

**The role of service delivery in the transformation of health  
sectors in the North West Province.**

**by**

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## ABSTRACT

The research aimed at investigating the role of service delivery transformation of health sectors. The study focused on the North West Province, with reference to the Mafikeng Health Sub-district.

A quantitative research method was used with a sample of seventy managerial health staff, professional staff, auxiliary nurses, assistant nurses and environmental health workers to determine the role of service delivery in the transformation of health sectors.

The past health system experienced a great deal of duplication of services and resulted in wastage of resources. The study shows that the development of a health system should ensure equity in service provision in long term, the planning management and delivery of health services should be comprehensive and integrated. The structures available for health must be used to produce the best health results at the level lowest possible cost. All people should have access to the health services.

The research found that the government structure of the District Health generally referred to district Health Management Team is responsible for providing health services in the areas including health and is accountable to the people in that area.

The research recommends that the management structure should encourage community participatory forums to advocate for the health needs of the community. This may assist in conducting a situational analysis in the communities, advising and participating in the decision making process and in planning, implementing and evaluating the health programmes.

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## DECLARATION

I declare that this dissertation is my own unaided work. It is submitted in partial fulfillment of the requirements for the degree of Master of Business Administration (MBA), at the North West University, Mafikeng Campus .It has not been submitted before in any degree or examination in any other university

Signed.....  
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## CHAPTER ONE: ORIENTATION

### 1.1 INTRODUCTION

The current South African Health System has inherited problems of coverage, access, equity, management high costs and effectiveness. Following the transition to democracy in 1994, the health system has been undergoing substantial structural changes. The state is attempting to ensure equity between provinces and reorient the public sector towards primary care. South Africa's system consists of a large public sector and smaller but fast growing private sector. Health care is offered free by the state and highly specialized hi-tech is available in the private sector for those who can afford it (National Health Services 2005).

The public sector's health system is under resourced and over used, while the mushrooming private sector's run largely on commercial lines, caters to middle and high income earners who tend to be members of medical schemes, and to foreigners looking for top quality surgical procedures of relatively affordable prices. The private sector attracts most of the country's health professionals. Although the state contributes about 40% of all expenditure on health, the public health sector is under pressure to deliver services to about 80% of the population. Despite this, most recourse are contracted in the private health sector, which sees to the health needs of the remaining 20% of the population (National Health Services 2005).

Public health consumes around 11% of the total budget, which is allocated and spent by the nine provinces. How these resources are allocated and the standard of health care delivered varies from province to province, with less resources and more poor people, cash strapped provinces like the Eastern Cape encounter greater health challenges than wealthier provinces like Gauteng and Western Cape (Department of Health 2005).

South Africa continues to be on the road to economic transformation and health reform. The record in socio-economic reform remained mixed, social infrastructure was improved but the community still suffer from an immune unemployment rate of 30 percent to 40 percent, severe poverty problem, enormous level of inequalities and

burgeoning HIV and AIDS problem. The South African government has recognized these deficits and reacted with renewed efforts to meet these challenges. One of the efforts is services transformation which aimed at addressing the problem of social injustices and inequalities in health sectors (Department of Health 2005).

The aim of the study is to determine the role of services delivery in transformation of district health sectors. Tarimo (2001) defines a district health system based on primary health care as more or less self contained segment of the national health system. It comprised of first and foremost a well defined population living with a clearly delineated administrative and geographical area. It includes all the relevant health care activities in the area. The World Health Organization (WHO) views a district as an integrated health system as vehicle for delivery of integrated care (WHO Technical Report Services 2000).

The White Paper (1997) deals with the transformation of the health services to reduce the large level of social inequality in health services. Its aim is to introduce a strong shift towards universal and free access to comprehensive health care and change the disproportionate level of preventable diseases and parameters deaths in certain segments of the population. A constant theme of the policy document is one of reallocation and this is evident in the call to shift resources from tertiary services in metropolitan areas towards overcoming the inadequacies of hospital and clinics in rural areas. Transformation of the health system in South Africa emphasizes the integrated and comprehensive service delivery.

The present study was aimed at determining the role of the management in the implementation of health care services for the benefit of client in the rural areas. The White Paper which exactly states that management should be responsible for the control of its health budget and the provision and purchases of compressive primary health care services within its areas of jurisdiction. Effective referral networks and system should be insured through co-operation with other health districts. All the services should be rendered in collaboration with other government, non-governmental and private sector. Restructuring health services requires that the new structures be staffed by skilled people to ensure efficiency and effectiveness in management and administration of health sector.

The study examined existing essential health care programs, system and services for the benefit of the community. The Department of health has a responsibility of providing services which cannot be cost effective and delivered elsewhere.

It is essential to obtain active participation and involvement of all sectors of the South African society in health and health related activities to provide leadership in planning for the strategic management and to ensure equity in the allocation of resources to the province and local government. All sectors of the communities, all members of households and families and all individual must be actively involved in order to achieve the health consciousness and commitment necessary for the attainment of goals set at various levels. Without active participation and involvement, little progress can be made in improving health status of the South Africans. Health teams and workers at all levels should develop a carrying ethos and commit themselves to the improvement of the health status of their communities. Health workers should not only be responsible for their patients who attend their health facilitation but also have a sense of responsibility towards the majority of the population in their catchments area.

## **1.2 OBJECTIVES OF THE STUDY**

The objectives of this study were

1. To determine the role of service delivery in the transformation of health sector.
2. To assess the different types of health services and systems which are in place at different health sector.
3. To determine the role of management in the implementation of health care programs, systems and services.
4. To determine the involvement of the communities in the health services.

## **1.3 IMPORTANCE OF THE STUDY**

Health services should be equally accessible to all people irrespective of their ability to pay and all (rich or poor urban and rural) should have access to health services. The study is important to communities in that it aimed at addressing the current imbalance

in health care by shifting the centre of gravity from cities where the majority of the health budget is spent on rural areas where the majority of people live in most of the South African countries.

Unity and national coherence in the national health system is important to ensure and achieve over time, a degree of equity in health care delivery within and between provinces and secondly to promote efficiencies that are gained through economies of scale.

Therefore this study is important to local communities because it outlines the primary health care services which are provided by the national health system. These services are determined by the available resources and should be implemented on a sustained and incremental basis over a ten year period from 2005.

The study examined the essential health care program, system and services which are in place for the benefit of the communities. The Department of Health has a responsibility to provide services which cannot be cost effective, delivered elsewhere, provide leadership in planning for the strategic management of the resources available for health care and to ensure equity in the allocation of resources to the provinces and municipalities and their appropriate utilisation.

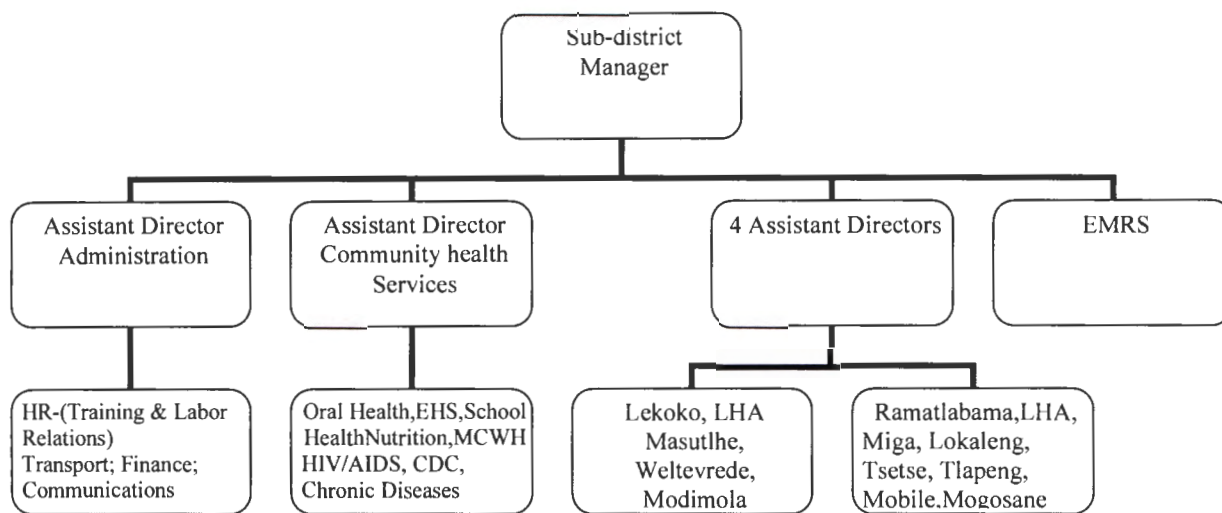
It is essential to obtain active participation and involvement of all sectors of South African society in health and health related activities. All sectors of the community, all members of household and families and all individual must be actively involved in order to achieve the health consciousness and commitment necessary for the attainment of goals set at various levels. Without active participation and involvement, little progress can be made in improving health status of the South Africans. Health teams and workers at all levels should develop a carry ethos and commit themselves to the improvement of the health status of their communities. Health workers should not only be responsible for their patients who attend their health facilitation but also have a sense of responsibility towards the majority of the population in their catchments area.

The government of South Africa publicly stated that commitment to a people-centred development approach which seeks to engage communities at the various stages and levels of development as an important international land mark. The study promotes the involvement of the community through fostering community participation across the health sector, involving communities in the planning management, delivery, monitoring and evaluation of health sector. This encourages public accountability, responsibility, dialogue and feedback between public and health providers.

#### **1.4 THE SCOPE OF THE STUDY**

South Africa has a population of over 40 million, 73% of whom are women and children. Although classified as middle income country and spending 8, 5% GDP on Health care, South Africa exhibits major disparities and inequalities. This is the results of the former apartheid policies which ensured racial, gender and provincial disparities. South Africa has inadequate access to basic services including health, clean water and basic sanitation. Statistics for 2004 suggest that between 35% and 55% of the population live in poverty. Fifty three percent live in rural areas. All three percent of the population lives in rural areas the visits majority of whom are poor.

The geographical parameter of this study was the North West Province with reference to the Mafikeng sub-district (Figure 1.1). The economic structure of the district is dominated by community, social and personal services sectors, other sectors are agriculture and manufacturing. Basic service provision is unequally distributed between urban and rural parts of the province.



**Figure 1.1 Organogram: Mafikeng Sub-district ( Department of health 2005)**

### 1.5 BACKGROUND OF THE STUDY

The greatest challenge facing the world is to combat and eradicate disparities. The main goal is to create unity, comprehensive, equitable and integrated natural health system. The challenge facing South Africa is to design a comprehensive program to redress social and economic injustice. Crashed property reduces waste, increases inefficiency and promotes greater control by communities and individuals over all aspects of their lives (<http://www.doh.gov.report/annual2006>).

In transforming health system the South Africans are faced with a serious challenge of providing quality health services. A quality service health does not have to give the highest quality of every patient who asks for care, but it should meet the needs of those patient most meet and in safe and effective way. It is better not to give service than to give one which could harm a patient or which could waste resources which could be used by other services. A service should follow standards which state which services to provide and how to provide them. Standards are needed for each three dimensions of quality community or patients quality: Standards are based on what people want, for example, maternity service, oral service:

- Professional quality: Standards for how to assess and treat patients effectively.

- Management quality: Standard for providing services efficiently without waste and following high level regulation.

A quality service is one which is accessible, affordable, acceptable, effective, efficient and lawful. It provides a range of services which meet the most important health needs of the population including preventable services in a safe and effective way without waste and within higher level regulations (Ovretveist 2004).

Between 1950 and 2000, the rural health has gone from 725 facilities to more than 163 000 facilities (Mavallankar and Amanmi, 2007) consisting of 4,000 rural sub district hospitals called community health centers, 24 000 primary health centers and 135 000 sub health centers.

