THE EXPERIENCES OF PROFESSIONAL NURSES REGARDING THE MANAGEMENT OF HEALTH SERVICES RENDERED TO TUBERCULOSIS PATIENTS

By

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I wish to express my sincere gratitude to:

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The World Health Organisation (WHO) declared tuberculosis (TB) a global emergency, and this infectious disease remains a health threat by being the leading cause of death amongst adults (Naidoo, Dick & Cooper, 2008:55). In 2005, South Africa was ranked seventh in the world for having the highest TB rate and the lowest TB success rate in the world.

As a professional nurse involved in the tuberculosis programme at a clinic in the Nelson Mandela Bay Municipality at local government level for approximately three years, the researcher observed that the morale of professional nurses who provide TB services appeared to be low. They also appeared to be frustrated because they feel that they are not winning the battle with regard to the TB epidemic in their communities irrespective of their efforts to try and curb the spread of the disease. The extent of the workload per person also appeared to add to the low morale and frustration of the professional nurses rendering TB health services because they feel that they are unable to manage everything.

The objectives of the study were therefore to explore and describe how professional nurses experienced the management of health services being rendered to TB patients in Sub district B of the Nelson Mandela Bay Municipality (NMBM) in order to make recommendations that could be used by the district manager to address the research findings.

The research study was based on a qualitative, explorative, descriptive and contextual research design. The research population consisted of all professional nurses who worked in the TB services of Sub district B. Non-probability, purposive sampling was used to select the participants for the study. Seven in-depth and three follow-up interviews were conducted before data saturation was achieved. The data gathered during the interview process by the researcher were transcribed and coded by an independent coder using Tech’s model for data analysis. Ethical considerations were adhered to throughout the research study. The aspect of trustworthiness according to Guba’s model was implemented in the research study and included credibility, applicability, consistency and neutrality.
One theme, two sub themes and categories were identified relating to the diverse experiences expressed by the participants relating to the management of health services being rendered to TB patients. The experiences expressed by the professional nurses included both negative and positive experiences. The negative experiences expressed by the participants were for example, a lack of resources as hampering adequate service delivery, a concern regarding the number of staff contracting TB due to a lack of infection control measures, a difference in conditions of service between the two local authorities and the DOTS supporters as being a threat to patient confidentiality. The positive experiences expressed by the participants included experiences relating to job satisfaction in rendering TB health services, the DOTS supporters as being supportive to the staff, the TB meetings serving as an appropriate platform for problem solving and the audits conducted by managers as being remedial.

The study concludes with recommendations made with regard to the areas of nursing practice, education and research.

**Keywords:** Pulmonary Tuberculosis (PTB), Tuberculosis (TB), Tuberculosis health services, Direct Treatment Shortcourse Strategy, Department of Health (DoH), Primary Health Care (PHC)
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DECLARATION BY STUDENT

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QUALIFICATION:  MA. Health and Welfare Management
_____________________________

DECLARATION:

In accordance with Rule G4.6.3, I hereby declare that the above-mentioned treatise/ dissertation/ thesis is my own work and that it has not previously been submitted for assessment to another University or for another qualification.

_____________________________
SIGNATURE:               

DATE:       28 January 2011
CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND LITERATURE REVIEW

Pulmonary Tuberculosis (PTB) is an infectious disease caused by the microorganism, called mycobacterium tuberculosis and Pulmonary Tuberculosis is spread via droplet infection when an infected person coughs or sneezes. The inhaled mycobacteria multiply to cause a primary infection in the lung or it disseminates to infect the regional lymph nodes and from there to the bloodstream and then too various organs in the body (Vlok, 1996:519). Tuberculosis can thus affect any part of the body, with pulmonary tuberculosis being the most common form of the disease, occurring in 80% of cases (Department of Health [DoH], 2000:11).

Tuberculosis is a global pandemic and an emergency in Africa (TB can be stopped, 2007:47). Tuberculosis is often thought of as an ancient disease that plagued large communities in years gone by. One third of the world’s population is being infected with TB, nearly two million people die of TB and nine million become infected with TB each year (TB can be stopped, 2007:47). According to the Tuberculosis Strategic Plan for South Africa compiled by the DoH (2007: 6) South Africa is regarded as one of the highest burdened countries that contribute to approximately 80% of the global burden of all Tuberculosis (TB) cases. The high incidence of TB in South Africa makes TB control a priority concern that must be addressed.

According to the World Health Organisation (WHO) (1998:[S.a]), as quoted by the Foundation for Professional Development (2004:43), a positive impact on the TB epidemic will not be achieved in low and middle income countries unless integration of TB control has taken place in the primary health care system. It therefore becomes important for health workers to devise strategies that would assist in controlling this epidemic. The primary health care approach remains the best option for this purpose and is critical in the management of this epidemic.
The philosophy of primary health care (PHC) was developed by the World Health Organization (WHO) and has been adopted by the South African government as the cornerstone of its health care system in the transformation process since 1994. The National Health Act No. 61 of 2003 (as amended) thus provides the framework for a structured unified health system based on the PHC approach. The aim of the implementation of the National Health Act is to decentralize the management of health care delivery services (Young, van Niekerk and Mogotlane, 2004:26). The delivery of services will therefore, be governed at provincial, district and local levels and the latter will ensure that the district health system is implemented in order to increase efficiency, local innovation, empowerment and accountability in the communities served (Young et.al, 2004:26).

According to van Rensburg (2004:422) the transformation of health services in South Africa requires a mechanism to define parameters for service delivery, as well as to ensure comparability in the rendering of services. This mechanism was realized in 1994 in the form of the comprehensive PHC service package that, firstly, entails a standardized comprehensive “basket” of services to be delivered at a primary care level. It may include promotive and preventive services, as well as basic curative and rehabilitative services. Secondly, the primary health care package stipulates the common quality norms and standards that are required for each PHC service and are shared by those delivering the service (DoH, 2001:12). The PHC package outlines services in terms of acceptable levels of care that are imminent to communities. The PHC package also stipulates approaches and activities that need to be implemented to ensure that the necessary requirements in terms of financial resources, infrastructure, equipment and staffing are met to ensure service delivery. The package thus serves as a planning and prioritization tool, with equity, efficiency and cost-effectiveness featuring prominently (van Rensburg, 2004:427).

Central to the PHC package is the set of norms and standards which provide direction to the rendering of health services at acceptable levels within the public sector. These norms and standards are defined by the National Department of Health in terms of the health needs of the general population. In terms of the PHC
service package, there are core norms and standards specific to all public PHC facilities. Tuberculosis services form part of the comprehensive primary health care services guided by the specific norms and standards as stipulated by the DoH to render a service that is acceptable for the TB patients. The core norms as stipulated by the DoH (2001:12) are as follows:

- The clinic renders comprehensive integrated PHC service using a one-stop shop approach for at least 8 hours a day, five days a week.
- Access, as measured by the proportion of people living within a five (5) kilometer of a clinic, is improved.
- The clinic receives a supportive monitoring visit at least once a month to support personnel, monitor the quality of service and identify needs and priorities.
- The clinic should have at least one member of staff who has completed a recognized PHC course.
- Doctors and other specialized professionals are accessible for consultation, support and referral and provide periodic visits.
- Clinic managers receive training in facilitation skills and PHC management.
- There is an annual evaluation of the provision of the PHC service to reduce the gap between the needs and service provision using a situational analysis of the community’s health needs and the regular health information data collected at the clinic.
- There is an annual plan based on this evaluation.
- The clinic has a mechanism for monitoring services and quality assurance and at least one annual service audit.
- Community perception of services is tested at least twice a year through patient interviews or anonymous patient questionnaires.

The following are the core standards needed for the provision of effective PHC services, including TB services, as stipulated by the DoH (2001:12):

- References, prints and educational material, including standard treatment guidelines, the Essential drug list manual, a mini library, appropriate national
and provincial health circulars and policy documents, copies of the patient rights charter, and supplies of health learning material in local languages

- Appropriate equipment needed for the effective execution of services should be available such as blood pressure apparatus, refrigeration facilities, infant scale and adequate numbers of consulting rooms

- Medicine and supplies, especially those pertaining to the PHC essential drug list, with a mechanism in place for the ordering and control of supplies as well as available electricity, and cold and warm water

- Competencies of health care providers, amongst others, the ability to organize and run the facility, setting up the system for referrals and feedback on referrals, and caring for patients through existing management protocols and standard treatment guidelines

- Patient education, where service providers are able to address community-based health problems in collaboration with health or clinic committees and civic organizations

- Records, specifically related to an integrated standard health information system that facilitates the collecting and utilization of data as well as ensuring that notifiable medical conditions are reported according to protocol and that the facility has a filing system that follows continuity of care

- Community and home-based activities, in the form of a functioning community health committee, as well as through linkages with civic organisations, workplaces, education facilities and home-based care initiatives

- Referral of patients to the next level of care whenever appropriate, including referral to social services, and ensuring that referrals within the facility are recorded in relevant registers, and

- Collaboration on an intersectoral basis with officials and service providers from social welfare, assistance and health-oriented civic organisations and workplaces.

According to a study conducted at PHC facilities in the Southern Cape in the Karoo region by Uys (2004) as quoted by Baloyi (2009:5) various obstacles and challenges preventing effective PHC services to the community within the area were identified.
The challenges identified by the participants of the latter research study were as follow:

- Shortage of staff with increased workload resulting in frustration and low morale
- Inadequate supplies of stock and drugs
- Shortage of equipment
- Poor infrastructure, such as inadequate facilities
- Lack of training sessions, especially in-service training
- Financial constraints
- Personnel not spending enough time with patients, resulting in the lack of patient care.

The latter study conducted in the Southern Cape emphasizes the challenges faced by the staff employed at PHC facilities in the country. These challenges necessitate the urgency of the South African Government to implement appropriate measures to facilitate the implementation of the norms and standards as stipulated by the PHC package.

In addition to the aforementioned core norms and standards, there are specific norms and standards stipulated for the 27 PHC services of which TB is one (van Rensburg, 2004:431). According to the DoH (2001:38) the additional norms and standards regulating TB services on a daily basis include:

- achieving a minimum of 85% cure rate of new sputum positive TB cases;
- to achieve a passive case finding rate per 100,000 population to be defined;
- achieving two days’ turnaround time of sputum results in more than 90% of cases;
- every clinic to have at least one staff member who has an opportunity for continuing education in TB management, and
- every clinic should receive a six-monthly assessment and evaluation by a supervisor regarding the quality of care rendered and also the degree of community involvement in planning and implementing care.
According to the Tuberculosis Strategic Plan for South Africa (DoH, 2007:6) the cure rate for Tuberculosis patients has improved from 50% in 2001 to 58% in 2005 and the treatment success has improved from 60% to 71%. The latter statistics provided by the DoH prove that South Africa is still far from achieving the 85% cure rate as stipulated by the norms and standards pertaining to TB. In 2005, the WHO ranked South Africa as having the seventh highest TB rate in the world, with a low treatment success rate. South Africa registered a total of 285 000 new cases of Tuberculosis patients in 2005 of which 116 000 are new smear-positive TB cases (Naidoo, Dick and Cooper, 2009:1).

The South African National Department of Health realized that its TB control efforts had been ineffective and adopted the comprehensive service delivery approach as stipulated by the PHC package to fight the spread of TB. The aforementioned comprehensive service delivery package therefore included the directly observed treatment short-course strategy (DOTS) as part of the review of the TB programme by the WHO and the DoH in 1996. The DOTS strategy is designed not only to treat the individual but also to safeguard the public’s health (Hansel, Wu, Chang and Diette, 2004:639). The five key elements of the DOTS strategy are:

- government commitment to sustained TB control activities;
- sputum smear microscopy to detect the infectious cases among those people attending health care facilities;
- standardised short-course anti-TB treatment for all confirmed TB cases;
- regular, uninterrupted supplies of all essential anti-TB drugs;
- standardised recording and reporting systems which allow for assessment of treatment results and overall programme performance (Department of Health, 2001: 9).

Moreover, the PHC Package pronounces that all nursing staff and DOTS supporters in clinics working with TB patients have a specific role that they should perform, in the facilities. The roles of the professional nurse are set out as standards in the PHC package as follows:
The professional nurse should:

- initiate and follow-up treatment of patients using the latest recommended TB management regimen and protocol;
- suspect and identify TB by early symptoms;
- educate the patients about tuberculosis with the emphasis on correcting misinformation and seeking to prevent the spread of the disease;
- initiating treatment of the TB patient and referring the patient for directly observed treatment (DOT) support by volunteers chosen and accepted by the patient;
- enter all sputum results on the TB register and forms (DoH. 2001:31).

The role of the DOTS supporters include:

- ensuring that the patient takes every dose of anti-TB drugs, as directed, until the end of the treatment course;
- being supportive, polite and considerate of the patient’s needs at every contact with the patient;
- having an interest in providing community services;
- nurturing a good, supportive relationship between the patient and community treatment supporter to help motivate the patient to continue and complete the treatment course. A negative attitude towards the patient can cause the patient to default on treatment (DoH, 2009:48).

The DOTS strategy is the most effective strategy available worldwide for controlling TB, developed from collective best practices, clinical trials and programmatic operations of TB control over the past two decades (DoH, 2000: 5). Short-course chemotherapy is a combination of potent anti-tuberculosis drugs which includes the TB treatment regimen comprising of isoniazid, rifampicin, pyrazinamide, streptomycin, ethambutol. The short-course chemotherapy has an initial phase of two to three months, and a continuation phase of four to seven more months (DoH, 2009:5). This strategy facilitates the management of TB compliance among patients by motivating them to continue treatment and counter the tendency to default treatment, and identifies early treatment interruption by patients.
Although most of the aforementioned norms and standards pertaining to TB health services and the DOTS strategy were implemented at local government level in the Nelson Mandela Bay Municipality (NMBM) it appears as if the clinics are still performing below the required specifications as stipulated by the PHC comprehensive service delivery package.

1.2 PROBLEM STATEMENT
The researcher is a professional nurse involved in the tuberculosis programme at a clinic in the Nelson Mandela Bay Municipality at local government level for approximately three years. While working at the clinics the researcher observed that the morale of professional nurses who provide TB services appeared to be low. They also appeared to be frustrated because they feel that they are not winning the battle with regard to the TB epidemic in their communities irrespective of their efforts to try and curb the spread of the disease. Based on anecdotal evidence the factors that make them feel this way include:

- the rise in the incidence of TB cases which is evident by the difference in statistics of 2004 and 2005 which indicated a rise of 259 patients for a period of 12 months for a particular community (monthly statistics). According to a report released by the WHO it was evident that the incidence of TB in South Africa has risen to 720 newly diagnosed smear positive TB patients per 100 000 of the population and for the Eastern Cape the TB incidence was 687 newly diagnosed smear positive cases per 100 000 of the population (DoH, 2009: 9).
- a high interruption rate of above 5% (clinic defaulter register) and
- cure rate of below 85% (Electronic TB register)

The aforementioned statistics are contrary to the norms and standards stipulated by the DoH. The researcher also observed that sometimes the TB clinics in the NMBM function with one professional nurse who becomes responsible for managing TB health services that address the needs of all TB patients. The responsibilities of the professional nurse include among others the administering of medication, administrative duties such as completing the TB register, doing patient observations,
home visits in order to trace treatment defaulters, preparing patients for admission to the TB control programme and arranging hospital admissions for complicated TB patients. The same professional nurse responsible for managing the TB health services must also attend to other acute and chronic ailments that need undivided nursing attention. The aforementioned workload for one person appears to add to the low morale and frustration of the professional nurses rendering TB services because they feel that they are unable to manage everything.

The aforementioned observations thus motivated the researcher to conduct this research in order to establish how professional nurses experience the management of health services rendered to TB patients. Thus the following research questions are posed:

- How do professional nurses experience the management of health services rendered to TB patients?
- What can be done to address the research findings?

1.3 RESEARCH OBJECTIVES
The objectives of this study are to:

- explore and describe the experiences of the professional nurses regarding the management of health services being rendered to TB patients within Sub-district B of the Nelson Mandela Bay Municipality
- make recommendations that could be used by the district manager of Sub-district B of NMBM to address the research findings.

1.4 CONCEPT CLARIFICATION
For the purpose of this study, the following concepts will be defined as follows:

1.4.1 Professional nurse
The Nursing Act of South Africa (Act no. 33 of 2005) defines a professional nurse as a person who is registered as a nurse under section 31 of this act (The Nursing Act no.33 of 2005). According to Section 31 of the Nursing Act No.33 of 2005 the practitioner who wishes to register as a professional nurse should apply in writing to
the registrar providing proof of qualifications as well as the necessary documentation and information in relation to his or her application as required by the registrar on instruction of the council (The Nursing Act No.33 of 2005: 37). For the purpose of this study the term professional nurse refers to all the professional nurses (male and female) employed by Sub-district B of NMBM and who partake in rendering TB health services in the community.

