UNIVERSITY OF KWAZULU NATAL

IMPACT OF MOBILE HEALTH SERVICES WITHIN ILEMBE HEALTH DISTRICT: A BATHO PELE PERSPECTIVE

By

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DECLARATION

I, ROSHILLA SAHADEO, declare that:

- The research reported in this dissertation, except where otherwise indicated, is my original research;
- This dissertation has not been submitted for any degree or examination at any other university;
- The dissertation does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons;
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Signature: 

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Stanger, June 2014

DEDICATION

I lovingly dedicate this research endeavour posthumously to my dad, Mr Devchan Madho whose belief in the value of education contributed to my academic achievements and many successes in life, and my dear husband, Mr Jags Sahadeo, whose relentless love and faith in me enabled me to overcome adversity and triumph amidst sorrow.

"Those we hold most dear never truly leave us……they live on in the kindness they showed, the comfort they shared and the love they brought into our lives. They will stay forever in our heart."

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"I don't want you to walk in my footsteps, but instead take the path next to me and go further than what I thought is possible."

ABSTRACT

With the launch of a representative government in 1994, the service transformation agenda highlighted the need for equitable and accessible services. The *locus* and *focus* of Primary Health Care lies in ensuring that preventative and promotive health services is available and universally accessible to the citizenry as, their initial level of interaction with the health care system and as close as possible to the place where the people reside and work.

The Public Service, with particular emphasis on the Department of Health and Ilembe Health District is committed in ensuring that the Batho Pele (*People First)* Principles are practised in order to provide an acceptable high quality health service delivery. This research study aimed to analyse the impact of mobile health services within the context of the Batho Pele perspective in Ilembe Health District. Mobile health services are part of outreach *viz* community oriented Primary Health Care which aims to provide the package of health care services in the study area of rural Maphumulo sub-district.

The literature review described the various prescripts and contextualised Public Health initiatives within a policy dimension and the Public Administration domain. The Negotiated Service Delivery Agreement of the Department of Health, the Millennium Development Goals and the Sustainable Development Goals post-2015 provide the framework upon which the strategic planning processes are based. The KwaZulu-Natal Citizens' Charter and the Patients' Rights Charter advances the directives as depicted in the White Paper for the Transformation of Public Services (Batho Pele Principles). These are the principles upon which clients levels of satisfaction with health services rendered to them are evaluated though exit interviews.

The empirical study which included the administration of questionnaires to management, health care workers and clients within Maphumulo sub-district: Ilembe Health District was conducted. Analysis of data illustrate that health care workers are courteous and provide the necessary information to clients despite working under resource and infrastructure constraints.

The research undertaking culminates with the key findings of the study. Quality Improvement programmes, integrated planning and revitalisation of the Batho Pele programme through training are a few recommendations for addressing some of the key findings of the study in order to improve service delivery through mobile health services.

“Education is not the learning of facts, but the training of the mind to think! “

Author: Albert Einstein

LIST OF ABBREVIATIONS AND ACRONYMS

ANC	African National Congress
APP	Annual Performance Plan
DHS	District Health System
DOH	Department of Health
EPMDS	Employee Performance Management and Development System
HCW	Health Care Workers
IDP	Integrated Development Planning
KZN	KwaZulu-Natal
MDGs	Millennium Development Goals
NCS	National Core Standards
NDP	National Development Plan
NHI	National Health Insurance
NSDA	Negotiated Service Delivery Agreement
NPM	New Public Management
OHSC	Office of Health Standards Compliance
OSS	Operation Sukuma Sakhe
PGDS	Provincial Growth and Development Strategy
PHC	Primary Health Care
RDP	Reconstruction and Development Programme
RSA	Republic of South Africa
SDGs	Sustainable Development Goals
SDIP	Service Delivery Improvement Plan
SPSS	Statistical Package for Social Sciences
QIPs	Quality Improvement Programmes

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CHAPTER ONE

INTRODUCTION AND OVERVIEW OF THE STUDY

"Everyone has the right to have access to health care services, including reproductive health care."

(Chapter 2, Bill of Rights, Constitution of the Republic of South Africa, 1996)

1.1 INTRODUCTION

The post-apartheid South African dispensation which was voted to power in 1994 had a mandate to render relevant, economic, accessible and equitable services to the citizenry. The enormous burden of diseases put emphasis on the need for the health care to be served to the citizenry at or closest to their residence or place of work. Therefore, fixed and mobile health services are required to fulfil health needs in a co-ordinated and complementary approach. However, concomitantly there is an increasing mortality and morbidity rate of treatable and even curable diseases primarily attributed to health services but not always within reach of the poorest-of-the-poor as the masses of people in the country. Hospitals and fixed clinics are limited in the provision of the range of health care, ranging from the basic Primary Health Care (PHC) to the essential health services required by citizens, more especially in semi-rural and deep rural areas.

The inflexibly located health service facilities pose challenges of accessibility - *ipso facto,* travelling distance between themselves and the health care users. It is therefore imperative that health services be brought closer to the dependent communities. Provision of mobile health services seeks to awaken underserved, rural communities by developing a sustainable health system that increases access to the package of PHC services, health promotion and disease prevention. The National Health Act 61 of 2003 in the Preamble recognises: "the need to heal the divisions of the past and to establish a society based on democratic values, social justice and fundamental human rights".

Mobile health units also referred to as “clinics on wheels”, aim to reduce the health service delivery gap in respect of accessibility by bringing the much-needed health services to the people through trained health care personnel at designated service points. This type of service addresses core health issues and align health services to:

- Apprise, educate, and empower citizens about health issues;
- Formulate policies and procedures that promote individual and community health efforts;
- Link people to appropriate and necessary personal health services; and
- Secure the provision of health care where it is non-existent.

The unit of analysis for this study was the mobile health services in Maphumulo sub-district within Ilembe Health District. The research locates the provision of mobile health services within a Batho Pele perspective directed at transforming the culture and ethos of the Ilembe Health District to enhance service delivery in the study area. The mandate is premised on the Primary Health Care Approach which focuses on the dispersion and development of community-oriented health service provision.

It is envisaged that the study will assist in determining the effectiveness of the current mobile health services from the client’s perspective and forging an understanding of the challenges and suggested recommendations for the improvement of the service from different units of observation (clients, health care workers and health service management). The two facets of research as deliberated upon by Wessels (2014: 142), *viz* the process and the goal/aim will be described in this chapter.

1.2 AIM OF THE STUDY

The Constitution of the Republic of South Africa (RSA), 1996, Section 27(1) (a) states, “Everyone has the right to have access to health care services, including reproductive health care;”. The Government’s responsibility in meeting this mandate is spelt out in Section 27(2), “The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.”

Daily, the mobile health service, as an extension of the PHC services renders basic patient services to the remote deep rural, underserved and uninsured populace of the Maphumulo sub-district. In this area the infrastructure is poorly developed and affordable transport system is limited to predominantly the peak morning and afternoon periods.

The provision of health services, like other public sector services, has to comply with the policy framework and implementation strategy aimed at transforming public services which is stipulated in the White Paper on Transforming Public Service Delivery (Batho Pele White Paper, 1459 of 1997). This research study, through the systematic process of collecting, analysing and interpreting data (Wessels, 2014: 142) aims to evaluate the success of the implementation, or lack thereof, of the Batho Pele Principles prevalent in the mobile health services. In particular, the effectiveness and efficiency of mobile health services to the identified rural community will be examined. These include critical factors such as provision of basic services, accessibility and staff attitudes. The study is grounded on the PHC package of services and directed by Constitutional imperatives and related legal prescripts.

1.3 OBJECTIVES OF THE STUDY

The following have been framed as the pivotal objectives of the study:

- To establish whether the health needs of the rural people are being met, within a Batho Pele perspective through provision of the existing mobile health services;
- Assess the enactment of the Batho Pele Principles in the provision of health service delivery rendered by mobile health services; and
- Identify challenges and propose suggestions to ensure that the health services rendered are of a high quality service to meet clients' expectations.

Literature will be reviewed to examine Mobile Health Service Delivery from a conceptual and contextual framework within the Department of Health (DOH) nationally and provincially. A comparative perspective will be drawn between a developed country (United States of America) and a developmental country, South Africa. Lessons learnt from this study could serve as a contribution towards "best practices" which could be adapted and implemented to improve service delivery and the quality of care.

1.4 KEY QUESTIONS IN THE STUDY

The following key questions to be explored in the study are identified as:

- *What is the origin of mobile health services?*

This question is answered in the literature review as a background to the study. It will also link up with the mandate of the DOH as the provider of public health services and the accompanying package of care to service provision in rural areas. The policies and legislation, as well as national and provincial priorities will be discussed in probing this question.

- *How accessible is mobile health services in rural areas?*

All citizens should have equal access to the service to which they are eligible and the different forms of access such as physical, cultural, language and adequate signage.

Various prescripts like the National Health Act 61 of 2003, the Batho Pele Principles (aimed at improving service delivery), the Patients' Rights Charter (linked to Chapter Two of the Constitution), and the KZN Citizens' Charter which was introduced by the Premier of the KZN Province as a commitment to service delivery in all government departments will be described in promoting accessibility to health services. These prescripts serve as important guiding policy documents for health services in the context of the research study in particular, and for public health.

- *Do the behavioural attributes of clients and health care workers significantly affect utilisation of mobile health services?*

Citizens should be treated with courtesy and consideration. Acknowledgement of health workers, job content and job satisfaction are important factors in an effective, efficient and economical discharge of services. Both clients and health care workers each have their own behaviour and attitude of what is expected of the other. Breakdown in services or sub optimal delivery of services can occur if there is a clash between the behaviour and attitude of these two groups.

- *Are the clients aware of Batho Pele for health care services and health care workers implementing the Principles?*

Citizens should be given full, accurate information about public services which should be provided economically and efficiently to ensure value-for-money. Information on Batho Pele should form part of health education given to clients during consultation, and whilst they are waiting to be treated. Evaluative mechanisms such as client surveys are useful in providing feedback on health care workers attitudes during service provision.

- *What is the overall impact of mobile health services?*

If the pledged service standards are not provided, the policy of redress should be given due consideration in addressing citizens' complaints.

The study concluded by probing current service standards in relation to the Batho Pele Principles and its impact on improving the Quality of Life through poverty alleviation in health care.

1.5 RESEARCH METHODOLOGY, DESIGN AND DATA PRESENTATION

Mouton (2001: 55-56) describes research methodology and design as the outline towards which the study will be directed. In this study, the data collection methods will be relevant, feasible, as accurate as possible, objective and ethical. A contemporary literature review on the subject was conducted. The research methodology chosen in this study meets the requirements of being relevant, feasible, accurate, objective and ethical.

Data was collected inductively using a mixed method research design: a qualitative research (interviews) and quantitative (questionnaires) was undertaken. Pilot and Hungler (2001: 217) support this design by indicating thus "…..many areas of inquiry can be enriched through the judicious blending of qualitative and quantitative data collection and analysis – that is, by undertaking multi-method research." Mouton (2001:100) proposes that during a systematic study or investigation, there should be a form of measuring instrument that is used for data collection that is relevant to the research process. During this study, the utilization of the questionnaire to the different groups of respondents was the formal element of data collection.

The worldview is that of social constructivism. Creswell (2009: 8) state that social constructivists "develop subjective meanings of their experiences, which in this study, is directed to the health care service provision obtained from the mobile health services. Furthermore, the study relied on the participants' (health care users and health care workers) views and meaning of the situation being studied. In order to enable triangulation, a multi – method approach to collecting data was used.

The dimension of this study was based on the first order of reality: the implementation of government policy. This is supported by Wessels (2014: 146) who states that this order focuses on the "practice of public administration." The strategy of inquiry is that of phenomenology. According to Creswell (2009: 13), "phenomenological research is a strategy of inquiry in which the researcher identifies the essence of human experiences" as the participants describe them.

Table 1.1: Sample population for the study

Target Group	**Number**
Health Service Management	10
Mobile Health Service Personnel	24
Clients from the Maphumulo sub-district	200
TOTAL	**234**

The sample comprised 234 respondents from the identified categories required for the study. It was neither feasible nor necessary to study all the participants in the study population. Health service management comprised Ilembe Health District management, PHC supervisors, Nursing Service Managers, Assistant Nurse Managers and a Chief Executive Officer.

All of the four mobile health service staff was sampled and the 200 clients sampled were drawn from 50% of the 59 service points. They were chosen according to the inclusion and demographic criteria for the research study. Owing to the sample size, a 5% margin of error will be accepted and a 95% confidence level is required. Representativeness was achieved although the sampling method was that of convenience by drawing respondents from the distinct group required for the study.

Primary data was obtained through the use of questionnaires, structured to acquire pertinent data relevant to the objectives of the research in accordance with the Batho Pele Principles. The surveys were co-ordinated by field assistants (for orientation and induction of participants) to the sample of health care users. Interviews were conducted between health care users and the health care workers. The data will be codified and analysed using the Statistical Package for Social Sciences (SPSS). The

data will be interpreted for statistical significance and association of key variables. The scientific enquiry and analysis will be done in conjunction with the assistance and academic guidance of the supervisor and statistician.

Secondary data such as articles, conference papers, other studies relating to this focus which includes dissertations and theses, contemporary readings on primary health care using mobile resources will also be examined in this study.

Data will be recorded manually during the interviews, later collated, analysed for statistical significance, summarised and presented graphically in tables with a written report with recommendations arising at the end of the study.

1.6 LIMITATIONS OF THE EMPIRICAL STUDY

The limitation of this study was the language barriers and high rates of illiteracy. It was necessary to discuss the content of the questionnaires with the interviewees to ensure understanding and purpose of the interview and survey by the fieldworkers. This was done without influencing the outcome of the responses. The assistance of field workers was enlisted in the completion of the questionnaires in order to ensure the sample population is covered. It was also necessary to transcribe information in some questionnaires.

Many clients refused to participate in the survey because they believed that if they were seen by health care workers, this could jeopardise the treatment that clients will receive at the service point during the subsequent visit. They appeared uneasy and anxious and feared victimisation if they expressed responses which highlighted service delivery challenges, although a full explanation was provided.

Health service management and health care workers completed the staff questionnaires. Here again, they were hesitant in providing their names on the consent form, preferring anonymity, which would have allowed for more honest responses. Indicating disagreements meant highlighting challenges which would reflect poorly on their management of mobile health services.

1.7 ETHICAL CONSIDERATIONS OF THE STUDY

The study followed the University's approved practices for ethical clearance and prior approval was sought *via* an ethical clearance number from the University Research and Ethics Committee prior to the administration of the questionnaires. Furthermore, permission was sought and obtained from the District Health Manager: Ilembe District. The following ethical considerations were paid attention to:

- *Explanation of the study, Informed Consent and Voluntary Participation*

The Constitution, Chapter Two provides for the respect for human dignity and human rights. All participants in this study were chosen on a voluntary basis and their anonymity will be maintained using the protocol of the University for Post-graduate Studies. They were also cognisant of their right to withdraw from participation at any time if they felt that they rights were being violated. All aspects of the research were explained and consent was sought from each participant in the predominant language of the people – isiZulu, before the data collection commenced (*per se*). This allowed for opportunities to ask questions and seek clarity prior to signing the informed consent.

- *Confidentiality, Privacy and Protection form Harm*

The participants were assured that they would be indemnified against any physical and emotional harm during the interview process, whilst the completed data collection will be stored in the University as per the protocol for post-graduation studies.

- *The Right to fair Treatment*

All members of the target population were treated as human beings with respect and courtesy. Those who refused to participate in the research were not prejudiced in any way in respect of current or future treatment.

- *Involvement of the researcher*

The researcher did not administer the questionnaires; instead field workers were employed to administer the questionnaires. The administration of the questionnaires was conducted in an objective manner.

1.8 OVERVIEW OF CHAPTERS

CHAPTER ONE: INTRODUCTION AND OVERVIEW OF THE STUDY

This chapter outlines the aim of the study, presents the three key objectives and the key questions to be answered. It further describes the research methodology, design and data presentation. Subsequently, the limitations of and ethical considerations in the study followed. An overview of the chapters of the research was diagrammatically presented.

CHAPTER TWO: CONCEPTUAL FRAMEWORK GOVERNING PUBLIC HEALTH AND PUBLIC ADMINISTRATION

Chapter Two conceptualises and contextualises health service delivery within a Public Administration paradigm. The Batho Pele framework and the development and implementation of health policies within a New Public Administration system in the transformation of the health service delivery are discussed. It further links New Public Management and Public Health *from* the Millennium Development Goals *to* Sustainable Development Goals.

CHAPTER THREE: POLICY PERSPECTIVES IMPACTING ON PUBLIC HEALTH

This chapter locates public health from a policy perspective. The public health care system is described with emphasis on mobile health services, which is the focus level of health care service provision in this study. The 5-C Protocol in policy implementation is described and presented from a Batho Pele and health dimension. The chapter concludes with the current changes and challenges facing public health.

CHAPTER FOUR: DESCRIPTION OF RESEARCH METHODOLOGY, ANALYSIS AND PRESENTATION OF DATA

This chapter deliberates on the research design, methodology, data collection and analysis of the study. The SPSS software package was used to present the data statistically from questionnaires, and significant association between variables was established and discussed.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

This final chapter presents the conclusion of the empirical research and provides recommendations arising from the study for the improvement of mobile health service delivery within the Batho Pele framework.

1.9 CONCLUSION

The White Paper on Transforming Public Service Delivery and the Department of Health's re-engineering of the PHC approach serves as the foundation for the conceptual background, the data collection tool and the presentation and conclusion of the study. Clients utilise public health care institutions and visit mobile health service points with the anticipation that the Government and health care workers will provide the necessary services and supporting resources in order to meet their health needs as legislated, and in the guiding policy documents. It is also expected that the above is done within a Batho Pele ethos. For all intents and purposes, the quality of service delivery will be notably influenced by the execution of the Batho Pele Principles by health care workers. This chapter sets the scene for the advancing of the subsequent chapters followed by the conclusion and recommendations of the research study.

CHAPTER TWO

RELATIONSHIP BETWEEN PUBLIC HEALTH AND PUBLIC ADMINISTRATION

"Batho Pele is not an end in itself, but a means designed to achieve the broad objective of transformation in the public service, as well as in the country as a whole."

(Khoza, 2003: 33)

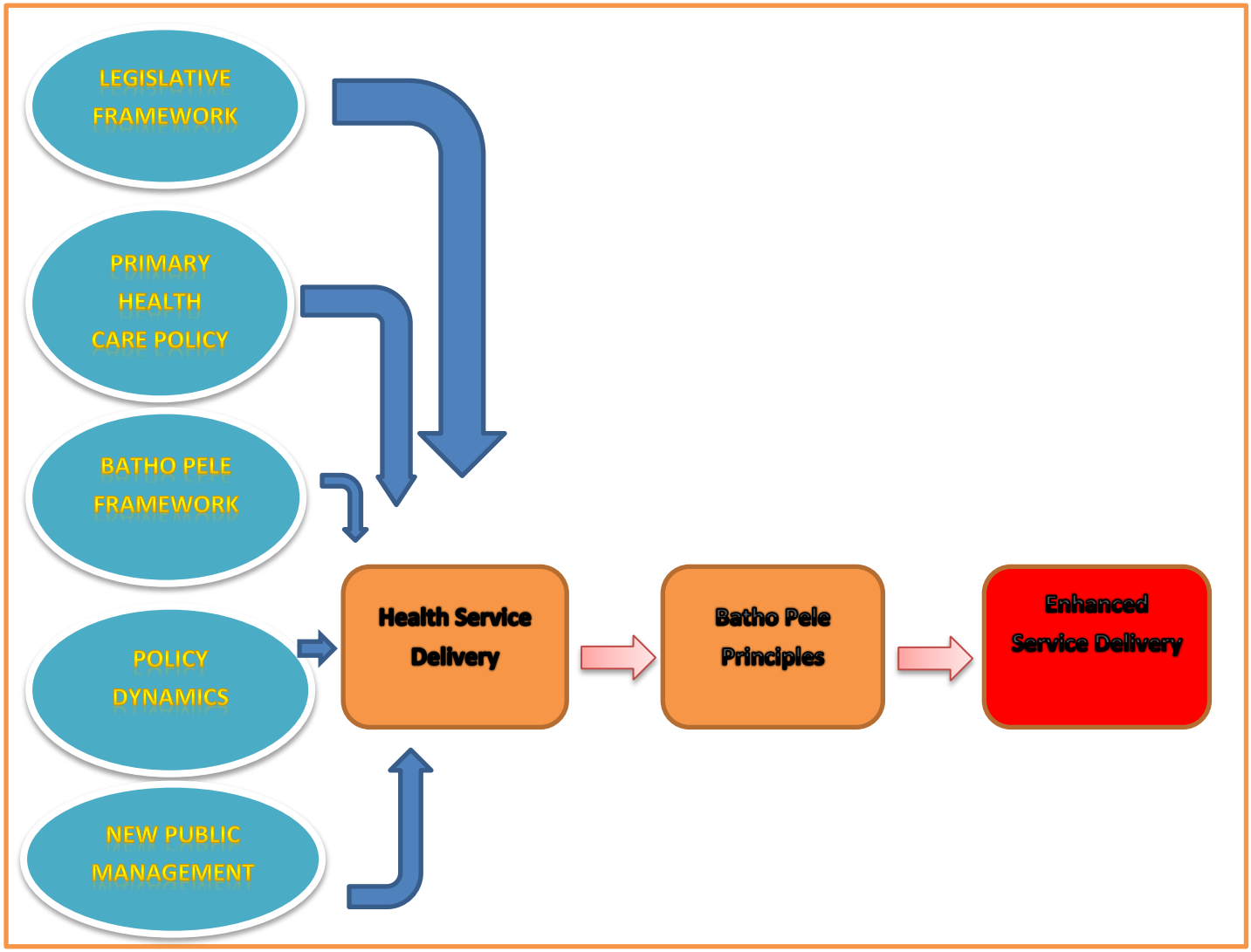
2.1 INTRODUCTION

This chapter conceptualises and contextualises health service delivery within a Public Administration paradigm. Following the ushering in of democracy in South Africa post 1994, there was an opportunity for new legislation and policies to be introduced and passed with the aim to bring about transformation and redress the imbalances of the past, more significantly within the government sphere. The Department of Health (DOH) has the mandate of ensuring a long and healthy life for all South Africans in accordance with the values and principles enshrined in the Constitution of the Republic of South Africa (RSA), 1996, which envisions a mission that ensures services are provided impartially, fairly and equitably. It is imperative for the DOH to determine the quality and effectiveness of health service delivery provision through the transformation that has occurred in and following implementation of health legislation and policy documents. This can be achieved by responding timeously, effectively and efficiently to the health needs of the citizenry.

The endorsement and adoption of the Primary Health Care (PHC) approach at the International Conference on Primary Health Care and the Alma-Ata Declaration (WHO, 1978: 3) affirms that PHC "forms an integral part of the country's health system. The approach is the central function and main focus, and of the overall social and economic development of the community." It is obligatory health care which is based on concrete, systematically reliable and publically suitable practices which are made comprehensively *accessible* to citizens through *consultation* and participation, upholding two Batho Pele Principles (as emphasised in the study).

Figure 2.1 that follows is a diagrammatic illustration outlining the conceptual framework which impacts on the need for high quality health service delivery through the implementation of the Batho Pele Principles as a benchmark and guideline. Mainstreaming of PHC was the mandate of the democratic government and was premised on legislation such as the Constitution of 1996. This called for transformation of health services, using the Batho Pele framework, development and implementation of health policies within a New Public Administration system to advance the Quality of Life and raise living standards of all South Africans. In this model, the Legislative framework, PHC Policy, Batho Pele framework, Policy Dynamics and New Public Management are the determinants for enhanced health service delivery guided by the Batho Pele Principles.

Figure 2.1: Conceptual framework



Source: Author's Perspective

2.2 DEFINITIONS

The following key definitions have relevance and context for the study:

2.2.1 PUBLIC ADMINISTRATION

Public Administration is defined by Van der Waldt and Du Toit (1997: 13) as being "concerned with handling public matters and the management of public institutions in such a way that resources are used efficiently and effectively to promote the general welfare of the public".

There is one fundamental matter which distinguishes Public Administration from other related disciplines, and that is the political milieu within which its functions are enacted. Public policy which is the domain of the political authority dictates all executive and decision-making issues that form the study of Public Administration and Management. Thus the political *milieu* puts it into a category of exclusivity, advances Thornhill, (2006: 805).

It advances the implementation of government policies according to the values which have determined it, and places emphasis on service delivery provided for the citizenry by public servants. It is within this context that the transformation agenda for public service delivery is interrogated.

2.2.2 PUBLIC HEALTH

Gillam, Yates and Badrinath (2007: 1) define public health as "the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society". The DOH and its relevant stakeholders have the mandate to bring the said definition to reality. The public health system entrenches a basic rights approach in order to ensure access to health care for all South African citizens. PHC services is the initial level of care and contact that the citizens have with the health system, and therefore brings health services within proximity of the place where people reside and work.

Since 1994, different prescripts and policies have been legislated to ensure that the rights of the people of the country, more especially the uninsured populations' right of entry to health care services are appreciated, protected, encouraged and fulfilled. These regulations and dogmas are directly intended at advancing admittance to and improving the value of public health care.

2.3 CONSTITUTIONAL FRAMEWORK GOVERNING PUBLIC HEALTH

The Constitution of the Republic of South Africa 1996 is the over-arching legislation of the country and sets out the legal foundation, the rights and duties of its citizens and defines the structure of government. The right to health care became embedded in the Constitution of South Africa. Section 27(1) stipulates that "everyone has the right to have access to: (A) health care services including reproductive health care….; (3) no one may be refused emergency medical treatment". Section 28(1) states that: "Every child has the right to….basic health care services". Section 195 (1) outlines important aspects guiding the conduct of public officials.

