



**AN ASSESSMENT OF THE IMPLEMENTATION OF BATHO PELE  
PRINCIPLES BY HEALTH CARE PROVIDERS AT SELECTED  
MENTAL HEALTH HOSPITALS IN THE LIMPOPO PROVINCE**

*by*

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*A thesis submitted in fulfilment of the requirements for the degree:*

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## DECLARATION

I, **Nkhensani Florence Mabunda**, declare that the thesis “**AN ASSESSMENT OF THE IMPLEMENTATION OF BATHO PELE PRINCIPLES BY HEALTH CARE PROVIDERS AT SELECTED MENTAL HEALTH HOSPITALS IN THE LIMPOPO PROVINCE**” hereby submitted for the degree **Magister Curationis (MCur)** at the University of Venda has not been submitted previously by me at this or any other institution, that it is my own work in design and in execution, and that the sources that I have cited have been indicated and acknowledged by means of complete references.

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# DEDICATION

This thesis is dedicated to:

- My late mother, n'wa Makhongele Dorah Mabunda, and my father, Zulu Daniel Mabunda.
- My uncle, Ben Makhongele, who supported me throughout this study.
- Special gratitude to my brothers and sisters, and all the grandsons and granddaughters of the Mabunda family. Thank you for your encouragement. You will always be in my thoughts.

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## ABSTRACT

The Batho Pele Principles is incorporated in the National Government's White Paper on the Transformation of the Public Service. It is applicable to the public sector, both National and Provincial Government which are regulated by Public Service Act, 1994, to guide public servants on how to practice (Draft White Paper, 1995:2). Furthermore, health care providers as public servants are expected to practice Batho Pele Principles to improve quality health care services. The purpose of this study was to evaluate the implementation of Batho Pele Principles by health care providers at selected mental health hospitals of Limpopo Province.

The objectives of the study were to assess the implementation of Batho Pele Principles at the selected mental health hospitals of the Limpopo Province, to describe the challenges experienced by health care providers in the implementation of Batho Pele Principles and to formulate specific recommendations to improve and promote the implementation of Batho Pele Principles. A quantitative, descriptive research design was used and the population for the study comprised health care providers working at the selected mental health hospitals in the Limpopo Province. A probability-stratified random sampling method was used to select participants. Data were collected using a questionnaire containing both open- and close-ended questions. Data were analyzed statistically by a statistician using the Statistical Package for Social Sciences (SPSS), version 21.

The Higher Degrees Committee of the University of Venda and the Limpopo Province Department of Health granted permission to conduct the study. The validity and reliability of the questionnaire was ensured through conducting a literature review, which also provided operational definitions of key concepts and development of the questionnaire from existing ones, in consultation with the supervisors of this study. Adherence to ethical considerations included approval from University of Venda Health, Safety and Research Ethics Committee, thus ensuring the quality of the research, confidentiality, anonymity and informed consent.

Study findings revealed that health care providers lacked certain skills in relation to mental health care users' (MHCUs') experiences, plans and needs and that the principles of openness and transparency, redress and value for money were not easily implemented. Challenges experienced by health care providers in the implementation of Batho Pele Principles were discussed according to the eight Batho Pele Principles. Recommendations were formulated based on the findings, related to nursing practice, management, education and further research. This study was conducted to evaluate the implementation of Batho Pele Principles by health care providers at the selected mental health hospitals of Limpopo Province as a strategy to improve quality nursing care.

**Keywords:** Batho Pele Principles, transformation, excellence in service delivery, quality health care services, quality service improvement

# ACRONYMS

<b>ANC</b>	African National Congress
<b>BEE</b>	Black Economic Empowerment
<b>CME</b>	Continuing Medical Education
<b>CPD</b>	Continuing Professional Development
<b>COSATU</b>	Congress of South African Trade Unions
<b>DENOSA</b>	Democratic Nursing Organization of South Africa
<b>DPE</b>	Department of Public Enterprises
<b>DPSA</b>	Department of Public Service and Administration
<b>DOH</b>	Department of Health
<b>DOL</b>	Department of Labour
<b>GEAR</b>	Growth Employment and Redistribution
<b>HPCSA</b>	Health Professions Council of South Africa
<b>ICN</b>	International Council of Nurses
<b>IMCI</b>	Integrated Management of Childhood Illness
<b>MHC</b>	Mental Health Care
<b>MHCUs</b>	Mental Health Care Users
<b>NCS</b>	National Core Standards
<b>NHI</b>	National Health Insurance
<b>PHC</b>	Primary Health Care
<b>PMTCT</b>	Prevention of Mother-to-Child Transmission (of HIV)
<b>PSC</b>	Public Services Commission
<b>RDP</b>	Reconstruction and Development Programme
<b>SACP</b>	South African Communist Party
<b>SAQI</b>	South African Quality Institute
<b>VCT</b>	Voluntary Counseling and Testing
<b>WHO</b>	World Health Organization
<b>WHO-AIMS</b>	World Health Organization's Assessment Instrument for Mental Health Systems
<b>WPTPS</b>	White Paper on Transformation of the Public Service

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# CHAPTER 1

## INTRODUCTION AND BACKGROUND TO THE STUDY

### 1.1 Introduction

Batho Pele is a Sotho concept meaning ‘people first’ (Draft White Paper, 1995:4). This concept means that citizens as customers of public services should be considered first. To treat citizens as customers implies that the service provider should listen to the customers’ views and take them into account when making decisions about the types of services to be provided; treating them with consideration and respect; making sure that the promised level and quality of services is always of the highest standard and responding swiftly and sympathetically when standards of services fall below the promised standards (Draft White Paper, 1995:4). The Batho Pele Principles is the South African National Government’s White Paper on the Transformation of the Public Service (WPTPS) which is applicable to those public sectors, both national and provincial which are regulated by Public Service Act, 1994, to guide public servants on how to practice and provide services to clients (Draft White Paper, 1995:6).

### 1.2 Background to the Study

South Africa's economy was facing a variety of serious operational and logistical problems by the end of Apartheid in 1994 April. The former government and National party’s practices had been damaging to the economic climate, with stagnant economic growth, declining per capita income, increasing unemployment and spiralling debt. The national debt had increased from less than 3% to 9% and total government debt had more than doubled (Rabbani, 1994:3).

The new ANC government attempted to put together a policy framework that could redress the plethora of economic problems.

The Reconstruction and Development Programme (RDP) was presented to Parliament in 1994 to identify economic, social, political, moral, cultural and environmental problems that the country faced. The South African socio-economic policy framework implemented by the African National Congress (ANC)-led government of Nelson Mandela in 1994 after months of discussion and consultations between the ANC, its Alliance partners the Congress of South African Trade Unions (COSATU) and the South African Communist Party (SACP) and other organizations of the masses and the wider society. The ANC's aim in developing and implementing the RDP was to redress the existing socio-economic problems brought about by the consequences of the struggle against its predecessors under Apartheid (ANC, 1994:4).

The advent of the new South African democratic government in 1994 saw the establishment of RDP that was drawn up by ANC-led alliance to address the inequalities of the past. WPTPS was established by ANC to improve service delivery from 1995 in the form of Batho Pele Principles (Smith, 2002:94). According to Smith (2002:94), all public servants are required to practice Batho Pele Principles or guidelines when delivering services to the clients. Thus, health care providers as public servants are expected to practice Batho Pele Principles when providing quality health care services to their clients. Components of Batho Pele Principles are consultation, service standards, access, courtesy, information, openness and transparency, redress and value for money. These principles are discussed below.

#### **CONSULTING THE USERS OF THE SERVICES**

All national and provincial departments must regularly and systematically consult not only about the services currently provided, but also make provision for other new basic services to those who lack them. This will give the citizens the opportunity of influencing decisions about public services, by providing objective evidence which determine service delivery priorities. Furthermore, the results of consultation process must be reported to the Ministers or members of executive committees (MECs) and made public (Draft White Paper, 1997:6).

In applying Batho Pele in the health services, Muller (2008:8) suggested that citizens should be consulted about the level and quality of the public services they receive and, where possible, should be given a choice about the services that they are offered. The professional nurse/midwife provider should be open-minded towards the patients' needs in this regard and initiate patient satisfaction.

### **SETTING SERVICE STANDARDS**

National and provincial departments must publish standards for the level and quality of service they provide, including the introduction of new services to those who have previously been denied access to them. This means that standards must be precise and measurable so that the users can judge for themselves whether they are receiving what was promised. Performance against standards must be reviewed annually and they should be progressively raised, year on year (Draft White Paper, 1997:7). In applying Batho Pele in the health services, Muller (2008:8) suggested that citizens should be told what level and quality of public services they will receive so that they are aware of what to expect. Health units should have quality improvement programmes in place and the patient should be aware of the expected level of nursing care that can be expected.

### **INCREASING ACCESS**

All national and provincial departments are required to specify and set targets for progressively increasing access to their services for those who have not previously received them. Service delivery programmes should therefore specifically address the need to progressively redress the disadvantages of all barriers (Draft White Paper, 1997:8). In applying Batho Pele in the health services, Muller (2008:8) suggested that all citizens should have equal access to the services to which they are entitled. The professional nurse/midwife should facilitate the principle of equity. This could be a problem in the private health sector, especially in the trauma/casualty units. In this case, there should be a hospital policy to make provision for the treatment of trauma patients within the 'Golden hour' period.

### **ENSURING COURTESY**

National and provincial departments must specify the standards for the way in which customers should be treated and include these in their departmental codes of conduct. The performance of staff who deal with the customers must be regularly monitored and those which fall below the specified standards should not be tolerated (Draft White Paper, 1997:8). In applying Batho Pele in the health services, Muller (2008:8) affirmed that citizens should be treated with courtesy and consideration.

### **PROVIDING MORE AND BETTER INFORMATION**

Information must be provided in a variety of media and languages to meet the differing needs of customers. There should always be a name and contact number for obtaining further information and advice (Draft White Paper, 1997:9). In applying Batho Pele in the health services, Muller (2008:8) indicated that citizens should be given full accurate information about the public services they are entitled to receive.

### **INCREASING OPENNESS AND TRANSPARENCY**

Reports to citizens should be published as widely as possible and should be also submitted to national and provincial legislatures in order to assist the relevant portfolio committees in scrutinising and monitoring departmental activities. However, national and provincial departments may utilize events such as open days, preferably not during normal working hours, to invite citizens to visit the department or institution to meet with all levels of officials to discuss service delivery issues, standards, problems, and so on. These events can also provide the department or institution with opportunities to advertise their services to the citizens (Draft White Paper, 1997:10). In applying Batho Pele in the health services, Muller (2008:8) noted that citizens should be told how national and provincial department are run, how much they cost and who is in charge.

## **REDRESSING WRONGS**

National and provincial departments are required to review and improve their complaints systems in line with accessibility, speed, fairness, confidentiality, responsiveness, review and training (Draft White Paper, 1997:5). In applying Batho Pele in the health services, Muller (2008: 8) indicated that if the promised standard of services is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy, and when complaints are made, citizens should receive a sympathetic, positive response.

## **GETTING THE BEST POSSIBLE VALUE FOR MONEY**

All national and provincial departments are required as part of their service delivery improvement programmes, to identify areas where efficiency saving will be sought, and the service delivery improvements which will result from achieving the savings (Draft White Paper, 1995:14). In applying Batho Pele in the health services, Muller (2008:8) specified that public services should provide services that are economic and efficient in order to give citizens the best value for money.

In a study conducted in America by Mays, Smith, Ingram, Racster, Lamberth and Lovely (2007:256) on public health service delivery system, it was revealed that new research is needed to evaluate nursing staff and financial recourses that affect provision of services to the community. Numerous gaps and uncertainties were identified regarding mechanisms through which organizational characteristics influence the effectiveness and efficiency of the public health service delivery (Mays et al., 2007:256).

Furthermore, it was identified that disparities and gaps in access to health care persist. The report showed trends by measuring health care quality core measures that include effectiveness, patient safety, timelines, patient-centeredness, efficiency health system infrastructure and access. It was concluded that all citizens should have access to high-quality, appropriate and safe health care (Mays et al., 2007:2653).

A study conducted in Beijing on community-based mental health services identified that mental care is still hampered by lack of resources with specialist psychiatric care essentially based in large, centrally-located mental hospitals (WHO, cited in Alem, Jacobsson & Hanlon (2008:1). The same study also indicated that the health care providers have low level of skills which were insufficient to provide adequate services to the community. Furthermore, to improve delivery of basic community health services, necessitates the supply of clear and detailed protocols, increased funding and skilled health care practitioners (Alem et al., 2008:1). In this study, health care providers were assessed on how they set service standards that are measurable in the selected hospitals of the Limpopo Province.

A study conducted in 2007 by the Public Services Commission (PSC) to evaluate public services delivery in the implementation of Batho Pele Principles in South Africa recognized that the implementation of Batho Pele Principles should be evaluated to promote excellence in the delivery of affordable and sustainable quality services. However, PSC was directed at assessing how each principle of the Batho Pele is being implemented in the Public Service (Sangweni cited in PSC, 2008:8). The present study therefore assesses how health care providers implement Batho Pele Principles at the selected hospitals of the Limpopo Province as a strategy to improve quality health care services.

### **1.3 Research Problem**

The researcher works in a mental health care (MHC) institution as a professional nurse. The researcher observed that the processes used to evaluate the implementation of Batho Pele Principles in its monthly audits might not be sufficient. Batho Pele Principles are pasted on the walls in every ward or unit. The auditing tool includes the assessment whether the ward/unit complies with the implementation of Batho Pele Principles to the mental health care users (MHCUs). However, it is not clear how the Batho Pele Principles are implemented. The presence of the Batho Pele Principles poster on the ward walls seems to be used as compliance with the implementation of the principles.

In wards where hyperactive and intellectual disability MHCUs patients only are admitted, there seems to be challenges on how the Batho Pele Principles are implemented because of such patients' unusual conditions and there are no trained staff or health care providers who can interpret such MHCUs. This reveals that the implementation of Batho Pele Principles might be insufficient in such situations. It was therefore considered necessary to assess how health care providers at the selected mental health hospitals implement the Batho Pele Principles to improve quality patient care to the different MHCUs' conditions.

#### **1.4 Purpose of the Study**

The purpose of the study was to evaluate the implementation of Batho Pele Principles at the selected mental health hospitals of the Limpopo Province.

#### **1.5 Research Question**

The research question for this study was “How do the health care providers implement Batho Pele Principles at the selected mental health hospitals of the Limpopo Province?”

#### **1.6 Objectives of the Study**

Objectives of the study were to:

- ★ Assess the implementation of Batho Pele Principles at the selected mental health hospitals of Limpopo Province.
- ★ Describe challenges experienced by health care providers in the implementation of Batho Pele Principles.
- ★ Formulate specific recommendations to improve and promote the implementation of Batho Pele Principles.

## **1.7 Significance of the Study**

The identified challenges and obstacles that health care providers experienced when implementing the Batho Pele Principles at the selected mental health hospitals of Limpopo Province have been described and prompted recommendations that may improve quality care in the hospitals. The proposed study may contribute towards improvement of knowledge of how to implement Batho Pele Principles to MHCUs and the health care providers. The hospital may also benefit from the study as quality patient care will be improved as Batho Pele Principles will be implemented depending on the recommendation of the study. In addition, the research findings indicated areas for further research in relation to Batho Pele Principles and revealed many ways in which Batho Pele Principles can be put into practice. The provincial and national health departments may benefit as the overall system's performance may improve and also challenge other health care providers in other public institutions to continue to evaluate the implementation of the Batho Pele Principles on a regular basis.

## **1.8 Definitions of Concepts**

### **1.8.1 Assessment**

A process of evaluating the behaviour of an individual (Stephen, 2005:556). In this study, 'assessment' means to evaluate the way in which Batho Pele Principles are implemented in the selected hospitals of the Limpopo Province. Hence, assessment and evaluation will be used interchangeably in this thesis.

### **1.8.2 Health Care Providers**

An individual or institution that provides, preventive, curative, promotional rehabilitative health care services in a systemic way to an individual, family or community (<http://www.wikipedia.org/wikj/healthcareprovider>: 1).

In this study ‘health care providers’ means all health professionals (doctors, psychologists, physiotherapists, occupational therapists, dieticians and nurses of different categories) who provide health care services to MHCUs in the selected mental health hospitals of the Limpopo Province.

### **1.8.3 Implementation**

To make something that has been officially decided upon, start to happen or be used (Oxford Advanced Learners Dictionary, 2009:148). In this study, ‘implementation’ means to provide MHC services according to Batho Pele Principles.

### **1.8.4 Batho Pele Principles**

Batho Pele Principles are the South African national government’s White Paper on the Transformation of the Public Service, to guide the public servants on what to practice when providing services (Draft White Paper, 1995:2). In this study, ‘Batho Pele’ principles means general guidelines to be followed when providing health services and considering MHCUs as a first priority at the selected mental health hospitals of the Limpopo Province.

### **1.8.5 Improvement Strategy**

Refers to systemic, data guided activities designed to bring about immediate improvement in health care delivery in a particular setting (<http://www.ncbi.nlm.nih.gov/books/nbk2682:667>). In this study, ‘improvement strategy’ means to implement Batho Pele Principles better than before.

### **1.8.6 Quality Nursing Care**

The ability to coordinate and integrate the multiple aspects of excellence within the care directly provided by nurses and across the care delivered by others in the health setting

(Hughes, 2008:2). In this study, ‘quality nursing care’ means nurses’ responsibility to provide excellent health care.

## 1.9 Organization of the Chapters

- Chapter 1:** Is an overview of study and contains the introduction, background, problem statement, purpose, objectives, research design and methodology, ethical considerations, significance of the study, definitions of concepts, acronyms and organization of the subsequent chapters.
- Chapter 2** Encompasses the literature review
- Chapter 3:** Outlines the research design and methodology, including the population and sample, research setting, data collection and data collecting instrument, reliability and validity as well as ethical considerations and data analysis.
- Chapter 4:** Contains the analysis and interpretation of the results.
- Chapter 5:** Summarizes the limitations, recommendations and conclusions of the study.

## 1.10 Summary

This chapter has briefly discussed the introduction, background, problem statement, purpose, objectives, research design and methodology, ethical considerations, significance of the study, definitions of concepts, list of acronyms as well as the organization of the subsequent chapters. Chapter 2 will deal with the reviewing of pertinent literature.

# CHAPTER 2

## LITERATURE REVIEW

### 2.1 Introduction

The previous chapter discussed the introduction, background, problem statement, purpose, objectives, research design and methodology, ethical considerations, significance of the study, definitions of concepts, list of acronyms as well as the organization of the subsequent chapters. This chapter focuses on the literature review on transformation of service delivery and the provision of quality health services. De Vos (2010:117) described a literature review as a process of finding, reading, understanding and forming conclusions about published research methodology and theory by authoritative scholars on a particular topic. A literature review identifies and compares earlier studies, and helps to avoid duplication and unnecessary repetition (Mouton, 2005:87).

Burns and Grove (2003:810) explained a literature review as an analysis and synthesis of research sources to generate a picture of what is known about a particular situation and knowledge gaps that exist in that situation. A literature is all the written sources relevant to the topic of interest. A literature review involves reading, understanding and forming conclusions about published research and theory as well as presenting it in an organized manner (Burns & Grove, 2005:93). According to Bless, Higson-Smith and Kagee (2006:183), a literature review is an integrated summary of all available information relevant to a particular research question. A literature review is obtained mainly by reading whatever has been published that appears relevant to the research topic as an on-going process.

Mouton (2005:91) stated that the review of literature should be structured around the key concepts of the research problem and research questions asked.

The purpose of the literature review is to conduct a critical analytical appraisal of the recent scholarly work on the topic, by determining what is already known about the topic, the researcher can thus obtain a comprehensive picture of the state of knowledge and so identify the research problem and refine the research question. However, the purpose of the literature review is to sharpen and deepen the theoretical framework of the research by studying different theories related to the topic, abstracting interdisciplinary perspectives, where possible, and to familiarize the researcher with the latest developments in the area of research. The literature review serves as well as to identify gaps in knowledge and weaknesses in previous studies, that is, to determine what has already been done and what is yet to be studied or improved (Bless et al., 2006:24; Brink, 2006:67).

## **2.2 The Establishment of the Reconstruction and Development Programme**

The Reconstruction Development Programme (RDP) was discussed in Chapter 1. ANC (1994) defined RDP as the plan to redress the many social and economic problems facing our country such as violence, lack of housing, lack of jobs, inadequate education and health care, lack of democracy and a failing economy. The study revealed that RDP is a programme to mobilize all our resources to ultimately get rid of Apartheid and built a democratic, non-racial and non-sexist future (ANC, 1994:5).

Five key programmes which aim to improve the standard of living and quality of life for all South Africans were identified—meeting basic needs, developing human resources, building economy, democratizing the state and society and implementing the RDP. Health care is part of basic needs to be provided to ensure that everyone has access to such services. Health care services can be affordable and can lead to improvement in physical and mental health while attending to combating disease (ANC, 1994:12).

The study revealed that ANC as a liberation movement and based on the traditions of the Freedom Charter is the only political organization which can bring together such a range of social movements, community-based organization and numerous other sectors and formation.

Furthermore, millions of ordinary South Africans citizens have struggled against the Apartheid system for many years in order to bring justice and prosperity to all. The first democratic elections held on the 27th April 1994 were a great victory for struggling South Africans. Elections are the first step to rebuilding a new democratic and prosperous country (ANC, 1994:3).

The RDP aims to promote health and increase the quality, quantity of health support and counselling services, particularly for those affected by difficulties or other social evils such as violence, by rape or child abuse. Furthermore, government developed a national health system offering affordable health care which is focused on primary health care to prevent diseases and promote health as well as to cure illness and also to improve and expand MHC (ANC, 1994:4). The programme to address the whole problem reveals that the effect of Apartheid cannot be overcome by policies which only look at some problems and ignore others. Thus, the RDP addresses all of the problems (ANC, 1994:6). Six basic principles or strategies of RDP are to:

- ★ Address the whole problem, not part of it—based on the needs and energies of all the people;
- ★ Provide peace and security for all;
- ★ Build a new nation;
- ★ Link reconstruction and development;
- ★ Build and strengthen democracy;
- ★ Make the best use of all of resources both now and for the future.

The programme which puts People First with hope is also included as the most important resource. According to ANC (1994:3), the RDP focuses on people's immediate needs, then on their energies to meet those needs.

The RDP reveals that a programme is required that is achievable, sustainable and meets the objectives of freedom, and improves the standard of living of all South Africans within a peaceful and stable society characterized by equitable economic growth. The six major principles which have been outlined and which will guide and give substance to the remainder of the programme include the following:

An integrated and sustainable programme which is essentially centred on, a people-driven processes which are closely bound up with, peace and security which will be able to embark upon, nation-building and which requires the citizens to link reconstruction and development; all five principles depend on a thorough democratization of South Africa (O'Malley, 2011:6).

The South African people recognize the injustices of the past, honour those who suffered for justice and freedom of South Africa, respect those who have worked to build and develop our country and believe that South Africa belongs to all who live in it; therefore the people are united in diversion. Freely-elected representatives adopt the constitution as the supreme law of the Republic to heal the division of the past and to establish a society based on democratic values, social justice and fundamental human rights. This had laid the foundations for the democratic and open society in which the government is based on the will of the people and every citizen is equally protected by law. This should improve the quality of life of all citizens, and build a united democratic South Africa able to take its rightful place as a sovereign state in the family of nations (O'Malley, 2011:87).

Chapter Two of the Bill of Rights, section 21 (1), deals with the right to health care, food, water and social security: (1) Everyone has a right to have access to health care services, including reproductive health care, sufficient food and water and social security. Schedule Six, Transitional arrangements (23) (2) (a) (1) states that everyone has a right to access to information held by the state or any of its organs in any sphere of government insofar as that information is required for the exercise of protection of any of their rights as adopted on 08 May 1996, and amended on 11 October 1996 by the Constitutional Assembly (South Africa,

1996:07, 162). In this study, access to health care services in the Bill of Rights is the same as the Batho Pele ‘access’ principle.

The Patients’ Right Charter as a common standard for achieving the realization of access to health care services revealed that everyone has a right of access to health care services that include: (vi) a positive disposition displayed by the health care providers that demonstrate courtesy, human dignity, patience empathy and tolerance; (vii) health information that include the availability of health care services and how best to use such services and such information shall be in the language understood by the patients (Khoza, 2009:15). The right to access in the Patients’ Right Charter is same as the Batho Pele ‘access’ principle and is directly related to the Bill of Right’s access to information.

### **2.3 White Paper on the Transformation of Public Services**

The South African Batho Pele Principles, as the national government’s White Paper on the Transformation of the Public Service (WPTPS)(The Constitution of South Africa, 1996) reveals that the effectiveness of the White Paper will assist in delivering services to meet the basic needs of all South African citizens. That is why meeting the basic needs is one of the key programmes of the government’s RDP. It is also the reason why the government’s macro-economic strategy called ‘Growth Employment and Redistribution’ (GEAR) calls for, among other things, the reduction in government consumption and the release for productive investment and their redirection to areas of greatest need (Draft White Paper, 1997:5).

Furthermore, the WPTPS also provides the framework to enable national and provincial departments to develop service delivery strategies that would promote continuous improvement in the quality and equity of service provision. Improving the delivery of public services means redressing the imbalances of the past while providing continuity of services to all levels of society, focusing on meeting the needs of the 40 % of South Africans who are living below the poverty line and those, such as the disabled and black women living in rural

areas, who have been previously disadvantaged in terms of service delivery (Draft White Paper, 1997:7).

WPTPS therefore, urgently seeks to introduce a fresh approach to service delivery; an approach which puts pressure on systems, procedures, attitudes and behaviour of employees within the public service. This approach is encapsulated in the name which has been adopted by this initiative Batho- Pele (a Sotho adage meaning 'People first'). The Batho Pele policy frameworks consist of eight service delivery principles which set out a practical agenda of transforming the delivery of public services. Therefore, the White Paper is applicable to those parts of the public sector, both national and provincial which are regulated by the Public Service Act, 1994. It is also relevant to all areas and employees of the public sector regulated by other legislation, such as local government and parastatals, teachers in education departments, as well as the South African Police Service, South African National Defence Force and Intelligence Services (Draft White Paper, 1997:5).

The White Paper reveals that putting the Batho Pele Principles into practice is the challenge now facing the South African public sector. These principles are what national and provincial departments will be required to do and also be regarded as guidance by all levels of Government and wider public sector when introducing their service delivery improvement programme. However, pilot areas of the public services are the National Department of Health (DOH), Department of Home Affairs and Provincial Administration in North-West. All the public servants are required to practice Batho Pele Principles or guidelines in the White Paper. These principles guide the public servants on what to practice (Draft White Paper, 1995:2). In the hospital situation, all health care providers are expected to put Batho Pele Principles into practice as a strategy to improve and promote quality care.

The Batho Pele Principles history reveals that Batho Pele has its roots in a series of policies and legislative frameworks which have been categorized into three themes, namely: those that are overarching or transversal, those that deal with access to information and those that

deal with transformation of service delivery. Overarching/transversal legislative frameworks. The Constitution of the Republic of South Africa of 1996 (as amended), Section 32, provides for the universal right of access to information held by the State to facilitate the exercise or protection of any right by citizens, e.g., the right to access public services in an equitable, convenient and cost-effective manner (DPSA, 2012:14).

WPTPS identified two legislative frameworks that seek to transform a culture of public service delivery from prescribing service packages to citizens, to putting citizens at the centre of service delivery Access to information and Transforming Public Service Delivery. These legislative frameworks are intended to give effect to the Constitutional right of the citizen to have access to any information held by the State and binds government institutions to have information available and regularly updated to meet the changing needs of the citizens. They include: Open Democracy Act of 2000, Promotion of Access to Information Act of 2000, Electronic Communications and Transactions Bill of 2002 and E-Government Strategy of 2001 (DPSA, 2012:18). Furthermore, these legislative prescripts provide for the progressive increase of access to public services and promote efficient administration and good governance in the public sector. They include: WPTPS of 1997, Promotion of Administration Justice Act (AJA) of 2000 and Public Finance Management Act of 1999. These legislative prescripts also cover the creation of a culture of accountability, openness and transparency in public administration (DPSA, 2012:19)

Therefore, visions and missions of Batho Pele Principles exist to instil a sense of common purpose and energize members of an organization towards action. Batho Pele vision and mission emanated from the realization that government should transform service delivery mechanisms to meet the needs of citizens. In this context, the following vision and mission statements were developed to energize the transformation efforts of public servants: *Vision* "To continually improve the lives of the People of South Africa by a transformed public service, which is representative, coherent, transparent, efficient, effective, accountable and responsive to the needs of all". *Mission* "The creation of a people-centred and a people-

driven public service that is characterized by equity, quality, confidence and a strong code of ethics" (DPSA, 2012:14). In the hospital situation, all health-care providers are expected to be in line with Batho Pele Principles and put them into practice as strategy to improve and promote quality care.

National Health Plan (NHP) for South Africa initiated in May 1994 as an extension of the RDP aim to increase efficiency as well as ensuring greater control by communities and individuals over aspects of their lives. In the health sector, the NHP involves a complete transformation of the national health care system with its goal to ensure that the emphasis is on health and not only on medical care. This implies that health care providers should inform patients about a healthy lifestyle before initiating medical treatment, 'providing of better information' is a principle of Batho Pele. Furthermore, to encourage and develop comprehensive health care practices that are in the line with international norms, ethics and standards 'setting service standards' that are reflected in the Batho Pele Principles (ANC, 1994:7).

Currently, no research has focused or evaluated the phenomena related to transformation of public service delivery for acute or chronic mental health. The policy on Quality in Health Care for South Africa states that improving quality in health care is a key national challenge. This policy also indicates that the national aims for improvement of quality in health care relevant to this study, is 'increasing access,' a principle of Batho Pele. It is indicated in the policy that the national health care capacity should be balanced to ensure that the underserved population also have access to health care services and equity is attained (National DOH, 2007:3).

Mpulo (2001:3) investigated the impact of the implementation of Batho Pele Principles at King Edward VIII Hospital. The study concentrated on how this respected health institution, both nationally and internationally, have implemented the prescripts pertaining to the improvement of service delivery. The discussion also focused on the extent of improving

service delivery (Batho Pele) in the hospital. Batho Pele was officially launched in December 1999 at the hospital as part of the provisions of the White Paper on the transformation of the public service (Mpulo, 2001:3). The study highlighted an emphasis on transforming the public service, the reasons being to improve the quality of life of all the communities of the country and to inculcate the principles of democracy and place the constitution as the supreme law of the Republic of South Africa. Therefore, transforming public service delivery requires a comprehensive document and much more which supports this change.

The study identified huge disparities in predominantly African institutions compared to historically white institutions that were advantaged by the inequity of the past Apartheid system. The emphasis of this new dispensation is that the service should be provided fairly and equitably (Mpulo, 2001:3). The study reflected 12 components for development of a strategic framework in South Africa which set out health priorities of the DOH for the period 1999–2004. This is for strengthening the implementation of efficient, effective and high quality health services (Mpulo, 2001:3).

**Components include:**

- ★ Decreasing morbidity and mortality rates through strategic interventions. Combat infant morbidity and mortality. poor nutrition and trauma;
- ★ Revitalizing of public hospitals and provincial physical facilities planning frameworks;
- ★ Accelerating delivery of an essential packages of primary health care services;
- ★ Training of staff in appropriate clinical and non-clinical skills;
- ★ Improving resource mobilization and management and equity allocation;
- ★ Optimizing the balance between personnel and operational expenditures;
- ★ Improving human resource development management—developing and implementing human resource policies;
- ★ Improving quality care by strengthening the Batho Pele Programme—currently being rolled out in the department incorporating the principle in the patient charter;
- ★ Enhancing communication and consultation in the health system and with communities and building communication as a management competence;

- ★ Changing of legislation (legislative reform) to allow non-medical personnel to head hospitals;
- ★ Re-organizing certain support service and restructuring and transforming emergency medical services; and
- ★ Strengthening co-operation with international partners, liaising with regards to medical officers (Mpulo, 2001:30).

Mpulo (2001:30) reckoned that the strategic framework and the national guidelines emerging for various health problems are in line with what is considered best practice internationally. There has been clear progress, though there have been questions about the ability to intensify success because some programmes have insufficient evidence that they are emerging at the scale required. The study implied that health departments cannot immediately afford to give all citizens the number of hospital beds they would like to and what modern medicine has to offer (Mpulo, 2001:30). However, in a country like South Africa, the issues are around consistent improvement of the baseline. South African issues are still geared towards providing services for all who were historically disadvantaged.

Mpulo (2001:50), highlighted that most of the strategic framework ultimately impacts on service quality and also that better wages have not brought greater staff commitment to Batho Pele and that finding sustainable ways of living up to Batho Pele still remains a key challenge. The sustainability of quality initiatives in the face of the financial pressures faced by provincial and local government will remain a major challenge and therefore a systematic effort, innovative approaches and allocation of resources will be required for improved quality service (Mpulo, 2001:50). According to Muller (2008:8), the South African Public Services will be judged by one criterion above all: its effectiveness in delivering of services which meet the basic needs of South African citizens; improving service delivery is, therefore, the ultimate goal of the Public Service Transforming Programme. The study also focused on professional nurses and midwives who should be acquainted with and should design strategies to ensure compliance with the Batho Pele Principles (Muller, 2008:8).

However, the International Council of Nurses (ICN) also espouses the implementation of the Batho Pele Principles. In 1953, the ICN developed a Code of Ethics for nurses based on four fundamental responsibilities promoting health, preventing illness, restoring health and alleviating suffering. Other elements reflected in the Code of Ethics include, nurse and people, nurse and practice, nurse and the profession, nurse and co-workers. Various Ethical Responsibilities within these elements are described and denoted in the form of standards which also reflect the application of Codes of Ethics. Moreover, every nurse/midwife practitioner should be acquainted with the ICN Code of Ethics in order to apply ethical principles within the professional ethical and legal framework of a particular country (Muller, 2008:8). The author also pointed out that the Pledge/Code of Service reflects the nursing profession's specific conviction about nursing; it is derived from the Nightingale Pledge and has been used since the beginning of nurse training in South Africa (Muller, 2008:8). When taking the pledge, a nurse/ midwife enter into a verbal agreement with the community:

*"The total health of my patient will be my first consideration.  
I will hold in confidence all personal matters coming to my knowledge.  
I will not permit consideration of my religion, nationality, race or social standing to  
intervene between my duty and my patients; "patient will be my first consideration."*

***Batho Pele Principles Framework***

Muller (2008:8) stated that the pledge reflects the nurse's service-directed mission thus implying that the nurse will always put the patient first, in other words, his/her own interest will always come second. A nurse/midwife rendering services to the individual, family, groups and community in any given country has four fundamental responsibilities that have to be carried out within the professional-ethical and legal framework. This entails the nurse/midwife applying Batho Pele Principles by promoting health, preventing illness, restoring health and alleviating suffering (Muller, 2008:8).

Muller (2008:8) asserted that it has been recommended that nurses should design a strategies to ensure facilitation of observing these ethos (people first) in their units, and should critically analyse and reflect on their abilities (knowledge, skills and attitude) by reflecting Batho Pele

Principles. It is important to continue with research studies in order to evaluate the impact of these principles in our society and to improve the implementation of Batho Pele Principles of service delivery and accountability by the government departments.