1.4.2 Management
According to Hornby (1995:712) to manage is referred to as continuing to live or meet one’s needs and to succeed in doing (something), especially with difficulty. Cullen, Higgelton and Collins (2004:513) define management as being able to do something and to succeed in doing it. For the purpose of this study management refers to the ability to do something (i.e. render health services to TB patients), and to succeed in doing it even if it is with difficulty.

1.4.3 TB health Service
A health service is defined as a service providing care and emergency medical treatment, contemplated in Section 27 of the Constitution of South Africa Act No. 61 of 2003 that stipulates that it conforms to the policies concerning any matter that will protect, promote, improve and maintain the health of the population (Constitution of South Africa Act No. 61 of 2003). For the purpose of this study a TB health service refers to a service that is implemented through a network of existing health services that is clinically efficient in rendering treatment to infected TB patients according to the National TB control programme.

1.4.4 Nurse Managers
According to Mathena (2002) as quoted by Finkelman (2006:21) nurse managers are internal stakeholders who play essential roles in managing change, cultural integration, retention, and direction of staff attitudes towards changing health care structures. Nurse managers are responsible to nurse executives and have more defined areas of nursing service. Advocating and allocating available resources to facilitate effective, efficient, safe and compassionate care based on standards of
practice are the cornerstone roles of the nurse manager (Roussel & Swanberg, 2009:24). The term nurse manager in this research will refer to a professional nurse who has qualified as a nurse and/or midwife and is appointed as a district manager in charge of a Sub-district of the Nelson Mandela Bay Municipality.

1.5 RESEARCH DESIGN AND METHOD
The research design and method refer to the type of study that will be conducted to address the research problem as well as to which design will produce the evidence or data needed to answer the research question (Babbie and Mouton, 2004:103). The research method comprises the methodical, systematic and accurate execution of the research design (Babbie and Mouton, 2004:74). To follow a proper research process various tools and methods are used to execute different research tasks. The following methodological procedures will be followed in this research process:

1.5.1 RESEARCH DESIGN
The research design will be qualitative, explorative, descriptive, and contextual in nature. The proposed research design will be described in detail in Chapter Two.

1.5.2. RESEARCH METHODS
According to De Vos, Strydom, Fouche and Delport (2002:120) the research methods provide a description of the technique to be employed, the specific measuring instruments to be used as well as the activities to be conducted in making the measurements. The research methods of this study include research population, research sampling, data collection, data analysis, pilot study, trustworthiness and the role of the researcher.

1.5.2.1 Research Population
The population of a study refers to the people about whom the researcher wants to draw conclusions (Babbie and Mouton, 2004:100). The population for the purpose of this study will be all professional nurses, registered with the South African Nursing Council (males and females), who work for the NMBM on a permanent or contractual basis and render a health service to TB patients in the PHC clinics.
1.5.2.2 Research Sampling
In this study the researcher will make use of non-probability, purposive sampling. Strydom and Venter (in De Vos, Strydom, Fouche & Delport, 2002:198) state that the purposive sample is based entirely on the judgment of the researcher and is composed of elements that contain the characteristics most representative, or attributes typical of the phenomenon to be studied. Chapter Two will provide the detail pertaining to the sampling strategy utilized.

1.5.2.3 Data Collection
The researcher will make use of an interpretive inquiry in the form of an in-depth interview as a means of data collection. According to Morse and Field (2002:72) an interview is a personal and intimate sharing of confidence amongst people and it should be treated in this manner. Janesick (1998) as cited by Esterberg (2002:83) defines an interview as the exchanging of information by two people through questions and responses, resulting in communication and joint construction of meaning about a particular topic.

1.5.2.4 Field notes and Observations
Field notes should contain a comprehensive account of the participants themselves, the events taking place, the actual discussions and communication, as well as the observer’s attitudes, perceptions and feelings (De Vos et al., 2002:286). An in-depth discussion on the data collection process will be given in Chapter Two.

1.5.2.5 Data Analysis
Qualitative data analysis is a systematic process of selecting, categorizing, comparing, synthesizing and interpreting data to provide explanations of the single phenomenon of interest (White, 2003:82). In qualitative analysis several simultaneous activities draw the attention of the researcher: collecting information from the field, sorting the information into categories, formatting the information into a story and actually then writing the qualitative text (Cresswell, 2009:151).
To assist the researcher in effectively executing the coding process Tesch’s generic steps as cited by Cresswell (2003: 190) will be applied. This will be discussed in more detail in Chapter Two of the study.

1.5.2.6 Pilot Study

According to Bless and Higson (2000) as quoted by De Vos et al. (2002: 211) a pilot study is a small study conducted prior to a larger piece of research to determine whether the methodology is appropriate and adequate. Van Teijlingen and Hundley (2001:1) on the other hand mention that a pilot study will give an advance warning about when the main research project could fail. For the purpose of this research a pilot study will be conducted using the same selection criteria as for the original research to ensure that the process or research design intended for the original research is adhered to and the results achieved. The specifics regarding the criteria used for the pilot study will be discussed in detail in Chapter Two of the research study.

1.5.2.7 Literature control

The purpose of a literature review is to demonstrate the key theories, arguments and controversies in the field. The literature review also highlights the way in which the research topic has been investigated up to date as well as to identify inconsistencies and gaps about the research topic that is worthy of further investigation (Gray, 2009: 53). Literature control for the purpose of the study will be ensured by comparing the themes, sub themes and categories that emerged from this study to the outcomes of research already undertaken in the past. The literature control will be concluded after the data have been analyzed in order to avoid developing preconceived ideas about the problem under review as indicated by the researcher.

1.6 TRUSTWORTHINESS

Rigour in research is required to prevent error of either a constant or intermittent nature (Morse and Field, 2002:118) therefore trustworthiness should be maintained during the research. According to Holloway and Wheeler (2002:256) a study is authentic when the strategies used are appropriate for the true reporting of the
participant's idea. When the study is fair and when it helps participants and similar groups to understand their world and improve it also enhances authenticity.

The researcher will apply Guba's model of validity and reliability to ensure trustworthiness. According to Morse and Field (2002:118) Guba's model addresses four aspects to ensure trustworthiness, namely credibility, applicability, consistency and neutrality. Each of these aspects will be discussed in more detail in Chapter Two of the study.

1.6.1 THE ROLE OF THE RESEARCHER
The role of the researcher is to plan the research and ensure that the process is followed through systematically and logically. The research must attain high ethical standards and therefore the researcher must be emotionally prepared. According to Henning (2004: 81) the researcher becomes the instrument of observation and “sees for herself” first-hand how people act in a specific setting and what the setting comprises. The researcher serves as a human instrument in an effort to explore and describe the experiences of the professional nurse in the management of health services rendered to TB patients. This means that the researcher should be non-judgmental and open-minded. The researcher must also ensure that a language that is acceptable to all participants is maintained. The researcher will be responsible for the gathering of the data, sorting of the data, analyzing the data, studying relevant literature and interpreting the findings. The researcher will therefore be acting as a research instrument. The researcher becomes immersed in data to generate familiarity with the setting, the process and the world of the participants (Holloway and Wheeler, 2002:55).

1.7 ETHICAL CONSIDERATIONS
Ethics is typically associated with morality, and both words concern matters of right and wrong (Babbie, 2004:63). The researcher will ensure that ethical standards for the purpose of the study are adhered to by ensuring

- that there is no harm to the participants,
- that the researcher utilises informed consent,
that no deception is perpetrated in regard to the respondents, by ensuring anonymity and confidentiality of the participants’ identity.

The ethical considerations pertaining to this study will be discussed in detail in Chapter Two.

1.8. STRUCTURE AND FORMAT OF RESEARCH REPORT

The research will comprise four chapters and the format will be as follows:

Chapter 1: Overview of the study
Chapter 2: Research Design and Methods
Chapter 3: Data Analysis and literature Control
Chapter 4: Summary, Conclusion, Limitations and Recommendations

1.9 CHAPTER SUMMARY

The aim of this study is to explore and describe the experiences of the professional nurses regarding the rendering of health services to TB patients in Sub-District B of the Nelson Mandela Bay Municipality. The aforementioned discussion gives a brief overview of the objectives as well as the methods that will be employed in conducting the research. The findings of the study will be used to make recommendations that could be used by the district manager in Sub-district B of the NMBM in improving the implementation of TB services.
CHAPTER 2

RESEARCH DESIGN AND METHOD

2.1 INTRODUCTION
The previous chapter gave an overview of the proposed study. In this chapter a detailed description of the research design and methods utilized to conduct the study will be described. The researcher explored and described the experiences of the professional nurses regarding the management of health services being rendered to TB patients. The methods of data collection, analysis and interpretation will be discussed in detail in this chapter.

2.2 RESEARCH DESIGN AND METHODS
The research design and methods used in the study will be discussed below. The research design refers to approaches in research, such as experiments, case studies, ethnography and action research (Gibson and Brown, 2009:48). The research methods refer to the data collection methods or rules by which a particular piece of research is undertaken. In a broader sense it also refers to the whole system of principles, theories and values that underpins a particular approach to research (Somekh and Lewin, 2005:346).

2.2.1 RESEARCH DESIGN
According to Gibson and Brown (2009:48) traditional researchers speak of the design of a study as the product of the planning stage of the research. Mouton (2001) as stated in De Vos et al. (2002:137) defines a research study design as a plan or blueprint of how one intends conducting the research. Burns and Grove (2005:225) also defines a research design as a blueprint for conducting the study that maximizes control over factors that could interfere with the validity of the findings and guides the researcher in planning and implementing study in a way that is most likely to achieve the intended goal. The study was conducted in all clinics in Sub-District B of the NMBM. The researcher selected a qualitative, explorative, descriptive and contextual design to explore and describe the experiences of the
professional nurse regarding the management of health services that are being rendered to TB patients.

2.2.1.1 Qualitative Research
According to Brink (2006:11) qualitative research stresses the importance of people's interpretations of events and circumstances. The qualitative data can also be explained by the fact that it focuses on evidence of what people think, feel and experience, and how they make sense of and interpret the world (Gomm, 2008:9).

According to Brink (2006:113) qualitative research methods are concerned with studying human experiences from the viewpoint of the research participant. The researcher endeavoured to study how professional nurses experienced the management of TB health services being rendered to patients in order to gain better insight into the phenomena being studied.

2.2.1.2 Explorative Design
Bless and Higson-Smith (1995) as quoted in De Vos et al. (2002:109) states that explorative research is conducted to gain insight into the situation, phenomenon, community or individual. According to Babbie and Mouton (2004:79) explorative research is conducted to explore a topic, or to provide a basic familiarity with the topic and this type of approach is used to examine a new interest or when the subject of study itself is relatively new.

Explorative research is therefore important to provide insight about the nature of the phenomenon. It explores the dimensions of a phenomenon, the manner in which it manifests and other factors to which it is related (Brink, 2006:113). The research was explorative in the sense that the experiences of the professional nurses regarding the management of health services being rendered to TB patients were explored by the researcher by conducting in-depth interviews. The in-depth interviews were conducted with all the participants so that better insight and understanding of the phenomena could be obtained and described.
2.2.1.3 Descriptive Research

Descriptive research is a way of discovering new meaning, describing what exists, determining the frequency with which the research study occurs and categorizing information (Burns and Grove, 2005:26). Descriptive design also aims at obtaining complete and accurate information about a phenomenon and describes it through observation, description and classification (Brink, 2006:113).

Babbie and Mouton (2004:272) also mention that descriptive research gives a thick description which is a lengthy description that captures the sense of actions as they occur. In this research the researcher gives a thick description of the experiences of the professional nurses with regard to the management of health services being rendered to TB patients.

2.2.1.4 Contextual Design

Morse and Field (2002:11) explain a contextual design as being the context in which the phenomenon occurs; it is considered to be part of the phenomenon itself, therefore it is necessary to understand the contextual factors. The context refers to the social-cultural, historical and temporal environment where the research is located as well as the conditions in which it occurs (Holloway, 2008:51).

The study has a contextual nature because it was conducted in the natural setting where the participants work namely the clinics. The PHC clinics are all situated in peri-urban areas characterized by poverty, high rates of unemployment and poor infrastructure. The PHC clinics are situated in areas that serve patients from different cultural, ethnic and socio-economic backgrounds. The patients attending the PHC clinic were from the Xhosa and coloured ethnic groups and were within the low to medium socio-economic groups. In the areas where the PHC clinics were situated there is a mixture of informal and formal housing and formal and informal trading. The research was contextual in nature because the participants were interviewed within their physical environment and cultural context.
2.2.2 RESEARCH METHOD
Green and Thorogood (2009:286) states that research methods include the philosophical principles that inform different approaches as well as the technical issue of how to generate and analyse data. The study explored and described the experiences of professional nurses regarding the management of health services being rendered to TB patients and the following research methods were utilized for conducting the research.

2.2.2.1 Research Population
The research population according to Babbie (2004:194) is the aggregation of elements from which the sample is actually collected. Holloway and Wheeler (2002:166) also indicates that a research population are the people identified by the researcher as having adequate knowledge of the topic or who are experts in an area of knowledge and are able to provide the relevant information required in order to gain insight into the specific experiences being investigated. For the purpose of the research study the population consisted of all professional nurses working in TB clinics that are situated in Sub-District B of the NMBM.

2.2.2.2 Research Sampling
The researcher made use of a non-probability, purposive sampling technique to select the participants for the study. According to Brink (2006:133) a purposive sample is selected on the basis of your own knowledge of the population, its elements, and the nature of your research aims: in short, based on your judgment and the purpose of the study. Therefore, the researcher purposively selected the participants using the following selection criteria:

All participants selected had to be:

- Professional nurses (male or female);
- employed by the Nelson Mandela Metropolitan Municipality for at least six months, (whether permanently or contractually) and managing the TB control Programme;
- able to converse in English to prevent misinterpretations by the researcher.
2.2.2.3 Data Collection

The researcher made use of an interpretive inquiry in the form of an in-depth interview for means of data collection. According to Morse and Field (2002:72) an interview is a personal and intimate sharing of confidential information amongst people and it should be treated in this manner. Janesick (1998) as cited by Esterberg (2002:83) defines an interview as the exchanging of information by two people through questions and responses, resulting in communication and joint construction of meaning about a particular topic.

The interviews were conducted in the natural setting of the PHC clinics where the professional nurses were employed at a time that was convenient to the professional nurse. The interviews were conducted in the afternoons, usually after lunch because the PHC clinics were found to be not so busy in the afternoon. Interviews with the participants were scheduled at times convenient to the participants in order to avoid interruption of service delivery to patients. The researcher obtained permission from all the participants to use a tape recorder for recording all interviews prior to conducting the interviews (see Annexure A). The reason for recording the interviews was for the researcher to capture everything that was said by the participant and also to maintain eye contact throughout the interviewing process. Qualitative interviews can be seen as an attempt to understand, from the participants’ point of view their meaning of the world and unfold the meaning of peoples’ experiences and to uncover their lived world prior to scientific explanation (Kvale, 1996 as quoted by De Vos et al., 2002:292). The interviews were all between 45-60 minutes long and the following research question was posed to all participants:

“How is it for you to manage health services that are being rendered to TB patients?”

Morse and Field (2002:76) explains the aforementioned questioning as useful because this technique ensures that the researcher obtains all information required and at the same time allows the participant freedom of responses and description to illustrate concepts. According to Somekh and Lewin (2005:220) open-ended
questions are far more common given that they aim at encouraging free response and continuous communication. The interviewing process extended until data saturation was evident and information was being repeated as the interviews progressed.

2.2.2.4 Field notes

Field notes were recorded, containing information of events taking place, facial expressions, the observer’s attitudes, perceptions and feelings as well as the actual conversation and discussion. According to de Vos et al. (2002:286) field notes should ideally contain a comprehensive account of the participants, the events taking place, the actual discussion and communication, as well as the observer’s attitudes, perceptions and feelings.

The information that couldn’t be captured by the audiotape, for example, body language, was noted and written immediately after the interview. These field notes were explained in the form of observational, theoretical and methodological notes.

- **Observational notes** were taken to keep account of what happened and were recorded immediately after the interview while it was still fresh in the researcher’s mind (De Vos et al., 2002:288). The researcher described the events as they happened by watching and listening and included them in the research process (Gibson and Brown, 2009:105). The observational notes that were made included the facial expressions as well as words mentioned by the participants during the interviews. The setting and the surroundings during the interview were also captured by the researcher.

- **Theoretical notes**: in this regard the researcher tried to capture the ideas and save them from being forgotten. The theoretical notes put forward explanations relevant to the research question being investigated (Somekh and Lewin, 2005:25). The researcher interpreted and analyzed the data obtained during the interview to develop themes that validated the experiences of the professional nurses. Prior to the interview the researcher
explained what the research was about to ensure that the participant would share the same experiences with the researcher.

- The personal notes made included the researcher’s own reflections and experiences on research strategy, methods and activities as the research unfolded (Somekh and Lewin, 2005:26). The researcher wrote down key words to remind herself and to reflect to the participant if any clarity was required by the participant.

