STRATEGIES TO FACILITATE THE PROVISION OF QUALITY HEALTHCARE SERVICES IN PUBLIC HEALTHCARE FACILITIES IN LIMPOPO PROVINCE SOUTH AFRICA

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DECLARATION

I declare that the thesis on **"STRATEGIES TO FACILITATE THE PROVISION OF QUALITY HEALTHCARE SERVICES IN PUBLIC HEALTH CARE FACILITIES OF LIMPOPO, SOUTH AFRICA"** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

Elmalomane

04 September 202

SIGNATURE

EL MALOMANE **DATE**

DEDICATION

I dedicate this thesis to:

My late dear mom and dad, Mr M.W Malomane and Mrs J.M Malomane who did not live to witness the completion of this thesis.

Their interests and enthusiasm in the education of all their children is greatly cherished and appreciated. Although they are no longer of this world, their memories continue to regulate my life.

I also dedicate the thesis to my beloved children who meant and continue to mean so much to me, Mxolisi. Ntshembo and Masungi who I love so dearly.

My late grandmother Nwamahaxana Ntongasi Mdhlovu Mnisi, whose love for me knew no bounds and, who taught me the value of hard work. Thank you so much “grandmother”, I will never forget you.

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ABSTRACT

Introduction: Quality healthcare provision is a fundamental need in the life of a person since it helps develop a positive self-image. Healthcare has always been an important issue for society, both economically and culturally. Contrary, dissatisfactions and litigations laid by clients/patients and relatives against the government due to poor service provision become unmanageable.

The purpose of the study was the development of strategies to facilitate provision of quality healthcare services in public healthcare facilities in Limpopo province, South Africa.

Methods: Qualitative and quantitative methods were adopted for the study. Population for the qualitative study was constituted by professional nurses, and stakeholders (Hospital boards and Clinic health Committees) who were, purposively selected from the randomly sampled hospitals and clinics. Focus Group discussion and questionnaires were conducted to collect data.

Analysis. The qualitative data was analysed qualitatively. Population for quantitative study consisted of Clients as stakeholders and professional nurses from randomly sampled hospitals and clinics. The qualitative results were used in the development of questions for questionnaire used in the quantitative approach. For the quantitative approach a self-administered questionnaire was used to collect data from the respondents. Data collection was carried out by means of two instruments for clients and professional nurses. Analysis was done using SPSS 25 version with the assistance of a Professional Statistician. The researcher used the Strength, Weaknesses, Opportunities and Threats analysis to develop strategies for enhancing quality healthcare service provision in the Department of health. The interaction between Strengths, Weaknesses, Opportunities and Threats was analysed and used to develop strategies to facilitate provision of quality health care services in public health care facilities in Limpopo Province.

Conclusion Findings of this study is expected to inform nursing education and nursing practice to review curricular on what to emphasize when training the

nursing students. The findings will also inform senior management when planning for improvement of health care provision improvement.

KeyWords: Health Facilities. Health service provision,Provision of Quality Health Service, Strategies,

LIST OF ACRONYMS AND ABBREVIATIONS

AIDS:	Acquired Immune Deficiency Syndrome
CHCs:	Community Health Centres
CHWs:	Community Health Workers
BESG:	Bellagio Essential Surgery Group
BP:	Batho Pele
CER:	Comparative Effectiveness Research
CHAs:	Community Health Assistants
DHB:	District Health Board
DOH:	Department of Health
DPME:	Department of Performance Monitoring and Evaluation
DPSA:	Department of Public Services Administration
FACS:	Fair Access to Care Services
FGD;	Focus Group Discussion
HB:	Hospital Boards
HC	Hospital Committee
GDP:	Gross Domestic Product
HCWs:	Health Care Workers
HR:	Human Resource
HRH:	Human Resource
HSRC:	Human Sciences Research Council
IOM:	Institute on Medicine
IQ:	Intelligence Quotient
LGAZ	The Local Government Association of Zambia
MSQ	Minnesota Satisfaction Questionnaire
NCDs	Non-Communicable diseases
NHI:	National Health Insurance
NHIS;	National Health Insurance Scheme

NHS:	National Health Scheme
NIOSH	National Institute for Occupational Safety and Health
NTLU	Nursing Tasks Left undone
OP:	Operational managers
P4P	Payment for Performance
PC:	Professional Nurse Clinics
PCC	Patient Centered Care
PH:	Professional Nurse Hospitals
PHC:	Primary Health Care
PN:	Professional Nurse
PPACA:	Patient Protection and Accountable Care Act
PSRO:	Professional Standards Review Organizations
PS:	Patient Satisfaction
PSC:	Public Service Commission
S.A:	South Africa
SDIP:	Service Delivery Improvement Plans
SASSA:	South African Social Agency
SPSS:	Statistical Package for the Social Sciences
SWOT:	Strengths, Weaknesses, Opportunities and Threats
UINCD:	Uganda Initiative of non-Communicable Diseases
UK:	United Kingdom
US:	United States
USA:	United States of America
USAID:	United States Agency for International Development
WHO:	World Health Organization
WPTPS:	White Paper on Transformation of Public Services

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 Definitions of Quality Health Care Provision

Various organisations and researchers adopted their definitions from the WHO definition in 1.1. Above, for example: Mosadeqhrad (2014:77) defines quality healthcare provision as "*consistently* delighting the patient by providing efficacious, effective, efficient and safe healthcare services according to the latest clinical guidelines and standards, which meets the patients' needs and satisfies providers. Whilst the Institute of Medicine in The United States of America(USA) (IOM) insists that quality in health care is "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" or A widely used definition of quality in general is, "the degree to which a set of inherent characteristics fulfills requirement (Marjoua & Bozic, 2012:266 ;Nylenna, et al., 2015:1). (Nylenna, et al (2015:1) also emphasized that quality in health care provision as very important. They argued that as quality becomes quantifiable, standardised, routinely measured, and reported, it could be linked to economic reward if it is positively experienced and penalties if it is negatively experienced. For the purposes of this study therefore WHO's definition was adopted as in 1.1.

1.1INTRODUCTION AND BACKGROUND

According to World Health Organization (WHO) (2006:9), quality of healthcare is defined as health care that is effective, efficient, accessible, acceptable and equitable. However, the health services in South Africa prior to 1994 were provided unequally along racial lines (Health Systems Trust, 2014:5). Most black people had no access to quality health services. Public health services for whites were better than those for blacks and those in the rural areas were significantly

worse off in terms of access to health services compared to their urban counterparts (Health Systems Trust, 2014:5). After 1994, the government of South Africa saw the need to put strategies in place to improve quality of healthcare services provision (Harrison, 2010:4; Young, 2016:1)

The government included in the Constitution of South Africa, 1996, ss 27 1a, which aimed to transform public services by emphasizing that everyone has a right to have access to effective, efficient, acceptable and equitable healthcare services including reproductive and emergency services (Department of Justice, 1996:7).To fulfill the aim of the constitution of South Africa, the white paper for the transformation of the health system in South Africa was implemented. "Improving the quality of service provision was the ultimate goal of the public service transformation programme" (Department of health, 1997:17). This was to be done through reorganising and transforming the whole system of health in the country namely: improving human resources for health, financial and physical resource, essential national research, health information, nutrition, maternal, child and woman's health, HIV(Human Immune Deficiency Virus) and sexually transmitted diseases, communicable diseases, environmental health, mental health and substance abuse, oral health occupational health, academic health service complexes, national health laboratory services and revised the role of hospitals(Department of health, 1997:17). The implementation of the White paper on Transformation of the Public Services Delivery or the Batho-Pele White Paper of 1997 (Notice No. 1459 of 1997) was done with the aim of making the public service in South Africa more efficient, effective and economical (Department of Public Service Administration, 1995:3).

The White paper on Transformation of Public Services Delivery sets out the eight Batho-Pele principles which are meant to serve as a vehicle to improve service provision as follows:

- Consultation Citizens
- Service Standards

- Access
- Courtesy.
- Information Citizens
- Openness and transparency
- Redress and
- Value for money (Chabane, 2013:2).

Having implemented the white paper on transformation of health system and white paper on transformation of public services, it became necessary to introduce and implement the policy framework of the Government Wide Monitoring and Evaluation. This is a statutory requirement that the accounting officer of a department or municipality, or the chief executive officer of a public entity, is required to establish a monitoring and evaluation system for the institution. Monitoring and Evaluation was recognized as important because it would provide an evidence base for public resource allocation decisions and helps identify how challenges should be addressed and successes (The Presidency, 2010:3).

Another strategy introduced by the department of health in South Africa is the sanctioning of the district health system as the vehicle for the implementation of primary health care at the community levels. This was done after acknowledging that Primary health care requires structural re-organisation, multidisciplinary team approach with clear lines of accountability, clear referral patterns in a two-way direction, improved access to health insurance to improve health coverage, and developing effective public-private partnerships. The universal core packages of health care should be evidence-based, cost-effective and appropriate to local needs (Dookie & Singh, 2012:1; Watson et al., 2017:1)

This study was conducted at the time when the Minister of Health in South Africa Dr Aaron Motsoaledi was introducing the National Health Insurance act (NHI) which would ensure that everyone in the country have access to appropriate

efficient and effective quality healthcare services and this would comprehensively address the historical inequalities of the past (Naidoo, 2012:1;Littlejohns, 2019:2).

According to Awases, Bezendhout and Roos (2013:2), professional nurses play a vital role in the provision of healthcare globally. The performance of health care workers, including professional nurses, link closely to the productivity and quality of healthcare provision within healthcare organizations. It was important to identify factors influencing the performance of professional nurses if the quality of healthcare delivery was to improve. In their study in general, including South Africa, Awases, Bezendhout and Roos (2013:2) found that professional nurses were not performing as well as is expected from them. The researchers identified factors affecting the performance of nurses negatively, they were as follows: lack of recognition of employees who are performing well, quality performance outcomes, an absence of a formal performance appraisal system, lack of continuing learning programmes and poor working conditions (Awases, Bezendhout and Roos, 2013:2).

Programmes for continuing learning workshops for professional nurses are regarded as very important and should be in place in all health institutions. Professional nurses should regularly be asked to identify areas where they need further training. Studies by Aminoroaia, Mashhadi, Maracy and Attani (2014:1) showed a significant increase in nurses' knowledge after attending continuing learning workshops. The researchers concluded that continuing education programs should be provided in conducive environments to facilitate learning and professional growth. Knowledgeable professional nurses can contribute to the improvement of quality of health service provision (Aminoroaia et al., 2014:1).

1.1. 1 Various Approaches to improving quality health care provision

There have been numerous attempts at conquering the challenges of improving healthcare quality and safety in the (USA). Some of the attempts were made through the following:

Medicare and the Medicaid programmes, Utilisation reviews committees, Professional Standards Review Organizations (PSROs) and many others. These attempts were able to bring about a reliable evidence base with valid and replicable data collection mechanisms, and a flexible, pragmatic approach to the pursuit of healthcare quality improvement that captures the input of all stakeholders involved (Marjoua & Bozic, 2012:266; McClellan, 2013:2). However, those successes were short-lived. It was found that the presence of leadership, infrastructural support, and prioritisation of healthcare quality within the culture of an organisation and the existence of performance measurement methods were of crucial importance in improving quality of healthcare provision .These were therefore, not substantiated enough to address the complex, and evolving challenges associated with achieving adequate healthcare quality (Marjoua & Bozic, 2012:266) and ; McClellan, 2013:2). The IOM (Institute on Medicine) further noted that patients in the USA received effective care only about half the time, and that gaps in coordination remained widespread. Serious preventable medical errors were also common, and more than 30 percent of health care costs could be avoided by improving quality and efficiency. Racial and ethnic minorities tended to receive lower quality of care, including preventive care, than non-minorities (McClellan, 2013:2).

The USA's intense focus on quality in healthcare was brought to the forefront with the passage of the Patient Protection and Accountable Care Act pub no 1 111-148: (PPACA), signed into law by President Obama on March 23, 2010. The law contains multiple provisions designed to modify the manner in which care is delivered to Medicare and Medicaid patients, and the system by which

provider payment is determined, with a central objective of improving quality while lowering healthcare costs and expanding access (McClellan, 2013:2). On the other hand, McClellan, (2013:2) argued that simply expanding health insurance coverage to promote access or trying to lower costs by cutting prices or by covered services, would not necessarily achieve the best healthcare for Americans; rather improving how care is provided was deemed essential (quality of care). Nickin (2015:3) believes that a higher quality of healthcare in an increasingly safe environment results from adherence to evidence-based set standards.

Accreditation confirms that an institution conforms to certain levels of set standards. Accreditation therefore could be used to improve the quality of healthcare provision and effectiveness of healthcare organizations. The USA study by Braithwaite, Greenfield, Westbrook Pawsey, Westbrook and Gibberd (2010:15) and Viswanathan & Salmon 2020:6) insisted that accreditation plays an important part in ensuring that the quality of healthcare provision is maintained. These researchers advanced two important factors in the accreditation process as follows:

Firstly, the standards encourage organizations to achieve a particular criteria of quality improvement.

Secondly, because the accreditation bodies revised their standards regularly, those standards could therefore, be regarded as up to date research and acceptable best practices (Braithwaite et al., 2010:15; Viswanathan & Salmon 2020:6).

WHO (2015:2) acknowledged that not all communities can afford the latest technologies to facilitate effective, efficient and accessible quality health care. However, the organisation insisted “where health systems are having financial problems, particularly in developing countries there is a need to optimise

resource use and expand population coverage". The process of improvement and scaling up needs was to be based on sound local strategies for quality so that the best possible results would be achieved from new investment" (WHO, 2006:2). Developing strategies to improve quality healthcare provision was regarded as critical. Even where health systems were well-developed and well resourced, there was clear evidence that quality remained a serious concern, with expected outcomes not predictably achieved and with wide variations in standards of healthcare delivery within and between health-care systems. Health expenditure in industrialized countries had doubled in the last 30 years; however, the highest-spending countries were not always those with the best results/outcomes (Mosadeqhrad, 2014:77; Aitken, 2012:10).

In response to the increased demand for healthcare, Germany and the United States dramatically increased in their healthcare expenditures. This was done through stepping up the amounts of money collected from citizens through taxes, insurance, out-of-pocket payments, or co-payments. According to the studies conducted by Aitken,(2012:1) and Kieft et al (2014:2) in various countries , on how professional nurses experience provision of quality healthcare, a substantial proportion of nurses in developed countries reported quality of care deficits, high nurse burn-out, job dissatisfaction, and intention to leave their current positions. Nurses in some developed countries reported a particularly high level of nurse burnout 78.0%, dissatisfaction 47.0% and intention to leave 49.0%.

In addition, nearly half described their wards as providing poor or fair quality of care, and almost one fifth gave their hospitals a poor or failing safety grade. In the Netherlands, nurse burnout, dissatisfaction, and intention to leave were lower than in most countries. However, these rates still ranged from 10.0% to 19.0%; and 6.0% of nurses gave their wards a poor or failing safety grade, and 35.0% rated care on their wards as fair or poor. The percentage of burnt out

and dissatisfied nurses in the US was close to the European median, but the percentage of US nurses intending to leave their jobs in the next year was lower than in all European countries (Aitken, 2012:1; Kieft et al., 2014:2).The same questions were asked from patients in the same institution that health professionals were asked. The results tallied on the level of quality provision related to whether they could recommend their hospitals to others (Aitken, 2012:2; Kieft et al 2014:2). Patients in hospitals with better work environments were more likely to rate their hospital highly and recommend their hospitals, whereas those with higher ratios patients to nurses were less likely to rate them highly or recommend them (Aitken, 2012:2; Kieft et al 2014:2).

Umeano-Enemuoh Onwujekwe Uzochukwu and Ezeoke (2014:1) conducted a study in Nigeria on client satisfaction on various categories of clients and the average scores were as follows: In the overall, patients were satisfied with the services provided by the different health care providers and had a mean score of 3.75, while satisfaction with quality of care was 3.45. Services received at the pharmacy had the highest satisfaction level with mean rating of 4.1, Mean rating of 3.4 was allocated to the doctors. The highest percentage the respondents showed greatest displeasure with the time that was spent at the facility. South Africa was no exception, also have issues with client satisfaction. Jacobsen and Hasumi (2014:8) found that client satisfaction rates were lower for black South Africans (87.0%) and low income households with monthly incomes of less than R2500 per month (86.3%). Client satisfaction was higher for white South Africans, 96.0% followed by those high income household of at least R8000 whose score was 94.0% (Jacobsen & Hasumi, 2014:8). The study also showed that most black people and low-income groups had low satisfaction rates.

1.1.2 Professional nurses' role in quality health care provision

According to the study conducted in South Africa by Awases, Bezeidenhout and Ross (2013:6), the role played by professional nurses in the provision of health care was found to be vital. The performance of health care workers, including professional nurses, linked closely to the productivity and quality of healthcare provision within healthcare organisations. It was therefore important to identify the factors influencing the performance of professional nurses if the quality of healthcare provision was to be improved. As a result, in this study, the following factors were described as factors facilitating personnel management that can lead to employee satisfaction and subsequent quality of health care:

- Building knowledge and competencies through continued professional development, in-service training programmes and clinical specialisation.
- Developing mechanisms for performance enhancement of nurses by means of a formal performance appraisal system, the development of performance standards and the proper management of the nursing health workforce system.
- This performance management system should address aspects such as human resources in nursing, motivation, remuneration and incentives, recognition and rewarding of professional nurses, work conditions and environment and increasing the numbers of nursing cadres.
- Development of leadership and management capacity through leadership development and management programmes, courses in interpersonal relations, communication and supportive supervision (Awases, Bezeidenhout and Ross, 2013:6).

One South African study and another in developed countries study conducted by Pillay (2009:10) and Kieft et al (2014:2) respectively, on service providers' views on the service provision, revealed that most of the respondents viewed aspects of their work which included, safety of work environment, comfortable

workplace environment, and work done by immediate supervisor and client services offered by the organisation, as of high quality and satisfactory. Public-sector nurses viewed their pay, and resources as inadequate while their workload was viewed as overwhelming. They only viewed their social context as satisfactory. On the other hand, Private-sector nurses viewed their pay and career development opportunities as dissatisfactory, while their work load and resources available to them were satisfactory (Pillay, 2009:10; Kieft et al., 2014:2).

1.1.3 Management of Quality improvement in various countries

It was however found that, one of the very few countries in the world that had managed to significantly improve the quality of healthcare services was Switzerland. Swedish people had equal access to health services, which was among the most efficient in the world, and most of the costs for health care were borne by the government through taxes. This healthcare was efficient and ensured easy access to healthcare (National Board of Health & Welfare, 2015:1). The Swedish achieved this through implementing the following:

- Measuring the quality and responding to the results. This was found to be a norm in Sweden.
- They annually conducted the National Patient Survey that provided an annual measurement of how patients rate quality of healthcare. Questions used were related to: concern over treatment, patient involvement, confidence in care and information.
- The results were used to develop an improvement plan based on the patient perspective.
- The Healthcare Barometer was also used as a yearly survey reflecting attitudes, knowledge and expectations relating to Swedish health care (National board of Health and Welfare (2015:1).

According to Worley (2015:1), Rwanda faced a severe health worker shortage and limited infrastructure after the genocide. The shortage of health workers led to high rates of maternal and child mortality. The Rwandan government managed to implement strategies that improved quality of health service delivery, specifically maternal health. The government achieved this by prioritising reproductive, maternal, new-born, and child health to rebuild basic systems and services through several complementary policies. The government of Rwanda also made sure that birth attendants were skilled, and generally bolstered its workforce to address maternal and child mortality. The health sector was also decentralised to strengthen community involvement and trained 45,000 community health workers to provide primary health services at the village level (Worley, 2015:1).

Henke, Kadonaga, and Kanzle (2009:1) and Gearhart. (2016:3) noted that on the surface**,** Japan's health care system seemed robust. The country's National Health Insurance (NHI) provided for universal access. Japan's citizens were found to be historically among the World's healthiest, living longer than those of any other country. Infant mortality rates were low, and Japan scored well on public-health metrics, while consistently spent less on health care than most other developed countries do. Despite this, problems were highlighted as follows:

- Absence of a way to allocate medical resources evenly, starting with doctors; this made it harder and harder for patients to get the care they need, when and where they need it.
- Every year Patients who needed care were turned away from institutions. because the waiting list was long and or there were not enough doctors

Furthermore, the quality of care varied markedly (Gearhart, 2016:3). In the study conducted in Nigeria, Van der Gaag (2015:2) found that Health insurance fund programmes were used to facilitate access to health care by improving the quality of health care provision in organisations. Once an organisation participated in the fund, it was automatically enrolled in the quality improvement of the

programme. The health insurance fund undertook to upgrade the medical and administrative capacity of the healthcare providers contracted under the programme. The idea was that once quality was in place; people would be more willing to pay for healthcare through the health insurance programme. The objective of improving quality of healthcare provision would have been met.

South Africa was no exception in this regard, the country also, to improve the quality of service provision, after 1994, the government restructured the public health sector by implementing the White paper on Transformation of the Health Services with the aim of making the public service in South Africa more efficient, effective and economical. This was to be done through reorganising and transforming the whole system of health in the country viz: improving Human resources for health, financial and physical resource Essential national research, Health information Nutrition Maternal , child and woman's health, HIV and sexually transmitted disease communicable diseases, Environmental health, mental health and substance abuse ,oral health occupational health, academic health service complexes, national health laboratory services and revised the role of hospitals (Department of health, 1997:17). However, the process of restructuring only achieved substantial improvements in terms of access, and rationalisation of health management and more equitable health expenditure. Quality of health care provision remained elusive (Harrison, 2010:1; Young, 2016:1).

1.1.4 Private sector versus Public sector on Health Care Provision

The state contributes about 40% of all expenditure on health through the public and private health institutions (Harrison, 2010:1; Young, 2016:1). The private sector, however, was found to be highly specialized and was run largely on commercial lines and catered to only 20% of the population who were middle and high-income earners who tended to be members of government-subsidized medical schemes. It also could attract most of the country's health professionals; hence quality of healthcare was found to be comparatively much better in the

private sector. The public health sector, on the other hand, was found to be under pressure to deliver services to about 80% of the population. The public sector was responsible for providing primary health care and curative health care to poorest people of South Africa. While access had improved, the quality of healthcare had deteriorated (Harrison, 2010:2; Young, 2016:1). The situation was exacerbated by the increased burden of Acquired Immuno-Deficiency Disease Syndrome (AIDS) on mortality and the health system. The result was poor health outcomes relative to total health expenditure. The challenge for policy-makers was to demonstrate rapid improvements in the quality of care and service provision indicators, such as waiting time and patient satisfaction rates (Harrison, 2010:2; Young, M. 2016:1).

The latest study on quality of health care was conducted in Mozambique by (Schwittes, Leder, Zilversmit, Gudo, Ramiro, Cumba, Mahangaja and Jorbateh 2015:2.). This study was confined to rural clinics. The study identified the following three main priorities to be addressed to enhance perceived quality of primary health care and health policy action:

- drug availability
- Interpersonal skills (including attitudes towards patients) and
- Transport

1.2 PROBLEM STATEMENT

Despite the efforts provided by the government of South Africa in the implementation of transformative policies such as white paper on transformation of health systems, incidences that leads to litigations still occurred. Workshops were part of the in-service training for doctors and professional nurses to equip health care providers. Increase shortage of professional nurses and doctors also posed a threat to the health care provision. Reports were also made by the public and media on shortage of equipment, medication and other valuable resources. In 2016 as many as 17900 litigations were reported. These law suits cost the

government a lot of money. The researcher worked as one of the managers in the provincial health department office in Limpopo Province. This influenced her to investigate the factors contributing to poor healthcare provision in Limpopo province and thereafter developed of the strategies to improve quality health care provision.

1.2 RESEARCH QUESTIONS

According to Cox (2012:4), if a research is exploratory and investigative, where data need to be collected analysed before drawing conclusions, then, research questions are required. An exploratory sequential mixed method was used for this study, hence the research questions. Cox (2012:4) further cautioned that a good research question ensures a good research. Emphasis is made that good research questions help to guide the research process, construct a logical flow of arguments write a literature review, plan thesis chapters and finally devise efficient search strategies.

The researcher took all the above-mentioned objectives into consideration as she developed the following research questions:

1.3.1 Phase I Questions

1.3.1 1 Stage one questions

- What are the views of professional nurses regarding the provision of healthcare rendered to clients/patients at the healthcare facilities of Limpopo Province?
- What experiences do stakeholders (clinic committees and Hospital boards) toward the provision of healthcare services in public healthcare facilities of Limpopo Province?

1.3.1.2 Stage 2 questions

- What are some challenges experienced by professional nurses regarding the provision healthcare services in public healthcare facilities?
- What are the factors contributing to healthcare provision in public healthcare facilities in Limpopo as perceived by Professional Nurses?
- Are the Current strategies of implementing healthcare services provision in public healthcare facilities of Limpopo Province implemented?
- What are the experiences of clients regarding provision of healthcare service within the public healthcare facilities in Limpopo Province?

1.3.2. Phase 2 questions

What strategies can be developed to facilitate the provision of quality healthcare service in public healthcare facilities in Limpopo Province?

1.4. RATIONALE

The provision of quality, safe and accessible healthcare has become the primary objective of most countries in the world, particularly developing countries. The demand for the provision of quality services and evidence-based care were continuing to be a trend in various discussions at the local, regional and national levels. Governments in developing countries, including South Africa, had become more aware of and were becoming more committed to the provision of effective and quality healthcare for their citizens. Although the quantity rather than quality of healthcare services had been the focus, historically in developing countries, ample evidence suggested that quality provision of care or the lack of it must be at the centre of every discussion about better healthcare. South Africa as one of the developing countries in Sub-Saharan Africa, was also faced with some constraints in its finances and shortages of resources in healthcare. Like any other country, South African people were demanding greater quality provision in healthcare as well as accountability from the health workers and

the healthcare system itself. Evidence for the need to improve quality healthcare provision was widespread. Large variations in patterns of practice were observed.

Those variations could not be explained by differences in the needs of the population served. Many healthcare workers also raised their voices regarding the quality of care they are giving. This study required a solution in which an improvement on quality provision on healthcare would be revived and all involved in health care provision would continue their professional development and can provide high quality care. This study is therefore important for the sake of improving the quality of service provision. Improving the quality of health care provision has a potential of improving the quality of life for people, increase their life span, and contribute to job satisfaction and decrease litigations (Hughes, 2008:1; Abrampah et al 2018:2).

1.5 SIGNIFICANCE OF THE STUDY

The significance of the findings are as follows:

- The findings of the study have a potential to contribute to the Development of Strategies to Facilitate the Provision of Quality Healthcare Services in Public Healthcare Facilities in Limpopo Province.
- Participation by service providers, the recipients of service in the study and the development of strategies to facilitate provision of quality healthcare enabled the researcher to develop strategies that are relevant and this may encourage a buy-in on implementation of the strategies developed.
- The recommendations of the study to improve patient satisfaction and employee satisfaction, if implemented by the department, may contribute in improving quality of health care provision. The rise in number of litigation due to unsatisfied clients and the negative financial implication justify the need to effective strategies to facilitate provision of quality healthcare services.

- Other provinces and other African countries may learn from the province in case of success.
- The study has a potential to contribute to the scientific body of knowledge by being shared in the health and medical journals nationally and internationally.
- It may trigger follow–up studies by other interested parties locally and internationally.
- This may encourage funders from the international world to fund follow-up studies.

1.7 PURPOSE OF THE STUDY

To develop strategies to facilitate provision of quality health care service in Public health care facilities in Limpopo Province South Africa.

1.8 OBJECTIVES OF THE STUDY

Research objectives described the actions taken to answer the research questions. Moreover, the objective of a study indicates how the research aim would be achieved (Feibert, Jacobsen & Wallin, 2017:1). The objectives of the study were arranged according to four phases including development of instrument in the study as follows:

1.8.1 Phase one objectives

1.8.1.1 Qualitative objectives were as follows:

- To describe the views of healthcare professionals regarding provision of healthcare services in public healthcare facilities of Limpopo Province.
- To explore the experiences of stakeholders (Clinic Health committees and Hospital board members) regarding provision healthcare services in public health care facilities of Limpopo Province.

1.8.1.2. Quantitative Objectives

- To assess the challenges faced by healthcare professionals towards the provision of quality healthcare services in public healthcare facilities of Limpopo Province.
- To describe factors contributing to the provision of healthcare services facilities in public healthcare facilities in Limpopo province.
- To evaluate strategies currently used to improve the provision of health care services in public healthcare facilities in Limpopo Province.
- To describe the experiences of clients regarding provision of healthcare service provision within the public healthcare facilities in Limpopo Province.

1.8.2 Phase 2 objectives

To develop strategies to facilitate the provision of quality healthcare service in public healthcare facilities in Limpopo province.

1.9 THEORETICAL FRAMEWORK

The study was guided by the Donabedian model (The American father of quality control). The Donabedian model is a conceptual model that provides a framework for examining health services and evaluating quality of health care. According to the model, information about quality of care can be drawn from three categories: “structure,” “process,” and “outcomes. Ayanian, and Markel (2016:2) and Ameh, Gomez-Olive, Kahn, Tollman, and Klipstein-Grobusch (2017:1) in their study on relationships between Structure, Process and Outcome to assess quality of integrated chronic disease management in a rural South African setting: applying a structural equation model by Donabedien confirmed that the mediation pathway showed that the relationships between structure, process and outcome represented quality systems in the ICDM model.

Structure refers to the human, material resources and organizational framework that is necessary for the work to be done.

Process deals with how the service is carried out. This is the interaction between the nurse and other health care workers and the patient

Outcomes are the end result of the care activities. Most people agree that the best measure of patient care is to look at the outcome (Shongwe 2000:21; Pantealeon 2019:3). In this study the outcome will show patient and employee satisfaction. Because these components are interdependent, their affect each other. For example, if the structure component is inadequate, this will influence service delivery in the process component. And in turn influence the outcome which in this study (because it is not strictly clinical) involve both patient and employee satisfaction. This conceptual framework highlights the challenges related to Structure, Process and Outcome. The challenges, through SWOT analysis were used to develop strategies to facilitate the improvement of health services provision (Figure 1.1)

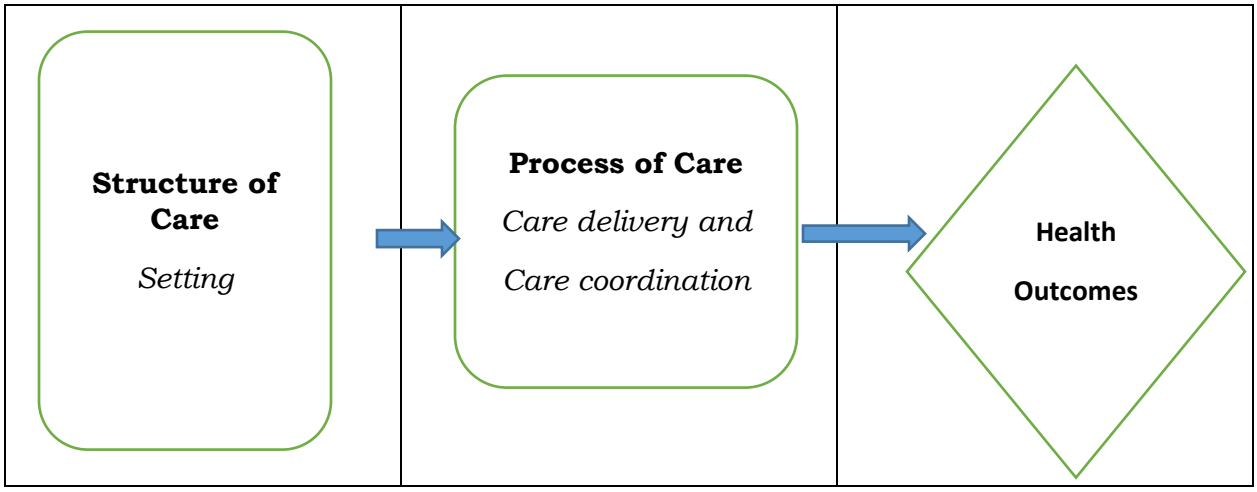


Figure 1.1: Donabedian's Theoretical model**:**

Adapted from: Donabedian, A (1966). Evaluating the quality of medical care. *Milbank Quarterly, 44*

1.9.1 Impact of Theoretical framework on the current study

The objectives and questions of the study were addressed through qualitative and quantitative approaches to the study. Structural, Processes and outcome challenges were identified (See table 1.1).The SWOT analysis was used to develop strategies to facilitate provision of quality service delivery.

1.10 DEFINITION AND OPERATIONALISATION OF CONCEPTS 1

1.10.1 Client/customer satisfaction

Xesfing and Vozikiz (2016:1) defined Patient satisfaction as an important measure of healthcare quality as it offers information on the provider's success at meeting clients' expectations and is a key determinant of patients' perspective behavioral intention. In this study clients (also regarded as stakeholders) referred to people visited hospitals and clinics to receive care.

1.10.2 Employee satisfaction

According to Heathfield (2014:2), employee satisfaction is the terminology used to describe whether employees are happy and contented and fulfilling their desires and needs at work. In this study, it referred to the responses by professional nurses when interviewed, if they are happy at their work stations.

1.10.3 A health professional

A health professional or healthcare provider is an individual who provides preventive, curative, promotional or rehabilitative health care services in a systematic way to people, families or communities based on the primary health care approach (The World Health Report WHO, 2006:1). In this study health professionals referred to nurses who participated in the study.

1.10.4 Quality of healthcare

Quality health care is easily defined as doing the right thing (getting the health care services you need), at the right time (when you need it), in the right way (using the appropriate test or procedure), to achieve the best possible results, ensuring that patients are safe , meaning they are not harmed, care is patient centered based on their needs, in time, that is, patient do not have to wait unnecessarily, as well as not being wasteful of scarce resource such as time and money (WHO, 2006:1).

1.10.5 Healthcare facilities/ institutions

Health care institution means every place, institution, building or agency, whether organized for profit or not, which provides facilities with medical services, nursing services, health screening services, other health-related services, supervisory care services, personal care services or directed care services and resource like time and money (WHO, 2006:2). In this study, Clinics and Hospitals were regarded as institutions.

1.10.6 Stake holder

A stakeholder is anybody who can affect or is affected by an organisation, strategy or project. They can be internal or external and they can be at senior or junior levels. Some definitions suggest that stakeholders are those who have the power to impact an organisation or project in some way (Dembczyk and Zaoral, 2014:12). In this study, Clients, clinic health committees, hospital boards including mental health boards were regarded as stakeholders.

1.11 CONCLUSION

This general introductory chapter presented the background to the study, rationale for the study, the significance of the study, problem statement, the research objective and questions, theoretical framework and definition of concepts. The next chapter will deal with the literature review of the study, based on the following sub headings: Quality of health care services provision within the public health institutions, Challenges contributing to dissatisfaction among health care professionals regarding the provision of quality health care service in public health institutions, The views of health care professionals regarding the care offered to clients at public health institutions, Strategies that are currently used to improve quality health care services provision in public health institutions and Factors influencing quality health service provision.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The previous chapter dealt with the introduction and background to the study, this chapter will present the review of literature on strategies that facilitate provision of quality health care. This will be based on Donabedian's model consisting of the following components: Structural. Process and Outcome.

2.2 BACKGROUND

According to Mahlathi and Dlamini (2015:1), post 1994, the health system in South Africa, is comprised of the public sector (run by the government) and the private sector. The public health services are divided into primary, secondary and tertiary through health facilities that are in and managed by the provincial departments of health. The majority of patients access health services through the public sector District Health System, which is the preferred government mechanism for health provision within a primary health care approach. The private sector serves 16.0% of the population while the public sector serves 84.0%. This is so despite the fact that the private sector gets allocated more financial resources than the private sector. Despite the fact that healthcare services became more accessible with the restructuring of health care services to incorporate free healthcare services at point of contact, challenges were still experienced with regard to affordability, availability, adequacy and long waiting time. This led to decreased satisfaction by clients and service providers as well as a decrease in quality of healthcare. These challenges were related to shortages of staff and increased burden of disease (Scheffer, Visagie and Schneider 2016:5).This necessitated the need to develop strategies to facilitate provision of quality health care services.

2.3 DEFINITION OF LITERATURE REVIEW

A Literature Review is "a systematic, explicit, and reproducible method for identifying, evaluating, and synthesizing the existing body of completed and recorded work produced by researchers, scholars, and practitioners (Arlene, 2010:1; Pare & Kitsiou 2017:1).

2.4 PURPOSE OF THE LITERATURE REVIEW

Maggio, Sewell and Artino (2016:1) maintains that a literature review is important in that it provides an overview of previous research on a topic that critically evaluates, classifies, and compares what has already been published on a topic. It allows the author to synthesize and place into context the research and scholarly literature relevant to the topic. It helps map the different approaches to a given question and reveals patterns. A literature search forms the foundation for the author's subsequent research and justifies the significance of the new investigation. The researcher reviewed literature that identifies the research problem with the work of other studies with similar topics and content to avoid duplication. Research journals, books, internet reports and extracts ranging from 2009 to 2019 pertaining to Quality service provision were reviewed. Where such material were unavailable earlier journals, books and internet reports were used if they were deemed to be more relevant to study.

Donabedian's theory of Structure, Process and Outcome components of quality care has been used to explain the factors that facilitate provision of quality healthcare in health care facilities.

2.5 DEFINITION OF QUALITY

WHO (2006:1) defines quality of care as "the extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care must meet the following requirements:

Safe. Delivering health care that minimizes risks and harm to service users, including avoiding preventable injuries and reducing medical errors.

Effective. Providing services based on scientific knowledge and evidence-based guidelines.

Timely. Reducing delays in providing and receiving health care.

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

Equitable. Delivering health care that does not differ in quality according to personal characteristics such as gender, race, ethnicity, geographical location or socioeconomic status.

People-centred. Providing care that takes into account the preferences and aspirations of individual service users and the culture of their communities (WHO, 2006:1).

2.6 DEFINITION OF STRATEGY

Marnandes, Ferrira and Raposo (2014:2) believe that there is no single definition to fit all contexts. A definition can take differing meanings depending on context. A strategy can be defined as meaning anything from a precisely formulated course of action, an action that managers take to attain one or more of the organization's goals. On the other hand it can be a general direction set for the company and its various components to achieve a desired state in the future. Strategies results from a detailed strategic planning process. According to George (2017:328), Strategic Planning, can contribute to positive outcomes for public organizations. However, this may depend on how the strategic planning is done e.g the manner in which strategic plans are used by politicians during decision-making (i.e. as instruments for informed decision-making) and the participatory nature of the Strategic Planning process (involvement of internal and external stakeholders). For this study a participatory strategic planning approach was implemented.

2.7 DONABEDIAN'S MODEL

Donabedian, the American father of quality control, broke quality down in three components, namely structure, process and outcome (Ayanian, and Markel (2016:2).

Structure refers to the human and material resources and organizational framework that is necessary for the work to be done.

Process deals with how the service is carried out. This is the interaction between the nurse and other health care workers and the patient.

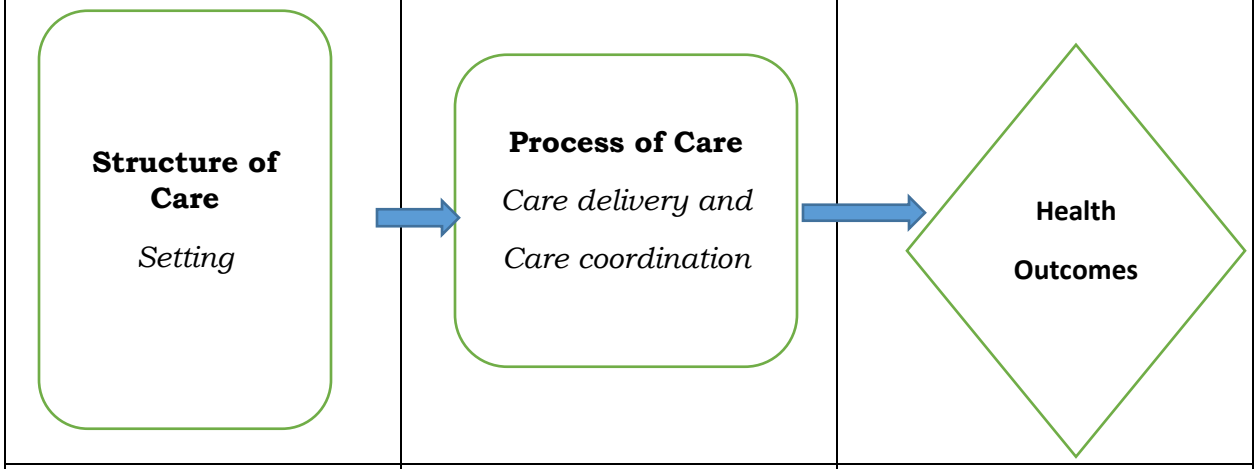
Outcomes are the end result of the care activities. Most people agree that the best measure of patient care is to look at the outcome (DeWan, Gage. Hirschhorn, Twum-Danso, Liljestr, Asante-Shongwe, Rodríguez, Yahya & Kruk 2019:3.) These components are interdependent, if the structure component is inadequate, this will influence service delivery in the process component. For instance if there is not enough staff or money to pay staff, there will be few nurses to see patients as well as provide preventative and curative treatment in the community. This means may lead to the outcome of high morbidity and mortality for the community. Because this study is not strictly in the clinical situation, the outcome have been adapted to involve service providers where applicable, in their case outcome will be employee satisfaction.

Ramani (2009:1) and Dwyer et al (2017:3) like Donabedian, noted that the quality of health provision in developed countries was much more advanced than in developing countries. Developing countries therefore were encouraged to avoid reinventing the wheel by learning from developed countries. The quality of health service provision meant optimising material inputs and practitioner skills. Their approach to improving the quality of service provision ensures that the following three elements are manipulated (Figure 2.1):

- Structure which refers to stable, material characteristics (infrastructure, tools, technology) and the resources of the organizations that provide care

and the financing of care (levels of funding, staffing, payment schemes, and incentives).

- Process is the interaction between caregivers and patients during which structural inputs from the health care system are transformed into health outcomes. In this study the interaction between the structure and employees were examined.
- Outcomes can be measured in terms of health status, deaths, or disability-adjusted life years: a measure that encompasses the morbidity and mortality of patients or groups of patients. Outcomes also include patient satisfaction or patient responsiveness to the health care system. It also includes employee satisfaction. The outcomes are dependent on the structure and process, hence, Peabody et al (2009:1) and Singer, Benzer, and Hamdan (2015:6) insist that the best approach to improving quality of service delivery is improving the structures and processes. In this study, Donabedians's model has been adapted and used to examine and explain the factors that are being implemented to facilitate the provision of health care provision in health facilities in department of health.



Implementation of White paper on transformation of public services Staffing Availability and maintenance of infrastructure Availability and maintenance of clinical equipment. Availability of Security services	Salary for professionals Respondents 's attendance to non-nursing duties Continuing learning /Opportunities for career development Working conditions Workload Monitoring and evaluation Referral of maternity patients implementation of monitoring and evaluation Involvement of stake holders in monitoring and evaluation. Manangement of Mental, orthopaedic and Acute MDR TB care Work load Working conditions	Communication Employee satisfaction 24 hrs service Availability of medicines Hygiene of facilities Waiting period Patient centred care Attitude of staff Respondents 's attendance to non-nursing duties Absenteeism Hospital stay

Figure 2.1. Categorising factors according to Donabedian's model (1966)

Adapted from: Donabedian, A (1966). Evaluating the quality of medical care. *Milbank Quarterly, 44*

2.8. FACTORS THAT CONTRIBUTE TO QUALITY OF POROVISION OF HEALTH CARE SERVICES.

2.8.1 Structure Factors

2.8.1.1 Implementation of White Paper on Transformation of Public Services (WPTPS)

In South Africa, the white paper as mentioned above was published by the Department of Public Services and Administration and implemented by departments (Department of Public Service and Administration, 1995:7; Department of Health, 1997:7). Since 1994 with the implementation of the white paper, access to government services have improved for many people in South Africa. However, reports by departments and studies undertaken highlight that government services were still not equally accessible to all South Africans, especially those in the rural areas. "There is an inefficient and ineffective mechanism for dealing with incapacity in terms of service delivery" (Department of Public Service and Administration, 1995:7).

