

Community participation in rural primary health care services from the community's perspective

M Ranthithi
23171162

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Supervisor: Mr FG Watson

Co-supervisor: Dr MJ Watson

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DECLARATION

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ABSTRACT

The World Health Organization (WHO) (WHO, 2004:20) describes a community as a social group of any size, with its members residing in a specific locality, sharing government and a common cultural and historical heritage. In the context of health, a community can be considered as those who are affected by similar health issues, or it can simply be defined as stakeholders, such as health professionals or patients. Community participation is collaboration in which people voluntarily, or due to some incentive, collaborate with externally determined projects, either contributing their labour and/or resources for some expected benefit. Within the health system community participation can either be guided by law or regulations, for instance, the White Paper for Transformation of the Health System in South Africa and the South African patients' bill of rights charter, or it can be on a voluntary basis without any guidelines. The researcher believes that the focus should be on how the community can participate in the decisions that affect their health.

The research was aimed at exploring and describing a rural community's perceptions on community participation in Primary Health Care (PHC) services rendered to improve the quality of the current PHC services. The main question asked was: What does effective community participation in PHC services entails to improve the quality of health care according to the community members' perspectives in a rural community?

A qualitative research approach was used to conduct the research on the perceptions of community members on community participation in PHC services. The research took place in Dewetsdorp, a rural area situated in the Xhariep district of the Free State province in South Africa. Data was collected by means of focus groups, making use of a semi-structured interview schedule consisting of four questions in an endeavour to reach an answer on the research question. Three focus groups realised; one consisting of the community leaders as members of the community, another consisting of members from Non-Governmental Organisations (NGOs) and the last consisting of community members utilising the PHC services in Dewetsdorp. Digitally voice recorded focus groups were transcribed for data analysis. Data saturation occurred after three focus groups, with an average of seven participants per group. The themes that emerged from the focus groups are discussed with

literature integration. The findings of the research suggest that the community members of Dewetsdorp have a strong sense that community participation should form part of the PHC services. They expressed the view that they play an important role that should be acknowledged and they want to be respected as partners who are willing to take ownership of the PHC services in their community through participation.

From the research results and conclusions, the researcher compiled recommendations for nursing education, nursing research and primary health care nursing practice.

[Key words: community, community member, rural, community participation, primary health care, primary health care nursing, quality health care services]

LIST OF ABBREVIATIONS

ANC	African National Congress
ARV	Anti-retroviral
CDC	Centre of Diseases Control
DHHS	Department of Health and Human Services
DOT	Directly Observed Therapy
ECD	Economic Cooperation and Development
HIV/AIDS	Human Immuno-Deficiency Virus / Acquired Immuno-Deficiency Syndrome
LMIC	Low and/or Middle Income Countries
MDG	Millennium Development Goals
NGOs	Non-Governmental Organisations
NHP	National Health Plan of South Africa
PHC	Primary Health Care
RDP	Reconstruction and Development Programme
SA	South Africa
TB	Tuberculosis
UNICEF	United Nations Children Fund
WHO	World Health Organization

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CHAPTER 1: OVERVIEW OF THE RESEARCH

1.1 INTRODUCTION AND PROBLEM STATEMENT

The World Health Organization (WHO) describes a community as social groups of any size, with its members residing in a specific locality, sharing a government with common cultural and historical heritage (Dennill & Rendall-Mkosi, 2012:128). In the context of health, a community can be considered to be those who are affected by the same health issues (Department of Health and Human Services [DHHS], 2011:XVII). Communities consist of different groups with diverse social structures and values, as well as diverse cultural understandings (Department of Health and Human Services [DHHS] 2011:10). The sense of belonging that individuals have in their community might influence their participation in community activities (Department of Health and Human Services [DHHS], 2011:6), however in modern society community members add more value to social accountability and participation (WHO, 2008:85).

Participation is considered to be an empowerment tool through which local communities take responsibility in identifying and addressing their own problems through collaboration. Collaboration means that people voluntarily, or due to some incentive, work with externally determined projects, either contributing their labour and/or resources for some expected benefit (Morgan, 2001:221). The author further argues that community participation can be seen as working collaboratively with groups of people staying in the same geographic proximity and having similar interests. Mbuyanzi, Mushi, Kumugisha, Massaga, Mdira, Segeja and Njunwa (2007:147) support this view and refer to community participation as letting someone into the system (health system) on a voluntary basis or through giving some incentive.

Following this clarification, it can be argued that community participation involves minimising the gap between health professionals and the community so that the health care professionals share some of their tasks with community members (Thompson, 2007:1297). The same author adds that for community participation to be successful, maintenance of trust is needed, because, if trust is lacking, it can lead to the community increasing demand for participation or self-exclusion. Chung, Grogan and Jennifer (2012:1653) also add that community participation suffers when there is a lack of trust in the process, as the community feels that their pleas are not

heard. Ideal community participation requires health professionals to engage in two-way communication and effectively share their power with the community based on mutual respect and trust. In agreement with this, Dyer (2004:340) states that it is assumed that community trust will follow when community members are involved in health service activities. The WHO explicitly states the role of key stakeholders in policy decision making processes in the World Health Report, and views stakeholders' participation as of central importance in any dialogue affecting community members' lives or that of the broader society (WHO, 2008:85).

It is further believed that community participation consists of more than physical participation, it should include the generation of ideas by the community so that they make contributions in decision-making (Department of Health and Human Services [DHHS], 2011:13). There are strategies that may facilitate community participation may occur, ranging from establishing partnerships with already existing organisations to engaging community health workers to establish governance structures with community representation (Dennill & Rendall-Mkosi, 2012:126).

Within the health system community participation can either be guided by law or regulations, for instance, the White Paper for the Transformation of the Health System in South Africa (1997) and the South African Patients' Rights Charter (Constitution of the Republic of South Africa [Act No. 108 of 1996]), or it can be on a voluntary basis without any guidelines (Mitton, Smith, Peacock, Evoy & Abelson, 2009:6). The authors identify that there is a ratio of 2:1 in favour of the initiation of voluntary community participation in health, and Morgan (2001:227) emphasises that community participation needs to be a continuous and sustainable process. The author is also of the opinion that the community should not only participate at a local level, but should extend to district level on health matters. The community, as the consumers of health services, are the most important participants within the health change processes. Therefore, they should not only be receivers of health services, but they should participate and contribute effectively in the process of generating solutions for their own health problems (Smith & Henry, 2009:e1).

The basis of community participation lies within Primary Health Care (PHC), as defined by the Alma-Ata Declaration of 1978, and PHC should emphasise community participation in all health-related activities (Reid, Mantenga, Nkabinde, Mhlongo & Mankanhla, 2006:16b). The same authors argue that the reference to the saying "communities having their own voice in tackling health problems", is not new, as in the 1950's and 1960's urban and rural community development initiatives started to

include local people in management and decision-making processes (Reid *et al.*, 2006:16b). However, due to the increase in technology and the centralisation of National Health Services, it not only has the possibility of exclusion, but most of the health services shifted to be the responsibility of professional health personnel (WHO, 2008:88). Although this reality is noted, community participation in health is still viewed as a valuable approach to improve health outcomes in vulnerable communities (Chung, Grogan & Jennifer, 2012:1653), such as rural communities, which forms the context of this research.

Following the analysis of the PHC implementation in Africa thirty years after the Alma-Ata Declaration, policy makers advocated for the need to accelerate the implementation of community participation in African governments, including the communities as partners (Department of Health and Human Services [DHHS], 2011:11). The mentioned advocacy that took place during the WHO International Conference in Ougadougou in 2008 underlined the essence of community participation and, if implemented effectively, it could improve PHC, resulting in political, social and economically accepted health services (WHO, 2008:91) in South Africa.

South Africa has been considered as a global pioneer in the conceptualisation of PHC throughout the twentieth century, with influential contribution projects like the Phelela health centre model, a good example of community participation (Kautzky & Tollman, 2008:17). Although the Gluckman Commission's Report recommended in 1944 that there should be a single national department serving all populations according to their needs regardless of race and colour (Dennill & Rendall-Mkosi, 2012:56), it was never implemented. However, in the mid-1960 in the United States, the office of economic opportunity suggested that, in order to deal with the causes of deprivation and inequality, community action programmes were needed, and the idea of community participation programmes were born. This was a result of the 'war on poverty'. This evolving idea was added to health centres traditionally known as curative and preventive services, leading to the discovery that these health services have the capacity to attack the cause of illness through community participation and development (Kautzky & Tollman, 2008:18).

Community participation continues to attract the attention of health policy members and analysts nearly a quarter of century after its introduction at the Alma-Ata conference (Morgan, 2001:222). It was during this conference that the concept of "health for all by the year 2000", was proposed, but not achieved, and as a result, the

Millennium Development Goals (MDG) were formulated (Walley, Lawn, Tinker, Francisco, Chopra, Rudan, Bhutta & Black, 2008:1002). In order to achieve these goals Walley *et al.* (2008:1003) propose the revitalisation of PHC, with community participation as a priority.

As part of revitalising PHC in the South African Government, the African National Congress (ANC) prepared a health plan, which was presented to South Africa in 1994 as the National Health Plan (NHP) (Kautzky & Tollman, 2008:23). From the NHP of South Africa, the district-based health service was advocated as the structure for implementing PHC (Dennill & Rendall-Mkosi, 2012:11). The National Health Plan not only advocates the community as equal partners in health, but also that PHC services should meet the needs of each community with more autonomy to the community to assess their own health needs and to plan their own health services to meet their planned needs. Dennill and Rendall-Mkosi (2012:12) furthermore state that a shift is needed from external agencies supplying health services to the community themselves, thereby becoming active participants in their own health care by generating their own ideas, assessing their needs, planning, implementing and even evaluating the care they receive.

The Department of Health (DoH) also developed the document called 'The PHC package for South Africa - a set of norms & standards', which was derived from existing national policies and other authoritative sources, such as the WHO and research undertaken in the country (Department of Health, 2000). The mentioned document advocates that PHC should consult the community members regarding the services they receive and the community should be given the opportunity to voice their concerns and to promote community participation. Subsequently, Chapter 2 of the Constitution of the Republic of South Africa (No. 108 of 1996) resulted in the Patients' Rights Charter, legalised by the Department of Health as a lawfully binding document. The specific reference to the statement contained in the document that every citizen has the right to participate in the development of health policies and that the patient has the right to participate in decision making in issues concerning his/her health, applies to the focus of this research (South Africa, 1996).

Community participation and inter-sectoral collaboration as an integral part of PHC services was endorsed by the 10-point plan made available during 2008 as one of the Government's major goals in the DoH's Strategic Plan for 2009 to 2014, aiming to improve the health profile of all South Africans (Dennill & Rendall-Mkosi, 2012:66). The success of the implementation of the 10-point plan requires the revitalisation of

the health system using a PHC approach, which is characterised by offering quality care that is integrated and comprehensive in nature. Lately, it appears that South Africa strongly strives to implement community participation, as the Minister of Health, Dr. Aaron Motsoaledi, stated in his speech. He said that for effective prevention and control of diseases, active participation of individuals, families and communities in health matters is needed (Motsoaledi, 2011:3).

After a visit to Brazil during 2010 by the mentioned Minister of Health, a three-stream PHC re-engineering model with a strong political commitment was adopted by the DoH, indicating the following:

- a) Ward-based PHC outreach teams for each electoral ward;
- b) strengthening of school health services; and
- c) district-based clinical specialist teams with an initial focus on improving maternal and child health.

The model aimed to development a PHC based health system, lead at the district level, with communities being serviced where they live (home-based care), through the appointment of a local health outreach team. Community participation forms a critical part of this model to ensure the promotion of basic health care (Dennill & Rendall-Mkosi, 2012:67). PHC re-engineering was implemented in April 2012 in ten districts of South Africa and focused mainly on community outreach services, ensuring that the services extend beyond services traditionally provided in health sectors, such as clinics to population-orientated health services with extensive community and family outreaches (South Africa [DoH], 2011:24). The community/home-based outreach teams were deployed in every municipal ward, each member of a team is allocated a certain number of families and they identify health problems that place communities at risk of diseases or injuries; additionally, they implement appropriate interventions to address the health problems (South Africa [DoH], 2011:24). Although it is believed that the community can benefit from the mentioned PHC re-engineering model and strategies, the question remains whether the community really participates in their own health decision making process, or are the health personnel the sole decision makers?

Important notation on community participation is that it also increases the community's capacity and empowers them to solve their own health problems, mostly resulting in a relationship built on trust and respect between the community members

and PHC personnel (Dennill & Rendall-Mkosi, 2012:13; Department of Health and Human Services [DHHS], 2011:13). It is, however, imperative that communities should be granted the opportunity to define their health needs and suggest ways of meeting them (Rifkin, 1996:79). Although community participation may sometimes be costly, the price is outweighed by the positive impact it has on improving the health of the communities (Dennill & Rendall-Mkosi, 2012:10).

Despite all the initiatives, it appears that the common approach in health care practices is still that of the medical health care model with a more curative emphasis, which means that community-wide preventative health programmes receive less funding (Gerger, 2002:1716). This reality, among others, adds the challenge of more community members seeking remuneration for their participation (Kironde & Kahirimbanyi, 2002:22). Other challenges that may influence community participation could be that although in some countries community health workers are becoming more recognised and accepted as part of the health work force, supervision, support and limited career opportunities are discouraging community health workers (Dennill & Rendall-Mkosi, 2012:133).

Motsoaledi (2011) acknowledges that there are challenges with the implementation of community participation in South Africa with the PHC approach as the underlying philosophy for restructuring of the health system. He admits that insufficient attention has been given to the implementation thereof, which includes taking comprehensive services to the communities. Subsequently, Longlett, Kruse and Wesley (2001:54), argue that, although community participation is important, it remains largely misunderstood by PHC practitioners, who usually view community participation as just a theory that is difficult to put into practice. The community themselves confirm that they feel underrepresented and that they value better representation across many government departments, including health (Chung *et al.*, 2012:1653). Mubyazi *et al.* (2007:150) in their study conducted in Tanzania found that community participation in many countries remains advocated in theory rather than being implemented properly, and this is due to the community lacking interest in participating in health issues.

The researcher is a community health professional nurse strongly believes that community participation can indeed improve PHC service quality and health care outcomes, as also stated by Dennill & Rendall-Mkosi (2012:126). They state that community participation improves health, as it increases the possibility of the development to reach the poor and marginalised communities and improves more

inclusive, realistic and sustainable initiatives. The authors also underline the fact that, for a comprehensive approach to address social determinants of health and to reduce preventable disease-burden, community participation should be applied. In addition, community participation in planning and implementing the health services will address community needs; therefore, services would not be misused, which will save the government a vast amount of revenue. Several authors argue that it is the community's constitutional right to participate in issues (health issues) concerning them (Bamford, 1997:4; Dyer, 2004:340 Checkoway, 2011:34).

Limited research has been conducted in the rural areas of the Free State province to explore community participation in the PHC services. The researcher therefore believes that the focus should be on how the community can be involved in the decisions that affect their health. This research will therefore contribute to this essential, yet complex issue, as the views of the involved community concerning community participation will be analysed and the knowledge gained can be used as a guide for improving community participation and consequently improving the quality of care rendered in PHC services.

From the above-mentioned problem statement and supporting literature, the following central question emerges:

What contributes to effective community participation in PHC services to improve the quality of health care according to the community members' perspectives in a rural community?

1.2 AIM AND OBJECTIVE OF THE RESEARCH

The overall aim of the research is to propose recommendations applicable in PHC services, health education and health research on community participation in PHC services to improve the quality of health care.

To achieve the aim of this research the following objective is put forth:

To explore and describe the perceptions of community members in a rural community on community participation in PHC services to improve the quality of health care.

1.3 PARADIGMATIC PERSPECTIVE

The paradigmatic perspective of this research is based on the researcher's own Christian philosophy.

1.3.1. Meta-theoretical statements

The meta-theoretical perspective, if formulated according to the Christian reformation philosophical view, views man as a God-created being.

1.3.1.1 Man

The concept of 'man' can be defined according to individual understanding and belief, although, from a Christian's perspective, God created man in His own image. Genesis 1:27 states: 'So God created man in his own image in the image of God, he created him male and female he created them' (Bible, 2008:1). It furthermore states that God blessed them and gave them authority over the earth. In the context of this research study, 'man' refers to a community member of Dewetsdorp in the Free State province of South Africa, who has the ability to contribute to community participation.

1.3.1.2 Health

The World Health Organization defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1946). On the other hand, Godlee (2011:343) defines health as the ability to adapt and self-manage in the face of social, physical and emotional challenge. Health does not only include physical, mental, emotional and social well-being, as defined by the World Health Organization and Godlee, but it should include spiritual well-being as well. For the purpose of this research, health is considered as health rendered by the PHC facility in Dewetsdorp.

1.3.1.3 Environment

Environment is defined as any place that forms a surrounding for both the living and non-living things; it can either be land, water or air (Ritenbaugh, 1999). The researcher believes that God has given men freedom to reign in his own environment and has blessed it so that man can enjoy being in it and can multiply and harvest the fruits, according to Genesis 1:26 (Bible, 2008:1). In this study, the environment is the community and geographical area of Dewetsdorp.

1.3.1.4 Nursing

Florence Nightingale defined nursing as putting a patient in the best condition for nature to act upon him (Mason, Isaacs & Colby, 2011:90). As a Christian, I believe nursing is a practice in relation to the nurse's spiritual instance in caring for the patients and participating in the provision of holistic care (O'Brien, 2010:2). Another definition that I agree with is that of Gillespie (2010), who claims that nursing is a profession that includes care of people needing medical care for different reasons, being physical, psychosocial and spiritual. The nursing profession involves comprehensive caring for the health of a living person who has value in the eyes of God. In the context of this research paper, nursing refers to PHC nursing.

1.3.2 Theoretical statements

The discussion of the central theoretical argument and conceptual definitions follows in the subsequent section.

1.3.2.1 Central theoretical statement

The central theoretical statement of the research is that the explanation and description of the perceptions of community members of the rural Dewetsdorp on community participation can offer a better understanding of the contributing factors to effective community participation to make recommendations for ultimately improved and quality health care.

1.3.2.2 Conceptual definitions

The following definitions are applicable to this research.

- **Community**

Community is defined by Random House Dictionary as a social group of any size, whose members are living in a specific locality, sharing a government and often sharing a common cultural and historical heritage (Griffen, 2002). Sociologists in turn define community as the social organisation made up of the same or similar characteristics in natural mind, belief, familiarity and social adherence. The social organisation can have different sizes, ranging from big to small; for example it can be a city, a country or even the entire earth (Xiao-yan, 2011:1943). Community can also refer to individuals who work, share recreation, or live in an area (Jones & Wells, 2007:407). A community is thus in short any group of people sharing common interests. For the purpose of this research, community refers to the people of Dewetsdorp.

- **Community members**

Community members are people living in the same locality, thus community as explained. At the same time the South African Concise Oxford Dictionary (2002:290) defines community members as groups of people living in the same place or having a particular characteristic in common. The community members referred to are thus all members using, working and contributing in some way to the PHC services in Dewetsdorp.

- **Rural**

Rural means relating to, or characteristic of the country side, rather than the town (South African Concise Oxford Dictionary, 2002:1299). The Health System Trust (2000) state that it is difficult to define rural as it is subjective. It should be defined in terms of a number of issues such as population density, remoteness and availability of facilities. In this study the researcher views Dewetsdorp as a rural area with a low population density, as well as a poorly developed business infrastructure with both formal and informal settlements.

- **Perceptions**

Perceptions involve the ability to see or become aware of something through the senses. It is the state of being or process of becoming something by regarding, understanding, or through interpreting something (South African Concise Oxford Dictionary, 2002:864). Perceptions concern the relation between belief and experience (Pitson, 1990:19). The author furthermore states that perceptions can either be perceptual belief or perceptual experience. Perceptions in this research refer to how the community members see, interpret, experience and understand community participation.

- **Community health worker**

Community health worker is a frontline public health care worker who is either a member of the community, or has an understanding of the community he serves and he works as a link between health and the community to facilitate access to the services and improve the quality of service delivery. The community health care workers within community health increases health knowledge of the community members through a range of activities, such as outreach programmes and community education (Findley, Matos, Hicks, Campbell, Moore & Diaz, 2012:1981).

