# FACTORS INFLUENCING POOR IMPLEMENTATION OF PRIMARY PREVENTIVE CARE IN PRIMARY HEALTH CARE FACILITIES OF MAKHADO MUNICIPALITY, VHEMBE DISTRICT IN LIMPOPO PROVINCE

By

**KWINIKA BONGANI**

**STUDENT NUMBER: 11631693**

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Masters in Nursing Science

**Department of Advanced Nursing Science**
**Faculty of Health Sciences**
**University of Venda**

**Supervisor: Dr Mulondo SA**
**Co-Supervisor: Dr Netshisahulu KG**

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## DECLARATION

I, Kwinika Bongani, hereby declare that the dissertation titled - ***"Factors influencing poor implementation of primary preventive care in primary health care facilities of Makhado Municipality, Vhembe District in Limpopo Province"*** - submitted by me, has not been submitted previously for a degree at this or any other university, that it is my own work in design and in execution, and that all reference materials contained therein have been duly acknowledged.

**Signature:**  **Date: 22/04/2022**

## DEDICATION

This study is dedicated to all healthcare workers for continuing to provide quality health care in the midst of the corona virus (COVID-19). It is also dedicated to my late parents, Mr Kwinika Ntshavheni Elias and Mrs Tambani Azwinndini Annah, who taught me about the importance of remaining focused on my career.

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## LIST OF ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| **AIDS-** | Acquired Immunodeficiency Syndrome |
| **ART-** | Anti-Retroviral Treatment |
| **CDC-** | Centre for Disease Control |
| **CDs-** | Communicable Diseases |
| **COVID-19-** | Coronavirus |
| **DoH-** | Department of Health |
| **HIV-** | Human Immunodeficiency Virus |
| **HPV-** | Human Papilloma Virus |
| **LMICs-** | Low- and Middle-Income Countries |
| **NCDs-** | Non-communicable Diseases |
| **NHI-** | National Health Insurance |
| **OECD-** | Organization for Economic Cooperation and Development |
| **PHC-** | Primary Health Care |
| **PIH-** | Pregnancy Induced Hypertension |
| **PPC-** | Primary Preventive Care |
| **PPE-** | Personal Protective Equipment |
| **SANC-** | South African Nursing Counsel |
| **STIs-** | Sexually Transmitted Infections |
| **TB-** | Tuberculosis |
| **USA-** | United States of America |
| **VCT-** | Voluntary Counselling and Testing |
| **ICRN-** | Ideal Clinic Realisation and Maintenance programme |

## ABSTRACT

**Introduction:** In South Africa, poor implementation of primary preventive care has resulted in an increased number of deaths due to the rise of disease burden, non-communicable and communicable diseases. The aim of the study was to determine factors influencing poor implementation of primary preventive care in primary health care facilities of Makhado Municipality.

**Methods:** The study adopted a qualitative design and used an exploratory and descriptive approach. The entire population of the study were registered professional nurses working in Makhado Municipality primary health care facilities. A non-probability purposive sampling was used to select registered professional nurses and primary health care facilities. Fifteen (15) registered professional nurses and four (04) primary health care facilities were selected. Pre-testing was done with two professional nurses from one of Makhado primary health care facility to determine if there are any flaws in the research interview guide. Data collection was guided by an interview guide using semi-structured interviews. Trustworthiness was ensured through credibility, transferability, dependability and conformability. To ensure that ethical principles were adhered to, ethical clearance certificates were obtained; there was ethical recruitment of subjects; informed consent was obtained from the participants; voluntary participation was maintained while, anonymity and confidentiality were guaranteed to all participants.

**Results:** the study findings revealed that primary health care nurses fail to provide quality health care services to their patients as a result of various shortages. For example, insufficient diagnostic medical devices such as, bloXod pressure monitoring machines and glucometer machines. Insufficient preventive medications were major challenge to nurses and the community at large as it also leads to unwanted pregnancies, termination of pregnancies which increases the workload for both primary health care facilities and secondary health care facilities. In addition, lack of awareness and religious beliefs were also common contributory factors for poor implementation of primary preventive care.

**Recommendations:** The researcher recommended that an increased budget on preventive care would curb the poor implementation of Primary Preventive Care. It was further recommended for research to be conducted on the same research topic; however, the research should be conducted in a different setting to generate more knowledge about the problem at hand. Authorities responsible for allocating budget to the Primary Health Care facilities must do clinic audits so that they identify the shortages in each clinic.

**Conclusion:** primary preventive care is a crucial part of the health system because preventing medical conditions helps with saving money for the Department of Health and ensuring that the population of South Africa remains healthy. The rise in non-communicable and

communicable disease that is reported daily, affirms that primary preventive care is still poorly implemented in the primary healthcare facilities and this calls for immediate intervention by the Department of Health.

**Key words:** Factors, implementation, Primary Health Care Facilities, Primary Health Care Nurse, Primary Preventive Care

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# CHAPTER 1

# OVERVIEW OF THE STUDY

## 1.1 Introduction and background

Primary Health Care (PHC) facility is suited for offering Primary Preventive Care (PPC) in the health care system, and it should be easily accessible to all members of the public. PPC includes initiatives to maintain or increase the level of wellness and to reduce risk factors associated with distinct diseases, through the promotion of lifestyle changes, It is well known, however, that there are some difficulties faced by the PHC professionals and the government regarding the implementation of PPC; for example, patients sometimes struggle to access these facilities which in turn hampers the implementation of PPC (Rubio-Valera, Pons-Vigue, Martı nez-Andre, Moreno-Peral & Berenguera, 2015).

A strong PHC system is required to provide the level of preventative health care and on-going chronic disease management required for an ageing population. In Australia, for example, this kind of primary preventive health care is best delivered and implemented by the government and its multidisciplinary teams working together to provide integrated health care to reduce the alarming rise of disease burden (Halcomb, Stephens, Bryce, Foley & Ashley, 2017). Every year, more than 100,000 lives in America could be saved if more people received recommended and proper implementation of PPC. Implementation of preventive health care services such as cancer screenings, tobacco cessation interventions, and vaccinations/immunization can help prevent 9 of the top 10 leading causes of death (Takler, Pfoh, Stange & Rothberg, 2018). The United States' population receives suboptimal levels of PPC, although, the country has a high prevalence of risky health behaviours. PPC services can have tremendous value in improving the health of a nation by identifying diseases at their earlier stages, when they are more treatable or when their chances of development can be reduced altogether (Siu, Domingo & Grossman, 2015; Simon, Soni & Cawley, 2017).

According to a study conducted in the United Kingdom it is indicated that many countries have introduced primary preventive health care services since the provision of such services can lead to health management in the early stages of diseases, hence, contribute to reducing the subsequent total cost of medical care (Rotarou & Sakellariou, 2018). Several studies have documented that many countries around the world, such as United State of America (USA) and South Africa, have insufficient implementation of PPC services in the PHC facilities (Rotarou & Sakellariou, 2018).

Nigeria also has a double burden of CDs and NCDs. The Nigerian Department of Health (DoH) has indicated that an increase in CDs and NCDs has been driven by insufficient implementation of PPC (Okpetu, Abimbola, Koot & Kane, 2018). This unsatisfactory situation is associated with factors such as - institutional (workload, time limitations, referral options); and community (social and cultural background of the population served, local referral resources, lifestyle modifications, diet change and environmental hazards resulting from globalisation) (Okpetu, Abimbola, Koot & Kane, 2018). The authors add that cardiovascular diseases, diabetes, cancers and chronic lung diseases are the major NCDs responsible for at least 70% of global mortality over the past decade with at least 75% occurring in Low-Middle-Income-Countries (LMICs) in 2015. With on-going CDs burden, LMICs are transitioning to a double burden of CDs and NCDs. Training of health care providers and modification of regulations that guide health professionals in Nigeria can decrease the high rate of burden of disease as nurses will be well equipped with skills and knowledge to combat the alarming problem in the country (Okpetu et al., 2018).

Two years after the Alma Ata Declaration in 1978, the government of Zimbabwe adopted the PHC approach, directing resources towards disadvantaged areas and active participation of communities in transforming their health. National health strategies have continued to endorse the PHC approach as underpinning health provision, but skills migration, low investment and limited resources have deterred this ambition. Tuberculosis, malaria and water-borne diseases continue to be high in prevalence, while NCDs are now 31% of the disease burden and this increase may be driven by insufficient implementation of PPC in PHC facilities in Zimbabwe (Ray & Masuka, 2017).

Rubio-Varela et al., (2015) proposed a four-level ecological model to identify factors influencing poor implementation of PPC in PHC facilities. These factors are - external context, organisational, professional and intervention). Such a model explicates about factors influencing the implementation of PPC to successfully reduce the high incidences of disease burden (Rubio-Valera et al., 2015).

Poor implementation of PPC in South Africa has resulted in increased deaths due to a rise in disease burden, namely, non-communicable (NCDs) and communicable disease (CDs) such as cardiovascular diseases, cancer, hypertension and diabetes, sexually-transmitted infections (STIs), tuberculosis, measles, hepatitis, malaria, influenza and many more diseases. In South Africa, the probability of dying between the age of 30 and 70 years from cancers, cardiovascular diseases, chronic respiratory diseases and diabetes is about 27%. This is caused by poor implementation of PPC in PHC (Centre for Disease Control (CDC), South Africa, 2017).

The Vhembe District Health Plan of 2018/2019 report that the dominant causes of mortality differ according to age and gender. The main causes of death in both male and female children under the age of five years from 2015-2017 remain diarrhoea (46.1%), lower respiratory infections (28.8%) and malnutrition (28.8%). Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) at (15.1%) and Tuberculosis (TB) at (4.2%) were low rate as compared to these other major diseases (Vhembe District Health Plan, 2018).

The most deadly diseases, in the age group of 5 years to 65 years are diabetes mellitus (29.6%), lower respiratory infections (45.8%), TB (84.3%), HIV/AIDS (83.2%) and cardiovascular diseases. The high incidences of these diseases might be due to poor implementation of PPC in Vhembe PHC facilities. The Vhembe District therefore needs to improve implementation of PPC at the hard-to-reach areas and ensure PHC facilities are up to standard (Vhembe District Health Plan, 2018).

### 1.2 Problem statement

The problem statement indicates the gap in the knowledge needed for quality practice. Groove, Gray & Burns (2015) explain that a problem statement usually provides a basis for a study or the purpose. The South African National Disease Profile reported that the Limpopo Province has the second highest disease burden percentages of non-communicable diseases (NCDs) and communicable diseases (CDs) of 53,5% topped by Western Cape with 70,3% and is associated with poor implementation of PPC (Mckenzie, Schneider, Schaay, Scott & Sanders, 2017). During the Limpopo DoH meetings and workshops, professional nurses from different districts also mentioned that there is poor implementation of PPC in their PHC facilities. The PHC facilities are expected to render the following services - antenatal care services, immunization, family planning, treatment of minor elements, tuberculosis, STIs, chronic diseases, mental health care and voluntary counselling and testing (VCT). The researcher is a registered professional nurse working at a PHC facility and has observed that there is insufficient - medical diagnostics, preventive medications and health educations sessions for the communities - which leads to poor implementation of PPC in the PHC facility. The Vhembe Diseases Profile of 2015 indicated that the leading cause of death remains CDs (56.3%) (Excluding HIV and TB). That is followed by NCDs, of which 41.3% is from chronic conditions such as cardiovascular disease and diabetes mellitus, especially, in Makhado Municipality. According to the DoH, the three most common causes of death in Vhembe District for children, under the age of 5 in Vhembe are: diarrhoea (21%), lower respiratory infections (13.5%) and pre-term birth complications (9. 2%). The top two causes of death for young women and men between the ages 15-24 are - accidental threats to breathing at 14.2%

and road injuries at 13.3%. In the age group 25 to 64, the top causes of death for males and females are TB, HIV/AIDS and lower respiratory infections. In addition, another cause of death affecting women of childbearing age is hypertension in pregnancy (20.2%). This shows that there is poor implementation of PPC in PHC facilities. The South African National Department of Health implemented the Ideal Clinic Realisation and Maintenance programme (ICRM) which aims at improving healthcare services, however, there are still huge problems within the public health sector (Vhembe District Municipality, 2020). It is for these reasons that the researcher decided to conduct a study in PHC facilities in Makhado Municipality, Vhembe District Limpopo Province to explore and describe factors influencing poor implementation of PPC in the PHC facilities.

### 1.3 Rationale of the study

South Africa has a health awareness calendar which guides the nation on how to promote and improve the standard of health system, however, studies indicate challenges in implementing such awareness. This can be due to factors associated with the implementation of PPC, such as concerns around - shortage of staff, skills, trainings, review of regulations, financial problems, infrastructures, resources, and management in the DoH (Health Awareness Calendar, 2019).

A study conducted by Mokoena (2017) in Mankweng Hospital in the Capricorn District of Limpopo Province, focused on the perceptions of professional nurses on the impact of shortage of resources for quality patient care in this public hospital. A study conducted by Ndlovu, Mweshi, Simpamba, Nkhata & Zulu (2017) investigated preventive and rehabilitative medicine. The researcher, however, found no studies that have specifically investigated factors influencing poor implementation of PPC in Makhado PHC facilities. Poor implementation might have negative impact on PPC and the entire health system; hence, it is necessary to describe factors influencing poor implementation of PPC in the Makhado Municipality, Vhembe District, in the Limpopo Province, in order to understand the seriousness of the problem in this area.

### 1.4 Significance of the study

This study may help the Limpopo DoH financial managers to see the need to increase the budget to improve implementation of PPC in PHC facilities. The policy makers in the DoH may see the need to revise their policies regarding the implementation of PPC, increasing the frequency of health care awareness and health promotion. This study may also help the health care professionals (nurses) to identify gaps in the provision of PPC and devise strategies to address these problems. It may help the pharmacy/health store management and the health

care authorities responsible for the allocation of PHC resources to see the need to increase the allocation of resources in the PHC facilities. From the findings, community members would become aware of the essential PPC services in the PHC facilities for the maintenance of good health. The body of knowledge on the topic would be become comprehensive through the dissemination of journal articles and reports based on the study. Lastly, it is evident that community members may benefit from the improved provision of patient care.

## 1.5 Purpose and objectives of the study

### 1.5.1 Study purpose

The purpose of the study was to determine factors influencing poor implementation of PPC in the PHC facilities of Makhado Municipality, Vhembe District in the Limpopo Province.

### 1.5.2. Study objectives

The objectives of the study were:

- To explore and describe factors that influence poor implementation of primary preventive care in primary health care facilities.
- To describe the impact of poor implementation of primary preventive care in primary health care facilities.
- To determine measures for improving the poor implementation of primary preventive care in primary health care facilities.

## 1.6 Definition of terms

**Factors** refer to controlled independent variables that influence dependant variables (Brink, Van Der Walt & Rensburg, 2017). In this study, factors refer to all elements that are involved in influencing the implementation of PPC.

**Implementation** refers to carrying out, execution, or practice of a plan, a method, or any design, idea, model, specification, standard or policy for doing something (Rouse, 2014). In this study, implementation refers to the actions of nurses and government to ensure that PPC is readily available to all those who need health care services.

**Primary Health Care facilities:** Mokoena (2017) indicates these facilities as places where PHC should be accessible, affordable, acceptable, available, equal, effective, efficient, continuous, caring, comprehensive, comfortable considerate scientifically advanced and caring for the patients' safety. In this study, PHC facilities refer to all primary public health institutions that provide preventive care.

**Primary preventive care:** The Centre for Disease Control (CDC) in the USA (2018) explains PPC as actions aimed at avoiding the manifestations of a disease. In this study, PPC refer to any actions by PHC facilities which have an impact on preventing diseases.

**Primary Health Care nurse:** According to the South African Nursing Council (SANC), government Gazette R2598, 2006, a nurse is a person registered under Section 31(a) of the Nursing Act No.33 of 2005. In this study, PHC nurse refer to a registered professional nurse who works in PHC facilities in the Makhado Municipality, Vhembe District in Limpopo Province.

### 1.7 Chapter outline

**Chapter 1: Overview of the study and background**

In this chapter is outlined the orientation of the study indicating the introduction, background, problem statement, significance of the study, purpose of the study, objectives, definition of terms, summary and the chapters' content.

**Chapter 2: Literature review**

This chapter focused on the literature related to factors influencing poor implementation of PPC in PHC facilities, internationally, nationally and specifically in the context of Makhado Municipality, Vhembe District in Limpopo Province

**Chapter 3: Research design and methodology**

In his chapter, the researcher elucidates the research methodology applied in order to address the objectives of this study.

**Chapter 4: Data presentation and discussion,**

Data collected, analysed and interpreted are presented in this chapter

**Chapter 5: Conclusions and recommendations**

This chapter covers the recommendations suggested, limitations, summary, and conclusion of the whole study.

# CHAPTER 2

# LITERATURE REVIEW

## 2.1 Introduction

A literature review is an objective, critical summary of published research literature relevant to a topic under consideration, for research (Brink et al., 2017). The main purpose of a literature review is to create familiarity with the study at hand and other similar topics. The literature review can also be defined as a logical combination of the existing studies around a specific field of study (Brink et al., 2017).

## 2.2 Factors that influence poor implementation of PPC in PHC facilities

### 2.2.1 Insufficient diagnostic medical devices

Diagnostic medical devices, such thermometers and blood pressure machines are essential in the health facilities as they are always needed to detect early manifestation of any kind of the disease. Without these devices wrong diagnoses can be made. Many health care facilities in Limpopo have a shortage of these devices, although, Washeya (2018) contends that the problem of shortage of PPC devices is not only in the Makhado Municipality but worldwide.

Lack of diagnostic medical equipment such as the shortage of glucometers strips, Baumanometers and lumber puncture needles impede the implementation of PPC. These shortages result in delayed diagnosis of conditions and contribute to the increasing burden of diseases which then hinder the implementation of PPC (Washeya, 2018).

