

**Nurses' knowledge and perceptions of and attitudes  
towards aspects of the new health systems framework:  
A qualitative case-study of the nurses employed at three  
public health facilities in the West District, City of  
Tygerberg, Cape Town**

**Colleen Marco**

**November 1999**

**A thesis submitted to the Faculty of Health Sciences, University of Cape  
Town, in fulfilment of the requirements for the Masters degree in  
Philosophy (M.PHIL) in Maternal and Child Health.  
Department of Paediatrics  
University of Cape Town**

**Supervisor: Dr. Di Cooper**

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

## DECLARATION

I, Colleen Marco, hereby declare that the work on which this thesis is based is my original (except where acknowledgements indicate otherwise), and that neither the whole nor any part of it has been, is being or is to be submitted for another degree in this or any other university.

I empower the University of Cape Town to reproduce for the purpose of research either the whole or any portion of the contents in any manner whatsoever.

Signed by candidate

\_\_\_\_\_  
Signature

29/5/2000

Date

## Table of contents

	<b>Page</b>
Acknowledgements	i
Abstract	ii
Researcher's background	iii
Organisation of thesis	vi
Definition of terms	vi
List of tables	xii
<b>Chapter one</b>	
Introduction	1
Research problem	4
Purpose and justification	8
Aims and objectives	9
References	10
<b>Chapter two</b>	
Literature review	11
Section one	12
The historical context of the SA health system	12
The primary health care approach	13
The structure of the South African health system	16
MCWH as a national priority program	17
Conclusion	28
Section two	
Introduction	29
The importance of human resource development	29
Nursing practice at PHC facilities	31
Nurses' relationship with PHC team	39
Nursing education and training	44
Conclusion	52
References	55
<b>Chapter three</b>	
Methodology	59
An explanation of a qualitative research program	59
The research paradigm chosen for this thesis	60
The study design	63
The study area and study sites	64
The study population and study sample	67
Table 3.1	68
Table 3.2	70

Phase one	
The sample and data selection process	74
The interview procedure at all three facilities	76
The data collection process at the Community Health Centre	76
The data collection process at the Clinic	77
The data collection process at the Midwife Obstetric Unit	77
Phase two	
The sample and data collection process	77
Data analysis	79
Table 3.3	80
Reliability and validity	81
Ethical considerations	83
Conclusion	84
References	85
<b>Chapter four</b>	
Findings and discussion of findings	87
Table 4.1	88
Findings of the individual in-depth interviews	88
The structure and function of the new health system	88
Working conditions	96
Nurses' skills competency and training	99
Job satisfaction	104
The findings of the focus group discussion	107
Discussion of findings	116
Conclusion	127
Recommendations	128
References	131
Appendices	134

## **Acknowledgements**

I hereby express my gratitude to the following individuals and institutions, for enabling me to complete my thesis.

A special word of thanks to the nurses, who voluntarily participated in this study and to all the other nursing staff, from the three health facilities for your co-operation.

Dr Di Cooper and Ms Gail Andrews thanks for your advice, support, and guidance.

I hereby also express my gratitude to the following individuals for granting me permission to conduct the research at the three public health facilities, in Elsie's River:

- The Head of the Western Cape Health Department (Community Health Services).
- The Head of the Health Department of the City of Tygerberg.
- The Chief Professional Nurse of Elsie's River Community Health Centre.
- The Chief Professional Nurse of Elsie's River Community Health Clinic.
- The Chief Professional Nurse of Elsie's River Midwife Obstetric Unit.
- The Sisters In-Charge of the three health facilities.

I would also like to acknowledge the contribution, in terms of advice and guidance given by the Nursing Lecturers of the Nico Malan Nursing College and the Nursing Department of the University of the Western Cape.

And finally

Mom thanks for your support.

## **ABSTRACT**

A qualitative case study was conducted amongst nurses employed at the Elsie's River's Community Health Centre, Community Health Clinic and Midwife Obstetric Unit. The purpose of the study was to gain insight into the nurses' knowledge and perceptions of and attitudes, towards key aspects of the new health systems framework, namely, the concept of Primary Health Care, the structure of the District Health System and selected aspects of the Maternal, Child and Women's Health Policy framework. An additional purpose was to gain insight into the nurses' Scope of Practice and whether nurses felt they were adequately skilled to provide a quality Primary Health Care service at district level. The first phase of the study involved individual interviews with nineteen nurses from the three main nursing categories. The second phase consisted of a focus group discussion in which five Registered Nurses participated. The study findings indicate that the nurses lack the knowledge and understanding of the key aspects of the new health systems framework. There has not been adequate consultation between the health authorities and the nurses, with respect to the formulation of the new health policy framework and the implementation thereof at local and district level. This resulted in negative attitudes being adopted by these nurses towards their superiors, the community and towards the new health systems framework. The nurses were found to not have adequate clinical skills to implement the new health policies. Furthermore, in-service training was identified as important, in order to render an effective Primary Health Care service. The training programs of these nurses were mainly curative-based and did not equip them to function competently within the Primary Health Care-based health service. Changes in the nursing education curriculum are discussed in order for a re-orientation towards Primary Health Care to occur. Specific recommendations are presented regarding the reorientation and training of nurses and appropriate methods to involve them in the development of the District Health System at local level.

## **THE RESEARCHER'S BACKGROUND**

I have decided to give you as the reader some insight as to who I am as the researcher in this study and background to the purpose and motivation as to why this particular topic was chosen for my Master's Thesis.

I completed my general nursing diploma in 1986, at Groote Schuur tertiary hospital. The tertiary institution at which I studied was the Nico Malan Nursing College. As the years progressed I completed a Diploma in Midwifery, and Community Nursing Science. In 1992, I began a Bachelor of Arts degree at the University of Western Cape. The aim of studying towards this degree was to complete two social science subjects, namely sociology and psychology. This was completed in 1995.

My reasons for having studied Psychology and Sociology at a university was because I felt I would be able to have a more holistic understanding of society and of how people behave, think and respond. In addition I felt that the nursing psychiatric course offered at various institutions would not give me the necessary holistic understanding of human behaviour and a broader insight into the various facets of society.

As I progressed in my nursing career I became more and more frustrated with the apathy of the nursing profession towards the current injustices taking place in the country, prior to the 1994 democratic elections. For example, when I worked at the community health clinics as a Registered Nurse part of my duties involved vaccinating children, under five years of age and advise mothers on how to care for their infants. Yet when I attempted to delve into the social and economic circumstances of the mothers, many of my colleagues felt this was unnecessary and involved in tasks beyond my scope of practice. However, for me the role of the community nurse was not limited to providing mother's with information and tell them what to do, but for example in partnership with the mother find appropriate strategies to care for the baby, or address what ever health or social problem she might experience.

In the early 1990's, I worked as a Registered Nurse at the Elsies River community health centre. During this time the health department established Strategic Management Teams to evaluate the health system at the time and make recommendations to the Health Ministry with respect to the health transformation process.

The structure and concept of the District Health System became a priority nationally and at provincial level. I was fortunate to then form part of the Elsies River Development Forum, of which health care was one of the components. It was however extremely difficult to work on this forum. At the time some meetings occurred during working hours, and I was not allowed to attend, as there were too few nurses on duty, to allow one time off. Secondly when meetings were arranged at the health facility to inform nurses and involve them, in the processes taking place, most were not interested in participating. This experience was traumatic and frustrating for me. As time progressed I tried to formulate reasons for this sense of apathy, on the part of nurses as well as what their concerns were with respect to their participation. I then left the formal public health sector in 1994, and worked as a researcher at the University of Cape Town.

The choice of this topic for my thesis was motivated by my experience as a nurse at primary health care facilities in the Western Cape, prior to the transformation process. The Elsies River area was selected because I had some insight into the circumstances of nurses employed in that area. In addition, I had been part of the initial transformation process in that area.

I believe my previous working experience has had a limited impact on the participants' participation, and their responses. This is discussed in chapter three, under the sample and data collection process. However my knowledge and familiarity of the Community Health Centre made it easier to gain access to the local facilities, particularly the community health centre.

This section is presented in the active voice, while the rest of the thesis is presented in the passive voice. This is aimed at ensuring that the main focus is not me but on the nurses who were prepared to offer their time, to allow you and I to gain insight into their thoughts and experiences as health providers in the Elsie's River area, in the West District of the City of Tygerberg.

## **ORGANISATION OF THE THESIS**

This thesis consists of four chapters. The introduction, purpose and justification of the study, the study aim and objectives are presented in chapter one.

Chapter two consists of a literature review. This chapter is presented in two sections. The first section describes the broad framework of the South African health system. The second section focuses on the South African experience with respect to human resource or health personnel development and compares it to the international experience.

Chapter three presents the study design, sample selection process, and the rationale for the sample selection, the data collection process and the process of analysis.

The final chapter, chapter four, consists of the study findings and the discussion thereof as well as the conclusion and recommendations.

## **DEFINITION OF TERMS**

### **A Health System:**

" A health system is the complex of interrelated elements that contribute to health in homes, educational institutions, workplaces, public places and communities, as well as in physical and psychological environment and the health and related sectors"(Tarimo, 1991:4).

### **The South African Health System**

The South African Health system is in the process of transformation. The aim is to develop an integrated unified comprehensive primary health care system. The organisational structure of the health system is designed in such a way as to ensure that the integration of services takes place at three levels. The levels are national, provincial and district. The three levels of health care provision are described below.

### **The National health department**

This consist of four branches each having directorates which execute specific functions. Three of the four branches deal with overall policy formulation and co-ordination in

health. The fourth is responsible for regulating health matters, rendering support services, establishing health programmes and promoting occupational health (Department of Health, White Paper, April 1997). A more detailed discussion is contained in chapter two, in the literature review.

### Provincial Health Departments

There are nine provincial health departments. Each provincial department is mandated to promote and monitor the health of the people in the province. They are also mandated to establish and develop a provincial district-based health system as defined below. This implies that each district should have an effective, functional health system, based on the principles of primary health care (Department of Health, White Paper April 1997). The principles of primary health care are listed in chapter two.

### District Health System (DHS)

The District Health System is made up of geographically defined health districts. The health system is based on the principles of Primary Health Care as listed in chapter two. These districts should be economically efficient, with an effective management, which is accountable to the local communities. It is a more or less a self-contained segment of the national health system. The health districts should be responsive to local needs through the participation of communities and staff in planning and management of services (Tarimo, 1991).

According to the long-term goals of the South African health department, the country will be divided into these geographically, functional health districts. In each health district a team will be responsible for the planning and management of local health services for a defined population. The district health team will not only comprise of health personnel, but it would include all sectors of that community and district. A District Health System is based on primary health care as defined below. The department envisages that comprehensive primary health care services will be provided at local level, with the

guidance and direction of provincial and national department policies and guidelines (Department of Health, White Paper, April 1997).

### **Primary Health Care (PHC)**

“Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination” (Ebrahim and Ranken, 1993: 4).

To ensure that all individuals in South Africa have access to appropriate health care, the department of health has decentralised health care to local level, as described in the explanation of a district health system. In this approach all sectors of society, including non-governmental organisations may work together to improve the economic, social and political conditions, which currently hamper the development of all South African citizens. These sectors may include the Agricultural, Educational, Business Community as well the Religious sector. Each of these sectors has specific knowledge, and when they collaborate to improve societal conditions, this can have a direct influence on individuals' lives and particularly impact on their health status.

### **Maternal, Child and Women's Health (MCWH)**

The 1995 National draft policy report on health has Maternal, Child and Women's Health (MCWH) as one of its priority programmes (Department of Health, 1995). A Maternal and Child Health (MCH) Directorate was established at a national level to co-ordinate and facilitate the formulation of policy and restructuring of MCWH health services. The policy incorporates a commitment to achieving universal access to health services for children including infants, children under five, adolescents and women, and improving the quality of services provided.

It is the intention of the Department of Health, to provide MCWH services which would

impact positively on the health of women, mothers, adolescents and children, rural as well as urban health districts. Areas of concern include reducing infant, child and maternal morbidity and mortality (Department of Health, White Paper of April 1997). The MCWH Committee commissioned by the Department of Health made various recommendations, pertaining to the restructuring of MCWH services within the country. The following are examples of the MCWH services proposed by the Department of Health's MCWH Committee, in 1997 (Executive Summary Report of the MCWH Committee, 1997):

- Developmental screening for children under six
- Growth, weight and nutrition monitoring
- Immunisation
- Family Planning
- Infertility
- Diagnosis and treatment of Sexually Transmitted Diseases
- Breast and Cervical screenings
- Antenatal care, delivery and post-natal care
- Abortion services
- Counselling and support services for rape and abused women and children

It is the health departments aim to provide improved and appropriate MCWH services, "to make its contribution to the reduction of infant, child and maternal morbidity and mortality" (Department of Health, White Paper of April 1997). There is currently an uneven delivery of all these services across health districts, in the nine provinces. It is the intention of the department to phase these services in over time.

### **Free Health Care Policy**

This policy was introduced in 1994, in which it is specified that free health care would be provided to all pregnant women and all children under the age of six years. This policy was introduced by the Department of Health, to reduce the barriers to health care.

Inability to pay a fee at health facilities was regarded as one of the main barriers to health care. In addition the department of health regard women and children as the most vulnerable in the South African society, hence a policy of this nature was introduced to address the barriers which have been determinants to the ill-health and continuous vulnerability of these two sectors (South African Health Review, 1996).

### **Nursing Categories**

The nursing profession is categorised into three main nursing categories. These are Registered Nurses, Enrolled Nurses and Enrolled Nursing Auxiliaries. The three categories each have specific roles and functions to perform. The Nursing Council has laid down certain educational requirements for each category. On achievement of these educational requirements, the nurse is authorised to practice within a specific nursing framework, known as the scope of nursing practice.

### **Primary Health Care Trained Nurse (PHCN)**

This is a Registered Nurse, as defined under nursing categories below, who is clinical skilled to diagnose and treat certain minor health problems. The skill is acquired through a Primary Health Care training course, offered at various health institutions. Various types of Primary Health Care Courses are offered throughout the country. The duration period of these courses range from six weeks to one year. A more detailed discussion on the clinical skills and training of this PHCN is found in chapter two, in the literature review.

### **Nurses Scope of Practice**

The scope of practice refers to the framework in which a nurse may practice. The South

African Nursing Council formulated this framework in the form of, nursing regulations and policies. There are regulations for each nurse category. There are also regulations and policy guidelines for each nurse category, which include additional, post- training qualifications. These regulations are included under various sections in the Nursing Act 50 of 1978, now the Nursing Act 19 of 1997.

### **Nursing Skills**

Nursing skills refer to what nurses actually require or need for the practical execution of their tasks. For example to vaccinate a child, a specific skill is required to perform this procedure. The skill needed involves knowing how to perform the procedure as well as factors such as knowledge of the purpose of the procedure, the implication of the performed procedure and what to do if an adverse reaction occurs.

## List of tables

Table 3.1	68
A sample distribution of the participants interviewed in phase one, according to the facility of employment and the nursing category	
Table 3.2	70
A sample distribution of the participants of the focus group discussion in phase two, according to the facility of employment and the total per nursing category	
Table 3.3	80
The development of the case-study record and data ordering	
Table 4.1	88
A summary of the main themes identified	

## **CHAPTER ONE**

### **INTRODUCTION**

#### **Background:**

#### **Organisation of the health system in South Africa**

##### **Pre - 1994**

During the Apartheid era in South Africa, the country was divided into four provinces and ten "self-governing states", each of which had their own health department. These health departments were fragmented in terms of their provision and organisation. Certain health services were managed and provided by the Provincial Health Authority and other services by the Local Health Authorities. The type of service provision varied in each of the provinces and the "self-governing states".

At Provincial level, health services were managed and provided by all three levels of government. These were National, Provincial and Local.

The organisation of health services in what was previously known as the Cape Province, will be discussed as an example, to illustrate the fragmentation and duplication of the health system in the past. As mentioned above, health delivery was provided at local level by the following three levels of government:

- The National Health Authority:

A Family Planning service, is an example of a national service, which was provided at Provincial hospitals, Day Hospitals known now as Community Health Centres and Child Health Clinics. Registered Nurses were trained to provide this service at the various health facilities. Family Planning nurses' working conditions differed to that of the other nurses employed at the same health facility. They were employed only to provide this single, vertical service to the community. There were differences in salary as well as in duration of working hours. This resulted in many staff conflicts.

- **The Provincial Health Authority:**

An example of a health facility at local level controlled and managed by the provincial health authority, were the Day Hospitals, now known as Community Health Centres. Preventative, Promotive, Curative and rehabilitative services were provided for all age groups.

- **The Local Health Authority:**

An example of a health facility at local level, controlled and managed by the local health authority were: Child Health Clinics for children under five years of age; Family Planning services; and diagnostic and treatment services for Tuberculosis and Sexually Transmitted Diseases.

This gives some indication of the duplication of services offered by the three health authorities. This duplication led to unnecessary expenditure of funds by authorities.

There was no appropriate referral system between services under the different health authorities. Patients, who were discharged from a tertiary hospital and perhaps required further treatment at a local clinic, received no referral letter to their local community health facility. In addition, to this most community members, by- passed the local health system and took their children straight to a tertiary facility. For example in Cape Town, often children were taken to Red Cross Children's Hospital, for a minor complaint, such as a skin rash, instead of going to a local clinic (Personal Communication: Registered Nurse, 1997). Local clinics were often limited in their ability to deal with such complaints, by not being equipped with the necessary supplies to treat the health problem. A further barrier was that nurses were not adequately clinically skilled to assess and manage minor health conditions (Personal Communication: Registered Nurse, 1997).

Since the democratic elections in 1994, major health policy changes were introduced.

These policy changes aim to integrate preventive and promotive care with curative services, at local clinics, and encourage more rational use of health resources.

## **POST- 1994**

In April 1994, a government of National Unity was democratically elected by the South African nation. The government aims to redress the injustices, discrimination and inequities to which the majority of the South African population was subjected in the past.

A new National Health Ministry was established shortly after the establishment of the new government. The main aim of the Ministry of Health is to restructure the previously fragmented health system, into a Unified, Integrated, Comprehensive Primary Health Care System. In order to effect change one of the priorities of the Ministry of Health is to provide an effective and sustainable District-based Health System with a Primary Health approach to ensure that every individual has access to the health system depending on their needs (Department of Health, White Paper of April 1997). According to the (Department of Health, White Paper of April 1997:28), the principles of the District Health System are:

- overcome fragmentation
- promote equity
- provide comprehensive services of high quality
- be economically efficient
- allow full community participation
- be accessible to all
- be accountable to the local community
- be based on development and an intersectoral philosophy
- decentralise powers and functions
- be sustainable

In order to ensure that the health system becomes an effective and sustainable system,

human resource development was seen as important. The department prioritised the development of human resources, as it was seen crucial to effect positive change within the new health system. Specific principles were published, relating to human resource development (Department of Health, White Paper of April 1997).

The following principles were included:

- Health personnel should be distributed throughout the country in an equitable manner.
- Particular emphasis should be placed on training personnel for the provision of effective Primary Health Care.
- Education and training programmes should be aimed at recruiting and developing personnel who are competent, to respond appropriately to the health needs of the people they serve.
- Clinical skills of health workers should be upgraded.
- The skills of managers at all levels should be developed, if substantive health reform is to be sustained.
- Research capacity focusing on essential health research strategy should be implemented to support health sector development.

For the purpose of this thesis, health personnel or human resource development is examined with respect to nurses employed at the following local primary health care facilities, within a specified health district: Community Health Clinics, Community Health Centres and Midwife Obstetric Units.

## **RESEARCH PROBLEM**

Bierman and Muller (1994) states that "nursing manpower constitutes 67,8% of the total health manpower in the Republic of South Africa" (Bierman and Muller, 1994: 29). The Regional Health Information Management Systems (ReHMIS) study conducted in South

Africa, in 1994/95, indicates that nurses form 86% of the health personnel in the public health sector (Health Systems Trust, 1996: 88). The Minister of Health, Dr Zuma, stated in 1995, that as nurses forms the largest sector of health personnel in the public sector, they would be depended upon to provide an efficient Primary Health Care service at district level. She has also placed emphasis on upgrading the training of nurses in the public sector, in order to provide a good quality Primary Health Care service (Health Systems Trust, 1996).

A number of South African studies show nurses have limited clinical skills and an even more limited understanding of the political and health framework, in this country. This is a concern given their numerical preponderance and the key human resource position they occupy in the health sector.

Research conducted amongst nurses in the Mpumalanga Province (Health Systems Trust, 1997), found that while nurses were expected to provide promotive, preventive and curative health services at clinics, they reported that they did not feel sufficiently enskilled clinically to provide the curative service expected of them. As a result, patients with minor ailments were referred to public hospitals. It was only after nurses completed a training course in Primary health care clinical skills, they felt more confident to assess health problems and felt they could clinically manage these problems in an appropriate manner.

Gmeiner and Poggenpoel (1996), also reported on problems experienced by nurses in the area of clinical competency. In addition, they identified problems in nurses' ability to implement policy based on transformation principles. They state that, nurses were faced with, a number of difficult challenges in participating in the transformation of the health system. For example, the new health system demands of nurses that they liase with communities, regarding the provision of health services. This is based on the new health policy, which encourages community participation. However nurses have not been

trained to liaise with the community as an equal partner.

A similar example, which highlights nurses' lack of adequate or appropriate training, is cited in chapter four of this thesis. It became evident that since the promulgation of the Termination of Pregnancy Act in February 1996, most nurses in the West district of the City of Tygerberg, have not been enskilled to provide a counselling service for women requesting a termination of pregnancy.

Strasser and Gwele (1998) in their review on the "Needs of nurses" and a "Review of Primary Health Care education for Nurses" reported that:

- Only a small percentage of Registered Nurses have been trained in Primary Health Care. These PHC Nurses are depended upon to provide a curative service at district level, in the absence of a Medical Practitioner. Most nurses employed at district health facilities have only been trained to provide health care within curative health facilities such as hospitals. In hospitals nurses provide a curative service, and carry out the orders of the medical doctor. The training of these PHC Nurses focuses on developing specialised clinical skills to supplement the curative role of a Medical Practitioner and to be able to render treatment in the absence of a medical doctor.
- Nurses' basic training does not adequately equip them to deliver appropriate Primary Health Care services.
- It is also reported that nurses need training and support to enable them to understand the health policies with particular reference to the development of health systems at district level.

They also found that nurses at local health facilities felt frustrated with their increased workload, and that they were not sure what their job descriptions were and hence, they frequently felt they were not appropriately skilled to perform certain functions. A more detailed discussion regarding nursing skills, their scope of practice and their training will be discussed in chapter two.

In summary, these studies and public statements seem to indicate that nurses are expected to participate in the development of the District Health System and implement the new policies, despite the fact that they do not possess the appropriate clinical skills or the theoretical framework in which to apply these skills.

The difficulties faced by nurses in implementing changes in health policy should be seen against the backdrop of changes in the way the nursing profession is organised and represented. These include the following changes:

- An Interim South African Nursing Council was established in 1995.
- Policy guidelines and principles for a new unified democratically elected Nursing Council have been established.
- A countrywide nurse' strike occurred in late 1995, to demand a general wage increase for all nurses.
- A new democratic Nursing Council was established in April 1998.

For some nurses, the numerous changes occurring on so many different levels may be difficult to deal with. Many of the changes have occurred at national level without the involvement of personnel at a local health facility level. At a local level, nurses are often faced with a variety of local problems and frustration, due to increased workload, uncertainty in terms of their job description and job security and low salaries. Not much attention has been focussed on gaining insight into district level nurses' knowledge of the changes in health policy, their attitudes towards and perceptions of key aspects of the new system such as the District Health System. In addition not much data has been gathered on, whether district level nurses feel adequately skilled to function effectively within the System. There are currently no mechanisms or processes in place to provide nurses, employed at local Primary Health Care facilities, with a forum to discuss their concerns about the changes in the health system as well as to participate fully in the

development of the District Health System.

It is therefore necessary, as an important starting point in restructuring health services, to examine nurse's attitudes', perceptions' and knowledge of the new health system.

This can assist policy makers, district health managers and nurse educators with some insight, in order to provide appropriate mechanisms or programs, to reorientate nurses to the new system.

## **PURPOSE and JUSTIFICATION**

In the light of the research problem discussed above, this thesis endeavours to contribute to the development of the transformation process of the health sector, as it relates to the provision of information and knowledge with respect to human resource development and needs. It focuses specifically on Primary Health Care facility nurses as a human resource within this sector.

As nurses constitute the largest sector of health personnel, it is of importance to determine the competency of these health workers, as they enter the new phase of the Health Systems Delivery in South Africa. In order to understand nurses' capacity to work effectively within the new health framework, it is important to examine the following:

- Nurses current skills
- Nurses understanding of the health system's framework
- Nurses perceptions of and attitudes towards the District Health System

The researcher, in conjunction with the participants in the study, has developed recommendations, pertaining to the reorientation and training of nurses, towards a district-based Primary Health Care system.

Recommendations from these research findings could be used to inform policy makers, nurse educators, district health managers and nurses employed at district level health facilities.

## **AIM AND OBJECTIVES**

### **AIM**

The aim of this case study conducted, in the West District of the City Of Tygerberg was, to gain insight into primary health care level nurses' understanding of some key aspects of the new SA health system's framework and to explore their current experience of working as health practitioners within the new health system's framework.

