A nursing service change strategy for health clinics

by

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SUMMARY

It is evident that the current political changes presently taking place in South Africa need to be accompanied by a dramatic transformation to accommodate the economic, social, technological and health changes amongst others. The nursing discipline is no exception. For a change to be felt by nursing staff and by health consumers, effective management strategies need to be developed to accommodate transformation guidelines as outlined by the Reconstruction and Development Programme, the National Health Plan and the Constitution which all emphasize the right to health, hence this study. This study focuses on a primary health care clinics.

This is a qualitative, contextual, exploratory and descriptive study with the overall aim of exploring and describing a nursing service strategy for change in Soweto Primary Health clinics where the researcher is employed. To accomplish this aim, the following objectives were formulated:

* to explore and describe the expectations of the managers and the functional nurses concerning the required nursing service strategy for change within Soweto Primary Health Clinics;
* to explore and describe the expectations of health consumers concerning the required nursing service strategy for change in Soweto Primary Health Clinics;
* to describe the required nursing service strategy for Soweto Primary Health Clinics.

Through purposive sampling, three focus groups were selected from the role players within Soweto who represent the nursing managers, the functional nurses' and the health consumers in order to infer the required change strategy for the nursing service.

i. Data was collected through these focus groups interviews using semi-structured questions. Data management and data analysis was done using the methods of content analysis according to Kerlinger (1986: 480). An research expert, was utilised as a reliability measure to identify and categorise themes separately from the researcher. The categories that emerged were subsequently refined through consensus discussions between the researcher and the independent researcher. Woods and Catanzaro`s measures (1988: 136) to ensure validity and reliability were applied in this study.

The results indicate that the expectations from the different role-players focused on change of attitudes, introduction of comprehensive or 1-stop health centres, staff and community involvement for ownership of health services, human resources development and equal distribution of available health resources. These were used as the basis for a nursing service change strategy and guidelines were formulated taking precautions to involve all relevant stakeholders. The recommendations includes nursing practice, nursing education and nursing research.

The recommendations focus on the implementation of the change strategy and conformation/change of attitude. Several hypothesis were also formulated.

UITTREKSEL

Dit is duidelik dat die huidige politieke verandering wat tans in Suid-Afrika plaasvind gepaard moet gaan met dinamiese omvorming om, ondermeer, die ekonomiese, sosiale, tegnologiese en gesondheidsveranderinge te kan akkommodeer. Die verpleegdissipline is geen uitsondering nie. Hierdie veranderinge noodsaak toereikende bestuurstrategieë om aan die vereistes van die Heropbou en Ontwikkelingsprogram, die Nasionale Gesondheidsplan, asook aan die Grondwet wat die reg op gesondheid beklemtoon, te voldoen. Hierdie studie word om hierdie rede uitgevoer en fokus op primêre gesondheidsorgklinieke.

Die doel met hierdie studie is om 'n verandergstrategie vir 'n verpleegdiens in Soweto Primêre Gesondheidsklinieke, waar die navorser werksaam is, te verken en te beskryf. Hierdie doelstelling is deur die volgende doelwitte verantwoord:

* om die bestuurders en funksionele verpleegkundiges se verwagtinge omtrent 'n veranderingstrategie vir 'n verpleegdiens in Soweto Primêre Gesondheidsklinieke te verken en te beskryf;
* om die gesondheidsverbruiker se verwagtinge omtrent die verpleegdiens se veranderingstrategie in Soweto Primêre Gesondheisklinieke te verken en te beskryf;
* om die vereiste veranderingstrategie vir Soweto Primêre Gesondheidsklinieke te beskryf.

Drie fokusgroepe is by wyse van doelgerigte streekproefneming geselekteer om die verskillende rolspelers in bestuur, funksionele verpleegkundiges en gesondheidsverbruiker te verteenwoordig ten einde die veranderingstrategie te kan saamstel.

Die data is deur middel van fokusgroeponderhoudvoering ingesamel, met semi-gestruktureerde vrae. Die hantering en ontleding van die data is uitgevoer volgens Kerlinger (1986: 480) se beginsels. 'n Navorsingsdeskundige was gebruik as kontrolemaatreël vir betroubaarheid om die kategorieë en temas onafhanklik van die navorser te identifiseer. Hierdie temas en kategorieë is vervolgens verfyn tydens konsensudebatvoering tussen die navorser en onafhanklike deskundige. Woods en Catanzaro (1988: 136) se beginsels vir geldigheid en betroubaarheid is deurlopend in hierdie studie toegepas.

Die resultate fokus op daardie verwagtinge wat 'n verandering in houdings, die instelling van 'n eenstop-omvattende gesondheidsdiens, personeel- en gemeenskapsbetrokkenheid vir die fasilitering van eienaarskap vir dienslewering, die ontwikkeling van menslike hulpbronne en gelyke verdeling van beskikbare gesondheidsbronne, kan meebring. Hierdie is gebruik as basis vir die ontwikkeling van die verpleegdiens-veranderingstrategie en riglyne is daarvolgens beskryf, om voorsiening te maak dat al die relevante rolspelers betrokke is. Die aanbevelings omvat aspekte vir die verpleegpraktyk, verpleegonderwys en verpleegnavorsing.

Die aanbevelings fokus op die implementering van die veranderingstrategie en houdingsverandering. Verskeie hipoteses word vir toetsing gestel.

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LIST OF ABBREVIATIONS

ANC - African National Congress

DHA - District Health Authority

GJTMC - Greater Johannesburg Transitional Metropolitan Council

HIV - Human Immuno-deficiency Virus

ORU - Oral Roberts University

PHC - Primary Health Care

RAU - Rand Afrikaans University

RDP - Reconstruction and Development Programme

STD - Sexually Transmitted Diseases

A NURSING SERVICE CHANGE STRATEGY FOR HEALTH CLINICS.

CHAPTER ONE

1.1 INTRODUCTION

A great political event has taken place in South Africa, sounding the bells of need for change for the better. The fundamental changes which go along with this event compel the society to restructure itself, the nursing profession is no exception. For South African nurses it means a direct confrontation with a rapidly changing society as political change has a direct impact on the nurses physically, mentally and spiritually meaning that their whole which is body, mind and soul need transformation rapidly to cope with change. The results of change will therefore influence the health delivery system to the general population as required by the Reconstruction and Development Programme of the National Health Plan. As nurses play a significant role in health care delivery they are therefore challenged in the changing society to participate in the reconstruction of health services but the biggest question is who is to initiate change in Soweto clinics and how?

In order to replace management styles of the past, in our efforts to bring about change, there arose a need within Health Municipal clinics to come up with a change strategy. The need was felt throughout hierarchy ranks, that is from senior nurse to junior nurses as well as the community. A change strategy will hopefully address all negative attitudes currently prevailing within nursing, brought about by bureaucracy and red-tape which have led to serious forms of apathy, radical attitudes coupled with a wait-to-be-told approach, permissiveness and a feeling of unworthiness by the juniors or functional nurses. An ineffective management style like autocracy which is prevalent should not be blamed as the managers' fault, but perhaps due to the type of training designed for the old system of dominance which was that of control by those in charge instead of development and capacity building. This ought to be replaced by adoption of acceptable leadership styles with participative management being the most practical for this purpose.