2.8.1.2. Staffing

Nursing staff are the backbone of health care provision yet it is always plagued by severe shortages that negatively affect quality health care provision .The paper by Marc, Bartosiewicz, Burzvnska, Jchmiel and Januszewicz (2018:5) argued that the causes of nursing shortages were multifaceted with no single global or local measure of its nature. An overview of the problem indicated ineffective planning and use of available nursing resources, poor recruitment or an undersupply of new staff, and global demographic conditions. The overview also highlighted the fact that nursing shortages had reached a critical point for healthcare services on both the local and global levels. The general recommendations for nursing policy to improve shortages included the need to: improve working and employment conditions, implementing mechanisms regulating salary and providing the possibility of lifelong learning for the professional nurses. Logically quality of health care provision leans heavily on

this category of health care providers and any problems related to professional nurses would have an impact in quality health care provision (WHO, 2013:2; Awases, Bezuidenhout & Roos, 2013:4) These researchers therefore gave the following comprehensive approach to ensure that professional nurses and midwives contributed effectively to quality health care provision:

Firstly, because shortages and financial constraints pose many challenges to the professional nursing and midwifery workforce and to service provision globally, investment in attracting and retaining these health professionals was urgently needed to enable quality health care provision and to ensure equitable access to health-care services. In order to encourage participation and cooperation. Secondly, WHO (2013:9) also insisted that Professional nurses and midwives must have an evidence-based education that enables them to meet changing health-care needs. Thirdly the professional nurses needed to be able work both on their own and in teams with other professionals along the entire continuum of health and illness. Fourthly In addition, their work needed to be systematically evaluated to show its efficiency and effectiveness (Awases, Bezuidenhout & Roos, and 2013:4). And fifthly, as responsible and accountable stakeholders in the delivery of care, health personnel especially, professional nurses and midwives, must engage with the forces that drive health care and become more involved in policy-making (WHO 2013:2-9; Awases, Bezuidenhout & Roos, 2013:4).

According to WHO (2013:10), to achieve all the above the following steps needed to be taken:

- Developing and implementing effective strategies to recruit and retain nurses and midwives to achieve a critical professional mass, making good HRH deficits.
- Standardizing entry requirements for pre- and postgraduate education and qualifications to ensure professional mobility.
- Building a critical mass of competent educators to train the researchers and global leaders of the future.

- Promoting greater multidisciplinary integration into health-care delivery teams at all levels of the care continuum.
- Developing new and advanced practice roles with established career pathways from the outset.
- Making effective use of available education and training resources. Implementation of global standards in nursing education could also simplify recruitment practices and ensure the employment of practitioners who are competent and who by providing high-quality care promote positive health outcomes in the populations they serve (WHO, 2013:10).

The results of Griffiths et al (2016:3) in their research in Switzerland, on improving health quality for nurses was able to confirm the suggestions above as follows:

- Research has shown that adverse events and mortality were highly dependent on professional nurse staffing levels and skills-mix.
- A significant reduction in morbidity was reported with increases in registered nursing levels, but these findings did not hold true for increasing staffing levels of licensed practical nurses or nurses' aide.
- The skills and levels of education of the nurses was important in the provision of quality of health care.
- Adequate nurse staffing levels led to increased staff retention, job satisfaction, productivity, and better outcomes.

In Nigeria, Olabode (2015:1) and Aluko, Anthea, and Modeste (2019:3) painted a dismal situation where the country seems to be still dealing with all the problems that are related to shortage of professional nurses: Non-conducive work environment, lack of discipline on the part of the professional nurses and lack of equipment, in addition, professional nurses and the profession itself are still

looked down upon. Professional nurses do not participate in policy- making and there is lack of continuous education for professional nurses (Olabode, 2015:1).

To address the huge human resources for health gap in Zambia, which hindered quality service provision, the Ministry of Health launched the National Community Health Assistant Strategy in 2010. The strategy aimed at integrating community-based health workers into the health system by creating a new group of workers, called community health assistants (Zulu, Hurtig, Kinsman Michelo, 2015:1). According to WHO (2013:1), the quality of health care in Zimbabwe was very low and there was 7.2 nurses for every 10 000. This was a result of failure by the country to contain and manage the loss of health sector personnel due to unattractive personnel incentives, poor or unequal personnel distribution within the sector and low turnout from the training of health workers.

In South Africa, the findings by Manyisa (2017:2) and Aluko, Anthea and Modeste (2019:1) and Mokoena (2017:1) concurred that shortage of health professionals in general and in the maternity wards had negative impact on provision of quality patient and women were not receiving quality maternal and neonatal cares at the maternity centres. The SA Health Review (2010:172) also highlighted the following regarding staffing in South Africa.

- The fact that 30.0% of doctors and15.5% of pharmacists and many nurses were employed in the public sector yet only a minority of these public sector workers were based in rural areas – where 43.0% of the population resides. This was because the working conditions in the rural areas were not conducive to satisfaction because of lack of resources to work with as well as resources to live with such as schools and entertainment. The researchers rightly suggested that access to health workers in remote and rural areas should be increased through improved recruitment and retention strategies. This was regarded as critical to improving the rights of rural communities to comprehensive, quality health care.

- There was enough evidence to show that universities were not training enough health care workers to meet the country's needs, and that health care professionals were least likely to work in rural areas. It was suggested that universities be given inputs on what skills were in demand so they could redirect their training appropriately.
- Data showed that vacancy rates for public sector medical practitioners in Limpopo reached a peak of 84.0%, while 66.8% of professional nursing posts were vacant in the Eastern Cape (both largely rural provinces). Further analysis showed that the Western Cape had more than double the number of doctors per 100 000 people than North West Province moreover, a study of the HR requirements for Primary Health Care (PHC) in South Africa in six of the poorest districts found only 7.0% of required doctors.

2.3.1.3 Medical equipment

Availability and maintenance of medical equipment is essential for smooth functioning in health facilities and contributes a lot in provision of quality healthcare Developed countries like UK seem to have a well-planned procurement and maintenance of equipment while developing countries do not.

Wyke (2009:1) and Moyimane, Matlala and Kekana (2017:1) in the UK and SA respectively acknowledged that faulty or lack of equipment hindered quality of service provision and could harm patients. The UK responded to this with the establishment of a medical equipment program that was being applied by all UK hospitals that included preventive maintenance, repair, and documentation of medical equipment. Medical equipment was categorised according to its use in the patient-care setting and was evaluated, based on established criteria for level of inclusion in the medical equipment management program with good effects. This meant that maintenance was part of the plan from before and after equipment was bought. This then minimised the chance of patient harm in the country's hospitals.

Shortage of equipment in Zimbabwe is a serious problem as well Worldnews reported that Senior doctors at Parirenyatwa General Hospital, Zimbabwe's biggest medical centre, hold placards during a demonstration to protest a lack of medicines, equipment, gloves and bandages in Harare, Zimbabwe (Bulawayo, 2019 p1).

Mokoena (2017:10) in the study conducted in South Africa revealed that the shortage of health professionals and inadequate resources like equipment had a negative impact on provision of quality patient care. This was confirmed by Mdunjwa (2015:1) who while leading the parliamentary monitoring group found that problems related to procurement of equipment was exacerbated by the fact that most provinces had a centralized approach to procurement with subsequent result of delaying procurement and purchase of poor quality equipment facilitated by the supply chain management process of selecting the cheapest quot. The result of purchasing the cheapest was that the equipment does not last long, becoming more expensive in the long run.

2.8.1.4. Infrastructure

WHO (2012:3) considered good quality infrastructure as a key component to sustainable health care service provision. Efficiency and sustainable health care cannot be optimised with poor infrastructure. Superior infrastructure promoted the efficiency of health professionals and thus, the level of quality so they could deliver the much needed services. Developed countries like the UK are on track regarding maintenance of infrastructure in health, they have developed programmes of infrastructure maintenance WHO (2012:3). Chilufya (2017:80) in the strategic plan developed in Zambia, highlighted that infrastructure in Zambia was in dire straits and there were no resources in the government or the private systems to maintain the current hospital infrastructure. According to Blas and Limbambaia, (2011: 3) and Khumalo, Choga and Munapo (2017:3), most of the public hospitals are in a state of disrepair owing to long periods of

underinvestment. In order to improve the situation, a hospital upgrading programme had been embarked upon. This was negatively affecting provision of quality healthcare provision. The problem could only be solved by planners and politicians who needed to take decisions to invest in infrastructure and its maintenance. Khumalo, Choga and Munapo (2017:3) in the study conducted in South Africa, were able to affirm that there was also major inefficiencies in the current infrastructure delivery model of the South African government. Major causes identified included factors such as inadequate infrastructure, inadequate maintenance, delays in payments, poor planning, subsiding levels of professional ethics and low standards exercised by professionals in the built environment, etc.

Dornan (2012:31) also suggested that provision of adequate funding, establishing appropriate incentive for maintenance and involving the private sector would ensure quality infrastructure. According to The Presidency (2014:1), donors needed to ensure that maintenance was provided to the physical infrastructure that they finance. Hence the Department of Health South Africa supports the "Management Bill", clauses 5(1) (c) and (e) which described infrastructure maintenance as follows: "Infrastructure is a means to an end. It supports quality of life and the economy if it delivers accessible and reliable services that individuals and institutions need. Infrastructure maintenance must be regarded as a strategic tool to promote improved service provision" (The Presidency, 2014:1).

2.8.1.5 Availability of Security

Smith (2016:3) and Macwan (2019:1) in the following articles respectively "Establishing a hospital security plan that works, Health facility management" and "The Role of Security Service in Hospitals – Explained! Availability of security services" both concurred that security services in hospital facilities was very critical in that it is responsible for ensuring the security and safety of the hospital plant, personnel, patients and public as well as regulating the traffic within the

hospital premises. While developed countries have achieved a high level of security in their facilities developing countries more especially in Africa and South Africa in particular are still battling to ensure the security of their healthcare personnel and patients. In South Africa, this was confirmed by Mojela (2018:p15 of 77) who reported **a**n armed robbery at the Letaba Hospital residence that saw three doctors shot and injured by men who entered the doctors' residence in the early hours of a Thursday morning has impacted badly on the province, jeopardising 24-hour health care. According to Okeke and Mabuza (2017:1) and; Stevenson, Jack, O'Mara and LeGris (2015:1), health workers are sometimes a target for both verbal and physical violence by patients. Adequate security is necessary for optimum delivery of service, an establishment therefore needs to ensure a safe and secure environment.

2.8.2 Process Factors

2.8.2.1 Salaries for professional nurses.

Salaries play a very important role in staff retention and improvement of performance and quality of services rendered. In a study conducted in Burundi, Rudasinwa and Uwizeye (2017:1) found that the salary top-ups for nurses and doctors were recognized as the most significant impetus to increase effort in improving the quality of care. This study therefore found that Performance Based Financing of salaries in particular had more potential to motivate medical staff to improve healthcare provision. The views of medical staff and the context of the area of implementation have to be taken into consideration when designing and implementing PBF schemes.

According to Werner, Konetzka and Polsky (2013:3), the use of pay-for-performance (P4P) to improve health care quality has become commonplace in the United States. P4P is based on the principle that provider payment should be determined by quality of care rather than intensity of care. Accordingly, P4P provides financial rewards on the salaries to providers who perform well on accepted measures of quality and shifts emphasis toward the quality rather than

the quantity of care. Werner, Konetzka and Polsky (2013:3) conducted a study on nursing homes that were benefitting on the scheme. Three clinical quality measures (the percent of residents being physically restrained, in moderate to severe pain, and developed pressure sores) improved with the implementation of P4P in states with P4P compared with states without P4P. The researchers were only concerned that the results may be not consistent.

South Africa is experiencing a serious shortage of nurses. Mokoka, Oosthuizen, and Ehlers (2010:4) and Brits, (2019:1) found that among other things salary plays an important role improving quality healthcare service. According to Mokoka, Oosthuizen, and Ehlers (2010:4) and; Hassana and Selvarajah (2015:3), nurse managers identified the importance of monetary and non-monetary rewards in order to increase retention and therefore improve quality of healthcare provision. Monetary rewards were mainly competitive salaries, performance bonuses and scarce skills remunerations. Non-monetary rewards included extended leave, promotions and creating facilities for child care and recreation. Participants viewed salary as the primary source of job dissatisfaction amongst professional nurses, and also did not think that messages of encouragement and congratulatory notes recognising good performance would make any difference to motivate nurses.

2.8.2.2. Nurses used for non-nursing duties

Because of shortages support staff like cleaners, porters etc., and nurses mostly find themselves performing non nursing duties in the interest of their patients. Unfortunately this sometimes make them neglect nursing duties. Such a situation have a potential to compromise quality health care provision.
Al-Kandari and Thomas (2009:1) and Bekker et al (2015:3) conducted studies in Kuwaiti general hospitals and SA and found that the nurse to patient ratio was very low with increased patient loads, resulting in increased frequency of nurses performing non-nursing tasks, which resulted in incompletion of nursing activities during the shift. Commonly nurses could not complete the following

nursing tasks: comfort talk with patient and family, adequate documentation of nursing care, oral hygiene, routine catheter care and starting or changing fluid on time. Al-Kandari and Thomas (2009:1 and Bekker et al (2015:3)) therefore suggested that emphasis should be given to maintaining the optimum nurse-patient load and decreasing the non-nursing workload of nurses to enhance the quality of nursing care.

Ball, Murrells, Rafferty, Morrow and Griffiths (2013:1) after a study conducted among the National Health Service Hospitals in England on care left undone also found that the low nurse patient ratios significantly affected the incidence of missed care and adversely affected quality of services and safety in hospitals. Nursing tasks left undone cause the greatest degree of job dissatisfaction amongst professional nurses and undermine provision of quality health care service. Support services should be employed and efficiently managed and used.

According to the study done by Grosso, Tonet, Bernard, Corso, De Marchi, Dorgio, Lessu, Oppio Pais dei Mori and Palese (2019:1), in Italy nurses perform various non-nursing duties, over and above their healthcare professionals' role. They do this mainly as a result of their felt moral obligation to offer the best to their patients. For example the nurse may feel obliged to scrub the floors if dirty before giving medicines to the patients. While this may be regarded as morally good, it have been found to negatively affect quality health care provision. Bekker, Coetzee, Klpper and Ellis (2015:3) found that nurses with non-nursing tasks tended to leave some nursing duties undone, experienced high level of patient adverse events and also experience greatest degree of job dissatisfaction Non nursing personnel should perform relevant duties, to release nurses to perform their professional responsibilities.

2.8.2.3 Opportunities for career development

Many things are changing rapidly, as national boarders continue to disappear and technology advances, healthcare workers require continued development in order to ensure the delivery of safe, quality healthcare services. Gesme, Towle and Wiseman (2010:1) and Smith et al (2019:1) in the study conducted with healthcare professionals found that encouraging staff to improve their careers through further studies added the following advantages: Employee retention, Staff morale, Practice efficiency: Job competency: Quality health care provision and Patient satisfaction. A similar study was done by Price and Reichert (2017:5) who found that Training and education were directly linked to nurses' career satisfaction. Healthy work environments were identified by nurses as those that invested in continuing professional development opportunities to ensure continuous growth in their practice and provide optimal quality patient care. Training and education emerged as a cross-cutting theme across all career stages and held implications for patient care, as well as retention and recruitment.

Poudel Panthi and Sharma Pant (2018:2) conducted a study on importance of Continuous Professional Development (CPD) and found that Results show that there exist personal and organizational benefits when employees participate in routine CPD activities. They are, increased job satisfaction, job retention, professional growth and the provision of high quality patient care. According to the literature, the motivating factors for CPD include an increase in the following: clinical competency, job security, health promotion and the enhancement of well-being at the workplace.

2.8.2.4 Absenteeism

Absenteeism refers to people who are illegitimately not at work their absence causes problems with provision of quality health care services. Kisakye, Tweheyo, Ssengooba,Georg, Pariyo, Rutebemberwa and Kiwanuka (2016:1) confirmed that absenteeism is an employee's intentional or habitual absence from work. Excessive absences result in decreased productivity and where health care

services are concerned, absenteeism reduces the effectiveness of health care provision and compromises the quality of services because fewer workers are left on duty, resulting in work overload or interrupted service delivery. For example Goldstein, Zivin, Habyarimana , Eleches and Thirumurthy (2013:2) found that that professional nurses's absenteeism was related to reductions in child and maternal health. For this reason Govule, Wananda and Katangole (2015:1) recommends the following: managing the attendance register and absence records implementing employee motivation practices while addressing the socio-demographic characteristics (that predict absenteeism) along the continuum of the hierarchy of needs could further reduce absenteeism. Supervisors therefore should make attempt to find out the problems that causes the official to be absent and or refer to places that can offer assistance to the official (Govule, Wananda & Katangole, 2015:1).

2.8.2.5 Working Conditions

Working conditions need to be conducive to work and make health care providers happy (Mafini and Pooe, 2013:1). Heathfield (2014:2) maintained that human resources are the most important among all the resources in an organization and it is very crucial to retain an efficient experienced, motivated and content workforce by facilitating the implementation of the five satisfaction factors, namely working conditions, ability, utilisation, creativity, teamwork and autonomy because they are key to facilitating quality health care improvements. Various studies on this issues were conducted identified factors negatively affecting the performance of nurses such as: lack of recognition of employees who are performing well, and an absence of formal performance appraisal system as well as poor working conditions (Awases et al., 2013:1). Awases et al (2013:1) also discovered that the number of nurses was not the only thing that was important, but the skills that they possess was equally important. Health care workers need training to deliver the standard of services required from them .In general nurses were overworked demoralised and burnt out (Awases, et al., 2013:1).

Implementation of Performance Management Policy implementation for professional nurses is therefore very critical for improving quality service provisions. This is so because performance management has the potential to increase the productivity of health workers significantly, by improving knowledge and skills, changing attitudes, and ensuring workers feel appropriately recognized as valued members of the wider health system. Performance management can include many elements, such as supportive supervision, job descriptions, continuous education and performance appraisal. Fostering positive work environments in this way can significantly improve recruitment and retention, and subsequently the quality of health care provision (WHO, 2013:35).

2.8.2.6 Workload

Increased workload means nurses' perform much more work than is normally required of them (Allen & Delahunty 2010:311; Harvei et al., 2020: 1).
This mostly happen because there may be very few professional nurses against the number of patients that need to be served. Kaur and Gujral (2017:1) in a study done in India, further highlighted the fact that heavy workload may affect the nurse-patient relationship due to lack of enough time for communication between patients and nurses. The nurses may also be affected as follows:, dissatisfaction among nurses because of the unsafe conditions for patient care, errors and poor job performance turnover, absenteeism, low morale, and poor job performance.

Khademi, Mohannadi and Vanaki (2015:2) through the study conducted in Iran on Resources–tasks imbalance: Experiences of nurses from factors influencing workload to increase discovered that a deep and comprehensive imbalance between recourses and tasks and expectations existed and was deemed to be the main source of work overload. There was a strong suggestion to pay more attention to resource allocation, education of quality workforce, and job description by managers. Yaylak, Çalışga, Karakaş, Mert, Öncel, Köse, Yücel and Inali (2015:1) conducted a study on volunteers from the University Faculty of

Medicine Hospital clinics in Turkey and found that increase in workload disturbed sleep patterns which affected nurses mentally and reduced their effectiveness in doing their job and causes lots of stress. The findings of this study were supported by Koroko and Sandal (2019:1) in their study of Ghanaians OPD nurses who confirmed that higher levels of workload were related to higher levels of job stress and poor performance.

2.8.2.7 The SWOT Analysis and development of strategies

The SWOT analysis is another approach to developing strategies to enhance service delivery provision. SWOT analysis is an examination of an organization's internal strengths and weaknesses, its opportunities for growth and improvement, and the threats the external environment presents to its survival. Originally designed for use in other industries, it has gained increased use in healthcare (Harrison, 2010:5; Daemmerich 2016:1).

Organisations and departments have been successfully using the approach to develop strategic plans. As a methodology for strategic positioning the SWOT analysis has been extended beyond companies to countries and industries and is used in virtually every published business. The additional use of SWOT is as a teaching tools by consultants, trainers and educators (Nixon, 2010:4; Asiana et al., 2014:1).

Afghanistan had been having problems with provision of quality healthcare services as it was difficult for them to prioritise and implement improvement plans. Turkey has also had been undergoing structural changes since 2005 in healthcare. These changes forced the country to reorganize its developing healthcare system. A SWOT analysis was done, by both countries. The SWOT analyses benefited both countries as at the end Strategies to improve health care service delivery were developed and implemented. Through the SWOT analysis Turkey was able to notice the fact that the quality of healthcare was definitely

low although health workers were able to see many patients (Ministry of Public Health Kabul, Afghanistan, 2011:4; Asiana Cinarb & Ozenec, 2014:3). The researcher used the SWOT analysis to categorise the results of the qualitative and quantitative approach and develop strategies to enhance the improvement of quality service provision in the Department of Health Limpopo Province, South Africa.

2.8.2.8. Referral: Maternity patients

The importance of a functional referral system can never be over emphasized. Studies have identified several factors (e.g. accessibility, acceptability, efficiency and effectiveness) that might influence a referral system and its usage. In most countries, patients often bypass these facilities and go directly to district hospitals, resulting in increased caseloads (Mojaki, Basu, Letshokgohla & Govend, 2011:2 ; Kruk et al 2013:1) Reasons for by passing the referral system vary as follows: cultural values where woman cannot make own decision without relatives, demografic risks and lack of knowledge (Pemba, Mbekenga , Olsson & Darj, 2017; Pembe Carlstedt, Urassa Lindmark, Nyström & Darj, 2010:2; Magoro (2015:2). In the United Republic of Tanzania, Kruk, Hermosilla, Larson and Mbaruku (2013:1) found that the United Republic of Tanzania has a policy of free delivery at clinics. Despite this and challenges of higher costs in transport to the hospital, nearly 16% of patients who bypassed reported having to borrow money or sell household assets to finance delivery, a measure of financial hardship that can lead to impoverishment. These findings above were further supported by the study conducted in South Africa by Mashishi (2012:6). According to the results of this study, the majority of low risk women who delivered their babies at Dilokong hospital were self-referred, while a high proportion of health practitioner- appropriately referred women to deliver at the hospital.

2.8.2.9 Monitoring and evaluation

Monitoring and evaluation is important in ensuring provision of quality health care services. It enables service providers to identify challenges and develop improvement plans to address them. The European, developed countries regard monitoring and evaluation as a very important strategy of improving health care service provision. They therefore have monitoring and evaluation guidelines in place for each programme. Unlike in developing countries, they have reasonable human and financial resources which they implement effectively (WHO, 2012:5). Guidelines for monitoring and evaluation of health service in low to middle income countries in sub-Saharan African countries have been developed but scarcity of resource hinders progress. However, a handbook was written to guide, monitoring and evaluation, considering the scarcity of resources
(WHO, 2012:5; The Department of Monitoring and Evaluation, 2013:9).

Meanwhile, monitoring and evaluation always came from the service providers who needed to account for the resources spent on a project, it always left the community members behind and uninvolved. In participatory monitoring and evaluation, stake-holders from the community are involved. In Kenya, it's participatory monitoring and evaluation in a nutrition project (Makueni Community-Based Nutrition project). This project was successful and was replicated in other countries such as Zambia, reviewed effect of community participation (Estrella & Gaventa, 2009:3; Hadane et al., 2019:2).

In Malawi communities participated by using community score cards in monitoring service provision (Wild and Harris, 2012:1). Another reason for monitoring and evaluation(of burden of diseases) was identified by Christopher, Murray, Alan and Lopez (2013:1) and Schwartz, Dunke, Akiteng, Barindwa-Malee, Kagimu, Mondo, Mutungi, Rabin, Skonieczny, Sykes and Mayanja-Kizz (2013:4).The reason was so that projections could be made to deal with diseases in future.

The main aim of the new government in 1994 was to among other things transform the health services so that quality of health service provision can be improved in South Africa. The national health plan, developed by the new democratic government outlined the following strategies to improve the quality of health services (African National Congress, 1994:8); (African National Congress Policy Documents, (1994:1). Implementation of those strategies need to be monitored hence the establishment of the monitoring and evaluation section (Gopane, 2012:90; Kariuki, Purshottama & Reddy 2017:1).

In the Department of Health in Limpopo, community members were not yet involved in monitoring service delivery. It was however, a viable option since South Africa is catching up with this notion since Republic of South Africa became democratic. The Department of Monitoring and Evaluation, (2013:9) outlined and defined plans to introduce a community-based Monitoring approach that was called Citizens-based Monitoring and would involve the citizens as they are the intended beneficiaries of public service. This was important because monitoring was dependent on government process and the voice of the citizen is mostly "absent". As a democratic nation, the voice of citizens is integral to building a capable, developmental state in South Africa, but more than anything else improving service provision is the most important aim (The Presidency, 2010:10).

2.8.2.10 Management of patients

2.8.2.10.1. Patient centred care

Treating people as individuals is very important. WHO (2015:1) came up with the WHO global strategy on people-centred and integrated health services. Countries the world over are confronted with challenges related to people living longer than before, resulting in long-term chronic diseases and threats that the quality of health care provision may decline. The WHO global strategy presented a compelling vision of a future in which all people need to have access to health services that are provided in a way that responds to their preferences, is well

coordinated around their needs and is safe, effective, timely, efficient, and of an acceptable quality. The WHO global strategy also presented a compelling vision where countries could implement a people centred and integrated health service (WHO, 2015:1). In general health professionals view clients and individuals with individual needs and also need to be empowered to manage their own health and administer their own treatment (Araki, 2019:5). Wyke (2009:2) and Araki (2019:5) conducted a survey on the views of professional nurses on patient centred care. The survey found among other things that more than 80% of respondents say patient-centred care was very important, or even critical, because it would contain the cost of healthcare spending and improve standards of medical care. The professionals identified lack of political will to change as a stumbling block (Araki, 2019:5)

Berghout et al (2015:1) also confirmed Araki (2019:5) findings that quality improvement efforts should recognise the needs of patients, insurers, regulators, and staff and the fact that, for the strategy to work, there should be a buy-in by the government of the day. In Australia implementation of patient centred care was successful because there was a buy in from the government. The government invested resources to the project .The health minister and federal health commission ensured that healthcare was safe, effective and easily accessible at all levels of provision and patients are well informed and involved in the processes behind the provision of health care (Hughes, 2008:44). In Australia patient centred care have been advanced to a higher level. There is patient and family centered care; meaning that each patient and their family would experience compassionate care, they would feel informed, supported and listened to, and would be engaged and involved in their care. A website for patient care experiences have been developed and ensures that clients can access information about the facilities independently and make informed choices about which facilities they can visit for care. Measures of patient care experiences and indicators have been standardised to ensure comparison of data across sections

of departments, national and international departments of health (Luxford et al., 2010:7; Waitemata District Health Board Quality Strategy, 2013–2016:1).

In South Africa after 1994, access to health care (within available resources) became an entrenched right in the constitution of South Africa. Section 27(1). The constitution stated that 'everyone had the right to have access to health care services including reproductive health care. No one could be refused emergency medical treatment' and according to Section 28 (1) every child had the right to basic health care services. Despite this approach quality of healthcare services is reported to have deteriorated (African National Congress, 1994:1). Governments the world over, including South Africa then realised that improving access to health services was not enough but it was also very important to improve how care is provided and incorporate patient centred care (McClellan, 2013:2).

2.8.3 Outcome Factors

Here the literature search was be on the outcome or results of health care provision which is said to be the best measure of patient care is to look at the outcome. Because of the nature of the study Employee satisfaction was included as outcomes (Xesfing & Vozikiz, 2016:1).

2.8.3.1 Employee satisfaction

In this study Employee satisfaction was treated as an outcome because this is not strictly a clinical setting study and it's a result of structure and process factors. However, this study considered the client satisfaction as a significant outcome of the structural and process factors and designed a questionnaire to study it (client satisfaction). Khamlub, Harun-Or-Rashid, Sarker, Hiromasa, Outavong and Sakamoto. (2013:1) defined job satisfaction as how employees feel about their jobs and different aspects of their jobs. Job satisfaction is one of the important variables in work and organizational psychology, is regarded as an indicator of working-life quality, and is a crucial variable used to determine the

quality of health-care system. WHO (2015:3) and Heathfield (2014:2) concurred that human resources are the most important among all the resources in an organisation and it is very crucial to retain an efficient experienced, motivated and content workforce because they are key to facilitating quality health care improvements. It was therefore suggested that strategies to improve quality of care need to target the competence, effort and attitudes of healthcare providers either directly or indirectly with the objective of improving their job satisfaction with its subsequent improvement of the quality of the patient-provider interaction. Job satisfaction or employee satisfaction is therefore sought worldwide in a bid to improve the quality of healthcare services.

Various studies in different countries have been done to identify the status of employee satisfaction as follows:

According to Kavanagh Candiotti, Abusalem and Coty (2012:385), new nurses in the USA were not satisfied because they felt they were not treated with respect as professionals. They were required to work at speeds similar to those of an experienced nurse with heavy workloads, and too many demands. This undermined quality healthcare provision because of the potential to make mistakes. Wyke (2009:1) and Araki (2019:5) conducted a study in various countries about the views of health professionals on the services they provide to the public and different opinions were brought forward. Though the healthcare professionals in developed countries were generally satisfied with their jobs, they were skeptical and viewed service delivery as having slowed down in last two years In other words, the citizens' overall wellness was no better now than it was two year ago and a significant number said it had deteriorated The UK, US and Germany professionals were however, less confident that their systems can cope with increased demands (Wyke, 2009:1; Araki, 2019:5). While the developed countries' reports shows a stagnation in health systems, in some developing countries like India the health professionals pointed to satisfaction with improvements across the board in the Indian Health system. More than 50% say the system is efficient and effective, with better training and easier access to the

latest treatments. It is however important to note that developed countries may have reached a kind of saturation point, having implemented all the advanced technologies.

The Indian Health system was having room for improvement though service was still basic in many respects (Araki 2019:5). The Minnesota Satisfaction Questionnaire (MSQ) was tested in a typical public sector organisation in sub-Saharan Africa. A very low level of job satisfaction was indicated, and more than (83%) of respondents indicated dissatisfaction in their pay and the amount of work they do. In most cases shortage of staff, dilapidated unsafe buildings and lack of functioning equipment were said to contribute to job dissatisfaction (Abugre, 2014:1; Cooke, Couper & Versteeg 2011:9) Health service providers in Ghana viewed were not happy the NHS scheme as it was not able to pay for services on time undermining the need for cash flow for service providers. The service providers therefore were inclined to view insured clients negatively in favour of the affluent and uninsured because they would be able to make instant cash payments for healthcare services (Dalinjong and SunkLataa 2012:1; Stevens, 2019:1).

In Tanzania and South Africa, studies that were conducted by Aongstad, Moland, Massay and Blystad (2012:1 and Stevens (2019:1) respectively showed that the healthcare workers were content to work in church-run hospitals generally as they were better equipped with equipment and infrastructures and provided better quality patient care. The public sector was only favoured for pension scheme benefits, to cater for old age. Most health workers would be happy to work where they would get pension benefits in old age than in well-equipped hospitals without security for old age. This was confirmed by results of a job satisfaction survey conducted in South Africa (Mohase & Khumalo, 2014:4).

Mafini and Pooe (2013:1) in South Africa confirmed from their study that job satisfaction improves productivity and performance. 83.5% of respondents agreed that job satisfaction affects the way they met their responsibilities. Five employee satisfaction factors, namely working conditions, ability, utilisation, creativity, teamwork and autonomy. Team work had the greatest impact on organisational performance. This meant that the improvement or not of these factors affect job satisfaction and quality health care service provision. Ditlopo, Blaauw, Penn-Kekana and Rispel (2014:7) found that a third of participants planned to leave their employment because of burnout.

Therefore, to improve the quality of service provision, it regarded as important that employees have a high level of satisfaction in the workplace. Dieleman and Harnemeijer (2006:2) and Munga and Mwangu (2013 :1) through their studies, in their respective countries, confirmed the importance of comprehensive approaches to address the Human Resources for Health retention and performance problems, sufficient financial resources and the contribution; commitment and buy-in of all stakeholders, such as the ministries of health, finance and education; professional associations and funding agencies, was important in improving quality health service provision. Institutional capacity at central level facility level needed to be strengthened. In addition, the basic principles to be considered more concerning health worker detail as follows:

Previous studies in South Africa only looked at the impact of development of strategies to improve provision of quality health services. Such studies were never done simultaneously on service providers and recipients of care but was done on either service providers or recipients using only one method viz Qualitative or quantitative at a time. The researcher identified this gap. The researcher sampled the hospitals and clinics, stakeholders and clients from hospitals and clinics for the study. Two research approaches were used viz: the qualitative and the qualitative. A SWOT analysis was done on data derived from the service providers, stake holders, clients and literature search. This approach was expected to add more values to the study.

2.8.3.2 Client Satisfaction

Xesfing and Vozikiz (2016:1) defined Patient satisfaction as an important measure of healthcare quality as it offers information on the provider's success at meeting clients' expectations and is a key determinant of patients' perspective behavioral intention. Tateke, Woldie and Ololo (2012:1) and Zhou et al (2017:1) supported the above mentioned definition by maintaining that Client satisfaction was a good indicator of service quality provision of services that meet the standards set. The higher the satisfaction rate the better the quality of services. Clients usually expressed dissatisfaction with services through complaints, suggestions and protests (In districts about hospitals). Client satisfaction is also described as a gap between the Clients 'expectations and the actual experiences of the service. Clients' expectations normally increase over time. As that happens, the quality of services must keep on improving to maintain or increase clients' level of satisfaction According to Tateke et al (2012:1) and Zhou et al (2017:1), various countries as well as hospitals had different levels of satisfaction.

In the United Kingdom (UK) hospital studies on Client Satisfaction found that clients there had a high satisfaction rate (Williams and Calnan, 2013:6). The clients' overall levels of satisfaction were mostly associated with access, availability and type of service provision. The general levels of satisfaction were as high as 95%. The UK rates highly on patient experience compared to other countries. A 2011 Commonwealth Fund study of eleven leading health services providers reported that 88% of patients in the UK described the quality of health care provision they had received in the last year as excellent or very good, ranking the UK as the best performing country. However, the data also showed that the UK lagged behind with regard to the coordination of care and patient-centred care (Williams & Calnan, 2013:6).

In a more current study Dyer, Owens and Robinson (2016:6) suggested that trust in clinicians and services was likely to be a better indicator of acceptability and quality than what they call "the illusive and transitory concept of patient satisfaction". They believe trust in clinicians and health care should be emphasised more in ensuring quality of health care provision than is happening currently. On the issue of trust in the clinicians, Croker, Swancutt, Roberts, Abel and Campbell (2013:1) conducted a study in a primary health care setting in the UK. The study aimed at investigating the relative contribution of the patient's ratings of interpersonal aspects of the consultation and their confidence and trust in the clinicians. The study found that the patient's age and ethnicity influenced how services were provided and how service provision was perceived. The older the client, and clients of European origin, felt that they could trust the clinician and therefore rated services as of high quality. On the other hand, those of non-European descent felt like they could not trust their clinicians completely and therefore rated the quality of services as of lower quality.

In Singapore, a comparative client satisfaction survey was conducted in ten public institutions. The comparison created motivation and competition to excel (Ministry of Health in Singapore, 2012:17). They conducted and compared clients' satisfaction survey of ten public institutions. They found that specialist outpatient clinics showed the biggest improvements among healthcare institutions in the 2012 patient satisfaction survey. This created motivation and or completion in all institutions to want to perform better and this helped improve service provision. Personal safety and cleanliness of facilities was regarded as the most important variable in the survey (Ministry of Health in Singapore, 2012:17).In Kenya, however, it was found that users of private and public health services were more likely to be very satisfied with health services than their counterparts who seek health care from traditional healers and pharmacies/over the counter-drugs. However, consumers of private health services were approximately 12 percentage points more likely to be satisfied than

subscribers of public health care (Nkentiah-Amponsah & Hiemenz, 2009:3; Young, 2016:2).

A study of client satisfaction compared responses of patients in public and private institutions hospitals in Addis Ababa Ethiopia, on the following variables: Expectation about the services, perceived adequacy of consultation duration, perceived providers' technical competency, perceived welcoming approach and perceived body signaling, were determinants of satisfaction at both public and private hospitals. They found that clients were more satisfied in the private hospitals than the public hospitals (Tateke, Woldie & Ololo 2012:4; Zhou et al., 2017:1). Khumalo (2013:1) also considered patient satisfaction as an important outcome of health care services and one that should be regarded as one of the desired outcomes of care. In the study she conducted in a Germiston hospital, South Africa, the results revealed there were varying levels of satisfaction with services during labour. Cleanliness, privacy and information sharing by nurses were viewed by women as adequate. In contrast, pain relief, time spent explaining procedures and information sharing by doctors was rated as unsatisfactory. These three factors should be considered when designing quality improvement programmes in the maternity department (Khumalo, 2013:1).

Lumadi and Buch (2011:1) and Adhikary et al (2018:2) in their study at a regional hospital of Limpopo and in India respectively discovered similar outcomes to Khumalo's study. In their study, mothers were mostly satisfied with the general cleanliness of the ward; the information provided by nurses about looking after themselves and their babies at home, including breastfeeding; the way privacy was maintained; and the thoroughness of examinations done by doctors and midwives. However, mothers were most dissatisfied with aspects concerning inadequate explanations of procedures and the lack of their involvement in decisions related to their care. Lack of pain relief during labour was also a serious concern. In this study six outcome factors were identified and examined as indicators of client satisfaction as follows:

2.8.3.2.1. Understanding language

Without communication in a language that both parties understand it would be difficult to assist the clients that visit the health facilities. According to Meuter, Gallois, Segalowitz, Ryder and Hocking (2015:2), it is important to understand the role that language plays in creating barriers to healthcare is critical for healthcare systems like South Africa, that are experiencing an increasing range of culturally and linguistically diverse populations both amongst patients and practitioners. Röysky (2015:3) from Russia emphasized the importance of native language use is particularly important in the beginning and end of the health care service process.

2.8.3.2.2 Twenty four (24 hours) services

It is very important that health care services be provided around the clock, in South Africa it is called 24 hours services while in USA it might be called afterhours care. Providing this service is problematic and costly more especially in developing countries. Depending on the financial status and how busy the facility is, an approved number of officials should always be on duty. O'Malley, Samuel, Bond and Carrier (2012:7) found that such care is poor even in USA. Becker, Dell, Jenkins and Sayed (2012:I) and and Visser, Marincowitz and Ogubanjo (2015:1) brought forward the fact that some patients find clinics that do provide 24 hours services unacceptable because of shortage of staff and medicines etc. They therefore automatically go to the hospital or health center. This need to be improved increased acceptability of the PHC services is needed.

2.8.3.2.3 Availability of medicine

Medicines are a very important part of treatment of most patients who visit the healthcare facilities. Availability of medicines in developing countries is a problem, however Alsari (2017:1) found that in developing countries, access to medicine confronts several barriers that induces an increase in the rates of mortality and morbidity. According to Dunwa 2015:1), though access to primary health care services have improved in South Africa, problems of medicine

availability, waiting time for consultation and the quality of medical equipment persists.

2.8.3.2.4 Cleanliness

Health care facility cleanliness outside and inside is very critical in preventing nosocomial infections which may lead to death and costly litigations. However Young (2016:2) compared with the private sector and public sector in South Africa. The researcher fond public sectors cleanliness not adequate for example there was no glove usage in the wards and same gloves used in between patients. There was lack of hand washing policies, multiple patients were using same bed linen and the sterility of instruments was not maintained because the hospital had an inadequate autoclave.

2.8.3.2.5. Attitude

The way clients are addressed when they visit health facilities contributes a lot to their levels of satisfaction. Some service provider complain that bad working conditions staff shortages may contribute to the bad attitude they give to patient. Obbinna (2011:1) and Karaca and Duma (2018:1) noted that impact of negative attitude to work by health care providers in public and private hospitals in Nigeria, was particularly worrisome and endangered lives of patients. Shortage of staff in Nigeria was critical and affects the private sector as well. The shortage of staff may be contributing to the bad attitude**.** Haskins, Phakathi, Grant and Horwood (2018:1) in the study conducted in South Africa, also highlighted isolated incidences of bad attitude to patients which were related to shortage of staff among other things.

2.8.3.2.6. Waiting time

Clients are always complaining about long waiting time when they visit clinics and the less they wait the more satisfied they feel. Egbujie; et al (2018:3) encouraged service providers to explain the reason for delay if it ever occur as this may help in waiting time satisfaction even if there are some delays. Egbujie; et al (2018:3) also noted that Implementation of the Ideal Clinic model in the

selected facilities led to changes in patient waiting time. Observed changes were positive when a clinic appointment system was successfully implemented and negative when this was unsuccessful. This confirms the notion in Ghana and Australia that private health provision is synonymous with reduced waiting time and quality care (Nkentiah- Amponsah & Hiemenz, 2009:3; Ward 2017:3). This implied that the public health system needed to work on reducing waiting time and some quality adjustments to bring it at par with private health care Furthermore, it was found that waiting time and maternal education were significant predictors of health care satisfaction (Nkentiah- Amponsah and Hiemenz, 2009:3; Ward 2017:3).

2.9 CONCLUSION

This chapter presented the review of literature based on the Structural, Process and Outcome factors. The next chapter will deal with the methodology.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The previous chapter the review of literature based on the following sub headings: Structural, Process and Outcome factors. This chapter presents the methodology used for the study. An exploratory sequential mixed methods approach was chosen as the methods of choice.

3.2. METATHEORETICAL APPROACH

The Pragmatist world view that does not see the world as an absolute unity was used. Answers may not come from one approach Thus a mixed method was used where qualitative and quantitative data because they can work to provide the best understanding of a research problem (Creswell , 2014).

3.3 RESEARCH DESIGN

Research design was defined by Creswell and Creswell (2018:1) as the overall strategy/plan that you choose to integrate the different components of the study in a coherent and logical way, thereby, ensuring you would effectively address the research problem. It constitutes the blueprint for the collection, measurement, and analysis of data. The research problem determines the type of design that should be used not the design determining the problem. These researchers further maintained that a research design was meant to ensure that the evidence obtained enabled the researcher to effectively address the research problem logically and as unambiguously as possible.

Three types of designs have been defined as follows:

- Descriptive with the example of a Case-study or naturalistic with the example of observation and surveys.
- Correlational with the example of Case-control study, observational study.
- Semi-experimental with the example of field experiment of a, quasi-experiment type.
- Experimental with random assignment
- Mixed approach research method applying quantitative and qualitative approaches in the one study (Creswell and Creswell 2018:1).

For this study the researcher used the exploratory sequential mixed method design as suggested by (Berman, 2017:2). The qualitative and quantitative approach were used.

3.4 DEFINITION OF RESEARCH METHODS AND METHODOLOGY

A research method refers to the different ways that you can collect data for the research project. Research methods generally fall into one of the two categories. If one needs quantitative data which consist of numerical data, then a survey method can be used or on line poll as your research method. In contrast, if one needs qualitative data which offers more descriptive data the interview or focus group discussion methods is used (Andrew and Halcom, 2009:1;Sileywe 2019:1).

For this study the researcher used both the qualitative and quantitative methods of collecting data. A focus group discussion method was used for the qualitative method, while survey using a questionnaire was used for the quantitative method. (Saunders, Lewis & Thornhill 2009:130; Sileywe, 2019:1).

On the other hand, a methodology means the science of how research is done scientifically and logically to solve a problem (Saunders et al., 2009:130; Sileywe 2019:1). A methodology is therefore a systematic process of employing the method or (the tool) used accomplish the goal of research. The methodology helps us understand the process and not just the product of research. It also analyses

the methods in addition to the information obtained (Saunders et al., 2009:130; Sileywe, 2019:1). For this study, the methodology was implemented as follows:

An exploratory sequential mixed method was used for this study. This was because mixed methods, in which qualitative and quantitative methods are combined, are increasingly recognised as valuable. The mixed method can capitalise on the respective strengths of each approach. Pairing quantitative and qualitative components of a larger study can achieve various aims, including corroborating findings, generating more complete data, and using results from one method to enhance insights attained with the complementary methods. Approaches to mixed-methods studies differ on the basis of the sequence in which the components occur and the emphasis given to each. The qualitative and quantitative components may be performed concurrently or sequentially, and emphasis may be placed on either component or equal weight given to both (Curry, Nembhard & Bradly 2009:2; Sileywe, 2019:1). In this study, the qualitative and quantitative components were used sequentially as shown in Figure 3.1 below.

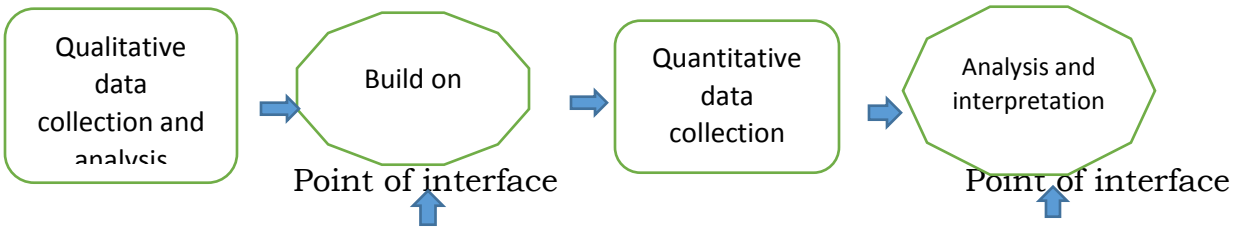


Figure 3.1: Sequential exploratory design of the study Adapted from de Vos et al. (2013:441)

The preliminary qualitative component was partly meant to generate the content for a questionnaire to be used in a follow-up quantitative study. In this approach, the researcher collected and analysed persuasively and rigorously both qualitative and quantitative data (based on research questions) then mixed (or integrated or linked) the two forms of data. The researcher considered and used

the mixed methods research as a separate methodology or method with its own philosophical assumptions and considerations, for methods of inquiry (De Vos et al., 2013:435; Creswell, 2009:5). The methods were used sequentially by having one build on the other. In this case, the quantitative research built on the qualitative research (De Vos et al., 2013:436). Exploratory Sequential Design is typically a two-phase design but in this case it was used as a three phase design for it included the instrument development (instrument development phase, a phase testing, and apply the instrument). Qualitative and quantitative data was collected at different times. The qualitative results helped and informed the second quantitative method (Creswell & Creswell, 2018:5).