### **OBJECTIVES**

The study had the following three objectives:

- To determine nurses attitudes towards and perceptions and knowledge of:
  - The Structure of the District Health System and how it is linked to the Primary Health Care Approach and concept.
  - Selected aspects of the Maternal, Child and Women's Health Policy, as it relates to their work environment at Primary Health Care facilities.
- To explore nurses perceptions of the adequacy of their nursing skills and their specific scope of practice and to identify gaps within the basic nursing training received by these nurses and skills needed to provide an effective health care service.
- To identify these nurses' concerns and problems with the transformation of the health system, particularly at district level.

## REFERENCES

1. Bierman J and Muller M, 1994. Legal Limitations In The Practice Of The Primary Health Care Nurse. Curationis, Vol.17, No.2, 1994: 29- 34.
2. Department of Health, 1997. White Paper For The Transformation Of The Health System In South Africa. Department of Health, Pretoria.
3. Ebrahim GI and Ranken JP, 1993. Primary Health Care: Reorienting Organisational Support. MacMillan Press Ltd, London.
4. Gmeiner A and Poggenpoel M, 1996. Nursing Service Mangers' Views On Problems They Experience In Their Everyday Lives: Part 1. Curationis, Vol.19, No.1, March 1996: 55-60.
5. Health Systems Trust, 1996. South African Health Review, 1996. Published jointly the Health Systems Trust and the Henry J. Kaiser Family Foundation, Durban.
6. Health Systems Trust, 1997. Primary Health Care Training. HST Update Issue No.26 August 1997:7-9.
7. Personal Communication: Registered Nurse, 1997. Elsie's River Community Health Centre. Western Cape Community Health Services. City of Tygerberg.
8. South African Nursing Council, 1978. Nursing Amendment Act 50 of 1978. South African Nursing Council, Pretoria.
9. South African Nursing Council, 1985. Regulation 425 of 1985. South African Nursing Council, Pretoria.
10. Strasser S and Gwele N, 1998. Nurses Oriented Primary Health Care. Health Systems Trust, 1998:83-92. South African Health Review, 1998. Published jointly by Health Systems Trust and the Henry J. Kaiser Family Foundation, Durban.
11. Tarimo E, 1991. Towards A Healthy District. Organizing and managing district health systems based on primary health care. World Health Organization, Geneva.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

This chapter provides the reader with an overview of the structure of the new health systems framework and the transformation process of the health system in South Africa. It also deals with nurses' role and function, particularly within a district health system, which is in a process of transformation.

This chapter is presented in two sections. The first section describes the broad framework of the South African health system under the following headings:

- The historical context of the SA health system
- The philosophy of the health care approach, namely PHC
- The structure of the South African health system
- Priority programs, specifically the MCWH program

In order for the health system to function effectively, it requires an efficient and competently skilled human resource component. This includes health personnel who provide and manage health services at public health facilities. The human resource component is discussed in section two of this chapter, under following headings:

- Introduction
- The importance of human resource development
- Nursing practice at PHC facilities
- Nurses relationship with the PHC team
- Nursing education and training

## **SECTION ONE**

### **The historical context of the SA health system**

In April 1994, the first democratic national elections took place in South Africa. Since then the newly elected government has made a political commitment to improve the social, economic and political conditions of the vast majority of its citizens who were disenfranchised prior to the 1994 elections. This commitment consists of a broad transformation framework, which includes all sectors and governmental departments. The health department and its system are one of the sectors, which this thesis focuses on.

The newly elected health department in after the 1994 elections has embarked upon a process of transformation, after having designed a broad framework in which to do this. Various policies were introduced to ensure that this framework is functional. The new health system focuses on:

- Working towards an integrated comprehensive health system.
- Ensuring equity, through introducing mechanisms which would facilitate the process of allowing all South African citizens to have access to essential health care services.
- Orientating the health professional to work towards this new approach in order to develop an effective health system.

The national health system consists of the three levels briefly described in the definition of terms, namely the national, provincial and districts levels. Each of these three levels has specific roles and functions. The specific roles and functions of the system are described later in this section.

Furthermore, the health department adopted a PHC approach, to transform the fragmented health system, and render appropriate health services. It also aims to improve the health status of particularly the rural people, poor, women and children in this country. These groups were identified as those most affected through the fragmented health

system and the apartheid policies of the previous regime that existed prior to the 1994 democratic elections.

Before describing the structure of the national health system, according to the three levels, it is important to first discuss the approach used to address inequities as well as implement the health systems policies at the various levels.

### **The PHC approach**

Traditionally PHC was referred to or was perceived as the first level of contact between patients or the community and the health services. However, this perception and notion of PHC changed. Research in the 1960's and 1970's, highlighted the fact that a large percentage of the rural populations in developing countries were not receiving basic health care. Countries such as China (Rohde,1989) and Cuba, (Werner,1989) demonstrated alternative approaches to health care provision, which resulted in great benefits to its citizens' at the time. In 1978, subsequent to various studies, an international conference was held in Alma-Ata, whereby the participants of more than a hundred countries, released a statement in the form of a declaration, on a new approach to health care. This declaration is known as the Alma-Ata Declaration (Ebrahim and Ranken, 1993). According to the Alma-Ata declaration, PHC aims to address the main health problems in communities, through promotive, preventative, curative and rehabilitative services. It also describe PHC as 'essential health care', consisting of at least the following eight elements:

1. Promotion of nutrition
2. Provision of adequate water supply
3. Provision of safe sanitation
4. Immunization against major illnesses
5. Maternal and child care and family planning
6. Prevention and control of endemic diseases.

7. Health Education, of health problems and methods to prevent and control these problems.

8. Appropriate treatment for common diseases and injuries.

PHC thus embodies an approach to address the basic needs of communities, as well as to provide essential services to these communities. Added to this, PHC also focus on three fundamental aspects, known as the pillars of PHC. It is also known as the three activity areas. According to Ebrahim et al., (1993) "PHC is a drive towards the front-line of day-to-day activities carried out within the community", (Ebrahim et al., 1993:16) and these pillars or activities are:

- Active involvement and participation of communities within the assessment, planning and implementation of health services.
- A process of intersectoral collaboration, meaning that basic health needs should be met and that other appropriate sectors such as Agriculture, Education and Welfare should participate in this process.
- Equity in health care and health provision is the third pillar. This means that health resources should be equally distributed, to ensure that all citizens have equal access to health care, if needed.

#### South African Health department's legislation regarding the PHC approach

The Department of Health's White Paper on the Transformation of the Health System (April 1997), reflects the commitment of the government on:

- Meeting the basic needs of the community
- Ensuring the development and improvement of housing services like water and sanitation, nutrition and health care provision.

According to the health department, this is being done through the three activities or pillars previously mentioned. However, in addition to that, the health department has

introduced specific strategies to ensure that the health system is being transformed.

These are:

- The health sector must promote equity, by developing a single unified health sector.
- The health system will focus on districts as the major locus of implementation.
- The national, provincial and district levels will play distinct and complementary roles.
- An integrated essential package of PHC services will be available to the entire population at the first point of contact. The first point of contact is referred to as the - local community health clinic, community health centre and or district hospital.

To focus on districts as the major locus of implementation, means that efficient district based health systems should be developed. Furthermore, it was also felt that to ensure good planning and management, as well as provision of a District health system and its services the collective responsibility of health professionals, workers and professionals from other sectors as well as the community members, would be required. Although the above framework has been put in place, the DHS is still non-existent in some of the provinces, or where they exist, they have poorly formulated plans. This seems to be a global phenomenon with transitional health systems such as South Africa's. This can be seen from local reports of the implementation of the new health system. For example, Tarimo (1991) states that the District Health Systems' "targets are vague and efficiency and effectiveness as well as the quality of services are seldom considered" (Tarimo, 1991:1). In addition, in the case of South Africa, health services are concentrated in particular areas, still leaving large population groups with little or no access to health care. It would appear that South Africa is not unique at its unequal distribution of health services.

Draft legislation on the DHS states that it should not function in isolation but should form part of the broad health systems framework. This means that it should receive support from the national and provincial health departments.

To place a more detailed discussion of the structure of the DHS in context, the role and function of the national and provincial departments is briefly explained.

### **The structure of the South African Health System**

This section draws mainly on the Department of Health's White Paper on the Transformation of the Health System in South Africa, April 1997. The function of the national health department are to:

- Provide leadership in the formulation of health policy and legislation.
- Provide leadership in the formulation of norms and standards, and in quality assurance.
- Build the capacity of provincial health departments.
- Ensure equity in the allocation of resources to the provinces and municipalities and their appropriate utilisation.
- Provide leadership in strategic planning and management of resources available to health care
- Develop co-ordinated information systems and monitor the progress of it.
- Support the provinces and municipalities in ensuring access to cost-effective and appropriate health commodities.

The organisational structure of the national department has been described in the definition of terms. Various national health programs formed by the national health department forms part of the organisational structure. One of the programs is elaborated on in this thesis. The Maternal, Child, and Women's Health (MCWH) is one of the priority national programs, discussed in detail, and also to provide information on this program

against which to measure the nurses' knowledge, attitudes and perceptions of this program as part of the broader health system's framework, later in this thesis.

### **MCWH as a national priority program**

It is a global phenomenon that women and children are two of the most vulnerable groups in their susceptibility to disease and mortality. Research by Solarsh and Xaba (1994), in South Africa indicated the following:

- Maternal mortality rates were unacceptably high.
- Causes of maternal morbidity and mortality were antepartum and intrpartum bleeding, infections, ruptured uterus, abortions and pregnancy-induced hypertension.
- There was a need for more effective fertility education and for attention to be given to the prevention of violence against women.
- Infant mortality rates in African children varied from 30 to 73 per 1000 live births. This was 7 times higher than in children of other population groups.
- Malnutrition and infection, especially diarrhoeal and acute respiratory infections, were the most important causes of morbidity and mortality in infants and young children.
- HIV and AIDS were rapidly becoming a threat to the health of women and children conceived and born from mothers who are HIV positive.

It is in this context that the new Ministry of Health in South Africa decided to give priority to Maternal, Child and Women's Health. A special ministerial commission on MCWH, in 1995, recommended that MCWH be accorded National program status. This commission also provided a policy framework based on the PHC approach. The main aim of the policy framework is that the National and Provincial MCWH Directorates, support the MCWH services delivery at district level (Health Systems Trust, 1996).

The South African Department of Health, in its White Paper on the transformation of the health system in South Africa of April 1997, provides the principles on which the MCWH policy is based. The principles are:

- The MCWH services should be integrated and comprehensive.
- The services should be accessible to all mothers, children and women. With specific focus on the rural and urban poor and farm workers.
- MCWH services should be efficient, cost-effective and of a good quality
- Women and men will be provided with services, which will enable them to achieve optimal reproductive and sexual health.

Furthermore, like other health services and health programs, the implementation strategies for the MCWH services to be re-organised would be done on national, provincial and district levels.

It is at this stage important to note, that according to research conducted by the Health Systems Trust in 1998, in evaluating MCWH program development the following information was reported:

The National Health Department set itself the following objectives to implement the MCWH program:

- In Maternal Health: To implement maternal death notifications and provide advanced training to midwives.
- In Child Health: To implement integrated management of childhood illnesses and to implement a national program of action. An example of a national program of action would be implementing a uniformed approach, in all nine provinces to detecting, diagnosing and treating certain childhood illnesses.
- In Women's Health: To implement the Termination of Pregnancy Act, improve access to contraceptives and to develop guidelines for survivors of violence.

- In Youth and Adolescent Health: To develop policy guidelines and reduce teenage pregnancies. (Health Systems Trust, 1998)

An evaluation of the MCWH program by the Health Systems Trust in 1998 found that there were various obstacles to achieving these broad objectives. These are:

- Institutions were fearful in reporting maternal deaths. Reasons for this were not elaborated on.
- Provincial training of midwives in "Advanced Midwifery" and in the PEP program was extremely slow.
- There were poor information systems.
- A gap was identified between policy and implementation.
- Staff shortages were prevalent
- Many health service personnel felt threatened by the community involvement initiative.

The Health Systems Trust (1998) report indicates that although attempts have been made to implement the objectives, many obstacles still exist, preventing this program from achieving its optimal goal, particularly at district level. It is clear from the obstacles mentioned above that an emphasis on the development of human resources such as their training and reorientation or retraining is essential. This alludes to nurses attitudes and needs being an important aspect to incorporate in addressing the development of human resources. Hence, this is discussed greater in detail in section two. Next to be discussed is the role and function of the provincial health department.

#### The functions of the provincial health department

The main functions of the provincial health department are:

- To promote and monitor the health of the people in the province and develop and support a caring and effective provincial health system.

- To establish and support a province-wide District Health System (DHS) based on the principles of the PHC approach.
- To ensure the provision of relevant regional and specialized hospital services.
- To ensure appropriate human resource management and development.
- To co-ordinate the funding and financial management of district health services.
- To formulate and implement health policies, norms, standards and legislation.
- To provide technical and logistical support to health districts.

Although the DHS appears to be at the lowest end of the, three tier system of the national health structure, it is the most important tier or component thereof. Details of the structure and functions of the DHS follows.

#### The District Health System (DHS)

The priority of South Africa's Health department is to restructure the health system, to ensure that a Comprehensive Primary Health Care service is provided to all South African citizens (Health Department's White Paper, April 1997). The following aims and goals form part of the District Health System. The aims of the DHS are to:

- Unify the fragmented health services, and to reduce disparities and inequities.
- Reduce disparities and inequities in health service delivery by ensuring accessibility.
- Give priority to maternal, child and women's health.
- Ensure the involvement of all partners specifically non-governmental organisation, communities and the private sector.

The goals of the DHS are to:

- Unify fragmented health services into an integrated national health system.
- Promote and ensure equity, accessibility and utilization of health services.
- Ensure the availability and appropriateness of health services.
- Develop health promotion activities.

- Foster community participation across the health sector.
- Develop the human resources available to the health sector.
- Improve the planning and the monitoring of health status and health services.

The Health Department in its White Paper of 1997, On the Transformation of the Health System in South Africa, specifies the following principles on which the DHS is based:

- To overcome fragmentation.
- Ensure equity of resources and services.
- Provide comprehensive primary health care services.
- The system must be effective, efficient and of a high quality.
- The services must be accessible to the people in the district.
- There must be a culture of accountability of the health service and health workers to the local communities within the districts.
- Community participation must be fostered.
- Intersectoral activity should take place amongst various sectors to improve the quality of life of the communities.

The specific functions of a DHS as specified in the Health department's White Paper of April 1997 are to:

- Ensure the availability of a full range of PHC and other relevant health services in communities, clinics, community health centers, district hospitals and other facilities.
- Provide for community participation in the health promotion and health service provision.
- Provide administrative, financial and support services to local health facilities.
- Plan and develop appropriate training and development programs for human personnel.
- Manage health information, by establishing health information systems.

- Monitor and evaluate health and health service provision.

The next section focuses on the structure of the DHS and how the three PHC pillars should facilitate the effective development of the DHS.

### The structure of the DHS and the three pillars of PHC

The structure consists of a district health authority, which is managed by a district health manager. Community participation is envisaged through the formation of community health committees. These committees consist of all sectors of the community. These committees would discuss issues and concerns regarding factors influencing their social and health status.

The health department has placed major emphasis on the community's participatory role within the planning and management of health service delivery. This process of community participation, which is one of the PHC pillars, is in accordance with the PHC approach. The following issues are dealt with below: what community participation means; how this component or pillar of PHC is implemented within a DHS locally in South Africa; and how the main role players (the community, health professionals and workers at local health facilities) relate to each other. In addition the other two PHC pillars, namely, Equity and Intersectoral Collaboration are discussed.

### Community Participation

Community Participation is the process used to ensure that PHC becomes an enabling mechanism for communities and health service personnel to work together. Ebrahim et al. (1993) and Macdonald (1995) have argued that this process, if implemented appropriately and skillfully, may contribute to improved health service planning and delivery. In addition, community participation can lead to health service delivery being more in keeping with the needs of the community.

However, although community participation is a crucial component of PHC, it is not easy to achieve and sustain (Dreyer, Hattingh and Lock, 1997 and David, Zakus and Lysack,

1998). Much has been written on the obstacles to achieving community participation. For example, David *et al.* (1998) have pointed out that “communities are very heterogeneous entities, not only in their demographic composition but also with respect to their interests and concerns” (David *et al.*, 1998: 6). These factors, makes it difficult to achieve community participation.

A number of researchers state that there need to be certain basic criteria, that should be adhered to, in order to develop and sustain community participation. For example some authors distinguish between passive and active participation of communities. Dreyer *et al.*, (1997) state that in terms of health planning, community participation is enhanced by involving all the major role players. Participation of the community in the discussion of planning as well as the decision making with respect to health care needs, encourages a process of active participation (Dreyer *et al.*, 1997). They argue that active participation results in more effective decision making and promotes commitment. According to them it, “facilitates analysis and understanding of the various concept, principles and terms used in the planning process, and by so doing making the process democratic and transparent for the health care provider the health care consumer and other sectors within the community” (Dreyer *et al.*, 1997:135).

David *et al.* (1998) lend support to this argument and state further that by actively involving the community yields particular benefits to all role players, including the community and the health system. David *et al.* (1998) also speak about positive outcomes or benefits arising from active community participation, such as a “heightened sense of responsibility and conscientiousness regarding their power achieved through the acquisition of new skills and control over resources”(David *et al.*, 1998: 2). This benefits the community as well the health system. For example, if there is a shortage of health personnel, there will be a greater likelihood of volunteers to help render basic services. This is because the community is fully involved and aware of the staff shortage and would

therefore be prepared to volunteer its services. Another example cited is that if the business sector is actively involved, they are more likely to contribute financially to the health service, reducing the cost of expenses from the health department's side.

David *et al.* (1998) suggests that community participation also foster a less authoritative relationship between the community and health care providers. They also state that if the community is actively involved in health service provision and planning, it would foster a greater sense of responsibility from the community's side. In addition, David *et al.* (1998) states that active or passive involvement of the community indicates the intensity of community participation and can be measured by the amount of power the community has. For example if the community has a limited say in the planning and management of the health services, it becomes obvious that they do not have real decision making powers. This may become evident in the fact that they do not participate visibly or by objecting to the services offered.

David *et al.* (1998) also mentions that at times the attitude of health providers towards community participation, is one of a "top-down" approach. This means that health providers expect the community to follow their instructions without question. This type of attitude could serve as a major constraint to effective community participation. In order to prevent these obstacles and constraints as argued by Dreyer *et al.* (1997), and David *et al.* (1998), health providers needs to be provided, with the appropriate information and training. This would enable health providers to implement the process of community participation effectively (Macdonald, 1995).

In June 1997, a final draft consisting of guidelines on participatory development was published, after a collaborative process by the Human Science Research Council, Medical Research Council and the South African Network of Community Partnerships In Health Personnel Education. These guidelines are intended to build the capacity of managers, facilitators and community members, who are involved in the process of community

participation. It is also intended to build the capacity of health and welfare personnel at local and district level.

"In most cases, involving communities in service delivery is a new challenge for departmental staff. Until recently, training did not include this aspect of service delivery" (Guidelines on Participatory Development, 1997: 71). The authors of the Guidelines on Participatory Development (1997) also points that "just as the capacity of the community has to be built for effective participation, the capacity of departmental personnel has to be built to accommodate community participation" (Guidelines on Participatory Development, 1997: 71). In addition the authors specifies the following guidelines, which could be applied by health authorities, particularly the district health authorities, to facilitate effective capacity building of health personnel:

- Brief personnel on the principles and practice of community participation in service delivery.
- Attempt to understand the feelings of the health and welfare personnel.
- Create an atmosphere of confidence and trust, increase their understanding of the new work situation and its challenges and rewards.
- Communicate and explain why transformation and restructuring take place.
- Involve them in planning and promote participation in the change process.
- Prevent the change process from becoming drawn-out.
- Manage conflict between interest groups.
- Provide support at all levels in the department.
- Provide training to staff to build their capacity for participatory service delivery.
- Regularly discuss progress or the lack of progress in community participation with the staff.

(Guidelines on Participatory Development, 1997:72)

Besides the broad general guidelines regarding community participation, as specified in the final draft of the Guidelines on Participatory Development (1997), no specific guidelines prevail for health departments and their personnel at district level. The Health Department's White Paper of 1997 only specifies that community health committees should be established and that these committees should serve as a forum in which community members may participate.

Currently there is a dearth of information regarding the functioning of these community health committees, let alone district health systems, in South Africa. Furthermore, as the South African health department has only recently introduced progressive health policies, seeing evidence of effective implementation will take some time. The fact that the country and the health department are in a process of total transformation means that that implementation of new policies, is not an easy process.

For community participation to be successful there should be a process of intersectoral collaboration (Macdonald, 1995). The health department's White Paper (1997), specifies that it cannot provide the PHC essential services, such as nutrition, safe sanitation, and housing, on its own. The next section briefly discusses intersectoral collaboration.

#### Intersectoral Collaboration

It is stated within the Alma-Ata Declaration of 1978, that "PHC involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors" (Macdonald, 1995: 111). In addition Macdonald (1995) points out that one of the three pillars of PHC is that the health sector work with other sectors, to address the social, economic and political factors that impact on health and health care delivery. This interactive process with other sectors is, known as intersectoral collaboration.

Furthermore, intersectoral collaboration means, that the health department cannot meet basic health needs alone but that other appropriate sectors such as Agriculture, Education and Welfare should participate in this process.

Most health departments in other countries acknowledge that not only curative measures can reduce and avoid a large number of illnesses, but that other measures also need to be employed (Ebrahim *et al.*, 1993). Other measures include for example, the improved supply of food and the supply of safe water, including sanitation.

It is important to note that beside the health sector, other sectors' activities can have beneficial effects on the health of individuals and communities. For example, in South Africa, the formal educational sector provides formal schooling for children up to supposedly 18 years of age. A number of non-governmental organisations offer literacy programs for adults. Education, formal and informal, can enable people to read which can enhance their health and the health of others. For example, being literate would enable a mother to read the instructions or information written on her child's "road to health card", and so take better care of her child's health. In addition, teachers could be used as resource in promoting health. They could be taught to recognise common diseases, physical and mental problems and to know when to refer these to the health sector.

The list of examples is endless as to how intersectoral collaboration could occur and is occurring in communities. The health department's commitment to transformation of the previously fragmented health system, into a unified integrated comprehensive health system, is based on the equity principle. The equity principle or process is the third pillar of PHC and is discussed below.

#### The Equity process or principle of PHC

Disparities in health status and an unequal distribution of health resources are apparent in many developing countries, including South Africa. The equity principle as specified in the

Alma-Ata Declaration of 1978, aims to address the differences and inequalities in “health status and access to health care” (Macdonald, 1995: 124).

The Health Department’s White Paper of 1997, specifies that the health sector should contribute to the transformation process by:

- Promoting equity, accessibility and appropriate utilization of services, by developing a single unified health system.
- Increase access to integrated health care services for all South Africans, particularly the rural, peri-urban and urban poor, and the aged.
- Distribute health personnel throughout the country in an equitable manner.

A key outcome in assessing whether equity exists is that there should be equal access to health care services. Furthermore, community participation and intersectoral collaboration of all stakeholders, including the health providers, play a role in attaining equity (Dreyer *et al.*, 1993 and Macdonald, 1995).

### **Conclusion**

The health policies of the South African health department cannot be implemented effectively if the human resources, particularly at ground level (in the PHC facilities within districts) have no conceptual framework of the purpose and function of the new health systems framework. Section two, provides a review of the experiences of South Africa and other countries’ approach, to the development of health personnel, within a transforming or changing health system.

## **SECTION TWO**

### **Introduction**

This section focuses on, the South African experience with respect to human resource or health personnel development and compares it to the international experience. There is widespread recognition that the district is the key point where national policies can be translated into community action and where various programs and institutions within the health system can most effectively be co-ordinated (Department of Health's White Paper, April 1997). However, without a, skilled health personnel, efficient service delivery will not occur. For the purpose of this discussion, the health personnel referred is that based at local primary health care facilities, which should be included as part of the District health team and is also referred to as the PHC team in this discussion. A PHC team at a local health facility or basic health unit, such as a community clinic or community health centre should include: community health nurses, midwives, doctors, primary health care nurses, enrolled nurses and enrolled nursing auxiliaries, oral hygienists/therapists, clerical and support staff and rehabilitation personnel (The White Paper, April 1997). It is stated that the health team should be appropriately skilled to deal with common conditions or refer appropriately. The health department endeavours to educate and train existing health personnel to become competent in the provision of services to meet the community's needs. In addition, the development process of health personnel should ensure a caring and compassionate health sector.

### **The importance of human resource development**

As reflected in the White Paper on the Transformation of the National Health system of April 1997, the South African Health Department has adopted certain principles to guide the development processes of health personnel. These principles were adopted because as stated in the White Paper of Transformation of the Health System (1997), "human

resource development is a critical factor in the implementation of health and social development”, (White Paper, 1997: 54). These principles are that:

- A national framework for the training and development of health personnel will be established.
- The skills, experience and expertise of all health personnel should be used optimally to ensure maximum coverage and cost-effectiveness.
- Health personnel should be distributed throughout the country in an equitable manner.

