

are not readily available or utilised. Mean total scores ranged between 1.75 (strongly agree) to 3.75 (disagree to strongly disagree).

Conclusion statements on the level of compliance with Information as viewed by health care personnel

- Compliance with this principle is at a significantly high level, with special reference to health education material that is available in the local language (SD=<0.001).
- There is a lack of interpreting services and it is not available as part of the services provided at the PHC clinics.

- **Level of compliance with Openness and Transparency**

This principle refers to the ability of the staff to outline the services provided at the PHC clinics, whether they know the number of staff working in the clinic, their level of involvement in the budget, and whether the responsibility of ensuring openness and transparency is delegated to a professional nurse.

Table 4.22: Level of compliance with Openness and Transparency as viewed by the health care personnel

CRITERIA	sa	a	d	sd	Missing values	Mean	SD
The staff can give an outline of the services provided at this clinic.	_	76.7%	19.7%	1.8%	1.8%	2.23	0.46
You know the number of staff working at this clinic.	23.3%	69.6%	7.1%	_	_	1.83	0.53
To what extent are you involved with the clinic budget?	5.4%	16%	21.5%	3.6%	53.5%	2.50	0.81
The responsibility of ensuring openness and transparency is delegated to one of the professional nurses.	_	_	7.2%	16%	76.8%	3.69	0.48

SD=standard deviation; sa=strongly agree; a=agree; d=disagree; sd=strongly disagree

When asked their opinion on whether staff members can give an outline of the services provided at the clinic, 76.7% of the participants agreed with the statement and 92.9% (23.3% + 69.6%) felt that they knew the number of staff working at the clinic. Regarding the level of involvement with the budget, 53.5% of participants did not answer the question, and a further 25.1% (21.5 + 3.6%) felt that they are

not involved with the clinic budget. Finally, 76.8% of the participants did not indicate whether the responsibility of ensuring openness and transparency is delegated to one of the professional nurses. Of those that did answer this question, 7.2% disagreed that the responsibility of ensuring openness and transparency is delegated to one of the professional nurses, whilst a further 16% strongly disagreed with this. Mean total scores ranged between 1.83 (strongly agree) to 3.69 (disagree to strongly disagree).

Conclusion statements on the level of compliance with Openness and Transparency as viewed by health care personnel

- Most of the health care personnel comply with openness and transparency in so far as providing information on services rendered and knowledge of staff numbers.
- It is clear, however, that the majority of health care personnel are not involved with the budgetary process of the clinic and are ignorant of the delegation of the responsibility for ensuring the values of openness and transparency.

- **Level of compliance with Redress**

The questions answered by the health care personnel on compliance with the principle of redress refer to whether there is a complaint mechanism in place, whether patients are allowed to lodge their complaints, whether patients receive feedback on their complaints, and whether patients are satisfied with the manner in which complaints are handled.

Table 4.23: Level of compliance with Redress as viewed by the health care personnel

CRITERIA	sa	a	d	sd	Missing values	Mean	SD
Is there a complaints mechanism in place?	55.3%	44.7%	--	--	--	1.44	0.50
To what degree are patients allowed to lodge their complaints?	10.8%	83.9%	1.8%	_	3.5%	1.90	0.35
To what extent do they receive feedback?	_	10.8%	66%	14.3%	8.9%	3.03	0.52
Are the patients satisfied with the way complaints are handled at this clinic?	1.7%	_	48.3%	39.3%	10.7%	3.40	0.60

SD=standard deviation; sa=strongly agree; a=agree; d=disagree; sd=strongly disagree

Of the fifty-six participants (n=56), 100% (55.3% + 44.7%) were of the opinion that there is a complaints mechanism in place. The majority, 94.7% (10.8% + 83.9%), of the participants indicated that patients are allowed to lodge complaints, whilst 80.3% (66% + 14.3%) felt that patients do not receive feedback. However, 87.6% (48.3% + 39.3%) of the health care personnel felt that patients are not satisfied with the way complaints are handled at the clinic. A further 10.7% did not answer this question. Mean total scores ranged between 1.44 (strongly agree) and 3.40 (disagree).

Conclusion statements on the level of compliance with Redress as viewed by health care personnel

- Even though patients are allowed to express their dissatisfaction by utilising the complaints mechanism put in place, complaints are not handled in an effective manner.
- Very little feedback is given to patients when they complain, thus, patients are not afforded the opportunity to make suggestions to the health care personnel, nor is there a mechanism in place to prevent the same problem from reoccurring.

- **Level of compliance with Value for Money**

The health care personnel had to answer questions regarding their knowledge of the budget, clinic strategies to improve efficiency and save costs, the ability of the nurse to explain the conditions of patients, and whether the quality of services are monitored at the PHC clinic.