There is a shortfall of 16 percent in the number of primary health centres and high as 58 percent in case of community health centre. Public health infrastructure is far from satisfactory as the delivery of services is hampered by several policy and management constraints (Mavalankar et al 2003). Particular concerns of public health infrastructure are non availability of staff, weak referral system recurrent funding short falls, lack of accountability for quality care and poor logistics management of supply of medicines and drugs (Silvestro 2002).

The utilization of massive public health infrastructure is subjectively low. Availability and access to public health facilities is very poor for women, children and socially disadvantaged section of our society. The governmental health programmes is refocusing on primary and rural health services. It has decided to provide 24 hour services, drugs a week, fifty percent of all primary care over the next ten years..

The present study is important to the local communities because it outlines the primary health care services which are provided by the district health system. These services are determined by the available resources and should be important on a sustained and incremental basis over a ten year period.

A White paper on transformation (1997) recognises the importance of knowledge information and evidence by stating the health sector must be linked and integrated

into planning, policies and programs implementation. Restructuring the health services requires that the new structure be staffed by skilled people, to ensure efficiency and effectiveness in management and administration of health sector.

## **1.6 CLARIFICATION OF CONCEPTS**

To understand the different concepts and their usage in the different parts of the report it is important to explain the key concepts used in this study which include the following:

- Basic services are necessary to ensure acceptable and reasonable quality of life and if not provided, would endanger public health or safety of environment.
- Public health refers what society collect to assure healthy conditions in which people can live healthy (Stanhope and Lancaster 2004:6).
- Consultation is described as process in which helper provides set of activities that help the clients perceive, understand and act on events occurring in their ' environments ( Standhope Lancaster 2004: 1012).
- Primary health services are acts that are intended to maintain or improve health e.g. communicable diseases control environmental health service and personal health services (Douglass 1992).
- Health care systems are the resources (money, people and technology) and organization configuration necessary to transform resources into health resources (Douglass 1992).
- Primary health care is an essential care based on practical, scientifically sound and socially accepted methods and technology made universal accessible to individuals and families in the community through their full participation and at a cost that a community and a country can afford to maintain at every stage of their development in the spirit of self reliance and self determinant (National Health Research Policy 2001).

- Community refers to people in the context of their environment as they continuously interact with each other in their environment (Kleinberg et al 1998).

## **1.7 LAYOUT OF THE STUDY**

Chapter one is an orientation leading the reader to the understanding of objectives, scope and the importance of the study. Chapter two reflects the theoretical foundation for the study. The literature review is provided in chapter three, Chapter four presents the statement of the problem. The research design and analysis are reflected in chapter five and the results of the study are presented in chapter six. Chapter seven is the final Chapter with discussion, recommendations and conclusion.

## **CHAPTER TWO: THEORETICAL FOUNDATION**

### **2.1 INTRODUCTION**

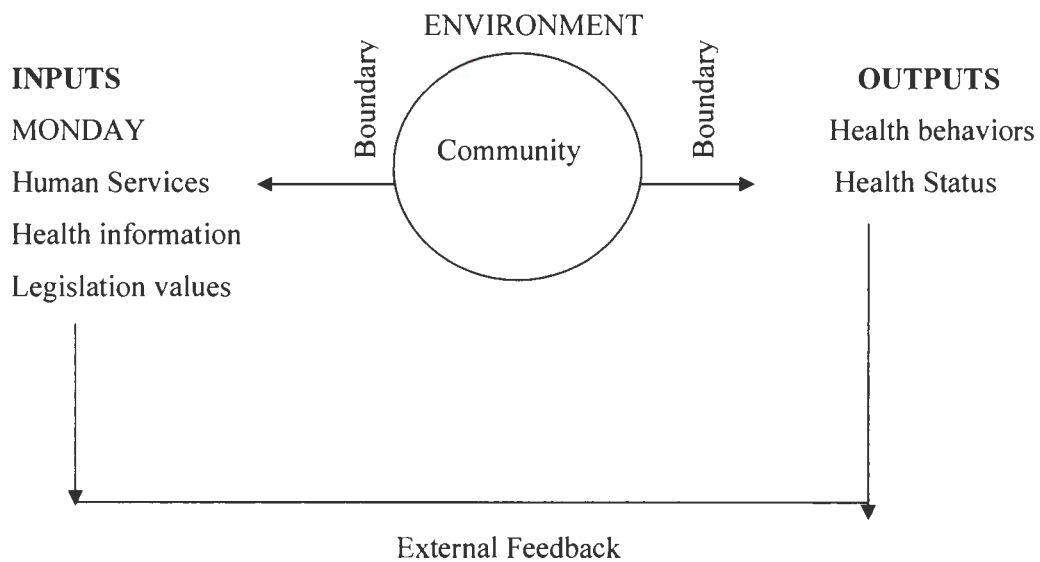
Chapter one introduced the reader to an understanding of the objectives, importance and the environment of the study. Certain concepts were clarified and the chapter ended with a layout of the study.

Chapter two deals with the role of service delivery in the transformation health sector. It presents an exposition of the different types of health services, program and system which are used by the department of health to improve service delivery in the disadvantaged areas. The chapter includes the role of management in the implementation of health program and the involvement of the community in the provision of health services.

### **2.2 COMMUNITY AS A SYSTEM THEORY**

Maurer and Smith (2005:52) define a health system as the organizational structure in which health care is delivered to the population. Most people really stop to think about the health care system and organisational structure that delivers care unless they have an unsatisfactory personal encounter. Clients dissatisfaction are building and leading to critical questions about the delivery system, identification of areas for change and how health system might change.

A system theory views a community as a dynamic model in which the community is constantly in process of responding and adapting to internal and external stimuli. The response aimed at developing and maintaining a sense of balance of equilibrium. The system model (Figure 2.1) serves as a tool to help the health primary workers to identify collect and organize appropriate data including critical components and their relationship to each other Maurer and Smith (2005:346).



**Figure 2.1 Community as a system (Maurer and Smith 2005: 350)**

The components of the system models for geopolitical and phenomenal communities are the same and consist of boundaries, goals, set facts, external influences, internal functioning output and feedback.

The community is defined in terms of three critical attributes people, place and social boundaries, established boundaries to help the primary health nurses to determine what data will be collected and consistent to the community as community information. The goals of the communities vary according to the type of community but in general they focus on maximizing the well being of members, promoting survival and meeting the needs of the community. According to Maurer and Smith (2005: 349) set of factors include physical, biological and social characteristic of the communities. These characteristics are often referred to as demographics.

All countries have external influences which affects their functioning and those external influences are called inputs. Inputs are matter, energy and information that come from outside the community and they may be either resources or demands on the community and may be imperative or voluntary. Some important inputs are money, facilities human resources, health information, legislation and values of supra-system (Mauerer and Smith *ibid* ).

The internal structures and process of community are called through puts. They include economy, polity, communication and values. Resources and demands may be found within each of these subsystems. The goal of economy subsystem is production and distribution of goods and services, this include human services money, facilities and educator. Polity is the politics of the community. The goal of policy is coordination, control and direction of activities to maintain the community and attain system goals. The government as well as informal leadership serves these functions. The policy system of community provides organizational structure, leadership, decision making and social control of its members in return for the member compliance and support (Stanhope and Lancaster: 2004:200).

The goal of the communication system is to provide identify and support to its members that is provide a sense of belonging. The communication subsystem includes the money effective relationship which exists among community members. This relationship provides the emotional tone of the community. The values as sub-system address the general originating principles that guide the socialization and behavior of members of the community. Community members accept and confirm to the standards of the community in return for approval. Patterns of behavior such as values, beliefs, standard, culture, ethic background, help determine the health action pattern of the community. These patterns of behavior include traditions, presence of identifiable subgroups, aesthetics, environment, health and homogeneity of the group. {Stanhope and Lancaster: 2004}.

Output includes measurable, health related behaviors that are exchanged from the community to the environment and is often referred to as health status. The health status of the community includes two interrelated factors, people and environment. General trends, trends in mortality and mobility, the presence of vulnerable groups or aggregates with at risk behaviors, prevalent of pre-symptomatic illness and level of social function are all the factors that impact or reflect on the health status (Maurer and Smith 2005:354).

Julia and George (2002:241) regard feedback as internal and external information from within the community that helps the community to monitor its functioning. External feedback is information from supra-system and larger involvement about

community functioning. This type of information helps the government to modify itself, adopt to changing environmental conduct and negotiate interchanges with its environment.

### **2.3 JOHNSON'S BEHAVIOURAL SYSTEM MODEL**

Johnson and Silburn (2002) believe an individual has patterned purposeful, repetitive ways of acting that comprise and behavioural system to that individual. These actions or behaviors from an organized and integrated functional unit determine and limit the interaction between the person and their environment and establish the relationship of the person to objectives, events and situation in their environment.

Johnson and Silburn (2002) view human beings as having two major systems, biological systems and behavioral systems. It is the role of the medicine to focus on the biological systems, whereas nursing's focus is the behavioral system. There is recognition of the reciprocal actions that occur between the biological and behavioral system when some type of dysfunction occurs in one or the other of the system

Society relates to the environment in which an individual exist. According to Johnson and Silburn (2002), an individual behavior is influenced by all the events in the environment. Cultural influences on the individual's behavior are viewed as profound. However it is felt that there are many paths, varying from culture to culture that influences specific behavior in a group of people although the outcome for all the groups or individuals is the same.

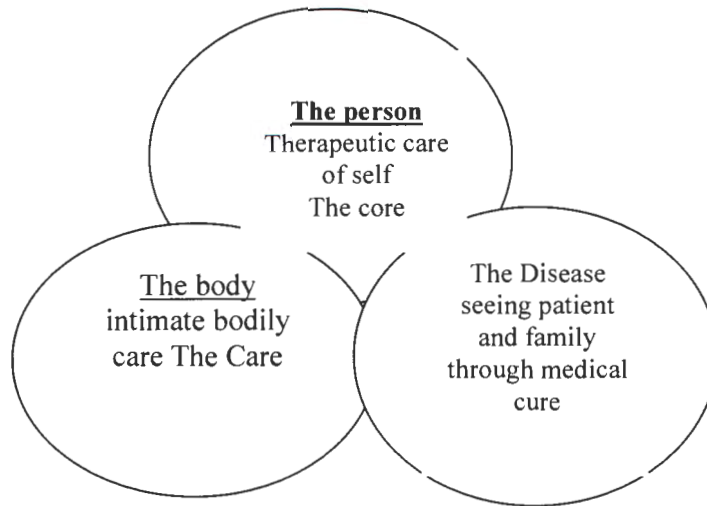
Health is an elusive state that is determined by psychological, social, biological factors. Johnson behaviour's model supports the idea that the individual is attempting to maintain some balance or equilibrium. The individual goal is to maintain the entire behavioural system efficiency and effectively but with enough flexibility to return to an acceptable balancing if a malfunction disrupts the original balance (Johnson and Silburn 2002).

## 2.4 CARE, CORE AND CURE THEORY

Julia and George (ibid) focus on three interlocking circles which represent a particular aspect of health service. The care circle represents the nurturing exponent which involves using the factors that make up the concepts of mothering. The professional health worker provides bodily care for the patient to complete basic daily biological functions as eating, bathing and dressing.

The care circle of patient care is based in the social sciences, it involves the therapeutic use of self and is shared with other members of the health team. The professional nurse should develop the interpersonal relationship with the patient to help him or her to verbally express feelings regarding to disease process and its affects as well as to discuss patient role of recovery. Through such expression the patient is able to gain self identity and further develop maturity (Julia and George 2002: 246). The core circle of patient is based in the pathological and therapeutic science and is shared with other members of the health. Julia and George (ibid) emphasize the importance of a total person approach, it is important that the three aspects of health services not be viewed as functioning independently but as interrelated. The three aspects that are behavioural interaction and the circles represent change in size depending on the patient's total course of progress.