### 2.2.2 Insufficient preventive medication

The availability of sensitive and specific diagnostic techniques has helped in decreasing the incidence of disease, for example, there has been a decrease in cervix carcinoma due to this. Medications, supplies and equipment that are used in the prevention of diseases are very crucial and should not be scarce as without these essential preventive medications and diagnostic techniques, there will be poor implementation of PPC services in the PHC facilities. Dang and Sharma (2018) argue that governments should ensure adequate supply of preventive medication and essential devices for prevention of diseases for the well-being of the nations.

### 2.2.3 Low budget on preventive care

In the USA it was reported that average expenditure on public health and prevention in 2016 was just over 3% of public spending, whereas the average spent on curative care was 57%. The USA is as guilty of this imbalance, as the rest of the countries that were surveyed including South Africa. There is more curative care focus than on preventative medical devices, although, the latter have the potential to more efficiently provide a higher standard of living and better overall health care. Numerous studies have found that, despite the proven benefit of preventative care, governments still allocate most of their healthcare expenditures for curative measures while neglecting preventative efforts in the PHC facilities (Organisation for Economic Cooperation and Development (OECD) in USA, 2016). The OECD furthermore complained that, despite the reported high burden of diseases, and the strong public health argument for increased preventive programs, expenditure on public health and prevention accounts for a small proportion of public health budgets (OECD in USA, 2016).

### 2.2.4 Lack of healthcare awareness of PPC in PHC facilities

There is comprehensive evidence that PPC can reduce the cost to the health system and improve PHC services uptake, despite this, the implementation of such services is relatively low. There is a lot of health awareness that focuses on PPC measures, according to the health calendar every year; for example, from 12th of February to the 16th it is STI, condom and pregnancy awareness week; 22 February is the healthy lifestyle awareness day, 24-30th of April is vaccination awareness week, however, these health awareness programmes have not resulted in better implementation of PPC (Sabbath, Sparer, Boden, Wagner, Hashimoto, Hoppcia & Sorensen, 2018).

### 2.2.5 Availability of curative care

Most people in the developing countries consider curative care to be more important. The push for curative medical devices and curative care leaves much needed preventative care devices underdeveloped, suppressing innovation and lowering both implementations of PPC and the quality of life for all patients in PHC facilities (OECD, 2016).

In the past, medical care focused on disease treatment which could reduce mortality rate and extend life expectancy. Some researchers have supported the fact that it is better for more finance to be provided on curative services than to be spent on PPC services. On the other hand, other researchers have concluded that preventing illness can in some cases reduce the overall cost in health care services. According to the OECD, indicators of risk factors to health that countries like the United States and Mexico are facing are challenges of overweight and obesity among children and adults. Countries in Europe, such as Austria and France, are

facing concerns linked to tobacco and alcohol consumption. These factors possibly lead to chronic illness and raise health expenditure. Early prevention with a well-planned implementation of PPC and intervention could lower the probability that the population will be in poor health and save subsequent curative expenditure (Wang, 2018).

### 2.2.6 Increased nursing workloads

Nursing workload can be caused by infectious diseases that are difficult to treat and easier to spread while nurses are on the frontline of preventing and controlling health-care associated infections. It is reported that adherence to guidelines and protocols developed by the CDC organisation can reduce the spread of these infectious diseases in PHC facilities. The increased burden of diseases often leads to increased workload in healthcare facilities, thus, the implementation of PPC services often require additional time and resources from healthcare teams that may compromise their routine workflow and distract nurses from other pressing needs (Hessels, Kelly, Chen, Cohen, Zachariah & Larson, 2019).

There is a relationship between nurse-staffing and decrease in the implementation of PPC, therefore, the global shortage of the nursing staff, especially in the PHC facilities, makes it difficult for health care providers (nurses) to effectively implement quality PPC services to patients in high need (Chitimwango, 2017).

In the past years, Vhembe District has been challenged by a shortage of professional nurses and other nursing categories. The low staffing levels can mean that workloads are particularly high in some PHC facilities in Vhembe (Massyn et al., 2015).

### 2.2.7 Patients' attitude towards prevention

Attitude is a significant indicator that can be used to assess the extent to which an individual can adopt a healthy behaviour to prevent diseases, therefore, patients' bad attitude towards prevention can lead to insufficient implementation of PPC services. Abdalrahim, Herzallah, Zeilani & Alhalaiqa (2014) observe that patients' bad attitude reduces the ability and strength of nurses to effectively implement health care services.

### 2.2.8 Nurses' attitude towards patients

The attitude of health service providers (nurses) towards patients plays a crucial role in determining the implementation of PPC as well as the utilization of PPC. Ndlovu et al., (2017) assert that most patients were reluctant to seek preventive care services in the PHC facilities because of the negative attitude of the nurses towards them.

### 2.3 The impact associated with poor implementation of PPC in PHC facilities

#### 2.3.1 Communicable and non-communicable diseases

The leading causes of death seem to be the disease burdens, namely, the CDs and NCDs worldwide, The cause of this are preventable risk factors which include NCDs (cardiovascular diseases, cancer, diabetes and many others) and CDs (HIV, TB, measles, hepatitis, influenza, malaria and many others). By prioritizing preventive care there can be on-going control of common diseases, reducing transmissions, mortality rate, morbidity rate and human suffering and gradually eliminating these diseases so that they cease to be a public health problem. In South Africa, the probability of dying between the age of 30 and 70 years from cancers, cardiovascular diseases, chronic respiratory diseases or diabetes is about 27%. These death and disease burdens are largely driven by insufficient implementation of PPC in PHC facilities (CDC South Africa, 2017).

- **Communicable diseases**

Major health problems in South Africa remain the HIV and TB epidemics which directly and indirectly contribute significantly to premature death and morbidity. The presence of this dual CDs further increases vulnerability to other prevalent CDs which in total account for 38% of deaths among under-fives, and just fewer than 40% of deaths in adults aged 15–45 years. Quan and McCarthy (2018) argue that a strong implementation of PPC can reduce the problem faced by the country.

It was reported that risk factors of CDs are clear and well known. These factors include unprotected sex, skipping of vaccination during childhood and unsanitary conditions. Clearly, these factors can be preventable with minimal costs by, for example, practising safe sexual intercourse by making use of condoms, prioritising immunization/vaccination, safe sanitary conditions and prophylaxis after exposure. Many of CDs can be reduced through early detection of individuals at risk. The CDC of South Africa indicated that prevention and early detection are, therefore, crucial for control and management of diseases and that failure to implement such measures in the PHC facilities can be costly (CDC South Africa, 2017).

- **Non-communicable diseases**

Chronic NCDs refer to a group of slow-progressive medical conditions or diseases of long duration (chronic), which are characteristically non-infectious and non-transmissible among people (CDs). They include heart disease, stroke, cancers, diabetes, chronic obstructive pulmonary disease (COPD), asthma, cataracts, and more, The chronic character of these diseases demands long-term care and they impose a continuous disease burden on an

already overstretched health system, like the way HIV infection does (Puoane, Tsolekile, Caldbick, Igumbor, Meghnath & Sanders, 2017).

It was further reported that in SA, NCDs account for an estimated 37% of all-causes of mortality and 16% of disability-adjusted life years. Ischaemic heart disease, stroke, diabetes mellitus and COPD account for 6.6%, 6.5%, 2.6%, and 2.5% of all deaths respectively. This disease burden varies significantly between population groups; for example, the age standardised cardiovascular disease mortality rate is 606.9 per 100 000 for Asians and 375.3 for Africans. This rise of disease burden can be due to poor implementation of PPC in PHC facilities (Puoane et al., 2017). Just like CDs, NCDs can also be prevented through focusing mostly on lifestyle behaviour. Risk factors include eating unhealthy diet, excessive consumption of alcohol and tobacco use and avoiding exercise. To overcome this burden is to do the opposite, by eating healthy diet, exercising and avoiding tobacco and alcohol and adhering to the health education given by health care workers (nurses) in PHC facilities to improve the implementation of PPC (Puoane et al., 2017).

## 2.4 Measures to improve poor implementation of PPC in PHC facilities

### 2.4.1 Increase budget on preventive care

The USA recent figures show that average expenditure on public health and prevention in 2016 was just over 3% of public spending whereas the average spent on curative care 57%. The USA is as guilty as the rest of the countries that were surveyed including South Africa (OECD USA, 2016).

### 2.4.2 Health awareness and health education

Increasing healthcare awareness and promoting health education in healthcare facilities is important and can help reduce the disease burden, The Health Awareness Calendar (2019) states that interventions such as medical advice, counselling, and health education about a healthy lifestyle, increasing exercise to reduce risk behaviours in vulnerable people are more successful in achieving reductions in risk factors and therefore preventing disease. This also improves the implementation of PPC in PHC facilities.

## 2.5 Conceptual framework

The proposed study will adopt the ecological model conceptual framework. This is theory that guides health promotion and practice and also explains the relationship between factors that may influence poor implementation of PPC services in the PHC setting.

## ECOLOGICAL MODEL

The ecological model (Rubio-Valera et al., 2015) refers to the interaction between, and the interdependence of factors within and across all levels of a health problem, Factors that influence individuals to practice prevention are similar to the factors that may influence the implementation of PPC by the nurses in PHC facilities; these factors include - external context, organisational, professional and intervention (Rubio-Varela et al., 2015).

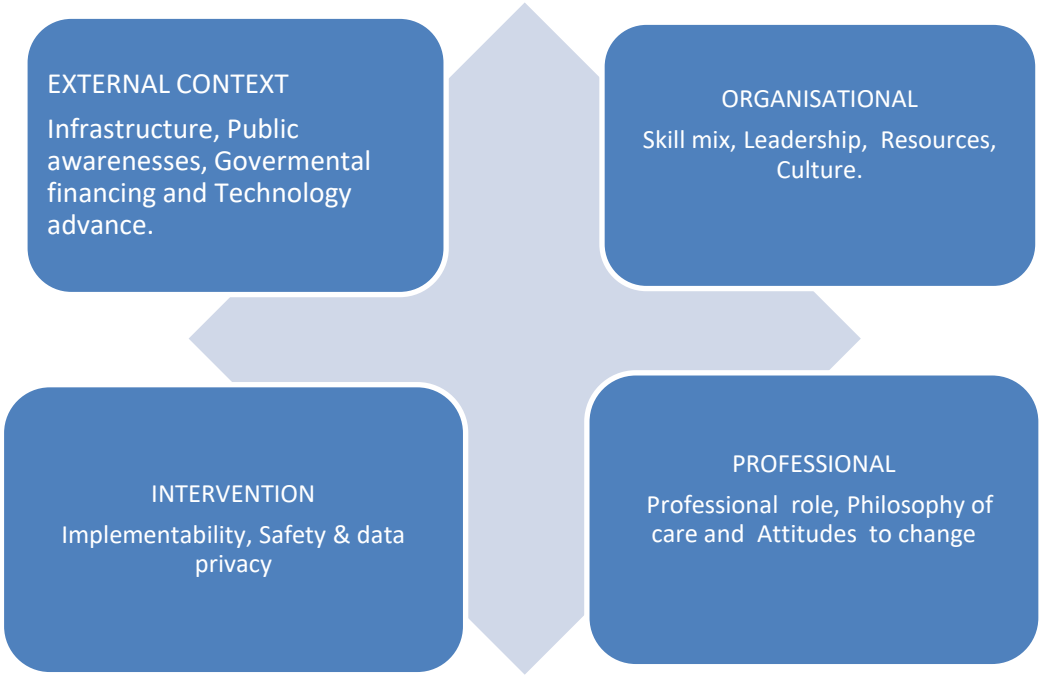


**Figure 1: Factors influencing poor implementation of PPC in PHC facilities**

### 2.5.1 External context

External context comprises six elements - infrastructure, public awareness, policy and legislation, governmental financing and technology advance and buy-in by internal or external stakeholders. These elements play an important role in promoting the implementation of PPC, however, this depends on the effort given by the Department of Health and its health care providers (Rubio-Valera et al., 2015).

- **Infrastructure**

Short comings, such as - unreliable internet access, lack of access to information, lack of mechanisms or systems to support storing or documenting information and lack of infrastructure support for implementation of PPC - are reported as impeding implementation, whereas the presence of these features promotes implementation of PPC in PHC facilities (Rubio-Valera et al., 2015).

Infrastructure in this study is significant because it influences the implementation of PPC. Most of the PHC facilities face challenges with their infrastructure, lack of storage for tools and cubicles, as well as halls for meetings are still a major challenge. All this affects the implementation of PPC, hence; contribute to an increase in disease burden.

- **Technology advance**

Advances in technology in health care have become increasingly salient. Technologies change health care delivery and the way in which information is provided for example: electronic patient records and telemedicine, there is a growth of interest in their use and this drives the implementation of PPC in a positive, insufficient training and provision of new technology materials jeopardise implementation of PPC and lead to an increase in diseases burden (Rubio-Valera et al., 2015).

Technology is important because proper health delivery and well established PHC facilities require technology for ordering supplies and recording patients' information. Lack of technological advances and insufficient training of the staff members also contribute to poor implementation of PPC.

- **Economics and financing**

The American government's policies on allocation of funding, and investment decisions made by local health authorities hamper the implementation of PPC guidelines, however, well-thought out plans should provide adequate funding for PHC facilities, thereby, improve the implementation of the PHC system and reduce the incidence of high rate of disease burden, CDs and NCDs (Rubio-Valera et al., 2015).

Financing is essential because lack of finance can impede the implementation of PPC. Moyimane, Matlala, & Kekana, (2017) found that despite evidence that primary prevention can save money and improve health, uptake and implementation of such services is relatively low, increased funding to PHC facilities can, thus, promote the implementation of PPC and reduce the burden of disease on South African citizens.

- **Public awareness**

Public awareness could result in pressure on DoH to introduce a new intervention. This is presented as a facilitator for motivating the uptake of telemedicine and for educating the public about new nurse practitioner roles; this awareness would help to improve the implementation of PPC in PHC facilities (Rubio-Valera et al., 2015).

In this study public awareness were health campaigns that support the prevention of various diseases in the country. There are a lot of health awareness programmes that focus on primary

preventive measures. According to the health calendar, every year from the 12th of February to the 16th it is STI, condom and pregnancy awareness week; 22 February is healthy lifestyle awareness day, 24-30th of April is vaccination awareness week, however, these initiatives are not followed up, thus, have little impact on the implementation of PPC.

### 2.5.2 Organisation

Organisation comprises five elements, namely, culture, resources, leaderships, relationships and skill-mix issues.

- **Culture**

The presence of a positive culture receptive to change and value innovation was viewed as necessary for the implementation of PPC in PHC facilities (Rubio-Varela et al., 2015). The understanding of one's cultural beliefs in health, facilitates on-going health care system without judgement of health providers and patients also facilitate workflow. In the end, this leads to a well-established implementation of PPC, hence, a reduction in sick people and workload for health care workers which relates to the study problem.

- **Leadership**

Lack of effective leadership to advocate change, set priorities or manage the implementation process and changes in leadership are barriers to the implementation of PPC in PHC facilities. Organisational readiness is the degree of preparation before implementation and it is able to show that lack of staff preparation or strategic planning impedes the implementation of PPC and can lead to increased workload for health care workers (Rubio-Valera et al., 2015).

In this study, leadership referred to all management personnel who that govern the smooth running of PHC facilities in preventing diseases and promoting workflow and trust between staff members and patients. Good and decisive leadership is crucial in PHC facilities and its absence impedes the implementation of PPC, whereas the opposite motivates the implementation.

- **Resources**

Rubio-Valera et al., (2015) reported that available resources, including time, funding, staff and technical support, can be both barriers and facilitators of the implementation of PPC in PHC system. They add that limited funding, in general, results in lack of time to plan or train staff members, insufficient equipment or administrative support to perform additional data entry or deal with paperwork and they are also barriers to implementation of PPC in PHC facilities.

Resources are all equipment required in PHC facilities to improve the standard of care provided by health professionals. Availability of resources is crucial because poor resources is a major challenge to the government and it impedes the implementation of PPC.

- **Relationships**

Relationships between nurses and patients influence the implementation of PPC in PHC facilities. Positive and trusting inter-professional relationships through the presence of bi-directional communication and giving staff abundant opportunity to discuss salient matters and provide input to challenges before and during the implementation of PPC, help in the delivery of effective health care. As a result of conflict from patients' expectations and concerns about patients' and health professionals' interaction, for example, when using the new health information system, nurses spend more time on documentation than on direct care. This could lead to a decrease in acceptability of an intervention and subsequently impede the implementation of PPC (Rubio-Valera et al., 2015).

Relationships were deemed important in this study because good nurse-patient relationships result in the smooth running of quality health care, On the other hand, misunderstandings between the two, jeopardise the implementation of PPC leading to an increase in disease burden in PHC facilities and to the community. Clearly, a balanced relationship between nurses and patients can promote the implementation of PPC.

- **Skills-mix issues**

The lack of clarity of roles, responsibilities and division of labour can be barriers to implementation of PPC in PHC facilities, as it leads to confusion about who should be responsible for implementing needed changes. The nature of the division of labour, defined as the allocation of responsibilities and the appropriate use of skills to accommodate new processes or implementation is also a factor that emerged from some reviews. The absence of personnel with the combination of skillset or a lack of appropriate expertise to perform specific tasks can impede the implementation of PPC (Rubio-Valera et al., 2015).

In this study, skills-mix is important because there are still many health care providers who lack skills to perform their duties due to insufficient training. Some are even resistant to learn new skills for providing quality health care. Proper training in new skills benefits PHC facilities by promoting implementation of PPC.

### 2.5.3 Professionals

This factor comprises two elements, namely, underlying philosophy of care and attitude to change. Within the professional theme there are perceptions of what it means to be a

professional, professionalism, peer influence, sense of self-efficacy and authority/influence. Professionalism, which includes using expert judgement to apply scientific and experiential knowledge and dealing with uncertainty, is viewed as a salient aspect to be considered in relation to implementation of PPC in PHC facilities (Rubio-Valera et al., 2015).