Table 4.24: Level of compliance with Value for Money as viewed by the health care personnel

CRITERIA	sa	a	d	sd	Missing values	Mean	SD
Do you know the budget allocated for this financial year?	7.1%	10.2%	21.1%	38.2%	23.4%	2.61	0.94
This clinic has strategies to improve efficiency and to save costs.	7.1%	12.6%	19.6%	7.2%	53.5%	2.57	0.94
During consultation, the nurse explains the condition of the patient.	39.3%	55.5%	1.7%	_	3.5%	1.61	0.52
To what extent is the quality of service monitored at this clinic?	51.8%	46.4%	_	_	1.8%	1.47	0.50

SD=standard deviation; sa=strongly agree; a=agree; d=disagree; sd=strongly disagree

Of the fifty-six participants, 23.4% did not indicate whether they know the budget allocated for this financial year, while a further 59.3% (21.1% + 38.2%) were not familiar with the annual budget. Again, 53.5% of the participants did not indicate whether the clinic has strategies in place to improve efficiency and to save costs, furthermore 26.8% (19.6% + 7.2%) indicated that they are of the opinion that there are no such strategies. Of the participants, 94.8% (39.3% + 55.5%) felt that the nurses explain the condition of a patient and 98.2% (51.8% + 46.4%) were of the opinion that the quality of services is monitored at the clinic. Mean total scores ranged between 1.47 (strongly agree) to 2.61 (strongly disagree).

The ratings indicated that most of the health care personnel do not comply with the value for money principle; hence, the majority were either uncertain about some of the questions asked in this category or they chose not to answer the questions.

Conclusion statements on the level of compliance with Value for Money as viewed by the health care personnel

- Health care personnel do explain the condition of the patient during consultation and are involved in quality monitoring in the PHC clinics.
- Health care personnel are not that well informed on the clinic's budget and strategies for saving costs and improving efficiency. Therefore, they are uncertain about these issues and tend to ignore them.

4.4 CHAPTER SUMMARY

The data collected during this study was presented, analysed and interpreted. Descriptive statistics, which are summative statistics, were used to achieve the objectives of the study. Descriptive statistics allow the researcher to organise data in order to give meaning to the phenomenon investigated. The demographic data, which was analysed by making use of frequencies, percentages, means, standard deviations, and ranges, was presented in tables and figures. The findings were computed and interpreted using a software package, i.e., Statistical Analysis System (SAS Institute Inc. 2007). Reliability of the data collecting instrument was estimated by calculating Chronbach's Alpha co-efficient that measured the internal consistency of the questions posed in the questionnaire. Because the study is quantitative in nature, the researcher determined the statistical and practical

significance of the results by comparing the means of the data obtained from the patient-participants and the health care personnel using the t-test. The results of the calculated p-values were smaller than 0.05, indicating that the results are statistically significant and, therefore, not due to chance (Burns & Grove, 2005:580).

In the following chapter, the researcher will present the conclusions, identify the limitations of the study, and formulate recommendations for further studies as identified from the present and previous studies in the same area of interest (Burns & Grove, 2005:582).

CHAPTER 5: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS OF THE STUDY

5.1 INTRODUCTION

The preceding chapters described how PHC services could be transformed in the spirit of Batho Pele, in order to provide quality health care in an equitable fashion, and within the knowledge that authorities administer public health functions to secure the well-being of all communities (WHO, 2008:41). It is expected that all public servants (including health care personnel) in all three spheres of government will comply with the Batho Pele programme. Therefore, pressure is exerted on PHC clinics, including the clinics targeted in this study, to comply with the Batho Pele principles and to promote a culture of "people first", people-centeredness, and to provide quality health care services that meet the needs, values, and expectations of patients, families and the community.

In this chapter, an evaluation of the study will follow; this includes a review of the study, a summary of the conclusions, limitations of the study, and recommendations for the nurses working in a PHC context, nursing education, and nursing research.

5.2 REVIEW OF THE STUDY

The purpose of the study; to make recommendations to enhance compliance with the Batho Pele principles in a PHC context; was achieved by fulfilling the following objectives:

Table 5.1: Objectives of the study

Objective 1	Objective 2
To describe the level of compliance with the Batho Pele principles as experienced by patients in a PHC context	To describe the level of compliance with the Batho Pele principles as viewed by the health care personnel in a PHC context

Chapter 1 provided background information to the government's objective of "putting the people first", with its aim to improve and provide effective, efficient and cost-effective service delivery mechanisms. An overview of the research, with the aim of preparing the reader for the subsequent chapters, was also provided. An introduction and problem statement,

including the research problem and limitations of the study, aims and objectives, theoretical perspective, literature review, research design and method, as well as ethical considerations of this study, were discussed.

Chapter 2 focused on the literature review and the impact of the Batho Pele principles on service delivery. Accordingly, as indicated, the purpose of conducting a literature review was to provide a holistic overview of what Batho Pele entails and the manner in which health care personnel are expected to comply with its practice in a PHC context so that the needs of the community can be met.

Chapter 3 gave a detailed explanation of the methodology. A non-experimental quantitative research design, to describe the findings within a specific context, was explained in the introductory chapter (see table 1.2) and was discussed in more detail during chapter 3. The philosophical framework of the eight Batho Pele principles was used as the main point of departure (see chapter 2). The research was conducted in two populations; a patient sample (see chapter 3, paragraph 3.3.3 and figure 3.2) and a health care personnel sample (n=56). In order to exclude participant bias (patients interviewed at PHC clinics, n=132), another sample was necessary (patients interviewed in their homes, n=101). After a preliminary data-analysis, the results showed a significant difference between the data gathered from patients at the PHC clinics and data gathered from patients in their homes. This important finding resulted in the exclusion of the data gathered from patients at the clinics from the final discussion of the results (see chapter 4, paragraph 4).