- **Community participation**

Community participation is defined as a representative mechanism allowing communities to influence to a certain extent the policy, planning, operation, use and enjoyment of benefits arising from service delivery (Barry, Somanje, Kirigia, Nyoni, Bessoud, Trapsida, Ndiokubwayo, Soumbey-Alley, Nyomiwaya, Tumussime, Kasilo, Diarra-Nama, Ngema, & Sambo, 2010:17). In the context of PHC services community participation refers to the involvement of all community members in the contribution to their own and others' quality of health through shared assessment, planning, implementation and evaluation of their health outcomes.

- **Primary Health Care (PHC) services**

PHC was first formally introduced at the Alma-Ata conference of 1978. In 1981, the WHO described it as

'essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of both the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact between individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the element of continuing health care service' (WHO, 2008:6).

Dewetsdorp has one permanent clinic that is open for eight hours, five days a week and two mobile clinics serving farm communities.

- **Primary Health Care Nurse**

A primary health nurse is a professional nurse registered by the South African Nursing Council (Nursing Act, 2005, [No. 33 of 2005]) who, after completing four years of a basic nursing course, may complete a clinical post-basic qualification in health assessment, treatment and care, internationally referred to as nurse clinicians (Dennill & Rendall-Mkosi, 2012:69). In the PHC services a professional nurse delivers comprehensive health care that is curative, promotive, preventive and rehabilitative in nature.

- **Quality health care**

Quality refers to the standard of something as measured against other things of a similar kind; the degree of excellence of something (South African Concise Oxford Dictionary, 2002:1087). Quality health care therefore means the degree of excellence of health care provided. Quality health care is a mandate in South Africa as the National Health Act (no. 61 of 2003), section 47(1) states that all health establishments must comply with the quality requirements and standards prescribed by the minister of health after consultation with National Health Council. Section 47 (3) further states that the office of standards compliance and the Inspectorate of Health Establishment must monitor and ensure that there is compliance with the quality requirements in all health facilities.

1.4 RESEARCH DESIGN AND METHOD

The research design and method will be discussed briefly in this section. However, a more detailed discussion follows in chapter two (refer to chapter 2, section 2.2),

1.4.1 Research design

A qualitative approach will be used to explore and describe (Burns & Grove, 2005:50) the perceptions of a rural community regarding their participation in PHC services rendered. The research will be conducted in Dewetsdorp, which is in the Xhariep district of the Free State province in South Africa.

1.4.2 Research method

The research method includes a brief description of the sampling, data collection, and data analysis and literature integration. In the following paragraphs short descriptions will be given on the research method. The reader should, however refer to chapter 2 for a detailed outline of the method for this specific research.

1.4.2.1 Population and sampling

In this research, the sampling will be conducted by concentrating on the following:

- **Population**

Population is defined as all individuals who meet the sample criteria for inclusion in a research study, sometimes referred to as a target population (Burns & Grove, 2009:714). For this study, the population included the community members who are

involved in PHC service activities on a regularly basis. Community members furthermore refer to patients, as well as other community stakeholders, such as traditional healers, community stakeholders from NGOs, and faith-based organisations in Dewetsdorp.

- **Sampling method**

The research focuses on the specific and desired sample from the population identified, and the focus therefore guides the method of purposive sampling (Maree, 2007:79). Purposive sampling is utilised as it will assist in obtaining the information-rich sources (Burns & Grove, 2005:355) from the community members.

- **The sample size**

The sample size is determined and guided by data saturation, which occurs when additional sampling provides no new information, only redundant or repetitive data (Burns & Grove, 2005:361, Maree, 2007:79).

1.4.2.2 Data Collection

Hereafter a brief description of data collection follows, which includes the consent process, the role of the researcher, physical environment and method of data collection.

- **Role of the researcher**

The researcher will complete the process of data collection; selection of participants, dealing with possible vulnerable participants, the physical environment and the consent process (refer to chapter 2, section 2.3.2.1 for a detailed description). The interviews were conducted in the language in which the participants felt comfortable, which is Sesotho, and the researcher translated it into English.

- **Selection of participants**

The researcher was involved in recruiting the sample participants and made use of gatekeepers and mediators, who are the area-managers and staff of the local PHC facility encapsulated in the research area. These individuals assisted the researcher in identifying individuals who are eligible for participating in the research. The researcher made use of an inclusion and exclusion criteria to identify the participants (refer to table 2.1 for inclusion and exclusion criteria).

- **Dealing with possible vulnerable participants**

The researcher ensured that no obvious (as per national ethical standards) vulnerable participants were included, as explained by the inclusion and exclusion criteria in chapter 2. Furthermore the researcher wishes to emphasise that the focus of this study is on perceptions of a service rendered and no sensitive topics were discussed.

- **Physical environment**

The participants and the researcher decided together on a place where the focus group discussions could be held. The chosen venue had to be private, convenient, and accessible to the participants. The researcher had to ensure that it is convenient in terms of quietness and comfort for the purpose of conducting successful focus group (Brink, 2006:153). The researcher provided refreshments to the participants during the focus group (refer to chapter 2, in section 2.3.2.1).

- **Consent process**

The participants were made aware of voluntary participation and that they had no obligation to participate in the study. It was a free and informed choice that the possible participants made. The community was ensured that if they choose not to participate they will not be penalised in any way (refer to chapter 2, section 2.3.2.1).

- **Method of data collection**

Data were collected by means of focus groups, as described by Brink (2006:151). The researcher made use of the semi-structured interview schedule during focus group discussions. The semi-structured interview consisted of open-ended questions, followed by probing questions, to increase detailed exploration (Brink, 2006:152). (refer to appendix G for semi-structured interview schedule and chapter 2, section 2.2 for detailed explanation). Field notes were taken by the researcher immediately after the focus group discussion and included reflective, descriptive and demographic notes (Creswell, 1994:154) to ensure that all possible aspects that might affect the research findings are included (refer to chapter 2, section 2.3.2.1).

1.4.2.3 Data Analysis

The data captured on a voice recorder were transcribed on completion of the focus groups, and analysed using a combination of content analysis techniques (refer to chapter 2, section 2.3.3) as defined by Brink (2006:184), Burns & Grove (2005:519) and Maree (2007:89).

1.4.2.4 Literature integration

To confirm the significance of data as generated by this study, the research results were compared with the relevant literature and existing research findings. New insights gained from this research were also highlighted (refer to chapter 2, section 2.3.4)

1.5 TRUSTWORTHINESS

The key principle of good science in qualitative research is its trustworthiness, which refers to the neutrality of the findings (Babbie & Mouton, 2006:277). The basis of trustworthiness is how the researcher can persuade the audiences that the findings of the research are worth taking into account. For this reason, maintaining trustworthiness in a qualitative study is of great importance. In an effort to ensure the trustworthiness of this research, the criteria identified by Lincoln and Guba (1985:290), including credibility, transferability, dependability and conformability, were used (refer to chapter 2, section 2.4).

1.6 ETHICAL CONSIDERATIONS

To ensure that ethical considerations are honoured, the researcher attempted to do this research honestly and competently. Ethical clearance was granted by the Research Ethics Committee (Humanities), Faculty of Health Sciences, North-West University (Potchefstroom Campus), ethics number NWU-00038-13-A1 (Refer appendix A). The researcher adhered to the guidelines for research ethics as set forth in the Manual for Post-graduate Studies at the North-West University (Potchefstroom Campus). Permission was further granted by the Head of Department of Health in the Free State province (refer appendix B) and from the Local Ward Councillor (refer appendix C) to protect the participants' rights, as well as that of the researcher (Brink, 2006:42) (Refer to chapter 2, section 2.4).

1.7 RECOMMENDATIONS

Recommendations to improve community participation, as a prerequisite for the quality of PHC services, were formulated based on the research results.

1.8 CHAPTER LAYOUT

Chapter 1: Overview of the research

Chapter 2: Research design and method

Chapter 3: Research findings and literature integration

Chapter 4: Conclusions, limitations and recommendations.

1.9 CHAPTER SUMMARY

In chapter 1 the researcher dealt with the introduction and problem statement of the research, the research question, objectives that the research aims to achieve, the research design and method as well as the trustworthiness and ethical considerations. The chapter was concluded with a provisional outline of all the chapters. In chapter 2 a detailed discussion of the research design and methods used, follows.

CHAPTER 2: RESEARCH DESIGN AND METHOD

2.1 INTRODUCTION

The previous chapter offered an overview of the research, including an introduction and the background of the research, problem statement, research question, aim and objective, paradigmatic perspective and a brief orientation of the methodology, including an introductory paragraph on the trustworthiness and the ethical considerations. In this chapter, a detailed discussion follows the research design and methodology related to the quality of the research.

2.2 RESEARCH DESIGN

A qualitative approach was used to explore and describe the perceptions of community members involved in and/or receiving health care in a rural community regarding community participation in Primary Health Care (PHC) services. A qualitative approach was chosen as it aims to discover and construct meaning and insights from the individuals' perspectives (Burns & Grove, 2005:50). In this research the human beings refer to the community members (receivers of PHC, as well as members informally and/or formally involved in PHC services) from Dewetsdorp. The experiences of the community members form their perceptions regarding participating as partners in PHC services. A systematic, interactive subjective approach was employed in an endeavour to understand the perceptions of Dewetsdorp's community members with regard to community participation in PHC services. For the sake of clarity on the context of this research, a short historical background, as well as the current status of the rural town Dewetsdorp is given.

The research took place within Dewetsdorp, a small rural town within the Naledi municipality, which lies within the Xhariep district in the Free State province of South Africa. The Naledi municipality was incorporated into the Xhariep District following the 2011 Local Government elections, initially forming part of the Motheo District (now known as the Mangaung Metro). Dewetsdorp was historically known for its establishment without approval from the Volksraad by Jacobus de Wet, the father of the Boer War general, Christiaan de Wet. The town was officially recognised as a municipality in 1890, and is now considered a rural district with a population estimated at 8037 people (Statistic South Africa, 2007:9).

The town, roughly estimated to be 3424km² in size, lies 75 kilometres south-east of Bloemfontein on the R702 road. It is located on the eastern highland of the eastern region and borders Lesotho. Dewetsdorp consists of mostly rural areas, with almost a third of its land used for farming cattle, sheep and grain. The racial makeup composes of Black African 91,1%, White 6,4%, Coloured 1,2% and others 1,3%. The main language used is Sesotho, 84,6% of inhabitants using this as a first language, thereafter Afrikaans, which accounts for 7,5% and other languages like English and other African languages account for 7,9% (South African Year Book, 2012).

Dewetsdorp is served by one permanent PHC clinic, which delivers comprehensive PHC services and operates from 7:30 to 16:00 from Monday to Friday. The personnel working in the clinic consists of professional nurses, enrolled nurses, nursing assistants, administration clerks, cleaners and a pharmacist assistant. In addition to the permanent PHC clinic, there are two mobile clinics delivering comprehensive PHC services to the rural farming communities surrounding Dewetsdorp, operating from 7:30 to 16:00 each day, Monday to Friday with a professional nurse and enrolled nurse on board (Naledi PHC staff establishment, 2013-2014). Figure 1.2 below indicates the geographical location of Xhariep.



Figure 2.1: Map indicating where the research took place in the Free State Province
(Source: <http://en.wikipedia.org/wiki/Dewetsdorp/freestate/605>)

2.3. RESEARCH METHOD

A short description of the research method was given in chapter 1. This chapter provides a detailed description of the sample, the method of data collection, data analysis, literature integration, ethical considerations and trustworthiness.

2.3.1 Population and sampling

The population, method of sampling, sample size, selection of participants, and dealing with vulnerable participants, as well as consent process follows hereafter.

2.3.1.1 Population

Population can be defined as the total number of units from which data can be potentially collected. These units can be individuals, organisations, events. It is not always possible to include the entire population in a study because of the costs involved. More participants mean that the researcher spends more time collecting and analysing data, so the lifespan of the project increases. It is easier to collect more and in-depth data from smaller than large number of people (Parahoo, 2006:256). For the purpose of this study, one population was used, namely the population of Dewetsdorp. This can be understood as the community members who make use of the PHC services and/or are involved in PHC services on a regular basis. Community members refer to community leaders, like traditional healers, community stakeholders from public services, members from non-governmental organisations and faith-based organisations, as well as the community members utilising the PHC services in Dewetsdorp.

2.3.1.2 Sampling method

The research method focuses on the specific and desired sample from the identified population. The sample was based on knowledge of the population and the purpose of the study and therefore it constitutes purposive sampling, as selection was based on certain defining characteristics (Maree, 2007:79) with the aim to obtain information-rich sources (Burns & Grove, 2005:355). The researcher's knowledge of the population was used to select and invite the participants to be included in the study (Refer to table 2.1 on inclusion and exclusion criteria).

Table 2.1: The eligibility (inclusion & exclusion) criteria of the research

Inclusion criteria of the study	Exclusion criteria of the study
Community leaders such as: <ul style="list-style-type: none"> • Political leaders, • Faith-based organisations, • Traditional leaders, • Traditional healers. 	Community leaders that seldom visit Dewetsdorp
Community members from non-governmental organisations (NGO's) in Dewetsdorp that are directly or indirectly involved in rendering community services, namely: <ul style="list-style-type: none"> • Home-based carers, • Clinic committee members, • Support groups, • Older person groups, and • Youth groups. 	Community members who were excluded are: <ul style="list-style-type: none"> • Employees working at the PHC services in Dewetsdorp, • Obvious vulnerable individuals, like the acutely ill, mentally challenged and mothers with acutely ill babies, • Individuals under the age of 18 and • Individuals who did not give consent to participate in the research.
Community members utilising PHC services on regularly basis.	Community members who are barely using or not utilising PHC services on a regularly basis, and who are not involved in activities at the services. <ul style="list-style-type: none"> • Patients who rarely use the services (less than every six months). • Patients who are visitors in Dewetsdorp.
Government officials such as: <ul style="list-style-type: none"> • Teachers • Police officers • Other civil servants 	

2.3.1.3 Sample size

The focus for the research is on the nature and quality of information obtained from the community members as participants. The sample size will thus be guided by the principle of data saturation, which occurs when additional sampling provides no new information, only redundancy of previously collected data (Burns & Grove, 2005:361; Maree, 2007:88).

2.3.2 Data collection

Having identified the sample for the research, a description of data collection follows, including the role of the researcher, physical environment and method of data collection.

2.3.2.1 Role of the researcher

Before the data collection started, the researcher planned the process and clearly identified the role of the researcher pertaining to the selection of participants, inviting the mediators, dealing with possible vulnerable participants, the physical environment and the consent process. The researcher furthermore discusses the method of data collection and data analysis.

- **Selection of participants**

The researcher and the mediators were involved in the recruiting process. The mediators are staff of the local PHC services included in the research. These individuals assisted the researcher with identifying community members' eligible (refer to table 2.1) for participating in the research. The researcher contacted the chairpersons of different organisations and managers of different departments to share the names of their members who were willing to participate in the research. The endorsement of managers and leaders of different organisations assisted in giving the organisations a "sense of ownership in an attempt to increase participation" (Burns & Grove, 2005:365). The community's traditional healers, traditional leaders, political leaders and faith-based organisations' leaders were recruited by the researcher through the relevant gatekeepers and by contacting them directly.

- **Dealing with possible vulnerable participants**

The research did not pose any risks, as no interventions or experiments were planned. The research with its focus on community participation was not identified as a sensitive topic that will hurt community members' feelings; it was rather viewed as an opportunity for sharing of valuable perceptions, experiences and knowledge. As indicated in the inclusion criteria, only participants older than 18 years of age were asked to participate, thus any person younger than 18 years of age was excluded from the research to ensure minimisation of possible risks. However, it was noted that all patients visiting PHC services were viewed as vulnerable, therefore the researcher, a professional nurse working in PHC services, was aware of possible

emotional reactions that could occur during focus groups, and organised to have a counsellor allocated for that purpose if needed.

- **Physical environment**

The setting of the focus groups was chosen by the researcher, who ensured that it was accessible and convenient in terms of privacy, quietness and comfort for conducting successful focus groups (Brink, 2006:153). The researcher did not make any attempt to manipulate the environment, in other words, the focus group interviews were carried out in the natural environment (Maree, 2007:78). The researcher provided refreshments to the participants before the focus group discussions to ensure a comfortable and welcoming atmosphere. A digital voice recorder was used to record the focus group discussions, as recommended by Silverman (2013:220) as recording allows the researcher to return to data in its original form as often as needed. The participants and the researcher sat comfortably in a “U” shape and maintained eye contact with one another. The participants were informed about the use of the digital voice recorder, as well as about their confidentiality and anonymity through the information and consent forms that they were asked to sign (Burns & Grove, 2005:514; Maree, 2007:89).

- **Consent process**

The participants were made aware of voluntary participation and that they had no obligation to participate in the research. The participation was done willingly and the participants were free to make an informed choice to participate or withdraw. On the day of the focus groups, each participant signed a written consent form (refer to appendix D) to voluntary participation after being informed about the research.

2.3.3 Method of data collection

Data was collected by means of focus group discussions (refer to table 2.2 on the planned focus group schedule). Focus groups can be described as interaction between one or more researchers and more than one respondent for the purpose of collecting research data (Parahoo, 2006:330). Focus groups were preferred as it is the most direct method of obtaining rich data from participants (Brink, 2006:151) and are thus useful in ascertaining perceptions on community participation in PHC services. Some community members and more often in rural communities, cannot read and/or write; therefore focus groups will be relevant to avoid bias, it does limit participation to literate people, but give all the community members an equal opportunity to raise their voices through verbal discussions (Brink, 2006:151).

Table 2.2: Planned focus group schedule

Community members as part of the population	Method of data collection	Sample size
Community members (patients) who use and/or are involved with PHC services regularly.	Focus group	<ul style="list-style-type: none"> • Minimum of 1 Focus group (5-10 participants,) or until data saturation
Community members from NGOs in Dewetsdorp who are directly or indirectly involved with PHC, namely: <ul style="list-style-type: none"> • Home-based carers, • Clinic committees members, • Support groups, • Old persons groups, and • Youth groups. 	Focus group	<ul style="list-style-type: none"> • 1 Focus group (5-10 participants, representing all the mentioned groups) • Data saturation
Community leaders such as: <ul style="list-style-type: none"> • Political leaders, • Faith-based leaders, • Traditional leaders and • Traditional healers. 	Focus group	<ul style="list-style-type: none"> • 1 Focus group (5-10 participants, representing all the mentioned groups) • Data saturation
Government officials such as: <ul style="list-style-type: none"> • Teachers, • Police officers, and • Other civil servants. 	Focus group	<ul style="list-style-type: none"> • 1 Focus group (5-10 participants, representing all the mentioned groups) • Data saturation

The researcher made use of a semi-structured interview schedule during focus group discussions. The semi-structured interview consisted of open-ended questions, followed by probing questions to increase detailed exploration (Brink, 2006:152) in an endeavour to answer the research question: “What contributes to effective community participation in PHC services to improve the quality of health care according to the community members’ perspectives in a rural community?”

The semi-structured questionnaire consisted of the following questions (refer to appendix G):

- What is your understanding concerning community participation in PHC services?
- What do you think about current community participation in the PHC services?
- According to your view, what should be done in future, concerning community participation in PHC services?
- What do you think is the relationship between community participation and quality of care rendered in PHC services?

Each focus group discussion involved five (5) to ten (10) participants. Although the limitation of this method is that some participants are not comfortable with talking in a group, it is useful where the topic is of practical concern (Brink, 2006:125). Focus groups are also useful in finding information that can be missed in face-to-face interviews as groups tend to allow a space in which people get to know and create meaning among themselves rather than individually (Babbie & Mouton, 2006:292). In addition, it is also believed that another feature of focus group discussion is that correction by the group concerning views that are not correct, not socially shared or extreme can be used as a means of validating statements (Flick, 2014:244).

The discussion began with the researcher outlining the topic she intended to cover with the participants. The researcher went through the proposed questions one by one. Additional probing were done by using techniques such as nodding, making sounds indicating interest and encouraging the participant to talk and steering the discussions (Burns & Grove 2009:355; Okun, 2002:96; Maree, 2007:91).