The care, core and cure theory places the motivation and energy needed for healing the client (Figure 2.2). This theory influences the health practitioner's total approach to the six phases of health process that is assessment, diagnoses outcomes, planning implementation and evaluation. The assessment phase involves collection of data about the health status of the individual. It should be directed toward increasing patient self-awareness, diagnosis is a statement of patient's needs or problems area. Outcomes and planning involve setting outcomes goals. The patient decides what is of highest priority and also what outcomes and goals are desirable. The role of the health workers is to make help the clients to become aware of and understand need, feelings and motivation. The health worker together with the patients keeps the goal consistent with medical prescription.



**Figure 2.2 The Care, Core and Cure Therapy ( Julia and George 2002: 115)**

Implementation involves the actual institution of the plan of care. The health worker helps the patient and family through the cure aspects of working with the patient and family to help the understanding and implementation the medical plan. Evaluation is the process of assessing the patient progress toward the health goals. The evaluation phase of the process is directed toward deciding whether or not the patient is successful in reaching the establishing goals.

## **2.5 PUBLIC HEALTH THEORY**

According to Maurer and Claudia (2005:10) public health theory is concerned with the health of the population of human beings. It is a practice discipline that applies knowledge from the physical, biological and social science to promote health and to prevent disease, injury, disability and premature death. The important concepts in public health theory are population risk and prevention.

Population refers to people residing in an area or community or set of persons under statistical study. The initial goals of public health theory were to prevent and control communicable diseases that were major causes of deaths within human population. Population also refers to a set of persons having common personal environmental characteristics. The common characteristics might be anything to relate to health, age, race, sex, social class, medical diagnosis level of disability, exposure to a toxin, or participation in a health seeking behavior such as smoking cessation. It is the health

worker who identifies the characteristic and set of persons that make up this population. In epidemiology, numerous sets of persons are studied clinically and statistically to identify the causes of accidents, disabilities and premature death. Maurer and Claudia (2005)

In community health care epidemiologic information is used to identify populations at higher risk for specific preventable health conditions. Risk is a statistical concept based on probability. Community health workers are concerned with human risk of diseases disability and premature death. Therefore community health workers work with persons within the population condition (Schneider et al 1997)).

Aggregate is a synonym for population. Aggregate are people who do not have the relatedness necessary to constitute an interpersonal group but who have one or more characteristics in commerce such as pregnant teenagers. Williams (1997) focused attention on the aggregate as an additional type of client with whom community health nurses apply the problem solving process.

Maurer and Smith (2005:17) describe prevention as a complex concept that also evolved from an attempt to control disease among the public. The natural history of a disease involves a pre symptomatic period, and resolution (deaths, disability, complication and recovery) Friedman 1994:167). Prevention has three levels: Primary, secondary and tertiary.

The goal of primary prevention is the prevention of the occurrence of the disease. Activities of primary prevention include environmental protection such as mummifying and avoiding smoking. The goal of secondary prevention is the detection and treatment of disease as early possible during the natural history of the disease. Tertiary prevention is geared toward preventing disability complications and deaths from the disease- tertiary prevention include rehabilitation (Friedman-1994).

All levels of prevention can be accomplished through work with individuals, families and groups. Prevention can also be accomplished by targeting changes in the behavioral of specified population, changes in social functioning of communities

(law, social mores), and changes in physical environment population within the community is to ultimate goal of public health.

## **2.6 MANAGEMENT THEORY**

Many early management theories tried to predict how to encourage health workers to be productive using micro level approaches. Increasing productivity usually means increasing numbers of billable activities in which one has engaged, such as numbers of patient seen, numbers of home visits provided, numbers of immunization given. It is still unclear how to best measure productivity in health care and many ethical issues relate to decisions about increasing productivity (Stanhope and Lancaster: 2000:1013).

Classical management theory states that the best way to increase worker productivity is to identify the most efficient way to do a task and then assign person to do that task repeatedly. If the organisational structure is large enough to organise special duty of nurse, it might be able to increase productivity by doing this. Nurses-on an intravenous therapy team in a visits nurse structure are organised according to this theory because they specialise in task related to intravenous therapy (Hapiere, 1997). Neoclassical management theory also known as the human relations approach, argues that managers should pay attention to workers human needs and group a dynamic and foster corporations to increase productivity. A nurse manager might consider identifying the types of clinical cases nurses are most interested in and assigning them only to these types of clients. However this could lead to inefficiency because nurses would not always be able to organise their work geographically and may spend more time than necessary in travel.

## **2.7 CONSULTATION THEORY**

The goal of consultation is to help the client, empower themselves to take more responsibility, feel more secure, deal with their feelings and with others in interactions and are flexible and create problem solving skills. Citizens should be consulted about the level of quality of health services they receive and they should be given a choice about the services that are offered. Consultation promotes participative and co-

operative relationship between the provider and user of health services (Batho-pele Principle: 1997:16).

The consultation model focuses on the consistent with the nursing process and with nursing values of empowering client and collaboratively working and partners with clients. The process consultation model focuses on the process of problem solving and collaboration between, consultant and client (Rockwood: 1993). The major goal of the process model is to help the client assess both problem and the kind of solution needed to solve it. Process consultation includes assessing the underlying agency culture that influences the problem and its solution. Both the consultant and the client participate in the problem solving steps that lead to changes or to actions for problems solutions. Process consultation recommends that consultants be willing to offer opinions and advice at all stages of the consultation process (Schmitz, 1996).

In the process model, the consultant is a resources person whose primary goal is to provide client with choices for decision. Process consultation model includes some steps of the nearby process, establishing a nurse client relationship based on trust to assess the problem, planning and implementation of actions and evaluation of the outcome of nursing intervention. Nursing interventions may be described as direct client care or as consultation activities, depending on the goal of the intervention (Schmitz, 1996).

Process of consultation involves a temporary relationship between client and a consultant for the purpose of bringing about a change. Consultation is proactive or relative. Proactive consultation is directed toward anticipating a future consultation is directed toward anticipating a future problem and taking steps to prevent it. Reactive consultation is directed toward carrying an existing problem through therapeutic intervention (Standhope and Lancaster 2004: 1021).

The client is identified by determining who in the situation has problem and needs to change. There are five basic intervention techniques that can be applied to process consultation model: acceptant, catalytic, confrontation, prescriptive and theory principles: (Standhope and Lancaster 2004:).

- Acceptable intervention involves classifying emotional reactions so that more objective problem solving can begin intervention benefits clients by improving self acceptance, emotional health and the ability to objectively define and deal with problem.
- In catalytic interaction model, the consultant helps the client broaden their view of the situation by gaining optimal insight. The consultant helps the clients clarify and undertake the problem. Underlying of problems by increasing available information and breaking down the barriers to communication by identifying communication and raising the awareness of all involved regarding the problem. The consultant is a facilitator providing the client with the information needed to solve a problem.
- Confrontation interaction mode presents the client with facts that reveal the client values and assumptions in ways that cannot be denied or disputed. It provides clients with an objective look at how their values and beliefs control their behaviour.
- Prescriptive intervention model requires less collaboration between consultant and client the consultant tells the patient interaction mode requires that the client learn theories such as behaviour theory and their application or problem solving.
- The theory principle allows the client to apply the theories to problem situation while developing skills in problem diagnose and solution.

The major challenge with this mode is determining how to help client to learn practical ways to apply the theory. This model can be combined with another model because consultation involves facilitating client.

## **2.8 SUMMARY**

Different theories are used to explain the role of services delivery in the transformation health sector and how services could be utilised effectively and efficient to benefit all the citizens.

In the system theory, community is made up of group and organization and is regarded as social system the primary focus is the relationship of the parts. A change in one part of the system affects the whole system. In a behavioural system, the behaviour of the individual is influenced by all events in the environment and the individual maintain some balance of equilibrium. The individual to be healed care, core and cure are needed. The consultation theory stresses the nursing values of empowering clients and the skills of identifying problems.

## **CHAPTER THREE: LITERATURE REVIEW**

### **3.1 INTRODUCTION**

In chapter two the theoretical foundation of the study was given. Chapter three presents the survey of literature relating to the research problem more specifically literature relating to the attitudes of patients toward service delivery and the health programmes, services and systems in place in the health sector.

The current government of South African inherited health system fraught with difficulties. The nature and distribution of health problems indicates the discrepancies in the standard of living and inequalities in resource allocation of urban versus rural areas and for different racial groups. The National Health plan was developed on the basic human for all. This chapter provides relevant literature on issues pertaining to the role of service delivery in the transformation of health sectors and different health services that are in place Batho Pele Principles (1997). Furthermore, the literature deals with the role of health managers in empowering the community about service available in the organizational structure and how the community is involved.

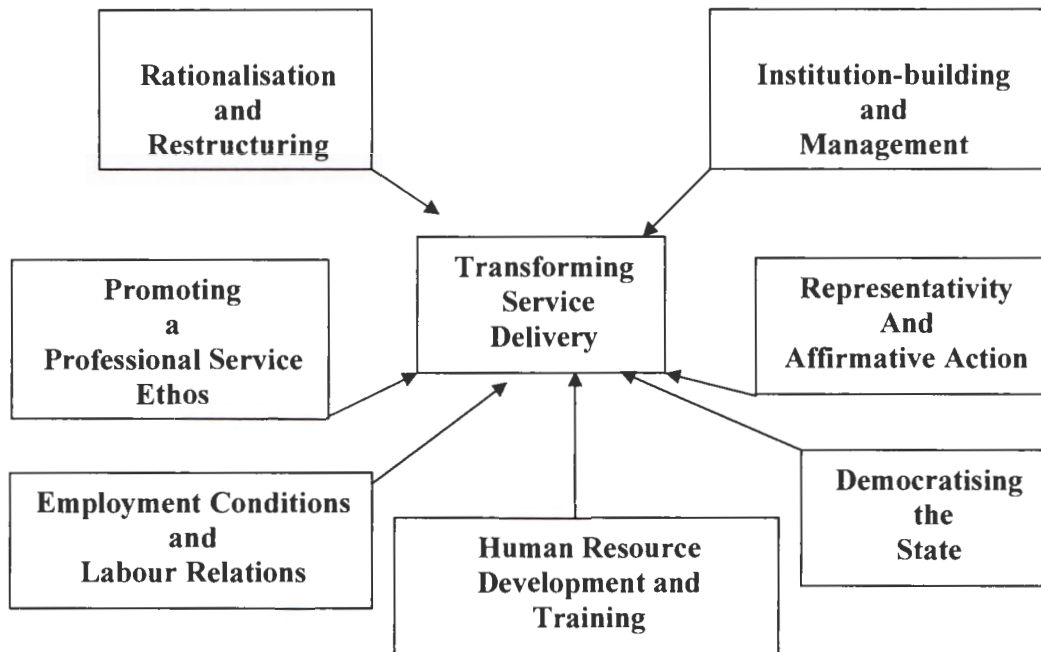
The literature review is presented under the following sub-headings:

- The role of service delivery in transforming health sectors.
- The community health services in place.
- The role of the management in the implementation of community health services.
- Community involvement in health services.

### **3.2 SERVICE DELIVERY IN TRANSFORMING HEALTH SECTORS**

The White Paper on the Transformation of the Public Service (WTPS), published on 24 November 1995 sets out eight transformation priorities as illustrated in a Figure 3.2.1 amongst others, transformation of services delivery being the key. This is because a transformed South African Public Service will be judged by one criterion above all which is effectiveness delivery of services meets the basic needs of all South

African Citizens. Improving service delivery is therefore, the ultimate goal of the public service transformation program.