A pilot study (see chapter 3, paragraph 3.4.1) of five (n=5) patients and three (n=3) health care personnel participants was conducted prior to the research project using similar subjects included in the actual research project, a similar setting, and the same data collection instrument (questionnaire). A non-probability, convenience voluntary sampling method was used to select patient-participants and an all-inclusive approach was used to select the health care personnel participants who met the inclusion criteria of this study (see chapter 3, paragraph 3.3.2).

In chapter 4, the data collected to the reach the objectives of the study, was organised and presented as analysed. Data was gathered from both populations using a structured questionnaire in order to achieve the objectives and the purpose of the study. The Statistical

Services of the NWU, Potchefstroom Campus, was consulted and assisted with the preparation for data analysis. Descriptive statistics allowed the researcher to summarise and describe the gathered data. Internal reliability was tested to determine how repeatable data gathered by means of the questionnaire is, i.e., stability and homogeneity, to test reliability without administering the test twice. Internal consistency was enhanced and estimated through Cronbach's Alpha coefficient that assesses items to determine their congruency (see chapter 4, paragraph 4.2.1).

The data from both population samples was analysed with frequencies, percentages, means and standard deviations and presented graphically in tables and figures. The data was described and discussed in a systematic manner; the eight Batho Pele principles formed the main categories followed by a description of all four items as sub-categories. All the findings presented in Chapter 4 were computed and interpreted using the Statistical Analysis System (SAS Institute Inc., 2007; Lohr, 2009:393; Burns & Grove, 2005:455).

Limitations were highlighted and conclusions were stated, which gives an indication that the health care personnel in a PHC context can do much better to provide quality care. The reality is that more emphasis should be placed on strengthening current compliance with the Batho Pele principles to improve the quality of service delivery.

In order to accomplish the purpose of this study, a summary of conclusions and recommendations based on the findings is provided, and serves as a starting point for recommendations regarding nursing practice, nursing education and further nursing research.

5.3 SUMMARY OF CONCLUSION STATEMENTS

The summarised conclusion statement should serve as the starting point for enhancing compliance with the Batho Pele principles in nursing practice, nursing education, and further research to address the identified shortcomings. Based on the results of this study, the level of compliance with the Batho Pele principles, as experienced by the patients, show some similarities but also significant differences with the level of compliance as viewed by health care personnel. It is noteworthy that the patients, who completed the questionnaire at home, had more freedom to express themselves without fear of discrimination. This reveals that patients feel more secure at home and this could be an important fact to take into

consideration when conducting patient satisfaction surveys or when determining the level of compliance with Batho Pele.

Both the patients and the health care personnel agreed that the clinic manager is the only person who makes decisions about the services that should be rendered in the PHC clinic. The **consultation process** requires participative decision-making to enable patients to have a say in decisions affecting their health. Although the health care personnel believe that supplying information to patients is part of the consultation process, patients feel that they are excluded from participating in decisions regarding the services provided and the hours when the services should be provided.

In contemplation of its definition, during the launch of the Batho Pele White Paper in 1997, the Batho Pele principles were developed to improve service delivery and put the people at the centre of public service delivery (see chapter 1, paragraph 1.1). Hence, patients should be aware of the standards they can and should demand. Differences in the opinions of health care personnel and patients regarding compliance with the **service standards** principle, and more specifically rendering services according to the expectations of patients, can be questioned. Patients do return to PHC clinics for services, although the majority are of the opinion that their health care expectations are not met. The researcher is of the opinion that patients return to the PHC services because they do not have any real alternative when seeking health care.

This conclusion add credence to the fact that both patients and health care personnel feel that patients do not have **equal access** to PHC clinics. Notwithstanding the fact that patients with disabilities are afforded no special treatment and are not regarded as a priority, all the patients who visit the clinics in the Umzinyathi district feel that the health personnel comply well with the **courtesy** principle.

Furthermore, it is clear that the health care personnel do comply with the **information** principle to a high degree, but an important aspect to consider is the need expressed by patients to know who to contact in case of emergency or when they need assistance.

Most of the health care personnel comply with **openness and transparency** in providing information on services rendered and know the number of staff working in the PHC clinic. It is

clear, however, that according to patients, information about openness and transparency in terms of resources are not provided to them. Compliance with openness and transparency remains a challenge in terms of the involvement of health care personnel with the budgetary process of the clinic, and the delegation of the responsibility of ensuring the values of openness and transparency.

With regard to **redress**, it appears that patients do not receive feedback on their complaints and complaints are not dealt with effectively. Even though patients are allowed to express their dissatisfaction and utilise the complaint mechanism that is in place, complaints are not handled in an effective manner. Very little feedback is given to patients when they complain, thus, patients are not given the opportunity to make suggestions to the health care personnel, nor is there a mechanism in place to prevent the same problem from reoccurring.

When the question on compliance with **value for money** was analysed the researcher found that the health care personnel are not well informed on the clinic's budget and strategies for saving costs and improving efficiency. It could be that they are uncertain about these issues and tend to ignore them because the majority chose not to answer the question. Some patients indicated that they were not given information or an explanation about the condition they were diagnosed with. Most patients and health care personnel were not familiar with the clinic's budget; therefore, patients are not empowered to take responsibility for their own health, nor are the health care personnel to provide quality care in a cost-effective manner.

The findings of this study, gathered from the empirical world and weighed against the reality of the literature review, revealed that the patients were more dissatisfied with the level of compliance with the Batho Pele principles than the health care personnel on most items.