The findings from the focus groups method in qualitative approach were used for the quantitative research to build on. Ultimately the results of the qualitative and quantitative research were compared and analysed. This approach was meant to increase the validity of the findings. The two methods were also able to complement each other (Creswell & Creswell, 2018:5).

3.3. THE THEORETICAL FRAMEWORK

In this study the researcher used the Donabedian's model made out of the three components, namely Structure, Process and Outcome (Ayanian & Markel, 2016:2).

Structure refers to the human and material resources and organizational framework that is necessary for the work to be done.

Process deals with how the service is carried out. This is the interaction between the nurse and other health care workers and the patient

Outcomes are the end result of the care activities. Most people agree that the best measure of patient care is to look at the outcome (Ayanian & Markel, 2016:2).

These components are interdependent, if the structure component is inadequate, this will influence service delivery in the process component. For instance if

there is not enough staff or money to pay staff, fewer patients will be seen and more illnesses will prevail in the community. This means that the morbidity and mortality for the community will be high, which impact on the outcome component. If the outcome component is unsatisfactory, more work has to be done by less people, thus the outcome component influences the process component. Because this study is not strictly in the clinical situation, the outcome have been adapted to involve service providers where applicable. However in this study because of time and financial constraints conclusions on outcomes factors will be based on the outcomes expressed by clients.

3.4 SETTING OF THE STUDY

Labaree (2009:8) and Sileywe (2019:1) define a research setting as the environment within which studies are conducted. The environment can be physical, social and cultural. Identifying the setting for the research can be informed by the type of study and the type of data to be collected. The results, if they can be generalized must reflect real life. The study was conducted in Limpopo province department of health. Limpopo Province is situated in the north-eastern corner of the Republic of South Africa. This province shares international borders with three other countries: Botswana to the west and north-west, Zimbabwe to the north, and Mozambique to the east. The facilities that were included in the study are shown in (Figure 3.2). The Health care in the Limpopo Department of Health is provided through the 49 hospitals, 27 health centres and 408 clinics, distributed over the five districts (Department of Health, 2014:1).

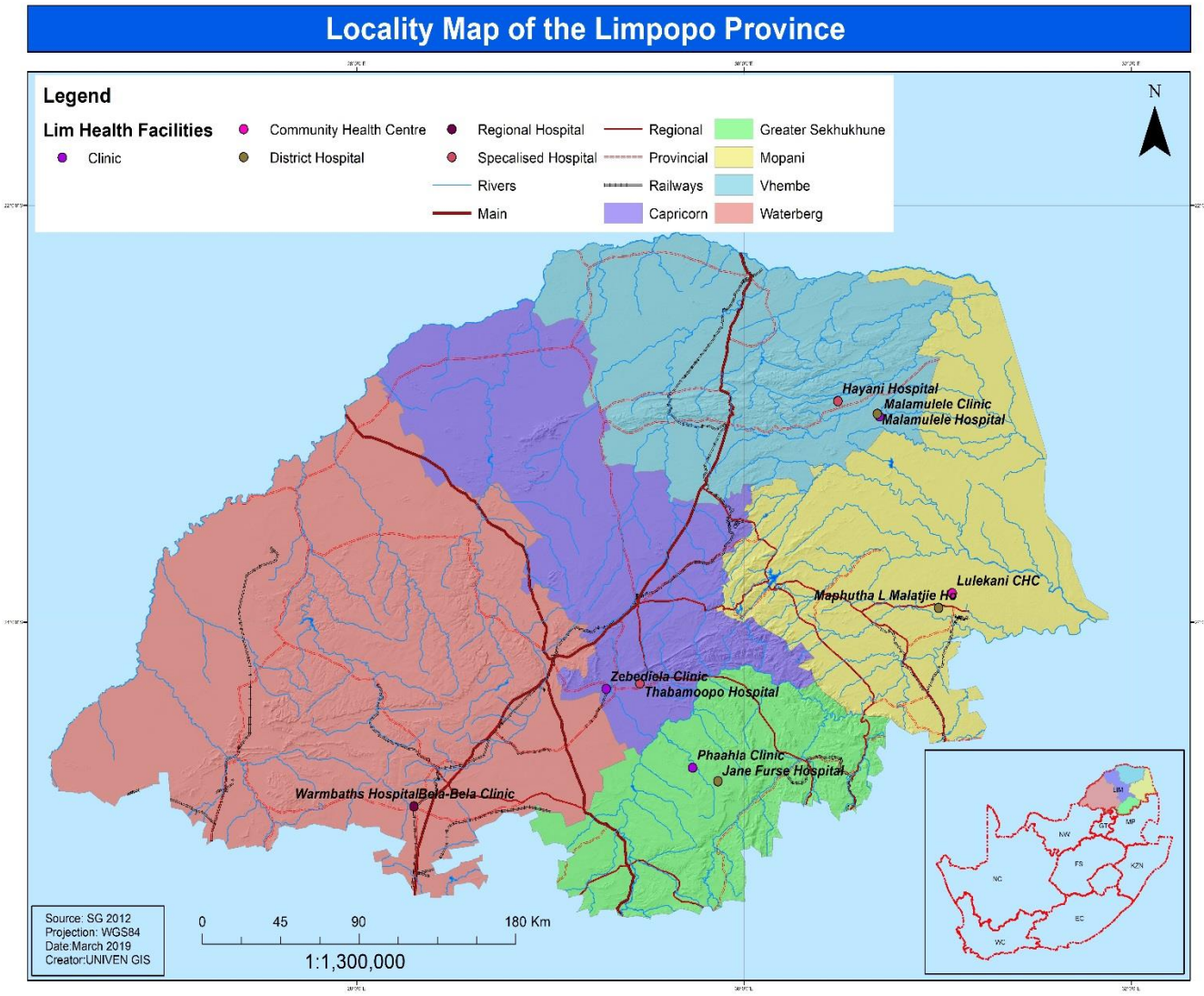


Figure 3.2.Distribution of facilities per district

Figure 3.1 Source: SG2012, Projection WGS84, Date March 2019', .reator UNVEN GIS

3.5 RESEARCH PHASES

The study comprised the following two phases the empirical and development of the strategies:

3 .5.1. Phase one: Empirical Phase: Exploratory sequential mixed methods

3.5.1.1. Stage one Qualitative Approach

According to Bradshow, Atikinson and Doody (2017:4) and Kim, Sefcik and Bradway (2017:1), qualitative methods are methods of research used to understand complex social processes, to capture essential aspects of a phenomenon from the perspective of study participants, and to uncover beliefs, values, and motivations that underlie individual health behaviours.

3.5.1.1.1: Objective one Qualitative approach

- To explore the experiences of stakeholders regarding the quality of healthcare rendered to clients at the Public Healthcare Institutions in Limpopo Province, South Africa

3.5.1.1.2 The Design

An exploratory contextual design was used

3.5.1.1.3 Population

A research population is also known as a well-defined collection of individuals or objects known to have similar characteristics. All individuals or objects within a certain population usually have a common, binding characteristic or trait (Robinson, 2014:7; Mohamed & Ahmed, 2017:2). Population included Hospital boards and Health committee members from the participating hospitals and clinics.

3.5.1.1.4 Sampling Methods

A sample can be defined as a group of relatively smaller number of people selected from a population for investigation purposes. The members of the sample are called participants (Mohamed & Ahmed, 2017:2).

Random sampling is the process of selecting cases from a list of all (or most) cases within the sample universe population using random selection procedure (Mohamed & Ahmed, 2017:2). Multistage sampling was used to sample the hospitals, clinics and participants. Multistage sampling refers to sampling plans where the sampling is carried out sequentially or in stages across two or more hierarchical levels/stage using smaller sampling units at each level/stage (Sedwick, 2015:1; Babat, 2017:3).

In this study, sampling was conducted as follows:

(a) Sampling of hospitals and clinics

Random sampling was used to sample five hospitals from the five districts (one hospital each district). The names of all hospital in each district were written in small papers and put on a bowl. The assistant researcher randomly picked one paper from the bowl. The name of the hospital written on the paper was included in the study. This resulted in five hospitals randomly selected, one from each district. A random sample was also used to sample five clinics, one clinic from each district. The names of the clinics served by each randomly selected hospital were written on small papers and put in bowl. The assistant researcher randomly picked one paper from the bowl. This resulted with five clinics, one from each district. This ensured that all institutions have equal chance to be included. Purposive sample was applied to professional nurses and stakeholders in the sampled hospitals and clinics. Thabamoopo hospital and Hayani hospital were included as they are specialized mental hospital. This resulted in the total number of sampled facilities to be as follows: Seven hospitals and five clinics with a total of 12 facilities.

(b) Sampling of participants

Purposive sampling referred to as "non-probability" sampling. It is called this due to the researcher applying their own criteria when defining their sample, this involves identifying and selecting individuals or groups of individuals that are especially knowledgeable or experienced, and available communicate in an articulate expressive and reflective manner and willing to participate with a phenomenon of interest (Palinkas, Horwitz, Green, Wisdom, Duan & Hoagwood, 2016:534). The rationale for employing a purposive strategy is that the researcher assumed, based on the a-priori theoretical understanding of the topic being studied, that certain categories of individuals may have a unique, different or important perspective on the phenomenon in question and their presence in the sample should be ensured (Robinson, 2014:7). Purposive sampling was used to select hospital board members, mental health board members and clinic committee members. Approximately 10 participants per hospital board and clinic committee participated per FGD.

3.5.1.1.4 Inclusion Criteria

Inclusion criteria refer to characteristics that the potential participants must have in order to participate in the study. Inclusion criteria should respond to the scientific objective of the study and are critical to accomplish it. Proper selection of inclusion criteria was supposed to optimize the external and internal validity of the study, improve its feasibility, lower its costs, and minimize ethical concerns; specifically, good selection criteria was also supposed to ensure homogeneity of the sample population, reduce confounding, and increase the likelihood of finding a true association between exposure/intervention and outcomes (Robinson, 2014:10). In this study the inclusion criteria were as follows:

- Participants should be both male and female.
- Participants should have served in the committee or board for at least a year.
- Participants should reside in the jurisdiction of the study.

3.5.1.1.5 Exclusion Criteria

Exclusion criteria are any characteristics that potential participants might have that would disqualify them from participating in the study. Exclusion criteria are put in place to protect potential participants and to maintain proper ethical standards, in addition to ensuring that the sample is appropriate for addressing your research questions. Proper selection of inclusion criteria will optimize the external and internal validity of the study (Robinson, 2014:10; Mohamed & Ahmed, 2017:2).

In this study exclusion Criteria were as follows:

- Individuals who have not been active in the committee for about one year.
- Individuals who do not belong to the jurisdiction of the study.

3.5.1.1.6 Data collection instrument

Measurement instrument refers to various methods through which a researcher obtains data from respondents for his research work. There are different types of measurement instruments that can be used by researchers for their studies; it depends on the nature of research that is to be carried out (Yaya, 2014:1).

Focus Group Discussions (using semi- structured interview guide) was used as an instrument for data collection. Jameshed (2014:1) defines an unstructured interview as an interview where the researcher comes to the interview with no predefined theoretical framework, and thus no hypotheses and questions about the social realities under investigation. Rather, the researcher has conversations with interviewees and generates questions in response to the interviewees' narrations. Interviewer started with an open-ended question. A semi-structured interview is a method of research used most often in the social sciences. While an interview has a rigorous set of questions which does not allow one to divert, a semi-structured interview is open, allowing new ideas to be brought up during the interview as a result of what the interviewee says. The interviewer in a semi-structured interview generally has a framework of themes to be explored (Onwuegbuzie, Bustamante & Nelson, 2010:57; Dejonkheere & Vaugn 2019:5).

In this study, a semi-structured interview was prepared. The following questions were covered:

About four opening questions were posed as follows:

How do you feel on the services received by clients at the hospital/ clinic?

What are the things you like bout the hospital/ clinic?

What are the things you don't like bout the hospital/ clinic?

What are your suggestion for improvement?"

Probing questions emanating from the discussion questions were used to encourage the discussion (Okeeffe, Buytaert, Mijic, Brozovic & Sinha, and 2016:1).

(a) Pretesting

Pretesting was done with three participants one in a hospital and two others in a clinic. The results were used to see if the question elicit expected responses.

3.5.1.1.7 Data collection

Data collection is the process of gathering and measuring information on variables of interest, in an established systematic fashion that enables one to answer stated research questions, test hypotheses, and evaluate outcomes (Reddy, 2018:1). The researcher chose Focus Groups Discussions (FGD) for this study. According to Curry et al (2009:1) and de Vos et al. (2013:361) and (Reddy, 2018:1), FGDs are guided discussions among a small group of people who share a common characteristic central to the topic of interest. The group interaction served as catalysts to generate unique insights into understanding of shared experiences and social norms. The group interactions also encouraged participants to speak with candor and had less inhibitions. . Meeting about 10 people at the same time saved time and cut costs as instead of meeting people individually over many days 10 people could be met in one day (Curry, et al., 2009:1; Reddy, 2018:1). The discussion guide consisted of 5 to open-ended questions designed to stimulate discussion on central topics of interest. Focus group moderators were encouraged to be adept at guiding the dialogue while

permitting free exchange and ensuring that participants feel comfortable in expressing discordant.

(a)Focus Group Discussion

12 focus group discussions were scheduled for the stakeholders

Stake holders FGD

Each group of stake holders was made from 10 members. Seven group discussions of stakeholders from the seven hospital stakeholders (10 members for each group discussion), and five group discussions of stakeholders from the five clinics (ten members for each group discussion). This resulted in 12 group discussions with 120 participants.

Table 3.1 No of Focus Groups Discussions and participants interviewed: (Stakeholders).

	Clinic(10) per group)	**Hospital (10per group)**	**Total no of groups**
Planned no of groups	5 groups	7 groups	12(120 participants)
Actual groups Interviewed	4 groups	4 groups	8 groups (80 participants)
No of participants	40	40	80

3.5.1.1.8. Objective two: Qualitative Approach.

- To describe the views of health care professionals regarding care rendered to clients at the public health institutions in Limpopo Province, South Africa**.**

3.5.1.1.9 Population

Population included all professional nurses in charge of section in hospitals and those professional nurses working in clinics.

3.5.1.1.10 Sampling Methods

The same hospitals and clinics randomly sampled in stage one were used. Purposive sampling was used to select ten (10) professional nurses from the

sampled hospitals and five professional nurses from sampled clinics. Participating hospitals were seven (7) therefore the number of purposely selected professional nurses was seventy (70), since ten sampled professional nurses drawn from each hospital. By the fourth group there was saturation of the information and therefore the researcher arrived at fourty (40) participants who participated in the interviews due to saturation of information. For the clinic facilities, purposive sampling was used to sample five (5) professional nurses from the participating clinics. Participating clinics were five (5) therefore number of purposely selected professional nurses was twenty (25) since five (5) professional nurses were drawn from each clinic. By the third FGD there was saturation of information and therefore the researcher arrived at fifteen (15) participants who participated in the in the interviews because of saturation of the information.

(a) Inclusion Criteria used

In this study, the inclusion criteria were as follows:

- Participants who were employed at the sampled facility.
- Participants should have been working in the sampled facility in Limpopo province for at least six months.

(b) Exclusion Criteria used

In this study, the exclusion criteria were as follows:

Professional nurses who have been employed in the facility sampled for less than six months were excluded.

3.**5.1.1.11 Data collection instrument: Semi-structured interview**

The semi structured interview was used as described under objective one

3.5.1.1.12 Data collection

Focus group discussion was used as discussed under objective one

(a) Professional nurses FGD

Each group of professional nurses was made from between 5 to 10 members. Seven FGD group discussions of professional nurses from the seven hospital (ten members for each group discussion) and five group discussions of professional nurses from the five clinics (five members for each group discussion) because clinics had limited number of professional nurses a maximum of five professional nurses per clinic was planned. This resulted in 12 group discussions with 95 participants.

Table 3.2 No of focus groups' discussions and participants interviewed: Professional nurses in hospitals and clinics

	Clinic(5 per group)	Hospital (10per group)	Total no of groups
Planned no of groups	5 groups	7 groups	12(95)participants
Actual groups Interviewed	3 groups	4 groups	8 groups
No of participants	15	40	55

3.5.1.1.13 Qualitative Data Analysis

Qualitative analysis is the non-numerical examination and interpretation of observations, for the purpose of discovering underlying meanings and patterns of relationships (De Vos, et al., 2013:399; Autin & Sutton, 2014:3).

The researcher used the proposed eight steps by (Creswell, 2014:2) in data analysis:

- The researcher listened to the tapes
- Transcripts were made after carefully listening to the audiotapes.

- Coding and categorizing of the data was be done soon before collecting data.
- Coding was used to reorganize the data to be collected in the interviews. Themes were highlighted from questions asked.
- These themes were followed by categories.
- The identified themes were verified with experts.
- An independent coder was asked to encode the same data by checking for agreement. This was meant to ensure reliability.
- A thorough review of all recorded information that the researcher obtained during the course of the data collection was manually analyzed, leaving sufficient space on the margin of page for coding purposes (Creswell 2009:155; Burns & Grove, 2009:524; Akinyode & Khan 2018:1).

3.5.1.1.14 Measures to ensure trustworthiness of the research

Validity refers to consistency with which the research will produce the same results if repeated. Validity refers to accuracy or correctness of the findings. It is mostly implemented in quantitative research. Qualitative research is based on subjective, interpretive and contextual data, making the findings more likely to be scrutinized and questioned. Reliability and trustworthiness is relevant for Qualitative research. It was therefore, critical that researcher took necessary steps to ensure the reliability and trustworthiness the research findings (Lincoln and Guba, 1985:317; Lemon & Hayes 2020: 2).

(a) Trustworthiness

The trustworthiness principle, for measuring reliability in qualitative research is recommended because qualitative research uses non-numerical examination and interpretation of observations. The researcher therefore used the four criteria for trustworthiness proposed by Lincoln and Guba (1985:317) and Guba, (1985:317) and Lemon and Hayes (2020: 2) for judging the soundness of qualitative research. These criteria below are offered as alternative to more traditional quantitatively-oriented criteria:

- Credibility
- Transferability
- Dependability
- Confirmability

These guidelines guided the field activities and imposed checks to insure that the proposed procedures were in fact being followed. Comprehensive lists of guidelines/criteria to ensure trust worthiness were developed and used (Loh, (2013:1) and Anney (2014:4). For the purposes of this study, the researcher tried to ensure trustworthiness (quality of study) by applying mostly the Lincoln and Guba (2009:318) and Lemon and Hayes (2020: 2) criteria as follows:

(ai) Credibility

Credibility is explained as the confidence in the 'truth' and believability of the findings (Internal validity). This can be achieved in different ways and one of them is spending enough time with respondents to learn about their culture and to observe the dynamics of the group and developing rapport and trust. Member checking can be done both formally and informally as opportunities for member checks may arise during the normal course of observation and conversation as well as after the interview. Lincoln and Guba, 92009:317) and Lemon and Hayes, (2020: 2) further highlighted the advantage of member checking as that it provides an opportunity to researcher understand and assess what the participant intended to do through his or her actions. Member checking also provides the participant the opportunity to correct errors and challenge what are perceived as wrong interpretations and to volunteer additional information which may be stimulated by the playing back process.

(aii) Application of credibility in the study

The researcher spent more time with the participants even after the interview. Refreshments were served and this enabled the participants to relax more and express more insight to the interview at the same time the researcher observed the surroundings and dynamics of the situation. The final report was taken to

the participants; that is, the professionals and the stake-holders so that they could explain the reasons for the responses they gave if necessary and also to validate the reports.

(b)Transferability

The researchers described transferability (Often called external validity) as showing that the findings (results) have applicability in other contexts. This means that the results are generalizable and can be applied to other settings, populations and situations. Thick description is described by Lincoln and Guba, (2009:316) and Lemon and Hayes, (2020: 2.) as a way of achieving a type of external validity. By describing the phenomenon in sufficient detail one can begin to evaluate the extent to which the conclusions drawn are transferable to other times, settings, situations, and people. This is described as thick descriptions referring to detailed account of field experiences in which the researcher makes explicit the patterns of cultural and social relationships and puts them in context.

(bi) Application of transferability to the study

In this study, the researcher archived transferability by describing in detail the phenomenon or methodology and context of the setting, for example the setting of the study was described in detail. A map was provided for the contest.

(c)Dependability

Dependability, otherwise known as reliability, refers to the consistency with which the study could be repeated and result in similar findings. It is described as showing that the findings are consistent and can be repeated. The researchers recommend external audits which involve a researcher not involved in the research to process examine both the process and product of the research study. The purpose is to evaluate the accuracy and evaluate whether the findings, interpretations and conclusions are supported by the data (Lincoln & Guba, 2009:317; Ferero et al., 2018:1).

In order to estimate reliability, quantitative researchers construct various hypothetical notions (for example true score theory), the researcher, however, was aware that this is not applicable to qualitative approach therefore the concept of dependability was applied (Lincoln & Guba, 2009:317; Ferero et al., 2018:1).

(c i)Application of Dependability in the study

The researcher realized that the nature of qualitative research often results in an ever-changing research setting and changing contexts, the researcher documented all aspects of the processes and any changes or unexpected occurrences to further explain the findings. The researchers wanted to enable other researchers to replicate the study if necessary. A pretest was done before collecting data. The information was similar.

(d) Confirm ability

Confirm ability is described as the degree of neutrality or the extent to which the findings of a study are shaped by the respondents and not researcher bias, motivation, or interests. Conformability further refers to the degree to which the results could be confirmed or corroborated by others. This gives a measure of objectivity in evaluating the results, other researchers examine how well the research findings are supported by actual data (Lincoln & Guba, 2009:317). The researchers believe that a single method can never adequately shed light on a phenomenon. To ensure conformability multiple methods are believed help facilitate deeper understanding. Triangulation_is one of the methods that can ensure that an account is rich, robust, comprehensive and well-developed. Rather than seeing triangulation as a method for validation or verification (Lincoln & Guba, 2009:317; Ferero et al., 2018:1).

Through triangulation more reliable answers to research questions can be answered through integrating results from other different approaches that have different key sources of potential bias that are unrelated to the other approach

(Lawlor, Tilling & Smith 2017:1) . In this study the quantitative approach served the purposes of triangulation

(d i) Application of confirm ability to the study

Questions were posed to encourage participants to express why they believe things happen the way they did (De Vos et al., 2013:36). Feedback given to respondents; the results were presented to the respondents in the form of feedback and the respondents were able to confirm or correct points of view recorded. Supervisors examined the report to check if the data is related to the study.

3.5.1.2 Stage two Quantitative Study

Labaree (2009:6) and Moseholm and Fetter (2017:3) define quantitative methods as those that emphasize objective measurements and the statistical, mathematical, or numerical analysis of data collected through polls, questionnaires, surveys, or by manipulating pre-existing statistical data using computational techniques. Quantitative research focuses on gathering numerical data and generalising it across groups of people or to explain a particular phenomenon. Furthermore, quantitative research focuses on gathering numerical data and generalizing it across groups of people or to explain a particular phenomenon.

Quantitative research designs are either descriptive (subjects usually measured once) or experimental (subjects measured before and after a treatment). The researcher however, used a quantitative descriptive research design. This design was implemented by the researcher to describe the factors and challenges regarding the provision of quality health as experienced by the service providers (professional nurses) and recipients of the service (clients) in facilities in the Province (Labaree, 2009:6 ; Moseholm and Fetter 2017:3).

In choosing the method, the researcher considered the following characteristics of quantitative research:

- The research study can be replicated because of the use of structured instrument
- The study had clearly defined questions that would provide objective answers.
- Data would be in the form of numbers and statistics, often arranged in tables, charts, figures, or other non-textual forms.
- A larger sample could be reached with questionnaires and could influence representativeness. This phase addressed four objectives, namely objectives 3,4,5,6, and were discussed in two stages as follows:

3.5.1.2.1 Objectives (three, four, five)

In this stage (stage one of quantitative approach) the three objectives concerning the professional nurses in hospitals and clinics were addressed as follows:

- To assess the challenges faced by healthcare professionals towards the provision of quality healthcare services in public healthcare facilities of Limpopo Province.
- To describe factors contributing to the provision of healthcare services facilities in public healthcare facilities in Limpopo province.
- To explain the strategies used to improve healthcare service provision in the public healthcare facilities in Limpopo Province.

3.5.1.2.2 Population

A research population is also known as a well-defined collection of individuals or objects known to have similar characteristics. All individuals or objects within a certain population usually have a common, binding characteristic or trait (Robinson, 2014:7). Population included all Professional nurses in charge of sections in the hospitals and in the selected clinics.

3.5.1.2.3 Sampling Method

A sample can be defined as a group of relatively smaller number of people selected from a population for investigation purposes. The members of the sample are called participants (Robinson, 2014:7). Random sampling is the process of selecting cases from a list of all (or most) cases within the sample universe population using some kind of random selection procedure (Robinson, 2014:7). Multistage sampling was used to sample the hospitals, clinics and participants. Multistage sampling refers to sampling plans where the sampling is carried out sequentially or in stages across two or more hierarchical levels/stage using smaller and smaller sampling units at each level/stage (Sedwick, 2015:1). In this study, sampling was conducted as follows:

3.5.1.2.4 Sampling of hospitals and clinics (first stage sampling)

The same hospitals and clinics samples in stage one of the qualitative approach were used.

(a) Hospitals and facilities in the study

Purposive sample was applied to professional nurses and stakeholders in the sampled hospitals and clinics. Thabamoopo hospital and Hayani hospital were included as they are specialized mental hospital. The total number of the sampled facilities came to be 12. Hospitals.

Table 3.3 Names of all facilities used in the study

Type of facility	Capricorn	Mopani	Sekhukhune	Waterberg	Vhembe
Hospital	Zebediela	Maphuta	Jane Furse	Bela bela	Malamulele
Clinic	Zebediela	Lulekani	Phaahla	BelaBela	Malamulele
			Thaba moopo mental		Hayani Mental hospital

(b) **Sampling of participants (second stage sampling**).

Sampling of participants occurred as described in item 3.5.1.1.3. (b)

(bi). Size of sample

Purposive sampling was used to sample 220 professional nurses in charge of sections in hospitals and clinics sampled. The distribution was as follows: 172 from district hospitals 38 from mental hospitals and 10 from clinics.

(bii)2 Inclusion Criteria

Inclusion criteria refer to characteristics that your potential respondents must have in order to participate in the study. Inclusion criteria should respond to the scientific objective of the study and are critical to accomplish it. Proper selection of inclusion criteria will optimize the external and internal validity of the study, improve its feasibility, lower its costs, and minimize ethical concerns; specifically, good selection criteria will ensure the homogeneity of the sample population, reduce confounding, and increase the likelihood of finding a true association between exposure/intervention and outcomes (Robinson, 2014:10). In this study the inclusion criteria were as follows:

- Respondents who were employed at the sampled facility.

- Respondents should have been working in the sampled facility for at least six months.
- The professional nurses who had been employed for at least 6 months.

(biii).3 Exclusion Criteria

Exclusion criteria are any characteristics that potential respondents might have that would disqualify them from participating in the study exclusion criteria are put in place to protect potential participants and to maintain proper ethical standards, in addition to ensuring that your sample is appropriate for addressing your research questions. When considering exclusion criteria, you need to be aware of your role as the researcher and your relationship to potential participants. Proper selection of exclusion criteria will optimize the external and internal validity of the study (Robinson, 2014:10). In this study, the exclusion criteria were as follows:

- Those who participated in the focus group discussion.
- Have been in position for less than six months were excluded.

3.5.1.2.5 Data collection instrument

Measurement instrument refers to various methods through which a researcher obtains data from respondents for the research work (Abawi, 2013:1). There are different types of measurement instruments that can be used by researchers to collect data. The type of instrument used is informed by the type of study that is to be carried out (Yaya, 2014:1). For this study a questionnaire for the service providers (professional nurses was developed in phase 2. This questionnaire was developed to address research objectives three, four and six.

The quantitative design built on the data from the qualitative design that was conducted first because this study is a mixed methods approach of an exploratory type. The data from the qualitative research and literature search was used to inform the questions that were asked in the quantitative approach (Labaree, 2009:8: Abawi 2013:1). An instrument was therefore developed. According to Abawi (2013:1), an accurate and systematic instrument is needed

to be able to ensure an accurate data collection. Data collection is critical in that it allows us to collect information that we want to collect about our study objects. Abawi (2013:1) notes that depending on research type, methods of data collection include: documents review, observation, questionnaire, measuring, or a combination of different methods. For this quantitative design, a questionnaire was found to be appropriate. From the literature search and qualitative research results behaviours and themes were identified respectively for service providers and client. These behaviours and themes were in alignment to the objectives and questions of the study. This was important as it ensured that the instrument was relevant to the construct being researched
(Onwuegbuzie, et al., 2010: 57; Hartveit, et al 2019:5).

(a)Pretesting

Pretesting was done with three participants one in a hospital and two others in a clinic. The results were used to see if the question elicit expected responses.

(b)Data collection

Data collection is the process of gathering and measuring information on variables of interest, in an established systematic fashion that enables one to answer stated research questions, test hypotheses, and evaluate outcomes (Reddy, 2018:1). The researcher requested permission from the managers to see the respondents in groups during a convenient time to complete the questionnaire. All available professional nurses assembled in a boardroom.
They were informed about the purpose of the meeting. Explanations about consent forms were made emphasising that participation is voluntary. The respondents provided informed written consent before the completion of the questionnaires Self-administered questionnaires were distributed to the respondents to complete in their respective facilities. The completion of the questionnaires took about 15 to 20 minutes in the presence of the researcher.

The questionnaires were therefore collected from respondents soon after completion.

3.5.1.2.6. Objective six

This objective measured outcome factors

To describe the experiences of clients regarding of healthcare service provision within the public healthcare facilities in Limpopo Province.

(a) Population included

Clients leaving hospital or clinic after consultation and discharged after admission.

(b) Sampling Methods

(bii) Sampling hospitals and clinics

The same hospitals and clinics randomly sampled in stage one and two of qualitative research were used.

(c)Participants

Purposive sampling was used to sample one hundred and eighty-five (185) and only one hundred and eighty (180) completed questionnaire well. Ninety-eight (98) clients from hospitals completed questionnaire while eighty-two (82) from clinics completed. Clients from mental hospitals were excluded. Clients that were found in the randomly selected hospitals and clinics on that day were given questionnaire to complete while researcher and assistants waited for them.

(d) Inclusion Criteria

In this study the inclusion criteria were as follows**:**

- Must have attended the clinic or hospital on that day of interview.
- Must have been discharged on the day of interview.

(c) Exclusion Criteria

In this study the exclusion criteria were as follows:

- If a visitor and have no experience about the hospital.

- Mentally ill patients.
- Minor children under 16 years.

3.5.1.3.7 Data collection instrument

The questionnaire was in English, but this was no problem since researcher and assistants were very fluent in English and all the African languages in Limpopo.

3.5.1.2.8 Data collection

The same process followed in item 3.5.1.1.7 was used. For those clients who could not read or write, the research assistants were ready to assist as they can speak all the local languages.

3.5.1.2.9 Data Analysis

Quantitative data was analysed using the Statistical Package of Social Sciences (SPSS version 25). The level of reliability of the instrument was tested in item 3.5.1.2.10(c) using Cronbach's alpha as a measure of reliability. The discriptive statistic was computed to provide the overall picture of the data correlation.

3.5.1.2.10 Validity

(a) Internal validity

Internal Validity is the approximate truth about inferences regarding cause-effect or causal relationships. All that internal validity means is that you have evidence that what you did in the study (i.e., the program) caused what you observed (i.e., the outcome) to happen Internal validity also refers to how well an experiment is done, especially whether it avoids confounding (more than one possible independent variable [cause] acting at the same time) and minimises systemic error, that is bias The less chance for confounding in a study and bias, the higher its internal validity. Internal validity of the quantitative design depends on the internal validity of the instrument.

(ai) Application of internal validity to the study

The instrument for this study was checked for internal validity see 3.5.1.1.4 above. Randomisation of facilities was done, while the participants were purposely assigned. The two studies were conducted a week in between to prevent other issues to happen that could influence results.

(b) External Validity

This refers to the degree of similarity among the sample used in the study, the population from which sample drawn and the target to which the sample is to be generalised Thus, external validity is generally concerned with the generalisability of research results and findings to the population that the sample has been taken from. It is a very important concept in all types of research designs (true experimental, quasi-experimental, and non-experimental) including ones that use surveys to gather data. Therefore, assuring the external validity and the generalisability of the findings should be one of the primary goals of the survey researcher (Mohajan, 2017:18).

(b1) Application to this study

To ensure generalisability in this study the setting was described and a large sample was included. Hospitals and clinics were randomly selected participants were purposely selected.

(c) Reliability

According to Wiid and Digines (2019:249, reliability is the consistency of a set of measurements of a measuring instrument. Reliability answers the question of whether a measurement measures of the same construct gives the same values. For this study the researcher used Cronbach's alpha to measure consistency of the questionnaire. Cronbach's alpha can be calculated using SPSS. The following rules of the thumb suggested by Wiid and Digines

(2019:249) for determining consistency of questionnaire in calculating cronbach's were use :

- The number of minimum responses is determined by multiplying the number of levels with the number of items, or questions in the construct.
- The construct with the most items should be used.

The researcher used a four point Likert scale in her questionnaire and all the constructs in the questionnaire had five items The minimum responses for the test was therefore 4 x5 (four times five)= 20(twenty).
In a table the variances for each item were calculated and then added together. see Annexure M

For each item the variance of each questionnaire was determined by subtracting the mean of the item from each question and then squaring the answers. There answers were then divided by N-1.

The sample variance was also determined by finding the variance of the sum of all the respondents. The same process of finding the mean of the sum of respondents, subtracting the mean from each respondent's response, squaring them and dividing by the N- 1 as shown n Annexure M

Cronbach (α) = $\left(\frac{K}{K-1}\right)\left(\frac{X_Y^2-\Sigma S_i^2}{X_Y^2}\right)$
Where K= Number of Items
X_Y^2 = Sum of the variance of each items
ΣS_i^2 = The variance of the total column
(α) = $\left(\frac{20}{20-1}\right)\left(\frac{46.5-5.}{46.5}\right)$ = 0,892473

According to Wiid and Digines (2019:249), any value above 8, reliability is considered good. This means that the questionnaire used is reliable.

3.5.1.2.7 Stage 3 Integration of Mixed Studies

O'Cathain, Murphy and Nicoll (2010:1) and Fetters, Curry and Creswell (2013:4) agree that Integration is an important and essential interaction or conversation between the qualitative and quantitative components of a mixed methods research and it is important that the results should cohere because without this type of integration research cannot be called mixed. Onwuegbuzie, Bustamante and Nelson (2010:1) however describes various levels and sublevels of integration. In this thesis the integration was implemented as follows:

The contiguous approach of integration was used, though the presentation of findings is within a single report, the qualitative and quantitative findings are reported in different sections. For example, the qualitative findings have been reported in the first half of the results section and the quantitative results in a subsequent part of the report (Onwuegbuzie, Bustamante & Nelson, 2010:1; Moseholm & Fetter 2017:3).

3.5.1.3 Phase two the development of the strategies

This phase addressed object seven: To develop strategies to facilitate healthcare Service provision in the public healthcare institutions of Limpopo Province. The development of the strategies was informed by the qualitative and quantitative results from the previous two phases.

Osborn (2018:1) identified five stages of development of strategies, viz: Goal setting, Analysis, Strategy Formulation, Strategy Implementation and Strategy monitoring .In this study the strategies were implemented as follows

3.5.1.3 1. Methodology in development of strategies

Goal/Purpose

According to Osborn (2018:1) members of an organisation should share in development of the strategies in the initial stages of identifying the goal or purpose of

the strategic development. For this study, relevant officers and experts were only involved in the SWOT analysis and the validation of the developed strategies. The purpose of development of these strategies was to facilitate the provision of quality health care services in the public health care facilities in Limpopo.

Analysis

Osborn (2018:1) further suggests that information should be gathered and analysed before strategies can be developed.. For this study a SWOT analysis was used to analyse information gathered from the hospitals and clinics.

Strategy Formation

According to Osborn (2018:1), analysis is followed by use of all intelligence and data one have gathered to formulate strategies. In this study, through the SWOT analysis, Strength, Weaknesses, Opportunities and threats were identified and prioritised. Strategies were formulated to address the prioritised Strengths, Weaknesses, Opportunities and threats.

Strategy Implementation

In general the reason for developing strategies is to implement them to improve service delivery. Osborn (2018:1) believes t implementation is the most important part of the entire strategic development process. For this study Implementation of the strategy will follow after the policy makers have accepted the recommended strategies.

Strategy Monitoring

Before implementation of strategies is done, a plan of monitoring each part of your strategy, and ensuring that it aligns with the end goal should be made (Osborn, 2018:1). For this study Monitoring of strategies developed will not occur. Plans of monitoring need to be informed by the implementation plan

3.5.2.1 The SWOT Analysis

Various authors have defined and used the SWOT analysis using various terminologies (Renault, 2015:3);(Overseas Development Institute 2009.1). However, all those definitions concur that the SWOT analysis involves: Strengths, weaknesses, opportunities and strengths. A SWOT analysis guides one to identify the positives and negatives inside one's organization (Strengths and weaknesses and in the environmental Opportunities and Threats). Developing a full awareness of the situation can help with development of strategic plans and decision making. They, moreover seem to agree that the SWOT analysis offers a simple way of communicating about ones' initiatives or programmes as well as an excellent way to organize information that one has gathered from studies or surveys (Renault, 2015:3). The researcher used the SWOT analysis to develop strategies for facilitate provision of quality healthcare service delivery in the healthcare facilities in the department of Health, Limpopo Province. The information was gleaned from the literature search, qualitative and quantitative research. A team of relevant stake holders was constituted. The team included managers, stakeholders and professional nurses. Table 3.4 presents the 4 steps in SWOT analysis.

Table 3.4: The SWOT analysis

Internal Analytical Area	**Step 1 Strengths**	**Step 3 Weaknesses**
External Analytical Area	Step 2.Opportunities	Step 4 Threats

(a)Step 1: Strengths

In this step the strength of the department of health in the process of service delivery provision were identified from the literature search and interviews (Renault, 2015:3).

(b) Step 2: Weaknesses

In this step the weaknesses that is the factors that hinder or stand in the way of the Department's enhancement of services provision were identified (Renault, 2015:3).

(c) Step 3: Opportunities

In this step the factors that have the potential to be helpful in enhancing health services provision were identified (Renault, 2015:3).

(d) Step 4: Threats

Factors that can prevent enhancement of service provision were identified (Renault, 2015:3). All these were listed in the SWOT matrix. In developing the strategies, the following questions were asked:

- How can the Department maximize/ build on its strength?
- How can the Department overcome/minimize identified weaknesses?
- How can the Department take advantage of or seize the opportunities?
- How can the Department overcome/minimize/counteract the identified threats? (Renault, 2015:3).The results of this process were turned into recommended strategies that can be acted upon.

3.5.1.3.2 Validation

Through validation one needs to check the applicability of each strategy. All the people who were involved development of the strategies were involved in validation. A checklist was developed, and the stakeholders responded to it according to whether the strategy if feasible or not. The data was analysed using descriptive statistics. See table 6.2, 6.3 6.4 and 6.5.

3.5.1.4 Ethical Considerations

3.5.1.4.1 Permission to conduct the study

The University of Venda Higher Degrees Committee approved the proposal and the University Ethics Committee issued an ethical clearance. The Limpopo Department of Health provided permission to conduct study within the health facilities (Annexure E).

3.5.1.4.2 Ethical considerations regarding participants

Research in human sciences involves a very close interaction between researcher and the population of interest. Social norms and ethics are involved and conflicts may arise. The researcher in this study therefore observed mainly the principles put forward (Human Sciences Research Council, 2015:9). The principles are as follows: respect and protection, transparency, scientific and academic professionalism and accountability.

(a) Respect

(b)Self determination

Participants were encouraged to choose the level of participation that suits them. They could withdraw their participation anytime without incurring any sanctions. Participants could ask for clarity on specific issues.

(c) Full Disclosure/Transparency

Details of the study was fully explained to participants to enable them to make informed consent. Participants' were reassured that they are free to refuse participation (Polit and Beck, 2013:140).

(d) Confidentiality

The participants were reassured that their identity would not be revealed unless a signed consent is given. Provision was made for those who would choose to respond anonymously. This is relevant as the study was asking sensitive questions to service providers; questions that could implicate their supervisors or management (Polit and Beck, 2013:140).

(e)Protection from harm and exploitation

The researcher prevented and avoided inflicting psychological harm to participants by making sure questions are carefully phrased, allowing participants to ask questions for clarification and making sure that all questions are answered. Participants received debriefing sessions. In addition, participants were reassured that their participation or refusal would not be used against them.

(f) Obtaining Consent

(g) Informed consent from participants

Before undertaking the present study, the researcher ensured that the participants are clearly briefed on the aims and implications of the research, as well as the possible outcomes and benefits of the research (Good or bad). The fact that the study will contribute towards improving service delivery in the Department and contribute towards the researcher‘s academic qualifications was made clear to participants. The participants were made aware that the results may be published in relevant journals (Annexure C). The researcher obtained informed consent from the participants (Polit and Beck, 2013:140).

This consent was given in writing. The researcher designed a consent form that highlighted the fact that individuals have the right to refuse to participate in the

research and to withdraw their participation at any stage (Brink, Van der Walt & van Rensburg, 2012:37). Written and signed permission from the Head of Department of Health, University of Venda was produced to the participants before requesting their cooperation. The participants did not have to spend time over and above their working hours. The researcher would ask questions immediately after the Batho Pele Forum meeting, or any district meetings that involves the stakeholders (participants in the study) because they involve all the stake-holders in the study. Research assistants will be employed to facilitate the completion of the questionnaires and compile a report.

(h). Accountability

Feedback sessions were organized for the participants. The proposal was presented to the Department of Health Ethical Clearance Committee to ensure it meet the research standards and the ethical code on research (Polit & Beck, 2013:140).

(i) Ethical clearance

The ethical clearance letter was issued by the University of Venda on the 21stof August 2017. Project no**:** SHS/17/PDC/20/1208

3.6 CONCLUSION

This chapter dealt with the methodology: the implementation of the qualitative and quantitative research. Development of instrument and development of strategies were described. The next chapter will deal with Research findings and presentation.

CHAPTER 4

PRESENTATION AND DISCUSSION OF FINDINGS

4.1 INTRODUCTION

The previous chapter discussed the methodology used in this study. The current chapter presents the analysis of both quantitative and qualitative data as shown in table 4.1, 4.2 and 4.3.This will be followed by discussion of the results. The star * against a response to a factor indicated that there was no agreement ins the responses between qualitative and quantitative approach results.

Table 4.1 Structural factors analysis

Item	**Qualitative Approach**	**Quantitative approach**
1.Structural		
	PARTICIPANTS REPORTED THE FOLLOWING	**RESPONDENTS REPORTED THE FOLLOWING**
Implementation of the White paper on Transformation of the Public Services Delivery (or Batho-Pele White paper	*Not implemented all the time when chasing queue	* Majority reported implementation of White paper on Transformation of the Public Services Delivery (or Batho-Pele White paper
Staffung	Shortage of staff	Confirmed shortage of staff
Infrastructure , medical equipment and maintenance there of	Dilapidated infrastructure, inadequate medical equipment and inadequate maintenance thereof	Confirmed dilapidated infrastructure, inadequate medical equipment and inadequate maintenance thereof
Availability of security	Lack of effective security	Respondents confirmed lack of effective security

Table 4.2. Process related factors analysis

Process related factors		
Item	**Qualitative Approach**	**Quantitative approach**
Salaries	Salaries not satisfactory.Administrators take too long to adjust newly employed	Majority of respondents reported and confirmed that salaries for nurses are not satisfactory
Respondents' attendance to non-nursing duties (Professional nurses)	Nurses used for non-nursing duties.	Most respondents reported and confirmed that nurses are used for non-nursing duties
Opportunities for career development	*No opportunities for career guidance	*Most respondents reported that opportunities for career guidance existed
Absenteeism	High level of absenteeism	Majority respondents reported and confirmed high absenteeism
Working conditions	Poor working conditions reported by participants	Working conditions were neve adequate
Work load	Work load is always high	Majority confirmed that workload was always high
Referall issues.	Midwives at primary levels refer maternity patients unnecessarily	Confirmed that large numbers of maternity patients refred to hospital unnecessary
Availability of monitoring and Evaluation	Monitoring and evaluation sections exists in the department	Confirmed that Monitoring and Evaluation unit available Most confirmed implementation of monitoring and evaluation
Implementation of monitoring and Evaluation	Monitoring and evaluation is implemented	Many confirmed monitoring and evaluation implemented
Involvemnt of stakeholders in monitoring and Evaluation	Stake holders are not involved in monitoring and evaluation	Many confirmed that stakeholders not involved in monitoring and evaluation
Patient centered cre	Patient centered care is practiced	Majority confirmed that patient centered health care is practiced
Mental Health Patient Care	Mental Health Patient do not want to stay in the community even if they are stable	Majority confirmed that that mental health patients were always kept longer than necessary in the mental hospitals leading to them not wanting to stay home anymore
Orthopedic Patients care	Orthopedic Patients stay long in hospitals unnecessarily	Majority confirmed that Orthopedic Patients stay long in hospitals unnecessarily
MDR TB Patients Care.	*MDR TB Patients are admitted in wards with other sick patients	*Majority indicated that MDR TB patients always separated

Table 4.3. Outcome relates analysis

3.Outcome related factors	**Qualitative Approach**	**Quantitative approach**
Employees satisfaction	*Employees not satisfied with their work	*Most respondents are not planning to leave hence they are satisfied with their work.
Client Satisfaction		
Understanding language by patients and service providers	All concerned understand languages spoken in their institutions	Majority indicated and confirmed that they understand language used in institutions
24 hours service provision	No 24 hours is provided	Confirmed that majority of institutions do not provide 24 hrs service
Medicines availability	*Patients able to access prescribed medicines	*Majority did not have prescribed medicines
Cleanliness problems	*Hospitals dirty and smell	*Majority of respondents reported clean facilities
Attitude of staff	Some nurses are rude	Majority confirmed bad attitude
Waiting period	Waiting for much more than 3 hours	Most confirmed waiting more than 3 hours

The researcher analysed the factors contributing to quality healthcare services according to Donabedian model. The Structural factors, Process factors and Outcome factors were analysed separately.