- **Underlying philosophy of care**

This includes personal style and relationship between health care providers (nurses) and patients. Personal style, defined as the perceived fit between the intervention and the preferred style of PHC practice, such as nurses' communication style, personality and philosophical approach to the intervention, can be barriers to implementation of PPC. Additionally, patient values, preferences and concerns about nurse-patient relationships can impede the implementation PPC (Rubio-Valera et al., 2015).

In this study, the philosophy of care is considered because it outlines how a poor relationship between the patient and the nurse affects the implementation of PPC and causes an increase in disease burden in PHC facilities. It is obvious that communication can affect or promote implementation, hence, bad behaviour towards patient by nurses impedes the implementation of PPC.

- **Attitudes to change**

Prior experience, motivation and priority, familiarity and awareness, perception of time and workload, attitudes and beliefs are shaped by personal beliefs and experience, education and training and peer networks. These are significant in relation to the implementation of PPC and can be both barriers and a facilitators of PPC; lack of motivation and low awareness of the intervention can impede the implementation of PPC in PHC facilities (Rubio-Valera et al., 2015).

Attitudes to change is relevant in this study as the attitude of health service providers towards patients plays a role in determining the implementation of PPC, as well as the utilization of primary preventive services. Ndlovu et al., (2017) reported that most patients face challenges when they seek preventive care services in the PHC facilities because of the negative attitude of nurses towards them. Similarly, nurses also complain of the same issue from patients, therefore, if both patient and nurses work together as a team PPC, would be promoted to become top standard care.

### 2.5.4 Intervention

An intervention involves implementation. The nature and characteristics of an intervention which includes the complexity of the intervention, evidence of benefit, applicability and

relevance, costs of an intervention, cost-effectiveness of an intervention, clarity, practicality and utility of intervention, customisation of intervention and IT compatibility, are all viewed as aspects to be considered during the implementation of PPC in PHC facilities (Rubio-Valera et al., 2015).

- **Implementability**

This model also focuses on the complexity, benefit and harm as well as resource requirement in the implementation process of PPC in PHC facilities. The complexity of an implementation can be determined by the scale of implementation, number of sites and processes required. The adoption of a new intervention or process might bring potential benefit or harm to other aspects of care. For instance, implementing a new PPC in PHC facilities usually requires shifting organisational priorities and putting other projects on hold which may result in initial lower productivity and increased staff workload and resources required. Effective implementation requires sufficient resources and funding to support not only start-up costs but also on-going costs and attention to sustainability (Rubio-Valera et al., 2015). Implementability is considered in the study because improper implementation of PPC in PHC facilities by changing of policies and regulations, and shifting of organisational focus and involving new projects or staff, can lead to poor productivity and increased workload, as well as disease burden. If, however, the plan for new system to enhance implementation is properly introduced to staff members, it can benefit the PHC facilities by reducing costs, workload and other needs.

# CHAPTER 3

# RESEARCH METHODOLOGY

## 3. Introduction

There are two accepted designs to research, namely, qualitative and quantitative. Research methodology is a descriptive of what the activity of research is, how to carry it out, how to measure its progress and what constitute its success (Brink et al., 2017). This study used qualitative design to expand knowledge about the factors influencing poor implementation of PPC in PHC facilities.

## 3.1 Qualitative design

A qualitative design refers to a systematic design used to describe experiences and situations from the perspective of the person in the situation (Groove et al., 2015). In this study, a qualitative design helped because it assisted to obtain in-depth information from participants and the design also assisted in collecting thick descriptions of participants' feelings, opinions and experiences and to interpret the meanings of the participants' actions. This design also allowed the researcher to analyse participants' words, find meaning in the words and description of the experience to promote a deeper understanding of the factors influencing poor implementation of PPC in PHC. The systematic design has approaches namely, exploratory and descriptive approach which are detailed below.

### Exploratory approach

An exploratory approach ensures that a study provides information and insight into clinical or practice problems (Groove et al., 2015). The purpose of the study was achieved by using an exploratory approach which assisted when using probing questions on the interview guide (Mokoena, 2017). Through this approach, the researcher was able to have a better understanding of existing problems and obtain in-depth information from nurses regarding factors influencing poor implementation of PPC in PHC facilities.

### Descriptive approach

According to Mokoena (2017), a descriptive approach is designed to gain the required information about salient characteristics of a particular field of study; it provides details of a situation as it naturally occurs. The descriptive approach facilitated the obtaining of data and that the analysis can be made to describe the factors that influence poor implementation of primary preventive care in PHC facilities.

### 3.2 Study setting

Groove et al., (2015) states that study setting refers to the location for conducting research which can be natural, partially controlled, or highly controlled. Makhado Municipality is geographically the largest and the second highest populated municipality in the Vhembe District. It borders Musina in the north, Thulamela in the east, Molemole in the west and Giyani in the south. The Makhado Municipality has 4 formal towns and more than 200 villages, 3 hospitals, 44 clinics, 7 mobile clinics and 4 health centres (Massyn et al., 2015).

Makhado PHC facilities render the following services: health education, health awareness, health promotion and preventive, maternity care and general patient care. The study was conducted at selected PHC facilities in the Makhado Municipality.

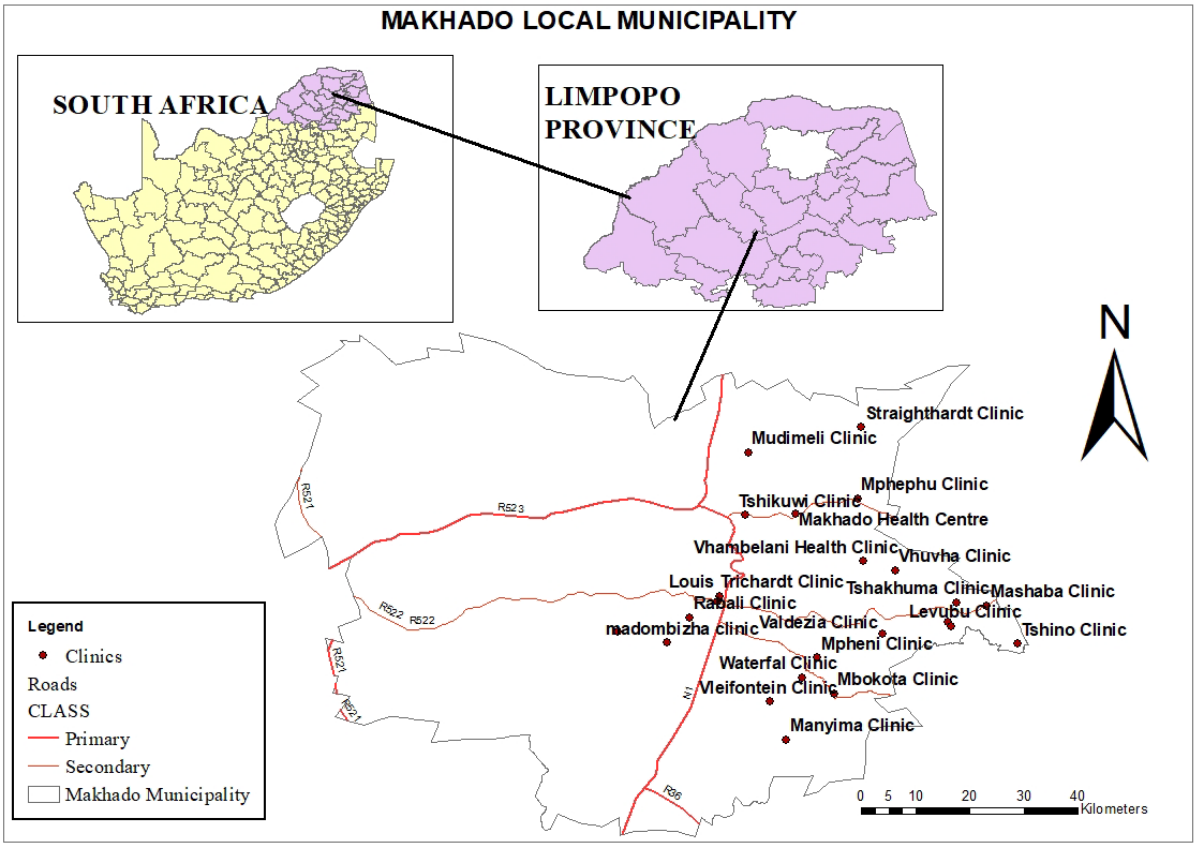


**Figure 2. Makhado local municipality map (Arc Geographical Information System, 2019).**

### 3.3 Study population and sampling

#### 3.3.1 Study population

A study population refers to all elements (people, objects, events, or substances) that meet the sample criteria for inclusion in a study; sometimes referred to as a 'target population' (Groove et al., 2015). The entire population of the study consisted of registered professional

nurses working in Makhado Municipality's facilities. According to Mokoena (2017), an accessible population is the portion of the target population to which the researcher has reasonable access. Accessible population was registered professional nurses (males and females) who agreed to participate in the study during data collection in Makhado PHC facilities.

### 3.3.2 Sample and Sampling

**Sample** refers to a subset of population that is selected for a study (Groove et al., 2015).

**Sampling** is taking a portion of the population and considering it as a representative of the population (Brink et al., 2017). Non-probability purposive sampling is a method where data is collected from participants chosen because they illustrate some features that are of interest in a certain study (Mokoena, 2017). Non-probability purposive sampling was used and helped in judging and selecting the participants who know most about the phenomenon being investigated.

**Sampling of PHC facilities**

A non-probability purposive sampling method was also used when selecting the PHC facilities. Five PHC facilities with a high percentage of disease burdens, namely NCDs and CDs, were selected from the 48 PHC facilities in Makhado Municipality.

**Sampling of participant**

The non-probability purposive sampling method was used to select 20 registered professional nurses. Brink et al., (2017) cautions that the sample size in qualitative studies should not be too small. All registered professional nurses in the selected PHC facility who met the inclusion criteria, were available and agreed to participate, became the respondents.

### 3.4 Inclusion and exclusion criteria

**Inclusion criteria**

For Groove, Gray & Burns (2015), the inclusion criteria refer to characteristics that potential participants must have in order to participate in a study. Registered professional nurses (males and females), aged 25-65 years, who have two years working experience in the PHC facilities participated in this study because they were deemed familiar with the preventive care measures that are practiced in their health facilities.

**Exclusion criteria**

Exclusion criteria refer to features of the potential study participants who, although, they meet the inclusion criteria but present with additional characteristics that could interfere with the success of the study or increase the risk of collecting irrelevant data. In this study, community service professional nurses (still on probation) did not form part of the study because they are

still working under supervision, therefore, they do not have sufficient experience regarding the poor implementation of primary preventive care (Groove et al., 2015).

### 3.5 Data collection method

Data collection is the most crucial part of a research study and may involve a face to-face interaction between the researcher and participants, according to Brink et al., (2017). The researcher used a semi-structured interview guide with questions that were formulated in English and based on the research objectives.

The researcher interviewed registered professional nurses who meet the inclusion criteria and agreed to participate, however; data saturation was reached after interviewing 15 participants in 3 selected PHC facilities, hence, the other 2 PHC facilities were not visited for interviews.

### 3.6 Pre-test

In order to test the practical aspects of the interview, the researcher conducted a pre-test with two professional nurses who met the inclusion criteria (Brink et al., 2017). Two professional nurses from one Makhado PHC facility were interviewed to determine if there were any flaws in the research interview guide.

### 3.7 Trustworthiness

Trustworthiness is a concept of establishing rigor in qualitative research without sacrificing relevance and assists a researcher in preventing errors. Brink et al., (2017) mentions the following criteria to ensure trustworthiness:

- **Transferability**

Transferability refers to the general extent to which the findings can be transferred to other settings or groups (Brink et al., 2017). This was ensured by selecting a sample which represents the entire population of the study. A rich description of the research design and results was undertaken to enhance transferability to other settings. The background information of participants, context and technique of the research were comprehensively explained.

- **Credibility**

Brink et al., (2017), maintain that credibility is achieved when the researcher has adequate time to get to know participants. Brink et al., (2017) document the following techniques to establish credibility of a research:

**Prolonged engagement**

Prolonged engagement refers to staying in the field until data saturation is reached (Brink et al., 2017). In-depth understanding of the phenomenon and specific aspects of the participants such as perceptions or views, culture and experiences were gained through this prolonged engagement with the participants. Prolonged engagement helped to build trust and rapport with the participants and this was needed for gathering rich data.

**Persistent observation**

Persistent observation is ensured by consistently pursuing interpretation in various ways (Brink et al., 2017). Multiple influences were identified through a process of continual and tentative analysis to determine what counts and what does not.

**Triangulation**

Triangulation refers to the use of two or more theories, methods, data sources, investigators, or analysis methods in a study (Groove et al., 2015). Triangulation was achieved by asking different questions, seeking different sources and using different methods in the data collection procedures. This included collecting the data about different points and relationships from differing points of view. Triangulation helped to capture different dimensions of the research study at hand and ensured that data was collected from different PHC facilities and from registered professional nurses with different working experiences and gender.

**Peer debriefing**

Peer debriefing is ensured by talking to peers who have similar status or are colleagues who are experts in either the method or the phenomenon being studied (Groove et al., 2015). The peers selected had a general understanding of the study and were able to debate with the researcher each step of the research process.

**Member checks**

Member checks refer to the on-going formal and informal validation of data, analysis of themes and categories, interpretations and conclusions with participants from whom the data was collected (Brink et al., 2017). This was ensured by discussing the intentionality of the participants, to correct obvious errors and to provide additional information. The emerging findings were taken back to the participants in order for the interpretations of the data, as well as the adequacy thereof, to be discussed and confirmed.

- **Dependability**

According to Brink et al., (2017), dependability is criterion used to establish trustworthiness by having a peer researcher perform an audit of the study. Furthermore, dependability is the provision of sufficient evidence such that if another study was to be conducted with the same or similar context, its findings would be similar; when dependability is absent, credibility cannot be attained. Dependability was ensured by sending the researcher's findings to the supervisors and co-supervisors for audit trial.

- **Conformability**

Conformability refers to the potential for congruency of data in terms of accuracy, relevance or meaning, It is concerned with establishing whether the data represent the information provided by the participants and that the interpretations of the data are not fuelled by the researcher's imagination; data must reflect the voice of the participants and not the researcher's biased perceptions (Brink et al., 2017). This was ensured by guaranteeing that the findings, conclusions and recommendations were supported by the data and that there was an internal agreement between the investigator's interpretation and the actual evidence. This was also accomplished by incorporating an audit procedure.

### 3.8 Plans for data collection

#### 3.8.1. Data collection procedure

Brink et al., (2017) explain that data collection, through interviews, involves a face-to-face interaction between a researcher and subject and may necessitate observation. Appointments were made by visiting all selected Makhado PHC facilities managers after receiving letters of permission from the Limpopo Provincial Government Director of research and DoH Vhembe District Chief Director, to conduct the study. The interviews took place in a natural setting and the researcher ensured that the environment was quiet, comfortable and conducive.

Before the interview commenced, participants were made to feel comfortable and at ease. Participants were also provided with information leaflets so that they could familiarize themselves with what was expected of them. Field notes were written immediately after the interview sessions to avoid forgetting some aspects of the data. Field notes refer to the information recorded by the researcher from observation during the interview sessions (Groove et al., 2015).

Interviews were conducted during participants' free time to ensure that the interviews did not interfere with their work; interviews were conducted in English. According to Jamshed (2014),

the duration of an effective semi-structured interview should vary between 30 minutes to more than an hour. The interviews conducted for this study lasted between 45-60 minutes, depending on each participant's pace of responses.

### 3.9 Data management and analysis

Data management and analysis refers to the technique that is used in the reduction and organisation of data, as well as in giving meaning to data (Groove et al., 2015). A narrative method to analyse the collected data was used. During this process, the collected data was read and re-read to obtain a sense of the whole information. A list of data was made available on cards and editing was performed in order to make gathered information retrievable and to discard unmanageable aspects. This process enabled the researcher to familiarise himself with the collected data, summarise the field notes and scrutinise the words of participants. Thereafter, the researcher developed codes into categories to enable understanding of the participants' construction of reality. The final step of analysis was to interpret and represent the data, give an overall description of notes and interpret the data by organising it into manageable categories and themes to present the information in a narrative form. The following questions which were formulated from the objectives were used to collect data:

- What are the factors that influence poor implementation of primary preventive care in primary health care facilities?
- What are the impacts associated with poor implementation of primary preventive care in primary health care facilities?
- What are measures for improving poor implementation of primary preventive care in primary health care facilities?

**Transcribing interviews**

The recorded interviews were transcribed verbatim after completing all the interviews. All expressions such as exclamations, laughter, crying and expletives were included in the text and separated from the verbal text by square brackets.

**Immersion in the data**

Interviews were transcribed and the researcher immediately immersed himself in the data. During this stage, the researcher became familiar with the collected data by reading and rereading the transcripts, reading field notes for recorded experiences, as well as repeatedly listening to audio-tapes.

**Data reduction**

During this step, the researcher reduced the acquired data and tentatively attached meanings to the elements in the data (Groove et al., 2015). Data was reduced by classifying it into main categories based on the words used by participants, then grouped in an orderly manner to prevent misinterpretation and omission of any information. Deductive and inductive approaches were used to group categories and themes in terms of the aims and objectives of the study, available literature and the conceptual framework developed.

**Coding**

Coding refers to the way of indexing or identifying categories in qualitative data (Groove et al., 2015). The collected data was read, breaking the text down into smaller parts and labelling those parts. Hand-written codes were used to classify words and phrases in the data which consisted of the interview transcripts and the researcher's observations' field notes.