5.4 SIGNIFICANCE OF THE STUDY

Based on the summary of conclusions and recommendations, the findings concerning the level and importance of compliance with the Batho Pele principles and the significance of patient satisfaction and quality care service delivery, can assist health care personnel to measure their performance against set standards so that the quality of health care service delivery can improve. According to Booyens (2008:267) standards, and the criteria used to measure those standards, are interchangeable as far as quality is concerned. Therefore,

maintenance of service standards should improve quality health care to meet the patients' values, needs, preferences, and expectations.

5.5 LIMITATIONS OF THE STUDY

A few shortcomings were identified during this study, as indicated below.

- The study was limited to the chosen sub-districts of the Umzinyathi Health District in the KZN Province, and the non-probability sampling used in this study does not permit generalisation of the research findings to other sub-districts and provinces, or the rest of the country for that matter.

- The patient-participants in this study were predominantly black Zulu speaking persons; therefore, the results are not representative of other population groups.

- Although most of the health care personnel working in the PHC clinics at the time of the research were interested in becoming involved in the study, the actual number who participated were limited due to staff shortages.

- The researcher observed that the patient-participants were uncomfortable when answering the questionnaire at the clinic and concluded that the participants were not completely honest with their answers, as they tended to agree with most items, thus, influencing the results. Participant bias became a threat to the study and when it became clear that a number of patients were reluctant to give out information they thought sensitive, the researcher opted to interview them in their homes (see paragraph 4.2.2).

- Although the researcher believed that the patient-participants all lived in the same catchment area, as they attended PHC clinics that are situated within the boundaries adjacent to each other, it might not have been the case. This could have influenced the findings regarding the access principle.

- The structured questionnaire used in this study was not a standardised questionnaire and this might have influenced the internal consistency (see chapter 4, paragraph 4.2.1 and table 4.2).

5.6 RECOMMENDATIONS

The overall purpose of this study was to make recommendations that can enhance current compliance with the Batho Pele principles so that quality care and patient satisfaction can be improved. As discussed in chapter 2, all government departments are expected to develop a Service Delivery Charter indicating the types, standards and quality of services to be provided in order to facilitate patient satisfaction (SA, 1997:16; SA, **s.a.**: 39; SA, 2004: 11). Therefore, the recommendations below focus on nursing practice, nursing education, and nursing research.

5.6.1 RECOMMENDATIONS FOR NURSING PRACTICE

This study contributes to PHC practice and the recommendations provided include all health care personnel and the services they render to patients, as members of the community, with special reference to compliance with the Batho Pele principles, used as a framework to enhance the quality of care and patient satisfaction:

- New PHC clinic staff members should be taught how to comply with the Batho Pele principles during orientation and induction. The receptionists and/or clinic support personnel should attend a customer care course and be involved in customer satisfaction surveys, which are conducted twice a year.
- The patients who visit the different PHC clinics should be assured that they could be open and honest when scoring the standards and quality of services they receive and be free of fear of discrimination. This can happen by:
    - Adhering to the cultural values of *ubuntu* and staff pledges to respect these values should be encouraged (SA, 2004: 13, Mapadimeng, 2007:258). Posts for dedicated Batho Pele officers in PHC clinics should also be created.
    - Regular meetings with clinic committees and open days with the community should become common practise. Providing the contact details of the responsible person-in-charge of the clinic should be encouraged in order to increase transparency. Clinic committees should also be involved in participative decision-making and attend to complaints.

- Participative decision-making should be enhanced through the involvement of a wide range of civil society stakeholders, working together in a movement for equity (WHO, 2008:88).
- Integration of service needs should take place as soon as possible to overcome the dilemma of staff shortages so that health care personnel can work together as a team and provide quality care, bearing in mind the aim to satisfy the needs and expectations of patients. A patient survey should be conducted to determine the needs of patients. The identified needs of the people should be considered first and addressed as cost-effectively as possible, thus enabling health care services to become more effective.
- Equal access to clinics should be given attention and service hours should be convenient to the community. At least 12-hours of service should be provided to meet and accommodate the needs of working patients in the community.
- New emphasis should be placed on the importance of fast queues at all PHC clinics. Patients with disabilities and the elderly should be assisted and afforded special consideration.
- Placing media articles in community newspapers, like the Northern KwaZulu-Natal Courier, and announcements on radio stations, like Ukhozi FM, should be encouraged. This would consistently inform and update communities regarding health-related information, like what to do and who to contact in case of an emergency.
- Managers should ensure that all personnel working in PHC clinics are familiar with the Batho Pele principle regarding redress and are able to handle complaints in a correct and efficient manner. The community members (patients) should be allowed to make recommendations on how they would like complaints to be handled.
- The budget of each PHC clinic should not only be allocated according to the needs of the people, the needs of health care personnel should be considered as well. Patients should be provided with information on the budget and, thus, gain insight into how the money is spend to render health care that is effective, efficient and cost-effective.