The eleven Constitutional doctrines that are envisioned to steer the revolution of the public service from a rules-bound perspective to results-driven initiatives, are unambiguously indicated in the Constitution stipulating that the public service "must be governed by the democratic values and principles enshrined in the Constitution". The values are that of human self-respect and esteem, attainment of equality, the advancement of human rights and freedom, non-racism, non-sexism, the Rule of Law, universal adult sufferage, accountability, responsiveness and openness.

In substantiation of the preceding discussion, Chapter 2 of the Constitution details the Bill of Rights, stating that all citizens are entitled to an affordable, accessible, non-discriminatory and quality health care provided for a competent and capable workforce. To give further effect to this, the DOH has created the Patients' Rights Charter as a generic standard to realize the right of access to health care services.

The National Health Act 61 of 2003 affords a designed outline for the national health system, taking into cognisance the obligations and responsibilities enforced by the Constitution on national, provincial and local government in respect of the directive and delivery of health care services. Section 27(2) of the Constitution states that "the State must take reasonable legislative and other measures within its available resources to achieve the progressive realisation of the right of the people of South Africa to health care services, including reproductive health care", (Government Gazette No. 26595, 2004: 2). The Act recognises that no matter whether one is able to make payment or not; he/she is still permitted to an acceptable level of care as a user and consumer of the health service at public health facilities.

2.4 PRIMARY HEALTH CARE (PHC) POLICY DOMAIN

The development of the African National Congress's (ANC) National Health Plan (NHP) which was framed on the Alma-Ata Declaration, prior to 1994, anticipated the essential functioning and reorganisation of the national health system premised on the PHC policy domain.

The term 'Primary Health Care Approach' (Global Health Watch: 56 – 57) is linked with the health care rudiments of the Alma-Ata Declaration and is condensed as follows:

- *Firstly,* it emphasises an *all-inclusive* methodology to health through strategies directed at endorsing and shielding health which places more importance on preventative measures and opposes the bias of many health care systems thus promoting a multi-disciplinary approach to health.

- *Secondly*, it promotes *integration* – of various medical services within health institutions, of health programmes and of different spheres of the health care system.

- *Thirdly,* it emphasizes *equity*. This seeks to rectify the disregard of country populaces, as well as community and economically relegated sectors, within many health care systems.

- *Fourthly,* it campaigns for the usage of *'appropriate' health technology*, and health services that are socially and culturally acceptable.

- *Fifthly,* it accentuates appropriate and effective *community participation* within the health care system and

- *Lastly,* it embraces a robust *human rights standpoint* on health by upholding the essential human right to health and the obligation of administrations to develop the necessary policies, strategies and plans of action.

The above elements of the PHC approach echoes the core values and the ideologies enshrined in Constitution of the RSA, Batho Pele Principles and the Patients' Rights Charter. It therefore complements the research study.

Post 1994, South Africa joined a few other countries of the world, where overhauling and advancement of the health system commenced with a transparent political commitment, which ensured equitable resource distribution, reform of the health system in line with the District Health System (DHS), which is defined as: "the lowest management unit that organises health care delivery through clinics, health centres and district hospitals in a geographically defined area", and rendering health care services in accordance with the principles of the PHC approach (WHO, 1978: 3). The NHP endeavoured to make comprehensive, community-based health care more accessible through the establishment of PHC centres as a foundation to the system, (ANC, 1994: 1 – 5).

The health districts have the responsibility of ensuring that there is an equitable distribution of health services. Mobile health services can assist in bridging the gap between fixed health care facilities and the ever increasing users of health care services. Clemen-Stone (1995: 825) notes that there is a considerable increase in the number of mobile health clinics throughout the districts of the country due to involvement of donor funding. Human resources are a critical component in determining the need and the number of mobile health units, and fulfil significant roles, so that client needs are met and service provision is at its optimal. These

services include the PHC package, focusing primarily on health promotion and education, screening, physical assessment for minor ailments, pre and ante natal services as well as VCT. The huge burden of disease, new incidence rates and its prevalence, especially in the rural poor communities necessitates an improved, integrated healthcare service which is community focused. Mobile health units can assist in providing health care services in the clients' settings at designated service points.

To further give effect to the above, mobile health care units form an extension of fixed health facilities and aims to address the health problems of communities by providing promotive, preventive, curative and rehabilitative health services within available resources. It requires health care workers to socially and technically work as teams to adhere to the needs of the community.

According to Tanser, Hosegood, Benzler and Solarsh (2001: 826), the proximity of PHC services has been a noteworthy factor in determining the health standing of the population. In addition to the proximity, is the physical accessibility of the health care facility and services to the users, Tanser *et al.* (2001: 826) further states that this is "determined by the geographical location of client homesteads in relation to available facilities, by physical and topographical barriers and by modes of transport that are available to reach these destinations." Physical accessibility to a health service point may be a factor to the decreased attendance rates at health care facilities. The introduction of mobile health services was therefore to provide the necessary health care to people closer to their homes, and help ease the accessibility challenges. This study will therefore focus on accessibility as one of the crucial factors to be explored which mobile health services aims to bridge, as an important aspect for due consideration of the DOH.

Egunjobi, Habib & Vaughan and Van der Stuyft *et al.* cited (in Tanser *et al*. 2001: 827) have studied various social factors that affect the use of health care services. Some of these socio-cultural factors included the income of the health care user, the quality of care received at the health care facility, the health care user's perceived level of illness experienced, the availability of transport and the relationship that the health care user has with the health care facility staff.

2.5 BATHO PELE FRAMEWORK

Job creation, health, education, nutrition, housing, water, social welfare and security have been identified as one of the five prioritised cluster programmes of the Reconstruction and Development Programme (RDP), (November, 1994: 9-12). However, the draft White Paper on Transforming Public Service Delivery (DPSA, 1997: 1) provides the legislative guideline on how service delivery transformation should be addressed to remedy the disparities of the past, and confirm the provision of enhanced quality of services which strives to advance the Quality of Life of the people of the country. It is stated as follows:

- "….a transformed South African public service will be judged by one criterion above all: its effectiveness in delivering services which meet the basic needs of all South African citizens. Improving service delivery is, therefore, the ultimate goal of the public service transformation"; and
- The purpose of the White Paper on the Transformation of the Public Service (DPSA, 1995: 4) "is to establish a policy framework to guide the introduction and implementation of new policies and legislation aimed at transforming the South African public service." It is primarily about how services in the public sector are delivered, and explicitly about the efficiency and effectiveness of the manner in which the delivery of health care is provided through the Batho Pele approach. This emphasis is in accordance with international best practices and demonstrates commitment to the significance of service delivery and customer care for the citizenry from their public officials and public services.

It was therefore clear, that henceforth, public institutions such as the Department of Health would be guided by service standards, and a service ethos that would be reactive to the requirements of the population and of exceptional quality.

Based on two policy documents; the guiding principles of the *White Paper on Transformation of the Public Service (1995)* and the *Constitution of the Republic of South Africa (1996)*, the Batho Pele-"People First", White Paper on Transforming Public Service Delivery (DPSA, 1997: 3) was formulated to "provide a policy framework and a practical implementation strategy for the transformation of public

service delivery" strongly signifying government's assurance to adopting a citizen-oriented approach to improving service delivery.

- The main thrust of Batho Pele is that it is a customer-positioned approach that pursues to enhance the capability of health institutions to meet the needs of customers or clients by persistently orientating organisational structure, behaviour and culture to attain this objective;
- The Batho Pele White Paper aimed to "introduce a renewed approach to service delivery; an approach which puts pressure on systems, procedures , attitudes and behaviour within the Public Service and re-orients them in the customer's favour, an approach which puts people first" (White Paper on Transformation of Public Service 1997 Section 1.2.12); and
- The launching of the Batho Pele White Paper in 1997 was not a 'public relations' assignment, but it was a strategic intent to imbibe a culture of accountability and caring by public officials to the citizenry. This strategy hopes to encourage government officials to become more service-oriented; endeavour to achieve excellence and to pledge to unceasing service delivery improvements.
- Batho Pele is a contrivance through its Principles which permits clients to hold public officials accountable for the quality of services rendered. It signals the government's strong intentions to promote a citizen-oriented approach to service delivery improvement.

The following list highlights the eleven Batho Pele Principles in KZN. Whilst all Principles are important as a benchmark for service delivery, emphasis and attention is drawn (in italics) on a few pertinent highlighted Principles relating to its relevance for and focus in the research study.

2.5.1 THE BATHO PELE PRINCIPLES ARE:

- Consultation
- Setting of service standards
- Increasing access
- Ensuring courtesy
- Providing information
- Redress

- Value for money
- Openness and transparency
- Encouraging innovation and rewarding excellence
- Customer impact
- Leadership and strategic direction

These Batho Pele Principles have been viewed within the context of health care and focused on some of the challenges experienced in the public health sector.

2.5.2 IMPLICATIONS OF THE BATHO PELE PRINCIPLES FOR HEALTH CARE:

- Clients should be engaged on the quality of health care services they receive and, if necessary, be offered choices on the range of services that are rendered.
- They ought to be informed on the quality of health services they will receive in relation to their expectations.
- All health care users must have equal access to the services to which they are entitled.
- Clients should be treated in a courteous manner and with due consideration.
- Clients should be given complete information regarding health care services.
- Should there be a compromise in service standards, clients should be offered an explanation with alternate remedies. It is important and necessary that clients should be given clarity in relation to health care services.
- Health care services should take cognisance of a value-for-money approach to service delivery.
- Clients should be informed on how national and provincial departments are run, how much they cost, and who is in charge.
- Impact necessitates reviewing the benefits we have afforded our customers both internal and external – it's how the eleven Principles relate together to illustrate the extent of improvement on overall service delivery and customer satisfaction. It is also about ensuring that all clients are conscious of and exercising their rights in terms of these Principles.

- Innovation can be seen as improved methods of rendering better service, curbing costs, raising standards, streamlining and largely making modifications which link in with the spirit and essence of Batho Pele. The focus also includes providing incentives to staff who "go the extra mile" to assist clients.
- Good governance is one of the key determinants for efficacious institutes. Organisations which do well in being of service to their customers can reveal that they display visionary leadership by encouraging ownership of the strategic intent for health care.

2.6 BACKGROUND TO POLICY DYNAMICS *VIS-À-VIS* PUBLIC HEALTH

The dawn of a democratic South Africa saw the adoption of the Constitution, thus providing the policy framework that spelt out the principles and values that underpin all prescripts and guidelines in the management of public affairs. According to Hogwood and Gunn (in Cloete, Wissink & de Coning 2006: 15), public policy "must to some degree have been generated or at least processed within the framework of governmental procedures, influences and organisations."

South African public service policies, post-1994 has endeavoured to deal with service delivery needs and improvement in service delivery. It was noted that the improvements of health policy was significantly more progressive than policy in other public domains. The NHP was the basis of the new government health policies until the White paper for the transformation of the health system in South Africa (1997) was introduced. There had been discussions and consultations resulting in agreements between policy-makers and policy-implementers on the need to re-engineer PHC services. The above was achieved within the health sector because it forms a large part of the public sector in service delivery. Stack and Hlela (2002: 6) note three reasons as follows: "it is one of the two largest social services, it is a function of concurrent national and provincial legislative competence, and is facing the greatest epidemic this country has yet seen, which threatens to undermine progress in development across the board".

2.6.1 CONTEXTUALISING POLICY IN PUBLIC HEALTH

Health service delivery is linked to government policy and the implementation thereof which affects aspects of daily life, actions, behaviours and decision-making which is of public interest. These policies have a significant role in the protection of the citizenry against harm, disease, disability, risk mitigation and the reduction of inequalities and exclusions. Public health policies were embraced in the securities of refining justness in admittance to, and value of, health care services, primarily due to the advancement of a PHC policy perspective.

Evaluating the impact of the effectiveness of the Principles of Batho Pele on the health services at Ilembe Health District is viewed from a policy-dimension because the agenda for service delivery is a milestone policy framework. It is within this policy context that the research study is contextualised in this chapter.

According to Markides (2012: 3), 'health policies lie within the largest context of social policy and the social development goals of nations". To this effect, three of the eight Millennium Development Goals (MDGs), focus on health. These are goals 4, 5 and 6 which are to decrease child mortality, advance maternal health and combat HIV/AIDS, malaria and other diseases respectively, as stated in the Millennium Development Goals Country Report (2010: 13). These goals form an important link to the policy dimension and discussion of the research study.

2.6.2 THE PROVINCIAL GROWTH AND DEVELOPMENT STRATEGY (PGDS)

The Provincial Government of KwaZulu-Natal (KZN) has introduced a 20 year plan to propagate the economy of the Province for the development of the Quality of Life of all people living in KZN. The 2011 KwaZulu-Natal Provincial Growth and Development Strategy (KZN PGDS) boosts the Province's pledge to attaining the vision of the Province as a "Prosperous Province with a *healthy*, secure and skilled population, acting as a gateway to Africa and the world", (KZN Provincial Planning Commission, 2011: 8). The executive summary states: "Abject poverty….. *the current disease burden should be history*…….. The people will have options on where and how they opt to live, work and play, where *the principle of putting people first* and where leadership, partnership and prosperity in action, has become a

normal way of life". The KZN Department of Health (DOH) reinforces the highlighted key aspects of the KZN PGDS through its vision statement of ensuring "Optimal health status for all persons in KwaZulu-Natal." The KZN eleven Batho Pele Principles is the framework through which high quality of services must be rendered.

For the vision of the KZN PGDS to materialise as reality, a seven point Strategic Framework has been established focusing on the key issues of job creation; human resource development; human and community development wherein the DOH is responsible to ensure and enhance the health and safety of communities and citizens (as listed in the strategic objectives of the KZN PGDS); strategic infrastructure; environmental sustainability; governance and policy and spatial equity.

The Provincial Growth and Development Plan (PGDP) is the operational structure incorporating the monitoring, evaluation, reporting and reviewing components, which brings together the intended key indicators, targets and interventions necessary for achievement of the strategies envisaged in the 2011 PGDS. KZN Provincial Planning Commission (PPC) plays the lead focus in monitoring and advancing alignment of the plan and implementation of development strategies amongst all stakeholders, particularly in relation to alignment of the three spheres of government in the Province, (KZN Provincial Planning Commission, 2011: 13). The DOH's Planning, Monitoring and Evaluation Unit is aligned accordingly in order to collect and report on specific health indicators.

2.6.3 THE NATIONAL DEVELOPMENT PLAN (NDP)

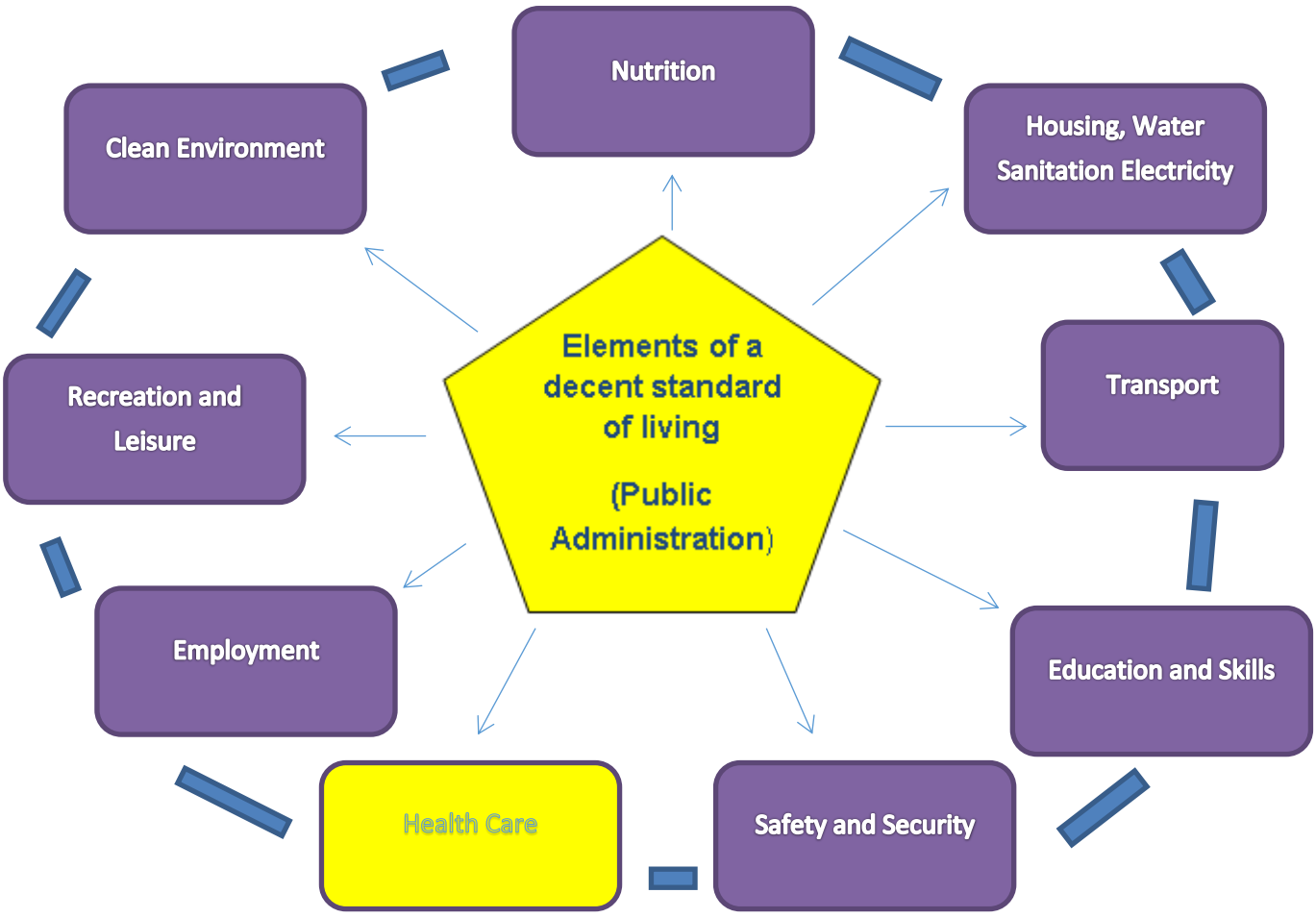
"No political democracy can survive and flourish if the exodus of citizens is trapped in poverty, without material benefits for survival. Addressing the ills of poverty and growing deprivation ought to be a key focus area of a democratic government (RDP, 1994: preface). The National Development Plan strives to eradicate poverty and decrease inequality by 2030. South Africa can attain these goals by drawing on the intellect of its people, developing an all-encompassing economy, fostering competencies, improving the capability of the state, and supporting leadership and collaboration throughout society. Access to services has to be extended by the DOH Primary Health Care and Mobile Health Services to reach the most inaccessible

communities. The NDP recognizes the chore of refining the quality of public services as critical to attaining transformation; to this effect the DOH has adopted the Batho Pele Policy Framework for transformation of services resulting in improved Quality of Life of all citizens, which is viewed as an integral part of good public administration.

Elements of a decent standard of living

The figure below highlights and links the focus areas of the NDP (National Development Plan 2030: 31) which formulates a well-founded commitment to realising a minimum standard of living which can be gradually attained through a multi-pronged strategy. Access to and the provision of health services is one of the critical elements of a decent standard of living and is integral to the national imperative of government, as depicted in the diagram below.

Figure 2.2: Elements of a decent standard of living



Source: Adapted from NDP (2010: 31)

- **Quality health care for all**

Long-term health outcomes are moulded by issues mostly external to the health system: lifestyle, diet and nutritional levels, education, sexual behaviour, exercise, road accidents and the level of violence. These are societal responsibilities that warrant seriousness by every citizen, and promoted by families and referred to by institutions. A spate of challenges together with an ineffective health system can pose major risks to health care and increase the burden of diseases. The South African's Government's vision of achieving quality health care for all is hampered by a fragmented public health system and must be fixed. An attempt to advance the quality of care is required, particularly at primary level. By 2030, the health care system should render enhanced services, accessible either free at the point of service, or through public or privately means. The primary and district health system should render universal access, with attention on prevention, education, disease management and treatment. Hospitals should be geared for quality delivery of services at secondary and tertiary levels having a sufficient cohort of health care professionals (National Development Plan, 2030: 14 – 18).

- **Public health system reform**

Transformation of public health service delivery should be directed towards:

- Improving management, particularly at institutional level;
- Additional and skilled health professionals;
- Improved decision-making over clinical and administrative matters at facility level, pooled with effective accountability;
- Improved patient data management systems;
- Enhanced decentralised and home-based care models;
- Emphasis on maternal and infant health care;
- Launching of the programme to evaluate management competence by the department of Health, at institutional level to assist with improving management skills and resolving the current management crisis. Corresponding improvements should comprise more entrustment of authority over staffing, shift structures and routine procurement;

- Promoting the district-based approach to primary health care as part of the initial phase of national health insurance. The efficacy of the health care system is dependent on sufficient and qualified professionals, paramedics and support staff to address the demands placed on it;
- Reductions in HIV/AIDS infections and other non-communicable diseases will reduce the demand on the current system. The pandemic has exemplified South Africa's ability to address socio-political realities and to devise programmes and projects addressing the state of health care in the country over the last five years is laudable. There is an on-going necessity for education, prevention, testing and treatment;
- Adopting the National Health Insurance (NHI) system which is the key contemporary objective; and
- Concentrating on the four fundamentals to its realisation *viz* enhancing the quality of public health service delivery, decreasing the comparative cost of private care, employing more health professionals in both the public and private sectors, and acquiring a health information system that extends to public and private health providers.

2.7 LOCATING MILLENNIUM DEVELOPMENT GOALS (MDGs) WITHIN PUBLIC HEALTH

A continuous striving in the direction of realizing the Millennium Development Goals (MDGs) secures the possibility of "saving millions of lives; empowering women; addressing the scourge of illiteracy, hunger and malnutrition; and ensuring that Africa's children have access to high-quality education and good health to lead productive lives", in accordance with the commendations of the MDG Africa Steering Group (2008: 7). An agreed measure of Sustainable Development Goals (SDGs) which will be constructed upon the existing MDGs and will unite with the post 2015 development agenda was one of the main conclusions of the Rio+20 Conference. This will create an: ""*inclusive and transparent intergovernmental process open to all stakeholders, with a view to developing global sustainable development goals to be agreed by the General Assembly*".
http://sustainabledevelopment.un.org/index.php?menu=1300.

According to Markides (2012: 3), “health policies lie within the largest context of social policy and the social development goals of nations.” To this effect, three of the eight Millennium Development Goals (MDGs), focus on health. These are goals 4, 5 and 6 which are to reduce child mortality, advance maternal health and combat HIV/AIDS, malaria and other diseases respectively, as stated in the Millennium Development Goals Country Report (2010: 13).

The MDG Africa Steering Group (2008: 10) has identified various tangible occasions to execute and heighten interventions in support of the MDGs. The actions linked to the DOH include:

- Intensifying health system effectiveness and implementing of child survival strategies to achieve a two-thirds decrease in child mortality rates;
- Promoting access to emergency maternal care for all women by 2015 to achieve an increased reduction in maternal mortality rates;
- Ensuring the provision of family planning services for all by 2015; and
- Combatting infectious diseases by:
    - providing comprehensive access to HIV/AIDS treatment by 2010;
    - halving the malaria burden by 2010 (from 2000 levels) and eliminating malaria mortality rates by 2015;
    - ensuring effective diagnosis and treatment of TB by executing the Global Stop TB Plan of Action; and
    - controlling Neglected Tropical Diseases by 2015.

Based on the MDGs, the Government released a programme of action to improve health service delivery, referred to as the Health Improvement Plan (10 point plan 2010-2014). In 2010 the Minister of Health, Dr Aaron Motsoaledi, reiterated his commitment to the key priorities of the plan which link up well with the *locus* and *focus* of health care:

- Ensure the development and provision of strategic leadership and creation of a social compact for improved health outcomes;
- Operationalizing of National Health Insurance (NHI);
- Enhancing the quality of health services;

- Transforming the health care system and refining its management;
- Improving human resources management, planning and development;
- Revitalisation of health infrastructure;
- Hastened implementation of the National HIV&AIDS and STI National Strategic Plan (2007-2011) and amplified emphasis on TB and other communicable diseases;
- Increased mobilisation for improved health outcomes for the citizenry;
- Evaluation of the drug policy; and
- Intensifying health research and development.

These preceding commitments were enacted into the Negotiated Service Delivery Agreement (NSDA) that was contracted by the Minister of Health in September 2010. The NSDA is an agreement that echoes the commitment of key partners to attaining the aims of the DOH as a priority is improving the health status of the populace and to contribute to Government's vision of A Long and Healthy Life for All South Africans, (Department of Health KwaZulu-Natal).

The sentiments of the NSDA emphasises the centrality of health care to sustainable development; as a prerequisite as well as an indicator and outcome of progress. Universal Health Coverage (UHC) which is defined as: "*a practical expression of the concern for health equity and the right to health……knowing that the health services they might need are available, of good quality, and affordable.''* (WHO Discussion Paper, 2012: 3) will be used in the post 2015 schema to address health care needs (prevention, promotion, treatment and rehabilitation) and achieve health goals.