The statistical information was derived from a sample of 220 professional nurses and 180 clients who completed questionnaires as well as 15 professional nurses' and 80 stake holders who participated in focus group discussions. The percentages were calculated on the number of responses to each item (valid percent), not on the total number of questionnaires received. The data collected enabled the researcher to compare where possible the qualitative and quantitative results and draw conclusions. Data analysis was conducted using the SPSS version 25 programme assisted by a Statistician at the Department of Statistics at the University of Venda. Development of the instrument as well as development of strategies were described. In chapter 3, the researcher presented and discussed the findings using Chats and tables.

4.1.1 The purpose of this study.

The purpose of this study was to develop Strategies to facilitate provision of quality healthcare Services in public healthcare facilities in Limpopo Province.

4.1.2 Objectives of the study

The objectives of this study were:

- To describe the views of healthcare professionals regarding provision of quality healthcare services in public healthcare facilities of Limpopo Province.
- To explore the experiences of stakeholders (Clinic Health committees and Hospital board members) regarding provision of quality healthcare services in public healthcare facilities of Limpopo Province.

- To assess the challenges faced by healthcare professionals towards the provision of quality healthcare services in public healthcare facilities of Limpopo Province.
- To describe factors contributing to the provision of quality healthcare services in public healthcare facilities in Limpopo province.
- To evaluate the strategies used to improve provision of quality healthcare service in the public healthcare facilities in Limpopo Province.
- To describe the experiences of clients regarding provision of quality healthcare service within the public healthcare facilities in Limpopo Province.
- To develop strategies to facilitate the provision of quality healthcare service in public healthcare facilities in Limpopo province.

4.1.3 The Research questions

The research questions of this study were:

- What are the views of professional nurses regarding the provision of quality healthcare rendered to clients/patients at the healthcare facilities of Limpopo Province?
- What experiences do stakeholders (clinic committees and Hospital boards) toward the provision of quality healthcare services in public healthcare facilities of Limpopo Province?
- What instrument can be developed for collecting data for the qualitative approach?
- What are some challenges experienced by professional nurses regarding the provision of quality healthcare services in public healthcare facilities?
- What are the factors contributing to quality healthcare provision in public healthcare facilities in Limpopo as perceived by Professional Nurses?
- Are there current strategies for provding quality healthcare services provision in public healthcare facilities of Limpopo Province implemented?
- What are the experiences of clients regarding provision of quality healthcare service within the public healthcare facilities in Limpopo Province?

- What strategies can be developed to facilitate the provision of quality healthcare service in public healthcare facilities in Limpopo province?

4.1.4 The sample size Qualitative approach

Seven (7) groups of professional nurse(Ten(10)participants in each group) from hospitals and five (5) groups from clinics with(five (5) participants each group) were purposely selected for FGDs. Total number of groups were twelve(12) and total number of participants were ninety five (95). The actual number of groups and participants interviewew from hospitals was five (4)(Ten(10) participants in each group). The actual number of groups from clinics were Three (3) with five participants in each group. The total number of actual professional nurse participants was fifty five (55).

For stakeholders, Seven (7) groups of ten (10) participants in each group from c hospitals and and five (5) groups of ten participants each from clinics were purposively selected for the study. Total groups selected were 12 and total participants were one hundred and twenty (120)

The actual number of groups and participants interviewew from hospitals was five (4)(Ten(10) participants in each group). The actual number of groups from clinics were four (4) with 10 participants in each group. The total number of actual stakeholder participants was Eighty (80).

Quantitative data was analysed using the Statistical Package of Social Sciences (SPSS) version 25.This study adopted an exploratory sequentially mixed methods design, therefore the results were presented one after the other, Qualitative results first followed by Quantitative results. Figures and tables were used to visualize the results.

4.2 PRESENTATION OF THE RESULTS:

The presentation started with the Qualitative data, starting with biographical data, followed by quantitative analysis and discussions of results.

4.2. Biographical Data (Qualitative)

Demographic issues addressed in the qualitative data included respondents' age, Gender, qualifications, field of experiences years of professional experience in the first sections of the qualitative.

4.2.1 Age distribution of professional nurses and stake holders

Table 4.4: Age distribution of Participants (qualitative)

Professional nurses	**Frequency**	**%**
20-29	3	5
30-39		
40-49	12	22
50-59	40	73
60 and above	-	-
TOTAL	**55**	**100**
Stakeholder		
Stake holders	**Frequency**	**%**
20-29	55	68.7
30-39	`	-
40-49	10	12.6
50-59	15	18.8.
60 and above		
TOTAL	80	**100**

Table 4.4 displays the age distribution of the participants (qualitative)

Table 4.4 Among the 55 participants for the qualitative methods the findings also revealed that 3 (5.0%) were still young between the ages of 20-22, while 40 (73.0%) of the participants were between 50 – 59 years of age. It is surprising to find that amongst the participants, there were no one above 60 years of age. It is believed that when the professional grow older in the profession, experiences are accumulated which could be used to prevent medico legal hazard as well, thus providing quality care.

4.2.2 Gender distribution of participants

Table 4.5 Gender distribution of participants

Professional nurses			**Stake holders**		
Gender	**Frequency**	**%**	**Gender**	**Frequency**	**%**
Male	5	9		50	62.5
Female	49	91		30	37.5
TOTAL	**55**	**100**		**80**	**100**

Table 4.5 displays the gender distribution of the participants who participated in the qualitative study. Of the 55 participants of this study who participated on the gender question, majority of the participants 59 (91.0%) were females, while the minority, 5 (9.0%) were males. It was not surprising to find most of the participants in this study being females because historically, nursing was predominantly a female profession. While other careers and professions such as information technology, finances and science actively recruited women, since the 1980s and 1990s, nursing has failed to attract more men into the profession. Calzado (2013:1) confirmed that female nurses are more than male nurses.

Table 4.5 also reflected the gender of the stake holder as they participated in this question. Majority 50 (62.5%) of the stake holder were males, while 30 (37.5%) were females. The finding showed that amongst the stake holders, males were more than females. This finding was supported by Colman (2016:1) that, South Africa ranked 17th out of 145 countries when it comes to closing the gender gap, ranking above both the UK (18) and the USA (28).

4.2.3 Qualifications of participants (Professional nurses)

Table 4.6: Qualifications of participants (Professional nurses)

Qualifications prof/nurse	Frequency	Percent (%)
Doctoral degree	0	0
Master's degree	-	0
Honors degree	1	2
Post basic nursing degree	1	2.
Post basic nursing diploma	11	20
Basic nursing degree	3	5.
Basic Nursing diploma	39	71
Total no	**55**	**100**

Out of 55 (100.0%) participants who participated, 39 (71.0) obtained basic Nursing Diploma, while only 11 (20.0%) hold post basic Nursing Diploma. Amongst all the participants, no one had PhD qualification. In this study very few participants held senior degrees relevant to their working situations**.** This might have a negative effect on provision of quality health care services as supported by Gaspard and Yang (2016:6). The authors further reported that there was a need to provide training according to needs, particularly in developing countries where resources are limited.

4.2.4 Field of experience of participants (Professional nurses)

Table 4.7: Experience of participants (Professional nurses)

Field of experience /prof/ nurse	Frequency	Percent%
Operational manager clinic	5	9
General Nurse	35	64
Psychiatric nurse	4	7
Community nurse	5	9
Midwife	5	9
Nurse Education	1	2
Nursing Manager /Administration	-	
Total	**55**	**100**

Table 4.7 illustrates that as many as 35 (64.0%) of the participants qualified as general nurses, minority as reflected on this table held specialized in psychiatry as displayed in table 4.7. According to the findings of this study, very few professional nurses had experience in community health nursing, nursing management and nurse education. This could be related to the very limited posts structure more especially in Primary Health care facilities. WHO (2013:1) highlighted the fact that attracting enough numbers of skilled staff into the public health sector remained a challenge. The lack of sanctioned posts for some cadres and facilities also limited the numbers that could be recruited. Rural areas experienced more problems. More posts need to be created to meet the needs and improve quality health provision.

4.2.5 Years of experience as a professional nurse

Table 4.8: Years of experience as a professional nurse

Years of experience/Prof/nurse	Frequency	%
1-3	5	9
4-5	11	20
5 and above	39	71
Total	**55**	**100**

As depicted by table 4.8, majority 39 (71.0%) of the participants reported to have working for more than 5 years and above while 11(20.0%) of the participants reported to be over by 4-5 years and below 5 (10.0%). However, the results depicted a minority of the newly qualified professionals without much experience. This had potential for more medico legal hazards and poor caring of patients in the health facilities. According to Hill (2010:1); Matlhaba et al (2019:1), there was evidence that years of experience in nursing supported expertise and had a positive impact on the quality of care provided. In this case there was a low intake of new nurses with high numbers of older nurses who were soon to retire. There is a need therefore to develop and implement strategies to retain experienced nurse within the nursing workforce.

4.3 QUALITATIVE DATA ANALYSIS

Of the 5 groups of clinic committee with 10 members each group with 50 participants only. Four groups who consisted of 40 participants were interviewed. At the fourth group participants were reporting the same information. Of the 7 groups of hospital boards which consisted of seventy participants, only four groups with 40 participants were interviewed, in the fourth group people were reporting the same information. Therefore, 8 groups of

stakeholders who consisted of 80 participants, out of 12 planned groups, 120 participants were interviewed see table 3.1.

4.3.1. Planned and actual groups interviewed professional nurse and stake holders

Table 4.9 Participants who participated in interviews

Professional nurses			
Item	**Clinic (5 per group)**	**Hospital (10 per group)**	**Total no of groups**
Planned no of groups	5 groups	7 groups	12 (95) participants
Actual groups Interviewed	3 groups	4 groups	7 groups
No of participants	15	40	55
Stakeholders			
Item	Clinic (10) per group)	Hospital (10per group)	Total no of groups
Planned no of groups	5 groups	7 groups	12 (120) Participants)
Actual groups Interviewed	4 groups	4 groups	8 groups (80 participants)
No of participants	40	40	80

Of the 5 groups of clinic professional nurses which consisted of 25 participants, only 3 groups that had 15 participants were interviewed. By the third groups people were reporting the same information. Of the 7 groups of hospital professional nurses that consisted of 70 participants, only 4 groups that had 40 participants were interviewed. By the 4th group the professional nurses were reporting the same information. Therefore only 7 groups of professional nurses with 55 participants were interviewed. The planned groups were 12 groups with 95 participants, see table 3.3. The main aim under the qualitative phase was to

explore the experiences of the stakeholders (health committees, Hospital boards) and viewpoints of professional nurses from the clinics and hospitals. An average of 10 participants per focus group were interviewed. Three major themes emerged from the collected data and subthemes were also identified as shown in Table as summarized in Table 4.10 below.

4.3.2 Themes and sub-themes emerged from focus group discussions (objective one and objective two (Incorporated factors and challenges)

Table 4.10: Themes and sub-themes emerged from focus group discussions

Themes	Sub-themes
STRUCTURAL FACTORS	Current **used by health professionals on provision of healthcare services in** public healthcare institutions Implementation of White paper on Batho pele Staffing Availability of Clinical equipment Maintenance of Clinical equipment Infrastructural problems/space Maintenance of infrastructure a security
PROCESS FACTORS	Challenges **that are faced by health professionals in the provision of client health care services in public health institutions** Salaries for professional nurses Nurses used for non-nursing duties* Opportunities for career development Factors contributing to provision of quality health care services **by professionals in public health care institutions** Absenteeism Working conditions: Dilapidated infrastructure, financial resources, workload Referral maternity patients Management of patients Availability of monitoring and Evaluation
OUTCOME FACTORS	**Experiences of clients and stakeholders on health care provided by health professionals in public health care** Employee satisfaction* Client satisfaction Access to Health care service Waiting period Availability of medicine Cleanliness Attitude

T

4.3.2.1 Presentations of the Themes and Sub themes

The results of the study were discussed along the themes and subthemes that were derived from the data. Applicable direct quotes were supplied to substantiate relevant results. Appropriate research reports were also cited to support findings.

4.3.2.1.1 Experiences of stakeholders and service providers: Institution related

The participants raised several factors related to the institution. Seven sub-themes emerged including the current strategies for improvement of health care services staffing issues, Equipment issues, infrastructural issues security services issues.

Table 4.11: Theme and subtheme: Experiences of stakeholders and service providers: Structural factors

Themes	Sub-themes
Structural factors	**Current strategies I for improvement of health care services :** Implementation of White paper on Batho pele Staffing Availability of Clinical equipment Maintenance of Clinical equipment Infrastructural problems/space Maintenance of infrastructure a security

4.3.2.1.2 Structural factors (Qualitative Approach)

(a) Current strategies used to facilitate quality service provision

(a) Implementation of the White paper on Transformation of the

The professional nurses who participated in the study raised a concern that the implementation of the Batho-Pele white paper was complicated by shortages of staff.

> *"We understand the need to implement the Batho-Pele principles in our daily work the posters are on the wall to remind us but when we are chasing the queue , when patients are too many, we can't spend more time with each patient" FGD 2* CPN *5.*

Khoza, Du Toit and Roos (2010:1) and Jarden-Baoo et al (2016:398) revealed and confirmed that, only few of the Batho Pele Principles were implemented effectively and that patients in general were not satisfied with treatment in public hospitals. Shortcomings are attributed to insufficient management skills and knowledge at different levels of the health care system, as well as patients' lack of awareness about their health care rights and responsibilities.

(b)Staffing

Participants of this study were concerned about staff shortage as a problem in most of the facilities. According to professional nurses working at the clinics, one nurse was expected to do the work which was supposed to be done by four nurses. The clinic committee members raised the same complaints related to nurses and doctors some respondents suggested that there should be doctors in the clinic facilities as well. The following are some of the comments by professional nurses working at the clinics: There was a suggestion to increase the number of nurses.

> "*There is a serious shortage of one nurse does the work of four other nurses whose posts have been frozen. Patients in clinics can wait for*

more than four weeks to be seen by doctor, this is because a doctor can prepare to come to the clinic to see the doctor, but if an emergency come along he has to cancel his trip to the clinic It would be better if doctors were residing in the village or in the clinic" FGD 1 CPN *5.*

"The problem is if some nurses have died and or retired but they have not been replaced, this is confusing "FGD2 CPN *5.*

"We don't have enough staff to be able to provide 24 hours' services either through on call or night duty systems. We refer all patients after hours to the hospital:" "We are worried that people die on their way to hospital because there is not enough staff to serve during the night," FGD 3 CPN *1.*

This was also raised by Clinic committees from the clinics who indicated that nurses who retired or died are not replaced.

"Sometimes we can feel for the poor nurses they hardly go to eat. The clinic is full every time we come here "FGD 1 CC10.

"As Health committees we made representations for the retired or dead nurses to be replaced but there is no help" FGD2 CC 4.

'In some cases, you can see that the nurse is sick ---- You cannot tell her to work when she is sick" FGD 3 CPN *2.*

"Despite implementation of the white paper on transformation of health services in South Africa which integrated different departments of health from the Apartheid era, shortage of staff is still a problem, its killing us, sometimes we cannot afford to take leave or offs because the wards will not be covered. We therefore become tired and when you are tired you make mistakes" FGD4 HPN1.

Nurses are always off sick we don't know if it is related to overwork. The patients suffer when nurses are off sick FGD 2 HPN *3.*

"Doctors don't spend enough time at the facilities because they are rushing to the next clinic to see more patients. We need more doctors to be stationed at the clinics level" FGD 3 CPN *2.*

"One nurse is doing work for four nurses, a cleaner and a data capture. Why can't the salary be upgraded? That is why professional nurses and patients believed health services have not improved in the past few years What happens to the money that was supposed to pay the other people" FGD 2 CPN *2.*

According to the Analysis by SA Health Review (2010:172), data showed that vacancy rates for public sector medical practitioners in Limpopo reached a peak of 84%, while 66.8% of professional nursing posts were vacant in the Eastern Cape (both largely rural provinces). Further analysis showed that the Western Cape had more than double the number of doctors per 100 000 people than North West province moreover. A study of the HR requirements for Primary Health Care (PHC) in South Africa in six of the poorest districts found only 7% of required doctors.

Abugre (2014:1) and Versteeg, Dutoit, and Couper (2013:1) on the other hand found that in South Africa (SA) 30% of doctors and 15.5% of pharmacists were employed in the public sector, yet only a minority of these public sector workers were based in rural areas – where 43% of the population resides. This was because the working conditions in the rural areas were not conducive to satisfaction because of lack of resources to work with as well as resources to live with e.g. schools and entertainment. The researchers rightly suggested access to health workers in remote and rural areas should be increased through improved recruitment and retention strategies. This is critical to improving the rights of rural communities to comprehensive, quality health care.

"We need more staff in our clinics, as it is when one staff member goes or dies no replacement is given This undermines service

delivery, and everybody has a right to access to quality health services" FGD 3 CPN *5.*

(c) Availability of Clinical Equipment

Availability of Clinical equipment were reported by health professionals and it mainly concerned primary health facilities though hospitals had a few issues as well. These were reported are as follows:

> *"The clinic facilities sometimes go for a long time without some of the diagnostic equipment like for example a blood pressure machine and dipsticks, this is a serious thing for all patients but much more dangerous for the pregnant women who may miss her vital diagnosis of High Blood Pressure, if it is faulty it may give one a false diagnosis only to get surprised later on" This makes the professionals to fear coming to work for fear of you being the one the patient dies on" FGD 1* CPN *3.*
>
> *"Some equipment that we have is not durable. e.g. some blood pressure machines break after using it for a hundred patients. "The importance of a mere Blood pressure machine can never be overemphasized, even where the doctor or nurse have taken history, they need diagnostic equipment to verify" Yet in most cases the clinics don't have blood pressure machines" FGD 3* CPN *3.*
>
> *"In my clinic we don't have a baby scale for close to a year. The patients must be referred to other far clinics. They then have to spend money. If they don't have, they stay. This means that the child cannot be correctly diagnosed for a long time" FGD2* CPN *1.*
>
> *"'I really hate to say this but some equipment is shipped in just before ICRM assessment and taken away thereafter. This*

happens because people do need to comply and be ideal, but lack of equipment is a problem" FGD1 CPN 2.

Shortage of medical equipment, either due to unavailability or non-functioning, is a barrier to the ability of the health system to deliver quality health services. Moyimane, Matlala and Kekana (2017:1) acknowledged that, access to functioning medical equipment was a challenge in low- and middle-income countries. Equipment were mostly unavailable or if available the equipment was of low quality and poorly maintained.

"Most of the equipment delivered to us are not durable e.g. some of the BP machines always fail by the 50-eth client. Thereafter the healthcare providers have to wait for the next delivery of equipment --- A long wait" FGD 1 CPN *4.*

Patients sitting on very old broken furniture its dangerous some patients just stand, and they are ills FGD 2 HPN *5.*

Apparently, this situation was more likely to negatively contribute to quality of health service provision. Kutor, Agede and Ali (2017:1) insisted that in addition to physical examinations or patients' descriptions of their symptoms, physicians relied on diagnostic instruments to check for signs of diseases. Therefore, the availability and optimal utilization of medical equipment is important in improving the quality of service delivery (Kutor, Agede and Ali ,2017:1).

(i) Maintenance of Clinical Equipment

Professional nurses brought about the lack of supervision and a rooster for maintenance of clinical equipment in the clinic facilities. They also suggested that budget should be increased for quality clinical equipment procurement and maintenance thereof.

"Maintenance *clinical equipment is not reliable, some service providers just come and put a sticker of servicing while they did*

> *not. This is very serious and scary that nurses are afraid of any emergencies because anything may happen", we might find that the fire extinguisher is not working besides" FGD1* CPN *3.*
>
> *"There is no rooster for maintenance and we don't know who to contact to remind to come and maintain outstanding equipment. The equipment stays for years and years without being services or fixed. What happens if a patient needing that equipment in a situation of life or death?" FGD2* CPN 5.
>
> "*There is a need for a maintenance rooster and to have the service provider accompanied by a government employee as they service equipment as* they, they should be made to sign in the presence of a witness who actually saw them service the equipment" FGD 3 CPN 2.

The suggestions by Moyimane, Matlala and Kekana (2017:1) was that, management and government structures should be strengthened to ensure the procurement and maintenance plans for medical equipment are developed.

(d) Availability of Infrastructure/space

According to Dejager (2015:9), service delivery in the healthcare sector is profoundly affected by the built infrastructure provided to support it. The built environment could undermine health and healing and aid or cause ill-health or promote wellness and healing. South Africans have the Constitutional rights to: an environment that is not harmful to their health or well-being; and access to - health care service. Participants in the hospitals and clinic facilities brought out space issues related to availability of space in facilities. They also brought out the fact that some clinics are small and placed very far from where people are.

> *"We are unable to comply with the Ideal Clinic Realisation and maintenance because of the lack of room space for the different programmes. Many patients are cramped in one room, which is*

unhealthy and can encourage cross infection and it do not have the following: filling room, counsellors room, only consultation room no mentor mothers 'room, no space to hold meetings; currently using the kitchen, no storage room for condoms; currently stored in an office which sometimes not easily accessible, no waiting area; no chairs; few cubicles; cubicles without medicine trolleys, no rest rooms, staff use their own cars to rest and eat; no kitchen, fridge, oven, bathrooms are leaking ,no meeting/ boardroom room, rest room, parking area., yet some of the clinics cater more than 5000 patients per month" FGD 3 CPN *1.*

"Most of our clinics have the open waiting room area and sick people are exposed to cold and rain during the relevant seasons. Something needs to be done about this" FGD1 CC3.

"Some hospitals buildings are more than 100 years and the sewage system cannot cope with today's load ---always blocked There is a need to budget more money for infrastructure" FGD 4 HPN *4.*

These facilities obviously did not comply with recommendations of the World Health Organisation. According to WHO (2012:3), good quality infrastructure is a key component to sustainable health care service provision. Efficiency and sustainable health care cannot be optimized with poor infrastructure. Superior infrastructure promotes the efficiency of our health professionals and thus, the level of quality so they can deliver the much-needed services. Developing countries should pick up their pace when it comes to developing programmes of maintenance, Developing countries like the UK are on track regarding maintenance of infrastructure in health, they have developed programs of infrastructure maintenance (Moyimane, Matlala and Kekana, (2017:1), Department of Health 2014:1) and Dornan (2012:31) further suggested solutions

to this as adequate funding and establishing appropriate incentives for maintenance and involving the private sector. Infrastructure maintenance must be regarded as a strategic tool to promote improved service provision" (The Presidency, 2014; De Jager (2012:1).

(i) Maintenance of Infrastructure.

Participants from both clinic and hospital facilities raised concerns about the lack of maintenance of the infrastructure like dilapidated old building, not well-ventilated buildings and lack of yard maintenance.

> "*Our clinics 'infrastructure is dilapidated deteriorated; very old and some clinics with broken windows, damaged ceiling and not being maintained properly or renovated" FGD 7 CC 6.*

Clean and well-constructed buildings also contribute to quality provided in health institutions .Similar findings were reported by De Jager (2015:1) in his African study on quality provision.

> *'My clinic's maternity room is not conducive for keeping babies in there because it can be extremely cold in winter" FGD 3 CC 5*
>
> *"There are so many things that we can talk about, "Regular electrical malfunction presents risk to patients and staff." FGD 3* HPN *7.*

> "*Lack of yard maintenance in this allows for the creation of ponds that can breed mosquitos. Mosquitos in turn may lead to malaria; leaking toilet not being fixed even after reporting. Patients feel neglected because building is neglected. "This is not acceptable Maintenance must be budgeted for." FGD 2 HPN 10.*

Neglecting maintenance was regarded as very costly and unsustainable (Dejager, (2015:9; Department of public works, 2007:1).

(e) Availability of security

Provision of security, services to the clinics and hospitals in all government institutions is an important aspect to be considered, Clinic committees and and professional nurses expressed the willingness to take calls at night in order to provide quality day and night, if only they had adequate security. Participants were concerned that some of the fences had holes even where there were security guards one found only one security guard with a gun that had only one bullet or and very old security guard with less chances of overpowering intruders.

> *"We do want to take calls but there are no security personnel here and one nurse have been raped in one of the villages …Its really dangerous There is a need for security in all clinics" FGD4 CC 4.*

> *"The fence has holes, dogs and cattle come and go into the clinic even during the night. It's not safe. A new fencing must be put up" FGD 3 CC5.*

> "*The shortage of Security staff is problematic one male security guard with one gun that has only one bullet. Accompanied by one female security guard cannot protect the nurses. One nurse in the nearby clinic was raped last year. The security should be well armed*" FGD 2 CC 3.

> *"Some of the security personnel are very old they cannot be able to overpower the thug really" FGD 2* CPN *2.*

Magmutual (2017:1) confirmed the need for "toothed" security officers in health institutions. According to Magmutual (2017:1), highly trained hospital security officers who should adapt to your culture and values and are skilled in the special needs of healthcare facilities should be employed. The company further brought forward a study by the National Institute for Occupational Safety and Health (NIOSH), which found out that healthcare and social service

workers faced significant risks of job-related violence. Healthcare workers suffered 50% of all assaults, hence need for security (Magmutual, 2017:1).

4.3.2.1.3 Process Factors (Qualitative Approach)

Challenges that are faced by health professionals in the provision health care services in public health institutions

Table 4.12 Theme and subtheme: Process Related factors

Themes	Sub-themes
Process -related factors	Challenges **that are faced by health professionals in the provision of client health care services in public health institutions.** Salaries * Nurses used for non-nursing duties* Opportunities for career development Factors contributing to provision of quality health care services **by professionals in public health care institutions** Absenteeism Working conditions: Dilapidated infrastructure, workload Referral Availability of Monitoring and Evaluation Management of patients Availability of monitoring and Evaluation

(a)Challenges that are faced by health professionals in the provision of client health care services in public health institutions.

(i)Salary for professionals

Here the professional nurses were never satisfied with their salaries and even adjusting the salary of one professional nurse took a lot of time.

> *The operational manager was concerned about a salary in general and said the salaries "of nurses are not competitive, they are very low nurses' salaries are indeed very low for the work load" FCGD 4* CPN *1.*

According to Okeke, Nwele and Achilike (2012:1) and Johnson (2018:1) the feeling of not being paid fairly in relation to workload had a negative impact on

motivation, and found that employees who are unhappy with levels of pay were more inclined to change jobs (37%) than employees who felt their salary was fair (18%). On the other hand, employees were prepared to trade off lower salary against certain benefits, including higher pension pay-out
(Okeke, et al., 2012:1: Johnson, 2018:1).

(ii) Nurses used for non-nursing duties

Nurses complained that when a cleaner, a porter, or a messenger was not there, they had to take on the roles of these people and quality provision of services suffers.

> "*When a cleaner in the clinic did not come because he or she is sick the nurse has to clean to avoid working in a dirty smelling place" "It would be something at least if during Performance Agreement reviews" this was acknowledged and a higher score given. The professional nurse in charge spends a lot of time seeing patients instead of doing the administrative duties FGD 3* CPN *5.*
>
> *"In this hospital Nurses act as porters or messengers, the take specimen to the laboratory and bring back, while they are doing that nursing care suffers, there is nobody to attend to the patients' needs" FGD 5* HPN *9.*

Armstrong, Rispel and Penn-Kekana (2015:8) found that nursing unit managers spent only about a quarter of their time 25.8% of their time on direct patient care, and the rest on non-nursing duties. These were some of the factors that contributed to low quality of health service delivery.

(iii) Opportunities for Career development

Professional nurses were interviewed, and all were unhappy with the apparent lack of career development in hospital and clinic facilities. Shortage of staff might be paying a role in the situation.

> *One hospital Professional nurse explained: "None in my ward has had an opportunity to go for continuing education or in-service training to improve their careers in 2 years. The last in-service training took place two years ago" no career development here FGD1* CPN *4.*
>
> *"How are we supposed to be up to date with the new developments? Nobody must tell us that our service is not up to standard if we don't get continuing education*" FGD 3 CPN 5.
>
> *"Shortage of staff in the ward does not allow individual to attend in-service training or to go for a year-long training to develop their careers" FGD 4* HPN *6.*

Price and Reichert (2017:3) discovered that, ongoing professional development helped to ensure competency, continuous growth in their nursing practice, quality patient care throughout the span of nurses' careers, as well as optimal quality patient care.

(b)Factors contributing to provision of quality health care services by **professionals in public health care institutions**

(i)Absenteeism

Professional nurses' main concern was the high prevalence of absent officials who mostly present a sick leave. These sick leave requests may be related to demoralisation and the unfavourable conditions officials worked in.

> *"Sometimes the Operational manager in charge is left by herself here, we have many sickly officials. I am not surprised, the unfavorable*

conditions we are working under e.g. staff shortages lack of promotions and long working hours are contributory" said one operational manager" FGD3 CPN *5.*

"*In some cases, you can see that the nurse is sick ---- You cannot tell her to work when she is sick" FGD 1* CPN *3.*

"Most of the nurses are demoralized and burnt out they always say that if they had anywhere to go, they would, they are even prepared to strike" FGD 3 CPN *5 .*

"Absenteeism and sick leaves are so common It is difficult to confirm fakeness and genuine illness" FGD 5 PH 5.

Accordng to Mudaly and Nkosi (2015:4), lack of motivation to attend work, illness, finance, favouritism, unfriendly nurse managers, long work hours, increased workload, unsatisfactory work conditions, lack of equipment, unfair promotions and selection of nurses for training, staff shortages, lack of a reward system and incoherent decision-making caused nurse absenteeism. The study by Mogale, Mothiba and Malema (2015:4) demonstrated the ripple effect of shortage of professional nurses in a Limpopo hospital (Mokopane Hospital). The findings revealed that with shortage of professional nurses, other nurses to experience high workload and worked overtime, became tired all the time. This always led to job dissatisfaction, and absenteeism. Absenteeism greatly compromised nursing care. This resulted in patient dissatisfaction and sometimes led to deaths that could have been prevented (Mogale, Mothiba, and Malema, 2015: 4).

(ii) Working conditions

All the professional nurses that were interviewed complained of poor working conditions concerning the facilities they work in and the accommodation. Some even mentioned that better working conditions are better than bigger salaries.

> *"Nurses sleep in dilapidated houses, People are dissatisfied, they are ready to strike" FGD 3 CPN 3.*
>
> *Some nurses in some clinics still need to share a room when they are on call, this should change*" More nurses' homes must be built and be up to standard FGD 2 CPN 5.
>
> *"We also work in dilapidated facilities, some of which it is dangerous to be in hayi! ---- It's tough" FGD 3 CPN 4.*

According to Matamane (2014:91), poor accommodation was one of the factors that significantly affected nurses" intention to leave. This was supported by Edem, Akpan and People (2017:10) who found that there was a need for health worker's job satisfaction to be the target for health system improvements. The results from this study showed the effect of workplace environmental factor on health workers performance and productivity and suggested that efforts should be geared towards improving the physical environment, social environment, and work system associated with the workplace. Effort should focus on providing healthcare workers with the infrastructure and tools they needed to do their job.

> *"Even if we can be underpaid but if we can have better working conditions better pension plans it can be much better" FGD 4* HPN *7.*

Okeke, et al (2012:1) and Johnson (2018:1) found that improving working conditions, would significantly improve recruitment and retention. Subsequently the quality of health care provision (WHO, 2013:3).

(iii) Work load

Professional nurses complained about high work load that was made worse by staff shortages. They complained that high work load can lead them to omit doing other responsibilities or omit to record.

> *"Because of shortage of staff workload is always high and sometimes nurses have to work past their knock off time for no pay. Mistakes happen when there is a high workload "FGD* 2 CPN 5.

Shihundla, Lebese and Maputle (2016:3) were able to show that increased nurses' workload in Limpopo province could pose a serious challenge to the documented patient information and the documents themselves. The more the documents there was to be written by a few overworked nurses executing the duties, the more they become demotivated and failed to record relevant information.

(iv) Referral: Maternity patients

In this study, the professional nurses interviewed raised problems that were related to midwives at primary health care levels referring patients unnecessary. One professional nurse at the hospital put it this way: However, some clinic professional nurses also explained why they are forced to refer to hospitals.

> "*Something must be done about the midwives who refer patient to hospital unnecessarily to avoid delivering them at the clinic If referral is not indicated then we at hospital are just doing their work while they can go home and relax* "FGD 4 HB 10.

According to Mojaki, Basu and Govender (2011:2) and Singh et al (2016:3) the South African public health sector and the Indian health systems respectively follow a hierarchical referral system. Clinic and CHC refer difficult patient to district hospitals who in turn sent difficult patients to tertiary or academic hospitals.. However, patients often went directly to district hospitals, resulting in increased caseloads. They found that found that most patients seen in OPD and casualty had bypassed the referral system. The researchers attributed this to failure of the PHC facilities to attract their catchment population because of attitude, perception of superior care and resource availability in hospitals, desire

to be seen by medical doctors, and that a hospital may be the nearest health facility. Unless poor attitudes were acknowledged and addressed, it will remain impossible to provide good quality of nursing care to vulnerable patients attending the public (Singh et al., 2016:3). Becker, Dell, Jenkins &Sayed (2012:1) found that acceptability of the PHC services is needed, as most clients believed PHC services were not as good as the hospital.

(v)Monitoring and evaluation

(v) Availability of monitoring and Evaluation

Professional nurses acknowledged the existence of a monitoring and evaluation section in their department.

> *Monitoring and evaluation section exist with a full staff establishment. Dedicated staff member is dedicated to evaluat4 allocated sections FGD CPN4.*

(vi) Implementation of Monitoring and evaluation

The professional nurses were also happy that the monitoring and evaluation section was active and implementing the monitoring and evaluation.

> *"Regular monitoring and evaluation occurring but the problems is the findings/improvement plans cannot be implemented because of lack of physical and financial resource, and the other problem is that clinic health committees and hospital boards are not involved* FGD 2 CPN 5.

Gopane (2012:90) and Kariuki, Purshottama Reddy (2017:1) found conflicting result in the Cacadu District Municipality, the study revealed that whilst the Constitution, 1996 provides for monitoring of local government by provincial government, there appeared to be a conflict between the two spheres, which resulted in some municipalities not following through advice, which was given

by the provincial government and with-holding vital Monitoring and Evaluation information.

(vii) Involvement of Stakeholders in monitoring and evaluation

The clinic committees and hospital boards were interviewed. They were concerned that as stakeholders they were not involves in the monitoring and evaluation of institutions or any community related activities.

> *"We feel we can help but nobody informs or involve us in any activities to improve the clinic and hospital facilities we feel so frustrated"* FGD 2 CC 1.

Jones et al (2017:1) in their study on how hospital boards governed in England found that active clinical leadership, that is informing the hospital boards on the latest developments boards engaging with staff and patients as well as basing decisions on data were some of the things that enabled hospital board in England to succeed in governing hospitals for Quality improvement. Supporting districts to have crosscutting, routine information generating and sharing platforms that bring together stakeholders from different sectors is therefore crucial for the successful implementation of complex development interventions (Kananura et al., 2017:1).

(c)Management of Patients

(i) Patient centered Care

The professional nurses and the Stake holders in their interview indicated the need to emphasize and give patient centered care to patients in Limpopo province. This is because the public consist of different cultural groups that may have different beliefs. All No district serves only one cultural group.

> *Some patients may want to do some rituals before their loved one admitted to hospital…. Like "informing the ancestors" that about this, or they might come to" take his or her spirit home". They are*

allowed to do it as long as it does not pose danger to other patients FGD1 HPN *3.*

This is also supported by Merav (2017:597) who believed that working with the beliefs and values of the patient, engagement, empathetic presence, shared decision-making, and delivery of holistic care was part of patient centred care and improved quality of care. The patients' right charter as detailed by the department of health also allows patients the right to complain about the quality of health service and also encourages the service providers to take the circumstances of the patients into consideration as they provide services (Department of Health 2000:3.). Though patient centred care was satisfactorily practiced, professional nurses and some stake holders were especially worried by the treatment of the three categories of patients as discussed below:

(ii) Mental Health Patient Care

The professional nurses and Hospital board members expressed concern about mental health patients who stay for a very long time in the mental health institution. The problems seem to be the fact that they cannot even stay home for the whole holidays. The respondents even suggested that the patients should be discharged as soon as possible, and the relatives be educated and be prepared to receive them back.

"*There is a big problem regarding mentally ill patients, who stays for years in the mental hospitals until they don't want to stay in the community. During holidays when we allow them to go home, they cannot stay for even a week. They start to act out so they can be brought back to hospital" FGD2* HB *1.*

"My suggestion is there must be a way to inform relatives that when we admit mentally ill patients it's only temporary, so that they can be prepared to have them back" CGD 1 PH 2.

> *"Also, patients must be sent home as soon as possible before they develop hospital neurosis and not want to go home* "FGD 1 HPN 2.

> "*There is a big problem regarding mentally ill patients, during holidays when we allow them to go home, they cannot stay for even a week, they start to act out so they can be brought back to hospital" FGD1* HPN *3.*

Bezudenhoudt (2016:1) following the "Life Esidimeni" crisis in South Africa, where mentally ill patients were moved from a reasonably safe mental health care centres, to places that were not secured and a number of mentally ill patients died, highlighted the fact South Africa, together with the rest of the developing countries still struggled with offering dignified care to mental ill individuals. .She suggested de-institutionalisation of mental health care so that community-based care can be set up in a systematic way, and increased funding and train mental health.

> *"My suggestion is, there must be a way to inform relatives that when we admit mentally ill patients it's only temporary, so that they can be prepared to have them back. Also, patients must be sent home as soon as possible before they develop hospital neurosis and not want to go home* "FGD 1 HPN 10.

Chakraborti and Gajendragad (2015:54) emphasised the need for adequate infrastructure at state and district level to ensure provision of comprehensive treatment and rehabilitation programmes at a place near their homes for persons with mental illness, involvement of private institutions as partners and a need for a clear legislation that will help reintegration. Family members need to be educated so they cango out of their way to make the patient feel part of the family again (Chakraborti and Gajendragad, 2015:54).

(iii) Orthopaedic Patients care

There is also concern expressed by professional nurses towards the increased length of stay by Orthopaedic patients: in the hospital. They also gave advice on how this should be dealt with.

> "*Orthopedic patients stay for a long time in the hospital, I mean I am not talking about weeks but I am talking months…. This robs other acute patients of a bed and costs the hospitals a lot of money. I wish management can do something about this!" FGD 3* HPN *9.*

> *"Patients and their families should health educated to be able to care for patients at home this is beneficial for patient as well because secondary infections can be avoided" "Involvement of physiotherapist should be started at the beginning" FGD 4* HB *4.*

Gholson, Noiseux Otero and GAO (2017:1) discovered that there were patient characteristics like, congestive heart failure and underweight status were the greatest predictors of increased length of stay. COPD, diabetes, morbid obesity, and hypertension represent other modifiable risk factors do play a role in increasing length of stay. This data could be used to counsel patients and their families regarding anticipated duration of hospitalization.

> *Orthopedic patients stay for a long time in the hospital It costs a lot of money and prevent new patients from getting a bed, involvement of physiotherapist should be started at the beginning as patient is admitted FGD 1* HB *4.*

Santy-Tomlinson (2016:1) studied orthopedic patients and found average length of stay had been reduced in qualifying patents through technology progress improved including surgical procedures, implants and external procedures this would enabled patients to go home much earlier therefore saving costs and possibility of nosocomial infections related to long stay.

(iv) MDR TB Patients Care

In this study, the professional nurses from one district reported that MDR resistant patients are admitted with other patients in a general ward. They expressed fear of going to court to answer to any medico legal hazard and made suggestions for a separate ward for TB treatment.

> "*We are so scared; MDR TB patients are admitted in wards with other patients who are already weakened with disease*; FGD 4 HPN 8.
>
> *"This is scary what if they get the disease"? "What if we are sued for it"?*
>
> *"In court as a person in charge of the ward you will be answerable" FGD 3* HPN *7.*
>
> *"A separate ward for the TB patients should be built as well as a separate one for MDR patients"* FGD 4 HPN 8.

According to guideline, Department of health (2007:1), isolation was very important for MDR TB Patients for at least 2 weeks after they are on treatment.

> "*A separate ward for the TB patients should be built as well as a separate one for MDR Patients.* Nursing infectious patients in same ward can lead to cross infection and litigations" FGD3 HPN 2.

The study conducted by Tshitangano (2014:1) in South Africa confirmed that, TB cubicles were not reserved for patients with infectious TB and that many TB inpatients at hospitals of one district were not isolated; masks were not used consistently or appropriately by patients, staff or visitors. Furthermore, the movement of TB inpatients in isolation was not restricted. This therefore posed an unnecessary risk of becoming infected with TB at the rural hospitals of the one district as a result of incorrect isolation practices. The development and implementation of a quality control programme, as well as ongoing training at

the hospital level, would improve the TB infection control measures practiced by healthcare workers at hospitals in the identified district and reduce the risk of acquiring TB at these hospitals.

4.3.2.1.4 Outcome Factors

The outcome factors in this study were represented by the employee satisfaction and the client satisfaction factor .The extent to which employees and clients are satisfied is influenced by the structural and process factors in a health facility. Because of time and financial constraints, only the outcome factors results of clients were considered in the discussions and conclusion

Because

Table 4.13 Outcome Factors

Themes	Sub-themes
Outcome related factors	**Experiences of professional nurses and stakeholders** Employee satisfaction Client Satisfaction : Access to health care service Understanding language Availability of medicine Cleanliness Attitude Waiting period

(a) Employee satisfaction

According to Janicijevic, Seke, Djokovic, and Filipovic (2013:1), satisfaction in health care provision - represents a positive appraisal of provided healthcare with respect to the client's goals and expectations as well as healthcare worker job satisfaction. Health worker satisfaction has a great impact on client satisfaction, quality, and effectiveness, commitment to work and on health care costs. Janicijevic, Seke, Djokovic and Filipovic(2013:1) in a study conducted in

secondary healthcare institutions in Serbia was able to corroborate the fact that healthcare worker satisfaction did impact patient satisfaction.

One operational nurse described a situation of dissatisfaction in her clinic. She was not happy that there is so much staff shortages and nurses sleeping in dilapidated houses.

> *" I am worried about the future of clinics! Most staff are planning to leave as soon as they get better offers because of the pressures they are receiving in facilities because of shortage working and sleeping in dilapidated houses and sometimes sharing a bed" FGD 5 CPN 6.*

Mafini and Pooe (2013:1) and Lega, Prenestini, and Spurgeon (2013:1) found that there were positive correlations between organizational performance and employee satisfaction factors.Employee satisfaction is the terminology used to describe whether employees were happy and contented and fulfilling their desires and needs at work. Heathfield (2014:2) emphasised the importance of employee satisfaction and motivated employees could help make an organisation more profitable.

(b) Client Satisfaction

Six factors were identified as determinants of client satisfaction as follows:

(c) Understanding of language by patients and service providers

The professional nurses responded to this item positively insisting that there was no language barrier between the service providers and the patients in all the five districts.

> *"As far as languages are concerned all patients understand languages spoken at their district sub district and local levels.*

Professionals are able to give instructions and patients are able to receive instructions and understand" FGD 3 CPN *5.*

The quality of communication between patients and providers is a strong determinant of whether patients receive optimal care. Baruch and Walker (2013:1) highlighted the importance of effective communication between patient and the staff as essential for achieving positive health outcomes. Patients must be able to make appointments. Providers must be able to obtain a medical history and discuss symptoms. Health educators must be able to explain the nature of disease and prevention. Patients and their families must be able to understand diagnosed medical conditions and recommended courses of treatment. The rise in language diversity in the United States brings with it several challenges to ensuring effective communication. Organizations that work to address these challenges, however, can realize their goal of providing high-quality care to all patients.