**Reflection**

Reflection refers to the researcher discussing his/her position within the study and how personal beliefs and past training may have influenced the research findings (Groove et al., 2015). In this study, the researcher's own preconceived ideas were set aside and focus was placed on the available data to avoid bias.

**Identifying themes**

Themes and sub-themes were developed from the objectives and codes were linked to data. Codes that frequently appeared were grouped to form a theme and then sub-themes.

**Interpretation**

The findings and verified evidence through peer reading were examined. Interpretations were further verified by the supervisor and the co-supervisor for consensus. The researcher explored the significance and meaning of data by contextualizing the findings and linking themes to each other. The findings were generalized by considering implications and suggesting possible future research. A report of the interpretations that emerged from data analysis was compiled.

### 3.10 Ethical consideration

#### Ethical certificate

According to Brink et al., (2017), ethics is a set of rules or standards that regulate people's lives and are used for decision–making. The welfare of participants and moral standards were observed. The study was submitted to the University of Venda research ethics committee and ethical clearance was obtained, Project number (SHS/20/PDC/43/2021)

Approval for conduction of the study was received from the Provincial Research Committee Director, Limpopo DoH, Project number (LP_2020_11_043) and District Executive Manager of Vhembe District and operational managers of the five selected PHC facilities.

#### Recruitment of subjects

Efforts to identify and recruit potential human research subjects should be designed to respect personal rights to privacy and confidentiality (Brink et al., 2017). Everything possible should be done to avoid coercion of subjects in their recruitment for research participation (Brink et al., 2017). The rights of participants were protected.

#### Informed consent

Informed consent refers to an ethical principle that requires a researcher to obtain the voluntary participation of the subjects after fully informing them of the study, including any potential benefits and risks to the participant (Brink et al., 2017). Written informed consent was obtained from participants before conducting the study. Participants were told that participation in the study was voluntary and they had the right to terminate their participation at any stage of the project, despite their initial consent, without any adverse consequences.

#### Voluntary participation

Voluntary participation refers to the decision made by a prospective subject, or participant based on his/her own volition, without being forced or influenced to participate in a study (Groove et al., 2015). Participants have the right to know what the research is about, how it affects them, the risks and benefits of participation and the fact that they have the right to withdraw from participation if they feel like doing so (Brink et al., 2017). Explanation was given to the participants on what the study entitles and the requirements for participation; that it is voluntary thus, participants may decide to stop participation at any time and there would be no penalty for withdrawal. A participant has the right to ask for any data that would have been supplied up to the of point withdrawal.

### Anonymity

Brink et al., (2017) defined anonymity as the act of keeping individuals nameless in relation to their participation in research. During report writing, participants' anonymity was maintained by not mentioning their names rather they will be labelled as A or B. The research interviews were conducted, in privacy, in selected PHC facilities to protect the rights of the participants.

### Confidentiality

Confidentiality refers to the protection and unavailability of participants' information (Brink et al., 2017). Information gathered during the study was protected and made unavailable to anyone other than the researcher; data collected was kept under secure conditions. Participants were protected from physical or psychological harm at all time.

## 3.11 Delimitations of the study

Delimitations refer to those characteristics that restrict certain aspects of the study, such as the population having to be a homogeneous group of subjects or the nature of the approach taken (Brink et al., 2017). The study focused on factors influencing poor implementation of PPC, therefore, secondary and tertiary preventive care was not investigated.

## 3.12 Plans for data dissemination and implementation of the results

Data dissemination refers to the communication of research findings through presentations and publications (Brink et al., 2017). The results of the study would be disseminated through articles in peer-reviewed and accredited journals. The personnel in the Health Department were made aware of the findings to give them an opportunity to come up with strategies to address the problem that had been identified. The researcher did a conference presentation and soft copies of the final thesis were sent to the provincial and the local offices, as well as the University of Venda library.

## 3.13 Conclusions

The study adopted a qualitative design with an exploratory and descriptive approach. A non-probability purposive sampling was used to select registered professional nurses and PHC facilities. Pre-testing was done with two professional nurses from one of Makhado PHC Facility. The researcher used a narrative method to analyse the collected data. Data collection was guided by an interview guide using semi-structured questions. Trustworthiness was ensured through transferability, credibility, dependability and conformability. Approval for conduction of the study was received from the Provincial Research Committee Director,

Limpopo DoH, District Executive Manager of Vhembe District and the operational managers of the five selected PHC facilities.

# CHAPTER 4

## PRESENTATION OF RESULTS AND DISCUSSION OF THE FINDINGS

### 4.1 Introduction

This chapter presents the demographic characteristics of the participants, the findings, discussions and conclusion. The purpose of the study was to determine factors influencing poor implementation of PPC in the PHC facilities of Makhado Municipality, Vhembe District in the Limpopo Province. The study adopted a qualitative design and used an exploratory and descriptive approach. Data were collected from fifteen (15) registered professional nurses working in four (04) selected PHC facilities. The study aimed to achieve the following objectives:

- To explore and describe factors that influence poor implementation of primary preventive care in primary health care facilities.
- To describe the impact of poor implementation of primary preventive care in primary health care facilities
- To determine measures for improving the poor implementation of primary preventive care in primary health care facilities.

### 4.2 Results

The results of the study comprise the demographic profile of the participants and the findings from the interview conducted with 15 registered professional nurses regarding factors influencing poor implementation of PPC in PHC facilities.

#### 4.2.1 Demographic characteristic

Table 4.1 shows the demographic characteristics of the registered professional nurses who participated in the study. Females constituted 87% of the participants and males 13%. In terms of race, 100% participants were blacks/Africans. In terms of age, 47% of the participants were aged between 25-39 years, and those aged from 40 years and above were a total of 53%. In terms of the working experience, 40% of the participant had 2-10 years working experience and 60% had 11 years and above. This is presented in the table below.

**Table 4.1: Demographic profile for participants**

| CHARACTERISTICS | NUMBER OF PARTICIPANTS | IN % |
|---|---|---|
| **GENDER** | | |
| **Male:** | **02** | **13%** |
| **Female:** | **13** | **87%** |
| | | |
| **AGE** | | |
| **25-39:** | **07** | **47%** |
| **40 and above:** | **08** | **53%** |
| | | |
| **ETHNICITY** | | |
| **White:** | **0** | **0%** |
| **Coloured:** | **0** | **0%** |
| **Indian:** | **0** | **0%** |
| **Black:** | **15** | **100%** |
| | | |
| **WORKING EXPERIENCE** | | |
| **From 2 to 10 years** | **06** | **40%** |
| **From 11 years and Above:** | **09** | **60%** |

### 4.2.2. Presentation of findings

The researcher used a narrative method that allows the identification of essential constructs that emerge during data collection. The researcher identified three themes from the answers to the questions developed by the interviewer, from the objectives on factors influencing poor implementation of PPC in PHC facilities. Sub-themes emerged from each theme as shown in Table 4.2.

**Table 4.2: Themes and sub-themes**

| THEMES | SUB-THEMES |
|---|---|
| Factors influencing poor implementation of primary preventive care in primary health care facilities | • Poor allocation of funds for primary preventive care<br>• Prioritization of curative care at the expense of primary preventive care<br>• Shortage of human and material resources versus the implementation of primary preventive care<br>• Negative attitude and beliefs towards primary preventive care |
| Factors associated with the impact of poor implementation of primary preventive care in primary health care facilities | • Increased disease burden<br>• Increased expenditure to the health care department<br>• Increased workload in secondary health care facilities<br>• Absenteeism and burnout among nurses<br>• Low rating on work performance |
| Measures to improve implementation of primary preventive care in primary health care facilities | • Increase budget on preventive care<br>• Provision of accurate health information regarding primary preventive care<br>• Adequate health care personnel in PHC facilities<br>• Good working relationship among nurses, patients and the Department of Health |

#### 4.2.2.1. Theme 1: Factors influencing poor implementation of primary preventive care

From the data collected, majority of participants expressed various factors that influence poor implementation of PPC in PHC facilities of Makhado Municipality. The factors included - poor allocation of funds for PPC, prioritization of curative care at the expense of PPC, shortage of human and material resources versus the implementation of PPC, negative attitude and beliefs towards PPC. These four sub-themes are discussed below:

- **Sub-theme 1: Poor allocation of funds on primary preventive care**

Poor allocation of fund on PPC was identified as a barrier to the implementation of PPC in PHC facilities, by majority of participants. When there are insufficient funds, the implementation of PPC becomes ineffective as resources are needed for the purchasing of

enough diagnostic devices, preventive medications and supplies as well as for the hiring of enough healthcare personnel. The participants expressed that they lack medical devices, medications and personnel that are so much needed for effective implementation of PPC and the participants blamed the DoH for not allocating enough funds to the PHC facilities.

This is supported by excerpts from the participants:

> *"It is very painful working here, there is nothing at this clinic, we do not have speculums and we always have shortage of contraceptives and all the time we ask from the logistics management and pharmacy directors to give us the resources that we need to work with, they always say that there is not enough budget to buy what we are asking for. Its tiring you know!" (P G)*

Another participant said:

> *"The personnel from our district offices always tell us that they do not have sufficient budget to meet all our needs. They usually complain that the budget allocated to us is insufficient, therefore, we will lack some of the things we need including pregnancy test strips, pregnancy supplements and glucometer machines as they won't be able to afford them". (P K)*

Another participant said:

> *"In this facility the biggest problem that we are facing is shortage of blood pressure monitoring machine, pregnancy test strips and glucometers strips. Those are the things that give us challenges because every sick patient must be checked for blood pressure to rule out Hypertension and also we often have to rule out pregnancy in women who are not on birth control before we can help them but without those diagnostic medical devices it becomes difficult for us to make proper diagnoses. This is due to poor allocation of funds to PHC facilities". (P J)*

Another participant said*:*

> *"In our clinic the most challenging thing is shortage of urine test strips because we often need them when women come for Ante-natal visits to exclude Pregnancy Induced Hypertension (PIH) and urinary tract infections but without them it becomes a problem as we are experiencing a lot of maternal complication as we are failing to manage patients accordingly. Even the lack of glucometers strips is still a challenge because every patient is diabetic unless proven otherwise, so this also reduces our morale to work with passion and trust in ourselves due to those shortages". (P E)*

Other participants indicated that shortage of preventive medications is still a major problem which is related to poor allocation of funds. These poor allocations of funds influence poor implementation of PPC in PHC facilities. This is expressed by participants below:

> *"Recently in our clinic we had an increase in the number of PIH patients and I think it is due to the fact that they were not receiving calcium supplement which is known to be important in the prevention of PIH, this definitely shows that implementation of PPC is still poor as we are unable to tackle some dangerous diseases of the patients because of insufficient funds to buy enough medications for all the clinics". (P A)*

Another participant said:

> *"As you know that in Limpopo we experienced a huge shortage of vaccines in the beginning of the year 2021. We experienced a high number of children coming to the clinic for missed doses of vaccinations and this resulted in nurses assisting a high volume of patients each day. Some of the children end up not being vaccinated for certain diseases because they have surpassed the age limit for certain vaccines which then exposes them to diseases". (P D)*

Even though the medical devices and preventive medications are insufficient in PHC facilities, the DoH do supply the PHC facilities with some medications. The findings about prioritization of curative care at the expense of primary preventive care are reported below.

**Sub- theme 2: Prioritization of curative care at expense of primary preventive care**

The research findings show that there is prioritization of curative care over the PPC. This was identified by majority of participants as a contributory factor to the poor implementation of PPC. Participants expressed their views below:

> *"People in our community are more interested in the curative measures than the preventive care; I am saying this because mostly when we advise them to take the condoms from the clinic so that they engage in safe sex they usually refuse saying that they do not want to use the condoms, yet, they later come complaining of sexually-transmitted infections (STIs) including gonorrhoea, syphilis and genital warts which could be prevented by using condoms without any cost. As it stands, this shows that poor implementation of PPC is still a burden to clinics and the community at large (P B)".*

Another participant said:

> *"More curative medications and medical devices are readily available in our facilities and the mere preventive medications and medical devices used in the preventive care are always insufficient; for example, we always have medications for the management of hypertension despite there being no calcium carbonate for pregnant women in anti-natal care. We have only one blood pressure monitoring machine which sometimes does not work properly, this can only mean one thing which is that we are failing to detect hypertension in its early stages when it's still preventable from becoming a complicated condition but we have medications that are to be used in a complicated hypertension. Where are we really going as a Department if this is what we do to the patients?" (P A)*

This is supported by another participant who said:

> *"Here in this facility in each shift we mostly have only two professional nurses and it becomes impossible for us to conduct health care campaigns and this disadvantages the community and us as nurses. Without health information given out to the community at large we are failing to properly implement our sole goal which is to provide quality PPC. This only shows that preventive care is not prioritised to the top standard of care". (P C)*

Majority of participants agreed that preventive care is very important and it is high time that the DoH together with the population of South Africa as a whole prioritize PPC more than the curative care. Findings about shortage of human and material resources versus the implementation of primary preventive care are reported below:

**Sub-theme 3: Shortage of human and material resources versus the implementation of primary preventive care**

Shortage of human and material resources was identified as a factor that is facilitating poor implementation of PPC. Majority of participants stressed the fact that the shortage of the healthcare personnel and the lack of medical devices and medications used in the implementation of PPC hinders them from effectively implementing PPC in their respective PHC facilities.

A participant said:

> *"Here in this facility in each shift we mostly have only two registered professional nurses, sometimes if one happens to be sick it will be only one registered professional*

*nurse per shift. This is a huge shortage of staff which influences poor implementation of PPC since many activities are not well implemented, such as giving health education to patients, conducting of campaigns and rendering of quality health care". (P O)*

Another participant said:

*"To tell you the truth, the number of patients that we see each day makes it impossible for us to do our best in the implementation of PPC in our facility. Instead of creating campaigns and screening patients for medical conditions we will be busy working as fast as we can to try and help all the patients in time." (P I)*

One participant however who said:

*Despite the fact that some clinics have poor staffing, in our clinic we have enough staff members because per shift it is three registered professional nurses, every day in the morning we manage to give health education to our patients. We are even able to in-service each other, once per week for provision of quality health care (P D)".*

Material resources shortages have been a major challenge to many PHC facilities of Makhado Municipality. The lack of these materials is facilitating poor implementation of PPC in PHC facilities as some of the medical devices for diagnostics are still insufficient. This is expressed by majority of participants below:

*"There are not enough materials to work with, we are in short of green needles, and the blood pressure monitoring machine is old and sometimes I do not even trust its readings". (P N)*

Another participant adds:

*"We have challenges of materials in our clinic, some we do have and we turn to use them but as often as we use them, they lose quality. Some we use and discard like speculums, needles, gloves, bandages and many more. The problem is that ones they are finished it takes time for the deliverance of that equipment which takes us back to providing patients with poor PPC".*

Some of the PHC facilities in Makhado Municipality have enough staff members which enable them to provide health education to patients and also have a fair workload. However, most PHC facilities have a shortage of staff members which is influencing poor implementation of PPC in PHC facilities. It makes it difficult for nurses to perform some activities, such as giving health educations and in-service training of staff members. Material resource is also identified as a huge problem which is causing late diagnoses of diseases and mismanagement of

patients. Findings about negative attitude and beliefs towards primary preventive care are reported below:

- **Sub-theme 4: Negative attitude and beliefs towards primary preventive care**

Majority of the participants reported that negative attitude and beliefs towards PPC also contribute greatly to the poor implementation of PPC in the PHC facilities. The participants claimed that the patients display a negative attitude towards PPC and this defeats their efforts in convincing them to practice preventive measures. The research findings also show that some registered professional nurses allow their negative attitude and beliefs against PPC to stop them from performing their duties as outlined in the scope of practice.

This is supported by one participant who said:

> *"There are patients who are displaying a very bad attitude towards vaccine against the covid-19; this is defeating the effort of the DoH in trying to slow down the spread of the corona virus." (P M)*

Another participant said:

> *"I remember the other day this patient who is a chronic patient and we had to take blood for better understanding and diagnoses of his problems but the patient refused for blood to be taken, which left us with no choice but to proceed assisting the patient because there is nothing else we could do without those blood results. The patient even signed refusal of treatment form reporting that his religion forbids removal of tissues from their bodies". (P I)*

This is supported by another participant who said:

> *"A few patients have bad attitude towards preventive care from our clinic because they adhere to health education we give. Some patient once told us that contraceptives are not important as the bible says they have to give birth to many children as they can to fill the world. We have many women who have complicated pregnancies and deliveries because they are having many children without even spacing the birth of their children." (P B)*

Another participant said:

> *"There are some nurses who facilitate the poor implementation of PPC, because they take their beliefs to work and they somehow discourage the patients to practice some preventive care as they believe that certain preventive are unnecessary or useless like telling patients who want to terminate pregnancy that is not good thing to do as God*

*does not like. These nurses have forgotten that their scope of practice is to give health education to the patient and allow the patient to take a decision." (P D)*

Another participant said:

*"To tell you the truth, there are some nurses who are so rude to the patients and they cause the patients to not come to the clinic for preventive care. Some nurses get mad at young girls who are below the age of 18 who come for contraceptives; they scold them and call them names, so this really makes them to stop coming to the clinic for contraceptives and we end up having more teenage pregnancies." (P G)*

This is supported by another participant who said:

*"I still remember this other nurse that I work with telling a patient from a foreign country that she must stop bringing her child to the clinic for immunization, she must go to her own country. This is not good because this woman is currently living here and she is entitled to receive health care. So you see that this will also make patients from the foreign countries who are currently living here to stop attending for their children's immunizations, anti-natal care and other minor diseases they might be suffering. This also put other community people in danger of some infections that could have been prevented (P C)."*

Majority of the participants reported that there is poor allocation of funds, prioritization of curative care over PPC, and that there is a huge shortage of human and material resources thus hindering the effective implementation of PPC in PHC facilities. Majority of the participants also expressed that patients have negative attitude and beliefs towards PPC.