## **2.4 Batho Pele Principles**

### **2.4.1 Consultation**

All national and provincial departments must regularly and systematically consult not only about the services currently provided, but also make provision for other new basic services to those who lack them. This will give citizens the opportunity to influence decisions about public services, by providing objective evidence which determine service delivery priorities. Furthermore, the results of consultation processes must be reported to the Ministers or MECs and made public (Draft White Paper, 1997:6).

Wagner, Smits, Sorra, and Huang (2013:1) examined patient safety culture in hospitals in three countries, the Netherlands, the USA and Taiwan, and to diagnose common and country-specific strengths and weaknesses. Their study revealed that in order to reduce the number of adverse events, hospitals have to stimulate a more open culture and reflective attitude towards errors and patient safety. However, hospitals in all three countries have high scores on teamwork within units. Also the area with a high potential for improvement in all three countries is handoffs and transitions (Wagner et al., 2013:1).

In addition, differences between countries exist in the following dimensions: non-punitive response to error, feedback and communication about error, communication openness, management support for patient safety and organizational learning-continuous improvement. On the whole, US respondents were more positive about the safety culture in their hospitals than Dutch and Taiwanese respondents. Nevertheless, there are even larger differences between hospitals within a country. Equally, all three countries can improve areas of their patient safety culture. Countries can identify and share best practices and learn from each

other (Wagner et al., 2013:3). In this study, health care providers were assessed on how they implemented consultation and identified challenges they experienced as a strategy to improve quality nursing care.

The study by Mays (2008: 263) suggested that public health systems can be defined from multiple perspectives, including the governmental system, service delivery systems and casual systems. Regarding the *Service Delivery System*, the study reflected that perspectives encompass the services that both governmental and private organizations perform to protect and promote health at the popular level. Furthermore, many organizations are striving to become more customer-centred in their services and products. Organizations will need to ensure that their employees are aware of customer expectations and meet those expectations, suggesting that research should investigate the congruency of the employee-customer assessment and the effects that such congruency will contribute to the efforts of these organizations (Mays et al., 2008:263). In this study, health care providers were assessed on how they consulted the users of the services so that they could improve, where necessary.

Furthermore, public health agencies, professionals, and others involved in the delivery of public health need to be more directly involved in the conceptualization, design and conduct of research of public health systems. Researchers from a broad spectrum of social, behavioural, and scientific disciplines must be engaged in applying the methodological advance from their field of study of public health systems thereby ensuring improvements in scholarship. Study results suggested that new research is needed to evaluate the effects of on-going changes in mental health delivery system structure (Mays et al., 2008:263). Although the research process in the study was not indicative or exhaustive, the four structural dimensions represented some of the most tangible and tractable characteristics of the public health system that are amenable to change through policy and administration (Mays et al., 2008:264).

A study conducted by Young, Meterko, Mohr, Shwartz and Lin (2009:127) in the United States on assessment of service quality between the health care providers and health consumers. Discussions reflect that the study was systematically investigating whether and to what degree health care providers assessed the quality of services of their organizations and to their customers since many organizations were now striving to become more customer-centred in the services and products they produce (Young et al., 2009:127). A customer health care service that was initiated in the United States was likely the same as the People First framework that is, consulting the user in South Africa to improve and promote health care (Draft White Paper, 1997:6).

A study by WHO (2005:22) identified that specialized mental health expertise should be available including community health workers with special skills in mental health to improve the standards of mental health services. The necessity of on-going monitoring was stressed. The effective practice will be disseminated by increasing involvement of patient, family and community in mental health institutions. The development of mental health services according to the special needs and the social and cultural conditions has also been recommended to improve the quality of mental health services (WHO, 2005:22). The study recommended that health care providers involve the patient, family and the community, which is related to the consultation principle that gives citizen opportunity to influence decisions for public services (Draft White Paper, 1997:6).

Wakemen and Humphreys (2011:2) conducted a study in Australia on sustainable Primary Health Care (PHC) services in order to develop appropriate, accessible and sustainable PHC services to difficult-services communities. Study results highlighted the strong history of PHC innovation, successful health systems are contextualized to adhere diverse conditions. It was also identified that health systems require systemic solutions which address a range of interlinked factors such as governance, leadership management, inadequate funding, infrastructure, service link and workshop. However, effective systemic approaches rely on alignment of changes in health care services. Those in the external policy environment,

ideally every level of government of health authority need to agree on policy and funding arrangement for optional service delivery (Wakermen & Humphreys, 2011:2).

The same study also highlighted the importance of a systems approach in addressing health service requirements, although health care providers, funders and consumers need to know the type of level of services they can reasonably expect in different contexts. These are the same as the setting service standards principle, citizens should be told what level and quality of public services they will receive so that they are aware of what to expect. Health units should have quality improvement programmes in place and the patient should be aware of the expected level of nursing care that can be expected (Wakermen & Humphreys, 2011:2). Addressing health service in this study is the same as consulting the user of the services in accordance with the Batho Pele Principles.

Swana (2008:3) conducted a study to assess the implementation of Batho Pele Principles in the Department of Agriculture in Limpopo Province of South Africa. The study revealed that improved public service delivery depends on several aspects ranging from human resource development to performance measurement and accountability. The study identified that larger percentage of the officials in the Limpopo Department of Agriculture do not satisfactorily implement the Batho Pele Principles. However, this lack of proper implementation of the principles by the employees in the department implies that service delivery does not take into cognisance the notion of 'People First' and thus customers' satisfaction cannot be guaranteed (Swana, 2008:3). In this study, challenges experienced by health care providers when implementing Batho Pele Principles were identified.

Batho Pele Principles are regarded by officials as an additional activity that could be done on a voluntary basis; the employees' performance against the principles has not been included in their performance contracts and thus is not monitored. The study has investigated the extent of compliance to the Batho Pele Principles and the impact of their implementation on service delivery within the department. Focus was also given to how the compliance audit is being

undertaken, as well as possible mechanisms to address the issue of non-compliance and redress issues. Swana (2008:58) indicated that the department is doing fairly well in terms of general compliance to the Batho Pele Principles. However, consultation processes do take place and are done at a satisfactory frequency, such as monthly and quarterly (Swana, 2008:58).

Swana (2008:59) further indicated that the consultative mechanisms ranging from imbizos, workshops, meetings, stakeholder forums, circulars to summits are being used in the department. However, the challenge with regard to the principle of service standards emanated during the stage of developing and reviewing was identified. Swana (2008:59) specified that the affected parties did not form part of the process. Furthermore, in spite of service standards having to be implemented by officials at the Department of Agriculture, it became evident that they were not incorporated in their performance contracts or job descriptions (Swana, 2008:59).

The Department of Public Enterprises (DPE) released a progress report with regard to the implementation of Batho Pele Principles and contended that initiatives must be understood from the context of the mandate and mission of the department. These will serve as a vehicle to manage government shareholder interest through monitoring and evaluation of the overall performance of the state. Furthermore, the department also serves to promote and advocate best performance management practices, which will enhance the shareholder value within an improved corporate governance environment (DPE, 2011:2).

The DPE highlighted that consulting users of service means that the department does not provide services directly to end-users, through its performance monitoring and benchmarking unit, the DPE monitors services that state-owned enterprises provide to the end-users. Furthermore, the department does not consult with users unless there is a crisis, which the state-owned enterprises cannot handle by themselves, for example, during the Eskom-Soweto electricity collapse, the minister of the DPE went to Soweto to talk to the users (DPE,

2011:3). In this study, challenges experienced by health care providers when consulting users of services were identified as a strategy to improve quality nursing care.

The Public Service Commission (PSC) also highlighted *Batho Pele Revitalisation Programmes* to address challenges to the roll-out of Batho Pele Flagship Programmes. In 2004, Cabinet approved that Batho Pele be implemented and promoted according to 4 key themes, namely: taking public services to the people; know your service rights campaign; putting people first; mainstreaming, institutionalizing, sustaining and fostering accountability for the implementation of Batho Pele. Furthermore, studies highlighted *Batho Pele Impact Assessment Programme Now* that refocuses the Batho Pele approach. The refocus entails: integrated service delivery approach using Batho Pele as a vehicle for allocation of separate principles to each province (PSC, 2003:5). The PSC has also conducted studies between 2000 and 2007 to promote the constitutionally enshrined democratic principles and values of the Public Service by investigating, monitoring, evaluating communicating and reporting on public administration. Evaluation of performance and compliance with Batho Pele Principles of consultation was studied in 2007, while a survey of compliance with the Batho Pele policy was conducted in 2000 (PSC, 2008:2). The PSC also conducted a study to assess the degree to which the Public Service complies with the consultation principle as required by the White Paper. The study revealed that almost all departments that responded to the study indicated that they do incorporate some form of consultation (PSC, 2007:3).

However, the survey found that there was a confusion of differentiating between communication and consultation. Communication mechanisms such as Annual Reports and advertisements were often mentioned as a consultation tool. The study also indicated that these measures do not normally provide the public with the opportunity to raise concerns. The study recommended that departments should prioritise the concretisation of consultation standards and the purpose that such standards need to be fulfilled. Furthermore, the department should improve the manner in which it monitor and evaluate the implementation

of their consultation process so that timely steps can be taken to address areas of ineffectiveness and limited success (PSC, 2007:32).

A study conducted by National Executive Committee (NEC) of Democratic Nursing Organization of South Africa (DENOSA) in 2008 determined the extent of DENOSA members' (dis)satisfaction and attitudes in respect of services provided to them by the organization. The purpose of the study was to build nurses' capacity to create a work environment that will allow them to deliver quality of care. The study will therefore adopt the tool: Health Worker for Change, a manual to improve quality of care. (DENOSA, 2010:12).

President Jacob Zuma indicated that public servants who respect the citizens they serve are needed. He said this in his briefing to the portfolio committee on the Batho Pele Programme of the Department of Public Service and Administration (DPSA) at his meeting with top managers held on 23 April 2010. He also indicated that all government departments, both national and provincial, are compelled to align their service delivery mandate and improvement plan with the overall service priorities of government based on the needs of the citizens. The rationale for the development of Batho Pele Programme was borne from a need for commitment to service excellence—Batho Pele is about real professionals doing real jobs addressing real issues which affect real people (DPSA, 2010:2).

President Jacob Zuma also highlighted a need for the revitalization of Batho Pele as a way of life. This means that departments should take stock of their values, as well as behaviour and attitudes of employees and then take necessary steps to prepare public servants for a revitalized Batho Pele culture of responsiveness, efficiently and effectiveness in delivering services to the public. A New Belief Set was also highlighted as “we belong, we care and we serve” to endorse the eight Batho Pele Principles. President Jacob Zuma also indicated the Belief Set as an integral part of any service planning and implementation strategy of all programmes (DPSA, 2010:11). In this study, health care providers have taken the necessary

steps to improve the implementation of Batho Pele Principles by identifying challenges they experienced when implementing Batho Pele Principles.

Verbal presentation on the Anti-Corruption Programme of the DPSA by Clark, Acting Director-General, revealed that the Draft Public Service Charter should be seen by public servants as a living document. However, it was aimed at public servants to re-commit themselves to the principles of the existing Code of Conduct and the Batho Pele Principles. Clark further highlighted that the PSC was a statement of commitment to the people of South Africa for the conduct of public servants and would contribute towards a fairer, sustainable and better future for all. Furthermore, the following components were addressed in the Charter: the eight attributes of a public servant; the nine commitments of a public servant to the people of South Africa; the seven rules of engagement for public servants and the 12 commitments of a public servant to the public service. The Charter, a key instrument still undergoing consultation, was established in 2003 to co-ordinate anti-corruption activities in the public service. It included senior representatives of key departments (DPSA, 2010:22). Therefore, it is necessary to consult the user of the services in order to identify the shortcomings and improve where necessary. In this study, challenges experienced by health care providers when implementing Batho Pele Principles were identified to improve quality nursing care.

A study on improving quality of services in Western Cape district hospitals also supported consultation and recommended that districts and other health managers need to take the lead in developing a culture of quality in health services by setting vision, encouraging and supporting initiatives at district and facility levels; to learn, teach and use the patient-centred clinical model as the usual approach in consultations (Shaw et al., 2005: 178, 186). The policy on quality in health care for South Africa supported consultation principle and reflected its essence in reducing errors in health care; this policy revealed that health care and health status can be enhanced by improving patient safety and reducing the level of error in health care delivery. Moreover, systems can be designed and health professionals trained in

methods to improve patient safety by reducing hazards in health care, and to render the consequences of errors less serious when they do occur. The policy also identified the targets of quality assurance interventions which are: health professionals, patients, community and health care service delivery (DOH, 2007:5).

Interventions aimed at health professionals include traditional approaches to keeping health professionals up-to-date is Continuing Professional Development (CPD), using the Continuing Medical Education (CME) conference. However, health care can be improved by increasing patient safety. There is a need to develop expertise to help clinicians modernize their practice. Feedback to health professionals about their performance has also proved to be a useful way of improving quality. Furthermore, the policy recommends a range of interventions, rather than one or two single measures to assist health professionals to keep abreast of changes in health care knowledge and practice (DOH, 2007:6).

An intervention aimed at patients involves understanding patients' perceptions. However, there is a growing emphasis in health care on partnerships between the patient and the provider. It is clear that improved communication between the health professional and the patient, and providing patients with understandable information about their condition and treatment options, has a positive effect on health outcomes. Furthermore, interventions aimed at the community needs an active involvement of the overall health status of the population. However, not only is individual patient participation important in improving quality, but also the active involvement of whole communities. This has been amply demonstrated in the key role played by communities in the fight against HIV/AIDS. Partnerships with community structures such as Non-Governmental Organizations (NGOs) and community-based organizations are important for mobilizing community action and advocacy around health issues (DOH, 2007:7).

Xaba et al., (2012:5) explored perceptions of registered nurses regarding factors influencing service delivery and identified community education including the use of clinic committee

members to educate the community on health service operational issues and create awareness of available services. Clinic committees must be reintroduced for better participation.

This was also supported by Heunis et al., (2006:39) who stated that the use of clinic committees should be motivated as a good strategy to invite community participation. This is the same as consulting the user of the services of this study. However, Heunis et al., (2006:44) state that community participation is an essential pillar of PHC and can be affected through clinic committees. Informing the community about the operational hours of clinics is one of the aspects of the Batho Pele Principles introduced by the DPSA in 1997 to guide the health services of South Africa (Xaba et al., 2012:7).

This was also supported in a study conducted by Peltzer et al. (2005:39) to identify factors that influenced prevention of mother-to-child transmission (PMTCT), concluded that family and community support should be improved through peer support groups and training of community counsellors. This could also be done by fostering couple and community discussions. Botma et al., (2007:53) suggested that in order to integrate topics on HIV/AIDS into the education of the community; the community needs to be educated on parental and school guidance.

Xaba et al., (2012:5) found that the factors that affect service delivery in a PHC setting are interrelated and have a negative impact on quality of care. The study recommended that integration of programmes and coordination be done at a provincial level and planned together with the training centres in order to alleviate problems in service delivery. Training on expansion programmes in the form of in-service education should be carried out continually in the region. Furthermore, services such as family planning should be extended to weekends and after-hours for clients who work or attend school.

Based on the results of the study, further research on the effects of the shortage of skills and lack of space on integration of the expansion programmes in the PHC setting is recommended. It is important that comprehensive basic training of nurses on the expansion

programmes related to mother and child health and HIV and AIDS is included in the curriculum. Further research should be conducted on the actual effects of factors related to inadequate skills on the quality of service delivery (Xaba et al., 2012:7) In this study, recommendations were made based on the results of the study as a strategy to improve quality nursing care.

#### **2.4.2 Setting Service Standards**

Citizens should be told what level and quality of public services they will receive so that they are aware of what to expect. Health units should have quality improvement programmes in place and the patient should be aware of the expected level of nursing care that can be expected (Muller, 2008:8). A comprehensive study conducted in America by Mays, Smith, Ingram, Racster, Lamberth and Lovely (2007:256) in relation to current public health service delivery systems, highlighted the fact that new research is needed. Numerous gaps and uncertainties were identified regarding mechanism through which organizational characteristics influence the effectiveness and efficiency of the public mental health service delivery. Concerns about such gaps in availability and quality have grown rapidly in recent years in response to both new and persistent health risks including emerging and resurgent infectious diseases, the threats of bioterrorism, large-scale disasters leading to mental illness and the advance of the obesity and related chronic diseases (Mays et al., 2008:256). In this study, health care providers were assessed on service standards as a strategy to improve quality nursing care.

Modi and Ledingham (2013:1) conducted a study to investigate and improve performance in primary and secondary care of mental illness. They stated that patients with psychotic illnesses are predicted to die 15 years younger than the national average. However, evidence-based guidelines including those produced by the National Institutes of Health and Clinical Excellence, and the Quality Outcomes Framework, recommended regular monitoring of their cardiovascular risk. Following an audit in general practice, it became clear that there was a

group of patients that were chronic non-attenders. It was not clear whether these patients were the responsibility of the general practices or psychiatric services. An audit in secondary care then looked at the level of cardiovascular health monitoring in that setting, and the communication of results to primary care (Modi & Ledingham, 2013:1). The researcher assumed that regular monitoring of cardiovascular risk was redressing patients who were chronic non-attenders.

A comprehensive study by Herman, Mattke, Somekh, Silverheilm, Goldner, Glover, Pirkis Maiz and Chan (2006:2) identified that there is lack of agreement on which measures should be used to improve MHC. The challenges are to some extent even greater than the diverse nature of the field and competing priority among stakeholders have showed consensus development on a core set of measures for common use. The study revealed that several countries have implemented measures to evaluate MHC, and highlighted that panellist evaluation was conducted. In the first phase, panellists anonymously rated measures on numerical scales for importance, soundness and feasibility. It is indicated that in selecting quality measures, organizations typically seek to maximize desirable measure attributes, e.g., the Organization for Economic and Community Developments' Health Care Quality Indicators regards as important scientific soundness and feasibility (Herman et al., 2006:2).

Herman et al (2006:8) indicated that a more extensive, but crucial undertaking is developing consensus nationally and internationally on standardized methods for structured assessment of clinical diagnoses, symptoms severity and functional impairment as well as tools to evaluate patients' experiences and treatment fidelity. The measure set recommended provided a starting point for international benchmarking of MHC. Even though much work will be needed to refine, specify implement and argument these measures, they provide a foundation for further progress (Herman et al., 2006:8). Developing consensus nationally and internationally on standardized methods for structured assessment is the same as setting service standards principles in this study.

Mkize (2007:62) made recommendations with regard to the neglect of patients—the Patients’ Rights Charter should be supported, implemented and monitored, and every morning Batho Pele Principles should be read and internalized by the staff on duty. Further, the Charter’s 139 principles should be communicated regularly to patients as part of ward routine to promote monitoring by patients. Service standards should be clearly defined and prominently displayed at service delivery points. This would make it easier for the public to recognize what constitutes acceptable professional behaviour. Close-circuit television cameras should be installed at strategic points and there should 24-hour monitoring by the security company (Mkize, 2007:62).

However, with regard to sexual abuse, the staff member who was accused of raping a patient should be charged accordingly, and the employer should refer this matter to the South African Police Services. Therefore, all cases of alleged sexual and physical abuse should be handled according to the protocol, which would ensure that the patient be examined by at least 2 independent medical practitioners. Furthermore, all suspected or reported cases of sexual abuse should be handed over to the SAPS. There should be separate wards for children and adolescents to avoid sexual abuse. Condoms should be readily available to patients (Mkize, 2007:63).

For physical abuse, staff should be trained on how to handle violent and aggressive patients. Protocols on how to handle acutely disturbed patients should be made available to staff members. The study recommended that all cases of physical abuse should be reported to the SAPS. However, the committee found it difficult to recommend on theft of patients’ food because of lack of clearly defined procedures in handling patients’ food. A full inventory of the patients’ belongings should be kept and updated as patients are moved from ward to ward (Mkize, 2007:64).

Regarding patients sleeping on the floor, Mkize (2007:65) indicated that the practice were more prevalent in the seclusion rooms, the committee recommended that beds should be fixed

to the floor. Female patients not allowed access to underwear; disposable underwear should be purchased for psychotic patients. Abuse of staff members by patients, staff should be aware that because of the nature of their illness, mentally ill patients tend to be abusive. Therefore, patients should be treated with tact, tolerance and compassion. Protocols should be followed in handling aggressive patients. In recognition of the dangers of the work environment, the incentive of a danger allowance should be reinstated (Mkize, 2007:65).

For staff reporting on duty under the influence of alcohol, breathalyser tests should be kept in the matron's office; any staff member suspected of intoxication should be reported immediately and the breathalyser test should be administered. All suspected cases of intoxication should be examined by a doctor on call. An Employee Assistance Programme should be instituted. Due processes should be implemented, including disciplinary action and dismissal. High rates of absenteeism were found to be directly related to alcohol abuse, HIV/AIDS, poor working conditions, annual leave (Mkize, 2007:67).

Furthermore, the following measures were proposed to address the issue of poor working conditions: infrastructure upgrade, danger allowance, all vacant posts to be advertised and filled, proper supervision, clear career-patching, and improved relationship with unions. The institution should plan even distribution of leave for nurses throughout the year. The present leave committee should be disbanded and a new committee reporting to the hospital board should be established. All doctors' certificates should be scrutinized by the new leave committee and irregular certificates should be reported to the Health Professions Council of South Africa (HPCSA) (Mkize, 2007:69).

Additional recommendations for poor patient management include guidelines should be developed to assist practitioners to maintain a balance between carrying out their duty of care and getting enmeshed in the affairs of health care users thereby running the risk of violating human rights. Co-ordinated interdepartmental collaboration should be fostered between the Departments of Health and Social Development in the provision of mental health services.

The Department of Social Development should be involved in the humane placement of geriatric patients being kept illegally at the hospital. The hospital should institute sustained MHC campaigns incorporating a human rights culture and a positive image of the hospital (Mkize, 2007:71). Development of guidelines to assist practitioners in carrying out their duty is the same as setting service standards principle in the study.

According to the Department of Public Enterprises (DPE), setting service standards means that state-owned enterprises set themselves standards, which form part of their business cases and shareholder compacts and the DPE approves these after rigorous scrutiny and benchmarking them with their peers. Furthermore, performance monitoring and benchmarking units employ the agreed upon performance and set targets to monitor and implement those standards which state-owned enterprises submit in quarterly reports, which help in monitoring their performances throughout the year (DPE, 2011:3). Muller (2008:8) suggested that citizens should be told what level and quality of public services they will receive so that they are aware of what to expect. Setting service standards in this study means that MHCUs should be told what level and quality of public services they will receive so that they are aware of what to expect. Furthermore, challenges experienced by health care providers when setting service standards were identified.

PSC (2003: 2-4) conducted a survey to assess compliance to Batho Pele Principles; the study identified differential levels of implementation of the 8 Principles of Batho Pele. However, service improvement was seen as a separate campaign and not integrated into the daily core business of departments—thus, the study identified that service delivery improvement programmes were merely listing procedures without necessarily indicating how an improvement of quality, quantity or efficiency level will be attained by departments. Batho Pele Principles has to change the historical attitudes of how frontline personnel work and behave towards the public in the delivery of services and lack of adherence to basic Public Administration practices (PSC, 2003:4).

Batho Pele Principles has to be incorporated into the Performance Management System of all departments, including absence of basic requirements in departments, e.g. service standards, service delivery improvement plans, signage and redress mechanisms plans. PSC indicated that the service delivery charter is a statement of commitment that a department makes towards service delivery based on its mandate, capacity and resources. These reinforce service delivery improvement to all recipients by meeting their reasonable expectations (PSC, 2003:4). In this study, health care providers were assessed on how they implement Batho Pele Principles as a strategy to improve quality nursing care.

PSC highlighted the following challenges which are being addressed by the introduction of the Batho Pele Revitalisation Strategy in order to ensure compliance: public servants lack practical skills to apply the Batho Pele Principles, narrow and uneven interpretation of Batho Pele, no service standards are set to mediate citizen expectations of service delivery. Service Delivery Improvement programmes are not aligned with service delivery capacity and resources in departments (PSC, 2003:5).

According to Khoza (2009:86), insufficient planning and budgeting for capital expenditure at the level of the hospital management hinders the implementation of the Batho Pele Principles. The fact that the Batho Pele Principles, Patients Right Charter and the complaint boxes had not been placed conspicuously in the units/wards, obstructs the "setting of standards", which state that standards must be precise and measurable so that the users can judge for themselves whether they are receiving what was promised (Draft White Paper, 1997:7).

A study conducted by National Executive Committee (NEC) of Democratic Nursing Organization of South Africa (DENOSA) in 2008 determined the extent of DENOSA members' (dis)satisfaction and attitudes towards in respect of services provided to them by the organization as both labour unions and professional association for nurses and nursing (DENOSA, 2010:12). The study revealed that there was a generally high level of satisfaction

with the effectiveness of services delivered by DENOSA. Furthermore, members were satisfied with the current benefits offered to them and current levels of services delivered.

However, there were few areas of dissatisfaction that require improvements such as communication between members and DENOSA staff at local level, accessibility of DENOSA members at local level and disconnection between the national and local personnel. The study recommended that DENOSA should re-train and re-orientate their local staff to communicate with their members, leadership should call a national summit to specifically find ways to unlock any disconnections between national and local official (DENOSA, 2010:30). Therefore, it is also important to conduct research evaluating services provided so that recommendations and suggestions can improve the level of current standards.

The president of South Africa, Jacob Zuma, has also urged nurses to raise their standards. He was addressing a nursing seminar with the Health Minister Aaron Motsoaledi at the opening of 3-day National Nursing Summit in Sandton that was held under the theme: *Reconstructing and Revitalising the Nursing Profession for a Long and Healthy Life for all South Africa*. He said that nurses should remember that health care is a right not a favour. He indicated that nurses are the key sources of information, comfort, assurance and delivery of treatment to the patients and that nurses are a pivotal service delivery unit in the health care sector. He emphasized this point because he felt that at times public servants may think they are doing members of the public a favour when in fact they are providing services that the citizens are entitled to (Mapumulo, 2011:2). President Jacob Zuma also indicated Belief Set as an integral part of any service planning and implementation strategy of all programmes. The New Belief Set is also highlighted as “we belong, we care and we serve” to endorse the eight Batho Pele Principles. “We serve”, in order to have a sense of services, the public should develop service standards, provide information, seek service delivery solutions and go beyond the call off duty (DPSA, 2010:11).

According to DPSA (2010:22), Corruption Management Information System (CMIS) was being developed to collect data on corruption. Clark addressed the system allowed for e-filing of financial disclosure forms and was linked with other relevant databases to monitor corruption. Clark said that over and above the activities as presented, the DPSA would jointly implement additional activities supporting these activities that include conducting public perception surveys and the implementation of a national, standardized ethics campaign for the public sector. Continued capacity building was the key factor. The conduct and attitudes of public servants would be evaluated against the principles of Batho Pele (DPSA, 2010:22).

Legodi (2008:94) revealed that standards of service delivery in health care, especially at PHC level, and strategies to assess and monitor the implementation of Batho Pele Principles have not been fully established. The study highlighted the challenges faced by the clinics of Capricorn District in the provision of quality care according to Batho Pele Principles (Legodi, 2008:94). Legodi (2008:99) also recommended that research should be conducted into: strategies to improve client participation in improving health services at PHC level, strategies to monitor service standards level of PHC on a continuous basis, especially in rural areas.

A study by Shaw et al., (2005:178) on improving quality of services in Western Cape district hospitals identified challenges to improving quality around issues such as development of basic management and health information system, patient and community feedback mechanism, asking available existing standards and creating effective referral. The study also recommended that districts and other health managers need to co-design any quality initiative and service description with the community to ensure that measurable standards are created to assess the achievement of these standards (Shaw et al., 2005:178). Therefore, it is necessary to set measurable standards so that the users can judge for themselves whether or not they are receiving what was promised (Draft White Paper, 1997:7).

According to Sepahzad et al., (2013:3), health professionals need to be informed of protocols in their local department, whether they are clinical, procedural or for the use of a service as ultimately better knowledge of service leads to better use of it. Health professionals were reminded of their responsibility in maintaining patient safety and the importance of regular involvement in quality improvement at any level in training. The study revealed that the transport of urgent specimens to an off-site laboratory is a complex service involving multiple members of staff and a number of steps. It was also revealed that multiple factors were the cause of the delay in the transport of urgent specimen, compromising patient safety (Sepahzad et al., 2013:3). Muller (2008:8) suggested that citizens should be told what level and quality of public services they will receive so that they are aware of what to expect. Health units should have quality improvement programmes in place and patients should be aware of the expected level of nursing care that can be expected.

However, the measures implemented dramatically reduced specimen transport time and have led to positive changes in the service leading to improved patient care. Development of a new central specimen reception will hopefully contribute in improving the problem throughout the hospital. Furthermore, for the outcome to be sustainable, it is important that staff involved are regularly informed and reminded of the protocol in place for sending urgent microbiology specimens and that regular audit is implemented to ensure a high quality service is maintained (Sepahzad et al., 2013:3). In this study, health care providers were assessed on how they implemented Batho Pele Principles, the challenges experienced by health care providers when implementing service standard principles were described as a strategy to improve quality nursing care.

Gibson, Heaney and Hull (2013:1) conducted a study to investigate in-patient falls in an elderly care ward to reduce inpatient falls by 20% and to improve quality of care provided post-fall. The study identified that approximately 282,000 inpatient falls were reported to the National Patient Safety Agency, making them the most common patient safety incident reported annually. However, national audits have found low levels and/or poor

implementation of relevant evidence-based assessments and interventions throughout the UK. However, the Fallsafe project: a quality improvement initiative focusing on prevention and management of falls, identified that successful studies used ward-based leaders rather than visiting specialists, engaged a multidisciplinary team, and addressed five to fifteen risk factors for falls in their interventions. In addition, it was noted that combinations of evidence-based interventions were required to improve patient outcomes (Gibson et al., 2013:3).

Gibson et al., (2013:3) revealed that care plans were introduced initially for use with one consultant's patients who were admitted with a fall. Furthermore, the number of falls in an Elderly Care ward can be reduced by the use of a multi-factorial assessment and an interventional care plan. Moreover, a multidisciplinary team approach is necessary for success and the authors suggested a dedicated time for the clinical lead to educate staff. In hindsight, as most interventions are nurse-orientated, a ward-based nurse would be best placed to fulfil the role of clinical lead. The same study demonstrated good compliance with a multi-factorial falls assessment and care plan and an incentive poster, as well as positive feedback from staff regarding usage (Gibson et al., 2013:3). These observations revealed that service standards were measurable as the staff demonstrated good compliance. In this study, challenges experienced by health care providers when implementing Batho Pele Principles were identified as a strategy to improve quality nursing care.

The policy on quality in health care for South Africa supported service standards principle and indicted that it is sensible to have a national policy and develop national standards for both public and private health care facilities; it is the task of staff in each sector to deliver the quality improvements. This requires a *Quality Assurance* culture and approach to the delivery of health care. For the public sector, this requires action at all levels. This policy document describes proposed methods to be used that follow the approaches outlined above. Moreover, consistent local action is needed to ensure that national standards and guidelines are reflected in the delivery of services (DOH, 2007:14).

### 2.4.3 Access

In applying Batho Pele in the health services, Muller (2008:8) advocated that all citizens should have equal access to the services to which they are entitled. The professional nurse/midwife should facilitate the principle of equity. A study conducted in Australia by Duong, Binns & Lee in 2004 to investigate factors that influence the utilization of delivery services at the PHC level, indicated that clients perceived quality of services, socio-cultural and economic factors rather than geographical access that can affect the utilization of service delivery. The same study indicated that currently the government had implemented several interventions to improve the access and quality of health services, including mental health and maternity services (Duong et al., 2004:26). Several interventions that have been implemented in Australia to improve public access to health care services are the same as increasing access in the Batho Pele Principles that is being implemented in South Africa.

The study revealed that China has made a great effort to improve the health of its huge population, and had made considerable successes in this endeavour. However, excessive health care costs and inconvenient access to healthcare are still major health care problems in China. In order to solve these problems, China has initiated a new approach which includes improving PHC facilities and offering equitable access to public health services across the country (Zhao et al., 2009:40). The results further suggest that in order to improve the delivery of public health services, it is necessary for Beijing Municipal Government to supply clear and detailed protocols, increasing funding and increasing the number of skilled health care practitioners in the community services (Zhao et al., 2009:42). The study did not reflect on how the initiated approach is going to be reviewed to evaluate its impact on the public to access health service delivery like the transformation of public service in South Africa.

Izibeloko, Jack and Leana (2013:12) conducted a study to explore barriers that prevent people from utilising mental health services and to identify key factors to increase access and improved service delivery. The study identified that mental illness is a disabling, chronic

condition that poses numerous challenges in its management and as risk factors for other health problems and that the centralized mental health service for a population of over four million is unable to provide the required services and support. However, effective utilization of service needs to be supported by adequate resources and staffed facilities that encourage good health seeking behaviour and sustain treatment follow-up. To overcome these barriers, priority should be given to mental health service delivery (Izibeloko et al., 2013:15).

Furthermore, services should be provided throughout the health care system to enable people to access them locally and affordably, preventing the need to travel and promoting service uptake and treatment continuation, only then will persons with mental disorders live productive and fulfilled lives. The study findings presented many factors that were found to act as barriers to mental health service utilization. Barriers were categorized as physical, financial and cultural.

### **PHYSICAL BARRIERS**

Izibeloko et al., (2013:15) identified factors relating to physical barriers to service utilization, i.e., the awareness of available services and the ability to access them, with three themes emerging, namely, poor knowledge of mental health service, centralized mental health service and waiting time. However, caregivers and clients held similar views that poor knowledge of the available mental health service, and the uncertainty about where to go for treatment being reasons for not seeking the needed care. The study identified that caregivers observed that during psychiatric emergencies, i.e., relapse or adverse drug reactions where prompt attention was required, they relied on locally available sources for support (spiritual healers) due to the absence of mental health service outside the Rumuigbo Hospital, this being particularly problematic for those living in rural communities (Izibeloko et al., 2013:15). Furthermore, long waiting times for mental health services at the clinic was raised as a significant issue by both clients and caregivers, and concerns were expressed regarding the lack of staff. The study identified that the public is still only vaguely aware of mental disorders, the availability of mental health services and effective treatment outcomes.

Although long waiting times at the hospital makes access to mental health service very difficult and resulted in some service users giving up without receiving the necessary care. Also, long distances travelled to access mental health service created barriers for many service users, this being more common for rural dwellers that lack transportation, which had to take time away from their trade, work or home responsibilities (Izibeloko et al., 2013:17).

### **FINANCIAL BARRIERS**

Izibeloko et al., (2013:19) identified the economic implications of obtaining mental health services, three themes were observed: travel distance/transportation, high cost of services and loss of productive income. For clients, long journeys to access services were cumbersome and costly, and lack of money for transport to the hospital meant that they could not always access the care needed. However, with regard to high cost of services both groups felt that their poor financial circumstances resulted in their inability to utilize mental health services. Service users experienced financial burdens in accessing MHC, keeping follow-up appointments and paying for treatment. Furthermore, the need to pay for services resulted in many individuals being unable to sustain treatment, with the continuous use of prescribed medications being necessary to maintain an improved mental state (Izibeloko et al., 2013:19).

### **CULTURAL BARRIERS**

The same study identified that community members held negative perceptions about mental disorders that resulted in families and affect persons experiencing stigma and feelings of shame. For stigma/discrimination, the study identified that participants observed that due to the public's negative perception, information about mental disorders was considered too intimate to share with people outside of the nuclear family without attracting stigma. Caregivers and clients viewed feelings of shame as experienced in Rumuigbo Hospital, as one of the main barriers to accessing services. Access to early MHC and sustaining the treatment is critical to promote mental health well-being, as well as to identify mental health issues and prevent the disease progression. However, good MHC is important for the general population, but particularly vital for individuals and families living with mental disorders.