The communication techniques described by Okun (2002:75-76) were used during the focus groups and it included:

- *Clarifying*: A technique used to clarify unclear statements, for example “Is that what you meant.....?”
- *Paraphrasing*: Repeating the participants’ words by using synonyms.
- *Probing*: An open-ended question that will encourage the participants to give more information, the interviewer used words like “Tell me more about it”.

- *Minimal verbal response* by the researcher by way of encouraging the participants to continue talking by nodding, saying “Hmm” or “yes”.
- *Reflecting*: Verbalising the concerns and perspectives of the participants to show understanding.
- *Summarising*: The questions are directed according to the interview in order to understand what the participants are saying.

The non-verbal communication and physical setting were taken into consideration to set the participants at ease, and to demonstrate interest and listening skills to enhance verbal communication (Okun, 2002:65).

Immediately after the focus group discussion, the interviewer recorded field notes once the participants had left the room to prevent the interviewer from forgetting some aspects that might affect or contribute to the richness of the research findings (refer to appendix E). Field notes utilised by the researcher were adapted from Creswell (1994:152):

- *Descriptive notes*: These are reports on the portraits or description of participants, physical setting, the interviewer’s account of particular events that occurred and activities that took place during the discussions.
- *Demographic notes*: These cover information with regard to the time, place, date and weather conditions that describe the field setting, when and where the interview took place.
- *Reflective notes*: A record of personal thoughts such as a speculation of incidents, feelings, problems encountered during an interview, ideas generated during the process, hunches, impressions and prejudices.

2.3.4 Data analysis

Qualitative data analysis is the interpretation and classification of linguistic or visual material collected during data collection. Qualitative data analysis often combines rough analysis of material (overviews, condensation, summaries) with detailed analysis with the aim of arriving at statements that can be generalised in one way or the other by comparing various materials, text or several cases (Flick, 2014:30). Data analysis was done concurrently with data collection, as is the case with a qualitative design (Brink, 2006:184; Maree, 2007:99; Babbie & Mouton, 2006:491). The analysis activities were conducted manually.

A combination of content analysis techniques, as defined by Brink (2006), Burns & Grove (2005) and Maree (2007) were used. Voice-recorded focus group discussions were transcribed verbatim, to form the raw data, in printed format, referred to as the transcripts (Burns & Grove, 2005:520). This was done as soon as possible after the focus group discussion by the researcher while she still remembered the discussion and included non-verbal cues (Maree, 2007:104). The analysis of the transcription was done in the following manner (refer to appendix F for example of transcribed focus group discussion):

- Each transcript was divided into two columns, with the first column being used for the interviewer's questions and the second column showing the participants' responses.
- The researcher read through all the transcripts first to get a sense of all the perceptions described by the participants in their own words.
- The researcher chose one transcript that was the most interesting.
- The researcher carefully read through that transcript again to try and establish what it was all about. The ideas that came to mind were jotted down in the right column (coding).
- The researcher read again this particular transcript, this time underlining the themes, words and phrases as stated by the participants.
- The underlined themes were then written in the right hand column.
- The identified themes were grouped into main themes and some sub-themes.
- This process was followed with each transcript.

Lastly, the most prevalent themes were identified, and were compared with themes from other interviews to determine final themes (Brink, 2006:185). Finally, the different themes were compared to discover the connection between them and were interpreted and summarised to ensure that they brought meaning to the text (Maree, 2007:108). After all data had been analysed, it was interpreted by integrating current literature.

Finally the transcripts (refer to appendix F), field notes (refer to appendix E), the semi-structured interview schedule (refer to appendix G), and the objectives of the research were all given to a co-coder. The co-coder and the researcher

independently analysed the data. This was followed by a discussion meeting to reach consensus on the themes and sub-themes that emerged from the data.

2.3.5 Literature integration

The available literature, which includes journals, relevant research reports, electronic databases and books, were reviewed on the themes that emerged from the interviews to provide a scientific basis for the research and highlight new insights gained from it. The following databases and search engines were used from North-West University library: Emerald, GoogleScholar, EbscoHost, Science Direct, and SAE-publications.

2.4 ETHICAL CONSIDERATIONS

Ethical considerations address the question of which ethically relevant influences the researchers' interventions could have on the participants. There are procedures that should be followed to protect those who participate in the research (Flick, 2014:49). Qualitative research inevitably involves contact with human subjects in the field and therefore ethical problems may occur (Silverman, 2013:159). To ensure that ethical considerations were honoured, the researcher carried out the research honestly and competently. She acknowledged those who provided guidance and the results of the research will be communicated accurately to the involved parties, for example the North-West University (Potchefstroom Campus), the Department of Health (DoH) Free State, the relevant health care facility and the participants (Brink, 2006:30).

To begin with, the researcher ensured that institutional approval was granted from the North-West University's (Potchefstroom Campus) Ethical Committee (NUU-00038-13-A1) (Refer to appendix A), as recommended by Flick (2014:53), as he states that ethical committees have been established in order to ensure ethical standards as the committees examine the research design and methods before they can be applied. Subsequently the researcher adhered to the guidelines for research ethics as set forth in the Manual for Post-graduate studies at the North-West University (Potchefstroom Campus). The true information about the research proposal was provided and the research was conducted in accordance with approved research protocols as suggested by Babbie and Mouton (2006:529). Furthermore, permission was granted by the Head of the Department of Health in the Free State (refer to appendix B) and by the local ward councillor (refer to appendix C) to protect the participants' as well as the researcher's rights (Brink, 2006:42).

Informed consent was obtained from the prospective participants after assimilating essential verbal and written information (Burns & Grove, 2005:201). The aim of the

study was honestly communicated to avoid deceiving the participants (Flick, 2006:50, this is referred to as the principle of veracity by Parahoo, 2006:112). Building trust between the participant and the researcher is important and the latter should tell the truth, as withholding the information can deceive. Participation was voluntary and the prospective participants were allowed to exercise free power of choice, without the intervention of force or deceit (Burns & Grove, 2005:201). Three major elements received emphasis on the consent form, namely the type of information needed from participants, the degree of understanding that the participants must have to give consent, and the fact that the participants have the choice to give consent (Brink 2006:35).

Harm to the participants was avoided as the research was conducted in such a way that there was no harm or risk to the participants, as stated by Silverman (2013:162). In order to protect participants' anonymity, the master list containing participants' names and codes were kept in a locked area separate from the data collected (Brink, 2006:34). The signed consent forms were locked away with the master list, to avoid unauthorised persons identifying participants and their responses (Burns & Grove, 2005:197).

The researcher completed the data collection. The discussions were conducted in the local language, which is Sesotho, which is the language the participants felt comfortable with. The researcher then translated and transcribed the discussions. She was assisted by an experienced person, who has a background in research and is fluent in Sesotho and English.

2.5 TRUSTWORTHINESS

In qualitative research, the key principle of good science is its trustworthiness, which refers to the neutrality of the findings (Babbie & Mouton, 2006:277). The basis of trustworthiness is how the researcher can persuade the audiences that the findings of the research are worth taking into account. For this reason, maintaining trustworthiness in a qualitative study is of great importance and the trustworthiness of this research was assured by the criteria identified by Lincoln and Guba (1985:290) which are credibility, transferability, dependability and conformability.

2.5.1 Credibility

Credibility refers to whether the research results 'ring true', that is, the compatibility between the existing realities constructed in the minds of participants and those that are attributed by them (Babbie & Mouton 2006:277).

In this research credibility was ensured by:

- The length of time the researcher spent with the participants (Sharts-Hopko, 2002:85). The researcher has been a professional nurse in PHC services for the past twelve years, and extended the period of fieldwork to ensure accuracy of data and ensure that the data gave a true reflection on the participants' perspectives.
- More time was spent on the issues that came up repeatedly during the discussions and participants were given time to relax and respond to the questions (Babbie & Mouton, 2006:278).
- Furthermore, the participants were provided with both written and verbal information prior to the focus group discussions and were allowed to ask questions for clarity purposes.
- The researcher also established trust with the participants as she did not rush into the interview, but started by having refreshments and providing the information in an informal, relaxing setting before the start of the real discussions.
- The researcher finally ensured credibility by using the experienced researcher to assist with the transcribing and translating of the focus group discussions and co-coding.

2.5.2 Dependability

Dependability means the research must provide results that, should it be repeated with the same/similar participants in the same/similar context the findings would be the same (Babbie & Mouton, 2006:279). Dependability was ensured in that an auditor would be allowed to audit the researcher's notes and the researcher's journal, the voice recorder, and transcripts and field notes to determine acceptability. He would also examine the data, findings, interpretations and recommendations to assure that they are supported by collected data should the need arise, as all the documents are kept for referential purposes.

2.5.3 Transferability

Transferability refers to the extent to which the research results can be applied in other contexts or with other respondents (Babbie & Mouton, 2006:277). In this research transferability was ensured by:

- The selection of participants, that is, purposive sampling was used to get the rich information about community participation.
- There was a full description of methodology, all the processes of data collection were fully described and sources were described well enough so that they could be located.
- The researcher furthermore used probing questions like “Is there anybody else who wants to add more?’ to allow participants to give rich information unit themes are repeated, that is, until data saturation has been reached.
- It was also ensured that the findings of this study can fit into the context outside the research situation as determined by the degree of similarity between two contexts. It is not the researcher’s responsibility to control the transferability, but that of a person who wants to transfer the findings into another situation.

2.5.4 Conformability

Conformability means the degree to which the findings are products of the focus of the research and not of the biases of the researcher (Lincoln & Guba, 1985:291). In the research conformability was reached by:

- Focus groups were conducted by the researcher, field notes were taken and literature control was conducted to ensure triangulation of data sources.
- The researcher also did not share participants’ lists with focus groups in advance to avoid opportunities of advance preparation that might skew the result.
- The researcher finally remained neutral to the discussion and was able to view each point based on its merits. She just led the discussions in a neutral manner.

2.6 RESULTS

The results of the research will be communicated to the involved parties, for example the North-West University, the Department of Health Free State and the relevant primary health care services (Brink, 2006:30). Furthermore, the recommendations

were formulated for nursing education, nursing research and primary health nursing practice to improve community participation as a prerequisite for quality primary health care services in Dewetsdorp Free State province (refer to paragraph 4, 5 for details).

2.7 CHAPTER SUMMARY

A detailed description of the sample, the method of data collection, ethical considerations, data analysis, literature integration and trustworthiness were discussed in this chapter. The next chapter deals with the discussion of the research findings and the literature integration.

CHAPTER 3: RESEARCH FINDINGS AND LITERATURE INTEGRATION

3.1 INTRODUCTION

Chapter two provided a detailed description of the research methodology. This chapter discusses the realisation of data collection and analysis. For clarity of the compilation of the participants a demographic profiling follows in table 3.1. A discussion of the research findings on the perceptions of the community members regarding their participation in Primary Health Care (PHC) services rendered will then follow and be integrated into existing literature that added to the richness of the data and findings. Conclusions and recommendations were possible after the resultant perceptions and understanding of the community members of Dewetsdorp unfolded and provided evidence.

3.2 REALISATION OF DATA COLLECTION AND DATA ANALYSIS

From the population of the community members of Dewetsdorp, a sample of four focus groups were planned, consisting of community leaders, Non-Governmental Organisations' (NGOs) members, community members who utilise PHC services regularly, as well as civil servants. Out of the four focus groups that were planned, arranged and consented for, only three materialised, since the civil servant focus group did not form part of the data collection process as they fail to attend the scheduled meetings as they reported to be busy with the work commitments.

The community leaders were recruited by the researcher. The chairpersons of the different NGOs also act as mediators and assisted with the recruiting of community members from their respective organisations to participate in the focus group discussions. The professional nurses from the local PHC services acted as mediators to recruit the participants for the focus group of community members attending the PHC services at least once per month. During recruitment the mediators explained the purpose of the research to the prospective participants.

Before each focus group, the researcher confirmed that the purpose of the research is clearly understood and that expectations and ethical considerations were clarified before written consent was obtained from each participant (refer to appendix D). The focus group discussion was held in a private comfortable room, without any interruptions (refer to section 2.3.2.1). The focus group discussions ranged between 58 minutes to 80 minutes each and the researcher made field notes immediately

after each focus group discussion (refer to appendix E). Digital voice recordings and field notes were labelled and electronically uploaded after each focus group discussion and safely stored by the researcher who was the only one with access to the password protected electronic data. Although the focus group discussions did not cause the researcher to be concerned about any emotional, psychological or physical discomfort, the participants were ensured through the duration of the discussion that if anyone experience discomfort, support is available. It was also clearly stated to the participants that they can at any stage discontinue their participation if they so wish. Digitally voice recorded focus groups were transcribed by the researcher, with the assistance of a co-transcriber, proficient in both English and Sesotho (refer to appendix F).

The transcripts were labelled, password protected and safely stored by the researcher and the supervisor according to the ethical standards as prescribed by the Health Research Ethics Committee of the Faculty of Health Sciences, North-West University (Potchefstroom Campus). The researcher analysed the data manually by using paper and pen techniques for data analysis (refer to chapter 2, section 2.3.3) described by Brink (2006:125) and Burns and Grove (2005:521).

The data was analysed by the researcher and an independent co-coder. A meeting was then scheduled between the researcher and co-coder during which they reached consensus on the themes that emerged from the data. The themes that emerged from the analysed data were summarised in three tables, one for each group of participants - the community leaders, members from NGOs and community members utilising the PHC services - as indicated in figure 3.1 hereafter.

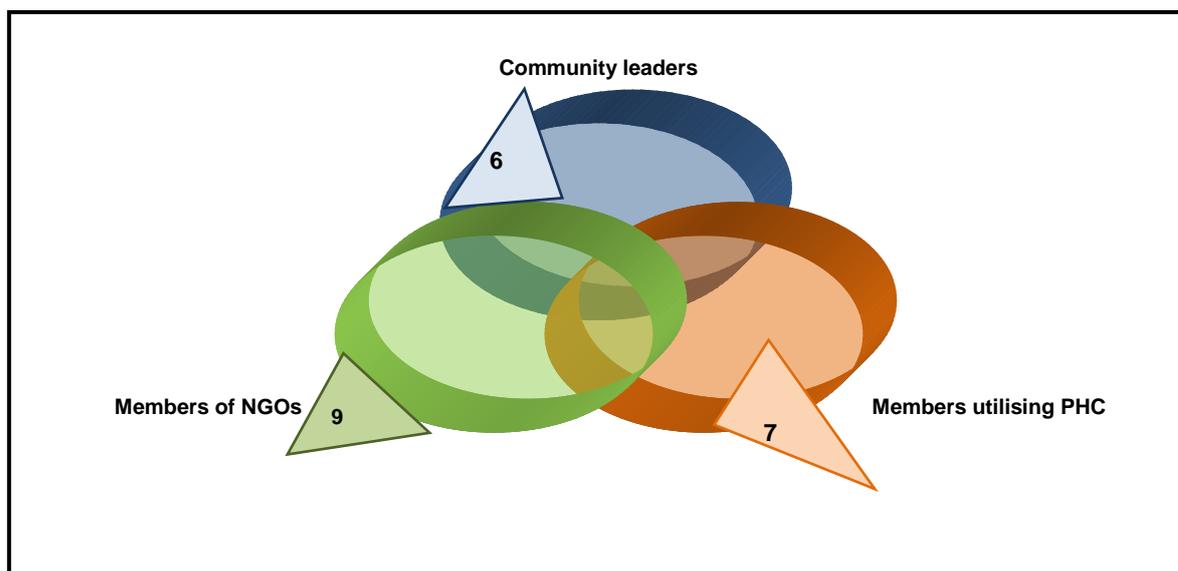


Figure 3.1: Three groups of participants who formed part of focus group discussions.

The three groups consisted of six community leaders within Dewetsdorp, which were the three traditional healers, two Faith-Based Organisations' (FBOs) leaders and one political leaders; the nine community members from different NGOs within Dewetsdorp, four home-based carers, two older persons groups, one youth groups and two clinic committee members; and seven community members who utilise PHC services regularly, that is, at least monthly (refer to figure 3.1).

Four questions were asked during each of the three focus groups to answer to the objective of the study, namely *“To explore and describe the perceptions of community members in a rural community on community participation in PHC services to improve the quality of health care”*. The questions asked are indicated in figure 3.2 below.

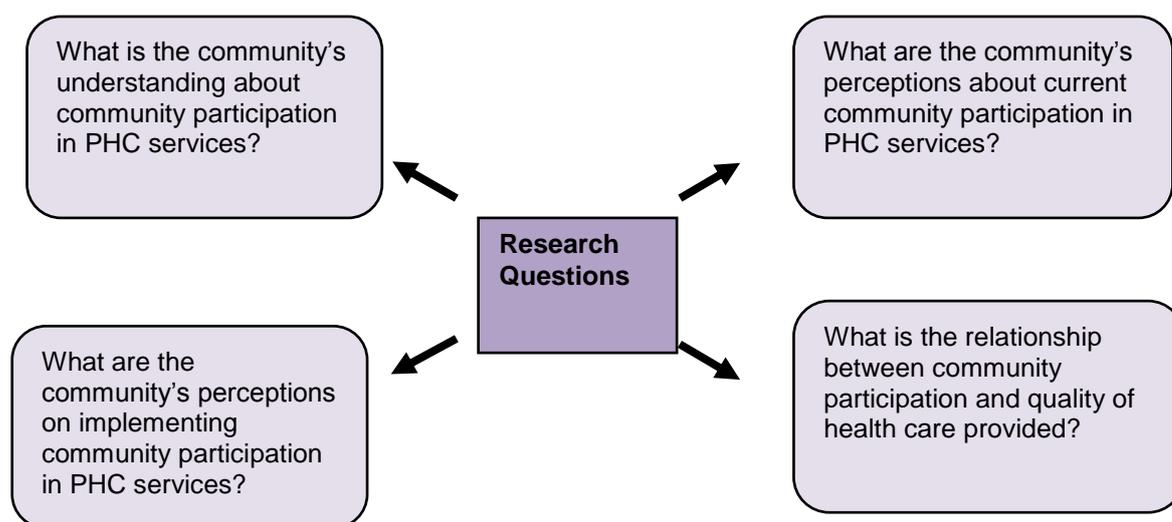


Figure 3.2: Four questions used in the focus group discussions

The findings of the data from three focus groups were analysed separately and displayed in three different tables (refer to tables 3.2, 3.3 and 3.4 respectively). The tables present the main themes and sub-themes that were guided by the 4 questions (refer to figure 3.2) asked to each focus group. A summarised and integrated discussion on the themes with relevant verbatim quotations from the participants to enrich data followed. Literature integration not only serves to confirm the findings, but also to enrich the participants' perceptions. The integrated conclusion on findings was then formulated.

The following section provides information on the demographic data of participants.

3.3 DEMOGRAPHIC PROFILE OF PARTICIPANTS

To clearly understand the compilation of the community members participating in the focus groups, the reader should refer to figure 3.1 above, as well as table 3.1 below on the demographic profile of the community members. The gender, age distribution, qualification and length of stay in Dewetsdorp of each group were determined.

Table 3.1: Demographic profile of the participants of all 3 the focus groups.

Category	Total sample (n=22)	Community leaders (n=6)	Community members from NGOs (n=9)	Community members (patients) utilising PHC (n=7)
Gender	Female	6	7	4
	Male	0	2	3
	n=22	6	9	7
Age distribution	20-30	0	4	0
	31-40	2	2	1
	41-50	1	1	2
	50 and above	3	2	4
	n=22	6	9	7
Qualification	None	0	0	0
	Primary education	2	1	4
	Secondary education Gr 8-10	4	3	1
	Secondary education Gr 10-12	0	5	2
	Tertiary education	0	0	0
	n=22	6	9	7
Length of stay in Dewetsdorp	1 to 10 years	0	0	0
	11 to 20 years	0	3	3
	21 years and longer	6	6	4
	n=22	6	9	7

The demographic data demonstrate that the groups were more or less the same size and well represented as community members at Dewetsdorp. It is also noticeable that there were more females (17) than males (5), the age distribution ranged from 20 years to above 50 years, more participants had secondary education (15) than primary education (7) and finally, most participants have been staying in Dewetsdorp

more than twenty one years (16) while the remaining (6) have been staying in Dewetsdorp between eleven and twenty years. From the demographic data indicated above it is clear that the participants that took part were knowledgeable and suitable representatives of Dewetsdorp to explore and describe their perceptions on community participation in PHC services.