#### 4.2.2.2. Theme 2: Factors associated with the impact of poor implementation of primary preventive care in primary health care facilities

The research findings revealed the factors associated with poor implementation of PPC, namely, increased disease burden, increased expenditure for the health care department, increased workload in secondary-health care facilities, absenteeism and burnout as well as low work performance.

- **Sub-theme 1: Increased disease burden**

Poor implementation of PPC in the PHC facilities increases the disease burden in the healthcare facilities, and this puts a lot of strain on the DoH because when the disease burden is high it means the DoH must utilize a lot of funds in order to help those who are sick. The

disease burden also increases the workload in the PHC and hospitals facilities, since a lot of individuals will be sick.

This is supported by a participant who said:

> *"When we fail to implement preventive care, we fail the whole DoH, as well as the whole population of our country, because the impact of poor implementation of preventive care is detrimental to the health status of the entire South African population, and it adds more pressure to the DoH and its employees. All this causes increase in workload of nurses which also leads to increase in disease burden". (P D)*

Another participant also said:

> *"The number of patients who are on anti-retroviral treatment for HIV are too much, it is shocking really. This can only mean one thing, which is that people are not practicing safe sex. They are not using condoms and really this is putting a strain on the DoH". (P E)*

Another participant said:

> *"It was announced that to curb the spread of Coronavirus (COVID-19), people must avoid overcrowded places but people are still going to gatherings with many people not wearing masks which further increases their risk of contracting corona virus. People are ignorant when it comes to the preventive measures". (P L)*

One other participant said:

> *"If people were so positive about the preventive care measures, not only in relation to COVID-19 but all infections we would by now have significantly reduced the rate of the corona virus infection in our country, however people are not adhering to the preventive measures, thus causing a rapid rise in the COVID-19 infections and disease burden". (P N)*

Increased disease burden is influenced by poor implementation of PPC in the PHC facilities. The DoH, healthcare personnel as well as the population at large is responsible for the implementation of PPC in the PHC facilities. Study findings about increased workload in secondary health care facilities are reported below:

**Sub-theme 2: Increased workload in secondary health care facilities**

Majority of the participants complained that poor implementation of PPC in the PHC facilities increases the workload in the hospitals as they had to admit more sick patients, thus, the workload of the nurses at the hospitals increases too.

This is supported by another participant who said that:

> *"There are pregnant women who come to the clinic for booking at a very late stage of pregnancy and this means that these women were not receiving important supplements that are given to all pregnant women for the prevention of pregnancy induced conditions such as PIH as well as foetal conditions such as birth defects. All these women who present late to the clinic are referred to the hospital to attend high-risk clinics. This means that the more these women are referred to the hospitals, the more the workload for the healthcare professionals working in these hospitals". (P D)*

Another participant also said:

> *"Sometimes it is not about patients refusing to practice preventive care measure but they are being failed by the DoH as they are not supplying us with enough preventive medical devices and preventive medications, so the Department must sometimes take responsibility for the rise in disease burden and teenage pregnancies. Imagine sending patient to hospital for dressing of wounds because we do not have betadine solution and normal saline or bandages, we always have frequent stock shortages of bandages, there is nothing we can do in this situation" (P I)*

PHC facilities' packages mainly consist of the preventive care services, which are aimed at reducing the disease burden. If there is poor implementation of preventive services in the PHC facilities, it means most people will become sick and require hospitalization which then increases the workload of the secondary health facilities' personnel. Findings about increased expenditure to the health care department will be reported below:

- **Sub-theme 3: Increased expenditure to the DoH**

Majority of participants reported that poor implementation of PPC in the PHC facilities result in the DoH spending more funds as many people will be sick and needing curative medical help which is expensive.

This is supported by the following comment:

> *"There is a saying that says: prevention is better than cure; but people wait to get sick and come for consultation while they could have prevented the condition from occurring. This makes the government has to spend a lot of money in purchasing chronic treatments". (P A)*

Another participant said:

> *"The hospital beds are full and most of the patients lying on those hospital beds are suffering from preventable medical conditions, now the hospitals are using a lot of money to purchase medical treatments to care for those patients". (P H)*

Prevention is better than cure; the more patients adhere to prevention the less DoH would spend on curative care measures. The research findings about absenteeism and burnout are presented below.

- **Sub-theme 4: Absenteeism and burnout**

Absenteeism and burnout are also influenced by poor implementation of PPC in the PHC facilities. The participants reported that working without enough diagnostic devices, preventive medication and supplies put them under a great deal of stress which then causes an increase in absenteeism and burnout.

This is a statement from a participant who said:

> *"To tell you the truth, it is very scary to help a patient with the COVID-19 symptoms without the full protective gear. We have been working and attending to patients with those symptoms without the N95 mask, this causes us a lot of stress and sometimes we just absent ourselves from work because it is scary; we are humans too. Working without all the necessary tools to help the patients in totality really frustrates me, and this is one of the factors that contribute to nurses absenting themselves from work". (P H)*

This is further supported by another participant who said:

> *"If the government is failing to properly implement PPC for its workers, what more about the patients? I refuse to attend to the patient without protecting myself, and yes sometimes I end up not coming to work knowing that if I come I will be at risk because I will be forced to work without proper PPE". (P D)*

Another participant also said that:

> *"In our facility, nurses force themselves to come to work even when they know that they are extremely tired. They end up mismanaging patients which lead to poor quality health care for the patients". (P F)*

The absenteeism rate in most PHC facilities is high and this is attributed to the poor implementation of PPC as reported by the participants. When nurses are frequently absent there is a shortage of staff which again affects implementation of PPC. Research findings about low rating on work performance is reported below:

- **Sub-theme 5: Low rating of work performance**

The findings of this study revealed that shortage of medical equipment such as diagnostic devices and the lack of medications and supplies used in the preventive care makes it difficult for registered professional nurses to perform their duties in the best way they know. This causes them to score less when their performances are rated by their supervisors.

A participant had this to say:

> *"I don't like it when I'm given a low rating on something that wasn't my fault. If the DoH is failing to give us vaccines, why should I get a low rating because there is no way I would have reached my vaccination target as there were no vaccines? It makes no sense at all (P B)."*

Another participant added:

> *"We are under-performing in most areas that involve preventive care services because sometimes it takes weeks to months without r devices or supplies used in preventive care, as well as medications used for prevention. This makes our supervisors to under-rate us on work performance because we are not reaching the target" (P A)*

Nurses know their scope of practice and what is expected of them, however, insufficient medical devices and staff members prevent them from reaching their standard of practice as they turn to perform some other person's duties which influence poor implementation of PPC. Findings about the measures to improve poor implementation of primary preventive care in primary health care facilities will be reported below.

#### 4.2.2.3 Theme 3: Measures to improve poor implementation of primary preventive care in primary health care facilities

The research findings identified measures to improve poor implementation of PPC in PHC facilities, namely, increased budget on preventive care, provision of accurate health information regarding primary preventive care, adequate health care personnel in PHC facilities and good working relationship between nurses, patients and the Department of Health.

- **Sub-theme 1: Increase budget on preventive care**

Majority of participants revealed that the DoH allocates insufficient funds to the PHC facilities and this causes the poor implementation of preventive care, therefore, an increase in funds allocated to the PHC facilities will help towards achieving effective implementation of PPC in PHC facilities.

Another participant from Makhado Municipality said:

> *"Just by allocating enough funds to the PHC facilities, a lot can be achieved. We will be able to purchase the resources, such as glucometer machine, speculums, urine test stripes and many more needed towards the implementation of PPC in our PHC facilities" (P F)*

This is also supported by another participant:

> *"I don't know if our human resource personnel misuse our budget or there is just not enough budget that is allocated to us by the DoH, but if we have enough funds that can cover a lot of things that we are lacking in our facility, I believe we will achieve our goal as PHC facilities which is rendering preventive care to the community members". (P D)*

- **Sub-theme 2: Provision of accurate health information regarding primary prevention care**

The research findings revealed that provision of accurate and adequate information regarding PPC will make people aware of preventive care measures available to prevent the rise in disease burden.

This is supported by a participant who said:

> *"Support by the DoH is lacking; I believe that if the DoH supports us they would know what we need to achieve the implementation of PPC in our PHC facilities. When we*

*propose that we want to conduct, for instance, cancer screening campaigns they must make sure they try by all means to provide us with cancer screening tools". (P L)*

Another participant said:

*"The DoH must hire enough nursing personnel so that we will be able to give health education and conduct healthcare awareness campaigns, because we fail to do this as we are very few and helping a lot of patients". (P G)*

This is supported by another participant:

*"Throughout the years that I have been working as a primary healthcare nurse, I have learned that people learn more about health information during health awareness campaigns". (P C)*

- **Sub-theme 3: Adequate health care personnel in PHC facilities**

During data collection majority of participants revealed that enough personnel in the PHC facilities will contribute towards effective implementation of PPC in the PHC facilities.

A participant said:

*"Let me just say this in simple terms, without enough staff in the clinics we will never be able to give total healthcare services to the patients and we cannot prioritise patients who came for contraceptives and neglect those who are sick. We won't achieve proper implementation of PPC if nurses are not enough to cater for the large volumes of patients in our facilities (P H)".*

This is supported by another participant who said:

*"The Department must make sure that all clinics have HIV counsellors, clerks and nurses, because, sometimes we fail to render some preventive care services effectively as there will be just the two of us". (P E)*

- **Sub-theme 4: Good working relationship between nurses, patients and the Department of health**

The findings of the study suggested that a good working relationship among the nurses, patients and the DoH will facilitate an effective implementation of PPC in the PHC facilities.

This is expressed a participant who said:

> *"If the DoH can start to have good relationship with the nurses in the PHC facilities, I believe that we could come up with solutions to most of our problems. Because if the DoH do frequent support visits, they would know what we need. Some nurses get frustrated that the health personnel at the district and provincial levels do not regularly visit the facilities but are always demanding quality patient care while we need many missing equipment to achieve that". (P F)*

Another participant said:

> *"I believe in the spirit of Ubuntu, which is why I have a good relationship with my patients, it becomes easy for me to convince my patients to do certain health screening and they understand me better when I give them health education". (P K)*

### 4.3 Discussion of the findings

#### 4.3.1 Theme 1: factors that influence poor implementation of primary preventive care

There are many factors that are causing poor implementation of PPC in PHC facilities, which lead to poor health care amongst the communities. The challenges identified during data collection are mainly preventable if proper measures are taken by the Health Department, healthcare personnel and the public, at large to overcome the problem.

The study cited similar findings which indicate that PPC can be effective in disease prevention, but to be effective it must be implemented. It is known that the provision of PPC in PHC falls below the recommended levels (Gowin, Dytfeld, Michalak & Sikorska, 2012). There are many barriers in the implementation of PPC, and these can be identified at all levels of primary care system - patients, medical staff, and organization of healthcare (Gowin, et al., 2012).

Poor allocation of funds is one of the factors influencing poor implementation of PPC in PHC facilities as is discussed below.

- **Sub-theme 1: Poor allocation of funds for primary preventive care**

PHC facilities are allocated insufficient funds to meet all the demands of the PHC facilities. This poor allocation of funds to the PHC facilities is a contributory factor to the insufficient diagnostic medical devices including speculum, glucometer machine, pregnancy test strips. There are also insufficient preventive medications including vaccines, folic acid, calcium, ferrous sulphate and contraceptives as well as the lack of healthcare awareness in the PHC facilities.

A similar study conducted in the USA by Rubio-Valera et al., (2015) also found that the available resources including funding can be both common barriers and facilitators of the implementation of PPC in PHC system. They further state that poor allocation of funds in general, insufficient equipment and supplies are also influencing poor implementation of PPC in PHC facilities.

A report from Limpopo DoH budget speech of 2015 indicated that the Limpopo Provincial Health Department has the lowest expenditure per capita on PHC in South Africa. Worryingly, between the 2015/16 and the 2016/17 financial years, this even spend dropped by 3, 8 %. It was particularly low in Mopani, Vhembe and Capricorn Districts (Vhembe District Health Plan 2018).

Most PHC facilities still complain of lack of diagnostic medical devices and supplies, and this lead to poor implementation of PPC because without these diagnostic devices and supplies nurses in the PHC facilities are not able to diagnose patients properly, leading to mismanagement of patients which can also result in legal actions being taken against the nurses.

The poor allocation of funds in the PHC facilities result in lack of primary preventive medications as the budget allocated is not enough for the purchasing of sufficient preventive medications such as contraceptives (pills and injections), vaccines and pregnancy supplements (folate, ferrous and calcium) which are very important in PPC. The contraceptives are important in reducing unwanted and teenage pregnancies; vaccines help children from birth to 12 years of age by preventing them from communicable diseases such as TB, measles, pneumonia, polio and Human Papilloma Virus (HPV). Pregnancy supplements are also essential for antenatal women as they help in preventing babies being born with deformities, as well as prevent anaemia, and PIH.

Conducting healthcare-awareness programmes assist in spreading health education to people about the importance of implementing preventive care. The study results showed that healthcare-awareness programmes, including cancer and immunization campaigns are not conducted properly since the DoH does not help financial-wise to carry out these campaigns. The study also revealed that the DoH only pay attention to some health-awareness programmes, such as for HIV, TB and cancer and ignore others, such as vaccination awareness and many others.

According to the health calendar in South Africa, from 12th of February to the 16th it is STI, condom and pregnancy awareness week; 22 February is the healthy lifestyle awareness day, 24-30th of April is vaccination awareness week, however, these health awareness programmes are not implemented (Sabbath et al., 2018).

From January to April 2021 there was a huge shortage of vaccines in the whole province of Limpopo, but according to the healthcare calendar from 24-30th of April is vaccination awareness week. This means that for the year 2021 the vaccination awareness week was not observed because there was shortage of vaccines for the programe to take place (Sabbath et al., 2018).

Healthcare awareness programmes play a pivotal role in the implementation of PPC, however; most PHC facilities are still facing a huge challenge to conduct different awareness programmes and this causes an increase of disease burden, while also causing frustrations and evoking complaints from healthcare providers.

- **Sub-theme 2: Prioritization of curative care at the expense of primary preventive care**

There is a lot more curative care in PHC facilities than the preventive care; this means that the community and the DoH have overlook preventive measures and has focused more on curative care. People engage in risky health behaviours, such as practicing unprotected sex, eating unhealthy food knowing that there are curative measures readily available to tackle their health issues.

A similar study from United State of America found that the average expenditure on public health and prevention in 2016 was just over 3% of public spending whereas the average spent on curative care was 57%, despite the benefits of preventative care (OECD USA, 2016), This is similar to what is happening in Vhembe PHC facilities which had the lowest expenditure in the preventive care budget in the year 2017 (Moyimane et al., 2017). Most people in developing countries consider curative care to be more relevant. The push for curative medical devices and curative care leaves much needed preventative care devices underdeveloped suppressing innovation and lowering both implementations of PPC and the quality of life for all patients in PHC facilities (OECD USA, 2016). This is similar to the findings of this study that confirmed that there are more curative medications and devices available in the PHC facilities than the preventive medications and devices used in the preventive care.

Preventive measures are always better than curative measures because they are cost-effective, however, the community at large still prefers curative than preventive measures. The Limpopo DoH also prioritizes curative care, as less budget is allocated on preventive care, which then results in the poor provision for preventive medications and devices in PHC facilities. This indicates that poor implementation of PPC is still a huge problem in the Limpopo DoH and needs to be tackled.

The more the DoH put its focus on the curative care, the more the shortages of material resources that are used in the implementation of preventive care; this influences poor implementation of PPC in the PHC facilities. It is widely known that nurses tend to migrate to well-resourced health facilities, therefore shortage of staff increases in health facilities that have shortage of material resources and this also leads to the poor implementation of PPC in the PHC facilities. Shortages of human and material resources versus the implementation of PPC are discussed below:

- **Sub-theme 3: Shortage of human and material resources versus the implementation of primary preventive care**

Human and material resources play a major role in the effective implementation of PPC in the PHC facilities, therefore; without sufficient human and material resources, PPC is poorly implemented. The shortage of human and material resources versus the implementation of primary preventive care was divided into two and they are fully discussed below.

  - **Shortage of material resources versus the implementation of primary preventive care**

The PHC facilities are the cornerstone of the health care system because they are there to minimize costs by preventing diseases before they become complicated and require more invasive medical measures that are expensive; therefore, the shortage of material resources such as the diagnostic devices, preventive medications and supplies are hindering efforts in implementing PPC effectively.

A study conducted in Canada by White, (2015) reported similar findings that indicated that in most Canadian health care facilities, the Health Department still supply insufficient material resources that are used in the implementation of PPC. This results in the country still undergoing poorly-implemented preventive care services and this has led to an increased disease burden in the Canadian country.

The health care facilities that have more material resources also attracts more human resources, as it is widely known that one of the main causes of migration of nurses from one country to the other is shortage of material resources. The shortage of material resources could contribute greatly to the shortage of the nursing personnel and this affects the implementation of PPC in the PHC facilities. How shortage of human resources impact the implementation of PPC is discussed below.

- **Shortage of human resources versus the implementation of primary preventive care**

PHC facilities are often managed and run by nursing personnel only without the help of the medical doctors; this means that nurses have many responsibilities and this adds to their workload. Shortage of clerks, HIV/AIDS councillors, cleaners and other general workers in most of the PHC facilities was reported; this also means that nurses are forced to perform non-nursing duties and an increase in their workload may mean that they may under-perform in some of their duties. Nurses are working with an increased workload and they are more likely to focus on clearing the long queues in the facility than giving health education to the patients and this means that there will be poor implementation of PPC.

A few community health centres in Limpopo Province are allocated doctors and this has proved to greatly decrease the nursing workload as the doctor allocated helps them with some of the patients. This shows that if the PHC facilities are allocated a doctor the workload will significantly become lower (Massyn et al., 2015).