(d) Twenty-four hours' service provision

Participants of this study who responded to this question showed concern that that they wished to take calls or to be on night duty since there is a shortage of staff. There is no proper security at the clinics and hospitals. The participants expressed concern that patients may die on their way to hospital when they could be served to the clinics.

"*We don't have enough staff to be able to provide 24 hours' services either through on call or night duty systems. We refer all patients after hours to the hospital:" We are worried that people die on their way to hospital because there is not enough staff to serve during the night. "More professional nurses should be employed" FGD 3* CPN *5.*

"We do want to take calls but there are no security personnel here and one nurse have been raped in one of the villages …Its really

dangerous "More and appropriately armed security personnel to be employed" FGD 3 CPN *4*

"The fence has holes, dogs and cattle come and go into the clinic even during the night. It's not safe' FGD 1 C C *2*

This situation is contrary to what the department of health prescribed. The system cannot be implemented because of shortage of staff and security reasons.

According to the Department of Health (2016:3), Primary Health Care Clinics should provide 24 hours services and only refer to district hospitals when they could not manage the cases. However the Department of Health (2016:3), acknowledges that because of infrastructural and human resource problems the clink facilities could not take calls since certain areas female nurses are raped and male nurses attacked.

(e) Medicines related issues

Most Participants however, were satisfied with the availability of medicines and the explanations thereof to the patients.

"What I have seen is that the patients are able to access prescribed medicine and nurses do explain how to use the medicine this is the bonus" FGD 2 HB *4: FGD 3* CPN *4.*

According to this section of the study there is no shortage of medicine and correct explanations are given. However it is important to note that soon after the interviews, many people in South Africa were complaining of stock outs in the facilities. For provision of quality health services access to prescribed medicines and correct explanation are vital for speedy recovery by patient. The importance of knowing how to take medicines can never be overestimated.

Kelly and Jorgeson (2012:1) and Usherwood, (2017:148) supported the importance of explaining the use of medicine to patients. In their study, they found that potentially serious health outcomes such as therapeutic failure,

unnecessary hospitalization, and even death could result from no adherence to prescribed medications.

(f) Cleanliness problems

Both professional nurses and Clinic committees expressed frustration on the fact that the health facilities were dirty. Poor clinic and hospital hygiene might be perpetuated by shortage of cleaners as it is witnessed currently in the health systems.

> "*The hospital is so dirty and one can smell it from the gate. There is litter all over "FGD 4* CC 3.
>
> *"We have lost two cleaners to retirement that is why the clinic is so dirty we are concerned with cross infection" FGD 3* CPN *2.*

According to Markkanen et al (2009:3) and Hague et al 2018: (2322), Cleanliness and controlling the spread of infections is particularly crucial in healthcare settings and for health care providers. A healthy safe and aesthetically pleasing space with clean surfaces is comforting to patients and their families by giving an impression of good quality care without additional health hazards. Cleaning holds special importance for hospitals and other healthcare facilities. Non clean environment may lead to nosocomial (Healthcare Associated illnesses) infection, death of patients and litigation. The researchers regarded cleaning to be as important as curative treatment (Hague et al., 2018: 2322).

(g) Attitude of staff

The stakeholders that included the clinic health committees and hospital boards complained about the attitude of the nursing staff. The main complaints were about how they treated their clients not explaining the type of diseases they had or giving themselves time to explain how medicines are to be taken.

> *"Some nurses are so rude that patients prefer to go to clinics that are far from home. This then cost money"* FGD 2 CC 5
>
> *"Nurses go to lunch and take more that the prescribed duration. The walls are decorated with Batho-Pele principles posters but it seems like the implementation there of is a problem "*
>
> *FGD 2* HB *4.*
>
> *"Most service providers do not wear their name tags even if they have brought them along. They don't address the patients respectfully according to how you address an elderly person because they are always chasing the long queue, they do not have time to provide explanations the type of illnesses clients has. In this way, one can say they are not able to carry out their responsibilities"* FGD 2 CC 5.

Haskins, Phakathi, Grant and Horwood (2018:1) in their study in Kwazulu Province of South Africa confirmed the concerns expressed by patients in their study. They also found that Nurses and patients described poor nursing practices and abuse of patients. Therefore strongly suggested that the problem should be urgently addressed wherever it occurs. Nurses could no longer accept or give the excuse of difficult working conditions. Every nurse who abuses patients must be disciplined. Staff shortages should be addressed, including issues of nurses' absenteeism rates. The problem of nurse-patient relationships requires investigations about the causes of these problem.

(h) Waiting period

Clinic committee members and the Professional nurses were concerned about the long waiting time and they attributed this to the shortage of staff

> "*Service here is very slow; you can't believe it but one can wait from 8 to 3 or even 8 o'clock… I am not exaggerating health services provision seems to be regressing" FGD* 2 CC 5.

> "*I feel sorry for my client who have to wait almost the whole day because we are short staffed and we cannot help them fast enough*" CGD 4 CPN 5.

Ogali and Menzie-Okoye (2017:1) in their study in the university teaching hospital of Port Harcourt, South Africa, concluded that the waiting time for patient accessing general outpatient care in the teaching hospital was indeed long and it was a major contributor to negative patient experiences.

4.4 QUANTITATIVE DATA ANALYSIS AND ITERPRETATION

4.4.1 Introduction

This section presents the analysed data and the interpretation of the quantitative data findings of the Quantitative study. Which focused on service providers and clients. The questionnaire was arranged according to the objectives to ensure relevance. Data was analysed based on the study specific objectives and results related to specific study objectives are presented in the subsequent sections. Two hundred and twenty (220) questionnaires were distributed to respondents who consented to participate in the study and 219 questionnaires were satisfactorily filled in and returned, thus the response rate was 98% for service providers. The response rate varied with some sections ranging between, the consistency of a set of measurements217 and 218.

4.4.2 Biographical Data

4.4.2.1 Age distribution respondents (Professional nurses and clients)

Table 4.14 Age distribution respondents (Professional nurses and clients) quantitative

Professional nurses			**Clients**		
AGE	**FREQUENCY**	**%**	**Age**	**FREQUENCY**	**%**
20-29	22	10	20-29	80	44.
30-39			30-39	7	3.9
40-49	43	20	40-49		
50-59	152	70	50-59	20	11.11
60 and above	-		60 and above	10	5.55
Total	217	100	Total	180	100

In table 4.14 of all the respondents, 217 (Professional nurses) indicated their age. Majority 152 (70.0%) of respondents indicated that their age was between 50 and 59 while 43 (20.0%) indicated their age to be between 40 and 49 and a minority

of 22 (10.0%) indicated their age being between 20 and 29. This result showed majority of staff being elderly and about to retire while the 22(10.0%) minority would not be able to replace the 152(70.0%) professionals that are about to retire. Wyman, Ezra and Benger (2018:1) described Ageism as bias against older persons and might affect all people who live long. Elderly nurses might be forced to retire against their will simply because they were old the elderly patients might also be discriminated against in the health facility. All these may affect quality provision because the elderly nurses with their experience would be forced to go resulting in the elderly patients' health care services being compromised. Data analysis was also aligned to the three factors of Donabeiden model viz< Sructural, Process and Outcome factors.

Furthermore, table 4.14 of all the respondents 180, (clients) indicated their age. Majority of respondents (clients) 80 (44.0%) were between 20-29 years while 11(11.0%) were between 50-59 years, 10 (5.5%) were 60 years and above. Majority of respondents, 80 (44.0%) were between 20 and 29 they were at child bearing age. Services catering for the child bearing age need to be put in place. The study findings by Avortri and Modiba (2018:2) highlighted and confirmed the importance of paying attention to factors such as service organisation and coordination, high workload, inadequate number of staffs, in response to the type of services that were provided at a facility. In the facilities that were studied there is therefore a need for reorganising services for the elderly and child bearing age.

4.4.2.2 Distribution of gender of respondents

Table 4.15 Gender distribution of respondents quantitative

Professional nurses				**Clients**	
GENDER	**FREQUENCY**	**%**	**GENDER**	**FREQUENCY**	**%**
MALE	19	8.7	MALE	67	37.3
FEMALE	200	91.3	FEMALE	113	62.7
Total	219	100	Total	180	10

In Table 4.15, of the 219 professional nurses that indicated their gender 200 were female and 19 were male. This reflected the current stereotype where nursing is still regarded as a female profession. This was confirmed by Zamanzadeh, Valizadeh, Reza ,Negarandeh, Morteza Monadi and Az, (2013:1) in their study of literature where they discovered that those males who came to nursing encountered unique difficulties and challenges in nursing educational and clinical settings. They were mostly marginalised, and sometimes not accepted, within nursing. In table 4.15 180 clients indicated their gender. Majority of 113 (67.7%) were females while a minority of 67(37.3%) were males. According to Avortri and Modiba (2018:2), there is a need for more services for women.

Item 4.4.2.3 Qualifications for professional nurses

Table 4.16 Qualifications of respondents (professional nurses) quantitative

Qualifications prof/nurse	Frequency	Percent (%)
Doctoral degree	0	0
Master's degree	9	4.
Honors degree	9	4.
Post basic nursing degree	4	2.
Post basic nursing diploma	55	26
Basic nursing degree	9	4.
Basic Nursing diploma	131	60
TOTAL NO	**217**	**100**

Table 4.16 indicate qualification. The respondents were requested to indicate their qualifications. Of the respondents, 217 who responded to this question, majority 131 (60.0%) of the respondents reported to have qualified as Nursing Diploma holders. However, almost 55 (26.0%) of the respondents report to have qualified as Post Basic Nursing Diploma holders. Surprisingly, finding of this study revealed that respondents who participated in this study could not study further. No respondent reported to had qualified as a PhD, Masters and Honours degree in nursing holders. Implications of holding higher qualifications in nursing, could be linked with matured in professional hood, and the best practices in the prevention of medico-legal hazards. Similar findings were reported by a study conducted in Croatia in Europe by Fumić Marinović and Brajan (2014:1) on the importance of continuous education which the researchers reported that to be highly educated improves the quality of nursing healthcare and increases the effectiveness of patient care, consequently maintaining and enhancing patient safety.

4.4.2.4 Respondents' field of expertise/experiences (professional nurses)

Table 4.17 Respondents' field of expertise/experiences (professional nurses) quantitative

Field of experience /prof/ nurse	Frequency	Percent%
Operational manager clinic	5	2
General Nurse	100	46
Psychiatric nurse	10	5
Community nurse	5	2
Midwife	95	44
Nurse Education	1	5
Nursing Manager /Administration	1	5
TOTAL	217	100

Table 4.17 shows an analysis of the respondents' expertise/experiences in nursing profession. Out of responses received, only 5 (2.0%) were Operational Managers at the clinic level and hospital wards. As many as 100 (46.0%) of the respondents in this study, reported that they hold general nursing qualifications. Amongst the respondents who responded to this study, no one had an advanced qualification. Only 95 (44.0%) were qualified and had experience in midwifery, while 10 (5.0%) and only a minority of 1 (0.5%) Qualified and experienced as Nurse Administrators and nurse educators. Armstrong, Rispel and Penn-Kekana (2015:8) found that higher qualifications and expertise of professional nurses was associated with higher prevention of medico-legal hazards in the healthcare fraternity. Majority respondents in this study only have basic qualification and expertise.

4.4.2.5 Respondents' years of experience (professional nurses)

Table 4.18 Respondents' years of experience (Professional nurse) quantitative

Years of experience/Prof/nurse	Frequency	Percent%
1-3	22	10
4-5	48	22
5 and above	147	68
Total	217	100

Questionnaire on years of experience as a professional nurse was completed by 217 respondents. In table 4.18, of the 217 that responded to this question majority of 147(68.0%) had experience of 5 years and above with a minority of 22 (10.0%) below 5 years. Minority of professional nurses had less years of experience with a potential to have those with more experience leaving the inexperience on retirement**.** To maintain the quality of health care provision, strategies to keep the experienced nurses longer in service need to be developed. This was supported by Hill (2010:1) and Bekker et al (2015:3), who presented five vehicles to increase the retention of the experienced nurse within the nursing profession as follows: 1.Cultivating a climate of continuous, career-long learning, 2.Developing a career portfolio, so that the elderly and experienced nurses do not have to take on the traditional employment but can do flexi hours if they so wish. 3.Making ergonomic accommodations designing the working condition in such a way that everybody is comfortable working and is not strained 4.Implementing strategies to support succession planning, by ensuring that the near retiring nurse grooms his or her successor and as well as 5.Implementing phased retirement.

4.4.3. Structure factors

4.4.3.1 Implementation of the White paper on Transformation of the Public Services Delivery (or Batho-Pele White paper implementation)

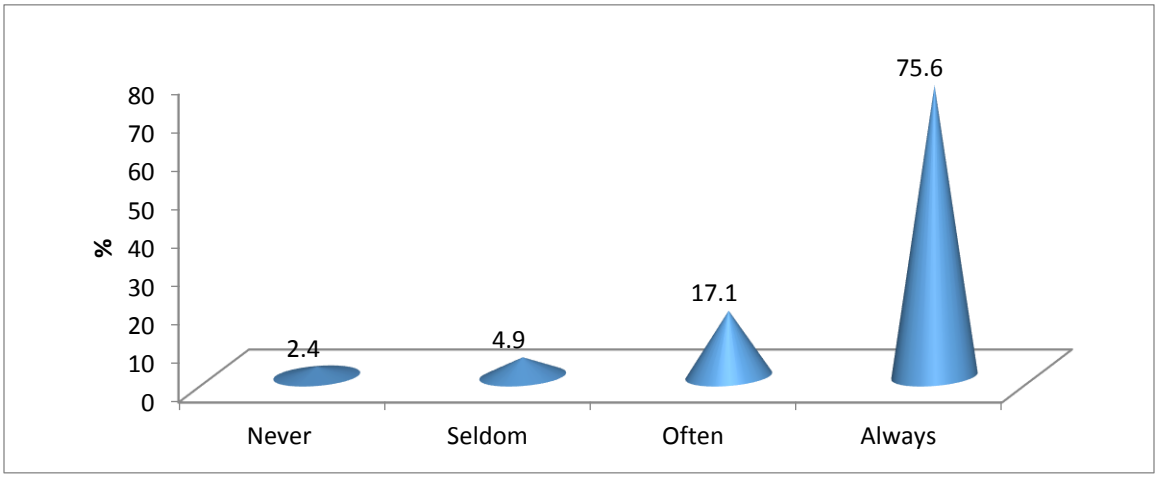


Figure 4.1 Respondents' response on Batho pele principle (n= 211)

Figure 4.1 Shows that majority of the respondents159 (75.6%) indicated that Batho pele white paper was always used as a strategy to improve service delivery. However, the minority of 5 (2.4%) of the respondents indicated that the Batho pele White paper was never used as a strategy to improve service delivery. For transformation of public services, the White paper on transformation of Public services had to be implemented. This study found that the Batho-Pele white paper was being implemented. These findings differed from the contribution by Figure 3.2 Distribution of facilities per district.

The hospital board members in the. the focus group discussion, who observed that nurses took more that the prescribed lunch yet the hospital walls were decorated with Batho-Pele principles posters but it seems like the implementation there of is a problem. Khoza, Du Toit and Roos (2010:1)and Jarden-Baoo et al (2016:398) also indicated that none of the Batho Pele

Principles were included in the research were implemented effectively. The shortfalls were identified as being inefficient management and patients' lack of knowledge about their rights in health care.

4.19. Experiences of stakeholders and service providers on care rendered

Item	Always		Often		Seldom		Never		Total	
	F	%	F	%	F	%	F	%	No	%
There is enough Staff for the job	18	8.2	22	10.2	58	26.5	120	55.1	219	100
Availability of Infrastructure / space	18	8,3	18	8.3	80	37	100	46	216	100
Maintenance of facility infrastructure	17	8	20	9	30	14	150	69	217	100
Availability of clinical equipment	17	8	20	9	30	14	150	69	217	100
Maintenance of clinical equipment is adequate	17	8	20	9	30	14	150	69	217	100
Availability of security	6	3	70	32	60	28	80	37	216	100

4.19. Experiences of stakeholders and service providers on care rendered

4.4.3.2. Staffing

The findings of this study revealed that shortage of staff which was experienced during the time of data collection by almost all the public institution that participated in the study. 219 respondents responded to the question of staffing. Table 4.19 showed that the majority of the respondents 120(55.1%) indicated that the staff was never enough for the job, while the minority of only18 (.8.2%) of respondents who reported that staff was always enough. Therefore in most hospitals, working overtime as well as job dissatisfaction was experienced. Quality of health care was an outcome of shortage of staff.

Manyisa (2016:1) found that workload (correlated with shortage of staff) has been found to be the most important predictor of burnout, lack of involvement and dehumanization of patients by health care personnel. It is also a major cause of dissatisfaction among health care givers and support staff and has been found to have an influence on staff decisions as whether to leave or remain in their jobs. On the other hand, Van Rensburg, (2014:3) warned that the shortage of staff influences responsiveness to the needs of the community and patients negatively and was associated with poor performance and inability to provide care according to standards. Since 2007, the government has been placing its hope on an NHI Plan and accompanying strategies as a possible solution to the need to balance the distribution of the workforce and to secure universal and equitable access to health services for the entire population**.**

4.4.3.3 Availability of Infrastructure/space

Questionnaire on availability of space / infrastructure was important in order to find out whether professional nurses are satisfied with the space or infrastructure. Table 4.19 shows that of the 216 respondents 100(46.0%) reported that the problems associated with space are influencing poor provision of care and service provision delays. Lack of space in rural facilities was a common complaint. It was also a serious challenge that hindered quality service provision. Lack of space can compromise privacy of patients and can also cause

cross infection if people who are sick can be cramped in a small space. Some clinics have not been built according to regulations. Egbujie, et al (2018:1); Manyisa and Aswegen (2017:28) also confirmed that lack of space was problematic and compromised patients' right to privacy. Many institutions were identified as being too small to cope with the demands upon them, as some complained that their catchment areas were too large. Reports of exhaustingly long queues at facility pharmacies due to small and cramped waiting areas were common complaints about the public facilities (Manyisa and Aswegen, 2017:29).

4.4.3.3.1 Maintenance of infrastructure and equipment

Table 4.19 also reported that most 150 (69.0%) out of 217 respondents expressed concern that maintenance of infrastructure was never adequate with a minority of only 17(8%) respondents indicated that availability of equipment, maintenance of infrastructure and equipment was always adequate. It is surprising to find that 17 (8.0%) of the minority of the respondents from the public institutions reporting adequate availability of clinical equipment. It could be possible that some of the respondents were not open enough to report actual and proper information about the current information. The study by Tateke, Woldie and Ololo (2012:10-11) and Nkala, (2016:4) found the perceived cleanliness score of hospitals to be associated with the satisfaction score by patients and service provider.

4.4.3.4. Availability of clinical equipment

Regarding availability of equipment table4.19 showed that the majority 150 (69.0%) of the respondents indicated that availability of equipment was never adequate as equipment was never enough. and maintenance of infrastructure and equipment was never adequate with a minority only 17(8%) respondents indicated that equipment were always available availability.

4.4.3.5 Maintenance of Clinical equipment

On the question of maintenance of the clinical equipment Table 4.19, majority of 150(69.0%) Were concerned that maintenance of clinical equipment was never adequate. A minority of 17(8%) respondents indicated that maintenance of clinicl equipment was always adequate. Availability of equipment, Infrastructure and equipment maintenance is vital in the management of patients. Equipment is important in diagnosing and treatment of patients. Quality services cannot be provided if equipment is not working, diagnosis and treatment may be compromised. According to this study maintenance of infrastructure and equipment is never adequate. Erasmus, Poluta and Weeks (2012:1)and (Dejager, P (2015:9) also agreed with the fact that Quality services can only be provided when physical facilities, installations and equipment are in good working condition to provide a fully functional and operational environment. The study by Egbujie et al (2018:3) in primary health care clinics in Kwazulu Natal Province, S.A. confirmed that inadequate supply of equipment and consumables as a common factor which may influence the management of quality nursing in all the 8 rural district hospitals in the west coast Wine.

4.4.3.6 Availability of Security

Table 4.19 showed that most respondents 80 (37.0%) of a total of 216 respondents indicated that security was never adequate, while 60 (28.0%) respondents reported that security is seldom adequate while only a minority of 6 (3.0%) respondents indicated that security was always adequate. According to this study security is never adequate. Security in the facilities was very important for the provision of quality service delivery. There is a history of some nurses being raped and some security guards being killed during the night. Without adequate security the health professionals could not provide 24 hours services. Problems with attaining security standards seemed to be common in most developing countries. Bigira and Katangole (2015:1) found that only two out of six hospitals they studied in western Uganda, fairly met the security standards with identified gaps like lack of security guidelines, security plans, security committees, security equipment like guns, not enough security personnel and non-availability of training opportunities for security personnel. The structural theme issues because of their cost implications for the department, were mostly left for followup studies

4.4.3.6 Process Factors

4.4.3.6.1. Challenges affecting provision of quality delivery

Table 4.20: Challenges affecting provision of quality delivery

Item	Always		Often		Seldom		Never		Total	
	(f)	(%)	(f)	(%)	(f)	(%)	(f)	(%)	(n)	(%)
Employee satisfaction Staff planning to relocate to other job opportunities	51	23.4	46	21.3	51	23.4	69	31.9	217	100
Salaries for nurses are satisfactory	10	4.6	32	14.9	46.	21.1	129	59.4	217	100
Nurses used for non-nursing duties	150	69.0	41	18.8	41	18.8	17	8.0 %	218	100
Opportunities for career Development are available	88	40.4	46	21.3	88	40.4	37	17	217	100

(a) Employee satisfaction; planning to relocate to other job opportunities

Table 4.20 displays that about 69 (31.9%) of the respondents reported that they were not planning to relocate to other job opportunities while 51 (23.4%) of the respondents indicated that they seldom plan to relocate to other job opportunities, with a minority of 46 (21.4%) respondents indicated that were always planning to relocate to other job opportunities. Majority are not planning to relocate. According to this study majority of staff is not planning to relocate to other job opportunities.

According to Manyisa (2016:1), workload has been found to be the most important predictor of burnout, lack of involvement and dehumanization of patients by health care personnel. It is also a major cause of dissatisfaction among health care givers and support staff and has been found to have an influence on staff decisions as whether to leave or remain in their jobs. Asegid, Belachew and Yima (2014:2) conducted studies that showed that nurses were mostly dissatisfied with salary and this motivated them to relocate. Mafini & Pooe (2013:1) however discovered that not only salary can influence whether professionals think of leaving or not but incentives, working conditions can be important predictors as well as also other intrinsic factors such as achievement, recognition, responsibility, opportunity for personal growth are also important for job satisfaction.

(b) Salary for professionals

In table 4.20 regarding salaries of professional nurses the majority of respondents 136 (62.5 %), found salaries for professional to be not satisfactory. A minority of only 9 (4.2%) found salaries for professionals to be always satisfactory. According to this study salaries for professionals is never satisfactory. Salary for service providers should be able to meet the basic needs of the service providers and it's equally important that resources to provide services should be available. Failure to secure the above mentioned could lead to burnout of the service providers. When service providers experience burnout, they can have a potential to make more mistakes that can results in death and litigations. Asegid et al (2014:10), Bhatnagar and Srivastava, (2012:77) and Asekun (2015:7), in their studies reported that salary satisfaction and benefits subscales are correlated with job satisfaction.

(c) Nurses used for non-nursing duties

Table 4.20 also shows that Majority of respondents 150 (69.0%) out of 218 respondents, of this study reported the concern that nurses are also attending to non-nursing duties such as cleaning the floors and walls. When they are made to do non nursing duties their patients suffer. This can result in medico legal hazards and litigation. It was observed that sometimes nurses got used to doing non nursing duties as part of their job description. Becker (2013:3) confirmed this in the study conducted in South Africa. Three main non-nursing tasks (NNTs) commonly performed by nurses were identified i.e.: filling-in for non-nursing services viz: cleaning patient's rooms and equipment, and obtaining supplies and equipment .This study also confirmed that professional nurses seemed to have grown accustomed to performing the non-nursing duties as part of their workload. They said performing non-nursing duty did not affect their job satisfaction seemingly, unaware that this took them away from nursing tasks which should improve job satisfaction (Becker, 2013:3).

(d) Opportunities for Career development

Table 4.20 showed that as many as 88 (40.4%) out of 217 respondents indicated that opportunities for career development were always available while the minority of 37(17.0%) indicated that there were never opportunities for career guidance. People work better and harder if they know they are going to be acknowledged in one way or another. Career development enable people to grow professionally and improve their skills. This growth may affect quality health care provision positively. This was confirmed by Asegid et al (2014: 142) and Price and Reichert (2017:3) in their study in Sidama Zone Public Health Facilities, South Ethiopia who reported that career opportunities and training afford individuals the prospect of further developing themselves and growing within the ranks of their career and ensured continuous growth in their practice and improved quality of care.

4.4.3.6.2. Factors affecting quality health care service provision

Table 4.21. Factors that affect provision of quality service delivery

Item	Always		Often		Seldom		Never		Total	
	(f)	(%)	(f)	(%)	(f)	(%)	(f)	(%)	(n)	(%)
Staff absenteeism is high	**150**	**69**	**30**	**14**	**20**	**09**	**19**	**08**	**219**	**100**
Working conditions infrastructure at work and nurses home adequate	5	2.1	18	8.5	28	12.8	166	76.6	**219**	**100**
Work load is high in public services	186	85.4	18	8.3	5	2.1	9	4.2	218	100
Patient centred health care is practiced.	**122**	**56.2**	**60**	**27.6**	**30**	**13.8**	**5**	**2.3.**	**217**	**100**

(a) Absenteeism

The results regarding absenteeism in table 4.21 showed that majority, 150 (69.0%) out of 219 respondents indicated that absenteeism in professional nurses was always high, with a minority of only19 (8.0%) of respondents who indicated that staff absenteeism was never high. According to this study Absenteeism by professional nurses is always high. Potential causes for absenteeism are bad relations at work, burnout syndrome, work overload and long working hours. Absenteeism hinders quality service provision in that there will always be less staff at work, further perpetuating work overload. Mudaly and Nkosi (2013:1) in their study, in Durban hospitals South Africa, confirmed the reasons mentioned above for absenteeism. All reasons were related to the working conditions at the institutions such as: lack of motivation to attend work, illness, finance, favoritism, unfriendly nurse managers, long work hours, increased workload, unsatisfactory work conditions, lack of equipment, unfair promotions and selection of nurses for training, staff shortages, lack of a reward

system and incoherent decision-making contributed to nursing staff absenteeism.

(b) Working conditions

Regarding working conditions, Out of the 219 respondents, the majority of respondents 166 (76.6%) in table 4.21 indicated that working conditions i.e. Infrastructure at work and nurses' home was never adequate, while only a minority of 5 (2.1%) respondents indicated that it was always adequate. Bad working conditions may negatively affect quality health provision. Edem et al (2017:1) and Mustapha and Zakaria (2013) in their study on job satisfaction among academic in higher public institution in Malaysia insisted that the relationship between the health worker, work and the workplace environment was very crucial and hence it would become an integral part of work itself. Management effort in ensuring an active workforce should therefore be focused on employee personal motivation and the infrastructure of the work environment. They also found that there was a positive significant relationship between promotion opportunity and job satisfaction.

(c) Work load

Table 4.21 showed that majority 186 (85.4 %) out of 218 respondents indicated that work load was always high in public services. While as much as 9 (4.2%) of respondents indicated that workload was never high in public services and a minority of only 5 (2.1%) respondents indicated that work load is seldom high in public services. According to this study workload is always high in public service. It is important that workload should be enough to allow service providers to spend enough time with patients according to their needs. Quality of health service provision is compromised if health care providers are always facing high workload. According Mayoasi and Benata (2014:1348), in their study in South Africa, explained workload as being related to the growing burden of

communicable and non-communicable disease as well as persisting social disparities and inadequate human resource. Which persisted even though South Africa underwent a peaceful transition from apartheid to a constitutional democracy.

Benatar (2013:6) confirmed this in the study conducted in South Africa, and attributed this to the fact that South Africa spends more money in the private sector that have less people to take care of than in the public sector. Yet the public sector have about six time more people than the private To address these issues the NHI system which was spearheaded by Dr Motsoaledi plans to recruit retired doctors (and nurses) and to revise salary for all m the health personnel (doctors and nurses) The national health insurance plans to introduce workload reducing mechanism viz. computerized filling system, proper appointment times made and adhered to by the patients including pre booking , pre retrieving of files , prepacking of treatment and implement one stop shop and integrated services. This would involve educating the patients and service providers on implementation of these workload reducing mechanisms (Department of Health, 2014:4).

(d) Patient centred health care is practiced

On the question of practicing patient centred care 217 respondents responded. Table 4.21 showed that majority 122 (56.5%) of respondents indicated that patient centred health was always practiced. A minority of 5 (2.2%) indicated that patient centered health care was never practiced. Majority of respondent believe in patient centred health care.Patient centred approach to patient care is vital if quality of health care provision is to be improved. South Africa have always been multiracial and multicultural. Service providers in S.A seems to be used to different cultures and different languages. Baboo, Van Rooyen, Ricks and Jordan (2016:399) conducted a study In Nelson Mandela bay public hospitals Participants observed that having knowledge of the culture and language of the patient would enabled the nurses to know how to care for a

patient by taking the patient's culture into consideration. This was considered to be akin to rendering patient-centered care

(e) Referral Maternity patients

Large numbers of maternity patients referred to deliver in hospitals are unnecessary.

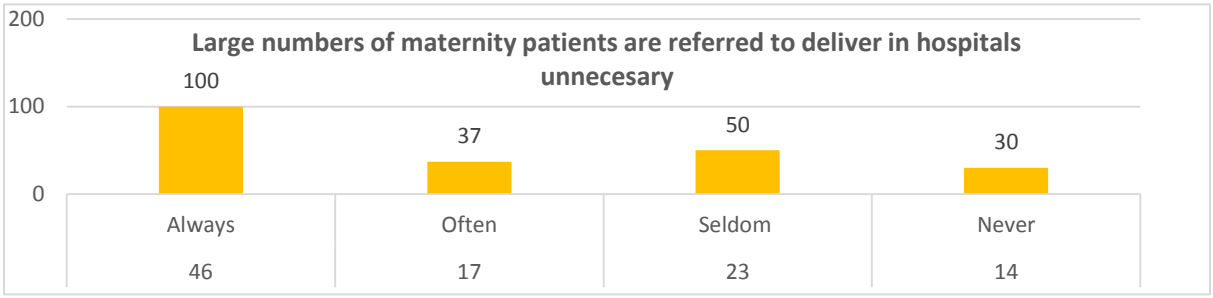


Figure 4.2 Respondents' responses to referral of maternity patients (n=217)

Figure 4.2 showed that majority of respondents100 (46.0%) out of 217 respondents reported the fact that large numbers of maternity patients referred to deliver in hospitals are always unnecessary, while only a minority 30 (14.0%) of respondents indicated that large numbers of maternity patients referred to deliver in hospitals are never unnecessary. It is very important to refer only complicated maternity cases to the hospitals. This would enable the hospitals to be able to deal mostly with complicated cases instead of dealing with cases that could be dealt with at primary health care levels. Referred maternity patients to hospitals was unnecessary. This might be related to the shortage of staff and inadequate security in the clinic facilities. Singh, Doyle, Campbell, Murthy and Soon (2016:6) in their study in India found that health care providers there mostly referred obstructed labour, haemorrhage pregnancy induced hypertension severe anaemia complicated abortion post-partum haemorrhage and twin pregnancy. These referrals were legitimate. This happened because they had no shortage of staff, and had adequate security I their institutions (Singh et al., 2016:1).

(f) Monitoring and evaluation

Table 4.22 Availability of Monitoring and Evaluation

Item	Always		Often		Seldom		Never		Total	
	(f)	(%)	(f)	(%)	(f)	(%)	(f)	(%)	(n)	(%)
Availability of monitoring and	150	69.2.	30	13.8	25	11.5	12	5.5	217	100
Implementation of monitoring and	69	35	61	29.2	16.7	20.8	43	3.33	218	100
Stake hoholders are involved in involved and evaluation	39	17.8	48	22.2	53	24.4	77	35.6	217	100

(g) Availability of Monitoring and Evaluation Section

Table 4.22 displayed as many as 77 (35.6%) of the 217 respondents who answered the question about Monitoring and evaluation availability, indicated that a monitoring and evaluation unit was available with only a minority of 39 (17.8%) respondents indicating that monitoring and evaluation was never available. Based on these findings, it can be said that monitoring and evaluation is available in the department According to this study, monitoring and evaluation section is always available Despite the fact that the South African Constitution through new dispensation, placed a premium on a responsive, development oriented public service, effective and accountable stewardship of public resources, effective oversight by Parliament and the nine provincial legislatures, and public participation in policy and implementation, which needed to be realized through the presence of Monitoring and evaluation. Kariuki, Purshottama Reddy (2017:1) in their study found that monitoring and evaluation capacity is low in the majority of municipalities besides the Metro. The municipalities were inadequately

resourced with competent monitoring and evaluation human personnel, thereby stifling their capacity to deliver quality monitoring and evaluation services

(i)Implementation of Monitoring and Evaluation

218 respondents responded to the question of implementation of Monitoring and evaluation Table 4.22, displays that most respondents 69 (35.0%) indicated that monitoring and evaluation was always implemented while a minority of 43 (33.3%) indicated that monitoring and evaluation was never implemented. According to Chabane (2013:1), DPME and Offices of the Premier regularly visited all the departments for monitoring and evaluation. The Department of health have established its own monitoring and evaluation unit that internally monitor the implementation of the policies (Chabane, 2013:1). However, Gopane (2012:70) and Kariuki, Purshottama and Reddy (2017:1) .highlighted problems that hindered implementation of Monitoring and evaluation in some municipality the in South Africa The municipal officials were not cooperating and were reluctant to give vital information to the monitoring teams because they did not yet understand the objective of Monitoring and Evaluation. Kariuki, Purshottama and Reddy (2017:1) recommended that municipalities be adequately resourced with competent monitoring and evaluation human personnel. This is important for strengthening their capacity to deliver efficient monitoring and evaluation services.

(h)Involvement of stake holders in Monitoring and Evaluation

Table 4.22 regarding involvement of stakeholders showed that as many as 77 (35.6%) of the 217 respondents indicated that stakeholders were not involved or participated in monitoring and evaluation, while 53 (24.4%) of respondents who indicated that stake holders are seldom involved or participated with a minority of 38 (17.8%) of respondents who indicated that stake holders were always involved or participated in monitoring and evaluation. According to this study, stake holders were not involved or participated in monitoring and Evaluation.

Stake holders need to be involved in monitoring and evaluation so that they can be well informed on the standard set and how these can be improved. Kananura, et al (2017:5) in Kenya, Rwanda and Tanzania on the other hand was also able to demonstrate that participatory Monitoring and Evaluation was able to influence decision making in health. This necessitated the Department of Performance Monitoring and Evaluation (DPME) to start working on plan for citizens to monitor selected frontline service delivery against agreed standards. The (DPME) believes Government has responsibility to ensure citizens are aware and informed of the quality of service they can expect (Chabane, 2013:2).

.(I) Management of Patients

(i)Mental health patients their stay in hospital

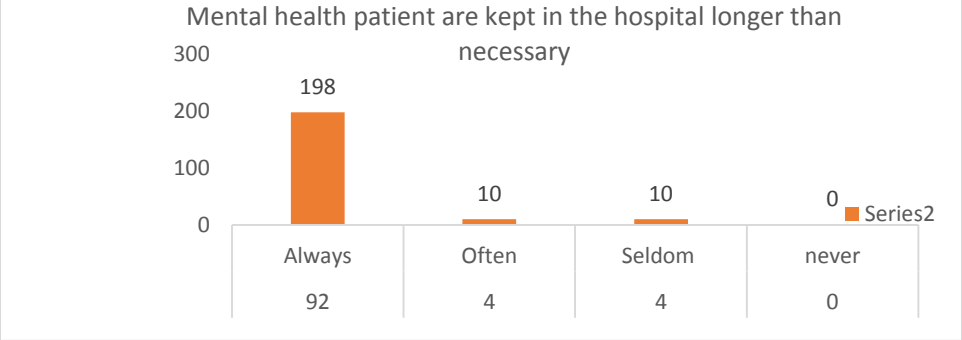


Figure **4.3:** Respondents 'responses to mental health patients (n=218

Figure 4.3 showed that majority of respondents 198 (92.0%) out of 218 respondents reported that mental health patients were always kept longer than necessary in the department while a minority of 10 (4.0%) of respondents indicated that mental health patients were seldom kept longer than necessary in the department. Keeping stabilised mentally ill patients in the hospital is very expensive for the hospitals concerned and separated them from their families. Many people were not in favour of the approach of keeping stable mentally ill patients in hospital wards. Campbell (2017:1) from Northern Ireland was one of these people who was advocating for stable mentally ill people to be cared for in their own communities or homes if it is possible. He insisted that in the 21st century, a hospital should never be considered 'home' for people with a mental health condition. Neuman (2013:2), agreed with Campbell (217:1), but highlighted that there may be valid reasons for admitting mentally ill patients.

(ii) Orthopedic patients experience long hospitals stay.

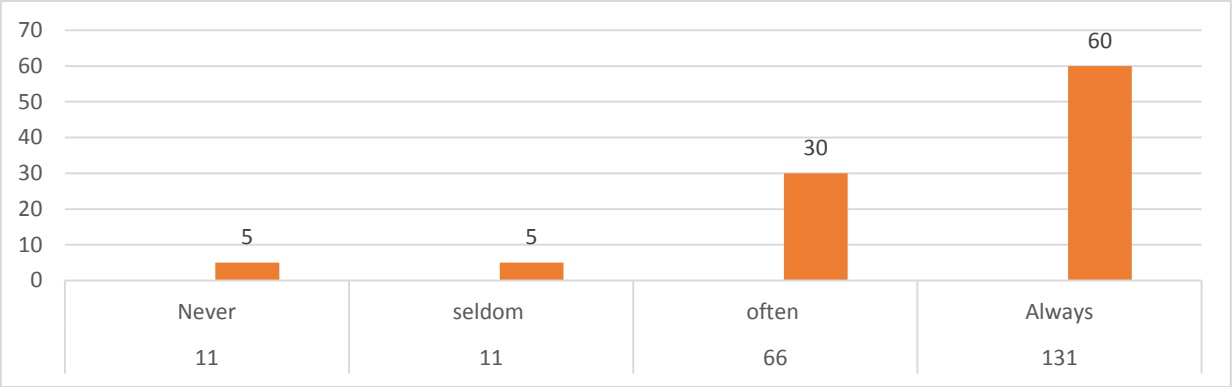


Figure 4.4 Respondents 'responses to orthopaedic patients (n=219).

Regarding orthopaedic patients" long hospital stay figure 4.4 showed that majority of respondents 131(60.0%) out of 219 respondents reported that orthopedic patients always experience long hospitals stay in the department. On the other hand, a minority of 11 (5.0. %) of the respondents indicated that orthopedic patients never experienced long hospital stay. Staying long in hospital by patents is expensive and this has a potential for patients to contract nosocomial infections. To avoid long hospital, stay for orthopaedic patients, they could be released to be cared for in the community by trained caregivers, in the patient's own home.

Mersal (2014:1) in her study in Egypt, noticed that caregivers could play a vital role in caring for orthopaedic patients when they were discharged to be cared for in the community. However, doctors were reluctant to send their orthopedic patients to be cared for by care givers in the home for fear of complications of immobilization. This fear of complications of immobilization therefore contributed to long hospital stay. If the caregivers were knowledgeable about the potential changes of immobility and diligent in implementing preventive interventions, they would avoid lots of discomfort, complications and cost for the patient however, in her study she discovered that nearly three quarter of the caregivers had unsatisfactory knowledge and inadequate performance.

Therefore; training and educational program to enhance knowledge and practice of caregivers are needed as well as ensuring availability and effective co-ordination of various types of facilities for medical care, and other services for the sick and infirm in the community (Mersal, 2014:1).

(iii) Acute TB and MDR Patients are separated in the department.

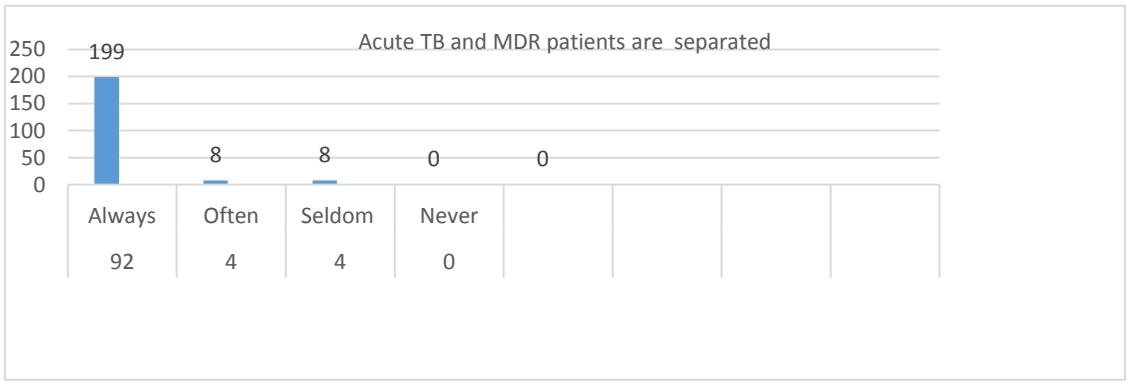


Figure 4.5 respondents' responses to Acute TB and MDR Patients are separated n =215

The figure 4.5 showed that majority of respondents 199(92.0%) out of 215 respondents indicated that Acute TB and MDR Patients were always separated. However, a minority of 8 (4.0%) reported that. Acute TB and MDR Patients are seldom separated in the department, and another 8 (4%) reported that Acute TB and MDR Patients are often separated in the department. It is important that acute TB and MDR are always separated so that those people who have acute TB and or MDR cannot infect each other or those around them. This however differed with the professional nurses from the focus group discussions who reported that MDR resistant patients were admitted with other patients in a general ward (4.3.4.4). The issue of non-separation only affected one district and it was resolved by the time the study was completed.

Lange, et al (2014:24) in their study in Minsk and Belarus agreed with the fact that Individuals suspected of having TB should be separated from other patients and evaluated for TB without waiting in general areas. Hospitalisation should

include airborne isolation precautions and be limited primarily to contagious AFB sputum smear-positive TB patients. Infectiousness is substantially reduced once a patient is on an adequate regimen and it is probably not necessary to keep a patient in hospital until their cultures become negative. The best way to prevent transmission of MDR/XDR-TB is a rapid diagnosis (high level of suspicion and rapid DST) and the prompt start of an effective treatment (Lange, et al., 2014:25); (Murray and Lopez, 2013:5). Non-financial incentives serve as motivational factors like increasing the remuneration, to invest in continuously career development or to improve the work equipment. However, these incentives will only have the desired effect, if they are introduced in supportive work environments.

4.4.3.7 Outcome factors

Because of time and financial constraints only clients were interviewed using a questionnaire specifically to identify outcome factors. On hundred and eighty-five (185) questionnaires were distributed to respondents who consented to participate in the study and 180 questionnaires were satisfactorily filled in and returned, thus the response rate was 97% for recipients of services. Experiences of clients regarding provision of healthcare service provision within the public healthcare facilities in Limpopo Province.

4.4.3.7.1 Understanding of language used

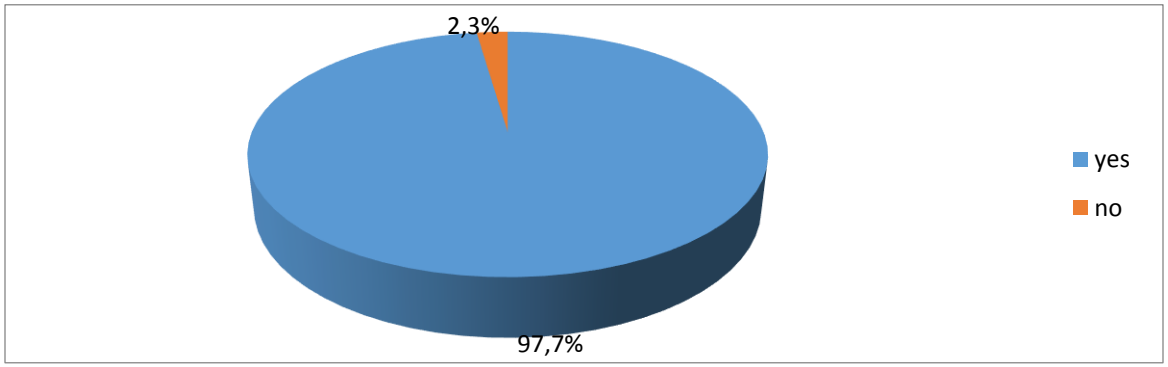


Figure 4.6: Respondents' response on understanding language used (N=180).