Since the introduction of the new health system and its transformation process, many changes occurred which have affected the health personnel. To mention a few: it's mandatory on completion of their training that medical doctors work within a rural community for a year as part of their community service; nurses at local PHC facilities are expected to perform more clinical functions and hence most require more training in specific clinical skills. In addition, the districts are in the process of integrating previously separately managed provincial health services with these managed by local health authority services. This has caused major confusion amongst health personnel, as conditions of service and job descriptions have not as yet been changed, in many provinces in South Africa (Health Systems Trust, 1998). In many cases, health districts have not been clearly defined. For example, a recent study conducted by Health Systems Trust (1999) has found that there are no clearly defined health district boundaries within the Western Cape. This is because the metropole is in the process of setting up a “megacity” and according to the study until those boundaries are clear, it would be difficult to divide up the health districts (Health Systems Trust, 1999). Another obstacle found in this study preventing implementation of policies at district level, was that there was no integration between the staff at facilities of the previous provincial health department and those of local authorities. This means that differences remain in conditions of service of particularly those of nursing staff of the two authorities, which further hampers nurse's

willingness to sincerely implement the policies. The study was conducted in the Ocean View Area, part of the South Peninsula Municipal Sub-Structure in the Western Cape.

A key concern is: Are nurses who are known to be the largest workforce in the public health sector and the Backbone of the health system (Andrews, 1994 and Health Systems Trust, 1996) clinically skilled and conceptually adept to implement the new health system's framework? And in addition, how do they experience the transformation process?

The rest of this section provides an outline of national and international experiences of this sector of health personnel, under the following headings: nursing practice at primary health care facilities; nurses working relationships with other health team members; nurses role in policy implementation; and the clinical training and education of nurses.

#### **Nursing practice at PHC facilities**

As a profession nursing has and continues to play a vital role within the health care system (Oerman M, 1991). Nursing practice within PHC facilities differs from the nursing practice within the hospital setting. Research conducted in South Africa and internationally indicates that hospital based nursing care is task orientated. This means that each nurse has an individual function in the ward. In most hospitals, nurses apply the Nursing Process to design care plans for the individual patient. The Nursing Process has its origins in the American nursing system of the 1960's (Kyriacos and Van Der Walt, 1996).

Wiedenbach (1985) and Henderson (1985) also refer to the Nursing Process as a nursing care plan, which is unique to the needs of the individual patient. Within a hospital setting, the sick patient is dependent on the nurse to meet his or her basic needs as well as to ensure that the illness is being treated appropriately. Thus an individual nursing care plan within hospitals, best meets the needs of the individual patient.

While this nursing care plan is appropriate to caring for the sick individual in hospital, this approach cannot be used within nursing practice at local Primary Health Care facilities. Kyriacos and Van Der Walt (1996) argue that this Nursing Process is not appropriate for nursing practice at local health care facilities. They further argue that the Nursing Process is not a theory and can therefore not serve as a broad operative policy framework for nursing. They suggest that South Africa should design its own nursing theory and nursing model, applicable to the health needs and broad health principles of the country.

Kyriacos and Van Der Walt's (1996) argument is of particular importance to a nursing system, which is expected to provide nursing care within a Comprehensive Primary Health Care delivery system.

Ebrahim *et al.* (1993) argue that the major challenge for nurses in a developing country is to assist individuals and communities in their struggle for survival. They suggest an alternative model to that of curative-based care. This alternative model is called a Survival Model. This model is aimed at assisting individuals and communities to implement strategies to fulfill their survival needs. The Survival model not only includes the nursing care of the sick individual, but also encourages the nurse to approach nursing practice in a holistic way. This means that the nurse should concern himself or herself with the political, social and economic well-being of the individual who attend the local health facility, as well as the rest of the community's, socio-political and economic needs. Nurses should not do this on her own, but in collaboration with providers from other health disciplines and other sectors or social institutions.

The health department, endeavours to retrain and reorientate health personnel to become competent in the provision of health services to meet the community's needs (White Paper, 1997). For this to materialise within the nursing profession the argument presented by Kyriacos and Van Der Walt (1996), for an appropriate South African based nursing model thus needs to be addressed by nurse academics and nurse policy makers.

Nurses employed at local PHC facilities completed their basic training within hospitals. Registered Nurses have only been exposed to Community Health Nursing during their basic or initial clinical training since 1985. Currently, a large proportion of the student nurses' clinical training continues to be curative-based (South African Nursing Council, 1985). This can be seen, in that Nursing Regulation 425 of 1985 sets the allocation time of clinical practice in a curative health care setting such as the hospital, at nine months for student nurses. In contrast, the allocated training period for clinical practice in Promotive and Preventive Health Care settings is only six months (South African Nursing Council, 1985).

Literature on the training of Primary Health Care workers stresses the importance of adequate theoretical and skills training. Tarimo (1991) states that staff is often ill prepared to meet the demands of providing an effective Primary Health Care service. The South African Health Department has acknowledged this, hence the focus and earnestness in developing appropriate training and reorientation programs for health students and existing health personnel, particularly at district level (White Paper, 1997).

The South African Health Department (White Paper, 1997) is cognisant of the fact that the training and education of nurses did not usually provide them with appropriate Primary Health Care skills for them to:

- Fulfill competent management functions within Primary Health Care facilities.
- Be sufficiently sensitive to the communities social, economic and health needs.
- Collaborate as equal partners with other sectors.
- Lobby for better health facilities.
- Conduct epidemiological studies, to determine the cause of disease.
- Conduct research that can impact on policy formulation and local planning.

These PHC principles are critical to the theoretical conceptual framework in which nurses should practice. This excludes the necessary clinical skills, which is also needed to practice nursing.

It is evident from health service reports and health systems research study findings that numerous constraints still exist which contribute to nurses' limited skills capacity, under the current conditions to implement the principles of Primary Health Care, enshrined in the Alma-Ata Declaration of 1978 and the White Paper on the Transformation of the National Health System in South Africa, April 1997. Further detail is presented in chapter four to provide some insight into some of the three nurse categories experience, perceptions and understanding, with respect to their nursing functions and working conditions, at local Primary Health Care facilities, in the West Health District in the City of Tygerberg.

Various nursing-governing bodies govern the nursing profession throughout the world. Within South Africa the South African Nursing Council governs it. These governing bodies formulate the Scope of practice for each nurse category.

The following sub section, provides some insight into the type of nursing duties or functions performed by the three respective nurse categories in South Africa, and internationally. It also focuses on alternative strategies employed by countries such as the United Kingdom, and Australia, to address constraints, which were similar to these in the South African context.

#### Nurses scope of practice

For the purpose of this thesis the scope of practice refers to the framework in which the nurse may practice and the specific skills required to practice nursing, formulated by the South African Nursing Council. It is provided in the form of regulations and policies, specifically for each nurse category.

The three main nurse categories in South Africa are expected to perform specific nursing functions. The Registered Nurse practices according to the South African Nursing

Regulation 425 of 1985. The main functional categories are: clinical practice, supervision and delegation, teaching, administration and research. For Enrolled Nurses and Enrolled Nursing Auxiliaries the functional categories are: clinical practice and administration. The South African Nursing Council, as a statutory body ensures that the Nursing Act 19 of 1997 is adhered to. This Act states that nurses are responsible for their own acts and omissions. In essence this means that if a nurse does not practice within the prescribed scope of practice, relevant to his or her enrollment or registration, disciplinary action would be taken by, the Nursing Council. An extreme example of the severity of discipline, could be the expulsion of the nurse, from the nursing profession, and having his or her name removed from the professional register or roll.

Since the introduction of policies and measures to transform the health system nurses, are expected to take on more roles. Strasser and Gwele (1998), found that most nurses at Primary Health Care facilities in South Africa are not adequately skilled to put into effect the new health policies, particularly as it relates to their clinical skill competencies. Strasser and Gwele (1998) contend that clinic nurses are expected to provide ongoing care for chronic diseases such as hypertension and diabetes, as well as to provide management of Tuberculosis, Sexually Transmitted Diseases, and HIV and AIDS counseling and care. Yet, according to Strasser *et al.* (1998), the basic nurse training, does not properly equip nurses to deliver PHC services. The findings of Mofukeng and Roos (1999) also indicate that the clinical skills of nurses in Mobile health services are inadequate. They found that those nurses lacked appropriate communication skills during health education and were therefore unable to transfer to community members the necessary information. It was also found that those nurses failed to perform physical examinations on patients. According to Mofukeng *et al* (1999) this could be attributed partially to the lack of appropriate training to equip nurses to provide an effective PHC service on mobile clinics. Both of these South African studies suggest guidelines to

improve the clinical skill competencies and theoretical understanding of nurses. To mention a few: Strasser and McCoy (1996) suggest that nursing competencies must be addressed before service delivery begins, through pre-service training or orientation programs. They stress the need to build consensus on the minimum core competencies of clinic nurses. Strasser and Gwele (1998) suggests that clear, concise and consistent treatment guidelines, should be available for nurses. In addition a culture of learning must be developed so that nurses are keen to read and utilise the available material. They suggest that in order for nurses at local level to be comfortable and confident in the services they provide, nurses need a clear understanding of when and to whom referrals should be made. The study also suggests that clear referral guidelines and networks need to be available.

Both these studies have been conducted within local Primary Health Care settings, where not only Registered Nurses but Enrolled Nurses and Enrolled Nursing Auxiliaries are employed as well. It is apparent particularly at local health facilities, that definite role overlapping between Registered and Enrolled Nurses, occurs. Nurses also indicated that there seems to be role confusion, which results in work overload, work frustration, and working beyond the scope of practice. This phenomenon is prevalent in the European (Francis and Humphreys, 1999) and American (McNeese-Smith, 1999) nursing profession as well. Prior to discussing and comparing the South African context and approach with the various international approaches to this phenomenon, it is important to note that it has been extremely difficult to find recent research conducted on Enrolled Nurses and Enrolled Nursing Auxiliaries in South Africa. The dearth of information regarding nursing practices of Enrolled Nurses and Enrolled Nurse Auxiliaries, is cause for concern, and should be addressed by nurse policy makers, and nurse educators. In contrast there seems to be an abundance of literature available from the United Kingdom, America and Australian, which is discussed in the next section.

### Nursing roles and new role expectations of nurses.

Internationally the issue of role confusion and role expectation for different nurse categories has been addressed through the adoption of a number of different approaches. In the United Kingdom (UK) for example, a strategy was adopted to deal with the common situation that had evolved in nursing practice, where Enrolled Nurses were frequently expected by their employers "to perform the jobs of Registered Nurses but with lesser remuneration and career prospects, (Francis and Humphreys, 1999: 130). In an attempt to remedy this situation, the Enrolled Nurses was given the option to continue to work as Enrolled Nurse, until retirement date or to upgrade their qualification to Registered Nurse level, (Francis *et al.*, 1999). The English National Board assumed that few Enrolled Nurses would elect for the second option. However, many opted to further their studies and completed the educational training necessary to become a qualified Registered Nurse. By 1989, a project known as 'Project 2000' was adopted by the United Kingdom Central Council (UKCC), to address this issue through the nursing education system. Since 1989, the training of Enrolled Nurses was gradually phased out. During evaluation of the phasing out process of the Enrolled Nurse category, it was discovered that the removal of this nursing category left an obvious gap, in the UK nursing care. To solve this problem, a new category of health personnel, namely the Health Care Assistant (HCA), lesser qualified than the Enrolled Nurse, was introduced to assist the Registered Nurse. Since then, various reports indicate that the HCA, a non-nursing or non-professional category, is also being used by some employers to perform more complex tasks, as was the case previously with Enrolled Nurses. Francis *et al.* (1999) reports that as with Enrolled Nurses previously, this could result in a situation where HCA's are performing illegal nursing functions that may endanger patients lives and be detrimental to the wellbeing of the community. In effect it appears that the new UK strategy to address role confusion, and to provide efficient and effective nursing care, has not been that

successful. It appears that the Enrolled Nurse category has merely been recreated under the guise of HCA's. The effect and implication of this process, on the UK health system, continues to be the subject of debate in the UK.

Gray and Pratt (1992) also describe a situation of role overlap and confusion that has occurred between Registered and Enrolled Nurses in Australia. This was due to the role of the Registered Nurse been expanded to include providing acute curative care, leaving the Enrolled Nurse more responsibilities in providing sub-acute and convalescent care, including the provision of care, for chronically ill patients. Francis *et al.* (1999) argues that this places the Enrolled Nurse in a situation where he or she "holds the middle ground in nursing, allowing employers a resource of lesser-skilled but qualified nurses to perform duties deemed too difficult for non-professionals, yet too basic to require the expensive skills of degreed-qualified Registered Nurses" (Francis *et al.*, 1999: 133).

In Australia the Enrolled Nurse category was retained but upgraded to diploma level, and the Registered Nurse was upgraded to degree level. Gray *et al.* (1992), argue that overlapping of roles would remain a common problem until economic issues are addressed. The Australian health authority spends less money on the training program of Enrolled Nurses than the training program of Registered Nurses. The Enrolled Nurses program is a one year training program, in contrast to a three training program for Registered Nurses. The issue of economics highlighted by Gray *et al.* (1999) refer mainly to the amount of money which have to be invested into restructuring the training program of Enrolled Nurses. In addition, the employers of Enrolled Nurses benefit, by paying an Enrolled Nurse less than the Registered Nurse. They speak about a first, second and third level employment categories, referring to the three main nursing categories. They argue that if one category is replaced with the other, overlapping of roles and confusion will persist.

It is evident that the South African nursing profession is not unique, to its problem, regarding the clinical skill incompetence of nursing personnel and role confusion and overlapping of tasks and functions. How best to address the issue seems complex. Internationally, nursing bodies are grappling with this problem and introducing strategies to prevent the possible negative effects on the health care delivery system. The relevant South African bodies need to be cognisant of these developments whilst, nursing transformation is occurring in this country.

The next section focuses on the nurse relationship with other health professionals and how this relationship impacts on the perceived power relations between nurses and the rest of the primary health care team members.

#### **Nurses relationship with PHC team**

In addition to the role confusion that occurs between the various nurse categories, there is also evidence of this occurring between nurses and other health professionals. The legacy of subordination of nurses and feelings of inferiority when comparing themselves with other health personnel particularly the medical profession, has contributed to this, with nurses at most times merely being prepared to accept orders and be controlled by doctors. Medicine and nursing are two of the oldest of health professions and yet are so different in approach, training and status. Bullough and Bullough (1975), state that prior to new technology being introduced, nursing and medicine shared the care of patients with no dispute about territorial issues, or economic compensation or skill. However, they argue that as time progressed the education of doctors was transferred to universities, while nurses continued to be educated within the hospital system as apprentices, learning on the job. Bullough *et al.* (1975), argue that the nursing profession was rigid and regimented, with the emphasis on obedience and that any attempt at self assertion received strong negative sanctions.

From a South African perspective, Rispel and Schneider (1989), express similar sentiments to Bulloughs *et al.* (1975). They state that the nursing profession tends to uphold values such as: loyalty to the institution, respect for those in authority, certain traits and dress codes. According to Rispel *et al.* (1989), these values are militaristic in nature and based on the militaristic foundation of the early days of Florence Nightingale. Another Southern African nursing professor, Kupe (1993) further states that this militaristic culture of conforming is manifested in behaviour in which the nurse practitioner is discouraged from questioning authority. In addition, Andrews (1994) argues that nurses are controlled in a military way. The following example cited by her, illustrates the militaristic mechanisms or control: nurses are expected to wear epaulettes on their uniforms, which indicated the nursing category the nurse belongs to; the badge worn by the nurse indicates the nurse rank in the profession. No other health professionals wear or display distinguishing devices to indicate difference in rank, as the nursing profession does.

The variation in qualification amongst nurses creates perception of nurse role confusion, amongst other PHC team members. For example Lynch (1981), states that with respect to nurses unequal power relations particularly in relation to doctors in the health team, could be due the fact that nursing is a predominantly female profession and is subjected to a predominantly medical male profession. In addition, nurses normally adopt a defensive role and subordinating behaviour reinforcing the doctors higher status. These unequal power relations with team members could also be attributed to differences in educational training of nurses, and particularly of medical doctors, which assigns differences in status. This latter factor has been suggested by Bullough *et al.* (1975) as well.

Gray and Pratt (1992), take the argument to another level, by arguing for a new model within which a health team should operate. They state that there needs to be cooperation and collective action amongst health care providers, to ensure an effective, high quality

health service. The term used by them is "collegiality". Gray *et al.* (1992) highlights the following points to enhance a collegial approach:

- Sharing information when necessary, for personal growth and task accomplishment.
- Considering the opinions of others and objectively dealing with dissenting opinions.
- Respecting and building on the work of others.
- Encouraging risk-taking in self and others through collaborative problem solving and mutual support. (Gray *et al.*, 1992: 359-360)

The above mentioned approach to address the unequal power relations between nurses and other health professionals, is similar to the South African health departments broad principles regarding staff development and reorientation and capacity building (White Paper, April 1997: 68). These are:

- The clinical skills of health workers should be upgraded.
- The skills of managers at all levels should be developed, if substantive health reform is to be sustained.
- Institutional capacity to support human resource planning and management should be developed.
- Research capacity focusing on essential health research strategy should be implemented to support health sector development. (White Paper, April 1997:68)

It is noteworthy that all health personnel including nurses are recognised within this framework. The first policy strategy on clinical skill development, pays particular attention, to the importance of providing training to: PHC nurses, advanced midwives, community psychiatric nurses, paediatric nurses, chronic disease nurse clinicians. This indicates the health department's commitment to upgrade the clinical skills of nurses, as a response to the recommendation of various studies done on the subject. However, concern that may

be expressed is: are South African nurses ready for change; and will they commit themselves voluntarily to participate in the transformation process; and be prepared to learn new skills? Gray *et al.* (1992) mentioned that "nurses underestimate their potential as a group to exercise power. In so doing they often fall prey to others outside nursing who have in the past been all too ready to make decisions for them" (Gray *et al.*, 1992: 360).

Are South African nurses ready to transform oppose the militaristic image of the profession and the unequal power relations in local health facilities? There seems to be a dearth of South African literature on this subject. However, international studies examined various reasons as to why nurses do not respond to change or respond to change at a slow pace.

#### Nurses role in a transforming health system

Lancaster and Lancaster (1982) state " The success of any change depends largely on the change agents understanding of the system, in which the change is being introduced as well as the organizational characteristics and individual qualities of the participants" (Lancaster and Lancaster, 1982: 2).

They further state that people's response to change is determined by the way they conceptualise change. They mention potential characteristics which may influence nurses' perception of the process process, two of which are: changing roles of health providers and new modes of decision making in the health area which give consumers some responsibility for health planning. These are relevant to nurses in the transforming South African Health System. This in the sense, that nurses' roles are changing, and new modes of decision-making are occurring, such as the introduction of the process of community participation, used to ensure sufficient and active participation of community members in planning and decision-making processes.

Lancaster *et al.* (1982) argues that people are comfortable with change if it occurs at a satisfactory pace (not too fast) and does not significantly affect their values, and beliefs. Rodger's (1962), believes that for change to be rejected or accepted, is dependant on the extent to which the participants are interested and committed to working towards implementing the new policy of change, (Lancaster *et al.*, 1992: 9). Besides commitment Aroskar (1993), argues that nurses have an ethical obligation to participate with others in political activities and policy development to achieve nursing goals for health. In addition, Aroskar (1993) mentions that irrespective whether they choose to participate or not, they will be affected by the transformation occurring. Active involvement within the transformation process will entail hard work. However, if they choose not to be active participants they may run the risk, of being coerced into implementing policies, such as occurred in the case of the Health Systems Trust study, in Ocean View in the Western Cape.

Aroskar (1993) and Mason, Mc Eachen and Kovner (1993) argue for nurses being involved in developing and influencing the policies in the work place. They state that it is also important that nurses understand how they can participate in decision-making and effective strategies to effect institutional change (Minarik and Catrombane, 1993).

Capuzzi (1993) states that nurses are frequently encouraged to participate mainly in "lobbying and testifying", but are not encouraged to become directly involved in policy development (Capuzzi, 1993: 217). She also highlights the advantages of early involvement by nurses in policy development, by citing the following example: These were a group of nurses in Oregon, in the United States of America, 1991 who participated in developing, The Oregon Basic Health Services Act of 1991. Capuzzi (1993) said that early involvement allowed them an opportunity in shaping the issue and setting the agenda. According to her late entry into the process of planning and development process only permits one to work on what has already been created. Capuzzi (1993), also suggests

that, "nurses must collaborate more with other professionals and with the public advocacy groups if they are to influence the development of creative and effective policies needed to respond to the health care crisis that faces our country" (Capuzzi, 1993: 219).

Currently, most of South Africa's nurses employed at local PHC facilities have not as yet reached that stage of nurse involvement as described in the Oregon case study or experience. For example, the Ocean View study conducted about nurses' perceptions of the integration of health services, in Ocean View, an area in the Western Cape, found that nurses were merely expected to implement new policy (Health Systems Trust, 1999). They also felt that irrespective if they implement the policy according to the health authorities' expectation, the implementation process would not be effective. The study indicates that those nurses did not have any consultative meetings with the local authorities, to discuss their perceived obstacles to the policy implementation process. It is thus clearly evident, that the nurses interviewed at the Ocean View health facility, were not included as active participants in the policy development process in the health district, and their views on obstacles to effect policy were therefore not adequately taken into account. In the absence of being called upon to do so they were hesitant to confront the local health authority with their views and make suggestions as to how to progress to effectively implement the policy. South African policy-makers could learn from relevant, American, British and Australian experiences, in order to make policy implementation more effective.

### **Nursing education and training**

Nurses in South Africa form the largest sector amongst health personnel and as such constitute the backbone of the health system (Health Systems Trust, 1996). It is recommended that more emphasis be placed on unifying the nursing curriculum and also having it community or PHC-based (WHO, 1984 and Strasser, 1998).

Macdonald (1995) believes that a PHC-based system, demands a new kind of health professional, who has a holistic understanding of the community needs and is able to adopt an holistic approach to the provision of health care. Macdonald (1995) argues that by adopting an holistic approach the nurse would have the ability to promote and effectively implement community participation, equity, and intersectoral collaboration. Macdonald (1995) argues further that health workers' training should prepare them to work in the community for equitable health transformation and "not just on their behalf and for their benefit" (Macdonald, 1995:163). This means that planning of health services should not be determined primarily by the health department and health care providers but mainly by the health needs of the population. In addition, the training should equip the health providers, to collaborate with other sectors of government such as the agricultural, welfare and education sectors and the private sector, including non-governmental organisations and community-based organisations, to determine and reduce or eradicate the causative factors of ill health and disease within communities. This interaction with other sectors is known as intersectoral collaboration (Ebrahim *et al.*, 1993 and Macdonald, 1995).

Furthermore, Macdonald (1995) argues that a move towards a partnership between the public and health service providers requires health personnel with appropriate knowledge and skills. He argues that this would require a considerable degree of reorientation of health personnel. As previously discussed health personnel in South Africa particularly nurses do not possess the necessary clinical skills and theoretical understanding to function within a district health system based on a PHC approach (Strasser and Mc Coy, 1996; Strachan, 1999 and Dennill, 1999).

Dennill (1999) contends that although "nurses of the 1990's are more knowledgeable than ever before" this does not necessarily mean that they are clinically competent to fulfill their role within the clinic (Dennill, 1999:5). This concern of Dennill (1999) was shared by most

nurses who attended a nursing summit in the Gauteng province, in August 1999 (Strachan, 1999).

The World Health Organisation's (WHO) Expert Committee, in their report on the education of nurses teachers and managers with special regard to Primary Health Care, highlights similar concerns with regards to the clinical competence of nurses as those expressed at the nursing summit, in South Africa (WHO, 1984). The report states that nurses are expected to, perform functions such as: Assessing individuals and communities health status; facilitating community involvement in PHC; providing integrated health care including epidemiological surveillance; training and supervising health workers; collaborating with other sectors and providing health services at the periphery (WHO, 1984: 12). However, it was found that nurses were not adequately skilled, in policy formulation, providing statistical information, nor management of health teams outside the hospital setting, in order to perform the stated functions adequately. This has implications for nurse training in that there is a need to produce a curriculum which is, "community based and competency –orientated, based on a problem-solving approach, which is socially and technically appropriate and learner centered" (WHO, 1984: 13).

The Senegal experience of the reorientation of nurses between 1977 to 1981, is an example the South African nursing profession can learn from. The approach in Senegal to transforming the nursing education system was twofold. Firstly, a training program of three months was offered to nurses at local health facilities. Nurses were introduced to the philosophy and approach of PHC. They were trained as instructors to further train other local health workers and chiefs within the various rural communities. Secondly, on the academic level, the philosophy of PHC was integrated into the nursing curricula and offered at various schools and training institutions for nurses and midwifery personnel. The WHO Regional Office in Africa conducted most of the training of the student nurse

educators and qualified nurse educators. Since the inception of the transformation process of the nursing education system in Senegal, nurses have been doing community service of two to four months in rural areas. The duration of community service for nurses depends upon the individual nursing school. Ongoing training was provided in the form of bi-weekly workshops and seminars.

Similar recommendations emanate from the South African nursing summit in August (1999) such as:

- Nurses should do community service in rural areas, as was legislated for medical doctors in 1998.
- Incentives should be offered to nurses working in rural areas.