The Sustainable Development Goals capture the changing agenda of health care needs. Although the MDGs have been established to be an influential strength in setting health objectives to address the inequalities of the previous years and ensuring the equitable delivery of health services through the PHC approach, the SDGs contextualise health as "a human right; health equity; equality of opportunity; global agreements (International Health Regulations, Pandemic Influenza Preparedness framework) that enhance health security; stronger and more resilient health systems; innovation and efficiency as a response to financial constraints;

addressing the economic, social and environmental determinants of health; and multi-sectoral responses that see health as an outcome of all policies." (WHO Discussion Paper, 2012: 2).

It can consequently be contended that the health agenda has expanded and that "new" concerns such as non-communicable diseases, health systems, determinants and health security must be revealed in goals or targets.

2.8 *FROM* NEW PUBLIC MANAGEMENT *TO* PUBLIC HEALTH GOVERNANCE

The New Public Management Approach has been conceptualised to describe a management culture that places the client at the core of service delivery and holds the public official accountable for results, (Hood, 1991: 3-19). This creates an ideal opportunity for innovation and improved service delivery, of bringing services closer to the people and of providing "one stop" service centres. The plight of a responsive and accountable service occurs when health care workers pay little or no attention to the values and legislative prescripts of the public service and the Department of Health, which becomes a focal point relating to governance in health.

Levine (PSC 2012: 9) states that a change in attitudes, behaviours and "values in action" is an essential public service skill requirement. The author further concedes that the NPM paradigm has its core focus on improving service delivery.

Hughes (2003: 58-59) states that NPM identifies that there is a need for unswerving accountability between managers and the public, as the consequences of a mandate for a "client focus". The Batho Pele Framework expresses the "*language* of NPM" and cements the concept that the citizens are "customers" and hold government accountable for actions and omissions in service delivery. Hence, NPM as an advancement of traditional Public Administration in a post-modernist era has placed emphasis on citizen-oriented service delivery grounded on the implementation of the Batho Pele Principles. NPM is linked to the effective, efficient and economic use of resources through the conception of "*public value for public money*", another Batho Pele Principle emphasized (Hope, 2001: 120). NPM have also progressed along the concepts of new public services being a model for service delivery within the public health sector where ideals such as *efficiency and productivity* are placed in the

broader background of democracy, community and public interest (Hope, 2001: 122). According to Denhardt and Denhardt (2000: 553 – 557), the latter should be premised on these elements as described by Denhardt and Denhart (in Hope, 2001: 122). These include the following salient aspects:

- Serve, rather than steer: Health officials should be duty-bound to assist clients articulate and meet their shared interests, instead of attempting to control or steer society in new directions;
- Public interest is the aim, not the by-product: Health care managers should participate in building collective and collaborative public interests;
- Think and plan strategically, act democratically: Policies and health programs that meet public requirements can be most effectively and responsibly attained through collective efforts and collaborative processes;
- Serve citizens, not customers: Health officials should not merely respond to the demands of "customers" but concentrate on constructing relationships of trust and collaboration with and among citizens;
- Health officials should be attentive and accountable within statutory guidelines;
- The need for collaboration and shared leadership with mutual respect is preferred when working with clients in the service industry relating to health; and
- The intention is not to focus on self-enrichment. Denhardt and Denhardt (in Hope, 2001: 122).

These *tenets* are interrelated with the Batho Pele Principles in improving health service delivery, and their emphasis has significance and relevance for the research study.

2.9 CONCLUSION

This chapter defines and locates the relationship between public administration and public health service delivery. The provision of health services (primary health care and mobile health services included) derives its mandate from the Constitution and legislative prescripts that govern public administration. Primary health care in the current context of the country is a developmental approach to the provision of health services. It is a paradigm shift from caring for people with disease to a preventative, promotive and community-based discharge of health services, shifting the centre of gravity from quantity to quality of services rendered by health care providers.

The Batho Pele strategy is a policy framework which aims at transforming health services and improving service delivery. The focus is on client centred service delivery, promotion of human rights and monitoring of standards and performance of public officials. The Batho Pele Principles demonstrate Government's commitment to a citizen-centred approach to the improvement of service delivery. New Public Management practises have improved citizens' perceptions of effectiveness, efficiency, responsiveness and equity in health service delivery. The provision of high quality of health services will improve the lives of people, especially in inaccessible rural communities, contributing to building dignity and respect and a better life for all. Improving health and life expectancy is the second of the twelve outcomes of Government; to which the DOH adopted a human rights-based approach through PHC to achieve. Health matters are conspicuous in the existing MDG framework; three out of the eight goals directly refer to health conditions. The advanced recognition of civil, cultural and political as well as economic and social rights (inclusive of health care) is a requirement for viable growth and human development. The UNAIDS, UNICEF, UNFPA and WHO (signing agencies of the United Nations) in a Thematic Think Piece entitled "*Health in the post-2015 UN development agenda"* (2012: 7) affirms that the SDGs health agenda is positioned such that: "irrespective of where one lives, gender, age or socio-economic status being healthy and having access to quality and effective health care services is of fundamental importance for all people, while at the same time healthy populations are essential for the advancement of human development, well-being and economic growth." Consequently, the ensuing chapter will review policy perspectives influencing public health and service delivery.

CHAPTER THREE

POLICY PERSPECTIVES IMPACTING ON PUBLIC HEALTH

"… is concerned with limiting health disparities and a large part of public health is the fight for health care equity, quality, and accessibility."

(http://www.whatispublichealth.org/what/#Policy)

3.1 INTRODUCTION

Everything associated with wealth, happiness, and long life depends upon good health. The adept policy-maker must understand the linkages between the priorities of Government and seek to balance progress; concurrently recognizing that attitudes towards the health system are moulded at its interface with the public. Health policy initiatives consequently will only be commended if they can be implemented effectively, efficiently, economically and produce demonstrable results and benefits.

This chapter presents an overview of public health from a policy perspective. Operation Sukuma Sakhe (a flagship programme of the Office of the Premier in KwaZulu-Natal) is based on the principles of co-operative governance and integration of government services to ensure effective service delivery and uplift the lives of communities. It is discussed and located within a Batho Pele policy framework and contextualised within public health. Subsequently, the public health care system is described locating mobile health services, which is the focus level of health care service provision in this study.

In order to ensure high quality of health services are delivered, it is imperative that health care policies are implemented. The discussion thereafter locates the 5=C Protocol in policy implementation from a Batho Pele and health dimension. This is followed by the changes and challenges facing public health.

The chapter concludes with an international perspective on public health policy.

3.2 PUBLIC HEALTH BACKGROUND

Acknowledgement of public health and its affiliation to the health of citizens wavered in keeping with national and global events. However, since the advent of the democratic Government, which had an overwhelming mandate to attend to those marginalised by the apartheid era, a robust effort to strengthen public health and re-engineer Primary Health Services commenced, towards a people-oriented health care system and one that could realize the aspirations and dreams of those who struggled and persevered for a democratic South Africa.

3.2.1 PUBLIC HEALTH: CONTEMPORARY PERSPECTIVES

Public health has its *locus* and *focus* on co-ordinated efforts to improve the health of communities (Novick and Marrow, 2000:1). This definition emphasises the key elements of public health: co-ordinated and organised efforts which are directed at communities rather than on individual health. *The Future of Public Health,* the classic report which was published in the Institute of Medicine (IOM) shares a similar explanation of public health, defining it as: “organized community effort to address the public interest in health by applying scientific and technical knowledge to prevent disease and promote health” (1998: 7). The follow-up report entitled *The Future of the Public’s Health in the 21st Century* (IOM, 2003:1) further highlights the need for convincing public health policies, inter-departmental partnerships and effective communication and information sharing to ensure an optimally inclusive and effective public health system that can achieve national outcomes.

Hyde (1998: Introduction: i) summarises that the “nucleus” of public health is interventions rather than provisions, and focuses on the following activities towards attaining that outcome:

- Define issues/problems;
- Identify and collecting data;
- Develop hypotheses and theories;
- Plan interventions;
- Advocate a ‘whole-of-government” context (holistic);

- Acquisition of resources and commissioning program planning (in partnership with service providers); and
- Monitoring, Evaluation and Reporting.

The above activities require a multi-sectorial approach. In addition, factors which may influence health and public health practices, such as social and environmental, require integration of skills and interventions from other Government departments. Hence, modifications in health status can optimally be accomplished through collaborative partnerships at all levels between clinical efforts and community-based programmes. Operation Sukuma Sakhe programme is one such initiative where resources of all Government departments are pooled together to uplift communities, and is explored in the next discussion for health care.

3.3 OPERATION SUKUMA SAKHE (OSS) FROM A HEALTH DIMENSION

Previously known as the KZN Flagship Project, this programme was re-launched to integrate community participation and partnership and was re-branded Operation Sukuma Sakhe (OSS). It embraces the services of Government in order to enhance the Quality of Life of all citizens. The name is derived from the motto which is found on the crest within the logo of the Provincial Government of KwaZulu-Natal (KZN): "Masisukume Sakhe"- *Let Us Stand Up and Build!* With the Constitution of the Republic of South Africa, 1996; the Batho Pele Principles, the KZN Citizen's Charter; 12 National Outcomes of the country (Outcome Two focusing on health) and the Millennium Development Goals as its Constitutional framework, OSS is a call for the citizens of KZN to be resolute in overcoming concerns which have plagued communities like poverty, unemployment, crime, substance abuse and the ever increasing burden of diseases impacting adversely on the health status of the community such as the Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS), Tuberculosis (TB) and other chronic conditions. (Province of KwaZulu-Natal, 2011).

The Member of the Executive Council (MEC) for Health, Dr Sibongiseni Dlomo on the occasion of the AGM for Health and Welfare Seta (2011: 1) stated that in KwaZulu-Natal, the Department of Social Development and the Department of Health are integrated. He further stated that: The former Premier Dr Zweli Mkhize is very passionate about the health and social development of our people. In this province, the Premier is actively involved in the "flagship programme" called Operation Sukuma Sakhe. The MEC for Health highlighted the fact that, "South Africa as a developmental state is not immune to skills shortage faced by the first world countries". He further stated that the millennium development goals put a challenge on us as a country to achieve the targets set by 2014. There are four MDGs that directly put a responsibility to us as a sector to deliver the targets. In our country these goals have been integrated into one objective, which is the attainment of a long and healthy life for all South Africans. South Africa as a developmental state is not immune to skills shortage faced by the first world countries. The Millennium Development Goals placed a challenge on the country to achieve targets set by 2014. There are four MDG's that directly relate to the sectors to deliver targets. In our country, these goals have been integrated into one objective, which is the attainment of "A long and healthy life for all South Africans."

The KwaZulu-Natal Province has to make further efforts towards achievement of the above mentioned objective as correctly pointed out by our Honourable former Premier, Dr Zweli Mkhize, when he says; "It is important to acknowledge that the burden of disease that is affecting South Africa has its 'epicentre' in this province.", (Dlomo, 2011). This country has an overwhelming burden of diseases relating to the following:

- HIV, AIDS and TB;
- Increased maternal and child mortality rates;
- Alarming and ever increasing incidence of Non-Communicable Diseases, as well as; and
- The pandemic of violence and injury.

OSS acknowledges that Government cannot do everything alone and therefore enlists and integrates the services of traditional leaders, religious leaders, academics, Non-Governmental Organisations and community members in the programme of action to ensure thriving and healthier citizens and a better life for all through the spirit of nation-building.

3.3.1 LINKING OPERATION SUKUMA SAKHE (OSS) WITH BATHO PELE (BP): POLICY FRAMEWORK

Both Government programmes share a common vision of ultimately enhancing the Quality of Life of all citizens focusing on community development and improved service delivery. Government services are made available through the OSS community and wards needs assessment, identification and referral systems to all vulnerable groups and no citizen is denied access to services. Through community *consultation*, provision of relevant *information, openness and transparency, redress* and *increased access*, which are key Batho Pele Principles, citizens are better placed to make informed decisions in their quest for a long and healthy life. The OSS and BP initiatives hold public officials responsible for and accountable to the recipients of public goods and services for delivery of high quality of services.

The five focus areas of OSS (Province of KwaZulu-Natal, Operation Sukuma Sakhe 2012: 5) are:

- *Community partnerships* – the community should be involved and consulted in the planning and co-ordination of all activities so that they become aware of their rights and responsibilities and own the solutions. The OSS local task team meetings are platforms within the wards where community members can raise their concerns such as attitude of staff, professionalism of Government officials, efficiency, effectiveness and access regarding Government services.

- *Behaviour change* – whilst citizens are informed of their rights through the Citizens' Charter and Batho Pele, the implementation of which is the responsibility of Government, citizens are responsible for their own behaviour change, to be law abiding and live a healthy lifestyle.

- *Integration of Government services* – all Government departments must work in a co-ordinated approach as the key stakeholders, together with civic organisations and the private sector at the ward, district and provincial level to meet service delivery needs which are identified by community field workers through household and community profiling. Profiling contains ongoing and systematic gathering, analysis and interpretation of community health information, health status and community health needs together with interrelated health problems.

- *Economic care* – infrastructure development, such as the development of housing, roads and health care facilities enable opportunities for job creation and small businesses. War room meetings which are held in the wards encourage discussions for creating linkages to markets for locally produced goods and services. The 'One Home One Garden" programme's purpose is designed to alleviate poverty and create sustainable jobs.

- *The role of community champions in Behaviour Change Communication (BCC)* – all political, traditional, religious and civil society leaders, community caregivers, youth ambassadors and other cadres of fieldworkers can positively influence behaviour and environmental factors which directly or indirectly influence health, prevent illness, disease and harm. This can be achieved by the provision of information and communication by the champions. The Department of Health aligns its key messages in accordance with the health calendar.

These focus areas of OSS along with the eleven Batho Pele Principles (in KZN province) form the critical framework for the improvement of service delivery. With respect to improved health service delivery, the mainstreaming of Primary Health Care (PHC) has its focus on improving the health of families and communities, 'rather than individual health alone" (Kautzky and Tollman, ND: 18). Using mobile health units to encourage public health undertakings offers an efficient, effective, and beneficial response to overcoming health disparities and addressing social problems.

3.4 PUBLIC HEALTH CARE POLICY SYSTEM AND MOBILE HEALTH SERVICES

Mobile health service is an extension of Primary Health Care services which is an integral component of the public health care system and the focal study area. It refers to health services that are offered from an automobile specifically considered to transport necessary health care staff and equipment from one designated service point to another, thus bringing health care services to the healthcare users (Habedi, 2007: 9). Mortier and Coninx (2007: 1) describe mobile health units as: "part of a strategy for the provision of occasional ambulatory health services". There should be a fixed health care facility (clinic or hospital) to which the mobile health service is attached and to which patients can be referred. It falls within level 1 out of the 4 levels which the public health care system is categorised into.

Table 3.1: Structure of the public health care system.

LEVEL	INSTITUTION	TYPE OF HEALTH CARE
Level 1	Primary health care clinics, community health centres, mobile health services and health posts.	Initial contact into the public health care system. Staffed by nurses and visited by clinicians. Referrals are to the local district hospital, community health centre or fixed clinic.
	District hospital	Care rendered by clinicians and PHC nurses. Referral of clients to the local regional hospital.
Level 2	Regional hospital	Provides general specialist management on referral from district hospitals. Referrals are to provincial tertiary hospitals.
Level 3	Provincial tertiary hospital	Sub-specialist and generalist care is offered at these hospitals. Patients may be referred to a national central hospital.
Level 4	Central hospitals	Highest level hospitals, rendering high cost, multi-speciality services.
	Specialised hospitals	Include chronic psychiatric, TB, spinal injury, and acute infectious disease hospitals.

Source: Adapted from Stack and Hlela (2002: 13)

Ilembe Health District is divided into four sub-districts, namely: KwaDukuza, Mandeni, Ndwedwe and the study sub-district Maphumulo. Maphumulo sub-district has 21% of Ilembe Health District's population with 100% rural black population. The actual footprint of this sub-district is 894km2 and the population density is an average of 135 people per km2 (District Health Plan 2013/14: Introduction).

Through one of the key Batho Pele Principles, *viz.* access, the Ilembe Health District has brought the health services closer to the communities, which is an important aspect, *amongst others* in this study. There are currently four mobile health service units in the Maphumulo sub-district. There are fifty nine designated health service points which cover the eleven wards, making up the Maphumulo sub-district. The four mobile clinics service these fifty nine health service points, on a scheduled monthly basis only, posing a challenge of accessibility to health services. The human resource allocation per mobile vehicle comprises one or two professional nurses, one enrolled nurse, one enrolled nursing assistant and one Voluntary Counselling and Testing (VCT) counsellor. The range of PHC services offered is largely determined by the number and category of staff available on that day to provide the services.

Health services (both urban and rural) must be shared equally by all citizens, rich or poor and all persons must have access to such services, irrespective of their ability to pay. The provision of PHC by introducing more mobile service points and mobile health services aims to address the current imbalance and facilitate better access to health services, by focusing on the movement from cities where a majority of the budget for health is based and spent, to the rural areas where a vast majority of people live (WHO, 1978: 4). It is further stated in the Preamble to the Constitution of the World Health Organisation (WHO) that: "Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures."

The conventional stereotype of South Africans travelling to health care facilities has been substituted by the approach of securing the accessibility of essential health care services to every citizen, irrespective of where they live. According to Mueller (2009: 10), this will include "bringing providers to the community on a scheduled

basis, linking to providers in distant urban places, and integrating health care services with other sectors that contribute to individual and community well-being."

As of 1994, the post-apartheid South African government has located equity at the core of its health policy goals and the development of health policy advanced compared to the development of policy in the other sectors.

3.4.1 PUBLIC HEALTH POLICY IMPLEMENTATION THROUGH THE 5-C PROTOCOL

Hogwood and Gunn in (Cloete, Wissink and de Coning, 2006: 15) define public policy as:

…. patterns of decisions relating to circumstances including personal, group and organisational aspects have contributed…. policy requires an understanding of behaviour, involving interaction between and amongst organisational relationships. Policy is viewed as a "public policy" when it is contextualised within government processes.

Public policy reveals how the government acts in line with the 1996 Constitution and affects aspects of daily life, actions, behaviours and decision-making which is of public interest. Health service delivery is linked to government policy and the implementation thereof. These policies have a significant role in the protection of the citizenry against harm, disease, disability, risk mitigation and the reduction of inequalities and exclusions.

Policy implementation (the 5-C protocol) is one aspect of public policy. From the numerous policy areas in the health sector, implementation of the policy on hospital restructuring and rationalisation will be discussed as it is a focal area of the study. It was espoused in the welfare of refining impartiality in access to, and quality of, health care services, principally *via* the advancement of a Primary Health Care policy approach (Stack & Hlela, 2002: 6).

Policy implementation is described by Barret and Fudge (1981: 4) as “a process of interaction and negotiating, taking place over time, between those seeking to put policy into effect and those upon whom action depends.” A policy once developed does not necessarily imply that implementation will follow successfully by the intended implementers. A process which includes *amongst others*, persuasion, negotiation, coordination, compromise and bargaining should be anticipated to achieve the desired policy intent.

Thornhill (2005: 583) emphasises that the public service is the vehicle to implement policy directives. He further highlights that: “African countries as well as other developing countries indicate that the capacity to bring policies to fruition is often lacking.”

Successful policy implementation is linked to the 5-C protocol, which are the critical clusters of variables used to assess the course policy implementation is taking. They are interlinked and influence each other in the implementation process. The 5 C protocol is described by Brynard (2005: 16-21) as:

- *Content* of the policy itself: this is a process of interaction which characterises policy as distributive, regulatory or redistributive. The Batho Pele Principle of consultation is adopted as one of the methods utilized between the setting of goals and actions directed at achieving them.

- *Context* of the policy is based on the social, economic (financial), political and legal authenticities of the system in which it is implemented. The Batho Pele Principles of Consultation, Information, Openness and Transparency and Value-for- Money links to context of policy.

- *Commitment* of those entrusted with implementation: the most logical, rational and reasonable policies, which may pass expense/benefit analyses will not be achieved if those responsible and accountable for implementation are unwilling or unable to do so. Implementers must ensure that policy, once implemented has the desired Customer Impact (a Batho Pele Principle). Warwick in Cloete, Wissink and de Coning (2006: 198) states that: “Governments may have the most logical policy imaginable, …… but if those

responsible for carrying it out are unwilling or unable to do so, little will happen."

- *Capacity* of the implementers is viewed in terms of the structural, cultural and functional aptitude to implement the policy goals and objectives of the government of the day which is aimed at improving the quality of life of the citizenry. It includes tangible resources such as human, financial, material, technological and logistical resources and intangible characteristics such leadership, motivation, commitment, willingness and endurance which are necessary to convert policy into action. Furthermore, the political, administrative, economic, technological, cultural and social milieu must also be favourable for successful implementation. There should also be consultation with all relevant stakeholders.

- *Clients and coalitions* support: this is a critical variable necessary to support the implementation process and should include government joining forces with interest groups, opinion leaders and other relevant stakeholders. The principles of Information, Openness and Transparency and Value-for-Money are necessary during this phase.

The researcher further adds a sixth variable – *communication,* as an integral facilitator and component of successful policy implementation. This variable is a key determinant that ensures the Batho Principles of *Consultation*, setting and communicating of *Service Standards*, ensuring *Courtesy*, providing *Information,* ensuring *Openness and Transparency*, prompt *Redress* and the *Encouraging of Innovation and Rewarding Excellence* are effectively implemented on a daily basis.

However, despite consensus on the ideologies fundamental in the new public health policy between the policy-makers and implementers, and the lead in development thereof, policy implementation as described above, could not be successfully achieved (Stack and Hlela, 2002: 7).

3.5 CHANGES AND CHALLENGES FACING PUBLIC HEALTH

The origins of a dysfunctional health system stem from the country's history which was based on racial and gender discrimination, migrant labour system, income disparities and violence, had an inexorable effect on the health of the citizens, health policies and health services.

The policy of hospital rationalisation and strengthening Primary Health Care (PHC) emerged with the aim of transforming institutions and promoting an integrated comprehensive health service, thus disassembling apartheid practices in health care. Health facilities were available to all and this necessitated an improvement in the geographical spread of health facilities, with particular emphasis to expand access to historically disadvantaged areas. This called for the development of new health legislation, embracing of health policies, consistent with world-wide developments that altered the focus towards encompassing primary preventive care, instead of concentrating just about entirely on progressing curative tertiary care. Mobile health service is an extension of PHC services that brings health care to these previously inaccessible areas.

The White Paper for the Transformation of the Health System in South Africa (Department of Health, 1997) was founded on the approach adopted in the African National Congress's (ANC) National Health Plan (NHP) which was published in 1994 and was the post-apartheid model for changes in the health system (African National Congress, 30 May 1994). Its background lay in the PHC concept conveyed *via* a district health system, as endorsed at Alma Ata Conference as a cornerstone for health policy. It deliberates the function of hospitals within the *milieu* of the expansion of a PHC structure and outlines the fundamental ideologies on which policy regarding hospitals is grounded. Strategies were formulated for restructuring health care facilities thereafter.

There are positive attitudes towards the underlying principles of the new public health policies resulting in specific policy and programme changes in the four concurrent epidemics: HIV and tuberculosis, chronic illness and mental health, injury and violence and maternal, neonatal and child health (Mayosi, Lawn, van Niekerk, Bradshaw, Karim and Coovadia, 2009: 5). These authors (2009: 5) further state that: "Transformation of the health system into a national institution that is based on

equity and merit ……. could still place South Africa on track to achieve Millennium Development Goals (MDGs) 4, 5 and 6 and would enhance the lives of citizens." Where PHC clinics, outreach teams and mobile health services are now functioning effectively, access to health care has improved substantially, in spite of the magnitude of inherited health system disparities.

Coovadia, Jewkes, Brown, Barron, Sanders and Mcintyre (2009: 12) describe further public health policy successes. The previous fourteen health administrations were amalgamated to form one national and nine provincial administrations. The clinic upgrading and building programme resulted in improved availability of and access to health care facilities to where the most disadvantaged people reside. PHC became available cost free to health care users. Legislation was endorsed to change the regulatory bodies and make them representative of the South African citizens. Public health statute was also transformed to permit harmless and legitimate termination of pregnancy, control of firearms, and reduction in cigarette smoking and reinforce supportive care for rape victims. The HIV & AIDS and STI Strategic Plan for South Africa (Department of Health, 2007-2011) have been welcomed as an example of good policy.

Despite coming out of a past with historical injustices and disastrous health policies of the previous administration, there have been achievements and strides made towards the goal of transformation and improved health service delivery as described above. However, problems in public health policy formulation and implementation still exist. The next part of the discussion will describe some of the challenges which need to be addressed if the policy goals of Government are to be realised.

Stack and Hlela (2002: 29) highlights some of these factors below as:

- The *initial* element adding to the chasm between policy and implementation is the enormous degree and rapid timing of the transformations originally made to the health system. Government has been concurrently endeavouring to reallocate resources from financially distressed provinces and accommodating varying levels in the health care system.

- *Secondly*, simultaneously the administrative constitution of the national department was altered speedily to more closely mirror population proportions thus losing trained and skilled employees.
- *Thirdly*, the department adopted the tobacco, pharmaceutical and medical scheme industries and the pro-life lobby, with respect to key strategy initiatives and regulation; and
- *Thereafter*, significant changes of the health system were embarked on with an essentially novel management team who did not have recognized interactions or considerable related knowledge with implementation institutions and agencies on the ground. Hence, interaction and consultation between the department and implementers was not optimal.

The elaborate methodology that ensued, however, exposed a general lack of cognizance by policy-makers of the practical challenges in the current health system.