**Figure 3.2.1 Transforming Service Delivery (White Paper 1997:9)**

Health care is effective when it makes a procedure impact on health. Inappropriate treatment and poor relationships between health care providers and with recipients undermine the potential impact of care. The apartheid government of South Africa has created large racial inequalities in resource distribution. The simplest descriptions consistently revealed the same pattern of racial inequalities. Equity during apartheid periods was essentially a political one rather than a scientific one (National Health Service 2004-2009).

The White Paper on Health (1997) deals with transformation of the health service to reduce the large level of social inequality in health. The transformation programmes are aimed at introducing a strong shift towards universal and free access to comprehensive health care and change the disproportionate level of preventable diseases and premature deaths in certain segments of the population. Furthermore the

transformation programmes emphasizes reallocation shifting of resources from tertiary services in metropolitan areas towards overcoming the inadequate of hospitals and clinics in rural areas (White Paper 1997).

The utilisation of public health facilities is only about 20 percent for outpatient services. In such situation, poor people are forced to seek health care services from private sector by paying high user fee. Health insurance is one option to address concerns of affordability. Regional licensing of health insurance business and health insurance schemes are worth exploring. The government should facilitate the growth of private, social and community insurance to improve affordability (Sujutha 2004).

Cost of care can also be contained if the service levels in public sector can be substantially improved, referral system enforced and the unfinished agenda of controlling infectious disease achieved insurance services without availability of reasonable quality health care service delivery it could not serve the intended purpose. It is necessary to ensure availability of health services for any insurance scheme (Ramesh and Somen 2004).

Availability of health infrastructure is necessary condition but it is not sufficient, to guarantee delivery of services access to services is an equally important determinant in meeting the health care needs of people especially those in rural areas. Ambulance services transport seriously patients to referral centers are very minimal public transportation between primary health care to the district or state hospital is irregular and infrequent. Private transport is expensive. Many clinical Health Centers do not have telephones or wireless communication. The existing public health system in rural areas has therefore become very unreliable and undependable for access to health care facilities, especially in emergencies.( National Health Services 2005).

Access to health facilities is equally worthy in some large towns and urban areas, since the heterogeneous urban population have different expectation from urban health system. Even though urban areas have more health facilities and better transportation than rural areas, the location operating time and other characteristics of public health facilities do not favor the poor people.

Availability, access and affordability, fourth determination of the quality of health care services focus on equity of services. The attainment of health status differs significantly across the North West Provincial states. Inequality exists between low high performing states as well as between populations with different socio economic status, inequality concerns between rural and urban areas are different in nature. The dimension of equity assures larger proportions in urban areas because of socio-economic and cultural diversity of urban population. Health insurance mentioned earlier, addresses equity concern (Ramesh and Somen , 2004).

De la Torre and Estrada (2001) state that health does not exist in isolation from socio-economic factors. In fact socio economic status profoundly influences health status both positively and negatively as been shown in many studies (Stockdale et al, 2007) several socio economic characteristics of South African origin population have harmful effects on both general health status. Low income, substandard housing, inadequate or unsanitary living facilities, limited formal education ethical segregation and discrimination, poor nutrition and stress can affect the health of South Africa in number of ways.

South Africa has lower income, lower educational attainment and higher poverty ratios. The level of education influences the occupational status of the South African population, which in turn predicts whether or not they will rely on public and health care services. Education also influences the extent to which individuals are aware of risky behaviours or of predisposing conditions that may influence their health leading to decreased awareness of health promotion. Issues of language limitations, discriminations, misinformation and fear are also factors that make community access to care difficult (Kaiser Commission on Medicaid and Unisured 2000). These barriers limit utilization of healthcare and prescription medications and contribute to institutionalized racism and discrimination that the individual will choose alternative forms of health care which may be infective or even harmful.

Health care access is important because it influences health status and quality of life. Poor access is reflected in delayed care seeking, absence of preventative care and low patient satisfaction. The common health fund and health quality survey (2002) discovered that a higher proportion of the rate their health status as fair and poor and

they have a problem of understanding or communication with their doctor because they primarily speak African languages.

Most of the people who lack insurance experience poorer health outcomes such as preventable diseases, more severe diseases late diagnosis and even premature deaths (Stagoy 2000) Uninsured women with breast cancer are more than twice as likely to be diagnosed at a later stage. Uninsured children with asthma are six times more likely not to receive standard medical treatment. It is expensive to provide medical treatment for the uninsured than to provide preventative acute and chronic care on a regular basis.

According to Brow et al (2002) metropolitan areas are characterized by pronounced disparities in rates of health insurance coverage and access to care. White Paper (1997) well states that people with low income run greater risks of being uninsured. In addition, those with higher income are uninsured than those in the cities that have highest uninsured rates and also have lowest tasks of employer based health cover. Another reason for having poor access to services is that public hospitals and community health centres are overwhelmed by uninsured residents in cities that have large uninsured population public, hospitals and community health centres. Communities who lack health insurance often have no usual sources of health care. They depend on clinics, community health centers and hospitals outpatients department. Cultural and language barriers hinder communication and may produce confusion about diagnosis and treatment. This happens when services are not culturally competent.(National Health Policy 2003).

### **3.3 HEALTH SERVICES AND SYSTEMS IN PLACE**

Health and socio-economic development are so closely intertwined that is impossible to achieve one without the other. Economic development in South Africa has been gaining momentum over the last decade (1998-2008). The health system is at the crossroad today. The government initiatives in public health have recorded some noteworthy success over time (eradicating small pox, polio, Malaria card etc. Under Maternal deaths and disabilities more than 1000 mothers in South Africa die every year, more than 20 percent of the deaths are preventable if proper medical attention

can be provided on time. For every maternal death, there are one to five maternal disabilities, for lack of medical attention (National Health Services 2005). The provision of maternal, child and women's health services in South Africa has been fragmented and poorly coordinated with inadequate resources being provided.

An average Infant Mortality Rate of 30 percent 1000 live births and child mortality rate of 45 percent per 1000 live birth are very high compared with five to six child mortality rates in developed nations. Most of these deaths are preventable. Non communicable diseases are on the rise according to the recent study on the burden of disease in South Africa (NCHM2005). The number of cardiovascular disease is expected to rise from the current level of 18 million in 2005 to 34 million by 2015, and diabetes from 20 million in 2005 to 45 million cases by 2015.

Infectious and communicable diseases include Tuberculosis, hepatitis, measles, polio, diphtheria and malaria. The control of communicable diseases which are largely preventable is vital function of Department of Health. South Africa is facing one of the worst TB epidemics in the world and TB its one of South Africa most important public health problem. The prevention diagnosis and treatment of communicable diseases are essential components of comprehensive primary care TB is the most common opportunistic infection in people infected with HIV and kills more than any other infectious disease. Communicable disease control should be accessible and integrated into comprehensive primary health care services.

Contaminated water and poor sanitation is responsible for large proportion of disease in South Africa. Poor hygiene and sanitation account to 5 percent of all deaths and estimated 12.4 million years of life are lost each year in South Africa. However in spite of such staggered ill health caused by poor hygiene and sanitation scant attentions is being paid to its improvement. Currently about 20 percent of rural households have toilets. The rate of increase of toilets in rural areas is slow, that is why it will take 80 years to have 100% in rural areas (Mavalankar and Ramani 2005). Sanitation and hygiene are one of the urgent needs for improving rural health.

Support services such as blood banking ambulance services, communication, and social work are very essential to provide good quality of health and medical services. South

Africa's health care sector lacks good support services. There is a severe shortage of blood in many rural areas, ambulance services are unreliable and medical infection control and waste disposal are pathetic. Improving support services should form an important agenda for improving health care delivery.

Health is a priority goal in its own right, as well as a central input into economic development and poverty reduction. The World Health Organization (WHO 2000) report on investing in health for economic development suggests that for developing countries like South Africa health policies should focus on:

- Scaling financial resources (Example private partnership)
- Tackling the non financial obstacles in services delivery (logistics, HR and government issues).

Building health systems that are responsible to community needs, particular for the poor requires political difficult and administrative demanding choices. Health is a priority goal in its own right, as well as control input into economic development and poverty reduction. The WHO report on Investigation in Health for Economic Development (Sachs 2001) suggests that developing countries like South Africa, health policies should focus on scaling up financial resources and tackling non-financial obstacle in service delivery.

Health and socio-economic development follow each other. Health is a state subject in South Africa. The health management challenges are mainly to ensure availability access affordable and equity in delivery services to meet the community needs efficiently and effectively. The lack of reliable health information services is one of the major obstacles to the effective planning of health service in South Africa. The health sector has given priority to the development of a new national health information system and aims to contribute to the promotion of an information culture in South Africa. A comprehensive NHISSA is an overall parents system comprising various components individually and collectively. These components provides various type of information needed to support the health care delivery system in South Africa.( National Health Services 2005).

Nutrition is a basic human right and prerequisite for the attainment of persons physical and infallantal potentials. It is an outcome of developmental process in society and not simply a service to be delivered. Improving nutrition is thus an ethical imperative and a sound economic investment which is politically rewarding.

Malnutrition in South Africa has two major components. The first is under-nutrition, which manifests itself in infants and young children and pregnant women. South Africa has a high incidence of low birth weight babies (LBW) of about 16%. The 2004 survey was conducted by the South African Vitamin A. Consultation group found that one in three children in South Africa had marginal Vitamin A deficiency status one of five had iron deficiency anaemia, one in four were stunted and one in ten were underweight for age (WHO 2000).

### **3.4 THE ROLE OF THE MANAGEMENT IN THE IMPLEMENTATION OF THE HEALTH SERVICES.**

The World Health Organization defines health as complete physical mental and social well being not merely the absent of disease and injury (Parekh 2003). Accordingly, a country's health system comprises all the organization institution and resources devoted to produce health services. The transformation system is the emergence of the new and innovative organizational arrangement that have emerged to provide managed care. Managed care includes all types of services provided.

Managers in the public or private sector are under constant pressure to improve performance of their organization. They are expected to satisfactory a number of stakeholders, achieving increases in efficiency as well as effective attainment of organizational goals.

The government White Paper on (Department of Health 2002) outlines further changes to the national Health System describing them as evolutionary rather than revolutionary. Health organization within National Health Act (1996) faces tremendous and continuing pressure for change with delivery of services to meet the ever higher expectations.

The challenges faced by management are mainly to ensure availability access, affordability and equity in delivery health services to meet the community needs, efficiently and effectively. Public health infrastructure is far from satisfactory as the delivery of services is hampered by several policy and management constraints of non availability of staff and weak referral system and lack of accountability for quality care (Mavarankar et al 2003). Availability and access to public health facilities is very poor for women, children and the socially disadvantaged sections of our society in rural areas in forcing even the poor to seek health care from private sectors. The government is refocusing on primary and rural health services.

Management is about planning monitoring and controlling. Effective and efficient management relies on routine data collection, compilation, analysis and estimation of performance which is indicated at regular intervals and not on adhoc and unthoughtful data collection for statutory reporting that needs managerial solutions. The redelivery of improved health is increasingly dependent on the ability of desiring organization and department to work together across the conceptual and organizational boundaries (Murray, and 2000 cheater, 2003).

Quality management it's a way of planning monitory and controlling on organization based on proven guiding principles and techniques. A quality approach forms on customers and needs and expectations, and continues on improved involvement of all stakeholders in the process of healthcare. In the health sector quality management is a vehicle for continuous improvement imposed on outcomes and better patient care with the potential to impact across the spectrum of health clinical management (Ovretveit 2004).