5.6.2 RECOMMENDATIONS FOR NURSING EDUCATION

The ultimate goal of the Batho Pele principles is to improve service delivery and if these principles were included in the nursing education curriculum it could improve nursing practice focussed on PHC services, where the nurse plays an important role. The following are recommended in this regard:

- The Batho Pele principles should not only remain a theoretical concept, but the actual implementation and compliance with Batho Pele should be part of the curriculum. This would teach students to measure the standard of quality care at all times and enable students to render health care services in a much more effective, efficiency, cost-effective and equitable manner, once they enter practise.
- The Batho Pele principles should form part of all information and plans regarding health care service delivery systems to help achieve the three explicit health-related Millennium Development Goals mentioned in Chapter 1.1 (UN, 2010:i).
- Students should embrace the importance of the Batho Pele principles, which are in line with the rights to dignity and access to health care as enshrined in the Bill of Rights of the South African Constitution (1996). Knowledge and understanding of these rights and principles will enable students to treat patients and the community, as they would like to be treated themselves.
- Short courses on compliance with the Batho Pele principles should be implemented, focusing on financial management in PHC clinics, sharing and providing knowledge to the community, participative decision-making processes to enhance the transparency of services, and effective management of complaints.

5.6.3 RECOMMENDATIONS FOR FURTHER RESEARCH

In the light of the above information, based on the findings and supported by the literature review and limitations of the study, the following recommendations are made for further research:

- The replication of this study in other areas would yield interesting results, especially to ascertain whether other PHC clinics in the Umzinyathi Health District or elsewhere in the country experience the same problems.

- A qualitative study could be conducted to explore and describe the lived experiences of patients and health care personnel regarding compliance with Batho Pele principles in a PHC context. This will also help to understand the significant difference between the results obtained from patients when they visited the PHC clinics and the results obtained from patients in their homes.
- The actual practice, i.e., how services are being rendered in other districts, would be interesting to pursue, to be able to compare different practices with the facilities under study.
- The formulation of a standardised tool for measuring compliance with the Batho Pele principles in a PHC context is required.
- Explorative and descriptive studies are needed to understand the strengths and possible barriers to compliance with the Batho Pele principles.
- Participatory action research could help to investigate, plan and evaluate compliance with the Batho Pele principles in a more sustainable manner.

5.7 CHAPTER SUMMARY

The purpose of the study, to make recommendation to enhance compliance with the Batho Pele principles in a PHC context, has been achieved through this non-experimental, descriptive and quantitative study. This chapter concluded the study with a review thereof, a summary of the conclusion statements, the significance of the study, the limitations identified, and recommendations for PHC practice where the nurse plays a pivotal role, nursing education, and nursing research.

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APPENDIX A

REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT UMZINYATHI HEALTH DISTRICT

ATTENTION:
Mr J. Mndebele
The District Manager
Umzinyathi Health District
P.O Box 2052
DUNDEE
3000

Enquiries: Ms I.D. Khumalo
Tel: (W) 034 212 2121
Cell: 082 713 9051
(E- mail: idkhumalo@endumeni.gov.za)

23 July 2008

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT UMZINYATHI HEALTH DISTRICT

I am currently registered as a learner for the M Cur- Nursing Degree at North-West University (Potchefstroom Campus). As part of the degree, I must conduct research and the title of my study is “Compliance with the Batho Pele principles in a Primary Health Care Context”. Ethical approval has been given by the Ethics Committee of the North-West University to conduct this research.

The overall purpose of the study is to make recommendations to enhance compliance with the Batho Pele principles that will result in improved quality care and patient satisfaction in a Primary Health Care context.

The objectives of the study are:

- To describe the level of compliance with the Batho Pele principles as experienced by the patients in a Primary Health Care context
- To describe the level of compliance with the Batho Pele principles as viewed by the health care personnel in a Primary Health Care context.

In order to achieve these objectives, structured questionnaires will be used to collect data from the patients and the health care personnel of the four targeted PHC clinics in the two sub-districts, that is, Endumeni and Nquthu at the Umzinyathi Health District in the KwaZulu-Natal Province.

Criteria for inclusion are as follows:

The patients as participants:

- Voluntary participation and willing to complete a structured questionnaire
- Patients who attend the PHC clinics regularly, first time attendees will be excluded
- Being able to communicate in English and/or Zulu

The PHC personnel as participants:

- Voluntary participation and willing to complete a structured questionnaire
- Currently working in a Primary Health Care clinic for longer than six months
- Being able to communicate in English and/or Zulu

The process of data gathering through the use of structured questionnaires will take place during October 2008. The structured interviews will be conducted in private rooms at the clinics and will last approximately fifteen to thirty minutes per participant.

Anonymity and confidentiality will be maintained in all research proceedings. It will be appreciated if one health care personnel in each facility can be identified as a mediator.

Your timeous response will be appreciated, which will enable me to make further arrangements.

If more information is needed with regard to this research, please contact me at the numbers indicated above.

Yours faithfully

……

MS ID KHUMALO (Researcher)

…….

MRS MJ WATSON (**Supervisor)**

……..

MS CE MULLER (Co-supervisor)

APPENDIX B: INFORMED CONSENT FOR PATIENT AND HEALTH CARE PERSONNEL

Enquiries: Ms I.D. Khumalo
Tel: (W) 034 212 2121
Cell: 082 713 9051

(E- mail: idkhumalo@endumeni.gov.za)

23 July 2008

CONSENT TO PARTICIPATE IN NON NON-EXPERIMENTAL RESEARCH

Dear participant,

TITLE OF THE STUDY: Compliance with the Batho Pele principles in a Primary Health Care context

PURPOSE AND BACKGROUND OF STUDY:

I, Ms I.D Khumalo, am conducting research at the North-West University, Potchefstroom Campus. You are cordially requested to participate in this research because your input will assist me in achieving the objectives of the study explained hereafter.