3.4 DISCUSSION OF RESEARCH FINDINGS

The consensus between the researcher and the co-coder resulted in main themes and sub-themes (refer to table 3.2, 3.3. and 3.4) for the perceptions of community members in a rural community on community participation in PHC services to improve the quality of health care. For clarity the researcher managed the large amount of qualitative data in three sets of data (refer to headings of section 3.4.1, 3.4.2 and 3.4.3). A breakdown of the themes and sub-themes are indicated in table format together with applicable quotations, after which the findings from each focus group were summarised and literature integration was finally done.

3.4.1 Perceptions of community leaders on community participation in PHC services

The first set of data focused w the perceptions of **community leaders** on community participation in PHC services and were sorted under the four questions as headings (refer to figure 3.2 and table 3.2).

Table 3.2: Themes from perceptions of Community Leaders on community participation in PHC services

Community leaders' understanding of community participation in primary health care (PHC) services		
Main-theme	Sub-theme	Verbatim quotations
Community members play different roles in the PHC services	Community plays an advisory role	"We can give our contribution and make the clinic aware of some things [service that personnel give] that you are not aware of...offer some advice...'
	The community has a supporting role in PHC services	"We as the community should help the clinic so that everything...can run smoothly...like easy running of the services"
Community members play different roles in the PHC services (<i>cont.</i>)	The community has a service delivery role by assisting with patients tracing and referral to PHC services	"...there are some patients who do not go to the clinic when ill and...the community know ...if we are allowed we can take them to the clinic.'
	The community has an educational role about PHC services	"...as services keep on changing at the clinic ...like if there is the shortage of nurses we can provide information to others to take of pressure from nurses."
Formal PHC services committees are needed	Community participation can take place through clinic committees	"...the clinic committee is made up of people from the community..." "...the community take part as there is clinic committee"
PHC services should enhance community participation through certain basic principles	PHC services should be more accessible and equal	"People should go to the clinic freely...be free to participate in services"
	Community- and home-based approach should be emphasised	"There should be people who can help those people at their homes...If some members can go and consult...in his house?"
	Trust relationship between community and PHC services	"...when we go to the clinic we should show respect...respect one another...People should not be shouted at..."

Table 3.2: Themes from perceptions of Community Leaders on community participation in PHC services (cont.)

Community leaders' perceptions about current community participation in primary health care (PHC) services		
Main-theme	Sub-theme	Verbatim quotations
Lack of collaborative cooperation between existing clinic committee and PHC clinic	Lack of knowledge on roles and functions of existing clinic committee	"...there is the clinic committee but most people do not know about it...we should know the members of clinic committee... and meet the community...I agree... when she says she has heard about the clinic committee, but she has never seen it because most of the time we hold our meetings around 1 o'clock"
	The clinic committees have lost their voice in the community	"When there are some activities...the clinic personnel are the ones addressing the community...clinic committee...never address the community" "...long time ago. We were expected to go to the clinic in the mornings to ensure whether the clients were treated well, but nowadays...things have changed"
Community leaders render their support	Some Faith-Based Organisations (FBOs) do give support	"...some religious organisations...hold prayers and give some scriptures at the clinic and... that is important community participation"
	There is collaboration between traditional healers and PHC clinics	"Traditional healers and the clinic...work together..."
PHC services empower the community through sharing of knowledge	Workshops take place	"...if there are some workshops we are given some invitations" "...as traditional healers while working in traditional way some illnesses need western medicines...we now know how to handle such conditions"

Table 3.2: Themes from perceptions of Community Leaders on community participation in PHC services (cont.)

Community leaders' perceptions on implementing community participation in primary health care (PHC) services		
There is a need for a formal communication platform between the community and the PHC services	Regular, continuous meetings between the community and the PHC clinic personnel	<p>"There should be a meeting between...whereby clinic would tell the community what it is expected of them and the community could also tell the clinic their expectations"</p> <p>"Meeting with the management so that the concerns could be risen...organise the meeting with top management so that as the community can meet with them and discuss...our concerns"</p>
	Expectations to be shared	"The clinic should tell the community what is expected of them and the community could also tell the clinic their expectations..."
	The clinic committee should be known to the community	"...meet with the clinic committee and...should direct those challenges... to management...I believe we should know the members of clinic committee not by just seeing the names..."
PHC Re-engineering services should be strengthened as instrumental to community participation	Provision of home-based care by the PHC clinic	<p>"...so that there can be nurses who are providing Home-Based Care...the clinic can do some home visits and assist"</p> <p>"I am just waiting to get home-base care services from my home"</p>
	Community health care workers should provide services to chronic and elderly patients	<p>"Those organisations are doing home-based care to TB and HIV patients...referring to other patients with chronic conditions like Diabetes for support, High blood pressure and the elderly patients"</p> <p>"If there is an elderly patient who cannot go to the clinic...health care worker should be informed...so that she can accompany her to the clinic"</p>
	Tracing and referral of patients by community leaders to the PHC clinic	<p>"...if as community can take these people to the clinic to get medical assistance"</p> <p>"...sometimes there are patients who are hiding so as community we can inform the clinic"</p>
Integration of indigenous knowledge systems in PHC services	PHC service should increase integration of their services with traditional services	<p>"We would be glad if those that are to be trained to become traditional healers are also taken to the clinic"</p> <p>"...the boys should be taken to the clinic for HIV test before...initiation"</p>

Table 3.2: Themes from perceptions of Community Leaders on community participation in PHC services (cont.)

Community leaders' perception on the relationship between community participation and quality of health care provided		
Community participation can enhance the quality of PHC services	Shared responsibility is possible through community participation leading to improve quality of PHC services	<p>"...clinic and the community work together there will be improvement"</p> <p>"Clinic can do some home visits and assist; therefore reducing burden of the diseases... the clinic will hear from the community about those patients that they do not know about"</p>
	Community participation could lead to reduction of mortality and morbidity, therefore improving the quality of the community's health.	<p>"There would be the reduction in the death rates if the clinic and the community can work together...Deaths due to people not going to the clinic would be reduced...because if my neighbour is ill and the clinic is not aware as... I would take the responsibility of informing the clinic...If the clinic and the community work together it will be easy to tackle the illnesses in different ways"</p>
	Community participation can strengthen PHC's outcomes	<p>"Like when the house is on fire...not only one person goes to put off the fire..."</p>

The community leaders expressed three main themes in their **understanding of community participation** (Refer to table 3.2 for direct quotations in support of this finding). In community participation *the community plays different roles in the PHC services*, namely an advisory-, supporting-, and service delivery role through patient tracing and referral-, as well as an educational role. They further perceive that *formal PHC committees are needed* and that *PHC services should enhance community participation through certain basic principles*, namely accessibility and equality, community- and home-based approach with trust relationship between the community and the PHC services.

Community leaders voiced their perceptions on **current community participation** that *collaborative cooperation between existing clinic committee and PHC clinic demonstrate a vacuum* because of the lack of knowledge on the roles and functions of the existing clinic committee, and due to the fact that the clinic committees have lost their voice in the community. However they feel that *community leaders render their support* through FBOs and the collaboration between traditional healers and the

PHC services. The community leaders add on a positive note that the *PHC services empower the community through sharing of knowledge* through workshops. They further believed that there is community participation through clinic committees, although they viewed clinic committees as ineffective, stating different reasons. They also stated that PHC and community leaders, especially traditional healers and FBOs, support one another to some extent.

When they were asked about their **perceptions on implementing of community participation**, the community leaders expressed their need for a *formal communication platform between the community and the PHC services* to ensure regular, continuous meetings between the community and the PHC clinic personnel to share expectations and give the opportunity for community to know the PHC clinic personnel. They further think *re-engineering services should be strengthened* as it is instrumental to community participation and they believed this is possible through home-based care, including care of the chronically ill and elderly with the involvement of the community leaders. These leaders promised to trace and refer patients in the community to receive PHC services. It is interesting to note that the community leaders mentioned the need for *integration of indigenous knowledge systems in PHC services* and believe it is possible if the PHC services increase their integrating of their services with traditional services.

The community leaders strongly agreed that there is a positive relationship between community participation and quality of PHC services provided and that **community participation can enhance the quality of PHC services**. They pointed that community participation can lead to shared responsibilities that can improve quality of PHC services, and there would be reduction in mortality and morbidity due to joint effort to tackle health problems and finally community participation can strengthen PHC outcomes therefore improving the quality of the community's health.

3.4.2 Perceptions of members from Non Governmental Organisations (NGOs) on community participation in PHC services

The focus group included community members from different NGOs within Dewetsdorp. Some of these organisations were directly working with the clinic some were not working with the clinic at all. The group was asked the four questions (Refer to figure 3.2) and out of those questions the following themes and sub-themes emerged.

Table 3.3: Themes from perceptions of members of Non-Governmental Organisations (NGOs) on community participation in PHC services

NGOs' understanding of community participation in primary health care (PHC) services		
Main-theme	Sub-theme	Verbatim quotations
PHC services should involve shared ownership	Community feels free to use PHC clinic when they share ownership	"...they go there they feel free knowing that they own the services...feel free to use these public services... as they wish"
NGOs having a supporting role to PHC services	Community gives physical support to the PHC clinic	"They decide that today they clean the garden or plant the garden...with gardening services or doing (pause) other duties for the community's sake in the clinic".
	Sharing some activities with the personnel to reduce their workload at the PHC clinic	"If there are some problems somewhere, as a patient if I think I can assist...I can arrange the quire...so that there is no conflict as the services might be slow due to shortage of nurses...help nurses by taking medications to elderly people who struggle to get to the clinic...because nurses cannot be able to deal with the patients and at the same time clean the yard so the community can help..."
	Collaboration between NGOs and PHC clinic to do health awareness campaigns	"...organisations should work hand in hand with the clinic to make awareness campaigns..."

Table 3.3: Themes from perceptions of members of Non-Governmental Organisations (NGOs) on community participation in PHC services (cont.)

NGOs' perception about current community participation in primary health care (PHC) services		
Main-theme	Sub-theme	Verbatim quotations
Community members lack participating commitment.	Lack of commitment to attend meetings and health awareness campaigns	"The community does not usually attend...When the clinic is having some health awareness...which involve the community... only few people attend"
	Ignorance of community members	"...community participation is not good...The participation is too low due to ignorance on the part of community members... the community is the one which is ignorant...They (community) are so ignorant on the things which involve their lives...they have a tendency that HIV is boring..."
	Lack of acknowledgement and appreciation	"The clinic members should not despair those few members that are taking part should be provided with information....we (NGO) should work very hard to inform the community that it is expected to participate"
	Information sharing is not functioning well	"...when such invitations reach the organisation somebody will not share the contents of the invitation with other members...maybe the loud hailer...can be used to reach everybody...community is invited...the letters should be written on time...because sometimes if there is a short notice"
PHC not accommodating community participation	PHC clinic focus on curative services	"...clinic should go to the community as other people believe that the clinic is only there to provide curative services...the community does not usually attend"
NGOs obliged to take leading role in community participation	Participation by NGOs on request	"Different organisations still assist with cleaning campaigns when there are asked to by the clinic"
	Only the NGOs are involved in community participation	"The organisations are the ones who are mainly participating in the clinic...people who do not belong to the organisations are not be reached"

Table 3.3: Themes from perceptions of members of Non-Governmental Organisations (NGOs) on community participation in PHC services (cont.)

NGOs' perceptions on implementing community participation in primary health care (PHC) services		
Community participation should meet certain criteria	Health awareness should be community-centred	"...each organisation...least once per week should have health talks"
	Community participation should be based on a voluntary sharing relationship	"Should not volunteer for our individual benefits, but we should do it for the community...like the youth we can start to volunteer, not because we want to gain something from the clinic...They should have the relationship with the clinic...there should be communication between nurses and community...Suggestion box should be used...it is one thing that can make the community and the clinic to have a relationship"
	Formal platform for coordination and collaboration to ensure good communication	"...forum will get back to the organisations and also inform the clinic on agreed plans...Communication is facilitated as the clinic cannot communicate to individual organisations to avoid duplication of efforts...Clinic committee will send its members...they will keep reporting to the clinic"
	Community should participate to gain shared ownership of the PHC services	"The clinic is constituted of people working in it...and people who are attending the clinic...so...the community should participate...As youth, we can talk to nurses to find out how we can assist them"
	Empowerment of community	"...can take part in the health talks even on historic issues...we do not know and ignoring...Encourage people who are attending the clinic to also do health talk.....old people can... talk about initiation schools like kind of issues"
NGOs' perceptions on the relationship between community participation and quality of health care provided		
Community participation involves information sharing leading to enhanced quality of PHC services	"They do not become as ill a lot as when they would have not have been informed...they will know what are the challenges facing the community... the clinic will know exactly where to improve in order to address the challenges...The health facilities in South Africa are not involved therefore they are not aware that youth are affected by issues like peers...give community information and...quality of health service will improve"	

The NGOs expressed two main themes in their **understanding of community participation** (Refer to table 3.3. for direct quotations in support of this finding); *PHC should involve shared ownership* as this allows the community members to feel free to use the PHC clinic when they share ownership. They also believed that *NGOs have supporting role* by giving physical support to the PHC clinic, sharing some activities with the PHC personnel to reduce their workload and collaborating with PHC clinic in promoting health awareness.

On the issue of their **perceptions about the current community participation**, NGOs voiced their opinion that *community members lack participating commitment*; this is shown by lacking commitment to attend meetings and health awareness campaigns, ignorance of the community members and lack of acknowledgement and appreciation. They further expressed that *PHC is not accommodating community participation* as PHC clinic focus only on curative services. The NGOs also pointed out that *NGOs are obliged to take leading role in community participation* as they participate on request and they believed only NGOs are involved in community participation.

When asked about **the community's perceptions on implementing community participation**, the NGOs said *community participation should meet certain criteria* namely: health awareness should be community-centred, community participation should be based on voluntary sharing relationship, formal platform for coordination and collaboration should be there to ensure good communication, the community should participate to gain shared ownership of PHC services and finally, community participation should empower the community members.

The NGOs, like other groups agreed that there is a positive **relationship between community participation and quality of health care provided**. They stated that community participation involves information sharing leading to enhanced quality of PHC services.

3.4.3 Perceptions of community members utilising PHC services on a regular basis on community participation in PHC services

The focus group consisted of community members who utilise PHC services regularly. The group was allowed to voice out their perceptions on community participation in rural PHC service through the use of the 4 questions discussed above, from those questions the themes and sub-themes were formed.

Table 3.4 Themes from perceptions of community members utilising PHC services on a regular basis

Community members' understanding of community participation in primary health care (PHC) services		
Main-theme	Sub-theme	Verbatim quotations
Community participation is founded in shared ownership and collaboration	Community should share ownership and express their voice in the implementation of PHC services	"The clinic belongs to us; the community members not only to the workers...should voice our opinions so that we can be satisfied and feel good about our clinic...I can say we have the right; we have a voice in the clinic...having the voice too as the clinic belongs to us..."
	Community should have an advisory role in addressing the challenges encountered by the PHC services	"When the clinic is having certain challenges we as community should take part...Community participation is important issue because you have to be an eye...and give advice"
	Cooperation between the community and PHC personnel is essential for trust relationship	"...you should consult her and talk with her to find out if she will treat you as it was said...cooperation with the community so that we do not fear them"

Table 3.4 Themes from perceptions of community members utilising PHC services on a regular basis (cont.)

Community members' perceptions about current community participation in primary health care (PHC) services		
Main-theme	Sub-theme	Verbatim quotations
Lack of open trust relationship	Community does not exercise its right to freedom of speech	"There are some certain issues that make the community not satisfied, but because of fear we do not speak, whilst we do have the right to talk...when they have to say something about the clinic, they do not speak out..."
	Communication breakdown between community and PHC clinic	"...if they have complaints they do not go to the manager to complain instead they start to gossip around...There are posters with the address of the Department of Health so if they have the complaints they can even write to them, but they do not do so..."
	Community should be informed on the need to participate in the PHC services	"...if the community can be given that go ahead to participate there is no problem...do not know how to help, but when given freedom one can help...There are things we can do if we are given freedom to do so..."

Table 3.4 Themes from perceptions of community members utilising PHC services on a regular basis (cont.)

Community members' perceptions on implementing community participation in primary health care (PHC) services		
Community participation needs a formal platform for collaboration	Meetings between PHC clinic's personnel, PHC clinic committee and community members	"...clinic can meet with us ...and just give us instructions on what to do...We as community like to meet with the staff..."
Shared responsibility based on equal participation	Community should be allowed by the PHC clinic to participate in decision making	"...we and the clinic are one and we would like to give our opinions...Clinic can also call us... we will know how we can participate as the community without fear..."
	Community should voluntarily work together with PHC personnel	"Every one of us must have the courage from within to say she is part of the clinic and should go to the clinic management in order to be involved in different ways..."
Community members' perceptions on the relationship between community participation and quality of health care provided		
Community participation improves the quality of PHC services provided as both parties will have a shared vision and will work together to realise that vision		"...the quality, yes the quality will improve...If the community takes part, I think the quality of the service would improve because we would be working together as one team making the shared decisions"

The community members stated one main theme in their **understanding of community participation** (refer to table 3.4 for direct quotations in support of this finding); they believed *community participation is founded in shared ownership and collaboration*, they believed that the community should share ownership and express their voice in the implementation of PHC services, furthermore the community has an advisory role in addressing the challenges uncounted by PHC services, and finally,

cooperation between the community and PHC clinic personnel is essential for the trust relationship.

On the issue of their **perceptions about the current community participation**, community members stated that there is *lack of open trust relationship*, which is evident from the fact that the community does not exercise their right to freedom of speech. Also there is communication breakdown between community and PHC clinic and community should be informed on the need to participate in the PHC services.

When asked about the community's **perceptions on implementing community participation**, the community members expressed that *community participation needs a formal platform for collaboration*, which can be achieved through meetings between PHC personnel, PHC clinic committee and community members. They further believed that the community should be informed about the need to participate in the PHC services, and finally community should voluntarily work together with PHC personnel.

The community members, like all other community groups, strongly agreed that there is a positive **relationship between community participation and quality of PHC services provided**. They pointed out that community participation improves the quality of PHC services provided, as both parties will have a shared vision and will work together to realise that vision.

In the section hereafter an in-depth discussion on the above themes follows. The reader should take note that the integrative discussion refers to an integration of the themes as perceived by all the community members, that is the community leaders, members from different NGOs and the members that utilise the PHC services on a regular basis.

3.5 INTERGRATIVE DISCUSSION OF FINDINGS CONCERNING COMMUNITY PARTICIPATION IN PHC SERVICES

The perceptions of all community members of Dewetsdorp (refer to the different focus groups indicated in figure 3.1) that gave their perceptions on community participation in PHC services are subsequently discussed. The integrated discussion on themes derived from the four questions asked to each of the three focus groups, as summarised in table 3.5, describes the perceptions of the community members on community participation in PHC services.

Table 3.5: Integrative themes from perceptions of community members of Dewetsdorp on community participation in PHC

Community members' understanding of community participation in PHC services
<ul style="list-style-type: none"> • Community members play different roles in community participation • Formal PHC services committees are needed • PHC services should enhance community participation through certain basic principles • Community participation is founded in a shared ownership and collaboration
Community members' perceptions on current community participation in PHC services
<ul style="list-style-type: none"> • Lack of collaborative cooperation between existing clinic committee and PHC • Community leaders render their support • PHC services empower the community through sharing of knowledge • Community members lack participating commitment • PHC clinic not accommodating community participation • NGOs feel obliged to take a leading role in community participation • Lack of open trust relationship
Community members' perceptions on implementing community participation
<ul style="list-style-type: none"> • Community participation should meet certain criteria which are: <ul style="list-style-type: none"> ✓ Formal platform for coordination and collaboration to ensure good communication ✓ Health awareness should be community-centred ✓ Community participation should be voluntary ✓ Community should participate to gain shared ownership of the PHC services ✓ Community empowerment • Strengthening of PHC re-engineering services as instrumental to community participation • Integration of indigenous knowledge systems in PHC services • Sharing of information about community participation
Community members' perceptions on the relationship between community participation and quality of health care provided
<ul style="list-style-type: none"> • Community participation increases the quality of PHC services provided

3.5.1 Discussion of results on the community members' understanding on community participation in PHC services

From the findings of this study different community groups had different understanding about community participation in PHC services. Four themes were

developed out of those perceptions, and these are discussed below with the relevant quotations, as well as integration of supporting literature, where after concluding statements follow.