Fear of stigma/discrimination was an important reason for not seeking or sustaining treatment due to the fear of what others might think, thereby preventing many from sustaining their treatments, the findings being consistent with previous studies in Nigeria (Izibeloko et al., 2013:25).

The experiences associated with stigma/discrimination negatively impacted on their emotional/social well-being, resulting in families hiding ill relatives and not talk about it, which affected the families' perceptions and ability about seeking appropriate help. It is important for society to understand how stigma impacts on people with mental disorders and the need for change in public attitude—the study recommended these in order to improve access to mental health services and improve service delivery. Information about what services should available and where, needs to be widely disseminated to encourage people to seek treatment when they find themselves experiencing the signs and symptoms of mental disorders. Services need to be expanded and the number of mental health professionals increased to assist in the identification, management and prevention of symptoms at all levels of care (Izibeloko et al., 2013:30).

The challenges associated with centralized care need to be addressed, specifically the waiting times, access and the cost of services. Social welfare nets in the form of free medication or a subsidy for the low-income as a support mechanism would reduce the financial burden of many families and persons with mental illness, and allow them to sustain treatment. Social education needs to occur for people to overcome cultural barriers that impact on those with mental disorders and highlights the need for change in public attitude to support help seeking (Izibeloko et al., 2013:33). The access and information aspects on the study are the same as the South African Batho Pele Principles in this study, challenges experienced by health care providers when implementing these principles are discussed.

According to Myers (2012), there is growing concern about the increased demand for and limited access to substance abuse treatment in South Africa. The study revealed that

government has responded by allocating more money to the delivery of substance abuse treatment, expanding the number of state-funded treatment slots, and training additional health and social workers to deliver these services, particularly in provinces where the prevalence of substance-related problems is high, such as the Western Cape. While these efforts should be commended and continued, steps to improve service availability have occurred without adequate consideration of the quality of services provided (Myers, 2012:4). The study identified that treatment quality is especially important because of public and consumer concerns about the quality and effectiveness of substance abuse treatment and whether public money is being spent efficiently to achieve the best possible outcomes. However, quality service is a concern too of South African policy-makers. The Third (draft) National Drug Master Plan (2012 - 2016) and the DOH's Mini Drug Master Plan (2011 - 2014) specify quality service improvement as a priority requiring action. Furthermore, improving quality service is also a key focal area of the strategic framework for 2010 - 2013 of the National DOH, which established an Office of Health Standards Compliance in 2012 that is tasked with quality assurance activities (Meyer, 2010:7).

The study identified that in order to meet this goal of improving quality service, objective data on the quality of substance abuse treatment must be routinely collected from all service providers. However, quality service measurement system holds significant potential benefits for consumers, service providers and policy-makers. The steering committee first agreed upon the main goals for the substance abuse treatment system and through consensus identified five variable domains corresponding to these goals: treatment effectiveness, treatment efficiency, access to services, person-centred services, and quality of care. The committee identified potentially useful indicators for measuring progress within each domain (Meyer, 2010:7)

The study recommended retaining the current focus on generating usable data. This ensures that data allow for comparisons to be made across facilities and are accessible to providers in formats that they can easily understand and use to improve programmes. Finally, as the goal

of this initiative was to ensure that the data are used to improve quality service, study strongly recommended that capacity to interpret and use the data is developed among service providers and policy-makers before system implementation and that on-going support for data interpretation is provided to system end-users. However, developers of the National Health Insurance (NHI) should take notice of this initiative and consider how quality measurement can be built into the monitoring of the NHI from the outset. Failure to extend the current narrow focus on improving access to health services to include a quality focus may represent a missed opportunity to improve the health of South Africans (Meyer, 2010:18). In this study, health care providers were evaluated on how they implemented access principles in their institutions as a strategy to improve quality nursing care.

According to Swarts (2013:2) in improving access to quality health care, the National DOH has made community service mandatory in South Africa for newly graduated health professionals. The study revealed the shortage of health care professionals within the public health sector, the community service initiative can also be located within the larger global impetus of integrating mental health into primary health care. The study identified the challenges inherent in this placement site are numerous. These include patients' inability to access the service due to financial constraints and the lack of public transport, the burdensome work environment of generalized nursing personnel and their lack of training in MHC, the absence of mental health specialists and a multidisciplinary health team, the provision of MHC being embedded within the biomedical model, and a lack of institutional support (Swarts, 2013:4).

However, these weaknesses are largely reflective of the poorly integrated health system operative within the Overberg District Municipality. The study recommended that in order to ensure that the strategic thrust, as envisioned by the National DOH with the introduction of the community service initiative, comes to fruition in that individuals can access quality health care services within their respective communities at the primary level of care (Swarts, 2013:4).

According to Eistener, Filton and Delbaco (2002:53), determinants of service utilization have been the main focus. Negative perceptions and dissatisfaction with service quality also affect health-seeking behaviours and utilization of services. However, previous studies on the utilization of services often focused on quantitative socio-economic and demographic variables which did not explain clients' behaviour nor suggested potential intervention measures (Diehr & Lin, 1999:59). The study results were reviewed according to logistic regression model which state that access to services in terms of distance to community health centre has little influence on the service delivery option. Discussions revealed that perception of the quality of services is likely to contribute to the low rate of service delivery and the provider-client relationship have a major impact on the perception of the quality of services and in turn the utilisation of delivery services (Hipgrave, 2003:153).

The study suggested that the provision of accessible services does not guarantee their use and that other social and cultural considerations must be taken into account in order to increase access to health care services. The study concluded that client-perceived quality of services, socio-cultural and economic factors influenced the utilization of health services. Moreover, delivery of services should be provided in a client-oriented manner taking into account social and cultural factors as well as local features (Hipgrave, 2003:154). Bolin and Gamm (2005:2) conducted a study on access to quality health services in rural areas with special emphasis on health insurance. The study reflected that health insurance is a critical factor in influencing timely access to health care. However, persons without health insurance are less likely to have a regular or usual health provider, less likely to obtain preventive care, or to obtain needed tests and prescriptions. Therefore, the DOH and Human Services interagency workgroup has identified health insurance as one of the 10 leading health indicators and generally a reliable predictor of overall health status (Bolin & Gamm, 2005:2). Access to quality health services in this study is the same as the access in the Batho Pele Principles.

The study indicated that access to quality health services (which includes access to insurance) was most frequently identified as a rural health priority. Approximately three-quarters of the

respondents named access to quality health services as a priority. It was the most often selected priority among all four types of state and local rural health respondents in the survey and across all four geographic areas. Study results identified that working adults living in rural areas are less likely to be offered health insurance through their jobs, i.e., employer-sponsored insurance programmes. However, this difference is mostly associated with rural dependence on smaller firms and lower wage rates. The study also identified that rural residents had higher rates of private, self-purchased health insurance and were more likely to be uninsured (Bolin & Gamm, 2005:15).

The study by Herman et al., (2006:4) identified measures that are representative of highly diverse health care systems. The dimension of this diversity included domain for quality (e.g. prevention access, assessment treatment continuity coordination and outcomes). Furthermore, study results reflected that individuals with severe mental illness died at a younger age than members of the general population; and that better detection and general medical care for these individuals could contribute to narrowing this gap (Herman et al., 2006:4). In this study, challenges experienced by health care providers when implementing access principle were identified.

For specific cases, Mkize (2007:72) recommended that patients should not be discharged immediately from the hospital, and should be referred to the Review Board and the HPCSA as a violation of human rights. All patients should have access to their hospital records in accordance with the Access to Information Act. Inadequate recreational facilities, racism, nepotism and favouritism influence sufficient service delivery. The study recommended that a designated Transformation Committee should be formed as a matter of urgency to deal with these anomalies and to educate and train people on transformation. Furthermore, the DOH should investigate the management style at the hospital and appropriate action should be taken (Mkize, 2007:72). Access in the study is the same as access in the Batho Pele principle in this study.

However, Mkize (2007:86) identified that the Committee was unable to interview the previous Hospital manager, a main player in the previous poor management as mentioned above. Although mental health impacts on all aspects of life in the country, MHC is trivialized in a way that sabotages the good intentions of the law. Study Departmental strategic plans and budgets revealed that such revitalisation contributes to a denial of patient access to quality MHC. Furthermore, study recommended the DOH must work in collaboration with the Social Welfare Department, Department of Education and Department of Works in their respective roles to produce a sustainable and innovative solution in the interests of quality patient care (Mkize 2007:82). Moreover, the hospital board must monitor and evaluate implementation of the recommendations of this Committee. At a higher level the provincial and national Heads of Health Care must demonstrate commitment to sustained support of the laws and regulations that are in place to improve quality health care (Mkize, 2007:86).

Herman (2007:1) also conducted a study to measure the basic process of Mental Health Care (MHC), such as access, detection, treatment appropriateness, safety and community care. The study revealed that in improving MHC, a guide to Measurement-Based Quality Improvement integrates practical information about quality measures such as their clinical logic, validity and basis in scientific evidence into highly readable guide on how to implement measures and how to use the results to improve quality of care. The study identified that MHC can be improved by examining the clinical, policy and scientific underpinnings of the process measurement, widely used method of assessing quality of MHC. According to Herman, the use of measurement to improve quality may promote accountability, encourage evidence-based practice and shape incentives to favour the delivery of high quality care. It was identified that improving MHC helps health care providers and other stakeholders meet national mandates to assess and improve quality of care. Measures to improving the quality of MHC are the same as setting service standards principle in this study.

Kiguli, Ekarapa- Karacho, Okui and Mutebi (2009:79) conducted a study that assessed the community's perception and perspectives on quality of health care delivery at selected Uganda districts. The study focused on a poor vulnerable group that often bears a huge burden of diseases. The study revealed that the community's views were well solicited and obtained using group discussions. However, service delivery to the poor general population is perceived to be of low quality. The study identified factors that affected quality delivery, namely, inadequate trained health care providers, shortage of essential drugs, poor attitude on health care providers and long distance to health care facilities. The same study also suggested that quality of health care services can be improved with particular alternatives for the poor. Despite the improvement of infrastructure and donor funding, there was still low satisfaction with health care services and poor accessibility (Kiguli et al., 2009:79).

Natsayi and Till (2010:2) conducted a study to develop a better understanding on barriers to access quality health care services. The study revealed that even though the South African Constitution states that everyone has the right to essential health care services, many South African still do not have adequate access to quality health care services, and the Apartheid legacy of highly unequal health and health care remains a reality. Therefore, inequities in access exist between public and private sectors, as well as within the public sector itself, especially between urban and rural areas (Natsayi & Till, 2010:2). The same study identified three levels of access to quality health care services within the public health system: maternal health, tuberculosis and antiretroviral therapy. The study results indicated that the cost of accessing antiretroviral therapy was substantially higher.

Accessibility to health facilities was measured by the time it takes to get to the clinics and the time spent at waiting clinics to see health care providers. Furthermore, acceptability of the type of care was measured by general respect from the health care providers which was ranked highly across all sites (Natsayi & Till, 2010:4). According to Meyer (2010:2) access to health care services is a constitutional recognized right, under Section 27 of the South African Constitution that should not be ignored. The study revealed that South Africa faces

challenges that complicate the progress realization of access to health care. However, South Africa has the highest income inequality globally and the gap between the public and the private health care with regard to affordability and quality of services remains a great concern. The study pointed towards a way of redressing this problem it involves engaging ethical principles such as beneficence, non-maleficence, autonomy and justice (Meyer, 2010:2). Access to health care services in the constitution is the same as access in the Batho Pele Principles in this study.

Furthermore, the study highlighted the importance of making a moral argument for equal access to health care for all and the need for ethicists to become involved in arguments pertaining to the inequalities in distribution of social goods. However, legislation and case law of South Africa also affirm the right to access health care services and have their grounding in normative ethical tenets. Recommendations made by the South African Human Rights Commission, together with planned national health insurance are aimed at addressing the gap between public and private health care, and can only become a reality through successful implementation of a monitored process based on ethical principles (Meyer, 2010:3).

In addition, the study signalled the need for practical implementation of current ethic-legal and human rights principles through every phase of the health care system to serve as a monitor and to ensure the success of the guaranteed right that few people have genuinely seen realized. However, implementation of an equitable health service system that is of excellent standards will aid the process of ethical frameworks to be used to evaluate the policies form and align the way as well as the practical implementation thereof (Meyer, 2010:3).

Matthew and Davis (2013) determined how much availability there is in their communities for children and teens to receive healthcare services. They found that every day, news reports detail the impact of the deficiencies in the nation's MHC services. Even more startling, a survey from the University of Michigan revealed that many adults across the US believe

children and teens have extremely limited or no access to appropriate MHC services (Matthew & Davis, 2013:1). Likewise, the study showed a low availability of MHC for children and teens in the majority of communities across the US. However, in communities where there are lots of opportunities for children and teens to get primary care or hospital care, access to MHC is lacking. Furthermore, where there were perceived inequities at the community level there were also perceptions of diminished opportunities for young children and teens in the domains of nutrition, health, and healthcare (Matthew & Davis, 2013:2).

Deumert (2010:53) evaluated MHCUs' access to health care services in the Western Cape, but focused on the large number of isiXhosa-speaking patients who have entered the provincial system since early 1990. The study identified that the linguistic barriers between English/Afrikaans-speaking health care providers and isiXhosa speaking patients are deeply entrenched structural features of the public mental health system and significantly impede the provision of equitable and effective health care in fifteen years after the end of Apartheid.

The communication barrier affected isiXhosa speaking patients to access health care services. Although the DPE does not provide services to the end-users, increasing access to services means that it does execute transactions that dispose minority or majority stakes of some of the businesses of the state-owned enterprises and one main objective is to ensure access to services across race, gender and historically disadvantaged individuals. Moreover, systems have been put in place through different Legislations and Prescripts to ensure that government fulfils its obligations to the end-user through state-owned enterprises (DPE, 2011:3).

The PSC has conducted studies between 2000 and 2007 to promote the constitutionally enshrined democratic principles and values of the Public Service by investigating, monitoring, evaluating communicating and reporting on public administration. The scope of the study entailed both national and provincial governments. An evaluation of Service Standards in the Public Services was conducted in 2005 and an assessment of performance

and compliance with Batho Pele Principles of access was made in 2006. An evaluation of performance and compliance with Batho Pele Principle of Redress was studied in 2006 (PSC, 2008:2). According to Muller (2008:8), the Nurses' Pledge has been developed as part of the philosophical framework and this has been published in South Africa. Nurses and Midwives take this Pledge after completion of their basic training. The Pledge/Code of Service reflects the nursing profession's specific conviction about nursing; it is derived from the Nightingale Pledge and has been used since the beginning of nurse training in South Africa. When taking the pledge, nurse/ midwife enter into a verbal agreement with the community. The question that arises is, whether this Pledge reflects the dominant view of nurses in South Africa (Muller (2008:8). The South African Nurses' Pledge is as follows:

***I solemnly Pledge myself to the service of humanity and will endeavour to practice my profession with my conscience and with dignity, the "access" principle in the Batho Pele Principles.***

Khoza conducted a study on the implementation of Batho Pele Principles from patients' experiences. The purpose of the study was to identify the shortcomings in the implementation of Batho Pele Principles in public hospitals. The research findings revealed that none of the Batho Pele Principles were implemented effectively and that patients in general were not satisfied with their treatment in public hospitals. Inadequacies were attributed to insufficient management skills, insufficiency in knowledge of different levels of the health care system as well as of awareness among patients of their rights and responsibility in health care (Khoza, 2009:3).

Khoza (2009:86) highlighted the fact that the insufficient planning and budgeting for capital expenditure at the level of the hospital management hinders the implementation of the Batho Pele Principle of "increasing access". Therefore, planning and budgeting for capital expenditure should be improved by the hospital management to increase access to health care services. Furthermore, ineffective planning, organizing, leading and control by the unit management lead to ineffective "increasing access". Inadequate measurement of

performance of staff and poor leadership skills of unit managers resulting in below-standard quality services hampers the principles of “increasing access” (Khoza, 2009:86).

Legodi (2008:5) also conducted a study on the perception of community members of the quality of care rendered in Limpopo Province, in terms of Batho Pele Principles. The purpose of the study was to describe and explore the provision of quality care in the PHC clinics of Limpopo Province, within the framework of the Batho Pele Principles’ service standards by determining the level of implementation of these principles. The aim of the study was to improve compliance with the Batho Pele Principles which would positively improve quality of care, accessibility, acceptability and utilization of PHC services (Legodi, 2008:52).

According to Matsoso (2013:2), the principles for developing National Health Insurance (NHI) as described in the Green Paper are to improve access to quality health care services for the whole population and to provide financial risk protection against health-related catastrophic expenditures. However, comprehensive health care will be provided through accredited and contracted public and private providers, with a strong focus on health promotion and prevention services at the community and household levels. The first 5 years will focus on strengthening the public sector in preparation for new NHI systems, with the launch of the new central NHI fund envisaged for 2014/15. The study revealed the review progress since the Green Paper was launched in August 2011, and summarized a more in-depth review just completed.

The objectives of NHI are to:

- Improve access to quality health services for all South Africans, irrespective of whether they are employed or not;
- Pool risks and funds so that equity and social solidarity will be achieved through the creation of a single fund;

- Procure services on behalf of the entire population and efficiently mobilize and control key financial resources; and
- Strengthen the under-resourced and strained public sector to improve health systems performance (Matsoso, 2013:2).

The study revealed that the progress preparing for new arrangements under NHI in the future health services will be purchased from accredited public and private providers of services. In the short term, the scope and quality of public services must be improved, with private services contracted where they add value. However, international experience on defining packages of services has been studied and a starting point for South Africa is ensuring that a list of ‘non-negotiable’ services are adequately budgeted for and provided in all districts. Global experiences shows the importance of PHC being at the centre of service delivery, promoting good health, preventing illness, and acting as the first point of contact for most healthcare (Matsoso, 2013:5).

Same study indicated that the PHC platform in South Africa is being established across the country based on three complementary components:

- **Ward-based PHC agents:** Approximately 25% of the 40 000 community health workers have been re-trained in the new, national approach to community-orientated PHC.
- **School health services:** The national policy 6 focuses on the most disadvantaged schools, with mobile clinics to support preventive and health promotion services aimed at reducing health barriers to learning, and facilitating access to other services.
- **District clinical specialist teams:** These teams will focus on improving the health of mothers, new-borns and children. Every district will have a senior

obstetrician and gynaecologist, paediatrician, family physician, midwife, paediatric nurse and PHC nurse. Over 43% of positions have been filled, and the induction programme for these professionals is underway (Matsoso, 2013:7).

In this study, NHI was supported by evaluating health care providers on how they implemented Batho Pele Principles as a strategy to improve quality nursing care. Furthermore, health care providers as public servants are expected to practice Batho Pele Principles when providing quality of health care services to their clients.

Carpenter and Glenn (2013:1) investigated the barriers to use effective interventions emergency suction equipment. The study focused on improving the usability of cardiac arrest trolley suction: a complex process involving turning a small, hidden lever. It was identified that emergency suction is a fundamental item of equipment which should be readily available for use to all health care professionals in the hospital setting. Use of emergency suction can be vital in an emergency, for example, when dealing with vomit or secretions. The study revealed that across all of department's base wards, only 14% (n=8) of wall-mounted suction units (total of 131) were ready for use, with 70% having some but not all parts present, 10% having none of the required parts and 6% having all parts but unconnected (Carpenter & Glenn, 2013:2). Therefore, access to health care services can also be hampered by equipment being not ready to be used in case of emergency.

Carpenter and Glenn (2013:1) revealed the staff personal experiences with being unable to use emergency crash trolley suction were not the staff's fault. As with so many incidents, the problem was not with the individual, but with the equipment and with the system. It was also shown that the equipment was difficult to use and proved that in tests - an average of 47.8 seconds taken to operate emergency suction across both wards seems far from ideal, with many staff unable to operate it at all. Furthermore, an individual frustration was one shared across the full range of health care professionals, regardless of role or experience. Moreover, a simple intervention made a positive difference and rolling it out across the hospital as a

sustainable standard will have a lasting beneficial effect on patient safety (Carpenter & Glenn, 2013:2). Therefore, access to health care services can also be hampered by the equipment being difficult to use.

In 2008, the Office of Standards Compliance within the National DOH developed and piloted a set of National Core Standards (NCS) which form the basic requirements for quality and safe care, while also reflecting existing Government policies and guidelines. The NCS set the benchmark for quality improvement in public health establishments' standards, defined as "an expected level of performance". The main purposes of the NCS are to: develop a common definition of quality of care which should be found in all health establishments in South Africa as a guide to the public and to managers and staff at all levels; establish a benchmark against which public health establishments can be assessed, gaps identified and strengths appraised; and provide a framework for national certification of public health establishments (Whittakeri et al., 2013:5).

The NCS are structured into seven cross-cutting domains to reflect a health systems approach, and define the scope or intent of assessing a health area where quality or safety might be at risk. The first three domains relate to the core business of the health system while the other four domains refer to the support system that ensures that the former are delivered. These domains are further divided into sub-domains which comprise a set of standards with associated measurement criteria and measures (Whittakeri et al., 2013:6).

### **DOMAIN 1: PATIENTS' RIGHTS**

The domain of Patients' Rights sets out what a hospital or clinic must do to ensure that patients are respected and their rights upheld, including getting access to needed care and to respectful informed and dignified attention in an acceptable and hygienic environment seen from the point of view of the patient in accordance with Batho Pele Principles and the Patient Rights Charter, respect and dignity, information to patients, physical access, continuity of

care, reducing delays in care, emergency care, access to package of services and complaints management (Whittakeri et al., 2013:6).

## **DOMAIN 2: PATIENT SAFETY, CLINICAL GOVERNANCE AND CARE**

The Patient Safety Clinical Governance and Clinical Care domain cover quality nursing and clinical care and ethical practice; reduce unintended harm to healthcare users or patients in identified cases of greater clinical risk; prevent or manage problems or adverse events including health care associated infections; and support any affected patients or staff patient care, clinical management for improved health outcomes, clinical leadership, clinical risk, adverse events, infection prevention and control (Whittakeri et al., 2013:7).

## **DOMAIN 3: CLINICAL SUPPORT SERVICES**

This domain covers specific services essential in the provision of clinical care and includes the timely availability of medicines and efficient provision of diagnostic therapeutic and other clinical support services and necessary medical technology as well as systems to monitor the efficiency of the care provided to patients: pharmaceutical services, diagnostic services, therapeutic and support services, health technology services, sterilisation services, mortuary services and efficiency management (Whittakeri et al., 2013:7).

## **DOMAIN 4: PUBLIC HEALTH**

This domain covers how health facilities should work with NGOs and other health care providers along with local communities and relevant sectors to promote health, prevent illness and reduce further complications; and ensure that integrated and quality care is provided for their whole community including during disasters, population based service planning and delivery, health promotion and disease prevention, disaster preparedness and environment control (Whittakeri et al., 2013:8).

## **DOMAIN 5: LEADERSHIP AND CORPORATE GOVERNANCE**

This domain covers the strategic direction provided by senior management through proactive leadership planning and risk management supported by the hospital board clinic committee as well the relevant supervisory support structures and includes the strategic functions of communication and quality improvement, oversight and accountability, strategic management, risk management, quality management, effective leadership, communications and public relations (Whittakeri et al., 2013:8).

## **DOMAIN 6: OPERATIONAL MANAGEMENT**

This domain includes the day-to-day responsibilities involved in supporting and ensuring delivery of safe and effective patient care, including management of human resources, finances, assets and consumables, and of information and records, human resource management and development, employee wellness, financial resource management, supply chain management, transport and fleet management, information management, medical records (Whittakeri et al., 2013:8).

## **DOMAIN 7: FACILITIES AND INFRASTRUCTURE**

This domain encompasses the requirements for clean safe and secure physical infrastructure (buildings, plant and machinery equipment), functional well-managed hotel services, and effective waste disposal, buildings and grounds, machinery and utilities, safety and security, hygiene and cleanliness, linen and laundry and food services (Whittakeri et al., 2013:8).

Whittakeri et al., (2013:9) indicated that the provinces are currently being trained by the DOH to implement the NCS, although associated funding, staffing and training requirements have not yet been finalized. In this study, health care providers are assessed on how they implement Batho Pele Principles as a strategy to improve quality nursing care, and comply with the National Core Standards which form the basic requirements for quality and safe care, while also reflecting existing Government policies and guidelines.

The principle of increasing access is also supported by policy on quality in health care for South Africa which revealed that achieving the goal of a quality health care system requires a national commitment to measure, improve and maintain high-quality health care for all citizens. The key aims of the policy include: addressing access to quality health care; increasing patients' participation and the dignity affordable to them; reducing underlying causes of illness, injury and disability through preventive and health promotion activities; expanding research on evidence of effectiveness; ensuring the appropriate use of health care services; reducing health care errors (adverse events) The problem with quality in health include: under-use and overuse of services; poor delivery system; lack of resources; poor information disregard of human dignity; records not well kept; drug shortages variation of services inadequate referral system etc. (DOH, 2007:2).

This policy revealed that in improving access to quality health care, health care capacity should be matched to the health needs of the population. However, in improved co-ordination of capacity, access to knowledgeable and experienced health professionals is essential to improve access to quality health care. Also, research showed that facilities and practitioners that perform a higher volume of specific procedures can achieve better results than those that perform relatively few of the same procedures. Improved planning for which services are to be provided at which levels can help to maximize the benefits of volume and expertise. Although an increase in health care capacity increases health care use and more services and resources available, more people will want to use these services. This can help to extend the delivery of health care services to previously under-served populations. Furthermore, inadequate health care capacity, particularly in rural areas, needs to be targeted development efforts and new methods of delivering quality health care. For example, good quality care cannot be provided without high-quality doctors, but in many remote rural areas there are too few doctors (DOH, 2007:3).

The policy on quality in health care for South Africa supported the increasing access principle and indicted that continuous advances in health technology and patient care require

that the skills of health professionals be continually developed. However, professional competencies directly impact on the quality of care being provided and on the amount of trust patients and their families place in health professionals. Continuing Professional Development (CPD) will be expanded to include all categories of health professionals registered in terms of applicable legislation. Health professionals and professional bodies, in collaboration with their colleagues, will develop CPD programmes. Moreover, the institutions that educate health professionals, such as academic institutions, employer-based programmes, and other entities, need to embrace change if they are to succeed in preparing the next generation of physicians, nurses, allied health professionals, and other health care workers (DOH, 2007:14). Therefore, CPD programmes are congruent with the increasing access principle which states that service delivery programmes that specifically address the need to progressively redress the disadvantages of all barriers (Draft White Paper, 1997:8).

The policy further indicated that the District Health System is ideally positioned to facilitate this local action, because it is close enough to the community to be responsive to their needs, and is a powerful vehicle for improving the quality of care. However, Level II (Regional), Level III (Tertiary) and Specialized Hospitals that are not viewed as part of the health district will also require very special attention. The need for action at the local and hospital levels demands that competent health professionals are available to ensure quality in health care and to continuously improve the care that is being provided. Furthermore, competent and skilled health professionals can only be obtained by CPD (DOH, 2007:17). In this study, challenges experienced by health care providers implementing Batho Pele Principles were described as a strategy to improve quality nursing care.

Xaba, Peu and Phiri, (2012:1) conducted a study to explore and describe the perceptions of registered nurses regarding factors influencing service delivery regarding expansion programmes in a PHC setting, using a qualitative approach. Xaba et al., (2012:1) identified that some factors correlated with poor service delivery which were similar to those identified by Heunis, Van Rensburg and Classen (2006:44), such as inadequate staff and a shortage of

resources. These factors were impacting on the quality of service delivery and were experienced differently by the PHC nurses, resulting in different perceptions as experienced and interpreted by different people. Although the registered nurses were directly involved with the expansion programmes, Xaba et al., (2012:1) observed that there was a need to explore and describe the perceptions of registered nurses regarding factors affecting service delivery in respect of the expansion programmes in a PHC setting (Xaba et al., 2012:2).

However, categories, subcategories and themes were identified; those that formed the basis of discussion were disabling factors, enabling factors, client-related factors, service-related factors and solutions to problems. Xaba et al., (2012:2) indicated that the disabling factors emerged as the first category, and the subcategories were identified: time limitations, budgetary constraints, infrastructural problems and inadequate skills. With regard to time limitations; it was indicated that lack of extended hours for some programmes for tuberculosis (TB) and antiretroviral treatment (ART) services; family planning services not available after-hours for learners and workers; and statistical errors occurring with records because clients who came during weekends and after-hours were not properly recorded. Furthermore, some of the priority programmes were not accessible to all clients, including learners, despite the fact that the service hours had been extended (Xaba et al., 2012:2). This revealed that access to health care services was affected by lack of extended hours. Furthermore, statistical errors occurring with records may also affect the reviews access to clients who came during weekends and after-hours health care.

Xaba et al., (2012:2) also identified inadequate skills as a factor that affected access to health care services, the shortage was still experienced for professions such as doctors and physiotherapists. Furthermore, clinics were left with newly qualified nurses who still needed to be upgraded on certain skills. The participants also indicated that some training, like that for Integrated Management of Childhood Illness (IMCI), had to be cancelled because of a shortage of doctors to do the clinical accompaniment (Xaba et al., 2012:2). Xaba et al., (2012:5) suggested the upgrading of trained nurses, especially the older nurses, on expansion

programmes on a continual basis, and skills development for nurses on the expanded programmes to allow for rotation of staff and continuity of care. Emphasis was placed on training of more nurses in primary mental health. Nurses need to be upgraded in their skills by means of in-service training (Xaba et al., 2012:5).

This was also supported by Heunis et al., (2006:44) who stated that nurses should be trained in numerous key programmes in order to be able to implement the PHC package effectively. However, nursing service managers experienced a lack of training for health workers because bursaries and study leave were difficult to obtain. The lack of own professional development hindered the managers in administering the service effectively, as they needed to acquire the necessary competencies for effective change management (Buys & Muller 2000:53). This revealed that CPD should be emphasized to all health care providers to improve access to quality health care services.

#### **2.4.4 Ensuring Courtesy**

National and provincial health departments must specify the standards for the way in which customers should be treated and include these in their departmental codes of conduct. The performance of staff who deals with the customers must be regularly monitored and those which fall below the specified standards should not be tolerated (Draft White Paper, 1997:8). Mkize (2007:1)) investigated allegations of human rights abuses of psychiatric patients at a hospital and identified that systemic defects such as weak management over a long period of time, absence of a hospital board, inadequacies in the physical layout and quality of facilities, abuse of staff by patients, staff reporting on duty under the influence of alcohol, high rate of absenteeism, shortage of staff, lack of discipline, evidence of racism, nepotism and favouritism and strained relations between the management and unions confirm all media allegations of human rights abuses as appearing in the terms of reference (Mkize 2007:11).

However, Muller (2008:8) suggests that citizens should be treated with courtesy and consideration. The mandate of the committee of enquiry was to investigate allegations of

human rights abuses of psychiatric patients at the hospital. In line with the media reports, study identified neglect of patients, allegations of sexual abuse among patients with staff turning a blind eye, physical abuse of patients by staff members, theft of patients' food, theft of patients' belongings, patients sleeping on the floor, female patients not allowed access to underwear, physical abuse of staff members by patients, staff reporting on duty under the influence of alcohol, high rate of staff absenteeism, and any other matters the Committee deemed necessary (Mkize 2007:13).

Leah, Karliner, Jacobs, Chen, Sunita and Mutha (2007:1) examined whether professional medical interpreters have a positive impact on clinical care for limited English proficiency patients. Their study revealed the effects of interpreter use on four clinical topics that were most likely to either impact or reflect disparities in health and health care. Findings reflect that in all four areas examined, the use of professional interpreters is associated with improved clinical care more than is use by interpreters, and professional interpreters appear to raise the quality of clinical care for limited English proficiency patients to approach or equal that for patients without language barriers. Furthermore, published studies reported positive benefits of professional interpreters on communication (errors and comprehension), utilization, clinical outcomes and satisfaction with care (Leah et al., 2007:1).

The DPE also identified that the strategy of ensuring courtesy on service delivery is based on a clear understanding of where it is coming from and where it needs to go in terms of service delivery against the Batho Pele Principles. However, the development of the customer care strategy is coherent with the priorities to transforming Public Service Delivery and also aligns with the overall strategic intent of the Department. The South African Quality Institute (SAQI) is contracted to provide guidance and training in developing service standards. Three strategic objectives have been identified as priorities: implementing internal services standards and behavioural norms, improving internal service delivery and improving external service delivery. Furthermore, a customer care plan is developed which sets out clear standards and guidelines to follow in order to achieve better service delivery (DPE, 2011:3).

According to Muller (2008:8) when taking the pledge, nurse/ midwife enter into a verbal agreement with the community:

*I will maintain by all the means in my power the honour and noble tradition of my profession. I will maintain the utmost respect for human life. I make these promises solemnly, freely and upon my honour, the “courtesy” principle in the Batho Pele Principles.*

The question that arises is, whether this Pledge reflects the dominant view of nurses in South Africa.

Khoza (2009:3) conducted a study on the implementation of Batho Pele Principles from patients’ experience. The purpose of the study was to identify the shortcomings in the implementation of Batho Pele Principles in the public hospitals. The research findings revealed that none of the Batho Pele Principles were implemented effectively and that patients in general were not satisfied with their treatment in public hospital (Khoza, 2009:3). Khoza further indicated that inadequate measurement of performance of staff and poor leadership skills of unit managers resulting in below-standard quality services, hampers “ensuring courtesy” (Khoza, 2009:86).

President Jacob Zuma also indicated Belief Set as an integral part of any service planning and implementation strategy of all programmes (DPSA, 2010:11). New Belief Set is also highlighted as “we belong, we care and we serve” to endorse the eight Batho Pele Principles. “We care”, public servants should be courteous when providing services to the public by listening to their problems, apologising when necessary, and serving people with a smile.

#### **2.4.5 Information**

Information must be provided in a variety of media and languages to meet the differing needs of different customers. There should always be a name and contact number for obtaining further information and advice (Draft White Paper, 1997:9). Zhao, et al., (2009:37) identified

fifteen types of free basic health services being delivered in Beijing which included community health information management, communicable disease management, response to emergent public health hazards, chronic disease management, mental health, management of ophthalmologic and oral care, pest management, endemic management, immunisation, child care, maternal care, family planning, elderly care, services of disability and rehabilitation in community and health education (Zhao, et al., 2009:39). Research findings relate to content of basic public health services and providers who deliver basic public health services.

#### **CONTENT OF BASIC PUBLIC HEALTH SERVICES**

Among chronic disease are childhood immunization and care, maternal care, elderly care, disability and rehabilitation services, and health education to be supplied at high level. Most of the directors, considered the establishment of electronic health records to reduce the time spent on paperwork. Regarding maternal and childhood health, free breast and cervical cancer screening are delivered according to local government's regulations and childhood immunisations were implemented at highest rate.

#### **PROVIDERS WHO DELIVER PUBLIC HEALTH SERVICES**

Due to the broad scope of basic public health services and limited financial incentives, health care providers felt that they were under stress and many competing demands for their time. Time constraints and short supplies of public health service providers are barriers to the delivery of prevention. Furthermore, there are considerable concerns about public health among community health care providers (Zhao et al., 2009:40). Health information is the same as providing more and better information in this study. Muller (2008:8) suggested that citizens should be given full and accurate information about the public services they are entitled to receive.