- According to the provisions of the Constitution, health is a contemporaneous area of national and provincial legislative competency; both national and provincial governments can authorize health legislation and thus make policy. However, there appears to be limited synchronization in devising policies.
- An additional shortcoming identified is that while the national office may formulate policy, those who implement may not necessarily possess the ability to effect them appropriately.

The following recommendations by (Stack and Hlela, 2002: 89-90) were put forward to address the gaps identified for successful policy implementation:

- Establish policy planning, monitoring and evaluation components at the national and provincial echelons of the department that are adequately budgeted for, operated and that have the essential research competence, both to collect data and to co-ordinate the collection of data at all levels of the health system;
- Make policy adoptions about the description and scope of PHC facilities and outreach services to be delivered in view of financial and competency restrictions;

- Create thorough and merge comprehensive provincial and national hospital plans in consultation with policy implementers and with reasonable timelines and financial resources;
- These plans should be created after discussions with the HIV/AIDS planning departments to make certain that hospital and PHC facilities are involved with HIV/AIDS management approaches;
- Promptly ensure the decentralisation of authority to manage human resources to hospital managers wherever the competency exists to assume these powers; and
- Advance communication, consultation and interaction between the department and health officials at public health facilities through consistent updates and briefings on policy developments; disseminating the departmental organograms with identification and contact details of officials to provide clarity on concerns raised; and conducting support visits to health facilities on a routine basis to ascertain implementation hindrances and remedial measures.

The presence of disproportions in health care across countries and populations has been acknowledged by the World Health Organisation. Public Health policies globally place emphasis on preventive and promotive health with increased focus on access to services for better health outcomes.

3.6 COMPARATIVE PERSPECTIVE: PUBLIC HEALTH IN THE UNITED STATES OF AMERICA (USA) AND SOUTH AFRICA (SA)

The United States of America has *The Affordable Care Act* which enables health care users to be responsible for their own health and decisions thereto. There is also a *"Patient's Bill of Rights*" which affords the citizens the "stability and flexibility" required to make informed decisions and choices regarding their health http://www.hhs.gov/healthcare/rights/. Similarly, South Africa, has a Bill of Rights enshrined within the Constitution, Batho Pele framework and KwaZulu-Natal Citizens Charter, amongst other supporting legislation and prescripts, which creates a comparable background in this study.

Public Health in the USA is described in Managed Care (Marcille, 2005: 5) as "the shared responsibility of federal, state and local governmental health agencies that, together with business, voluntary and professional health associations provide basic health services to all Americans." The universally accepted four elements of public health, which are: prevention, science, care for the medically underserved and interdependence, describe the commitment and responsibility in protecting the nation against the peril of disease, epidemics, and bioterrorism. South Africa's Public Health care system functions on a three sphere system: national, provincial and at local government levels to ensure the delivery of health services in collaboration with among others, non-governmental and faith-based organisations, private-public partnerships, regulatory bodies and have also included traditional leadership in the quest to ensure an integrated and comprehensive health service.

Koplan (in Marcille 2005: 7) acknowledges that improvements in Public Health interventions are attributed to education, communication and policy intervention as opposed to scientific advances. He further noted that: "The general public and policy-makers would do well to remember that the stronger the public health infrastructure is for dealing with every day public health situations, the better equipped it will be to respond to emergency situations." PHC re-engineering is a policy adopted by the South African government to strengthen district health system (DHS) and place more pronounced significance on population-based health and community-based outcomes.

Public health has a distinct responsibility towards the medically underserved. In the USA health care is the greatest sector; however, access to health care is not a right. The responsibility of rendering health care services for the underserved falls heavily upon Public Health, which may be why most of the public perceives Public Health principally as the benefactor of clinical care for the poor (Marcille, 2005:13). In contrast, South African citizens have a right to health care as enshrined in the Constitution. Furthermore, the South African government is responding with an across-the-board transformation strategy to revitalise and restructure the South African health care system which includes fast-tracking the implementation of a National Health Insurance (NHI) scheme, which will ultimately enfold and provide universal health care to all South Africans.

3.6.1 LESSONS LEARNT FROM THE COMPARATIVE STUDY

The USA has the best health care in the world but that is directly related to the highest expenditure on health care provision than any other sector. Extending and strengthening PHC services can assist in improving health outcomes cost effectively (Borkan, Eeaton, Novillo-Ortiz, Corte and Jadad, 2010: 1432). With primary health care services which focus on prevention, health promotion, treatment and community care there is an increase in life expectancy, reduction in the rate of infant mortality.

Achieving justness in health care and eliminating inequities are priorities in the health system and are critical focal areas in discussions of the policymakers with the intention of improving the quality of care provided to citizens. The recognition of areas of improvement is the initial phase, but it should be followed by actionable strategies to make sustainable improvements. The increased usage of key data indicators, training and development of clinicians and support staff and increased diversity in governance and management are actions that are being used in the USA to eliminate health care disparities which Government can model successfully.

Whilst health care reforms in the USA aim to bend the health cost curves, it aims to improve patient outcomes whilst upholding performance standards. This requires extensive systemic changes, commitment of health care workers, management and policy makers and integration of different treatment modalities.

3.7 CONCLUSION

One of the elementary characteristics of the Provincial Government of KwaZulu-Natal (KZN) is the manner in which the administration inculcates and promotes a robust culture of encouraging exceptional customer service at all times. Operation Sukuma Sakhe is seen as an unceasing collaboration between Government and the public to work together cohesively to attain the twelve National Outcomes of the country. Social mobilization will be encouraged and government services must be delivered in a more integrated and co-ordinated way. Public health and public health policies are characterised by a robust slant towards pragmatism and utilitarianism. The participation in the policy process of those involved in the implementation of policy, advances good governance and yields the desired intent of the policy. A past, present and comparative account of Public Health outlined successes and challenges within the system. Addressing inequalities and strengthening integration and community participation are key principles on which Public Health policies are premised. The subsequent chapter will describe the research methodology, analysis and presentation of data in this study.

CHAPTER FOUR

FINDINGS, INTERPRETATION AND DISCUSSION OF THE PRIMARY DATA

"In every country public sector information represents a significant component of the overall information and knowledge economy."

(Davies, J. 2006)

4.1 INTRODUCTION

This chapter explicates the results and discusses the findings, based on an epistemic imperative, acquired from the questionnaires in this research study. The questionnaire was the primary instrument that was expended to collect information and was disseminated to patients at various mobile health services types. . Information collected from the responses was captured and analysed with Statistical Package for Social Sciences (SPSS). The findings will present the descriptive statistics in the form of graphs, cross tabulations and other figures for the qualitative data that was collected. Inferential techniques include the use of correlations and Chi-Square Test values; which are interpreted using the p-values.

4.2 DATA ANALYSIS

Sample

A total of 250 questionnaires were despatched to clients and 203 were returned which indicate an 81.2% response rate. This indicates a positive return rate and adds credibility to the study. A total of 24 questionnaires were despatched to Health Care Workers (HCW) and all were returned which gave a 100% response rate; a total of 12 questionnaires were despatched to Management and returned which gave a 100% response rate.

Research Instrument

The research instrument comprised similar elements, with a level of measurement at a nominal or an ordinal level. The questionnaire was separated into 5 sections which measured various themes as illustrated below:

Section 1 - Biographical data
Section 2 – Mobile Health Services
Section 3 – Staff Attitude and Behaviour
Section 4 – Batho Pele
Section 5 – Impact of mobile health services

Reliability Statistics

The two most significant facets of precision are **reliability** and **validity**. Reliability is computed by considering measurements on same subjects. A reliability coefficient of 0.70 or higher is considered as "acceptable". The tables below reflect Cronbach's Alpha score for all the items that constituted the questionnaire to confirm its reliability in the scores.

Clients

Table 4.1: Case processing and Reliability statistics – clients

Case Processing Summary

		N	%
Cases	Valid	195	96.1
	Excluded	8	3.9
	Total	203	100.0

Reliability Statistics

Cronbach's Alpha	N of Items
.564	4

The survey revealed that the overall reliability score for the ordinal data in the construct was 0.564 which is slightly below the recommended value of 0.70. This is mainly due to the construct being newly developed, and the limited number of ordinal variables within the sections. However, this does not have a huge impact on the study, but merely a relatively marginal difference.

Health Care Workers

Table 4.2: Reliability statistics – health care workers

Reliability Statistics – Q3.3 and Q3.4

Cronbach's Alpha	N of Items
.807	2

Reliability Statistics – Information

Cronbach's Alpha	N of Items
.937	5

Reliability Statistics – Staff Attitude

Cronbach's Alpha	N of Items
.891	5

It is evident that all of the sections have values that exceed the recommended value of 0.700. This implies a high degree of consistent scoring by the respondents for the different sections. The high reliability score emphasises that HCW engage clients courteously during consultation and provide health education in accordance with the principles of preventative and promotive health. Obtaining feedback from clients is an evaluative strategy for the improvement of health services rendered, and is highlighted in the KwaZulu-Natal Citizens' Charter, where the citizens are encouraged to "participate in the monitoring of the efficiency and effectiveness with

which delivery of services is effected." (KZN Citizens' Charter, 2009: 3). This is a significant finding as it highlights the adherence to the Code of Conduct by HCW in the execution of their duties.

Management

Table 4.3: Reliability statistics – management

Reliability Statistics: Q2.1 & Q2.3

Cronbach's Alpha	N of Items
.522	2

Reliability Statistics: Batho Pele

Cronbach's Alpha	N of Items
.797	8

Reliability Statistics: Impact

Cronbach's Alpha	N of Items
.686	3

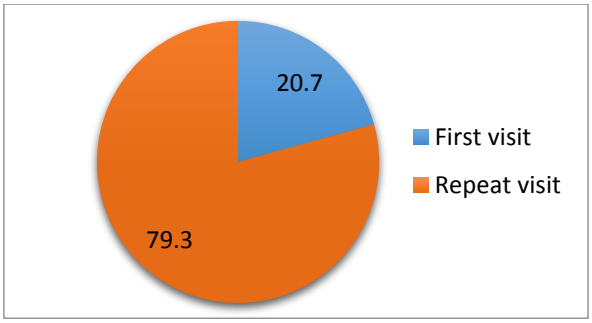
It is noted that only the first table has values slightly less than the acceptable standard of 0.700. This is primarily due to the minimum number of variables in the section; however this is marginal and does not compromise the findings of the study.

4.3 SECTION 1: Biographical data

This section summarises the biographical characteristics of the respondents.

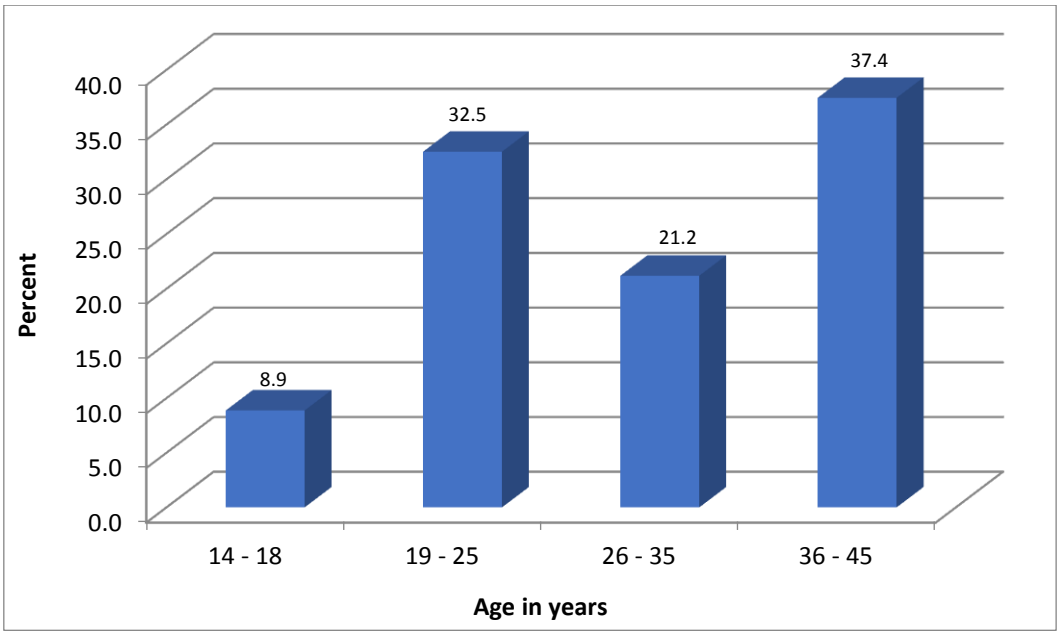
Clients

Figure 4.1: Classification of clients – visits



Nearly 80% were repeat patients. This is useful as the responses would be a fairly accurate measure of the experiences of patients for the various categories of this research as they are better suited to compare their experiences from each visit. Acutely ill patients seek immediate medical care at the nearest fixed PHC facilities or visit the hospital. In addition, more than half of the respondents (58.6%) were over the age of 25 years.

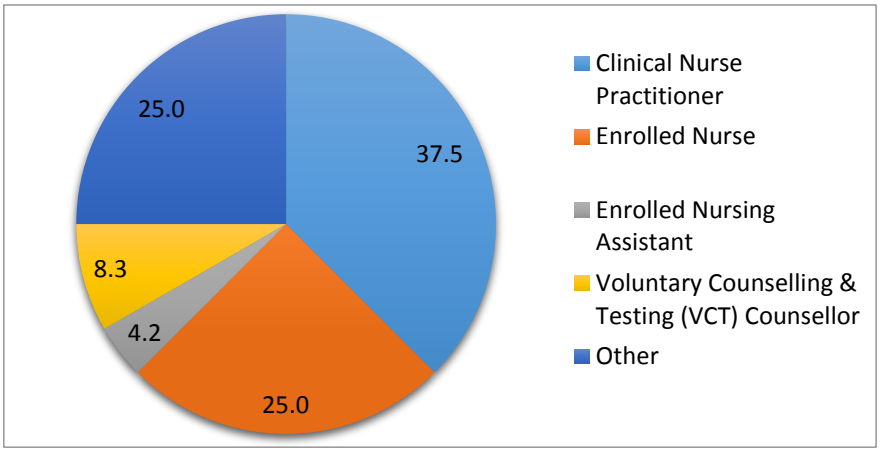
Figure 4.2: Classification of clients – age



This is also useful as the respondents have some degree of maturity which would enhance the accuracy of responses. However, this also highlights the point that mobile health services were primarily focusing on the meeting the health care needs of the stable chronically ill patients who are young adults, middle and older persons. The focus of PHC re-engineering is to ensure that a full range of services is offered at mobile health points targeting all age groups. This, therefore, is a key aspect for improvement of marketing the services offered by mobile services at venues such as schools, community and religious gatherings and local shopping areas where the younger population groups may be found.

Health Care Workers

Figure 4.3: Classification of health care worker category

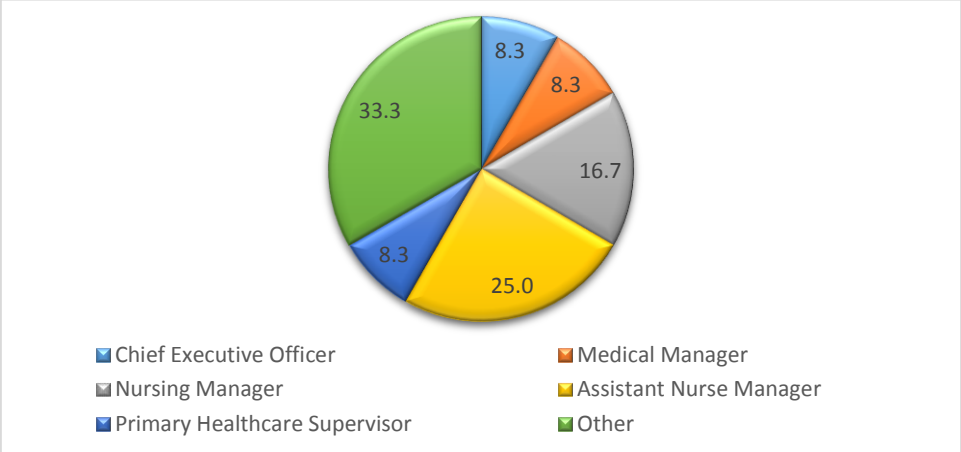


More than a third of the workers (37.5%) were Clinical Nurse Practitioners. This reflects the current staffing in the mobile health units. Out of a total of five or six allocated staff members, there are usually two to three clinical nurse practitioners and one of the other staff categories. Most of the PHC services are offered by the clinical nurse practitioner who is trained in Primary Health Diagnosis and Treatment.

A quarter of the respondents did not indicate the other classification categories.

Management

Figure 4.4: Managerial composition of the sample



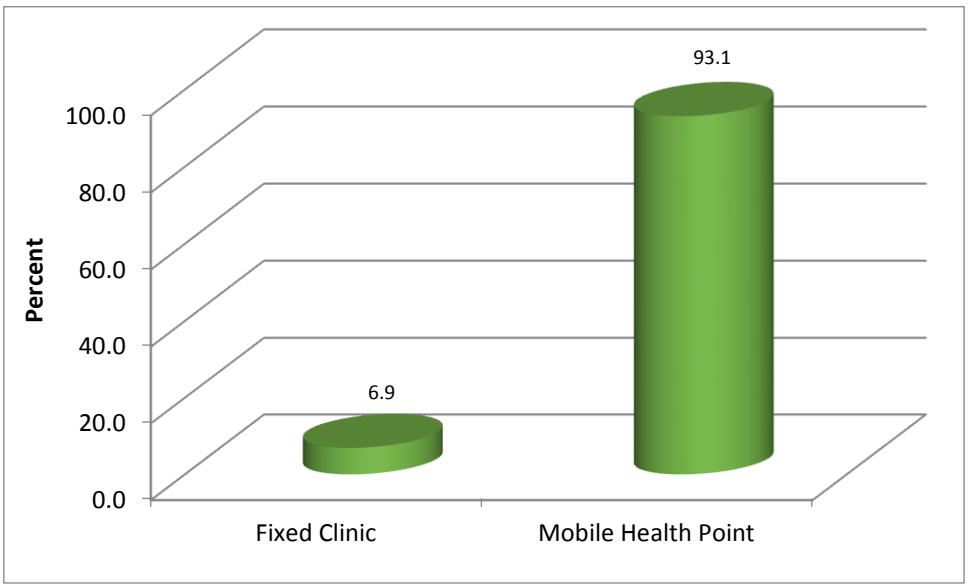
A quarter of the respondents (25.0%) were Assistant Nurse Managers. There were similar numbers of respondents (8.3%) for each of the categories of Chief Executive Officer, Medical Manager and Primary Healthcare Supervisor. The management sample was constituted with officials who were directly responsible for the management and allocation of PHC services from within the two sub-districts that make up the study area.

4.4 SECTION 2: Mobile Health Services

The section that ensues analyses the scoring patterns of the respondents per variable per section. The results are initially presented using summarised percentages for the variables that constitute each section. Results were analysed according to the significance of variables.

Clients

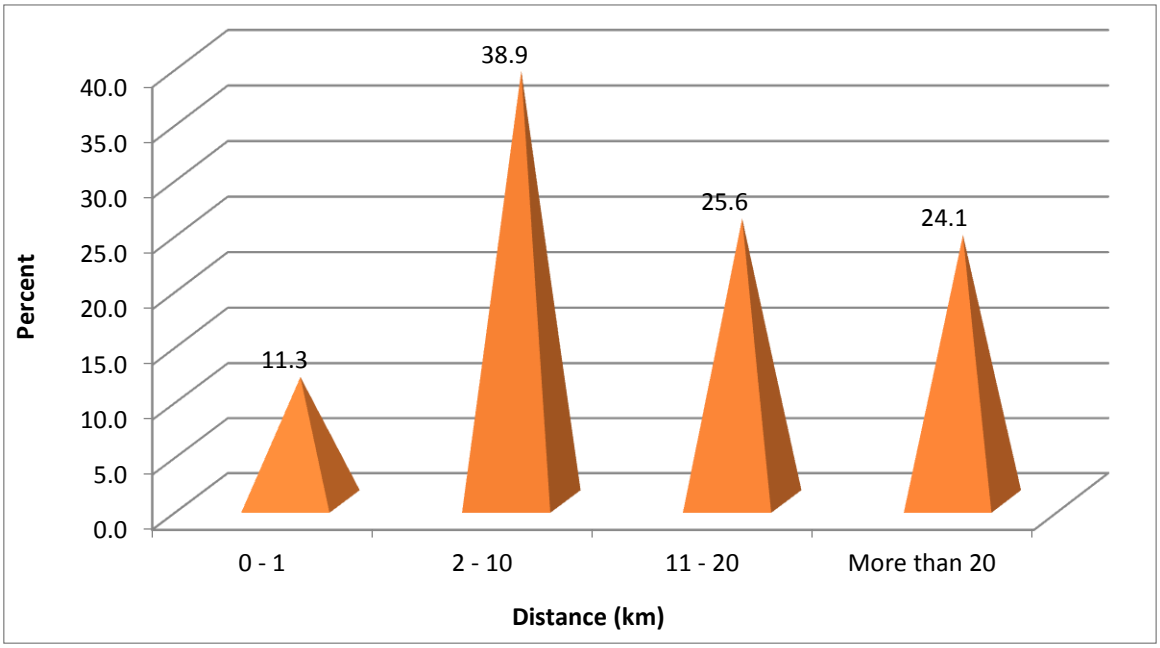
Figure 4.5: Type of health service utilised by clients.



More than 93% of the respondents attended a Mobile Health Point. This is a significant finding in the study which confirms that deep rural communities rely on the health care services which are rendered from the mobile health units instead of travelling to fixed health care facilities due to financial, infrastructure and travel constraints. The provision of mobile health services is an effective approach in bringing services closer to the people, and is in keeping with key Principles of Batho Pele which are access and consultation. Furthermore, there is emphasis on infrastructure development to ensure that services are accessible at health care centres. The State of the Nation Address, 2014 by the President echoes the need for attention on health care and infrastructure amongst others. This is synergistic with the National Development Plan 2014 – 2019 that incorporates the key indicators of the Industrial Policy Action Plan, the New Growth path and the Infrastructure Plan.

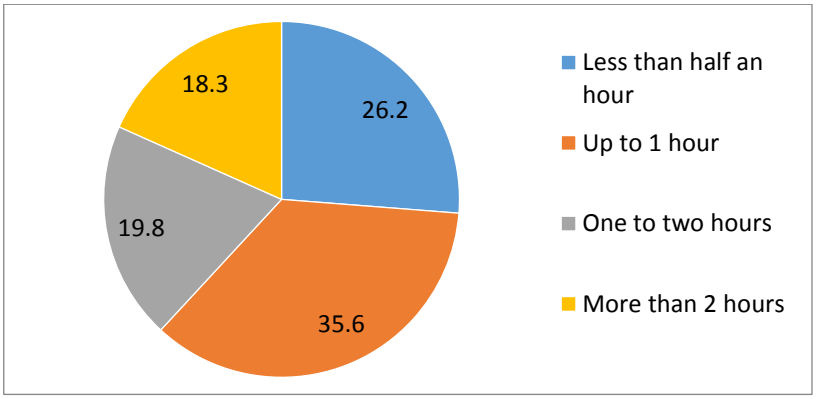
The figures that follow indicate the levels of accessibility for various variables.

Figure 4.6: Distance from the health care service – respondent



Approximately half of the respondents (49.7%) lived more than 10 km from the health service point, whilst the majority of respondents lived between 2 km to 10 km from the service point. This finding reveals a gap in the delivery of mobile health services and the Department of Health's vision of bringing health care services to those who are most in need thereof, as clients still have to travel a substantial distance to the service point. This gap is, therefore, significant for noting by the Maphumulo sub-district during the planning for procurement of mobile health vehicles and the subsequent allocation of staff, as well as for the Ilembe Health District Management's Clinic Upgrading and Building Programme (CUBP) when planning for new fixed clinics in the study area.

Figure 4.7: Time taken to access healthcare point



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More than 60% of the respondents were able to reach the service point in less than 1 hour. This links up with the finding that most of the respondents were repeat clients who are aware of the scheduled visit dates at the mobile service points and ensure that they arrange their transport timeously.

Table 4.4: Cross-tabulation – relationship between distance and time taken to service point

			Distance from health service in km				Total
			0 – 1	2 - 10	11 – 20	➢ 20	
Travelling time	Less than half an hour	Count	21	26	4	2	53
		% of Total	10.4%	12.9%	2.0%	1.0%	26.2%
	Up to 1 hour	Count	2	45	23	2	72
		% of Total	1.0%	22.3%	11.4%	1.0%	35.6%
	One to two hours	Count	0	6	18	16	40
		% of Total	0.0%	3.0%	8.9%	7.9%	19.8%
	More than 2 hours	Count	0	1	7	29	37
		% of Total	0.0%	0.5%	3.5%	14.4%	18.3%
Total		Count	23	78	52	49	202
		% of Total	11.4%	38.6%	25.7%	24.3%	100.0 %

The largest grouping of respondents (22.3%) travelled between 2 km to 10 km but it still took up to an hour to get to the service point. This is largely influenced by the transport route and times to or *via* the health service point. Travel from home to the transport route is by foot and clients usually do not include this in their calculation of travelling time.

Table 4.5: Mode of transport to service point and frequency of use

		Frequency			
		Monthly		First time	
		Count	Row N %	Count	Row N %
Nil, travel by foot	Yes	59	69.4%	26	30.6%
Own vehicle	Yes	16	76.2%	5	23.8%
Bus/taxi	Yes	72	86.7%	11	13.3%

Of the respondents who travelled by foot, 69.4% were monthly repeat patients, whilst the remaining were there for the first time. The statistics reveal that more chronic patients are dependent on the mobile clinic's services on a monthly basis. The mean and standard deviation of the distance travelled was 1.01 ± 0.55 km. The impact of the distance travelled indicates that mobile health services offer health services to clients in the deep rural areas whose only mode of transport is by foot or bus/taxi. Again this focal point emphasises access as one of the key Principles of Batho Pele and is also stipulated in the Patients' Rights Charter.