Techniques such as probing, follow-up questions, interpreting questions, silence between questions and summarizing were used to obtain relevant information from the participant. After the completion of each interview the audiotapes were labeled with a number, for example, interview 1 or interview 2, and the date and time were written on each tape. After all the interviews were conducted, all the labeled tapes were sent to an independent transcriber for verbatim transcribing. The transcribed interviews were sent to an independent coder with an accompanying letter (See Annexure B) instructing the independent coder to use the generic steps of Tesch as cited in Cresswell (2003:190) to conduct the data analysis and coding.

2.2.2.5 Data Analysis

Qualitative data analysis is a systematic process of selecting, categorizing, comparing, synthesizing and interpreting data to provide explanations of the single phenomenon of interest (White, 2003:82). In qualitative analysis several simultaneous activities draw the attention of the researcher, collecting information from the field, sorting the information into categories, formatting the information into a story and actually then writing the qualitative text (Cresswell, 2009:151).

During the research the information gathered during the interviewing sessions was scrutinized and then transcribed verbatim by an independent transcriber. The transcribed interviews were analysed and coded by both the independent coder and the researcher. Common themes and traits among respondents were identified. According to Marshall and Rossman (1999) in De Vos et al. (2005:337), this is the
most difficult, complex, ambiguous, creative and enjoyable phase of qualitative research.

To assist the researcher in effectively executing the coding process Tesch’s generic steps were applied as cited by Cresswell (2003:190) as follows: The data was organized and prepared for analysis by having the interviews transcribed, reviewing the field notes and sorting the data.

The researcher and independent coder then proceeded to do the following simultaneously:

- All the transcriptions were read through carefully to get a sense of the whole in order to give meaning by labeling the data. Documents were selected one at a time to analyse the underlying meaning by writing thoughts in margins.
- After completing the aforementioned task for several informants, a list of all topics, unique topics and leftovers were made.
- The list of topics was then assigned codes and the codes were then written next to the appropriate segment of the data text.
- The most descriptive wording was then identified for the topics which were turned into categories. The list of categories was then reduced by grouping related topics.
- Abbreviations were decided on for each category.
- The data material belonging to each category was assembled in one place and the preliminary analysis was then performed.
- Data was re-coded when considered necessary.

The researcher met with the independent coder after analysing the data to compare the themes identified in order to reach consensus.

2.2.2.6 Pilot Study

According to Neuman (2006:191) a pilot study should be conducted prior to the final research in order to ensure that the research process is reliable and extends to replicating the measures other researchers have used. According to Brink (2006:54)
the pilot study is a ‘dummy run’ or small scale version of the major study and by doing this the researcher can recognize and address some of the problems by obtaining information for improving the project, making adjustments to the instrument, or re-assessing the feasibility of the study.

For the purpose of this research a pilot study was conducted with two participants using the same selection criteria as for the original research to select the participants and also to ensure that the process or research design intended for the original research was adhered to and the results achieved. The participants were approached telephonically to ensure their willingness to participate in the study. Permission to perform the research was obtained from the Executive Director of Health of the Nelson Mandela Bay Municipality as well as the Sub-district B Manager respectively (See Annexures D and E). The pilot study served as a trial run prior to the original research and it allowed the researcher to gain experience in the questioning technique and interviewing of participants. The pilot study was conducted to assess the interviewing skills of the researcher and also to establish if the research objectives would be achieved. The pilot study also assessed the researcher’s data analyses techniques. The information obtained during the pilot study formed part of the original research process.

2.2.2.7 Literature control

According to Blaxter, Hughes and Tight (1996) as quoted by Jupp (2006:162) the literature review is a critical summary and assessment of the range of existing materials dealing with knowledge and understanding in the field being researched. The purpose of the literature review is to locate the research project, to form its context and background, and to provide insight into previous work. The aim of literature control is to determine whether the identified themes had been described previously (De Vos et al., 2002:129). Literature control for the purpose of the study was ensured by comparing the themes with recent research undertaken. The literature control was concluded after the data had been analyzed in order to avoid developing preconceived ideas about the problem under review as indicated by the researcher. According to Brink (2006:52) the initial review of the literature may
precede the identification of the problem as, through reading, the researcher’s conceptual insight and ideas regarding possible topics, and even approaches or techniques, may be stimulated. Validation of the literature was done and was scrutinized further and then refined.

2.3 TRUSTWORTHINESS

Rigour in research is required to prevent error of either a constant or intermittent nature (Morse and Field, 2002:118); therefore trustworthiness should be maintained throughout the research process. Guba’s model for assessing the trustworthiness of qualitative data was used according to Morse and Field (2002:118). Guba’s model addresses four aspects to ensure trustworthiness, namely credibility, applicability, consistency and neutrality.

- **Credibility**— The study is credible when it presents such accurate descriptions or interpretation of human experience that people who also share that experience would immediately recognize the descriptions (Krefting, 1991:215). It is subject-orientated and cannot be determined in advance by the researcher. The confidence of the researcher to undertake the research, his or her findings and the context in which the study was undertaken ensured the credibility of the research. The researcher conducted the interview process until the data were saturated. The researcher also pursued observations in different ways in conjunction with a process of constant and tentative analysis. The researcher recorded the interviewing process and this made the data credible. The following strategies were included to ensure credibility, namely prolonged and varied experiences and determining structured coherence were applied to the research study.

- **Applicability**— refers to the criterion used to determine whether the findings can be applied in other contexts or settings or with other groups (Morse & Field, 2002:118). In this study the researcher presented the data to allow for comparison. The strategy that was used to ensure applicability was dense description.
• **Consistency** - the emphasis is on whether the findings would be consistent if the inquiry would be repeated with the same subjects (Gray, 2009:375). Qualitative research emphasizes the uniqueness of the human being, so that variation in experience rather than identical repetition can be expected (Krefting, 1991:216). In this study the researcher recorded the interviewing sessions to serve as evidence of the thought processes of the respondents that led to conclusions made during the research. The strategies used to ensure consistency in the research process were dependability, dense description and code-recoded procedure.

• **Neutrality** - this would attempt to free findings from any biases, motivation and perspectives (Krefting, 1991:215). The researcher in this study used transcripts that were sent to an independent coder to verify the data against the recorded interviews and thus ensure trustworthiness. The themes and categories identified were then discussed by the researcher and the independent coder until consensus was reached. The researcher made use of confirmability and it included reflexibility to ensure neutrality in the study.

### 2.4 ETHICAL CONSIDERATIONS

Ethics is typically associated with morality, and both words concern matters of right and wrong (Babbie, 2004:63). The research proposal was presented to the Nursing Science Research Committee and a copy of the research proposal was submitted to the Faculty Research Technology and Innovations Committee for ethical approval. The researcher ensured that ethical standards for the purpose of the study were adhered as described below.

#### 2.4.1 No Harm to the Participants

According to Polit and Hungler (2001:358), humans should be treated as autonomous agents, capable of controlling their own activities and capabilities. Dane (1990) in De Vos et al. (2005:58) claims that an ethical obligation rests with the researcher to protect subjects, within reasonable limits, from any form of physical discomfort that may emerge from the research project. The participants were
protected from any form of harm by ensuring that arrangements were made for debriefing and counseling after the interview if necessary. None of the participants required any counseling post interview.

2.4.2 Informed Consent
According to De Vos et al. (2005:59) emphasis must be placed on providing accurate and complete information to the participants prior to data collection. The reason for this is that the participants will fully comprehend the research investigation and consequently be able to make a voluntary, thoroughly reasoned decision about their participation. The researcher obtained formal informed consent from the participants in writing. All the participants were involved in the research voluntarily and they were not forced to participate in any manner. The researcher therefore informed the participants about the nature of the research, the participant’s rights as well as the researcher’s responsibilities and the risks and benefits associated with the research. The duration of the research was revealed to the participants as well as how the results will be published and used. The consent form used for obtaining permission for the study is attached as Annexure B.

2.4.3 Deception of Participants
Babbie (2004:474) mentions that it is difficult to conceal the fact that research is being done but it is simple and appropriate to hide one’s purpose. Deception of the participants was guarded against by informing the participants that the research being performed forms part of a Masters’ degree programme at the Nelson Mandela Metropolitan University. According to Cresswell (2009:88) deception also occurs when the participants understand one purpose but the researcher has a different purpose in mind. The researcher guarded against deceiving the participants by concentrating on the agreed purpose of the study and not telling the participants one thing and doing another.

2.4.4 Anonymity
Sieber (1982) in De Vos et al. (2005: 61) defines privacy as the information that is not intended for others to observe or analyze. This means that in this research the
participants were not anonymous because the information was collected from an identifiable source but could not be traced back to the individual participants. The interviews were conducted in a private venue and the researcher ensured that no unauthorized individual was given access to the information gathered during the research.

2.4.5 Confidentiality
According to Babbie and Mouton (2004:523) confidentiality refers to the interviewer being able to identify the interviewee but promising not to do so publicly. During the research confidentiality was maintained by the researcher by not stating any names on the transcripts as well as not identifying the clinics visited during the research. Confidentiality was also ensured by keeping the transcripts and cassettes in a cupboard that could be locked. The participants were also informed that quotes would be used in the written report.

2.6 CHAPTER SUMMARY
A detailed description of the research design and method was discussed in this chapter. Credibility, consistency, neutrality and applicability were discussed explaining Guba’s model of trustworthiness. The ethical principles were highlighted to ensure that the research study is accepted as being ethical. A detailed description of the interviews and a discussion of the literature control follow in Chapter Three.
CHAPTER 3

DATA ANALYSIS AND LITERATURE CONTROL

3.1 INTRODUCTION
In the previous chapter an in-depth description of the research design and methods was provided. The focus of this chapter will be on the discussion of the findings of the study that emanated from the analysis of the interviews conducted with the research participants. A literature control is implemented to substantiate and verify the relevant research findings.

3.2 OPERATIONALISING OF DATA ANALYSIS
Data saturation was reached after seven in-depth interviews and three follow-up interviews were conducted among professional nurses in the natural setting of the PHC clinics where the professional nurses were employed. As mentioned in Chapter Two, the interviews were conducted at a time that was convenient to the professional nurses in order to avoid interruption of services to the patients for the period of the interview. The interviews were conducted in the afternoons, usually after lunch because the clinic was not so busy then. The researcher recorded all the information provided to ensure concentration on the interviewing process and the body language so that the researcher could detect what was not being said. The interviews conducted by the researcher were transcribed verbatim. The transcribed interviews were sent to an independent coder for assistance with data analysis and coding (see Annexure B).

The participants that were interviewed comprised of professional nurses who were involved in the management of health services rendered to TB patients.

3.3 IDENTIFIED THEMES
One main theme, two sub-themes and categories relating to the experiences of the professional nurses regarding the management of health services rendered to TB patients were identified. The identified themes are depicted in Table 3.1 below.
Table 3.1: The identified theme and sub-themes related to the experiences of professional nurses regarding the management of health services rendered to TB patients

<table>
<thead>
<tr>
<th>THEMES</th>
<th>SUB-THEMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Professional nurses expressed diverse experiences when managing health services rendered to TB patients</td>
<td>Sub-theme 1.1 Professional nurses experienced various challenges when managing health services rendered to TB patients.</td>
</tr>
<tr>
<td></td>
<td>Professional nurses experienced:</td>
</tr>
<tr>
<td></td>
<td>• a lack of resources as hampering adequate service delivery.</td>
</tr>
<tr>
<td></td>
<td>• a concern regarding the number of staff contracting TB because of a lack of infection control measures.</td>
</tr>
<tr>
<td></td>
<td>• differences in conditions of service between the two local authorities.</td>
</tr>
<tr>
<td></td>
<td>• DOTS supporters as being a threat to patient confidentiality.</td>
</tr>
<tr>
<td>1.2 Professional nurses also had positive experiences when managing health services rendered to TB patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Professional nurses experienced:</td>
</tr>
<tr>
<td></td>
<td>• Job satisfaction in rendering health services to TB patients</td>
</tr>
<tr>
<td></td>
<td>• The DOTS strategy as supportive and beneficial to the staff.</td>
</tr>
<tr>
<td></td>
<td>• The TB meetings as an appropriate platform for problem solving.</td>
</tr>
<tr>
<td></td>
<td>• The audit done by managers as remedial.</td>
</tr>
</tbody>
</table>
3.4 DISCUSSION OF THEMES AND LITERATURE CONTROL

A thick description of the theme, sub-themes and categories will be provided in this section and direct quotations from the raw data obtained from the participants will be used to support the identified theme, sub-themes and categories. Literature will be used to contextualize and verify the research findings. According to Henning (2004:27) the literature review is conducted to synthesize and to critically engage with the literature on the research conducted. The aim of the literature control is to verify the research findings and not merely to summarize previous research conducted (Mitchell and Jolley, 2010:547).

During the course of the interviews the participants appeared to be keen and uninhibited in sharing with the researcher their experiences regarding the management of health services rendered to TB patients. Five of the participants were from the Xhosa ethnic group and two were from the coloured population group. The ages of the participants ranged from twenty nine (29) years to fifty (50) years. The participants were employed for a period of 3-15 years in a comprehensive primary health care service. The data obtained from the participants revealed diverse experiences ranging from negative to positive.

3.4.1 MAIN THEME: PROFESSIONAL NURSES EXPRESSED DIVERSE EXPERIENCES WHEN MANAGING HEALTH SERVICES RENDERED TO TUBERCULOSIS PATIENTS

The main theme that emerged was the diverse experiences expressed by the professional nurses regarding the management of health services to TB patients. The term diverse refers to ideas that are very different from each other (Cobuild, 1987:412). Experiences, on the other hand, are defined as what happens to a person or what is seen and done by a person (Barnard & Barnard, 1991:749). The latter includes what is felt or lived through by a person such as all the actions, events or states which make up the life of a person, including the knowledge or skill gained by doing, observing or living through things. The experiences of individuals determine the mood that people find themselves in and, in turn, determine the general characteristics of their work, group or organization (Greenberg & Baron,
The diverse experiences expressed by the professional nurses were both negative and positive. The negative experiences expressed by the participants included, for example, a challenging and demanding work environment which frustrated and demotivated them. The positive experiences on the other hand included feelings of satisfaction and accomplishment.

“the day to day running of the TB programme or the TB department is really demanding and sometimes frustrating [to the professional nurse]”

“there are challenges that I [professional nurse] experience, and I have been experiencing these for the last four years”

“in the midst of these challenges, just to see your patients at the end of the day being cured of TB, healed completely at the end of the day, that is a positive for me.”

It is evident from the above discussion that the participants in the study expressed opposing feelings or forces that existed simultaneously within them. According to Fineman, Gabriel and Sims (2010:358) the latter feelings or forces can be described as ambivalence because the participants in the research expressed strong positive and strong negative emotions simultaneously.

The above findings appear to be congruent with the findings of a study conducted by the Consensus Research Group for the International Council of Nurses (ICN) among a random sample of 1000 nurses in 10 countries across Europe, North America, Asia and Africa. It was established that 75% of nurses experienced negative aspects regarding their working environment while only twenty-five percent (25%) had positive work experiences. The latter findings reflect that irrespective of where nurses are employed, they always appear to have positive and negative experiences in the workplace. The positive and negative experienced by the professional nurses will be discussed in the sub-themes below.
3.4.1.1 **Sub Theme 1: Professional nurses experienced various challenges when managing health services rendered to TB patients.**

The concept challenging is referred to as a task or job that requires great effort or determination if you are going to succeed at it (Cobuild, 1987:224). According to Fongqo (2009:58) the nursing profession in South Africa continues to face massive challenges and they must not get tired to reiterate to the authorities. In this research study it became evident that the participants were faced with multiple challenges in their working environment that hampered the management of health services rendered to TB patients. The different challenges that the participants faced in the management of health services rendered to TB patients are schematically presented in Figure 3.1 below:
The various challenges experienced by the participants when managing health services rendered to TB patients reflected in the above figure include:

- a lack of resources as hampering adequate service delivery,
- a concern regarding the number of staff contracting TB because of a lack of infection control measures,
- differences in conditions of service between the two local authorities, and
- the DOTS supporters being a threat to patient confidentiality.

The aforementioned challenges will now be described in the following paragraphs.

- **Professional nurses experienced a lack of resources as hampering adequate service delivery**

The research study revealed that the professional nurses experienced a lack of resources as hampering adequate service delivery. According to Wonderling, Gruen and Black (2006:199) resources are the ingredients of health interventions, for
example personnel, buildings, equipment, supplies and pharmaceuticals, transportation, training and social mobilization. The lack of resources in the study included human resources, infrastructure, equipment, adequate medication and transport.

The findings of the study are contrary to what is stated in the Constitution of the Republic of South Africa (The Constitution of the Republic of South Africa, Act No. 200 of 1993), which stipulates that all the citizens of the country have the right to health care services. Therefore, the government of South Africa must commit to ensuring that essential resources are available to ensure the realization of the aforementioned rights.