Furthermore, with regard to staff shortage Mkize (2007:74) recommended that strict adherence to the Norms Manual for Severe Psychiatric conditions issued by the DOH should

be enforced. All vacant posts should be advertised and filled. Orderlies should be employed. The DOH, the Department of Psychiatry and the Department of Nursing should meet as soon as possible with a view to developing a curriculum to train mid-level mental health workers. A psychiatric elective should be added to the training of staff nurses. There should be a conscious plan to recruit male nurses in the field of psychiatry (Mkize, 2007:74).

The retention strategy to prevent exodus of nurses should include plans for nurses to go abroad for a certain period to gain experience and be reabsorbed on return. Although, lack of discipline was identified, the study recommended that the ICN Code of Ethics for nurses should be put in place and practised, and any lack of discipline should be reported to the SANC. For strained relations between management and unions, there should be a clear recognition agreement between unions and management to regulate their relationship (Mkize, 2007:78)

Wakermen and Humphreys, 2011:2) also identified that in order to be able to comprehensively monitor and evaluate health care services as well as benchmarks, adequate national information is needed. These are the same as the Batho Pele provision of information principle in South African that citizens should be given full accurate information about the public services they are entitled to receive. It is identified that despite gaps in knowledge, there is significant lack of information about what works, where and why delivering services. Furthermore, at time of global PHC reform, applying this knowledge will contribute significantly to the level of appropriate sustainable PHC services and improving access to health care services. These are similar to the increasing access principle that all citizens should have equal access to the services to which they are entitled (Wakermen & Humphreys, 2011:2).

Petersen, Bhana, Campbell, Mjadu, Lund, Kleintjies, Hosegood and Flisher (2013) conducted a study to identify shift in emphasis to universal PHC in post-Apartheid South Africa. Their study revealed that South Africa has been accompanied by a process of decentralization of

mental health services to district level, as set out in the new Mental Health Care Act, No. 17, of 2002 and the 1997 White Paper on the Transformation of the Health System. The study sought to assess progress in South Africa with respect to deinstitutionalization and the integration of mental health into primary health care, with a view to understanding the resource implications of these processes at district level. However, situational analysis in one district site, typical of rural areas in South Africa, was conducted, based on qualitative interviews with key stakeholders and the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS) (Petersen et al., 2013:16).

The study found that the decentralization process remains largely limited to emergency management of psychiatric patients and on-going psychopharmacological care of patients with stabilized chronic conditions. In a similar vein to other low- to middle-income countries, deinstitutionalization and comprehensive integrated MHC in South Africa is hampered by a lack of resources for MHC within the PHC resource package, as well as the inefficient use of existing mental health resources (Petersen et al., 2013:16). This is the same as providing more and better information in applying the Batho Pele Principles. Muller (2008:8) proposed that citizens should be given full and accurate information about the public services they are entitled to receive.

Khoza (2009:86) also highlighted that insufficient planning and budgeting for capital expenditure on the level of the hospital management hindered the implementation of the Batho Pele Principles. The fact that the Batho Pele Principles, Patients Right Charter and the complaint boxes were not being placed conspicuously in the units/wards, also obstructed the “provision of better information”. Furthermore, inadequate measurement of performance of staff and poor leadership skills of unit managers resulting in below-standard quality services impeded the principle of “providing of better information”. Legodi (2008:96) also recommended that provision of information to patients through giving health education should be emphasized during in-service training sessions to develop and maintain skills effectively.

Service standards should be clearly displayed in a user-friendly way in all services areas, especially to inform clients about what they can expect from the service. This will add to transparency and accountability for the quality of service delivery. Shaw, Thetard and Browne conducted a study on improving quality of services in Western Cape district hospitals. The study revealed that an approach to improving quality, through a primary focus on the client, fits the principles and spirit of the Batho Pele document on transformation of the public service. The results also indicated that lack of sufficient medical personnel in smaller district hospitals, limits their effectiveness as support to PHC services (Shaw et al, 2005:178). In addition, these authors identified challenges to improving quality around issues such as development of basic management and health information systems, patient and community feedback mechanisms, support and continuing education processes as issues limiting their effectiveness and support to PHC (Shaw et al., 2005:181). Therefore, information can be improved through continuous health education and contribute in decision making to the user of the service.

Maputle (2010:1) conducted on woman-centred childbirth model to determine what care mothers experienced during childbirth and how midwives experienced the management of these mothers. The study aimed to develop a ‘woman-centred’ childbirth model that could be used to assist the attending midwives in the facilitation of mutual participation. The study indicated that managing the mothers during childbirth also enhanced the implementation of Batho Pele Principles (Maputle, 2010:1). In addition, Maputle (2010:4) revealed the process of the model that displayed the procedure of facilitating mutual participation. Integrated within the Batho Pele Principles, ‘woman-centred care’ can be achieved through mutual participation and egalitarian relationship; equality with the principle of power-sharing; partnership and collaboration in decision-making; well-informed to enhance self-esteem, self-determination and self-reliance and interdependence between the mothers and the midwives (Maputle, 2010:4).

Maputle (2010:7) recommended that to be in line with the White Paper on Transformation of Public Service Delivery, the Patients' Rights Charter and the Constitution of the Republic of South Africa, the woman-centred childbirth model must be implemented to facilitate mutual participation and responsibility-sharing, creation of opportunities for information-sharing and empowerment, open communication and listening, accommodative midwifery actions and maximization of human and material infrastructure during childbirth (Maputle, 2010:7). In this study, challenges experienced by health care providers when implementing Batho Pele Principles are described and strategies to improve quality health services at the selected mental hospital will be developed through suggested recommendations.

The policy on quality in health care for South Africa also supported the information principle through increasing patients' participation and affording dignity to them. Therefore, community participation and adoption of Batho Pele Principles are key to empowering users of services to take control of their own health care and of their families. However, informing patients and involving them in decision-making needs active participation of patients can improve the effectiveness and satisfaction with their care. Patients who are treated with dignity and are well-informed and able to participate in treatment decisions are more likely to comply with their treatment plans. Furthermore, prevention is a better way to reduce the burden of diseases and improve the quality of life. These can be achieved by ensuring that correct clinical preventive services are available and used is an important way to reduce the underlying causes of illness, injury, and disability (DOH, 2007:5).

The policy on quality in health care for South Africa also supported the information principle and revealed that fostering evidence-based practice requires building-up expertise in research effectiveness issues, health care technology assessment and dissemination of information on effective health care practice. Being able to adapt organizations for change requires skilled health care managers with a commitment to create learning organizations seeking excellence focused on users and working with clinicians. Furthermore, the three key areas that need to be considered when looking at the organizational development required to improve quality in

the National Health System are as follows: quality improvement requires leadership that can build an organizational culture that supports change, establishes aims for improvement, and mobilizes resources to meet those aims; a health care organization dedicated to continuous improvement, learning and organizational change (DOH, 2007:12).

However, health care professionals who are strongly dedicated to caring for patients, knowledgeable, well trained, and committed to continuous quality improvement and to secure in their employment, need to be further developed to improve the quality of care. Providing quality patient care requires training skilled health workers and establishing a culture that values lifelong learning and recognizes its important role in improving quality. The philosophy and approaches of this policy need to be reflected in under-graduate training curricula of all categories of health care workers and in the post-graduate training curricula of all categories of health professionals (DOH, 2007:14).

Xaba et al., (2012:2) explored perceptions of registered nurses regarding factors influencing service delivery and highlighted infrastructural problems that include lack of space for different programmes in a clinic, close proximity of some clinics to the hospital, and lack of equipment. The study indicated the need for privacy and a waiting area, especially if the ‘supermarket approach’ was to be used, and introduction of IMCI, PMTCT, and voluntary counselling and testing (VCT). The study revealed that a lack of provision of infrastructure in some clinics hampered service delivery, and also issues such as frequent breakdowns, lack of transport for patients and lack of telephones. The health providers also confirmed that lack of space particularly affected the quality of care (Xaba et al., 2012:2). This means that the need for privacy affect the quality of care which patients are entitled to receive. Furthermore, ensuring courtesy means that citizens should be treated with courtesy and consideration (Muller, 2008:8).

## 2.4.6 Openness and Transparency

Reports to citizens should be published as widely as possible and should be also submitted to national and provincial legislature in order to assist the relevant Portfolio Committees in scrutinizing and monitoring departmental activities. A study conducted in USA in 2004 to examine the impact of political decentralization on essential public services provided in almost all countries. The study indicated that the effects of decentralization seem to be different in low and middle-income countries, positive in low-income countries and negative in middle-income ones (Khaleghian, 2004:164). Furthermore, local government areas were prone to capture by locals whose health service preferences are typical for curative care. The same study suggested that policies to stimulate community involvement in low-income countries should continue to be general to promote community engagement in issues of public service provision. The study also recommended that a fruitful area of future research may be to differentiate services and to formulate guidelines to protect those who do poorly under a decentralized government (Khaleghian, 2004:180).

Izibeloko, Jack, Leana and Lyn (2013) investigate mental health nurses' experiences of providing mental health services at a hospital in an attempt to understand policy implications. The study identified difficulties and challenges of delivering MHC services. However, mental health services for Rivers State and surrounding States in the Niger Delta region of Nigeria are provided only at the neuropsychiatric Rumuigbo Hospital in Port Harcourt City, Rivers State, Nigeria. The study revealed that lack of political support and senior positions in the Ministry of Health hindered service delivery, the prevalence of institutionalized stigma, a lack of training, and system failure to provide services at all levels of care hampered service delivery (Izibeloko et al., 2013:12)

However, inadequate allocation of resources for hospital renovations and equipment is preventing appropriate client care, as does the lack of funding for drugs, the cost of which makes them unaffordable, affecting clients staying on treatment. The study recommended

that education and training of MHC professionals should be given priority to remedy human resource shortage, provide incentives to motivate health professionals for psychiatric practice, and move toward decentralization of care into general health care services. Information should be provided at all levels to overcome the myths surrounding the causes of mental illnesses, to reduce stigma and discrimination of the affected and their families (Izibeloko et al., 2013:12). In this study, challenges experienced by health care providers when implementing Batho Pele Principles are discussed.

Antonysamy (2013:1) researched how violence and aggression in psychiatric inpatient units can be reduced. The study revealed that the inpatient environments in psychiatric units were not always conducive to patient recovery. However, male patients could easily become bored, especially when they were not interested in indoor activities like arts and crafts. Outdoor activities were less well explored in psychiatric intensive care unit and partly this may reflect a 'risk averse' approach. The incidents of violence and aggression in their unit rose to 482 in 2011. Although there were initial reluctance and anxiety amongst staff to escort patients outside the unit, regular support and encouragement made them more confident and less risk adverse (Antonysamy, 2013:1).

The study indicated that the use of restraint and seclusion does not help in reducing the aggression levels and it may either exacerbate or maintain the aggression and violence in the unit. The use of pro re nata (PRN/as required) medications and secluding patients without actively engaging them in any therapeutic activity does not help in addressing patients' needs appropriately and makes them more lethargic and less able to express even normal emotions. However, the national audit carried out by the Healthcare Commission report also highlighted the impact of patient aggression on the duration of the recovery process and staff satisfaction with their jobs. The patients in psychiatric intensive care units were more likely to get abusive towards others than those in acute wards. Furthermore, patients were more likely to become aggressive towards staff and other patients (Antonysamy, 2013:5).

The study also showed that innovative projects led to a significant reduction in violence and aggression. Along with the zoo visit, the research team also incorporated other initiatives like breakfast club for patients, walking trips and training at the gym. Therefore, the average length of stay for patients was reduced from 90 to 30 days for an initial period and then remained stable at 55 days. The seclusion rates reduced significantly as well as staff sickness rates. Patients provided positive feedback about the zoo visit and apart from one delayed return to the ward. Moreover, the team were more geared to calculated positive risk taking and successfully discharged more than 25 patients directly to the community in 2012, out of two were readmitted in four to six weeks due to non-compliance (Antonyamy, 2013:6).

However, the use of resources outside the hospital helped to seek collaboration with partner organizations like the local authority and third sector. These partnerships helped to challenge the public's perception of mental illness. Their acceptance of patients helped this vulnerable group to re-integrate confidently into their own communities. Although tackling stigma was not one of the key intentions, the study team concluded they were very pleased to note that patients felt less stigmatized and they found the staff at the zoo were very friendly and approachable. Furthermore, a unit has been identified for best practices and similar initiatives are undertaken in other wards. Moreover, in order to expand partnership with other agencies seeking all opportunities can support patients and help them achieve their full potential and building on their hopes and aspirations (Antonyamy, 2013:6). In this study, health care providers identified challenges experienced when implementing openness and transparency principles as a strategy to improve quality nursing care.

The DPE also identified that increasing openness and transparency involves communications. The directorate serves to inform all stakeholders of progress and issues related to restructuring. Although information is communicated via press statements, DPE indicated that media briefings, annual reports, Ministers' speeches, and information brochures and a website should be implemented. Moreover, the DPE indicated that increasing responsiveness involves queries directed to the departmental website were attended to immediately, queries

regarding restructuring mainly about progress on restructuring transactions and about opportunities for interested parties as bidders or service providers (DPE, 2011:4). Openness and transparency in the DPE is the same as in this study which states that national and provincial departments may utilize events such as open days, preferably not during normal working hours, to invite citizens to visit the department or institution to meet with all levels of officials to discuss service delivery issues, standards, problems, and so on (Draft White Paper, 1997:10).

Another study was conducted in 2008 with the aim to establish the status of understanding and implementation of the Batho Pele Principles of Openness and Transparency (PSC, 2008:2). However, data collection was done using three phases. During phase one, letters were sent to all Heads of Departments of national and provincial departments asking them if they compile attribute Annual Reports to Citizens as required by the Batho Pele White Paper, and to submit copies of these reports. Seventy nine departments responded. Of the 138 Public Service departments, 18 provincial departments were found to comply with these requirements whereas 84 did not. No national department was found to have complied with the requirements. All the departments in the Limpopo Province complied, while in the Free State only two did not comply (PSC, 2008:3).

During the second phase, the purpose sample of departments that had not supplied Annual Reports to the Citizens was drawn; the sample comprised 31 national and provincial departments. Interviews were conducted with designated officials using questionnaires. Only 7 of 33 departments gave definitions of the principle of openness and transparency (PSC, 2008:4). During the third phase, a selection of critical documents was reviewed. Documents such as annual reports to citizens and departmental documents provided by departments in the interview were included in the document review. The study highlighted the importance of reviewing PSC reports which had a bearing on openness and transparency. However, it was recommended in the study that specific training with regard to openness and transparency should be provided; Annual Reports to the Citizens should be provided; targets

or standards for openness and transparency should be developed and a monitoring and evaluation system should be introduced so that the challenges can be identified and timely steps be taken to address areas of ineffectiveness or limited success (PSC, 2008:4). Increasing openness and transparency in the health services, Muller (2008:8) suggests that citizens should be told how national and provincial departments are run, how much they cost and who is in charge.

Xaba et al., (2012:2) surveyed perceptions of registered nurses regarding factors influencing service delivery and showed that strengthening of the available support groups to include other essential services such as nutrition and current programmes being expanded. Botma et al., (2007:48) stated that the greatest barrier to VCT is the fear of a positive diagnosis, but also reported that people would go for VCT if they could count on support from the community. The study also reflected the need to strengthen the support groups to meet the needs of patient nutrition groups, breast-feeding groups and mental health groups. Furthermore, awareness about the usability and user-friendliness of programmes should be created. This supported the notion of strengthening of community-based support groups for people living with HIV/AIDS (PLWHA). Kenyon et al. (2002:203) cited a study by Modiba et al., (2001:192) in which service users were interviewed, and affected clients responded that they belonged to a support group as a way of preventing boredom (Xaba et al., 2012:5).

#### **2.4.7 Redress**

In order to apply Batho Pele Principles in the health services, Muller (2008:8) suggested that citizens should be offered an apology, if the promised standard of services is not delivered, a full explanation and a speedy and effective remedy and when complaints are made, citizens should receive a sympathetic, positive response. However, the health care services of Southern African countries are going through a major change and MHC is incorporated into PHC for the first time. Steps at every MHC organizational level should be taken to improve the quality of nursing care (Leana & Lyn (2003:69). According to A-Kardan and Ogudeyin (1998), the major determinant of quality health service delivery system in the world is

nursing care. However, the nursing profession has a social obligation to monitor and evaluate the care provided to the patients and nurses are expected to act in a respectful, responsible and accountable manner. Furthermore, to assess and improve the quality of care provided is of vital importance in the context of health care (Johansson, 2002:15). In this study, health care providers were assessed on how they redress wrongs so that they improve in a respectful, responsible and accountable manner.

Modi and Ledingham (2013:5) identified that experiences of a placement in an urban general practice, and discussion with general practitioners working there, made it quite clear that with regards to the care of patients with psychotic illnesses, monitoring of cardiovascular health might be dangerously insufficient. However, severe mental illness is a highly prevalent problem. Patients can often lack insight into the nature of their condition and hence be more resistant to medical intervention, resulting in severe bio-psycho-social consequences (Modi & Ledingham, 2013:5). Therefore, the quality of health care provided makes a profound difference to patient outcomes. Patients are at a much greater risk of cardiovascular complications due to both patient factors, i.e., they demonstrate more cardiovascular risk factors such as smoking, and pharmacological factors such as metabolically disruptive antipsychotics. In addition, the impact of clinicians plays a role in adverse cardiovascular outcomes (Modi & Ledingham, 2013:5). In this study, challenges experienced by health care providers when redressing wrongs are described.

WHO (2005:9) revealed that health services are not provided equitably to people with mental disorders, and the quality of care for both mental and physical health conditions for these people could be improved. Although there is need to develop and evaluate psychosocial interventions that can be integrated into the management of communicable and non-communicable diseases. Furthermore, health care systems should be strengthened to improve delivery of MHC, by focusing on existing programmes and activities such as those which address the prevention and treatment of HIV/AIDS, TB, malaria, gender-based violence, antenatal care, integrated management of child illnesses and child nutrition, and innovative

management of chronic disease. However, estimates of the global burden of disease provide evidence of the relative effects of health problems worldwide. Moreover, non-communicable diseases are rapidly becoming dominant causes of ill health in all developing regions except sub-Saharan Africa (WHO, 2005:20). In this study challenges experienced by health care providers were identified as a strategy to improve quality nursing care.

Mkize (2007:21) investigated allegations of human rights abuses of psychiatric patients at a hospital, and identified that most of the adverse findings were a result of poor management over a number of years and the absence of an effective hospital board. Furthermore, there was no Provincial Director of Mental Health and Substance Abuse to support the hospital management. Lamentably, the National DOH also did not have a National Director of Mental Health and Substance Abuse to ensure a quality MHC service at the hospital. Therefore, the committee strongly recommended that hospital management should be strengthened by advertising and filling all the vacant management posts, and that the hospital board should be put in place without delay (Mkize, 2007:21).

Funk, Lund, Freeman and Drew (2009:3) conducted a study to develop international guidelines for improving quality of MHC in low- and middle-income countries. Their study revealed that community-based services with known efficacy are neglected, resulting in poor life conditions for millions of people. Many people with mental disorders face human rights abuses in their homes, communities and in health services that are meant to them. These revealed that quality improvement mechanisms are urgently needed to change these conditions change these conditions. The study identified that inadequate resources are reasons for poor quality MHC, especially in low- and middle-income countries. The same study also indicated that improving the quality of MHC involves respect of the rights of people with mental disorders and the provision of the best care possible, consistence with national circumstances.

Furthermore, quality encompasses the achievement of equitable care that is evidence-based and cost effective. Moreover, in order to achieve optimal quality, the systems for delivering MHC services must be conducive to treatment and recovery (Funk et al., 2009:10). The study recommended a 5-pronged approach to improving the quality of MHC that include: alignment of policy and legislation and development of key partners; alignment of funding; development and application of accreditation procedures; development and use of standards; and integrating improvement into routine service management and delivery (Funk et al., 2009:9). Approaches to improving the quality of MHC are the same as redressing wrongs which state that national and provincial departments are required to review and improve their complaints systems in line with accessibility, speed, fairness, confidentiality, responsiveness, review and training (Draft White Paper, 1997:5)

Honikman, Van Heyningen, Field, Baron and Tomlison (2012:1) develop a stepped care intervention approach for maternal mental health that is integrated into antenatal care. They found that maternal mental health is largely neglected in low- and middle-income countries; there is routine screening or treatment of maternal mental disorders in primary care settings in South Africa (Honikman et al., 2012:1). The same study detected that community-based epidemiological studies in South Africa have shown high prevalence rates of depressed moods amongst pregnant and postnatal woman. Furthermore, antenatal care was predominantly focused on physical examination, whereas during the post-partum period, the health care focus was commonly on the infant for immunization, growth, monitoring, and HIV testing. Moreover, the lack of integration between the maternal health services, child health services and mental health services in primary care, created a large gap in the screening and treatment of maternal mental disorders (Honikman et al., 2012:2). The authors also recommended that maternity health workers should be trained to screen and refer for mental distress in low-resourced primary care settings; training programmes that address and support the mental health needs of health care providers may help to staff to manage their workload and prevent compassion fatigue and 'burn out'; on-site, integrated mental health services increases access care to women who have scarce resources and competing health,

family and economic priorities; coordinating mental health visit with subsequent antenatal visits further facilitate access for woman with sufficient resources; dedicated supervised mental health counselling personnel are required to meet mental health needs of mothers living in adversity (Honikman et al., 2012:7). Training programmes that address and support the mental health needs of health care providers in this study redress the wrongs which are the same as in the Batho Pele Principles.

For redress, Swana (2008:59) identified challenges with regard to the tendency to verbally respond to the complaints or queries that have been raised in writing. Although a large percentage of the clients (78.8%) were aware of the existence of the complaints handling mechanism in the department, there was still 58.3% and 60% negative response with regard to the effectiveness of and access to the system, respectively. The study also acknowledged that the effective management of client requests and complaints are the key ingredients and management tool to ensuring service delivery cannot be ignored (Swana, 2008:59).

According to the DPE, ensuring redress means that in the event that any party to a restructuring transaction feels aggrieved, such a party has the option to seek redress via the department of before resorting to courts as last option. The DPE also identified that providing more and better information can be achieved through a credible information technology system. However, the distribution of commercially sensitive information is controlled and released only to approved and quality parties. The DPE also found that information is current as required for commercial due diligence, information is vetted by appropriate authorities (auditors, lawyers) as necessary and results of bids and government decisions on transactions are made public (DPE, 2011:4). In this study, redressing wrongs that means that if the promised standard of services is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy, and when complaints are made, citizens should receive a sympathetic, positive response (Muller, 2008:8).

Khoza (2009:86) highlighted the fact that the insufficient planning and budgeting for capital expenditure at the level of hospital management delayed the implementation of the Batho Pele Principles. The fact that the Batho Pele Principles, Patients' Rights Charter and the complaint boxes were not placed visibly in the units/wards, also obstructed "remedying mistakes and failures/redress". Khoza (2009:3) also indicated that lack of awareness and understanding of the Batho Pele Principles and the Patients' Right Charter by the patients and the general public hindered the "remedying of mistakes and failure/redress" (Khoza, 2009:86).

Khoza's study also recommended that a more extensive study should be done at the same hospital and repeated in other hospitals, including all the nursing units and other departments that deal directly with patients; this will give a clear picture of the implementation of Batho Pele Principles with regard to total health care delivery in the hospitals. All levels of management should ensure that quality assurance programmes are implemented and the performance of all levels of health care staff should be measured and monitored. The implementation of Batho Pele Principles and the Patients' Rights Charter should be an integral part of the human resource development programme and care should be taken that all categories of staff gain from it (Khoza, 2009:87).

Sepahzad, Ejiolor Giles and Klaber (2013:1) investigated the efficiency and reliability of urgent specimen transport revealed that delay in receiving microbiology results can impact clinical management, leading to empirical antibiotic treatment of infection and unnecessary, distressing repeat investigations. However, departmental audits highlighted a delay in this transport process with some samples taking in excess of eight hours to reach the laboratory and others being reported as 'missing'. The study revealed the complexity of one single service in a large hospital setting and how one service and its failure can impact on patient care. It is thus important to engage multiple stakeholders, and a large team, to achieve a successful outcome (Sepahzad et al., 2013:1). These indicated that if the promised standard of services is not delivered, citizens should be offered an apology, a full explanation and a

speedy and effective remedy, and when complaints are made, citizens should receive a sympathetic, positive response (Muller, 2008:8).

The policy on quality in health care for South Africa supported the redress principle and indicted interventions aimed at systems involves identifying weaknesses in systems that cause errors in processes or outcomes; the systems can be redesigned to avoid these errors and improve the quality of health care delivery. However, the results of changes to systems can be monitored and evaluated and further adjustments made where necessary. This is an on-going process of assessment, redesign and monitoring and evaluation that ensures that systems are constantly evaluated and, where necessary, modernized to improve quality (DOH, 2007:8). This policy is based on a two-pronged approach to quality improvement: Creating the environment in which quality health care will flourish building the capacity to improve quality. However, creating the environment will be done by: strengthening the hand of the user; focusing on equity of health care and vulnerable populations; promoting public/private partnerships and the accountability of both sectors for quality improvement; and reducing errors and increasing safety in health. Building the capacity to improve quality will be done by fostering evidence-based practices and innovation; adapting organizations for change; engaging the health care workforce; providing appropriate training; and investigating information systems that measure quality improvements (DOH, 2007:9).

Xaba et al., (2012:2) explored perceptions of registered nurses regarding factors influencing service delivery and identified solutions to redress the factors affecting service delivery, including integration of services, electronic record-keeping and strengthening of support groups. With regard to integration of services, the integration of HIV/AIDS services with mother and child services was identified as one of the solutions. However, the participants felt that the programmes that are being expanded could be integrated, with one person coordinating all of them. This would be beneficial, especially in the case of the integration of HIV/AIDS and mother and child health services. Integration of IMCI would enable the nurse to identify immunization problems or needs and also the Expanded Programme on

Immunization (EPI) would refer to IMCI. Integration of PMTCT with all mother and child health services, even IMCI, could make the services more comprehensive (Xaba et al., 2012:5).

#### **2.4.8 Value for Money**

According to Muller (2008:8), public services should provide services that are economic and efficient in order to give citizens the best value for money. Zhao, Yang, Wang, Guo, Liu & Liang (2009:37) identified that a health care system which has been reformed to suit the market economy, faces multiple challenges such as limited financial support from the government, high rates of catastrophic out-of-pocket spending and impoverishment through health expenses, inequalities in health and health care utilization and limited financial protection, even among those with insurance (Zhao et al., 2009:38). Research findings relating to funding support for basic public health services indicated that an average of £ 2.38 per person has been provided for basic public health services in Beijing since 2008 and each district government supplied different amounts of money for basic public health services in its communities according to its economic level and population. Moreover, there was a higher percentage of migrants in some districts due to the funding provided to the community and the Municipal government needed to think over the problems brought by migrants. Funding is crucial in improving quality of services, appointment of skilled people and other resources (Zhao et al., 2009:41).

Moreover, rural areas tend to have smaller businesses, resulting in higher premium costs for employer-based insurance spread across fewer employees. Combined with higher premiums for such occupations as farming, mining, logging, and fishing, many families may not be able to afford insurance. Although only 20 per cent of the overall American workforce is employed in firms with less than 25 employees, workers from these small firms account for 42 per cent of the uninsured workers in the country. Furthermore, persons living in rural

areas are more likely to have seasonal work and lower incomes, they are the most at-risk group of being both uninsured and living below federal poverty levels (Bolin & Gamm, 2005:27). Rural areas which tend to have smaller businesses, resulting in higher premium costs, is the same as getting the best possible value for money principle—which states that all national and provincial departments are required as part of their service delivery improvements programmes, to identify areas where efficiency saving will be sought, and the service delivery improvements which will result from achieving the savings (Draft White Paper, 1995:14). Same study also identified that here is a direct correlation between the percentage of those with income at or below the federal poverty level and degree of rurality. Twenty-two per cent of the population in rural counties away from metropolitan areas have incomes at or below the federal poverty level compared to 13.8 per cent for residents of metropolitan counties, and 15.8 per cent among rural counties adjacent to metropolitan areas. Moreover, higher poverty rates and overall lower wages in rural areas magnify the problem of a lack of employer-based health insurance coverage or coverage that is more costly to workers (Bolin & Gamm, 2005:29).

According to the DPE, getting better value for money means that economy is evaluated in the proceeds raised against the direct costs incurred to complete a transaction which involves fees to service providers. The DPE highlighted that encouraging innovation and rewarding excellence means restructuring that provides a platform for Black Economic Empowerment (BEE) and much effort goes into the means to implement BEE in the transaction process and with the assets restructured. Furthermore, innovations have been made in partnering BEE firms with established business with provision for skills transfer and excellent work is recognized by promotion of staff and merit awards (DPE, 2011:4).

Hogg and Samson together with the Department of Communication Development incorporated the study with attempts to shed light on service delivery capacity and quality challenges in South Africa by analysing the institutions that “produce” services (World Bank, 2003:64 cited by Hogg & Samson, 2011:14). Hogg and Samson (2011:15) identified that

when citizens have no control or choice over service providers, Accountability in Public Services in South Africa on those directly responsible for services delivery, typically service will fail (Fiszbein, 2005:4 cited by Hogg & Samson, 2011:18). According to Hogg and Samson the aim of Batho Pele Principles is to improve access to public services through increased transparency, accountability, and citizen involvement in public service planning and operations. However, the Batho Pele message resonates strongly with that of the 2004 World Development Report: services can improve by empowering poor people to monitor and discipline service providers by raising their voices in policymaking and strengthening incentives for service providers to serve the poor (Hogg & Samson, 2011:26). In this study, improving access to health care services means enhancing MHC services.

According to Cannon (2011:56), health services were the focus of national health policy in 2011. However, attention was given to local communities and their access issue. The study offered a conceptual framework and empirical analysis to identify the independent effect of predisposing enabling and medical needs factors to access to health care in local communities. These are the same as the increasing access principle that all citizens should have equal access to the services to which they are entitled (Cannon, 2011:56). Cannon identified that access limitation related to health plan and individual health care providers are incorporated into the access model. The most influential variable on access to health care services are enabling health care plan variable (Cannon, 2011:58).

The Public Service Commission has also conducted studies between 2000 and 2007 to promote the constitutionally enshrined democratic principles and values of the Public Service by investigating, monitoring, evaluating communicating and reporting on public administration. Evaluation of performance and compliance with the Batho Pele principle of value for money was studied in 2007 (PSC, 2008:2). The study conducted by Khoza (2009:3) on the implementation of Batho Pele Principles from patients' experience revealed that inadequate measurement of performance of staff and poor leadership skills of unit

managers resulted in below-standard quality services, hampered the implementation of the principle “getting possible value of money” (Khoza, 2009:86).

Xaba et al., (2012:2) explored perceptions of registered nurses regarding factors influencing service delivery and highlighted budgetary constraints that include limited funds, need for more stock, escalating client numbers, and not all services can be rendered in some clinics. Furthermore, in the clinic there are structural problems, some clinics are very small and cannot render all required services with limited resources, which affected the availability of space. This revealed that value for money is affected because some programmes could not be introduced in certain clinics. With regard to electronic record-keeping, Xaba et al., (2012:4) indicated that management of extensively drug-resistant tuberculosis (XDR-TB); use of technology for foetal monitoring graphs, technology should be used to prevent clients from having more than one file in one clinic. This revealed that the need for technology in these times of increasing demands on the health sector is crucial.

Therefore, in all planning the emphasis should be on equipment and material, including availability of skilled nurses. It is also important to consider the acceptability of technology to both clients and health care providers, including the cost of computerizing records to healthcare providers (Hattingh et al., 2006:123). Thus, value for money should be considered in strategic planning to improve quality of health care services. Furthermore, new technology, electronic workstations and internal communication networks will change the health care environment and subsequently the training of staff (Xaba et al., 2012:5).

## **2.5 Summary**

This chapter reviewed literature on the transformation of service delivery, implementation of Batho Pele Principles and improving the provision of quality health services. Batho Pele Principles is the South African national government’s White Paper on the Transformation of the Public Service (WPTPS). WPTPS is applicable to the public sectors and to guide the public servants on what to practice. For effective implementation of the Batho Pele

Principles there should be knowledge and understanding between the MHCUs and the health care providers. Therefore it is necessary to evaluate the implementation of Batho Pele Principles in order to improve the quality of health care services.

# CHAPTER 3

## RESEARCH DESIGN AND METHODOLOGY

### 3.1 Introduction

The previous chapter discussed the literature review on the transformation of service delivery, implementation of Batho Pele Principles and improving the provision of quality health services. This chapter outlines the research methodology, research design, research setting, the population and sampling, data collection and data analysis. Research methodology entails specific procedures used to gather and analyse data (De Vos, 2010:252). In this study, the descriptions of the research design, research setting, population and sampling, data collection, data analysis procedures, ethical considerations, validity and reliability are included in the discussion under research methodology.

### 3.2 Research Design

A research design is a plan or blue print of how a researcher intend conducting the research (Mouton, 2001:55). According to Mouton's explanation the research design focuses on the end product and formulating a research problem as a point of departure and focuses on the logistics of the research. Similarly, Bless et al., (2006:185) define 'design' of a research as the plan or blueprint according to which data are collected to investigate the research hypothesis or question in the most economical manner. Bless et al. (2006:71) indicated that the research design is also a specification of the most adequate operation to be performed in order to test a specific hypothesis under given conditions. In order construct a good research design, it is necessary for the researcher to answer several fundamental questions about research (Bless et al., 2006:185).

Polit and Beck (2006:209) indicated that selecting a good research design should be guided by an overarching consideration, namely, whether the design does the best possible job of

proving trustworthy answers to the research question. The design will assist the researcher to develop information on the phenomena that is accurate and interpretable. However, Burns and Grove (2003:482) described descriptive research as the exploration and description of phenomena in real life situations. Bless and Smith, (1995:63) defined research design as a specification of the most adequate operation to be performed in order to test a specific hypothesis under given conditions. Their definition means the overall plan for conducting the whole research study. There are two well-known and recognized approaches to research, namely, quantitative and qualitative research designs. These designs are used for different purposes and neither is superior to the other (De Vos, 2010:252). In this study, a quantitative descriptive research was used.

Creswell (1994:1) defined quantitative as an inquiry into a social or human problem, based on testing a theory composed of variables, measured with numbers and analysed with statistical procedures in order to determine whether the predictive generalization of the theory holds true. Several authors have distinguished quantitative from qualitative research designs—the quantitative category includes national systems, pre-experimental or hypothesis development, surveys or descriptive, quasi-experimental or associative studies and true experimental or cause-effect/explanatory relationships (Neuman, 2000:121; Welman, Kruger & Mitchell, 2005:78; De Vos, 2010:74).

Schneider, Elliott, Wood and Haber (2004:250) refer to a quantitative research design as studies whose findings are quantified and reported as summary statistics and analysis and often referred to scientific or empirical methods that depict reality as something that is objective and external to the researcher. The main aim is to maximize the degree of control over the variables tested. Various authors explain a quantitative research design as a research conducted using a range of methods which use measurements to record and investigate aspects of social reality. Furthermore, a quantitative research design relies on measurement to compare and analyse different variables. In this study, data were collected to answer the research question in an economical manner using descriptive quantitative approach (Bless et al., 2006:43).