Table 4.6: Summary – communication at service point

			Did you understand the language spoken by the health care workers	Total
			Yes	
Medium of Communication	IsiZulu	Count	201	201
		% of Total	100.0%	100.0%
Total		Count	201	201
		% of Total	100.0%	100.0%

All of the respondents understood the IsiZulu language which was used as the medium of communication by health care workers.

Table 4.7: Right to privacy

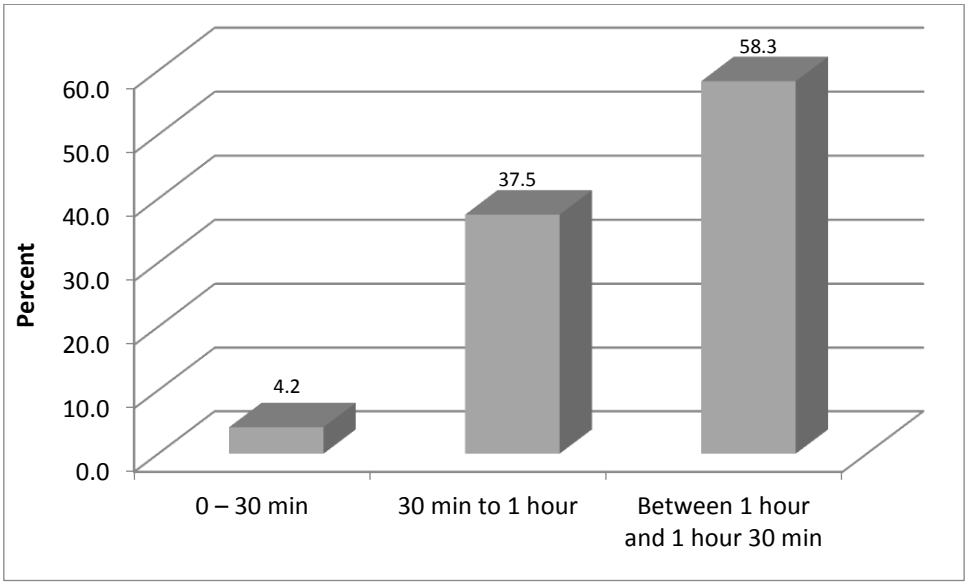
	Frequency	Percent
Yes	200	98.5
No	2	1.0
Missing System	1	.5
TOTAL	203	100.0

Almost all of the respondents (98.5%) indicated that they had been accorded the right to privacy. This finding confirms that HCW are courteous and are aware of and are implementing Batho Pele in the execution of their duties. This is one of the key questions raised in the study.

Health Care Workers

All of the respondents indicated that the roads leading to the mobile health clinics were gravel.

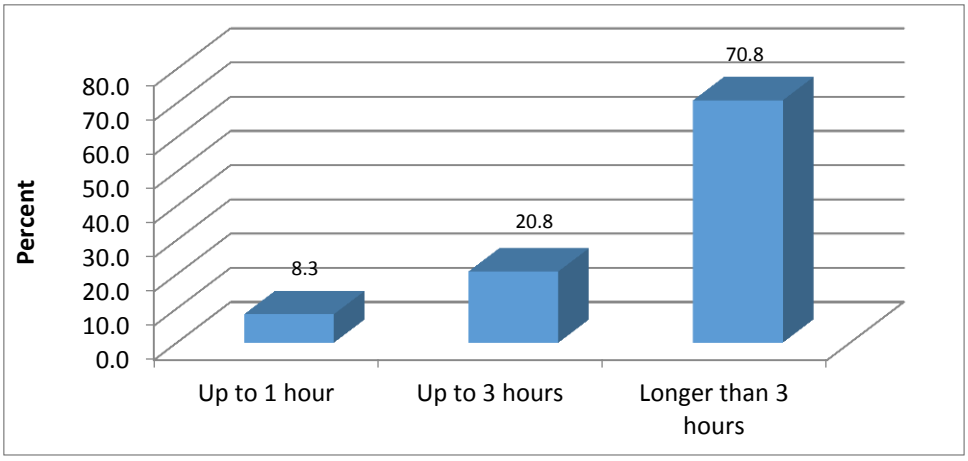
Figure 4.8: Approximate time to the clinic



Nearly 60% of the respondents indicated that it took between 60 to 90 minutes to reach the clinic. This finding supports the need for an increase in mobile health points in the deep rural areas, and the subsequent decrease in travelling time.

Furthermore, it indicates the need for the development of roads which would increase accessibility to the mobile health vehicles and public transport. This is indicative of intergovernmental co-ordination of joint projects for planning of infrastructure (roads) as reflected in the Integrated Development Plan of Ilembe Municipality.

Figure 4.9: Duration spent at the clinic



Most respondents (70.8%) indicated that they spent more than 3 hours at the clinic. Mobile health services are provided once a month. At this visit, clients seek to address most, if not all, of their health needs. A “one stop shop” of health services is provided by the limited number of HCW, especially the professional nurses, on the team. Health services are provided on modified vehicles for the purposes of consultation with clients to maintain privacy and to undertake certain examinations required on the clients *eg.* cervical cancer screening tests This increases the waiting time of clients as there is only one vehicle. However, this is one of the limitations of providing these mobile health services.

Table 4.8: Type of services to clients

These services are beyond the scope of services that mobile health care teams can offer due to the lack of doctor, necessary allied health professional or equipment.

	Frequency	Percent
Clients with HIV sexually transmitted diseases	1	4.2
Complications	1	4.2
Complications & Reviews	1	4.2
Complications in Hypertension, Diabetes	1	4.2
Complications of chronic patients, ARVs, Maternity, TB treatment	1	4.2
Conditions of medical & surgical cases	1	4.2
Eye problems, Dental	1	4.2
HIV/AIDS, diabetes, Hbp, Epilepsy, TB, Antenatal	1	4.2
Investigations eg. X-Rays	1	4.2
Laboratory	1	4.2
Maternity, ARVs, lab	1	4.2
Optometrist, Dietician, Doctor	1	4.2
Physiotherapy rehabilitation patients	1	4.2
Poor social & medical condition	1	4.2
Uncontrolled chronic illness, TB, Antenatal	1	4.2
Underweight children and suck	1	4.2
Complications of chronic care, reviews	2	8.3
H C T Services	2	8.3
NIL	4	16.7
TOTAL	24	100.0

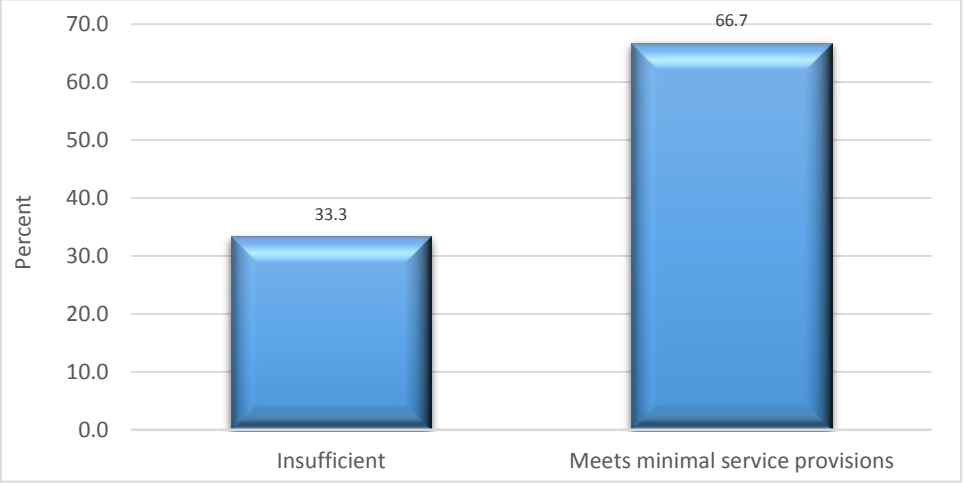
Table 4.9: Frequency of service

	Frequency	Percent
Current service is adequate	9	37.5
Twice a month	15	62.5
TOTAL	24	100.0

Nearly a third of the respondents (37.5%) believed that the frequency of service currently was adequate. The remainder believed that this needed to be done twice a month. This finding would be given due consideration in the recommendations in the following chapter.

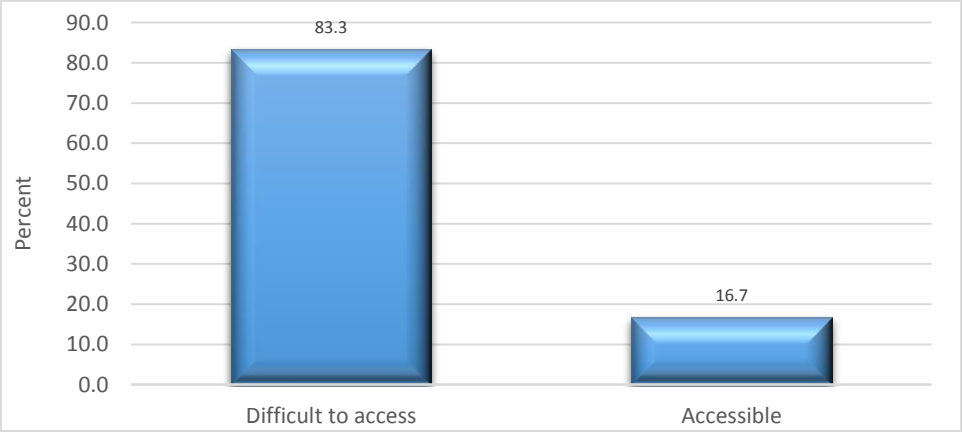
Management

Figure 4.10: Accessibility – provision of mobile health services



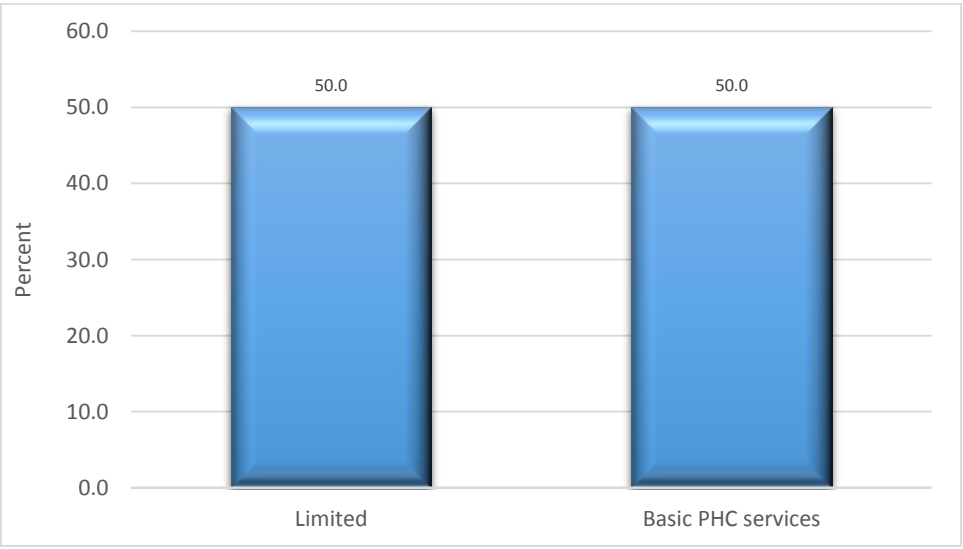
A third of the respondents indicated that the provision of the service was not adequate, with the remainder indicating that minimum service levels were met. No respondents believed that the provision was sufficient. The KwaZulu-Natal Department of Health's Strategic Plan 2010 – 2014 (DOH, 2009: 30) has identified the "revitalisation of PHC services as per the Service Transformation" as a key activity in improving the delivery of PHC services. Targets include: implementing the PHC strategy, the increasing of PHC utilisation rates, increasing the PHC budget and increasing PHC supervision rates. These targets will be evaluated at the end of this financial year and the above findings can be used as input for Ilembe Health District in the next strategic planning session.

Figure 4.11: Accessibility – mobile health points



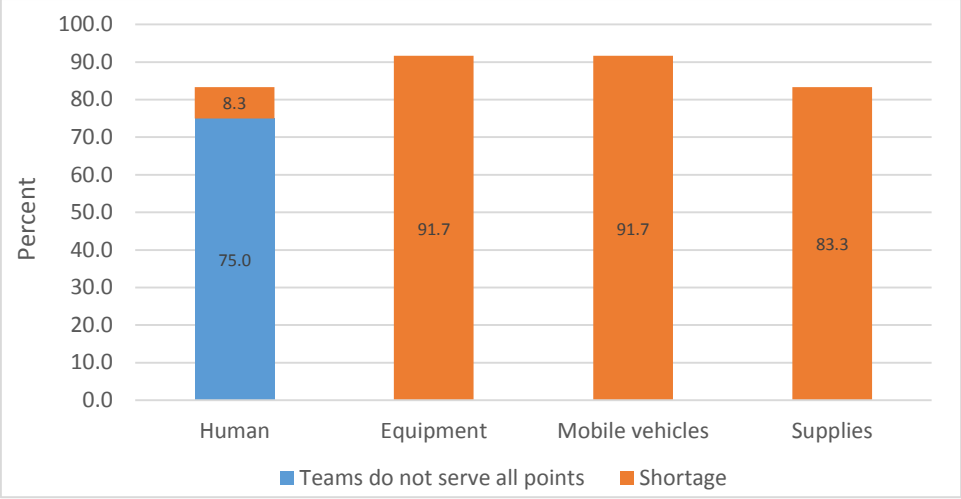
Approximately 17% of the respondents indicated that the health points were easy to access. The rest believed that this was not the case. This is attributed to the lack of roads in the sub-district which is deeply rural, from the majority of homesteads to the mobile health points. Therefore, the only way to access the service point is to travel by foot. This gap can only be addressed by the local municipality's Integrated Development Plan (IDP) to improve infrastructure.

Figure 4.12: Accessibility – package of services provided



Respondents were evenly split regarding the above with respect to the two options.

Figure 4.13: Factor/s influencing package of services offered



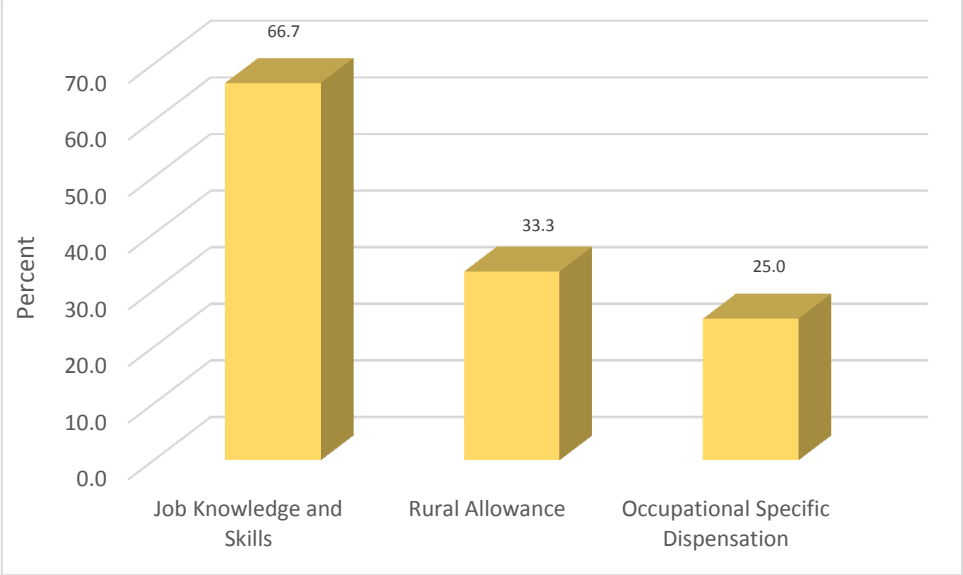
Multiple responses were allowed and results are presented as percentage of cases. With regards to the Human (Personnel) variable, 75.0% of the respondents indicated that teams did not serve all service points. All other variables related to factors where high numbers of respondents indicated that there was a shortage in each. This finding relates to the first objective of the study which is: "to determine whether the health needs of the rural people are being met ….. through the provision of the existing mobile health services". The finding provides the need for shortages of equipment and supplies to be addressed in the Quality Improvement Plans in order to improve service delivery. Human resources can be increased when there are more mobile health vehicles to accommodate these teams.

Table 4.10: Other factors

	Frequency	Percent
Delays by other processes eg. Scans	1	8.3
Distance travelled to services	1	8.3
Gravel roads	1	8.3
Inadequate	1	8.3

Multiple responses were allowed and results are presented as percentage of cases.

Figure 4.14: Contributing factors



Multiple responses were allowed and results are presented as percentage of cases. The influences of the above factors on the package of service offered are described below.

- **Job Knowledge and Skills**

In order to render the full package of PHC services, both clinical and non-clinical staff have to be suitably qualified and updated on the latest guiding documents and standard treatment protocols. Further specialized training in PHC is necessary to be adequately equipped with the required skills. Currently, there is a high attrition rate amongst skilled clinical staff, most of whom are migrating for more lucrative working conditions and benefits. There is an ever increasing burden of disease which places increasing demands on health care such as the expansion of the anti-retroviral (ART) programme and the integration of the community home-based care into PHC service. This viewpoint is supported by George, Quinian, Reardon & Aguilera (2012: 2) wherein it is noted that there are more clients who require a comprehensive continuum of care with limited human resources. This poses a challenge for trained and skilled staff that focuses on delivering *quantity* rather than *quality* services.

- **Rural Allowance**

The skewed distribution of HCWs, particularly clinical staff, between rural and urban areas in the country called for definitive strategies to be formulated and implemented to correct this imbalance. Reid (2004: 3) states that: “Financial and non-financial incentives have been used in other countries to recruit and retain health professionals in areas of need.” This kind of system, the rural recruitment allowance was introduced in 1994 South Africa by the National Minister of Health as an incentive to attract, recruit and retain staff at rural health facilities. However, whilst the implementation of rural allowance did assist in luring health professionals to the rural hospitals, clinics and mobile health services, there are other non-financial factors such as job satisfaction, career development and social motivators that impact on the retention of these officials.

- **Occupation Specific Dispensation (OSD)**

Occupation Specific Dispensation (OSD) was presented in 2007 and aimed to advance the public services’ capability to attract and retain skilled officials within the country. The development and implementation of the OSD was prompted by the realisation that improvement in the conditions of service and remuneration for health professionals presents a priority. It focused on improving the conditions of service and remuneration for public service workers, including public sector health professionals. According to George & Rhodes (2012:1), “the objectives of the OSD were to improve the public services’ ability to attract and retain employees, provide differentiated remuneration dispensations for the vast number of occupations in the public service, cater for the unique needs of the different occupations, provide a unique salary structure per occupation, prescribe grading structures and job profiles to eliminate inter-provincial variations, and provide adequate and clear salary progression and career path opportunities based on competencies, experience, and performance.” As with the rural allowance that was implemented, improving remuneration packages in various categories of health professionals is commendable; however, it is critical that working conditions and other motivating factors are considered within the district health system to maintain this momentum.

Table 4.11: Quality Improvement Plans

	Frequency	Percent
Attendance of Sukuma Sakhe meetings	1	8.3
Enough human resources, more than one visit, have enough equipment	1	8.3
Free services, adequate equipment	1	8.3
Improve mobile vehicles to 4X4	1	8.3
Increase number of fixed clinics and mobile points	1	8.3
Introduce more mobile points & vehicles	1	8.3
Liaise with district pharmacy	1	8.3
More mobile points, training	1	8.3
More staff & equipment, responsibility, rural allowance	1	8.3
To have enough resources to implement effective services	1	8.3
Training & onsite relationships	1	8.3
Well equipped vehicles, training & development of staff	1	8.3
TOTAL	12	100.0

The above suggestions for improvement can be classified under the following themes in line with the relevant Batho Pele Principles:

THEME	BATHO PELE PRINCIPLE
Sukuma Sakhe Forum Forum has representation from all government departments and is ward- based. Appropriate for providing information related to health services and for marketing health services.	Consultation, Information
Provision of Resources Adequacy of supplies of medicines, equipment, budget and staff will enable the full package of PHC services to be rendered in order to meet the health needs of the community.	Improve Service Standards
Training and Development Update staff on the latest policies, procedures and guidelines to ensure effective and efficient service delivery.	Providing Leadership and Strategic Direction, Encouraging Innovation and Rewarding Excellence
Increase Mobile Health Service Points Ensure equitable access to health services, decrease travelling costs and time and decrease waiting times at the mobile points.	Improving Accessibility

The need for mobile health services

Almost 93% of the Clients were prepared to travel to the mobile service points indicating that clients were willing to make an effort to get to the service points. Two-thirds of Management believed that the service provided was adequate with the remaining indicating that more could be done.

Table 4.12: Accessibility of services for medical assistance

			Distance from health service in km				Total
			0 – 1	2 – 10	11 – 20	➢ 20	
Travelling time	Less than half an hour	Count	21	26	4	2	53
		% of Total	10.4%	12.9%	2.0%	1.0%	26.2%
	Up to 1 hour	Count	2	45	23	2	72
		% of Total	1.0%	22.3%	11.4%	1.0%	35.6%
	One to two hours	Count	0	6	18	16	40
		% of Total	0.0%	3.0%	8.9%	7.9%	19.8%
	More than 2 hours	Count	0	1	7	29	37
		% of Total	0.0%	0.5%	3.5%	14.4%	18.3%
Total		Count	23	78	52	49	202
		% of Total	11.4%	38.6%	25.7%	24.3%	100.0 %

As many as a quarter of the clients (24.3%) had to travel more than 20 km whilst 18.3% had to travel for more than 2 hours. This confirms the inaccessibility due to lack of infrastructure in the study area which is deeply rural. The only access to a vast majority of mobile health points is by foot through foot paths or uneven gravel roads. This is indicative of a need to address infrastructure leading to access points to the clinic.

The study revealed that nearly 60% (58.3%) of the HCW indicated that it took between 60 to 90 minutes to reach the clinic. More than 70% of the HCW remained at the clinic for more than 3 hours. The long service period is also an indication that the service is needed as HCW were busy for long periods.

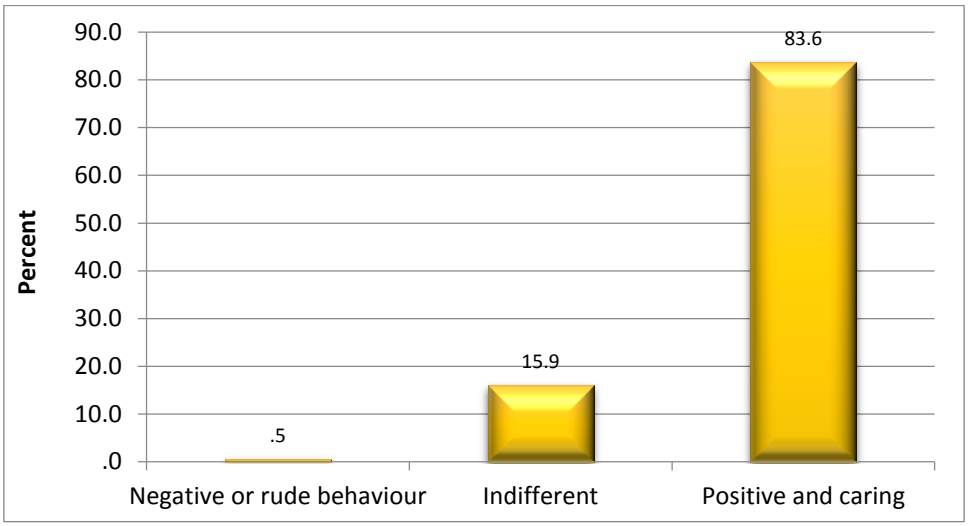
Approximately 17% of the Management respondents indicated that the health points were easy to access. The rest believed that this was not the case. In terms of the services provided, respondents were evenly split regarding the two options: Limited Services and Basic PHC Services.

4.5 SECTION 3: Staff Attitude and Behaviour

This section is concerned with attitude of staff in the execution of their duties and the influence it has on clients.

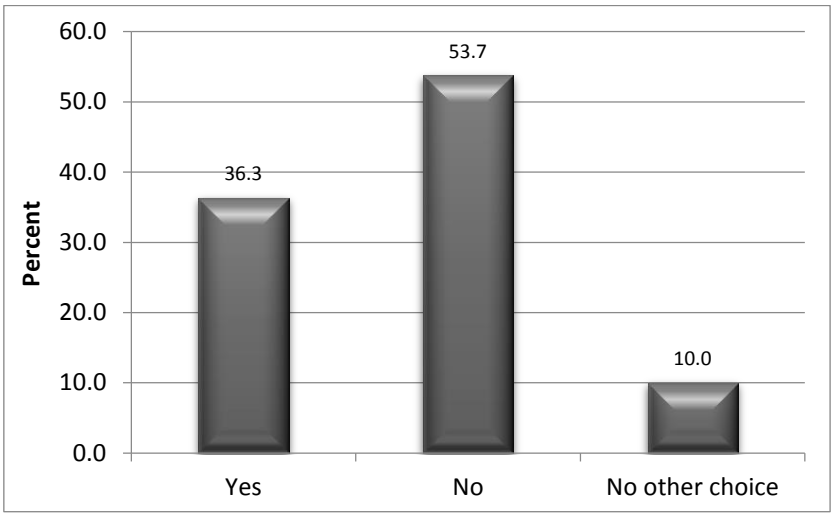
Clients

Figure 4.15: Overall rating of the staff attitude



Less than a percent of the respondents experienced negative attitudes, with 83.6% being satisfied with the positive and caring attitude shown to them. The mobile health staff appears to be aware of and are fulfilling the Batho Pele mandate by the Department. Externalising the Principles of Batho Pele is an important point for health care workers.