Many people are asking the question whether is it managers as people who resist

change or is it an overdose of the wrong type of management prevailing? Either way it is not managers who are to blame but a system of management which is not fit for the purpose. In this instance the purpose is implementation of Primary Health Care within all health clinics within Greater Johannesburg Transitional Municipal Council which is not taking off as expected.

In this study, the context will be the Local Authority clinics. The need to initiate change in these clinics emanates from the mass resignations. The exit register of Soweto City Council where Soweto City health clinics are administered shows these statistics between March 1993 to February 1994 from ten (10) clinics : seventy seven (77) resignations. This is cause for concern. Those remaining are restless, job hunting and continuously off-sick; industrial actions are on going. It must be remembered that most nurses who come over to Municipal clinics have this desire to work within the community for preventive, promotive and rehabilitative aspects of care, therefore the failure of primary health care to take off the ground is frustrating to most nurses. This means therefore that efficient and strategic management is now a necessity as change management requires skills which are unfortunately a rare commodity within the discipline, as this requires attitude change which is not easily learnt, if primary health care is to be implemented in its pure form in the near future.

This will be effected or attainable if there is desire to change by all nurses, both seniors and juniors, instead of an on going stand off that is prevailing, as well as accusations between seniors and juniors. This will be realised if there is confidence, assertiveness and expertise in handling change by all ranks of nurses, not forgetting change which can be effected by the ignored stakeholders, which is the community.

Perhaps the starting point should be the focus on the reconstruction and development programme (RDP) as proposed in its policy documents that is " one of the priorities is to draw all different role players in to the national health service. This must include both public and private providers of health, must be organised at national, provincial and district to community levels" (African National Congress, 1994:43). This still will be hampered by a failure to identify what the cause is in order to treat the symptoms.

1.1.1 RDP RELEVANCE FOR THIS STUDY (policy framework).

The RDP serves as a policy framework for change in health issues and services. There is a single Minister of Health and a single national health authority to develop national

policies, standards, co-ordinate the human resource development policy and co-ordinate condition of service of health workers (African National Congress, 1994:44).

At Provincial level:
Each province must have a provincial health authority to provide support to the district health authorities in its province. The aim is to encourage high quality, efficient service through de-centralised management and local accountability.

At Local level:
The main bodies responsible for ensuring access to and the delivery of health services must be the DHAs, their boundaries must, as far as possible, be the same as the new local government boundaries. Each DHA will be responsible for all primary health care services in its district. The DHA must have as much control over its budget as possible, within the national and provincial guidelines (African National Congress, 1994:45).

The main aim of the RDP is the transformation of the existing human resources and Management development in the post apartheid era to establish, strengthen, sustain the health infrastructure and management system which will introduce the envisaged change management strategies since the future health managers at all levels will deal with issues of planning, co-ordination and integration, financial management and human resource management. Whilst South Africa has large numbers of highly skilled workers, much of the training has been inappropriate and they are poorly distributed in relation to health and health needs. The transformation of the health system to one based on the PHC approach will require re -orientation of existing personnel, fuller use of their present skills and in-service training and acquisition of new skills to enable them to play a more effective role in promoting, maintaining and restoring health (African National Congress, 1994:79). If this is achieved within Municipal clinics, emphasis will focus on introducing management practises that promote efficient delivery of service in order to ensure respect for human rights and accountability to users, clients and the public at large as RDP stresses people driven policies. It should also be noted that democracy means a shift from resistance to reconstruction and reconciliation.This will improve staff mental health so as to improve their quality of service delivery which will be in line with RDP.

1.1.2 FIELD OF RESEARCH

The Soweto Municipal clinics are ten (10) in number, serve a population of about

four million. Their purpose is directed towards preventive, promotive and rehabilitative care which theme is going to be primary health care approach. The scope of service covers the following areas:

* Mother and child care which further includes these divisions:
  - immunisations
  - health education sessions
  - treatment of minor ailments
  - home visits, follow-ups and referrals.
* Nutrition assessment and assistance programmes.
* Family planning services for :
  - family planning methods for example pills, injections etc.
  - sterilisation
  - treatment of sexually transmitted diseases
  - health education sessions and counselling
* Tuberculosis and HIV clinics for:
  - home visits
  - contact tracing
  - X-ray services
  - supervision of daily treatments
* Geriatrics services
* Recruiting and training of community health workers.

With the ever expanding squatter areas there are also five mobile clinics to provide the same services.

1.1.3 MANAGEMENT STYLE AND NURSES' ATTITUDE

Many numbers of nurses leaving for greener pastures continue to rise month after month. This may be attributed to cultural shock brought about by the changing patterns as demanded by the current political climate and its demand of accountability. There has suddenly been the introduction of technology (computerised information system), also a need for inter-disciplinary collaboration. These require a complete transformation and adaptation to a change in leadership style which will conform to RDP requirements of community involvement, consultation and transparency. The question now facing us is are we ready to accept change and sustain it? Presently the leadership styles are not acceptable to the junior nurses as well as the community whilst seniors feel that accepting change means succumbing to pressure. On the other

hand why are juniors not pro-active enough to put wheels of change in motion? Must they only pressurise through strikes without setting an example? It must be remembered that using patients as bargaining pawns during strikes is both unethical and unacceptable to the society we serve.

Many people ask the question whether it is managers as people who resist change or is it an overdose of the wrong type of management prevailing? Either way it seems as if it is not managers who are to blame but a system of management which is not fit for the purpose.

The challenge is therefore on all nurses of Soweto Municipal clinics to manage this change properly. Let us remember that the essence of health care success depends on the alliance of clinical management, skills and activity. These are complimentary. Any profession would experience problems in adapting to changed responsibilities and expectations, but clinicians who resent management as an intrusion on clinical freedom miss the point. The essence is effective patient care , effective management and clinical capacity, even during a change process . It must be remembered that whilst change within an organisation creates uncertainty and discomfort, it often leads to real innovation providing abundant opportunities for creating a better way. We as nurses should always remember that the challenge is clear cut for us as nurses in South Africa - to create change for ourselves, our institutions, our professional organisation and to manage the current nursing environment. Change is burden when it is done to us but a rewarding challenge when it is done by us, only if we manage it pro-actively and creatively.

In Soweto clinics therefore change in attitude and styles will focus on organisational change, practitioner change, that is managers and clinicians as well as health consumer orientation.

As stated by RDP White Paper (ANC, 1994), reconstruction in the health sector will involve complete transformation of the entire delivery system. Instead of concentrating on management for control, the emphasis should now be on staff and community development. This is what is envisaged:

* All providers of health services should be accountable to the local communities they serve through a system of community committees, through the DHAs which must be part of democratically elected local government; including a Charter of patients

rights that will be displayed in all health facilities.