According to Brink (2006:102), descriptive research designs are used in studies where more information is required in a particular field through the provision of a picture of the phenomenon as it occurs naturally. Although descriptive designs are concerned with gathering information from a representative sample of the population (Brink 2006:103), Bless et al. (2006:43) indicated that descriptive research has the primary aim of describing rather than explaining a particular phenomenon. Burns & Grove (2003:482) stated that descriptive research plans to gain information about a phenomenon in a particular field of study. Also, a descriptive research design focuses on specific details of a situation and asks ‘why’ and ‘how’ questions—descriptive research begins with a well-defined subject and is conducted to describe it accurately (De Vos, 2002:110).

In this study, the researcher maximized the variable using a descriptive research design to assess what exists, how Batho Pele Principles are being implemented in different conditions which MHCUs are exposed to, and categorized the challenges experienced by health care providers when implementing these principles. The main aim was to obtain as complete as possible and accurate information which is not known about the implementation of Batho Pele in the hospital setting.

### **3.3 Research Setting**

Miller and Salkind (2002) as cited by Burns & Grove (2011:40) referred to research setting as the location in which a research study is conducted. The context of this study was the clinical settings at Evuxakeni, Hayani and Thabomoopo Mental Health Hospitals of the Limpopo Province. Evuxakeni Hospital is the only MHC hospital in the Mopani District situated in Giyani East location, Section A. Evuxakeni Hospital is 5.5 km from the R81 highway in the Greater Giyani Municipality of the Mopani District. Hayani Hospital is the only MHC hospital in Vhembe District situated opposite Makwarela in Sibasa. Hayani Hospital is 6.5 km from the R524 interchange in the Greater Thulamela Municipality in the Vhembe District. Thabamoopo Psychiatric Hospital is off the R518 freeway and on the R37 road in Lebowakgomo. All mental health hospitals in Limpopo, i.e., Mopani District (Evuxakeni),

Vhembe District (Hayani) and Capricorn District (Thabomoopo) also admit acute psychiatric MHCUs.

### **3.4 Population and Sampling**

#### **3.4.1 Population**

According to Schneider, Elliott, Wood and Haber (2004:257), a population is the set of cases about whom the researcher would like to make generalisation. It establishes the target population but it is not feasible, because of the time, money and personnel, to pursue the entire target population. Polit and Beck (2006:289) defined a population as an entire aggregation of cases that meet a designated set of criteria. The target population is the aggregate of cases about which the researcher would like to make generalizations (Polit & Beck 2006:290). Several authors defined population as a complete set of persons or object that possess some common characteristics that are of the interest to the researcher, in other words, that meet the criteria which the researcher is interested in studying (Polit & Hungler, 1995; Brink & Wood, 1999; Polgar & Thomas, 2000; De Vos, 2002; Brink, 2006:106; Burns & Grove, 2003; Rossouw, 2003).

Polit and Beck (2006:289) define a population as an entire aggregation of cases that meet a designated set of criteria. The target population is the aggregate of cases about which the researcher would like to make generalizations (Polit & Beck 2006:290). According to Bless et al. (2006:184) population is the complete set of events, people or things to which the research findings are to be applied. In this study the accessible target population were all health care providers working at Evuxaken, Hayani and Thabomoopo hospitals as the researcher is working at Evuxakeni Hospital, Hayani Hospital is near the University of Venda where the researcher is studying, and Thabomoopo hospital is the third mental health hospital in Limpopo province.

### 3.4.2 Sampling

Arkava and Lane (1983: 27) explained that a sample comprises of the population considered for actual inclusion in the study or a subset of measurements drawn from a population in whom the researchers are interested. Bless et al., (2006:185) defined a sample as the group of elements drawn from a population that is considered to be representative of the population and which is studied in order to acquire some knowledge about the entire population. According to Brink (2006:124), a sample is a part or fraction of a whole or a subject of a larger set, selected by a researcher to participate in a research study. Sampling refers to the researcher's process of selecting the sample from a population in order to obtain information regarding a phenomenon in a way that represents the population of interest (Brink, 2006:124).

Sampling is the technique by which a sample is drawn from the population. The major issue in sampling is to determine a sample that best represents the population to allow for the accurate generalization of the results (Bless et al., 2006:100). However, Polit and Beck (2004:278) referred to sampling as the process of selecting a portion of the population to represent the entire population and a sample is a subset of the population that is selected to participate in a research study. Reid and & Smith (1981:170) and Sarantakos (2000:139) stated that the major reason for sampling is feasibility. Types of sampling are probability and non-probability.

Probability sampling is a method of sampling in which every participant from a population have chance to be chosen to participate in the study (Brink, 2007:135). According to Brink (2006:126), the sample is much more likely to be representative of the population and to reflect its variations; it implies that all the elements have an equal chance of being included in the sample. Bless et al., (2006:100) defined probability sampling as the sampling techniques where the probability of each element of the population being included in the sample can be determined. Non-probability sampling refers to the techniques where the probability of each

element of the population being included in the sample is not known. According to Schneider (2004:259), non-probability sampling is less rigorous than probability sampling strategy and tends to produce a less accurate and less representative sample, thus limiting the ability of the researcher to make generalizations about the findings at the population level.

Approaches to probability sampling include simple random, systemic, stratified random, cluster and panel sampling. Non-probability samplings include accidental, purposive, quota, dimensional, target, snowball and spatial sampling (De Vos, 2010:204). In probability sample each person in the population has the same known probability of being selected (Seaberg, 1988:244; Kirk, 1999:367). De Vos (2010:200) referred to probability as a sampling in which the odds of selecting a particular individual are known and can be calculated. In this study, the stratified probability random sampling method was used because each participant in the population had an equal chance of being included in the sample.

According to Brink (2006:130), in stratified random sampling, the population is divided into subgroups or strata according to a variable or variables of importance in the study, so that each element of the population belongs to one and only one stratum. This increases the availability of adequate lists and facilitates selection of simple random elements without decreasing the quality of the sample in any way (Bless et al., 2006:103). In this study, the population was divided into strata or sub-groups as follows: A-Doctors, B-Dietecians, C-Nursing Managers, all Professional Nurses and sub categories, D- Physiotherapists, E-Occupational Therapists and F-Social Workers. About 200 respondents from each health section was drawn randomly from 471 health care providers in Evuxakeni and Hayani hospitals, to achieve a greater degree of representation. The population was stratified according to any number of attributes, such as age, gender, ethnicity socio economic status or level of completed education.

### 3.5 Data Collection

Data collection is the information systematically collected in the course of a study (Schneider, Elliott, Wood & Haber, 2004:442). In quantitative data collection, methods often employ measuring instruments. It is essential that the researcher understands concepts and principles that are fundamental to measurement before considering a specific measuring instrument such as concept of measurement, validity and reliability of the measuring instrument and levels of measurement (De Vos, 2010:159). Data collection is the process of gathering information to address a research problem (Polit & Beck, 2004:716).

Types of data collection methods include questionnaires and checklists. A checklist is a certain type of questionnaire consisting of a series of items which the respondents are required to indicate as most applicable to them or describe the situation best. Questionnaires are defined as a set of questions on a form which is completed by a respondent in respect of a research project (New Dictionary of Social Work, 1995:51, De Vos, 2010:51).

Types of questionnaires include mailed questionnaires which are sent off by mail and hoped that the respondent will complete and return it. Telephonic questionnaire involves asking questions telephonically to the respondents while completing the questionnaires. Self-administered questionnaires are handed to the respondents to complete in the presence of the researcher. Lastly, group administered questionnaires require respondents to be present and each group complete a questionnaire on their own without discussion with other members of the group. The data collection instrument for this research project was self-administered questionnaires.

Respondents were given self-administered questionnaires while they were on-duty and after prior appointments had been arranged with the sub-group supervisors. Each respondent completed a questionnaire on his/her own without discussing with each other. The researcher was available in case problems were experienced. Types of questions which the researcher selected include closed and open-ended questions. Close-ended questions give the responded

the opportunity of selecting one or more responses from the number provided according to the instructions. It is advantageous when a substantial amount of information about a subject exists and the response opinions are relatively well-known. The respondents understand the meaning of a question better; questions can be answered within the same framework; responses can consequently be compared better with one another; answers are easier to code and statistically analysed (Neuman, 2003:278; De Vos, 2010:174).

Open-ended questions give the respondents the opportunity of writing any answer in their own words. It has an advantage when a variable relatively explores or is unknown to the researcher; it also enables the researcher to explore the variable better and to obtain some idea of the wider spectrum of possible responses. In this study, the estimated time for completing the questionnaire was 45 minutes; data collection was for two months to include even those on annual leaves.

### **3.5.1 Validity and Reliability**

Validity and reliability are two statistical properties used to evaluate the quality of the research instrument. The quality of a research instrument is determined by its validity and reliability (De Vos, 2005:160). The researcher needs to consider both validity and reliability qualities when selecting a research instrument. The important skill in developing or finding good measurement techniques involves being able to recognize a technique that is adequate in terms of both validity and reliability (Brink, 2006:165). Validity refers to the extent to which an empirical measure accurately reflects the concept, variable or empirical measure it is intended measure (Babbie, 2004:87; De Vos, 2005:160; Brink, 2006:209). In this study, the researcher developed an instrument that was reliable to meet the goals of the study.

The researcher ensured validity by conducting a literature review and providing operational definitions of key concepts. Face validity was observed to avoid bias and to ensure that the instrument measures the contents that it is desired to measure; the questionnaire was tested by the researcher's supervisors. Face validity is the simplest definition of validity (Gravette &

Forzano, 2003:87). This means that at a face value, the questionnaire appears to be a relevant measure of the content under discussion in the research.

Brink (2006:202) regarded face validity as a subjective determination that an instrument is adequate for obtaining the desired information; on the 'face' of the instrument it appears to be an adequate means of obtaining the desired data. Face validity is the most obvious and weakest kind of instrument validity. It merely means that the instrument appears to measure what is supposed to measure (Brink, 2006:160). Reliability is the degree of consistency or dependability with which the instrument measures the attribute it is designed to measure. This means that if the same variable is measured under the same conditions, a reliable measurement procedure will produce identical results (De Vos, 2005:163). If the instrument is reliable, the results will be the same each time the test is repeated (Polit & Beck, 2006:308).

According to Brink (2006:163), reliability is the degree to which the instrument can be depended upon to yield consistent results, if used repeatedly over time on the same person, or if used by two researchers. Reliability refers to the extent to which independent administration of the same instrument consistently yield the same under comparable condition (De Vos, 2010:163). Reliability is concerned with how well the instrument is measuring the data. If the instrument is reliable, the results will be the same each time the test is repeated (Polit & Beck, 2006:308).

In this study, the researcher ensures that the information in the questionnaire is reliable and valid based on current research. The instrument was pre-tested by administering the questionnaire to some participants from a target group before the main study. The researcher ensured the reliability by developing questionnaire from existing ones in consultation with the supervisors. (Annexure D).

### 3.5.2 Eligibility

Eligibility encompass those characteristics that restrict a homogenous group of subjects and include factors such as gender, age, marital status, religion ethnicity, level of education, etc. (Schneider, et al., 2004:157). In this study, all the health care providers were included in order to determine how they implemented Batho Pele Principles in the hospital. A pre-testing of the instrument was done with 20 participants who were not included in the main study. The purpose was to check the relevance and clarity of the questions as well as the time needed to complete the questionnaire. The researcher adapted an existing questionnaire that has been used in other research. The purpose of pre-testing was to determine if the questions were well understandable and if the necessary data to address the objectives of the study were generated.

### 3.6 Pilot Study

According to Mouton (2001:103), a pilot study is one way in which prospective researchers can orientate themselves to projects they have in mind. A pilot study forms an integral part of the research process, it also functions in the formulation of research problems and a tentative planning of the investigation (De Vos, 2010:205). A pilot study is a smaller version of the main study, conducted after the literature review to identify problems in the research and to refine the data collection instrument and data analysis methods (Meyer, Van Niekerk & Naude, 2009:275).

Brink (2006:206) referred to a pilot study as a small small-scale, trial run of an actual research study. The purpose of pilot study is to investigate the feasibility of the proposed study and to detect possible flaws in data collection instruments, such as ambiguous instructions or wording, inadequate time limits as well as whether the variables defined by the operational definitions are actually observable and measurable. The researcher can conduct a pilot study in order to test practical aspects of the research study (Brink, 2006:167). In this study, the researcher developed a measurement instrument to identify any difficulty

before administering it to the actual sample, 10% of the sample were selected and were not be included in the research project. This increased the validity and reliability of the data collection instrument and also saved time for the study during the implementation of the main research project.

### **3.7 Data Analysis**

Data analysis is the systemic organization and synthesis of research data and the testing of a research hypothesis using data collected. The purpose of analysis is to reduce data to an intelligible and interpretable form so that the relations of research problems can be studied, tested and conclusions drawn (De Vos, 2010:218). Data analysis is conducted to reduce, organize and give meaning to the data. The analysis techniques implemented are determined primarily by the research objectives, questions or hypothesis (Burns & Grove, 2003:43).

Quantitative, descriptive statistics may assist to investigate and describe the data by means of frequencies and percentages (Burns & Grove, 2003:409). Descriptive statistics enables the researcher to organize the data in ways that give meaning and facilitate insight. In this study, statistical data analysis was used to investigate the research question by means of inferential statistical method in order to draw statistically valid conclusions (Welman, Kruger & Mitchell, 2005:224).

Data were analysed using the Statistical Package for Social Sciences (SPSS) version 21. SPSS is a popular computer programme for data analysis. This software provides a comprehensive set of flexible tools that can be used to accomplish a wide variety of data analysis tasks (Einspruch, 1998:2). The graphical and numerical techniques for organising and interpreting data enable trends and differences to be noted and calculations of the simple statistics such as frequency, percentage and proportion of the score.

### **3.8 Ethical Considerations**

Ethics is a set of moral principles which is suggested by an individual or group, they are widely accepted and offer rules and behavioural expectations about the most correct conduct towards participants, employees, employer, sponsors, other researchers, assistants and students (Polit & Beck, 2008:753). Ethical considerations are a set of moral principles that are used to guide the planning, implementation and evaluation of any research project suggested by an individual or group (Meyer, Van Niekerk & Naude, 2009:277). In this study, ethical procedures were followed (Annexure A).

#### **3.8.1 Approval to Conduct the Study**

The researcher has been granted ethical clearance by the University of Venda Health, Safety and Research Ethics Committee (Annexure A) and permission by Limpopo Province Department of Health and Social Development (Annexure B1) to conduct the study at Evuxaken, Hayani and Thabomooop hospitals. Furthermore, the researcher obtained informed consent from the participants and observed ethical standards to protect them from physical and mental discomfort (Annexure C).

#### **3.8.2 Quality of the Researcher and the Research Project**

In this study the identity, qualifications and experience of the researcher was formally introduced to the participants (Annexure C). In all steps of the research project, the researcher adhered to the highest possible ethical standards and did not attempt to research the project beyond the researcher's knowledge skills and experience without seeking guidance and support from experienced researchers.

#### **3.8.3 Confidentiality**

Information that the participants provided publicly reported in a manner that identifies the participants or made accessible to parties other than those involved in the research (De Vos,

2010:59). The information provided was neither shared with strangers nor with people known to the participants such as family members, co-workers, physicians and other health care providers, unless the researcher had been given explicit permission to share the information.

### **3.8.4 Anonymity**

Anonymity involves protection of participants' identity (Meyer, Van Niekerk & Naude, 2009:277). The participants' names were not written on the questionnaires provided during data collection. Health care providers were identified as follows:

A - Psychiatrists and Medical Doctors.

B - Dieticians

C - Nursing Managers, all Professional Nurses and sub categories.

D - Physiotherapists

E - Occupational Therapists

F - Social Workers

By so doing it was not be easy to identify the exact participant's name.

### **3.8.5 Informed Consent**

Informed consent is an ethical principle that requires the researcher to obtain voluntary participation of a subject after giving information of the possible risks and benefit to participation (De Vos, 2010:59). The returns of completed questionnaires also reflect their voluntary consent to participate. The participants were given adequate information regarding the research so that they were free to participate and had the powers of free choice enabling them to consent to or decline participation in the research voluntarily. The purpose of the

study, objectives and their rights to participate or refuse to participate were explained (Annexure C).

### **3.9 Summary**

Chapter 3 discussed the research methodology used for this study, in particular, the research design, research setting, population and sampling, research setting, data collection, data analysis procedures and ethical considerations. Chapter 4 provides the analysis and the interpretation of the results.

# CHAPTER 4

## ANALYSIS AND INTERPRETATION OF THE RESULTS

### 4.1 Introduction

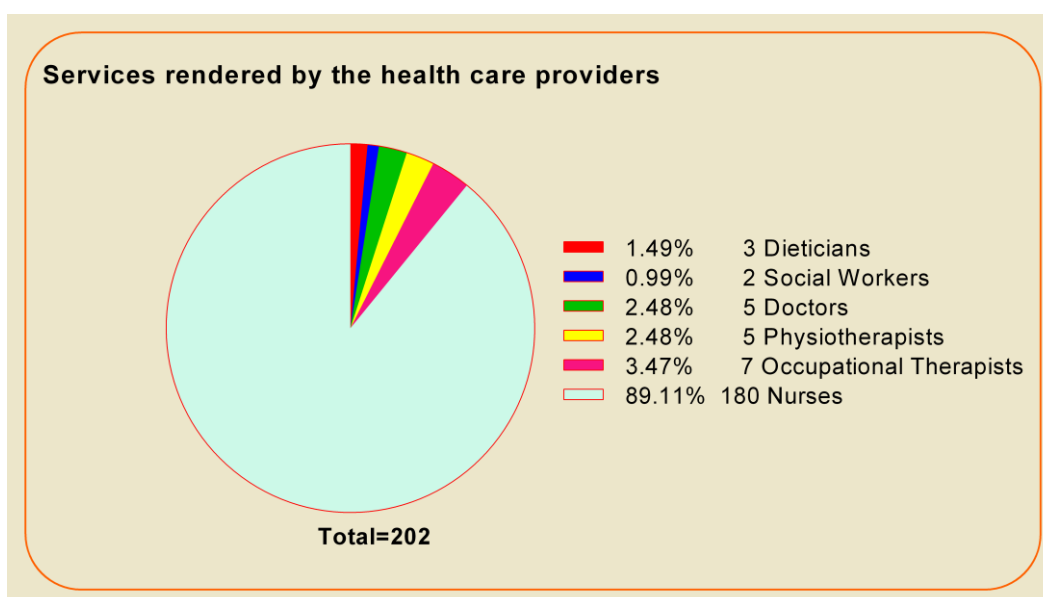
The previous chapter discussed the research methodology that was used for the study, i.e., the research design, research setting, population and sampling, research setting, data collection, and data analysis. This chapter focuses on the analysis and the interpretation of the results. A quantitative, descriptive strategy was used in this study to assess how health care providers implement Batho Pele Principles at the selected mental health hospitals of Limpopo Province. The main aim was to obtain complete and accurate information not known about the implementation of the Batho Pele at the selected mental health hospitals. Data were collected using self-administered questionnaires. Two hundred and fifteen questionnaires were handed to the respondents who were on-duty; appointments were arranged with the sub-group supervisors. Two hundred and two questionnaires were completed of which thirteen were spoiled (demographic data incomplete).

The questionnaire consisted of two sections. Section A indicated demographic data of the participants who were health care providers at the selected mental health hospitals. Section B consisted of self-assessment questions to assess how the Batho Pele Principles were implemented, a description of challenges experienced by health care providers in the implementation of Batho Pele Principles. This section made provision for the health professionals to give their own opinion regarding the implementation of Batho Pele Principles. Descriptive statistical SPSS version 21 data analysis was used to investigate the research question by means of inferential statistical methods in order to draw statistically valid conclusions. Descriptive statistics are procedures that describe numerical data that assist in sample data organising, summarizing and interpreting (Monnette et al., cited by De Vos, 2011:251).

Data were analysed by a statistician using the Statistical Package for Social Sciences (SPSS) version 21. The graphical and numerical techniques for organizing and interpreting data were used to enable trends and differences to be noted and calculations of the summary statistics such as frequency, percentage and proportion of the score. Analysis of data and interpretation of each item from questionnaires were discussed in the context of references to the literature review, where applicable.

## 4.2 Demographics and Description of the Data

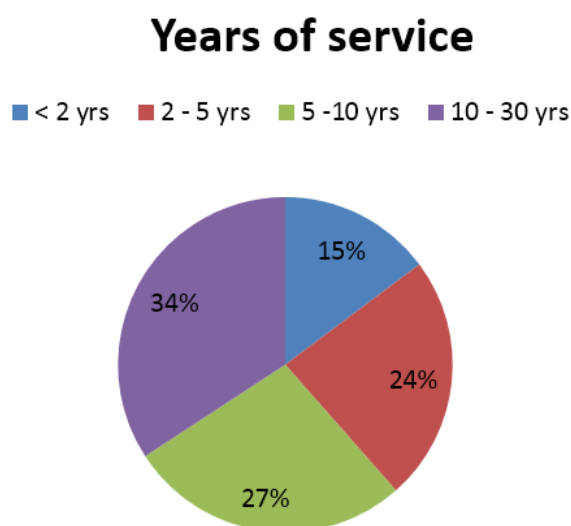
Figure 4.1 summarizes the distribution of health care providers in the data by services being rendered at the selected mental health hospitals. Out of 202 health care providers who participated in the study, 3 (1.5%) were dieticians, 2 (1.0%) social workers, 5 (2.5%) doctors, 5 (2.5%) physiotherapists, 7 (3.5%) occupational therapist and 180 (89.1%) nurses of different ranks (nursing managers, professional nurses, enrolled nurses and enrolled nursing assistants). This question was important to ask because the professionals formed the multi-disciplinary team involved in providing health care services to patients. The researcher assumed that high number of nurses could be explained by the fact that nurses are the predominant PHC providers for the patients for twenty-four hours, more than other the health care providers.



**Figure 4.1:** Services rendered by the health care providers.

Figure 4.2 shows the distribution of health care providers by year of service that they were providing health care services to the MHCUs. Of 202 health care providers who participated in the study, 30 (14.8%) worked for less than 2 years, 48 (23.7%) worked for 2 to 5 years, 55 (27.3%) worked for 5 to 10 years and 69 (34.2%) worked for 10 to 30 years. Almost 70% of the health care providers in this study worked for more than 10 years. This question was crucial to establish if differences in years of work experience of the health care providers had an impact on how the Batho Pele Principles were implemented in the mental health services. The study assumed that the longer the employee worked in the hospital, the better they would report on their experiences and make valuable inputs for the study.

Table 4.1 shows the distribution of health care providers by gender. Of the 202 health care providers in the study, 149 (73.7%) were females and 53 (26.3%) were males. Gender-based views and perceptions were considered essential to this study.



**Figure 4.2:** Years of service of the health care providers.

**Table 4.1:** Gender of the health care providers

Gender	Frequency	Percent
--------	-----------	---------

Male	53	26.3
Female	149	73.7

The researcher assumed that highest number of female nurses could be ascribed to the fact that nursing had been predominantly female profession. This assumption was guided by a case study of the Human Sciences Research Council (HSRC) conducted by Wildschut & Mqolozana (2008:6) which indicated that female nurses remain the majority across all nursing categories. For the total number of 196,914 nurses, 183,085 (92.9%) were female and 13,829 (7.0%) were males (SANC, 2007, cited by Wildschut & Mqolozana, 2008:6). This could indicate that low numbers men are starting to infiltrate the profession, but this has not yet translated to the higher levels due to the expected time lag of education and training. Men have only recently started entering the profession in bigger numbers. Similar to the trends in the professional learning category, females remain the majority of all categories of student nurses, although at lower proportions. However, the majority of learners were found in the student category. Out of 27,924 learners, 23,554 (84.3%) were female student nurses and 4,370 (15.7%) males, suggesting that gender transformation of the nursing profession is starting slowly at the learner level, with male students starting to comprise bigger proportions in comparison to the distributions at professional level (SANC, 2007 cited by Wildschut and Mqolozana, 2008:8).

Table 4.2 shows the distribution of health care providers by age. Of 202 health care providers 32 (16.7%) were aged from 20 to 30 years, 57 (27.0%) from 30 to 40 years, 76 (37.0%) from 40 to 50 years and 37 (19.3%) were aged above 55 years.

**Table 4.2:** Age of the health care providers

Age	Frequency	Percent
20 - 30 yrs	32	16.7
30 - 40 yrs	57	27.0
40 - 50 yrs	76	37.0
> 55	37	19.3
<b>Total</b>	<b>202</b>	<b>100</b>

Almost 37.0% form part of higher number of the health care providers in this study were aged between 40 to 50 years. Age was important to this study, as it helped to identify variances and inputs from different health care providers. The implication of the findings might indicate that most of the health care providers were approaching retirement age during the period of this study. The study assumed that older participants were considered to have more knowledge, skills, positive attitudes and experience that could assist in the mentorship to newly qualified health care providers. Age was also important as it was expected that it will shed light in relation to how these principles are implemented.

### 4.3 Assessment of the Implementation of the Batho Pele Principles

The aims of this section were to assess how the Batho Pele Principles were implemented, to describe challenges experienced by health care providers in such implementation and to make provision for the health professionals to give their own opinions regarding the issue. The results were interpreted separately and some items with similar focus were clustered together for easier interpretation.

Table 4.3 shows the frequency and percentage of the participants' responses to policies and protocols developed to provide quality MHC services or to integrate them into existing frameworks.

**Table 4.3:** Participants' responses to policies and protocols developed to provide quality MHC services

<b>Does hospital develop policies and protocols to provide quality mental health care services or integrate them into existing framework?</b>		
	<b>Frequency</b>	<b>Percent</b>
<b>Yes</b>	184	91.0
<b>No</b>	18	9.0
<b>Total</b>	<b>202</b>	<b>100.0</b>

Of the 202 health care providers, 184 (91%) responded that the hospital had developed policies and protocols to provide quality MHC services and 14 (7.9%) responded that the

hospital did not. This finding means that the hospitals developed policies and protocols to provide quality MHC services. The policy on quality in health care for South Africa revealed that achieving the goal of a quality health care system requires a national commitment to measure, improve and maintain high-quality health care for all citizens (DOH, 2007:14).

However, the key aims of the policy include: addressing access to quality health care; increasing patients' participation and the dignity affordable to them; reducing underlying causes of illness, injury and disability through preventive and health promotion activities; expanding research on evidence of effectiveness; ensuring the appropriate use of health care services; reducing health care errors (adverse events) (DOH, 2007:14). Likewise, it is sensible to have a national policy and develop national standards for both public and private health care sectors; it is the task of staff in each sector to deliver the quality improvements. This requires a Quality Assurance culture and approach to the delivery of health care. For the public sector, this necessitates action at all levels. The policy on quality in health care for South Africa document describes proposed methods to be used that follow the approaches outlined above. Moreover, consistent local action is needed to ensure that national standards and guidelines are reflected in the delivery of services (DOH, 2007:14).

According to Funk et al. (2009:9), approaches to improving the quality of MHC include alignment of policy and legislation. According to Meyer (2004:138) policies and protocols regarding quality patient care are developed within the framework of the hospital. However, the policy states the person responsible for a specific task and describes what should be done. Advantages of policy are that: it is a written instruction of what is expected; protects the employer, employee and the patient; promotes interdepartmental co-ordinating and is of great value in the orientation and training of personnel. Furthermore, policies for the different units should be congruent to the policies, procedures, mission statement, philosophy aims and objectives of the institution (Meyer et al., 2004:138).

This implies that it is important for institutions to have policies that guide their activities. Herman (2007:1) identified that MHC can be improved by examining the clinical, policy and scientific underpinnings of the process measurement, a widely used method of assessing quality of MHC. However, the use of measurement to improve quality may promote accountability, encourage evidence-based practices and shape incentives to favour the delivery of high quality care. It is acknowledged that improving MHC helps health care providers and other stakeholders meet national mandates to assess and improve quality of care (Herman, 2007:1). In this study, Table 4.3 revealed that policies and protocols to provide quality MHC services or integrate them into existing framework are sufficient. This finding is in the line with the requirement of the national government's WPTPS framework, "national and provincial departments should develop departmental service delivery strategies which promote continuous improvement in the quality and equity of the service provision".

The policy also identified the targets of quality assurance interventions which are: health professionals, patients, community and health care service delivery (DOH, 2007:5). Interventions aimed at health professionals include traditional approaches to keeping health professionals up-to-date are CPD, using the CME conference. However, health care can be improved by increasing patient safety. There is a need to develop expertise to help clinicians modernize their practices. Feedback to health professionals about their performance has also proved to be a useful way of improving quality. Furthermore, the policy recommends a range of interventions, rather one or two single measures to assist health professionals to keep abreast of changes in health care knowledge and practice (DOH, 2007:6).

An intervention aimed at patients involves understanding patients' perceptions. However, there is a growing emphasis in health care on partnerships between the patient and the provider. It is clear that improved communication between the health professional and the patient, and providing patients with understandable information about their condition and treatment options, has a positive effect on health outcomes. Furthermore, interventions aimed at the community needs an active involvement of the overall health status of the

population. However, not only is individual patient participation important in improving quality, but also the active involvement of whole communities. This has been amply demonstrated in the key role played by communities in the fight against HIV/AIDS. Partnerships with community structures such as non-governmental organizations (NGOs) and community-based organizations (CBOs) are important for mobilizing community action and advocacy around health issues (DOH, 2007:7).

Interventions aimed at systems involves identifying weaknesses in systems that cause errors in processes or outcomes, the systems can be redesigned to avoid these errors and improve the quality of health care delivery. However, the results of changes to systems can be monitored and evaluated and further adjustments made where necessary. This is an on-going process of assessment, redesign and monitoring and evaluation that ensures that systems are constantly evaluated and, where necessary, modernized to improve quality (DOH, 2007:8).

Table 4.4 shows the frequency in percentage of how often are Batho Pele Principles in-service education given in the units.

**Table 4.4:** Participants' responses to how often Batho Pele Principles education is given in units

<b>How often is Batho Pele Principles education given in your unit?</b>		
	<b>Frequency</b>	<b>Percent</b>
<b>Once per month</b>	59	29.3
<b>Twice per month</b>	43	21.3
<b>Every week</b>	70	34.6
<b>None of above</b>	30	14.8
<b>Total</b>	<b>202</b>	<b>100</b>

Of 202 health care providers, 59 (29.3%) were given Batho Pele education once per month, 43 (21.3%) twice per month and 70 (34.6%) every week. This finding revealed that Batho Pele Principles education is given in some of the units. The researcher assumed that the challenge in giving Batho Pele Principles education may be classification of MHCUs in

different units. However, it is easy for health care providers to give education to MHCUs who are stable, but what about those who are caring intellectually disabled MHCUs. Furthermore, in-service education may differ depending on the vision and mission of the unit. The researcher also assumed that MHCUs who were admitted in acute wards may not benefit from “once per month, twice per month” Batho Pele Principles education as it may be given before admission or after discharge, since only those who are in chronic wards may benefit.

According to De Haan (1998:19), health education is an active process aimed to change people’s attitudes and influence their actions with regard to health-related matters. All members of the health team should be involved in patient teaching. However, for patient teaching to occur, interpersonal interaction between patients and health care providers is necessary. An integral part of this interaction should be with caring as the main aspects. Furthermore, the intervention should be focused on changing the behaviour of the patient by acquisition of new skill and knowledge that will have positive influences on health matters in the present as well as in the future (De Haan, 1998:19).

According to Muller (2008:8), nurses should design strategies to ensure facilitation of observing this ethos (people first) in their units, and should critically analyse and reflect on their abilities (knowledge, skills and attitude) by reflecting Batho Pele Principles as the national government’s WPTPS framework. Furthermore, quality improvement mechanisms are urgently needed to change these conditions and approach to improving the quality of MHC (Funk et al., 2009:9).

In this study, Table 4.4 revealed that in-service education of Batho Pele Principles is sufficient. This finding is in the line with the requirements of the policy on quality in health care for South African which state that a continuous advance in health technology and patient care requires that the skills of health professionals be continually developed. Moreover, the institutions that educate health professionals, such as academic institutions, employer-based programmes and other entities need to embrace change if they are to succeed in preparing the

next generation of physicians, nurses, allied health professionals and other health care workers (DOH, 2007:14).

Table 4.5 shows the frequency and percentage of health care providers that treated MHCUs as customers, listening to their views and taking them into account when making decisions about mental health services that they should receive.

**Table 4.5:** Health care providers treating MHCUs as customers

<b>Do you treat MHCUs as customers, listening to their views and taking into account of them in making decisions about what mental health services should be provided in your unit?</b>		
	<b>Frequency</b>	<b>Percent</b>
<b>Yes</b>	178	88.1
<b>No</b>	24	11.9
<b>Total</b>	<b>202</b>	<b>100</b>

Of 202 health care providers, 178 (88.1%) agreed that they treated MHCUs as customers, listening to their views and taking them into account of them when making decisions and 24 (11.9%) disagreed. Table 4.5 reflect that MHCUs are treated as customers. Health care providers listened to the patients and took them into account when making decisions about the type of mental health services they should receive. Therefore, Batho Pele Principles as a Government initiative putting people first, should be adapted in order to facilitate mutual participation between health care providers and MHCUs. This finding is in line with the requirement of Batho Pele principle “consulting the user of the services” that state that, departments must regularly and systematically consult not only about the services currently provided, but also make provision for other new basic services to those who lack them.

The policy on quality in health care for South Africa also signify that in increasing patients' participation and the dignity afforded to them, community participation and adoption of Batho Pele Principles are key to empowering users of services to take control of their own health care and of their families (DOH, 2007:5). However, informing patients and involving

them in decision-making needs active participation of patients in their care to improve the effectiveness of care as well as their satisfaction with their care. Patients who are treated with dignity and are well informed and able to participate in treatment decisions are more likely to comply with their treatment plans (DOH, 2007:5). In order to ensure that strengthening and improvement of the consultation process is applied, an acknowledgement should be made of the fact that the department is utilizing various consultative methods to reach out to its clients. The purpose of the consultation process should be to inform and legitimize decisions about what services should be provided and how they should be delivered (Swana, 2008:62).

Table 4.6 shows the frequency and percentage of how health care providers ensured accurate and proper recording keeping to improve MHC.

**Table 4.6:** Health care providers' responses to accurate and proper record keeping

<b>Do you ensure that there is accurate and proper record keeping to improve mental health care?</b>		
	<b>Frequency</b>	<b>Percent</b>
<b>Definitely</b>	131	64.8
<b>Most definitely</b>	56	27.8
<b>Not all</b>	13	6.5
<b>None of above</b>	2	0.9
<b>Total</b>	<b>202</b>	<b>100.0</b>

Of 202 health care providers, 131 (64.8%) responded definitely, 56 (27.8%) most definitely, 13 (6.5%) not all and 2 (0.9%) none of above. This finding indicates that the majority of health care providers (64.8%) agreed that with accurate and proper record keeping can improve MHC. According to Meyer, Van Niekerk and Noude (2004:40), records are legal documents and recording is the legal and professional responsibility of every health professional. However, the importance of accurate record keeping is to enhance quality patient care. If nursing action has not been recorded, it is difficult to prove that it has been implemented. Furthermore, personnel should remember to that another professional may not

be criticized in patients' records. Records should be kept to make it possible for each health worker to use the records in rendering comprehensive quality health care (Meyer et al., 2004:40). Mkize (2007:72) revealed that all patients should have access to his hospital records in accordance with the Access to Information Act. Furthermore, the DOH should investigate the management style at the hospital and appropriate action should be taken (Mkize 2007:72).