A similar study also found that shortages of nurses and other healthcare personnel in PHC facilities, particularly, acute in most rural areas, are pervasive in both low- and middle-income countries, thus, although 45% of the world's population lives in rural areas, only few healthcare personnel practice there. This limits the potential of health promotion and preventive care strategy in addressing the challenge of poor implementation of PPC in the PHC facilities (Kruk, Nigenda & Knaul, 2015).

A similar study also found t that shortage of staff contributed about 78% to long waiting periods for patients and it caused complaints and mistrust of nurses leading to poor implementation of PPC in PHC facilities (Burger & Christian, 2018).

This current study found that staffing was inadequate in PHC facilities and the poor quality of physical infrastructure has a major impact on the implementation of PPC services and client satisfaction with services. Most nurses in the PHC facilities are needed for proper and quality rendering of patient care and prevention of diseases. Shortage of staff is causing a rise in diseases burden because patients are being mismanaged as nurses performs many duties which are not in their scope and it leads to exhaustion. This clearly indicates that there is still poor implementation of PPC in PHC facilities.

Contrary to this study's findings, the Vhembe District in 2013-2015, however, recorded a workload that was lower than the national average. The clinical workload for PHC registered professional nurses – representing the average number of clients seen per a professional nurse in a clinical work-day - has been fairly stable in Vhembe from 2010-2015. In 2013,

nurses covered 22.1 clients, which is lower than both the national average of 29.7 and the provincial average of 24.1 clients. It should be noted that the numbers of clients seen by community health workers are not included in these figures (Massyn, 2015).

The Vhembe District has been struggling with shortages of nursing and medical staff for a few years. The ideal situation of all clinics being visited by a doctor at least once a week was not met in most districts, especially, those in rural settings. In 2013, Limpopo as a whole had the highest public sector vacancy rate in the country at 86% (Massyn, 2015).

There are people who still do not have faith in the effectiveness of the modern medical care services and they usually have negative attitude towards PPC services offered in the PHC facilities. Negative attitude and beliefs towards PPC are discussed below:

- **Sub-theme 4: Negative attitude and beliefs towards primary preventive care**

The findings of the study revealed that some nurses and patients have a negative attitude towards preventive care, and they both also have beliefs that do not support the use of PPC.

  - **Nurses' negative attitude and beliefs towards primary preventive care**

Everyone in SA has the right to have religious beliefs, however, the beliefs that nurses have must not affect their nursing duties because every nurse pledged to give total care and to put their patients as their first priority. Nurses must perform all their nursing duties as outlined in their scope of practice, therefore, their beliefs must not be used as an excuse not to render preventive care to the patients, as by doing so is also violating the right of the patients who are seeking PPC, as it is their right to be given total health care services without being judged.

The similar study by Rubio-Valera et al., (2017) of the ecological model framework reported that attitudes and beliefs are important in relation to the implementation of PPC and can be both a barrier and a facilitator of PPC. The authors also reported that lack of motivation and low awareness of the intervention can impede the implementation of PPC in PHC facilities.

This study findings also revealed that some nurses display negative attitudes towards the patients who are coming to the PHC facility for preventive care services. This behaviour makes patients feel too uncomfortable to visit health facilities for preventive care which increases the number of preventable diseases. The attitude of nurses towards patients does not affect patients only but the entire Health Department is affected because when patients fail to seek preventive care from healthcare personnel there will be an increase in disease burden, which indicates poor implementation of PPC.

- **Patients' negative attitude and beliefs towards primary preventive care**

Some patients display negative attitude and beliefs towards the PPC and this hinders the efforts of the DoH in achieving the goal of preventing diseases so as to lower the disease burden. The widely known contributory factors to patients' negative attitude and beliefs are cultural values as well as the negative attitude that nurses display towards these patients.
A similar study conducted in South Africa by Ndlovu et al., (2017) found that most patients are reluctant to seek preventive care services in the PHC facilities because of the negative attitude of the nurses towards them and this results in poor implementation of PPC leading to a rise in disease burden.

Burger and Christian (2018) also reported findings that are similar to the findings of this study; these revealed that 38% of patients bypass their closest PHC facilities reporting that nurses are rude and uncaring.

The cultural diversity in South Africa comes with variety of cultural beliefs and values which may also mean that patients will have a lot of different views and opinions about the preventive care; some South African people still have little faith in the modern medical care, thus, they do not value the PPC; most still believe in the traditional African medicine.

### 4.3.2 Theme 2: The impact associated with poor implementation of primary preventive care

The study findings revealed that the poor implementation of PPC in the PHC facilities has many negative impact, further putting pressure on the DoH. The more PHC facilities fail to implement PPC the more the increase in disease burden, increase in workload in the secondary healthcare facilities, increase in expenditure of the DoH, increase in absenteeism and burnout, as well as low rating on nurses' work performance.

- **Sub-theme 1: Increased disease burden**

Most NCDs and CDs are preventable but the statistics shows a rapid rise in these conditions daily putting the healthcare system under enormous pressure. The rise in these preventable conditions is found to be caused by the poor implementation of PPC in the PHC facilities. Major conditions, including COVID-19 and the rules and regulations against the spread COVID-19 are clear and simple to adhere to, however, most people are not taking precautionary measures, some are attending big gatherings even when is prohibited; some do not wear masks in public, which is dangerous to the community and all citizens of South Africa. This type of behaviour is causing many deaths and an increase in diseases burden.

There is provision of condoms and health education for people, despite that some people are still practicing unprotected sexual intercourse and this results in many citizens suffering from HIV and other STIs which simply indicate that poor implementation of PPC is still a major problem.

A study conducted in the Vhembe District by Massyn et al., (2015) also found that NCDs (cardiovascular diseases, cancer, diabetes and many others) and CDs (HIV, TB, measles, hepatitis, influenza, malaria, and many others) are the leading cause of death in South Africa but these conditions are preventable; this situation can then be associated with poor implementation of PPC in the PHC facilities, thus leading to many people suffering from these preventable conditions.

Prioritization of preventive care result in an on-going control of common diseases, reduction in transmissions, mortality rate, morbidity rate and human suffering and gradually eliminating these diseases so that they cease to be a public health problem. People, however, are still reluctant to adhere to preventive care measures. The measures that are used in prevention are mostly simple and more cost-effective than measures towards the management of already existing medical conditions.

- **Sub-theme 2: Increased workload in secondary health care facilities**

PHC facilities were implemented to ease pressure on secondary healthcare facilities by rendering services for - all minor conditions, stabilizing of all sick patients requiring urgent referral to hospital, handling normal deliveries and caring for all chronic patients by giving them their medications and reviewing them. Most patients, however, do not value preventive care, hence, most of them come to the PHC facilities when they are already sick as they would have neglected practicing preventive measures, including late booking for pregnant women. They, thus, present to the PHC facilities with complicated medical conditions that require referral to the secondary health care facilities which is perceived to increase workload in these secondary facilities.

Some referrals are made because PHC facilities do not have enough resources for detections and preventions of diseases; some are referred because of shortage of resource such as blood pressure monitoring machines and this is perceived as a cause of increased workload in the secondary healthcare facilities.

Another similar study found that PHC facilities are dependent on an integrated referral system to facilitate continuous care, however, due to the shortage of some medical equipment, supplies and medications used in preventive care, nurses in the PHC facilities are referring more patients to the secondary health care facilities which is a problem as it is adding more

workload to healthcare personnel in the secondary health care facilities (Visagie & Schneider, 2014).

Massyn et al., 2015 conducted a research in the Vhembe District that confirmed that the workload in the secondary health facilities is very high and this was attributed to the poor implementation of PPC in the PHC facilities.

The assumption that the poor implementation of PPC in the PHC facilities is adding more workload in the secondary health facilities is clearly a true reflection of what is happening in the Vhembe secondary healthcare facilities.

- **Sub-theme 3: Increased expenditure to the health care department**

Prevention is the other quality and effective strategy to reduce the expenditure in the DoH and the government as well. Prevention is more cost-effective than curative care because in preventive care only a few resources are required to prevent certain conditions, for example, condoms are cheaper than the Anti-Retroviral Treatment (ART). This means that people's failure to adhere to prevention means the more they get sick; this causes the DoH to purchase more equipment and medications, an indication that there is poor implementation of PPC in PHC facilities.

The study conducted in the USA by the OECD, 2016 reported findings that are similar to the findings of this study - that the health care department is experiencing financial strains due to challenges that can be prevented with few costs. Provision of resources that are required for preventive care services to PHC facilities can quickly assist in preventing diseases, than waiting to treat complicated diseases as treating is more expensive, as compared to preventing.

The DoH is spending a lot in purchasing material resources for curative care, which is more expensive. When the cost rises, it indicates a rise in disease burden and this also shows a poor implementation of PPC.

- **Sub-theme 5: Absenteeism and burnout**

Poor implementation of PPC in the PHC facilities influences absenteeism from work by the nurses as well as stress, resulting in burnout. Nurses tend to absent themselves from work when there are no proper medical resources needed for the protection of nurses from cross infections. This was observed mostly in the beginning of the Covid-19 infections in South Africa as nurses did not have PPE for the protection of themselves from becoming infected by the corona virus when helping patients.

Swerissen, Duckett and Wright (2016) of Australia reported similar findings that indicated that working in a poorly-functioning health care facility increases work-related stress which result in burnout. The authors continued that working in a healthcare facility that does not have sufficient materials to work with also contributes greatly to increasing absenteeism.

Nurses work in a high-pressure environment as they deal with different patients with different medical problems, therefore, the poor implementation of PPC in the PHC facilities results in burnout as most of the factors that cause poor implementation of PPC in PHC facilities also result in increased workload and stress in nurses.

- **Sub-theme 6: Low rating on work performance**

Nurses, like any other professionals are rated frequently to check their work performance and a low rating means that the person is performing poorly and is not reaching their stipulated target on work performance. When the PHC facility is performing poorly on the implementation of PPC, it means that even the nurses who are working there will have a low rating on PPC target.

A Limpopo study conducted by Moyimane et al., (2017) reported similar findings that the healthcare providers are expected to perform quality work and to provide quality health care to the patients. They are rated quarterly to assess their performance, therefore, the barriers that facilitate poor work performance also cause them to receive poor rating from their supervisors.

Registered professional nurses work hard and put all effort into rendering quality patient care, however, because of shortage of equipment and supplies they receive low rating as they are unable to conduct some services such as awareness campaigns due to lacking proper equipment to carry out the programme. It is clear that a rise in diseases burden results in low rating of nurses, which in turn reduces their morale in rendering quality patient care.

### 4.3.3 Theme 3: Measures to improve poor implementation of primary preventive care

- **Sub-theme 1: Increase budget on preventive care**

Insufficient budget is a major problem in the DoH and if this problem is addressed, there would be an increase in the budget so that there is enough funds to utilize in the implementation of PPC in the PHC facilities. Even though the preventive care services are not costly, they still require funds so that resources that are required in the preventive care services can be purchased.

A similar study by Erika et al., (2018) indicated that despite evidence that primary prevention can save money and improve health, uptake and implementation of such services is relatively low. Increased budget to PHC facilities can promote the implementation of PPC and reduce the burden of disease in South African citizens.

Another study by Rubio-Valera et al., (2017) revealed that in the ecological model framework the way government allocates funding, and investment decisions made by local health authorities may hamper the implementation of PPC guidelines and new rules. Adequate funding in PHC facilities improves the implementation of the PHC system and reduces the incidence of high rate of disease burden, CDs and NCDs.

To achieve better and effective implementation of PPC, more funding to PHC facilities is the solution to reduce the diseases burden as more resource will be made available and ready for the provision of quality patient care. The DoH, unfortunately, is overlooking PPC when it comes to allocation of enough funds, as there is still a huge shortage of resource and equipment, leading to poor implementation of PPC.

- **Sub-theme 2: Provision of accurate health information regarding primary prevention care**

Health awareness campaigns and health education sessions are very crucial in the provision of health information to the community at large regarding the urgency of implementing PPC. Most PHC facilities are unable to conduct healthcare campaigns because of shortages of equipment, supplies, and medications as well as shortage of the nursing personnel. The government, therefore, must provide enough equipment, supplies, medication and hire enough nursing personnel so that PPC can be implemented through the provision of preventive care health information to community members.

There are health care awareness programmes that are not implemented accordingly by the DoH in the PHC facilities. Some awareness programmes that are not fairly implemented include, those on TB, vaccinations, HIV and cancer due to shortage of equipment and medical supplies.

Health care awareness campaigns are very effective when it comes to distribution of health information, towards the implementation of PPC in PHC facilities. Community members are easily convinced if a certain health screening is done by many people during campaigns than when the nurses try to convince them as individuals in their consulting rooms. The health information provided to patients will reduce poor implementation of PPC in PHC facilities as many will be aware of the urgency of PPC and they will be taking care of their health.

A memo issued in the first quarter of the year 2021 by the DoH Limpopo reported a provincial shortage of vaccines for children; this made it impossible for the nurses to commemorate the vaccination week (April 24-30). This is also supported by the health calendar of south Africa that indicates that from the 24-30$^{th}$ of April, it is South Africa's vaccination week (Health Awareness Calendar, 2019)

The health care awareness programmes are essential in the provision of health information to the population. Adequate provision of health information has been proven to effectively reduce the disease burden.

- **Sub-theme 3: Adequate health care personnel in PHC facilities**

Shortage of healthcare personnel in PHC facilities is one of the major problems that influence poor implementation of PPC. Shortage of nursing personnel and the unavailability of other allied healthcare personnel, such as HIV/AIDS counsellors and clerks add to the already existing abnormal workload which usually results in other spheres of the PPC services being neglected. Nurses are working under pressure because if they do not have enough staff, they are more likely to neglect the preventive care services and attend to patients who are sick and need urgent attention. Increasing nursing personnel and filling the vacant posts of clerks and counsellors in the PHC facilities would ease the workload and the facilities would have enough staff who can be delegated to the preventive care services; then those allocated to deal with preventive care services will be able to effectively ensure proper implementation of PPC in the PHC facilities.

A similar study by Klurk et al., (2015) discovered that shortage of staff has cost many nurses their job as they were faced with law-suits for mismanaging patient; this situation is facilitated by exhaustions and increased workload in their PHC facilities. Patients also complain of long waiting period, poor health education, all being the results of shortage of staff.

Most registered professional nurses complain that they are working under pressure and stress because their PHC facilities are serving large communities with few staff members per shift. Some indicated that shortage of staff is causing increased work-load which is preventing them from rendering quality nursing services, rather it results in poor implementation. It is important for the DoH to employ more nursing personnel and other health personnel for rendering of quality patient care in PHC facilities.

- **Sub-theme 4: Good working relationship between nurses, patients and the Department of Health**

Good relationships among nurses, patients and the DoH influence the implementation of PPC in PHC facilities. Positive and trusting inter-professional relationships through the presence of bi-directional communication and giving of staff abundant opportunity to discuss salient matters and provide input to challenges before and during the implementation of PPC, help in the delivery of effective primary health care. There is, however, poor relationships amongst patients and nurses which is facilitated by attitude, dependent on their personalities and religions. This kind of behaviours is causing poor team-work and forces some patients to default treatment as they feel unwelcome in the PHC facilities and this is increasing the number of disease burden.

An ecological framework model reported similar findings by indicating that relationships between nurses and patients play an important part when it comes to effective implementation of PPC in PHC facilities, but poor nurse/patient relationship is still a big challenge to tackle in health facilities. Some nurses tend to practice absenteeism because of boredom and fear created in them by patients' behaviours and the same goes for the patients who stop attending PHC facilities being scared of how nurses will react to their personal issues (Rubio-Valera et al., 2017)

It is worth noting that not all nurses and patients have bad attitudes towards prevention and to each other, however, many patients are reported as displaying bad behaviour towards nurses, demanding that they have a rights to treatment yet not observing the responsibilities of those rights. This simply indicates that there is poor implementation of PPC in PHC facilities. When nurses have good work relationship with their patients, the implementation of proper PPC becomes effective and patients become more open and receptive making it easier for nurses to convince them to do screening test as a step towards implementing PPC.

### 4.4 Conclusion

This chapter provided a detailed presentation of results and discussion of the findings. Themes and subthemes were created from the objectives and from the information provided by the participants in order to focus on the problem of the study and to achieve all the objectives.

The study findings confirm that there is poor implementation of PPC in the PHC facilities of Makhado Municipality which led to increased disease burden in the Makhado Municipality. This leaves a space for constructive criticism with regard to the responsibility of the DoH in the provision of enough supply of health personnel, medical equipment, medications and

funding to the PHC facilities, for the implementation of effective PPC. Most of the identified fault by the participants was emanated from DoH, even though nurses and patients also play a part in causing poor implementation of PPC. For quality implementation to be achieved, it requires co-ordination and understanding of PPC by all health stake-holders.

# CHAPTER 5

# SUMMARY, LIMITATIONS CONCLUSION AND RECOMMENDATIONS

## 5.1. Introduction

This chapter presents the summary of the whole study, based on the data collection findings, in addition, limitations, recommendations and conclusion are discussed.

## 5.2. Summary of the study

The aim of the study was to describe factors influencing poor implementation of PPC in PHC facilities of Makhado Municipality.

### Chapter 1: Overview of the study

The researcher identified the problem that there is poor implementation of PPC in the Makhado PHC facilities and the problem identified by the researcher was clearly supported by the literature reviewed. The objectives set out for this research study were all reached and the research question was effectively answered.

### Chapter 2: Literature review

The literature reviewed by the researcher abled the researcher to familiarise himself with the problem identified and similar ones. The ecological framework model was suitable and applicable to the study, therefore, assisted in achieving the study's objectives.