These two recommendations are particularly relevant in developing countries where PHC was adopted as a strategy to address imbalances within the health system and to provide appropriate health care services according to the population's needs (Rohde, Chatterjee and Morley, 1993 and Macdonald, 1995).

The next section on nurse training will examine to what extent nurse training is meeting the needs of the health context in which it is operating.

#### An overview of nurse training in South Africa

The training of nurses was initially offered at nursing colleges only. Practical clinical training was done in the hospitals, mainly secondary and tertiary hospitals. The three main nursing categories received nurse training according to different curricula and for different lengths of time.

#### The training of Registered Nurses

According to the South African Nursing Council (SANC), there are 90 986 nurses registered with the nursing council (SANC, 1999). Prior to 1985, the basic training of Registered Nurses consisted of a General Nursing Diploma course of three years which was offered at various nursing colleges or a basic nursing degree of three years in

General Nursing was offered at various university nursing schools. On completion of the basic training course, Registered Nurses had the option of specialising in one of the numerous post-basic nursing courses. These included:

- Community Health Nursing
- Midwifery
- Psychiatry
- Occupational Nursing
- Theater Nursing
- Nursing Administration

In February 1985, a new nursing regulation was introduced which changed the nursing curriculum of Registered Nurses. Nursing Regulation 425 of 1985 determined that the basic training of Registered Nurses should be modified to include not only, General Nursing but Midwifery, Psychiatric Nursing and Community Health Nursing (Gwele and Uys, 1995). The new program is known as the Comprehensive Basic Nursing Program (CBNP). It became mandatory for all nursing institutions to include some areas of nursing previously regarded as areas of specialisation in the basic training of Registered Nurses. At the same time the course was extended from three to four years. This meant that nurses could now qualify in these areas of nursing as part of their basic training, rather than spending six to seven years, completing each of these courses separately (Gwele *et al.*, 1995). The purpose of the introduction of this policy was to produce a new cadre of nurse, more suitable for the demands of an integrated comprehensive health system, (Gwele *et al.*, 1995).

However research conducted to evaluate the new CBNP, found a number of deficiencies in the program. For example, Viljoen (1989) in her study identified the following problems with the new program:

- Limited opportunity for students to transfer from one college to another due to different curricula.
- Difficulty in student selection.
- Reluctance to accept students into the clinical settings, especially in Community Health and Psychiatric Nursing.

Research conducted by Gwele *et al.* (1995) found that there were positive and negative factors operating when comparing diplomats who completed the CBNP and those who had completed the old Diploma course (prior to 1985).

The positive factors were:

- The CBNP diplomats are capable of writing a more comprehensive nursing care plans, in comparison to their counterparts.
- The CBNP diplomats could be placed in any clinical setting upon graduation.
- The CBNP diplomats are capable of integrating knowledge in rendering patient care.

The negative factors were:

- The CBNP diplomats lack clinical experience.
- The CBNP diplomats could suffer from feelings of inadequacy, amongst their more experienced colleagues. (Gwele *et al.*, 1995:8)

#### The training of PHC Nurses / Clinical Nurse Practitioners

By the late 1970's Registered Nurses employed at local, community-based health facilities such as the community health centers and certain community health clinics, were diagnosing and treating minor ailments of community members who attended these local health facilities. Nurses performed these functions in the absence of a medical doctor, as doctors were not available on a continuous basis at these facilities. This led to the realisation within the nursing profession, that nurses needed specific training in these procedures, rendered at PHC, community-based facilities Marks (1994). As a result, a

clinical skills-based course was introduced at various hospitals and colleges around the country, with each providing a different name for the course. The most common name for this clinical skills-based course is known as the Primary Health Care course. This course was introduced in the 1980's.

Apart from inadequacies in the content of nurse training, problems exist with the number of adequately trained nurses available to meet the country's, health needs at a Primary Health Care level. For example, many studies have reported that there is a shortage of trained PHC Nurses in the country. A recent study reports that, "one of the most obvious gaps is the number of nurses with post basic nursing training in skills to diagnose and treat common complaints. The number of nurses trained is much too low to meet the needs of the country" (Strasser, 1999:7). According to Strasser (1999) there are not enough PHC nurses trained to provide adequate health care to community members who attend their facilities. Strasser (1999) states that in December 1993, there were 1229 PHC nurses. Five years later there were only 3000 nurses with some form of training, in PHC clinical skills. This indicates that during a period of five years less than 2000 nurses were trained in PHC clinical skills. Many of these nurses had variable types of PHC clinical skills training. Some had attended a one-month, others a six months, one year or an 18-month training course. According to Strasser (1998) these courses also varied in their content. Hence there is a lack of consistency in training programs for PHC Nurses. Similar problems have been reported in the United Kingdom (Hicks C and Hennessy D, 1999), with respect to PHC training.

In the UK with the restructuring of the National Health Service (NHS) the emphasis in health care delivery shifted from secondary to primary level health care. The Primary Care Act of 1997 was introduced, to facilitate this process ( Hicks and Hennessy, 1999). This reform had similar effects on the health system, to that reported in South Africa, such as:

- A rise in clinical case loads at primary facilities.

- Role confusion and the need to reconsider the professional roles of the primary health care team.

Hicks *et al.* (1999) reported that "one potential solution to the problems created by the reforms has been the introduction of the nurse practitioner (NP)" (Hicks *et al.*, 1999: 667). It was believed that a nurse practitioner with advanced clinical skills could be independent and autonomous from the medical doctor and at the same time, "maintaining the quality of care, whilst simultaneously containing costs and resources (Hicks *et al.*, 1999: 667). However, Hicks *et al.* (1999) further reports that there is no national or formal definition of the NP, and they argue without this "there can be no framework for regulation, either of clinical practice or training" (Hicks *et al.*, 1999: 668).

In both the South African and UK contexts, there is clearly a need to develop a unified regulation to provide a framework for a standardized national training program for PHC clinically trained nurse as well as to draw up well formulated job descriptions. There was support for this by many health policy researchers and most recently at a nursing summit in August of this year.

#### The training of the Enrolled Nurse

According to the South African Nursing Council (SANC), there are 32 733 Enrolled Nurses, enrolled with the nursing council in 1999 (SANC, 1999). Prior to 1986, Enrolled Nurses' basic training consisted of two years. Since 1986, the SANC has mandated that no formal training programs be offered to produce Enrolled Nurses. However, Bridging courses are currently being offered at various public and private hospitals and nursing training colleges across the country. An attempt had since been made to upgrade the status and training of Enrolled Nurses to that of Registered Nurses. In 1986, the two-year "Bridging Course" was approved and introduced by the South African Nursing Council, to provide these nurses with the necessary theoretical knowledge and practical skills equivalent to that received during the old General Nursing Diploma course. This course

was introduced at various hospitals public and private and training nursing colleges, through out the country (Rispel and Schneider, 1989 and Mpaka and Uys, 1999).

However, a recent study conducted by Mpaka *et al.* (1999), on the critical thinking ability of diplomats who completed the Bridging program, indicates that these nurses have difficulty in applying or transforming content across various contexts in the practical situation. This means that they cannot apply the theory provided and learnt, within their clinical practice. The lack of success of this type of Bridging program in extending the theoretical and clinical skills of Enrolled Nurses needs to be further investigated.

#### The training of Enrolled Nursing Auxiliaries

According to the SANC, there are 49 928 Enrolled Nursing Auxiliaries, enrolled with the nursing council, in 1999 (SANC, 1999). The training of this category is provided at various hospitals and at registered training schools, across the country. The duration of the nurse-training program is one year.

#### Conclusion

Nurse educators, are aware of the crucial need for nurses to be trained within a PHC educational framework which focuses not only on the theoretical concept and its philosophy but enables the student to acquire and become competent in the clinical skills required when practicing as a health practitioner in the community (Health Systems Trust, 1998).

However, some nurse educators feel that the lack of adequate community-based teaching facilities makes it difficult to implement such training. For example, Pat McInery, chairwoman of the governing committee of the Wits Department of Nursing, acknowledges that hospital-based training does not equip nurses sufficiently to work in rural and community-based health care settings. However, she argues that there are a lack of "decent Primary Health Care facilities", for teaching the PHC approach (Health Systems Trust, 1996: 11).

Others such as Ebrahim *et al.* (1993) and Strasser and Gwele (1998) argue that the problem lies rather in the fact that few nursing education programs prepare nurses to work in primary health settings. Ebrahim *et al.* (1993) argues for a broader approach to PHC training in which nurses are trained within the ecological setting of the country. This means that PHC training should take place at community-based health facilities, even if resources are limited, as this nevertheless mirrors the environment in which members of the community live. In this way nurses will develop an epidemiological understanding of the social and economic factors, which contribute to ill health (WHO, 1984; Ebrahim *et al.*, 1993 and Macdonald, 1995).

Ebrahim *et al.* (1993) further argues that PHC should not only be offered to equip nurses with clinical skills but also to improve their theoretical understanding and knowledge of PHC. In contrast to Pat McNery's position as presented by Health Systems Trust (1996) it is argued by Ebrahim *et al.* (1993) that providing PHC training at facilities where resources are currently limited would be the most appropriate approach. This situation would enable nurses to address and apply the PHC principles (Tarimo, 1991).

Since the new health system was introduced the nursing education and training system has come under scrutiny by health policy makers and nursing educators and various initiatives are underway to transform nursing education and training. In the 1990's, new governmental legislation was introduced to reduce the existing number of nursing colleges. It has been proposed that a rationalisation process be followed and that nursing colleges should integrate and become Nursing Schools of Education (Gunthorpe, 1995).

In addition, task teams have been set up nationally to look at an alternative nursing curriculum, with the aim of transforming it from a previously curative-based curriculum, to that of a PHC-based approach (Draft Provincial Health Plan, 1995). This new approach to nursing training is reflected in the health department's White Paper on Transformation of the Health System (1997), as one of the principles of the Human Resource Department.

Furthermore, with these initiatives underway there will no doubt remain a number of challenges in transforming the nursing education in South Africa, into a standardised, unified educational framework, based on a PHC approach.

## REFERENCES

1. Andrews G, 1994. Health in Our Hands, Proceedings and Policies of the 1994 Women's Health Conference. Women's Health Project. Centre for Health Policy. University of Witwatersrand, Johannesburg.
2. Aroskar M A, 1993. Ethical Issues: Politics, Power and Policy. In Mason D, Talbott S and Leavitt J, 1993:200-208. Policy and politics For Nurse. Action and change in the work place, Government, Organisations and Community. Second Edition. W B Saunders Company, United States of America.
3. Bullough and Bullough, 1975. In Gray G and Pratt R, 1992. Issues in Australian Nursing. Longman Singmore Publishers (Pty) Ltd. Singapore.
4. Capuzzi C, 1993. Rationalizing Health Care: The Oregon Story. In Mason D, Talbott S and Leavitt J, 1993:208-217. Policy and Politics For Nurses. Action and change in the work place, Government , Organisations and Community. Second Edition. W B Saunders Company, United States of America.
5. David J, Zakus L and Lysack CL, 1998. Review Article. Revisiting community participation. Health Policy And Planning. Oxford University Press, 1998.
6. Dennill K, 1999. Overview of nursing in South Africa. HST Update, Issue No.46, September 1999:5
7. Department of Health, 1995. Draft Provincial Health Plan, 1995. Strategic Management Team. Ministry of Health and Social Services. Department of Health, Western Cape.
8. Department of Health, 1997. White Paper For The Transformation Of The Health System In South Africa. Department of Health, Pretoria.
9. Dreyer M, Hattingh S and Lock M, 1997. Fundamental Aspects of Community Nursing, Second Edition. Community Health Care In Southern Africa. Published by International Thompson Publishing (Southern Africa) (Pty) Ltd.
10. Ebrahim G I and Ranken J P 1993. Primary Health Care: Reorienting Organisational Support. MacMillan Press LTD, London.
11. Francis B and Humphreys J, 1999. Enrolled nurses and the professionalisation of nursing: a comparison of nurse education and skill-mix in Australia and the UK. International Journal Of Nursing Studies, Vol.36, 1999:127-1135.
12. Gray G and Pratt R, 1992. Issues in Australian Nursing. Longman Singmore Publishers (Pty) Ltd. Singapore.

13. Gunthorpe A, 1995. Department of Health. Report on the Integration of Nursing Colleges in the Western Cape. Department of Health, Western Cape.
14. Gwele N S and Uys L R, 1995. Views of leading nurse educators regarding the Comprehensive Basic Nursing Program. Curationis Vol. 18, No.1, 1995: 5
15. Health Systems Trust, 1996. South African Health Review, 1996. Published jointly the Health Systems Trust and the Henry J. Kaiser Family Foundation, Durban.
16. Health Systems Trust, 1998. South African Health Review, 1998. Published jointly by Health Systems Trust and the Henry J. Kaiser Family Foundation, Durban.
17. Health Systems Trust, 1999. Integration of health services. HST Update, Issue No.45, August 1999:7-10.
18. Henderson V, 1985. Henderson And The Nursing Process. In George J B, 1985:79-80. Nursing Theories: The Base For Professional Nursing Practice. Second Edition. Prentice-Hall, Inc., Englewood Cliffs, New Jersey.
19. Hicks C and Hennessy D, 1999. A task-based approach to defining the role of the nurse practioner: the views of UK acute and primary sector nurses. Journal of Advance Nursing, Vol 29, No.3, June 1999: 666-673.
20. Human Science Research Council, Medical Research Council and the South African Network of Community Partnerships In Health Personnel Education. Final Draft on Guidelines On Participatory Development For Health And Welfare Personnel At Local And district Level, 1997. Centre for Population, Health and Development Research, Pretoria.
21. Kupe, 1993. Empowering Nurses for Action within Power Politics of the Health Care and Social Systems. Paper presentation at the Nurses Conference, held at the University of Western Cape. Cape Town.
22. Kyriacos U and Van Der Walt A M, 1996. Attitudes of the diploma prepared and graduate registered nurses: Towards Nursing Models: A comparative study. Curationis, Vol.19, No.3, September 1996: 2-6.
23. Lancaster J and Lancaster W, 1982. Concepts For Advance Nursing Practice. The nurse as a change agent. The C V Mosby Company, London.
24. Lynch B L, 1981. In Gray G and Pratt R, 1992. Issues in Australian Nursing. Longman Singmore Publishers (Pty) Ltd. Singapore.
25. Macdonald J, 1995. Primary Health Care. Medicine In Its Place. Earthscan Publications Ltd, London

26. Marks S, 1994. *Divided Sisterhood: race, gender and class in the South African Nursing profession*. Witwatersrand University Press. South Africa, 1994.
27. Mason D, Mc Eachen I and Kovner T, 1993. Contemporary issues in the work place. In Mason D, Talbott S and Leavitt J, 1993:223-241. *Policy and politics For Nurse. Action and change in the work place, Government, Organisations and Community*. Second Edition. W B Saunders Company, United States of America.
28. McNeese-Smith D K, 1999. A content analysis of staff nurse descriptions of job satisfaction and dissatisfaction. Journal of Advanced Nursing, Vol 29, No.6, June 1999:1332-1341.
29. Minarik and Catrombane, 1993. Collective Participation in the workplace Decision Making. In Mason D, Talbott S and Leavitt J, 1993:306-328. *Policy and politics For Nurse. Action and change in the work place, Government, Organisations and Community*. Second Edition. W B Saunders Company, United States of America.
30. Mofukeng D B and Roos S D, 1999. Clinical Skills Of Nurses In Mobile Health Services. Curationis, Vol.22, No.2, June 1999: 4-6.
31. Mpaka and Uys, 1999. The critical thinking ability of diplomates from different types of bridging programs. Curationis, Vol.22, No.3, September 1999: 14-17
32. Oerman M, 1991. *Professional Nursing Practice: a conceptual approach*. Phillidelphia: Lippincott, 1991.
33. Personal communication: Registered Nurse and Enrolled Nurse, Community Health Centre, 1997.
34. Rhode J, 1989. Health for all in China: principles and relevance for other countries. In Morley D, Rohde J and Williams G, 1989:5-16. *Practicing Health for All*. Oxford Medical Publications.
35. Rispel L and Schneider H, 1989. *Nursing At The Crossroads: Organisation, Professionalisation and Politicisation (Proceedings Of A Symposium; held at the University of the Witwatersrand, December 1989)*. Published by the Centre for the study of health policy, Community Health Department, University of Witwatersrand.
36. Rispel L and Schneider H, 1989. *Professionalisation Of South African Nursing: Who benefits?* Centre for the study of health policy, Community Health Department, University of Witwatersrand.
37. Rohde J, Chatterjee M and Morley D, 1993. *Reaching Health For All*. Oxford University Press, Bombay.

38. Solarsh G and Xaba M, 1996. Maternal, Child and Women's Health Recapping Issues Of 1995. Health Systems Trust, 1996:173-178. South African Health Review, 1996. Published jointly by Health Systems Trust and the Henry J. Kaiser Family Foundation, Durban.
39. South African Nursing Council, 1978. Nursing Amendment Act 50 of 1978. South African Nursing Council, Pretoria.
40. South African Nursing Council, 1985. Regulation 425 of 1985. South African Nursing Council, Pretoria.
41. South African Nursing Council, 1997. Nursing Act 19 of 1997. South African Nursing Council, Pretoria.
42. Strachan K, 1999. The nursing summit charters a way forward. HST Update, Issue No.46, September 1999: 9.
43. Strasser S and Gwele N, 1998. Nurses Oriented Primary Health Care. Health Systems Trust, 1998:83-92. South African Health Review, 1998. Published jointly by Health Systems Trust and the Henry J. Kaiser Family Foundation, Durban.
44. Strasser S and McCoy D, 1996. A Paper presentation: Developing A Rational In-Service Training Programme for Health Districts. Health Systems Trust, Durban.
45. Strasser S, 1999. Transforming Nursing Education towards Primary Health Care. HST Update, Issue No.46, September 1999: 6-7.
46. Tarimo E, 1991. Towards A Healthy District. Organizing and managing district health systems based on primary health care. World Health Organization, Geneva.
47. Viljoen, 1989. In Gwele N S and Uys L R. Views of leading nurse educators regarding the Comprehensive Basic Nursing Program. Curationis, Vol. 18, No.1, 1995: 5.
48. Werner D, 1989. Health care in Cuba: a model service or a means of social control – or both? In Morley D, Rohde J and Williams G, 1989: 17-37. Practicing Health for All. Oxford Medical Publications.
49. WHO, 1984. Education and training of nurse teachers and managers with special regard to primary health care. Report of a WHO Expert Committee. World Health Organization, Geneva 1984.
50. Wiedenbach E, 1985. Weidenbach's Conceptualization of Nursing Practice And Process. In George J B, 1985:99-102. Nursing Theories: The Base For Professional Nursing Practice. Second Edition. Prentice-Hall, Inc., Englewood Cliffs, New Jersey.

## **CHAPTER THREE**

### **METHODOLOGY**

This thesis is based on a qualitative paradigm, with a case study approach. This section explains what a qualitative paradigm is, as well as the difference between a qualitative and quantitative research paradigm. A definition and explanation of a case study approach is presented. It also explains why the researcher chose this framework and approach to conduct the research. The role of the researcher is discussed in each sub-section.

#### **An explanation of a qualitative research paradigm**

“Qualitative research methods offer a valuable new and promising alternative means to explain the complex and obscure dimensions of nursing phenomena” (Leininger, 1985:3).

Leininger (1985) further states that, “ the qualitative type of research refers to the methods and techniques of observing, documenting and interpreting attributes, patterns, characteristics and meanings of specific, contextual or gestaltic features of phenomena under study” (Leininger, 1985:3). This means that with qualitative research it is possible to gain in-depth insight into a particular phenomenon or problem, by observing what it is and fully describing it, not only from the researcher’s perspective but more importantly from the researched participants’ perspective. Besides describing the context in which the research has taken place, the participants’ comments and responses are recorded verbatim, which lends more power to the validity and reliability of qualitative data. This issue of data reliability and validity is discussed later.

According to Patton (1990) qualitative methods consist of three kinds of data collection: “ in-depth, open-ended interviews, direct observations and written documents” (Patton, 1990:10-11). The in-depth interviews consist of the verbatim viewpoints of the

participants' feelings, perceptions and knowledge. The data from direct observations describe the participants' activities, behaviours and the organisational structure. Written documents yield excerpts and or quotations from personal diaries, program records and official publications. The field research done to acquire the information is organised into "narrative descriptions with major themes, categories, and illustrative case examples extracted through content analysis" (Patton, 1990:10-11). In addition, Patton (1990) purports that the value of qualitative research is embedded in the 'findings, understandings and insights' that emerge from the fieldwork Patton (1990:10).

Miles and Huberman (1994) state that qualitative data is "locally grounded", reflecting the exact viewpoints, descriptive settings and observations of the researched and research process (Miles and Huberman, 1994:10). In addition, the data and findings according them has a "ring of truthness" making an impact on the reader (Miles et al., 1994:10).

### **The research paradigm chosen for this thesis**

A qualitative descriptive study using a case study approach was conducted to determine nurses' attitudes towards and perceptions and knowledge of the New Health System. "A qualitative case-study is an intensive, holistic description and analysis of a single instance, phenomena or social unit" (Merriam, 1988:21).

Before discussing rest of the sections in the methodology chapter, it is important to briefly discuss the differences between the two research paradigms, namely qualitative and quantitative paradigms.

Patton (1990) states that there are no constraints of "predetermined categories of analysis" when conducting fieldwork with a qualitative approach. He also states that this contributes to the "depth, openness, and detail of qualitative inquiry" (Patton, 1990:13).

In addition to that qualitative data is reduced to themes and categories and evaluated subjectively (Rudestam and Newton, 1992:31).

Quantitative research on the other hand, “require the use of standardised measures so that the varying perspectives and experiences of people can be fit into a limited number of predetermined response categories to which numbers are assigned” (Patton, 1990:14). The statistical presentation of data that is presented in quantitative research provides a concise account of the information gathered, in terms of the amount and the distribution. It does not provide in-depth information on the nature of the problem, or its causes.

Another difference between qualitative and quantitative research is that with the latter, the aim is to prove or disprove a hypothesis, determined prior to data collection (Neuman, 1994). This hypothesis is predetermined and a set of clear questions are designed with a particular measurable instrument to either refute or support this predetermined statement or hypothesis (Neuman, 1994).

Neuman (1994) mentions that hypothesis testing has three outcomes:

1. The evidence clearly confirms or supports the hypothesis.
2. The evidence disconfirms or rejects the hypothesis.
3. The evidence partially supports or disconfirms the hypothesis.

(Neuman, 1994:99)

Conversely with qualitative research while there is a research question and a research problem, there is no clear statement of predetermined cause and resultant outcome of the research. Qualitative research aims to gain in-depth insight and tends to describe in detail what the phenomena are. On the other hand, Searight (1990) states “unlike non-experimental or naturalistic methods, experimental or quasiexperimental methods

(quantitative methods), cannot gain psychologically rich, in-depth understanding of individuals” quoted by (Rudestam and Newton, 1992:31).

Whilst quantitative data provide a broad general set of findings, qualitative data provide depth and detail at a very personal level of experience from a smaller number of participants. This is precisely what this thesis aimed to achieve, through a case-study approach, amongst a group of nurses employed in the West District of the City of Tygerberg. A qualitative methodological approach was therefore felt to be best suited, in gaining insight into nurses’ perceptions. It was important to record what they said their perceptions, understandings, and concerns were regarding key aspects, of the new National Health Systems Framework. In addition to that, it was important, to gain an insight into nurses’ perceptions of their working experiences within a transitional health system.

Although it is argued that with a larger sample the quantitative data can be more generalisable to similar research settings and sectors, the in-depth detail of individual experience will not be represented within a quantitative framework. Hence conducting a qualitative study will reduce the generalisability of the data to a broader population, in this instance to all other nurses not employed in Primary Health Care facilities of the West District, or in Hospitals (Patton, 1990). Therefore in order to gain insight into the nurses’ understanding and perceptions of the new health systems framework, a qualitative research design was chosen.

There is an ongoing debate as to the actual relevance of qualitative data, in terms of it not being generalisable (Patton, 1990). Cronbach, Lee and Associates (1980) suggest an alternative strategy to generalisation (Cronbach, Lee and Associates, 1980: 231-235). They suggest that it would be useful to speak of “extrapolation” of data. Meaning that certain information could be extrapolated from the data and used for example by

policy makers, decision makers and educators, other researchers and organisations, interested in a particular aspect of the research process and findings. It is the researcher's hope that the findings would at least be of use to the West District Health Authority. In addition to other district health authorities, nurse educators and policy makers may find certain aspects of the research findings useful, as a base-line particularly for district level planning and decision making.

### **THE STUDY DESIGN**

A descriptive study using a case-study approach was conducted to determine nurses' attitudes towards and perceptions and knowledge of key aspects of the new health systems framework and the nurses' level of competency and experience within a transforming health system.

The key aspects were the:

- The structure of the District Health System
- The philosophy and approach of Primary Health Care.
- Selected aspects of the Maternal, Child and Women's Health Policy.

The study was conducted in two phases. The first phase entailed individual interviews with a sample of nurses from the three main nursing categories: Registered Nurses, Enrolled Nurses and Enrolled Nursing Auxiliaries. The interviews were recorded with a tape-recorder and transcribed by the researcher.

The second phase entailed a focus group discussion, to consolidate the information and internally validate the information received from the individual interviews. Five Registered Nurses participated in the focus group discussion.