In this study, Table 4.6 revealed that accurate and proper record keeping is satisfactory. This finding is in the line with the requirement of Batho Pele principle "Providing more and better information" which states that Information must be provided in a variety of media and languages to meet the differing needs of different customers. Therefore, proper recording keeping serve as source of information when it is needed.

Table 4.7 shows the frequency and percentage of health care providers that allocate adequate staff to provide quality mental health care in their units. Of 202 health care providers, 108(53.3%) responded definitely, 52 (25.5%) most definitely, 21 (10.2%) not all and 23 (11.2%) none of above. This finding reflects that there are insufficient staffs to provide quality MHC. The researcher assumed that some of the health care professionals did not have additional staff or sub-categories such as social workers. According to Jooste, Prinsloo & De Wet (2009:162), the availability of sufficient trained health care professionals with competencies is central to the success of transformation process of health care system in South Africa.

**Table 4.7:** Health care providers that allocate adequate staff to provide quality mental health care in their units

<b>Do you allocate adequate staff to provide quality mental health care?</b>		
	<b>Frequency</b>	<b>Percent</b>
<b>Definitely</b>	108	53.3
<b>Most definitely</b>	52	25.5
<b>Not at all</b>	21	10.2
<b>None of above</b>	23	11.2
<b>Total</b>	<b>202</b>	<b>100</b>

However, Staffing should be an orderly systematic process based upon a sound rationale and applied to determine the number and kind of personnel required to provide health care of predetermined standard to a group of clients in a unit setting (Swansburg, 1996:113). According to Muller (1998:303), an under-supply of personnel gives rise to poor health care and demoralizing effects on personnel and causes of frustration and exhaustion. With regard to staff shortage, Mkize (2007:74) recommended that strict adherence to the Norms Manual for Severe Psychiatric conditions issued by the DOH should be enforced. Therefore, all vacant posts should be advertised and filled. Orderlies should be employed.

However, psychiatric electives should be added to the training of staff nurses and there should be a conscious plan to recruit male nurses in the field of psychiatry. Mpulo revealed that inadequate specialized and general management skills, high turnover of staff, and shortage of critical staff and poor delegations of Human Resource affect the provision of quality health care. Moreover, it is the reflection of the dedication of managers and staff at the institution to provide quality patient care (Mpulo, 2001:75). In this study, Table 4.7 showed that there is shortage of staff to provide quality MHC. This finding is of concern in line with the requirement of the Norms Manual for Severe Psychiatric conditions, which state that all vacant posts should be advertised and filled. Thus, this study result reflects that there are insufficient staffs to provide quality MHC.

Table 4.8 shows the frequency and percentage on how health care providers regarded their knowledge about Batho Pele Principles.

**Table 4.8:** Health care providers' responses with regard to their knowledge of Batho Pele Principles

<b>How do you regard your knowledge of Batho Pele Principles?</b>		
	<b>Frequency</b>	<b>Percent</b>
<b>Excellent</b>	76	37.6
<b>Good</b>	83	41.0
<b>Average</b>	27	13.5

<b>Very poor</b>	16	7.9
<b>Total</b>	<b>202</b>	<b>100</b>

Of 202 health care providers, 76 (37.6%) regarded their knowledge as being excellent, 83 (41.0%) indicated that it is good, 2 (13%) responded that it is average and 16 (7.9%) said that it was very poor. According to Mokoena and Jooste (2000:33), Batho Pele is an initiative to encourage public servants, including nurses, to be service-orientated, to strive for excellence in service delivery and to commit to continuous service delivery improvements. The Batho Pele Principles were developed to serve as an acceptable policy and legislative framework for health care service delivery. Khoza (2009:87) revealed that more extensive studies should be done at hospitals, including all nursing units and other departments that deal directly with patients; this will give a clear picture of the implementation of Batho Pele Principles with regard to total health care delivery in the hospitals. Furthermore, job descriptions of the employees should reflect the standards so that implementation is guaranteed as the job description informs the performance contract (Swana, 2008:60).

Therefore, every employee of the department should be assessed and evaluated on the implementation of the principles in their daily duties. This will ensure that shortfalls are detected at an early stage since performance monitoring is done continuously and reviewed quarterly. The necessary improvement measures can then be instituted and compliance levels enhanced (Swana, 2008:60). In this study, Table 4.8 revealed that health care providers' knowledge regarding Batho Pele Principles is sufficient. This finding is compatible with the requirement of the national government's WPTPS framework, which states that all the public servants are required to practice Batho Pele Principles or guidelines when delivering services to the clients.

Table 4.9 shows the frequency and percentage of health care providers who create an environment that fosters a trusting relationship through openness and transparency.

**Table 4.9:** Health care providers fostering a trust relationship through openness and transparency

<b>Do you create an environment that fosters a trusting relationship through openness and transparency?</b>		
	<b>Frequency</b>	<b>Percent</b>
<b>Yes</b>	178	88.2
<b>No</b>	24	11.8
<b>Total</b>	<b>202</b>	<b>100</b>

Of 202 health care providers, 178 (88.2%) responded that they created an environment that fostered a trusting relationship and 24 (11.8%) responded “no”. This finding reveals that health care providers created an environment that fostered a trusting relationship through openness and transparency. However, WPTPS indicates that the importance of public service delivery lies in the need to build confidence and trust between the provider and the user (DPSA, 2010:11). Funk et al., (2009:3) affirmed that improving the quality of MHC involves respect of the rights of people with mental disorders and the provision of the best care possible, consistent with national circumstances. Moreover, to achieve optimal quality, the systems for delivering MHC services must be conducive to treatment and recovery (Funk et al., 2009:10).

The policy on quality in health care for South Africa reflects an intervention aimed at patients involves understanding patients’ perceptions. However, there is a growing emphasis in health care on partnerships between the patient and the provider. It is clear that improved communication between the health professional and the patient, and providing patients with understandable information about their condition and treatment options, has a positive effect on health outcomes (DOH, 2007:7). In this study, Table 4.9 indicated that health care providers’ creation of a trusting relationship through openness and transparency is sufficient. This finding is consistent with the requirement of Batho Pele principle “Increasing Openness

and Transparency” which states that citizens should be told how national and provincial department are run, how much they cost and who is in charge.

Table 4.10 shows the frequency and percentage of health care providers who considered the sensitivity and not asking MHCUs to reveal unnecessary personal information.

**Table 4.10:** Health care providers considering the sensitivity of MHCUs

<b>Do you consider sensitivity and not asking MHCUs to reveal unnecessary personal information?</b>		
	<b>Frequency</b>	<b>Percent</b>
<b>Yes</b>	168	83.2
<b>No</b>	34	16.8
<b>Total</b>	<b>202</b>	<b>100</b>

Of 202 health care providers, 168 (83.2%) responded “yes” and 34 (16.8%) responded “no”. This finding reflects that health care providers had a positive attitude towards MHCUs. However, the policy on quality in health care for South Africa reflects that creating an environment in which quality health care will flourish by strengthening the hand of the user and requires information that they can use to make informed choices. Furthermore, users need understandable and reliable information about quality to effectively participate in efforts to improve quality and fully exercise their rights and responsibilities (DOH, 2007:9). Departments should take stock of their values, as well as behaviour and attitudes of employees and then take necessary steps to prepare public servants for a revitalized Batho Pele culture of responsiveness as well as efficiency and effectiveness in delivering services to the public. Public servants are social-beings whose needs should be recognized and fulfilled. Public servants should likewise be courteous when providing services to the public by listening to their problems, apologizing when necessary, and serving people with a smile (DPSA, 2010:12).

Kiguli et al., (2009: 79) identified factors affecting quality delivery, including inadequate trained health care providers and poor attitude of health care providers. Their study revealed that there should be improvement on quality of health care services with particular alternatives being paid for the poor general population. Despite the improvement of infrastructure and donor funding, there was still low satisfaction with health care services and poor accessibility. In this study, Table 4.10 showed that health care providers considered sensitivity and did not ask MHCUs to reveal unnecessary personal information. Health care providers respected MHCUs as social-beings whose needs should be recognised and fulfilled. This finding is in the line with the requirement of the national DPSA framework, which states that public servants are social-beings whose needs should be recognized and fulfilled.

Table 4.11 shows the frequency and percentage of health care providers who responded to hospital development of departmental codes and training programmes that integrate Batho Pele Principles to ensure that MHCUs are treated with courtesy, respect and dignity.

**Table 4.11:** Hospital training programmes that integrate Batho Pele Principles in services to MHCUs

<b>Does the hospital develop departmental codes and training programmes that integrate Batho Pele Principles to ensure that MHCUs are treated with courtesy, respect and dignity?</b>		
	<b>Frequency</b>	<b>Percent</b>
<b>Yes</b>	148	73.3
<b>No</b>	54	26.7
<b>Total</b>	<b>202</b>	<b>100</b>

Of 202 health care providers, 148 (73.3%) responded that hospitals developed departmental codes and training programmes that integrate Batho Pele Principles and 54 (26.7%) responded that they did not. Thus, hospitals did develop departmental codes and training programmes that integrate Batho Pele Principles in services provided to MHCUs.

However, providing quality patient care requires training skilled health workers and establishing a culture that values lifelong learning and recognizes its important role in

improving quality. The philosophy and approaches of the policy on quality in health care for South Africa need to be reflected in under-graduate training curricula of all categories of health care workers and in the post-graduate training curricula of all categories of health professionals. Furthermore, health professionals and professional bodies, in collaboration with their colleagues, should develop CPD programmes. Moreover, the institutions that educate health professionals, such as academic institutions, employer-based programmes, and other entities, need to adopt transformation if they are to succeed in preparing the next generation of physicians, nurses, allied health professionals, and other health care workers (DOH, 2007:14).

Wakermen and Humphreys (2011:2) indicated that in order to be able to comprehensively monitor and evaluate health care services as well as benchmarks, adequate national information is needed to improve quality health care services. However, health units should have quality improvement programmes in place and patients should be aware of the expected level of nursing care that can be expected. Furthermore, patients who are treated with dignity and are well informed and able to participate in treatment decisions are more likely to comply with their treatment plans. Prevention is a better way to reduce the burden of diseases and improve the quality of life (DOH, 2007:5). In this study, Table 4.11 revealed that hospitals sufficiently developed departmental codes and training programmes that integrate Batho Pele Principles to ensure that MHCUs are treated with courtesy, respect and dignity. This finding is in accord with the requirement of the WPTPS framework, which states that the performance of staff who deal with the customers must be regularly monitored and those which fall below the specified standards should not be tolerated.

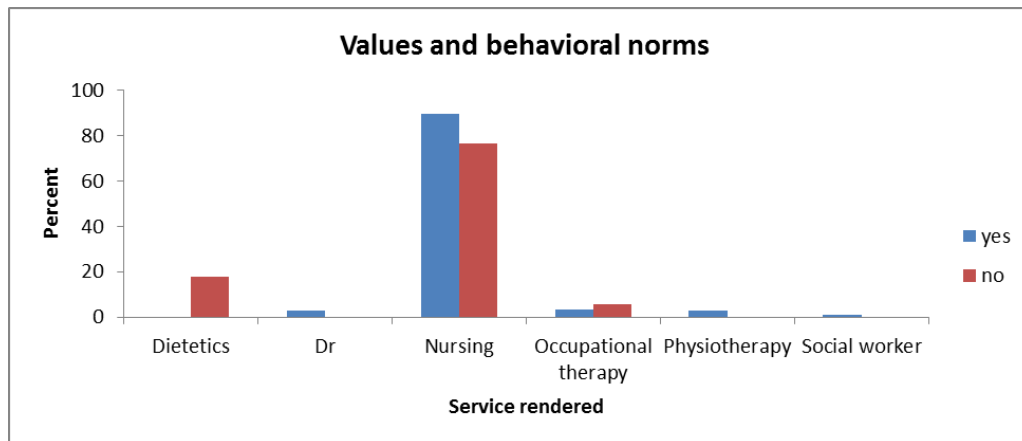
Table 4.12 shows the frequency and percentage how health care providers rate their hospital's compliance with the implementation of Batho Pele Principles.

**Table 4.12:** Hospitals' compliance with the implementation of the Batho Pele Principles

<b>How would you rate your hospital's compliance with the implementation of Batho Pele Principles?</b>		
	<b>Frequency</b>	<b>Percent</b>
<b>Excellent</b>	47	23.3
<b>Good</b>	78	38.6
<b>Average</b>	53	26.3
<b>Very poor</b>	24	11.8
<b>Total</b>	<b>202</b>	<b>100</b>

Out of 202 health care providers, 47 (23.3%) responded excellent, 78 (38.6%) good, 53 (26.3%) average and 24 (11.8%) very poor. This finding suggests that the hospitals complied with the implementation of Batho Pele Principles. The policy on quality in health care for South Africa revealed that achieving the goal of a quality health care system requires a national commitment to measure, improve and maintain high-quality health care for all citizens. However, the key aims of the policy include: addressing access to quality health care; increasing patients' participation and the dignity affordable to them; reducing underlying causes of illness, injury and disability through preventive and health promotion activities; expanding research on evidence of effectiveness; ensuring the appropriate use of health care services; reducing health care errors (adverse events) (DOH, 2007:2). The DPE revealed that the progress report with regard to the implementation of Batho Pele initiatives must be understood from the context of the Mandate and Mission of the department. These will serve as a vehicle to manage government-shareholder interests through monitoring and evaluation of the overall performance of the state. Furthermore, the department also serves to promote and advocate best performance management practices, which will enhance the shareholder value within an improved corporate governance environment (DPE, 2011:2). In this study, Table 4.12 revealed that hospital's compliance with the implementation of Batho Pele is adequate. This finding resonates well with the requirement of the national government's WPTPS framework, which states that all the public servants are required to practice Batho Pele Principles or guidelines when delivering services to the clients.

Figure 4.3 shows the values and behavioural norms of the units that were in the line with the Batho-Pele Principles.



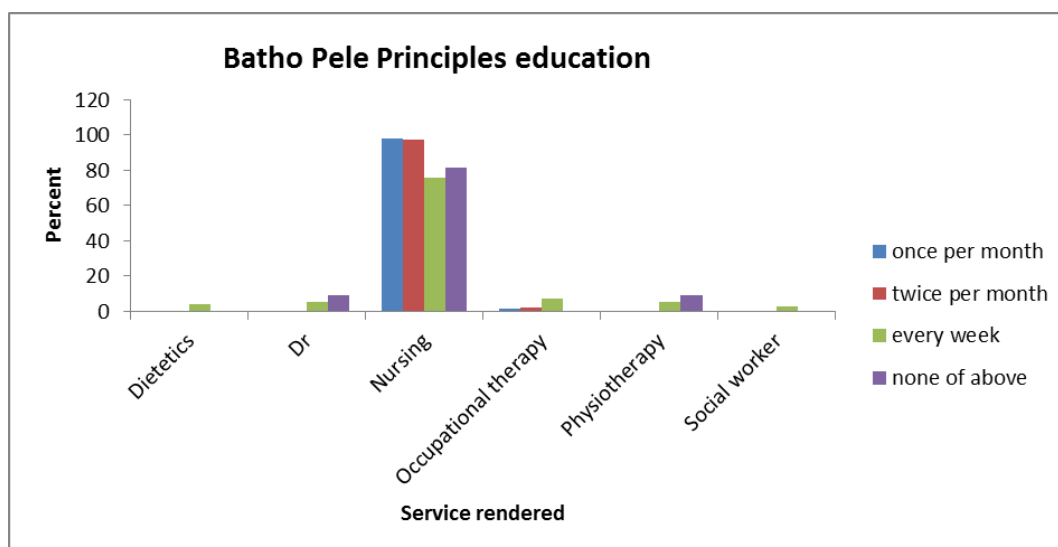
**Figure 4.3:** Values and behavioural norms of units in the line with the Batho-Pele Principles.

Out of 202 health care providers who participated in the study, 3 (17.65%) dieticians responded they did not have values and behavioural norms of the unit that were in the line with the Batho-Pele principles. Other health care providers responded that they had values and behavioural norms of the unit that were in the line with the Batho-Pele principles: 5 (2.87%) doctors responded “yes”; of 170 (89.1%) from the nursing section, 157 (90.23%) nurses responded “yes” while 13 (7.647%) responded “no”. Of 7 (3.5%) of occupational therapy, 6 (3.87%) responded “yes”, while 1 (5.88%) responded “no”, and social workers, 2 (1.15%) responded “yes”. This finding reflects that written values and behavioural norms were not available to all categories.

According to Mokoena and Jooste (2000:33), Batho Pele is an initiative to encourage public servants, including nurses, to service-orientated, to strive for excellence in service delivery and to commit to continuous service delivery improvements. Batho Pele Principles were developed to serve as an acceptable policy and legislative framework for health care service delivery. Figure 4.3 reveals that there were written values and behavioural norms in some of the units—in the line with the Batho Pele Principles and the requirement of the national government’s WPTPS framework, which state that “national and provincial departments

should develop departmental service delivery strategies which promote continuous improvement in the quality and equity of the service provision”.

Figure 4.4 shows the frequency of Batho Pele Principles education given in different units. Out of 202 health care providers who participated in the study, 58 (75.71%) nurses and 1 (1.69%) occupational therapists provided Batho Pele Principles education once per month; 45 (97.67%) nurses and 1 (2.33%) occupational therapist, twice per month; 3 (4.39%) dieticians, 4(5.39%) doctors, 58 (75.71%) nurses, 5 (7.14%) occupational therapist, 4 (5.71%) physiotherapist and 2 (2.86%) social workers every week; 1 (9.09%) doctors, 19 (81.82%) nurses and 1(9.09%) physiotherapist did none.

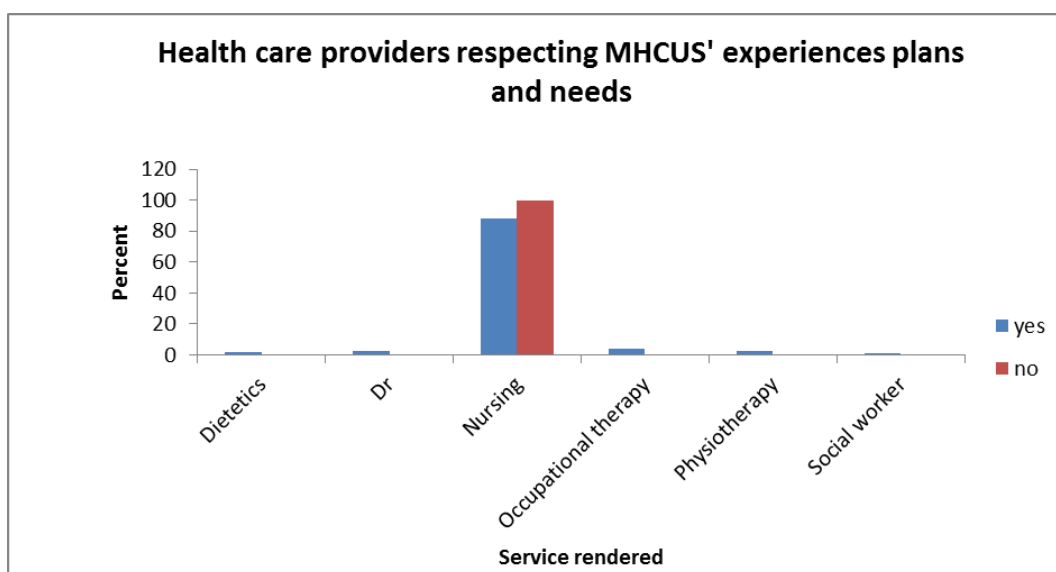


**Figure 4.4:** Frequency of Batho Pele Principles education given in different hospital units.

Figure 4.4 revealed that the frequency of Batho Pele Principles education in different hospital units is sufficient. However, the policy on quality in health care for South Africa states that a continuous advance in health technology and patient care requires the skills of health professionals be continually developed. Professional competencies directly impact on the quality of care being provided and on the amount of trust patients and their families place in health professionals (DOH, 2007:14). Muller (2008:8) revealed that strategies exist to ensure facilitation of observing this ethos (people first) in their units, and should critically analyse and reflect on their abilities (knowledge, skills and attitude) of Batho Pele Principles as the

national government's WPTPS. This finding is also in the line with the requirement of the national government's WPTPS framework, which states that strategies to ensure facilitation of observing this ethos (people first), should be developed to improve knowledge, skills and attitude in the units.

Figure 4.5 shows the percent of health care providers respecting the MHCUs experiences, plans and needs.

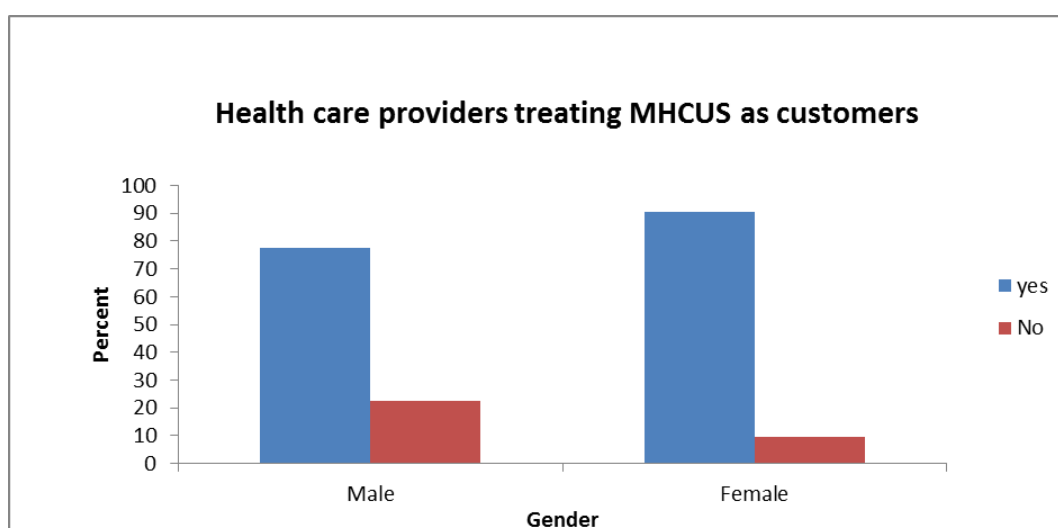


**Figure 4.5:** Health care providers respecting MHCUs' experiences plans and needs.

Out of 202 health care providers who participated in the study, 3 (4.39%) dieticians, 5 (2.87%) doctors, 7 (4.79%) occupational therapist responded that they respected MHCUs experiences, plans and needs, 166 (97%) nurses, 5 (3.43%) physiotherapists and 2 (1.37%) social workers also responded that they respected MHCUs experiences, plans and needs. Although health care providers of different sections/units seem to be respecting MHCUs' experiences, plans and needs, 4 (100%) in the nursing section responded that they did not respect MHCUs experiences, plans and needs, and were not in the line with the requirements of Batho Pele Principles. However, patients who are treated with dignity and are well informed and able to participate in treatment decisions are more likely to comply with their treatment plans (DOH, 2007:5). The Government's initiative of putting people first, should be adopted in order to facilitate mutual participation between health care providers and

MHCUs (Khoza, 2009:15). Figure 4.5 revealed that health care providers respecting the MHCUs experiences, plans and needs are insufficient. This finding is conflicting with the requirement of Batho Pele principle “consulting the user of the services” which states that, departments must regularly and systematically consult not only about the services currently provided, but also make provision for other new basic services to those who lack them.

Figure 4.6 shows the percent of the health care providers who treated MHCUs as customers and respected their experiences, plans and needs.

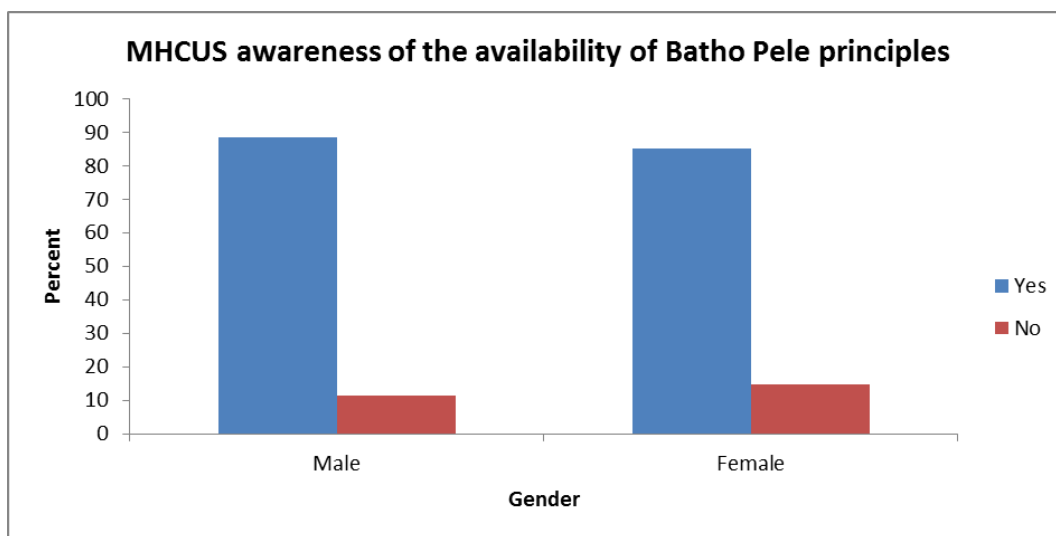


**Figure 4.6:** Health care providers treating MHCUs as customers.

Out of 202 health care providers who participated in the study, 41 (77.4%) males and 135 (90.6%) females responded “yes”, 12 (22.6%) males and 14 (9.4%) females responded ”no”. This finding is the line with the requirement of Batho Pele principle “consulting the user of the services” which states that departments must regularly and systematically consult not only about the services currently provided, but also make provision for other new basic services to those who lack them. However, Batho Pele Principles are key to empowering users of services to take control of their own health care and that of their families. Informing patients and involving them in decision-making needs active participation of patients in their care and can improve the effectiveness of care as well as their satisfaction with their care (DOH, 2007:5). Figure 4.6 shows that health care providers treating MHCUs as customers, MHCUs,

experiences, plans and needs is sufficient. This finding is also in the line with the requirement of the national government’s WPTPS framework, which states that all the public servants are required to practice Batho Pele Principles or guidelines when delivering services to the clients.

Figure 4.7 shows the percent health care providers who know that MHCUs in their unit are aware of the availability of the Batho Pele Principles.

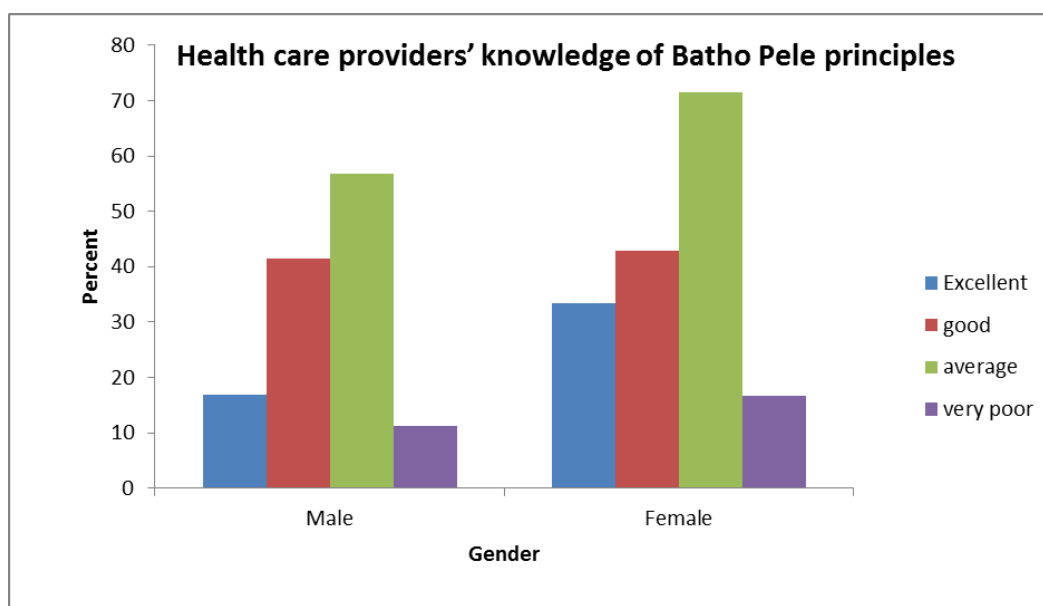


**Figure 4.7:** MHCUs awareness of the Batho Pele Principles.

Out of 202 health care providers who participated in the study, 47 (88.6%) males and 127 (85.2%) females responded that MHCUs in their unit were aware of the availability of the Batho Pele Principles; 6 (11.4%) males and 22 (14.7%) females responded that MHCUs in their unit were not aware. According to Mokoena and Jooste (2000:33), Batho Pele is an initiative to encourage public servants, including nurses to service orientated, to strive for excellence in service delivery and to commit to continuous service delivery improvements. Batho Pele Principles were developed to serve as an acceptable policy and legislative framework for health care service delivery. Furthermore, this finding is in the line with the requirement of the Batho Pele Principles “setting service standards” which states that standards should be displayed continuously. Figure 4.7 revealed that MHCUs’ awareness of availability of the Batho Pele Principles is sufficient. This finding is also harmonizes with

the requirement of Batho Pele principle “consulting the user of the services” which states that departments must regularly and systematically consult not only about the services currently provided but also make provision for other new basic services to those who lack them.

Figure 4.8 summarizes how health care providers scored their knowledge of Batho Pele Principles. Out of 202 health care providers who participated in the study, 9 (16.9%) males and 50 (33.5%) females responded that they regarded their knowledge of Batho Pele Principles as excellent, 22 (41.5%) males and 64 (42.9%) females indicated their knowledge as good, 16 (56.7%) males and 25 (71.4%) females responded that their knowledge was average, 6 (11.3%) males and 10 (16.7%) females indicated their knowledge as very poor. However, health care professionals who are strongly dedicated to caring for patients, knowledgeable, well-trained, and committed to continuous quality improvement and secure in their employment, need to be further developed to improve the quality of care (DOH, 2007:14).

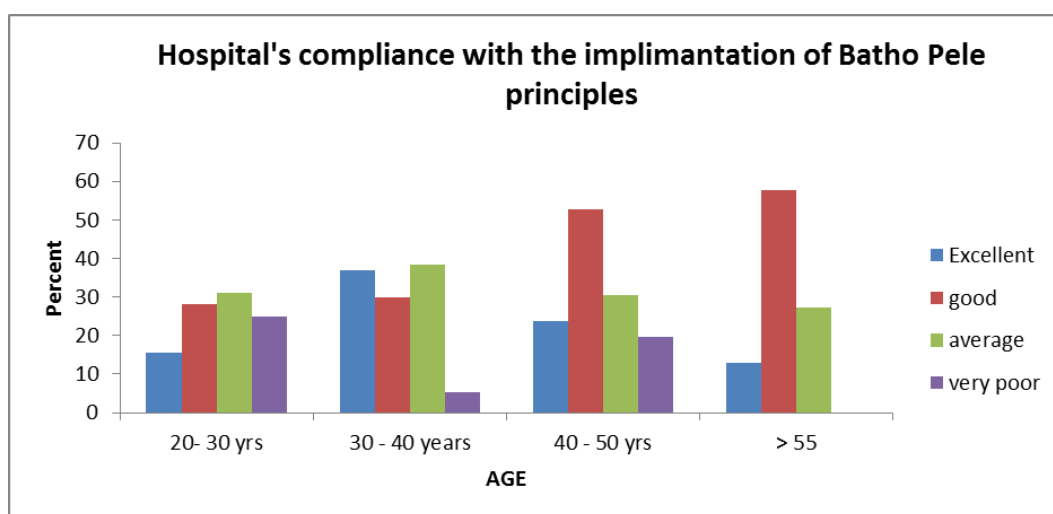


**Figure 4.8:** Health care providers' knowledge of Batho Pele Principles according to gender.

According to Swana (2008:60), every employee of the department should be assessed and evaluated on the implementation of the Batho Pele Principles in their daily duties. Job descriptions of the employees should reflect the standards so that implementation of Batho

Pele Principles is guaranteed as the job description informs the performance contract (Swana, 2008:60). Figure 4.8 revealed that health care providers had average knowledge of Batho Pele Principles. This finding comes close to the requirement of the national government’s WPTPS framework, which states that all the public servants are required to practice Batho Pele Principles or guidelines when delivering services to the clients.

Figure 4.9 shows how the different age groups of the health care providers rated their hospital’s compliance with the implementation of Batho Pele Principles. Out of 202 health care providers, 5 (15.6%) in the 20-30 years age group rated their hospital’s compliance with the implementation of Batho Pele Principles as excellent, 9 (28.1%) indicated good, 10 (31.2%) responded average and 8 (25%) responded very poor; 17 (36.96%) of respondents in the 30-40 years age group also rated excellent, 15(29.8%) responded good, 22 (38.5%) responded average and 3 (5.2%) responded very poor. However, 18 (23.6%) of 40-50 year old respondents indicated excellent, 40 (52.6%) responded good, 15 (30.61%) responded average and 3 (19.7%) responded very poor. Almost 6 (13.04%) of the respondents over 55 years of age rated their hospital’s compliance with the implementation of Batho Pele Principles as excellent, 21 (57.7%) responded good, 10 (27.2%) responded average and 0 (0%) very poor.

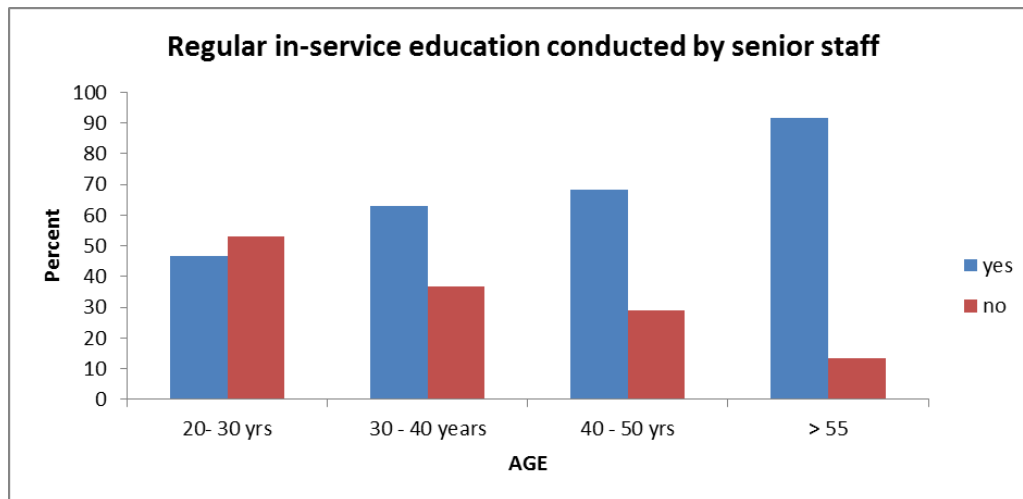


**Figure 4.9:** Hospitals’ compliance with the implementation of Batho Pele Principles.

However, interventions aimed at health professionals include traditional approaches to keeping health professionals up-to-date include CPD, using the CME conference. Moreover, health care can be improved by increasing patient safety. There is a need to develop expertise to help clinicians modernize their practice (DOH, 2007:5). Feedback to health professionals about their performance has also proved to be a useful way of improving quality. The DPE revealed that the progress report with regard to the implementation of Batho Pele initiatives must be understood from the context of the Mandate and Mission of the department (DPE, 2011:2).