Figure 4.16: Attitude and behaviour of health care workers on utilisation of health care services



A significant proportion of clients were not prejudiced by the attitude and behaviour of the health care workers as they felt that the staff was courteous and their health needs were attended to. This was also the only accessible health service available for them to use and if they missed the opportunity, then it would be a month's delay until the next service date at the mobile health point.

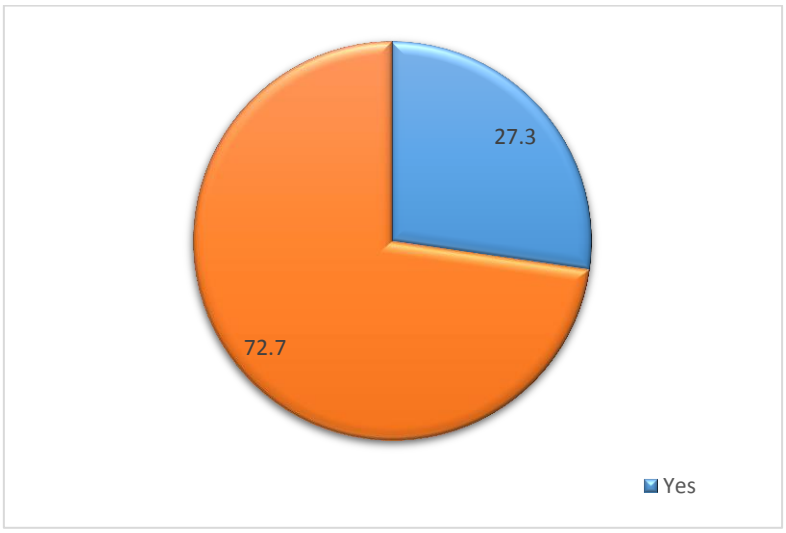
Health Care Workers

Figure 4.17: Responses – behaviour and attitude

The average score in this section is 97.5%. The lowest level of agreement was for the last statement regarding training received on Batho Pele. Formal training sessions are conducted at the hospital during the day when the mobile health teams are out on the field. To overcome the identified gap, mobile health teams should be targeted before their departure to the mobile points or upon their return to the hospital. Attendance registers of the training sessions will assist in identifying staff that are not yet trained and should be prioritised in the upcoming sessions.

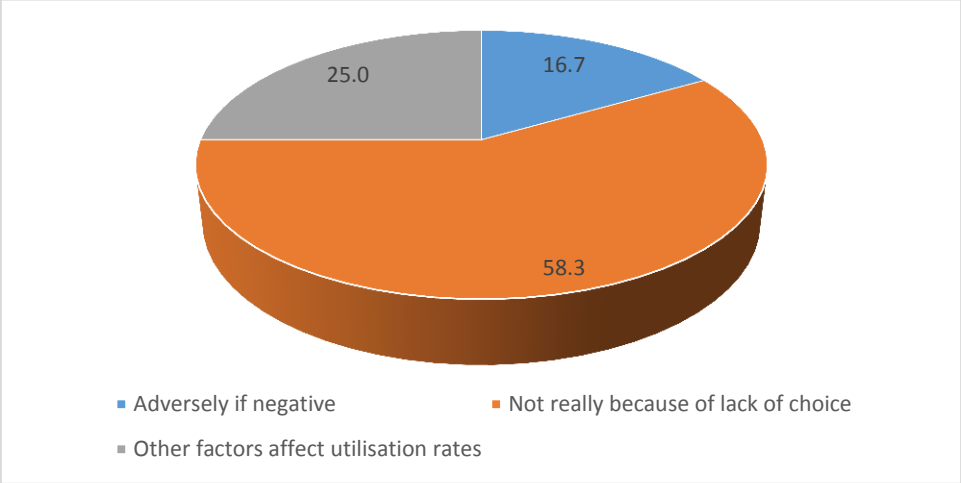
Management

Figure 4.18: Frequency of complaints



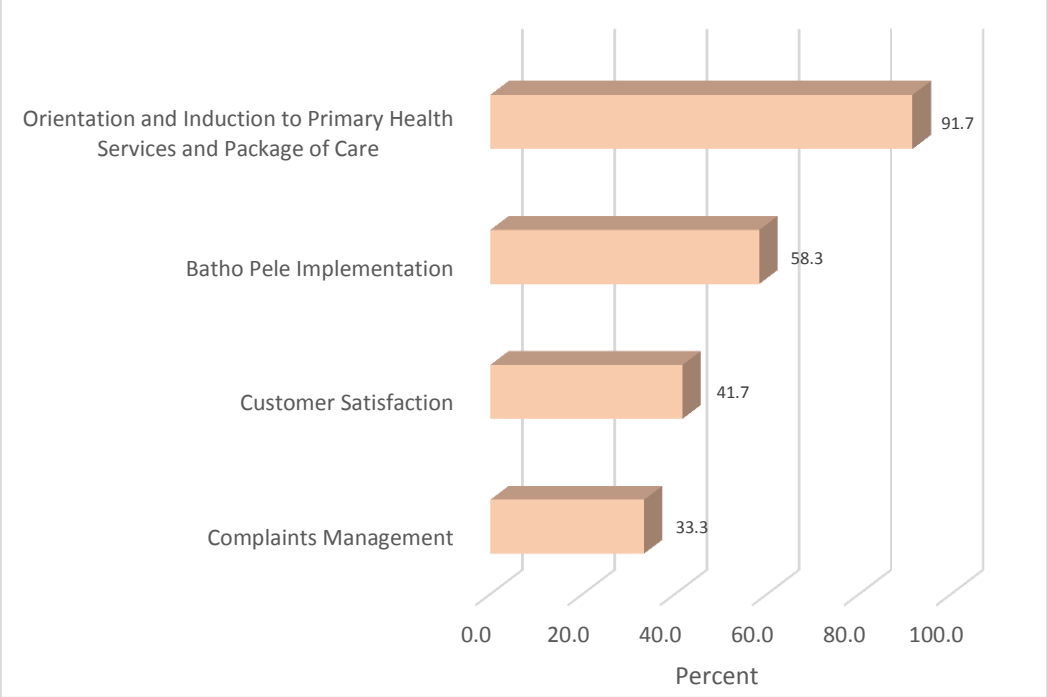
Management indicated that in some instances, they had received reports on negative staff attitudes and behaviour. This happened on average 27.3% of the time. The respondents indicated that attitude and behaviour of the health care workers influenced utilisation rate of mobile services. Emphasis is placed on 2 key aspects. *Firstly,* clients are aware of the complaints procedure and are able to voice their concerns to the appropriate channels for investigation and intervention. *Secondly,* training gaps are identified and corrective measures can be instituted to avoid recurrence of similar incidents.

Figure 4.19: Factors affecting utilisation rates



Nearly 60% of the respondents indicated that that they had no choice but to utilise the mobile health clinic irrespective of the negative factors because the service is only offered monthly.

Figure 4.20: Training afforded to health care staff



The most significant variable is Orientation and Induction to Primary Health Services and Package of Care (91.7%). The smallest percentage (33.3%) relates to Complaints management. This highlights the training gaps and will be noted and addressed in the in-service training programme.

Implementation/practice of Batho Pele Principles

Management (58.3%) believes that not all of the HCW are implementing Batho Pele correctly. There are higher levels of disagreement in Figure 4.23 (see in Batho Pele) by Management in terms of some aspects of the implementation especially in terms of accessibility and value-for-money (a key determinant for ensuring that resources are maximised for efficient, effective and economic service provision with emphasis in the context of this study for health care provision).

Impact of rendering health services within a Batho Pele Perspective

HCW and Management indicated high levels of agreement that the impact has been positive, even though there are limitations.

Training on Batho Pele done/required in order to improve services

Given the range of statements in the study, 8.3% of HCW indicated that they required more training regarding the Principles of Batho Pele. The majority of these HCW were newly appointed staff who have not undergone the orientation and induction programme. However, Batho Pele Principles and the implementation thereof will be addressed under the recommendations emanating from this study.

4.6 SECTION 4: Batho Pele

This section looks at the understanding of the respondents of the Batho Pele Principles.

Clients

Table 4.13: Interpretations – under Batho Pele Principles.

	Frequency	Percent
ACCESS		
free health services, have a right to good treatment, patients have a right to safe health care	39	19.2
COURTESY		
show respect, caring, pleasant staff, equal treatment, polite staff, love, provide fair treatment, to be kind to patients, be supportive, care for patients, treatment should be private	67	35.2
INFORMATION		
have rights, good information, health, staff provides good info, to bring life, to know your rights, give information, right to privacy, never heard of it, no knowledge of Batho Pele	21	10
SERVICE STANDARDS		
provide good service, service delivery to patients, first come first served, to give good care	11	5.5
REDRESS		
can complain, have rights to complain if not satisfied	2	1
VALUE FOR MONEY		
provide more services	1	.5
NO COMMENT	58	28.6
TOTAL	199	100.0

Majority of the clients understood the concept of “Batho Pele” as being the positive, caring and respectful attitude that is expected from HCW whilst performing their duties and which is incorporated in their Code of Conduct. This relates to the principle of Courtesy. The White Paper on Transforming

Public Service Delivery (Government Gazette No 18340, 1197: 18) states that the "Code of Conduct for Public Servants issued by the Public Service Commission makes it clear that courtesy and regard for the public is one of the fundamental duties of public servants." It is, therefore, expected that HCW treat citizens as clients who are entitled to receive the highest quality of service and health care. They should always strive to meet and exceed these expectations.

It is also evident from the above findings that the clients had a fair knowledge of the Batho Pele Principles although it was not directly mentioned as such. The need for getting information and receiving high standards and a total package of service was expressed through their responses. The Batho Pele Principle of "Providing more and better Information" emphasises that "*National and Provincial departments must provide full, accurate and up-to-date information about the services they provide, and who is entitled to them*" in terms of the Promotion of Access to Information Act.

Health Care Workers

All of the respondents indicated that they were mindful of the Batho Pele Principles. They all also agreed that these Principles have improved the quality of life of their clients. One of the services involves consultation and all respondents agreed that they engaged with clients regarding services provided. This discussion is reflected in the frequency tables attached as Annexure F2.

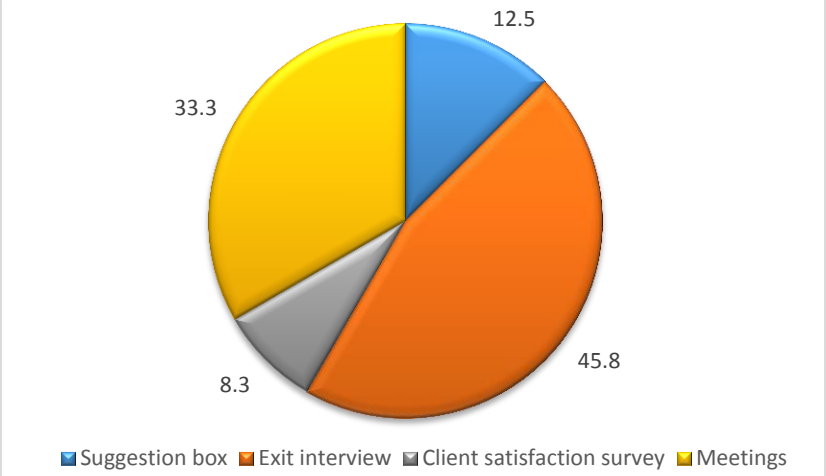
Another principle deals with confidentiality of the clients' information.

Table 4.14: Responses to privacy

	Frequency	Percent
IN VEHICLE		
back of van for shelter; doors are closed when counselling; from mobile vehicle; mobile vehicles are used to conduct HCT privately; sometimes go into mobile van or behind the parked van; this is a challenge; back of van	14	50.5
OUT OF VEHICLE/OTHER		
attend to one client at a time; client's house provides privacy for injections; consult far apart from each other; one to one consultation; patients are at home in our consulting rooms; talk softly, avoid interruptions; wards; closing curtains; covering patient with towels; gowns	10	49.5
TOTAL	24	100.0

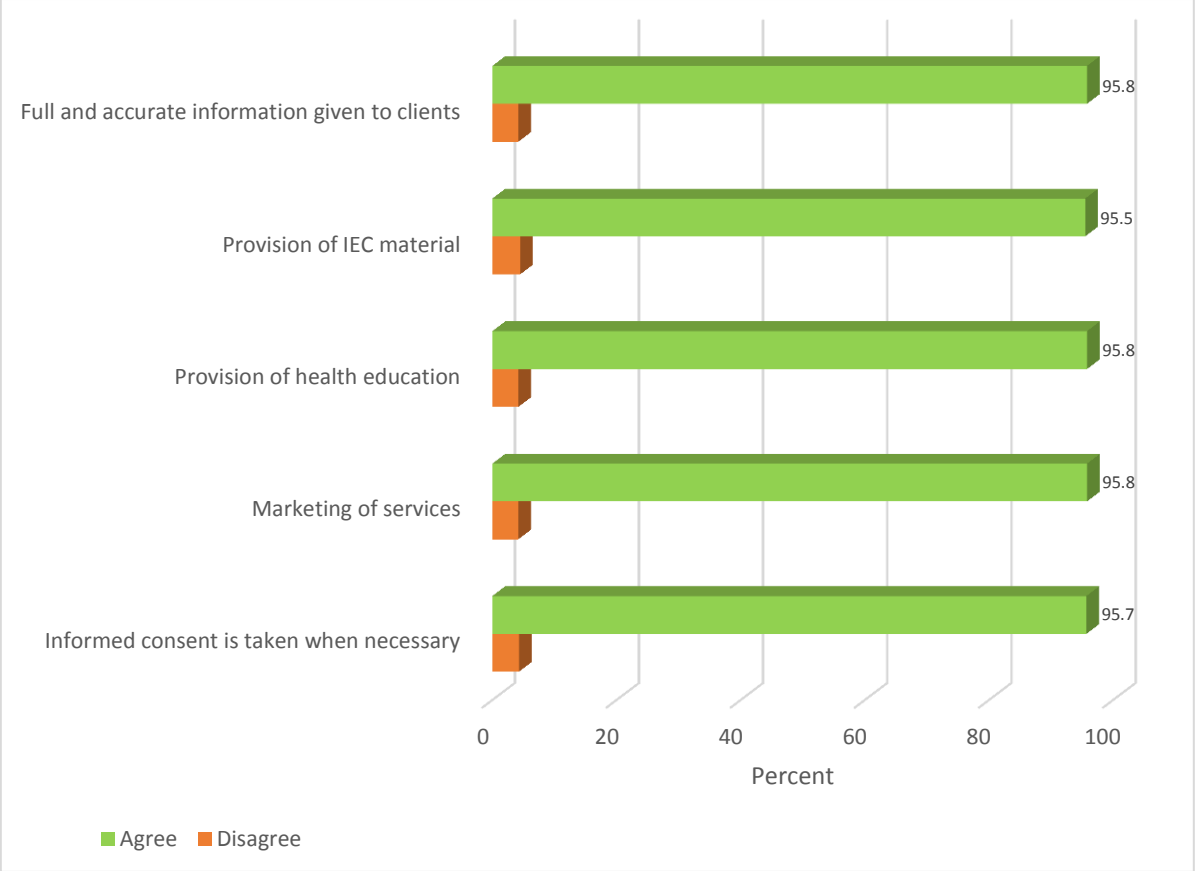
Maintaining privacy is a challenge in mobile health services due to the nature of how services are rendered. This is usually done under a tree or in the open fields where the mobile vehicle is located. The structurally modified vehicle is used for diagnostic screening procedures which require the use of the couch for ante-natal examinations. Only one client at a time can be accommodated through this method of operation. Despite this approach, HCW manages to seek alternative measures to maintain privacy as revealed in their responses.

Figure 4.21: Methods to obtain feedback from clients



Approximately 46% used exit interviews to obtain feedback. These interviews are done verbally and before the client exits the last service point. Client satisfaction surveys are conducted and reported on an annual basis in the Ilembe Health District, and therefore obtained the lowest score (8.3%) given its frequency.

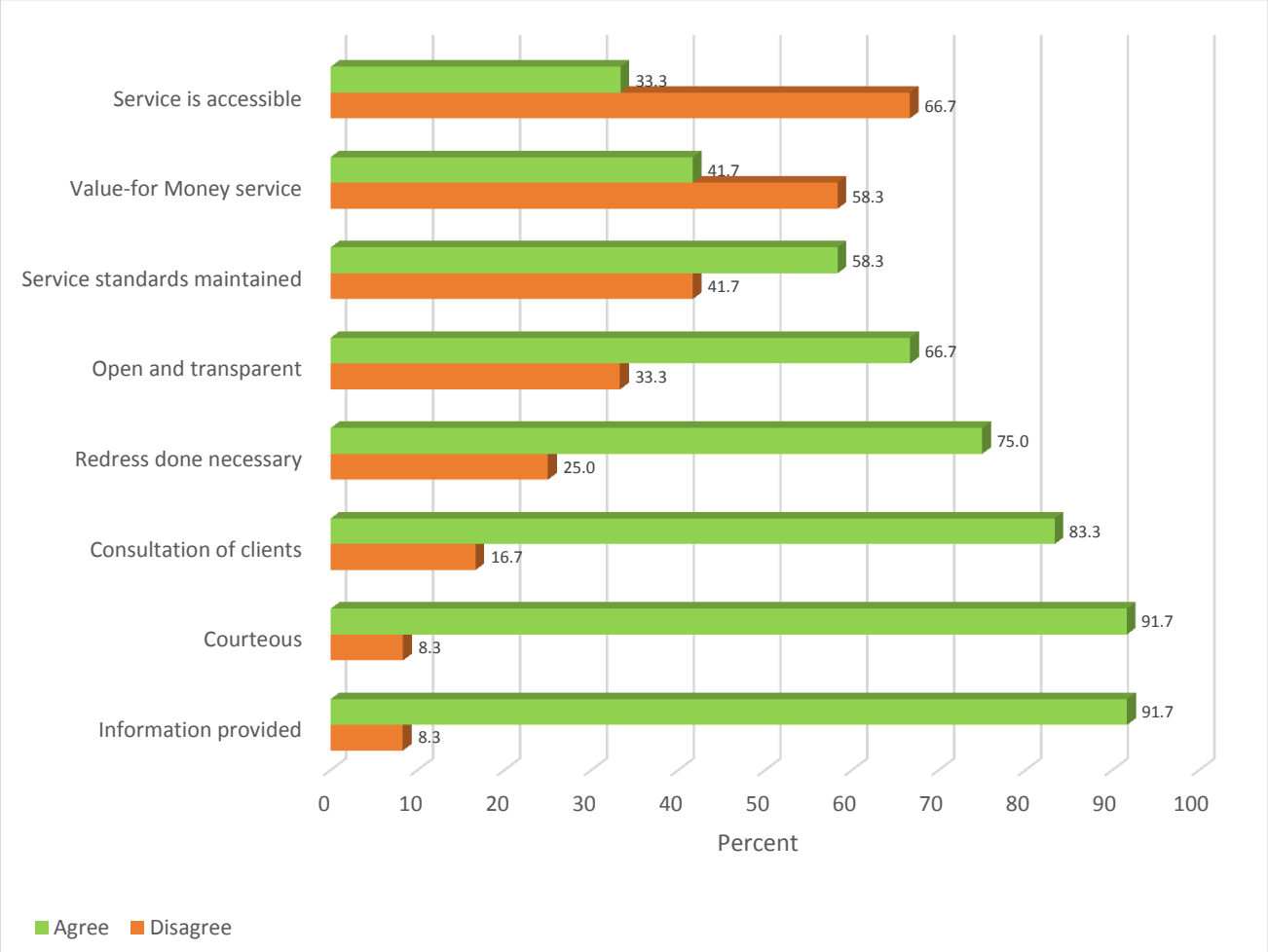
Figure 4.22: Information to and from clients



The average level of agreement in this section is 96%. Respondents believe that all of the statements are procedurally followed in terms of information collection and dissemination. Health education empowers health care users to make informed and appropriate health decisions. This view is supported by Koh, Berwick, Clancy, Baur, Brach, Harris and Zerhusen (2012: 1) who highlight the importance of health literacy as an improvement strategy aimed at "increasing access, improving quality, and better managing costs." They further affirm that if relevant health information is provided and prioritised then: "…health literacy can be advanced to the point at which it will play a major role in improving health care and health for all."

Management

Figure 4.23: Summarised scoring patterns



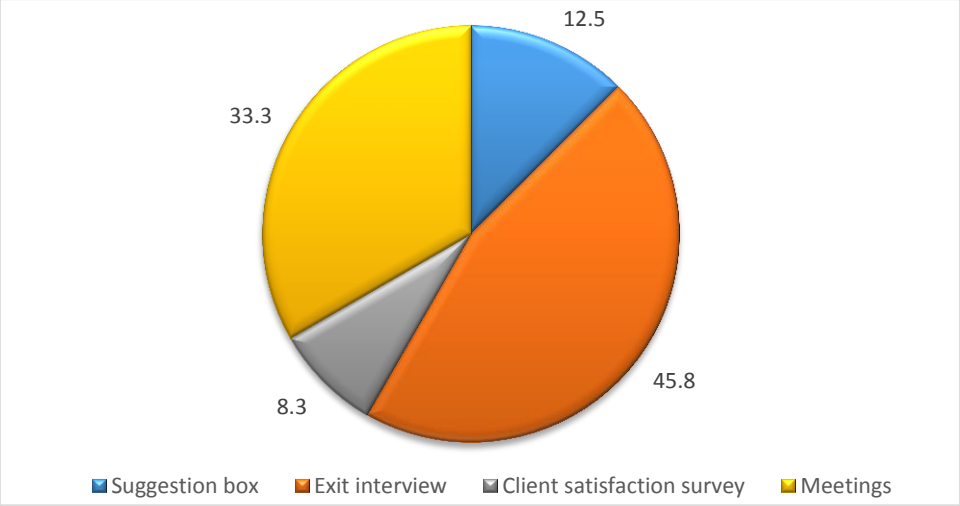
Management has the highest level of agreement (almost 92%) that HCW and the provision of mobile health service complies with the Batho Pele Principles of Information and Courtesy. This finding has significant implications for one of the key questions of the study; "What is the overall impact of mobile health services?" Having the necessary information is one of the most effective instruments at the clients' disposal which will enable him or her to exercise their right to high quality and a comprehensive health service. It will also require HCW to raise their levels of behaviour, ensuring increased levels of courtesy as seen above.

The variables: service is accessible and a value-for-money approach to services scored the highest levels of disagreement. Management acknowledges that there are some inequalities in the distribution and frequency of existing mobile health services. In this respect, the suggestions for improvement by HCW and clients are noted when setting targets to improve access to services. Quality Improvement Plans will continue to search for measures to improve efficiency and effectiveness of services provided within the current budgetary constraints.

Knowledge of Batho Pele

Clients and HCW had their own interpretations of what Batho Pele meant. In essence though, they both recognised that the People's First Principle does apply to the provision of health care services. Other factors were also included as per the tables (above).

Figure 4.24: Feedback mechanisms and redress



The HCW who are the "frontline" of service delivery use the feedback mechanisms given above to gain feedback from the clients. Management also indicated that consultations were done with clients regarding this. Verbal exit interviews conducted on clients and monthly staff meetings are the feedback mechanisms most widely used in the mobile health clinics. The findings are discussed in the meetings and action plan for improvements are implemented. The Operational Manager (OM) in

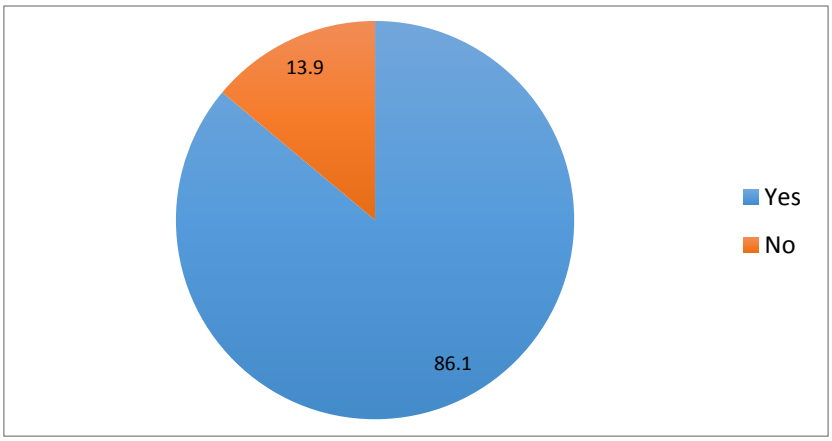
charge of the mobile health services is responsible to ensure that all staff is aware of the above. The PHC supervisor monitors and evaluates the performance of the OM.

4.7 SECTION 5: Impact of mobile health services

This section investigates whether the health needs of the community are met through the existing mobile health services provided.