Figure 4.6 shows that the majority of respondents175 (97.7%) out 180 indicated that they understood the language used in the institutions while only 5 (2.3%) did not understand the language used in the institution visited. According to the results of the sample there was no language problems in the district. Understanding the language that the patient used was important for good history taking that could lead to the correct diagnosis and treatment. Lack of understanding of each other's languages in the hospital and clinic facilities could affect access of services by immigrants who might not be able to explain their problems I the local languages. This was confirmed by Mafuwa (2015:20) in the

study conducted in Cape Town, South Africa, about the experiences of Zimbabweans when trying to access health services in Cape Town, brought forward the fact that communication between the ethnic minority patients and health care personnel were problematic. The inability to communicate in what was not their mother tongue inevitably led to discrimination, due to lack of a common language. They struggled to express their inner feelings, to ask questions, or to represent themselves. Language difficulties can have a detrimental effect upon the patient ability to comprehend proposed treatments and remedies, they also hampered the physician's attempts at obtaining vital medical history.

4.4.3.7.2 Twenty-four (24) Hours Service provision

Of the 5 clinic facilities visited only 1(20.0 %%) was providing 24 hours service and 4(80.0%) did not provide 24 hours services. With regard to 24 hours service, four of the five clinics sampled did not provide any form of 24 hours service. Reasons provided were shortage of security personnel and shortage of professional nurses. This resulted in loads of patients overcrowding hospitals unnecessarily. It is very important that primary health facilities offer 24 hours services. Becker, Dell, Jenkins and Sayed (2012:2) and Visser, Marincowitz and Ogubanjo (2015:1) in their study in George district in the Eastern Cape and Letaba Hospital In Limpopo respectively, found that patients who by passed clinics to attend the hospital also cited lack of 24 hours services and perceptions of low quality as the reason for bypassing the clinics. Maillacheruvu and McDuff (2013:2) also identified the severe shortage of staff equipment and burden of disease as being responsible for failure to implement 24 hours services in South Africa.

4.4.3.7.3 Medicine related Issues

Table 4.23: Respondents' responses to availability of medicine

Items	Responses N (%)		Total
	Yes	No	
Did you get the medicine prescribed for you from the pharmacy	176 (97.6%)	4 (2.4%)	180
Did they explain how medicine must be administered and stored	(100%) 180		180

In table 4.23, majority 176 (97.6%) of the respondents indicated that they got the prescribed medicine from the pharmacy while only a minority of 4 (2.4%) reported not getting the medicine prescribed for them. Regarding whether clients got explanations on use and storage of medicine, table 4.23 showed that all respondents 180 (100%) indicated that they got explanations on how medicine should be administered and stored. According to this study there was no shortage of medicine and correct explanations were given. For provision of quality health services access to prescribed medicines and correct explanation were vital for speedy recovery by patient. Availability and explanations of medicines is very important for encouragement of adherence to medicine which in turn would increase effectiveness of medicine and early recovery. However before the end of the study communities were complaining about continuous stock outs of medicines in health facilities. This could be related to the inconsistent supply of pharmaceutical supplies in the province. Usherwood (2017:148) in the study conducted in low income countries agrees with this statement that for quality of service provision to be improved it is of importance that explanation of how medicines prescribed for patients need to be administered be made. This is important because medicines do not work if they are not administered. Non-adherence, whether by intent or due to cost,

complexity, or forgetfulness, is a major cause of reduced effectiveness and hence of preventable morbidity and mortality.

4.4.3.7.4 Cleanness of facility

Table 4.24. Respondents' responses Cleanness of facility.

Items	Responses N (%)		Total
	Yes	No	
4.4.5.1. Was the facility clean	144 (80.5%)	35 (19.5%)	180
4.4.5.2. Was it free from odour	140 (78%)	40 (22%)	180
4.4.5.3Was the facility free of litter	129 1.8%)	51 (28.2%)	180

Table 4.24. Showed that majority 144 (80.5%) of the respondents indicated that the facilities they visited were clean only minority of 35(19.5%) of the respondents reported that facilities were not clean. With regard to facilities odour, table 4.24 showed that majority of respondents 140 (78.0%) indicated that facilities they visited were free from odour, 0nly 40 (22.0%) reported that facilities were not free from odour. Table 4.24 showed that Majority of respondents 129 (71.8%) indicated the facilities were free from littering. Only 51 (28.2%) reported littering. A clean odorless and litter less facility is important as this would prevent hospital infection that could lead to litigation.

Despite these favourable results from this study, South Africa, however is still plagued with problems related to cleanliness as shown by the report below. Molelekwa (2015:1) reported on the status of cleanliness in a hospital, reported by a relative who said, "I opened the shelf on my husband's bed and there were

hundreds of cockroaches in there," she added. "I was so shocked" Another report came through "the Maverick". Many hospitals were assessed in the country; one hospital scored so badly: Its leadership scored below 20 percent; cleanliness was rated as lowly 41. percent Only one of 394 hospitals audited by the department of health met the accepted standards for cleanliness, infection, drug stocks, staff attitude, patient safety and waiting time **(**Cullinan, 2014:1).

4.4.3.7.5 Attitude

Table 4.25: Respondents responses to attitudes related questions

Items	Responses N (%)		Total
	No	Yes	
Were you treated with respect	171(95.2%)	9(4.8%)	180
Did the person who treated you had a name tag/identification tag?	170(90%)	10(10%)	180
Were you addressed properly using your name?	170(90)	10(10%)	180
The service providers in this facility are competent to their job. Table 4.6 (Item 4.3.5.2).	174.6(97%)	5.4(3%)	180
I am satisfied with services received from this facility	170(90%)	10(10%)	180
I waited less than three hours	170(90%)	10(10%)	180
There is enough staff for the job (clinicians, nurses, pharmacists)	60(33.3%)	120(66.7%)	180

Table 4.25 displays majority of the respondents with negative experiences regarding the attitude of staff .Majority of respondents described experiences as follows: 171(95.2%) indicated that they were not treated with respect; 170 (90%) indicated that persons who treated them had no name tags;170 (90%) indicated that they were not properly addressed with their names; 175 (97.1%) indicated that they did not get explanations regarding their illnesses and; 174.6 (97.1%) indicated that service providers in the facilities they visited are not competent to their job. And 170 (100%) indicated that they were not satisfied with services they received from facilities. Majority of respondent 120 (66.7%) respondents indicated that there is not enough staff for the job in the facilities they visited. Only a minority of 60 (33.3%) reported that staff was enough. Having enough

staff contributes to staff satisfaction as well as patient satisfaction. Enough staff would enable nurses to have time to be with patients. The study by Nunu (2017:3) painted a different picture in some provinces like Gauteng Province and Free State where clients were satisfied with: Time spent at the clinics, being listened to by nurses, knowing the name of nurse, privacy being respected, being given information on the condition they were suffering from and being treated politely were significantly associated with patient satisfaction in both provinces. These findings also found that patient interaction with staff members improved the understanding of treatment plans, boosted patients' morale and improved chances of them abiding to treatment plans and thus better health outcome.

4.4.3.7.6 Waiting period

Most respondents 170 (100.0%) I table 4.25 indicated that they waited for more than 3 hours in the institution and were not satisfied with services they received from facilities. Only a minority of 10(10.0%) waited less than 3 hours. The time clients spend waiting to be served influences patient satisfaction and quality of service provision. Daniels (2015:1) in his study in Cape Town South Africa, found out that many patient satisfaction surveys in the past have shown that there was a general dissatisfaction with waiting times and waiting times was an important factor that influenced client satisfaction.

Mayen and Wolvaardt (2015:1) among other things also identified waiting times as a problem in health institutions, most common problems experienced by healthcare users in public institutions include: lack of cleanliness; poor safety and security; long waiting times and shortage of staff". On the other hand, Egbujie et al (2018:1) in their study I South Africa, discovered that implementation of the Ideal Clinic model in the selected facilities led to changes in patient waiting time. Observed changes were positive when a clinic appointment system was successfully implemented and negative when this was unsuccessful. This would translate to patient satisfaction. Implementing the Ideal clinic is encouraged.

4.5 DISCUSSION OF THE RESULTS

4.5.1 Biographical data

Both the qualitative and quantitative methods of data collecting were used. The quantitative method used a survey method with a self-administered questionnaire while the qualitative methods used focus group discussion methods with the aid of a semi structured questionnaire. The qualitative and quantitative components were used sequentially as shown in Figure 3.1. It is for that reason that the discussion of both results is discussed underneath.

4.5.1.1 Age distribution.

4.5.1.1.1 Age distribution among stakeholders and clients

The age distribution of clients and stake holders could be compared because they came from the same communities and both could be regarded as stakeholders as they used the same facilities for health services. The quantitative result concerning age distribution of respondents (clients) as presented in table 4.14 had as many as 80 (44.0. %) out of 180 respondents that were between the ages 20 and 29. This supported the qualitative result in table 4.4 that had 55 (68.7%) out of 80 participants (stake holders) between the ages of 20 and 29. Table 4.1 also had as many as 15 (18.8%) participants (stakeholders) between the ages of 50 and 59 while Table 4.12 had had as many 20 (11.11%) respondents (clients) out of 180 between the ages of 50 and 59.

These results highlighted two issues: Firstly that there was a concentration of people who were in the childbearing age between 20 and 29-years level. This may be an indication of a definite need for various new or increased services. Secondly there was a steadily growing number of people between the ages of 50 to 59 and 60 and above. Health systems need to respond to these issues: Services to cater for the rapidly growing number of the people between 20 and 29 must be developed in time to meet the growing needs. The study by Lassi, Kumar and

Bhutta, (2016:12) agreed with this statement as they noticed that as countries grow as a result of increased global economic development, existing health care systems may become ill equipped to deal with the new population increments. Population growth may continue to increase the Maternal, neonatal, and child mortality and morbidity particularly in rural areas. Though the growth of the elderly population is not very high, it warrants the same attention as those in child bearing level. Preparing for services of the elderly is important. Wyman, et al (2018:1) highlighted the fact that the elderly patients may also be discriminated against in the health facility more especially if their services are not well organized.

(a) Recommendations to address the need of providing services for the growing population

The department need to develop services that will cater for the child bearing and elderly communities.

4.5.1.1.2 Age distribution among professional nurses

The quantitative result concerning age distribution of respondents (professional nurses) as presented in table 4.14 showed a majority of 152 (70.0%) out of 217 respondents were between the ages of 50 and 59 years. This confirmed the qualitative result in table 4.4 that had a majority of 40 (73.0%) out of 55 participants between 50 and 59 years. Both these results showed a concentration of elderly experienced nurses with very few intakes of new young nurses. This may create a problem of shortage of staff and of experienced staff in particular. This may happen because currently when the elderly nurses retire in the department of health Limpopo, they are not replaced. In instances where circumstances may force them to retire, they are replaced with newly qualified nurses with minimal experience. Both those scenarios contribute negatively quality health care provision.

The trend of having most nurses concentrated around retiring age is common. This was supported by The Department of Health Victorian government report (2010:1) and Wyman, Ezra and Benge (2018:1) highlighted the fact that the nurse work force was ageing rapidly but was not being replaced as rapidly as they were ageing and retiring was acknowledged. As they were retiring the department was losing the substantial accumulated skills and experiences. The departments of health could do well to try and retain their skills as long as they can instead of pushing them to retire.

Wyman, Ezra and Benge (2018:1) also described Ageism as a bias against older persons and may affect all of people who live long, elderly nurses and patients. One of the ways elderly nurses may be discriminated was explained as when the elderly they could be forced to retire against their will simply because they are old and earning more. Some private facilities may need to cut costs by employing three people in the place of one elderly person. Though this may succeed in saving money, it may affect quality provision negatively because the elderly nurses with their experience would have been forced to go.

(a) Recommendations to address the challenge large number of skilled retiring nurses

The department need to develop retention programmes for the ageing nurses, as well as and education programmes for the new nurses and to recruit more nurses.

4.5.1.2 Gender distribution

4.5.1.2.1 Gender distribution among Stakeholders and clients

The gender distribution of clients and stake holders could be compared because they came from the same communities and both could be regarded as stakeholders as they used the same facilities for health services. The quantitative result as presented in table 4.15 regarding gender distribution among clients and stakeholders, the majority of 113 (62.7%) of the respondents were females. However, the qualitative results as presented in table 4.5 differed from the quantitative results in that the majority 50 (62.5%) participants (stake holder) were males, while 30 (37.5%) were females. As far as nursing profession is concerned, females are more than males. This is expected since nursing profession is female dominated whilst stakeholders were dominated by males.

The finding from the qualitative approach table 4.2 showed that amongst the stake holder's males were more than females. Though the number of females is less than the male participants the representation is significant. The stake holder services used to be predominantly male dominated. This may have been influenced by the fact that traditionally, only males were elected to the positions of Health committees and hospital board members, the situation is changing as more women became available as gender equality is implemented in the new dispensation in South Africa. This finding was supported in the report by Colman (2016:1) in the FA news who showed that according to the World Economic Forum's 2015 Global Gender Gap Index, South Africa ranked 17th out of 145 countries when it comes to closing the gender gap, ranking above both the UK (18) and the USA (28). Health committees existed so they could advise the clinic and hospital facilities. If it was only represented by males only, then opinions could be biased in favour of males.

4.5.1.2.1.1 Recommendations to encourage representation in clinic health committees by women

Female representation among the clinic health committees should be encouraged.

4.5.1.2 2 Gender distribution among professional nurses

The quantitative results regarding gender distribution of respondents (professional nurses) as presented in table 4.15 showed majority 200 (91.3%) of respondents were females. This agrees with the qualitative result in table 4.5 where majority of 49 (91.0%) participants were female. This may be related to the fact that Nursing have for a long time been regarded as a profession for females. Calzado (2013:1) confirmed that Nursing is still predominately female dominated. Her study confirmed that more females were interested nursing than males as depicted in his study by the higher rate of enrolment for females than for males, which was found to be 452 (74.0 %) for females and 161(26.0%) for males. On the other hand, Zamanzadeh et al (2013:1) in their study of literature discovered that those males who come to nursing encounter unique difficulties and challenges in nursing educational and clinical settings. They are mostly marginalized, and sometimes not accepted, within nursing. Also, male nurses must deal with the stereotypes where people expect women to be nurses. There is a need to recruit more males to nursing.

4.5.1.2 2.1 Recommendations for addressing the need to recruit and retain male nurses

The department need to create a programme to recruit and retain male nurses as well. There is always shortage of staff in nursing as a profession and as many people that are interested in nursing as possible must be recruited. Gender equality needs to be implemented to attract and retain male nurses.

4.5.1.3 Qualifications of professional nurses

The quantitative data regarding qualifications of professional nurses in table 4.16, 113 (60.0%) had the basic diploma as a qualification while 55 (26.0% had post basic degrees and in the minority are honors and master's degree who scored 9 (4.0%). A similar trend noticed in the qualitative results as depicted by table 4.6 where 39 (71.0) reported that they obtained basic Nursing Diploma, while only 11 (20.0%) hold Post basic Nursing Diploma and Post basic nursing degree 3 (5.0%).

The results depict a shortage of nurses with post basic degrees. Nurses seem to be stuck at diploma levels. The quality of nursing services increases as nurses acquire higher qualifications because they get more information to deal with situations. This is supported by Fumić Marinović and Brajan (2014:1) who in their study in Croacia found that Continuous education improved the quality of nursing care and increased the effectiveness of patient care, consequently maintaining and enhancing patient safety. Continuing education was seen as also a means of preparing for retirement of the elderly nurses. By training and educating all the staff one could then have a pool of staff to draw from as the elderly nurses retire (McHugh, 2010:2; Drennan et al 2016:3).

4.5.1.3.1 Recommendations to address the low qualifications of nurses

There is a need to establish regular in-service training and to provide more opportunities for career development for the professional nurses.

4.5.1.4 Field of experience of professional nurses

The quantitative result regarding field of experience of professional nurses as presented in table 4.17 majority of 100 (46.0%) qualified as general nurses while 95 (44.0%) were midwives and in the minority were Nurse education and nurse administration with 1 (5.0%) each. A similar trend is noticed with the qualitative

result of professional nurses in table 4.7 show that as many as 35 (64.0%) of the participants hold qualifications as general nurse 5 (9.0%) h have midwifery, community health and operational manager each. 4 (7.0%) had psychiatric nursing as their field of experience. This may be related to the very limited post structure. Currently one needs to have a post before they are sent for post basic course. WHO (2012:1) highlighted the fact that attracting sufficient numbers of skilled staff into the public health sector remains a challenge. The lack of sanctioned posts for some cadres and facilities also limits the numbers that can be recruited. Rural areas experienced more problems.

4.5.1.4.1 Recommendations to address the shortage of posts

The department needs to create more posts to meet the needs of institutions and improve quality health provision.

4.5.1.5 Years of experience

The quantitative data regarding years of experience as professional nurses as presented in table 4.18 majority147 (68.0%) had 5 year and above while 48 (22.0%) had between 4 and 5 years and minority of 22 (1.0%) had experience of between 1 and 3 years. A similar trend was noted in the qualitative result in table 4.8 in that they had experience majority 39 (71.0%9) of the participants reported to have working for more than 5 years and above while 11(20.0%) of the participants reported to be over by 4-5 years and below 5 (10.0%).Experienced nurses are able to make informed decisions that can improve quality health care provision, avoid medico legal hazards and save lives.

According to Hill (2010:1) and Bekker et al (2015:3), there was evidence that years of experience in nursing supported expertise and had a positive impact on the quality of care provided. Currently in the department of health there is a low intake of new nurses yet there is high numbers of older nurses who are soon to

retire. There is a need therefore to develop and implement strategies to retain experienced nurse within the workforce.

In addition to identifying the positive impact of age and expertise on quality health provision, Hill (2010:1) believes that to increase retention of experienced nurses within the profession the following must be implemented:: Cultivating a climate of continuous, career-long learning, Developing a career portfolio, so that the elderly nurses do not have to take on the traditional employment but can do flexi hours if they so wish Making ergonomic accommodations designing the working condition in such a way that everybody is working comfortably, by ensuring that the near retiring nurses grooms their successor as well as implementing phased retirement.

4.5.1.5.1 Recommendations to address the need for experienced professional nurses

The department needs to train all staff members and to implement retention strategies suggested by Hill (2010:1).

4.5.2 Factors that Influence Provision of Health Care Services

4.5.2.1 Structural factors

4.5.2.1.1 Implementation of the White paper on Transformation of the Public Services Delivery (or Batho-Pele White paper implementation)

The quantitative result regarding implementation of Batho Pele white paper as presented in Figure 4.1. 159 (75.6%) It shows that majority of the respondents indicated that Batho-Pele white paper was always used as a strategy to improve service delivery. This does not agree with the qualitative result in item 4.3.2.1.2 (a) that showed implementation of the Batho-Pele White paper was problematic when there are long queues in facilities. Most staff members do not give themselves time to .to understand how they can implement the Batho Pele principles in their everyday work activities. Khoza, Du Toit and Roos (2010:1)

and Jarden-Baoo et al (2016:398) in their study in South Africa revealed and confirmed that few of the Batho Pele Principles were implemented effectively and that patients in general were not satisfied with treatment in public hospitals. Shortcomings were attributed to insufficient management skills and knowledge at different levels of the health care system, as well as patients' lack of awareness about their health care rights and responsibilities.

(a)Recommendations to encourage implementation Of the Batho-pele principles

There is a need to dedicate a staff member to facilitate and encourage learning more about implementing the Batho-pele principles.

4.5.2.1.2 Staffing

The quantitative results regarding staffing as presented in the following tables: table 4.19 majority 120 (55.1%) of professional nurses and table 4.24 majority 120(66.7%) of clients agreed that there was never enough staff in the facilities this confirmed the qualitative result in item 4.3.2.1.2 (b) where participants complained of staff shortages despite the implementation of the White paper on transformation of health services. Shortage of staff affects service delivery negatively as it leads to burnout and staff dissatisfaction with their work. According to Analysis by S A Health Review (2010 :172), data showed that vacancy rates for public sector medical practitioners in Limpopo reached a peak of 84%, while 66.8% of professional nursing posts were vacant in the Eastern Cape (both largely rural provinces). Abugre (2014:1), Cooke, Couper and Versteeg (2011:9) and Brits, (2019:1) on the other hand found that in South Africa (SA) severe shortage of staff is experienced and most 30% doctors and 15.5% of pharmacists are employed in the public sector, yet only a minority of these public sector workers are based in rural areas – where 43% of the population resides. This is because the working conditions in the rural areas are not conducive to job satisfaction because of lack of resources to work with as well as

resources to live with e.g. schools and entertainment. The researchers rightly suggest access to health workers in remote and rural areas should be increased through improved recruitment and retention strategies. Zulu, et al (2015:3) suggested integrating health assistants at primary health care level as a solution to the staffing problem. This is critical to improving the rights of rural communities to comprehensive, quality health care. According to Eygelaar and stellenberg (2012:1) and Roos , Gumede and Mlanda (2016: 59) the inadequacies which existed in staffing, professional development opportunities, equipment and consumables, negatively influenced the management of quality health care in the eight rural district hospitals in the West Coast Winelands regions including Kwazulu Natal.

(a) Recommendations to address the staffing problems

Implementation of the ICRM and NHI should be fast tracked as it will improve the staff shortages as well.

4.5.2.1.3 Availability of clinical equipment

The quantitative result on availability of clinical equipment as presented in table 4.19 majority 150 (69.0%) of the respondents showed that availability of clinical equipment was never adequate as equipment was never enough. This result agreed with the qualitative result in item 4.3.2.1.2 (c) where participants complained that there was always shortage of equipment that were not even durable and breaks easily. Lack of and faulty equipment can lead to medico legal hazard and or death. A patient can be harmed if for instance there is no blood pressure machine or even if it is there it is not working well. The study by Egbujie et al (2018:3) in primary health care clinics in Kwazulu Natal Province, S.A confirmed that inadequate supply of equipment and consumables was a common factor which influenced the management of quality nursing in all the 8 rural district hospitals in the west coast Wine.

(a) Recommendations to address shortage of durable equipment

Enough durable clinical equipment should be procured and distributed to the facilities.

4.5.2.1.4 Maintenance of Clinical equipment

The quantitative result on Maintenance of Clinical Equipment as presented in table 4.19 where majority 150 (69.0%) indicated that maintenance of clinical equipment is not enough. This confirmed the qualitative result by participants in item 4.3.2.1.2 (c) i where participants said that maintenance of clinical equipment was never regular or enough. Maintenance of equipment is cost saving as well as lifesaving. Therefore, it is regarded as very important in improving quality of health care provision. According to Egbujie et al (2018:3), faulty unmaintained or lack of equipment hinders quality of service provision and could harm patients, and as a result establishment of a medical equipment program in hospitals and clinic facilities that would include preventive maintenance, repair, and documentation of medical equipment could be prioritised.

(a) Recommendations to address inadequate maintenance of equipment

A medical equipment programme should be established that can focus on maintenance of equipment in the department.

4.5.2.1.5 Availability of infrastructure/space

The quantitative result regarding Infrastructure /space as presented in table 4.19 most 100 (46.0%) respondents indicated that infrastructure/space was never enough, and this agreed with the quantitative result in item 4.3.2.1.2(d)

where participants expressed concern that the space is not enough or adequate to meet the needs of the idea clinic requirements and some buildings are dilapidated. To comply with the needs of the ICRM, there must be enough rooms to accommodate all the services that must be implemented to improve quality of health care services. There is a need for more funding for good quality infrastructure and a need to involve donors and private sector in making sure there is good infrastructure.

WHO (2012:3) also confirmed that good quality infrastructure is a key component to sustainable and efficient health care service provision. Poluta and Weeks (2012:1) and Nkala, (2016:4) in their study in South Africa, also found that Quality services can only be provided when physical facilities, installations and equipment are in good working condition to provide a fully functional and operational environment. Muhammed, Umeh, Nasir and Suleman (2013:1) in their study in Batsari Local Government in Katsina State, Nigeria found that the commonest reasons why respondents did not utilize these services were lack of essential drugs, high cost of services as well as inadequate infrastructure in primary healthcare facilities. Dornan (2012:31) and Dejager, P (2015:9) further suggested solutions to problems with infrastructure. The researcher suggested the following:

- Adequate funding
- Establishing appropriate incentives for maintenance,
- Involving donors and private sector and
- Donors clearly need to ensure that maintenance is provided to the physical infrastructure that they finance.

(a) Recommendations to address inadequate and dilapidated infrastructure issues

New infrastructure must be constructed in line with the needs of ICRM.

4.5.2.1.6 Maintenance of Infrastructure

The quantitative result regarding maintenance of infrastructure as presented in table 4.19, majority 150 (69.0%) showed that maintenance of infrastructure is never adequate. This supported the facts brought by the qualitative result in item 4.3.2.1.2 (d) **i** where participants were unhappy with infrastructure that is not being properly maintained. Maintenance of infrastructure is important in saving costs. Dejager (2015:9) also insisted that neglecting maintenance is very costly and is unsustainable. According to the Infrastructure development act (2014:1) infrastructure maintenance must be regarded as a strategic tool to promote improved service provision.

(a) Recommendations to address infrastructural maintenance issues

Like maintenance of clinical equipment, there is a need to develop programmes of infrastructure maintenance, focusing on maintenance of infrastructure. Some form of incentives could be introduced to encourage maintenance in the facilities.

4.5.2.1.7 Availability of Security

The quantitative result concerning availability of security as presented in table 4.19 as many as 80 (37.0%), respondents indicated that security was never adequate the result confirmed the result of the qualitative report in item 4.3.2.1.2(e) where participants could not take calls because of lack of adequate security in facilities. Lack of or inadequate security affect provision of quality healthcare services in that professionals are not able to provide 24 hours services. There is a need for adequate well-trained security staff. Magmutual, (2017:1) confirmed the need for "toothed" security officers in health

institutions. According to Magmutual (2017:1), highly trained hospital security officers who should adapt to the local culture and values and are skilled in the special needs of healthcare facilities should be employed. The company further brought forward a study by the National Institute for Occupational Safety and Health (NIOSH), which found out that healthcare and social service workers faced significant risks of job-related violence. Healthcare workers suffered 50.0% of all assaults, hence need for security (Magmutual, 2017:1).

(a) Recommendations to address security problems in facilities

All facilities should have enough well-trained security personnel and security equipment. This should be treated as a priority.

4.5.2.2 Process factors

4.5.2.2.1 Challenges that affect quality health care services

(a)Salary for professionals

The quantitative result regarding salary for professionals as presented in table 4.20 majority of respondents 136 (62.5 %), were found to be never satisfactory and confirmed the qualitative result in item 4.3.2.1.3 (a) i where participants complained that professional nurses' salaries were indeed very low and uncompetitive. Salary is important for the lively hood of the professionals and thus there is a need that it be enough or satisfactorily. Many researchers did studies on the effect of salary on provision of quality health care provision. Bhatnagar and Srivastava (2012:77) and Asegid et al (2014:13) in their studies found that satisfaction with salary scales led to job satisfaction with subsequent result of quality service provision. However, they also found that, when budget constraints limit increases to salary and benefits., Job satisfaction can be increased by attending to motivating factors, such as making work more

interesting, requiring more initiative, creativity, and planning. This was confirmed by (Bhatnagar and Srivastava, 2012:77; Asekun 2015:7).

(a i). Recommendations to dress salary issues among professional nurses

Salary increases might be difficult to implement immediately, but what all managers must do now is to make life more interesting by encouraging nurses to be initiative, innovative and as autonomous as possible.

(b) Nurses used for non-nursing duties

The quantitative result regarding use of nurses for non-nursing duties as presented in table 4.20 showed that most of the respondents 150 (69.0%) indicated that nurses were always used for non-nursing duties .This confirmed and supported the qualitative result**.** In item 4.3.2.1.3 (a) ii where participants where complained that a nurse could replace anybody who is not on duty from a porter laboratory technician etc**.** The time nurses took to do non nursing duties was the time that could be used for patient care; hence it negatively affects quality health care provision. Nurses are being taken away from the patients' side. Becker (2013:3) in the study conducted in South Africa identified three main non-nursing tasks (NNTs) commonly performed by nurses i.e.: filling-in for non-nursing services viz: cleaning patient's rooms and equipment, and obtaining supplies and equipment. This study also confirmed that professional nurses seemed to have grown accustomed to performing the non-nursing duties as part of their workload. They said performing non-nursing duty did not affect their job satisfaction seemingly, unaware that this takes them away from nursing tasks which should improve job satisfaction (Bekker, 2013:3). Armstrong, Rispel and Penn-Kekana (2015:8) found that nursing unit managers spent 25.8% of their time on direct patient care, and the rest was spent on non-nursing duties. There is need to increase staff for the non-nursing duties and to orientate nurses to focus on nursing duties.

(a i)Recommendations for addressing the challenge of nurses being used for non-nursing duties

Professional nurses should be relieved from performing non nursing duties as a matter of urgency. This will improve quality health care provision.

(c) Opportunities for career development

The Quantitative results regarding availability of opportunities for career development being always available in table 4.20, as many as 88 (40.4%) of respondents indicated that there was always availability of opportunities for career development. Contrary to what the qualitative result in item 4.3.2.1.3 (a) iii showed that the participants complained about non- availability of opportunities for career development. Item 1.3 on qualifications by nurses showed that most nurses seemed to be stuck at diploma levels. Some people experienced career development opportunities while most did not. Tables 4.3 and 4.13 showed a most nurses qualified at the diploma level indicating that majority of nurses never had opportunities for career development. The more qualified one is the better they are able to deal with problems at work, improving quality of health services provision. Price and Reichert (2017:3) discovered that, ongoing professional development helped to ensure competency, continuous growth in their nursing practice, quality patient care throughout the span of nurses' careers, as well as optimal quality patient care.

(c i)Recommendations to increase opportunities for career development

The department needs to increase funding for continuing education and develop a programme for nurses to qualify for post basic education and training.

4.5.2.2.2 Factors that affect provision of quality service delivery

(a) Absenteeism

The quantitative result levels of absenteeism as presented in item table 4.21 with majority, 150 (69.0%) of the respondents indicated that absenteeism in professional nurses was always high this agreed with results from qualitative result in item 4.3.3.2.1 where participants complained that absenteeism and sick leaves were very common .Absenteeism is usually a symptom of some underlying problems for the professionals. When most staff are absent quality of health care services is compromised.

The study by Mudaly and Nkosi (2015:4) identified that Lack of motivation to attend work, illness, finance, favouritism, unfriendly nurse managers, long work hours, increased workload, unsatisfactory work conditions, lack of equipment, unfair promotions and selection of nurses for training, staff shortages, lack of a reward system and incoherent decision-making caused nurse absenteeism. All the reasons were found to be related to the working conditions (Mudaly and Nkosi, 2015:4). The study by (Mogale, Mothiba, and Malema (2015:4) in a Limpopo hospital (Mokopane Hospital) demonstrated the ripple effect of shortage of professional nurses. The findings revealed that every unit was experiencing a shortage of professional nurses, which caused other nurses to work overtime with an inevitable increase in workload. That led to tiredness, conflict amongst professional nurses, job dissatisfaction, and absenteeism which compromised quality of nursing care. This resulted in patient dissatisfaction and sometimes led to deaths that could have been prevented (Mogale, Mothiba, and Malema 2015:4).

(a i)Recommendations to address the challenge of absenteeism

The department of health should increase funding to increase staffing.

Operational managers should be trained to manage their staff in such a way that working conditions are improved, e.g. being friendly, involving them in decision making etc.

(b) Working conditions

The quantitative result regarding the condition of infrastructure at work and nurses_home as presented in table 4.21, majority of respondents 166 (76.6%) indicated that: infrastructure at work and nurses' home was never adequate. This confirmed the qualitative result in item 4.3.2.1.3(b) ii where Participants complained that they slept and worked in dilapidated facilities.

The work place environment and infrastructure at the nurses' home plays a very important role in the employee's life. If nurses are demoralized by the environment then quality of health service provision will suffer. The study by Edem, Akpan and Pepple (2017:1) confirmed that the relationship between the health worker, work and the workplace environment was very crucial and hence it could become an integral part of work itself. Management effort in ensuring an active workforce should be focused on employee personal motivation and the infrastructure of the work environment. These researchers further highlighted that there was a need for health worker's job satisfaction to be the target for health system improvements. Health worker satisfaction was found to be associated with intent to stay, and health worker retention was necessary for the provision of high quality health care. The results from this study have shown the effect of workplace environmental factor on health workers performance and productivity and suggested that efforts should be geared towards improving the physical environment, social environment, and work system associated with the workplace (Edem, Akpan and Pepple, 2017:1; Ulmann, 2013). Effort should focus on providing healthcare workers with the infrastructure and tools they needed to do their job.

(b i)Recommendations to address the infrastructural issues that are currently negatively influencing working condition

Since the condition of infrastructure is one of the factors that can influence job satisfaction and subsequently quality of health care service provision, upgrading the infrastructure should be one of the priorities.

(c) Workload

The qualitative result regarding workload as presented in table 4.21 showed that the majority 186 (85.4 %) of respondents indicated that work load was always high in public services. This supported the qualitative result in item 4.3.2.1.3(b)iii where participants complained the workload was so high that professional nurses work past they knock off time. Overworked nurses were not able to finish their work in time and document the patient information. When service providers experience burnout, they can have a potential to make more mistakes that can results in death and litigations. Shihundla, Lebese and Maputle (2016:3) in their study in Limpopo province, South Africa, were able to show that increased nurses' workload related to shortage of staff could pose a serious challenge to the documented patient information and the documents themselves. According Mayoasi and Benatar (2014:1348) and Benatar, 2013:60) in their study also in South Africa, workload could be explained as being related to the growing burden of communicable and non-communicable disease as well as the persisting social disparities and inadequate human. They attributed this different funding systems for private and for public sector as well as the burden of infectious and no communicable diseases, persisting social disparities, and inadequate human resources to provide care for a growing population with a rising tide of refugees and economic migrants. Keft, Brouwer, Franke and Delnoji (2014:3) were able to show that if the work environment of the nurses is not favourable it would negatively affect the patient's experiences of care. According to Department of Health South Africa (2014:4), in the process of implementing the ICRM and INH the workload reducing mechanisms e.g computerized filling system, proper

appointment times made and adhered to by the patients including pre booking, pre retrieving of files and prepacking of treatment) implement one stop shop and integrating of services will go a long way in reducing workload for the nurses.

(c i)Recommendations to address work load issues

Increasing staff is a long-term plan but implementing the workload reducing activities mentioned above can be productive and can improve quality health care provision.

(d) Patient centered Care

The quantitative result with regard to Patient centered Care as presented in table 4.21 most respondents 122 (56.5%) indicated that patient centered health was always practiced. This confirmed the qualitative result in item 4.3.2.1.3 (c) i where participants explained that patients and families are allowed to perform traditional rituals, for example family members talking to their ancestors in behalf of their patients in hospital ground. Patients that are seen in healthcare facilities come from diverse backgrounds and belief systems. It is important to treat them as a total human being and where possible adapt treatment to suit their personal circumstances and values. This is also supported by Merav (2017:597) who believed that working with the beliefs and values of the patient, engagement, empathetic presence, shared decision-making, and delivery of holistic care was part of patient centred care and improved quality of care. To be able to work with patients in this manner one needs to have knowledge of the patient's culture and beliefs. (Baboo, et al., (2016:399) and AL-Abri and Al Balu (2014:1) highlighted the importance of patient satisfaction surveys as tool of quality improvement.

(d i). Recommendations to encourage the nurses to maintain the patient centred approach

Patient centred approach to patient care is vital if quality of health care provision is to be improved. South Africa have always been multiracial and multicultural. Service providers in S.A needs to be sensitive to the cultural needs of their patients. Service providers must be encouraged to learn about patients' cultures.

(e) Referral Maternity patients

The quantitative result regarding referral of maternity patients to hospital as presented in the figure 4.2 showed that majority of respondents 100 (46.0%) reported the fact that large numbers of maternity patients referred to deliver in hospitals were always unnecessary. This confirmed the qualitative result in item 4.3.2.1.3 (b) iv where the participants complained that that staff refer maternity patients to hospitals unnecessarily. It is important for patients and maternity patients in particular to deliver at appropriate levels e.g clinics and CHC's to avoid overworking the district hospitals. Some reasons given for referral are shortage of staff at the different levels of referral.

According to Mojaki, Basu and Govender (2011:2) and Singh et al (2016:3) the South African public health sector follows a hierarchical referral system. Clinic and CHC refer difficult patient to district hospitals who in turn sent difficult patients to tertiary or academic hospitals.. However, patients often went directly to district hospitals, resulting in increased caseloads. Mojaki, Basu and Govender (2011:2) and Singh et al (2016:3) found that most patients seen in OPD and casualty had bypassed the referral system. The researchers attributed this to failure of the PHC facilities to attract their catchment population because of attitude, perception of superior care and resource availability in hospitals, desire to be seen by medical doctors, and that a hospital may be the nearest health facility. Unless poor attitudes were acknowledged and addressed, it will remain impossible to provide good quality of nursing care to vulnerable patients

attending the public. (Mojaki, Basu andGovender 2011:2), (Singh et al (2016:3) and Atuoye, Dixon, Rishworth, Galaa, Boamah and Luginah (2015:3) identified transport problems as contributing to bypassing referral hierarchy as patients my go to a facility they easily reach and afford the transport fee.

(e i) Recommendations to address unnecessary referrals of maternity patients

There is a need to conduct workshops to retrain nurses on customer care so that patients would not by pass clinic because of bad attitude. Patients need to be educated on the importance of the different levels of care they need to pass through before they get to a district hospital or tertiary hospital.

(f) Monitoring and Evaluation

(f) Availability of monitoring and Evaluation Section

The quantitative result on availability of monitoring and evaluation section as presented in in table 4.22 showed that majority, 150 (69.2%) of respondents indicated that monitoring and evaluation section was always available. This concurs with the qualitative result findings in 4.3.2.1.3 (b) v where the participants acknowledged the availability of Monitoring and evaluation section. Monitoring and evaluation are very important for improving quality of health care service provisionDespite the fact that the South African Constitution through new dispensation, placed a premium on a responsive, development oriented public service, effective and accountable stewardship of public resources, effective oversight by Parliament and the nine provincial legislatures, and public participation in policy and implementation, which needed to be realized through the presence of Monitoring and evaluation Kariuki, Purshottama and Reddy (2017:1) in their study found that monitoring and evaluation capacity is low in the majority of municipalities besides the Metro. The municipalities were inadequately resourced with competent monitoring and

evaluation human personnel, thereby stifling their capacity to deliver quality monitoring and evaluation services.

(f i) Recommendations for availability of monitoring and evaluation section:

Strengthen the capacity of the section Aby investing financial and human resources on the section.

(g) Implementation of Monitoring and evaluation

The quantitative result with regard to implementation of monitoring and evaluation in table 4.22 as many as 86 (39.6%) of respondents reported that regular monitoring and evaluation always occurred this confirmed the qualitative results in item 4.3.2.1.3 (b) vi where participants said that regular monitoring and evaluation always occurred. Implementing Monitoring and Evaluation can help detect and deal with problems that can hinder quality health care provision early. According to Chabane (2013:1), DPME and Offices of the Premier regularly visit, health facilities in the department of health for monitoring and evaluation. Department of health also established its own monitoring and evaluation unit that internally monitor the implementation of the policies. 4.3.2.1.3 (b) vi.

(g i)Recommendations on implementation of Monitoring and evaluation

To continue with regular evaluation and monitoring and include implementing improvement plans

(h)Involvement of stake holders in Monitoring and Evaluation

The qualitative result on 4.3.2.1.3 (b) vii is supported by the quantitative result on Involvement of Stakeholders in monitoring and evaluation as represented in table 4.22 which had as many as 77 (35.6%) of respondents indicated that

stakeholders were never involved or participated in monitoring and evaluation. This agreed with the complaint by participants that they were never involved in monitoring and evaluation. Involvement of citizens is important will make sure that citizens are informed of quality of services provided for them and they can make informed decisions. Jones et al (2017:1) in their study ln England on how hospital boards govern, found that involving hospital boards in hospital activities enabled hospital board in England to succeed in governing hospitals for Quality improvement. The Department of Performance Monitoring and Evaluation (DPME) in South Africa recently started working on plans to involve citizens in monitoring selected frontline service delivery against agreed standards. The (DPME) believes Government has responsibility to ensure citizens are aware and informed. Matsiliza, (2012:4) and Carother and Brechenmacher, (2014:2) indicated that PME plays a pivotal role in ensuring accountability and transparency of institutions to the communities they serve, giving decision makers an additional public sector management tool, and building on the capacities of the beneficiaries. Therefore it was suggested that should be a standard practice among public sector institutions that embrace PME techniques.

(h i) Recommendations to address lack of involvement of stake holders

The department need to develop plans and strategies to involve stakeholders in some aspects of monitoring and evaluation. Monitoring and evaluation must be continued as it enables service providers to identify problems that may hinder provision of quality health care.

(j) Management of Patients

(i)Mental Health care

The quantitative results in Figure 4.3 showed that majority of respondents 198(92.0%) reported that mental health patients are always kept patients longer

than necessary in the facilities this concurred with the qualitative result in item 4.3.4.2 where participants complained about mentally ill but stable patients staying in the mental hospital for years. It is important that mentally ill patients be allowed back to the communities as soon as they are stable enough to prevent overcrowding in hospitals. Campbell, (2017:1) from Northern Ireland was one of these people who was advocating for stable mentally ill people to be cared for in their own communities or homes. He insisted that in the 21st century, a hospital should never be considered 'home' for people with a mental health condition. Neuman (2013:2) on the other hand acknowledged that there were serious reasons for admitting mentally ill patients and also there were mentally ill patients that could be treated at home or only need short stays in hospitals. Yet he was also concerned about mental health patients that stay longer than necessary. Bezudenhoudt (2016:1) brought out many suggestions to deal with the problems some of which are: to de-institutionalize mental health care so that community-based care could be set up in a systematic way, increase funding and train mental health.

(a)Recommendations to address the need for mental heal patients to be reintegrated to the community

A programme to ensure that mentally ill patients are reintegrated to the communities as soon as possible needs to be developed involving the community.

(ii) Orthopaedic Patients

The quantitative result as presented in figure 4.4 showed that majority of respondents (professional nurses) 131(60.0%) reported that orthopedic patients always experienced long hospitals stay in the health facilities confirming the qualitative result in item 4.3.1.3(c) iii where participants raised some concern over the fact that Orthopedic patients stay for a long time in the hospital. It is in

the interest of patients that they be discharged early from hospital to recuperate at home. Staying too long in the hospital could lead to hospital infections.

Gholson, Noiseux, Otero and Gao (2017:1) in their study of Length of Stay by orthopedic patients discovered that there were patient characteristics like, congestive heart failure, underweight and other chronic diseases like diabetes and hypertension do play a role in increasing length of stay .Patients and family need to be made aware of this. Mersal (2014:1) in her study in Egypt, noticed that doctors had a fear that their care givers would not be able to take care of the patients well at home and the patients would have complications related to immobilisation. The doctors would therefore keep patients in hospital longer. Therefore; training and educational program to enhance knowledge and practice of caregivers was suggested so the care givers could be able to prevent complications (Mersa, 2014:1).

(a**) Recommendations to reduce long hospital stay by orthopaedic patients**

Orthopedic patients with risk factors to e.g diabetes, morbid obesity should together with their families be counseled, educated and trained regarding what they can do to mitigate against long hospital stay. Training and educational programmes should be developed to enhance practice of care givers in the community to prevent complications.

(iii) MDR and TB patients care

The quantitative result regarding the issue of acute TB and MDR Patients nursed in same wards as presented in figure 4.5 showed that majority of respondents 199 (92.0%) of respondents indicated that Acute TB and MDR Patients were always separated. This did not support the qualitative result in item 4.3.1.3. (c) iv where participants were concerned that Acute TB and MDR patients were nursed in the same wards. The observation that acute TB and MDR were nursed in the same ward may have occurred in one district as confirmed

by the study conducted by Tshitangano (2014:1) who confirmed that, TB cubicles were not reserved for patients with infectious TB and that many TB inpatients at hospitals of Vhembe district were not isolated; masks were not used consistently or appropriately by patients, staff or visitors.. It is important that acute TB and MDR are always separated so that those people who have acute TB and or MDR cannot infect each other or those around them. The following researchers, Lange et al (2014:24) and Belarus, Murray and Lopez (2013.:5) in their study in Minsk agreed with the fact that Individuals suspected of having TB should be separated from other patients and evaluated for TB without waiting in general areas. According to guideline Department of health S.A (2007:1), isolation is very important for MDR TB Patients for at least 2 weeks after they are on treatment.

(j i) Recommendations to ensure all district are able to separate MDR and TB patients

The isolation principles for MDR TB patients need to be observed all the times.

4.5.2.3 Outcome factors

4.5.2.3.1 Employee satisfaction

Though employee satisfaction could be regarded as outcome in the Donabedien conceptual framework, in this study discussions and conclusions were only based on outcome factors from clients. The quantitative result with regard to respondents planning to relocate to other job opportunities as presented in table 4.19, most 69 (31.9%) of respondents indicated that they were never planning to relocate to other job opportunities. This did not support the qualitative result in item 4.3.3.1.1 where participants were worried that staff would relocate as soon as they get better offers. When staff is not satisfied, they always think of leaving for better employment and at work dissatisfied staff was more likely to make serious errors that could lead to litigation.