Managers need to continually improve their services. This is one of the changes in management which follows from more demanding patients, evidence of safety deficiencies and government regulators. According to Ovretveit (2004) a manager is a person holding a formed position in a hierarchy who is answerable for others work. Health leaders have an important role in the improvement of and in quality performance. Management actions are associated with poor quality and safety performance or with organizational failure. Organizational failure of leadership is a key that contributes to poor organizational performance.

Investigation reports in this category include the UK British strategy which note that senior leadership had not given the resources and support for clinical audit and tendency towards confidentiality and are secretive about audit and quality issues (Kennedy, 2000). One analysis of failures of care in which patient are harmed or lives are lost and concluded that these problems seem to happen in organizations with inadequate or weak leadership (Walshe, 2003). The UK NHS inspectorate reported that breakdown of leadership have contributed to how death rates in UK have suffered from heart and lung transplant programmes (Shortell 2004). Leaders of the health organization or sub department need to design a strategy for improvement suited to aspects of their organization and its operating environment. Leadership needs to prepare by gaining skills and knowledge of the principles and methods of quality service in order to improve current pressures which help and hinder improvement (Ovretveit 2004).

Health managers need to create an inspiring vision of what the improved organization should look like and provide patients and personnel in five years, throughout a participatory vision creating process. They also need to create an agreed and achieved strategy for achieving this vision, which defined the quality and safety priority target which are strategically important to the organization, structures and systems and a strategy plan with dates for reviews (Bradley et al).The structure and system changes need to be accompanied by training in quality methods and project management, change to induction training as well as bringing in quality skills and expertise development. A human resource program for quality and safety will need to be developed which contributes to the culture change which is needed for true patient focused care staff safety reporting and risk prevention (Berner et al 2003).

Changes will not succeed without allocation to the human side of quality which includes efforts by leaders repeatedly to communication the importance of quality especially through their actions and the time they give to quality and safety issues Health managers have to understand what motivates personnel to spend time and attention on quality issues and preventing them from doing so, and design strategies to remove barriers and motivate personnel. Multi skill has been the most enduring event of patients focused on care in the United Kingdoms (UK). A recent report from the

Manchester University of Health Services Management unit extended the multi-skills debate and offered a framework policy along multi skills lines.

Multi-skill calls for traditional and professional skill borders to be appraised and work roles redesigned for health workers to be able to deliver a wide range of services to patients (HF NO 1, 1993 17). According to the reports of department of the cancer services, they show a clear need for specialist nurses and radiographers (Calcman, 2003). Multi-skill promotes efficient and effective health services. This is improving production of quality care by increasing professionals direct care time by shifting inappropriate duties to support workers (Anderson 2003). High quality care is more likely in unit with multi skilled staff through increased job satisfaction. Because of career opportunities more empowered staff improved staff moral and continuity of care for patients (Anderson 2003). Multi-skill with National and qualification framework develops and enhances health workers careers and this improves the patient's welfare.

### **3.5 COMMUNITY PARTICIPATION IN HELATH SERVICES**

Community participation is an active process in the clients, or those who will benefit, influence the direction and implementation of a development project aimed at improving the welfare of people in terms of income, personal growth, independence and other values regarded as valuable. It is a process of forming mutual growth and development by sharing of resources, skills and knowledge. It is a process by which efforts of potential beneficiaries of development program are mobilized to improve the economic, social and cultural condition of communities in to national program an to enhance community levels of contribution to development of project (<http://www.homeandcommunity.org/PPage.html>).

Problems of implementing and evaluating community development programs pose more technical rationalities and are a risk because of the very different rationalized ,understanding and valuing of the process, that exist between communities and health promoting agencies support for community development approaches as a mean of achieving public involvement has been growing in S.A. It is important to be clear about what community development means. Community development nurtures

collective action, challenges discrimination and actively involves and empowers traditionally marginalized members of the community (Crawford et al 2000).

The government thinking about patient involvement in the health service has encompassed both consumers approach led by concept of government at accountability. According to Lewis et al (2006), community involvement is seen as driver for quality. Community involvement is one of the mechanisms through which the health services is accountable to its users Health workers are more aware of the agenda around community patient choice, complaints, providing information to patients and patients satisfaction (Caulter and Elwin, 2002).

There are both ideological and practical arguments why community should participate in health care decision making including people's basic right to participate in their health care and system they fund. Accountability pressure in health care and increased effectiveness and appropriateness of health services based on community input (Florin and Dixon 2004). Health care policies in Australia and overseas have increasingly sought to support and promote the involvement of patients and community members in planning and delivery of health services (Butter, 2002, Salter 2003).

Community participation in health services influences decision making health agencies (Crawford and Rutter, 2002). It is difficult to identify the contribution of community participation, as part of a complex interaction of factors, to health services outcomes and evaluation of initiatives has generally been poor or non existent. It is equally likely that despite the rhetoric in support of community participation, consumers face both structural and other barriers to achieving significant influence, not least is the willingness of the health service staff to share power in decision making (Johnson and Silburn 2008). South Africa is not alone in struggling with this issue, communities in the United Kingdom (UK) have reflected on community participation in the National Health Service (NHS) stating that longstanding professional and manager's interest.

The NHS may resist a transfer of power and this could result in token public involvement with no real input on decision making (Florin and Dixon 2004) Others have questioned the impact of patient and their representatives in the UK health

policy community and suspect that they have been accommodated in ways that preserve the traditional distribution of power (Sajutha 2003). A lack of strong evidence of the impact of consumer and community participation in health care and concerns about patients relative power in decision making have not deterred government around the world from pursuing. This important dimension of health service reform, patients and communities are seen as being at the centre of the health system or at the very least key stakeholders in decision making (National Health Service 2005).

Support organizational structures and positive staff attitude to community participation have been identified as key contribution to effective participation with communities in decision making (Pickin and Popay, 2002) An examination of four case studies of community, consultant in Australia concluded that guides, manuals and resources kit will result in only limited change in the quality of consultant exercise if structural and organizational context is not also addressed. Structural consideration which are likely to enhance an organizational ability to consult effectively stressed official endorsement at senior level, clear and consist structures and procedures , continuing of staff , constructive and ongoing relationship with communities an valuing the knowledge of community members .

A study in the UK (NHS 2003) examined the capacity of statutory organizations to work in partnership with community, and stressed that community capacity staff skills, the dominant professional and overall organizational ethos and culture, all contribute to the effectiveness of organizational community participation (Pickin and Popay 2002). Staff attitudes play an important role in determining the acceptability of community participation with an organization and it's likely to influence on decision making. An Australian study reported the views of staff in a major metropolitan hospital which initiated a community participation project focused on improving a community metropolitan project. Focused on improving maternal and infant health services involving nine consumers over and four months period (Carr, 2001).

Primary Health Care calls for the involvement of individuals in their own health care. Improvement in health care can come about through information and education to the public to enable them to make healthy choices. Primary Health Care strategy in Kenya

focuses on health promotion through the provision of timely information at the community level. The aim of the community based health care is that the community must be informed, motivated and involved (Ministry of Finance and Economic Planning, 2000). Through community based health schemes the standard down approach of conventional based health care delivery would be replaced by an approach in which the organisation and activities for health care within the community are determined by local needs and conditions.

Health concerns have been brought into the mainstream of community activities Health communities should be formed and community health workers should be appointment. These personnel help create a heightened community understanding of how people can organise themselves to present disease and empower them health. This way individuals gradually develop a positive attitude towards their own health as well as the community well being and the ability to become developmental conscious.

### **3.6 CONCLUSION**

The transformation plans (STP) are intended to assist in re-shaping and re-sizing health services to develop appropriate, adequate and sustainable health service delivery platforms which are responsible to the current challenges. Transformation of service delivery calls for a shift away from inward looking, bureaucratic system, process and attitudes and search for new ways working which put the needs of the public first.

The availability, access and affordability of services determine the quality of health care services provided in the area. The cost of services should be affordable fro the disadvantaged groups in remote areas. Every effort should be made to ensure the improvement in the quality of services at all levels. Government stressed the need of increasing access to integrated health care services for all South Africans focusing on the rural, peri-urban and urban poor. The socio-economic characteristics influence the service provision, which in most cases resulted in some barriers which hamper access to health care, low income educational attainment poverty, malnutrition and discrimination affect service provision. Most of the poor people lack insurance and

they receive poor health care which in most cases resulted in premature deaths (Stagg 2000).

The provision of maternal, child and women's health services in South Africa has been fragmented poorly coordinated with inadequate resources health services should be improved for disadvantaged population. The health sector is responsible for the developing communicable disease control service, Immunized, health information, services, nutrition services and environmental services. Primary health care stressed the important of comprehensive services which include diagnostic, therapeutic and rehabilitative services. The above services should be made universally accessible to affordable to individuals and families in communities. (National Health Services).

Full participation of the community in the discussion of health services is an essential element of community development. Such participation has a demonstrable impact in ways in which local health services are planned and delivered support for community development used as means of public involvement has been growing. Community development nurtures collective action, challenges discrimination and entirely involves and empowers traditionally marginalized members of the community. Community development enables the community to define their own needs and set their own agenda. Community development is a key to engage committees in tackling health inequalities and overcoming barriers to service needs (Department of health 2002).

Health services workers should develop constructive relationships with community members on decision making. Lack of significant change in staff attitudes particularly around the influence and independence of community representatives signal, need to go beyond change organizational structures and processes in health services to facilitate community participation.

Quality management is used to support the development of quality services. Quality improvement plays an important role in health reforms and that has a significant potential role on the impact of health systems and services. It ensures that minimum strengths are developed and met. Improved data and health management system

provide indicators of health system. Clinical training packages help to improve skills and refocuses on clinical practice towards outcome international stabled.

Quality improvement in management capacity emphasizes the value of quality health system and techniques to meet future goals and objectives. A good quality service is not a luxury for people but necessity.

## **CHAPTER FOUR: THE PROBLEM STATEMENT**

### **4.1 INTRODUCTION**

The previous chapter dealt with the literature review relating to the role of service delivery in the transformation of health sector. The literature of the study stressed the need to transform service delivery with an aim of reducing social inequalities in the health sector. The primary health care regarded as most effective and cost affection approach of improving the population health for implementing health services.

In this chapter, the research problem is firstly formulated in general terms, and then in the form of four research questions in line with the objectives as spelled out in chapter one.

### **4.2 STATEMENT OF THE PROBLEM**

South Africa has a population of over 40 million, 73% of whom are women and children. Although classified as middle income country and spending 8,5% of GDP on health care. South Africa has exhibits major disparities and inequalities. This is the result of former apartheid policies which ensured racial, gender and provincial disparities. The majority of the population of South Africa has inadequate access to basic sanitation. Statistics for 2004 suggest that between 15% and 25% of the population live in poverty. Fifty three percent of the population live in rural areas where the vast majority of whom are poor.(National Health Services 2005).

The South African Government has developed a framework for socio-economic development in its reconstruction and development program (RDP), in which it said out broad principles and strategies for development in all key areas and sector in order to effectively address the various problems facing the majority of the people of all the citizens and promote gender equality. Poverty is widely recognized as major determinant of the health status of individuals, household and communities. The major thrust of the RDP is building economic development that is equipping individuals with necessary knowledge of care for themselves towards improving their health. The emphasis of the study is on planning and implementing resources

development to improve health. The focus is on meeting basic needs, developing and improving health services like water and sanitation, environmental nutrition and health care. (World Health Organisation 2000).

The South Africa's health system consists of large public sector and smaller but fast growing private sector. Health care varies from most basic primary health offered by the state to highly specialized hi-tech health services available in private sector for those who can not afford it. Public sector is under resourced and over useful, while mushrooming private sector, largely on commercial lines caters for middle and high income earners who tend to be member of medical schemes (18% of the population). The private sector attracts most of the country's health professionals. (National Health Policy 2003).