* Communities must be encouraged to participate actively in the planning, managing, delivery, monitoring and evaluation of the health services in their areas (RDP, 1994, 44 - 45). This was unheard of previously, the community and the staff used to receive instruction from top management. This therefore emphasises dual planning between staff, irrespective of their positions as well as the community. Gone are the days of imposing to the community. The challenge is therefore on health professionals to redefine their roles and responsibilities in the new system where accountability and transparency are emphasised. A strategy for change should therefore include re-training and re-orientation to new policies, rules and standards as a priority for staff to make a meaningful input to RDP.

1.2 THE PROBLEM STATEMENT

Resistance to change by all staff members at Soweto Municipal clinics is an observable fact. This includes managers right through all categories of staff. All but are aware of the need to change, the problem lies in its initiation and implementation.

The ongoing stand-off between seniors and juniors has a negative impact on inter-personal relationships leading to delay in implementing meaningful primary health care.

The health consumers are not adequately informed about the changes affecting the envisaged health care delivery which will be comprehensive in nature. The public is having high expectations from the government of national unity. They expect visible changes in health matters. In 1994, a plan that had been endorsed in 1993 to build additional clinics in Soweto got rejected by the community as this had been initiated and concluded without their involvement. We are now expected by National Health to come up with another plan of additional clinics, a plan which needs to take care of community health problems as proposed and agreed to by all stakeholders.

The Human Resource Development report of the Transitional Metropolitan Council identifies change management as a priority in all levels of health service delivery whilst Soweto clinics do not have a change strategy as yet to effectively implement the desired change. As a result the Council (TMC) has given proposals for managers to undergo change management workshops. This has not even taken off as everybody is still gripped by transitional shock. The staff also still needs to be

orientated about the envisaged strategic management plans where they need to participate. The cause of failure to initiate both plans is related to staff uncertainty as to the effect change will bring to their conditions of service, the proposed staff re-deployment plans to meet the finalised DHAs which are a district per two hundred thousand people.

The reality of the situation is that health professionals are expected to deliver the services, not to wonder about them. The purpose of this research is to explore and describe the change strategy required to effectively implement Primary Health Care. The following questions are applicable:

* What are the expectations of the selected stakeholders (nurse-managers, other nursing categories and health consumers) concerning change that has to be implemented in relation to effective health care?

* What change strategy is required within the clinics to implement this Primary Health Care concept?

1.3 OBJECTIVES

The objectives of this study are as follows:

1.3.1 to explore and describe the expectations of the staff and health consumers concerning the desired nursing service change strategy for health clinics in Soweto;

1.3.2 to explore and describe the expectations of health consumers regarding change strategy required for health clinics in Soweto;

1.3.3 to describe a nursing service strategy for change in Soweto health clinics.

1.4 THE PARADIGM

The paradigmatic perspective of this research project is Nursing for the Whole Person Theory (Oral Roberts University Anna Vaughan School of Nursing, 1990:136-142; the Rand Afrikaans University, Department of Nursing Science, 1992). The researcher accepts Nursing for the Whole Person Theory because of its congruence with the philosophy of RAU and the South African Nursing Council, where man is viewed as body, mind and spirit interacting with the external environment (physical, social, and spiritual).

Within this framework of reference, the focus will be on the continuous quest for wholeness. Man is a spiritual being who functions in a bio-psychosocial manner in his quest for wholeness. Man is an individual but also forms an integral part of a family, co-existing in a community (O.R.U., 1990:136-142). The primary health care nurse strives towards quality primary health care and effective change in the health clinic.

1.4.1 Meta-theoretical assumptions

The meta-theoretical assumptions of Nursing for the Whole Person Theory are accepted regarding person, health, illness and nursing (O.R.U.,1990:142).

1.4.1.1 Person

A person is a spiritual being who functions in an integrated bio-psychosocial manner to achieve his quest for wholeness. A person interacts with his external environment wholistically. In this study persons will be nurses and health consumers.

1.4.1.2 Health

Health is a state of physical, spiritual and mental wholeness. The person's pattern of interaction with his internal and external environment determines his health status. Health can be qualitatively described on a continuum from maximum to minimum health. Illness potential exists in those who are healthy (RAU, 1992:5). In this study health is replaced by a successful change strategy for health.

1.4.1.3 Illness

Illness is a dynamic state that reflects the nature of the person's interactive patterns with stressors in his internal and external environment. Illness can be qualitatively described in a continuum from severe illness to minimum illness. Health potential exists in all those who are ill (RAU, 1992:6). In this study illness will be the result of job dissatisfaction for staff thereby affecting the body, mind and spirit negatively as well as result of ineffective health delivery to health consumers thereby affecting body, mind and spirit negatively.

1.4.1.4 Nursing

Nursing is the goal-directed service to assist the individual, family and or community to promote, maintain and restore health. Central to this service is the concept of nursing for the whole person. Promotion, maintenance and restoration of health has been defined as follows:

* Promotion of health refers to the nursing activities contributing to a greater degree of wholeness for the individual, family and or community.

* Maintenance of health refers to those missing activities directed towards continuing or preserving the health status of individual, families and or communities.

* Restoration of health refers to those missing activities which facilitates the return to the previously experienced levels of health of individuals, families and or communities (RAU, 1992:6). In this study clinical nursing care is replaced with change management in order to address and meet the requirements of PHC approach as defined for the RDP, that is development of human resources effectively for meeting community health needs.

1.4.1.5 Nursing Service

A nursing service is a specialized department in the health clinic with a nursing service manager accountable for the managerial outputs within the health clinic.

1.4.1.6 Change strategy

A change strategy is a structured plan of action, based on the expectations of relevant role-players within the health clinic to facilitate desired change.

1.4.1.7 Health clinic

Is a primary health care centre in a specific geographic area for health delivery to a specific community.

1.4.2 PARAMETERS OF NURSING

These include the individual, family and the community and all are interrelated i.e. service with a focus on one parameter cannot lead to quest for wholeness. These parameters are:

1.4.2.1 Individual

The individual is a spiritual being who functions in an integrated bio-psychosocial manner within the family or community (RAU, 1992:7).

1.4.2.2 Family

The family group is a basic unit of society composed of individuals mutually valued

and interacting (RAU, 1992:7).

1.4.2.3 Community

A community is an identifiable group of persons who share a common interactive pattern and or geographical location (RAU, 1992:7).

1.4.2.4 Environment

This concept included an internal as well as external environment. The nature of the internal environment is body, mind and spirit and that of the external environment is physical, social and spiritual. Patterns of interaction with internal and external environment determines the status of health (RAU, 1992:7).

1.4.3 THE RELEVANCE OF THESE PARAMETERS TO THIS RESEARCH

The nurses ought to accept change as a way of growth, innovation and re-organising for the clinics of Soweto with Local Government, to bring about involvement and willingness to work on the change process. The effect of change will then be felt positively which will assist an improvement of lives for nurses and health consumers as individuals, for families who are made of these fulfilled individuals, leading to fulfilment of communities where content families interact and share a common pattern in the same geographical location. Change for the better which is positively implemented contribute greatly to the physical, spiritual and psychological aspects of life. This will only happen if all nurses long for quest for wholeness.