### Chapter 3: Methodology

The study adopted a qualitative design with an exploratory and descriptive approach. A non-probability purposive sampling was used to select registered professional nurses and PHC facilities; fifteen (15) nurses and four PHC facilities were selected. Pre-testing was done with two professional nurses from one of Makhado PHC Facility to determine if there were any flaws in the research interview guide. Professional nurses and PHC facility that were selected for pre-test were not part of the main study. The researcher used a narrative method to analyse the collected data. Data collection was guided by an interview guide using semi-structured questions. Trustworthiness was ensured through transferability, credibility, dependability and conformability. Approval for conduction of the study was received from the Provincial Research Committee Director, Limpopo DoH, District Executive Manager of Vhembe District and the operational managers of the five selected PHC facilities. Participants were told that participation is voluntary, hence, can terminate their participation at any stage of the research project.

**Chapter 4: data analysis and findings**

Data was analysed using the verbatim quotations of the participants; the 15 participants interviewed were quoted to support the findings of the study. The problem of insufficient preventive medications as well as diagnostic and medical devices in the PHC facilities were established as contributing to the poor implementation of PPC. The low-budget allocation to the Limpopo PHC facilities makes it difficult for the conducting of health care awareness programmes and also contributes to the shortage of human and material resources. The more available curative care is, the more PPC is neglected, and therefore, the availability of curative care and the attention that the DoH gives to curative care is actually making it difficult for healthcare workers and patients to prioritize PPC. The shortage of human resources results in an increased workload in PHC. The attitude that the patients have towards preventive care contributes to the poor implementation of PPC, this also applies to some nurses who have negative attitude towards PPC; this impacted negatively on the implementation of PPC. Various cultural beliefs and values also contribute to the poor implementation of PPC in the PHC facilities, and some religious beliefs do not support the utilisation of PPC. When PPC is neglected in the PHC facilities there will be an increase in communicable and non-communicable diseases. The secondary healthcare facilities are over-burdened when the PHC facilities are failing to implement PPC as more people will become sick and require secondary management. PPC is cost-effective and the poor implementation of PPC results in an increased expenditure to the health care department as more secondary interventions will be needed. There are measures that the DoH can take in order to ensure effective implementation of PPC in the PHC facilities. These measures include - increasing the budget on preventive care to curb the poor implementation of PPC, conducting health awareness and health education campaigns, as well as employing sufficient nursing personnel in PHC facilities so as to achieve effective implementation of PPC as more nurses will be available for its provision.

**Chapter 5**

Summary of the whole study presented according to chapters and recommendations made based on the study findings.

**5.3. Limitation**

The sampling size for this study was relatively small, however, the research method employed, met with the requirements for this study. For this reason the findings of this study cannot be generalised but can be used as a guide for further studies that involve similar themes.

### 5.4. Recommendations

#### 5.4.1 Department of Health

- The DoH must employ all trained registered professional nurses to curb the shortage of nursing personnel, for effective implementation of PPC.
- The DoH must increase funding in PHC facilities for the purchasing of preventive medical devices, medications and supplies.
- The DoH must conduct frequent healthcare awareness about PPC by providing the PHC facilities with all required material and medical resources for programmes
- The DoH must re-workshop nurses on the importance of PPC and put an emphasis on their scope of practice.

#### 5.4.2. Registered professional nurses

- All nurses are required to provide health education to patients regarding PPC to enforce understanding about the importance of implementing PPC.
- All nurses must be in-serviced about the nurse-patient relationship as well as professional conduct, so as to make them aware of how the DoH requires them to behave in the workplace in order to avoid negative attitude.

#### 5.4.3 Community members

- Religious leaders must be given health education regarding the importance of proper implementation of PPC, so that they can spread this information to their clients.
- Community members must be encouraged to participate in the outreach programmes so that they gain health –related knowledge.
- Encourage community members to write their compliments and complaints and put them in the suggestion box so that healthcare personnel will be able to know where they are lacking or excelling so as to come up with solutions to the identified problems.

### 5.5 Conclusion

The problem identified by the researcher was comprehensively supported by the literature reviewed and the methodology employed abled the researcher to collect data and find information from the registered professional nurses which also confirmed the problem at hand.

This chapter has provided a summary of the study, limitations, conclusion and recommendations provided by the interpreted raw data from participants. The recommendations were made based on the findings.

Poor implementation of PPC in the PHC facilities of Makhado Municipality is still a problem that needs urgent intervention by the DoH. The rise in NCDs and CDs in the Makhado municipality is evidence that the problem identified still prevails; this was also supported by the registered professional nurses who were interviewed, however, there are measures that can be taken in order to address the problem at hand.

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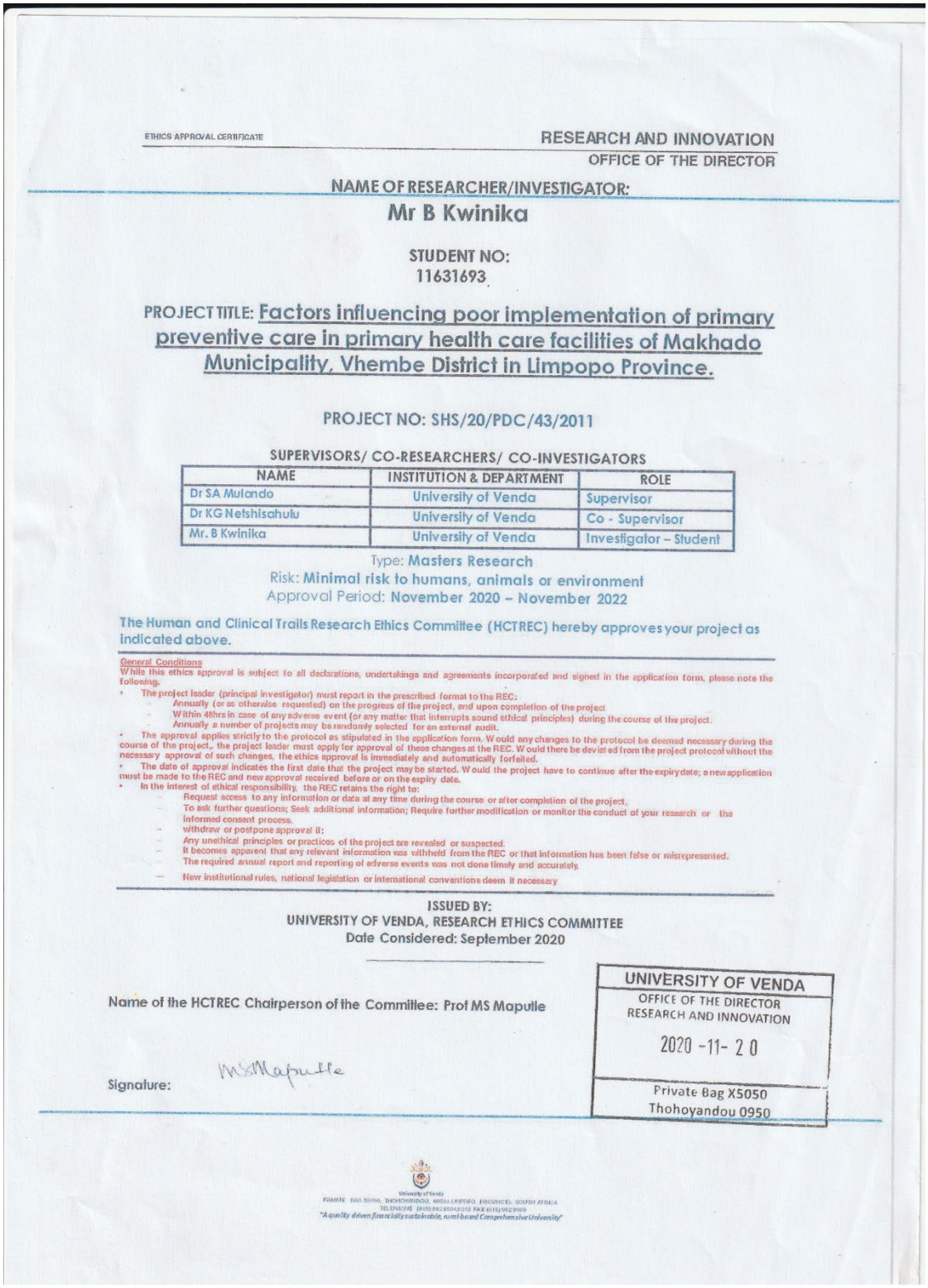
## ANEXURE A: Ethical clearance certificate



ETHICS APPROVAL CERTIFICATE

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
**Mr B Kwinika**

STUDENT NO:
11631693

PROJECT TITLE: **Factors influencing poor implementation of primary preventive care in primary health care facilities of Makhado Municipality, Vhembe District in Limpopo Province.**

PROJECT NO: SHS/20/PDC/43/2011

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

| NAME | INSTITUTION & DEPARTMENT | ROLE |
|---|---|---|
| Dr SA Mulando | University of Venda | Supervisor |
| Dr KG Netshisahulu | University of Venda | Co - Supervisor |
| Mr. B Kwinika | University of Venda | Investigator – Student |

Type: Masters Research
Risk: Minimal risk to humans, animals or environment
Approval Period: November 2020 – November 2022

The Human and Clinical Trails Research Ethics Committee (HCTREC) hereby approves your project as indicated above.

General Conditions
While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following.

- The project leader (principal investigator) must report in the prescribed format to the REC:
  - Annually (or as otherwise requested) on the progress of the project, and upon completion of the project
  - Within 48hrs in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.
  - Annually a number of projects may be randomly selected for an external audit.
- The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project,. the project leader must apply for approval of these changes at the REC. Would there be deviated from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date; a new application must be made to the REC and new approval received before or on the expiry date.
- In the interest of ethical responsibility the REC retains the right to:
  - Request access to any information or data at any time during the course or after completion of the project.
  - To ask further questions; Seek additional information; Require further modification or monitor the conduct of your research or the informed consent process.
  - withdraw or postpone approval if:
  - Any unethical principles or practices of the project are revealed or suspected.
  - It becomes apparent that any relevant information was withheld from the REC or that information has been false or misrepresented.
  - The required annual report and reporting of adverse events was not done timely and accurately.
  - New institutional rules, national legislation or international conventions deem it necessary

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE
Date Considered: September 2020

Name of the HCTREC Chairperson of the Committee: Prof MS Mapulle

Signature: MS Mapulle

UNIVERSITY OF VENDA
OFFICE OF THE DIRECTOR
RESEARCH AND INNOVATION
2020 -11- 20
Private Bag X5050
Thohoyandou 0950

University of Venda
PRIVATE BAG X5050, THOHOYANDOU, 0950, LIMPOPO PROVINCE, SOUTH AFRICA
TELEPHONE (015) 962 8504/8210 FAX (015) 962 9069
"A quality driven financially sustainable, rural-based Comprehensive University"

**ANNEXURE B: Application letters to conduct the study**

**Letter requesting permission from Department of Health, Vhembe District to conduct research study at Makhado primary health care facilities**

University of Venda (School of Health Sciences)

Private Bag X5050

THOHOYANDOU

095

Department of Health, Vhembe District Executive manager

Private Bag X5006

THOHOYANDOU

0950

**To whom it may concern**

**RE: Letter requesting permission to conduct research at Makhado primary health care facilities**

I am a Nursing Masters (MCUR) student at the University of Venda and I am asking for permission to conduct a research at Makhado PHC facilities.

**Research topic**: Factors influencing poor implementation of primary preventive care in primary health care facilities of Makhado Municipality, Vhembe District in Limpopo Province

**Objectives of the study**

- To explore and describe factors that influence poor implementation of primary preventive care in primary health care facilities.
- To describe the impact of poor implementation of primary preventive care in primary health care facilities
- To determine measures for improving poor implementation of primary preventive care in primary health care facilities.

**Study population**

Study population refers to all elements (people, objects, events, or substances) that meet the sample criteria for inclusion in a study; sometimes referred to as a 'target population' (Grove et al., 2015). The entire population of the study will be registered professional nurses working in Vhembe District facilities.

According to Mokoena (2017), an accessible population is the portion of the target population to which the researcher has reasonable access. Accessible population was registered professional nurses (males and females) who agreed to participate in the study during data collection in Makhado PHC facilities.

**Data collection procedure**

Brink et al. (2017) state that data collection involves a face-to-face situation between the researcher and the subject and may necessitate observation, in certain instances it facilitates participation on the part of the researcher. The study will use semi-structured interviews. The researcher will make proper arrangements with the Makhado PHC facilities' managers through direct discussion with them by visiting all selected PHC facilities and then making appointments. The interviews will take place in a natural setting and the researcher will ensure that the environment is quiet, comfortable and conducive.

Before the interview commences, participants will be made to feel comfortable and at ease. Participants will be asked to voluntarily sign the consent forms before interviews commence. They will also be provided with information leaflets so that they familiarize themselves with what is expected of them. The interviews will be recorded using an electronic tape-recorder; this will ensure that the data collected is captured accurately. Field notes will be written immediately at the end of the interview sessions to avoid forgetting some aspects of the data. Field notes refer to the information recorded by the researcher while the observation is taking place (Grove et al., 2015). The field notes will be written in English. Interviews will be conducted during participants' free time to ensure that they do not interfere with nurses' work. Interviews will be conducted in English.

Participants will be addressed as A or B and no names will be mentioned by the researcher during the report writing to ensure anonymity. To maintain confidentiality, the information obtained from the interviews will only be shared among the researcher, the supervisor and the co-supervisor. According to Jamshed (2014), the duration of an effective semi-structured interview varies between 30 minutes to more than an hour. In the proposed study, the researcher plans to conduct interviews lasting between 45-60 minutes depending on each participant's pace of responses.

**Yours sincerely**

**Kwinika B** **082 737 0438**

**Letter requesting permission from Limpopo provincial government to conduct research study at Makhado primary health care facilities**

University of Venda School of Health Sciences

Private Bag X5050

THOHOYANDOU

0950

Limpopo Department of Health Head Office

Private Bag X9302

POLOKWANE

0700

**To whom it may concern**

**RE: Letter requesting permission to conduct research at Makhado primary health care facilities**

I am a Nursing Masters (MCUR) student at the University of Venda and I am asking for a permission to conduct a research at Makhado PHC facilities.

**RESEARCH TOPIC**: Factors influencing poor implementation of primary preventive care in primary health facilities of Makhado Municipality, Vhembe District in Limpopo Province

**Objectives of the study**

- To explore and describe factors that influence poor implementation of primary preventive care in primary health care facilities
- To describe the impact of poor implementation of primary preventive care in primary health care facilities
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Before the interview commences, participants will be made to feel comfortable and at ease. Participants will be asked to voluntarily sign the consent forms before interviews commence. Participants will also be provided with information leaflets so that they familiarize themselves with what is expected of them. The interviews will be recorded using an electronic tape-recorder. This will ensure that the data recorded is captured accurately. Field notes will be written immediately at the end of the interview sessions to avoid forgetting some aspects of the data. Field notes refer to the information recorded by the researcher while the observation is taking place (Grove et al., 2015). Field notes will be written in English. Interviews will be conducted during participants' free time to ensure that the interviews do not interfere with the nurses' duty. Interviews will be conducted in English.

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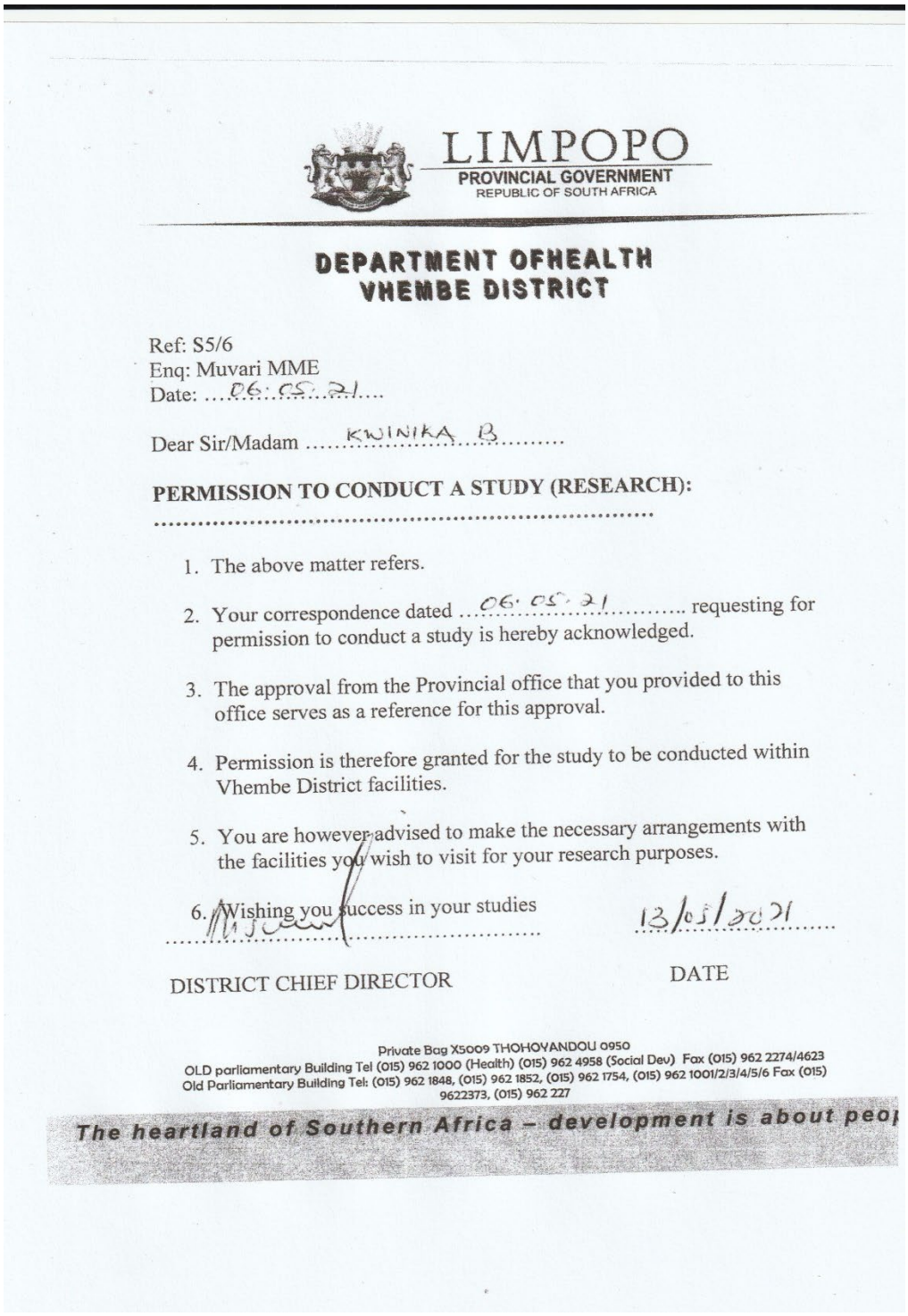
**Yours sincerely Kwinika B** **082 737 0438**