The findings of this study indicate that the hospitals comply with the implementation of Batho Pele Principles. Maputle (2010:5) pointed out that the Bill of Rights and the Batho Pele Principles as a Government initiative to put people first, will be adapted in order to facilitate mutual participation between the provider and the consumer. Figure 4.9 revealed that the study hospitals' compliance with the implementation of Batho Pele Principles is sufficient. This finding corresponds with the requirement of the national government's WPTPS framework, which states that all the public servants are required to practice Batho Pele Principles or guidelines when delivering services to clients.

Figure 4.10 shows the degree of in-service education conducted by senior staff in units, according to responses from participants in different age groups.



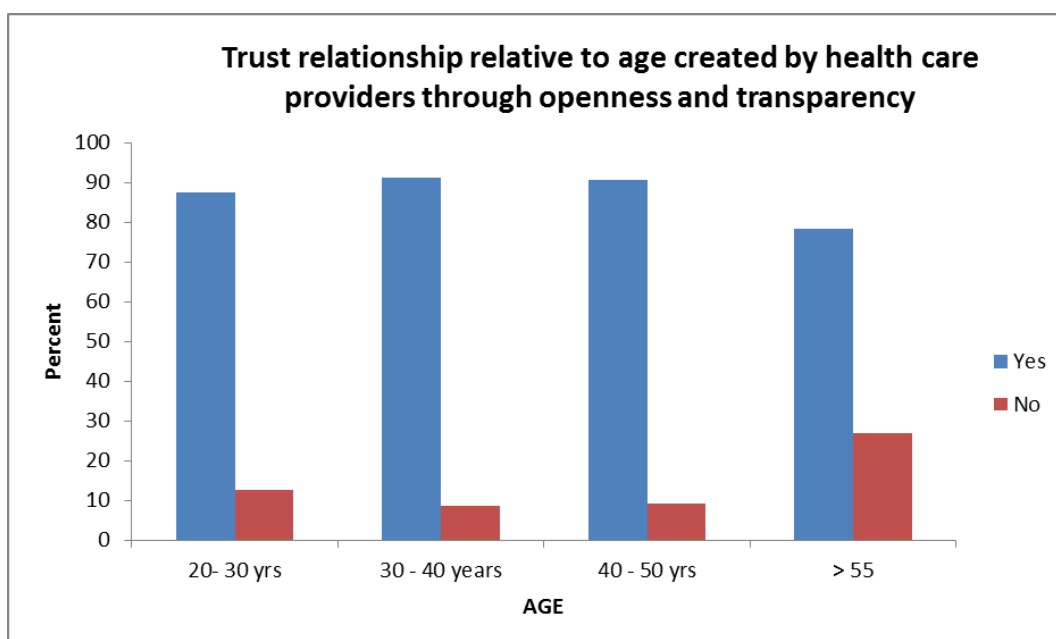
**Figure 4.10:** Regular in-service education conducted by senior staff.

Of 202 health care providers in different units, 15 (46.8%) of the 20-30 age group responded that regular in-service education by senior staff were conducted in their units and 17 (53.1%) responded that there were no regular in-service education provided by senior staff; 36 (63.1%) of respondents in the 30-40 age indicated that regular in-service education by senior staff was conducted in their units and 21(36.8%) responded no. However, 52 (68.4%) of 40-50 age group indicated yes and 22 (28.9%) indicated no whereas 34 (91.8%) of respondents above 55 age indicated that in-service education is conducted and 5 (13.5%) responded that in-service was not conducted.

In order to reduce errors in health care, the policy on quality in health care for South Africa revealed that health care and health status can be improved by reducing the level of error in health care delivery. Moreover, systems can be designed and health professionals trained in methods to improve patient safety by reducing hazards in health care, and to make the consequences of errors less serious when they do occur (DOH, 2007:5). According to Jooster, Prinsloo and de Wet (2009:162), the availability of sufficient trained health care professionals with competencies is central to the success of any transformation process of the health care system in South Africa. Wakermen and Humphreys (2011: 2) reiterated that in

order to be able to comprehensively monitor and evaluate health care services as well as benchmarks, adequate national information is needed. Muller (2008:8) revealed that strategies to ensure facilitation of observing this ethos (people first) in their units, and should critically analyzes and reflect on their abilities (knowledge, skills and attitude) by reflecting Batho Pele Principles as the national government’s WPTPS. Figure 4.10 showed that the in-service education conducted by senior staff in different units is sufficient. This finding is in the line with the requirement of the national government’s WPTPS framework, which states that all the public servants are required to practice Batho Pele Principles.

Figure 4.11 shows the extent to which health care providers created an environment that fosters a trusting relationship through openness and transparency.



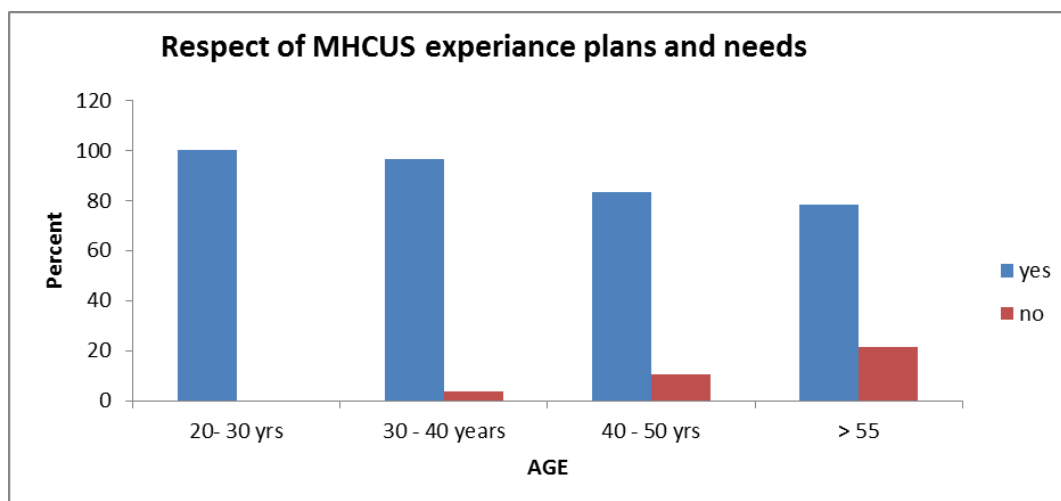
**Figure 4.11:** Trust relationship created by health care providers through openness and transparency.

Out of 202 health care providers, 28 (87.5%) of the 20-30 age group responded that they created an environment that fosters a trusting relationship through openness and transparency and 4 (12.5%) responded that they did not; 52 (91.2%) of 30-40 age group indicated that they did and 7 (9.2%) responded “no”. However, 69 (90.7%) of 40-50 age group responded “yes”

and 5 (8.7%) responded “no”. Almost 29 (78.3%) of those above 55 years responded “yes” and 10 (27.0%) responded “no”.

An intervention aimed at patients involves understanding patients’ perceptions. However, there is a growing emphasis in health care on partnerships between the patient and the provider. It is clear that improved communication between the health professional and the patient, and providing patients with understandable information about their condition and treatment options, has a positive effect on health outcomes (DOH, 2007:7). Funk et al. (2009:3) indicated that improving the quality of MHC involves respect of the rights of people with mental disorders and the provision of the best care possible, consistent with national circumstances. This finding (Figure 4.11) is in the line with the requirement of Batho Pele principle “Increasing Openness and Transparency” which states that citizen should be told how national and provincial department are run, how much they cost and who is in charge.

Figure 4.12 shows the percent of health care providers respecting the MHCUs experiences, plans and needs.

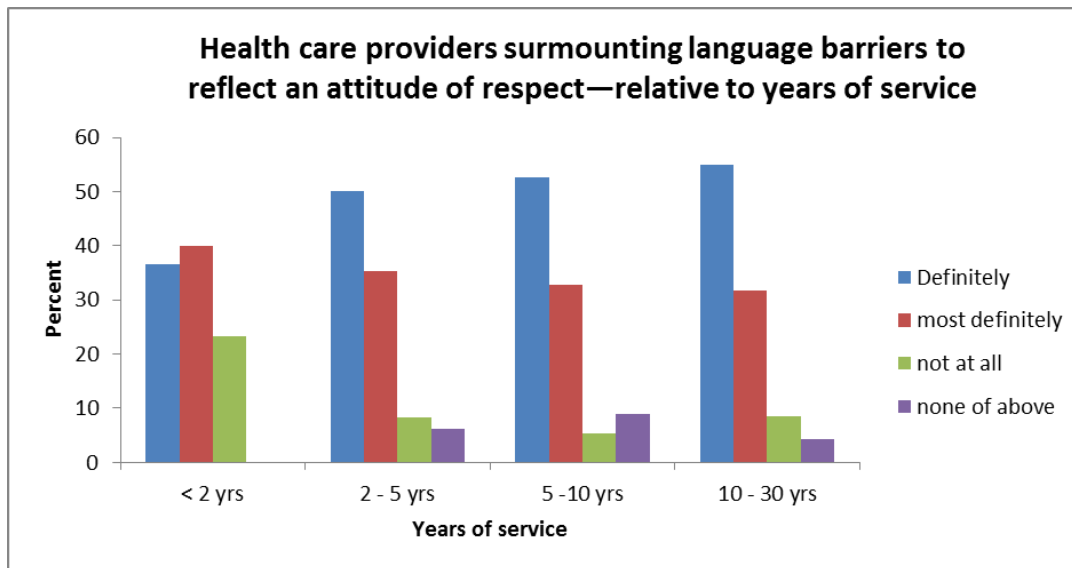


**Figure 4.12:** Health care providers respecting MHCUs’ experiences, plans and needs.

Out of 202 health care providers, 32 (100%) in the 20-30 age group and 55 (96.4%) in the 30-40 age group responded that they respected MHCUs' experiences, plans and needs and 2 (3.5%) responded they did not. However, 68 (83.4%) of 40-50 year old respondents

indicated “yes” and 8 (10.5%) “no”. Almost 29 (78.3%) of those above 55 years of age responded “yes” and 8 (21.6%) responded “no”. Departments should take stock of their values, as well as the behaviour and attitudes of employees and then take necessary steps to prepare public servants for a revitalized Batho Pele culture of responsiveness, efficiency and effectiveness in delivering services to the public. As mentioned before, public servants are social-beings whose needs should be recognized and fulfilled, public servants should be courteous when providing services to the public by listening to their problems, apologizing when necessary, and serving people with a smile (DPSA, 2010:12). Figure 4.12 revealed that health care providers respecting the MHCUs experiences, plans and needs is sufficient. This finding matches the requirement of the national government’s WPTPS framework, which states that all the public servants are required to practice Batho Pele Principles or guidelines when delivering services to the clients.

Figure 4.13 shows the percent of health care providers, as a function of years of service, which minimized language barriers by choosing a style of language and words that can reflect an attitude of respect. Out of 202 health care providers health care providers who participated in the study, 11 (36.6%) of less than two years’ service responded that they surmounted language barriers by choosing a style of language and words that can reflect an attitude of respect, 12 (40%) indicated most definitely, 7 (23.3%) not at all; 24 (50%) with 2-5 years’ experience responded definitely, 17 (35.4%) most definitely, 4 (8.3%) not at all and 3 (6.2%) none of above. However, 29 (52.7%) of those with 5-10 years’ service responded definitely, 18 (32.7%) most definitely, 3 (5.4%) not at all, and 5 (9.0%) none of above. Almost 38 (55.0%) with 10-30 years’ service responded definitely, 22 (31.8%) most definitely, 6 (8.6%) not at all, and 3 (4.3%) none of above.

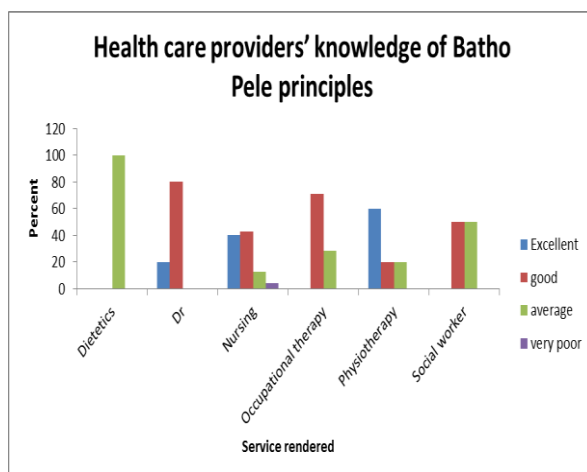


**Figure 4.13:** Health care providers surmounting language barriers to reflect an attitude of respect.

Departments should take stock of their values, as well as the behaviour and attitudes of employees and then take necessary steps to prepare public servants for a revitalized Batho Pele culture of responsiveness, efficiency and effectiveness in delivering services to the public (DPSA, 2010:12). Figure 4.13 confirmed that health care providers minimized language barriers by choosing a style of language and words that can reflect an attitude of respect is above average.

This finding is in the line with the requirement of the national government’s WPTPS framework, which state that strategies to ensure facilitation of observing this ethos (people first), should be developed to improve knowledge, skills and attitude in the units. However, public servants are social-beings whose needs should be recognized and fulfilled, public servants should be courteous when providing services to the public by listening to their problems, apologizing when necessary, and serving (DPSA, 2010:12).

Figure 4.14 shows how the health care providers, according to the service they provided, regarded their knowledge of Batho Pele Principles.

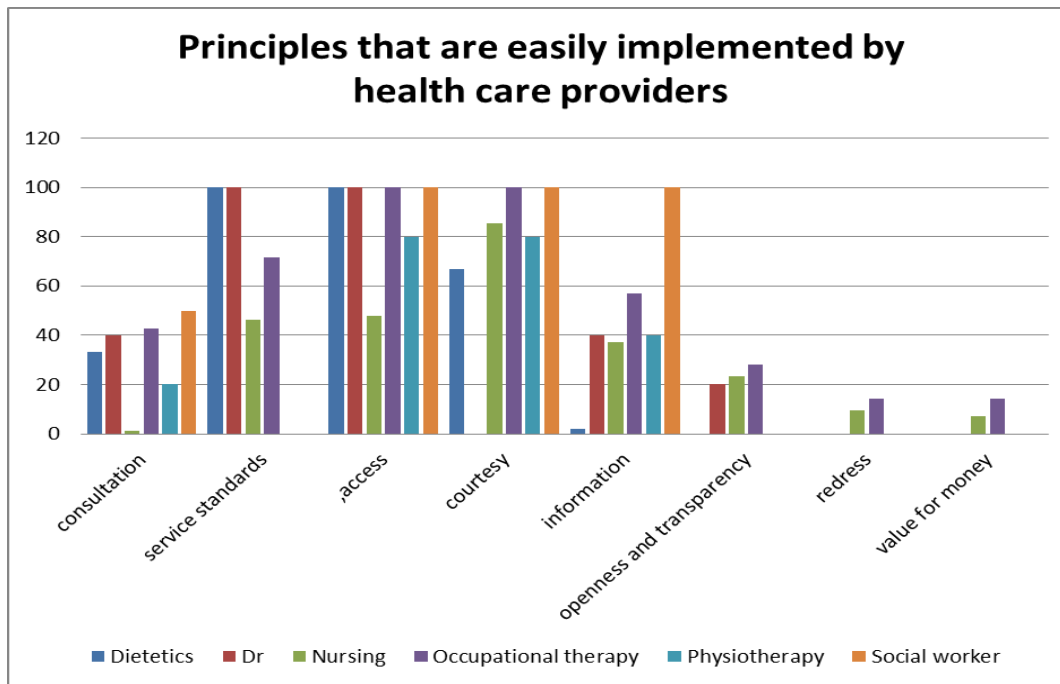


**Figure 4.14:** Health care providers' knowledge of Batho Pele Principles according to service provided.

Of 202 health care providers, 3 (100%) dieticians responded their knowledge of Batho Pele Principles was average; 1 (20%) of doctors responded excellent and 4 (80%) indicated that their knowledge good; 72 (40%) nurses responded excellent, 77 (42.8%) good and 8 (4.4%) very poor; 5 (71.4%) occupational therapists responded good and 2 (28.6%) average. However, 3 (60%) physiotherapists responded excellent, 1 (20%) indicated good and 1 (20%) average; 1 (50%) social worker responded good and 1 (50%) average.

Swana (2008:60) revealed that job descriptions of the employees should reflect the standards so that implementation of Batho Pele Principles is guaranteed as the job description informs the performance contract. Figure 4.14 revealed a sufficient knowledge of Batho Pele Principles among health care providers which is in the line with the requirement of the national government's WPTPS framework—which states that all the public servants are required to practice Batho Pele Principles or guidelines when delivering services to the clients. Muller (2008:8) revealed that health care providers should develop strategies to ensure facilitation of observing this ethos (people first) in their units, and should critically analyze and reflect on their abilities (knowledge, skills and attitude) of Batho Pele Principles as the national government's WPTPS.

Figure 4.15 shows the type of services rendered and principles that are easily implemented by health care providers.



**Figure 4.15:** Batho Pele Principles that are easily implemented according to service provided.

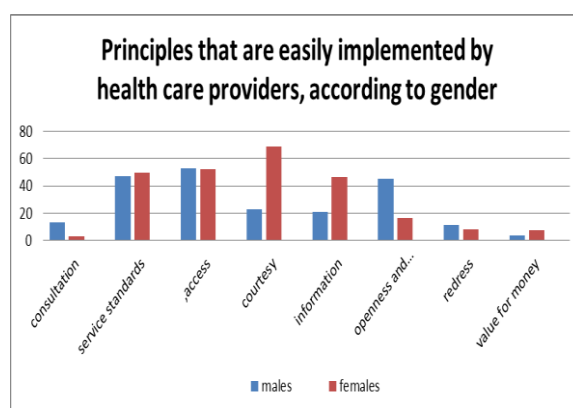
Out of 202 health care providers who participated in the study, 28 (13.8%) responded that consultation is easily implemented, almost 96 (47.5%) responded that service standards are easily implemented, 106 (52.4%) access, and 170 (84.2%) courtesy. However, 90 (45.5%) responded that information is easily implemented, 45 (22.3%) openness and transparency while 18 (9.9%) indicated that redress is easily implemented. Almost 14 (6.9%) responded that value for money is easily implemented.

The Constitution of South Africa (1996) reveals that effectiveness of the WPTPS will assist in delivering services to meet the basic needs of all South Africans. That is why meeting the basic needs is one of the key programmes of the government's RDP. It is also the reason why the government's macro-economic strategy called 'Growth Employment and Redistribution' (GEAR) calls for, among other things, the reduction in government consumption and the release for productive investment and the White Paper reveals that putting the Principles of Batho Pele into practice is the challenge now facing the South African public sector. These principles are what national and provincial departments will be required to do and also be regarded as guidance by all levels of Government and wider public

sector when introducing their service delivery improvement programme (Draft White Paper, 1997:2).

The policy on Quality in Health Care for South Africa states that improving quality in health care is a key national challenge. This policy also indicates that the national policy aims for improvement of quality in health care relevant to this study, is ‘increasing access’ a principle of Batho Pele. It is indicated in the policy that the national health care capacity should be balanced to ensure that under-served population also has access to health care services and equity is attained (DOH, 2007:3). Furthermore, the department should improve the manner in which they monitor and evaluate the implementation of their consultation response so that timely steps can be taken to address areas of ineffectiveness and limited success (PSC, 2007:32). Figure 4.15 revealed that implementation of Batho Pele Principles, according to service provided, is sufficient. This finding is in the line with the requirement of the national government’s WPTPS framework, which state that all the public servants are required to practice Batho Pele Principles or guidelines when delivering services to the clients.

Figure 4.16 shows principles that are easily implemented by the health providers, according to gender.



**Figure 4.16:** Batho Pele Principles that are easily implemented by health care providers, according to gender.

Out of 202 health care providers who participated in the study, 28 (52.8%) males and 78 (52.4%) females revealed that principle of access is also easily implemented, whereas 147

(98.6%) females revealed that principle of courtesy is easily implemented. The White Paper reveals that putting the Principles of Batho Pele into practice is the challenge now facing the South African public sector. These principles are what national and provincial department will be required to do and also regarded as guidance by all levels of Government and wider public sector when introducing their service delivery improvement programme (Draft White Paper, 1997:2). Figure 4.16 revealed that the overall implementation of Batho Pele Principles, according to gender, is average. This finding is in the line with the requirement of the national government's WPTPS framework, which states that all the public servants are required to practice Batho Pele Principles or guidelines when delivering services to the clients.

#### **4.4 Challenges Experienced by Health Care Providers on the Implementation of the Batho Pele Principles**

Table 4.13 shows challenges experienced by health care providers in the implementation of Batho Pele Principles. The findings are discussed according to the eight Batho Pele Principles. Out of 202 health care providers who participated in the study, 168(83.2%) indicated communication barriers, 34(16.8%) indicated that decision are taken without consulting the user and 178(88.2%) indicated that MHCUs do not respond, even if consulted, as challenges affecting implementation of consultation principle.

However, concerning the in-service standards principle, 108(53.3%) indicated shortage of staff, 24(11.8%) medical equipment and 62(25.5%) infrastructure, as affecting implementation of service standards. Out of 202 health care providers who participated in the study, 76(37.6%) indicated that vacant posts being acted and 21(10.2%) shortage of staff are challenges to implementation of the access principle. On the information principle, out of 202 health care providers who participated in the study, 83 (41.0%) respondents also indicated that communication barriers and 148 (73.3%) indicated material resources are challenges to implementation of the information principle.

**Table 4.13:** Challenges experienced by health care providers in the implementation of Batho Pele Principles

<b>Batho Pele Principle</b>	<b>Challenges</b>	<b>Frequency</b>	<b>%</b>
<b>Consultation</b>	Communication barrier	168	83.2
	Decision are taken without consulting the user	34	16.8
	MHCUs does not respond, even if consulted	178	88.2
<b>Service standards</b>	Shortage of staff	108	53.3
	Medical equipment	24	11.8
	Infrastructure	52	25.5
<b>Access</b>	Vacant post being acted	76	37.6
	Shortage of staff	21	10.2
<b>Information</b>	Communication barrier	83	41.0
	Material resource	148	73.3
<b>Openness and transparency</b>	Communication barrier	54	26.7
<b>Redress</b>	Communication barrier	47	23.3
<b>Courtesy</b>	In-service training	23	11.2
	Managers acting for vacant post	27	13.5
<b>Value for money</b>	Communication barrier	16	7.9
	Material	78	38.6
	Equipment	53	26.3
<b>Total</b>		<b>202</b>	<b>100</b>

Out of 202 health care providers who participated in the study, 54 (26.7%) also indicated that communication barriers pose a challenge to the openness and transparency principle and 47(23.3%) indicated challenges in the redress principle. However, 23(11.2%) indicated that in-service training and 27(13.5%) indicated managers acting for vacant post are challenges to the courtesy principle. Out of 202 health care providers who participated in the study, 16 (7.9%) indicated that communication barriers, 78 (38.6%) indicated material and 53 (26.3%) indicated that equipment are challenges to the value for money principle. This finding

revealed that challenges experienced by health care providers hinder the implementation of the Batho Pele Principles.

Therefore, Batho Pele Principles as the South African national government's WPTPS which is applicable to public sectors, both national and provincial which are regulated by the Public Service Act, 1994, to guide the public servants on how to practice and provide services to the clients should be evaluated (Draft White Paper, 1995:6). Challenges experienced by health care providers in the implementation of Batho Pele Principles are discussed, in turn.

### **CONSULTATION**

When consultation takes place, the access principle should be taken into consideration. These include considering language barriers, level of literacy and fear of authority (Maputle, 2010:5). Health care providers who participated in the study revealed that communication is a barrier to the implementation of the Batho Pele principles. The communication is a barrier is due to the mental status of the patients. Decisions were taken mostly without consulting other important stakeholders, but not deliberate. This was based on the assumption that there would be no problems emanating from such decisions. The majority of the MHCUs do not respond, even if consulted, and thus decisions were taken by the management without proper consultation due to the intellectual disability of the MHCUs. Therefore, consultation is affected by communication barriers. However, the requirements of Batho Pele principle of consultation state that all citizens should be consulted about the level and quality of the public services they receive and, where possible, should be given a choice about the services that they are offered (Muller, 2008:8). Furthermore, users of services may be consulted by, inter alia, conducting customer surveys, interviewing individual users, consulting with groups and holding meetings with consumer representative bodies (Mokoena & Jooste, 2000:33).

### **SERVICE STANDARDS**

DPSA (2007), as cited by Maputle (2010:5), indicated that service standards are commitments to provide a specified level and quality of service to individual customers at a

given point in time. In this study, service standards were shown to be affected by the consultation process. Health care providers who participated in the study responded that material resources, both human and non-human, to provide the planned service standards were major challenges, e.g., there were shortages of staff and medical equipment. However, lack of relevant and required resources such as trained staff for sign language is a challenge. Poor hospital infrastructure, no out-patient department and measurable service standards were written, but not implemented due to staff shortages.

The requirements of Batho Pele principle of service standards state that citizens should be told what level and quality of public services they will receive so that they are aware of what to expect (Muller, 2008:8). However, respondents indicated that even though quality improvement programme service standards were properly placed, MHCUs were still not aware of the expected level of nursing care that they were entitled to. The service standards principle reinforces the need for benchmarks to constantly measure the extent to which the community is satisfied with the service they receive from health care institution (Mokoena & Jooste, 2000:33).

## **ACCESS**

WPTPS states that the service delivery programmes need to be progressive to redress the disadvantages of all barriers to access. Health care providers who participated in this study revealed that vacant posts being acted in (CEO, nursing service manager, and area manager) are barriers to the access principle, and thus shortage of staff becomes a major challenge. The policy on quality in health care for South Africa reflects that in improving access to quality health care, health care capacity should be matched to the health needs of the population. Furthermore, inadequate health care capacity, particularly in rural areas, needs to be targeted by development efforts and new methods of delivering quality health care. For example, good quality care cannot be provided without high-quality doctors, but in many remote rural areas there are too few doctors (DOH, 2007:3).

According to Mokoena and Jooste (2000:33), there should be a framework for making decisions about delivering health care services to South Africans who do not have access to them. Batho Pele aims to rectify inequalities in the distribution of existing services. This finding revealed that access principle is affected by shortage of staff. The requirements of Batho Pele principle of access state that all citizens should have equal access to the services to which they are entitled. Accordingly, health care providers should facilitate the principle of equity (Muller, 2008:8).

## **INFORMATION**

Information sharing is the mutual responsibility of the health care provider and the customer. The consultation process should be used to find out what the customer needs to know, and where and when the information can be best provided (Maputle, 2010:5). Health care providers, who participated in this study, revealed that communication is a barrier to the implementation of the Batho Pele Principles—the languages used to display information is also difficult to be understood by MHCUs due to their mental status and intellectual disability. There was also a lack of resources to inform patients and relatives or community members about the services that are provided.

Only few MHCUs were able to peruse given information, health care providers were trying to give information, but were not sure whether the information is understood. According to Mokoena and Jooste (2000:33), information about services should be made available at the point of delivery. Other arrangements should be made for the users far removed from the point of service delivery. This finding revealed that information is affected by communication, the languages used to display information, and resources to inform patients and relatives. The requirements of Batho Pele principle of information states that citizens should be given full and accurate information about the public services they are entitled to receive (Muller, 2008:8).

## **OPENNESS AND TRANSPARENCY**

WPTPS revealed that the importance of public service delivery lies in the need to build confidence and trust between the provider and the user (DPSA, 2010:11). Pera and Van Tonder (1996:61), as cited by Maputle (2010:5), affirmed that the most satisfactory nurse-patient relationship is characterized by mutual trust which forms the basis of a successful and effective health care relationship. Health care providers who participated in the study cited communication as a barrier to openness and transparency due to MHCUs condition—some of them do not have insight of their mental illness. The community should know the how health care institutions operate, how well they utilize the resources they consume and who is in charge (Mokoena & Jooste, 2000:33). This finding revealed that openness and transparency is affected by communication. The requirements of the Batho Pele principle of openness and transparency states that citizens should be told how national and provincial departments are run, how much they cost and who is in charge (Muller, 2008:8).

## **REDRESS**

National and provincial departments are required to review and improve complaint systems in line with accessibility, speed, fairness, confidentiality, responsiveness, review and training (Draft White Paper, 1997:5). Health care providers who participated in the study identified communication barriers as a major challenge due to MHCUs condition—some of them were unable to follow simple instructions and no trained staffs for sign language interpretation were available. The policy on quality health care for South Africa reflects that it is clear that improved communication between the health professional and the patient, and providing patients with understandable information about their condition and treatment options, has a positive effect on health outcomes (DOH, 2007:7).

According to Mokoena and Jooste (2000:33), there is a need to establish quickly and accurately when services are failing below the promised standard and to have procedures in place to remedy the situation. This finding revealed that redress is affected by communication. The requirements of the Batho Pele principle of redress states that citizens

should be offered an apology, a full explanation and a speedy and effective remedy, and when complaints are made, citizens should receive a sympathetic, positive response (Muller, 2008:8).

### **COURTESY**

National and provincial departments must specify the standards for the way in which customers should be treated and include these in their departmental codes of conduct. The performance of staff who deals with customers must be regularly monitored and those which fall below the specified standards should not be tolerated (Draft White Paper, 1997:8). Health care providers, who participated in the study indicated that in-service training programmes by managers that include day-to-day guidance to ensure that Batho Pele Principles are implemented were insufficient. However, this goes beyond a polite smile and saying “please” and “thank you”. It requires health care providers to empathize with the community and treat them with as much consideration and respect as they would like for themselves. This involves communicating information about services and products and about problems which may hamper or delay the efficient delivery of services to the promised standards (Mokoena & Jooste, 2000:33). This finding revealed that courtesy is affected by under-supervision as managers were acting in vacant posts. The requirements of Batho Pele principle of courtesy states that citizens should be treated with courtesy and consideration (Muller, 2008:8).

### **VALUE FOR MONEY**

All national and provincial departments are required, as part of their service delivery improvements programmes, to identify areas where efficiency saving will be sought, and the service delivery improvements which will result from achieving the savings (Draft White Paper, 1995:14). Health care providers, who participated in the study, revealed that communication barrier is the major challenge due to MHCUs mental status and intellectual disability. However, lack of material and equipment is a major obstacle to the implementation process. Staff’s knowledge and understanding of Batho Pele Principles in

relation to MHCUs are insufficient. Many improvements that the community would like to see require no additional resources and may sometimes even reduce costs (Mokoena & Jooste, 2000:33). This finding revealed that value for money is also affected. The Batho Pele principle of value for money states that public services should provide services that are economically and efficient in order to give citizens the best value of money.

#### 4.5 Health Care Providers' Suggestions and Comments on the Implementation of the Batho Pele Principles

Table 4.14 summarizes health care providers' suggestions and comments on the implementation of the Batho Pele Principles.

**Table 4.14:** Health care providers' suggestions and comments on the implementation of the Batho Pele Principles

Suggestions/Comments	Frequency	%
Regular in-service training	168	83.2
Awareness of these Batho Pele Principles	34	16.8
Advertisement of vacant post	78	38.6
<b>Total</b>	<b>202</b>	<b>100</b>

Out of 202 health care providers who participated in the study, 168 (83.2) suggested regular in-service training on Batho Pele Principles, 34 (16.8) suggested awareness of these Batho Pele Principles and 78 (38.6) suggested that vacant post should be advertised. The Draft White Paper (1995:6) states that Batho Pele Principles is the South African national government's WPTPS which is applicable to those public sectors, both national and provincial, which are regulated by Public Service Act, 1994, to guide public servants on how to practice and provide services to the clients. Health care providers who participated in the study, suggested that regular in-service training and awareness of these Batho Pele Principles should be conducted with the entire government workforce and vacant posts should be advertised and filled. The policy on quality in health care for South Africa states that continuous advances in health technology and patient care require that the skills of health professionals be continually developed. Professional competencies directly impact on the

quality of care being provided and on the amount of trust patients and their families place in health professionals. CPD will be expanded to include all categories of health professionals registered in terms of applicable legislation (DOH, 2007:14).

Therefore, workshops on Batho Pele Principles and regular in-service training programmes by management should be facilitated. Moreover, the institutions that educate health professionals such as academic institutions, employer-based programmes and other entities need to embrace change if they are to succeed in preparing the next generation of physicians, nurses, allied health professionals, and other health care workers (DOH, 2007:14). Vacant posts should be advertised so that those who are acting should return to their posts. According to Jooste, Prinsloo and De Wet (2009:162), the availability of sufficient trained health care professionals with competencies is central to the success of transformation process of health care system in South Africa.

Staffing should be an orderly, systematic process based upon a sound rationale and applied to determine the number and kind of personnel required to provide health care of predetermined standards to a group of clients in a unit setting (Swansburg, 1996:113). Furthermore, the DOH should consider staff shortage and development in the MHC institutions. However, Level II (Regional), Level III (Tertiary) and Specialized Hospitals that are not viewed as part of the health district will also require very special attention. The need for action at the local and hospital level demands that competent health professionals are available to assure quality in health care and to continuously improve the care that is being provided. Furthermore, competent and skilled health professionals can only be obtained by CPD (DOH, 2007:17).

#### **4.6 Discussion of the Findings**

Chapter 2 of this study covered the literature of research studies with topics related to the transformation of quality health care services. This chapter provided a detailed description of the research findings of the study conducted, viz., assessment of the implementation of Batho Pele Principles by health care providers at selected mental health hospitals as a strategy to

improve quality MHC services. The discussion of findings was based on the results presented with particular reference to the literature reviewed.

According to Schroeder (2004:3), as cited by Legodi (2008:30), quality improvements is the commitment and approach used to continuously improve every process in every part of an organization, with the intention of meeting and exceeding customers' expectations and outcomes. However, quality enhancement stimulates individuals and teams to look at better ways in which they can deliver health care services, to identify root of causes of problems in the system, and then to innovate to make improvements. Booyens (2003:581), as cited by Legodi (2008:30), revealed that quality improvements are a system in which the quality of health care services is formally monitored and assessed.

The study results reflect a lack of experience and skill of health care providers in the following aspects: respect for MHCUs' experiences, plans and needs; principles of openness and transparency, redress and value for money were not easily implemented and challenges experienced by health care providers when the implementing the Batho Pele Principles.

#### **4.6.1 Respect for Mental Health Care Users' Experiences, Plans and Needs**

This study revealed that health care providers' lack of respecting the MHCUs experiences, plans and needs is disappointing. This finding is not in the line with the requirement of the national government's WPTPS framework, which states that all the public servants are required to practice Batho Pele Principles or guidelines when delivering services to clients. Moreover, Batho Pele Principles as a Government initiative, putting people first, should be adapted in order to facilitate mutual participation between health care providers and MHCUs (Khoza, 2000:15).

However, Social Institutes for Excellence (2010:3) revealed that all staff involved in providing health care services should: treat people with respect and as individuals and fellow human beings; avoid labelling people because of their diagnosis or their association with any

other group; and provide person-centred care and support—place the individual and their needs, preferences and aspirations at the centre of care. Quite importantly, an ethos of person-centred care upholds the dignity both of people using services and of staff. Health care providers should promote good practice in safeguarding, i.e., focuses on prevention and make proportionate, person-centred responses to abuse. Furthermore, health care providers should adopt a recovery approach to mental health—in particular, help people sustain their personal identity and self-respect, which are both closely associated with the concept of dignity (Social Institutes for Excellence, 2010: 4).