The state contributes about 40% of expenditure on health, the public health sector is under pressure to deliver services to about 80% of the population. Most resources are found in private health sector, which provide to the health needs of the remaining 20% of the population.

#### **4.2.1 RESEARCH QUESTION**

##### **4.2.1.1 Research Question One: What is the role of service delivery in Health sector?**

The study aimed to determine the role of service delivery in transforming health sectors. Health care is effective when it makes a positive impact on health. Apartheid has created large racial inequalities in resources distribution at further demonstrated delivery of ineffective care in a range of public at private health care setting. Inappropriate treatment and poor relationships between health care providers and with receipts undermine. The potential impacts of care service delivery are not a privileged in a civilized and democratic society but a legitimate expectation. The South Africa constitutional principle (1996) stressed the need of national provincial and local health departments to make services delivery a priority.

#### **4.2.1.2 Research Question Two: What services and systems are in place to transform health sectors for effective and efficient delivery?**

South Africa has well established and high technological hospitals in the main cities, but underdeveloped basic health services, especially in former rural homelands. As a consequence, essential health care is deficient for the poorer two thirds of the population. The mission of the provincial health department as mandated by the constitution (1996) of South Africa is to promote and monitor the health of the people in the province and develop a caring effective provincial health system through the establishment of province wide district health system based on the principle of primary health care.

#### **4.2.1.3 Research Question Three: What is the role of Health Managers in the implementation of Health Services?**

Every effort should be made to ensure the improvement in the quality of services at all levels emphasis should be placed on reaching the poor, the underserved, the aged, women and children who and amongst vulnerable district health managers are responsible for the provision of health care administrators, financial, support services, planning and human resources. Through leadership and guidance to the health system the managers should promote and monitor the health of all people in South Africa and provide carrying and effective services through a primary health care approach.

#### **4.2.1.4 Research Question Four: How community is involved in service delivery.**

It is essential to maintain the active participation and involvement of all sectors of South Africa society in health and health related activities. All sections of the community, all members of the households and families and individual should be actively involved in order to achieve the health cons consciousness and commitment necessary for the attainment of goals set at the various levels. Health teams and workers at all levels should develop a carrying ethos and commit themselves to the improvement of the health status of their community. They should have sense of responsibility toward the majority of the population in their catchments area.

### **4.3 SUMMARY**

Service delivery in health sectors should be equitable accessible, effective and efficient and to transform the health sector. The study should promote active participation of the communities in all services available at different health sector. The question remains on whether transform the health sectors for the benefit of South Africans. All questions for the basis of the research and results will be discussed in the following chapter.

## **CHAPTER FIVE: RESEARCH DESIGN AND ANALYSIS**

### **5.1 INTRODUCTION**

The research focuses on the role of service delivery in the transformation of health sectors with references to Mafikeng in the North West. In performing this, it involved department literature review and some of the relevant issues pertaining to Health services and health systems conducted. In this study with this research, the considered opinion of health managers primary nurses, midwife, nursing assistant and environmental officers, stakeholders, members of the community were taken into account.

In this chapter, an exposition is given of the methodology followed in the study. More specifically the following aspects are covered: measuring instrument, sampling and data analysis.

### **5.2 RESEARCH DESIGN**

Cooper and Schindler (2004: 771) define a research design as the blue print for fulfilling research objects and answering question. Burn et al (1987: 221) define research design as the structural framework or blueprint of the study that guides the researcher in planning and implementation of the study, while optional control is achieved over facts that could influence the study.

Cooper Schindler (2004 772) proposed the essentials of research design:

- The design is an activity and time based plan
- The design is always based on research questions
- The research guides the selection of sources and types of information.
- The design is a framework specifying the relationship among study variables
- The design outlines procedure for any research activity

In this study, the research is explored the role of service delivery in transforming health sector and how the community is involved in rendering service. The purpose of

such exploration is to gain insight about structural changes in health system and how health services benefit the community and the extent of knowledge and services available in health sectors.

The data are collected from health managers, professional nurses, auxiliary nurses, assistant nurses, community health workers and the community to provide information in order to make some conclusions on the research questions.

### **5.3 MEASURING INSTRUMENT**

According to Cooper and Shrinkler (2001:82) data collection is gathering of data that may range from a simple observation at one location to a grandiose survey of multinational corporations at sites in different parts of the world. For the purpose of this study the questionnaire was the major instrument for alerting data for the survey because it best suited the nature and purpose of the study. A questionnaire was used to collect data from the Mafikeng sub-health district.

De Vos (1998: 290) describes a questionnaire as an instrument with open and closed ended question or statement to which a respondent must react. It is means of communication between the respondents and the researcher, furthermore it is used to explore or describe the situation, but also to assess correlation between two variables.

The questionnaire comprised of twenty questions most, of each were closed ended, formally constructed with a set of multiple choice answers and guidelines on the procedure that had to be followed (for example, ranking agree, totally agree, disagree, totally disagree). Thus the study was mostly quantitative in nature. The language used in the questionnaire was English. An effort was made to construct questions that were directly related to the area being studied, the questions were simple to understand.

Although the language was English for those community members unfamiliar with English, the questionnaire was translated into Setswana. The questionnaire was designed considering its validity and reliability (Annexure A). A good measurement is evaluated based on a tool. It measures validity, reliability and practicality. Reliability means dependently, so that the numerical outcomes never due to the nature of the

measurement process or the measurement instrument, itself some of the problems, which threaten the reliability of the study, occur when there are missing data, data being lost after collecting or data never being collected. Cooper and Shrinkler (2001:82) The reliability can also be compromised when the official definitions of the methods of collection and documentary information change over time, or if there is no proper documentation system for the entity, which is to be measured. (De Vos, 1998: 301) Reliability of a measuring instrument is the degree of consistency with which it measures whatever it is measuring furthermore. Cooper and Schindler (2001:210) maintain that reliability had to do with accuracy and precision of a measured procedure.

Validity refers to the extent to which a test measures what it actually wish us to measure (Cooper or Schindler *ibid*). Newman (2000:167) suggests validity as true and correct and its simplest form. It is part of the dynamic process where the accumulation of evidence related to an indicator brings meaning to all units of measurements by interrelating with each other. Validity is the degree to which a test is capable of achieving certain aims. The questionnaire considered both theory and measuring instrument being used.

The questionnaire was designed taking into consideration management, non management and communities involved in health sectors to reflect their opinion on the role of service delivery in transforming health care. The questionnaire was reliable because it was used to get views form members who were engaged in providing services at the different levels of the health situations. The questionnaire is practical because responsible respondents could understand and answer each question without difficulties.

### **5.3.1 ADVANTAGES AND DISADVANTAGES OF QUESTIONNAIRES**

The biggest advantage is that questionnaire gives feedback from the point of view of the user because if the questionnaire is reliable, feedback of the study will be trustworthy. Furthermore, measures gained from the questionnaire are to a large extent independent of the task which the questionnaire was used. A questionnaire can

be used as reliable basis for comparison or demonstrating the questionnaire target (Cooper and Schindler, 2003).

The biggest advantage is that questionnaire tells the researcher only the user's reaction as the user perceives the situation. There are some kind of questions, for instance, to do with time measurement or frequency of event occurrence, that are not useful to distinguish between subjective measures and performance measures.

The advantages of using a questionnaire is that respondent have time to think about the answer to the various questions. This advantage is that the researcher is not always at hand to explain. According to Vos (1998: 304) a questionnaire is one of the most useful instrument in research as the researcher had tangible evidence sampling was used, the researcher was obliged to select respondent on the basis o validity.

#### **5.4 SAMPLING**

According to Cooper and Shindler (2001:164) sampling is a process of selecting some elements from a population to represent the population as a whole for the purpose of the study, the disproportionate stratified random sampling was used to select the respondents. The steps in stratified sampling are:

- Determine the variables to be used in stratified
- Determine the proportion of the stratification variables in the population.
- Select disproportionate stratification based on the research needs.
- Divide the sample frame into separate frames for each stratum
- Rationalize the elements within systematic procedure to draw the samples  
(ibid 185-6).

A population is an aggregate of all units or cases that conforms to some designed set of criteria. Population elements are sign member units of a population, they can be saved as people, social, actions and events (Bark Holder 2002). The population in this study was divided into the following strata: District Manager, Assistant directors, Areas facilitating managers, Professional nurses, Auxiliary nurses, Assistant nurses and community health staff. A stratified random sampling selected from Mafikeng sub-district clinics. The number of clinics and nurse are selected after examining the

total number of clinics in Mafikeng district. Each employee (Health worker) had an equal chance to be selected into the samples as such making it more presentable.

The 77 sample units were chosen from a total population of 247. Out of this, five (6%) represented the top management which is made up of district manager and Assistant Directors, 16 (21%) represented the facility managers in sub clinics. The rest of the staff included 25 (33%) professional nurses, 13 (17%) of auxiliary nurses ten (13%) assistant-nurses ten (13%) and eight (10%) community health services staff Table 5.1.

**Table 5.1 Sample from each stratum**

Groups	No of representatives	Percentage
District manager	1	1%
Assistant District Directors	4	5%
Facility Managers	16	21%
Professional nurses	25	33%
Auxiliary nurses	13	17%
Assistant Nurses	10	13%
Community health service	8	10%
Total	77	100%

## 5.5 DATA ANALYSIS

According to Cooper and Schindler (2001:82) data analysis involves reducing accumulated data to a manageable size, developing summaries, looking for patterns and applying statistical techniques. A descriptive statistical approach was used to analyze the data. The data are presented in tables in form of frequencies and percentages.

## **5.6 SUMMARY**

The chapter provided an outline of the research design and analysis. In the next chapter results of the study are presented.

## CHAPTER SIX: RESEARCH RESULT

### 6.1 INTRODUCTION

Chapter 5 covered research design and analysis. In chapter 6 the response rate is dealt with and the results of the study are presented and interpreted in relation to the objectives of the research, which are spelled out in Chapter I.

### 6.2 BIOGRAPHICAL PROFILE OF RESPONDENTS

The questionnaire was administered to the Mafikeng Health sub district staff consisting of 247 members. Out of 77 members 64 returned the questionnaire. Seven copies of the questionnaire out of 64 were not properly completed, leaving 57 usable copies of the questionnaire. Out of these 57 questionnaires, 16 were filled by management staff, 37 by non management and four by the community health specialist.

The qualifications of respondents are reflected in table 6.2.1. Most of the respondents (68%) had post-matriculation qualifications only 32% with certificates in nursing. This is an indication that the majority of health workers are qualified and understand the need of service delivery in health sectors.

**TABLE 6.2.1 Biographical data of respondents**

<b>Qualification</b>	<b>Respondents</b>	<b>Percentage</b>
Certificate	18	32%
Diploma	22	39%
Undergraduate degree	15	26%
Master	2	30%
<b>Total</b>	<b>57</b>	<b>100%</b>

Fifty one percent of respondents have been in the sub district clinic for more than ten years. This suggests that the health nurses should have a reasonable knowledge on

delivering services to the community. The Batho-pele principle on transformation had been in place for ten years.

**Table 6.2.2 Years in health sectors.**

0-3 yrs	16	28%
4-5 yrs	12	21%
6-10 yrs	18	32%
More than 10 yrs	11	19%
<b>Total</b>	<b>57</b>	<b>100%</b>

In Table 6.2.3 the gender of the respondents is reflected. Most of the respondents (81%) are females and 19% males. This is an indication that gender sensitivity is still a serious concern, most of the health workers are females.

**Table 6.2.3 Biographical data for male and female in Mafikeng sub-district.**

<b>Gender</b>	<b>Respondents</b>	<b>Percentage</b>
Males	11	19%
Females	46	81%
<b>Total</b>	<b>57</b>	<b>100%</b>

### **6.3 RESULTS ON THE ROLE OF SERVICE DELIVERY IN THE TRANSFORMATION OF HEALTH SECTOR.**

Most of the respondents 61% stressed lack of access to health care services in the rural and farm areas. Mobiles are used to provide them with services twice in a month. This is still a serious problem because 25% respondents support the idea of provision of services in rural and 14% are still not sure.