3.5.1.1 Community members play different roles in community participation

From the findings of this study, the community members from the focus groups identified different roles that they play in community participation in PHC services. The members refer to an **advisory role**: *“we can give our contribution and make the clinic aware of some things [service that personnel give] that you are not aware of...offer some advice...”* Community participation is considered as the right of the community to participate effectively and responsibly in health care decisions, as well as advising and implementing their decisions in PHC services (Morgan, 2001:222). On the other hand, the author believes that community participation should give the community opportunity to have a seat at the table where policies are made, and they should speak up and give necessary advice. Sines *et al.* (2009:353) also developed a model that enables the community to advise and come with tough choices in planning PHC services. Furthermore, Rosen *et al.* (2001:127) stress that community participation should entail community advising PHC especially in these growing number of treatment alternatives in order for the PHC services to identify community preferences of treatment to promote community satisfaction.

A supporting role was highlighted during the discussions: *“We as the community should help the clinic so that everything...can run smoothly...like easy running of the services...”* Community participation through community support is seen as a way of addressing the human resource crisis in health in many low and middle income settings, including South Africa, as Dawad and Jobson (2011:1999) also believe that although support by community alone is not expected to resolve the health workforce crisis, but is a step of community participation towards alleviating the pressure on health care services by the community. Lord Professor Ara Darzi (cited in Sines *et al.*, 2009:353), on the other hand identifies the importance of encouraging support from community, as the user of health care services to address the challenges in the community posed by long term health conditions. Also to promote healthy lifestyle, foster self-care of individuals' health, stimulate community capacity to be active partners in identification, prioritisation, planning and management of community health problems.

Service delivery role through patient tracing and referral was also stressed by the community members-, “...*there are some patients who do not go to the clinic when ill and...the community know ...if we are allowed we can take them to the clinic.*’ It is believed that in PHC services there is delegation of tasks to community health workers (Lehmann, 2008:172), but there is a growing realisation that these cadres are presently being under-utilised and that they could play a more active role in the clinic if they consider themselves to be partners in primary health. Thompson (2007:4) states that the gap between health professional and community members should be minimised for community participation to be successfully maintained. He urges that the PHC personnel should accept the community as their partners in PHC service.

Finally, the community members agree that they play an **educational role** “...*as services keep on changing at the clinic, ask how the services are conducted...we are trying to inform the community...like if there is the shortage of nurses we can provide information to others to take of pressure from nurses.*”. Health education forms one of the basic components of PHC, therefore health education, on prevailing health problems and methods of prevention is important in PHC services (Dennill & Rendall-Mkosi, 2012:4). Health education is devoted to promoting the health of communities and it enables people to increase control over and improve their lives (Setswe, Naude & Zungu, 2011:205). PHC services are expected to be open to exchange the ideas with the community members. It is important that health education by the PHC personnel should be developed in consultation with the communities to ensure a high level of relevance and acceptability by the community members (Swanepoel & de Beer, 2011:26).

3.5.1.2 Formal PHC services committees are needed

The community members stressed that community participation refers to the presence of some formal PHC committee. The following quote supports this fact, “...*the clinic committee is made up of people from the community...the community take part as there is clinic committee*”. Community participation through participation of clinic committees is not a new concept in South Africa as it is stated in the white paper for transforming public service delivery ‘Batho Pele’ (1997). Chapter 2 of The White Paper advocates for fostering community participation across the health sector in South Africa. The paper encourages the establishment of clinic committees to promote community participation. The appointing of clinic committee is a government initiative to improve community participation, but many countries, including South

Africa agree that although community participation is an essential component of PHC, putting it into practice has proven difficult (Bamford, 1997:28). The same author identifies the following factors as contributing to this failure: meaningful community participation should be continuous; the aim of community participation is not clear, and lastly, there are not enough resources to sustain the desired form of participation.

3.5.1.3 PHC services should enhance community participation through certain basic principles

The community members believed that the first principle is making PHC services more **accessible and equal**, as one participant stated: *“People should go to the clinic freely...be free to participate in services”*. The Alma-Ata Declaration, which emphasises health ‘as a fundamental human right’ states that PHC should be accessible, affordable and socially relevant to meet the needs of the community (Aibinuomo, 2011:529). It is difficult, if not impossible, to separate PHC to community participation as community participation is component of PHC, therefore PHC should be accessible for effective community participation to occur (Lehmann, 2008:164). On the other hand, Swanepoel and de Beer (2011:51) believe that community participation should be equal. They urge that often the poorest of the poor do not get their fair share of community participation. The South African health plan also advocates that the community is an equal partner in health and that PHC services should meet the needs of each community, and much attention should be given to the community to access the PHC services and plan their own services (Dennill & Rendall-Mkosi, 2012:11).

The second basic principle identified was that **community- and home-based approach contributes to effective community participation**, as was stated: *“There should be people who can help those people at their homes...”* Another participant stressed community participation as meaning people are consulted in the own homes, *“If some members can go and consult...in his house?”* The concept of task shifting HIV treatment and care from PHC nurses to Community Health Care Workers was elaborated by World Health Organization (WHO) in 2004 as an immediate way to address shortage of staff while delivering good quality of care, as community-based care is economical and effective (Callaghan, Ford & Schneider, 2010:2). Community- and home-based care is also highly advocated in South Africa and other African countries. This approach has been implemented to promote home-based care to people living with HIV/AIDS as large proportion of people seeking care

in South Africa are infected with HIV. In December 2001 the South African government published the national guidelines on Home-Based Care (Akintola, 2006:237) in which they indicated the advantage of home-based care in that it can improve the experience of dealing with HIV/AIDS and reduce the overload at the PHC clinics. South Africa has the most rapidly growing HIV prevalence in the world, therefore in dealing with this it is now common practice for PHC clinics to develop alternative community based care structures (Russel & Schneider, 2000:6).

Community members finally believed that **trust and respect is important between community and PHC services** for the effective community participation, they further believe that trust and respect should be two way process between the community and PHC personnel, “...when we go to the clinic we should show respect...respect one another...People should not be shouted at...”. The principle of trust was stressed by the community members as they believed trust between the community and PHC personnel is essential for community participation, it was pointed out by another participant that, “...you should consult her and talk with her to find out if she will treat you as it was said...cooperation with the community so that we do not fear them“ The literature supports the issue of respect by stating that for effective community participation there should be mutual respect between the community and PHC service, as if respect is compromised, trust is also compromised, affecting the effectiveness of community participation (Chung *et al.*, 2012:1653). The authors argued that Ideal community participation requires health personnel to engage in two-way communication and effectively share their power with the community based on mutual respect and trust as community participation suffers when there is a lack of trust because the community feel as if they are not listened to. Browns (2008) on the other hand believes that community participation is concerned with ensuring that community treated in mutually respectful way and is properly informed about negotiations concerning their health.

3.5.1.4 Community participation is founded in shared ownership of PHC services

Community members believed PHC services' ownership should be shared by both the PHC personnel and the community members. It was mentioned by one participant that ownership of PHC services allow freedom to participate, “...they go there they feel free knowing that they own the services...feel free to use these public services... as they wish”. They further believed that the community feel freer to use PHC services when they share its ownership: “The clinic belongs to us; the

community members not only to the workers...I can say we have the right...as the clinic belongs to us... Various literature supports that the community is indeed partners in health care services and should participate in their health, not just be consumers of the health services. Through community participation the community members are taking ownership of their own health problems (Swanepoel & de Deer, 2011:51; Department of Health and Human Services (DHHS), 2011:13; Smith & Henry, 2009:e1). Community participation also helps the community's internal strengths to be recognised and their self-esteem to be developed so that the community can believe on itself and be encouraged to take ownership of their health (Aibinuomo, 2011:532). Therefore having ownership of health services not only increases capacity of the community to solve their own health problems, but improves the relationship between the community members and the PHC personnel (Dennill & Rendall-Mkosi, 2012:13).

3.5.1.5 Concluding statements on community members' understanding of community participation

The community understands community participation as playing different roles in the PHC services, namely an advisory, supporting, service delivery role through patient tracing and referral, as well as an educational role. It will thus be imperative to acknowledge the community members' roles and enhance that in the PHC services as it became evident that they do have a need to share their wisdom and that they can play an important role in improving the quality of PHC services.

The community members stressed repeatedly that they should be allowed co-ownership of PHC services, it is therefore important for PHC services to accommodate community members into the services in different ways.

The community members regarded existence of fully functional clinic committee to be the gate for the community members to participate, this should challenge the PHC services in Dewetsdorp to advocate and mobilise for the effective clinic committees and ensure that the members are represented and the roles and functions of such committees are understood by the community members.

These principles were identified as illustrating community participation in PHC services namely: accessibility and equality, community and home base care approach, as well as mutual trust between the community members and the PHC services. PHC services should allow the community member to feel involved in PHC

services so that trust can be enhanced. Implementation of home and community based care should be fast-tracked to allow effective community participation as the community members regard themselves as equal stakeholders in PHC services.

3.5.2 Community members' perceptions about current community participation in PHC services

This question relates to the community's perceptions about the current community participation in PHC services in Dewetsdorp. Different community groups had different perceptions during the focus group discussions. These perceptions were divided into the themes and sub-themes that are discussed below with the integration of literature, as well as direct quotations from the discussions. In the final instance the discussion ends with a concluding statement.

3.5.2.1 Lack of collaborative cooperation between existing clinic committee and PHC

When asked about the current situation of community participation in PHC service, the community members mentioned that the existence of the clinic committee is just a known theory, as the community lack knowledge on roles and functions of the existing clinic committee. One community member stated: *"...there is the clinic committee but most people do not know about it...we should know the members of clinic committee... and meet the community"*. The community members also had a strong believe that the clinic committees have lost their voice in the community, as it was mentioned that the clinic personnel are doing duties that the clinic committee can do, *"When there are some activities...the clinic personnel are the ones addressing the community...clinic committee...never address the community"*. Another participant believed that the clinic committee was previously participating in the PHC services, but now it has lost its voice and as the results the quality of PHC services has deteriorated *"...long time ago we were expected to go to the clinic in the mornings to ensure that the clients were treated well, but nowadays...things have changed"*.

Some health service personnel are reluctant to involve community members in the execution of health programmes as they consider this as dilution of their own expertise (Kironde & Kahirimbanyi, 2002:18) and this has indeed resulted in the clinic committees being poorly recognised by PHC clinics. Booth and Halseth (2010:4) state that participation without redistribution of power is frustrating to the community,

leading to them to be reluctant to participate. Swanepoel and de Beer (2011:50) argue that participation means to be allowed into the organisation under certain conditions, but when the community participates they do so fully, in all aspects. It becomes the part of the decision-making, planning, implementation, as well as evaluation.

3.5.2.2 Community leaders render their support

The community participates in PHC services as the community leaders from FBOs render their support to PHC services in the form of praying for the services and strengthening the health personnel and clients with scriptures for the smooth running of the services '*...some religious organisations...hold prayers and give some scriptures at the clinic and...That is important community participation*'. On the other hand the traditional leaders mentioned that they also contribute to community participation by collaborating their traditional services with PHC services, by using some western medicines practices, while providing their traditional services '*...as traditional healers while working in traditional way some illnesses need western medicines....we now know how to handle such conditions*'.

Aderson *et al.* (2003:68) refer to health care service that should be sensitive to the community culture to avoid compromising the quality of health care services, they believe that integrating community culture and PHC has potential to improve health outcomes and result in greater clients' satisfaction with the services. They further believed that integrating culture with health care services can ensure the provision of appropriate health care services and can help to avoid conflict between health care services and the community. On the other hand, it is stated that health care personnel should assume strong leadership for effective and culturally relevant health care to occur as health services provide therapeutic care to people of diverse cultures, and therefore health care and cultural practices should integrate (Leininger & MacFarland, 2006:94). Involvement of religion in health care service is a strong predictor of positive quality of life among communities (Ellison *et al.*, 2000:632). The authors believe that religion has played a distinctive role in the collective and individual lives of the community as it enhances social ties and improve health practices to decrease the risk of diseases, therefore integrating religion with health care services can benefit the community.

3.5.2.3 PHC services empower the community through sharing of knowledge

The community members had a strong belief that PHC services empower the community (especially the traditional healers) through sharing of knowledge. It was mentioned that PHC services empower traditional healers with knowledge to ensure that they are well informed with health information to ensure that they provide their traditional services in a healthy manner *'...if there are some workshops we are given some invitations...as traditional healers while working in traditional way some illnesses need western medicines....we now know how to handle such conditions'*. Health care services and community members (patients) often have different views on health and illness, leading to the patient seeking traditional service intervention therefore PHC services and traditional services has to integrate for the sake of the improvement of quality of the health of the community (Pachter, 1994:690), and for this integration to be effective the PHC personnel should equip the traditional healers with necessary information. Ellis, Lincoln, Charney, Ford-Paz, Benson and Strunin, (2010:789) also confirm in their study that there are some cultural barriers in other communities leading to health care services being underutilised as the community seek traditional health interventions therefore empowering the traditional healers can benefit such communities.

3.5.2.4 Community members lack participating commitment

Although the PHC services are trying to involve the community in the services, the community members lack participating commitment; one participant blamed this on ignorance. *'... the participation is too low due to ignorance on the part of community members...They are so ignorant on the things which involve their lives...'* One participant was concerned that community members do not participate because there have a belief that health issues are boring and monotonous *'...when the clinic is having some health awareness... which involve the community only few people attend.'* The lack of participatory commitment by the community is supported by the findings of Morgan (2001:223), who argues that although facilitators and policy makers are more willing to assume the responsibilities of enhancing participation, there are complex of factors varying from country to country - including political, economical and social status - that keep the majority of rural people from participating. The author further argued that poverty and despair discourage people from playing more active roles in changing health care services (Morgan, 2001:223). Mubyazi *et al.* (2007:150) also stress that community participation in many countries remains advocated in theory rather than being implemented practically, and they said this is due to community lacking interest in participating in health issues.

3.5.2.5 PHC services do not accommodate community participation

The community members pointed out that PHC services are not accommodating community participation as they place more focus on curative services than preventive health and health promotion service should allow community participation: *"...clinic should go to the community as other people believe that the clinic is only there to provide curative services...the community does not usually attend"*.

As it is stated in the literature, PHC does not only concentrate on curative services as PHC is defined as an approach to the provision of health services which emphasises on promotion of health through partnership between health and other professionals and the community, as well as curative care based on meeting the health needs of population to be served (Jason, Le May, Lewin & Ross, 2011:13). Gibbs and Campbell (2012:20) also state that alongside promoting PHC, the Alma-Ata Declaration provided a new political approach to health, moving health away from the biomedical perspective to include an emphasis on the need for the communities to actively participate in response to ill health.

3.5.2.6 NGOs feel obliged to take a leading role in community participation

It emerged during the focus group discussion with the community members that the community members belonging to organisations are the ones who usually participate in PHC services, but individual community members don't participate in their personal capacity *'...the organisations are the ones who are mainly are participating in the PHC services'*. Another participant adds that *'...people who do not belong to the organisations are not being reached...different organisations still assist with cleaning campaigns when they are asked to by the clinic'*.

South African government, after 1994 elections was unexpectedly reluctant to support community health care workers' organisations as more effort was put on supporting staffing of PHC services with nurses and doctors, ignoring the community health care worker cadre (Clarke *et al.*, 2008:680). In early 2000 though, there was rapid growth of community health care organisations, especially lay counsellors, TB directly observed treatment supporters and home-based carers, the National Department of health introduced a national community health programme which provides for the payment of stipend by different appointed NGOs and these are attached to PHC facilities. Moreover, PHC services in provinces and districts are challenged to regularise implementation of community health care workers, although many NGOs fund the running of community health care workers programmes, but the programmes have not been comprehensively evaluated (Lehmann, 2008:17).

Morgan (2001:221) states that community participation tends to be complicated and difficult to implement due to definitional disputes and operational challenges around its implementation.

3.5.2.7 Lack of open trust relationship

Gilson and Erasmus (2006) state that “Trust is often the foundation for co-operation in pursuit of positive social outcomes. Its key characteristics may be summarised as integrity, benevolence and competence”

The role of trust in service delivery (PHC services) is important and should not be underestimated in community participation. In the findings of this research the theme trust seems to surface strongly as it became evident that the community members feel that they do not have an open relationship with the PHC personnel. Although the community members realise that they have that right to the freedom of speech, they are afraid to voice their opinion: *“there are some certain issues that make the community not satisfied, but because of fear...we do not speak, whilst we do have the right to talk’*. The other aspect mentioned was that there exist a communication breakdown between the community and the PHC services because of fear to participate and to rather complain to themselves: *‘...when they have to say something about the clinic, they do not speak out, like if they have complaints’*.

In a study done by Gilson and Erasmus (2006) on the improvement of health services through trust building, a health committee member as participant quoted the following that summarise the importance of building trust relationships between community members and the health services: “I really understand that what we are looking at is the lives of our people...the reward would be the way our community is treated and the way our community feels about the services at the clinic”.

3.5.2.8 Concluding statements on community perception about the current community participation in PHC services

From the findings it is clear that community members feel that although there are clinic committees participating in PHC services, it was seen as ineffective as it is not allowed to exercise its roles and functions by the PHC services, therefore clinic committee should be allowed respect and autonomy so that they are not be passive.

It is clear that religion and culture still play an important role in community participation and is acknowledged by the community leaders. Community leaders believe they can contribute to quality of PHC services through their religious and cultural sensitivity to the community members possible through community participation. Community leaders (traditional healers) acknowledge cultural sensitivity and belief in integration of the traditional medicine with Western medicine.

The individual community members were seen as not playing their role in community participation, leaving the responsibilities to the NGOs, which form an important part of community participation, although it seems that they do not always have enough participation commitment to address the challenges in the community.

Lastly, the community members see that there is lack of trust between the community members and PHC service, which inhibits the community members' freedom to participate; the community members believe that if mandated to participate they will do so. The PHC services should demonstrate open trust to the community by openly inviting them to form part of PHC service.

3.5.3 Community members' perceptions on implementing community participation in PHC services

The question relates to the understanding of the community members' perceptions on implementing community participation in PHC services. The themes are discussed below with the integration of literature and support of some direct quotations, followed by concluding statements.

3.5.3.1 Community participation should meet certain criteria

It was highlighted during focus group discussions that for community participation to be more effective it should meet certain criteria discussed below:

- **There should be a formal platform for coordination and collaboration to ensure good communication**

It was a common understanding during all the focus groups that for the effective community participation formal platform for coordination and collaboration is needed to ensure good communication. All the focus groups had strong perceptions that there is a communication gap between PHC service and the community that should be bridged. It was highlighted that the communication gap can be bridged by regular, continuous meetings between community and PHC service. The NGOs' members

believed that formal platform for coordination and collaboration was one criterion that community participation should meet. *“...forum will get back to the organisations and also inform the clinic on agreed plans...Communication is facilitated as the clinic cannot communicate to individual organisations to avoid duplication of efforts...Clinic committee will send its members...they will keep reporting to the clinic”*. Another participant add to this and said that *“there should be a meeting between...whereby clinic would tell the community what it is expected of them and the community could also tell the clinic their expectations...Meeting with the management so that the concerns could be risen...organise the meeting with top management so that as the community can meet with them and discuss...our concerns”*. One participant mentioned that the community and PHC should meet regularly and on continuous basis to share their expectations on the issues affecting them both *‘...there should be a meeting between...whereby clinic would tell the community what is expected of them and the community could also tell the clinic their expectations’*.