1.4.4 THEORETICAL ASSUMPTIONS

This research will be based on the theoretical assumptions of Nursing for the Whole Person Theory. The theoretical assumptions derived for this study are as follows:

* All categories of nurses should initiate change through effective change management process, leading to effective service provision in order to facilitate the promotion, maintenance and the restoration of individual health within the clinics of Soweto.

* As they continue their professional and personal growth, they will also contribute positively to the health of the individuals who are the community they serve.

1.4.5 METHODOLOGICAL ASSUMPTIONS

A functional approach will be pursued. This school of thought implies that the goal of research and theory development in nursing is aimed at providing the actions related to the prescriptions within a specified context, for application and improvement of the nursing practice. The usability of the result of this research will serve as guidelines for its validity. It is also assumed that the research and theory formulation do not take place in isolation, but rather in relation to the nursing practice and the philosophy of nursing science (Botes, 1989:20).

1.5 THE RESEARCH DESIGN

An exploratory, descriptive design will be used within the context of nursing services in Soweto health clinics. The strategy will be qualitative and descriptive in nature. The context will be within Soweto. The goal which is pursued in this is the exploration of a relatively unknown area (Mouton & Marais, 1993:43), namely the overview of the expectations of all nurses and health consumers in order to gain new insights in to the phenomenon of change, as well as the exploration and description of the strategy to be used in bringing about acceptable change.

1.5.1 POPULATION AND SAMPLING

The focus of sampling will be on the nursing discipline. The target population will be a representative sample of both nurses (being Nursing Service Management and functional Nurses) and health consumers, to accuratively reflect the population under study being the nursing staff and the health consumers.

* Sampling will be purposive. Purposive sampling is preferred as it leads to conscious selection by the researcher of certain subjects to include in the study (Burns & Grove, 1993:246).

* Sample size will be determined by saturation during data gathering.

1.5.2 DATA COLLECTION

For purpose of clarity, the organogram of Soweto City Clinics is now described below in order to capture and have an idea as to who is on the staff establishment within Soweto health clinics. The 10 clinics have a Medical Officer of Health as overall in charge and accountable for delivery of primary health care services within Soweto.

The staff establishment consists of the following:

* the medical officer of health
* medical officers
* nursing services managers
* chief professional nurses
* community health nurses
* professional nurses
* nursing assistants
* health inspectors
* administrative staff
* radiologists

(see figure 2.1).

The expectations of selected stakeholders in these clinics namely; nurse managers, functional nurses and health consumers will be explored by means of focus groups interviews based on principles of Kingry, Tiedje & Kruger (1990: 124). Meaning that a content analysis of the transcribed focus groups interviews will be done to identify main themes and subcategories for a conceptual framework on which a change strategy should be based. The results of the focus groups will be exposed to a literature control and thereafter a refinement of the conceptual framework for a "Nursing strategy for change within Soweto clinics". Finally the nursing service strategy will be described.

1.5.3 FOCUS GROUP INTERVIEW

1.5.3.1 Definition

The focus group interview means conducting an interview with a group of people rather than being confined to one individual at a time, in order to seek clues to diverse definitions of the situation which will yield a more diversified array of responses and afford a more extended basis for designing systematic research on the situation at hand, also for suggesting interpretations grounded in experience, of experimental data on the effects of that situation (Merton, Fiske & Kendall, 1965: 135).

1.5.3.2 Principles of focus group interview

The principles of focus group interview are as follows:-

* Interviewees are known to have been involved in a particular situation in an uncontrolled but observable social situations.

* The investigator has provisionally analysed the situation and developed hypotheses regarding probable responses.

* This situational analysis provides basis for the interview guide, setting forth the major areas of inquiry and the hypotheses which provide criteria of relevance for the data to be obtained in the interview.

* Must satisfy the criteria related range of responses, specificity, depth, personal context and homogeneity (Merton, Fiske & Kendall, 1965:3).

As the semi-structured interview with open-ended questions will be used, questions to be asked must be:

* prepared before hand not during the interview;
* questions phrased so that they are easily understood and put across one at a time;
* non-confining to single alternatives but phrased to enable free which go beyond factual information but lead into the one area of hidden motivations that lie behind attitudes, interests, preferences and decisions that is to be both introspective and extrospective.

1.5.4 RELIABILITY AND VALIDITY

Contextual studies relates towards internal validity. A serious concern related to qualitative research is the lack of strategies to determine the validity of the measurements that led top development of the theory, as qualitative researchers tend to work alone; therefore biases in their work, which threaten validity, tend to easily go undetected (Burns & Grove, 1993:349). In this study, triangulation of data, methods, investigator,theory and analysis triangulation will be made use of to minimise threats to validity.

For reliability, the use of the independent researcher or coder will be sought to assess and confirm reliability. According to Sampson & Marthas (1981: 230) the reliability of qualitative studies is judged by whether an independent researcher would generate the same constructs in a similar situation or would place the data in the same previously generated constructs.

1.5.5 DATA ANALYSIS AND INTEPRETATIONS

For this process mentorship by the experts will be preferred as qualitative data analysis and interpretation occur concurrently with data collection. Therefore the researcher is attempting to simultaneously gather data whilst managing a growing bulk of collected data and to interpret it at the same time. Qualitative data analysis techniques use words rather than numbers as the basis of analysis (Burns & Grove, 1993:563).

1.5.6 ETHICAL CONSIDERATIONS

Observing ethical obligations of the profession is important when human beings are to be engaged in a research project. Precautions will therefore be taken by the researcher to protect the rights of respondents. Both the setting and respondents need relevant arrangements for informed consent as some questions could be of sensitive nature especially if it comes to giving out information which concerns seniors and vice versa with juniors. Obtaining written consent will be ensured as well as means of ensuring confidentiality.

1.6 CONCLUSION

With the transformation of health services, the main focus is now towards Primary Health Care (PHC) implementation, therefore a nursing service strategy for change is required to urgently address fragmentation which is currently in force within Gauteng Province, Soweto clinics being no exception hence this effort to undertake this research from the nursing perspective where all stakeholders (nursing staff and health consumers) of Soweto health clinics will hopefully give their input in nursing service strategy required to implement change within Soweto and how these stakeholders see their role in bringing about this change.

The objective of this research will be achieved by qualitative research. This will be through focus groups interviews. The stakeholders will be represented by focus groups comprising of Nursing Service Managers and Chief Professional Nurses (Seniors), Functional Nurses as well as Health Consumers representatives. This is because these are officially recognised stakeholders within Greater Johannesburg Transitional Metropolitan Council where Soweto is located.

The researcher views change as a living reality that has been forced upon us from the

outside therefore as an organisation we have to respond by developing our abilities to cope with change in order to have a successful organisation in the long run hence this research project which aims to explore and describe reality through the eyes of the stakeholders. As a learning organisation, all input derived from stakeholders could hopefully assist in unlearning old habits and to relearn new habits as all data obtained can be used to develop new ideas in bringing about change for Soweto health clinics as the research data will be made available to management to hopefully start taking informed decisions.