The overall purpose of the study is to make recommendations to enhance compliance with the Batho Pele principles that will result in improved quality care and patient satisfaction in a Primary Health Care context.

The objectives of the study are:

- To describe the level of compliance with the Batho Pele principles as experienced by the patients in a Primary Health Care context
- To describe the level of compliance with the Batho Pele principles as viewed by the health care personnel in a Primary Health Care context.

You will be asked by the researcher to complete a structured questionnaire that consist of 32 questions on the eight Batho Pele principles. It will take fifteen to thirty minutes to complete the questionnaire. The data gathered from all the participants will be code protected and the

data-analysis process will be monitored by the Statistical Services of the NWU, Potchefstroom Campus.

CONFIDENTIALITY

The data you provide to the researcher will be dealt with confidentially. No other person beside the researcher and the research team members will have access to data provided. Anonymity will be ensured since no names will be used in data collection, analysis and dissemination of the research findings.

RISKS/ DISCOMFORTS

- I do not foresee that you will experience any discomfort and there will be no risks involved in this research.
- The interview might however create emotional discomfort because of past experiences and you are not at liberty to answer them.

BENEFITS

- Benefits will be that you will be the part of a team that contribute to new knowledge derived from the study that will result to improved quality care and patient satisfaction.
- The results will be communicated to you personally and in writing or in any other way that is preferred by the participants and the researcher at the end of the study.

COSTS

- No costs are involved for you to participate in this research.

PAYMENT

- No payment will be made to you for participating in the research. The researcher will be visiting the PHC clinics using her transport.
- Water and tea with refreshments will be available for you at the clinic where the structured questionnaires will be completed.

If you need further clarification and have questions to ask, consult Ms I.D Khumalo or call her at 082 713 9051.

CONSENT

- Copy of consent is provided for you to keep.

PARTICIPATION IN THIS STUDY IS VOLUNTARY

You are free to withdraw from the research at any time and you are also free not to accept to be in this research. Your non-participation in this research will have no impact on the present or future use of our PHC services.

PARTICIPANT NAME:_____(Please print)

PARTICIPANT SIGNATURE:_____**DATE:**_____

RESEARCHER NAME:_____(Please print)

RESEARCHER SIGNATURE:_____**DATE:**_____

APPENDIX C: ETHICAL APPROVAL

NORTH-WEST UNIVERSI
YUNIBESITI YA BOKONE
NOORDWES-UNIVERSITE
POTCHEFSTROOM

Privaatsak X6001, Potchefstroom
Suid-Afrika, 2520

Tel: (018) 299-1111/2222
Web: http://www.nwu.ac.za

FA 9.1: AUTHeR
Tel: (018) 299 4037
Faks: (018) 299 2464
E-pos: Este.Vorster@nwu.ac.za

Mev. Marietjie Halgryn
Institutional Research Support Office
NWU

10 September 2008

Dear Marietjie

ETHICS APPLICATION: NWU-0071-08-A1 (MEV. M.J. WATSON)

Title: Explaratory and descriptive study on the compliances to the Batho Pele principles in a Primary health context

The above application was reviewed by our Ethics panel. Ethical approval is granted above project.

Regards

Este' (H.H.) Vorster

Prof. H.H. Vorster

APPENDIX D: PERMISSION GRANTED UMZINYATHI HEALTH DISTRICT

HEALTH
KwaZulu-Natal

UMZINYATHI HEALTH DISTRICT OFFICE (DC24)
Private Bag X2052, Dundee, 3000
Tel.. 034- 2999 113 Fax: 034-2123139 / 2124500
Email: diana.govender@kznhealth.gov.za
www.kznhealth.gov.za

Date: 25/09/2008
Enquiries: Diana Govender
Ref: PME 002

Ms. I D Khumalo
DP/Bag 2024
Dundee
3000

Re – Permission granted to conduct Research at PHC facilities in Umzinyathi Health District

I have pleasure in informing you that permission has been granted to you, by Umzinyathi Health District Office, to conduct research on "Exploratory and descriptive study to the compliance to the Batho Pele principles in primary Health Care context".

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from The Research Unit in the KZN Department of Health.
3. Please ensure that this office is informed before you commence your research.
4. The district office will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office

Thanking you

Yours faithfully

D. J. Govender (Mrs.)
Deputy District Manager
Health Services Planning, Monitoring and Evaluation
Umzinyathi Health District

Cc: Mr. J. Mndebele – District Manager
Mrs. N. F. Ngema – Deputy District Manager

APPENDIX E: PERMISSION GRANTED HEALTH KWAZULU NATAL

HEALTH
KwaZulu Natal

Health Research & Knowledge Management sub component
10 – 103 Natalia Building, 330 Langalibalele Street
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Pietermaritzburg
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Tel.: 033 – 3953189
Fax.: 033 394 3782
Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM079/08
Enquiries : Mrs G Khumalo
Telephone : 033 – 395 3189

03 October 2008

Dear Ms Khumalo

Subject: Approval of a Research Proposal

1. The research proposal titled **'Exploratory and Descriptive Study on the Compliance to the Batho Pele Principles in a Primary Health Care Context'** was reviewed by the KwaZulu-Natal Department of Health. The proposal is hereby **approved** for research to be undertaken at uMzinyathi District.
2. You are requested to undertake the following:
   a. Make the necessary arrangement with identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mrs G Khumalo on 033-3953189.