Although all the groups believe that communication is an essential criterion for effective community participation, there were mixed opinions about what level meetings could the meetings be held at. One participant believed that the meetings could be between the community and PHC management *‘Meeting with the management so that the concerns could be risen...organise the meeting with top management so that as the community we can meet with them and discuss...our concerns’*, while another participant believed that it was not really necessary for the individual community members to meet with PHC management, but the clinic committee could intermediate between the community and PHC management *‘...meet with the clinic committee and...should direct those challenges... to management.’* Communication as strengthening community participation is supported by several authors for instance; Sines *et al.* (2009:1999) clarify the importance of dialogue and relationship in sustaining a productive relationship between community and PHC service. The same authors developed the model that enables PHC services and the community to learn together and to share discussions concerning implementation of PHC services. In addition, Hildebrandt developed the conceptual model for community-based intervention in a black township in South Africa, which helped the professionals to transfer their expertise to the community through communication (Hildebrandt, 1994:11). It is further believed that communication empowers the community members and allows them to be self-reliant and build their leadership skills accordingly (Swanepoel & de Beer, 2011:46).

- **Health awareness should be community-centred**

The community members also believed that health awareness should be age appropriate and community-centred to enhance full community participation during such events. *'...meet somewhere, somehow, we have to have... campaigns which are meant for the youth only...old people can... talk about initiation schools like kind of issues.'* More comments of the participants were that *"...health events is not good...health issues are monotonous and boring....youths, they usually do not attend the clinic, the health events which are targeting the youth should be done at the places here where most young people are found and they should be made as exciting as possible so that they can fully participate"*.

Health promotion as part of PHC services is promoted in the Alma-Alma Declaration as an approach to refrain health from a curative perspective only (Gibbs & Campbell, 2012:12). It should emphasise the need for communities to actively participate in health awareness campaigns to tackle some causes of ill health and extending the reach of PHC into hard-to-reach communities. This study therefore adds that for health awareness campaigns to reach the objective that was stated by the Alma-Ata Declaration, it should be community-centred.

- **Community participation should be voluntary**

The third criterion highlighted by the community members was that community participation should be based on a voluntary sharing relationship and should be done to benefit the entire community, not just an individual person who wants to get something in return from volunteering *"Should not volunteer for our individual benefits but we should do it for the community...like the youth we can start to volunteer, not because we want to gain something from the clinic...."*. The community members also believed that the community should voluntarily work together with PHC personnel, *"Every one of us must have the courage from within to say she is part of the clinic and should go to the clinic management in order to be involved in different ways..."*.

Literature states that community participation refers to letting someone in the system on a voluntary basis through persuasion or through coercion (Bamford, 1997:26); Botha (1983:699) has a different view on this as he argues that voluntary participation is not always sufficient, therefore certain persuasions must be put in place. On the other hand though, it is believed that voluntary participation without an remuneration leads to challenges as community members seek remuneration for

participating, making community participation not to be sustainable in poorly resourced low and middle income countries (Kironde & Kahirimbanyi, 2002:22). Bamford (1997:28) also identifies less funding as a challenge that contributes to a failure of complementing community participation.

- **Community members should participate to gain shared ownership of the PHC services**

Shared ownership seemed to be important as the community members acknowledge it again in their saying that *“The clinic is constituted of people working in it...and people who are attending the clinic...so...the community should participate...”*. The community members also believed that in order for community participation to be effectively implemented, there should be a shared responsibility between the community members and the PHC personnel, as they believe that both parties deserve equal participation as they are partners. They strongly believed that the community should be allowed by the clinic to participate in the decision making, *“...we and the clinic are one and we would like to give our opinions...Clinic can also call us... we will know how we can participate as the community without fear...”*

PHC services to be owned by community is over thirty years overdue, since it is something that was stated in the Alma-Ata Declaration on PHC in 1978. Since then many countries in the first decade responded by developing national programmes allowing communities to be equal partners in PHC services (Jason *et al.*, 2011:9). The authors also believe that involving the community effectively in PHC programmes could potentially improve health outcomes such as child survival in sub-Saharan African. It is further stated that although ownership of PHC services by the communities has been poorly implemented, PHC programmes have little chance to succeed if community members do not own PHC services (Gibbs & Campbell, 2012:20). When community members are allowed to participate it should not just make them part of the service or just to do physical work, they should be mobilised because they have democratic rights to ownership of PHC services (Swanepoel & de Beer, 2011:51)

- **Community empowerment**

The last criterion that was highlighted was community participation should bring about community empowerment. The community members stated that for the community to effectively participate in PHC services they should be empowered so

that they can be at the position to translate the knowledge to other community members. *"...Can take part in the health talks even on historic issues...we do not know and ignoring...Encourage people who are attending the clinic to also do health talk.....old people can... talk about initiation schools like kind of issues"* Another participant pointed out that the information that is there is written and other members cannot read, therefore the community should be given verbal education to ensure that they all understand *"there are posters with the address of the Department of Health so if they have the complaints they should write to them, but they do not do so as some cannot read"*.

Although it is well-known that community participation is considered essential, little information on this matter is available (Akukwe, 2006:184), therefore much effort is still needed to educate the community about it. Community participation in many countries is still not implemented effectively due to the community lacking information on how to participate in health issues. The community should be empowered to turn community participation into a reality (Mubyazi *et al.*, 2007:150). Empowerment should accompany participation, as participation without power and information is frustrating to the community (Swanepoel & de Beer, 2011 51)

3.5.3.2 Strengthening of PHC Re-engineering services as instrumental to community participation

Community members are of the meaning that community participation could be enhanced by strengthening of PHC Re-engineering services. They believed that this could be achieved by the provision of home-based care by the PHC services and that this can benefit the community as some patients are too ill to go to the PHC services *"...so that there can be nurses who are providing Home-Based Care...the clinic can do some home visits and assist...I am just waiting to get home-base care services from my home"* On the other hand another participant said Community Health Care Workers (CHCWs) should extend their services beyond providing care to HIV/AIDS and TB patients to providing medications to patients with other chronic conditions, for instance controlled hypertension and diabetes mellitus to promote effective interaction between community and PHC services *'Those organisations which are doing home-based care to TB and HIV patients,...referring to other patients with chronic conditions like Diabetes, High blood pressure and the elderly patients'*.

In South Africa, in 2010 the Department of Health (DoH) released the document called 'Re-engineering of Primary Health Care'; which is aimed at the development of a PHC based health system. It promotes the idea that the communities should be serviced where they live through the appointment of health team. PHC Re-engineering promotes basic health care through community participation. It is composed of community health workers and health personnel. The PHC Re-engineering was first piloted in April 2012 in 10 districts in South Africa (Dennill & Rendall-Mkosi, 2012:67). South African government also emphasizes support by PHC to the community by the introduction of PHC re-engineering, which places greater emphasis on population-based health outcomes. The outcomes include a new strategy for community-based services through PHC outreach teams (South Africa [DoH], 2013). The teams facilitate community participation by identifying health problems that place communities at risk of diseases or injuries; they further implement appropriate interventions to address the health problems at the houses of the community (South Africa [DoH], 2011:24). This initiative was mentioned by the community leaders as meaning the support given by PHC services to the community.

The global recommendation was made for community participation, therefore, to propose it as an approach to strengthen the health workforce to increase access to HIV and other health services (Dawad & Jobson, 2011:1999). This adds to the use of lay members in the community to provide health care as a practice with a long history in South Africa to reduce the high workload of primary health care personnel (Clarke *et al.*, 2008:679).

Community participation also allows for the transfer and management of certain patients from the health care service into the community (Botha, 1983:700), therefore community care workers act as the link between communities and PHC personnel, and support for this concept has recently increased due to high prevalence of HIV/AIDS and TB and the ongoing emigration of health personnel (Clarke *et al.*, 2008:680; Schneider *et al.*, 2008:181). Lehmann (2008:170) further urges that in early 2000, there was rapid growth of the community health care cadre; especially lay counsellors, TB directly observed treatment supporters and home-based carers, but there is a growing realisation that these cadres are presently being under-utilised and that they could play a more active role in PHC services.

3.5.3.3 Integration of indigenous knowledge systems in PHC services

Community members believed that PHC services should increase the integration of their services with traditional services for effective community participation. They stressed that they appreciate the fact that to certain extent the PHC clinic empower the traditional leaders with information, but they still believe that the integration is not enough. It was emphasised that in this era of complicated and infectious illnesses, it would be appreciate if PHC service could support the traditional leaders with screening and examination of the clients to prevent the spread of infections and some complication that could have been prevented; *“We would be glad if those that are to be trained to become traditional healers are also taken to the clinic...the boys should be taken to the clinic for HIV test before...initiation”*.

Traditional medicine is defined by WHO as knowledge, skills and practices based on theories, beliefs and experiences indigenous to different cultures used in maintenance of health and in the prevention, diagnosis, improvement or treatment of physical and mental illness (WHO, 2000). Authors and researchers support that there is a need to integrate western medicine and traditional medicine. Abdjullahi (2011:115) points out that prior to introduction of western medicine, traditional medicine used to be the dominant medical system available for millions of people in Africa in both rural and urban communities and is still used by the majority of people even to date. Traditional healers are believed to treat patients holistically, reconnecting the social and emotional balance of patients based on community rules and relationship, unlike western medicine, which concentrates on treating only disease in a person.

3.5.3.4 Sharing of information about community participation

The participants from all the focus groups agreed that community members should be informed about the need for community participation in PHC services. It emerged that information could be shared in different ways by different people. It was mentioned that community leaders should first start by being the agents of change as far as community participation is concerned. Community participation should first be understood and be brought into practice by the community leaders, and then they should disseminate the information to the rest of the community *‘As services keep on changing at the clinic...ask how the services are conducted and inform the community.’*

Information could also be promoted by the use of a suggestion box and it was mentioned that some community members do not feel comfortable to communicate verbally with PHC services: *'suggestion box... is one thing that can make the community and the clinic to have a relationship ...'* During the focus group discussions it was discovered that community members could participate in PHC service provided if they are informed to do so, as some were not aware that they have the right to participate... *if the community can be given that go ahead to participate there is no problem.'* and *'...there are things we can do if we are given freedom to do so.'* Sharing of information is essential as it breaks the bond of dependence of the community members on health personnel, therefore allowing effective community participation (Kahassay & Oakley, 1999:11). Aibinuomo (2011:535) agrees that social mobilisation is needed in breaching the information gap between community and PHC services, therefore the role of community leaders in mobilising the community to participate in the PHC services can breach that gap.

3.5.3.5 Concluding statements regarding community perceptions on implementing community participation in PHC service

The community members acknowledged that although there is currently some community participation, they feel that some improvements should be introduced to make it more effective and to contribute to an improvement in the quality of PHC services. Formal education platforms between the community members and PHC services were needed for effective community participation to be implemented and sustained. Regular discussions are imperative in community participation and therefore there should be regular meetings between the community members and PHC services to share their vision and expectations, as well as to build trust.

PHC Re-engineering was needed as a tool to enhance community participation within PHC services and Dewetsdorp should therefore strengthen its home- and community-based care systems to enhance effective community participation. Integration of indigenous knowledge in PHC services was also advocated as community members felt the two kinds of medicines were essential and should complement one another. The PHC service should prioritise this integration by incorporating the traditional medicine in its services by working together with traditional healers and sharing expertise on both visions.

The community members identified some criteria that they seemed important for community participation, for instance health awareness campaigns that should be community-centred to accommodate all community members of different ages; community participation that should be voluntary therefore PHC services should equip the community member with information on community participation to enhance the community to voluntary participation; there should be a formal platform for coordination and collaboration to ensure communication between PHC service and the community members.

The community members saw themselves as having ownership in PHC services and they should be allowed to exercise that ownership through community participation, as this will also allow empowerment of the community members with information that will not only improve their health outcomes, but build the self-esteem of the whole community of Dewetsdorp.

3.5.4 Community perceptions about the relationship between community participation and quality of health care services provided

The question relates to getting the community members' perceptions on determining the relationship between community participation and the quality of PHC services provided.

3.5.4.1 Community participation increases the quality of PHC services provided

It was a common understanding in all the three focus group discussions that community participation increases the quality of PHC services provided '*The quality, yes the quality will improve*'. Different community members had different perceptions on how community participation could improve the quality of health care: "*...clinic and the community work together there will be improvement...clinic can do some home visits and assist; therefore reducing burden of the diseases... the clinic will hear from the community about those patients that they do not know about*". The community members furthermore believed that there would be the reduction in the mobility and mortality rates if community participate in PHC service, "*there would be the reduction in the death rates if the clinic and the community can work together...deaths due to people not going to the clinic would be reduced...because if my neighbour is ill and the clinic is not aware as... I would take the responsibility of informing the clinic...If the clinic and the community work together it will be easy to tackle the illnesses in different ways*". Community leaders finally stressed that there would be an

improvement of health outcomes as the community and the PHC clinic would be involved in shared decision making in addressing the community's health needs *'...if the community takes part, I think the quality of the service would improve because we would be working together as one team making the shared decisions'*.

On the other hand, community participation involves information sharing, which can enhance quality of PHC services. One community member mentioned that community participation would increase quality of PHC services as the informed community would utilise the services effectively, therefore reducing the overcrowding at the PHC clinic therefore leading to high quality of services provided as more effort would be given to those patients who really need it *'...give community information and ...quality of health service will improve, informed community will be healthy and will utilise the services less'*. Community members also urged that information sharing would assist PHC services to know the unique health needs of the community they serve and therefore address those needs more effectively. *'... they will know what are the challenges facing the community... the clinic will know exactly where to improve in order to address the challenges, and ...the health facilities in South Africa are not involved therefore they are not aware that youth are affected by issues like peer'*

The participants concluded that community participation improves the quality of PHC services provided as both parties will have a shared vision and will work together to realise that vision as one stated: *'When the house is on fire not only one person goes to put off the fire' '...if the clinic and the community work together it will be easy to tackle the illnesses in different ways...clinic and the community work together there will be improvement...there would be the reduction in the death rates if the clinic and the community can work together'*. Researchers support the view that community participation improves quality and care outcomes of PHC services (Thompson, 2007:4). Although community members have different opinions on what is effective community participation, they agree that it is important to include stakeholders in sharing of information openly for quality of care to improve (Booth & Halseth 2010:4). On the other hand Dennill and Rendall-Mkosi (2012:126) state that community participation improves quality of health services because it increases the possibility of reaching the poor and marginalised communities and improves more inclusive, realistic and sustainable initiatives intended to improve community lives, as well as the quality of health care services provided.

3.5.4.2 Concluding statements on community perception regarding relationship between community participation and quality of health care services provided

Community participation can improve quality of health care in different ways. Through sharing of information and concerns, community members can greatly contribute to the early detection of lost and/or new cases. This will not only be essential for reducing morbidity and mortality, but will contribute to reducing the workload of the PHC services as the informed community will apply the preventative measures leading to healthier outcomes. The PHC services would know the community's needs and problems and therefore they will in time address those challenges affecting the community, be able to prioritise, leaving those challenges that are not relevant or urgent to save time and money. Through promoting and sustaining community participation, the quality of PHC services will be improved and the health outcomes will thus also improve.

3.6 CHAPTER SUMMARY

The realisation of data collection on community perceptions about community participation in PHC service and data analysis were discussed in this chapter.

This was followed by the demographic profiling of participants who took part in the three focus group discussions. The discussion of the research findings on the perceptions of the community members regarding their participation in PHC services rendered followed and was confirmed against existing literature concerning community participation in PHC. The findings of this research included different themes and sub-themes that were integrated with relevant existing literature for confirmation, followed by concluding statements. Chapter 4 deals with a discussion of the conclusions by the researcher, evaluation of the research, limitations and recommendations.

CHAPTER 4: CONCLUSIONS, EVALUATION OF RESEARCH, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

The previous chapter discussed the realisation of data collection and data analysis, followed by research results with literature integration and concluding statements. This chapter offers a final conclusion on the findings. Thereafter the chapter evaluates the study, and the study is concluded with a discussion of the shortcomings. Recommendations were formulated for nursing education, nursing research and Primary Health Care (PHC) services to improve community participation in PHC services in Dewetsdorp in the Free State province.

4.2 CONCLUSION STATEMENTS

The overall aim of this research, namely *“To explore and describe the perceptions of community members in a rural community on community participation in PHC services to improve the quality of health care”* was reached, as the perceptions of the different community members, which included the community leaders, community members from different Non-Governmental Organisations (NGOs) and community members utilising PHC services on the regular basis, were explored and described. From the findings of this study, community members of Dewetsdorp, regardless of their position in society, had similar perceptions on community participation in PHC services.

Community participation in PHC services is understood by the community members as meaning the community sharing the ownership of PHC services rendered, therefore the community members see the need to form a support structure for the services by giving advice and providing other forms of support, ranging from physical support to spiritual support. Formal clinic committees are regarded as contributing to effective community participation in PHC services. The accessibility of the PHC services for the community members forms a big part of community participation. Community participation

also means that the community members should voice their concerns and assist with addressing the challenges faced by PHC services.

Community members acknowledge that there is currently community participation in PHC services, although there are still some challenges and gaps in its implementation. Community members are believed to be ignorant and unresponsive in the matters affecting their health and they lack information on community participation. The presence of clinic committees is noticeable, but it is perceived as not functional as its roles and functions are not known to the community members and the PHC services deny the clinic committees the autonomy to perform the functions that could otherwise be performed by them. There is also a belief that community participation is not equally implemented as community members belonging to the NGOs directly involved with PHC services are the only ones participating, and individuals who do not belong to the NGOs do not participate in PHC services.

In order to improve the existing community participation to better the quality of PHC services provided, there are certain considerations that should be put in place. The communication gap between the community members and PHC services should be bridged by regular meetings between the community members and PHC services to discuss the health issues affecting the community. Information should also be disseminated to all the community members about their participatory role in PHC services; this can be done by either the PHC services or other informed community members, especially the community leaders.

For effective and sustainable community participation, the community members need to participate in PHC services on a voluntary basis, and this can only be achieved if the community is equipped with the necessary knowledge. There is also a need to strengthen the community- and home-based care approach through the implementation of PHC re-engineering in rural communities. Finally, as the community members seemed to have lost interest in participating in health awareness campaigns, the campaigns should be designed to fit the individual community groups to improve the attendance. It is lastly concluded that community participation, if implemented effectively,

will improve the quality of PHC services, as well as the health outcomes, which can in turn assist the Department of Health (DoH) to reach the Millennium Development Goals (MDGs) related to health.

4.3 EVALUATION OF THE RESEARCH

The evaluation of this study addresses the significance of this study topic, the process of reaching the research aim and objectives, and gives critical feedback on the central theoretical statement and appropriateness of the research methodology.

In summary, the research topic was to get the perspectives of the rural community about community participation in rural PHC services. The significance of this research topic is confirmed by the background problem statement in this research study, as formulated in chapter 1. The feedback of the community members during the data collection phase serves as an indication of the significance of this research topic.

The research aim and objectives were reached on completion of this research. The aim of the research was to propose recommendations applicable in PHC services, health education and health research on community participation in PHC services to improve the quality of health care. The objective was to explore and describe the perceptions of the community members regarding their participation in PHC services rendered. The researcher gained a better understanding of the community members' perceptions on community participation in PHC services. The community's perceptions were divided into themes and sub-themes, which were described and discussed with literature integration. In the following paragraphs recommendations are formulated for nursing education, nursing research and primary health care nursing practices.

The central theoretical statement has been realised in the sense that the research added new knowledge and confirmed previous knowledge for a better understanding of community participation in PHC services, which in turn provided direction to the researcher in formulating recommendations to

nursing education, nursing research and PHC services to enhance community participation and therefore enhance the quality of health care.

The utilisation of a qualitative research design through focus group discussions was appropriate as it became evident through the demographic data that the participants were knowledgeable and that the wisdom they expressed added to the findings and consequently gave more insight into community participation in PHC services. Although four focus groups were initially planned, only three materialised and the research results were sufficient for discussion and literature integration.