According to National Institutes for Health and Care Excellence (NICE) Pathways (2012), respecting the user of a service means that the provider should listen to and address any health beliefs, concerns and preferences that the patient has, and be aware that these affect how and whether they engage with treatment. Respect their views and offer support if needed to help them engage effectively with healthcare services and participate in self-management as appropriate. Avoid making assumptions about the patient based on their appearance or other personal characteristics. Take into account the requirements of the Equality Act of 2010 and make sure services are equally accessible to, and supportive of, all people using adult National Health Services (NHS) services. If appropriate, discuss with patients their need for psychological, social, spiritual and/or financial support. Offer support and information to the patient and/or direct them to sources of support and information. Review their circumstances and need for support regularly (NICE Pathways, 2012:5).

However, NICE Pathways (2012:6) also indicated that all staff involved in providing NHS services should: treat patients with respect, kindness, dignity, compassion, understanding, courtesy and honesty, respect the patient's right to confidentiality, not discuss the patient in their presence without involving them in the discussion. Health care providers should be prepared to raise and discuss sensitive issues (such as sexual activity, continence or end-of-life care), as these are unlikely to be raised by some patients. Listen to and discuss any fears or concerns the patient has in a non-judgmental and sensitive manner (NICE Pathways,

2012:5). Jenkins, Mezzina, Daumerie, O'Halloran and Coleman (2010) stated that every person has the right to be treated with respect and dignity. It is essential that this is common practice by professionals, organizations and the public as it enhances people's feeling that they are worthwhile, they are valued as fellow human beings, feeling useful and important. This will lead to the user gaining confidence in their self-worth, self-respect, ability and contribution to society.

This was also supported by a comprehensive study conducted by Wallcraft, Amering, Freidin Davar, Froggatt, Jafri, Javed, Katontoka, Raja, Rataemane, Steffen, Tyano, Underhill, Wahlberg, Warner and Herrman (2011: 4), who emphasized that respecting human rights is the basis of successful partnerships for mental health. However, there were differing opinions about the application of human rights. Some argued that, even if physical restraint is needed, attitudes and behaviour should be respectful of the person. Some argued that coercion is almost always experienced as disrespectful, and were concerned that enactments of human rights legislation in some countries explicitly exclude people with a psychiatric diagnosis from some provisions. Others reasoned that human rights have to be set aside when someone is in a psychotic state.

Respondents from the World Psychiatric Association (WPA) Board and Council similarly agreed that human rights are a basis for practice, but some contended that respect was more important than generalized rights. Others stated that health and treatment are rights, and this could necessitate treatment against someone's will when psychotic (Wallcraft, et al., 2011:6). Furthermore, since mental health is a contested area, service users need to ensure the service they receive is respectful of persons as citizens. There were concerns that power differentials between patients and service providers can make genuine collaboration difficult. Respondents from the WPA Board and Council further agreed there should be more progress towards genuine collaboration, but raised concerns about who should be consulted to ensure genuine representation of those who suffer most serious mental illness and their families, and local needs and culture (Wallcraft, et al., 2011:8).

#### 4.6.2 Batho Pele Principles Not Easily Implemented

In this study, it was shown that the principles of openness and transparency, redress and value for money were not easily implemented. This finding is in conflict with the requirement of the national government's WPTPS framework, which states that all public servants are required to practice Batho Pele Principles or guidelines when delivering services to the clients. In this study it was revealed that challenges were experienced by health care providers when they attempted implementation of Batho Pele Principles. However, implementation of Batho Pele Principles should form part of the key performance areas of all health care providers. This would improve compliance with the implementation of principles. Furthermore, if positive results were not met, targets should be set for the next evaluation (Legodi, 2008:33).

With regard to the Batho Pele principle of openness and transparency, which states that all citizens should know how decisions are made and departments are run (<http://www.etu.org.za/toolbox/docs/govern/bathopele.html#principles>) it was revealed that it is very important for the Public Service and administration to be run as an open book. The Public Service is there to serve the people and they have a right to the services it offers. Many people, especially poor people, do not yet have access to free basic services or social grants, simply because they do not have the information to access it. In this study, health care providers indicated that it was not easy to implement openness and transparency, and hence the researcher assumed that challenges experienced when implementing this principle might contribute to this insufficiency. Communication barriers affect the entire implementation process, because of MHCUs condition. The people also have the right to know how decisions are made, how a department works, who is in charge and what its plans and budgets are (<http://www.etu.org.za/toolbox/docs/govern/bathopele.html#principles>).

This was also supported by DPSA (1991:6) which stated that openness and transparency are the hallmarks of a democratic government and fundamental to the public service

transformation process. In terms of public service delivery, their importance lies in the need to build confidence and trust between the public sector and the public they serve. Therefore, a key aspect of this is that the public should know more about the way national and provincial departments are run, how well they perform, the resources they consume, and who is in charge (DPSA, 1991:6).

With regard to the Batho Pele principle of redressing wrongs, which state that when people do not get what they are entitled to from the Public Service, they have a right to redress (<http://www.etu.org.za/toolbox/docs/govern/bathopele.html#principles>). It is accepted that the public servant should immediately apologize to clients and also tell them what solution they are offering to their problem. If the public servant has none, they should speak to their manager or supervisor and make sure that the problem is sorted out. The Public Service's success and image is built on its ability to deliver what people expect from them. In this study, health care providers indicated that it was not easy to implement the Batho Pele principle of redress, and so the researcher assumed that challenges experienced when implementing this principle might also contribute to this principle not easily being implemented. Furthermore, when complaints were made, there was a communication barrier between the customers and the health care provider. However, DPSA (1991:6) highlighted that the capacity and willingness to take action when things go wrong is the necessary counterpart of the standard setting process. It is also an important constitutional principle.

Therefore, MHCUs should not just receive a sympathetic and a positive response. However, the Promotion of Administrative Justice Act allows for citizens to ask for reasons for any decision taken by government that affects them—even if they asked, in all likelihood there will be no trained staff to interpret the complaint to the health care provider. The aforementioned Act ensures that citizens have a right to administrative decisions that are lawful, reasonable and procedurally fair. Where citizens are dissatisfied with the reasons given, the Act allows people to appeal the decision or ask for the review of the administrative

action by a court or, where appropriate, an independent and impartial tribunal (<http://www.etu.org.za/toolbox/docs/govern/bathopele.html> #principles).

Considering the Batho Pele principle of value for money, all services provided should offer value for money and, correspondingly, it is very important for the Public Service and its administration to be run as an open book. The Public Service is there to serve the people and they have a right to the services it offers. As mentioned, many people, especially poor people, do not yet have access to free basic services or social grants, simply because they do not have the information to access it. In this study, health care providers indicated that it was not easy to implement openness and transparency, and the researcher assumed that challenges experienced when implementing this principle might exacerbate the deficiency. Communication barriers affect the implementation process, mainly because of MHCUs' condition. The people also have the right to know how decisions are made, how a department works, who is in charge and what its plans and budgets are.

#### **4.6.3 Challenges Experienced by Health Care Providers Implementing the Batho Pele Principles**

According to Legodi (2008:3), quality refers to meeting customers' needs or expectations, implied by consistently applying or adherence to Batho Pele Principles in all activities carried out by health care providers. Petersen and Lund (2011:6) conducted a study to identify progress and challenges in mental healthcare in South Africa, as well as future mental health services research priorities. Their study suggests that the status of mental healthcare services involves insufficient resources to adequately support mental disorders and remain largely undetected and untreated in primary healthcare. Although there has been some progress in the decentralization of mental health service provision, substantial gaps in service delivery remain a concern.

Petersen and Lund (2011:7) further indicated that intervention research is needed to provide evidence of the organizational and human resource mix requirements, as well as the cost-effectiveness of a culturally appropriate, task shifting and stepped care approach for severe and common mental disorders at PHC level. In this study, results indicate that challenges experienced by health care providers when the implementing of Batho Pele Principles hindered the provision of quality nursing care.

### **CONSULTING THE USERS OF THE SERVICES**

Health care providers who participated in this study indicated that communication is a barrier to the implementation of the Batho Pele principle due to mental status of the patients. Muller (2008:8) recommended that citizens should be consulted about the level and quality of the public services they receive and, where possible, should be given a choice about the services that they are offered. The professional nurse/midwife provider should be open-minded towards the patients' needs in this regard and initiate patient satisfaction. Consultation requires all health care providers to consult the clients about their needs and how these needs could be met. Furthermore, consulting with the clients implies that sufficient time should be available to listen to, inform, verify and communicate with the clients (Legodi, 2008:4).

### **SERVICE STANDARDS**

Health care providers who participated in this study pointed out that material, both human and non-human resources, to provide the planned service standards were major challenges as there were shortages of staff and medical equipment. Service standards provide criteria against which the quality of services can be measured. Standards should be realistic, attainable with available resources, and utilized at regular intervals in the hospitals to determine and improve the quality of service delivery (Legodi, 2008:4). Citizens should be told what level and quality of public services they will receive so that they are aware of what to expect. Health units should have quality improvement programmes in place and the patient should be aware of the expected level of nursing care that can be expected (Muller, 2008:8).

## **INCREASING ACCESS**

Health care providers who participated in this study revealed that vacant posts being acted in (e.g., CEO, nursing service manager, and area manager) due to shortage of staff was a major challenge. According to Legodi (2008:4), accessibility of services includes the availability of the services in terms of times of a day, availability of necessary equipment and supplies, access of information in terms of public servants who can converse in their own language, and accessibility of buildings, toilets and public areas with special needs such as disabilities. Citizens should have equal access to the services to which they are entitled. The professional nurse/midwife should facilitate the principle of equity. This could be a problem in the private health sector, especially in the trauma/casualty units. In this case there should be a hospital policy to make provision for the treatment of trauma patient within the ‘Golden hour’ period (Muller, 2008:8).

## **INFORMATION**

In this study, health care providers indicated that communication was a barrier to the implementation of Batho Pele Principles. For example, languages used to display information was difficult to be understood by MHCUs due to their mental status and intellectual disability. Not enough resources were available to inform patients and relatives or community members about the services. Only few MHCUs were able to review given information. Health care providers tried to give information, but were not sure whether such information was understood. Muller (2008:8) emphasized that citizens should be given full and accurate information about public services they are entitled to receive, and could be conveyed face-to-face, telephonically or electronically, posters, leaflets, newspapers as well as radio or television. Information should be provided in a language and at the level that customers can understand (Legodi, 2008:5).

## **OPENNESS AND TRANSPARENCY**

Health care providers who participated in this study identified communication barriers as a major problem due to MHCUs condition; some of them do not have insight of their mental illness. According to Legodi (2008:5), health care providers should be honest about positive and negative aspects and how they plan to improve services in future. Citizens should be told how national and provincial departments are run, how much they cost and who is in charge (Muller, 2008:8).

## **REDRESSING WRONGS**

Health care providers who participated in this study, revealed that communication barrier is the major challenge due to MHCUs condition; some of them are unable to follow simple instruction, no trained staff for sign language. According to Legodi (2008:5) redress or righting the wrong create an opportunity for growth, development and improvements. This implies that strategies should be in place in the hospitals for individuals groups to complain, make suggestions and contributes to better understanding of both needs and expectation. If the promised standard of services is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy, and when complaints are made, citizens should receive a sympathetic, positive response (Muller, 2008:8).

## **ENSURING COURTESY**

Health care providers who participated in this study indicated that in-service training programmes by managers that include day-to-day guidance to ensure that Batho Pele Principles are implemented were insufficient. Muller (2008:8) affirmed that citizens should be treated with courtesy and consideration. Courtesy incorporates basic social values such as being friendly, polite and helpful and treating everyone with respect. However, health care providers are expected to display a code of conduct that commits providers to these values and rules. All health care providers should be continuously sensitized to these values.

Furthermore, strategies should be established to assess the level of adherence to these values (Legodi, 2008:5).

### **GETTING THE BEST POSSIBLE VALUE FOR MONEY**

Health care providers who participated in the study identified communication barriers as the major challenge to implementation of the Batho Pele Principles due to MHCUs mental status and intellectual disability. However, lack of material and equipment exacerbated the implementation process. Staff knowledge and understanding of Batho Pele Principles to the MHCUs are insufficient. Citizens should be told how national and provincial departments are run, how much they cost and who is in charge (Muller, 2008:8). However, value for money is about giving customers the best services in the most efficient way. Health care providers should avoid wasting resources and eliminate fraud and corruption. Furthermore, money can be saved by doing things right the first time as well as by forming partnerships with other service providers and working together as a team that helps to ensure that the best possible of service for money is given (Legodi, 2008:6). The findings of this study indicate that health care providers identified a need for training to enhance skills and establish a culture that values lifelong learning and recognizes its role in improving quality nursing care. Furthermore, the researcher assumed that implementation of Batho Pele Principles will emphasize customer care and on-going monitoring and evaluation to ensure continuous improvement of quality health care services in the hospitals.

### **SUGGESTIONS AND COMMENTS ON THE IMPLEMENTATION OF THE BATHO PELE PRINCIPLES**

With reference to Table 4.14 which summarises health care providers' suggestions and comments on the implementation of the Batho Pele Principles, the study suggested regular in-service training, awareness education programmes of Batho Pele Principles should be conducted to the entire government workforce. Workshops on Batho Pele Principles and regular in-service training by management should be facilitated. Vacant posts should be advertised so that those who are acting should return to their original post. The DOH should as well consider alleviating staff shortages in the MHC institutions.

Newton & Mike (2011:3) investigated the effectiveness of in-service training of health professionals and found limited evidence that in-service neonatal emergency care courses improved health-workers' practices when caring for seriously ill new-borns. In addition, rigorous trials evaluating the impact of refresher emergency care training on long-term professional practices are needed. Implications for Newton & Mike (2011:4) include that rigorous trials should involve direct head-to-head comparisons of courses with varied lengths, aimed to include seriously ill new-borns and incorporating data on resources and costs of training implementation.

According to <http://www.nelsonmandelabay.gov.za/Content.aspx%3FobjID%3D242>, an in-service training and CPD programme is responsible for updating skills development database for all health employees. In addition, the Annual Skills Development Plan implies that health employees need to be adequately trained in order to deliver a quality service. Therefore, this assessment of the implementation of Batho Pele revealed that managers should plan and ensure CPD for employees (especially lower qualified employees) to facilitate the acquisition of sufficient skills to develop their career and to improve quality nursing care.

However, the key to improvements is to empower people infrastructure that promote increased participation and shared authority. Managers should ensure that all health care providers are trained in the implementation of Batho Pele Principles. Training should be continuous and consistent, on-going monitoring and evaluation should be done to ensure compliance with the implementation of Batho Pele Principles. Furthermore, health care providers should be conversant with the Batho Pele Principles and all policies that support quality improvements (Legodi, 2008:5).

This was also supported by Kawaguchi and Mori (2010:3) who asserted that success of in-service training of health-care professionals depends on a number of important factors, especially appropriately skilled and required numbers of instructors and suitable, locally adapted training materials. Their study also highlighted that it is important to ensure

sustainability of in-service courses to increase short-term knowledge and attitudes of health-care workers. The implication is that further research is needed on all types of training courses in various settings to measure clinical outcomes. In addition, studies should focus on evaluating the costs of and human resources needed for conducting in-service training in low-income settings. In this study, findings indicate that there is a dire need for in-service training—this revealed that further research is needed to assess the impact of Batho Pele Principles on in-service training.

A comprehensive study conducted by Stiffman, Hadley-Ives, Doré, Polgar, Horvath, Striley and Elze (2000:8) highlighted that health care providers with training in and knowledge of mental health resources are more likely to recognize youths' mental health problems, and provide youths with quality health care services. Stiffman et al., (2000:12) indicated that training (both professional and in-service) contributes to higher assessments of youths' problems and greater resource knowledge, which is associated with increased service provision. Furthermore, health care providers from the mental health and child welfare sectors have more professional training in mental health and are more likely to receive in-service training. In-service training should be offered to all who work with youths. In this study, the results suggested that regular in-service training, awareness of the Batho Pele Principles should be conducted with the entire government workforce. This indicates that Batho Pele Principles were not adequately included in in-service training programmes.

#### **4.7 Summary**

This chapter discussed the analysis and interpretation of the results, including a demographic description of the data and assessment of the implementation of Batho Pele Principles, challenges experienced by healthcare providers, suggestions and findings. Chapter 5 is an overview and summary of the study, its limitations, and outlines some recommendations for improving health care of MHCUs.

# CHAPTER 5

## SUMMARY, RECOMMENDATIONS, LIMITATIONS AND CONCLUSIONS

### 5.1 Summary

The previous chapter discussed the analysis and interpretation of the results. This was a quantitative, descriptive study. The purpose of this study was to assess the implementation of Batho Pele Principles by health care providers at the selected mental health hospitals of Limpopo Province. The objectives of the study were to assess the implementation of Batho Pele Principles; to describe the challenges experienced by health care providers in the implementation of Batho Pele Principles and to formulate specific recommendations to improve the implementation of these principles as a strategy to improve quality nursing care. Data were collected using a questionnaire and analysed statistically. Discussion of the findings was covered in Chapter 4. This chapter provides a summary of the study, recommendations, limitations and conclusion. It is an evaluation against the purpose and objectives of the study as set out in Chapter 1. Recommendations were made in terms of management, education and further research. Conclusions of the study were based on findings of the study.

### 5.2 Study Overview

The purpose of the study was to assess the implementation of Batho Pele Principles by health care providers at the selected mental health hospitals of the Limpopo Province.

Objectives of the study were to:

1. Assess the implementation of Batho Pele Principles at the selected mental health hospitals of Limpopo Province.
2. Describe challenges experienced by health care providers in the implementation of Batho Pele Principles.

3. Formulate specific recommendations to improve and promote the implementation of Batho Pele Principles.

Objective one was met during data collection. Objective two was also met during data collection. Data was collected using self-administered questionnaires. Two hundred and fifteen questionnaires were handed to the respondents who were on-duty; appointments were arranged with the sub-group supervisors. Two hundred and two questionnaires were completed of which ten questionnaires were spoiled (demographic data incomplete). Objective three was borne out by specific recommendations made with specific reference to implementation of Batho Pele Principles by health care providers in caring for MHCUs.

The questionnaire consisted of two sections. Section A comprised demographic data and Section B incorporated eighteen open-ended questions (Q1-Q18) and Q19-Q20 was close-ended question. Descriptive statistical data analysis was used to investigate the research question in order to draw statistically valid conclusions. Data were analysed by a statistician using the Statistical Package for Social Sciences (SPSS). The graphical and numerical techniques for organizing and interpreting data enabled trends and differences to be noted and calculations of the simple statistics such as frequency, percentage and proportions of the scores.

Analysis of data and interpretation of each item from the questionnaire were discussed in Chapter 4 with references to the literature review, where applicable. The researcher strived to adhere to ethical considerations throughout the research. Descriptions of findings of the study and challenges experienced by health care providers in the implementation of Batho Pele Principles were discussed according to the eight principles in Chapter 5. However, communication barriers constituted a major challenge to the implementation of all Batho Pele Principles.

### 5.3 Recommendations

Recommendations were formulated based on the findings and conclusion to ensure that Batho Pele Principles are implemented as a strategy to improve quality nursing care—to be in the line with the White paper on the Transformation of Public Service Delivery, Patients’ Rights Charter and the Constitution of the Republic of South Africa (1996). The researcher made recommendations related to nursing practice, management, education and further research.

#### **NURSING PRACTICE**

In order to improve quality health care services in psychiatric institutions, it is recommended that:

- ☞ The set policies, norms and standards that govern the practice of Batho-Pele Principles should be developed and disseminated, for example, application of the principles should become an imperative for all health care professionals providing MHC services at clinics, public and specialized hospitals.
- ☞ Continuous professional development programmes that include implementation of Batho-Pele Principles should be provided to all nurses providing comprehensive MHC services.
- ☞ Regular in-service education regarding implementation of Batho-Pele principles should be developed to meet MHCUs needs. This could be achieved by workshops or in-service training programmes at the hospital to maintain their competency level.
- ☞ Peer review assessment regarding implementation of Batho-Pele principles should be developed to evaluate nurses’ competency.

#### **CONSULTATION**

Nurses should conduct customer surveys, listen to, inform, verify and communicate with the customers (MHCUs) or their relatives in order to achieve their needs and plan how these needs should be met.

#### **SETTING SERVICE STANDARDS**

Standards should be realistic, measurable and attainable with available resources to create realistic expectations for the customers (MHCUs).

### **INCREASING ACCESS**

Customers (MHCUs) should access mental health services in terms of daily needs, necessary equipment and supplies, information for those who have insight of their mental illness and accessibility of buildings, toilets with special needs such as disability. Customers' (MHCUs) relatives should also have access to necessary information on health services, how they can access the multi-disciplinary team; such as referrals to social workers, physiotherapists, psychologists and doctors in case they want to.

### **ENSURING COURTESY**

Nurses should be polite, helpful and treat every customer (MHCU) with dignity and respect, regardless of any mental health condition. Nurses should be friendly and empathize with the customers' (MHCUs') relatives and treat them with as much consideration and respect as they would like for themselves.

### **PROVISION OF INFORMATION**

Information about services should be made available, customers (MHCUs) and their relatives should be provided with necessary information about the mental health services they are entitled to receive, to make informed decisions.

### **OPENNESS AND TRANSPARENCY**

Nurses should be open and honest about the positive and negative aspects to the customers (MHCUs) and their relatives and explain how they plan to improve services in future, how national and provincial departments are run, how much services cost and who is in charge.

### **REDRESS**

Customers (MHCUs) and their relatives should be offered an apology, if the promised standard of services is not delivered or fall the promised standard; full explanation and a speedy and effective remedy; when complaints are made, nurses should have procedures in place to remedy the situation.

## **VALUE FOR MONEY**

Nurses should give customers (MHCUs) the best services in the most efficient way, and avoid wasting resources and form partnership with service providers.

## **MANAGEMENT**

The management should:

- ☞ Identify problem areas in the implementation of Batho Pele Principles and these should be addressed and monitored on a continuous basis.
- ☞ Devise strategies to ensure that all health care providers understand the application of Batho Pele Principles and these should be planned, monitored and evaluated.
- ☞ Perform internal and external auditing to evaluation methods for assessing the application of Batho Pele Principles.
- ☞ Conduct regular in-service training, awareness of the Batho Pele Principles. This should include the entire government workforce.
- ☞ Vacant posts should be advertised considering staff shortages, and train staff at MHC institutions in sign language interpretation.

## **EDUCATION**

- ☞ The value of lifelong learning must be established at all mental health hospitals.
- ☞ The implementation of the Batho Pele Principles should be covered in workshops that include all categories of staff as an integral part of the human resource development programme.
- ☞ Continuous professional development programmes of the Batho Pele Principles should be provided for all health care providers working on MHC institutions.

## **FURTHER RESEARCH**

- ☞ Extensive studies should be done in other hospitals to obtain a clear picture of their successes and challenges with regard to the implementation of the Batho Pele Principles and the total health care service delivery in the hospital.
- ☞ Research topics should include challenges experienced by health care providers and factors that affect the application of the Batho Pele Principles.
- ☞ Further qualitative research studies will yield valuable information about the implementation of the Batho Pele Principles.

## 5.4 Limitations

Approval from the provincial Department of Health and Social Development were delayed and initially affected the progress of the study. Approval from Hayani Hospital was also delayed as the new CEO was on orientation and the nursing service manager was on leave, and this slowed down the study. The recommendations are applicable only to mental health care facilities in the Limpopo Province, but can be extended to other provinces with follow-up research.

## 5.5 Summary

This study was conducted to assess the implementation of Batho Pele Principles by health care providers at the selected mental health hospitals of the Limpopo Province as a strategy to improve quality nursing care. Study findings indicated that some of the Batho Pele Principles were implemented effectively. Shortfalls identified include communication skills, lack of knowledge pertaining to application of Batho Pele Principles, shortages of staff and equipment. The researcher hopes that this study will prompt hospital managements, and provincial and national departments to initiate programmes, to ensure effective implementation and validation of Batho Pele Principles as a strategy to improve quality health care services in South Africa.

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# ANNEXURE A

## Ethics Clearance Certificate Issued by the University of Venda Health, Safety and Research Ethics Committee

RESEARCH AND INNOVATION  
OFFICE OF THE DIRECTOR

S163

NAME OF RESEARCHER/INVESTIGATOR:

**Mabunda NF**

**Student No: 11563647**

**PROJECT TITLE: ASSESSMENT OF THE IMPLEMENTATION ON  
BATHO PELE PRINCIPLES BY HEALTH CARE PROVIDERS AT  
SELECTED MENTAL HOSPITALS OF LIMPOPO PROVINCE.**

**PROJECT NO: SHS/12/PDC/11/1012**

**SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS**

NAME	INSTITUTION & DEPARTMENT	ROLE
Dr RT Lebese	University of Venda,	Supervisor
Prof LB Khoza	University of Venda,	Co-supervisor
Ms Mabunda NF	University of Venda,	Investigator - Student

ISSUED BY:

**UNIVERSITY OF VENDA, HEALTH, SAFETY AND RESEARCH ETHICS  
COMMITTEE**

Date Considered: October 2012

Decision by Ethical Clearance Committee Granted

Signature of Chairperson of the Committee: 

Name of the Chairperson of the Committee: Prof. X.G Mbhenyane



University of Venda

PRIVATE BAG X5050, TSHOHAYANDOU, 0950, LIMPOPO PROVINCE, SOUTH AFRICA  
TELEPHONE (015) 962 8504/8484 /8313 FAX (015) 962 8439

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# ANNEXURE B1

## Application to Limpopo Province Department of Health and Social Development to Conduct Research

PO Box 6389

Giyani

0826

17/04/2011

The Director General  
Department of Health and Social Development  
Polokwane  
0700

**Ref: Application for Permission to Conduct Research**

Dear Sir/Madam

I, the researcher, am currently pursuing a Magister Curationis Degree at the University of Venda hereby applying to be granted permission to conduct the study at the selected mental health hospitals of Limpopo Province.

The title of the study is “**An Assessment of the Implementation of Bath Pele Principles at the Selected Mental Hospitals of Limpopo Province.**” Participants will be the health care providers working at Evuxaken, Hayani and Thabomoopo Hospitals of the Limpopo Province.

Looking forward to your positive response on this regard.

Yours faithfully,

Miss N.F. Mabunda

## ANNEXURE B2

### Application to Evuxaken, Hayani and Thabomoopo Hospitals to Conduct Research

PO Box 6389

Giyani

0826

17/04/2011

The CEO

**Ref: Application for Permission to Conduct Research**

Dear Sir/Madam

I, the researcher, am currently pursuing a Magister Curationis Degree at the University of Venda hereby applying to be granted permission to conduct the study at the selected mental health hospitals of Limpopo Province.

The title of the study is “**An Assessment of the Implementation of Bath Pele Principles at the Selected Mental Hospitals of Limpopo Province.**” Participants will be the health care providers working at Evuxaken, Hayani and Thabomoopo Hospitals of the Limpopo Province.

Looking forward to your positive response on this regard.

Yours faithfully,

Miss N.F. Mabunda

## ANNEXURE B3

### Approval by the Limpopo Province Department of Health and Social Development to Conduct the Study



**LIMPOPO**  
PROVINCIAL GOVERNMENT  
REPUBLIC OF SOUTH AFRICA

#### DEPARTMENT OF HEALTH

Enquiries: Selamolela Donald

Ref:4/2/2

Mabunda NF  
P O Box 6389  
Giyani  
0826

Dear Ms Mabunda NF

**Re: Permission to conduct the study titled: An assessment of the implementation of batho pele principles by health health-care providers at selected mental health hospitals of Limpopo Province**

1. The above matter refers.
2. Permission to conduct the above mentioned study is hereby granted.
3. Kindly be informed that:-
  - Further arrangement should be made with the targeted institutions.
  - In the course of your study there should be no action that disrupts the services.
  - After completion of the study, a copy should be submitted to the Department to serve as a resource.
  - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.

Your cooperation will be highly appreciated.

  
General Manager: Strategic Planning, Policy and Monitoring

Date: 11/10/2013

18 College Street, Polokwane, 0700, Private Bag x9302, POLOLKWANE, 0700  
Tel: (015) 293 6000, Fax: (015) 293 6211/20 Website: <http://www.limpopo.gov.za>

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# ANNEXURE C

## Informed Consent / Participant's and Investigator's Statement Form

Dear Participant

I am conducting a research project on the topic – An assessment of the implementation of Batho Pele Principles by health care providers in our hospital. I need your participation and feedback, as the aim is to improve the quality of implementation of Batho Pele Principles in our hospital. The aim will be accomplished through the following objectives:

- To assess the implementation of the Batho Pele Principles.
- To describe challenges experienced by Health Care Providers in the implementation of Batho Pele Principles.
- To formulate specific recommendations in order to improve and promote the implementation of Batho Pele Principles.

You are requested to fill one questionnaire which will take 45 minutes of your time. Your anonymity is guaranteed, as neither your name nor name of nursing unit is required. All questionnaires and raw data will be destroyed after the compilation of the final report. Your participation is voluntary and you will receive no remuneration. Your participation will be of value to future MHCUs.

Data collected from this project will be disseminated through a research report and an article in an accredited nursing journal.

Yours truly

Mabunda N.F.

I \_\_\_\_\_ agree to participate in the research project on assessment of the implementation of Batho Pele Principles in the hospital and understand the conditions and the type of participation needed for this research project.

Participant's Signature: ..... Date: .....

Researcher's Signature: ..... Date: .....

**PARTICIPANT'S STATEMENT**

1. I .....have been asked to participate in the research study to be conducted by N.F. Mabunda The title of the research is: **“An Assessment of the Implementation of Bath Pele Principles at the Selected Mental Hospitals of Limpopo Province.”**
2. The aim of the study was explained to me and my rights to participate/terminate my participation was also explained to me.
3. I understand the benefits from participating in this study may help improve the quality of implementation of Batho Pele Principles in our hospital.
4. I was assured confidentiality of information that I will provide and the research will be used to identify my response from those of other patients and no information will be linked to my personal details.
5. I understand that my refusal to participate will involve no penalty or loss of rights to which I am entitled to. I may withdraw from the study at any time without fear of losing any services or benefits
6. The study is one of the requirements of Masters in Nursing at the University of Venda.

.....  
**Name of Participant**

.....  
**Signature of Participant** .....  
**Date**

.....  
**Name of Witness**

.....  
**Signature of Witness** .....  
**Date**

**INVESTIGATOR'S STATEMENT**

I, the undersigned, have defined and explained to the volunteer in a language s/he understands, the procedures of this study, its aims and the risks and benefits associated with his/her participation. I have informed the volunteer that confidentiality will be preserved, that s/he is free to withdraw from the study at any time without affecting the care s/he will receive at the clinic. Following my definitions and explanations, the volunteer agreed to participate in this study.

.....  
**Name of Investigator**

.....  
**Signature of Investigator** .....  
**Date**

# ANNEXURE D

## Questionnaire

**NOTE TO PARTICIPANTS:**

Make a cross (X) next to an option/statement that reflects your choice. Every answer is correct.

SECTION A							
<b>Service rendered</b>							
<b>Years of service</b>	<2 yrs		2 - 5 yrs		5 - 10 yrs		10 - 30 yrs
<b>Gender</b>	Male						
	Female						
<b>Age</b>	20-30 yrs		30 - 40 yrs		40 - 50 yrs		>55 yrs
SECTION B							
<b>1.</b> Does the hospital developed polices and protocols to provide quality mental health care services or integrate them into existing framework?				Yes	No		
<b>2.</b> Do you have written values and behavioural norms of the unit that are in the line with the Batho-Pele principles?				Yes	No		
<b>3.</b> Do you include Batho Pele Principles in your education programme?				Yes	No		
<b>4.</b> How often is Batho Pele Principles education given in your unit?				Once per month			
				Twice per month			
				Every week			
				None of above			
<b>5.</b> Do you treat MHCUs as customers, listening to their views and taking into account of them in making decisions about what mental health services should be provided in your unit?				Yes	No		
<b>6.</b> Are the MHCUs in your unit aware of the availability of the Batho Pele Principles?				Yes	No		
				Some of them			
<b>7.</b> Do you respect MHCUs' experiences, plans and needs?				Yes	No		
<b>8.</b> Do you ensure that there is accurate and proper record-keeping to improve mental health care?				Definitely			
				Most definitely			
				Not at all			
				None of above			
<b>9.</b> Do you allocate adequate staff to					Definitely		

provide quality mental health care?		Most definitely
		Not at all
		None of above

<b>10.</b> Do you minimize language barrier by choosing style of language and words that can reflect an attitude of respect or disrespect?		Definitely
		Most definitely
		Not at all
		None of above
<b>11.</b> Do you listen and encourage MHCUs to express their different point of view?	Yes	No
<b>12.</b> How do you regard your knowledge of Batho Pele Principles?		Excellent
		Good
		Average
		Very poor
<b>13.</b> Do you create an environment that fosters a trusting relationship through openness and transparency?	Yes	No
<b>14.</b> Do you consider the sensitivity and not asking MHCUs to reveal unnecessary personal information?	Yes	No
<b>15.</b> Do you ensure that a written, comprehensive care plan indicates the assessment of the individual needs of the MHCUs?	Yes	No
<b>16.</b> Is the regular in-service education by senior staff conducted in your unit?	Yes	No
<b>17.</b> Does the hospital develop departmental codes and training programmes that integrate Batho Pele Principles to ensure that MHCUs are treated with courtesy, respect and dignity?	Yes	No
<b>18.</b> How would you rate your hospital's compliance with the implementation of Batho Pele Principles?		Excellent
		Good
		Average
		Very poor
<b>19.</b> What principles are easily implemented?	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	
<b>20.</b> List challenges that you experience in the implementation of the Batho Pele principle of <b>Consultation</b> .		

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**21.** List challenges that you experience in the implementation of the Batho Pele principle of **Service standards**.

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**22.** List challenges that you experience in the implementation of the Batho Pele principle of **Access**.

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**23.** List challenges that you experience in the implementation of the Batho Pele principle of **Courtesy**.

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**24.** List challenges that you experience in the implementation of the Batho Pele principle of **Information**.

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**25.** List challenges that you experience in the implementation of the Batho Pele principle of **Openness and Transparency**.

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**26.** List challenges that you experience in the implementation of the Batho Pele principle of **Redress**.

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**27.** List challenges that you experience in the implementation of the Batho Pele principle of **Value for money**.

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**28.** Please put down any suggestion/comments on the implementation of the Batho Pele Principles in your unit.

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# ANNEXURE E

## Letter from the Language Editor



**FACULTY OF NATURAL  
SCIENCES  
DEPARTMENT OF MEDICAL BIOSCIENCES**



Donavon C. Hiss  
University of the Western Cape  
Private Bag X17  
Bellville 7535  
South Africa

Tel: 021 959 2334  
Cell: 0722001086  
Fax: 021 959 1563  
E-mail: dhiss@uwc.ac.za or hiss@gmx.us

6 February 2014

To Whom it May Concern

This serves to confirm that I have edited the language, spelling, grammar and style of the MCur thesis by **Mabunda Nkhensani Florence**: **“AN ASSESSMENT OF THE IMPLEMENTATION OF BATHO PELE PRINCIPLES BY HEALTH CARE PROVIDERS AT SELECTED MENTAL HEALTH HOSPITALS IN THE LIMPOPO PROVINCE”**.

Sincerely Yours



Donavon C. Hiss  
Dip. Freelance Journalism, Dip. Creative Writing, MSc (Medicine), PhD



UNIVERSITY of the  
WESTERN CAPE

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