Yours Sincerely

Dr. S.S.S. Buthelezi
Chairperson: Provincial Health Research Committee
KwaZulu-Natal Department of Health

APPENDIX F: INTERVIEW SCHEDULE AND FRAMEWORK FOR PATIENTS AS PARTICIPANTS

Introduction to the interview	
Introducion to the respondant that participate in the quantitave study that is descriptive in nature	The researcher clarifies that the participant and the interviewer (researcher) agree to the context and concepts used in this research. It is important to translate difficult professional terms into simple and understandable concepts. The context of this study refers to the PHC facilities situated in the sub-district of Nquthu and Endumeni in the Umzinyathi Health District of the KwaZulu-Natal Province The aim of this study is to identify and describe the experiences of patients and health care personnel regarding compliance with the Batho Pele Principles in a PHC context. Compliance in the study will be measured based on the Batho Pele Principle which are: **1. Consultation:** Citizens should be consulted about the level and quality of the public services they receive and wherever possible should be given a choice about the services they are offered. **2. Service Standards:** Citizens should be told what level and quality of the public services they will receive and, so they are aware what to expect. **3. Access:** All citizens should have equal access to the services to which they are entitled. **4. Courtesy:** Citizens should be treated with courtesy and consideration. **5. Information:** Citizens should be given full, accurate information about the public services they are entitled to receive. **6. Openness and Transparency:** Citizens should be told how National and Provincial departments are run, how much they costs, who are in- charge. **7. Redress:** If the appropriate standard of service is not delivered, citizens should be offered an apology, a full explanation and speedy and effective remedy; and when complaints are made, citizens should receive a sympathetic positive response. **8. Value for money:** Public services should be provided economically and efficiently in order to give citizens the best value for money.
Objective 1: **To describe the level of compliance with the Batho Pele principles as experienced by the patients in a PHC context.**	
Objective 2: **To describe the level of compliance with the Batho Pele principles as viewed by the health care personnel in a PHC context.**	

INTERVIEW FRAMEWORK- PATIENTS

STUDY TITLE: COMPLIANCE WITH THE BATHO PELE PRINCIPLES IN A PHC CONTEXT.

PURPOSE:

- To create an environment that is conducive to the patients.
- To improve and sustain patients' satisfaction
- To increase access to services
- To maintain client-staff relationship in the clinics
- To improve quality care services rendered in the spirit of Batho Pele.

THE ROLE OF THE INTERVIEWER

- Self introduction by the researcher or interviewer
- The purpose of the interview is outlined
- The duration of the interview is explained
- The manner in which the interview results will be utilized is confirmed
- The interviewee's general comments are taken note of.

GUIDELINES FOR COMPLETION OF THE TOOL

- Participants to be as objective and honest as possible.
- Participants to answer all questions to their best possible knowledge.
- You may not identify self by name.
- All answers will be treated with confidence and appreciation.

Please do not write your name as this interview is conducted anonymously.

BATHO PELE QUESTIONS- PATIENTS

Interview schedule (questionnaire) of a descriptive study on the compliance with the Batho Pele principles in a Primary Health Care context as adapted from the studies done by Mohoboko (2003) and Mbanga (2006) and partly from the surveys conducted by the Dundee Hospital on quality assurance and client satisfaction (2008).

SECTION A

Biographic Data

Please answer the following questions by putting a cross (x) on the appropriate number in the box.

1. **Your age category in years**

1	Below 20		5	50- 60	
2	20- 30		6	60- 70	

3	30- 40		7	70- 80	
4	40- 50		8	80 and above	

2. Gender

1	Male	
2	Female	

SECTION B

Question under Section B require that you indicate on a four-point Likert-based rating scale (marked 1-4) the level to which you agree or disagree with the given statement as follows:

1	2	3	4

1 = strongly agree

2= Agree

3= Disagree

4= strongly disagree

1.Compliance with Consultation	**SA**	**A**	**D**	**SD**
1.1 You are aware of the services rendered at this clinic				
1.2 Only the clinic manager decides on which services to be provided				
1.3 Services are provided at hours requested by the community				
1.4 You have been informed by the clinic staff about the services provided at this clinic				

2.Compliance with service standards	**SA**	**A**	**D**	**SD**
2.1 The services are good at this clinic				
2.2 Services are rendered according to your expectations				
2.3 To what extent have services received met your needs?				
2.4 Would you come back to this clinic if you were to seek help for the same reason again?				
3. Compliance with Access	**SA**	**A**	**D**	**SD**
3.1 It takes more than one hour to get to this clinic				

3.2 You do visit other clinics				
3.3 Patients have equal access to all services rendered				
3.4 You are satisfied about the services provided at this clinic.				
4.Compliance with Courtesy	**SA**	**A**	**D**	**SD**
4.1 The staff treats all the patients with respect				
4.2 The patients are treated with dignity in this clinic				
4.3 You are satisfied with the amount of help received from this clinic				
4.4 If a friend were in need of similar help, would you recommend our services to him /her?				
5. Compliance with Information	**SA**	**A**	**D**	**SD**
5.1 Patients are provided with up-to-date information about the services they are entitled to.				
5.2 Information is available in one official language				
5.3 You know who to call in cases of emergency				
5.4 Members of the community are given information about services				
6. Compliance with Openness & Transparency	**SA**	**A**	**D**	**SD**
6.1 You know the person in-charge of the clinic				
6.2 You feel free to ask about money spent on medicines				
6.3 You know the number of staff working at this clinic.				
6.4 The clinic staff wear name badges				

7. Compliance with redress	**SA**	**A**	**D**	**SD**
7.1 Did you experience problems during your visit to this clinic?				
7.2 Are you allowed complaining if you are not satisfied with the services that are being provided?				
7.3 When you complain, to what extent do you receive feedback?				
7.4 Has your complaint been dealt with satisfactory?				
8. Compliance with Value for Money	**SA**	**A**	**D**	**SD**
8.1 You have been informed about the clinic budget.				
8.2 This clinic saves costs.				
8.3 Did the nurse explain your condition?				
8.4 Did this service help to deal with your problems?				