**ANEXURE C: Letters of permission to conduct the study**

**Approval letter to conduct a research study from department of health Vhembe district**



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OFHEALTH
VHEMBE DISTRICT

Ref: S5/6
Enq: Muvari MME
Date: 06.05.21

Dear Sir/Madam KWINIKA B

PERMISSION TO CONDUCT A STUDY (RESEARCH):

1. The above matter refers.
2. Your correspondence dated 06.05.21 requesting for permission to conduct a study is hereby acknowledged.
3. The approval from the Provincial office that you provided to this office serves as a reference for this approval.
4. Permission is therefore granted for the study to be conducted within Vhembe District facilities.
5. You are however advised to make the necessary arrangements with the facilities you wish to visit for your research purposes.
6. Wishing you success in your studies

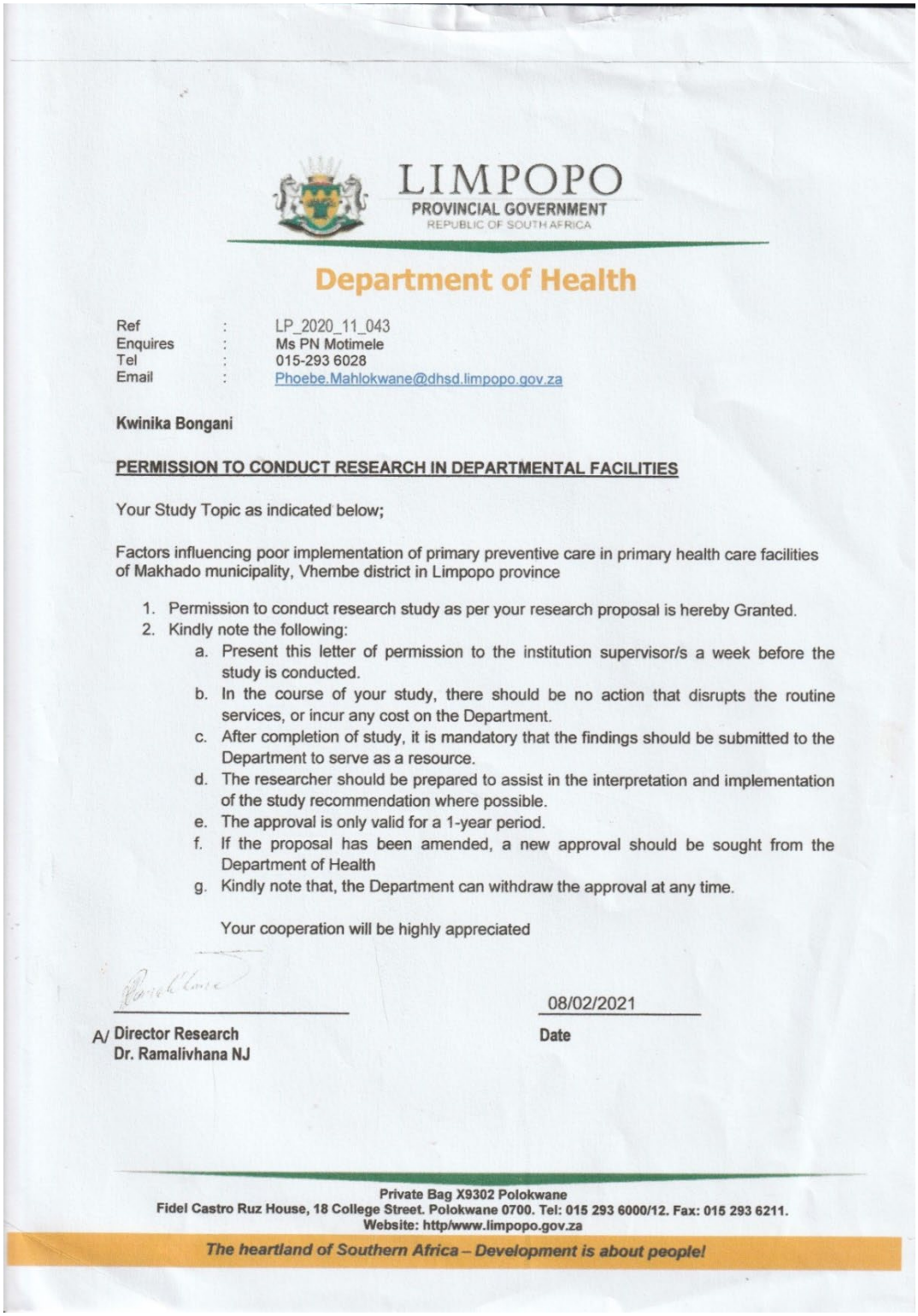
13/05/2021

DISTRICT CHIEF DIRECTOR DATE

Private Bag X5009 THOHOYANDOU 0950
OLD parliamentary Building Tel (015) 962 1000 (Health) (015) 962 4958 (Social Dev) Fax (015) 962 2274/4623
Old Parliamentary Building Tel: (015) 962 1848, (015) 962 1852, (015) 962 1754, (015) 962 1001/2/3/4/5/6 Fax (015) 9622373, (015) 962 227

The heartland of Southern Africa – development is about peo

**Approval letter to conduct research study from Limpopo provincial government**



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

Department of Health

Ref : LP_2020_11_043
Enquires : Ms PN Motimele
Tel : 015-293 6028
Email : Phoebe.Mahlokwane@dhsd.limpopo.gov.za

**Kwinika Bongani**

**PERMISSION TO CONDUCT RESEARCH IN DEPARTMENTAL FACILITIES**

Your Study Topic as indicated below;

Factors influencing poor implementation of primary preventive care in primary health care facilities of Makhado municipality, Vhembe district in Limpopo province

1. Permission to conduct research study as per your research proposal is hereby Granted.
2. Kindly note the following:
   a. Present this letter of permission to the institution supervisor/s a week before the study is conducted.
   b. In the course of your study, there should be no action that disrupts the routine services, or incur any cost on the Department.
   c. After completion of study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
   d. The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   e. The approval is only valid for a 1-year period.
   f. If the proposal has been amended, a new approval should be sought from the Department of Health
   g. Kindly note that, the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated

08/02/2021

A/ Director Research
Dr. Ramalivhana NJ

Date

Private Bag X9302 Polokwane
Fidel Castro Ruz House, 18 College Street. Polokwane 0700. Tel: 015 293 6000/12. Fax: 015 293 6211.
Website: http/www.limpopo.gov.za

*The heartland of Southern Africa – Development is about people!*

**ANNEXURE D: Informed consent**

**Consent Form**

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, (*Kwinika Bongani*), about the nature, conduct, benefits and risks of this study .
- I have also received, read and understood the above written information (*Participant Letter of Information*) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

**I, (Name of Participant)……..Date…/……/…… Time……..Signature……..……**

(*Kwinika Bongani*) herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

**Kwinika Bongani** Date…….. Signature……..

Full Name of Witness (If applicable)…….Date……. Signature……

Full Name of Legal Guardian (If applicable)……Date……Signature…….

**Annexure E: Participant information sheet**

**Title of the Research Study** : Factors influencing poor implementation of primary preventive care in primary health facilities of Makhado Municipality, Vhembe District in Limpopo Province

**Principal Investigator/s/ researcher**: (Kwinika Bongani, Honours Degree in Nursing Sciences)
**Co-Investigator/s/supervisor/s**: (Dr Mulondo, Doctorate in Nursing Sciences)
: (Dr Netshisaulu, Doctorate in Nursing Sciences)
You are invited to participate in a study conducted by Kwinika Bongani, a Masters student in nursing from the School of Nursing Science, University of Venda. Your area has been chosen by the researcher for the study.

**WHAT WILL HAPPEN**

The purpose of this study is to determine factors influencing poor implementation of primary preventive care in the PHC facilities of Makhado Municipality, Vhembe District in the Limpopo Province

**APPROVAL TO RESEARCH**

Ethical clearance was sought from the University of Venda, Limpopo Province.

**Reason/s why the Participant May Be Withdrawn from the Study**: Non-compliance, illness, and when the participants feels that he/she does not want to go further with the study. There will be no adverse consequences for the participant should he/she chooses to withdraw.
**Remuneration**: There will be no monies or any type of remuneration that will be benefited from this study.
**Costs of the Study**: There are no costs that the participants will be expected to pay.
**Confidentiality**: The data we collect would not contain any personal information about you. The information from you will remain confidential and will be disclosed only with your permission or as required by law. Your identity will be kept anonymous. No one will link the data you provide to any identifying information you supply, such as name and address.
**Research-related Injury**: In this research study there will be no harm related to the research whatsoever and the researcher will ensure the safety and security of all the participants.

**RISK OR DISCOMFORT INVOLVED**

There are no anticipated risks for you in this study. If you decide to participate, you will be asked to share your ideas and feelings about the factors influencing poor implementation of primary preventive care in primary health care facility. Participation in this study involves

answering of some in-depth unstructured questions. The interview will take about 60 minutes to complete and you will be audio taped if you give permission. It is not possible to provide feedback after the interview. The interview may help in identifying the problem that some people will like to discuss with appropriate executive managers.

**BENEFITS AND RISKS**

It is my hope that the obtained information will have potential benefits for the participants and communities because every individual is entitled to receive quality PHC services. Recommendations will be made based on the findings.

**COVID-19 REGULATIONS**: All Covid-19 regulations will be observed during the course of the study; social distancing will be maintained during the interaction with the participants and a limited number of participants will be allowed as per the regulations; it will be compulsory for all participants to wear masks and to sanitize hands with approved hand sanitizers.

**PARTICIPANTS' RIGHTS**

Your participation is voluntary. You may decide to stop being part of the study at any time. There will be no penalty laid upon your withdrawal from participation. You have the right to ask for any data you would have supplied up to that point to be withdrawn.

**INFORMATION CONTACT**

Persons to contact in the event of any problems or queries:
(Supervisors and details) Please contact the researcher (082 7370 438), my supervisor (082 4465 625) or the University Research Ethics Committee Secretariat on 015 962 9058. Complaints can be reported to the Director: Research and Innovation, Prof GE Ekosse on 015 962 8313 or Georges Ivo.Ekosse@univen.ac.za
Your signature indicates that you have read and understand the information that is provided above and that you are willing to participate, that you may withdraw your consent at any time, discontinue participation without penalty, that you will receive a copy of this form and that you are not waiving any legal claims.

Signature (researcher)  Date: ……...../……../……

Participant's name……..Date……/…./…. Signature……

## Annexure F: Interview guide

### Questions to be asked during the interviews

The qualitative questions will be in four categories, namely, biographic, main questions, follow-up, and probes.

**Biographic data**

- Gender
- Race
- Age
- Years of working experience
- Highest educational level

**Main/broad questions**

- What are the factors that influence poor implementation of primary preventive care in primary health care facilities?
- What is the impact of poor implementation of primary preventive care in primary health care facilities?
- What can be the measures for improving poor implementation of primary preventive care in primary health care facilities?

**Annexure G: Transcription**

**Transcript- interview with participant D**

The researcher introduced himself to the participant; showed the participant the permission letter granted by the University, provincial DoH and district DoH; provided the participant with an information sheet which included the purpose of the study, objectives, and the ethical considerations. The researcher allowed the participant time to go through the information sheet and also explained the content of the information to make sure that the participant understood everything before signing the consent form. The researcher also explained to the participant that no names will be mentioned during recordings as this may violate the right of anonymity.

**Researcher:** What are the factors that influence poor implementation of primary preventive care in primary health care facilities?

**Participant D:** *"There are so many factors that may influence poor implementation of PPC in our facility, firstly, the budget allocated for us as a PHC facility, I do not think it is enough to cover all our needs. The patients are also a barrier to the effective implementation of PPC because some are very reluctant to seek medical attention and lastly I can say that nurses are also contributing to the poor implementation of PPC as they fail to give adequate health information regarding'. PD*

**Researcher:** can you please elaborate more?

**Participant D:** *"ok let me start with the budget, the Limpopo DoH is always complaining that they do not have funds to cover everything that we are lacking. Then secondly, the patients are so reluctant in following the preventive measures that we offer to them. For example, we always tell our teenage girls to use condoms but they don't, they only come for injectable contraceptive then we end up having more teenagers who are testing positive for HIV".*

**Researcher:** what else do patients become reluctant about in addition to non-use of condoms by teenage girls?

**Participant D:** *"There are pregnant women who come to the clinic for booking at a very late stage of pregnancy and this means that these women were not receiving important supplements that are given to all pregnant women for the prevention of pregnancy-induced conditions such as PIH as well as foetal conditions such as birth defects. All these women who present late to the clinic are referred to the hospital to attend high risk clinic, which means*

*that the more of these women are referred to the hospitals, the more the workload for the healthcare professionals working in these hospitals".*

**Researcher:** you talked about nurses also contributing to poor implementation of PPC by not providing adequate health information, why is that so?

**Participant D: "***the shortage of nurses in the PHC facilities makes it difficult for us to be able to conduct health education session daily, therefore, the health information delivered to the patients is insufficient to have them adequately informed".*

**Research:** What is the impact of poor implementation of primary preventive care in primary health care facilities?
**Participant D:** *"As you know that in Limpopo, we experienced a huge shortage of vaccines in the beginning of the year 2021 and they have recently delivered them. We are experiencing a high number of children coming to the clinic for missed doses of vaccinations and this results in nurses assisting a high volume of patients each day which leads to increase in workload to the staff members".*
**Researcher:** what do you think was the cause for this provincial shortage of vaccines?

**Participant D:** *"I can't exactly tell you what was the cause, but what came to my knowledge is that the shortage was only in our province and from what I heard the provincial DoH reported that they do not have enough budgets for the vaccines"*

**Researcher:** how are you dealing with the increased workload?

**Participant D: "***what else can we do? We are just attending to them all, but with the spirit of teamwork we have, we are pushing through this huge workload".*

**Researcher:** Tell me more about the impact of poor implementation of PPC.

**Participant D:** *"when we fail to implement preventive care, we fail the whole Department of health, as well as the whole population of our country, because the impact of poor implementation of preventive care is detrimental to the health status of the entire South African population, and it adds more pressure to the Department of Health and its employees. All this causes increase in workload in nurses which also leads to increase in disease burden.*

**Researcher:** how does poor implementation of PPC affect your duties?

**Participant D:** *"if the government is failing to properly implement PPC on its workers what more about the patients? I refuse to attend to a patient without protecting myself and yes sometimes I end up not coming to work knowing that if I come, I will be at risk because I will be forced to work without proper PPE".*

**Researcher:** have you tried to submit your complaints to the relevant people regarding the shortage of PPEs?

**Participant D:** "we as registered professional nurses we sat down with our operational manger and explained to her our challenges so that she can report to those responsible in the district offices but she always tells us that she is still waiting for their response. These people never want to engage with their subordinates; Never!

**Researcher:** What can be measures for improving poor implementation of primary preventive care in primary health care facilities?

**Participant D:** *"I don't know if our human resource personnel misuses our budget or there is just not enough budget that is allocated to us by the DoH, but if we have enough funds, that can cover a lot of things that we are lacking in our facility. I believe we will achieve our goal as PHC a facility which is rendering preventive care to the community members".*

**Researcher:** what else could be done?

**Participant D:** *"hiring of adequate nursing personnel, provision of enough material resources and conducting more healthcare awareness campaigns, but you know. this comes back to money. I generally think that with enough budgets we can go a long way in ensuring proper implementation of PPC in our PHC facilities".*

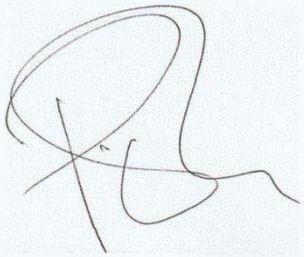
**Researcher:** "Okay I have understood your challenges and that will be all for now, thank you very much for your cooperation."

## Annexure H: Proof of editing

# PROOF OF EDITING

**18 February, 2022**

This is to certify that I, Dr P Kaburise, of the English Department, University of Venda, have proofread the dissertation titled - **FACTORS INFLUENCING POOR IMPLEMENTATION OF PRIMARY PREVENTIVE CARE IN PRIMARY HEALTH CARE FACILITIES OF MAKHADO MUNICIPALITY, VHEMBE DISTRICT IN LIMPOPO PROVINCE** - by Kwinika Bongani (student number: **11631693**). I have indicated some amendments which the student has undertaken to effect before the final dissertation is submitted.



**Dr P Kaburise (0794927451/ 0637348805; email: phyllis.kaburise@gmail.com)**

**Dr P Kaburise: BA (Hons) University of Ghana (Legon, Ghana); MEd University of East Anglia (Cambridge/East Anglia, United Kingdom); Cert. Teaching English as a Foreign Language (Cambridge University, United Kingdom); Cert. English Second Language Teaching, (Wellington, New Zealand); PhD University of Pretoria (South Africa)**