According to the National Health Act, 61 of 2003, all residents of South Africa should be provided with the best possible resources that are available. Kironde and Bamford (2002:284) state that adequate resources and capacity form an integral part in successful diagnosis, management and support of TB patients.

The participants experienced shortage of staff as a major hindrance in the execution of their daily tasks in managing the health services to TB patients. The participants indicated that the shortage of staff resulted in an increased workload with individual members of staff having to do the work of two people. The participants also indicated that some PHC clinics did not have a specific professional nurse managing the TB health services. According to the Tuberculosis Strategic Plan for South Africa (DoH, 2007-2011:75) at facility level there, should be at least one person responsible for the co-ordination of the TB programme if the case load is less than 200 patients. In facilities with higher case loads the suggested norm for managing TB health services is two to three professional nurses, with an additional enrolled nurse or enrolled nursing assistant to co-ordinate and render the TB programme in the facility. The latter experiences have resulted in the staff being frustrated and having low morale.

“The other challenge is that, as I’ve mentioned, the shortage of staff, né? That is a big challenge which make them to be, the
nursing staff are having that low morale because they are working so hard, doing the work of two people”

“By shortage of nurses I mean that in each facility we are supposed to have a dedicated TB nurse but unfortunately in most clinics there are no dedicated nurse.”

“nurses clinical workload of 30 plus per day per nurse, with no clinical support, with no pharmacy assistant or pharmacistso the frustration runs very high in smaller clinics than bigger facilities.”

The abovementioned findings are congruent with Ijumba ([s.a]:187) who states that a consequence of a shortage of staff is an unmanageable workload that results in stress, and manifests itself as low morale. A shortage of staff could also result in a rapid turnover of staff and detrimental effects on service delivery as well as interpersonal relationships which impact negatively on service delivery. According to an article in Nursing Update; Nurses love the job but not the work environment (2007:20) short staffing is one of the negative aspects of the nursing profession and it directly affects the delivery of quality health services. As a result of staff shortages problems of absenteeism, low morale, frustration and job satisfaction are experienced by the nurses The following quotes from the raw data are congruent with the latter statement because the participants experienced the high workload as hampering them in doing more for the patients and also in doing the right thing at all times. The professional nurses were of the view that the excessive workload contributes to their level of frustration and low morale:

“It's [workload] really demanding, and sometimes you feel you want to do more for the patients but sometimes you sit with patients with a total patients of sometimes 100 (one hundred)”

“Workload, Sister, we've got about 270 patients here in our clinic, né. At times it is full and then there’s a lot to do, checking the
patients records to make sure that the sputum have been collected and the TB register and the suspect register, and also to make sure that the sputum are entered in it. So it is at times really [very hard to do the right thing], especially when we have many admissions to attend to."

"Instances like there’s a shortage of staff in this clinic, I must also work to the primary health care side because there is no sister there. So now that day, it’s impossible for me to have admissions, to do them properly, so when I’ve got an admission, I will see that he’s okay, this one is supposed to start treatment, then I’ll just give the treatment and the patient goes. The patient doesn’t have full education first time, because when I am working now at the primary health side, or I’m helping at the baby clinic side. So it becomes impossible to cope."

The above quotes are congruent with an article in Nursing Update; Nurses love the job, but not the work environment (2007:20), that stated that the quality of service delivery is being hampered by the shortage of staff. The professional nurses noted that nursing agency contract staff was being appointed to address the shortage of staff. According to Robbins and Decenzo (2002:163) temporary employees are valuable in meeting short-term fluctuations in human resource management needs and have in the past been employed as administrative staff. However, contract workers were now being employed as nursing staff. The participants did not view this development as positive; on the contrary, they saw it as a waste of valuable time because the participants constantly have to train professional nurses as well as supervise the contract professional nurses to ensure competency in the work place.

The latter experiences are congruent with the findings of Purcell, Purcell and Tailby (2004:716) who stated that the employment of agency staff placed additional burdens on the permanent staff, for example with regard to orientation or induction of nurses unfamiliar to the nursing environment. The participants indicated that some of
the contract staff have been retired for some time and are out of touch with current practices. It therefore becomes a frustrating and time consuming exercise.

“you won’t know what is happening and it is quite frustrating to sit in a facility with all the nursing service people, they are not replaced by people that are newly trained and all that. We are getting people that have retired long ago. So it’s quite frustrating to work with such people.”

“And the other challenge now at present, our department now is using the nursing service people, people that’s not trained for all the things that we are doing.”

“Contractual municipal community health nurses and that impacts on service delivery in the TB department they [the professional nurses] are demoralized by those aspects and that also impacts on their TB management”

The results of a case study conducted by Couper, Tumbo, Harvey, Hugo and Malete, (2003:28) at two clinics in the Odi District of the North West Province regarding the key issues in clinic functioning revealed that the participants, namely the registered nurses, also experienced staff shortages and indicated that it was an ongoing problem. The participants in the aforementioned study indicated that the shortage of staff does not allow the professional nurses to run the services adequately because of an increased workload and a reduced amount of clinical support which resulted in disruptive continuity of patient care. Purcell, Purcell and Tailby (2004:716) also found that the use of temporary agency staff raised issues of quality control and continuity of patient care. The National Health Act, No.61 of 2003 stipulates that there should be adequate distribution of human resources in facilities and this regulates the provision of human resources and health professionals in the workforce of the Health Department in South Africa. A shortage in the provision of human resources, namely professional nurses is a contradiction to the National Health Act, no 61 of 2003. The
shortage of professional nurses may cripple the provision of health to the inhabitants of South Africa. To combat the staff shortages, four million healthcare workers need to be employed worldwide (Capazoria, 2006:10).

The participants in the research study also indicated that they experienced a lack of facilities that gave rise to an overwhelming level of frustration among the staff. The participants noted that the buildings were not conducive to competent practice because of the size of the rooms in which they have to work. The participants also indicated that the infrastructure of the facility did not allow for the rendering of multiple PHC services according to requirements stipulated in the Primary Health Care Package of South Africa. The following services should be included in a PHC facility to ensure that it conforms to the stipulated requirements according to the Primary Health Care Package of South Africa:

- Women’s Reproductive Health,
- Management and Prevention of Genetic Disorders and Birth Defects,
- Integrated Management of Childhood Illnesses (IMCI),
- Management of Asthma,
- Disease Prevention by Immunization,
- Adolescent and Youth Health,
- Management of Communicable Diseases,
- Prevention of Hearing Impairment due to Otitis Media,
- Rheumatic Heart Disease and Rheumatic Fever,
- Trauma and Emergency,
- Oral Health,
- Mental Health,
- Substance Abuse,
- Chronic Disease Management and
- Geriatrics and Rehabilitation Services (DoH, 2001:16).

The participants pointed out that the lack of adequate facilities resulted in multiple tasks being performed within one room. There should be a special TB room allocated for attending to TB patients but currently the room for dressings is also
used as a TB room. The professional nurses also indicated that the infrastructure did not allow for privacy when consulting with the patients because more than one registered nurse had to consult from the same consulting room.

“The one room that I’m using at the moment that is supposed to be the dressing room for all the injections, but now I’m also there doing the TB’s. So if there’s a dressing, it is done there whilst I’ve got a patient for admission at the same time, and now we have to convert the storeroom into another consulting room.”

“And also like the building is too small, né? Our buildings are not meant like for catering there to do infectious diseases”

“We are supposed to have a proper waiting area that is hyperventilated. At present we have a small cramped waiting area- actually there isn’t even enough space to move from one room to another.”

“Rendering the service at the present moment, it is impossible we’ve got only one room and that room is not big enough for the numbers that we are rendering there,”

The availability of adequate infrastructure, namely the buildings and equipment, is the most important requirement to sustain effective service delivery, especially in the National TB control programme. Some of the participants averred that inadequate buildings and non-functional medical equipment and even absence of medical equipment were challenges they were faced with in the execution of their duties. This was evident in the frustration they experienced. Blecher (2004:52) also emphasized that poor physical conditions of health facilities, namely, buildings and equipment, prevent adequate and competent healthcare delivery in the public sector.
According to the core standards and the core management standards of the Primary Health Care Package of South Africa (DoH, 2001:12) all facilities should have sufficient equipment as well as an adequate number of consulting rooms that is one for each professional nurse and medical officer working on the same shift.

A study conducted by Janse van Rensburg-Bonthuyzen, Engelbrecht, Steyn, Jacobs, Schneider and van Rensburg (2008:110) also found that the absence of an adequate number of consulting rooms and waiting areas was one of the most frequently reported problems that prevented adequate delivery of antiretroviral therapy at primary health care facilities in the Free State Province. The lack of space at PHC clinics could compromise patient confidentiality because of the lack of privacy. According to Tomey (2000:469) the invasion of privacy is a tort violation of a person’s right to make personal choices without interference and not to be subjected to uninvited publicity.

The participants in the study also experienced that the equipment used for the managing of health services rendered to TB patients was either old or outdated or there were no equipment for them to do the observations of the TB patients. The participants indicated that they were unable to conduct basic observations of the vital signs because of a lack of thermometers.

“It’s like when you have some shortage of baumonometers, you don’t have thermometers, we [the professional nurse] don’t have things like that, a shortage of those things you don’t have the equipment to treat the patient in totally.”

“The equipment we [the professional nurses] have is not enough to treat TB patients”

“The equipment, I mean that the folders of the clients, the cabinets of the clients, sometimes we don’t have injections for the streptomycin that we have to give, the syringes to give the
streptomycin, and sometimes we don’t have books to write, and sometimes we don’t have the receivers, or- anything that is re-used between the patients, and the baumonometers, we don’t have them. And if we like want to check the HB (haemoglobin) of the patients, you don’t have an HB machine, we don’t have a HGT (Haemoglucose test) machine, such things you know.”

It is evident from the aforementioned quotes that there is a lack of equipment in the facilities and this hampers competent assessments of patients resulting in poor service delivery at large. The latter findings are congruent with the article of Blecher (2004:56) that indicated that a lack of equipment hampers service delivery. According to the DoH (2001:47) the minimum requirements for equipment, namely screw top sputum containers as specified in the Primary Health Care Package, should be available for the appropriate level of care.

Shortages in essential medical supplies, including the relevant drugs needed in the TB programme, were also experienced by the nurses as a major challenge and frustration in managing health services for TB patients. Without the regular supply of drugs the TB programme is not sustainable because medical supplies and drugs are regarded as the most important resources for the effective and efficient functioning of the TB control programme.

“Sometimes the stores will say it’s out of stock, so the patients won’t have the streptomycin.”

“Okay, the challenge is the medication when it’s out of stock [unable to provide patients with their treatment timeously].”

“Medication, syringes what have you, all out of stock, especially when it’s towards the end of the financial year, everybody is suffering.”
According to the DoH Tuberculosis Strategic Plan of South Africa 2007-2011, the effective management of TB drugs is important to prevent interruption, mismanagement and availability of poor quality drugs, which may have serious consequences such as increased morbidity, defaulter rates and the development of resistance (DoH, 2007:27). The DoH also states that there need to be adequate supplies of quality drugs at facility level and buffer stocks maintained, to ensure that no patient has to delay initiation of treatment, or interrupt treatment, due to the lack of drugs. It is evident from the findings of the study that the stipulated legislation is not being adhered to at the PHC clinics because of the challenges being experienced by the participants in the management of health services to TB patients.

The participants involved in the study also indicated that the unavailability of transportation for patients between the different referral sites for the next level of patient management also impacts on service delivery. The lack in providing transport adds an unnecessary function to the overburdened staff working in the facilities. The lack of transport thus results in nursing staff functioning as drivers or as emergency personnel. The unavailability of transport also makes it difficult for the professional nurses to follow-up on patients that missed their TB treatment for some time and it also makes it difficult to have the patients transported to the TB hospital for admission.

“So I’m [professional nurse] supposed to take the people to PE, Jose Pearson Centre. Every month there’s no car. If I want a car, there’s no car because the clinic car was scrapped. So the management knows about the problem of the car, but there’s nothing done about that. So frustrating.”

“then there are patients who need to be traced with a car, and then you [professional nurse] are alone, and then you have to go to the laboratory to fetch the results, results that we [professional nurse working in the TB service] did not receive, then it is difficult for us to carry out our work because there is no car.”
A survey conducted amongst three clinics in Gauteng by Karasaridis, Zanyamakondo and Vermaak (2003:10) with regard to the importance of the availability of transport in rendering services; found that a lack of transport made it impossible for nurses to trace defaulters and also to follow-up on patients in the community. According to Hall, du Plessis and McCoy (2002:23) transport is essential for health service delivery, and it is required for mobile services, supervisory visits to clinics and communities, school health services, support of DOTS and other community-based health services. Transportation is also essential for transferring patients as well as for support services such as collection and delivery of supplies and drugs, general administration and attending meetings.

The problem of transport was also identified in a study conducted at two clinics in the North West Province by Couper et al. (2003:27) as hampering service delivery. For example, participants indicated in the study that the taking of specimens from patients for laboratory testing had to be repeated because these could not be tested within the specified time. Transportation also assists in the follow-up of patients who default treatment as well as those patients who need to be traced or commence TB treatment. It is evident from the above discussion that adequate transportation is essential for rendering quality healthcare services to TB patients.

- **Professional nurses experienced a concern regarding the number of staff contracting TB because of a lack of infection control measures**

The participants in the study expressed concern regarding the increased numbers of staff who contract TB. According to the DoH (2009:93) there is an increased risk of TB amongst all categories of health personnel, namely, professional nurses, community health workers and volunteers. The participants indicated that they were at risk because they worked with TB patients in a poorly ventilated room.

> “Some of the challenges at present is the increased number of staff contracting TB, and the DOTS supporters contracting TB.”
Even recently now, we’ve got another member of the staff [who contracted TB] and he started treatment”

“If I can just out of my head mention for example, in sub district B I know of already 4 (four) people who contracted TB. That is in one sub district and also in other sub districts I know of another particular person in one particular sub district. That is already five (5), and I mean one is already too many for healthcare personnel, because we are suppose to be healthy”

“We are exposed, we are at risk. I mean the statistics in terms of occupational incidences and occupational exposure of staff contracting TB in the Nelson Mandela Metro speaks for itself.”

“We had two nursing and one non-nursing staff who contracted TB in the facility so that is another frustrating thing”

A study conducted by Eshun-Wilson, Zeier, Barness and Taljaard (2008:17) at Tygerberg academic hospital, amongst nurses, characterizing occurrence, clinical spectrum and outcomes of TB infections, revealed that the nurses carried the greatest burden of TB infection. The study also revealed that mechanisms for improved screening decreased the risk of exposure to TB infections in the workplace. Improved screening measures should be considered in all health care facilities in South Africa. The stipulated measure in the National TB Control Guidelines specifies that the health personnel who are constantly exposed to and presented with TB symptoms should be evaluated as “high risk TB suspects” (DoH, 2009:95).

In the study the participants indicated that no proper infection control measures, for example administrative controls, environmental control and personnel respiratory control measures were implemented or adhered to by the NMBM health department. According to the specifications in the National TB control guidelines there is a commitment to the protection of the health personnel by ensuring that measures be
implemented to reduce the risk of exposure of the professional nurses managing the TB services.

The DOH defines infection control as measures, practices, protocols and procedures aimed at preventing and controlling infections and transmission of infections in health care settings (DoH, 2007:6). According to the DoH (2009:91) all health care facilities should implement administrative, environmental and personal respiratory control measures to assist in combating the spread of TB infections to all health care personnel and the general population. The National TB Control Guidelines also stipulate that it is the responsibility of management to minimize the risk of TB transmission in health facilities by ensuring that all the necessary infection control requirements are implemented in these facilities (DoH, 2009:91). The participants in the study revealed that in the facilities where they were working the environmental measures were not conducive to risk-free work. This is evident in the following quotations:

“it is a management issue you know, so that it is also frustrating you [the professional nurse working in the TB department] because there is no proper ventilation, extractor fans in the clinic so most of the time there is nothing that the management do to assist”

“and if you look at the area, there is no open space that is open enough for ventilation. Of course we've got fans but I think the government can do more by putting in something better like extractor fans, ultra violet lights. I think there is something that can be done to protect the staff.”

The most important thing is infection control, because we don't have fans- extractor fans for cross ventilation, the corridor is so small and also the infrastructure you see"
According to Joyut and Gomersall (2008:76) natural air circulation, in clinical areas on itself is insufficient for an infectious environment. The installation of simple ventilation systems, such as windows mounted industrial extractor fans, is an effective way to increase ventilation capacity at a clinical level. Eshun-Wilson et al. (2008:76) also mentions that the DoH should implement infection control measures for staff, for example, improved utilization of natural and artificial ventilation.

The participants in the study were also concerned that there was no proper infection control policy in place to assist them with implementing measures to prevent the spread of TB in the facility. The following quotation supports this statement:

"for instance there is no proper infection control policies [in the facilities]"

"I don’t know of any current infection control policy that from as far as my information goes I don’t know of any infection control policy that addresses these issues [infection control problems] that I’ve mentioned."