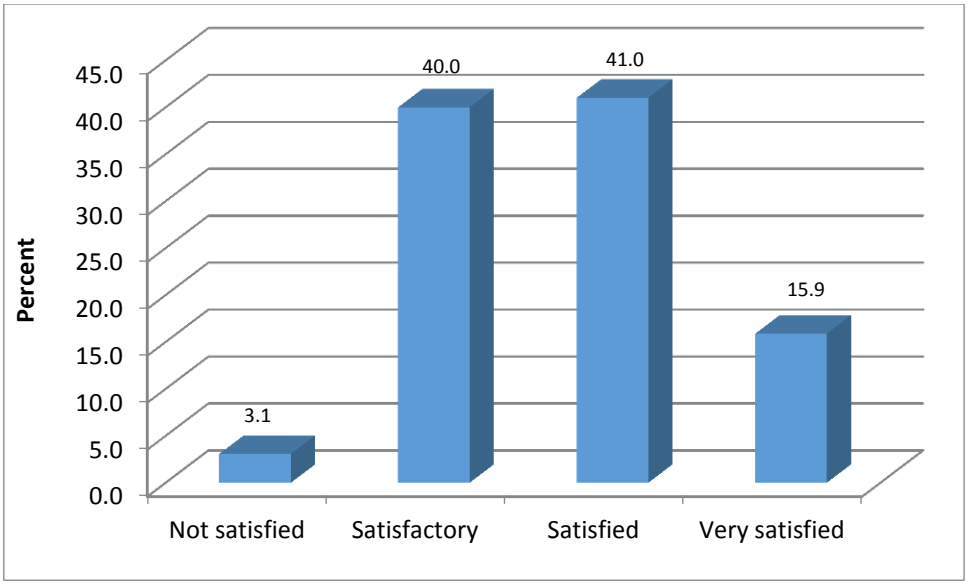
Clients

Figure 4.25: Perceptions of respondents on health needs



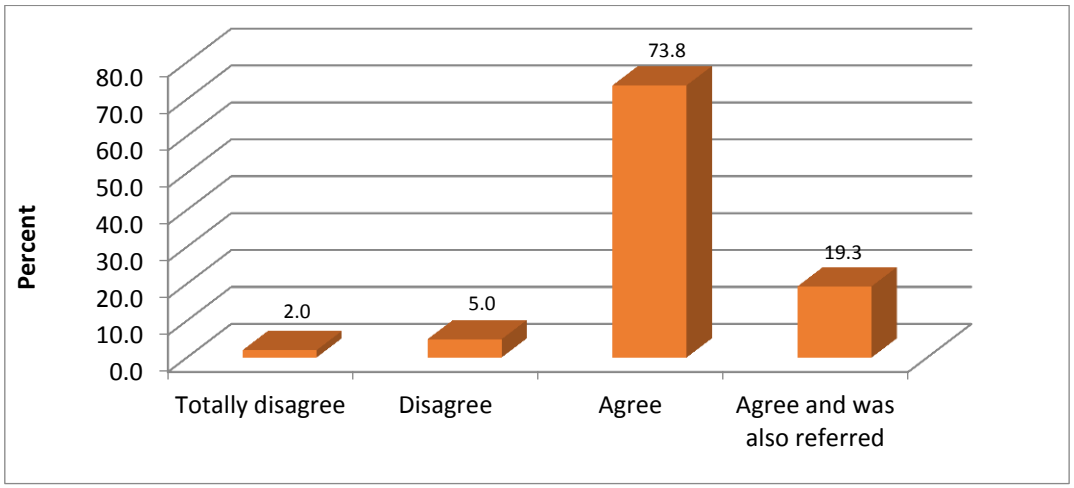
Approximately 86% of the respondents agreed with the statement. This implies that mobile health services are fulfilling the Primary Health Care Re-Engineering mandate of the National Health Council. The model consists of three streams: the PHC outreach teams of which mobile health care services are part of takes health services to the people. This is one of the significant 10 points in the Five Year Health Sector 10 Point Plan, noted as 'overhauling the healthcare system'. It is also the fourth pillar of the Negotiated Service Delivery Agreement as 'strengthening the effectiveness of the health system', (DOH, 2011: 1), and provides an important link to the overview of health care systems in this research study.

Figure 4.26: Level of satisfaction



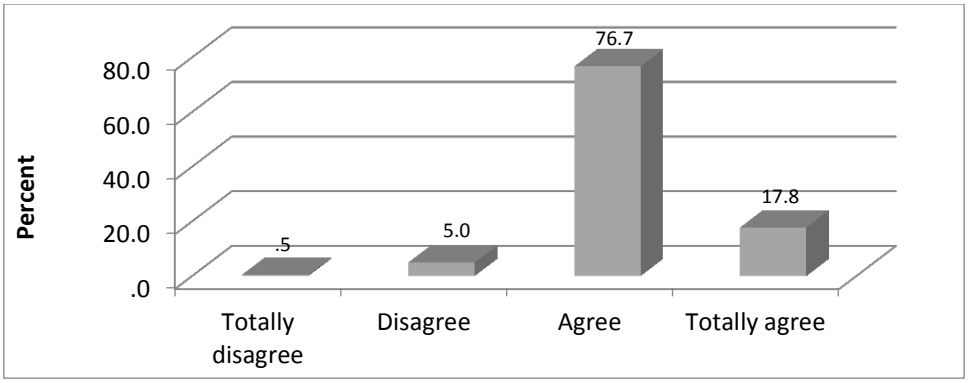
Approximately 3% were not satisfied, with 56.9% being satisfied with the services received. However, those clients not satisfied indicated that it was not because of the quality of services received on the day when they completed the questionnaire, but rather it was because of other factors, which are listed in their suggestions for improvement (as reflected in table 4.15).

Figure 4.27: Services and treatment options for respondents



All but 7% of respondents agreed that they were informed of other services available.

Figure 4.28: Recommendation of services by respondents



Less than 6% of the respondents disagreed with the statement.

Table 4.15: Suggestions to improve mobile health services

	Frequency	Percent
MEDICATION AND SUPPLIES		
prevent shortage of medication; medication should last for a month; provide medication on time; more medication to be available; like hospitals all medications should be provided; medication must be available	29	14.4
HUMAN RESOURCES		
more staff; more medication; doctors should be on time; nurses should be accompanied by doctors; staff should be well trained	35	17.4
MOBILE VEHICLES AND FACILITES		
provide more mobile vehicles; provide toilet facilities and shelter; build a fixed clinic; shuttle service	11	5.5
SERVICE STANDARDS AND SERVICE DELIVERY		
early morning visits; good health care provided; more regular visits; more services; provide better services; results should be confidential; arrive early; be punctual; promote services during weekends; provide x-ray services; to change venues; visit thrice a month; waiting times	40	20
RESPECT AND COURTESY		
treat with respect; friendly staff; staff nurses should be more tolerant; improve attitude; improve privacy	31	14.6
NONE	19	9.4
NO COMMENT	38	18.7
TOTAL	203	100.0

Health Care Workers

This section rates the overall impact of mobile clinics by HCW.

Table 4.16: Health needs met

	Frequency	Percent
Yes	18	75.0
No	6	25.0
TOTAL	24	100.0

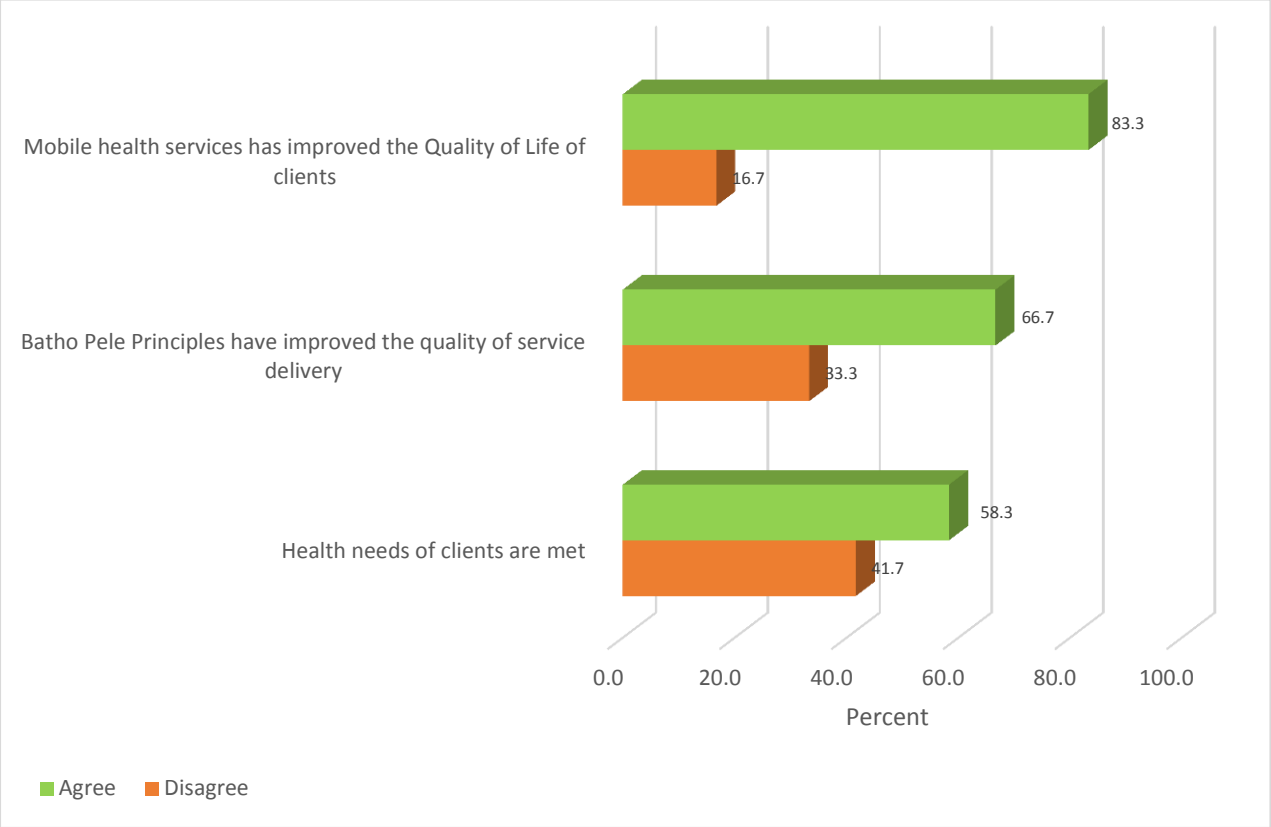
Three-quarter of the respondents believe that the health needs have been met.

Table 4.17: Respondents suggestions for improvement of mobile health services

	Frequency	Percent
Community meetings with other public service dept.	1	4.17
Doctor to visit mobile point at least once a quarter	1	4.17
Doctors, Dieticians & Dental services should also be provided. Only Physio & OT is provided at clinic	2	8.33
Increase staff and professional nurses; more updates; another team; allowances for enrolled nurses	6	25.00
mobile vehicles need to be improved	5	20.83
More equipment & marketing is needed for the different health professionals	1	4.17
More staff, equipment, shelters, screens	1	4.17
Shelters should be provided at mobile points	6	25.00
NIL	1	4.17
TOTAL	24	100.00

Management

Figure 4.29: Responses of management to impact of the services



The levels of agreement decrease from the first to the third statements. Respondents believe that even though the mobile clinics do improve the quality of life, almost 42% of them hold the view that it has not fully met their needs. They have provided suggestions for improvement (see table 4.15), which are significant for Ilembe Health District.

Table 4.18: Suggestions for improving services of the mobile clinics

	Frequency	Percent
Current mobiles are not conducive to weather	1	8.3
Doctors to accompany mobile teams; improve package of services offered	1	8.3
Employ passionate staff; offer rural allowance; procure quality equipment	1	8.3
Get vehicles that provide privacy; improve road infrastructure; employ more staff; more supplies	1	8.3
Increase access points; improve training of staff	1	8.3
Increase staff & mobile vehicles; doctors to be present,	4	33.2
Upgrade gravel roads; increase frequency of mobile visits	2	16.6

Are mobile health services assisting in the delivery of health services/bringing services closer to the people?

All three categories of respondents believe that there has been an improvement in the delivery of Health Services by the introduction of the mobile service computed as follows:

- Clients – 86.1%
- HCW – 75%
- Management – 66.7%

It is evident that management levels are lower than that of the other two categories.

4.8 CORRELATIONS

Bivariate correlation was also performed on the (ordinal) data. The results are found in Annexure F (F1: Management, F2: HCW and F3: Clients).

The results indicate the following patterns.

Positive values indicate a directly proportional relationship between the variables and a negative value indicates an inverse relationship. All significant relationships are indicated by a * or **. Negative values imply an inverse relationship. That is, the variables have an opposite effect on each other. The correlations are reflected as follows:

Clients

- Positive correlation

The correlation value between **"Distance from health service in km" and "Travelling Time" is 0.746.** This is a directly related proportionality. Respondents agree that the further they stayed from the service point, the longer they had to travel, and *vice versa.*

Table 4.19: Correlation – Utilization of health care services: Classification of client and influence of attitude and behaviour of the health care workers

			Classification of client		Total
			First visit	Repeat visit	
Does the attitude and behaviour of the health care workers influence your utilisation of the health care services?	Yes	Count	23	50	73
		% of Total	11.4%	24.9%	36.3%
	No	Count	16	92	108
		% of Total	8.0%	45.8%	53.7%
	No other choice	Count	3	17	20
		% of Total	1.5%	8.5%	10.0%
Total		Count	42	159	201
		% of Total	20.9%	79.1%	100.0%

The correlation value is 184. This is a directly proportional relationship. That means, as one variable increases, so does the other. The relationship for "Frequency" was significant with two variables: "Does the attitude and behaviour of the health care workers influence your utilisation of the health care services?" (r = -.178) and "I would recommend the health service" (r = .194).

Table 4.20: Frequency – Attitude and behaviour of health care workers on health care services

			Frequency		Total
			Monthly	First time	
Does the attitude and behaviour of the health care workers influence your utilisation of the health care services?	Yes	Count	47	23	70
		% of Total	25.3%	12.4%	37.6%
	No	Count	82	16	98
		% of Total	44.1%	8.6%	52.7%
	No other choice	Count	15	3	18
		% of Total	8.1%	1.6%	9.7%
Total		Count	144	42	186
		% of Total	77.4%	22.6%	100.0%

The more frequent the visits, the less the negative attitudes of the staff affect the clients. This contributes to the satisfaction of the clients' needs and health care requests.

- Negative correlation

The correlation value between **"What is your level of satisfaction with the package of health care services received?" and "Age Cohort" is -0.155.** Respondents indicate that the younger the patients, the more satisfied they were with the service, and *vice versa.*

Table 4.21: Frequency – Recommendation of health care services

			Frequency		Total
			Monthly	First time	
I would recommend the health service	Totally disagree	Count	1	0	1
		% of Total	0.5%	0.0%	0.5%
	Disagree	Count	9	1	10
		% of Total	4.8%	0.5%	5.3%
	Agree	Count	115	28	143
		% of Total	61.5%	15.0%	76.5%
	Totally agree	Count	20	13	33
		% of Total	10.7%	7.0%	17.6%
Total		Count	145	42	187
		% of Total	77.5%	22.5%	100.0%

The more frequently the clients use a facility, the more likely they are to recommend the services. The value between "Were your health needs met by the provision of the mobile health services?" and "Description of staff attitude" is -.238**. The more

negative the staff attitude is, the less likely the health needs would be met by the provision of the mobile health services.

Health Care Workers

- Positive correlation

The correlation value between **"Batho Pele Principles have improved Quality of Life of clients using the services" and "Consultation" is 0.676**. This implies that the frequency of consultations plays an influential role in contributing to the demonstration of the Principles of Batho Pele thereby improving health care. The value between **"On average, what is the duration spent at this mobile point?" and "Based on statistics, how frequently do you think this mobile point needs to be serviced?" is .818.** The more time that is spent at the mobile clinic, the more frequently the mobile point needs to be serviced.

- Negative correlation

The correlation value between "Were the health needs met by the provision of the mobile health services?" and "Mechanisms used to receive feedback from clients" is -0.523. This finding implies that as the health needs of clients are being met, there will be greater satisfaction with health services; therefore fewer mechanisms are needed to guage feedback.

Management

- Positive correlation

There is a positive correlation between "Redress done necessary" and "Incidents of negative staff attitude or behaviour reported by clients within the past year?" is 0.770. This indicates that the more instances of negative reports that emerge, the more redress will be done and vice versa.

Table 4.22: Cross tabulation – Consultation of clients: human resources

			Human resources		Total
			Teams do not serve all points	Shortage	
Consultation of clients	Disagree	Count	1	1	2
		% of Total	10.0%	10.0%	20.0%
	Agree	Count	8	0	8
		% of Total	80.0%	0.0%	80.0%
Total		Count	9	1	10
		% of Total	90.0%	10.0%	100.0%

Information provided" shows two significant correlations with Courteous (.739**) and Mobile health services has improved the Quality of Life of clients (.739**). The more courteous the HCW were resulted in more information that was provided, resulting in an improvement of the quality of care and the quality of life of the clients.

The correlation value between "Health needs of clients are met" and "Open and transparent" is .824. Openness and Transparency are key determinants for addressing clients' needs in relation to health care in particular and public service delivery in general. All of the other values are not significantly correlated. That means that the variables do not affect the outcomes in each other.

- Negative correlation

There is a negative correlation between "Incidents of negative staff attitude or behaviour reported by clients within the past year?" and "Mobile health points" is -0.770. This is an inverse relationship. Provision of increased service points will reduce the number of complaints surrounding service delivery in mobile clinics

The correlation value between Package of Services provided *** Management Position is -.645***. This is an inverse relationship. That is, managers at different levels favour different packages of services provided.

Table 4.23: Distribution

			Management Position						Total
			Chief Executive Officer	Medical Manager	Nursing Manager	Assistant Nurse Manager	Primary Healthcare Supervisor	Other	
Package of services provided	Limited	Count	0	1	0	0	1	4	6
		% of Total	0.0%	8.3%	0.0%	0.0%	8.3%	33.3%	50.0%
	Basic PHC services	Count	1	0	2	3	0	0	6
		% of Total	8.3%	0.0%	16.7%	25.0%	0.0%	0.0%	50.0%
Total		Count	1	1	2	3	1	4	12
		% of Total	8.3%	8.3%	16.7%	25.0%	8.3%	33.3%	100.0%

The correlation value between **Human Resources availability and the Batho Pele Principle regarding Consultation of clients is -.667*.** This is also an inverse relationship. This implies that more clients agree that fewer teams are servicing all points.

4.9 CONCLUSION

Presentation, analysis and a discussion of the key findings was the focus of this chapter. The interpretations of the data were linked to the key objectives and questions of the study. The empirical study revealed, through the data analysis, that managers, HCW and clients agree that although mobile health services are delivered in relation to Batho Pele Principles, there are still various challenges that exist, and therefore there is room for improvement. The following and last chapter of the study will present the conclusion and recommendations arising from the study based on the interpretations of the data obtained from the questionnaires and from the previous chapters, as well as the opportunity for further research that is congenial to the salient aspects of the overall study.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

"At a broader level, we will enter a new phase in the implementation of the National Health Insurance programme which will extend quality healthcare to the poor."

(President Jacob Zuma, State of the Nation Address: 2014)

5.1 INTRODUCTION

South Africa faces an ongoing struggle in transforming its public health care delivery system; not only to meet but also to exceed citizens' expectations of high quality health care but also to improve in critical health care indicators and outcomes linked to the United Nation's Millennium Development Goals (MDGs), the Minister of Health's National Service Delivery Agreement (NSDA) and the Department of Health's (DOH) strategic intent based on the Annual Performance Plan (APP). The Office of the Health Standards Compliance (OHSC) has developed a set of National Core Standards (NCS) which sets the benchmark for safe, high quality health care within the public health facilities in line with the implementation of the National Health Insurance (NHI) for which funding has been set aside as conditional grants as revealed in Minister Pravin Gordhan's 2014 budget speech. Six priority areas which are linked *inter alia* with the eleven Batho Pele Principles have been identified *viz:*

- Improving staff values and attitudes;
- Decreasing waiting times;
- Ensuring patient safety;
- Ensuring environmental hygiene and cleanliness;
- Infection prevention and control and
- Ensuring the availability of medicines and supplies

To this end and to fulfil the aspirations in the Freedom Charter, the Patient's Rights Charter and the Mission of the DOH, "*to develop a sustainable, co-ordinated, integrated and comprehensive health system at all levels, based on the primary health care approach through the district health system*", as well as the findings of the empirical study, this chapter presents the conclusion and the recommendations.

5.2 SUMMARY OF CHAPTERS

Objectives of the study were met through the undertaking of a detailed literature review. Salient ideas relating to Batho Pele and health service delivery within a Primary Health Care (PHC) perspective were located in current public administration and management prose, relevant theories and social research studies. The general purpose of this study aimed to examine the impact and efficacy of mobile health services within a Batho Pele perspective at the designated mobile health service points.

It is evident from the study carried out that the efficient, economic and effective delivery of health services is a multi-disciplinary and co-ordinated approach that involve clients' participation and feedback, as well as that of health service management and health care workers, to ensure that it is one of high quality and meets the health needs of the target population. To this extent, causal factors in the improvement of health care services as well as the mobile health clinics of the existing PHC system, have become the variables among which correlations been theoretically and conceptually formulated. The discussion that ensues outlines the succinct issues of the preceding chapters in this research study.

Chapter One introduced, provided an overview of and defined the key concepts, the study area and the context of the study which is based on the PHC comprehensive package of services. This chapter outlined the key objectives and questions of the study. The Batho Pele Principles and ethos was also discussed. The research methodology, design and data collection presentation of the empirical study was also discussed.

Chapter Two provided an insight into the Batho Pele framework which is the corner stone to a citizen-centred approach to service delivery, the development and implementation of health policies and the transformation of health services. It conceptualised and contextualised Public Administration from a health perspective and described the legislative framework from which the delivery of health services derives its mandate.

In *Chapter Three*, Public Health was located from a policy perspective; Operation Sukuma Sakhe as a platform for inter-governmental stakeholder collaboration and the Exposition of the 5-C Protocol in policy implementation were described from a

Batho Pele and health dimension. A comparative account of Public Health outlined successes and challenges within the system.

Data was presented and analysed in *Chapter Four* using various statistical tools. Figures and tables were used to visually present data and concise explanations relating thereto were rendered. Testing for statistical significance and triangulation of results were performed. The calculated values of the test statistics and the levels of significance are also presented in the chapter. Positive and negative correlations were made to key findings in the study.

The *Fifth* and concluding Chapter derives the conclusion from the literature review and the empirical study and recommendations are made. Areas for improvement from the statistical analyses in the previous chapter are grouped as themes for the recommendations to the research problems and key questions presented in Chapter One. The findings of the research show that whilst health services are rendered within limited resources, certain Batho Pele Principles are adhered to more evidently than others. Improving Service Standards and ensuring a Value-for-Money service can be improved with the recommendations put forward.

5.3 KEY FINDINGS OF THE STUDY

- **Resources for the provision of a comprehensive package of PHC service**

Adequate human, financial, material (surgical supplies and equipment) and physical resources are necessary to ensure that service standards and high quality services are rendered. All possible resources that are necessary for health service provision should be made available to ensure a standard of service delivery that not only meets but surpasses clients' expectations. This requires appropriate financial planning, trained staff, a conducive environment which promote Patient's Rights and adequate number of mobile health vehicles to create an enabling environment for service provision. The study revealed that there is gross shortage of mobile health vehicles, hence there are only monthly visits conducted to the existing mobile service points, and it is, therefore, futile to add more service points.

- **Access to mobile health services**

Access to services is hindered because of the following identified factors: there are insufficient mobile health vehicles and accompanying mobile teams to provide the required health service; there are inadequate mobile health service points evident by the lengthy travelling distance to the existing points and due to underdeveloped infrastructure which is mainly foot paths and uneven gravel road which become totally inaccessible during and after rain. Ensuring an equitable distribution of health services is a prerogative of the Government and needs considerable attention in order to ensure that citizens who live in deep rural areas are still not being disadvantaged.

- **Training and development**

Although the study revealed that most of the respondents experienced a positive and caring attitude shown towards them and that HCW were providing them with necessary information, this accounts for only two (*ensuring courtesy* and *providing information*) of the eleven Batho Pele Principles being implemented to the desired standard. Management further agreed that other Batho Pele Principles *viz* "*accessibility* and *value-for-money*" was poorly implemented. HCW responded with the lowest level of agreement regarding having received formal training on Batho Pele. It is, therefore, evident that Batho Pele is yet to be internalised and externalised fully by HCW to deliver a high quality service which meets the service standards spelt out in the vision and mission statements of the Health District.

- **Conceptual analysis of Batho Pele**

Clients associated the concept of Batho Pele as that of HCW displaying a positive and caring attitude towards them whilst protecting their dignity during the execution of their duties. This emphasises the need for upholding the Patient's Rights Charter and the Code of Conduct. HCW, although not formally trained, understood the impact of abiding to the Bill of Rights as enshrined in the Constitution and were

found to be making a concerted effort within the constraints to ensure that services were rendered within a Batho Pele perspective.

However, in order to bridge the gaps identified in the empirical study, to improve the service delivery by mobile health services and to strengthen existing processes, the following recommendations are made, based on reliable knowledge as described in Fox, Schwella & Wissink (1991: 296).

5.4 CONCLUSION

The research study has attempted to explore, from clients' viewpoints, the impact of the existing mobile health services in meeting their health needs. The Batho Pele perspective was used as foundation on which health service delivery was rated. It was revealed that whilst health services are available, there is still room for improvement to meet service standards. To instil a spirit of *diakonia* and a culture of ensuring high quality service delivery in HCW and public officials is a challenging yet critical issue in order to meet the mandate of the Government and the Department of Health. It is ultimately necessary that policies are implemented properly, and monitoring and evaluation continue in order to deliver health services to the citizens that is equitably distributed, and have the desired impact through all possible means.