**Table 6.3.1 Respondents on access to health services in rural and farm areas**

<b>Access to health services</b>	<b>Respondents</b>	<b>Percentage</b>
Yes	14	25%
No	35	61%
Not sure	8	14%
<b>Total</b>	<b>57</b>	<b>100%</b>

**Table 6.3.2.** shows 26 (46%) of respondents who are not aware that services are affordable and 10% of those who are still in the darkness. Since transformation stressed the affordable health service there is still more that is to be done to inform the individuals, about health service. Awareness campaign should be conducted in all health services to equip individuals as beneficiaries of this transformation

**Table 6.3.2 affordability of services**

<b>Details</b>	<b>Respondent</b>	<b>Percentage</b>
Yes	25	44
No	26	46
Not sure	6	10
<b>Total</b>	<b>57</b>	<b>100%</b>

Table 6.3.3 suggests that the services are effective, efficient and economically, 40 (70%) of the respondents support the efficiency of services only 17 (30%) of the respondents disagree from the table challenges are still in existence about the efficient effective services.

**Table 6.3.3 Respondents on effective, efficient and economic utilization of service**

Details	Respondents	Percentage
Agree	18	31%
Totally Agree	22	39%
Disagree	12	21%
Totally disagree	5	9%
<b>Total</b>	<b>57</b>	<b>100%</b>

Table 6.3.4 Shows 43 (75%) respondents strongly criticized the quality of service provided this suggests that the health organizational sectors is faced with serious challenges of improving the service to meet the required standard. Only 14 (25%) of the respondents suggested that service are of a good quality. This suggests that health workers are responsible for providing poor services.

**Table 6.3.4 Respondents on the quality of services provided to communities**

Details	Respondents	Percentage
Good	14	25%
Bad	27	47%
Poor	16	28%
<b>Total</b>	<b>57</b>	<b>100%</b>

Table 6.3.5 20 (35%) participants do not know about shifting of resources from development metropolis clinic which suggested resources are still concentrated in metropolitan area. 21(37%) disagree on the shift of resources only 16 (28%) agree on the shift or resources . This suggest that there is still a burden on the health sector to address the problem as stipulated on the Batho-pele principle of transformation.

**Table 6.3.5 Respondents of the shift of resources from metropolitan areas to inadequate rural clinics.**

<b>Details</b>	<b>Respondents</b>	<b>Percentage</b>
Strongly agree	6	10%
Agree	10	18%
Strongly disagree	9	16%
Disagree	12	21%
Don't know	20	35%
<b>Total</b>	<b>57</b>	<b>100%</b>

#### **6.4 Results on the different types of health services in place**

Table 6.4.1 shows 69% of the respondents supported the need of coordinators of health information for effective rendering of services. This table suggests that priority should be given to health information system for the benefit of the community. Only 15 (26%) are not sure about the coordination of health information system. Furthermore the talk suggests need of establishment of health information system will promote coordination and management of health services at the district level and provide information to inform Natural Health.

**Table 6.4.1 Respondents on the coordination of health information services.**

<b>Details</b>	<b>Respondents</b>	<b>Percentage</b>
Yes	39	69%
No	3	5%
Not sure	15	26%
<b>Total</b>	<b>57</b>	<b>100%</b>

Table 6.4.2 indicates that 77% of respondents support that need of improving nutrition. Nutrition is the basic right and a prerequisite for the attainment of individual physical development only 13 (23%) did not here any information about nutritional

health services. This indicates that nutrition programs are important in prompting party alleviation and preventing and managing malnutrition.

**Table 6.4.2 Respondents on the improvement of nutrition as an ethical imperative and social economic investment in South Africa**

Details	Respondents	Percentage
Yes	44	77%
No	2	4%
Not sure	11	19%
<b>Total</b>	<b>57</b>	<b>100%</b>

Table 6.4.3 indicates that 36 (63%) of respondents regard prevention at diagnosis threaten as essential component of communicable diseases services. They totally support the accessibility of communicable disease in the primary health care system. 14 (25%) of the respondents are not aware at the remaining 17 (12%) respondents disagree with the statement. This study identified a need of Health education on communicable diseases to inform and empower individuals on health services.

**Table 6.4.3 The respondents opinion on the accessibility and integration of communicable disease into primary health care system.**

Opinions	Respondents	Percentage
Agree	15	26%
Strongly agree	21	37%
Disagree	4	7%
Strongly disagree	6	5%
Don't know	14	25%
<b>Total</b>	<b>57</b>	<b>100%</b>

Respondents generally know that environmental health services are essential and they limit health risks which arise from the physical and social end environmental condition.

Table 6.4.4 36 (63%) agreed on the health environment that promotes sustainability at, 12 (21%) did not commit themselves and only 9 (16%) disagreed with the statements. The table suggests that environmental health service is a community need which promotes clean water, adequate sanitation and food safety.

**Table 6.4.4 Respondents' views on access of knowledge on environmental health services available**

<b>Opinion</b>	<b>Respondents</b>	<b>Percentage</b>
Agree	23	40%
Totally Agree	13	23%
Disagree	5	9%
Totally disagree	4	7%
Don't know	12	21%
<b>Total</b>	<b>57</b>	<b>100%</b>

Table 6.4.5 suggests that Maternal Child Women Health Service is still a serious problem in the rural and farm areas. The majority of the respondents 29 (51%) did not know, only 13 (23%) are aware of the accessible maternal child women health services and 15 (25%) of the respondent are not sure of this service. This indicates that poor coordination and the inadequate resources provided by the health sector. The focus is on urban metropolitan areas.

**Table 6.4.5 Accessibility of Maternal Child Women Health Service to mothers as well as children of all ages in rural and farm areas.**

<b>Opinion</b>	<b>Respondent</b>	<b>Percentage</b>
Yes	13	23
No	29	51
Not sure	15	26
<b>Total</b>	<b>57</b>	<b>100%</b>

## 6.5 Results on the role of the management in the implementation of health services.

In Table 6.5.1 the majority of the respondents supported the need of essential skills in the management stratum. Managers require essential skill for effective implementation of health service. The manager as an organizational leader manages the boundaries. Table 6.5.1 shows 51 (89,5%) total support of information flow. The manager as key ingredients should keep the organization informed. Only six (11%) disagree on the need of information. The respondents regard communication, problem solving stress handling and resource organisation as skills needed by a leader for smooth, effective and efficient running of the sub clinics. Fifty-four (99%) of the respondents regarded team empowerment and an instrument that is essential in the success of the sector.

**Table 6.5.1 Respondents' opinions about the essential skills**

Details : essential skills		Respondents	Percentage
Information flow	Yes	51	89%
	No	6	11%
Total	Yes	57	100%
Communication skills	No	49	86%
	Yes	8	14%
Total	No	57	100%
Problem solving	Yes	50	88%
	No	7	12%
Total	Yes	57	100%
Resources organization	No	47	82%
	Yes	10	18%
Total			
Stress	Yes	45	80%
	No	12	200%
Total empowerment	Yes	54	99%
	No	3	10%
Total	100%		

Table 6.5.2 shows that (81%) of the participants require training in public health development, 5% of requires human resource management training and only 7% of both organizational skill and financial training are required. The data suggest that there is a serious need in training or empowering health workers on essential skills. Health managers as agents of local community are expected to gain multi skills to manage the boundaries.

**Table 6.5.2 Respondents on type of training**

<b>Details</b>	<b>Respondents</b>	<b>Percentage</b>
Skill development	47	81%
Management	3	5%
Professional support	4	7%
Financial	4	7%
<b>Total</b>	<b>57</b>	<b>100%</b>

Table 6.5.3 shows the importance of training health workers. All the respondents indicated that training is done to enhance performance, 19 (34%) think training is done to make people competent and 15 (26%) is to increase productivity. In general training in every departmental sector is important in service training because of the departmental changes in policies, structures and systems. Health workers need training to improve their performance and to move in line with transitional changes.

**Table 6.5.3 Respondents on the importance of health training**

<b>Details</b>	<b>Respondents</b>	<b>Percentage</b>
No response	-	-
Enhance performance	23	40%
Competency	19	34%
Increase productivity	15	26%
<b>Total</b>	<b>57</b>	<b>100%</b>

Table 6.5.4 shows that training should be conducted on quarterly basis. Out of 57 only two (3%) indicated that training should be conducted necessary and truly indicated that training should be conducted as required by managers generally from the table training is important because 52 (92%) supported the need of running training schedules but the difference is how often. Majority 46 (81%) supported the quarterly training sections to equip and empower health workers.

**Table 6.5.4 Respondents on how often training should take place**

<b>Details</b>	<b>Respondents</b>	<b>Percentage</b>
When necessary	2	3%
Monthly	6	11%
Quarterly	46	81%
As required by managers	3	5%
<b>Total</b>	<b>57</b>	<b>100%</b>

Table 6.5.5 shows that training should be conducted by facility managers 45 (80%) respondents strongly agreed and support the facility manager in training their health workers because they are regarded as unit managers. Only three (5%) prefer the support managers, four (7%) proffered health consultants and five (8%) respondents supported the team leaders in facility training. This suggest that only 12 (20%) are totally against facility manager in training health workers.

**Table 6.5.5 Who do respondents think is responsible for training?**

<b>Details</b>	<b>Respondents</b>	<b>Percentage</b>
Facility health managers	45	80%
Support in manger	3	5%
Health consultant	4	7%
Team leaders	5	8%
<b>Total</b>	<b>57</b>	<b>100%</b>

## 6.6 Results on the involvement of community in service delivery

Table 6.6.1 shows that consultative forums are important as platform for discussing and solving community problems. Out of 57, 43 (75%) of the respondents strongly supported the need of consultative forums and only 14 (25%) are not aware of the consultative forum. This indicates that extra miles are still important in informing the individuals about the community forums. Community forum promotes effective communication before community and the health sector (Department)

**Table 6.6.1 Respondents on the importance of consultative forum**

<b>Opinions</b>	<b>Respondents</b>	<b>Percentage</b>
Yes	43	75%
No	-	
Not sure	14	25%
total	57	100%

Table 6.6.2 shows that health consultative forum meeting with health workers took place on quarterly basis, 32 (56%) participants supported quarterly meeting 18 (32%) participants supported monthly basis. Out of 57 only seven (12%) responded. This table suggests that consultative meetings are important and should be conducted on quarterly basis.

**Table 6.6.2 Respondents on the consultative forum meeting schedule**

<b>Details</b>	<b>Respondents</b>	<b>Percentage</b>
Monthly	18	32%
Quarterly	32	56%
Every six months	4	7%
Annually	3	5%
<b>None</b>	<b>57</b>	<b>100%</b>

**Table 6.6.3** indicated that 33 (58%) of respondents totally disagree about the awareness on the standard of services provided by health sectors. Most of the community members are not totally aware of the expected standard of service provision. Batho-Pele Principle (White paper 1997:17) stressed that service standards must be relevant and meaningful to the community, only 24 (42%) of the respondent are relevant and meaningful.

**Table 6.6.3 Respondents on community Awareness on the standard of services provided.**

Details	Respondents	Percentage
Agree	7	12
Strongly agree	17	30
Disagree	20	35
Strongly disagree	13	23
<b>Total</b>	<b>57</b>	<b>100%</b>

Table 6.6.4 show that in some health sectors courtesy is not practiced because 36 (63%) of the respondents strongly disagree that citizens are considered. Only 21 (37%) supported courtesy as if the eight principle of Batho-pele (White paper 1997).