According to the South African Constitution, Act 108 of 1996, The National Health Act, No 61 of 2003, The Occupational Health and Safety Act, No 85 of 1993, the infection control policy should be developed and implemented. Non-compliance with this policy may result in litigation, disciplinary action, criminal or civil prosecution or loss of public confidence in the health establishments that serve the community (DoH, 2007:7). The purpose of the afore-mentioned Infection Control policy is to set national minimum standards for the effective management and prevention of health care associated infections. In this way hazards associated with biological agents are minimized for patients, visitors and health care personnel in health care establishments.

Booyens (2006:28) stipulates that policies exist to ensure standardization and to improve a source of guidance for the nursing profession. Infection control according
to Booyens (2006:201) is an area that should be addressed in policy formulation in the health institution. Productivity will increase if working procedures are improved. According to the infection Control Policy of the ECDoH (2006:7) the health care management team must ensure that the facilities are co-ordinated, managed and staffed to eliminate or reduce the risk of nosocomial infections in patients, health workers and visitors. In terms of the infection control policy the Eastern Cape will focus on the challenges the areas are faced with which include standards and policies, educational programmes and quality improvement.

According to Muller, Bezuidenhout and Jooste (2006:161) infection control should form part of the integrated dimension of the adverse event management of the quality management programme of an organisation. The prevention and control of infections is one of the key risk management responsibilities of the role players concerned in a healthcare organization. Muller et al. (2006:460) states that the goal of the infection control programme of an organization is to identify and reduce the risk of acquiring and/ or transmitting infections among patients and all health workers.

Clinical Governance describes systems such as clinical audits, risk management and monitoring outcomes of care which ensure that the quality of services is continuously improved, high standards of care are safeguarded and an environment that fosters clinical excellence is created. Clinical governance requires organizations to have accountability for quality at corporate level, clear lines of responsibility and mechanisms in place to establish and monitor the quality of service (Wilson, 2006:52). For the purpose of the study clinical governance is defined as “a framework” through which a health care organization and its organizational units are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical care will flourish (Eastern Cape Department of Health, 2006:4). The infection control programme will therefore be underpinned by the principles of quality improvement within the quality assurance framework ensuring that the facilities conform to the Infection Control
measures as stipulated in National TB Control Guidelines as well as the National TB Infection Control Guidelines.

The participants in the study also felt that there was a lack of training regarding infection control measures. There was also no infection control policy amongst the staff managing the TB services. The fact that the professional nurses were not adequately trained regarding the best practices of infection control in the management of TB services hugely contributed to the frustration they felt as professionals. Muller et al. (2006:461) mentions that infection control should form part of the in-service training and skills development programmes of organizations. The National TB guidelines also stipulate that all health care personnel need to be trained to ensure that they understand the importance of infection control and be familiar with best practices on how to protect themselves against TB (DoH, 2009:94). For the purpose of this study training is that which must be provided in order for an employee to improve his job performance (Gerber, Nel and Van Dyk (1995) as quoted by Booyens (2006:169)). The following quotations will support these statements:

“there’s supposed to be an infection control policy and there are supposed to be in services training to people [the staff in the facilities] so that they know that are going on, so that everybody is aware of how to control the infection in any area where you are”

In a study conducted in 2006 with professional nurses in Kenya and Benin it became evident that training can serve an important purpose, especially in human resource management. The nurses revealed that that they felt more comfortable and confident in their working environment after receiving training. The training they received increased their motivation (Mathauer & Imhoff, 2006:17). Mathauer and Imhoff (2006:17) further advise that the training provided to the professional nurses must be adapted to the local context: the actual working conditions in the TB services. One of the principles stipulated by the Infection Control Policy (DoH, 2007:9) is occupational health and safety. The latter ensures that the health and safety of all health care
workers are ensured. It stipulates that this must be considered with every plan, action and intervention.

- **Professional nurses experienced differences in conditions of service between the two local authorities**

The professional nurses in the research indicated that there were two health authorities responsible for the delivery of health services in the Nelson Mandela Bay Municipality with different conditions of service. The staff of both health authorities worked under one roof and therefore compared their conditions of service. The two health authorities were established by the previous government and have still not merged even though the staff from both health authorities is allocated to the same service. The researcher noted how frustrated the staff was when the participants mentioned that there were differences in the remuneration of the professional nurses working for the two different authorities although they were doing the same job.

Remuneration refers to what the employees receive in turn for their services (Nieman & Bennet, 2006:253). Remuneration is one of the major aspects in an organization that gives rise to dissatisfaction amongst employees and can have an influence on the employee as well as the organization (Nieman & Bennet, 2006:253). The dissatisfaction expressed by the professional nurses is evident in the following quotations:

“I mean if I am in the same building and in the same position, same years of experience of that person, also our ranks are different, naming of our ranks are different but it boils down to professional nurses with the same training, same numbers of years experience, but at the end of the day your salaries are totally different.”

“With salaries, it is quite frustrating because even in the managerial posts you find that also the facility managers are getting lesser money than they are supposed to get and then there’s a big gap in between in the salaries, so you find it quite
frustrating because the people are working so hard, the people are doing their work but at the end of the day they don’t get satisfaction when it comes to money.”

“There are other challenges of course, like salaries, especially as we know that the salary and negotiations that is going on”

According to Decenzo and Robbins (2002:316) the motivation-hygiene theory of Frederick Hertzberg states that both intrinsic and extrinsic factors are related to job satisfaction and job dissatisfaction. The intrinsic factors relating to job satisfaction are achievement, recognition and the work itself. The extrinsic factors are company policy, working conditions and salaries. Motivational factors refer to elements that generate satisfaction from within the individual, such as innovation and creativity in the job. The aforementioned factors are generally factors that motivate employees, such as recognition, creativity and innovation. The hygiene factor refers to those elements in the environment that influence an individual’s satisfaction. They also relate to relationships, working conditions and salary.

A study conducted by Minnaar (2003), cited in an article in the Nursing Update, Our greatest loss (2009:29), confirms that remuneration directly relates to job satisfaction. This is congruent with the findings in this research study where the participants expressed their dissatisfaction with regard to the differences in salaries of the two health authorities. Nurses appear to be unhappy about their salaries and workload in other provinces as well because a study conducted in KwaZulu Natal Province also reflects that nurses were unhappy about their salaries, workload and their work culture (Minnaar, Reid, Uys,& Naidoo, 2004: 50-56).

The participants in the research study also stated that their morale was affected because of the difference in conditions of services offered by the different health authorities. According to Jackson and Schuler (2002:632) conditions of service are stipulated in the employment contract, for example, wages, working hours, type of
work. The following quotations illustrate the experiences of the participants with regard to low morale due to discrepancies in the conditions of service:

“I’m [professional nurse] demotivated because of the money, and also because of the conditions that you are working on, especially the containers.”

“You [professional nurse] feel very bad, money that you are getting for the workload is so little, ne, it’s not fulfilling your needs because you are doing so much but you are getting so little.”

According to Tolom (2010:29) there is overlapping of services rendered by different entities within the public sector. The salaries and conditions of service vary greatly between the NMBM and the public administration. Inefficiencies and inequalities will prevail unless restructuring at district level takes place. These inequities should be addressed in terms of the Basic Conditions of Employment Act, No.75 of 1977, and The Public Service Act no. 111 of 1984 with a view to creating uniform conditions of services (Booyens, 2006:35).

Professional nurses experienced DOTS supporters as being a threat to patient confidentiality

A DOTS supporter is a person who watches the client swallowing the tablets, in a way that is sensitive to and supportive of the needs of the client (DoH, 2009:48). The DOTS strategy has been the initiative of the National Government to assist in the National TB control programme to reinforce the fight against TB in South Africa. The duties of the DOTS supporter are to directly supervise the patients in taking their treatment, to assist the registered nurse in monitoring treatment adherence of the TB patients and also to educate the patients on matters related to TB.

The professional nurses experienced the DOTS supporters who work in the TB clinic as a threat to patient confidentiality because they live in the same community as the
patients that they directly observe in taking their treatment. The professional nurses indicated that the patients were not comfortable in receiving their treatment from a DOTS supporter because the patients indicated that they were scared of being stigmatized or discriminated against in the community for being infected with TB. This posed a threat to adherence of the patients to their TB treatment.

“It’s [DOTS supporters] sometimes not that good because the patients know the DOTS [supporter], they are friends in the community you see, and the patients are not comfortable taking their treatment at people’s houses that they know”

“I think people still have the stigma around TB that is, I don’t know, it’s a ‘skande’”

The findings of this research are congruent with the findings of a study conducted by Wang and Hongbing (2009:307) with regard to how patients perceived the DOTS programme. The latter study revealed that only 19.5% of patients wanted to be supervised by a DOTS supporter, while 80.5% indicated that it was unnecessary to be supervised by the DOTS supporter. They feared that it would not be possible for them to maintain their privacy and confidentiality as they were known to the supporters. The patients in the study of Wang and Hongbing (2009:307) experienced the DOTS programme as being authoritarian and making them feel alienated and stigmatized.

According to Madru (2003:39), stigmatization obstructs the ability of health care workers to communicate with patients and the potential to support people. The experience of stigma within the clinical setting influences the access of a client to medical care, and impairs the sharing of medical information. According to Madru (2003:39) it is evident that non-adherence of patients to treatment is directly related to stigmatization of patients infected with TB. A study conducted in the Western Cape by Naidoo, Dick and Cooper (2009:67) supports the latter statement. The aforementioned authors established that patients indicated that they felt prejudiced
and discriminated against and also disadvantaged in the community when they disclosed their TB status.

The professional nurses felt that the breaching of the confidentiality of patients is posing a major threat to the rendering of health services. Healthcare workers in South Africa should be very sensitive to all issues pertaining to the confidentiality of a patient.

“okay with that prejudice I mean that you know like HIV at the moment, you know people still have this thing attached to TB patients, you know, and if you even go and do home visits, uh, at the patients’ homes they don’t want you to come to their homes because they want to know why is the health worker at their houses, you see?”

According to the DoH ([s.a]:43) the patient and family rights and responsibility strategy stipulates that all patients have the right to confidentiality. Confidentiality is the ability to keep information private or a secret when necessary (Cobuild, 1987:293). All health care providers are ethically and legally obligated to maintain confidentiality in respect of any patient information. According to the National Health Act, No 61 of 2003, information concerning patients is confidential, including information pertaining to their health status, treatment or stay in an institution. The researcher is of the opinion that the DOTS supporter is a health care provider and is thus bound to confidentiality in terms of the National Health Act, No.61 of 2003.

3.4.1.2 Sub Theme1.2: Professional nurses had positive experiences when managing health services rendered to TB patients:
A diagrammatic representation of sub theme two is illustrated below.
The positive experiences of the participants when managing the TB health services portrayed in the above figure included their job satisfaction being experienced in rendering health services to the patients, the DOTS services as being supportive and beneficial to the staff, the TB meetings as being an appropriate platform for problem solving and the audits done by the managers as being remedial. The aforementioned positive experiences will now be discussed in detail.

- The professional nurses experienced job satisfaction in managing health services to TB patients

The professional nurses expressed job satisfaction and feelings of fulfilment in managing TB health services especially when the TB patients expressed gratitude towards them for healing them and also when they observed the patients’ condition improving from being extremely ill to being cured. According to Schultz and Schultz (2002:235) the positive and negative feelings and attitudes we hold about our job are referred to as job satisfaction. Employees’ job satisfaction depends on many work-related factors, especially the sense of fulfillment we get from our daily tasks. The following direct quotes illustrate this:

“like coming back to the clinic [the patient] and you know praising you as a nurse or somebody who has helped me to become better”

“he [the patient] comes into your office, he greets and he thanks you, you know and then he thanks you at the end of the day to say ‘Thank You, you’ve helped me to become uh well, well again, I can go to work again, to work for my family again’”.
“Um, positives for me [the professional nurse] is to see my patients cured. He comes in to your door very sick, umm, the satisfaction at the end of the day which can be taken as a positive.”

“In the midst of these challenges, just to see your patients at the end of the day being cured of TB, healed completely at the end of the day, that is a positive for me.

The above-mentioned is evident of the professional nurses’ feelings and sense of fulfillment because the patients they have nursed regained their health and expressed their sincere gratitude. The latter findings are congruent with the findings in a study conducted by De Gieter, Cooman, Pepermans, Caers, Du Bois and Jegers. (2006:8) that indicated that nurses value not only financial rewards but also psychological as well as physical rewards. Psychological rewards such as recognition, appreciation shown, relationship with patients, ability to help others and compliments from patients attribute markedly to the employees’ level of job satisfaction. Therefore, the gratitude expressed by the patients in the study was deemed very rewarding and gratifying to the professional nurses.

The professional nurses also indicated that having the National Guidelines for the management of TB and medical doctors available at the time of need was conducive to creating job satisfaction. They did not feel isolated and alone and their doubts and queries could be addressed immediately.

“feeling satisfied [professional nurse] because at least have a doctor that you can refer the patient or you can discuss the patient, so you’re not there on your own”

“and you know what also uhh, what is nice is that you [professional nurse] have your guideline, your National Guidelines next to you, uhh, that guides you so I think that is in itself a very positive thing, to have something available to you,
uhh – that you can use when you’re not sure what you should do.”

From the previous quotes it is clear to the researcher that the participants deemed the availability of the National TB Control Guidelines useful.

> The professional nurses experienced the DOTS strategy as being supportive and beneficial to the staff

The DoH has adopted the DOTS strategy to assist with the control of TB in order to combat the TB epidemic that the country is faced with (Kironde & Bamford, 2002:283). The South African Government committed itself to accelerated action against combating TB by signing the Amsterdam Declaration to stop TB. After signing the Alma Ata Declaration on Primary Health Care, community health workers were promoted and became part of the health systems of many countries of which South Africa was one (Schneider, Hlope & van Rensburg, 2008:1). Countries steered away from community health worker programmes, but the community health worker did not disappear from the system. The community health workers were associated with specific programmes, for example the DOTS strategy for the treatment of TB. The DOTS strategy makes provision for employing volunteers to assist the professional nurses with tracing patients, providing them with community-based supervision, providing the patients with treatment and reporting to the registered nurse about the condition of patients after follow-up has been done. The term community health worker was introduced as the umbrella concept for all community workers, lay workers, DOTS supporters and volunteers (Schneider et al., 2008:1).

The participants in the study revealed that the DOTS supporters constituted an important link in the management of the health service to TB patients even though some of them did not receive any stipend. The participants indicated that they feared that the DOTS supporters who were not receiving a stipend would go out and look for other jobs that would pay them for services rendered. The participants experienced the DOTS supporters as being supportive and beneficial to the staff.
because they work very hard and are keen to learn and render the service to the community.

“And also I [professional nurse] have the DOT supporters, I’ve got eight of them who are a team. Five of them they are not getting a stipend. I’m trying on my own to praise them because they are coming to the clinic Fridays to give the reports, give the medication to collect the medication, so those five are not getting a stipend the three(3) are getting.”

“They [DOTS supporters] are working very hard because whenever I have got a problem, I just phone them, ‘Come and trace-come and trace, come and go and check, this patient's not coming for treatment’ so they are working very well with the clinic”

“They [DOTS supporters] are so eager to learn, even if you are asking them to do something, I don't have problems so I'm worried about them because at the end of the day I might lose them because they are looking for a job, because they are not getting anything, any stipends.”

In a study conducted in the Free State Province by Janse van Rensburg-Bonthuyzen (2005:207) it was also found that the DOTS supporters played a beneficial part in the effective management of the National TB Control Programme. The Directly Observed Treatment forms a crucial part of the DOTS Strategy implemented by the World Health Organisation (WHO).

The participants also revealed that the DOTS supporters show enthusiasm and dedication to the TB control programme because they come to the clinic on a weekly basis to have feedback meetings with the registered nurse in charge of the TB clinic.
“And what I can also add maybe, is the volunteer or the DOTS that we are having in our clinics are enthusiastic. That also aids you know, say for instance if a patient have converted, a patient goes into the community and there are DOT supporters in the community that supports the patient you know, giving out treatment in the community, that makes it more accessible for the patients, so that also is a positive thing in the management.”

“They [The DOTS supporters] are so eager to learn, even if you are asking them to do something, they are willing to do that”

A study conducted amongst community health workers by Lehmann and Sanders (2007:26) revealed that community health workers (CHW) can make a valuable contribution to community development and, more specifically, can improve access to and coverage of communities with basic health services. The latter will be successful if the CHW are appropriately trained and adequately and continuously supported.

- The professional nurses experienced the TB meetings as an appropriate platform for problem solving

The participants interviewed indicated that they experienced the meetings that they had as being supportive to staff that managed the TB control programme. The participants indicated that these meetings held with all the TB nurses and the TB programme manager were an appropriate platform for them to get clarity on any problems that they encountered while managing the TB programme at the facilities. The majority of the participants felt that these meetings were an appropriate forum for information sharing as well as problem solving.