Before the commencement of the study, the researcher undertook the following preliminary steps:

- A copy of the research proposal was submitted to the ethics committee of the University of Cape Town for approval.
- A copy of the proposal and a letter requesting permission to conduct the research within the three health facilities were sent to the Head of Health Services of these three facilities

(See Appendix A and Appendix B).

- The researcher then sent a letter to the Chief Professional Nurse, who managed the nursing section of the organisation at district level, and was then granted telephonic permission from the respective health managers.

### **THE STUDY AREA AND STUDY SITES**

The study was conducted at three health facilities in the Elsies River area. Elsies River forms part of the City of Tygerberg. The City of Tygerberg is divided into three health districts. The Elsies River area is situated in one of the three districts, namely, the West District. The estimated population of the City of Tygerberg is 700 000. The total population of the West District is

126 000 (Elsies River District Development Draft Proposal, 1995).

#### **The Health Status of the Population**

The majority of the population in Elsies River lives in poor socio-economic conditions. There is a high unemployment rate. The most common childhood diseases are Malnutrition, Diarrhoea and Tuberculosis (TB). The adult TB incidence rate is high. According statistics received from the Health Department of the City Of Tygerberg, the TB notifications for the year 1997 were 275 and 394 notifiable Sexually Transmitted Diseases, in the Elsies River Primary Health Care facilities.

## The Health Facilities

There are three types of public health facilities, one pharmacy and ten General Practitioners in Elsie's River. The three types of public health facilities are Community Health Clinics, a Midwife Obstetric Unit (MOU) and one Community Health Centre (CHC). The School Health Service, previously a vertical program is integrated with the Primary Health Care Services, provided from the Community Health Centre. These Public Health Facilities provide the following services:

### The Community Health Clinics (Clinics)

These clinics were previously known as Child Health Clinics or Mother and Child Clinics. There are six of these Primary Level Health Care facilities in Elsie's River. They are known as Primary Level Health Care facilities because they are normally the first point of entry into the health system for most members of the community. A Comprehensive, Integrated Primary Health Care service is provided for children up to age thirteen. In addition to that, the following Reproductive Health Services are provided to other members of the community:

- A Family Planning Service for teenage girls and women of child bearing age. The Family Planning Service also provides barrier methods (condoms) and information and counselling on reproductive health to teenage boys and men.
- A Cervical Screening Service is available for all sexually active teenage girls and women.
- A detection and treatment service for Sexually Transmitted Diseases is provided for both male and female members of the community.
- A service is provided to prevent, treat and control the spread of infection. This includes immunising children, against certain notifiable diseases, before and up to age five years. Environmental Health Officers are based at the facility who work on

maintaining a clean and healthy environment within the area. The facility also provides individuals as well as the whole community with information regarding the prevention of infectious diseases as well as the detection and treatment thereof.

#### The Community Health Centre (CHC)

A Comprehensive Primary Health Care service is provided for adults and children. Screening procedures are available such as, Cervical Screening for women, Electro Cardiograph Monitoring for cardiac problems, and an X-ray facility. The facility has a 24-hour emergency service as well. Two nurses from the facility provide the School Health service. In addition a District nursing component, provides the following services:

- Detection and treatment of minor injuries and ailments. This service is managed by a Registered Nurse employed at the CHC. The service is provided at one of the Community Health Clinics in the area. The reason for this is that community members don't need to access the large facility for minor treatments of wounds and to replace surgical wound dressings. The Registered Nurse conduct home visits to accommodate those that are not ambulant but require the same procedures.
- Home visits also entail providing nursing care to patients suffering from chronic illnesses.

#### The Midwife Obstetric Unit (MOU)

An Antenatal, Delivery and Postnatal Service is provided for pregnant women, mothers and neonates. All pregnant women are screened for possible complications. The following are examples of available screening services:

- Blood tests to determine whether the woman has a Sexually Transmitted Disease, to determine the blood group status of the mother and to determine blood compatibility status of the mother in relation to the foetus.

- A Cervical screening service is provided.
- An Ultrasound screening service is available

If complications are present and too complex, the pregnant woman is referred to Tygerberg Hospital.

## **THE STUDY POPULATION AND STUDY SAMPLE**

### **The study population**

The population of the study consisted of all Registered Nurses, Enrolled Nurses and Enrolled Nursing Auxiliaries, employed in the three public health facilities. The total population of nurses per category per health facility were as follows:

#### **At the Community Health Clinic or Clinic:**

- 6 Registered Nurses
- 1 Enrolled Nurse

#### **At the Community Health Centre:**

- 14 Registered Nurses
- 8 Enrolled Nurses
- 6 Enrolled Nursing Auxiliaries

#### **At the Midwife Obstetric Unit:**

- 9 Registered Nurses
- 1 Enrolled Nurse
- 6 Enrolled Nursing Auxiliaries.

The total population at the three health facilities consisted of 66 nurses.

### **The Study Sample**

The sample consisted of twenty-four nurse participants. Nineteen nurses were interviewed individually and five nurses participated in a focus group discussion. The following two

Tables, Table 3.1 and Table 3.2, illustrate the sample distribution of the nurses who participated in the study.

**TABLE 3.1. A sample distribution of the participants interviewed in phase one, according to the facility of employment and the nursing category.**

FACILITY	RN	EN	ENA
CHC	4	4	1
MOU	3	1	1
CLINIC	4	1	0
TOTAL	11	6	2

KEY: Facility: CHC (Community Health Centre); MOU (Midwife Obstetric Unit)  
Nursing Category: RN (Registered Nurse); EN (Enrolled Nurse); ENA (Enrolled Nursing Auxiliary)

Individual in-depth interviews were conducted with nineteen nurses. Four of the fourteen Registered Nurses and four of the eight Enrolled Nurses employed at the CHC participated. Only one Enrolled Nursing Auxiliary out of the six employed at the CHC was a participant.

Of the nurses employed at the MOU, three of the nine Registered Nurses and one Enrolled Nurse, participated. Only one Enrolled Nursing Auxiliary out of the six employed at the MOU was a participant.

There were seven nurses employed at the Clinic. Four of the six Registered Nurses and the one Enrolled Nurse employed at the clinic agreed to participate. There were no Enrolled Nursing Auxiliaries employed at the clinic.

There were various reasons why only some nurses participated. The one being that the researcher's sampling frame consisted of a certain amount of nurses per category. It was the intention of the researcher to not sample more than twenty nurses. With qualitative research, the sample size need not be too large. A small sample size manageable, to do in-depth interviews and determine and gain insight about the subjects experiences about a phenomena is important. As Patton (1990) states

“qualitative inquiry typically focuses in depth on relatively small samples, even single cases, selected purposefully (Patton, 1990: 169).

The researcher when she introduced herself to the nurses and told them about the purpose of the research and the process she also stressed that she would not be able to interview every nurse at the facility.

The two Enrolled Nursing Auxiliaries who participated expressed surprise at being asked to participate. They stated that normally Registered Nurses and occasionally Enrolled Nurses were consulted and asked to participate in research. The Enrolled Nursing Auxiliaries employed at the other two health facilities expressed the same views. Despite the fact that the researcher tried to explain that all nurse categories should participate in this research, many Enrolled Nursing Auxiliaries did not feel comfortable about participating. This was also the case for those amongst the other two nurse categories that were not prepared to participate.

At this stage it is important to inform the reader that amongst the Registered Nurses who participated some had acquired post-basic nursing qualifications, such as Nursing Administration, Community Nursing, Midwifery, and PHC clinical skills. Likewise the Enrolled Nurses and Enrolled Nursing Assistants also attended certain courses to improve their clinical nursing skills. A more detailed discussion of the nurses training skills and theoretical skills are presented in Chapter two and four. Details of the participants' perceptions and experiences related to the appropriateness of their basic nursing clinical training received and additional skills training courses, are also presented in Chapter four. Appendix C, present a schematic presentation of the profile of the nurses who participated in, phase one.

Table 3.2, presents a sample distribution of the participants who participated in the focus group discussion, in phase two.

**TABLE 3.2. A sample distribution of the participants of the focus-group discussion in phase two, according to the facility of employment and the total per nursing category.**

FACILITY	REGISTERED NURSES
Community Health Centre	2
Midwife Obstetric Unit	1
Clinic	2
TOTAL	5

Patton (1990) states that “ a focus group interview is an interview with a small group of people on a specific topic. Groups are typically six to eight people who participate in the interview for one and half to two hours” (Patton, 1990:335).

During the field research of this thesis, five Registered Nurses volunteered to participate in the focus-group discussion. Two were employed at the Elsie's River Clinic and two were employed at the Community Health Centre and one at the Midwife Obstetric Unit. Appendix D, presents a brief profile of the participants in phase two.

It was the researcher's initial intention to have three separate focus group discussions for the three nursing categories. However this was changed slightly during the research process. This is discussed in the Sample Rationale section below.

### **THE RATIONALE FOR SAMPLE SELECTION**

Miles and Huberman (1994) state that qualitative researchers normally work with small samples of people situated in their context, and are studied in-depth. They also suggest that boundaries need to be set in which samples are chosen. This means that the sample or cases needs to be well defined. They further state that “ a qualitative case may range widely in definition from individuals to roles, groups, organisations, programs and cultures” (Miles and Huberman, 1994:29). Within this thesis the group of nurses employed at the three primary level health care facilities, were defined as a case. The process and rationale for the selection of samples for each phase was as follows.

### **Phase One:**

Merriam (1988) observes that the main research focus of a case study is on one unit of analysis. McMillan and Schumacher (1984) states " The one unit may be an institution, a program, a process or an organisational position" quoted by (Merriam, 1988:46). The unit of analysis for this case study was the nurses, employed at the three primary level health care facilities, in Elsie's River.

According to Merriam (1988), Patton (1990) and Neuman (1994), the most common sampling method of choice in qualitative research is purposeful sampling. "Purposeful sampling is based on the assumption that one wants to discover, understand, gain insight" (Merriam, 1988:48).

Patton (1990:169) states that "the power of purposeful sampling lies in the selecting of information-rich cases for the study in depth". He also argues that a lot can be learnt from cases with "rich-information" (Patton, 1990:169). The information thus received is purposeful for the study aims and objectives.

Neuman (1994) also provides a few justifications for purposeful sampling. He suggests three reasons for purposeful sampling. Firstly a researcher uses it to select cases that are especially informative. Secondly the researcher may use purposeful sampling to select members of a specialised group who are "difficult-to-reach" (Neuman, 1994:198). Thirdly purposeful sampling is used when a researcher wants to, identify particular types of cases for in-depth investigation.

In this case study nurses who are recognised as the main primary level health care providers were considered to have the best information regarding their experiences and perceptions. For this reason purposeful sampling was conducted, in order to obtain unique as well as specific detail about their experiences, perceptions, attitudes and knowledge of the health systems framework (Neuman, 1994:198).

The sample was drawn from a "larger pool of cases" (Neuman, 1994:195). This larger pool of cases was the total nursing population from the three health facilities in Elsie's River. Neuman (1994) also mentions that cases can be selected from various sites, the nineteen nurses selected were from three health facilities.

In addition the researcher felt that to gain in-depth purposeful information about this sector of nurses only a small sample would be selected from a specific area, from which information gathering of a "rich nature" (Patton, 1990), would be collected. Patton (1990) states that "There are no rule rules for sample size in qualitative inquiry" (Patton, 1990:184). He also states that data with in-depth information from a small sample size is valuable especially if the aim is to gain insight and understanding.

Neuman (1994) argues that "The purpose is less to generalise to a larger population than it is to gain a deeper understanding of types" (Neuman, 1994:198).

The researcher is confident that the information received from the nineteen participants is insightful. The information received is presented in a format which produce direct quotes to provide interested readers and other researchers and particularly the West District Health Authority with information regarding these nurses perceptions, knowledge and experiences within the new health systems framework.

The sample selection process for the individual interviews was done at the same time as the data collection process. Both processes are discussed further, in the next section.

### **Phase Two:**

Many qualitative authors and researchers are in agreement that by combining various research techniques and or methods, it strengthens the reliability and validity of the data. Mouton (1994) observes that the use of more than one method and technique for data collection is likely to increase the reliability of the data and makes the data more

valid. The common term for the use of multiple methods in one research study is known as Triangulation (Mouton, 1994).

Sensitive issues such as, the participants' attitude towards their management, their job description, their scope of practice, their clinical training, and their relationships with each other, arose during the individual interviews. The researcher felt that these sensitive issues needed further exploration and clarification. The appropriate method of choice for consolidation and further exploration and clarification was to conduct a focus group discussion. By employing the process of triangulation the researcher aimed to strengthen the data collected during the individual interviews, thereby enhancing the reliability and validity of the study.

Phase two was conducted to validate the data received in phase one. A focus group discussion was held, in which Five Registered Nurses participated. The purposeful sampling framework was used based on the factual information discussed in phase one. The initial intention according to the study protocol was to have three separate focus group discussions, for the three nursing categories. However, it became clear from the responses of the Enrolled Nurses and Enrolled Nursing Auxiliaries participants, related to their understanding of the concept PHC, the structure of the DHS and certain key aspects of the MCWH Policy framework in phase one, that they were not familiar with these terms and concepts. However, with regards to their work experience in terms of their scope of practice, they expressed concern at their work overload, and expressed concern that they were doing work which were not in their scope of practice. More detail regarding their contribution is discussed in Chapter four.

Miles et al (1994) states that as the fieldwork progress the parameters or sampling framework boundaries may change. For example they state that within case study sampling, the question constantly needs to be asked "what can adding cases do for us"

(Miles et al, 1994:29). With regards to this thesis, the researcher posed the question of what relevance would more in-depth focus group discussions reveal, with Enrolled Nurses and Enrolled Nursing Auxiliaries.

The researcher's conclusion was that the contributions of the Enrolled Nurses and Enrolled Nursing Auxiliaries were limited. The limitation is with reference to their perceptions, attitudes and knowledge of the key aspects of the New Health Systems Framework. The researcher felt because the Enrolled Nurses and Enrolled Nursing Auxiliaries had no conceptual framework of the key aspects of the new health systems framework, conducting a focused discussion with them, would not significantly add new information or insights. In addition, analysis of the interviews of these participants required no further validation. For this reason a focus group discussion was held with Registered Nurses only. Further discussion on the sample selection process, of phase two, is discussed later.

## **THE SAMPLE AND DATA COLLECTION PROCESS**

### **Phase One**

#### **A summary of how the researcher gained access to the nurses at the facilities**

Permission was granted by the Nurse-in-charge to gain access to each facility. The nurses then agreed to meet the researcher to inform them about the purpose of the research.

The information meetings with the nurses occurred over several days and nights at the three facilities, to accommodate the day and night staff (at the CHC and MOU). The researcher informed the nurses that they could volunteer to participate and if they at any stage were not prepared to continue within the research process, could feel free to withdraw from the study. Some nurses were not willing to participate in the study. Reasons mentioned by them, related to previous negative experience with participation

in research. For example, one nurse said “people are always using nurses to do the research, yet never do they report back “ (Personal Communication: Enrolled Nursing Auxiliary, 1997). The researcher respected these nurses reason for not participating. The sample therefore consisted of nurses who volunteered to be interviewed by the researcher. This formed part of the sample selection process. Nurses either made telephonic arrangements with the researcher or informed her personally at the facility, that they were willing to participate. The arrangement was either made on the day of the interview or a day or two prior to the interview.

Prior to each interview the researcher introduced herself to the participant and informed her that the information would be held in the strictest confidence. There was no written confidential contract, only a verbal agreement was established between the researcher and the nurse.

Nurses were interviewed in a separate room at the health facilities, to ensure privacy and confidentiality. This contributed to the nurses being relaxed and at times revealed very sensitive information. In addition, the reason why the interviews were conducted at the facility was because nurses were not prepared, to be interviewed at their homes.

Gaining access to nurses was a long drawn out process. There were a number of factors that contributed to this. These included changes in the on duty times of the nurses and how busy nurses were on a particular occasion. In addition, it also depended on whether nurses were able to take time off for the interview. This lead to interviews often having to be rescheduled.

Another obstacle according to the researcher was the time factor. This meant that on several occasions a planned or arranged interview was cancelled because the nurse had no time to take off to be interviewed. For example, although the researcher was on time, the workload was just too much for the nurse to be spared an hour to participate

in an interview. Therefore at times nurses who had originally agreed to be interviewed were replaced with other volunteers. Fortunately, there was always another nurse who was not too busy in her department, and volunteered to be interviewed. An interview guide was used as a research instrument (See Appendix E).

### **The interview procedure at all three facilities**

Prior to using the interview guide for the interview, the researcher introduced the study in the following way:

- She introduced herself by name and surname.
- The researcher informed the participant that she had been a Registered nurse at the facility previously and gave a brief history of her career path.
- The participant was informed about the twofold purpose of the study: of which one was to complete a Master's thesis and the other to contribute to the development of nursing personnel at district level.
- It was also mentioned that all information revealed by the participant would not be analysed by name, but by the nurse category and name of facility.
- The researcher used the first four questions of the interview guide to gather demographic data from the participants. The interview guide is Appendix E.
- Once the participant was relaxed and comfortable in the presence of the tape-recorder, the other questions were asked.
- The interviews each lasted approximately one hour.

The researcher concluded the interview by thanking the participant, and also mentioned that once the report was written it would be made available to them.

### **The data collection process at the Community Health Centre**

Several contact meetings were held with the nurses, to inform them about the study.

On several occasions interviews, had to be rescheduled due to reasons previously

mentioned. The interviews occurred during the day and at night. The interviews occurred over a period of five months.

#### **The data collection process at the Clinic**

One contact meeting was held with the nursing staff to inform them about the purpose of the research and the research process and their role. The researcher either visited the facility or contacted nurses telephonically to arrange the interviews. The nurses at the initial contact meeting suggested the arrangement method. The interviews occurred over a period of one month. The meetings occurred during the day, as this particular facility only provided a 7am to 5pm service.

#### **The data collection process at the Midwife Obstetric Unit**

Several contact meetings were held with the nursing staff. These meetings occurred during the day, later afternoons, and at night, as there were nurses working on day and night shift, at this 24-hour health facility. The situation regarding the working environment was similar to that of the Community Health Centre. Nurses made telephonic or personal arrangements with the researcher. It also happened where interviews had to be rescheduled because the nurse who volunteered to participate was too busy. Only one Enrolled Nursing Auxiliary participated.

#### **Phase Two:**

##### **The sample and data collection process**

At each initial contact meeting the researcher informed the nurses about the focus group discussion to be held, after the individual interviews. After each individual interview the researcher asked the participant if she would be interested to participate in the second phase of the study. Most of the participants were not interested. Time was a major deterrent for these nurses.

After the contact session, the Registered Nurses who participated gave their names to the researcher telephonically. A brief meeting was arranged at the separate facilities to inform those who volunteered about the process.

The researcher informed them why they were only selected for the second phase of the study and explained what a focus group discussion was about. They were also informed in that a tape-recorder was to be used and that the researcher would facilitate the discussion and take notes. As with the first phase, an interview guide was used, (See Appendix F).

Once the nurses agreed to participate, the researcher had to arrange a date and time as well as a suitable venue, for the discussion to take place. The participants felt that they would feel more relaxed if the discussion did not occur at work. They mentioned that they wanted to be away from the "stress" of work. Also four of them were married and mothers and wanted to go home after work and be with their children first.

The logistical arrangements were quite difficult. It took the researcher at least two weeks to establish the date, and time of the focus group discussion. After a week a relative of the researcher volunteered his house for the venue. All were satisfied with the choice of venue as it was suitable in terms of distance and therefore accessible to all. The occupants of the house were not at home during the discussion. The participants were relaxed and felt free to speak about sensitive issues without concerns of being over heard by anyone. The participants each had their own transport. No payment was expected and the researcher provided refreshments.

The focus group discussion occurred on the 15th of March 1998. All, including the researcher, were seated in a circle in the lounge of the house. The researcher started off by introducing herself and allowed them to introduce themselves. It was interesting that although these nurses worked in the same area, they had never before met each

other on an informal basis. It was emphasised by the researcher that all information collected would remain confidential. Added to that, they were told that the only people who would have access to the information were themselves as participants, the researcher and the researcher's advisor.

The participants were also informed that a tape-recorder would be used to record the discussion. The tape-recorder was placed on a small table in the centre of the group. The discussion took two hours, from 7 PM to 9 PM. The researcher transcribed the discussion.

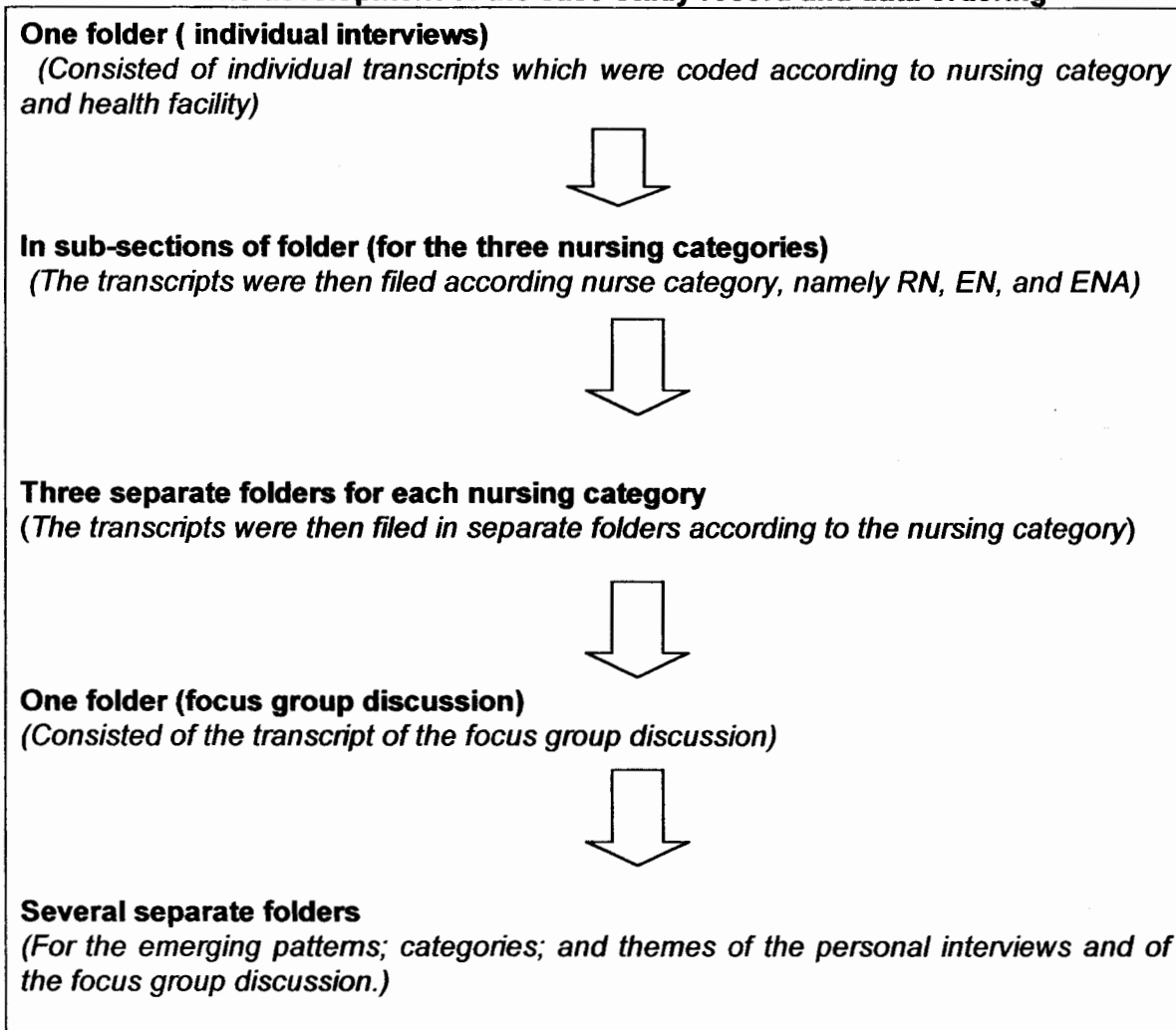
### **DATA ANALYSIS**

The data was analysed by means of content analysis which is a process of "identifying, coding and categorising the primary patterns in the data" (Patton 1990: 381). The data in phase one was coded according to the nursing category, and per facility. The data per nursing category was then categorised further and these categories were grouped into themes.

The data collected in the focus-group discussion was also analysed in a similar manner. It was analysed by extracting primary patterns of data, coding and categorising it into themes. These themes emerging from the focus group discussion were compared to those from the individual interviews.

The researcher created folders and organised the data within each folder for further analysis. This approach conforms to a model of analysis suggested by Merriam (1988). Table 3.3, illustrates the process of how the raw data was initially organised into a case-study record.

**TABLE. 3. 3. The development of the case-study record and data ordering**



Once the case-study record was developed, each transcript was taken and analysed individually. Then the emerging primary patterns were categorised. Which were further reduced into themes. The exploration of the themes is discussed in chapter four. Likewise, the focus group discussion was analysed in a similar manner, except that there was only one transcript and one nursing category. The emerging themes were compared to that of the individual interviews. More detail regarding the interpretation of the information is found in chapter four.