**Table 6.6.4 Respondents on treating community with courtesy and consistent**

Details	Yes	21	37%
	No	36	63%
<b>Total</b>		<b>57</b>	<b>100%</b>

## 6.7 Summary

Chapter six dealt with the result of the research. It indicated the role of service delivery in the transformation of health sector. It further assesses the different health services in place and the role of the management in the implementation of health

services. It also indicates how important the community is in the provision of health services. Chapter seven focuses on the conclusion and recommendations based on the research results.

## **CHAPTER SEVEN: DISCUSSION, RECOMMENDATION AND CONCLUSION**

### **7.1 INTRODUCTION**

In chapter 1 an orientation was given and objectives were spelled out. Chapter 2 provides the theoretical foundation. The literature review is given in chapter 3 and thereafter the problem of the study is stated in chapter 4. An exposition of the investigation follows in chapter 5. The results of the study are reflected in chapter 6. In chapter seven the outcome of the study is discussed with other relevant studies, as well as the underlying theory. This chapter ends with a general conclusion and sectors for effective recommendations.

### **7.2 Discussion**

#### **7.2.1 Discussion with regard to role of service delivery in the transformation of health sectors.**

Service delivery in South Africa is regarded as priority to all the citizens. It affects the economic, political, social development of the country and it also affects sustainable development. Transformation of the health services is still a problem in reducing the large level of social inequalities in health. Policies emphasized a strong shift of universal and free access comprehensive health care and change of disproportionate level of preventable diseases.

A total of 77 health workers have been incorporated into Mafikeng health sub-district staff. There were 57 respondents including 11 males and 46 females. The respondents ranged in educational attainment from certificate in nursing to diploma in nursing and 15 respondents with inadequate degrees and two with master degrees. The overall biographical data shows that most of respondents were females with certificate in nursing.

The study indicates that access of health services in the rural and farm areas is still a serious problem that needs attention. Services should be provided as stated in the

Batho-pele principle (White paper: 1997), which stresses that all people have equal dignity, worth irrespective of their race, colour, gender and creed. Health care should be made accessible and affordable to all individuals and families despite the country's economic constraints and regardless of race, gender in line with reconstruction and development program (RDP).

The findings of the study indicated that services are not efficient and effective and the quality of services is still a question. Services have direct and immediate effect on the quality of the lives of the people in the community. Poor services can also make it difficult to attract business. All people involved in health sectors must know the quality and standard services to be provided. The findings of the study indicated that resources are still concentrated in urban areas.

Service has a direct and immediate effect on the quality of the lives of the people in community. Poor service can also make it difficult to attain business to an area. Services have a direct and immediate effect on the quality of the lives of the people in community. Poor service can also make it difficult to attract business to an area.

### **7.2.2 The different Health Services in place**

Information is power therefore health information empowers communities to promote their own health and protect the health of their members (Kleinberg et al 1998). The study indicated the health information is critical for rendering services and needs to be established to support coordination and management of health services at the district level and provide information to inform national health system.

The majority of primary health workers in the Mafikeng sub-district (97%) agreed that Nutritional services are an ethical and zonal investment in South Africa. Effective nutrition interventions are social and economic investment, vital for economic growth. Adequate nutrition is necessary for and is an essential outcome of development in a country. RDP stressed the Government committee should address problems of under nutrition and hunger.

Prevention, diagnosis and treatment are essential components of communication services. The primary and essential role of the entire medical industry is to protect and promote the health of the public. Public health care focused on the aggregate level interventions of direct services at the whole age group or populations is at risk. Immunization, sexually transmitted diseases and sanitation monitoring for communication disease are examples of public health interest. The department of health has legal mandate to meet the overall health needs of the people.

The society relates to the environment in which an individual exists. An individual's behaviour is influenced by the external events in the environment. The findings on environment health services stress the point that it is essential to provide clean water, adequate sanitation provisioning and food supplying schemes which must be aimed at redressing risks in the affected areas within the province. The health service is responsible for the provision of accessible services as well to support committees in managing environmental health risks (Maurer and Smith 2005).

### **7.2.3 The role of the Management in the implementation of health services**

The implementation of district health system and the establishment of new management structure require health personnel to develop a different mentality to health care and new range of skills. Health personnel need to build their capacity to implement primary health care. Most of the respondents from the study indicated that communication level in problem solving skills, and team empowerment skills are essential case elements of the services of health manager. Effective management of the health district is dependent upon up to date available information regarding progress on resources utilized and achieved.

Training programmes build the management capacity of the district health sector. The results showed that training is essential. The management team needs to equip primary health services to work within the primary health care approaches, to build intersection links and involve the community. Training programmes need to reflect emphasis on team management. They should be decentralized and to be problem-free. Furthermore, training enhances performance, competence and it increases the

performance into the health organization sections. The district health structure is responsible for training the primary health nurses.

#### **7.2.4 Community involvement**

Community participation is essential in helping that basic health needs are achievable. The main intention of the study is to involve community in local health seminars to transform health sector from apartheid setup in order to ensure that all citizens are equally provided with basic needs. The results of the study indicate that the community must be involved in community matters, health representatives and consultations' forums. Such involvement, therefore, can promote community's flexibility and awareness. In addition, the findings on community participation indicate the importance of meetings which can be held monthly or quarterly.

### **7.3 LIMITATION OF THE STUDY**

The study was conducted by taking samples from the total population of the Mafikeng sub-district only. The findings have identified problems and recommendations have been given based on the research. It was only restructured to the Mafikeng sub-district because of its geographical constraints. The sub-district is made up of 34 health centers, geographically. These health centers are isolated. It is hoped that the findings therefore will have universal application in the health centers of South Africa responsible for implementing health services for transformation.

### **7.4 RECOMMENDATION**

Comprehensive and culturally competent service, as well as high quality medical care can make a difference in improving access to medical care, thus the importance of diversity in the health care setting as expressed by diverse groups.

Health educators would empower the community by building capacity to improve health institutions and direct participation.

The government has to improve availability, equity and quality of health care services as well as to ensure basic care to the poor and the marginalized. The government should encourage social health insurance which are on cost subsidized insurance packages especially developed for the poor and lower socio-economic classes.

There were 57 respondents for this study and they represented 22% of the Mafikeng sub-district primary health workers. The sample included 27% of management of the management staff and 73% of non management staff. The non-management includes professional nurse, enrolled nurses, assistant nurses and environmental health staff with 32% of health nurses certification 39% of diploma and 29% of post graduate qualification and 51% of the respondents that served in the clinics for more than ten years. Most of the respondents are females amounting to 81%:

- 75% of the respondents agreed that access of services in rural areas is very slow and services provided are not of quality and standard expected
- 69% of the respondents supported coordination of health information services.
- The research indicated that nutritional services (75%) and accessibility of communicable diseases control services (63%) are provided in the clinics .The respondents strongly agreed that environmental health services is essential and it limits health risks.
- The majority of the respondents (80%) supported the needs of essential skills for efficient management of the health sector. The respondents strongly stressed the need of developing information flow skills, communication skills, stress handling skills and team empowerment form services management of the health sector.
- The study indicated that training is essential because it enhances performance competency and it increases performance and training should take place monthly and quarterly.
- The research study indicated that consultative forums are important and should be used to promote involvement of the community in health related sector. The respondents supported quarterly and monthly meetings to inform community on health issues.

Based on the findings, the following recommendations are made:

- Management must be encouraged to increase access to integrated health care services for all South Africans, focusing on the rural peri-urban. Health care policies should be established to promote equity between people living in rural and urban areas and between people living in rural and urban areas and between people served by public and private health sectors.
- Establish information health system for facilitation of the measurement and monitoring of the health status of the South Africa.
- Environmental health services should be accessible, affordable and equitable.
- Training programmes must be encouraged to instruct organisational skills, management skills, information, financial management, human resources management, inequality management and change management.
- Community consultative forums should be established to promote partnership in health services and share information.
- Communities should be empowered to take full responsibilities of their health status.
- Education in health and basic science must be an investment for the majority of South Africans.
- Health Technologists should be trained to address health problems.

## **7.5 CONCLUSION**

Chapter Seven of the study concludes on the following aspects, redressing of social inequalities in health sectors, role of service delivery in transforming the affected public health sectors, the role of management implementing health services to the communities and communities' involvement in the public health sectors' forums and planning. In addition, with regard to sampling findings, much is required to redress the imbalances in public health sectors. Rural and farm areas are the communities mostly affected. They need to be equally accessible to quality health service and right to health training. The recommendations suggested the fact that regular consultation between public health sector and community will be to the advantage of the communities' empowerment and accountability to secure better health status.

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## ANNEXURE A: QUESTIONNAIRE

### BIOGRAPHICAL DATA

Kindly place an "X" in the relevant boxes below to indicate your position.

(a) Position you occupy in Local Municipality

Management		Non-management	
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(b) your qualification

Certificate in Nursing	Diploma in Nursing	Degree in Nursing	Master's Degree

(c) How long have you been in health department sectors

0-3 year	4-5 years	6-10 years	11-20 years

(d) Your age group

Below 20 years	20-24 years	25-29 years	30-34 years	40 years

(e) Gender Health sub district clinics

Male	Female

Research question the role of service delivery the transformation of health services

Please answer the following question to the best of your ability

1. Do you think most of the people in rural areas and peri-urban areas have adequate access to health care services

Yes		No		Not sure	
-----	--	----	--	----------	--

2. Do you think services are affordable?

Yes		No		Not sure	
-----	--	----	--	----------	--

3. Are the resources utilized efficiently, economically and effective

Agree		Totally agree		Disagree		Totally Disagree	
-------	--	---------------	--	----------	--	------------------	--

5. What is your opinion on the basis of the quality of services provided to the community?

High		Poor		Bad	
------	--	------	--	-----	--

5. Do you think there is shift of resources from fertilizing services in metropolitan areas to the inadequacies of clinics in rural areas?

Yes		No	
-----	--	----	--

6. Do you think health information should be considered to support effective delivery of services?

Yes		No		Not sure	
-----	--	----	--	----------	--

7. Do you think non proficiency nutrition is an ethical imperative and sound economic investment in S.A.?

Yes		No		Not sure	
-----	--	----	--	----------	--

8. Do you think communicable disease control services are accessible and intergraded into primary health care system?

Agree		Totally agree		Disagree		Totally disagree	
-------	--	---------------	--	----------	--	------------------	--

9. What is your view on access to knowledge on environmental health matters and the environmental services available?

Agree		Totally agree		Disagree		Totally disagree		Don't	
-------	--	---------------	--	----------	--	------------------	--	-------	--

10. Do you think maternal, child, women's health services is accessible to mother, children and women of all ages on rural and poor farm areas?

Yes		No		Not sure	
-----	--	----	--	----------	--

11. The skill required for effective health manager

Information	Yes	No
Communication skills		
Problems solving		
Resource organization		
Stress Handling		
Team Empowerment		

12. What type of training does the Health workers?

Skill	Management	Professional support	Financial Training

13. The importance of training of health work

No response	Enhance performance	Competency	Increase productivity

14. How often should training of health workers take place?

When necessary	Monthly	Quarterly	As required by manager

15. Who is responsible for training on health services?

Facility health manger	Support managers	Health consultants	Team leaders

16. Do you think the consultative forums are important?

Yes	No	Not sure

17. High consultative form

Agree	Strongly agree	Disagree

18. Do you think that community members are treated with courtesy and

consideration?

Yes		No		Not sure	
-----	--	----	--	----------	--

19. How often should community consultation forum meetings take place?

Weekly		Monthly		Quarterly		Annually
--------	--	---------	--	-----------	--	----------

20. Do you think training is necessary for such forms?

Yes		No		Not sure	
-----	--	----	--	----------	--