Mafini and Pooe (2013:1) conducted a study to analyse the relationship between employee satisfaction and organisational performance in a public sector organisation. They found that there were positive correlations between organisational performance and employee satisfaction factors. This was confirmed by Mulhern (2009:1) and Matlhaba et al (2019:1) who found that employee satisfaction also appeared to have a strong relationship with the quality of care delivered and related costs. When employees were more satisfied it helped reduce stress, turnover, leaves of absence, and lowered work-related disability and violence claims and les errors that could lead to litigation, but Peltier and Dahl, (2009:1) also discovered that other working conditions could such as achievement, recognition, responsibility, opportunity for personal growth were also important for job satisfaction According to Manyisa (2016:1); Asegid, Belachew and Yima (2014:2), workload is also a major cause of dissatisfaction among health care givers and support staff and has been found to have an influence on staff decisions as whether to leave or remain in their jobs.

(a) Recommendations to address the employee satisfaction issues

There is a need for managers to strive to increase job satisfaction through giving opportunities for personal growth, recognize work well-done, giving more responsibilities and more independence in the work place.

4.5.2.3.2 Client Satisfaction

In this study understanding of language, access to medicine , access to 24 hours service , cleanliness attitude and waiting period were considered significant outcome factors that would be affected by structural and process issue and have important influence on provision of quality health care provision . A questionnaire for clients was therefore designed and implemented. An in-depth study of these aspects was done and results were discussed below

4.5.2.3.3 Understanding language

This qualitative result regarding understanding of language as presented in figure 4.6 showed that in item the majority of respondents 175 (97.7%) indicated that they understood the language used in the institutions. This agreed with qualitative result in item 4.3.2.1.4. (c), where participants indicated that they understood the language spoken in facilities. Understanding the language that the patient uses is important for good history taking that can lead the correct diagnosis and treatment. Lack of understanding of each other's languages in the hospital and clinic facilities can affect access of services by immigrant who might not be able to explain their problems.

The quality of communication between patients and providers was a strong determinant of whether patients received optimal care. Baruch and Walker (2013:1) highlighted the importance of effective communication between patient and the staff as essential for achieving positive health outcomes. Mafuwa (2015:20) in the study conducted in Cape Town, South Africa, about the experiences of Zimbabweans when trying to access health services in Cape Town, brought forward the fact that communication between the ethnic minority patients and health care personnel were problematic. The inability to communicate in what was not their mother tongue inevitably led to discrimination, due to lack of a common language. They struggled to express their inner feelings, to ask questions, or to represent themselves. Language difficulties could have a detrimental effect upon the patient ability to comprehend proposed treatments and remedies, they also hampered the physician's attempts at obtaining vital medical history.

(a) Recommendations to encourage sustenance in good communication

Service providers should continue to make sure that they are sensitive to the communication needs of their patients so quality health care can be provided.

4.5.2.3.3 Twenty-four hours services

The quantitative result as presented in Item 4.3.2.1.4. (d), confirmed that majority of clinic facilities did not provide twenty-four (24) Hours Service. Of the 5 clinic facilities visited only 1(2%) was providing 24 hours service and 4 (80%) did not provide 24 hours services. This situation is contrary to what the department of health prescribed. The system cannot be implemented because of shortage of staff and security reasons. According to Department of Health (2016:3), A Primary Health Care Clinic was the first step in the provision of health care and offer services such as immunization, family planning, anti-natal care, and treatment of common diseases, treatment and management of Tuberculosis, HIV/AIDS counselling, amongst other services. If the clinic cannot assist, they would refer the patient to the next level. To prevent patients flocking to hospitals unnecessarily, they should provide 24 hours service.

(a)Recommendations to address the contributing factors to lack of 24 hours service

Recruitment of professional nurses and security staff is crucial to solving the problem of lack of 24 hours in the clinic facilities.

4.5.2.3.4 Medicine related issues

The quantitative results from Table 4.23: confirmed the results from the qualitative results in item 4.3.2.1.4. (e). Respondents' responses to availability of medicine and explanation on how medicine should be administered and stored. The Majority, 176 (97.6%) of the respondents indicated that they got the prescribed medicine from the pharmacy and 180 (100.0%) of the respondents indicated that they got explanations on how medicine should be administered and stored. According to this study there was no shortage of medicine and correct explanations are given. For provision of quality health services access to prescribed medicines and correct explanation are vital for speedy recovery by

patient. The importance of knowing how to take medicines can never be over emphasised. It is important that the use of medicine be explained to patients. In their study. Potentially serious health outcomes could result from non-adherence to prescribed medications, such as therapeutic failure, unnecessary hospitalization, and even death. Another critical issue related to non-adherence was cost. (Kelly and Jorgeson, 2012:1; Usherwood, 2017:148).

(a) Recommendations to encourage the service providers to maintain the good work

Service providers should continue to make sure medicines are available by ordering on time before stock is exhausted.

4.5.2.3.5 Cleanliness of facilities

The quantitative results with regard to cleanliness of the facilities as presented in table 4.24, 144 (80.5%) of the respondents indicated that the facilities they visited were clean, while 140 (78.0%) indicated that facilities they visited were free from odour and 129 (71.8%) indicated the facilities were free from littering. However the qualitative result present a different picture in item 4.3.2.1.4. (f) where participants complained that some facilities were dirty, smelly and full of litter.

Though some clinics were clean some have been reported dirty because of lack of cleaning staff. Dirty environment in hospital and clinic facilities are very dangerous as it can lead to nosocomial infections. This therefore can compromise quality health care provision leading to death and litigation.

According to Markkanen, Quin and Galligan (2009:3) and Hague et al (2018: 2322), cleanliness and controlling the spread of infections was particularly crucial in healthcare settings and for health care providers. These researchers insisted that a healthy safe and aesthetically pleasing space with clean surfaces

was comforting to patients and their families by giving an impression of good quality care without additional health hazards. Cleaning held special importance for hospitals and other healthcare facilities. Non clean environment could lead to nosocomial (Healthcare Associated illnesses) infection, death of patients and litigation. The researchers regard cleaning to be as important as curative treatment (Markkanen,et al., 2009:3 ; Hague et al 2018:1).

Despite these favourable results from this study, South Africa, however was still plagued with problems related to cleanliness as shown by the report below. Molelekwa (2015:1) reported negatively on the status of one hospital cleanliness, after visiting a hospital to visit her sick husband." Another report came through "the Maverick". Many hospitals were assessed in the country; one hospital scored so badly: Its leadership scored below 20 percent; cleanliness was rated as lowly 41. percent Only one of 394 hospitals audited by the department of health met the accepted standards for cleanliness, infection, drug stocks, staff attitude, patient safety and waiting time (Cullinan, 2014:1).

(a)Recommendations to address the shortage f cleaning staff

There is a need to hire more cleaning staff and to train them on how to clean and keep environment clean. Hospital and clinic facilities need to be kept clean all the time. The department need to employ train enough cleaners for the facilities.

4.5.2.3.6 Attitude

The quantitative results with regard to attitude of the staff as presented in table 4.25 showed 171(95.2%) indicated that they were not treated with respect; 170 (90.0%) indicated that persons who treated them had no name tags;170 (90.0%) indicated that they were not properly addressed with their names; 175 (97.1%) indicated that they did not get explanations regarding their illnesses and.; 175 (97.1%) indicated that service providers in the facilities they visited are not

competent to their job. And 170 (100.0%) indicated that they were not satisfied with services they received from facilities. This confirmed the qualitative result in 4.3.2.1.4. (g), participants complained that service providers do not wear their name tags, don't explain or address patients properly about their illnesses. Attitude of staff is an important factor in quality health care provision. Patients should be treated with respect and should get proper explanations of their diseases. Haskins, Phakathi, Grant and Horwood (2018) in their study confirmed the concerns expressed by patients in this study. They also found that nurses and patients described poor nursing practices and abuse of patients. They therefore strongly suggested that the problem should be urgently addressed wherever it occurs. Nurses can no longer accept or give the excuse of difficult working conditions. Any nurse who abuses patients must be disciplined. Staff shortages should be addressed, including issues of nurses' absenteeism rates. The problem of nurse-patient relationships requires investigations about the causes of these problem.

(a) Recommendations to address the bad attitude by professional nurses

Attitude problems should be addressed using workshops and discipline where indicated.

4.5.2.3.7 Waiting Period

The quantitative result concerning waiting time presented in table 4.25 170 (90.0%) indicated that they waited for more than 3 hours in the institution were not satisfied with services they received from facilities. This confirmed the qualitative results in item 4.3.2.1.4. (h) where participants complained that service was very slow and clients had to sometimes wait for the whole day to be helped. Long waiting time is one of the determinants of patients' experience of care. Ogali and Menzie-Okoye (2017:1) in their study in the university teaching hospital of Port Harcourt, concluded that the waiting time for patient accessing general outpatient care in the teaching hospital was indeed long and it was a

major contributor to negative patient experiences. However Daniels (2015:1) in the study conducted in Cape Town, South Africa was able to demonstrate the usefulness of waiting time surveys.

According to the Department of Health South Africa (2015:3), acceptable waiting times have been prescribed which took into consideration the capacities of facilities.

(a) Recommendations to address long waiting times related to workload

Implementing the workload reducing activities from the ICRM and NHI approach will help in improving quality health care provision.

4.6. CONCLUSION

This chapter dealt with Presentation of qualitative, quantitative research findings and discussion thereof. The next chapter will deal with development of strategies to facilitate the provision of quality healthcare services.

CHAPTER 5

STRATEGIES TO FACILITATE THE PROVISION OF QUALITY HEALTHCARE SERVICES IN PUBLIC HEALTHCARE FACILITIES IN LIMPOPO PROVINCE SOUTH AFRICA: USING THE SWOT ANALYSIS

5.1 INTRODUCTION

In the previous chapter, the researcher presented and discussed the findings using Chats and tables. In this chapter the development of strategies using the SWOT analysis was discussed.

5.2 BACK GROUND

A literature search was done on challenges and factors that contribute to quality healthcare provision. The literature search, the proposal, the collection and presentation of the results was done according to the Donabedian model's three factors viz: Structural, Process and Outcome factors. The qualitative approach using focus group discussions was used to collect data from stake holders and professional nurses followed by a quantitative approach using questionnaires which were given to clients and professional nurses in the five districts of Limpopo Department of Health. Seven hospitals and five clinics were involved. The aim of the study was to develop strategies to facilitate provision of quality healthcare in public healthcare facilities in the Department of Health, Limpopo province South Africa. The collected data was organized into the SWOT analysis plan. The result of the SWOT analysis informed the strategies developed. Because the list of the weaknesses was very long it was not practically possible

to address them all. A priority list was drawn and addressed. It was realized that when one strategy is implemented, that implementation may improve more than one problem e.g.an improved referral system may relieve workload and shortage of staff. The template suggested by Fergusson (2015:1) was preferred to develop the Strategies through SWOT analysis.

5.3 DEVELOPMENT OF STRATEGIES

5.3.1 Using SWOT Analysis

Data was collected and organized into a SWOT analysis plan The Qualitative and quantitative results were categorized into structural, Process and outcome factors suggested by the Donabedian model. A team of experts consisting of professional nurses and stakeholders were nominated and met to analyse and categorise the strengths and weaknesses opportunities and Threats of the study. This was followed by prioritising the list of challenges, then developing strategies. The challenges were identified as listed in table 5.1, 5.2 5.3 and 5.4

5.3.2 Results from SWOT analysis

Table 5.1. Results of AWOT Analysis results: Strengths and weaknesses: Structural and process factors

INTERNAL STRENGTHS	INTERNAL WEAKNESSES
STRUCTURAL FACTORS	
Some facilities environment clean	Shortage of staff
	Clinical equipment Problems Not enough
	Maintenance of clinical equipment not adequate
	Infrastructural/space problems:
	Not enough and dilapidated
	Maintenance of infrastructural not adequate
	Lack of effective security
	Majority of professional nurses between the ages of 50 and 59 while minority of between the ages of 20 and 29
PROCESS FACTORS	
Employee satisfaction : Majority the staff is not planning to relocate to other job	Salaries of professionals unsatisfactory
	Nurses used for non-nursing duties
	Less opportunities for career development
	Absenteeism was rife
	Poor working conditions: Nurses live and work in dilapidated infrastructure
	Workload was always high
	Large numbers of maternity patients referred to deliver in hospitals were always unnecessary
Monitoring and evaluation units available	No involvement of stakeholders in monitoring and evaluation
There is implementation of monitoring and evaluation	Mental health patents are unnecessarily kept for long periods of time in hospitals
Practice patient centred care is practiced	Acute TB and MDR kept in same ward in one district
	Orthopaedic patients have long hospital stay
	Some staff do not implement the Batho Pele white paper on transformation of public services

Table 5.2.Results of SWOT analysis internal strengths and week nesses Outcome factors

INTERNAL STRENGTHS	INTERNAL WEAKNESSES
OUTCOME FACTORS	
understand the language used in the institutions	Most clinic facilities did not provide twenty-four (24) hours Service
explanations on how medicine should be administered and stored	Most facilities were dirty smelly and full of litter
got the prescribed medicine from the pharmacy	Clients complained that they were not treated with respect
Community is involved in governance of health care services(Clinic health committees and hospital boards)	Clients complained that they were not treated by a service provider that had a nametag
	Clients complained that they were not properly addressed.
	Clients complained that their illnesses were not properly explained
	Clients complained that service providers were not competent to do their job
	Clients said they were not satisfied with services they received from the facilities
	Clients complained of long waiting period

Table 5.3.Results of SWOT analysis Opportunities, Threats for structural Process and Outcome factors

THREATS AND OPPORTUNITIES RESULTS	
OPPORTUNITIES	**THREATS**
STRUCTURAL	
A	Medico legal hazards might occur because of dilapidated infrastructure, mixing mental health patients with not mentally ill patients, mixing infectious patients e.g. TB and MDR patient.
	Suing of the Department because of lack of equipment
PROCESS FACTORS	
Non-governmental organisation to spread all over the province	
Implementation of the ICRM Programmed	Professional nurse may want to relocate to better job opportunities if dissatisfied with their work.
Implementation of the National Health Insurance	There might be a potential of strikes because of low salaries and poor working conditions
Implementation of WISN	
OUTCOME FACTORS	
	Outbreak of infections in hospitals and clinics

5.4 STRATEGIES TO FACILITATE THE PROVISION OF QUALITY HEALTHCARE SERVICES IN PUBLIC HEALTHCARE FACILITIES IN LIMPOPO PROVINCE

5.4.4 Introduction

Bradely, Pallas, Bashyal Berman and Curry (2010:5) and Rowe et al (2018:1) noticed that since organisations are diverse and therefore methods to development of strategies could not be a one size fit all. Managers need to adapt approaches they select to use in development of strategies to the situation and the environment at hand. It is important to develop relevant strategies because it contributes to improving health service delivery and ultimately health outcomes. (Bradely, Pallas, Bashyal Berman and Curry, 2010:5; Rowe et al 2018:1).

After the compilation of the literature search, qualitative interviews and Quantitative Questionnaire results, the strength, weaknesses, Threats and opportunities as indicated in table 5.1, .5.2 and 5.3 above were identified. The researcher and her team of experts realized that the department of health did not have the financial capacity to address at once all the challenges identified through this study. The researcher and team of experts therefore prioritised challenges that could be addressed without a big budget and had potential to address more than one challenge when implemented. See table 5.4. For example, improving the referral system had the potential of addressing staff shortages, work load and costs of going to hospital for something that could be solved at clinic levels.

5.4.5 Priority Challenges

Table 5.4. Prioritised challenges for strategies to be developed

Prioritised Challenges	
Strength	**Weaknesses**
STRUCTURAL	
PROCESS FACTORS	
Majority of staff is not planning on relocation to new job opportunities	
Community is involved in governance of health care services(Clinic health committees and hospital boards)	Professional nurse may want to relocate to better job opportunities if dissatisfied with their work.
	There might be a potential of strikes because of low salaries and poor working conditions
	Shortage of staff, work overload
	maternity patients referred to deliver in hospitals were always unnecessary
	Nurses perform non-nursing duties Non nursing duties.
	Lack of management support
OUTCOME FACTORS	
	Employees dissatisfied in their work (bad working conditions).
	Long waiting time
OPPORTUNITIES	THREATS
Came from process factors	**Came from structural factors**
Implementation of the National Health Insurance	Medico legal hazard because of unmaintained non-functional equipment which may lead to litigation
Implementation of WISN	Medico legal hazards because of dilapidated dangerous infrastructure.
Non-governmental organisation to spread all over the province	

5.4.6 Main Strategies developed according to the prioritized challenges

Title :

Strategies To Facilitate Provision of Quality Health Care Provision in Public Facilities in Limpopo Province South Africa.

Purpose: To guide the implementation of improvement of health care provision

Ratonale:

- Implementation of strategies will reduce litigations
- Implementation of process structure strategies is cost effective because it mostly need changes in how things are done
- The strategies can be monitored and improved continuously

5.4.6.1 Strategies building on strengths

5.5. Building on strengths

BUILDING ON STRENGTHS	STRATEGY
PROCESS FACTORS	
Title Strenthening Authority for more experienced Employee	
Purpose :**To** retain experienced staff and increase job satisfaction	
Rationale .Professionals are satisfied when allowed more autonomous nursing decisions. supported by study by **(Asgid et al.,2014:1)**	
Strength	Strategy
Majority of staff is not planning on relocation to new job opportunities	Employees are allocated areas of responsibilities in the department or in the area of work with minimum supervision.
Role players	Responsibility: Researcher, District PHC managers and CEOs. Of hospitals

Table 5.6 Strategies: Building on strengths

Title Providing support to HIV TB AIDS and mental health	
Purpose : **To increase cure rate** **Rationale** :Support groups encourage Adherence to treatment (Chime et al., 2018:1)	
Strength	Strategy
Community is involved in governance of health care services(Clinic health committees and hospital boards)	Constitute and train Community support groups per local area for HIV AIDS, TB and mental health.
Role players	Responsibility: Researcher, District PHC managers and CEOs.

5.4.6.2 Strategies overcoming weaknesses

Table 5.7. Strategies: Overcoming weaknesses

OVERCOMING WEAKNESSES	STRATEGY
Weakness	**Strategy**
PROCESS FACTORS	
Title Improving coverage by professional nurses **Purpose** : To introduce user friendly shifts for professional nurses . **Rationale** :User friendly shifts will relieve shortage of staff and work overload (Lin et al., 2014:1)	
Weakness	**Main Strategy**
Shortage of staff, work overload	User friendly shifts are developed that will allow professionals to rest in between to ensure coverage in 24 hours e.g 7 to1, 1 t to 4 4 to 7 7to7.
Role players	**Researcher, District PHC managers and Local area managers.**
Title Designing a referral system between Clinics health centres and hospitals **Purpose :To control referral between clinics, health centres and hospitals** **Rationale : When there is a good referral system hospitals will give quality treatment only patient referred (Singh et al., 2016:3)**	
Weakness	**Main Strategy**
maternity patients referred to deliver in hospitals were always unnecessary	A referral system designed that will control the movement of clients from Primary Health care facilities to hospital facilities.
Role players	**Researcher, District PHC managers and Local area managers.**

Table 5.8. Strategies: Overcoming weaknesses

OVERCOMING WEAKNESSES	**STRATEGY**
Weakness	**Strategy**
PROCESS FACTORS	
Title Nurses doing non-nursing duties Purpose :To discourage Nusrses from doing non nursing duties Rationale : Nursing duties left undone by nurses is decreased employee and client satisfaction increased(**Becker, 2013:3).**	
Weakness	**Main Strategy**
Nurses perform non-nursing duties Non nursing duties.	A policy to concietise professional nurses and support workers on the importance of nurses doing nursing duties is designed and implemented
Role players	**Responsibility: Researcher, District PHC managers and CEOs.**
Title Training of local arear managers and ward supervisors on importance of regular supervision **Purpose :** To improve professional nurses support by Managers **.** **Rationale :** When professional nurses are supported there is increased job satisfaction **(Munyewende et al., 2014:2)**	
Weakness	**Main Strategy**
Lack of management support	Local area managers and Ward supervisors are trained on the importance of regular supervision as well as useful methods of supervision.
Role players	**: Researcher, District PHC managers and CEOs.**

Table 5.9. Strategies: Overcoming weaknesses

OVERCOMING WEAKNESSES	STRATEGY
PROCESS FACTORS	
OUTCOME FACTORS	
Title: Training local area managers on how to communicate and motivate facility staff members **Purpose:** To open lines of communication between front line staff and supervisors**.** **Rationale:** Open communication leads to job satisfaction **(**Zangeneh et al., 2019:1**)**	
Weakness	**Strategy**
Employees dissatisfied in their work (bad working conditions.	Local area mangers are trained to regularly train facility managers on communication and motivation of facility staff members in the next three financial year.
Role players	**Researcher, District PHC managers**
Title : Designing a policy to manage waiting in PHC facilities and hospitals **Purpose :** To reduce waiting time in PHC facilities and **hospitals** **Rationale: Client satisfactions tends to increase with reduced waiting time (Matlhaba et al., 2019:1).**	
Weakness	**Strategy**
Long waiting time	A policy to manage waiting times is designed and implemented in all primary health care facilities and hospitals.
Role players	**Researcher, District PHC managers and Local area managers**

Table 5.10. Strategies: Overcoming weaknesses

OVERCOMING WEAKNESSES	STRATEGY
PROCESS FACTORS	
OUTCOME FACTORS	
Title: Introduce appointment system for patients **Purpose :** To reduce waiting time and increase job satisfaction **Rationale:** Reduced waiting time through appointment system will increase client and employee satisfaction (Ogali and Menzie-Okoye, 2017:1)	
Weakness	**Main Strategy**
Long waiting time	Introduce an appointment system for patient that goes together with the shift system, through the evening and weekend
Role players	**Researcher, District PHC managers and Local area managers.**

5.4.6.3 Strategies, taking advantage of opportunities

5.11; Strateges taking advantage of opportunities

Taking advantage of opportunities	**STRATEGY**
PROCESS FACTORS	
Title : Update NGO's about ICRM and what is relevant for the NGO to contribute **Purpose :** To encourage NGO's to contribute according to the needs of the department of health Rationale : Duplication and waste of resources is avoided (Piotrowicz, & Cianciara, 2013:151).	
Opportunities	**Main Strategies**
PROCESS FACTORS	
Non-governmental organisations are working with department of health on ICRM.	Update non-governmental organisations in writing or in workshops about the ICRM and indicate what the current needs for the department is, (e.g. it could be vital equipment) so they can channel their help to the areas of need. Acceptance of their support will depend on if they satisfy a need by the department.
Role players	Researcher, District PHC managers and local area managers.

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5.12 Strategies Taking advantage of opportunities

Title: Training non-professionals on ICRM **Purpose**: To ensure buy in by training non professionals **Rationale** : People participate more when involved (Amin et al., 2017:1**).**	
Opportunities	**Main Strategy**
The ICRM programme is in place in the department.	Training on implementation of ICRM should be extended to nonprofessional workers in the primary health institutions, clinic committees and other community formations to ensure a buy in and the necessary support. This should happen quarterly.
Role players	Responsibility: Researcher, District PHC managers and local area managers.
Title: Feedback on NHI and WISN Purpose ; To be ready to implement NHI WSN principles in time Rationale: NHI and WSN will solve all problems related to staffing ,employee satisfaction and client satisfaction	
Opportunities	**Main Strategy**
Opportunities	**Main Strategy**
Plans to implement NHI and WISN are in an advanced stage.	Yearly feedback sessions on progress on NHI and WISN to clinic committees and hospital boards are conducted to make sure communities are updated and can give inputs.
Role players	Researcher, District PHC managers, local area managers and CEOs.

5.4.6.4 Strategies Mitigating threats

Table 5.13 Strategies: mitigating threats

Mitigating on threats	**Strategies**
STRUCTURAL FACTORS	
Title : Maintenance of clinical equipment **Purpose :** To establish in house clinical equipment maintenance teams at local areas **Rationale** : Decentralised maintenance teams will be accessible to facilities (Dejager, 2015:9).	
Threats	**Main Strategy**
Medico legal hazard because of unmaintained non-functional equipment which may lead to litigation.	In house clinical equipment maintenance teams per local area and per hospital are identified and trained in all local areas and hospital facilities in the next three financial years. Their main focus will be to provide maintenance in the designated local area and hospital.
Medico legal hazard because of unmaintained non-functional equipment which may lead to litigation.	In house clinical medical maintenance teams train end users to do simple maintenance in the next three financial years
Role players	District PHC Managers and local area managers and Hospital CEOs
Title : Maintenance of Infrastructure **Purpose:** To establish in house infrastructure maintenance teams at local areas **Rationale;** Decentralised maintenance teams will be accessible to facilities	
Threats	**Main Strategy**
Medico legal hazards because of dilapidated dangerous infrastructure.	In-house infrastructure maintenance teams for local areas and hospitals are identified and trained to do infrastructure maintenance for local areas clinic facilities and hospitals.
Role players	Researcher, District PHC Managers and local area managers and hospital CEOs

5.4.6.5. How Deductive, inductive and synthesis reasoning was introduced in development of strategies.

5.4.6.5.1. Inductive reasoning

Gabriel (2013:1) described the difference between deductive reasoning and inductive reasoning was that in deductive reasoning one works from the general to the specific e.g. you can start from a theory to a hypothesis that can be tested to observables that may address the hypothesis. This is called the top down. On the other hand in Inductive reasoning one moves from observed specifics to generalizations when noticing patterns.

5.4.6.5.1.1 Application of inductive in this study in the development of strategies.

In development of strategies for this study only inductive reasoning was applied. Observations were made by the various participants. From the observed patterns Strategies to solve problems were developed.

5.4.6.5.2 Synthesis Reasoning

According to Garside (2015:1), Research synthesis is the overarching term we use to describe approaches to combining, aggregating, integrating, and synthesizing primary research findings. Each synthesis methodology draws on different types of findings depending on the purpose and product of the chosen synthesis

5.4.6.5.2.1 Application of synthesis in this study:

The outcome of the study brought forward the fact that both professional nurses and clients were dissatisfied. The professional nurses with their working conditions and the clients with waiting time. The strategies that were developed were synthesised so that would be able to solve both the client and

professional nurse's problems .e.g. "Introduce an appointment system for patient that goes together with the shift system, through the evening and weekend "This strategy would reduce waiting time and reduce the workload for the professional nurses and subsequently improve working conditions

6 CONCLUSION

In this chapter the development of strategies using the SWOT analysis as well as developed strategies were discussed. In the next chapter validation of the developed strategies will be discussed.

CHAPTER 6

VALIDATION OF THE DEVELOPED STRATEGIES

6.1 INTRODUCTION

In the previous chapter challenges were identified using the SWOT analysis .This was followed by the development of strategies based on the challenges. In this chapter validation of the developed strategies was discussed According to Driver (2016:5), most strategies about 90% of them have very little impact. Strategies should be meaningful and implementable. Driver (2016:5) suggests that strategies should be defined and validated before implementation. Validation include understanding of the language used to develop strategies by everybody. Through validation people are given a chance to feel whether it is feasible to implement the strategy, and whether it can yield results and feeds into the rest of the plans of the business or department. In this study, the strategies were presented to a sample of participants from the five districts, five clinics and five hospitals.

6.2 METHODOLOGY

A quantitative approach using a questionnaire was used (see Annexure G).

6.3 POPULATION

Population included all Professional nurses in charge of sections in the hospitals and clinics as well as all hospital boards and clinic health committees from sampled hospitals and clinics.

6.4 SAMPLING METHODS

The seven sampled hospitals and five sampled clinics were used.
Purposive sampling was used to sample 10 professional nurses from the sampled hospitals five professional nurses from sampled clinics, 5 hospital boards and 5 clinic health committee members from the sampled seven hospital and five clinics.

6.5 INCLUSION CRITERIA AND SIZE OF SAMPLE WAS AS FOLLOWS

The professional nurse, hospital board and clinic health committee members should have participated in the study.

6.6 EXCLUSION CRITERIA WAS AS FOLLOWS:

Those who did not participate in the study and those who were involved in the pretest of the validation instrument were excluded.

6.7 DATA COLLECTION INSTRUMENT

A questionnaire was designed informed by information from the developed strategies. The questionnaire was pretested with five representatives from the population to check if it produced what it is supposed to produce. The results were used to modify the questionnaire. The questionnaire was in English since the respondents were professional nurses and the clinic health committees and hospital board members were proficient in English.

6.8 DATA COLLECTION

A self-administered questionnaire was distributed to the respondents to complete in their respective facilities. The researcher met the respondents, explained the questionnaire and waited for them to complete the questionnaire. Permission was requested from the managers to see the respondents during a convenient time to complete the questionnaire. The respondents provided informed written consent before the completion of the questionnaires. The

completion of the questionnaires took about 10 to 15 minutes and were collected from respondents on the same day they were completed.

6.9 DATA ANALYSIS

6.9.1 Presentation of the Results

The researcher presented results using Tables 6.1 and 6.2., 6.3.and 6.4

6.9.2 Biographical Data of the Participants for validation

Table 6.1 Biographical Data of the Participants: validation

Race/	**Frequency**	**Percent %**
African	25	100%
Other	25	
Grand Total	25	
Age distribution	**Frequency**	**Percent%**
20-29	6	24
30-39		
40-49	4	16
50-59	15	60
60 and above	-	-
Grand total	25	100
Gender	**Frequency**	**Percent %**
Male	5	20
Female	20	80
Grand Total	25	100
Qualifications	**Frequency**	**Percent%**
Doctoral degree	0	0
Master's degree		
Honors degree		
Post basic nursing degree	5	10
Post basic nursing diploma	5	10
Basic nursing degree		
Basic Nursing diploma	10	40
No specific qualification	10	40
Grand Total no	25	100
Years of experience	Frequency	Percent%
1-3	5	20
4-5	5	20
5 and above	15	60
Grand Total	25	100

6.10 DISCUSSION OF THE VALIDATION OF RESULTS

It is very important to note that for the sake of this study strategies most developed involved mainly the process and some outcome factors of Donabedian model, because the researchers and experts decided to prioritise strategies that involved changing the way things are done. This was so because structure factors would need a big budget and currently the department does not have money. The two structural factors that were included were addressed in a way that would not cost a lot, viz Identifying and training in house clinical equipment and infrastructure maintenance per local area and per hospital will improve maintenance in primary health care facilities and hospital facilities. Because the Donabedian's factors affect each other, trying to fix process and infrastructure factors would improve employee satisfaction and client satisfaction which are outcome factors.

6.10.1 Strengths and Weaknesses

6.10.1.1 Strengths

Table 6.2 Validating strategies: Building on strengths

Strategy	Frequency	%
Allocation of employees in areas of responsibility with minimum supervision strengthen employee job satisfaction	25	100
Constitution and training of community support groups per local area for HIV, TB and mental health will improve quality health care provision	25	100

From the validation results 25 out of 25 respondents (100%) agreed with all the strategies to build on strengths as follows:

6.10.1.1.1 Allocation of employees in areas with minimal supervision strengthen employee job satisfaction

Rigoni and Nelson (2016:2) in their study found out that engaged employees are less likely to consider leaving their jobs for other job opportunities. When employees are actively disengaged, the percentage who would consider leaving for a raise of 20.0% or less increases to 54.0%. On the other hand, when employees are fully engaged, when they feel involved in, enthusiastic about and committed to their work, the percentage who would consider leaving for a raise of 20.0% or less drops to 37.0%, or by slightly more than 30.0% compared with actively disengaged workers. Most actively disengaged workers are likely to bolt for almost any raise, while the majority of engaged workers would require more than a 20.0% raise to leave their current company (Rigoni and Nelson, (2016:2).

6.10.1.1.2. Constitution and training of community support groups per local area for TB and mental health will improve quality health care provision.

Pfeiffer et al (2011:2) and Fisher et al (2015:2) both described peer support as a critical and effective strategy for ongoing health care and was able to sustain behavior change for people with chronic diseases and other conditions and research on mentally ill patient showed that support interventions help reduce symptoms of depression. , Fisher et al (2015:2) further indicated that emerging research shows that peer support is broadly feasible and sustainable. Additional studies are needed to determine effectiveness in primary care and other settings with limited mental health resources.

6.10.1.2 Weaknesses

Table 6.3 Validating strategies: Overcoming weaknesses

Strategy	**Frequency**	**%**
Development and implementation of a policy to support nurses to do only nursing duties will improve client satisfaction and job satisfaction for the nurses	**25**	**100**
Training of local area managers and ward supervisors on importance of regular supervision be will improve job satisfaction for nurses	25	100
Development of user-friendly shifts that will allow professionals to rest between shifts and ensure coverage for 24 hours	**25**	**100**
Development and implementing a referral system that will control movement of patients from primary health care facilities to district and tertiary hospitals will release the district and tertiary hospitals to provide advanced health care services	**25**	**100**
Development and implementation of a policy to manage waiting times in primary health care facilities and hospitals will reduce waiting time s	25	100
Introduction of appointment system for patients in the primary health care facilities that go together with shift system will ensure coverage and reduce waiting time	25	100
Training of area managers to regularly workshop facility managers on communication and motivation will improve employee satisfaction leading to improvement of quality health care provision	25	100

6.10.1.2.1 Development and implementation of a policy to support nurses to do mainly nursing duties will improve client satisfaction and job satisfaction for the nurses

Becker (2013:9) concluded that: South African Professional Nurses perform many NNTs (Non-nursing tasks.) However, the performance of NNTs does not influence their job satisfaction to the extent the NTL.U (Non nursing tasks left undone) does. When nurses shift focus to non-nursing duties, or tasks, there are more chances for them to leave more nursing tasks undone. Leaving more nursing tasks undone may affect their job satisfaction and quality of health care provision negatively. Clarifying professional nurses' scope of practice and increasing the use of support services may provide professional nurses with more time to conduct nursing tasks which should improve job satisfaction and patient satisfaction. The professional. Nurses and the department can be sued for complications of nursing tasks left undone.

6.10.1.2.2 Training of local area managers and ward supervisors on importance of regular supervision will improve job satisfaction for nurses

Kisakye, Tweheyo, Ssengooba, Pariyo, Rutebemberwa and Kiwanuka (2016:83) believe that absenteeism reduces the effectiveness of health care provision. They also noted that only 4.0% of health worker absenteeism is caused by illness. It was found that infrequent supervision or inspection of health facilities, among other things contributed to absenteeism, therefore strengthening the managers and super visors on supervision is important.

6.10.1.2.3 Development of user-friendly shifts that will allow professionals to rest between shifts and ensure coverage for 24 hours

The study by Maphumulo and Bhengu (2019:2) also noted shortage of staff in South Africa to be problematic and inequitable access to health care persists with no hope of a solution in sight. The implementation of NHI is a long term

goal that could solve most of the shortage problems. Dhring, Von Treuer and Redly (2018:3) realised that reorganising shifts can help in covering time, provided the interests of both the patients and service providers are taken into consideration. Fiorio, Gorli and Verzillo (2018:2) therefore suggested the need for policy makers to invest in new organizational models close to the principles of PC hospital structures. Allocation of staff should be patient focused However Employers are encouraged to therefore make sure while implementing shift work that preservation of the shift workers' health as a whole is considered by ensuring that the shift work does not interfere with their family physical and psychological health (LittleJohn, Campbell, McNeil and Khayile, and 2012:2).

6.10.1.2.4 Development and implementation of a policy to manage waiting times in primary health care facilities and hospitals will reduce waiting times

Santibanez, Chow, Frech, Puterman and Tyldely (2013:1), conducted a study to see how to reduce patient waiting time. As a result of the study the following were recommended: Redistribution of workload evenly though out the week and day, Promoting punctuality, by introducing a no show policy, Collecting information before clients arrive, Designating a means of easily communicating with the clients and Constantly evaluating the scheduling practice. This approach can selectively be applied to the public facilities.

6.10.1.2.5 Development and implementing a referral system that will control movement of patients from primary health care facilities to district and tertiary hospitals will release the district and tertiary hospitals to provide advanced health care services

Masango-Makgobela, Govender and Ndimande (2013:5) in their study conducted in South Africa,found that for various reasons Patients always bypass clinics to hospitals even though the South African public health sector has designed a

hierarchical referral system. There is therefore a need to tighten the system to render it functional.

6.10.1.2.6 Training of area managers to regularly workshop facility managers on communication and motivation will improve employee satisfaction leading to improvement of quality health care provision

Mafini, and Pooe (2013:5) discovered that not only salary, but incentives, working conditions are important predictors but also other intrinsic factors such as achievement, recognition, responsibility, opportunity for personal growth are also important motivational factors for job satisfaction. Managers need to strive to make employees as happy as possible.

6.10.2 Opportunities and Threats

Table 6.4 Taking advantage of opportunities

Strategy	Frequency	%
Updating NGOs on the needs of the Departments will influence the NGOs to give relevant assistance.	25	100
Training non-professionals in primary health care institutions will ensure buy in and support for ICRM implementation	25	100
Yearly feedback on progress on NHI and WISN to clinic committees will ensure communities are informed and can give inputs for improvements of services	25	100

6.10.2.1. Taking advantage of opportunities

From the results respondents agreed on the following:

6.10.2.2 That updating NGOs on the needs of the departments will assist the NGOs to give relevant assistance to the department.

According to Hunter et al (2017:1), the Ideal Clinic Realisation and Maintenance (ICRM) programme was designed in response to the current deficiencies in the quality of primary health care services and to lay a strong foundation for the implementation of National Health Insurance, but problems that stands in the way of clinics becoming ideal are infrastructural problems, Human resource problems. Equipment and supply chain problems. It is therefore important to update the non-governmental organisations so they can choose relevant sections or items to fund.

6.10.2.3 That training nonprofessionals in primary health care institutions will ensure buy in and support for ICRM NHI implementation

According to Hunter et al (2017:1), The fact that most of the problems hindering clinics from reaching and maintaining Ideal status are not in the control of professional nurses but in other non-professional persons like infrastructure and supply chain management was highlighted. These non-health professionals should be trained on the importance of their inputs (Grewar, 2017:1).

6.10.2.4 Yearly feedback on progress of NHI and WISN to the clinic health committees will ensure communities are informed and can give inputs for improvement of services. This was indicated by 100% of the respondents

According to Ravhengani and Mtshali (2017:1), Implementing WISN has the potential to provide solutions for the current problems of: Unstandardised health workforce planning practices. Maldistribution and inequitable distribution of services, Critical shortage of professional staff and inadequate management of PHC facilities. Over and above all that, the WISN tool facilitates bottom-up health workforce planning, facilitates implementation of Ideal Clinic Realisation and Maintenance and WISN is a tool that facilitates effective management and planning of facilities. It is therefore very important to make communities and professionals appreciate that WISN is very important in improving quality health care provision through implementation of staff establishment for ICRM.

6.10.2.5 Threats

Table 6.5. Mitigating threats

Strategy	Frequency	%
Identifying and training in house clinical equipment maintenance per local area and per hospital will improve maintenance in primary health care facilities and hospital facilities	25	100
Training of in-house clinical maintenance teams that train end users to do simple maintenance will improve maintenance and life of equipment	25	100
Identifying and training of in-house infrastructure maintenance teams to do maintenance for local areas clinics and hospitals will improve maintenance and improve the life of the infrastructure	25	100

From the results all respondents: 100.0% agreed on the following:

6.10.2.5.1. Identifying and training in house clinical equipment maintenance teams per local area and per hospital will improve maintenance in primary health care and hospital facilities

6.10.2.5.2. Training of in-house clinical maintenance teams that train end users to do simple maintenance will improve maintenance and life of the equipment.

6.10.5.2.3 Identifying and training of in-house infrastructure maintenance teams to do maintenance for local areas clinics and hospitals

This will improve maintenance and improve the life of equipment and infrastructure.

Mutla, Kihiu and Maranga (2012:1) and Sezd (2016:2) in their research found that the planned preventive maintenance is not prioritised leading to failure of the equipment due to undetectable defects, low safety factors, abuse and natural failures. The public maintenance managers did not have adequate information of most of the products thus developing ineffective manuals. Healthcare equipment that is out of order quickly leads to a decline in demand, which will in turn reduce the income and quality of services of the health facilities. The hospital may lose clients if, for example, it becomes known that malfunctioning of medical equipment, for instance if sterilisation equipment may endanger the health of the patients. Similarly, patients will avoid visiting health facilities which do not possess functioning diagnostic equipment, because of fear of harm. Clients may sue institutions if they come to harm because faulty equipment was used. Walia and Cordero (2010:1)and Sezd (2016:2) on the other hand suggests that equipment users including operating theatre staff be trained to perform many of the simple care and maintenance e.g. dusting, cleaning lubricating, protecting and checking equipment including safety checks some maintenance

can be done in house, more complex work can be done by more specialised team. Unmaintained dilapidated infrastructure is a danger to professionals and clients. The department could adopt this approach to improve quality service provision.

6.7 APPLICABILITY AND SUITABILITY OF THE DEVELOPED STRATEGY

All respondents indicated that the developed strategies were suitable and applicable for improving provision of quality Health services.

6.8 SUMMARY

Validation of the strategy was conducted with 25 respondents who participated in the main study visits.

6.9 CONCLUSION

In the previous chapter validation of the developed strategies was be discussed.

The next chapter will discuss Conclusions, Limitations and Recommendations

CHAPTER 7

CONCLUSIONS, LIMITATIONS, RECOMMENDATION, SUMMARY

7.1 INTRODUCTION

In the previous chapter, validation of the developed strategies was presented and discussed. Validation data was collected from a sample of the participants who participated in the study. No gaps were identified from the developed strategies. This chapter presents the conclusions, limitations, recommendations and summary of the study.

7.2 PURPOSE OF THE STUDY

Development of Strategies to Facilitate the Provision of Quality Healthcare Services in Public Healthcare Facilities in Limpopo Province, South Africa

7.3 CONCLUSIONS

7.3.1 Conclusions related to phases and objectives of the thesis

The conclusions were discussed according to the four Phases and seven objectives of the study.

7.3.1.1 Phase one: Empirical phase

Stage one: Qualitative approaches

Objective one

To Explore the Experiences of Stakeholders regarding the quality of healthcare rendered to clients at the Public Healthcare Institutions in Limpopo Province, South Africa.

Objective two

To determine views of health care professionals regarding care rendered to clients at the public health institutions in Limpopo Province, South Africa**.**

The questions according to the semi structured interview guide were posed to stake holders and professional nurses in sampled hospitals and clinics. The results were integrated and indicated in Chapter 4. The qualitative research discussion was done separately according to themes. Three main themes and subtheme emerged from the qualitative focus group discussions and were categorised acording to Donabedian's model as presented below. Participants in this phase included professional nurses, hospital board and clinic health committee members.

7.3.1.1.1 Structure factors

Implementation of Batho-pele white paper, staffing, availability of clinical equipment maintenance of clinical equipment; Availability of infrastructural Maintenance inadequate availability of security.

(a) Implementation of the Batho pele White paper

The qualitative result in item 4.3.2.1.2 (a) showed that implementation of the Batho-Pele White paper was problematic when there were long queues in facilities.

(b) Staffing

Qualitative results regarding staffing showed that shortage of staff affects service delivery negatively as it leads to burnout and staff dissatisfaction with their work. In some instance one nurse was be expected to do the work which was supposed to be done by four nurses.

(c) Availability of clinical equipment

The result of the qualitative approach showed that shortage of equipment is a problem. The participants complained that the available equipment is not durable.

(d) Maintenance of clinical equipment

The participants from the qualitative approach reported inadequate maintenance of clinical equipment. This is problematic because regular and adequate clinical equipment maintenance can save costs and lives. Clinical equipment problems were mainly for primary health facilities though hospitals had a few issues as well. Their concerns were mainly a lack of equipment e.g. BP machines and lack of baby scales as well as broken laundry machines. Maintenance in almost all the facilities was not structured, there was no rooster for maintenance of equipment. This resulted in equipment not being serviced in time. Because of lack of supervision, some service providers just put a sticker on an equipment without the service being done. Some fire extinguishers had not been serviced for a very long time.

(e) Availability of infrastructure

Participants from qualitative approach reported that infrastructure/pace was never enough or adequate to meet the needs of the ideal clinic requirements and some buildings are dilapidated.

(f)Maintenance of infrastructure

Participants indicated that maintenance of infrastructure is never adequate. Most buildings in the hospitals and clinics are dilapidated and not fit for human use. In some clinic's nurses had to work from mobile homes because the

buildings were very old and needed to be renovated. The regular electrical malfunction and the stagnant ponds presented risks to patients.

(g) Availability of security

Qualitative result indicated that security was never adequate. The complaints were of lack of security staff fences had holes that intruders can come in through. The nurses could not take calls because of lack of adequate security and inadequate number of security staff in the facilities. Even where there was some security some fences had holes. In one such case a security guard was killed by robbers, in another clinic one nurse was raped. Nurses could not take calls or provide 24 hours services under such circumstances.

(h) Process factors

According to the qualitative results the department reflected a lot of weaknesses related to service provider issues. Process factors were divided into Challenges that affect quality healthcare service provision and factors that affect quality healthcare service provision as follows:

(i) Challenges that affect quality health care services

These were studied under the following headings: Salaries for professionals, Nurses used for non-nursing duties and Opportunities for career development.

(j) Salaries for professional nurses

Result from qualitative research showed that nurses' salaries were never satisfactory and uncompetitive. Even adjusting a nurse's salary took unnecessary long periods of time.

(k)Nurses used for non-nursing duties.