“I [professional nurse] think they had that monthly meetings but I also think that was also a very nice platform for TB nurses to talk to each other, solve problems, any issues on umm, uhh, management of patients that nurses are not uhh-uhh familiar with,
you know, they can share with one another and if there is maybe misinterpretations of the National Guidelines, things were cleared on those, uhh, at those kind of meetings and that is also- actually a very nice platform for TB nurses to learn and build on what they are doing here.”

“they [the TB manager and the TB staff] have got quarterly and monthly meetings so that each and everyone is aware of whatever you are handling [problems in the TB programme]”

Communication in the nursing profession plays a vital role in the direct management of clients on a day-to-day basis. The communication structure implemented should be flexible and logically implemented to suit the type of programme for which it is used. Meetings are one of the communication platforms used in the nursing profession for participative problem solving, decision-making, co-ordination, information sharing and morale building (Tomey, 2000:44). According to Muller (2002:226) meetings should be purposeful and as brief as possible. It is also advisable to hold meetings at least once a month to discuss general matters in the unit and to maintain group cohesion.

A study conducted by Janse van Rensburg-Bonthuyzen (2005:214) in the Free State Province revealed that the communication structure for problem-solving and communication with the relevant managers was sub-optimal and could be detrimental to the TB control programme. Furthermore, Janse van Rensburg-Bonthuyzen (2005:214) mentions that communication between the personnel of the TB unit and the TB programme manager should take place on a regular basis to improve the consultation process. This in turn will improve the quality of service delivery.

The participants in the research study also revealed that they had feedback meetings with the DOTS supporters so that progress reports regarding the patients they were supervising were given to the professional nurse. They felt
that these meetings assisted them and kept them up to date with the progress of the patients. The following quotation illustrates the importance of the meetings with the DOTS supporters:

“So they [DOTS supporters] come to clinic Fridays, once a week with their problems, or they're coming to collect medication, so when they come and they want to see the blue cards and update the blue cards, they also give feedback [in the meetings held with the DOTS supporters and the professional nurse] on their challenges and problems, ja when they are dealing with the patients.”

It is clear from the aforementioned discussion that the participants regarded the meetings held with the staff managing the TB service as an appropriate platform for problem-solving.

- **The professional nurses experienced the the audits done by managers as remedial**

An audit is a systematic independent examination and review to determine whether actual activities and results comply with planned arrangements or predetermined standards and criteria (Muller *et al.* 2006:518). In the nursing profession, the auditing process is the process whereby performances are compared with previously set standards of care to reveal shortcomings; these should then be corrected to initiate change which will result in the improvement of care (Booyens, 2006:327). According to the ECDoH (2006:4) a clinical audit is a professionally-led initiative which seeks to improve the quality of care with a systematic and critical analysis of the quality of clinical care. This includes the procedure used for the diagnosis, treatment and care, the associated use of resources, the resulting outcome and quality of life for the patient.

The participants indicated that the District Rapid Assessment Tool (DRAT) was used by the TB programme managers to conduct quarterly audits at the TB health services to identify gaps and highlight successes. The latter tool has been used in
the Nelson Mandela Bay Municipality on a quarterly basis. An audit team comprising the TB programme manager and other identified parties visit facilities in the municipality scrutinizing all facets of the TB programme. The DRAT tool assesses the progress of facilities in terms of implementation of the National TB control guidelines. It also monitors and evaluates records, the smear conversion rate, treatment failure rate, the collaboration of HIV and TB and recording and reporting in the patient records. According to Jon Rohde as cited in Kironde and Bamford (2002:287) the DRAT tools have been designed to improve monitoring and the management of the patients they serve in the metro health service. The data obtained from the DRAT tool is used to encourage case finding and improve DOTS treatment. It is also used to report back to the health workers and the community. The participants indicated that they experienced the quarterly audits as very positive because these highlighted their mistakes and assisted in their growth and development. The participants also experienced the audits as being supportive because at the time of the audits they could resolve some problems that they were experiencing in the TB health service.

“we had 100% on the DRAT when our TB coordinator evaluate us every quarter to see the performance, the improvement so that also encourages you to work, to see your mistakes, I’ve got weak points there, you see, so we are doing well”

“they [programme managers] come in, they support you, and it will also boost your morale, it will even help you to be more motivated, because you know you have programme managers who are behind you”

“the DRAT visits that they do, you know, the support from your programme manager, you see, I can remember the time they did DRAT at one of the small clinics, I related my problem to the manager [and she assisted me to resolve it]”
In view of the above findings it can be concluded that the programme managers for TB health services are adhering to the requirements of the Quality Assurance Policy of the National Department of Health (2007:19). The latter policy stipulates that there should be ongoing quality monitoring processes within the Provincial Health System to determine whether health services are delivering the quality care that patients have the right to expect. The Quality Assurance Policy stipulates specific standards that must be implemented to ensure that the policy is operational in the health departments.

The Eastern Cape Department of Health (ECDoH) has an Audit policy, introduced in July 2006, stipulating that its purpose is to develop and sustain a culture of best practices in improving the quality of care that the provincial health service can offer to all patients. The Audit Policy of July 2006 also aims at facilitating the achievement of clinical excellence and reduces clinical errors and risks in all institutions (ECDoH, 2006:5). In addition to the above-mentioned, the Primary Health Care Supervision Manual A guide to PHC Facility Supervision (DoH, 2009:12) stipulates that the facility should receive a supportive monitoring visit at least once a month to support personnel, monitor the quality of service and identify needs and priorities.

In view of the above-mentioned discussion it can be concluded that audits of performance, including both process and outcome measures, are essential for a quality improvement effort and should be coupled with feedback to achieve sufficient quality improvement (Sales & Schalm, 2010:1).

3.5 CHAPTER SUMMARY

This chapter mainly focused on discussion of the data analysis which emerged from the in-depth interviews conducted with the professional nurses in Sub-District B of the Nelson Mandela Bay Municipality. The identified theme, sub-themes and categories clearly described the experiences of the professional nurses regarding the management of health services to TB patients. Literature control was done to validate the outcomes of the relevant themes and placed in context with the research
study. Recommendations and the limitations to the study will be dealt with in Chapter Four.
CHAPTER 4

SUMMARY, CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION
In the previous chapter a thick description of the research results was provided. The focus of this chapter will be a summary of the research findings, conclusions drawn and the limitations experienced by the researcher in conducting the study. Recommendations based on the research findings will be made at the end of this chapter. These recommendations could be used by programme managers of TB health services to facilitate the effective management of health services for TB patients.

4.2 SUMMARY AND CONCLUSION OF RESEARCH FINDINGS
A brief summary of the research findings and conclusions drawn will be provided in the following paragraphs.

A qualitative, explorative, descriptive and contextual research design was used to conduct this research. Seven professional nurses rendering health services to TB patients were non-randomly selected by using purposive sampling to participate in the study. In-depth interviews were used to obtain the necessary data relating to their experiences regarding the management of health services to TB patients in sub-district B of the NMBM. The data gathered were analyzed and coded according to Tesch as stipulated in Cresswell (2009:186). One main theme and two sub-themes and their categories were identified (see Table 3.1) and a detailed explanation was given.

The professional nurses expressed diverse experiences regarding the management of health services to TB patients and this formed the main theme of the research study. The diverse experiences expressed by the participants were both negative and positive. The negative experiences expressed by the participants included, for example, a challenging and demanding work environment which frustrated and
demotivated them. The positive experiences, on the other hand, included feelings of satisfaction and accomplishment. It became evident in this study that participants experienced opposing feelings that existed simultaneously within them. According to Fineman (2000:205) these feelings can be described as ambivalence because the participants in the research expressed strong positive and strong negative emotions simultaneously.

Generally the participants experienced various challenges in the management of health services to TB patients. The challenges experienced by the participants included:

- A lack of resources such as staff shortages, lack of facilities, equipment, supplies and pharmaceuticals and transport which all hampered service delivery resulting in low morale and frustration among the participants
- A concern regarding the number of staff contracting TB due to poor infection control measures. No in-service training regarding infection control also raised concerns amongst the participants and added to their frustration
- A difference in conditions of service between two local authorities that created frustration amongst the participants resulting in low morale and demoralization
- DOTS supporters being perceived as a threat to patient confidentiality, thus compromising patient care.

The positive experiences expressed by the professional nurses in the research study included:

- Job satisfaction expressed by the participants especially in respect of the gratitude extended to them; this gave them a sense of fulfillment in rendering health services to the patients.
- The participants experienced the DOTS services as supportive and beneficial to the staff because they lightened the workload of the professional nurses by administering treatment of a satisfactory nature to the patients.
- The regular TB meetings were also identified as an appropriate platform for problem-solving especially if there was uncertainty with regard to the
management of a patient in the TB control programme. The TB meetings were also regarded as a platform to share experiences as well as voice opinions regarding the TB control programme.

- The participants also regarded the audits done by the programme managers as remedial, in the sense that they could improve on service delivery with the outcome provided in the audit reports.

According to the above summary of the research findings it can be concluded that the researcher succeeded in achieving the first objective of the study: exploring and describing the experiences of professional nurses regarding the management of health services to TB patients.

4.3 LIMITATIONS OF THE STUDY

- Generalisation was not possible because qualitative research provides a limited sample size.
- The study was restricted to registered nurses working in the TB control programme of Sub-District B in the NMBM. Input from registered nurses in the entire NMBM could be of value to this study.
- Although confidentiality was ensured as far as possible, the fact that there is a limited number of facilities in sub-district B of the NMBM could compromise the anonymity of the participants in so far as it concerned the input they provided in the research study.

4.4 RECOMMENDATIONS

The following recommendations have been formulated for nursing practice, education and research. These were developed in light of the research findings and the limitations of the research study conducted.

4.4.1 Recommendations for nursing practice

The district manager of Sub-district B should ensure that the challenges highlighted in the study are addressed to ensure adequate management of health services rendered to TB patients.
• Management must advertise the vacant posts for professional nurses and fill the vacancies with competent staff to reduce the workload on the current staff members.

• Management must motivate for the buildings to be renovated in order that the staff have adequate working space and proper ventilation in the PHC clinic resulting in increasing their morale and minimizing their frustration.

• The District pharmacist should ensure that there is sufficient stock in the pharmacy depot preventing the PHC clinics from running out of medication resulting in poor continuity of patient care.

• The facility managers at the various PHC clinics should ensure that the necessary medication is ordered at the correct times according to the ordering schedule provided by the pharmacy depot so that the PHC clinics are always well stocked with the necessary medication.

• Management should allocate a vehicle to each facility to assist with transporting the patients so that this function could be removed from the professional nurses resulting in them being used constructively to render health services to patients.

• Management should ensure that the necessary Infection Control measures such as masks, extractor fans, ultraviolet germicidal irradiation and exhaust ventilation systems be implemented in the PHC facilities to reduce the risks of contracting TB by staff members.

• The training department must schedule regular in-service training to all staff regarding the infection control policy and infection control measures. The training schedule must be circulated to all the PHC
clinics to ensure that the facility managers send the staff to the in-service training scheduled on the training roster.

- The TB programme managers must arrange monthly meetings with the TB staff to create a platform for the staff working in the TB department to raise their problems and concerns, clarify any uncertainty they have regarding the management of the TB patients and to share the experiences encountered in the field.

- The training department should also include the importance of nursing ethics and confidentiality into the training schedule. All staff are to be trained on ethical issues especially confidentiality.

- Management should consult with the relevant stakeholders of the DOH regarding the establishment of a unified Health System to control the governance of health services in Nelson Mandela Bay Municipality.

- The management of the health directorate of the NMBM as well as personnel working in the TB control programme should be made aware of the findings of this research study through dissemination of the results. The participants of the study will be called to a meeting informing them about the outcome of the study. A copy of the research project will be given to the NMBM health Directorate for future reference.

4.4.2 Recommendations for nursing education

The following recommendations are proposed for nursing education:

- In-depth training regarding the National TB Control Guidelines should be given to all nurses in training.
• Infection Control should be emphasized in the curriculum of training institutions educating nursing students.

• The code of ethics and professional conduct should be emphasized in the curriculum of student nurses at training institutions.

4.4.3 Recommendations for nursing research
The following recommendations are proposed for nursing research:

• A similar study could be conducted in other areas amongst registered nurses working in the TB control programme.

• A follow-up study could be conducted extending the research to the other Sub-Districts in the NMBM.

• A questionnaire based on the themes identified in the research study could be developed for use in a quantitative study, to establish whether the research findings could be generalized.

4.5 CHAPTER SUMMARY
This study provides insight into the experiences of professional nurses regarding the management of health services to TB patients in Sub-District B of the NMBM. The challenges the participants experienced are listed, and ranged from positive to negative. A brief description of the positive and negative experiences is provided. On the basis of the findings of the research study recommendations were made for nursing practice, nursing education and nursing research. The recommendations could be used by the Nursing Manager of Sub-District B to assist with improving service delivery to TB patients.


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Naidoo, P., Dick, J.& Cooper, D. 2009. Exploring tuberculosis patients’ adherence to treatment regimens and prevention programs at a public health Site. Qualitative Health Research. 19(1), 55-70. Retrieved online Nelson Mandela Metropolitan University from http//qhr.sagepub.com/content/19/1/55 on 19 October 2010


Nurses love the job but not the work environment. 2007. Nursing Update. 31(5), 20.


TB can be stopped. 2007. Nursing Update, 31(1), 47.


Annexure A

PARTICIPANT CONSENT FORM
**Title of the research project**  
The experiences of Registered Nurses regarding the rendering of health services to TB patients

**Reference number**

**Principal investigator**  
Leigh-Anne Rene Jantjies

**Address**

4 Myrtle Str  
Strelitzia Park  
Uitenhage  
6230

**Contact telephone number**  
(041) 9882222

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### A. DECLARATION BY OR ON BEHALF OF PARTICIPANT

(Person legally competent to give consent on behalf of the participant)

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<th>I, the participant and the undersigned</th>
<th>(full names)</th>
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<td>I, in my capacity as</td>
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### A.1 I HEREBY CONFIRM AS FOLLOWS:

1. I, the participant, was invited to participate in the above-mentioned research project that is being undertaken by

   Leigh-Anne Rene Jantjies  
   Nursing  
   Nursing Science  
   of the Department of Nursing  
   in the Faculty of Nursing Science  
   of the Nelson Mandela Metropolitan University.

2. The following aspects have been explained to me, the participant:

   **Aim:** The investigators are studying: The experience of Registered nurses regarding the rendering of health services to TB patients
The information will be used to/for: Partial fulfilment of the requirements for the degree Magister Artium in Health and Welfare Management at the Nelson Mandela Metropolitan University.

2.2 Procedures: The interviews will be conducted at a time that is convenient to the participant. The participant will indicate the time and place where the interviews should be conducted. The identity of the participant will remain confidential and will be allowed to withdraw from the research project at any time. The participant will be explained the purpose and aim of the research.

2.3 Risks: N/A

2.4 Possible benefits: As a result of my participation in this study N/A

2.5 Confidentiality: My identity will not be revealed in any discussion, description or scientific publications by the investigators.

2.6 Access to findings: Any new information/or benefit that develops during the course of the study will be shared as follows: The outcome of the research study will be shared with the participants. The results will also be made available to the library of the NMMU as well as to the Department of health of the NMBM for participants to read.

2.7 Voluntary participation/refusal/discontinuation:

| My participation is voluntary | YES | NO |
| My decision whether or not to participate will in no way affect my present or future care/employment/lifestyle | TRUE | FALSE |

3. The information above was explained to me/the participant by

(name of relevant person) Leigh-Anne Rene Jantjies

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and I am in command of this language/it was satisfactorily translated to me by

(name of translator)

I was given the opportunity to ask questions and all these questions were answered satisfactorily.

4. No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalisation.

5. Participation in this study will not result in any additional cost to myself.
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<th>B. STATEMENT BY OR ON BEHALF OF INVESTIGATOR(S)</th>
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<td>- I have explained the information given in this document to</td>
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<th>C. DECLARATION BY TRANSLATOR</th>
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I, I.D. number
Qualifications and/or
Current employment

confirm that I
- translated the contents of this document from English into
  (indicate the relevant language) to the participant/the participant’s representative;
- also translated the
  questions posed by
  as well as the answers given by the investigator/representative; and
- conveyed a factually correct version of what was related to me.

Signed/confirmed at ___________________________ on ___________________________ 20

I hereby declare that all information acquired by me for the purposes of this study will be kept confidential

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D. IMPORTANT MESSAGE TO PATIENT/REPRESENTATIVE OF PARTICIPANT

Dear participant/representative of the participant

Thank you for your/the participant’s participation in this study. Should, at any time during the study:
- an emergency arise as a result of the research, or
- you require any further information with regard to the study, or
- the following occur

(indicate any circumstances which should be reported to the investigator)

Kindly contact at telephone Leigh-Anne Rene Jantjies
  (041) 9882222

(It must be a number where help will be available on a 24 hour basis, if the research project warrants it)
ANNEXURE B
LETTER: INSTRUCTIONS TO THE INDEPENDENT CODER
Re: independent coding Details
Thank you for agreeing to do my independent coding of the transcribed interviews conducted for my research. Please find enclosed a clean set of transcriptions of the seven interviews and three follow-up interviews to be analysed.