THE RESEARCH DESIGN AND METHOD

CHAPTER TWO

2.1 INTRODUCTION

In this chapter the design and method are elucidated through research objectives, the research strategy, methods of data gathering, data analysis, target population as well as methods to ensure validity and reliability.

2.2 OBJECTIVES

The objectives of this study are:

2.2.1 to explore and describe expectations of the nursing staff concerning the desired nursing service change strategy for health clinics;

2.2.2 to explore and describe the expectations of health consumers regarding a change strategy required for health clinics;

2.2.3 to describe a nursing service strategy for change in health clinics.

2.3 THE RESEARCH DESIGN

The combination of exploratory and descriptive methods will be pursued. This study is qualitative and contextual in nature as it is done in the context of 10 Soweto Municipal clinics.

2.3.1 EXPLORATORY

* The expectations of both nurse-managers and functional nurses in search of a suitable change strategy will be explored.

* The expectations of the health consumers regarding the primary health care approach will be explored. Again this a relatively unknown area to the community.

2.3.2 DESCRIPTIVE

Nurses and the health consumers need to accurately and exactly describe what would be the ideal change strategy (expectations) which will then be implemented as an effective, meaningful and acceptable health delivery system.

2.3.3 CONTEXTUAL

This study will be contextual in nature within the context of 10 Soweto Municipal clinics where the is change required towards health service management for Primary Health Care to be implemented and sustained.

2.3.4 QUALITATIVE

The study will be qualitative as described by Schmidt (in Krefting, 1991:214) who defines qualitative research as the study of the empirical world from the viewpoint of the person under study.

2.4 DATA GATHERING

This will be done through focus groups interviews, using semi-structured interviews. The open-ended types of questions will allow free expression of ideas by the participants.

2.4.1 THE FOCUS GROUP INTERVIEW

According to Krueger (1988) this means interviewing a group of selected people instead of one individual at a time in order to seek a more diversified array of responses and to afford a more extended basis for suggesting interpretations, grounded in experience, of experimented data on the effects of that situation It is also a carefully planned discussion designed to obtain perceptions on a defined area of interest in permissive, non-threatening environment.

For this study, different focus groups of different nurses' categories and community members will be utilised for development of an acceptable change strategy. This is fully described in 2.6.

2.4.1.1 Population / Sampling

For clarity purposes, the hierachy of the nursing section or fraternity will be illustrated below, in order to capture the idea of which nurses will be part of the focus groups interviews.

2.4.1.2 The organogram of Soweto primary health clinics.

(10 Soweto clinics - same organogram in each clinic)

Figure 2.1

NURSING STAFF IN ACCORDANCE WITH AN ORGANOGRAM

1 Senior Nursing Service Manager	
2 Nursing Service Managers [1 Per area]	
AREA 1	AREA 2
Clinic A	Clinic G
Clinic B	Clinic H
Clinic C	Clinic I
Clinic D	Clinic J
Clinic E	Clinic K
Clinic F	Clinic L
6-7 Senior community health nurses per clinic	
6-7 Community health nurses per clinic	
2-3 Nursing auxiliaries per clinic	

2.4.1.3 Services rendered for health consumers

As a preventive and promotive health service, Soweto Municipal clinics are patronised by the clients who come for these services per clinic.

2.4.1.4 Well-baby clinic

* health education
* consultations
* weighing
* immunizations
* nutrition assistance

* home visiting for: social welfare cases
  : tracing of defaulters
  : child abuse cases
  : counselling
  : referrals to relevant resources

2.4.1.5 Tuberculosis, HIV and Rheumatic heart clinics

* health education
* consultations
* investigation through : X-rays
  : sputa
  : heaf tests
* domicilliary treatments : at home
  :at clinic
  : at schools
  : at work
* nutrition assistance
* home visits to follow-up: contacts
  : defaulters
* counselling

2.4.1.6 Family planning and sexually transmitted diseases and HIV clinics

* health education
* consultations
* contraceptives : injections
  : pills
  : intra-uterine devices etc.
  : sterilizations
* home visits to trace : defaulters
  : HIV contacts
  : STD contacts
* counselling
* referrals to appropriate resources.

2.4.2 TARGET POPULATION

An accessible population will be participants comprising of the following:

* Nursing service managers
* Functional nurses
* Health consumers who patronise the clinics.

Due to the small number of nursing service managers, they will be interviewed together with all ten chief professional nurses. If the accessible population is small e.g. nursing service managers, all members of the defined population are included or sought for a study (Burns & Grove, 1993:236).

The functional nurses that is chief professional nurses, senior and community health nurses as well as nursing assistants will be selected to form one focus group for representativity and manageability.

For health consumers, selection will be from all different services offered per clinic throughout Soweto. Care will be taken towards gender inclusivity.

2.4.3 SAMPLING

2.4.3.1 Sampling frame

In order for each person in the accessible population to have an opportunity for selection in the sample, each person in the population must be identified by listing every member of the population (Burns & Grove, 1993:239). In this study all staff members will be listed as per category and clinic; health consumers will also be selected using an attendance register in different clinics attended on the basis that they are regular attenders, for example those that attend daily or weekly.

2.4.3.2 The sampling method

For purposes of representativeness, two methods of sampling will be combined, that is method triangulation. These are probability and non-probability sampling.

2.4.3.2.1 The stratified purposive sampling (probability)

Stratified sampling is used in situations where the researcher knows some of the variables in the population that are critical to achieving representativeness (Burns &

Grove,1993: 240). In this case, the different categories of nurses will be stratified and a desired number per category will be included by purposive sampling or selection. Selection will purposefully target nursing service managers and a reprecentative sample of practional nurses. Stratification ensures that all levels of the identified variables will be adequately represented in the sample. Stratification allows the researcher to use a small sample size and achieve the same degree of representativeness as a large sample (Burns & Grove, 1993:241). The sampling error is therefore decreased, data collection time is reduced and the cost of the study is lower. If a researcher has done this in proportion to the actual size of each stratum then she has achieved repesentativeness on that characteristic to achieve a bias-free selection (Fox, 1986:286).

2.4.3.2.2 Non-probability sampling (purposive)

If it is believed that a population contains elements particularly crucial to the study, then the only way to assure their presence in the sample is to deliberately select them as it may be that they are persons whose backgrounds or experiences are desired. Purposive sampling involves the conscious selection by the researcher of certain respondents to include in the study. This approach is often used in qualitative studied, the qualitative researcher may decide to seek respondents with particular characteristics in order to increase theoretical understanding of some facet of the phenomenon being studied (Burns & Grove, 1993:246).

In this study the phenomenon which seeks to address a desired change strategy will be different categories of nurses and certain health consumers within Soweto Municipal clinics.

2.4.4 RECRUITING AND RETAINING RESPONDENTS

A plan for recruiting should always be acceptable and appreciable to avoid respondent loss once the size has been determined. The approach should be positive and pleasant. On the ground that the researcher will be actively involved in data gathering, analysis and management, the approach needs to be very convincing without coercion. The importance of the study is explained and the researcher makes clear what the respondents will be asked to do and how much time will be involved (Burns & Grove, 1993:253). This is because the actions of the researcher can either influence positively or negatively the decision of the potential respondent. The ability to sell to the respondents the importance of their contribution will be of crucial value as the respondents are the only valuable resource for a study to succeed.