4.4 LIMITATIONS OF THE RESEARCH

The discussions of the limitations of the research as experienced and observed by the researcher in the course of this research is as follows:

- From the four focus groups planned, arranged and consented for, only three materialised. Even though the researcher rescheduled with the participants that would have participated in the civil servant focus group, they did not attend. The researcher therefore decided to discontinue the focus group after discussing the decision with the supervisor, who concurred with the decision. The researcher is of the opinion that community members from different civil organisations could add more insight into the challenges posed by community participation in Dewetsdorp because most of them believed to have medical aid so they have access to private health services, therefore are would be in the position to compare the two services.
- For the community leaders' focus group, political leaders were invited and consented, but in the end only one showed up, so political leaders' perspectives are insufficient in this research.
- The participants know the researcher as a professional nurse so it took time for the researcher to explain to them to be free and not be bias when giving their perceptions.

4.5 RECOMMENDATIONS

Recommendations to enhance community participation in PHC service in Dewetsdorp are formulated regarding nursing education, nursing research and PHC services. Recommendations follow in this section with reference to the finding of this research, the literature and conclusions that were made.

4.5.1 Recommendations for nursing education

Recommendations for nursing education are aimed at assisting PHC nurses in implementing effective community participation in PHC services. Recommendations include important aspects identified in the study to be included in the curriculum.

- The right of the community to participate in PHC nursing services should be included in the curricula for basic nursing programmes, including enrolled auxiliary nurses, enrolled nurses, bridging programmes that lead to registration with the South African Nursing Council as a nurse and as a midwife, as well as in the curricula for PHC programmes. The student nurses should, as part of their practical, start to spend time in the community so that they can learn to understand what community participation really entails and to encourage the community to observe the willingness of the nursing students to be involved.
- The results of this research and the guidelines on implementing effective community participations could be valuable if included in the in-service training programmes of the PHC nurses, NGOs, community health workers, community leaders, as well as the clinic committee members.
- The findings on community participation in PHC services as formulated by the community members can be applied to facilitate the knowledge of the professional nurses and other personnel working in the PHC through the workshops and conferences to acquire the requisite knowledge on facilitating the implementation of community participation in PHC services.

4.5.2 Recommendations for nursing research

Some recommendations are made for further research regarding community participation in PHC services.

- Similar research can be conducted in other districts and provinces to identify possible correlation between the perceptions of other communities on community participation in PHC services.
- Research is needed to determine the perceptions and knowledge of PHC personnel, with special reference to the nursing personnel, regarding implementing community participation in PHC services.
- In-depth research can be done to determine factors affecting community participation in PHC services.
- Research can be conducted to determine the relationship between quality of PHC services rendered and community participation.

4.5.3 Recommendations for PHC services

Recommendations are provided to implement effective community participation in PHC services, which will improve the quality of health care services provided.

- PHC policy makers at district, provisional and national levels need to ensure that community participation policies and guidelines become priority areas and form part of national core standards evaluation based on which PHC services are evaluated.
- Community participation should form part of quality improvement project for PHC service and should be monitored to ensure that it is effectively implemented.
- Community participation should form part of PHC managers' key performance area and managers' appraisal should be based on the implementation of community participation.

- Community participation through clinic committees should be improved by formulating and adhering to the guidelines allowing clinic committee to form part of the PHC clinic. The guidelines should direct the clinic committee on how to represent the community during the meetings and how to provide the feedback to the community.
- Community participation should form part of health dialogues involving the community, and information should not be limited to PHC facilities, but should be communicated in public places and even in the media.
- Guidelines should be formulated to ensure that there is effective participation of community leaders in the PHC. The guidelines should include how to integrate traditional health services with PHC services and how the referral system should be implemented.
- The implementation of PHC re-engineering should be rolled out to all the community wards in South Africa as it will facilitate community participation and therefore improve quality of care provided to the South Africans.
- The guideline should be formulated to ensure that community health care workers' scope of practice extend beyond providing care to HIV/AIDS and TB patients only, to offering community health care to other patients with chronic conditions and elderly patients to reduce the load of primary health care services.
- The community members and the PHC services should meet regularly and discuss how best community participation can be implemented and all the recommendations should be implemented and the community should be given feedback on a regular basis.

4.6 CHAPTER SUMMARY

The overall aim of the research is to propose recommendations applicable to PHC services, health education and health research on community participation in PHC services to improve the quality of health care. The objective was to explore and describe the perceptions of the community members regarding their participation in primary health care services rendered. The researcher has reached the aim and objective of this research. Community perceptions were explored and described based on the data given by the participants, and main themes and sub-themes emerged. This research finding and recommendations will contribute to the implementation of community participation in PHC services.

The chapter ends the research with an evaluation of the study, which was followed by a discussion of the shortcomings. Recommendations were formulated for nursing education, nursing research and primary health nursing practice to improve community participation as a prerequisite for quality PHC services in Dewetsdorp, Free State province.

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APPENDIX A: Ethical approval from North-West University, Potchefstroom Campus



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

Private Bag X6001, Potchefstroom
South Africa 2520

Tel: (018) 299-4900
Faks: (018) 299-4910
Web: <http://www.nwu.ac.za>

Ethics Committee
Tel +27 18 299 4852
Email Ethics@nwu.ac.za

10 June 2013

ETHICS APPROVAL OF PROJECT

The North-West University Ethics Committee (NWU-EC) hereby approves your project as indicated below. This implies that the NWU-EC grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the project may be initiated, using the ethics number below.

Project title: Community participation in primary health care services: Dewetsdorp community's perspectives.	
Project Leader: Francois Watson	
Ethics number:	N W U - 0 0 0 3 8 - 1 3 - A 1
<small>Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation</small>	
Approval date: 2013/06/10	Expiry date: 2018/06/09

Special conditions of the approval (if any): None

General conditions:

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

- The project leader (principle investigator) must report in the prescribed format to the NWU-EC:
 - annually (or as otherwise requested) on the progress of the project,
 - without any delay in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.
- The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the NWU-EC. Would there be deviation from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date, a new application must be made to the NWU-EC and new approval received before or on the expiry date.
- In the interest of ethical responsibility the NWU-EC retains the right to:
 - request access to any information or data at any time during the course or after completion of the project;
 - withdraw or postpone approval if:
 - any unethical principles or practices of the project are revealed or suspected,
 - it becomes apparent that any relevant information was withheld from the NWU-EC or that information has been false or misrepresented,
 - the required annual report and reporting of adverse events was not done timely and accurately,
 - new institutional rules, national legislation or international conventions deem it necessary.

The Ethics Committee would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the Ethics Committee for any further enquiries or requests for assistance.

Yours sincerely

Prof Amanda Lourens
(chair NWU Ethics Committee)

APPENDIX B: Consent from the Department of Health, Free State province to conduct research


health
Department of
Health
FREE STATE PROVINCE

27 August 2013

Ms. Mokhantso Ranthithi
One Stop Clinic
Dewetsdorp
9940

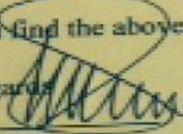
Dear Ms. Ranthithi

Subject: COMMUNITY PARTICIPATION IN RURAL PRIMARY HEALTH CARE SERVICES

The above mentioned correspondence bears reference.

- Permission is hereby granted for the above – mentioned research on the following conditions:
- Participation must be voluntary.
- Written consent by each participants.
- Ascertain that your data collection exercise neither interferes with the day to day running of the health facilities nor the performance of duties by the respondents.
- Serious Adverse events to be reported and/ or termination of the study.
- Confidentiality of information will be ensured and no names will be used.
- Research results and a complete report should be made available to the Free State Department of Health on completion of the study.
- Progress report must be presented not later than one year after approval of the project to the Human Sciences Research Council of Pretoria and to Free State Department of Health.
- Need to provide Free State Department of Health with a list of Health institutions that you want to make use of before you commence with the study.
- Department of Health to be fully indemnified from any harm that patient and staff experiences in the study.

Trust you find the above in order.

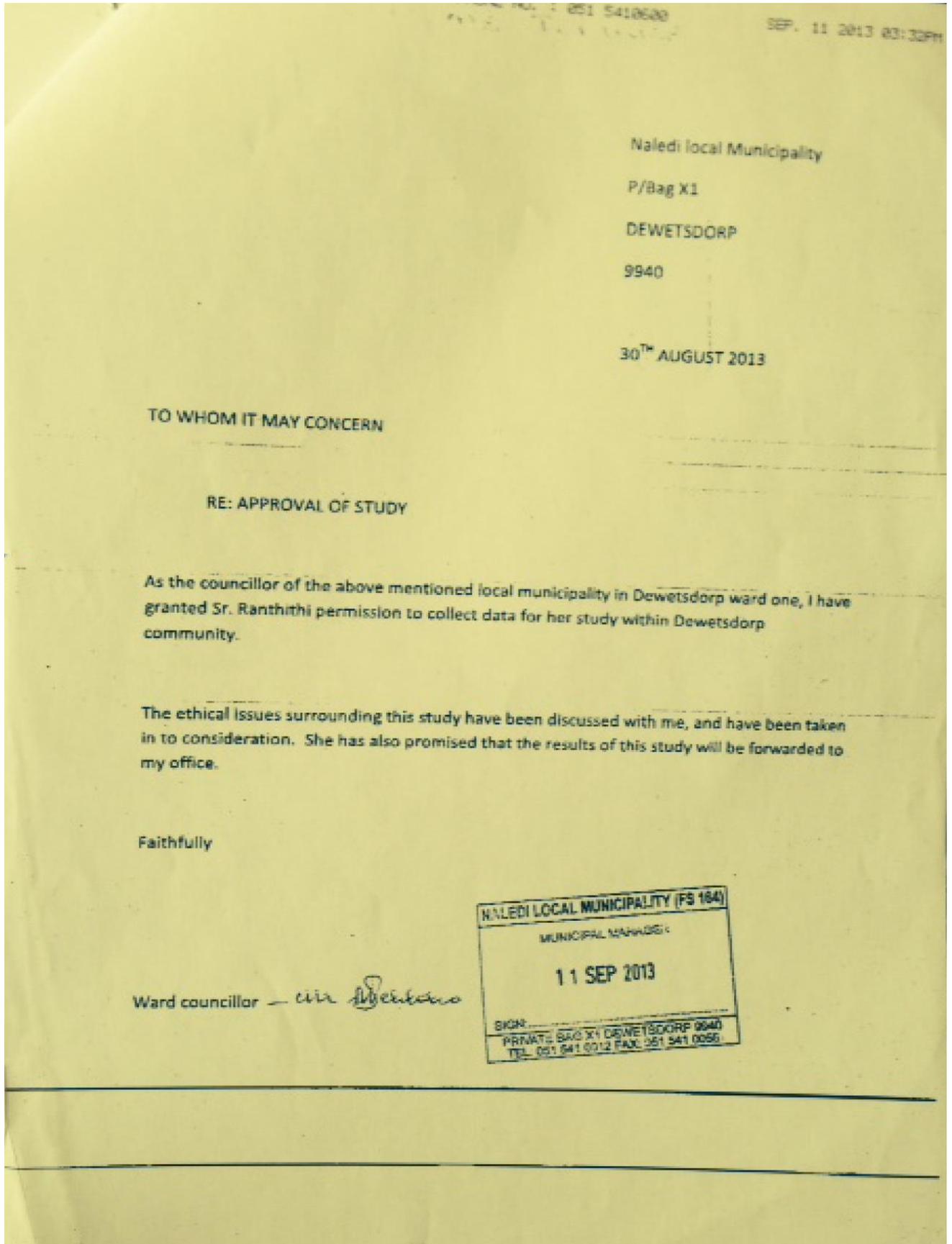
Kind Regards 

Dr D Motau
HEAD: HEALTH
Date: 8/10/13

Head : Health
PO Box 227, Bloemfontein, 5000
4th Floor, Executive Suite, Bophelo House, on Maitland and Harvey Road, Bloemfontein
Tel: (051) 408 1546 Fax: (051) 408 1556 e-mail: stuceme@bhealff.gov.za sa@hhealth.gov.za sa@hhealth.gov.za

www.fs.gov.za

APPENDIX C: Consent from community councillor to conduct research



APPENDIX D: Research information letter and voluntary consent granted by participants



NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
POTCHEFSTROOM CAMPUS

INFORMATION SHEET AND CONSENT

COMMUNITY PARTICIPATION IN RURAL HEALTH CARE

Invitation to participate: You are invited to participate in the above-mentioned research study.

Study Aim: The overall aim of this study is to propose recommendation applicable in PHC services, health education and health research on community participation in PHC services to improve the quality of health care.

Study objective: To explore and describe the perceptions of I community members in a rural community on community participation in primary health care services to improve the quality of car.

Participation: You are asked to participate in the focus group aimed at explore and describe the perceptions of rural community members regarding their participation in primary health care services. Your participation will take approximately 45 to 60 minutes. The results will be used to formulate recommendations on improving current community participation in primary health care services rendered in a rural community. Only the researcher, co-coder, translator and the study supervisor/s will be permitted to access the data.

Risks: Minimum risk is expected from your participation in this study. There is a risk of emotional discomfort and therefore support will be available if needed, in the form of someone who will be available for support/debriefing if needed. Your decision as to whether or not to participate in the study will not

have any positive or negative repercussions for you. You are assured that you can withdraw as participant at any time during the focus group discussion. You are advised to say only what you are comfortable saying. Permission has been given by provincial department of health and local ward councillor, but your individual responses will not be shared with them. At the end of the focus group discussions, you will be asked if there are any portions of what you have said that you do not want to be noted, and this request will be recorded on the digital voice recorder and in a written note by the interviewer.

Benefits: Your participation in this study will not be of direct benefit to you; however, it will give you an opportunity to contribute to addressing the current challenges community participation in primary health care. The information you share may help the researcher to make some recommendations on improving current community participation in primary health care rendered in a rural communities.

Confidentiality and anonymity: You have received assurance from the researcher that any information shared will remain strictly confidential. You understand that the contents will be used only for the purpose of the study and that your identity will be protected. The content will only be discussed within the research team (the researcher, co-coder, the translator and the supervisor/s). Anonymity will be ensured by not recording your name with your responses or identified in any way. Since only aggregate results will be published, your identity will not be revealed in any reports or publications.

Conservation of data: Raw data (digital voice recordings, transcriptions and field notes) and all other data generated by the research will be locked in a special data cupboard at the School of Nursing Science, North-West University (NWU) for a period of 5 years. All electronic data will be password protected by using the “password protect” function in MS Word and by saving and archiving the data on the NWU’s computers as they all are password protected.

Compensation: There will be no monetary compensation for your participation in the study.

Voluntary Participation: You are under no obligation to participate; if you choose to participate, you may withdraw from the study at any time and /or refuse to answer any questions.

This study has received ethics approval from the North-West University Research Ethics Committee. Furthermore the research has received full ethical approval and permission from:

- Department of Health – Free State Province and
- The relevant Naledi Ward councillor.

For queries please contact:

Supervisor:Mr.F.G. Watson

Student: Me M. Ranthithi

Tel (w): 018 299 1874

Tel: 051 5410304

Fax: 018 299 1827

Cell: 0835395395

Email:

Email: mokhantsoranthithi@gmail.com

francois.watson@nwu.ac.za

CONSENT

I, _____ (print name), have understood to my satisfaction the information regarding my participation in the research project “*Community participation in Primary Health Care Services*”. I am aware that data will be accessible only to the researcher, co-code, translator and the supervisor/s.

Participant’s Signature: _____ Date: _____

Please tear here

Researchers Copy

CONSENT

I, _____ (print name), have understood to my satisfaction the information regarding my participation in the research project “*Community participation in rural Primary Health Care Services*” and agree to participate as a participant. I also give permission that the focus group discussion may be audio recorded. I am aware that data will be accessible only to the researcher, co-coder, the translator and the supervisor/s.

Participant’s Signature: _____ Date: _____

APPENDIX E: Field notes compiled from individual interviews

FIELD NOTES

Focus group 1 (Community leaders)

Demographic notes

The focus group was conducted at the office of one of the Non-Governmental Organization; on the 6th December 2013 at 12:30. It was a warm day. The discussion lasted for 48 minutes. The discussions started with the participants and the researcher having some refreshments, the interviewer explained the consent forms and the participants signed them and also filled their demographic profiling.

Descriptive notes

The group consisted of all 6 female community leaders with their ages ranging from 31 years to above 50 years. The male leaders were also invited but did not show up, so at the end the group consisted of only females. There were 2 members from two different Faith-Based Organizations, 2 traditional healers, 1 member of clinic committee and 1 leader from the political party. The focus group was held in the offices of one of the Non-Governmental Organizations. It was quite although in the next room there were people taking and closing the door time and again. Towards the end of the discussion there was a knock at the door by the person who was not aware of the discussion which was continuing but was stopped by the people in the nearby office.

Reflective notes

The discussion started very well, with participants open and answering the questions freely and giving lot of answers to elaborate their points, most of the participants were engaged in the discussion although other were more talking than others. Although time and again some participants were losing the topic under discussion, for example the other participant started to complain about shortage of staff at clinic, but the researcher kept parting them back on the point which was discussed. The group was free and there were some

laughing during the discussion. Local language, which is Sesotho, was used throughout the discussion.

Focus Group 2 (NGOs)

Demographic notes

The focus group was conducted at the office of one of the Non-Governmental Organization; on the 24th November 2013. It started at 12:05pm and lasted 41 minutes. It was a warm day. The discussions started with the participants and the researcher having cold drink and some biscuits. The interviewer explained the consent forms and the participants signed them and also filled their demographic profiling.

Descriptive notes

The focus group consisted of 9 participants, 7 females and 2 males from different organizations in Dewetsdorp. 1 participant was from organization of people with disabilities, 1 participant was from an organization of elderly people, 2 participants from 2 different youth organizations, 2 participants from two different Home Based Care organizations, 1 participant from An organization providing DOT and the last 2 are from HIV/AIDS support group. Their ages ranges from 20 to above 50 years. The interview was conducted in the offices of one of the community organizations. There were sounds of moving cars heard occasionally and some flipping of papers during the discussions.

Reflective notes

The discussion started very slowly, with participants responding to questions after long pauses, making the interviewer to repeat the questions over and over. Some participants were talking more than others but the interviewer ensured that all the participants are engaged in the discussions. Some participants gave very brief answers while others were elaborating their points. Towards the end of the discussion the participants started to open up and talk more freely. Local language, which is Sesotho, was used throughout the discussion.

Focus group 3 (community members)

Demographic notes

The focus group was conducted at the office of one of the Non-Governmental Organization; on the 6th December 2013 at 10.00am it took 34 minutes. It was a warm summer day.

Descriptive notes

The focus group consisted of 7 community members who visited the clinic at least monthly to seek the services, of which 4 were females and 3 were males. Their ages ranged between 31 years to over 50 years. Before the discussion started the researcher had some refreshments with the group and while still talking she noticed that 2 of the community members who were there did not meet the study criteria as they rarely obtained the services from the clinic; they got the information that they were called to receive some food parcels. After the study was explained they left without participating, leaving 5 members who were meeting the study criteria. The study was conducted in the office belonging to one Non Governmental Organization. The place was quiet although there were sounds of children playing, sounds of dogs barking as well as moving vehicles at the background.

Reflective notes

The discussion was very brief, with participants reluctant to respond to the questions, when they do so, they were so brief and giving the researcher the idea that they were not feeling free to discuss the issue. As the discussion continued some participants started to open up and talk more freely and the interviewer kept on reminding them that they should feel free to talk. During the discussion some participants would raise some irrelevant points, for example one started to report that they would like the clinic to be extended while the other reported that some clinic personnel are having bad attitudes towards them as patients. The researcher kept on getting them back to the relevant discussion. Local language, which is Sesotho, was used throughout the discussion.