The interviews must be coded according to Tesch’s method as it is listed below:

- Get a sense of the whole. Transcriptions should be read carefully and short notes jotted down clearly

- Take one document at a time, read thoroughly and try and make meaning of the contents and write short notes in the margin.

- After completion of several documents make a list of topics. Cluster all the similar topics together and arrange them to form a major topics, unique topics and remainders.

- Take the compiled list and go back to the transcribed interviews. Abbreviate the topics as codes and write the next to the relevant segments in the text and see whether new categories emerge.

- Find the most suitable wording for the topics and convert them into categories.

- Group the topics together that relate to one another.

- Make a decision on the abbreviation of the categories and arrange the alphabetically.

- Assemble all the relevant data that belong together in one place and perform an analysis.
• Re-code the data if the need arises.

Thanking you for your assistance.
Yours in Health
Leigh-Anne Jantjies
Cell: 0834648235
ANNEXURE C
CONSENT FROM THE FRTI
Copy to: Dr EJ Ricks
Dr S James
Ms N Ahmed

Summerstrand South
Faculty of Health Sciences
Tel: +27 (0)41 504 2121 Fax: +27 (0)41 504 0403
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Ref: 1934155000

Contact Person: Ms N Ahmed

August 2008

Ms LR Jantjes
4 Myrtle Street
Strelitzia Park
UITENHAGE
6230

Dear Ms Jantjes,

FINAL RESEARCH PROPOSAL - MA HEALTH AND WELFARE MANAGEMENT

Please be advised that your final research proposal was approved by the Faculty Research, Technology and Innovation Committee subject to the following amendments/recommendations being made to the satisfaction of your Supervisor:

Comments

1. That the title be changed to read as: “EXPERIENCES OF REGISTERED NURSES REGARDING THE MANAGEMENT OF HEALTH SERVICES FOR TUBERCULOSIS PATIENTS”;
2. that the reference list include all authors cited in the text and the reference in the study be corrected e.g. et al;
3. that the paragraph on pg 15 after the last bullet be included in the section on data analysis;
4. that the word on pg 23 in the conclusion be changed from “implementation” to “management”.

Yours sincerely,

[Signature]

[Signature]

Ms N Ahmed
Faculty Officer
Faculty of Health Sciences
ANNEXURE D

PERMISSION FROM THE ASSISTANT DIRECTOR OF SUB DISTRICT B OF THE NMBM
Re: Permission to conduct research

I hereby wish to inform you that permission is granted to Mrs. L.R. Jantjes to conduct her research in clinics of Sub District B of the Nelson Mandela Bay Municipality.

Topic: The experiences of professional nurses regarding the management of health services to TB patients.

Thanking You

S.J. Forbes
Assistant Director Sub District B
Nelson Mandela Bay Municipality
ANNEXURE E

LETTER OF PERMISSION FROM THE NELSON MANDELA HEALTH DIRECTORATE
Dear Madam,

EXPERIENCES OF REGISTERED NURSES REGARDING THE MANAGEMENT OF HEALTH SERVICES FOR TUBERCULOSIS PATIENTS (IN SUB-DISTRICT B OF NELSON MANDELA BAY MUNICIPALITY)

In response to your application for permission to conduct the above study (Faculty Research, Technology and Innovation Committee Reference Number: 1934155000, dated August 2008) in part fulfilment of your studies toward the degree MA Health and Welfare Management within the Nelson Mandela Bay Metropolitan Municipality (NMBMM), permission is hereby granted with the following proviso:

1. Corrections as recommended in the research approval letter from NMMU are included in the final research proposal for which permission is granted.
2. There should be no negative impact on existing health service delivery operations.
3. All required data should be collected by the Researcher or designated fieldworker (whose name should be forwarded to the Director: PHC Services prior to data collection)
4. This letter should be presented when trying to access any municipal service required for the purpose of completing this research. This letter should also be presented when interacting with any of the three municipal Assistant Directors for the PHC Services sub-Directorate listed below.

Sub District A - Mrs Nonxuba (or Mrs Yoyo), Tel: 041 508 7425, Cell: 079 490 0670,
Sub District B - Mrs Sarah Forbes, Tel: 041 994 1228, Cell: 079 490 0674,
Sub District C - Mrs Nola Monteith, Tel: 041 508 7424, Cell: 079 490 0742,
The Executive Director for Public Health, or designate, will be the Project Manager to assist with further co-ordination of this research on behalf of the NMBMM.

The Nelson Mandela Bay Metropolitan Municipality, as the research site, will expect a copy of the final research report when the study is completed. If the duration of the research period is required to be extended, the NMBMM should be informed accordingly.

We would like to take this opportunity to wish you well for your research study.

Recommended by

(Date: 3/1/2010)

(Director: Primary Health Care Services: Dr E Hoosain)

Approved by

(Date: 3/1/2010)

(Executive Director: Public Health: Dr M Chabula-Nxiweni)

Yours faithfully

DR EM CHABULA-NXIWENI
EXECUTIVE DIRECTOR
PUBLIC HEALTH DIRECTORATE
ANNEXURE F
TRANSCRIPTION OF INTERVIEW
Interview conducted with participant on 27 April 2009.
Interviewer: L.R. Jantjies

Good Afternoon …………….. I am Sister …………….. I am currently doing my studies at the Nelson Mandela Bay Municipality University. I am studies in Health Welfare Management. I Have secured this and time with you to conduct this today. I would just like some information. I am first going to ask you a question and have a follow up question, if you can just elaborate on that for me. In between I will probably stop you here there just to probe the information that gave me. We can commence anytime.

Interviewer: The first question that I have for you today, is how is it for you to render health services to the TB patients.

Participant: Okay, …………… the first word I have use as descriptive word is challenging. The second descriptive would be demanding. To add more detail what I’m saying now is, basically to render service to TB patients currently is not just a matter rendering a TB programme or TB just in a nutshell. Attached to the TB patient, we speak also of HIV and that is a collaborative aspect. TB treatment can given to the patient, but attached to the TB Programme is HIV and with HIV goes another aspect on his own, the fact that you must start manage the patient for TB and also for HIV. HIV/AIDS as an aspect in the patient’ life is also a challenge to us a healthcare personal, because you need to draw bloods for that specific patient if he is HIV positive. I am not going into detail about the negative, negative has got another management on its own. In terms of HIV positive TB patient, you need to draw bloods for that patient. As a professionalist you need to prepare that patient if it comes to that aspect of preparation in terms of anti-retroviral treatment if he qualifies, based on the World Health Organisation staging, method and the other clinical signs and symptoms that we have to keep in mind and his blood results. At the end of the day you are overloaded with administrative duties the TB department. Administrative duties speaking of the electronic TB register, speaking of the sputum suspect register, you know the
suspect that deals with the sputums of our suspect and of the cases of our regular treatment. The other aspect of [the day to day running of the TB programme or the TB Department, it’s really demanding and sometimes frustrating], because your patients comes with minor ailments and you treat those patients comprehensively, because if the patients has got minor ailments you need to intervene in that situation also prescribe, assess, diagnose and prescribe medication for that. And you have to deal with Community Health Workers who are DOT supporters, and our Lay Health Councillors, because our Lay Health Councillors are also functioning in that department, our DOT supporters are basically our hands, the outreach aspect of that aspect of that specific department into the community where we give them patients who are stable and then to DOT or to apply the direct observe treatment short course method on those patients in the community. But at the end of the you are supposed to manage your patients and on the other hand also manage you DOT supporters or your community health workers, which is another challenge on its own, but in terms of managing TB, it’s a real frustration to me as a Health Care Provider, because it’s not like in the olden days straight forward TB management. You need to manage TB in collaboration with HIV. You need to deal with these aspects, and also the day to day running. It’s real demand on human being. Apart from the fact that you are a Health Care Provider, you are a human being, and to see your patients wasting in front of you especially if they come to the clinic late being co-infected with HIV, with the HI virus. It’s really demanding and sometimes you feel that you want to do more for the patients but sometimes you sit with patients with a total patients of sometimes 100 (one hundred), sometimes 70 (seventy) and the admissions day to day you are admitting patients also and you need to screen those patients HIV and then you take it from there. It is really demanding especially if you are placed in the TB Department for one full year because the requirement is that we should stay in
that department for at least one year, to have an outcomes on your patients. But as I’ve said at the beginning it’s frustrating and demanding.

**Interviewer:** I like the fact that you’ve said that it is frustrating and demanding. Are there any other frustrations that you can elaborate on for me?

**Participant:** Okay I can go to the infrastructure. The infrastructure within the Nelson Mandela Bay Municipality, we are sitting with …… if I can speak in terms of my own facilities and also my previous experience and with other facilities. We are sitting with facilities who are not actually meant, or cannot actually manage patients in small cubicles where there’s sometimes 2 (two) windows with no proper extractor fans or other infrastructure that can protect us also because nowadays we are also contracting TB and it’s really frustrating when you are faced with the situation where you are getting patients into a room and that room is not actually conducive when you speak of ventilation, when you speak of ventilation, because there are certain requirements in terms of ventilation that must be at least specific aspects that you need to cover like, the extractor fans, ceiling fans, proper windows and also the size of the rooms like the current room in ……Should I mention names or just in general?

**Interviewer:** Just in general.

**Participant:** General. Generalize. Clinics the size of those rooms are too small to manage TB patients, because in that very same room you are not the only one in that room. Your furniture is there, your tables and chairs and also your stationary, because you need to keep some stationary also in that room and in terms bodies, human beings you are having your DOT supporters also there and your Lay Health councilor. That is part of your day to day running and sometimes you are overwhelmed by sometimes suspects from the other departments that needs investigations. Sometimes a situation
where you really need to intervene to protect yourself like limiting the access of the patients to your specific room so that at the end of the day you limit your exposure to the bacteria that causes TB and so on. But otherwise the infrastructure is really not conducive to manage TB currently according to my view because we need more in terms of size, the room size need to extended. And also looking at proper windows and proper protection in terms extractor fans putting them into ceilings. Perhaps also into the walls, because as far as possible we need to protect ourselves as staff members.

Interviewer: Okay thank you. If I just hear you correctly, are you also telling me that the staff is exposed to a high risk that the TB virus can be transmitted to the staff because of the infrastructure that is not sufficient?

Participant: It is definitely yes.

Interviewer: Okay.

Participant: We are exposed, we are at risk. I mean the statistics in terms of occupational incidences and occupational exposure of staff contracting TB in the Nelson Mandela Metro, it speaks for itself.

Interviewer: Okay you are talking about statistics regarding the transmissions to staff members. Do you have any statistics that you can provide me with?

Participant: Okay out of my head I know in sub-district b, including our Community Health Workers. If I can just out of my head mention for example, in sub-district b I know of already ±4 (four) people who contracted TB. That is in one sand also in other in other sub-districts I know of another particular person in one particular sub-district. That is already five, and I mean one is already too many for healthcare personnel, because we are supposed to be healthy, we are supposed to treat patients seeking healthcare from us, and I mean at the end of the day and I mean if we also fall ill of these diseases you know communicable diseases then at the end of the
day we are sitting with health system with health care personnel who are also sick and won’t be effective to render healthcare at the end of the day because we are also supposed to be booked off for extended periods and that also impacts on your continuity of service, because at the end of the day we speak also of continuity of service where a patient should be treated by a specific sister for at least for a specific time to have outcomes on that patient you are the person who also develops a relationships with these patients positive relationships that speaks of motivation because we need to motivate our patients to be cured to complete that treatment and to comply with the TB treatment and interventions.

**Interviewer:** Okay. Coming back to infection control. How do you see infection control in the municipality, regarding the rendering of the services to your patients and how so you find the policy if there is any?

**Participant:** Okay, I don’t really know of any current infection control policy that from as far as my information goes I don’t know of any infection control policy that addresses these issues that I’ve mentioned now. There was one in service in Livingstone hospital – TB risk assessment. There was a tool formulated from not even the municipality, from a non governmental organisations. On the other side of our employer it speaks of negligence, it speaks as if there is a don’t care attitude towards the staff. We’ve got occupational health and safety committees in place which are driven by the personnel themselves and, here and there on some sub-district level, here and there your occupational or health inspectors. But at the end of the day from a policy point of view because if there’s a policy in place, at least that policy can give us direction as to how we can protect ourselves from a legitimate point of view, because policies are usually based on circulars coming from the Provincial Department or from our Municipality themselves. From a legal point of view at least we are covered but at the end of the day currently, we are just doing what we feel is right ourselves.
Interviewer: Okay, if I understand you correctly you are telling me that management is not concerned about the staff rendering services to the TB patient seen that you are not aware of a policy that is in place in the Municipality.

Participant: That is correct, that is what I am saying yes.

Interviewer: Okay coming back to the beginning you said that staff was overloaded with Administrative duties. Can we explore or tell me more about which Administrative duties your service entails?

Participant: With specific reference to TB?

Interviewer: Yes

Participant: If you can look at the number of register that we are using in the TB office, I would mention the electronic TB register the paper based one which is kept at the facility level at the clinic level where you register a patient if he is diagnosed with TB and also suspect who are entering your office, you need to have a suspect register. You are supposed to write down those suspect details and when that it also pertaining to management of sputums in the department because if the sputums' results comes back then you need to enter them and that happens on a day to day basis. On a daily basis you need to keep that register up to date. And also you need to also have the blue PC4 or the patient or facility retained TB Control register. And that register on its own is also link to your ETR because whatever is reflected in the ETR or your Electronic TB Register need to reflect on your facility based blue patient record. Managing that record it needs for you to even go to the extent of having the sputums up to date because there is specific timeframes attached to specific patients sputums. When it is a new patient who started positive sputums we need to convert that patient in two months you need to convert that patient in five months and that is the Administrative duties on their own.

Interviewer: Okay so what you are telling me Administrative Duties pertaining to the registered nurse
Participant: That is relevant to the registered nurse because our community health workers may only write in the patient suspect register, we do allow them in that register, because at the end of the day it is not such real challenge to them. But when it comes to blue facility patient record TB record that one is only meant because it is legal documents it is only meant for you as the professional nurse pr the registered nurse. And you need to keep it up date on a daily basis and also the electronic TB register is that also another aspect on its own that needs to be kept up to date because of the day there are timeframes also involved with regard to submission of the different coloured papers like the pink sheets that need to go in terms of different case findings so that that can also be captured on the electronic, that is also the computerized version of your ETR and then there are a lot of things you need to keep your hands on and you are the only one in that office with the support of your Community Health Workers limited support especially when it comes to Administrative duties. They’ve attached some time ago they’ve implemented the data capturer / project of the data capturers from the district office. It is a provincial initiative where they attached to facilities unemployed matriculant’s where they train them to become data capturer it is almost like a learnership programme. But these are fresh school and they do not always know everything. I mean they do not know everything but they need to help, they are exposed to health issues only now and that is another case on its own. You need to also coach and mentor those people to teach them how to use paper based format, because they can also we do allow them to write in the paper based electronic register the TB register at facility level. But that is another thing, and a challenge and a demand from you because implements these things at the end of the day who is implementers it’s us at facility level the TB nurses.
Interviewer: Okay, I hear what you saying but so you are actually trying to tell me one Registered nurse is managing all those duties. So if I hear correctly you are to tell me that there is a shortage of staff?

Participant: I would say yes, because if you look at the nurse patient ratio at some or majority of the facilities. We do not meet even the requirement of the world health organization that speaks of 1 as to 35 I understand the other day they said now it is supposed to be 1 as to 45. But ratios is a norm but the practical situation do not always tell you your ratios, because a patient is not a ratio only a patient is a human being, a patient presents with different things in front of you. As I have said earlier, you do not just treat TB anymore in our TB patients, you even treat HIV/AIDS in that same room.

Interviewer: If I hear you correctly you are also telling me that the one registered nurse in the department need to see the other need of one specific patient, so the demand on the registered nurse if great?

Participant: Ja, that patient like I said earlier also if he during course of his treatment, whilst on the treatment or even initially when he has got other ailments or minor ailments perhaps some of them are even on chronic medication you know and then some of them even come to your office on anti-retral viral treatment with lot of side effects because we are speaking of a lot of different drugs entering the body of that patient and need to be well informed about those aspects. You need to intervene when necessary.

Interviewer: Okay, If I hear you, you are telling me that you have to provide holistic service to the patient and that the demand is great on the registered nurse because they have to see all those of the one patient.

Participant: Yes, yes.

Interviewer: Okay.