## RELIABILITY AND VALIDITY

### Reliability

In quantitative research, reliability “refers to the extent to which one’s findings can be replicated” (Merriam, 1988:170). This means that if this same study is repeated it should produce the same results. This is not possible in qualitative research, which “describes and explains” the interpretation or perception of a situation or phenomenon, from those who are being interviewed or studied (Merriam, 1988:170).

Lincoln and Guba (1985) suggest that in qualitative research, “thinking about “dependability” or “consistency” of the results obtained from the data”, makes more sense “than demanding that outsiders get the same results” (Merriam 1988:172). They further suggest that it is more appropriate for qualitative researchers to expect other researchers to concur that the results makes sense and are consistent and dependable. Conforming to suggestions made by Lincoln and Guba (1985) the researcher employed the following techniques to ensure that the results are dependable:

- The researcher explained to the reader, her *role* within the study, the *assumptions and theory* behind the study and the *social context* in which the research took place.
- The researcher *described in full detail* the study aims, and objectives, purpose and justification of study, the sampling selection process and rationale, data collection and analysis.
- The process of *Triangulation* was employed, whereby the focus group discussion was used to validate the information of phase one.

### **Internal Validity**

According to Merriam (1988) internal validity refers to how much truth is in the data, and does it make sense to the reader, in terms of meeting the studies objectives. Miles et al. (1994) also speaks about the “truth value”, and are the data “credible” to the participants and the reader (Miles et al., 1994:278)

Miles et al. (1994) states that to ensure that data is truthful, real and credible, a detailed description of the research process is important. The researcher employed the following strategies to ensure internal validity, which are similar to those discussed under reliability:

- Triangulation was employed, to confirm the emerging findings, thus strengthening the validity of the data.
- The researcher’s biases were clarified, by providing a brief detail of who the researcher was and her role within the research process.

Reliability and internal validity are linked in the conduct of research, hence similar strategies were employed to ensure reliability and internal validity within this study, (Merriam, 1988).

### **External Validity**

External validity is concerned with the extent to which the findings can be applied to other situations (Miles et al., 1994). Firestone (1993) suggests that, “Generalizability requires such connection-making, either to unstudied parts of the original case or other cases” (Miles et al., 1994:279). Qualitative research does not make claim to being generalisable.

According to Merriam (1988) that the intent of qualitative research is not to generalise conclusions of the study, but to provide in-depth insight about a certain phenomenon or

phenomena. Hence, although the findings and conclusions of this thesis cannot be generalised to other districts, it is believed that this thesis:

- Provides insightful information to the broader research population (*other nurses at the three facilities and at other primary level care facilities in the West Health District*), the West District Health Authority, and the Health Authority of the City of Tygerberg, regarding a few nurses perceptions and understanding and experiences within the new health system.
- The detailed descriptions of the research process could possibly serve as baseline information or a guide, for the development of further research within the district, or other districts within the City of Tygerberg.

## **ETHICAL CONSIDERATIONS**

### **A summary of the ethical steps undertaken prior to and during the study:**

- Prior to conducting the research:
  - Approval was gained from the Ethics Committee of the University of Cape Town.
  - Permission to conduct the research study at the three health facilities, within the West Health District and access gained to the nursing personnel at each facility.
- Also, as previously explained nurses were verbally informed about the aims and objectives of the study, their role within it and the researcher's role. The participants' indicated that they understood the purpose of the study and their role as well as that of the researcher.
- Informed verbal consent was obtained from each participant, prior to conducting the interviews, and the focus group discussion.
- Each participant was asked in which language she preferred to be interviewed. The participants were interviewed in the language of their choice, by the bilingual researcher. The language of choice was either Afrikaans or English.

- Confidentiality has been addressed by ensuring that participants names are not mentioned in the research. This was particularly important to ensure as certain sensitive issues pertaining to the participants concerns and feelings regarding the community and their management was discussed.

## **CONCLUSION**

The reader having now acquired the necessary information and researcher motivation and justification for the choice of methodology, is now introduced to chapter four, in which the findings are presented by citing direct quotations from the interviews, and where the findings are discussed in detail.

## REFERENCES:

1. Cronbach, Lee and Associates, 1980. In Patton M, 1990. Qualitative Evaluation and Research Methods (2<sup>nd</sup> ed.). Newbury Park, CA: Sage Publications.
2. Department of Health, 1995. Elsies River Draft Proposal for District Development, 1995. Department of Health, Western Cape.
3. Leininger M M, 1985. Qualitative research methods in nursing. Grune and Stratton, Ltd. London.
4. Lincoln and Guba, 1985. In Merriam S, 1988. Case Study Research in Education: A Qualitative Approach. Jossey -Bass Publishers. San Fransisco.
5. McMillan and Schumacher, 1984. In Merriam S, 1988. Case Study Research in Education: A Qualitative Approach. Jossey -Bass Publishers. San Fransisco.
6. Merriam S, 1988. Case Study Research in Education: A Qualitative Approach. Jossey – Bass Publishers. San Fransisco.
7. Miles M and Huberman A, 1994. Qualitative Data Analysis: An Expanded Sourcebook (2<sup>nd</sup> ed.). Newbury Park, CA: Sage Publications.
8. Mouton J, 1994. Understanding Social Research. Pretoria: J L van Schaik.
9. Neuman W L, 1994. Social Research Methods. Qualitative And Quantitative Approaches. 2<sup>nd</sup> Edition. University of Wisconsin, Whitewater.
10. Patton M Q, 1990. Qualitative Evaluation and Research Methods (2<sup>nd</sup> ed.). Newbury Park, CA: Sage Publications.
11. Personal Communication, Enrolled Nursing Auxiliary, 1997. Elsies River Community Health Centre. Western Cape Community Health Services. City of Tygerberg, Western Cape.
12. Rudestam K and Newton R, 1992. Surviving Your Dissertation: A Comprehensive Guide to Content and Process. Newbury Park, CA: Sage Publications.

13. Searight, 1990. In Rudestam K and Newton R, 1992. *Surviving Your Dissertation: A Comprehensive Guide to Content and Process*. Newbury Park, CA: Sage Publications.

## **CHAPTER FOUR**

### **FINDINGS AND DISCUSSION OF FINDINGS**

This chapter firstly reports on the views expressed by the participants in the in-depth interviews and in the focus group discussion. In the second section of this chapter, there is a discussion of the findings. The responses of each nurse category are presented separately but under the same headings of discussion. These are:

- The structure and function of the new health system
- Working Conditions
- Skills competency and training
- Job satisfaction

Some repetition of responses does occur in the three categories of nurses. However, the researcher felt it appropriate to present the information received from each category separately, in order to give the reader some insight of how each nurse category understood and perceived the new health system's framework and their role within it.

Throughout this chapter the words response and responses are used interchangeably, as it both refer to the findings. Similarly the words participant, participants, and respondents, are used interchangeably, as these refer to the nurses who participated in this study. Secondly, under each heading the responses are further presented under various sub-headings. Prior to the presentation of the findings the following, table 4.1 consist of a summary of the main themes identified during the analysis of the findings. The themes are discussed under four main headings and various subheadings throughout the chapter.

**Table 4.1: A summary of the main themes identified**

1.	The DHS is a new approach to the existing district nursing out-reach program.
2.	PHC is a philosophy which encompassing the social and economic well being of the individual and not only the health status.
3.	The “one-stop shop”, is a termed coined to describe the structure of the DHS.
4.	Increased patient attendance to local health facilities, since the introduction of the new health system and its various policies.
5.	Increased work overload for nurses at local health facilities since services were decentralised.
6.	All three nurse categories are at times working beyond their scope of practice.
7.	More appropriate in-service training is needed to enhance nurses’ clinical skill competencies to address the increased demand of curative service provision at local health facilities.
8.	All Registered Nurses should be trained in PHC curative clinical skills. The basic nursing training of Enrolled nurses need to be upgraded to that of Registered Nurses.
9.	Health Education as a component of PHC and is provided to the community, to impart limited skills for the community members to recognise and treat minor ailments at home.
10.	Community participation means that the community should not take an active role in decision making and planning of health services, but participate only in health education programs.
11.	Feelings of resentment towards the health authorities for lack of consultation with nurses, with respect to the introduction of new health policies and development of district health systems.
12.	Feelings of inadequacy and disempowerment.

## **FINDINGS OF THE INDIVIDUAL IN-DEPTH INTERVIEWS**

### **The structure and function of the new health system**

#### **The Responses of Registered Nurses**

#### **The structure of the District Health System (DHS)**

These nurses saw the District health system to be a process introduced by the Minister of Health, to assure effective amalgamation of services at local level, in order to eradicate the duplication of service provision. The following quotes summarise the nurses’ perceptions of the District Health System: “ I think now everybody will work together in one building, but the issue of salaries and working conditions still differ, and must be the same”. The second quote also refers to service integration. As one of the nurses stated, “ it is the amalgamation of all health services at local level”.

These nurses also perceived the District Health System (DHS) to be a renewed process to improve the District Nursing Component, of service delivery from the Clinics, Community Health Centre (CHC) and Midwife Obstetric Unit (MOU). This would take the form of providing a District Nursing Care service or District Nursing Out-reach activities. Nurses would be trained to improve the quality of district nursing care rendered. The following three broad principles were mentioned by the participants in terms of how they understood the District Nursing Care service:

- Nurses would conduct home visits to the sick.
- Nurses would dispense the prescribed medication, for example, such as Tuberculosis medication to Tuberculosis patients at home.
- Nurses would trace defaulters, to special clinics such as patients who missed attendance at for example the monthly Tuberculosis or Diabetic clinic.

The following responses are cited as examples of how some participants' perceived the structure of the DHS, more as a District Nursing Care service or District Out-Reach Program:

*" District Health for me is when a Sister (Registered Nurse), goes out to visit a patient who is unable to attend a hospital".*

*" I think it is the people in our community, it can be children and it can be mothers, for which home visits must be done, also to old age homes and creches".*

It is important to note that the nurses who held this view believed that they would receive specific training to improve the quality of the District Nursing Care service. However, questioning did not elicit examples on the type of training needed and why it was necessary to improve the district nursing service or out-reach program in the district.

#### The concept Primary Health Care (PHC)

No connection was made between the concept Primary Health Care and the Structure and function of the DHS. The Registered Nurses defined the concept of PHC according

to the World Health Organisation's Definition, (see definition quoted in definition of terms). However for most of the participants PHC was seen as encompassing individuals' and communities' socio-economic, political and health status. One of the participants mentioned that, *"PHC is not a method, it is a philosophy, ....you should try and make people responsible for their own health .... You should never send people away from a service... the community must be involved"*. However, no examples were cited as to how the PHC approach would in a concrete sense encompass the individual and community.

Another participant stated that, *"it is important for the community to get involved in improving the health and to take responsibility for their own health"*. A further response was that it meant that the community would, *"not run here for unnecessary minor ailments such as a common cold, cough and minor first degree burns"*. This could be interpreted to mean that the community's involvement in managing their own minor health problems would eventually enable them to manage these minor problems at home and feel more responsible to take charge of their own health. Hence as mentioned by the participants, they as a community will then not visit the health facility as often.

For others however, PHC was also perceived as the provision of specific Health programs to prevent and treat communicable or infectious diseases. These would include Immunisation Programs and Screening Programs for the early detection of communicable diseases, such as Tuberculosis. One participant, expressed this as follows: *"for example the screening program would entail Tuberculosis Skin Tests, X-ray facilities and taking Laboratory specimens such as sputum"*.

#### The Maternal, Child and Women's Health Policy Framework.

The Registered Nurses' initial responses were that they have not heard about the MCWH policy. However, after probing, when they were asked if there were any new policies introduced dealing with children and mothers, responses were elicited. The

participants based at the CHC, responded by stating that they had limited involvement with mothers and children which was as follows:

*"Yes we see children of all age groups, only when sick"*

*" We normally then carry out the doctors orders, in giving prescribed injections, or do various screening tests, for the doctor, to make a final diagnosis on the child".*

*" Well there was a circular released on how to deal with a Termination at least for someone who comes and wants an abortion".* None mentioned that they had been actively involved in implementing the policy with respect to Termination of Pregnancy, or whether any had been performed at their facility. They did not give their opinions on the issue, as it is still regarded by some health personnel as a very controversial medical issue.

The participants from the clinic said that the MCHW policy included the care of children to age 13 years who presented with an illness at this health facility. The participants from the MOU mentioned the Termination of Pregnancy Act of 1997 as one of the key aspects of the broad MCWH policy framework. A medical doctor from Tygerberg Hospital had discussed the Act with them.

A general response by participants was that since the introduction of the Free Health Care Policy in 1994, for pregnant women and children under six, their workload increased. The following quote is an example of how one participant felt about the effects of this particular policy, *" there is a shortage of staff and equipment, but we are still expected to see all this children now".* More detail on their views with respect to their working conditions is presented and discussed under the topic of working conditions.

#### The Responses of the Enrolled Nurses

#### The Structure of the District Health System

Some of the participants' understood the DHS to mean a geographically defined area in which health services would be rendered. As one stated, *"The DHS is divided into*

*districts and every patient is treated in his or her residential area, which is clearly marked from area to area*". However they did not elaborate on the type of services and whether it would be curative, preventative, promotive and or rehabilitative.

One participant based at the CHC mentioned that the DHS involved referral of the patient to the appropriate level of care. She stated that, *"the patient cannot go to hospital without a referral letter"*, from a doctor or nurses at a primary level health facility. This means that because community members have no direct access to the Hospital any longer, more will visit the local or primary level health facilities. This also meant that patient numbers are increased at PHC facilities. The participants measured their increased workload, according to the amount of patients who attend the facility.

All these nurses used the term 'one stop shop' as an analogy for the restructured unified health system. This implied that all health services would be provided at one facility and co-ordinated and managed by one health authority. They felt that this led to more pressure being placed on the nurse. As one nurse stated, *"if everything is going to be really under one roof, more pressure will be on the nursing personnel, in actual fact it's already so and we cannot cope"*.

The participants expressed their anger and frustration towards their immediate management, namely the Health Authorities of the City of Tygerberg and towards the provincial and national health authorities, in relegating them to the role of merely implementing already finalised policies. As one participant stated, *" they treat us like puppets, it is so frustrating because they just introduce new things and we must just do the work"*. More detail regarding this is presented under the headings of Working Conditions and Job satisfaction.

#### The concept Primary Health Care

Some nurses saw the concept, as referring not only to the health care of the sick individual in the community, but encompassing individuals socio-economic status as

well. Others perceived the PHC concept involving the rendering of curative care by suitably clinically qualified nursing personnel at local health facilities. For example one participant said, *"PHC is treating the sick with medication, it is only the sister (Registered Nurse), who had PHC, could give PHC"*. The PHC qualification of Registered Nurses, refers to those nurses trained in curative clinical skills to further enable them to render appropriate curative nursing health care, at local health facilities. The reader is also referred to the definition of terms in chapter one, which includes a brief description of a PHC trained or clinically skilled nurse.

Some nurses saw a main feature of PHC as being that services would be made more accessible to the community in terms of distance. One of the participants based at CHC, cited the opening of a 24-hour emergency service linked to the CHC as an example of the establishment of a service provided close to the community of Elsie's River. In this way the community, *"don't need to take a bus or wait on transport to take them to Tygerberg hospital for emergency care"*.

Furthermore, the nurses referred to Health Education as an important element of PHC. It was felt that nurses had an important role in providing health education and health programs to the community. For example as one participant stated, *"PHC is when one moves closer to the community and educate the community about minor health problems and how to prevent them or treat them"*. Another stated that, *"health education is important for nurses to provide in the clinic and in the community, so that people can learn to understand diseases and also be able to treat them"*. They did however mention that they had limited time in providing health education. More detail with respect to these constraints is presented under the heading Working Conditions.

#### The Maternal, Child and Women's Health Policy.

These participants perception of the policy was that it had to do with the provision of health services for mothers, children and teenagers. All stated that they have not seen

the policy but could mention a few key aspects of the policy as it pertained to their work environment. These were some of the key aspects mentioned by the participants: the Termination of Pregnancy Act of 1996 and the Free Health Care of 1994 for pregnant women and children under 6 years, a new policy introduced at clinics to attend to children up to age 13 years. The participants were however not too enthusiastic about the policy changes for reasons similar to those expressed by the Registered Nurses. The following two quotes illustrate examples cited by participants based at the CHC and clinic respectively, on their perceptions of the effects of the new health policies:

The one said that, *“since part of the Paediatric department from Tygerberg Hospital came over, we see lot of sick children, we just have to carry out doctor’s orders, and there is no time to give health education to the moms”*. Hence, the decentralisation of certain tertiary and secondary health services, to the CHC, has led to more community members attending the facility, increasing the number of patients attending and the nurses’ workload. Another Enrolled Nurse participant based at the clinic, stated that, *“things have changed we now have to see children up to age 13 years, and we not sure how to treat them and sometimes I don’t know what advice to give the mom... more are now coming to the clinic, and at times we are so busy that we don’t have time to give proper health education to the children’s ‘parents”*. The concerns and problems cited were similar at all three facilities.

#### The Responses of the Enrolled Nursing Auxiliaries

Each had their own perception and understanding of the key aspects of the new health systems framework.

#### The Structure of the District Health System

The following quotes are cited as examples of these nurses’ viewpoints:

*“No I don’t really know about the DHS and how it works”*

*"I just heard about it in bits and pieces, but don't know what it entails"*

*" All health services will be under one umbrella, namely the Day hospital (CHC), the MOU and the Clinic".* The participant meant that the health services provided by all the latter mentioned facilities, would all be provided from one building, hence "under one umbrella". No mention was made as to whether the District or Provincial Health Department would provide and manage these health services.

The second participant understood the DHS to be a renewed process to improve the district-nursing component as a service provided from various health facilities. She stated that, *"the DHS is when the nurses go out to the houses, it is known as district nursing, to visit the sick and sometimes recall defaulters"*. No reference was made of the structure of the health system and how it is or should be managed.

#### The Concept Primary Health Care

The participants initially responded by stating that they were unsure of what the concept meant. They then said that they heard about the concept but did not fully comprehend the meaning and relevance thereof. After further probing, one participant responded as follows, *"I think it means that the nurse must at all times give health education to the patients"*. In addition to that she also perceived the concept PHC as the curative aspect of health care provision, at local health facilities. The second participant just said, *"I don't know what it means, I just heard about it"*.

#### The Maternal, Child and Women's Health Policy

Similarly their understanding of the MCWH policy framework and its key components were limited. Initially the participants said they had not heard of the policy. On probing, the participant based at the CHC, mentioned that the policy referred to the health services provided for mothers and children. However, she did not mention what the type of services these were.

The participant based at the MOU said that, “ *this MCWH policy for me working here means you must always understand the patient, and make the patient comfortable*”. Added to that she also said that, “*one of the key aspects of the MCWH policy was the Termination of Pregnancy Act*”. She also mentioned that an official circular about the management of a Termination of Pregnancy was available at the MOU. The latter two quotes summarise the nurse’s perceptions of the MCWH policy framework, which is: to provide a caring ethos in the workplace and that it involved the Termination of Pregnancy Act of 1996.

As previously mentioned, further analysis from the interviews revealed additional themes which are discussed below under the following three headings: Working Conditions, Skills competency and training and Job satisfaction.

### **Working Conditions**

#### **The Responses of Registered Nurses**

The Registered Nurses felt that staff allocation at health facilities was limited. For example the participants based at the Community Health Center said that there were only three nurses and two doctors allocated to provide the service at the emergency unit, linked to this health facility. These nurses felt that the authorities were not concerned about the nurses’ well being, “*they increased the allocation of doctors from one to two, but the number of nurses for the emergency unit, remains at only three*”. All the participants based at this health facility cited this example.

The participants believed that their increased workload was due to the introduction of the Free Health Policy for pregnant women and children. It was mentioned that they did not mind the attendance of pregnant women, but found the increased number of children seen at the CHC health facility, burdensome. The nurses also felt that most of the health complaints that clients presented were minor, and could have been treated by the parents at home. For example, as one participant stated, “*They bring children in with*

*common colds, and minor burns, and many times diarrhoea, and fevers*". The nurses felt that the large number of clients needing attention left them no time to provide appropriate health education to mothers, because they had to *"carry out doctors orders, by providing the appropriate treatment, as well as dispense the medication"*. This according to the participants, led to feelings of anger, frustration, and increased absenteeism, amongst the nursing staff.

The participants based at the Clinic and MOU expressed similar feelings and cited similar examples related to increased patient load, leading to work overload. For example as one clinic nurse said, *" more children are now attending our clinic, since the Free Health Policy was introduced, and not only that... it was also since the closure of hospital outpatient department"*. With the process of decentralisation of health services, community members are expected to seek medical assistance at a local health facility, in the first instance. If the nature of the problem warrants more advanced treatment, the individual will then be referred to the district or secondary hospital, such as Tygerberg Hospital. Prior to these policy changes many individuals preferred seeking medical assistance directly at the hospital. The nurses felt this was because, *" the community has a great belief in hospitals, because, they get better medication and there are doctors to help them, and not nurses"*.

The decentralisation process has become a very contentious issue. It seems to have had a negative impact on the relationship between the nurses and community members at these health facilities. For example, the participants stated that community members were often impatient and rude towards the nursing staff, at the facilities. They felt that this behaviour of community members arose as a direct consequence of the introduction of the decentralisation process. This was because there was inadequate consultation about the introduction of new health policies, with the community and nursing staff, also as to the type of possible problems that might arise in service delivery, within the new

framework. The problems, now evident at the health facilities, includes staff shortages, increased patient and workload for nurses, minimal appropriate equipment and longer waiting times for community members. The participants felt that these problems contributed to nurses not experiencing job satisfaction. More detail on the latter is discussed under the last heading of Job satisfaction.

#### The Responses of Enrolled Nurses

The Enrolled Nurses expressed similar views to the Registered Nurses about their increased workload, as a result of the number of procedures they needed to perform and the large number of patients seen daily. It was felt that due to staff shortages in all nursing categories they were unable to render a good quality service to the community. As one participant stated, *“we cannot give a proper service, because the manpower is too little”*. The participants based at the CHC also mentioned that there was a shortage of staff at the Emergency Unit of the CHC. The participants based at the three facilities also felt that they had no time to provide health education programs to the patients because according to them they were so *“busy carrying out doctors orders”*(CHC based participants), or *“performing clinical tasks”* (clinic and MOU based Nurses).

A statement by one participant summarise how these Enrolled Nurses felt about their working conditions: *“working at a local primary health care facility is different than working in a hospital, here one is forced and just expected to do certain things, with not much assistance and support, at least in the hospital there is routine and support and everybody do what is expected of them”*.

#### The Responses of the Enrolled Nursing Auxiliaries

The two Enrolled Nursing Auxiliaries shared the same perceptions and concerns regarding their working conditions. These were, such as *“too few”* nursing personnel on duty and that the increased patient load at health facilities had a negative impact on their workload.

## **Nurses' Skills competency and Training**

### **The Responses of the Registered Nurses**

All the participants were familiar with their scope of practice. They knew what they were expected to do in terms of nursing functions and what they were not suppose to do, according to the nursing regulations in terms of their scope of practice. However, they expressed concern about their incompetence, relating to certain clinical aspects of their work. The following are the specific viewpoints of the Registered Nurses based at the three health facilities:

The Registered Nurses at the Clinic expressed concern about the introduction of a curative service for children over 6 years of age. They stated that they had only been trained to treat children to age 6 years. The nurses said that only nurses, who had six or twelve months post-basic PHC qualification<sup>1</sup>, were capable of assessing the older age group of children.

As one participant stated, *"Often I'm unsure of making a diagnosis, I normally refer the child to a nurse who has done the six month PHC course"*. The PHC course referred to, is a clinical skills course offered to nurses, which enables them to provide an appropriate curative nursing care service, to children and adults, in addition to providing an appropriate health promotive, preventive and rehabilitative health service.

However, the nurses who were PHC trained at the clinic also felt insecure with regard to making a nursing diagnosis, without the confirmation and support of a medical doctor. For example, as one participant stated, *"I'm sometimes not sure whether I'm doing the right thing or giving the person the correct medication, and there is no doctor to consult "*. Some nurses felt a doctor should be based on the premises, in case of nurses being unsure of the treatment regime.

---

<sup>1</sup> PHC qualification refers, to those nurses trained in curative clinical skills to further enable them to render an appropriate health service at primary level health facilities.

The Registered Nurses at the MOU also mentioned that they worked without the physical support of medical doctors. They felt that their level of competency would increase if they were trained in the "Advanced post-basic course in midwifery". One participant said, "*in midwifery nurses work without the presence of a doctor and I feel if only we were more trained, in Advance midwifery, it would not be necessary to refer unnecessary cases to the Tygerberg hospital*". Many of the participants felt that they would feel more comfortable in their job and more competent if they received more training. Besides being trained in Advanced Midwifery they also suggested that, "*nurses needs lots of training there's always something new that she needs to know how to do*". One example mentioned was the need to be trained to counsel women who requested advice on the "termination of pregnancy". Another example mentioned was training in communication skills to deal competently with the " new type of patient attending the service". When asked who they saw as the 'new type of patient', they stated that it was someone who knew what type and quality of service ought to be offered. They also felt that if they were not competent in rendering the service, the community would not be respectful towards them.