Most of the participants and respondents indicated that nurses were always used for non-nursing duties. A nurse could replace anybody who is not on duty from a porter, cleaner to laboratory technicians. This is done at the expense of patients care and it is not recognised even during reviews.

(l) Opportunities for career development

Participants from the qualitative approach were not satisfied with career development opportunities and said there were no opportunities for career development. The biographical data in biographical data tables 4.4 and 4.14 also showed that most nurses are at the diploma level qualification indicating that majority of nurses never had opportunities for career development. Item 1.3 on qualifications by nurses showed that most nurses seemed to be stuck at diploma levels.

(m) Factors that affect provision of quality service delivery

Absenteeism, Working conditions, Work load, Referral for maternity patients; Monitoring and evaluation: Availability of Monitoring and evaluation, Implementation of Monitoring And Evaluation, Involvement of stake holders in monitoring and evaluation, Management of patients, Patient centred care, Mental health patient care, Orthopaedic patient care, Acute TB and MDR patient care.

(n) Absenteeism

Participants indicated that absenteeism in professional nurses was always a problem. This was said to be related to the unfavorable condition under which they worked such as lack of promotions, shortage of staff and long working hours contributing to burnout.

(o) Working conditions

Participants indicated that: infrastructure at work and nurses' homes was never adequate. They complained that the houses where nurses slept and worked were dilapidated and in some cases the nurses were forced by circumstances to share a room.

(p) Work load

Participants indicated that work load was always high in public services.to the extent that professional nurses work past they knock off time. The nurses expressed concern that they are afraid they may make mistakes when there is a workload of work.

(q) Referral maternity patients

Participants reported the fact that large numbers of maternity patients referred to deliver in hospitals were always unnecessary. But some clinic nurses indicated that they refer because of shortage of staff which prevent them to do 24 hours services in their clinics.

(r) Monitoring and Evaluation

(r) Availability of monitoring and evaluation

Participants appreciated the availability of monitoring and evaluation section which have a full staff establishment with members dedicated to evaluate allocated sections.

(s) Implementation of monitoring and evaluation

There was an agreement between the participants and respondents that regular monitoring and evaluation always occur the only problem was related to inability to implement findings because of lack of physical and financial resource.

(t) Involvement of stakeholders in monitoring and evaluation

There was an indication by the participants that stakeholders were never involved or participated in monitoring and evaluation. The stakeholders themselves expressed frustration at not being involved or informed.

(u) Management of Patients

(i) Patient centred care

Results from the qualitative approach indicated that patient centered health was always practiced. It was given as an example that patients and families were allowed to perform traditional rituals, in the hospital when necessary. \

(ii) Mental Health patient care

Participants indicated that stable mental health patients were always kept longer than necessary in the facilities until they didn't really want to stay in the communities they come from anymore. Patients didn't even want to stay home for a week during holidays. The problem is that they overcrowded the hospital and compromise quality healthcare provision.

(iii) Orthopaedic patient care

Participants) reported that orthopedic patients always experienced long hospitals stay in the health facilities. There were concerns that other acute patients could have access to needed beds and it costs the hospitals a lot of money. Long hospital stay could lead to nosocomial infections.

(iv) Acute TB and MDR patient management

Majority of respondents indicated that Acute TB and MDR Patients were always separated. Only some participants in qualitative approach saidTB MDR in one district were nursed in the same ward.

7.3.1.1.3 Outcome factors:

(i) Employee satisfaction

In this study discussions and conclusions were only based on outcome factors from clients

(ii) Clients' Satisfaction

Understanding language, twenty-four hours' service Medicine related issues cleanliness of facilities Attitude of staff long waiting Period.

Clients brought up issues related to access to the facilities.

(iii) Understanding of language spoken

Participants indicated that they understood the language spoken in the clinic and the professionals also understood the language spoken by clients.

(iv) Twenty-four hours service

Majority of clinics did not provide 24 hours services reasons provided were shortage of nurses and security staff.

(v) Medicines prescribed

Participants indicated that they got the prescribed medicine from the pharmacy and got explanations on how medicine should be administered and stored.

(vi) Cleanliness.

Participants indicated d that some facilities were dirty, smelly and full of litter.

(vii) Attitude of Staff

Result from participants indicated that they were not treated with respect; who treated them had no name tags; that they were not properly addressed with their names; that they did not get explanations regarding their illnesses and.; that service providers in the facilities they visited therefore are not competent to their job. And that they were not satisfied with services they received from facilities.

(viii) Waiting period

Participants indicated that they waited for more than 3 hours in the institution which is very long.

7.3.2 The Instrument Development

The objective of this phase was to use information from qualitative approach to develop an instrument to collect data for the quantitative approach. The instrument was validated by a group of experts and pretested before it was used.

7.3.3 Stage Two Quantitative Approach

Two questionnaires were designed. One questionnaire was designed to meet the needs of Objective three, four five and six, (completed by service providers) while another met the needs of objective six competed by (individual clients) The results of the two stages were presented separately in chapter 4. These results will also be discussed separately in this section, first the Professional nurse's questionnaire results followed by that of clients' questionnaire results.

7.3.3.1.1 Objective three

To assess the challenges contributing to dissatisfaction among health care professionals regarding the provision of quality health care service in the public health facilities in Limpopo province, South Africa.

(.a) Personnel Management

Respondents reported one strength related to working conditions

There was one strength: Personnel not planning to relocate.

The weaknesses reported by respondents were as follows:

- Salary scales not satisfactory.
- Nurses were used for non-nursing duties.
- Less opportunities for career development not available.

7.3.3.1.2 Objective four

To describe factors contributing to quality health provision by Professional nurses in public health institution in Limpopo province South Africa. 'The results showed the following:

7.3.3.1.3 Structural Factors

With regard infrastructural issues respondents reported no strength. The negatives and the weaknesses were highlighted as follows. Infrastructure/space and its maintenance was never adequate, Clinical equipment and its maintenance were inadequate and that security was never adequate.

7.3.3.1.4 Process Factors

With regard to process related results, the respondents reported strengths and weaknesses were identified as follows:

(a) Strengths:
The following strengths were identified:

- Availability of monitoring and evaluation section.
- Implementation of monitoring and evaluation.
- Implementation of patent centred care.
- Separation of acute TB and MDR TB in majority of districts

(b)Weaknesses

- Absenteeism was rife.
- They worked under bad condition.
- Work load was always high in public services.
- Salaries of nurses in adequate.
- Maternity patients referred unnecessarily.
- Stake holders not involved in monitoring and evaluation.
- Mentally ill patients and orthopaedic patients hospitals facilities for longer than is necessary.

7.3.3.1.5 Objective five

To explain the strategies used to improve quality healthcare service provision in the public healthcare facilities in Limpopo Province, South Africa.
No weakness was identified.

(a)Strengths
Batho-pele. White Paper on Transformation of Health Services is used as a strategy to improve health care service provision

7.3.3.1.6 Objective six

To describe the experiences of clients regarding quality of health care service provision within the public health facilities in Limpopo province, South Africa.

7.3.3.1.7 Outcome Factors

(a) Employee satisfaction

Though employee satisfaction was regarded as an outcome factor of the working conditions of the healthcare service providers it was left out in the in-depth interviews because of time and financial constraints. In general employees reported dissatisfaction with their working conditions but for this study this was not explored for lack of time and finances .Employee satisfaction may be a topic for another study

(b) Client satisfaction

The respondent reported the following Strengths

- Language well understood.
- Medicines are available.
- Facilities visited were clean.

The following Weaknesses were reported by respondents

- Bad attitude from service providers reported.
- Twenty-four hours not provided.
- Long waiting hours.

7.3.4 Conclusions Based on the Phase two: Developed Strategies:

7.3.4 Phase two: Development of strategies to facilitate the provision of quality health care provision in the department on health Limpopo province

7.3.4.1 Objective seven

To develop strategies to facilitate healthcare Service provision in the public healthcare institutions of Limpopo Province. The development of the strategies was informed by the qualitative and quantitative results from the previous two phases. The researcher, using the SWOT analysis developed strategies to

facilitate provision of quality health provision in the department of health Limpopo province. The SWOT analysis was used to categorise the Strengths, Weaknesses Opportunities and Threats. Then strategies to address all the categories of the SWOT analysis were developed. The various strategies came about as follows: strategies that built on strengths, strategies to overcoming Weakness, Strategies to advantages of opportunities and Strategies that mitigated on threats. In all 14 strategies were developed and responsible people for implementation were identified.

7.3.5 Conclusion Based on Strategy Validation

The 25 respondents for validation from the sampled hospitals and clinics. 15 were professional nurses from the sampled hospitals and clinics, while 5 were hospital board members from sampled hospitals and and 5 were from the sampled clinics. The researcher and participants agreed with the 14 strategies that were developed and the strategies were as follows:

1. Employees are allocated areas of responsibilities in the department or area of work with minimum supervision.
2. Constitute and train Community support groups per local area for TB and mental health (home based carer).
3. A policy to manage waiting times is designed and implemented in all primary health care facilities and hospitals.
4. User friendly shifts are developed that will allow professionals to rest in between to ensure coverage in 24 hours e.g 7 to1, 1 t to 4 4to7 7to7.
5. Introduce an appointment system for patient that goes together with the shift system, through the evening and weekend.
6. A referral system designed that will control the movement of clients from Primary Health care facilities to hospital facilities.

7. Local area mangers are trained to regularly train facility managers on communication and motivation of facility staff members in the next three financial year.
8. A policy to concietise professional nurses and support workers on the importance of nurses doing nursing duties is designed and implemented.
9. Local area managers and Ward supervisors are trained on the importance of regular supervision as well as useful methods of supervision.
10. Update non-governmental organisations in writing or in workshops about the ICRM and indicate what the current needs for the department is, (e.g. it could be vital equipment) so they can channel their help to the areas of need. Acceptance of their support will depend on if they satisfy a need by the department.
11. Training on implementation of ICRM should be extended to nonprofessional workers in the primary health institutions, clinic committees and other community formations to ensure a buy in and the necessary support. This should happen quarterly.
12. Yearly feedback sessions on progress on NHI and WISN to clinic committees and hospital boards are conducted to make sure communities are updated and can give inputs.
13. In house clinical equipment maintenance teams per local area and per hospital are identified and trained in all local areas and hospital facilities. In the next three financial years. Their main focus will be to provide maintenance in the designated local area and hospital.
14. In house clinical equipment maintenance teams per local area and per hospital are identified and trained in all local areas and hospital facilities. In the next three financial years. Their main focus will be to provide maintenance in the designated local area and hospital.

7.4 LIMITATIONS OF THE STUDY

The purposive sampling procedure decreased the generalizability of findings. This study will not be generalizable to all areas of health. The study was done in a mostly rural area so generalizability to other non-rural areas may be limited.

7.5 RECOMMENDATIONS

7.5.1 Recommendations for the NDOH

The National department of health needs to accelerate the implementation of NHI and ICRM. The NDoH needs to be serious about addressing the infrastructural and equipment problems. A programme for innovation and upgrade of infrastructure need to be prioritised. There is a need to increase provincial budget so they can be able to maintain infrastructure and equipment and employ more staff.

7.5.2 Recommendations for the Provincial DOH

The provincial DoH needs to aggressively address the staff shortages by advertising all vacant posts for professional nurses. They need to plan paying stipends for hospital boards and clinic health committees. Implementation of a maintenance plan for both infrastructure and equipment should be treated as a matter of urgency. It would be helpful if the provincial DoH can facilitate and prioritise the implementation of the developed strategies.

7.5.3 Recommendations for the Districts DoH

The districts should focus on the items that don't need a lot of money to implement like improving supervision by training supervisors, training maintenance staff for infrastructure and medical equipment. Most principles ICRM can be implemented without needing a lot of capital.

7.5.4 Recommendations Based on the Developed Strategy

The developed strategies and the rest of the results of the study will be submitted to the Provincial DOH and the District DOH. All the responsible people mentioned under each strategy must plan implementation after going through the whole document. The provincial department of health must submit the document to the national department of health. It is recommended that the National DOH, the Provincial DOH and the District DOH budget according to the needs identified here. It is recommended that infrastructural and staffing problems be proritised. It is also recommended to try implement all the strategies because to implement them will need more restructuring than more money. The local area managers, the operational managers need workshops to redirect their way of doing thing in the hospitals and clinic facilities

7.5.5 Recommendations for Further Research

The purpose of this study was:" Development of Strategies to Facilitate the Provision of Quality Healthcare Services in Public Healthcare Facilities in Limpopo Province South Africa". Seven objectives were addressed as follows:

To Explore the Experiences of Stakeholders regarding the quality of healthcare rendered to clients at the Public Healthcare Institutions in Limpopo Province, South Africa

To determine views of health care professionals regarding care rendered to clients at the public health institutions in Limpopo Province, South Africa

To assess the challenges contributing to dissatisfaction among health care professionals regarding the provision of quality healthcare service in the public healthcare facilities in Limpopo province, South Africa

To describe factors contributing to quality healthcare provision by Professional nurses in public healthcare institution in Limpopo province South Africa

To explain the strategies used to improve quality healthcare service provision in the public healthcare facilities in Limpopo Province

To describe the experiences of clients regarding quality of health care service provision within the public health facilities in Limpopo province, South Africa.
To develop strategies to facilitate healthcare Service provision in the public healthcare institutions of Limpopo Province. The researcher identified that there is was need for further research into the impact of implementing the strategies.

It is recommended that implementation of the developed strategies should be under taken by researcher or other researchers. An in-depth study on Employee satisfaction is recommended.

7.6 SUMMARY OF THE STUDY

The aim of this study was to develop strategies to facilitate the provision of quality healthcare services in public healthcare facilities in Limpopo province South Africa. The qualitative and quantitative approach was used to collect data from the participants. The researcher used questionnaires to collect descriptive data from the professional nurses and clients (patient). Focus group discussions were used to collect qualitative data from professional nurses and stake holders (Clinic health committees, hospital boards and clients). Quality health care provision is very important as it can prevent both employee and clients' dissatisfaction.

A lot of challenges and factors affecting quality health care provision were identified. A SWOT analysis was done in the process of developing the strategies. Resources like equipment, infrastructure and human resources were identified as major issues that are needed to improve quality of health care provision, yet they are very expensive and cannot be achieved in the short term. There are other, strategies resulting from weaknesses opportunities and threats that can be addressed without investing a lot of capital. These could be addressed by rearranging the services. Using the example of shortage of staff. An example is the implementation of the integrated services approach like pre booking of

clients, pre retrieving of clients' files and prepacking of clients 'medicines. This, if successful could reduce waiting time and improve the quality of health care provision. Service providers would need to be retrained to be able to implement the new strategies. The buy in by management will need to be coerced. The Limpopo province is mostly rural therefore has a lot of problems related to developing countries.

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ANNEXURES

ANNEXURE A: INFORMATION LETTER

I am planning to conduct a research study as part of the requirement for acquisition of PHD degree. The study will be done under the supervision of Prof ML Netshikweta from the Department of advanced Nursing science at the University of Venda. The study is on **DEVELOPMENT OF STRATEGIES TO FACILITATE PROVISION OF QUALITY HEALTH SERVICES IN PUBLIC HEALTH CARE FACILITIES IN LIMPOPO PROVINCE SOUTH AFRICA**

The purpose of this research is to explore service providers and recipients' views on strategies to enhance service provision, so that that information can be used to develop strategies to enhance service provision for the department of Health. I would like to ask for your permission to conduct an interview, using a questionnaire with you. This will be followed by a focus group interview. You will be part of a group of 15-20 people. An audiotape recorder will be used during the both types of interviews to tape the interview. I will thereafter transcribe and analyse the data. , The tapes will be destroyed soon after the research is completed. The interviewer will take notes during the interview for purposes of cross references. Your name will not appear in the records of the interview results, only a number will be used for analysis purposes .All your personal details will be treated with strict confidentiality.

The information gathered during the interview will be utilised in developing guidelines to develop strategies for enhancing service provision. This will contribute in in the provision of quality service delivery. Arrangements will be made with you to meet at a convenient venue and adequate time will be allocated to make provision for your physical comfort during the interview. The interview will be conducted in English for you to be able to express yourself

Information obtained during the interview will be shared with the study supervisor, and any other person needed to assist in the interpretation of and analysis of the data acquired during the interview. The result of the interview will be made available to you on request after completion of research study. If you agree to the abovementioned conditions please give your informed consent for this research study by attaching your signature and date on the consent form provided. You have the right to withdraw your consent at any stage of the research process. It should be clearly understood that you are under no obligation bound to participate in this research study,

Should you have any queries regarding the proposed research I will gladly address them.. My contact details are as follows:

Telephone: 015 293 6083

Cell: 082 374 4093 Email: Malomanee@gmail.com

Malomane Elizabeth Lisbeth (PHD student

Promoter: Prof Netshikweta ML

ANNEXURE B: CONSENT FORM

1,----------

have understood the study purpose after reading the information letter.

and

Willingly give consent to participate in the study. I agree to be interviewed and have the information thus gathered under the conditions as set above

---

Signature (participant)

Date

Signature (Interviewer)

Date

ANNEXURE C: DEPARTMENTAL PERMISSION REQUEST

PO Box 55438

Polokwane

0700

26June 2015

The Health, Safety and Research Ethics Committee

Department of Health

LIMPOPO PROVINCE

PERMISSION TO CONDUCT RESEARCH

1. The above refers

2. I am a registered PHD student at the University of Venda and I wish to conduct a research study on **DEVELOPMENT OF STRATEGIES TO FACILITATE PROVISION OF QUALITY SERVICES IN PUBLIC HEALTH CARE FACILITIES IN LIMPOPO PROVINCE SOUTH AFRICA**

These strategies will assist policy makers to facilitate improvement of health in the Department of Health

3. I therefore request for the permission to conduct this study in institutions of the five district of Limpopo Province

4. Thanks in anticipation

_____

ELIZABETH LISBETH MALOMANE

DATE

ANNEXURE D: QUESTIONNAIRE FOR SERVICE PROVIDERS

Questionnaire about Strategies to Enhance Quality Service Provision in Institutions in The Department of Health Limpopo Province, South Africa

SECTION A: BIOGRAPHICAL DATA

1. State your age

Mark with an x in the appropriate space given below:

2. State whether

MALE	FEMALE

Mark with an x to indicate your response in the appropriate space given below:

3 Indicate your highest qualification/s

QUALIFICATIONS	RESPONSE

4. Indicate all your professional qualifications

PROFESSIONAL QUALIFICATION	**RESPONSE**
OTHERS (SPECIFY)	
ALLIED SERVICES QUALIFICATION	
MEDICAL DOCTOR	
DOCTORAL DEGREE	
MASTERS DEGREE	
HONOURS DEGREE	
POST BASIC NURSING DEGREE	
POST BASIC NURSING DIPLOMA	
BASIC NURSING DEGREE	
BASIC NURSING DEPLOMA	
NURSING AUXILLARY	
E/N/A	

5 State years of professional experience

PROFESSIONAL EXPERIENCE	RESPONSE
Other (specify)	
Financial resource Manager	
Human resource Manager	
Clinical Manager	

Programme Manager (specify programme)	
Operational manager clinic	
Quality coordinator hospital	
Quality coordinator district	
General Nurse	
Psychiatric nurse	
Community Nurse	
Midwife	
Nurse Educator	
Nursing manager/Administrator	

5. State your years of professional experience

6 State your Race

6. Indicate the type of Institution in which you work

TYPE OF INSTITUTION	**RESPONSE**
Provincial Office	
Local area	
Mobile clinic	
Psychiatric hospital	
Regional Hospital	
Tertiary hospital	
District Hospital	
Clinic	
Community Health Centre	
Other (Specify)	

Use an x to mark in the column that closely describes your perception on the statements listed here under

To explain the strategies used to improve quality healthcare service provision in the public healthcare facilities

	Always	Often	Seldom	Never
Structural	5	4	3	2
To assess the Institution related factors affecting the quality of health care provision				
Description				
1.The Batho pele white paper is currently used as a strategy to facilitate quality service provision				
2.There is enough staff in the facility				
3.Maintenance of infrastructure is adequate				
4.There is adequate availability and maintenance of clinical equipment				
5.The security system is adequate				
Process				
Challenges facing professional nurses in providing quality health care services				
7.Employee satisfaction: Staff is planning to relocate to other job opportunities				
8.Salaries of professional nurses is satisfactory				
9.There are opportunities for for career development				
10.Nurses used for non-nursing duties				
11 Absenteeism is high in the facility				
Factors affecting the provision of quality health care services by professional nurses				

12.There is a monitoring and evaluation section in the department				
13.Working Conditions: Infrastructure in the nurses home and facility is adequate				
14 Workload is high in the facility				
15.Referral: Large number of maternity patients referred to hospital were unnecessary)				
Stake holders				
16 Monitoring and evaluation				
17 A monitori ng unit is available in your province and district				
18 Monitoring and evaluation is implemented				
19.Stake holders are involved in monitoring and evaluation				
Patient Management issues				
20 Patient centred care is practices				
21 Mental health patient care patients stay for a long in facilities				
22 Orthopaedic patients experience long hospitals stay				
23 Acute TB and MDR patients are not separated in the department				
Other, (specify)				

ANNEXURE E: QUESTIONNARE FOR CLIENTS

QUESTIONNAIRE ABOUT STRATEGIES TO ENHANCE QUALITY SERVICE PROVISION IN INSTITUTIONS IN THE DEPARTMENT OF HEALTH LIMPOPO PROVINCE SOUTH AFRICA

TARGET: CLIENT VISITING PRIMARY HEALTH CARE INSTITUTIONS AND HOSPITALS

SECTION A: BIOGRAPHICAL DATA

1. INSTITUTIONS VISITED

Hospital	
Primary Health facility	

2. State your age

Mark with an x in the appropriate space given below:

3. State whether | MALE | FEMALE |

State your Race

Mark with an x to indicate your response in the appropriate space given below

SECTION B

OUTCOME RELATED QUESTIONS

1. ACCESS TO SERVICES

		Yes	**No**
1.1	Did you understand the language that was used		
	Does facility provide 24 hours service		
1.2	Did you get the medicine prescribed for you from the pharmacy		
1.3.	Did they explain how the medicine is to be used and stored?		

2. CLEANLINESS

		Yes	**No**
2.1	Was the facility clean		
2.2	Was it free of odors		
2.3.	Was it free of litter		

3. ATTITUDE

		Yes	No
3.1.	Were you treated with respect		
3.2	Did the person who attended to you have a name tag?		
3.3	Were you addressed appropriately using your name?		

3.4.	The service provider in the facility is competent to do their job?		
3.5.	I am satisfied with the with service from the facility		

4 WAITING PERIOD

		More than 3 hours	Less than 2hours
4.1.	How long did you wait to be seen by a health official?		

ANNEXURE F: SEMI-STRUCTURED INTERVIEW GUIDE

No	Item
1,	Introduction of research project
2.	Confirm if consent signed and reassure maintenance of privacy
3	Gather descriptive data about participants
3.1.	Name and Surname
3.2.	Age
3.3.	Gender
3.4.	Educational status
3.5.	Marital status
4	What is your opinion services provided in your Hospital/clinic?
4.1.	What are the things you like about the Hospital /clinics?
4.2.	What are the things you don't like about the Hospital /clinic?
4.3.	What are your suggestions for improvement
5	Thanking participants for participating

ANNEXURE G: QUESTIONNAIRE FOR VALIDATING THE STRATEGIES

TARGET: SERVICE PROVIDERS

SECTION A: BIOGRAPHICAL DATA

1. State your age

Mark with an x in the appropriate space given below:

2. State whether MALE FEMALE

Institution_____-

DEVELOPMENT OF STRATEGIES TO FACILITATE THE PROVISION OF QUALITY HEALTH SERVICES IN PUBLIC HEALTH CARE FACILITIES IN LIMPOPO PROVINCE SOUTH AFRICA Validation questionnaire

Taking advantage of opportunities

Strategy	**Agrees**	**Disagrees**	**Comment**
Update non-governmental organisations in writing or in workshops about the ICRM and indicate what the current needs for the department is, (e.g. it could be vital equipment) so they can channel their help to the areas of need. This will contribute to quality of service delivery improvement			

Updating NGOs on the needs of the Departments of will influence the NGOs to give relevant assistance.			
Training on implementation of ICRM should be extended to nonprofessional workers in the primary health institutions, clinic committees and other community formations to ensure a buy in and the necessary support. This should happen quarterly			
Training non-professionals in primary health care institutions will ensure buy in and support for ICRM implementation			
Yearly feedback sessions on progress on NHI and WISN to clinic committees and hospital boards are conducted to make sure communities are updated and can give inputs			
Yearly feedback on progress on NHI and WSN will ensure communities are informed and can give inputs for improvements of services			

Building on strength

Strategy	**Agrees**	**Disagrees**	**Comment**
Employees are allocated areas of responsibilities in the department or in the area of work with minimum supervision to strengthen job satisfaction			
Allocation of employees in areas of responsibility with minimum supervision strengthen employee job satisfaction			
Responsibility: Researcher, District PHC managers and CEOs			
Constitute and train Community support groups per local area for HIV AIDS , TB and mental health to help improve quality of health care provision			
C**onstitution and training of community support groups per local area for HIV, TB and mental health will improve quality health care provision**			

Overcoming weaknesses

Strategy	**Agrees**	**Disagrees**	**Comment**
A policy to concietise professional nurses and support workers on the importance of nurses doing nursing duties is designed and implemented to ensure nurses don't spend most of their time doing non-nursing duties			
Development and implementation of a policy to support nurses to mainly nursing duties be helpful			
Local area managers and Ward supervisors are trained on the importance of regular supervision as well as useful methods of supervision,will improve supervision and quality service provision			
Training of local area managers and ward supervisors on importantnce of regular supervision be will be helpful?			
A policy to manage waiting times is designed and implemented in all primary health care facilities and hospitals to reduce waiting time			
Development and implementation of a policy to manage waiting times in primary health care facilities and hospitals will reduce waiting time s			
To develop user friendly shifts that will allow professionals to rest in between to ensure coverage in 24 hours e.g 7 to1, 1 t to 4 4to7 7to7			
Development of user friendly shifts that will allow professionals to rest between shifts and ensure coverage for 24 hrs			

A referral systems designed that will control the movement of clients from Primary Health care facilities to districts and tertiary facilities so that the district and tertiary institutions are released to provide advanced health care services			
Development and implementing a referral system that will control movement of patients from primary health care facilities to district and tertiary hospitals will release the district and tertiary hospitals to provide advanced health care services			
Introduce an appointment system for patients in the primary health care facilities that goes together with the shift system , through the evening and weekends to ensure coverage and reduce waiting time			
Introduction of appointment system for patients in the primary health care facilities that go to gether with shift system will ensure coverage and reduce waiting time			
Local area mangers are trained to regularly train facility managers on communication and motivation of facility staff members to improve employee satisfaction leading to improve quality health care provision			
Training of area managers to regularly facility managers on communication and motivation will improve employee satisfaction leading to improvement of quality health care provision			

Mitigating threats

Strategy	**Agrees**	**Disagrees**	**Comment**
In house clinical equipment maintenance teams per local area and per hospital are identified and trained in all local areas and hospital facilities In the next three financial years. Their main focus will be to provide maintenance in the designated local area and hospital with the aim of improving maintenance in the primary and hospital facilities			
Identifying and training in house clinical equipment maintenance teams per local area and per hospital will improve maintenance in primary health care facilities and hospital facilities			
In house clinical medical maintenance teams train end users to do simple maintenance in the next three financial years to improve maintenance and life of equipment			
Training of in-house clinical maintenance teams that train end users to do simple maintenance will improve maintenance and life of equipment			
In-house infrastructure maintenance teams for local areas and hospitals are identified and trained to do infrastructure maintenance for local areas clinic facilities and hospitals. This will improve the life of the infrastructure			
Identifying and training of in-house infrastructure maintenance teams to do			

maintenance for local areas clinics and hospitals will improve maintenance and improve the life of the infrastructure			

Suitability And Applicability Of Strategy	**Yes**	**No**	**Comments**
1. Any gaps identified in the above strategies that can enhance the developed strategy			
2.Is the developed strategy applicable and suitable for the improvement of service delivery provision			
3.Will the strategy be easily implemented			

Any suggestions that will enhance the developed strategy

ANNEXURE H: ETHICAL CLEARANCE

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Ms EL Malomane

Student No:
11641203

PROJECT TITLE: Development of Strategies to facilitate the provision of Quality Health Services in Public Health Care Facilities in Limpopo Province, South Africa.

PROJECT NO: SHS/17/PDC/20/1208

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof ML Netshikweta	University of Venda	Promoter
Prof LB Khoza	University of Venda	Co-Promoter
Ms EL Malomane	University of Venda	Investigator – Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: August 2017
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: .....
Name of the Chairperson of the Committee: Prof. G.E. EKOBO

UNIVERSITY OF VENDA
DIRECTOR
RESEARCH AND INNOVATION
2017 -09- 21
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"A quality driven financially sustainable, rural-based Comprehensive University"

ANNEXURE I: UNIVERSITY APPROVAL OF THESIS

UNIVERSITY OF VENDA

OFFICE OF THE DEPUTY VICE-CHANCELLOR: ACADEMIC

TO : MR/MS E.L MALOMANE

SCHOOL OF HEALTH SCIENCES

FROM: PROF J.E. CRAFFORD

DEPUTY VICE-CHANCELLOR: ACADEMIC

DATE : 02 FEBRUARY 2016

DECISIONS TAKEN BY UHDC OF 24TH FEBRUARY 2017

Application for approval of Thesis research proposal in Health Sciences: **E.L Malomane (11641203)**

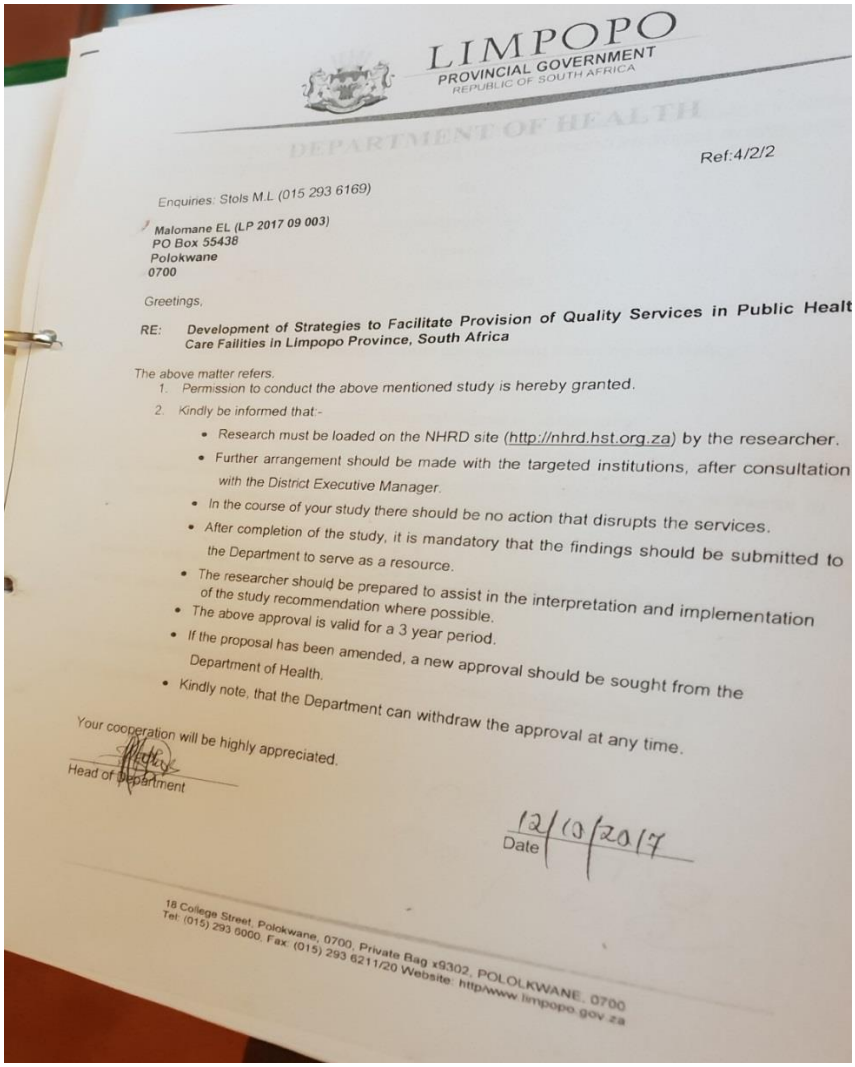
Topic: "Development of strategies to facilitate the provision of quality health services in Public Health Care Facilities in Limpopo Province, South Africa."

Promoter	UNIVEN	Prof. M.L Netshikweta
Co-promoter	UNIVEN	Prof. L.B Khoza

UHDC approved Thesis proposal

PROF. J.E CRAFFORD
DEPUTY VICE-CHANCELLOR: ACADEMIC

ANNEXURE J : APPROVAL LETTER FOR CONDUCTING STUDY, FROM THE DEPARTMENT OF HEALTH



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA
DEPARTMENT OF HEALTH

Ref:4/2/2

Enquiries: Stols M.L (015 293 6169)

Malomane EL (LP 2017 09 003)
PO Box 55438
Polokwane
0700

Greetings,

RE: **Development of Strategies to Facilitate Provision of Quality Services in Public Healt Care Failities in Limpopo Province, South Africa**

The above matter refers.

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that:-
   - Research must be loaded on the NHRD site (http://nhrd.hst.org.za) by the researcher.
   - Further arrangement should be made with the targeted institutions, after consultation with the District Executive Manager.
   - In the course of your study there should be no action that disrupts the services.
   - After completion of the study, it is mandatory that the findings 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.
   - The above approval is valid for a 3 year period.
   - If the proposal has been amended, a new approval should be sought from the Department of Health.
   - Kindly note, that the Department can withdraw the approval at any time.

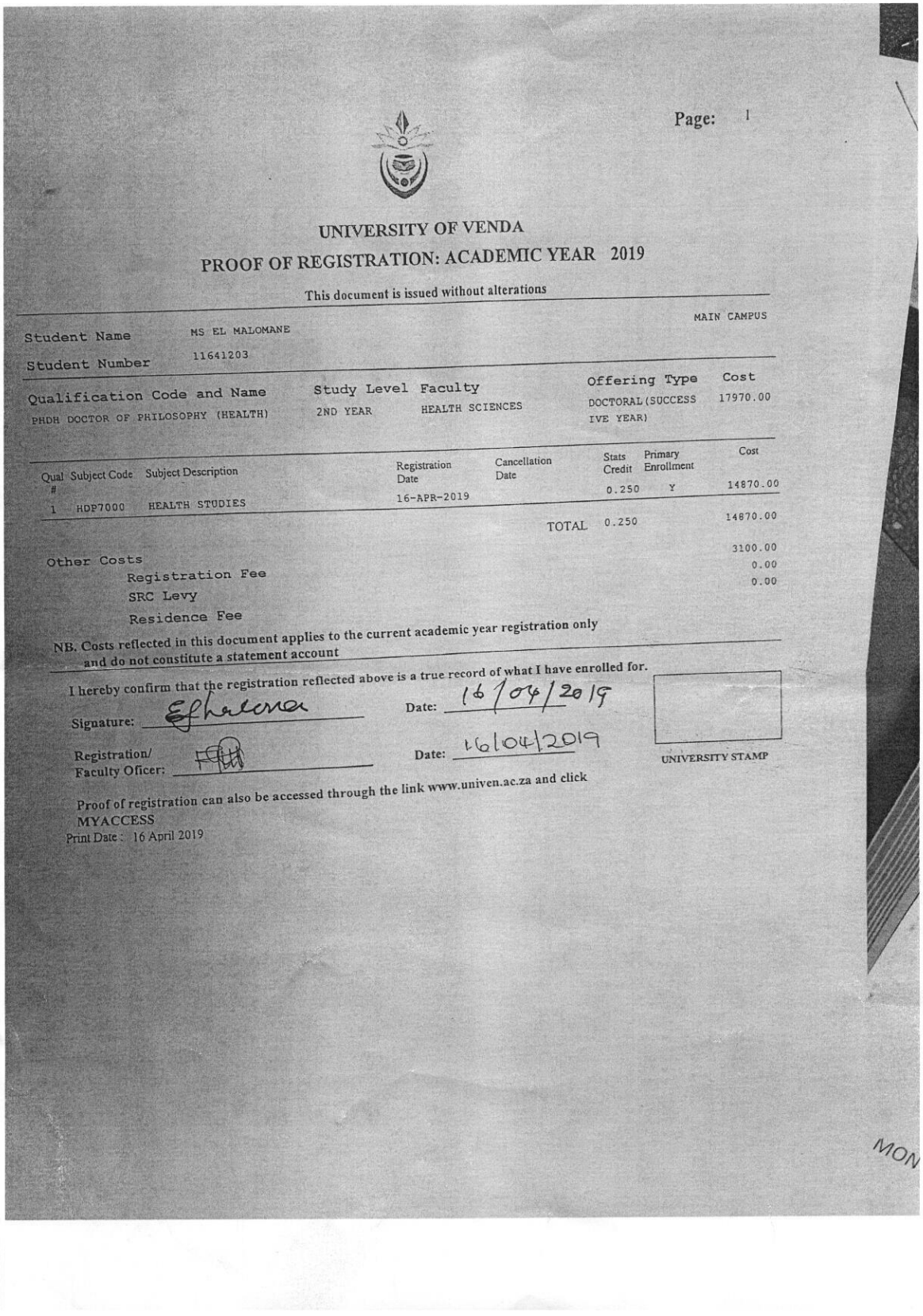
Your cooperation will be highly appreciated.

Head of Department

Date 12/10/2017

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

ANNEXURE K: PROOF OF REGISTRATION



Page: 1

UNIVERSITY OF VENDA

PROOF OF REGISTRATION: ACADEMIC YEAR 2019

This document is issued without alterations

MAIN CAMPUS

Student Name MS EL MALOMANE

Student Number 11641203

Qualification Code and Name	Study Level	Faculty	Offering Type	Cost
PHDH DOCTOR OF PHILOSOPHY (HEALTH)	2ND YEAR	HEALTH SCIENCES	DOCTORAL (SUCCESSIVE YEAR)	17970.00

Qual #	Subject Code	Subject Description	Registration Date	Cancellation Date	Stats Credit	Primary Enrollment	Cost
1	HDP7000	HEALTH STUDIES	16-APR-2019		0.250	Y	14870.00
				TOTAL	0.250		14870.00

Other Costs

Registration Fee	3100.00
SRC Levy	0.00
Residence Fee	0.00

NB. Costs reflected in this document applies to the current academic year registration only and do not constitute a statement account

I hereby confirm that the registration reflected above is a true record of what I have enrolled for.

Signature: _____ Date: 16/04/2019

Registration/ Faculty Oficer: _____ Date: 16/04/2019

UNIVERSITY STAMP

Proof of registration can also be accessed through the link www.univen.ac.za and click MYACCESS

Print Date : 16 April 2019

ANNEXURE L: EDITORS'S CERTIFICATE

STEVENS EDITING AND PROOFREADING
~ EDITING ~ PROOFREADING ~ WRITING ~

BA: English; Industrial psychology (Unisa)
Sole Proprietor
***Membership*:**
PEG (SA)
SfEP (UK-Intermediate)
IPEd (WA)

17 May 2019

THIS IS TO CERTIFY THAT:

I have language edited a thesis titled *strategies to facilitate the provision of quality healthcare services in public healthcare facilities in Limpopo province South Africa*

for Ms Elizabeth Lisbeth Malomane, E-mail: malomanee@gmail.com, a Phd student in Health studies at the University of Venda, South Africa.

The scope of my editing comprised:

- Spelling
- Tense
- Vocabulary
- Punctuation
- Word usage
- Language and sentence structure
- Checking of referencing style

It has been a gratifying experience working with this student who has clearly displayed integrity in a well-prepared paper and prompt communication with the editor when necessary.
My best wishes for good success and a great career accompany Ms Malomane.

Yours faithfully,
Charlotte Stevens (Ms)
Stevens Editing and Proofreading
e: ajc.stevens@gmail.com
[Note: Signature withheld for security purposes.]

ANNEXURE M: CALCULATION OF THE CRONBACH'SALPHA

	Item 1			Item 2			Item 3			Item 4			Item 5			Total		
1	5	1.1 x1.1	1.21	4	0,1 x0.1	0.01	5	1.1 x1.1	1.21	5	1.1 x1.1	1.21	4	0,1 x0.1	0.01	23	8x8	64
2	4	0,1 x0.1	0.01	5	1.1 x1.1	1.21	4	0,1 x0.1	0.01	3	0.9 x 0.9	0.81	5	1.1 x1.1	1.21	21	6x6	36
3	3	0.9 x 0.9	0.81	3	0.9 x 0.9	0.81	3	0.9 x 0.9	0.81	2	1,9 x-1.9	3.61	3	0.9 x 0.9	0.81	14	-1x-1	1
4	5	1.1 x1.1	1.21	4	0,1 x0.1	0.01	5	1.1 x1.1	1.21	5	1.1 x1.1	1.21	4	0,1 x0.1	0.01	22	7x7	49
5	2	1,9 x-1.9	3.61	3	0.9 x 0.9	0.81	2	1,9 x-1.9	3.61	3	0.9 x 0.9	0.81	2	1,9 x-1.9	3.61	12	-3x-3	9
6	3	0.9 x -0.9	0.81	2	1,9 x-1.9	3.61	3	0.9 x 0.9	0.81	5	1.1 x1.1	1.21	3	0.9 x 0.9	0.81	14	1x-1	1
7	5	1.1 x1.1	1.21	5	1.1 x1.1	1.21	5	1.1 x1.1	1.21	4	0,1 x0.1	0.01	5	1.1 x1.1	1.21	25	10x10	100
8	5	1.1 x1.1	1.21	5	1.1 x1.1	1.21	5	1.1 x1.1	1.21	5	1.1 x1.1	1.21	5	1.1 x1.1	1.21	25	10x10	100
9	4	0,1 x0.1	0.01	5	1.1 x1.1	1.21	5			4	0,1 x0.1	0.01	5	1.1 x1.1	1.21	24	9x9	81
10	3	0.9 x 0.9	0.81	2	1,9 x-1.9	3.61	3	0.9 x 0.9	0.81	5	1.1 x1.1	1.21	3	0.9 x 0.9	0.81	16	1x1	1
11	4	0,1 x0.1	0.01	5	1.1 x1.1	1.21	4	0,1 x0.1	0.01	4	0,1 x0.1	0.01	5	1.1 x1.1	1.21	23	8x8	64
12	5	1.1 x1.1	1.21	3	0.9 x 0.9	0.81	5	1.1 x1.1	1.21	3	0.9 x 0.9	0.81	4	0,1 x0.1	0.01	21	6x6	36

	Item 1			Item 2			Item 3			Item 4			Item 5			Total		
13	**3**	**0.9 x 0.9**	**0.81**	**2**	**1,9 x-1.9**	**3.61**	**3**	**0.9 x 0.9**	**0.81**	**5**	**1.1 x1.1**	**1.21**	**3**	**0.9 x 0.9**	**0.81**	**14**	-1x-1	1
14	**4**	**0,1 x0.1**	**0.01**	**5**	**1.1 x1.1**	**1.21**	**4**	**0,1 x0.1**	**0.01**	**2**	**1,9 x-1.9**	**3.61**	**5**	**1.1 x1.1**	**1.21**	**22**	7x7	49
15	**2**	**1,9 x-1.9**	**3.61**	**3**	**0.9 x 0.9**	**0.81**	**3**	**0.9 x 0.9**	**0.81**	**3**	**0.9 x 0.9**	**0.81**	**2**	**1,9 x-1.9**	**3.61**	**12**	-3x-3	9
16	**3**	**0.9 x -0.9**	**0.81**	**3**	**0.9 x 0.9**	**0.81**	**2**	**1,9 x-1.9**	**3.61**	**5**	**1.1 x1.1**	**1.21**	**3**	**0.9 x 0.9**	**0.81**	**14**	1x-1	1
17	**5**	**1.1 x1.1**	**1.21**	**5**	**1.1 x1.1**	**1.21**	**5**	**1.1 x1.1**	**1.21**	**5**	**1.1 x1.1**	**1.21**	**5**	**1.1 x1.1**	**1.21**	**25**	10x10	100
18	**5**	**1.1 x1.1**	**1.21**	**4**	**0,1 x0.1**	**0.01**	**5**	**1.1 x1.1**	**1.21**	**5**	**1.1 x1.1**	**1.21**	**5**	**1.1 x1.1**	**1.21**	**25**	10x10	100
19	**5**	**1.1 x1.1**	**1.21**	**5**	**1.1 x1.1**	**1.21**	**5**	**1.1 x1.1**	**1.21**	**4**	**0,1 x0.1**	**0.01**	**5**	**1.1 x1.1**	**1.21**	**24**	9x9	81
20	**3**	**0.9 x -0.9**	**0.81**	**4**	**0,1 x0.1**	**0.01**	**3**	**0.9 x 0.9**	**0.81**	**3**	**0.9 x 0.9**	**0.81**	**3**	**0.9 x 0.9**	**0.81**	**16**	1x1	1
Items deviation		**1.0**			**1.0**			1.0			1.0			1.0			5	
Sample deviation		46.5																
Cronbach's alpha		0,892473																