Participant: Just to add more, sub-categories it's a luxury for some of our facilities. Other facilities minor and then the minority of the facilities have got some sub-categories in terms of enrolled nurses, enrolled
nursing assistants attached to that professional nurses, but then you get other facilities where this only registered nurse are supposed to be intervening.

**Interviewer:** Okay. If you can come back to infrastructure again. Thinking of infrastructure also include equipment and things. Is there anything you can add on regarding that?

**Participant:** The availability of the general equipment like weighing scales, wall mounted blood pressure machines or the manual machines they are available but at the end of the day if you are having all these equipments in place in a small room it tends to become problematic, because you fall over these things and you have to pack them away if you are having patients in front of you. We can have these, the relevant equipment in the room but where do you put them, that is my concern where do you put these things, because you are sitting with a situation where the office or the department where you are functioning from is so small you do not even have really space to keep these things and at the end of the day you rather go for the option of referring the patient to a central point where observations are being done observations and then the patient comes back to your office at the end of the day and also impacts on your day to day management of that patient because I personally feel that you should do everything relevant to that patient that specific room and then the patient just moves from here to his house. But now currently we must be creative nowadays to refer the patient to another in terms of the flow of the patient, that impacts the flow of equipment, we cannot keep it these small rooms.

**Interviewer:** So what you are telling me is that there is equipment available on site but it is not held in the TB department itself. You will have to send the patient from pillar to post to get their observations done and there is and overcrowding of your facility where you render TB services, is that what you are saying?
Participant: Yes, because I mean even the passenger TB is communicable disease so one should always be vigilant in how manage you patient flow, because do you not want a situation where a patient is not the only one in that building there’s also other pregnant females or ladies and there’s also children which are more at risk which are more at risk and also the pregnant ladies and there’s who are more at risk, because it is an airborne disease so the time that the patient spend in your building should be minimal, especially those who are undiagnosed suspect TB cases. One tend to rather prioritize those patients in order to protect yourself. You fast track those kind of patient. That is why it impacts on the patient flow if you are not having all the equipment in that specific room that you are operating from as you said now, we send a patient from pillar to post, which is not effective in terms of patient flow. A patient flow, normal patient flow and a logic patient speaks of I am a TB suspect or a case, I must be served by a specific room or department and I move from department out by the gate to my home.

Interviewer: Okay, so I hear you correctly what you are trying to tell me is that what is supposed to be done is the patients is supposed to be seen in one service and he has to be treated holistically but at the moment it is not being done like that so there is a contravening the issue of the primary health care principles.

Participant: Yes

Interviewer: Okay. Is there anything else regarding your challenges that is demanding, or any other challenges that you would like to explore?

Participant: In terms of TB management, I feel that the staffing issue should be addressed as soon as possible, by management sometimes feels that you are okay there in your office, you are dealing with TB, that us the mindset, even of the other staff members, they think that you are only focusing on one programme, because TB is seen as a programme. They think that you are focusing on one programme, but then at the end of the day you are not the only one focusing on
one programme, it's actually a mixture of other programmes that are also presenting in your office, as I've said primary health care in terms of acute management of patients, acute illnesses, minor ailments as I've said and those things its really a challenge for the TB nurse. If a TB Nurse can have the support, not just of the staff in general, but as a staff who are placed there as a TB Nurse, and attach to that TB Nurse at least one sub-category in the form of an enrolled Nurse perhaps, because that enrolled nurse can help you with muscular injections giving the streptomycin and that enrolled Nurse can even go to the extent of helping you with your TB/ Hive collaboration in terms of VCT because she may prick and you can perhaps teach that person and mentor that person to help you with the day to day running. Delegate some tasks, relevant task, within the scope of his or her practice. I think the issue as we have already mentioned it the infrastructure also needs urgent attention from management, because I feel that management sometimes and most of the time the response is especially with the fragmentation of health services. Fragmentation referring to you get your Eastern Cape Department of Health Nurses in the same building and sometimes you get your Municipal Health Services personnel and that also affects the staff because at the end of the day some facilities are overstaffed, I know of one facility that has got even two professional nurses. Two professional Nurses plus a sub-category in the form and enrolled Nurse whereas the Municipal, that is now the Eastern Cape Department of Health facility who are manage by the district office. Eastern Cape Department of Health, district office, local office in Port Elizabeth, those kind of facilities in contrast with to the Municipal Health Services, those services who are rendered by Municipal Health and local government authorities. We are sitting on the other side with facilities who are having only one professional Nurse and even the statistics if you can compare statistics, it’s a frustration to us and it impacts of staff morale the
aspect of facilities who are having exactly the same number of patients and even more that is now the district or Eastern Cape Department of Health facilities your Municipal Local Authorities Facilities. You’ve got that irony of over staffing in the Eastern Cape Department of Health facilities and the Municipal facilities where you get understaffing. If you look at those issues it impacts on you rendering the service. You ask yourself why are they managed in this way and us managed in that way, whilst we are part of the same Department of Health. Understaffing is another issue we speak in terms of the different authorities who are rendering or who are responsible for the implementation of Health Care provision to our communities. That is another frustration on its own and I think that can also be addressed because you cannot have a situation where on the one side there is overstaffing and on the side there is understaffing.

**Interviewer:** You mentioned the morale of the staff being affected. How is the morale being affected? Can you give some examples or elaborate on that for me please.

**Participant:** Okay, I can elaborate on that. If you look at one facility with a ration of ±200 patients. TB patient cases managed by one professional Nurse and ±4 – 5 dot supporters plus attaches to that professional Nurse no sub-category only a health advisor, and what is a health advisor. It is somebody that is affiliated with the Eastern Cape Department of Health, not with the Municipal Health Authority. Still I want to highlight this aspect, still the one professional nurse with these sub-categories. She is surviving currently, she is managing the TB very well and effective, but at the end of the day when you look at another facility that where you are having two professional nurses with more or less the same number of patients on register, it has been proven, with even sub-category of enrolled nurse. The situation is that the sister knows about this and at the end of the day it impacts on her morale the fact that if you look at the performance
of that facility who are having two professional nurses, are they performing well? They are not performing well. Now you ask yourself why do you start a facility that where there is even under performance. Why not boost the morale of the current sister who dealing with the ±200 patients on her own and still performing. Why not attach professional nurses there, and that speaks of unequal distribution of staff within the Department of Health because at the end of the day even if you are affiliated with the Eastern Cape Department of Health or with local Authority who are still health services and you are serving the Department of Health. That in equality in terms of distribution of staff or even resources that impacts on us or you as a TB nurse. Because you ask yourself why don’t they look at the figures, the district health information system. You submit statistics, you report that I am under staffed you talk in meeting about this issues, but at the end of the day nothing comes of it. It impacts on you.

**Interviewer:** So what you are telling me is that certain facilities in the Nelson Mandela Metropole has one registered nurse attached to TB services where other services has two or more registered nurses attached to rendering the same services, and due to this the morale of the registered nurses is affected in their performances to treating the patients at the end of the day.

**Participant:** Yes definitely. I think I forgot to also bring in the aspect of the high staff turnover, especially in the municipal health authority side. Currently there is also high staff turnover the OSD because a person can speak of OSD the occupational specific dispensation only implemented on the side of the Eastern Cape Department of Health personnel when we speak in terms of salaries. Eastern Cape Department of Health personnel who are on per sell system, those people they received more money and their salaries were uplifted or their notches were progressed. There was progression into their notches, but if you look at the poor sister who is on the other side
who is just a TB nurse in the Municipal Health services side that impacts on them also, at the end of the day you have that migration of the Municipal Health personnel migrating to the Eastern Cape Department of Health to become part of the per sell system and then at the end of the day who is suffering? The facility and community, because it breaks or breaches the continuity of care. You need to now retrain another TB Nurse, send that nurse for 1 weeks training again and this nurse who are appointed because there is a current status quo in the Municipal Health Authority side. The status quo that we are rendering services even with Nursing Agencies, which speaks of another problem on its own because people are not permanently employed, we make use of them that is what we are having currently. We make use of them and they mess up, because that person perhaps is on holiday for two weeks and that person comes and renders service for you. He is just there for two weeks then he is out, so there is no proper or effective commitment in what he or she is doing because she is there only temporarily, I mean Nursing Agency personnel they are temps, temporary nurses. Some facilities are having the situation where they are having majority people on contract. Even that is another issue on its own. Contractual Municipal Community Health nurse and that impacts on service delivery in the TB Department because those people has been there for years in the on contract without benefits in terms of Provident fund or Pension fund and Medical Aid Schemes and those people demoralized by those aspects and that also impacts on their TB management because some of them are TB nurses and at the end of the day you are sitting with personnel who are demoralized by exploitation, I mean if I am on contract for five, four, three or seven years, some of them are there for seven years on contract. Such situations tend to have a negative impact on the personnel themselves and the fact that this impacts negative on the personnel’s service delivery relevant to TB in this situation.
Interviewer: So what you told me now is that there are different remuneration packages in one facility, or in different health facilities in the metro, because of the different authorities they are giving different remuneration packages to the nurses that must provide the same TB services to their patients, and this is causing the morale of some of the nurses to drop?

Participant: Yes, definite yes I can answer on that because I mean if I am in the same building and in the same position, years of experience of that person, also our ranks are different, ranking of our ranks are different but it boils down to registered nurses with same training, same number of years of experience, but at the end of the day your salaries are totally different.

Interviewer: Okay, you also mentioned something about exploitation. Can you tell me more about that please?

Participant: Exploitation in the sense that we are having professional nursing agency staff members. I feel that nursing agency staff members should not be utilized in any health services, when it comes to public health, because public health should have a permanent staff member who are rendering the services, and who getting all the benefits in terms of pension, provident and medical aid, because then the persons morale would be much more effective in terms of service delivery. That person would have a positive morale. When he comes on duty. He knows that it would be business as usual for him. I am supposed to render a service, I am here for here until I am retired. But on the other hand you get the irony of having contractual workers. That person do not have any benefits. That person has got a family to take care of, children who are at school, who fall ill, no medical aid scheme for that person, no provident fund, no bonus in some situations for that person. A permanent staff member gets a bonus perhaps November/ December or what ever relevant times they get their bonus, and then you talk in a team about these issues, hey I am looking forward to my bonus. It
impacts on their morale. It impacts on service delivery, and I personally felt that the department of health personnel should be permanent, because we owe it to our communities. Any service that is rendered by the Department of Health, because that is the umbrella department when you speak of the department. We are serving the department of health at the end of the day in this country. When we go down on a smaller scale, the Eastern Cape Department of Health, because we belong to the Eastern Cape Province. It is unacceptable to have according to my opinion in our buildings in our services people who are nursing agencies personnel who are there, I speaking to one of them just the other day, this old woman, some of them are 67 years old, I know of a case of ±70 years old, she was having a birthday party the other day in Port Elizabeth, still coming on duty, those people are dangerous with service delivery and they are no more productive. That is why I say, when these people come to your facilities as nursing agency personnel, or even being on contract with the current municipal health authority. It speaks of exploitation, because I feel that people should have permanent employment when they work for any department of health or public institution.

**Interviewer:** If I hear you correctly, you mention the ages of some of the staff members. Are you telling me that the municipality are making use of retired staff to come back and do the work?

**Participant:** Yes, I even underlined the word yes. Definitely it is happening. It is general practice currently. That is the status quo that is what is happening in our facilities. We have retired people coming back as nursing agency personnel or they are put on contract. You know, temporary contract without any benefits and I don’t think it’s right towards our communities and then even that same staff member I don’t know their reasons are for coming back but I think from a management point of view, our managers should not allow that situation because we have nursing colleges who are producing our
future nurses, fresh, you know, people who are energetic in comparison to old your old geriatrics, because they are geriatrics. If you are 60 and above you are a geriatric. How can you come on duty at 65 and I’ve got, I’m having evidence of one personnel in PE in a brand new clinic, 71 years old plus minus, 71 years old. She had her birthday the other day.

**Interviewer:** Okay, in a nutshell you’ve given me challenges and your demand. Are there any other challenges that you can think of that you would like to elaborate on. Or anything else regarding your experience and working with the TB Department and TB Service.

**Participant:** At this point in time, no. There are some challenges, more challenges, but I can’t think of something else now.

**Interviewer:** Okay

**Participant:** I’m exhausted now, I’ve exhausted all my challenges.

**Interviewer:** So we can move onto the next question. Are there any suggestions or recommendations that you can give on how to improve services.

**Participant:** Yes, I will start with the last one I have stopped with. Have the permanently places health care personnel or registered nurse, rendering our services in the public health facilities. That is number one. To do away with exploitations, for example having nursing agencies, geriatrics come on duty, do away with such negative things. Have the proper infrastructure in place, speaking of proper ventilation, speaking of proper size of rooms where you can operate from in terms of your TB rooms, having the latest technology, and there is budget for that technology in terms of ventilation, moving airflow in that office. There are technology and there is budget for that technology, we can provide these technologies, because the department owes it to us, we are the backbone of the health system of our country as registered nurses. The manager should look after us by preventing illnesses as TB, that is number 2. I think also the staffing issue, I did say in number one that it should be permanent. I think we need to do a job analysis. I don’t know how you call it, but
perhaps a job analysis as to what is the TB nurse actually doing currently, because perhaps we see the TB nurse as a registered and but at the end of the day what she does in that room or that department needs to be taken note of. We should as Human Resources Department to come in and see exactly what she these people are doing point A-Z, and perhaps have recommendations based on these expertise from Human Resources. Perhaps our people are even overloaded with work, and at the end of the day that is why people they tend to become ill or fall ill because of their immune systems decreasing. I also think the support from management should also become visible in terms of support visits from our supervisors and managers. Not just critical support visits, but in terms of support visits in the true sense of support, where they come out and see especially in the morning sessions when it is full to see how we are operating. To have insight when they do decision making on our behalf in the boardrooms, because they can see exactly what is happening, they will have and insight as to how they should approach staffing and allocation of staff in terms of TB control programme, because the TB control programme is very demanding as I have said. I also think as a matter of urgency, the infection control policy should be formulated, as a matter of urgency and should be prioritized by management and full implementation and support from management with regard to this infection control policy to protect their assets which are called registered nurses and TB nurses.

Interviewer: Are their any other recommendations that you can think of or would like to elaborate on?

Participant: The aspect of looking at the various health authorities, that should also be investigate as to how this impacts on Tb management or service delivery in terms of TB, because I did not mention in terms of the staff morale, which are affected by various health authorities, having various or different salary scales or notches, because if you
are having a situation under one roof (a) municipal health services
(b) eastern cape department of health, same years of experience,
same training, different salary scales. That also impacts on service
delivery in terms of TB management, that should be dealt with at
higher levels, because this issue is beyond control at this level
speaking from a TB nurse point of view. Management should also
address issue.

**Interviewer:** Are there any other recommendations on your behalf?

**Participant:** I can’t think of any more.

**Interviewer:** Thank you ……………., it is highly appreciated. Thank you for your
time and input. Thank you.
ANNEXURE G
LETTER OF REQUEST TO CONDUCT RESEARCH STUDY
APPLICATION TO CONDUCT RESEARCH

An application is hereby submitted requesting permission to conduct research in the above mentioned department where I am currently employed as a senior community health nurse. I am currently registered with the Nelson Mandela Metropolitan University as a student studying towards the degree Magister Artium in Health and Welfare Management. My research topic is entitled: “The experiences of registered nurses regarding the rendering of health services to Tuberculosis patients”. My treatise is being conducted under the leadership of Dr. E. Ricks and Dr. S. James of the Nursing Science Faculty at NMMU.

The main aim of the study is to explore and describe the experiences of the registered nurses regarding the rendering of health services to the TB patients. The collected data will be analyzed and recommendations based on these findings will be made to the sub district manager. A copy of the final report will be made available to you.

The method of data collection will be the in-depth interview. Therefore, when permission to conduct the research is granted the interviews will take place during the period June –August 2008. The interviews will be conducted at a time and a place that is convenient to the participants. Consent for entering the premises will be obtained from the clinic supervisors before approaching the participants. Participants will be informed regarding the purpose of the research. The research will be conducted voluntarily and the participant may withdraw at any time, should they so desire.

A copy of the proposal and consent form is enclosed for your perusal. Should you have any queries regarding this request, please contact my supervisor, Dr. E. Ricks, during office hours at (041)5042122

Thanking You.
Yours in Health

My contact details are as follow:

Leigh Anne Jantjies
(041) 9882222
Student
Student number: 193415000
ANNEXURE H
LETTER TO CERTIFY EDITING
TO WHOM IT MAY CONCERN

Kindly be informed that I, the undersigned, hereby certify that I undertook the editing of the dissertation of Ms Leigh-Anne Rene Jantjes, which she will submit in respect of the requirements for the degree of Magister Health and Management at the Nelson Mandela Metropolitan University.

I am a former high school language master and I have for several years been teaching on a part-time basis in language and literacy programmes offered at the Nelson Mandela Metropolitan University. I have edited several academic pieces; my most recent editing has been in respect of a doctoral thesis.

JWM SLINGERS

JANUARY 2011