Retaining the respondents can be influenced negatively by circumstances that are beyond control like death, moving or falling sick. It is futile to start taking respondents for granted as word can go round and reach those who are still to participate when their turn comes. It is important to maintain a pleasant climate for the data collection process, which will pay off in the quality of data collected and participant retention (Burns & Grove, 1993:256). For this study respondents will have a personal investment in the study as what will be recommended by them will in actual fact be implemented for their benefit.

2.5 RELIABILITY AND VALIDITY

The adequacy of the research design depends on the quality of the measurement procedures themselves, their validity and reliability as the answer to the question is based on the data collected by these procedures, according to Brink (1993: 35-58).The two concepts central to the collection of data is that the method used must be both valid and reliable. Stated simply, validity refers to whether or not a method measures what it sets out to measure e.g. in this study, is a strategy for change really a change strategy? Reliability also refers to the issue of whether or not a method of measurement works consistently in producing similar results in similar situations. In this study reliabilty of the instrument, that is focus group interview, should yield to the same results as groups are homogenous, that is all are affected by the same management style as well as the community members who are served by the same nurses in the same area of Soweto.

2.5.1 THREATS TO RELIABILITY

As this was a qualitative study there were threats that could be envisaged. (Woods & Catanzaro, 1988: 136). Threats to reliability included:

2.5.1.1 The researcher's position

As the researcher will be well known to the participants, the role of the researcher and her position to those senior or junior to her can cause apprehension. Again the participants may judge the appropriateness of information in relation to their context (Woods & Catanzaro, 1988:136). This may lead to responses which the respondents think may please the researcher.

2.5.1.2 The participants choice

The researcher may only select those who are judged as good respondents therefore

will tend to feel obliged to the researcher which encourages false responses therefore data bias due to sifting of information by the respondents.

2.5.1.3 Group dynamics

The principle of group dynamics is applied to guard against dominance by one person which monopolise responses from others if the researcher is not experienced in facilitating equal opportunities to respond and a know-it-all syndrome as respondents are known to the researcher. This happens where there are monopolising respondents or misrepresenting of claims whilst trying to put themselves in the best light to the researcher.

2.5.1.4 Deficient observation

Drifting off of focus by the researcher leads to escape of some responses leading to failure to capture and record what exactly transpired during the interview.

2.5.2 CONTROL MEASURES

The following control measures are applied to ensure reliability of the results:

* The researcher ought to clearly identify the researcher's role in the setting.
* Delineate the context in which data are captured and generated.
* Transcribe recorded interviews verbatim.
* At least two coders perform theoretical coding (Woods & Catanzaro, 1988:136).

2.5.2.1 Data-collection reliability

To ensure the reliability of data-collection, the following will be measures of estimating which are test-re test and equivalence.

* Test-re test

The identical interview may be given to the same individuals at different times under eqivalent conditions, and the results of the two data collections can be compared. Of course, there is a possibility of a permanent genuine change between the two settings.

* Equivalence

We assume a single observer was responsible for all data-collection made, but what if this collection was biased or careless ? You can eliminate this by the possibility of having different observers who have been trained in the same way watch the

respondents simultaneously and independently record the observations (Brink & Wood, 1978:122).

Both these data-collection measures will be realised if audio recording is done for independent researchers to confirm.

2.5.3 THREATS TO VALIDITY

One of the most serious concerns related to qualitative research has been lack of strategies to determine the validity of measurements that led to the development of theory. Qualitative researchers tend to work alone, biases in their work threaten validity and can easily go unnoticed leading to wholistic fallacy (Burns & Grove, 1993:425).

2.5.3.1 Researcher effects

* The researcher may see and report data as function of their position (Woods & Catanzaro, 1988:137). For this study this may be a threat as the researcher can be clouded by the fact that she works there.

* Participants may behave abnormally to put self in best light, lie, omit relevant data or misrepresent their claims leading to data bias. In many cases the researchers presence can alter behavior leading to invalid measures (Burns & Grove, 1993:349).

* Participants may become dependent on researcher for enhancement of status or satisfaction of psychological needs. The researcher in this case represents worker issues for both seniors and juniors at top management meetings. To prove loyalty, participants can develop a dependency problem.

2.5.3.2 The researcher role conflict

As the data collection will be in the form of interview, a role conflict during interaction can crop up as the researcher is a known figure within the Soweto Municipal clinics. If the researcher is collecting data whilst surrounded by familiar professionals with whom she typically interacts professionally and socially, it may sometimes be difficult to completely focus on the study leading to loss of data (Burns & Grove, 1993:428).

2.5.3.3 Level of motivation of the participants

The level of motivation is clearly influenced by a variety of factors such as interviewer

characteristics, contextual factors and the manner in which the questions are phrased.The level of threats posed by the questions will have an important bearing upon the willingness of people to respond to them (Mouton & Marais, 1993:88). This can be the case in this study as the senior and junior staff will be blame shifting trying to justify why the current management style has failed in bringing about job satisfaction. With health consumers it is likely that they respond only to please the researcher.

2.5.4 CONTROL MEASURES

* Recruiting participants who meet purposive sampling and inclusion criteria.
* Substantive and theoretical coding likely to elicit contrived responces.
* Avoid presentation of data in relation to researchers position and relationships (Woods & Catanzaro, 1988:137).
* Checking for researcher effects as the researcher is familiar with participants' behaviour.
* Triangulating

  As a qualitative researcher all measures from different sources need to be compared to determine the validity of the findings.
* Checking the meaning of outliers

  These outliers can be expected as data will be coming from different staff strata and the community. The extreme positions need to be examined, then a decision needs to be made about whether the differences are significant ones. Exceptions need to be identified and examined to provide a way to test the generality of findings (Burns & Grove,1993: 350).

2.6 FOCUS GROUP INTERVIEW

2.6.1 DEFINITION

A focus group interview is qualitative approach to learning about population subgroups with respect to conscious, semi-conscious and unconscious psychological and sociological characteristics and processes (Kingry,Tiedje & Friedman, 1990:124).

For the purpose of this study, the aim will be to seek clues from groups to diverse definitions of the situation, hoping to yield a more diversified array of responses for designing a systematic research and for suggesting interpretations, grounded in nature,

of experienced and experimented data on the effects of ineffective management styles in Soweto Municipal clinics.

With focus group interview, an interview is conducted as an open conversation in which each participant may ask questions, comments and responds to comments. Interaction among the respondents is encouraged to stimulate indepth discussion.

2.6.2 HOW TO CONDUCT A FOCUS GROUP INTERVIEW

Planning about the participants, the environment and questions are a key to successful focus group interviews, therefore certain principles need to be followed with regard to participants, homogeneity, the environment, the moderator,question development, questions and facilitating the session.