THANK YOU FOR PARTICIPATING IN THIS RESEARCH.

APPENDIX G: INTERVIEW SCHEDULE AND FRAMEWORK FOR HEALTH CARE PERSONNEL AS PARTICIPANTS

BATHO PELE QUESTIONS FOR THE HEALTH CARE PERSONNEL (refer to appendix F for the introduction on the study and the Batho Pele principles)

GUIDELINES FOR COMPLETION OF THE TOOL

- Participants to be as objective and honest as possible.
- Participants to answer all questions to their best possible knowledge
- You may not identify self by name
- You may not identify self by name.
- All answers will be treated with confidence and appreciation.

Please do not write your name as this interview is conducted anonymously

Interview schedule (questionnaire) of a descriptive study on the compliance with the Batho Pele principles in a Primary Health Care context as adapted from the studies done by Mohoboko (2003) and Mbanga (2006) and partly from the surveys conducted by the Dundee Hospital on quality assurance and client satisfaction (2008).

SECTION A

Biographical Information

This section of a questionnaire refers to the background information of the participants. Although I am aware of the sensitive questions in this questionnaire, the information will allow me to compare the groups of participants. Once again you are assured that your response will remain anonymous and your co-operation will be highly appreciated.

Mark the appropriate box with a cross (x).

Age group (in years)	30 yrs or less	31- 40 yrs	41- 50 yrs	51- 60 yrs	61 yrs and above
Race	African	Coloured	White	Indian	Other
Gender	Male	Female			
Highest educational qualification	Grade 12 or less	Certificate	National Diploma	Baccalaureate Degree	Post-graduate Degree
Designation	General Assistant	HIV and AIDS counselor	Clinic supporter	ENA/ Enrolled nurse	Professional nurse
Years of service	5 yrs or less	6- 10 yrs	11- 20 yrs	21- 30 yrs	31yrs and above

SECTION B

Question under Section B require that you indicate on a five-point scale (marked 1-5) the extent to which you agree or disagree with the given statement as follows:

1	2	3	4

1 = strongly agree

2= Agree

3= Disagree

4= strongly disagree

1. Compliance with Consultation	**SA**	**A**	**D**	**SD**
1.1 The services are good at this clinic				
1.2 Only the clinic manager decides on which services to be provided at this clinic.				
1.3 You are aware of the guidelines in this clinic that informs you on how services are conducted.				
1.4 You have been orientated about the services provided at this clinic.				
2.Compliance with service standards	**SA**	**A**	**D**	**SD**
2.1 The services are good at this clinic.				
2.2 Services are rendered according to your expectations.				
2.3 To what extent have the services received meet the community needs?				
2.4 Would you recommend the services provided at this clinic to another person?				
3. Compliance with Access	**SA**	**A**	**D**	**SD**
3.1 This clinic provides comprehensive (supermarket approach) services to the community.				
3.2 the clinic cater for the elderly citizens				
3.3 Patients have equal access to all services rendered at this clinic.				
3.4 Operating hours are convenient to the users of this facility.				

4.Compliance with Courtesy	**SA**	**A**	**D**	**SD**
4.1 There is a fast queue for the patients with disabilities.				
4.2 The elderly patients are treated with dignity.				
4.3 The staff treats patients with respect.				
4.4 To what extent are you satisfied with the level of care provided at this clinic?				
5.Compliance with information	**SA**	**A**	**D**	**SD**
5.1 It is easy to find this clinic.				
5.2 The health education material is available in local language.				
5.3 During consultation procedures are explained to the patients.				
5.4 Interpreter services are arranged.				
6.Compliance with openness and transparency	**SA**	**A**	**D**	**SD**
6.1 The staff can give an outline of the services provided at this clinic.				
6.2 You know the number of the staff working at this clinic.				
6.3 To what extent are you involved with the clinic budget?				
6.4 The responsibility of ensuring openness and transparency is delegated to one of the professional nurses.				
7.Compliance with redress	**SA**	**A**	**D**	**SD**
7.1 Is there a complaints mechanism in place?				
7.2 To what degree are the patients allowed to lodge their complaints?				
7.3 To what extent do they receive feedback?				
7.4 Are they satisfied with the way complaints are handled at this clinic?				
8.Compliance with value for money	**SA**	**A**	**D**	**SD**
8.1 Do you know the budget allocated for this financial year?				
8.2 This clinic has strategies to improve efficiency saving.				
8.3 During consultation, the nurse explains the condition of the patient.				
8.4 To what extent does the quality of service monitored at this clinic?				

THANK YOU VERY MUCH FOR YOUR VALUABLE TIME AND PARTICIPATING IN THIS RESEARCH.