The Registered Nurses based at the CHC expressed similar views and concerns with regards to their level of skills competency. These participants felt that all nurses should be trained in PHC. This would equip the nurse, with the necessary skills to do full physical assessments and make appropriate diagnoses for example of minor ailments such as common colds, coughs, certain respiratory disorders, and certain skin disorders. They should also have the necessary clinical skills to prescribe appropriate treatment and medication. For example as one participant cited, "*I feel that all Registered Nurses must be trained for a year in PHC, so that they can all be able to make an appropriate nursing diagnosis and treat people or know when to refer people to a doctor for more*

*advanced treatment*". Lack of this training in clinical PHC skills means that some of these nurses did not feel competent enough to treat patients at local level.

The participants also felt a need for more ongoing in-service training. As one participant said, *" more in-service training is needed to improve nurses skills, we are just expected to do certain things, without being asked whether we feel competent to do it"*. Several nurses stressed the need for regular in-service training to update clinical skills:

*" I think clinical trained PHC nurses must be evaluated every year, because you think you are competent then sometimes you are not, so that they can send us on refresher courses, to update us again"*

*" We need to be updated regularly, because in midwifery you work alone and we cannot rely on the doctor, as this is the only way we'll be able to improve our clinical skills"*

*"I'm doing district nursing I'm on my own and have to make my decisions... now I feel I need some form of in-service training, but since I'm here I've not been sent on any training"*.

*"It's your responsibility to know how to handle the patient, and what advice to give to the pregnant women or the mother with her new baby, but sometimes I'm not too sure on what advice to give, therefore I think regular forms of in-service training just to be updated with new information or to teach us new clinical skills will help us to become more competent as midwives"*.

The nurses felt that because they were not at times adequately skilled to render a good quality service, they became frustrated and angry not only towards their managers but also towards the community. The nurses mentioned that their feelings of dissatisfaction within the work environment impacts on the provision of health care in the community.

#### The Responses of the Enrolled Nurses

Enrolled Nurses said they worked under the direct supervision of the Registered Nurse.

The scope of practice of the Enrolled Nurse includes: Administering of prescribed

injections and medications; Measuring and recording of vital signs such as blood pressures, temperatures and the measurement of the weights and heights of patients. Although the participants competent within their scope of practice, they expressed concerned about their increasing, unofficial roles and functions. The following examples illustrate some of the participants' confidence they've acquired, in the work they were doing, but however, also expressed concern that they were at times performing nursing functions beyond their legislative scope of practice:

*"I'm doing just about everything I don't even bother at times with my scope of practice".*

*" You not allowed to put up drips (Intravenous therapy), but if you are confident enough they (Registered Nurse) allows you to do it".*

*" Sometimes I do more than my scope of practice, especially weekends, when there is only one Registered nurse, a Staff Nurse (Enrolled Nurse) and an Assistant Nurse (Enrolled Nursing Auxiliary), on duty".*

*"We do more than what we are suppose to do because there is a shortage of staff, what I mean is that there are too few Sisters (Registered Nurses), so we are expected to perform the tasks then".*

*"Many times we do things beyond our scope of practice, which we were not trained to do, but learnt by just working with the sister (Registered Nurse)".* The dispensing of medication at the Emergency Unit at the CHC as well as the procedures of wound suturing were cited as examples, as functions performed beyond their legal scope of practice. The Enrolled Nurses based at the CHC specifically mentioned this concern.

Some participants felt that they required more in-service training, so that, *"we could officially learn the correct way of doing certain things and not by trial and error"*. This statement reflects both the inadequacies they felt about certain tasks that they were expected to perform. It also reflects these participants' desire to improve their skills so

that they could perform the same functions as that of the Registered Nurses, in an official capacity.

The Enrolled Nurse participants felt that by retraining them and upgrading their qualification status would contribute to addressing the shortage of skilled PHC trained Nurses. Training Enrolled Nurses to legitimately perform certain nursing duties, previously performed only by Registered Nurses, would enable them to operate as clinically skilled nurse practitioners and provide a good quality of health care.

#### The Responses of the Enrolled Nursing Auxiliaries

These participants also said that they worked under direct supervision of the Registered Nurse and that they also had to assist the Registered Nurses and Enrolled Nurse in their duties. Their specific duties included: The measurement and recording of the patients' weights and heights, and recording of vital signs such as blood pressures and temperatures. In addition, they were required to obtain laboratory specimens from the patients, such as urine, stool and sputum, where necessary. They were also required to perform basic nursing functions, such as bathing a newborn at the MOU, and provide support for the patient, during physical examinations.

These participants were also concerned about the increased number of patients attending local health facilities, which had increased their workload. They too stated that at times they were expected to perform functions for which they were not clinically trained and that their functions overlapped with that of the other two categories. For example as one participant stated, "*a person does such a lot of things, like over weekends, in the emergency unit, we at times must dispense the medications, give injections, sometimes without checking with the sister (Registered Nurses), because there is no time*".

Both participants indicated the need for in-service training in order to improve and acquire more clinical skills.

## Job Satisfaction

### The Responses of the Registered Nurses

These nurses mentioned a number of issues that impacted negatively on their job satisfaction. One participant said, *"we are like Florence Nightingale, you must just do something because there is a service to be rendered"*. Most participants felt that the authorities merely expected them to perform new tasks without prior consultation. A much cited example was that the clinic nurses were expected to attend to children older than 6 years irrespective of whether they were trained to work with them or not. They felt these types of demands caused major frustration amongst staff. Another stated that, *"nurses are struggling to make ends meet with the increased workload, they are burnt out and become fed up and just go off-sick frequently"*. This was felt by some participants, which according to them have led to increased absenteeism among nurses.

Some participants also expressed feelings of disillusionment with the nursing profession, by stating that they did not feel like nurses any longer. To quote one, *"these days I don't feel like helping people any longer.... but I just do my work because I need to pay my bills and not because I love my job"*. This viewpoint was shared by some participants as they felt that many new policies had been introduced into the health system, and without them understanding the purpose and how best to effect these policies. These nurses felt under pressure and coerced into accepting the new policies. Policies cited as examples were the: Free health care policy for pregnant women and children under 6 years; the decentralisation of certain health services from secondary and tertiary hospitals, and the provision of the counseling for those seeking advice on termination of pregnancies. These participants felt that they were, *"used, exploited, and disregarded as health professionals"*. They stated that if the health authorities had consulted with them in an appropriate manner, they would not have felt so demoralised about the new health system.

Conflict between nurses and clients was cited as another source of job frustration. Nurses based at the CHC felt that unnecessary demands were, made by clients on overworked nursing staff. They stated that many of the health problems clients presented with could have been treated at home. As one nurse stated, *"the community have no perception of what an emergency is"*. This led to confrontation between community members and nursing staff over long waiting times, patient dissatisfaction with the minimal time spent with them, or if they did not receive any medication to take home. For example the participants based at the CHC said that most often children who suffered mild diarrhea, received oral rehydration therapy and the child was discharged with advice to mother. This was unacceptable to many mothers, as they expected as previously to receive medication, rather than advice. To quote one participant, *"patients have been spoilt over the years, whenever they saw a doctor, medication was given irrespective of whether it was needed or not, ...now today because we nurses attend to most of these types of cases for example childhood diarrhea, the community feels we are incompetent or plain selfish, and this leads to major arguments between nurses and patients"*.

In conclusion, the participants felt that the staff shortage problems, lack of consultation regarding the changes to be introduced in the work place and lack of adequate clinical training had adverse effects on job satisfaction of nurses and on their ability to effectively implement the new health system.

#### The Responses of the Enrolled Nurses

These participants expressed similarly strong feelings of dissatisfaction about the impact of the new health policies on their work. They believed that moves to decentralise and rationalise the health system had increased their workload. This was exacerbated by staff shortages. In addition they too complained about the lack of consultation with nurses when introducing the changes. The following quotes illustrate this.

*" I don't know the information about the DHS and how it is suppose to function, it is given in bits and pieces from the authorities, no official meeting was held with us to tell us about the changes"*

*" We are very unsure about the rationalisation process, hospital wards are just closing and the sick people are being discharged early from hospital, we are stuck with these sick people because now we must go out to care for them at home, I mean this is not fair"*

*"It is so frustrating, for example the statistic form (recording of monthly attendance and work procedures done), change continuously, there is no consultation with us we are just told to use a new form every time "*

*"I just come to work because I need the money, the authorities don' care about us, we are so short staffed, but yet they just tell the community to attend the local health services, we are so sick and tired of all this work now".*

*" We are not machines or conveyer belts, you cannot render a quality service if your staff is too few".*

Thus as one participant stated, if appropriate consultation had occurred they would have,

*"felt more at ease as to where we as nurses fit in, and what the changes in the health system consist of "*

### The Responses of the Enrolled Nursing Auxiliaries

The Enrolled Nursing Auxiliaries too expressed frustration at the increased workload as they perceived the changes in the health system to have brought, as one participant said *"we are so frustrated because we are just loaded with more work now, for example the babies and children to 6 years is included at the Day hospital, I don't mind the work, but the load is just too much, sometimes we just can't cope".* She also said that since the downscaling of tertiary health services the community members preferred attending the

CHC, because they were convinced they would be attended to by a doctor who would give them medication to use at home and not receive advice from nursing staff. This led to a situation where, as one participant stated,

*“ over weekends it is so hectic and we are already so fed up and exhausted with all the unnecessary cases who attend the Day Hospital”.* The other participant did not raise any dissatisfaction or concerns about her work, other than what already has been mentioned, regarding the need for in-service training and to increase the nursing staff allocation at the primary level health facilities.

### **Conclusion**

The following key points emerged from these individual interviews which the researcher felt needed further exploration: Health Education; Community Participation and involvement; PHC clinical training and in-service training; Downscaling of services and New Referral procedures. These key points have been further explored during the focus group discussion. The following introductory question was posed prior to using the questions in the Interview Guide as specified in Appendix F, to elicit information from the participants of the focus group:

*“ What do you understand by the new health systems framework and how do you feel about the changes within the new health system”.* The information gained from the focus group discussion is presented below.

### **THE FINDINGS OF THE FOCUS GROUP DISCUSSION**

This section is presented under the following headings:

- The approach of the new health systems framework.
- Community Participation
- Health education.
- Feelings about changes within the health system

- Nursing training and education

### **The approach of the new health systems framework.**

All five participants perceived the new health systems framework to be based on the PHC approach. They saw the PHC concept encompassing eight elements “as enshrined in the Alma-Ata Declaration”. These elements “encompass the social, economic and environmental and political aspect of the individual and communities”. This viewpoint is similar to that expressed during the personal interviews. These nurses also saw the new health system as district based and involving the process of decentralisation of services and amalgamation of health services at local level.

Participants expressed concern what they perceived to be an over-emphasis on the provision of curative services at the local health facilities. This they felt was ultimately not only to the detriment the nursing personnel, but to the community as well. As one participant stated, “ *I think they are ignoring the prevention side of health care, and focusing more on curative care.... you can't just treat people for their illness all the time, you actually achieve nothing, they come back with the same problems and this is why the services are always overloaded with sick people*”. The other participants echoed similar sentiments and added that the emphasis on curative care led to nurses not having “ *time to give the client health information about his illness and how to prevent it's recurrence, for example if it is a preventative illness like for example TB*”. They felt this was a major flaw in the way the PHC approach was being implemented. They believed that the Health Authorities had to “ *first focus on improving the communities', social and environmental conditions*”, then “ *adopt the PHC approach*”.

Some participants expressed reservations about the integration of all health services. As one participant said, “ *there'll never be much attention paid to preventative health care, if all the services are placed under one roof... because now more sick people will attend the Day Hospital and clinics to be treated for their ailment... and once again our job will*

*just be to nurse this sick people and give them medication". Another viewpoint expressed was that PHC would not be successful if no focus was placed on prevention, "for example the population is just increasing because there is no proper focus on population or fertility control".*

The participants felt that there were no appropriate, *" health promotion programs to reduce risk behaviour such as alcohol and drug abuse, as well as practicing appropriate fertility control measures that enhance appropriate family planning".*

One participant felt that the PHC concept has a broader focus and includes, *"intersectoral collaboration and community participation".* She felt that the basic training of nurses has not equipped them to *" fully comprehend these two components".* The group was critical of the health authorities and in particular, Doctor Zuma, the former Minister of Health for, *" expecting us just to allow the communities to participate in the management of services, yet we don't know how this should be done".* One participant identified appropriate training to deliver PHC as a problem. She stated that, *"Doctor Zuma say we are the backbone of the PHC system, but we are not even trained properly to provide appropriate health care".*

### **Community Participation**

The participants felt that one aspect of community participation involved health providers reaching out to the community and concerning themselves not only with the provision of health care at health facilities, but focusing on the social and environmental conditions of the community. As one participant said, *"I think the problem lies with us nurses ourselves, I think it is time that we get out into the area and check on the type of housing and sewerage problems, and how it affects the peoples health...we do home visits ... we can make a difference to peoples lives".* However, in order to do this, some participants felt that *"nurses would have to change their mind set in order to be able to participate with the community".* They felt that nurses were not trained to work with the

communities, but were trained to, *“only to give them orders and advice, yet not to work with the communities to solve problems”*. Further discussion about the training of nurses is discussed under the heading, Nurse training and education.

The participants were against community participation being interpreted by the health authorities to mean, permitting communities to participate in the planning and management of health services at district level. One participant said, *“they are trying to implement community participation so that communities become involved in planning and managing services... how can you allow the community to do this and not the staff (nurses), where do you draw the line?”* They expressed resentment that the health authorities involved communities in the planning of services, but did not involve nurses. As one participant said, *“we as nurses were not consulted about how the health services will be changed and what new policies will be introduced. Our nursing managers just come down and tell us about the new policies that we need to implement, never do they ask us for advice on how we think the services must be run, but they go outside and ask the community”*. The participants felt that their managers afforded greater priority to community involvement than to staff involvement. They also felt that encouraging communities to participate in the management of health services, lead to community members no longer having respect for nurses. Besides the community's disrespect the participants believed that the community was insensitive to the working conditions of nurses at local health facilities. One participant said, *“the attitude of the community is not on, they accuse us of working too slow, and when they have to wait in the long queues since the downscaling of services, they blame us, and not the health authorities that made these changes”*.

The focus group members also commented on the role that Community Health Workers (CHWs), played in the community. They expressed reservations about functions CHWs were permitted to perform. One participant said: *“some of these CHWs do more than*

*what an Enrolled Nurse and Enrolled Nursing Auxiliary is permitted to do. These people (CHWs), well some of them for example in Khayelitsha they advise people in the community and they counsel young women and teenagers on contraceptive methods and also if they have problems, and refer them. I can't understand how they can do the counseling, and the Nursing Council don't permit the Enrolled Nurse and Enrolled Nursing Auxiliary to give that type of advice to clients".* The participants felt that the nursing regulations relating to the **Scope of practice** of Enrolled and Enrolled Nurse Auxiliaries should be altered, to allow them to perform the functions performed by CHWs.

The participants believed that CHW should continue to play a role in health education.

As one participant stated: *"I think these CHWs are doing a good job of giving health education to the community, and their main role should continue to be that".* They did not appear to appreciate any role for the CHWs beyond this. The researcher has not explored with the group as to whether they saw CHWs operating as part of the public health sector, and employed within it or working outside of it.

### **Health Education**

Participants felt that health education was a crucial component of health service provision at local health facilities. They felt that, *"health education was important because it tied in with PHC. For example once the client is treated you should send that person home with the necessary information, which would enable that client to prevent the illness from occurring again".* Ideally health education of clients would:

- Enable the client to recognise the signs and symptoms of the problem.
- Enable the client to know what action could be resorted to when at home, and to become vigilant if the symptoms of the condition deteriorate, and to seek medical assistance if necessary.

- Contribute towards reducing the number of community members who attend the health facilities for minor ailments, *“which they could have treated at home, if only they knew what to do or what to use”*.

However, nurses felt health education was being neglected as they *“hardly have time to provide health education”*. This was because they had to spend most of their time providing a curative service, to the large number of patients attending local health facilities. In addition to that they expressed they expressed the view that the patients or clients had become reliant on the health service to provide all treatment, and tended to be unreceptive to health information, that would assist them to take control of their own health and well-being.

### **Feelings about changes in the health system**

The participants felt that they had not been consulted during the process of transformation or officially consulted about the policy changes and possible implementation strategies. They believed this had the effect of disempowering nurses. As one participant mentioned, *“nurses were generally ignored and my concern is, what input did nurses really have in restructuring the PHC services... practically nothing. Only the CPNs (Chief Professional Nurses) were involved. And what they did was to report to us on what they felt was necessary. For me they left us with nothing much, because we still are unsure of how things are suppose to function. This is what I mean we are still disempowered, because we know so little about the new health system”*. They perceived the process of disempowerment as a factor that limited the process of transformation amongst nurses.

The participants felt that nurses' current disempowerment in relation to changes in the health system took place within a context of more general disempowerment of nurses. For example one participant said, *“nurses never support each other”*. Another said, *“we disempower ourselves... because for example when one speak out or show*

*dissatisfaction about something at work, your colleagues will not like you... and your superiors sometimes victimize you".* The group stated that where the views of nurses differed from those of the nursing authorities, they were liable of being victimized. The process of victimization took on many forms, such as no study leave opportunities, or no job promotion.

The participants also expressed feelings of subservience and inferiority towards others within the medical profession and other health professionals. They felt that they were at times seen as inferior by other health professionals. One participant stated that, *"I had a debate with an environmental health officer yesterday. I told him I have lots of experience, and about six years of training, i.e. General, Midwifery, Community Health, yet he said he is better qualified than I am. He told me that although I was the Nurse In-Charge at this health facility, my training did not equip me to function as a critical thinking health practitioner, in a PHC environment"*. The participants felt that this was the general pervasive attitude amongst the environmental health officers that they encountered.

### **Nurse training and education**

The nursing curriculum these nurses were exposed during their basic nursing training was based on a curative model. The group members expressed dissatisfaction with the type of as they stated, *"as student nurses there was something about our training curriculum that ensured that we always obeyed and never questioned our seniors, it had a hidden agenda, ya it was a hidden-curriculum"*, practiced within the nursing education. This term "hidden curriculum" used by the participants, refers to the underlying philosophy of the profession, to ensure that nurses became subservient and obedient health professionals. They felt that the student nurse, *"was trained to be subservient towards the nursing hierarchy as well as to the medical profession"*. Thus the feeling of

disempowerment as expressed earlier, was according to the participants, a manifestation of the aim of the "hidden-curriculum".

The group also perceived the process of disempowerment as a limiting factor within the process of transformation of health personnel and specifically amongst nurses. They said nurses do not allow each other the potential to develop. As one participant mentioned, "*when I was doing the Community Health Course at Technikon, the moment you aired your views and it differed from your colleagues, they labeled me as aggressive and unprofessional*". She felt that the negative attitude of the learners was an example of the impact of the "hidden curriculum" of the nursing education they received. It was furthermore mentioned that nurses who were at all times questioning the validity of information received from their nursing superiors were regarded as "*trouble makers, and unprofessional*".

It was mentioned that nurses use to work alongside the medical doctor and did not take sole responsibility for the wellbeing of the patient. Within the new health system, nurses at most times are expected to make decisions about the client or patients health without the assistants or opinion of a medical doctor. The participants felt nurses are not sufficiently trained to make such decisions on their own. They also felt that their training was inferior to that of medical doctors. They did not only refer to the basic clinical training of the Registered Nurse but of the PHC clinical trained nurse as well. One participant stated, "*as nurses we were trained to look more at the curative side, and carried out the orders of the doctor, in the hospital.... now here at the local health facilities, you are expected to use your own initiative at times*". These nurses reiterated what has been said within the personal interviews that nurses who were clinically trained in clinical curative skills (PHC trained), were expected to provide a similar service to the doctor. It was felt that too much was expected of the PHC trained nurses, also known as the Clinical Nurse Practitioner (CPN).

The group's perception was that although their clinical training was inferior to that of doctors, they were expected to perform similar tasks and at times the same as the doctor. As one participant stated, *"we are expected to see these children now up to age 13 years, now I trained sometime back and sometimes not to sure whether my assessment of the problem is correct, however there is no doctor to confirm my findings with...but if I make the wrong diagnosis and give the wrong dosage. I'll be held responsible for my own actions by the Nursing Council. They won't consider the fact that there was no doctor to consult, they'll just claim that I was irresponsible"*.

These nurses saw themselves as *"cheap skilled labour"*, in the absence of a doctor. They believed that although nurses were expected to perform all these tasks, they were never on the *"fore-front"*, but that *"medical doctors were always in charge of health services and in the fore-front of making decisions"*. The reason why nurses are not in the forefront of health care provision and decision making, *"is because the nursing education system forced them to remain subservient to other health professions, particularly the medical profession"*.

The participants felt that in the light of the issues raised under the various headings, *"the nursing education system must change"*. One participant stated: *"it is going to be difficult for us to get to grips with PHC, so I feel we need to be trained in what the concept means and not only offer the clinical training course to us. That course only equip us to assess and provide the clinical care, but we have no knowledge of for example to plan our own service and organise health promotion programs with the community"*. Another participant felt that not only should the nursing education be changed but that, *"we must get nurses to a higher level of education, instead of be taught at nursing colleges all nursing education programs must be part of the mainstream university courses"*. It was felt that by including nursing education as part of mainstream tertiary education at an university, *"the nurses level of knowledge pertaining to the socio- political contexts could*

*be broaden and not only their understanding of health care.” They felt that only then would nurses be on an “equal footing” with other health professionals.*

The participants also felt that only one nurse category should be trained. This would enable the nurse to become a clinically skilled nurse practitioner, *“preventing her from working beyond her scope of practice and solve the current staff shortage problem”.*

### **Conclusion**

The participants saw nurses as being excluded as active role players in the transformation process within the health sector. They expressed the need for nurses to be forceful and to make their voices heard at forum meetings, in order to receive information and to become part of the development of their district health system.

Participants also felt that nurses should organise themselves, into district-based forums, so as to discuss issues of mutual concern. In addition, these forums could serve as a vehicle through which nurses within the same district could discuss their role in the development process of the DHS.

## **DISCUSSION OF FINDINGS**

### **Introduction**

Since the 1994 democratic elections in South Africa, the priority of the health department has been to restructure the health system, to ensure that a Comprehensive district - based PHC system is provided to all South Africans (Department of Health’s White Paper of April, 1997). To this end the health department has endeavoured to strengthen the district health systems within the nine provinces in South Africa.

Most South African studies conducted amongst nurses in primary level services, focus on the type of clinical skills they have, and whether they need further training to up-grade their clinical skills. However, not much attention is accorded to nurses understanding of the framework of the new health system and their perceptions thereof.

Ebrahim et al. (1993) and Macdonald (1995) argue that it is important for health workers to have an understanding of the PHC approach, in order for them to effectively implement the policies based on the PHC philosophy. The aim of this study was therefore intended to gain insight from the nurses, regarding their understanding of the new health systems framework. In addition, whether they have, the necessary clinical skills, and theoretical skills to work effectively within a transforming health care delivery system, that is based on a PHC approach. The findings of this study provide insight regarding the nurses' clinical skills competencies and their understanding and perceptions as health workers within this new health system.

**The findings highlight the following key areas of concern in this study group:**

- Nurses lack the knowledge and understanding of the concepts and policies of the new health systems framework, such as the concept of PHC, the structure of the DHS and the purpose of various national health programs, such as, the MCWH program.
- The health authorities did not adequately consult with nurses, regarding the formulation of the new health policy framework, and the implementation thereof at local and district level, in the area in which this study was conducted.
- Nurses lack the necessary clinical skills to implement the new policies.
- The training programs of these nurses were mainly curative-based and did not equip them to function as competent health practitioners, within a health service, based on a PHC approach.
- Nurses have adopted negative attitudes towards their superiors, the community, and towards the new health systems framework.

These key areas are discussed below.

**Nurses lack the knowledge and understanding of the concepts and policies of the new health system.**

The findings indicate, that the nurses, have a limited understanding of the following three key areas: The concept of PHC, the structure of the DHS and the MCWH program, as an example of one of the national health programs.

The nurses' were unable to identify the broader environmental and socio-economic aspects integral to the PHC approach. These include three of the eight basic elements of PHC, namely, promotion of nutrition, the provision of adequate and safe water supply and the provision of basic sanitation (Alma-Ata Declaration, 1978). The nurses' limited conceptual framework of the new PHC-based health system, is indicative of the inappropriate basic nursing training programs, which have been mainly hospital-based and curative-based. This is consistent with the findings of the WHO expert report on nursing education (WHO, 1984) which highlighted the fact that nurses were not adequately trained in a PHC, Community-based curriculum and were not skilled to perform the necessary supervisory and management functions and clinical tasks, expected of them.

The nurses had a limited understanding of how the DHS would function. Terms such as "downscaling and integration of services" were used to describe the DHS. They were however, unable to elaborate on its functioning in great detail. The nurses were unable to speak, positively about the relevance of these terms, possibly due to the fact that they were not actively involved within the restructuring process which Lancaster (1982), Capuzzi (1993) and Macdonald (1995) argue are so critical in enabling health service providers to effectively implement policies. In addition their basic nurse training programs were not PHC-based and Community-centered. This finding is similar to those in other studies (Macdonald, 1995 and Strasser and Gwele, 1998).