2.6.2.1 Participants

According to Basch (1987), focus groups usually include 4 to 12 participants to allow everyone to participate while still eliciting a range of responses.

2.6.2.2 Homogeneity

This is key principle in forming a focus group, determined mostly by the purpose of the study. For this study homogeneity will be ensured by planning focus groups which are category specific, for example. Functional Nurses alone, as well as Chief Professional Nurses alone.

2.6.2.3 The environment

The venue and the environment should be convenient for all participants. Focus groups interviews should be held in a comfortable, non threatening setting. Because sessions last from 1 to 3 hours, the comfort of participants is important. A high quality tape recorder, strategically placed to capture the dialogue between the moderator and participants, is a necessary equipment (Kingry, Tiedje & Friedman, 1990:124).

2.6.2.4 The moderator or facilitator

In focus groups, the moderator and the researcher or facilitator are one and the same. The facilitator's task is to develop questions, facilitate the session, documentation, analysis and interpretation of results (Kingry, Tiedje & Friedman, 1990:124).

2.6.2.5 Question development

Questions are based on the purpose of the study. As this will be a semi structured

interview, open-ended questions will be used, therefore questions to be asked should have been prepared beforehand, but the interviewer is permitted to use his or her discretion to depart from the set questions as well as the order of presentation as the situation demands; phrasing questions so that they are easily understood and put one at a time. Questions likely to embarass participants are avoided. They will be open-ended to enable the respondents to reply as they like and not confined to a single alternative but prepared for free responses which go beyond the factual information. In this manner, questions lead to the area of hidden motivations that lie beyond atittudes, interests, preferences and decisions. Therefore questions should be both introspective (about self) and extrospective (about someone else). It is advisable to start with a general introductory question to allow for participation by all group members, but to trigger specific short answers. This is to warm the group up and give everyone a chance to participate. From general proceed to specific, from non- threatening to more threatening or demanding questions (Kingry,Tiedje & Friedman, 1990:124).The respondents are guarded against rambling away from the essence of the question but not at the sacrifice of courtesy.

2.6.2.6 Questions

The questions to the focus groups participants will be the following:

* What are your expectations concerning the change strategy required for these health clinics and what will be your role in bringing about this envisaged change?

2.6.2.7 Facilitating the session.

Brief the respondents as to the nature and the purpose of the interview and attempt to make them feel at ease. "In the introduction, it is important to make group members feel that their contributions are valued and to give them permission to express themselves without fear that their ideas will be openly criticised. It is useful to explore reasons underlying particular viewpoints" (Kingry, Tiedje & Friedman, 1990:125).This will be important for this study as the researcher is a colleague to the nurse respondents and a professional to the health consumer respondents.

2.7 DATA MANAGEMENT

Prior to commencing, the manner in which responses will be recorded is explained. This is done to obtain the respondents' contact where preferred, anonymity and confidentiality maintained. Transcribing of tapes should be done as soon as possible after the session to prepare for data analysis. The cassette is then labelled, coded

immediately after recording and sent for data analysis and reduction by an independent researcher.

For this study, data collected will be in the form of audio cassettes recorded during focus groups interviews. For corrections, the researcher will listen to tapes whilst reading through transcribed version to complete missing words and to correct omissions.

According to Field & Morse (1985), at least three copies of transcripts are made and keeping the original separate from copies. They are stored separately to guard against loss, damage or any mishap. The copies are then sent to transcribers or independent coders who are independent researchers.

2.8 DATA ANALYSIS AND REDUCTION

This process needs to be systematic and verifiable. The process consists of compiling information about essential transcribed information recorded, formulating categories and clusters for analysis through words, phrases and actual quotes that reflect the sentiments of the focus groups (Kingry,Tiedje & Friedman, 1990:125). Qualitative research data analysis is mostly understood as reflected by Kerlinger's method (1986: 477-481) for content analysis in the focus group interview. It constitutes the following steps:

* definition and categorising of the universe.
* identification of units of analysis
* coding of data
* quantification of data.

2.8.1 DEVELOPING CATEGORIES

For this purpose, the universal categories will be identified as well as subcategories.

2.8.2 UNITS OF ANALYSIS

For this research, it would be useful to analyze by word, phrases or sentences as somebody's subjective response is analyzed, not statistics. The units of analysis will refer to the expected change strategy for Soweto clinics.

2.8.3 CODING OF DATA

A rational or illustration will be developed to guide the coding of data for purposes of guiding the external coder. The main categories are based on the questions asked in the interview, related to expectations.

2.8.4 QUANTIFICATION OF DATA

Themes are identified and grouped together. When groups of significant and frequent themes appear, they are counted and quantified, grouped into major universal categories.

Significance of responses comes about when more than half of respondents responded the same. Most significant means all responded the same. A theme will thereafter emerge.

2.9 ETHICAL CONSIDERATIONS

It is important to observe ethical obligations of the profession when human beings are to be engaged in a research project to protect their rights.

2.9.1 PERMISSION TO CONDUCT RESEARCH

For purposes of informing those in authority, a letter requesting permission to conduct research within the clinics will be written.It will outline the purpose of the research, categories of nurses and health consumers needed as well as the duration of each focus group interview.

2.9.2 INFORMED CONSENT

All participants will be given a consent form which also outlines the purpose of the study, which categories will be needed as participants, the duration per focus group interview etc., so that each participant has a chance of understanding why he/she has to participate. Coercion or force is ruled out but it is hoped that explaining clearly the purpose of the study and its contribution to the nursing care, can trigger the willingness to participate by choice before signing the consent form (see annexure 1 and 2).

2.10 CONCLUSION

In this chapter an exploratory, descriptive, contextual and qualitative research design was selected for purposes of exploring the expectations of the nursing staff and health consumers in a research setting concerning the nursing service change strategy required for Soweto health clinics as well as a description of a nursing service strategy for change in health clinics.

Data gathering is done by means of focus groups interviews targeting the senior nursing staff, the functional nurses and health consumers. This inductive approach should ensure a trustworthy conceptual framework for the change strategy by focussing on participants views on a change strategy required. The results of the focus groups will be used for the compilation of a provisional framework for the change strategy, followed by the literature control after which the final change strategy will be conceptualised. Reliability and validity is ensured by a combination of principles described by Woods and Catanzaro (1988: 136). In the next chapter, data analysis and discussion of research results will follow.

THE REALIZATION OF THE METHOD : DATA ANALYSIS , RESEARCH RESULTS AND DISCUSSION OF RESULTS.

CHAPTER 3

3.1 INTRODUCTION

In this chapter detailed description will be given of the sample realization, data collection, data management, data analysis, results and discussion of results.

3.2 METHOD AND SAMPLE REALIZATION

The semi-structured interview was the method used, through three (3) different focus groups interviews of the following groupings:

* the senior nurses (Nurse Managers)
* the functional nurses
* the health consumers.

The semi-structured interview assisted the researcher in seeking to understand how the respondents organise ideas on a particular topic and to also identify attitudes (Burns & Grove, 1993:365).