5.5 RECOMMENDATIONS

- **Formulate Quality Improvement Programmes (QIPs) to address shortage of supplies and equipment**

Shortage and/or the unavailability of medication, surgical supplies and necessary equipment for the monitoring of vital signs as well as the lack of furniture *eg* foldable chairs were identified by HCWS and clients in the study as limiting factors for the provision of quality health services by mobile health teams. These are challenges that have a high impact on service delivery but require low to medium resources that can be addressed in QIPs and be easily corrected. Continuous monitoring and

evaluation of identified actions and set timeframes need to be carried out by the Operational Manager and PHC Supervisor to ensure that these identified issues are addressed and to request interventions from higher authorities where necessary. Ensuring *adequate medication and availability of supplies* is one six priority areas identified by the MEC for Health Dr S. Dlomo for the improvement of services. On-going audits, as well as feedback from HCW and clients are essential to ensure compliance to this priority area through QIPs.

- I**ntegration of Batho Pele in the Strategic Planning Process**

The strategic position of the National and Provincial Department of Health is the basis of the District's strategic planning process. The National Health Insurance, NSDA and Ten Point Plan relate to the overhauling of health services through PHC re-engineering to improve quality in the District Health System (DHP 2013/14: 10). The vision, mission and goals of the District and the attainment thereof assist the Department of Health in fulfilling its mandate to the citizens. Therefore, this calls for a should be a strong commitment to adherence to Batho Pele as stipulated within the Batho Pele framework and SDIP in the strategic planning process. This subsequently, ensures leadership accountability and that it is not construed as an optional add on but instead as an integral value upon which service delivery is based. This recommendation inevitably leads to the following one.

- **Synergizing Batho Pele and Employee Performance Management and Development System (EPMDS)**

Service delivery in the Department of Health is driven by the guiding principles of the Patient's Rights Charter, KwaZulu-Natal Citizen's Charter, the Department's mission and vision, Code of Conduct and within the realms of the Batho Pele Principles. It is, therefore, imperative, that HCW and management alike embrace Batho Pele as a key result area to report on for EPMDS. This would ensure that responsibility and accountability for the implementation thereof is managed appropriately, and address the aspect of integration which is currently absent in EPMDS.

- **Integrated Development Planning (IDP) and stakeholder collaboration**

The New Public Management paradigm encourages intersectoral collaboration between the various Government departments, Public Private Partnerships and with Non-Governmental Organisations. Infrastructure development, specifically the development of roads is competency of the department of transport together with the local municipality, however, if there is no access to health services there is a negative impact on the health status on the community. It is, therefore, vital that these issues need to be presented during the IDP planning sessions where all stakeholders are represented and planning at a strategic level occurs. Increasing accessibility through infrastructure development is a focal area in the current political dispensation in realising the goal of promoting a better life for all.

- **Revitalisation of the Batho Pele training programme**

Variables under the category “Training and Development” relate to elevating the levels of awareness and practice of Batho Pele and the finding revealed a training gap. The recognition that the Batho Pele Principles is the fundamental embodiment of the Service Delivery Improvement Plan (SDIP) leaves no doubt that knowledge thereof, the implementation and monitoring should be executed effectively and through a rigorous training, development and mentorship programme targeting all categories of HCW, clients and families where possible. To ensure that service standards are upheld and constantly raised, Batho Pele should be internalised and externalised by both service providers and health service users. Batho Pele campaigns should be an on-going event which could only enhance the implementation of the Batho Pele framework. Training should also include management skills for effective supervision, monitoring and evaluation as well as customer care.

- **Improved marketing of mobile health services**

These services form an extension of the hospital and the fixed clinics within the allocated sub-district. Performance indicators and health outcomes are determined from collated data from these services. Therefore, endeavours to market the package of services should be made at every available opportunity. Forums such as the Sukuma Sakhe Local Task Team meetings, imbizos, during community dialogues and health awareness days, amongst others, provide an ideal opportunity for the marketing of this service. Clients should be encouraged to seek health care at the health facility closest to them, be it the mobile health service or the fixed clinic. The target population should include both the young and older people who could benefit from this preventative and promotive health service.

- **Areas for further research**

There are numerous programmes that are being rolled out to mobile health clinics as part of the PHC package of care. Down referral of clients from hospitals to fixed clinics and identified sites in the community for the collection of chronic medication including anti-retroviral medication, places greater need for health education and monitoring and evaluation by HCW to ensure compliance and timeous follow up. Mobile health services are part of this broader picture in health service delivery as they delve into the areas closest to where clients work and reside. Evidently, there is therefore a need to evaluate the impact of the different services offered by mobile health services in improving key health indicators. This could also necessitate the development of appropriate assessment tools which could be an area of research on its own.

"Improving the public service delivery is not a once-off exercise. It is an ongoing and dynamic process, because as standards are met, they must be progressively raised."

(White Paper on Transforming Public service Delivery, 1997: 30)

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ANNEXURES

ANNEXURE A

health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM 52/14
Enquiries : Mr X Xaba
Tel : 033 – 395 2805

Dear Mrs R. Sahadeo

Subject: Approval of a Research Proposal

1. The research proposal titled **"Impact of mobile health services within Ilembe health district: A Batho Pele perspective"** was reviewed by the KwaZulu-Natal Department of Health.

   The proposal is hereby **approved** for research to be undertaken at the Mobile health service points in the rural area of Maphumulo sub district.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

Dr E Lutge

Dr E Lutge
Chairperson, Health Research Committee
Date: 12/03/2014.

ANNEXURE B

health

Department:
Health
PROVINCE OF KWAZULU-NATAL

ILEMBE HEALTH DISTRICT OFFICE
OFFICE OF THE DISTRICT MANAGER
1st Floor OK Mall, Kwa Dukuza, 4450
Private Bag X 10620, Kwa Dukuza, 4450
Tel.: 032 4376 500 Fax.: 032 5511590/2
Email.:sibongile.dube@kznhealth.gov.za
www.kznhealth.gov.za

Reference: Research Dissertation
Enquiries: Ms S. D. Dube

01 March 2013

The Principal Researcher
Mrs R. Sahadeo
Ilembe Health District Office

Madam,

RE: PERMISSION TO CONDUCT RESEARCH WITHIN ILEMBE HEALTH DISTRICT

I have pleasure in informing you that permission has been granted to you to conduct research on: Impact of mobile health services within Ilembe Health District: A Batho Pele Perspective.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.

2. This research will only commence once this office has received confirmation of your ethical clearance.

3. Please ensure this office is informed before you commence your research.

4. The District Office will not provide any resources for this research.

5. You will be expected to provide feedback on your findings to the District Office Management team.

Thank you

Yours sincerely

Ms S. D. Dube
District Manager: Ilembe Health District

ANNEXURE C

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

02 September 2013

Mrs R Sahadeo
P.O Box 1080
Stanger
4450
samir@mweb.co.za

Dear Mrs Sahadeo

PROTOCOL: Impact of mobile health services within Ilembe Health District: A Batho Pele Perspective. REF: BE281/13.

EXPEDITED APPLICATION

A sub-committee of the Biomedical Research Ethics Committee has considered and noted your application received on 24 July 2013.

The study was provisionally approved pending appropriate responses to queries raised. Your responses received on 27 August 2013 to queries raised on 27 August 2013 have been noted by a sub-committee of the Biomedical Research Ethics Committee. The conditions have now been met and the study is given full ethics approval and may begin as from 02 September 2013.

This approval is valid for one year from **02 September 2013.** To ensure uninterrupted approval of this study beyond the approval expiry date, an application for recertification must be submitted to BREC on the appropriate BREC form 2-3 months before the expiry date.

Any amendments to this study, unless urgently required to ensure safety of participants, must be approved by BREC prior to implementation.

Your acceptance of this approval denotes your compliance with South African National Research Ethics Guidelines (2004), South African National Good Clinical Practice Guidelines (2006) (if applicable) and with UKZN BREC ethics requirements as contained in the UKZN BREC Terms of Reference and Standard Operating Procedures, all available at http://research.ukzn.ac.za/Research-Ethics/Biomedical-Research-Ethics.aspx.

BREC is registered with the South African National Health Research Ethics Council (REC-290408-009). BREC has US Office for Human Research Protections (OHRP) Federal-wide Assurance (FWA 678).

The sub-committee's decision will be **RATIFIED** by a full Committee at its next meeting taking place on **08 October 2013.**

We wish you well with this study. We would appreciate receiving copies of all publications arising out of this study.

Yours sincerely

Professor D.R Wassenaar
Chair: Biomedical Research Ethics Committee

ANNEXURE D

UNIVERSITY OF KWAZULU-NATAL (UKZN)
SCHOOL OF MANAGEMENT, IT AND GOVERNANCE
DISCIPLINE: PUBLIC GOVERNANCE

INFORMATION SHEET AND CONSENT TO PARTICIPATE IN RESEARCH

Good day,

My name is Roshilla Sahadeo. I am a Master of Public Administration student, at the School of Management, Information Technology and Governance, of the University of KwaZulu-Natal, Westville campus. I am employed by the Department of Health, at the Ilembe Health District Office. My contact details are as follows:
Telephone: (032) 4373 500 during office hours
Cellular phone: 083 469 7918
Email address: samir@mweb.co.za/roshilla.sahadeo@kznhealth.gov.za
My study supervisor is Dr M Subban, her contact number is (031) 260 7763.

You are being invited to consider participating in a study that involves research in a project entitled Impact of mobile health services within Ilembe Health District: A Batho Pele Perspective.

The aim of this study is to determine whether the health needs of the rural people are being met, within a Batho Pele perspective, through provision of the existing mobile health services. The study is expected to enroll 234 participants (Health Service Management 10, Mobile Health Service Personnel 24 and Clients from the Maphumulo sub-district 200). Health service management comprises of the two PHC supervisors, two Nursing Service Managers, two Assistant Nurse Managers responsible for the Out Patient Departments, two Chief Executive Officers and two members of the District Executive team. All of the four mobile health service staff will be sampled and 200 clients will be sampled drawn from 50% of the 59 mobile health service points surrounding Umphumulo and Untunjambili hospitals within Maphumulo sub-district in Ilembe Health District. Your participation would involve answering questions outlined in the respective questionnaire which should take about 15 minutes to complete. There is no identified risk and/or discomfort in your participation. This study is funded by myself.

Through your participation I hope to assess the implementation of the Batho Pele Principles in the provision of health service delivery rendered by mobile health services. The results of the survey are intended to identify challenges and propose suggestions to ensure that the health services rendered are of a high

quality service to meet clients' expectations. The study will provide no direct benefits to participants.

Your participation in this study is voluntary. You may refuse to participate or withdraw from the study at any time with no penalty or loss of future treatment or any other benefit that you may be entitled to from the Department of Health. There will be no monetary gain from participating in this survey. Confidentiality and anonymity of records identifying you as a participant will be maintained by the Management, Information Technology and Governance, UKZN. Completed questionnaires will be stored in a lockable cupboard for a period of 5 years, following which it will be shredded and discarded. Research data will be converted into PDF format, bound into a book as well as into a CD rom which will be stored in the library at UKZN.

This study has been ethically reviewed and approved by the UKZN Biomedical research Ethics Committee (approval number BE281/13).

In the event of any problems or concerns/questions you may contact the researcher (contact details as stated above) or the UKZN Biomedical Research Ethics Committee, contact details as follows:

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604769 - Fax: 27 31 2604609
Email: BREC@ukzn.ac.za

Sincerely

Researcher's Signature .....

Date .....

CONSENT

I, ...(name of participant) have been informed about the study entitled Impact of mobile health services within Ilembe Health District: A Batho Pele Perspective by ..... (name of researcher/fieldworker).

I understand the aim and purpose of the study. I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any treatment or care that I would usually be entitled to.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at Telephone: (032) 4373 500 during office hours, Cellular phone: 083 469 7918 or via email at samir@mweb.co.za or roshilla.sahadeo@kznhealth.gov.za. I may also contact the study supervisor, Dr M Subban, on (031) 260 7763.

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604769 - Fax: 27 31 2604609
Email: BREC@ukzn.ac.za

Signature of Participant	Date
Signature of Witness	Date
Signature of Translator (Where applicable)	Date

ANNEXURE E_1

Questionnaire – Health Services Management

Kindly provide the following information as accurately as possible.

SECTION 1 – Biographical Details

1.1. Management Position

Chief Executive Officer	
Medical Manager	
Nursing Manager	
Assistant Nurse Manager	
Primary Healthcare Supervisor	

SECTION 2 – Mobile Health Services

2.1. **Accessibility**: Provision of mobile health services

Insufficient	Meets minimal service provision	Sufficient

2.2. **Accessibility**: Mobile health points

Difficult to access	Accessible	Suitably located

2.3 **Accessibilty**: Package of services provided

Limited	Basic PHC services	Full package of services

2.4 What factor/s influence/s the package of service that is offered by mobile health services?

Resources	
Human	
Equipment	
Mobile vehicles	
Supplies	
Other (please specify)	
Job Knowledge and Skills	
Occupational Specific Dispensation	
Rural Allowance	
Other factors (please specify)	

2.5 What are the Quality Improvement Plans to address the above factors?

SECTION 3 – Staff Attitude and Behaviour

3.1 Incidents of negative staff attitude or behaviour reported by clients within the past year?

Yes	No

3.2. Attitude and behaviour of the health care workers influence utilisation rate of mobile services

Adversely if negative	Not really because of lack of choice	Other factors affect utilisation rates

3.3. Training/s provided to health care staff

Orientation and Induction to Primary Health Services and Package of Care	Batho Pele Implementation	Complaints Management	Customer Satisfaction

SECTION 4 – Batho Pele (BP)

4.1. Health care workers implement Batho Pele Principles

Principle	Strongly disagree	Disagree	Agree	Strongly agree
Consultation of clients				
Service standards maintained				
Information provided				
Open and transparent				
Redress done necessary				
Courteous				
Value-for Money service				
Service is accessible				

SECTION 5 – Impact of mobile health services

5.1 Health needs of clients are met

Strongly disagree	Disagree	Agree	Strongly agree

5.2 Batho Pele Principles have improved the quality of service delivery

Strongly disagree	Disagree	Agree	Strongly agree

5.3 Mobile health services has improved the Quality of Life of clients

Strongly disagree	Disagree	Agree	Strongly agree

5.4 What suggestions do you have for the improvement of mobile health services?

Thank you for your participation!

ANNEXURE E_2

Questionnaire – Health care workers

Kindly provide the following information as accurately as possible.

SECTION 1 – Biographical Data

1.1. Classification of health care workers

Health care Worker Category	
Clinical Nurse Practitioner	
Enrolled Nurse	
Enrolled Nursing Assistant	
Voluntary Counselling & Testing (VCT) Counsellor	
Other	

SECTION 2 – Mobile Health Services

1.1. Accessibility

1.1.1. Describe the roads leading to the mobile health points.

_____

1.1.2. Approximately how long does it take to reach the mobile health point?

Time			
0 – 30 min	30 min to 1 hour	Between 1 hour and 1 hour 30 min	Longer than 1 hour 30min

1.1.3. On average, what is the duration spent at this mobile point?

Time			
Up to 1 hour	Up to 2 hours	Up to 3 hours	Longer than 3 hours

1.1.4. For what type of service/s have you referred clients?

1.1.5. Based on statistics, how frequently do you think this mobile point needs to be serviced?

Frequency of service required		
Current service is adequate	Twice a month	Other

SECTION 3 – Batho Pele

3.1. I am aware of the Batho Pele Principles.

Yes	No

3.2. Batho Pele Principles have improved Quality of Life of clients using the services

Strongly disagree	Disagree	Agree	Strongly agree

3.3. **Consultation**

	Strongly disagree	Disagree	Agree	Strongly agree
Engagement of clients for services				

3.4. **Courtesy**

3.4.1. How do you maintain privacy for your clients?

3.4.2. Mechanisms used to receive feedback from clients

Feedback mechanisms				
Suggestion box	Exit interview	Client satisfaction survey	Meetings	Other

3.5. **Information**

	Strongly disagree	Disagree	Agree	Strongly agree
Full and accurate information given to clients				
Provision of IEC material				
Provision of health education				
Marketing of services				
Informed consent is taken when necessary				

SECTION 3 – Staff Attitude and Behaviour

	Strongly disagree	Disagree	Agree	Strongly agree
Healthcare workers are courteous and respectful to clients				
Adherence to Code of Conduct				
Staff are identified				
Continuous performance monitoring of staff				
Training on Batho Pele and Customer care received				

SECTION 4 – Overall impact of mobile health services

4.1. Were the health needs met by the provision of the mobile health services?

Yes	No

4.2. What suggestions do you have for the improvement of mobile health services?

Thank you for your participation!

ANNEXURE E3

Questionnaire – Clients

Kindly provide the following information as accurately as possible.

SECTION 1 – Biographical Details

1.1. Classification of client

Client category	
First visit	
Repeat visit	

1.2. Age Cohort

Age in years			
14 – 18	19 – 25	26 – 35	36 – 45

SECTION 2 – Mobile Health Services

Type	
Fixed clinic	
Mobile health point	

2.1 **Accessibility**: Travel and Distance

Distance from health service in kms			
0 – 1	2 – 10	11 – 20	More than 20

2.2 **Accessibility**: Time

Travelling time			
Less than half an hour	Up to one hour	One to two hours	More than two hours

2.3 **Accessibility:** Transport

Mode of transport	
Nil, travel by foot	
Own vehicle	
Bus/taxi	
Kindly indicate: • Frequency • Distance of drop off to nearest health service point	

2.4 **Accessibility**: Communication

Medium of communication	
IsiZulu	
English	
Did you understand the language spoken by the healthcare workers	
Yes	
No	

3. **Privacy**

Respect for Privacy	
Yes	
No	
Explain	

SECTION 3 – Staff Attitude and Behaviour

3.1. Description of staff attitude

Negative or rude behaviour	Indifferent	Positive and caring	Other

3.2. Does the attitude and behaviour of the health care workers influence your utilisation of the healthcare services?

Yes	No	I have no other choice

SECTION 4 – Batho Pele (BP)

4.1. What is your understanding of BP?

_____

_____

SECTION 5 – Impact of mobile health services

5.1 Were your health needs met by the provision of the mobile health services?

Yes	No

5.2 What is your level of satisfaction with the package of health care services received?

Not satisfied	Satisfactory	Satisfied	Very Satisfied

5.3 I was informed of other services and treatment options available

Totally disagree	Disagree	Agree	Agree and was also referred

5.4 I would recommend the health service

Totally disagree	Disagree	Agree	Totally agree

5.5 What suggestion/s do you have for the improvement of mobile health services?

Thank you for your participation!

ANNEXURE F1

Correlations MANAGEMENT

		agement Pos	ile health po	Human	ehaviour	re workers in	rmation provi	n and transp	-for Money service
Spearman's	Managemen Correlation	1.000							
	Mobile healt Correlation	-.333	1.000						
	Sig. (2-tailed	.291							
	N	12	12						
	Package of s Correlation	-.645*	0.000						
	Sig. (2-tailed	.024	1.000						
	N	12	12						
	Incidents of Correlation	.264	-.770**	-.500	1.000				
	Sig. (2-tailed	.433	.006	.170					
	N	11	11	9	11				
	Consultation Correlation	-.233	.200	-.667*	.516	.073			
	Sig. (2-tailed	.466	.533	.035	.104	.822			
	N	12	12	10	11	12			
	Courteous Correlation	-.359	.135	.111		.049	.739**	.367	
	Sig. (2-tailed	.252	.676	.760		.879	.006	.240	
	N	12	12	10	11	12	12	12	
	Value-for Mc Correlation	-.151	.076	-.272	.149	-.110	.414	.147	1.000
	Sig. (2-tailed	.640	.815	.447	.662	.733	.181	.648	
	N	12	12	10	11	12	12	12	12
	Health need Correlation	-.352	-.076	-.333	.386	.110	.414	.824**	.371
	Sig. (2-tailed	.262	.815	.347	.241	.733	.181	.001	.235
	N	12	12	10	11	12	12	12	12
	Batho Pele F Correlation	-.368	.316	-.408	.083	.375	0.000	.646*	-.120
	Sig. (2-tailed	.239	.317	.242	.808	.229	1.000	.023	.711
	N	12	12	10	11	12	12	12	12
	Mobile healt Correlation	-.440	.085	.072	0.000	-.202	.817**	.658*	.129
	Sig. (2-tailed	.153	.792	.844	1.000	.528	.001	.020	.690
	N	12	12	10	11	12	12	12	12

. Correlation is significant at the 0.05 level (2-tailed).

*. Correlation is significant at the 0.01 level (2-tailed).

ANNEXURE F2

Correlations HEALTH CARE WORKERS

		Health care Worker Category	ely how long does it take to reach the mobile health point?	On average, what is the duration spent at this mobile point?	statistics, how frequently do you think this mobile point needs	Principles have improved Quality of Life of clients using the	Consultation	Mechanisms used to receive feedback from clients	Marketing of services	Informed consent is taken when necessary	Healthcare workers are courteous and respectful to clients
Spearman's	Health care ' Correlation	1.000									
	Sig. (2-tailed)										
	N	24									
	Based on st Correlation	-.383	.416*	.818**	1.000						
	Sig. (2-tailed	.065	.043	.000							
	N	24	24	24	24						
	Consultation Correlation	-.191	-.338	-.191	-.218	.676**	1.000				
	Sig. (2-tailed	.371	.106	.370	.306	.000					
	N	24	24	24	24	24	24				
	Full and acc Correlation	-.297	-.050	-.117	-.084	.348	.581**	-.079			
	Sig. (2-tailed	.159	.816	.585	.695	.096	.003	.712			
	N	24	24	24	24	24	24	24			
	Healthcare v Correlation	-.118	.008	-.017	.118	.458*	.387	.470*	.682**	.719**	1.000
	Sig. (2-tailed	.584	.972	.939	.582	.024	.061	.021	.000	.000	
	N	24	24	24	24	24	24	24	24	23	24
	Adherence t Correlation	.006	-.179	-.078	.067	.430*	.218	.501*	.408*	.600**	.828**
	Sig. (2-tailed	.976	.401	.717	.757	.036	.306	.013	.048	.002	.000
	N	24	24	24	24	24	24	24	24	23	24
	Continuous Correlation	-.270	.009	.022	.133	.281	.323	.409*	.685**	.716**	.859**
	Sig. (2-tailed	.201	.968	.920	.535	.184	.124	.047	.000	.000	.000
	N	24	24	24	24	24	24	24	24	23	24
	Training on t Correlation	-.299	-.169	.233	.240	.609**	.515*	.407*	.493*	.699**	.686**
	Sig. (2-tailed	.155	.430	.273	.259	.002	.010	.049	.014	.000	.000

. Correlation is significant at the 0.05 level (2-tailed).

*. Correlation is significant at the 0.01 level (2-tailed).

ANNEXURE F3

Correlations CLIENTS

		sification of c	Age Cohort	Health Servic	om health se	ravelling tim	Frequency	f to nearest	spect for Priv	otion of staff attitude
Spearman's	Classificatio	Correlation	1.000							
		Sig. (2-tailed)								
		N	203							
	Travelling tir	Correlation	-.093	.427**	.024	.746**	1.000			
		Sig. (2-tailed	.186	.000	.734	.000				
		N	202	202	202	202	202			
	Does the att	Correlation	.184**	.023	.075	.061	.096	-.178*	.144	-.124	-.087
		Sig. (2-tailed	.009	.747	.290	.391	.178	.015	.235	.081	.221
		N	201	201	201	201	200	186	70	200	201
	Were your h	Correlation	.062	.022	.048	.040	.007	-.074	-.031	-.041	-.238**
		Sig. (2-tailed	.389	.764	.505	.579	.928	.326	.806	.569	.001
		N	194	194	194	194	193	179	67	193	194
	What is your	Correlation	-.129	-.155*	.031	-.175*	.000	.141	-.017	-.143*	.241**
		Sig. (2-tailed	.073	.030	.666	.014	.999	.059	.893	.046	.001
		N	195	195	195	195	194	180	67	194	195
	I was inform	Correlation	-.068	-.111	.105	-.089	.084	.089	.071	.078	.133
		Sig. (2-tailed	.337	.115	.136	.208	.236	.225	.551	.268	.061
		N	202	202	202	202	201	187	72	201	200
	I would reco	Correlation	-.180*	.025	.118	.026	.077	.194**	.094	-.132	.171*
		Sig. (2-tailed	.010	.723	.095	.709	.280	.008	.433	.062	.016
		N	202	202	202	202	201	187	72	201	200

. Correlation is significant at the 0.05 level (2-tailed).

*. Correlation is significant at the 0.01 level (2-tailed).

ANNEXURE G

Language Practitioner/Specialist: Language in Education

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To whom it may concern

Date 11 June 2014

Re : Language Practitioner Report

Roshilla Sahadeo Student number 210546152 UKZN

TOPIC : IMPACT OF MOBILE HEALTH SERVICES WITHIN ILEMBE HEALTH DISTRICT : A BATHO PELE PERSPECTIVE

I have had the pleasure of reading the above dissertation submitted for the degree of Master of Public Administration and found the language usage fluent and free of any grammatical inaccuracies.

The work has been read for punctuation, fluency, congruency and meets the language and stylistic writing at a postgraduate level.

I deem the dissertation acceptable for final admission.

Regards

T. Reddy

11/06/2014