The nurses had difficulty linking the PHC approach as outlined in the Department of Health's White Paper of 1997, to the organisation of integrated, comprehensive services at district level. It was only during the focus group discussion with the Registered Nurses that they identified a link between the PHC approach and the District Health System. Perhaps one of the main reasons for this is because some of the nurses who participated in the focus group discussion were active within the activities of community health forums in the area and by their involvement they gained some insight into the new health policy framework. In addition their involvement in the community health forums and committees perhaps enabled them to have a better understanding of the health policies, and hence also have a more positive attitude towards the transformation process. The arguments presented by Lancaster (1982) and Capuzzi (1993) lends weight to the fact that this positive attitude of the nurses in the focus group may be attributed to their active involvement within the transformation process in the district. Both authors argue that nurses, who are actively involved in the change process, develop a better understanding of the policy and hence, enabled to effectively implement new policy.

Health Education and Community Participation are two components of a PHC-based health care delivery service. The nurses' understanding of these areas are discussed below.

#### Health Education

The fact that the participants saw health education programs as an important part of health delivery service is positive. However, their perception of health education tended to be grounded in a top-down approach. This took the form nurses believing that due to their superior knowledge about health matters, they should tell patients about various aspects of health. They did not perceive health education as a two way process of communication, whereby health providers and communities could learn from each other

(Guidelines on participatory development, 1997). This approach is at odds with their stated belief that health education is needed to ensure that the community would eventually take responsibility for their own health and not be totally dependent on the health system. The nurses' tended to see the health service sector alone as determining the content of health education. This means that health education is viewed from their perspective only and no mention was made of any community input into determining what needs health education should address. This assumption once again, may be in part attributed to the fact that these nurses lacked the theoretical framework within which to view the relevance of health education and its link to community participation. While it is a useful and appropriate strategy to provide community members with relevant health information and education, the nurses' rationale for doing so, is inconsistent with the philosophy of PHC (Macdonald, 1995). This "top-down" attitude by the nurses of seeing themselves as instilling health knowledge into community members could also be a manifestation of the militaristic attitude encouraged amongst nurses during their basic-training. This can be seen as being perpetuated by nurses in their relationship and attitude towards the community (Rispel et al., 1989; Kupe, 1993 and Andrews, 1994).

These study findings, that nurses are not appropriately trained and skilled to conduct appropriate health education programs is in keeping with the study findings of Mofukeng et al.(1999) regarding the competency of Mobile Nurses.

More active involvement of the community could foster a culture of responsibility, as oppose to these nurses "top-down" approach (Dreyer et al., 1997; Guidelines on participatory development, 1997 and David et al., 1998).

### Community Participation

The Alma-Ata Declaration of 1978 specifies that community participation is one of the three main pillars of PHC (Ebrahim et al., 1993 and Macdonald, 1995). However, according to (Dreyer et al., 1997; Guidelines on participatory development, 1997 and

David et al., 1998) community participation is not easy to achieve. These study findings indicate that the nurses have not internalised the importance of active participation of community members, within health service planning and decision-making, which is encouraged in the health department's philosophy of promoting community participation. For example while the Registered nurses expressed the need for communities to become involved in health programs, in order to take responsibility for their own health, they held negative views on community members becoming involved in decision making processes, by providing input into the form health service delivery would take. This negativity was particularly apparent in the focus group discussion. It could be in part due to the fact that these nurses themselves had not been formally consulted by the health authorities to actively participate in discussion sessions that pertained to health service development and planning within the district. This could have led to feelings of resentment towards involving the community in a process from which they had felt excluded. In addition, the nurses' lack of understanding of community participation could also be attributed to the fact that they were merely informed through circulars and directives, that community participation should be fostered and had not participated actively in the formulation of local or district-based policies and guidelines to implement community participation effectively. The fact that no policy guidelines exist for nurses on what community participation means, and how to practice it effectively within their work may further hamper their understanding. While guidelines on participatory development which specifies how effective community participation can be implemented (Guidelines on participatory development, 1997) have been available since 1997, the findings indicate that none of the health facilities in Elsies River, have copies of these guidelines (Swarts, 1999). The fact that no guidelines are available and that there are no adequately functioning district health authorities within the City of Tygerberg can hamper the process of effective community participation.

Furthermore, the nurses' negative attitudes towards community participation could constitute a constraint, in terms of rendering appropriate and acceptable health services (Macdonald, 1995 and David et al., 1998).

#### The importance of the MCWH national health program

Each of the participant nurse categories had a different understanding with respect to MCWH as one of the national programs and its policy framework. The Free Health Care policy of 1994, for pregnant women and children under six, was mentioned as a key element of the MCWH framework. However, the nurses regarded the Free Health Care Policy of 1994 as problematic. The participants saw the Free Health Care and the downscaling of health services as contributory factors, to their increased workload. The participants did not appear to appreciate the public health importance of the provision of free health care to pregnant women and children under six, both of whom form vulnerable groups in terms of their health status in South Africa (Department of Health 's White Paper of 1997).

This limited understanding of the purpose of the Free Health Care policy could possibly be attributed to these nurses limited exposure to consultative and discussion forums on policy formulation, interpretation and the process of implementation. The reasons for this limitation could be similar to those suggested by Capuzzi (1993) that nurses were not consulted about the meaning of and reason for the Free Health Care policy. In addition, they were not consulted about the possible impact the implementation of this policy might have on their workload. This indicates the health department's failure to create effective structures to ensure that the health system's framework is adequately understood by all health practitioners and accepted by all (Macdonald, 1995).

### **Nurses limited clinical skills.**

The findings indicate that: nurses have inadequate clinical skills; there is role overlapping particularly between Registered and Enrolled Nurses and there is role confusion between nurses and doctors and amongst the various nurse categories.

Although the nurses have an understanding of their scope of practice, the findings indicate that they frequently work beyond their scope of practice, which results in overlapping of roles and role confusion. The fact that Enrolled Nurses and Enrolled Nursing Auxiliaries perform functions beyond their scope of practice is cause for concern. The findings include various suggestions from the nurses, in order to remedy this problem and prevent possible medical legal hazards. One of the key suggestions put forward by the nurses was that appropriate in-service training should be provided for them to improve and upgrade their clinical skills. Research has indicated that there is a lack of appropriate in-service training programs for nurses, currently in existence.

Strasser et al. (1998) suggests that the various health authorities should provide clear guidelines or standards on the core clinical competencies required from nurses. The research findings indicate that this is lacking within the West Health district.

In order to redress the pervasive problem limited clinical skills amongst the nurses, the participants suggested that all nurses should receive training in an appropriate PHC clinical skill course. While it would be the ideal to do this, this may not be a very practical solution. It will be very expensive and extremely complicated because this implies that there have to be three different training programs for the three nurse categories. In addition, the South African Nursing Council would have to change the legislative scope of practice of the various nurse categories. A practical solution to this issue would be to restructure the nursing profession, so that only two nurse categories exist. This has been implemented in the UK with a certain degree of success. South Africa could learn from those aspects of the UK experience which have been successful.

Reducing the number of nurse categories and up-grading them to one or two nurses categories, as in the U.K, would improve the quality of nursing care, as well as the status of the nursing profession, in a changing health system (Francis et al., 1999). The UK experienced indicates that by reducing the number of nurse categories to two, limits overlapping of roles, and together with appropriate upgraded training programs being introduced, leads to a more competent clinical skilled nurse (Francis et al., 1999).

Suggestions as to how to do it in the South African context are presented later in this chapter as part of the recommendations.

**Nurses' negative attitudes towards other health professionals, their superiors, the community, and towards the new health systems framework.**

The findings indicate that with the increasing workload of the nurses since the introduction of the new health policies, nurses experience feelings of frustration towards their health authorities and towards the community. This has led to, increased job dissatisfaction. They also have feelings of inadequacy due to limited clinical skills. Feelings of inferiority and subservience in relation to other health professionals, such as medical doctors and environmental health officers, also arose as an issue.

**Feelings of inadequacy and inferiority as a professional group**

The findings indicated that these nurses lack confidence in themselves and experience feelings of inferiority as a professional group, in relation to other health professionals, such as doctors and environmental health officers. This feeling of disempowerment was most pervasive amongst the Enrolled and Registered Nurses. In the focus group discussion, the participants expressed this sense of disempowerment as a more general manifestation of a subservient nursing culture learnt during their basic training and reinforced through their nursing management structure at the work place. As detailed in chapter two, others had identified this problem, in the literature (Rispel et al., 1989; Kupe, 1993 and Andrews, 1994). These feelings of inadequacy and inferiority are

compounded by the existence of an unequal relationship between nurses and other health professionals, particularly doctors (Gray et al., 1992).

While these nurses expressed feelings of inadequacy and inferiority, they also expressed a need to have an equal relationship with other health professionals. This was particularly evident amongst Registered Nurses.

Relations between health personnel is important at primary level health facilities, where all health providers need to have an understanding of each others scope of practice, in order to provide a consistent, good quality, integrated health care service (Gray et al., 1992; Ebrahim et al., 1993 and Macdonald, 1995). However, this "collegial relationship" can only be enhanced through appropriate structures, for example such as staff development programs at the workplace (Gray et al., 1992).

The findings indicate that there are no staff development programs in the West District, which focus on a "collegial approach" framework, for health personnel to function within (Gray et al., 1992). This collegial approach suggested by Gray et al. (1992) is a simple program that could be integrated into orientation programs or in-service training programs for health personnel at primary facilities. Providing these appropriate orientation programs for health care providers, would reduce the perceived culture of subservience internalised by these nurses. It would also enhance a sense of mutual respect amongst health professionals and nurses.

#### Negative attitudes towards their health authorities, superiors and the community

The nurses display a negative attitude towards, their health authorities, and the community members who attend the services in which they work.

Nurses believe that since the downscaling of health services to district level has occurred, the community members attend local health facilities with unnecessary complaints and minor ailments. This further increases their workload. In addition, the nurses felt that most of the community members prefer to be assessed by the doctor,

rather than a nurse. This had previously meant that in order to be seen by a doctor, many community members attended secondary and tertiary hospitals with minor ailments. Since the introduction of the new health policies the community still expected the same treatment, albeit it at local health facilities.

Furthermore, the nurses felt that they enjoyed low status amongst the community compared to doctors. Mofukeng et al. (1999) argues that nurses are unable to adequately provide the community with the necessary health information. In addition, Strasser and Gwele (1998) argue that nurses lack the necessary clinically skills required to render an appropriate comprehensive PHC service. These factors may contribute towards the community's preference to being attended to by doctors rather than nurses.

The nurses' feelings of frustration towards the health authorities were twofold. The one was that they were not formally consulted on appropriate methods of policy implementation. As one said "It is so frustrating, for example the statistic form (recording of monthly attendance and work procedures done), change continuously, there is no consultation with us we are just told to use a new form every time" (Elsies River Nurse participant, 1997). These nurses' experiences are similar to those interviewed in the Ocean View Study, conducted by Health Systems Trust (1999).

The nurses' concerns and sense of frustration are understandable in the context of not having been adequately informed of the reasons for the new policies. The nurses' limited understanding of the health system is supported by other study findings (Gwele and Uys, 1995; Strasser and Gwele 1998 and Mpaka and Uys, 1999).

The transformation process as it relates to policy implementation is seen as an arduous task for these nurses to understand and implement because they have not been exposed to policy formulation and policy development procedures and strategies, neither through their basic training nor through other forums (Capuzzi, 1993). To address this issue Capuzzi (1993) argues that if nurses were consulted as to how policies can be

implemented effectively at local level, they would have had a more positive attitude towards the transformation process. This approach argued by Capuzzi (1993) is lacking in the South African context.

According to Lancaster (1982) nurses' attitude towards policy changes depends on how they perceive the change process, and how the change impacts on their values and beliefs. Thus the nurses' limited understanding of the health system, could be one of the main reasons for their negative attitude towards the transformation process.

Unless nurses at district level are adequately clinically skilled, and have an understanding of the health systems framework, they would not be able to render an effective health care service at primary level. Therefore the staff development programs and nursing the education curriculum should have a PHC philosophy, and should be people-centered and community based, in order to enable the nurse to work as a competent agent of change in a transforming health system (WHO, 1984; Ebrahim et al., 1993 and Macdonald 1995).

## **CONCLUSION**

The Health Department's White Paper of April 1997, entitled Transformation of the health system in South Africa, emphasizes that PHC workers should have the necessary knowledge, skills and resources to effect policy change in this country.

The findings of this thesis indicate that these nurses in the West District do not possess the necessary knowledge of the new PHC-based health system and the necessary clinical skills, in order to function adequately and efficiently within the structure of the DHS as it is implemented in this area.

Specific strategies will need to be considered to address the concerns raised by nurses about their working conditions, lack of clinical skills competency, low job moral and lack of adequate knowledge and understanding of the new health system.

Through an interactive process with participants in the focus group, the researcher has compiled a list of recommendations which may assist nurses, nurse educators, nurse managers, district health managers and health policy makers in formulating appropriate policies and specific guidelines regarding the:

- Reorientation and retraining of nurses.
- Role of nurses in the development of the DHS at local level.
- Transformation of the nursing education system

### **RECOMMENDATIONS**

The fact that these nurses in the West district were not involved in any meaningful way in policy formulation and do not have an adequate understanding of the new health systems framework and its policies, could impede the process of health transformation within the district. To address this issue the following are recommended:

- Nurses to be included in local discussion programs on the process of the development of the DHS.
- Local workshops to be arranged by the district health authority, to introduce policy changes and to engender a culture of willingness, amongst nurses to participate as equal partners at local and district level.
- Fact sheets to be distributed for nurses, which define and explain concepts such as, PHC, the DHS, Community Participation, Intersectoral collaboration and Equity.
- Joint meetings to be held with the health personnel of the public health facilities, to foster a single vision of health provision, for all providers within the particular geographical area, as well as in the district.

In order to address the issue that most nurses are not adequately skilled to render an appropriate PHC service, it is recommended that Nurse Managers, consider the following mechanisms to reorientate and retrain nurses:

- Provide appropriate theoretical as well as practical in-service training programs to enskill nurses within PHC settings in local health facilities.
- All Registered and Enrolled Nurses should be sent on a revised PHC clinical skills training program, of one year.

Nurses were familiar with their scope of practice as specified in the Nursing Amendment Act 50 of 1978, now the Nursing Act 19 of 1997. Certain recommendations are made regarding the overlapping of nursing roles amongst the three nursing categories. These recommendations are aimed at preventing a situation where nurses, work beyond their scope of practice. They involve creating a greater pool of sufficiently competent Registered Nurses to carry out the nursing tasks. The following are recommended:

- There should be two nursing categories, those of Registered Nurses and Enrolled Nursing Auxiliaries.
- Enrolled Nurses training should be upgraded for them to become enskilled Registered Nurses.

The feeling of disempowerment expressed by the nurses, points to the need for nurses to support and strengthen each other and to become a unified force capable of dealing with issues of concern. The following are recommended to nurses employed at local PHC facilities:

- Nurses to foster working relations as well as to develop a support network with other nurses in the district, to exchange concerns, information and embark upon united action, if necessary,
- Staff development programs should be provided to enhance positive relationships between nurses and other health professionals.

There is evidence from the findings that the curative-based nursing curriculum contributes to the nurses' current position of not being appropriately knowledgeable and

skilled to function as PHC practitioners at local health facilities. The following are recommended, to address the nursing curriculum in order to transform it into a PHC oriented curriculum:

- The curriculum should focus on political, social and economic issues as it pertains to the community's health.
- The curriculum should have a PHC approach.
- Enrolled Nurses to complete the "Bridging Course", to upgrade their qualification to that of Registered Nurses.
- Nursing Education, should form part of the mainstream education, and taught at other tertiary institutions for example universities and technikons. This would promote the socialisation of nursing students, with the students of other disciplines. This process would minimise the individualism and separatism of nursing graduates and diplomats.

It is hoped that these study recommendations can contribute towards the development process of the DHS in the geographical area of Elsie's River as well as the West Health District of the City Of Tygerberg. Furthermore, that nurses, nurse managers, nurse educators, district health managers and health policy makers consider it.

## REFERENCES

1. Andrews G, 1994. Health in Our Hands, Proceedings and Policies of the 1994 Women's Health Conference. Women's Health Project. Centre for Health Policy. University of Witwatersrand, Johannesburg.
2. Capuzzi C, 1993. Rationalizing Health Care: The Oregon Story. Mason D, Talbott S and Leavitt J, 1993:208-217. Policy and Politics For Nurses. Action and change in the work place, Government , Organisations and Community. Second Edition. W B Saunders Company, United States of America.
3. David J, Zakus L and Lysack CL, 1998. Review Article. Revisiting community participation. Health Policy And Planning. Oxford University Press, 1998.
4. Department of Health, 1997. White Paper For The Transformation Of The Health System In South Africa. Department of Health, Pretoria.
5. Dreyer M, Hattingh S and Lock M, 1997. Fundamental Aspects of Community Nursing, Second Edition. Community Health Care In Southern Africa. Published by International Thompson Publishing (Southern Africa) (Pty) Ltd.
6. Ebrahim G I and Ranken J P, 1993. Primary Health Care: Reorienting Organisational Support. MacMillan Press Ltd, London
7. Francis B and Humphreys J, 1999. Enrolled nurses and the professionalisation of nursing: a comparison of nurse education and skill-mix in Australia and the UK. International Journal Of Nursing Studies, Vol.36, 1999:127-1135.
8. Gray G and Pratt R, 1992. Issues in Australian Nursing. Longman Singmore Publishers (Pte) Ltd. Singapore.
9. Gwele N S and Uys L R, 1995. Views of leading nurse educators regarding the Comprehensive Basic Nursing Program. Curationis, Vol. 18, No.1, 1995:5
10. Human Science Research Council, Medical Research Council and the South African Network of Community Partnerships In Health Personnel Education. Final Draft.

Guidelines On Participatory Development For Health And Welfare Personnel At Local And district Level, 1997. Centre for Population, Health and Development Research, Pretoria.

11. Kupe, 1993. Empowering Nurses for Action within Power Politics of the Health Care and Social Systems. Paper presentation at the Nurses Conference, held at the University of Western Cape. Cape Town.
12. Lancaster J and Lancaster W, 1982. Concepts For Advance Nursing Practice. The nurse as a change agent. The C V Mosby Company, London.
13. Macdonald J, 1995. Primary Health Care. Medicine In Its Place. Earthscan Publications Ltd, London.
14. Mofukeng D B and Roos S D, 1999. Clinical Skills Of Nurses In Mobile Health Services. Curationis, Vol.22, No.2, June 1999: 4-6.
15. Mpaka N M and Uys L R, 1999. The critical thinking ability of diplomates from different types of bridging programs. Curationis, Vol.22, No.3, September 1999:14-17
16. Rispel L and Schneider H, 1989. Nursing At The Crossroads: Organisation, Professionalisation and Politicisation (Proceedings Of A Symposium, held at the University of the Witwatersrand, December 1989). Published by the Centre for the study of health policy, Community Health Department, University of Witwatersrand.
17. Rispel L and Schneider H, 1989. Professionalisation Of South African Nursing: Who benefits? Centre for the study of health policy, Community Health Department, University of Witwatersrand.
18. Strasser S and Gwele N, 1998. Nurses Oriented Primary Health Care. Health Systems Trust, 1998:83-92. South African Health Review, 1998. Published jointly by Health Systems Trust and the Henry J. Kaiser Family Foundation, Durban.
19. Swarts, 1999. Personal Communication. Registered Nurse. Bishop Lavis Community Health Clinic. Bishop Lavis. City of Tygerberg.

**Appendix A - Permission letter to the Health Authority of the City of Tygerberg**

70 Appledene Road  
Silvertown  
Athlone  
7764  
1<sup>st</sup> September 1995

Dr. I Toms  
The Head of the Health Department  
City of Tygerberg  
7590

**Permission to conduct a qualitative study at the Elsies River Health facilities**

I hereby request your permission to conduct a qualitative study at the Elsies River Community Health Clinic.

I have registered with the University of Cape Town, to participate in a two year part-time Masters Course in Maternal and child health. The commencement date of the course was in March 1995, which will be completed, in 1997.

It is a criteria of the course to complete a mini thesis at the end of this structured course. The intended topic of the thesis is: A study to determine nurses' knowledge and attitudes towards and perceptions of the District Health System.

I would like to conduct in-depth interviews with a few Registered Nurses, Enrolled Nurses and Enrolled Nursing Auxiliaries.

Attached to the letter is a copy of the protocol.

I'll appreciate your co-operation in this matter.

Yours Sincerely

C M Marco

Appendix B – Permission letter to the Health Authority of the Community Health Services, Cape Town.

70 Appledene Road  
Silvertown  
Athlone  
7764  
1<sup>st</sup> September 1995

Dr. E Michaels  
The Head of Health Services  
Community Health Service Division  
Cape Town  
8000

Permission to conduct a qualitative study at the Elsies River Health facilities

I hereby request your permission to conduct a qualitative study at the Elsies River Community Health Centre and the Midwife Obstetric Unit.

I have registered with the University of Cape Town, to participate in a two year part-time Masters Course in Maternal and child health. The commencement date of the course was in March 1995, which will be completed, in 1997.

It is a criteria of the course to complete a mini thesis at the end of this structured course. The intended topic of the thesis is: A study to determine nurses' knowledge and attitudes towards and perceptions of the District Health System.

I would like to conduct in-depth interviews with a few Registered Nurses, Enrolled Nurses and Enrolled Nursing Auxiliaries.

Attached to the letter is a copy of the protocol.

I'll appreciate your co-operation in this matter.

Yours Sincerely

C M Marco

**Appendix C – A profile of nurses who participated in phase one**

<b>Facility</b>	<b>Nursing Category</b>	<b>Year qualified in basic training</b>	<b>Duration of working experience at Community Health facilities</b>
Community Health Centre	RN/ RM/ RC/ RA	1969	1978 – 1998
	RN/ RM/ RC	1975	1995 – 1998
	RN/ RM	1990	1995 - 1998
	RN (CBNP) 6/12 - PHC	1993	1995 – 1998
	EN	1974	1979 – 1998
	EN	1975	1996 – 1998
	EN	1977	1983 – 1998
	EN	1987	1993 – 1998
	ENA	1975	1992 – 1998
Midwife Obstetric Unit	RN/ RM	1978	1980 – 1998
	RN (CBNP)	1989	1995 – 1998
	RN (CBNP)	1989	1995 – 1998
	EN	1994	1995 – 1998
	ENA	1978	1997 – 1998
Community Health Clinic	RN/ RM/ RP	1962	1997 – 1998
	RN/ RM 6/12 PHC	1970	1972 – 1998
	RN/ RM/ RC 6/12 PHC	1972	1983 – 1998
	RN/ RC 1/12 PHC	1977	1996 – 1998
	EN	1972	1994 – 1998

KEY – RN= Registered Nurse / RM= Registered Midwife / RC= Registered Community Health Nurse/  
 RP= Registered Psychiatric Nurse / RA= Registered in Nursing Administration/  
 CBNP= Comprehensive Basic Nursing Programme/1/12 PHC= 1month training in PHC/ 6/12 PHC = 6  
 months training in PHC / EN=Enrolled Nurse/ENA=Enrolled Nursing Assistant.

## Appendix D – A brief profile of the participants who participated in phase two

### Participant 1:

Completed a Four Year Integrated Nursing Diploma Course, in 1995. She completed a Post-basic course in Primary Health Care, in 1996 and is currently employed at the Elsie River Community Health Centre.

### Participant 2:

Completed three Post-basic courses, in Midwifery, Community Health and Primary Health Care. She is currently employed at the Elsie River Clinic.

### Participant 3:

Completed a Nursing degree and two post-basic courses namely, Midwifery and Community Health and is employed at the Elsie River Clinic.

### Participant 4:

Completed three post-basic qualifications, in Midwifery, Community Health and Psychiatry, and is employed at the Elsie River Clinic.

### Participant 5:

Completed three post-basic qualifications, in Midwifery, Community health and Primary Health Care, and is employed at the Elsie River Clinic.

All, except participant one, are employed at Primary Health Care facilities, for more than five years. Participant one, is employed at the facility for two years. Before that, she had been employed, as a Registered nurse at Tygerberg Hospital.

**Appendix E – The Interview Guide**

1. What is your nursing qualification?
2. In what year did you complete your basic training?
3. At which health facility are you employed?
4. How long are you employed in a Community Primary Health Care setting?
5. Are you familiar with your nursing scope of practice?
6. Could you explain this briefly?
7. Do you feel competent to work within your scope of practice, or do you require further in-service training?
8. Do you know about the Maternal, Child and Women's Health Policy, in terms of your scope of practice? Please explain.
9. What do you understand by the concept Primary Health Care?
10. What is your understanding of the District Health System?
11. Where did you receive your knowledge about the District Health System?
12. What is your opinion about nurses' competency in their current clinical skills and communication skills, with regard to the role and function expected of them within a District Health System?
13. In your opinion how could nurses become equal participants in the development of the District Health System?

**Appendix F – The Interview Guide For the Focus Group Discussion**

1. How do you understand the new health system?
2. How do you understand the concept Primary Health Care?
3. Please explain your understanding and perceptions of the District Health System?
4. How do you understand the Maternal, Child and Women's Health Policy framework, in terms of your scope of practice? Please explain.
5. What is your opinion about nurses' competency in their current clinical skills and communication skills, with regard to the role and function expected of them within a District Health System?