APPENDIX F: Example of a transcription of an interview

Interviewer	Respondents (leaders focus group)
<p>Interviewer: As I have already explained the content of those consent forms you are having and you have already signed the consent forms can you start with our discussion. I would like to hear from the leaders what is their understanding about community participation in the running of the clinic? If you want to speak please indicate by the show of the hand. (Pause) Who would like to start? Yes madam.</p>	<p>Respondent 3, 1: Err... the way I understand it is that as the community, we can give our contribution and make the clinic aware of some things that you are not aware of in the clinic.</p>
<p>Interviewer: That is her opinion, any other opinion? Yes madam?</p>	<p>Respondent 3, 2: I understand that the community should help the clinic so that everything in the clinic can run smoothly.</p>
<p>Interviewer: Can you explain what you mean by helping, (long Pause).</p>	<p>Respondent 3, 2: For example if there is something that needs to be done at the clinic, the clinic staff should approach the community so that the community can assist.</p>
<p>Interviewer: I would you to explain the work 'help' so that we can understand better. Just make an example.</p>	<p>Respondent 3, 2: For example when there are some events.</p>
<p>Interviewer: I now understand; You are not a large group so everybody must give her opinion (soft laughter – back ground). (Long pause)</p>	<p>Respondent 3, 3: the community should take part in the clinic in that people should go to the clinic freely they should not be shouted at. The community also should show respect to the clinic staff, they should know that when they are at the clinic they are to get health services and they should be patient.</p>

<p>Interviewer: thank you madam. The lady thinks the community should feel free to go to the clinic not having fear to be shouted. Any other opinion?</p>	<p>Respondent 3, 3: Sometimes we must respect one another; I should respect you as you work at the clinic.</p>
<p>Interviewer: Thank you madam for your opinion. Can I have other opinions? Yes madam</p>	<p>Respondent 3, 1: Sometimes you found that there are some patients who do not go to the clinic when ill and you find that as the community we know of such patients so if we are allowed we can take them to the clinic. I believe that is the way we can help the clinic as the community.</p>
<p>Interviewer: Thank you. The lady brings another opinion that as the community, they can assist by taking patients who do not want to go to the clinic to the clinic. Yes madam.</p>	<p>Respondent 3, 3: In my neighborhood there is a certain gentleman who is not feeling well, I would like to know, as I have said that I usually do not go to the clinic or to the Doctor, even if I go there is just for checkup, that gentleman sometimes losses his mind so how about if some clinic members can go and consult this man in his house?</p>
<p>Interviewer: The lady is suggesting that the clinic should go to the community. Is that what you mean? (Yes – background). Would you like to explain your point further?</p>	<p>Respondent 3, 3: There are some people who are not able to go to the clinic just like me (yes – background) and again I am talking on behave of other people who cannot go to clinic for various reasons some are bedridden, so when you hire the car it is expensive, when you take them by the wheel chair to the clinic you wait for the long time. I was therefore asking that there should be people who can help those people at their homes.</p>
<p>Interviewer: that is her opinion we thank her. Can we have other opinions? (Long pause) Or should we pass it and move maybe it is not yet clear. So Interrupted. yes</p>	<p>Respondent 3, 4: As services keep on changing at the clinic so when we, as the community, go we expect things to be as there were when we were last there so I think as the</p>

	<p>community when we get to the clinic we should show respect and ask how are the services conducted; you should not for example expect to sit where you were sitting the last time you visited the clinic.</p>
<p>Interviewer: thank you madam. I believe we now understand the issue of community participation so let us move on, currently in your own clinic what do you think is the level of community participation? That is, do you currently think you as the community have a say in the clinic? (Long pause).</p>	<p>Respondent 3, 2: Yes there is part that the community takes as there is clinic committee; the clinic committee is made up of people from the community.</p>
<p>Interviewer: Thank you madam. The lady next to her please speak, but if you do not know be fair and say so, I just want you to be all freely involved as I have said (long pause).</p>	<p>Respondent 3, 4: We do not know when and how they meet, I hear it is said there is the clinic committee but most people do not know about it consult the community, as the community we are not sure when they meet with the community, I believe we should know the members of clinic committee not by just seeing the names but they should come and meet the community.</p>
<p>Interviewer: Thank you for your opinion. Yes madam, can I hear your opinion?</p>	<p>Respondent 3, 5: I really do not have much as I rarely go to the clinic but I think the community participates as when I went to the clinic I saw some changes as previously we were all using one building but now I see lot of changes because of the part taken by the clinic committee and I saw that there is an extra building, caravan and I even saw that the services were faster, and there were some real changes.</p>
<p>Interviewer: In other words you think the community has the voice although</p>	<p>Respondent 3, 1: I also believe that the community has a voice in the</p>

<p>you do not use the services frequently? Yes madam what are you saying?</p>	<p>clinic like as other respondents have already said there are lots of changes in the clinic especially this year. I agree with the lady when she says she has heard about the clinic committee but she has never seen it because most of the time we hold our meetings around 1 O'clock. When there are some activities at the clinic usually the clinic personnel are the ones addressing the community we as the members of clinic committee we have never address the community.</p>
<p>Interviewer: Ok I see that you keep on bringing the issue of clinic committee as part of representation of the community in the clinic. So I would like to hear from you madam as I can figure out that you are part of clinic committee so can you explain the role of the clinic committee in the clinic.</p>	<p>Respondent 3, 1: We are trying to inform the community for example if it is crowded at the clinic and there is the shortage of nurses we inform the community about the situation, as sometimes there is 2 or just 1 professional nurse, so that they cannot get cross. Sometimes you find that a person working in the chemist is having so stuff to do so she asks that the line should be cut and we explain such situations to the community that there is nobody working at the chemist.</p>
<p>Interviewer: Thank you madam.</p>	<p>Respondent 3, 3: I was once part of clinic committee, long time ago. We were expected to go to the clinic in the mornings to ensure whether the clients were treated well, but nowadays the is an increase in the population, things have changed a lot, nowadays when you go to the clinic you find long lines.</p>
<p>Interviewer: Ok madam, meaning you were once part of clinic committee, and you were usually at the clinic to arrange the line? (Yes ...</p>	<p>Respondent 3, 3: You know madam the services were fast, because I can still remember one day there was a neighbor of mine who drank paraffin, I</p>

<p>background). Why was it important for you, as clinic committee to be seen frequently in the clinic?</p>	<p>quickly rushed her to the clinic and we were fast tracked and asked to wait next to the professional nurse's consulting room then there came the other professional nurse and shouted at us saying we have pass other patients. I told her we were asked to stand there, anyway I left her alone and we were given the services fast and we and collected our medications and we left immediately.</p>
<p>Interviewer: In other words you think during those days when you as community through clinic committee, were frequently seen at the clinic the services were fast. (Yes ... background) Any other opinion? (Long pause) Can you say something madam.</p>	<p>Respondent 3, 1: there is a relationship between the traditional healers and the clinic because we work together with the clinic; if there are some workshops we are given some invitations. The clinic sometimes give us the forms to fill I therefore think the relationship is so good.</p>
<p>Interviewer: Madam what benefits are you as tradition healers or community members benefit from this cooperation you are having with a clinic?</p>	<p>Respondent 3, 1: It a helpful relationship because as traditional healers while working in traditional way, there are some illnesses that need western medications, as traditional healers we were not aware of such conditions and how to handle them but now we know how to handle certain medical conditions.</p>
<p>Interviewer: Thank you madam, I think you have explained it well. Anybody who would like to add or to explain it from any different angle, maybe from religion part of it? (Pause). Yes madam.</p>	<p>Respondent 3, 5: I would like to add on what she has said as there are some religious organizations like certain sister who usually hold prayers and gives some scriptures at the clinic and I think that as part of important community participation as before people can be consulted they should be given prayers. Starting with the prayer gives nurses strength to handle patients; that is one part that I personally like that there is a</p>

	<p>priest involved in the clinic to start daily work with prayer to give nurses power before handling patients.</p>
<p>Interviewer: I thank you madam. Any other opinion before we can move forward?</p>	<p>Respondent 3, 3: As part of traditional healers we are glad that before the traditional initiation can be performed the initiates are taken to the clinic for examinations. We would really be glad if even those that are to be trained to become traditional healers are also taken to the clinic as we sometimes encounter problems. Some of them would want us to train them as they have been showed by the ancestors that we should train them whilst our ancestors did not show them to us, but when you take a close look at that person you could see she is not healthy. You know the illnesses nowadays (soft laughter) can give some sort of funny dreams and if you are not aware you can think those dreams are brought by the ancestors, but before the training is totally completed you would end up with a corpse. I just want to make you aware of these traditions, like with the initiation schools if a child goes for initiation with illnesses like TB and that other condition that I do not even want to mention with a name will die because there at the initiation schools nurse are not there so nobody will consult him to find out which medication is needed.</p>
<p>Interviewer: Joo! The lady took it from another angle now; you are saying you do not even want to mention this illness (soft laughter – background) by the name? Say it so that we can know what you are talking about, (loud laughter) Fell free</p>	<p>Respondent 3, 3: (laughing) It is HIV. The boy should be taken to the clinic for HIV test before going for initiation. Even when we are attending the workshops we are tested for all sort of things even cancer so even those who need to be trained to be</p>

<p>to say it.</p>	<p>traditional healers should first go to the clinic for examination. HIV madam is affecting everybody, even as we are nursing this people. There was a lady who visited me and when I met her I told her that she looked unhealthy, she admitted being ill and she said it was due to nursing her daughter and her two sisters who had this same illness so I noticed that it was the reason she was ill. I then advised her to go to the clinic so that she could get help and I further I asked her to come and tell me when she was from the clinic so that we could see what we could do, as it is said there is no cure as yet for HIV, we also as traditional healers believe there is no cure but we also can help.</p>
<p>Interviewer: In summary you are saying you would like that the clinic and the traditional healers should work hand in hand to examine the students traditional healers before they could be trained (yes – background).</p>	<p>Respondent 3, 3: There is one that I have now stopped, she is a lady from the farm communities and when I looked at her she is ill-looking, I stopped her from attending the training and said next time when you come be ready to go with me to the clinic for examination and I want to get into the consulting room with you so I can be protected from her relatives in future if anything happens she anyway agreed so I will take her, although I am not really convinced about her calling.</p>
<p>Interviewer: Thank you madam. Yes madam your hand was up.</p>	<p>Respondent 3, 4: I was just making follow-up on what the other respondent has just said, I think there is the relationship between the community and the clinic because according to my knowledge all initiates before going to the initiation schools there would go to the clinic and be given each one a kit that he</p>

	will use, although I am not sure if it is still continuing or it has stopped. Each child was using his own individual kit because nowadays there are lot of illnesses and if we can enhance or strengthen that.
Interviewer: Thank you for all the answers. Any other opinions before we can move further? So I now want us to talk about way forward, what can be done in future to improve this participation. (Pause).	Respondent 3, 3: Madam I really agree with you because even as traditional healers we no longer share one blade, when a patient comes for consultation I ask her to go and buy her own blade of which I will open in front of her to see and when I have finished using it I burn it.
Interviewer: Who do you think should hold the meeting the clinic or the community, through the traditional healers?	Respondent 3, 3: The clinic should have the meeting with the community to explain that whoever wants to go for traditional healer trainer should start at the clinic for examination like those who go for initiation.
Interviewer: Thank you, I believe it is clear. Any other different opinions? Can you give your opinion madam?	Respondent 3, 2: I think the clinic, because if it is us they will think we like money. I think as people go to get the clinic services at the clinic, there should be one nurse or anybody who would advise them to go for examination before they could go for the training, just like with those who are going for initiation school.
Interviewer: In your mind how can that be achieved? I want, when we live this place, it should be clear how to implement this participation?	Respondent 3, 4: Yes, like it has already been mentioned that the clinic and the community should work collaboratively, I think if that is done everything will run smoothly.
Interviewer: Any other opinions, (Pause) We are about to finish.	Respondent 3, 4: I think there should be a meeting between the community and the clinic, whereby clinic would tell the community what it is expected of them and the

	community could also tell the clinic their expectations too.
	Respondent 3, 3: Can I ask? (yes – background) Is there a doctor at the clinic?
Interviewer: Yes there is a doctor although not coming on daily basis. Any other opinion? (Long pause) Yes madam anything you want to add.	Respondent 3, 1: I think as the lady had said there should be the meeting with the management (door opens and closes), so that the concerns could be risen. People have lot of diseases nowadays and people are not even attending the clinic when ill; therefore infecting other households as even our houses are so congested, so if we as community can take these people to the clinic so that they can get medical assistance.
Interviewer: You said there should be a meeting with the management, so who do you think should meet the management and how? Let me start with the other lady.	Respondent 3, 4: I think we as the community can ask permission from the clinic manager whether she cannot organize the meeting with top management so that as the community we can meet with them and discuss with them all our concerns.
Interviewer: Thank you, in other words you think the community or community representation should meeting with the Primary Health Care management. You can also speak, your hand was up.	Respondent 3, 2: It is more or less the same with what she said, we can meet with the clinic committee and tell them our challenges and they should direct those challenges to you and you can take them to top management.
Interviewer: When referring to 'you' what do you mean?	Respondent 3, 2: The clinic manager.
Interviewer: Thank you. It is clear now because when you are saying you I am going to translate it directly (laugh – background.) any other point before discussing the last point.	Respondent 3, 3: I would like to go back a little bit to what has been discussed before. There old people I am taking care of, and few days ago the old lady went to the clinic, as she

<p>Yes madam.</p>	<p>is now weak, it is as if she fell; so I am asking if there is no way that the nurse or anyone can go and provide the services at the community.</p>
<p>Interviewer: May I ask anyone to answer her.</p>	<p>Respondent 3, 2: There are some organization which assist provide home-based care services, they bring medications at home.</p>
<p>Interviewer Can you explain the functions of such organizations? (Long pause) Can you please briefly explain?</p>	<p>Respondent 3, 3: It is as if there were some people helping them with such services but it seems as if it is now 2 – 3 months that they do not go.</p>
	<p>Respondent 3, 2: There are some organizations working with the community, for instant those people who are very ill and TB patients they go to their houses on daily basis; those organizations are there within our community.</p>
<p>Interviewer: Ok.</p>	<p>Respondent 3, 1: Those organizations are doing home-based care to TB and HIV patients, so the lady was referring to other patients with chronic conditions like Diabetes, High Blood pressure and the elderly patients.</p>
<p>Interviewer: I will take this as part of the suggestions that apart from the Home-Based Care which is provided to the TB patients maybe there should be the same care to elderly patients. (Yes – background). Yes can the lady talk before you and you can talk.</p>	<p>Respondent 3, 1: Yes because even those people that the lady is referring to are elderly patients.</p>
<p>Interviewer: Yes madam your hand was up.</p>	<p>Respondent 3, 6: It is going to the same issue that we suggested that there should be an increase in the number of nurses so that there can be nurses who are providing Home-</p>

	Based Care, while others will still be clinic-based. So that while others will be in the community there should be others still assisting patients at the clinic. This location is large, it has lot of patients some are even hiding we do not know about them.
	Respondent 3, 2: I was saying if things are still the same, people who were on high blood treatment were taking some time before they were reviewed by the doctor so there we sending us to go to the clinic with their files to collect treatment for them.
Interviewer: You as who?	Respondent 3, 2: (interrupts) Home-based Careers.
	Respondent 3, 6: You mean their treatment was collected without any examination done? Maybe to check how is the blood pressure?
Interviewer: Meaning there was a Dr. who was checking the patients from their homes and then the Home-based Careers would take the patients' files to collect their treatment?	Respondent 3, 2: Doctor 'X' was going to the houses to check the blood pressure and we were taking that reading to the clinic.
	Respondent 3, 3: Yes but he is on pension now he is working at the old age home.
Interviewer: So if that Dr. is on pension so it is taking us to where you were saying if we can have such service again.	Respondent 3, 7: While Dr. 'X' is on pension, there is a nurse who is seeing the patients at their homes, she only goes on Thursdays, and even today I have seen her car somewhere. So I would like to explain that at first the treatment was given for six months but now they are only given three months treatment

	<p>before they can be consulted and examined by the doctor that is when that old lady fell. I was suggesting that if there is an elderly patient who cannot go to the clinic her career should be informed maybe a day before so that she can accompany her to the clinic if there is no relative who can do so for the Doctor's examination.</p>
<p>Interviewer: Thank you. Can you explain the word 'career'?</p>	<p>Respondent 3, 7: Community care givers are people who are trained to assist people at the homes like to take treatment to TB and HIV patients and those patients who are too ill to look after themselves, so they bath them.</p>
<p>Interviewer: Can you explain whether the career is part of community or clinic staff?</p>	<p>Respondent 3, 7: they are part of the community that has volunteered to do that work; they are not part of nursing staff.</p>
<p>Interviewer: Thank you madam The last point is; is there any relationship between community participation and quality of services? In other words do you think the quality of Primary Health Services if community participation improves, do you think it will be improved, same or decrease? (pause)</p>	<p>Respondent 3, 2: I think the quality can improve if the clinic works with the community because sometimes they are patients who are hiding so as community we can inform the clinic about such patients and the clinic can go to such patients.</p>
<p>Interviewer: So how do you think that can improve the level of quality of health services?</p>	<p>Respondent 3, 2: It would because lot of patients will be put on treatment and they can stay healthy.</p>
<p>Interviewer: Thank you. Any other opinion at least she gave us an idea about what I need?</p>	<p>Respondent 3, 1: I would like to second the previous speaker as she has said when the clinic and the community work together there will be improvement as the clinic will hear</p>

	<p>from the community about those patients that they do not know about as they do not want to go to the clinic and if the community would inform the clinic about such patients the clinic can do some home visits and assist; therefore reducing burden of the diseases.</p>
<p>Interviewer: Thank you madam.</p>	<p>Respondent 3, 3: Yes madam, usually when the house is on fire not only one person goes to put off the fire but everybody go with different helping tools; others will come with sand others with water to put off the fire, therefore if the clinic and the community can work together it will be easy to tackle the illnesses in different ways.</p>
<p>Interviewer: Thank you madam, we have explained in the way I really like.</p>	<p>Respondent 3, 5: In that case there would be the reduction in the death rates if the clinic and the community can meet and work together. I think there can be reduction in the mortality and mobility people would not be dying while hiding from in their homes and that can bring the good record.</p>
<p>Interviewer: You want to add on something?</p>	<p>Respondent 3, 4: She actually said what I wanted to say. (Laugh – background).</p>
<p>Interviewer: (laughing softly) Ok say it with you own words then.</p>	<p>Respondent 3, 4: I was going to say the deaths due to people not going to the clinic would be reduced and the bedridden patients’ health would improve because if maybe my neighbor is ill and the clinic is not aware as a neighbor I would take the responsibility of informing the clinic.</p>
<p>Interviewer: thank you. Do you have anything else?</p>	<p>Respondent 3, 6: Thank you I want to say if someone goes late to clinic</p>

	<p>while already very ill and dies it is not a good thing. We do not like when people die we want them to get well. So we do not want people to default their treatment or go to clinic while severely ill and at the end the blame is put on the clinic in fact we do not want people dying.</p>
<p>Interviewer: So what should be done?</p>	<p>Respondent 3, 6: we should as community speak with the patient while he can still walk to go and get services as when he is severely ill it is difficult to be assisted and they cannot even take medication well. We should encourage them to go to the clinic but if they refuse, Ache I do not know what we can do. We have lot of those stubborn patients who you would hear them saying ‘so now you take me to the clinic so that nurses can kill me’. (laughing – background) When you give them medications they think it is poison.</p>
<p>Interviewer: In other words you all think when there is community participation the level of quality of health will improve (will improve – background)?</p>	<p>Respondent 3, 3: (Interrupts with a low voice) and mostly the youth are the ones dying I do not know who will take care of us.</p>
<p>Interviewer: Thank you very much I know it is not easy to leave your work and participated. Any other thing you would like to know about?</p>	<p>Respondent 3, 3: I am just waiting to get home-base care services from my home.</p>
<p>Interviewer: Ok that is the only thing you are waiting for? (Raises the voice) Thank you very much (Amen background).</p>	

APPENDIX G Semi structured questions (interview schedule)

FOCUS GROUP INTERVIEW QUESTIONS

1. What is your understanding concerning community participation in primary health care service?
2. What do you think about the current community participation in primary health care?
3. According to your view, what should be done in future concerning community participation in primary health care?
4. What do you think is the relationship between quality health care and community participation?

APPENDIX H: Language editing certificate



Director: CME Terblanche - BA (Pol Sc), BA Hons (Eng), MA (Eng), TEFL
22 Strydom Street
Baillie Park, 2531
Tel 082 821 3083
cumlaudelanguage@gmail.com

Invoice: Editing

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CME TERBLANCHE

SATI Reg nr. 1001066

Bank details:

First National Bank: Potchefstroom Branch Branch Code: 240438

Cheque Account: Cum Laude Language Practitioners (cc)

Account Number: 6242 8108 577

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