3.2.1 CIRCUMSTANCES LEADING TO DATA COLLECTION

The independent researcher or facilitator was sought by the researcher to facilitate during the focus groups interview sessions. This was done to guard against any bias by the researcher who is also a colleague to nurse respondents and viewed as an authoritative figure by the health consumers. The facilitator was chosen by the researcher on the strength that she also has a Master Degree in Social Work, also interviewing and counselling are her areas of specialisation within Soweto Council.

Initially, an attempt has been made by the research to purposefully include nurse respondents from all ten (10) Soweto Municipal clinics as well as health consumers

who regularly attend in all different clinics. The initial plan was to have a maximum number of ten respondents per focus group interview.

Unfortunately, just at the week scheduled for data collection sessions, a strike by Municipal employees of the whole Gauteng Province commenced on 26 September 1995 and it lasted for three (3) weeks. This negatively affected all normal routines. There was a lot of intimidation to those who perform essential services, obviously the clinics were no exception.

As a result of the strike, some respondents could no longer be available as clinics were operating on skeleton staff. Instead of 10 per focus group, the breakdown therefore changed to :

* Group 1:6 participants (1 Nursing Service Manager + 5 Chief Professional Nurses).
* Group 2:6 participants (2 Senior Community Health Nurses, 2 Community Health Nurses and 2 Nursing Assistants).
* Group 3:6 participants (2 Health Consumers - Family Planning, 2 from Well-Baby Clinic, 1 from Geriatrics and 1 from Tuberculosis clinic).

Fortunately all sections of health care were represented by the health consumer respondents.

3.2.1.1 Contact with Participants

As the researcher works for Municipal clinics each prospective participant was personally approached by the researcher. A consent form was voluntarily signed by each respondent after a clear explanation of circumstances surrounding this research. These are :

* purpose of the study
* venue, date and time for focus group interviews
* why each participant was selected
* the method of data collection to be used during the interview (audio taping and why)
* confidentiality and anonymity, the benefits to staff and the community of such research
* consent by those in charge of the organisation for this research to be undertaken

After counter signature by the researcher, a copy of a consent form was given to each participant. All focus groups interviews were scheduled during the on duty time as permitted by those in authority.

3.2.2 VENUES AND ENVIRONMENT SELECTED FOR INTERVIEWING

The three (3) sessions all took place in different venues. This was done after consultation with prospective participants who all took into consideration factors like proximity to all areas, where there would be less disruptions like noise and where there are more offices to accommodate the groups comfortably. Comfortable chairs were selected as well as proximity to the places of convenience for those who might need such.

3.2.3 THE SEMI- STRUCTURED INTERVIEW

All participants arrived on time for the scheduled sessions. Greetings were exchanged amongst participants, the researcher and the facilitator. Refreshments were offered but all preferred to be served on completion of the interview. Interestingly, the nurse participants were at first wary of the presence of the facilitator who they know as the Chief Industrial Relations Officer for the organisation. After her role to these focus groups was explained as that of guarding against bias (since she is from a different department) everybody then welcomed her presence and they all felt at ease.

As for the health consumers, her presence was most welcomed as they viewed her as a person who would hasten responses to their concerns. They immediately informed her that Medical and Nursing personnel had failed to respond positively and timeously to their concerns over the years and that they hoped she would not also refer them to "red tape" delays.

Before commencement of the actual interview, an explanation was again given of the procedure to be followed. Those were :

* duration of each session which was an hour or one and a half hours
* why the presence of the tape recorder, the duration per side of the cassette
* the necessity for the researcher to take field notes which could be available on request.

To determine levels of recording, they each briefly spoke about anything for them to

adjust taped voice. For each person, playback was done which caused a lot of excitement, sparked by listening to themselves speaking. This helped each group to relax even further.

Introduction of the theme of interview after completion of preparation, each participant was to briefly introduce themselves to the group as well as the researcher and the facilitator. The main focus of the questions were : "What are your expectations concerning "Change" that would positively bring about effective health delivery throughout Soweto Municipal clinics.... What is the change strategy required for this to happen and what is your role in the new Health plan?".

During the interview, the facilitator and the researcher listened attentively. The researcher was taking field notes. The facilitator also took part by nodding the head or by encouraging talking, using "mmm..." "oh!". In most cases the respondents would digress but the facilitator would tactfully steer the respondents back to the research theme by repeating the question or by developing questions from their responses.

She would reflect back on their inputs and develop an interesting discussion and everybody would spontaneously participate. At no time did she urge response from participants as each was eager to make an input - interviewing and counselling are her field of practice.

At the end of each session, a playback was done briefly for participants to verify the content. At the end they all requested to be informed about the results which was agreed upon by the researcher.

3.3 DATA MANAGEMENT

Each recorded interview cassette was immediately labelled and sealed in an envelope which was also labelled and coded.

3.3.1 TRANSCRIPTS

The researcher thereafter started with the task of transcribing. Due to the non-availability of transcription machines the researcher had to embark on doing verbatim transcriptions of the three (3) cassettes, utilizing the tape recorder. This was a very tedious method as the researcher had to transcribe word for word, each 90 minute

cassette by hand and pencil.

On completion of transcribing, both the cassettes and the transcripts for each focus group interview were coded, sent to the facilitator who had agreed to be an editor. A note was written for her to verify by playing the cassette and comparing if each word was captured on transcripts contents by the editor, she transcribed all these handwritten transcripts, produced photostat copies- one for the editor; one for the translator who is a researcher ; one for submission to the supervisor, one for safekeeping at home.

The cassettes were also kept safely for referral/auditing purposes, should there arise a need for such.

3.4 DATA ANALYSIS

Data analysis was done by using Kerlinger's (1986:477-481) method of content analysis (see 2.8). This was done by the researcher and an independent researcher (same facilitator). The independent researcher was chosen as she already knows the process through her facilitator's role. She was given a copy of the guidelines to acquaint herself with the data analysis process. The two met to agree on the process as outlined by Kerlinger to reach consensus on the written protocol to be followed as outlined in Annexure C.

An agreement was reached between the researcher and independent researcher that no meetings would take place between the two except for the meeting for both to present and discuss the results of the categorization before submitting same to the supervisor for comments or critique. Thereafter a meeting was arranged after seeing he supervisor for discussion of the evaluation of the results.

3.4.1 METHOD FOR CONTENT ANALYSIS

An exposition of the method for content analysis is given.

3.4.1.1 Identification of the main categories

After reading and re-reading the transcripts, in order to get the sense of the whole, the categories were identified and determined by both the researcher and the independent researcher of course after much debate to reach consensus. These were confirmed by

the researcher's supervisor. These were agreed after consideration was given to all verbal responses to the main question : "What are your expectations about change in Soweto clinics; What are the change strategies required?".

The main categories that emerged from the three (3) focus groups intended transcripts were :

* EXPECTATIONS (E)
* STRATEGIES (S)

3.4.1.2 Identifying sub-categories

Again this necessitated reading through the three transcripts of the different focus groups interviews. This is done to ensure that all aspects of data are objectively considered. Words and phrases which reflected the participants view on expectations and strategies were underlined and interpreted.

Thereafter a sub-category was assigned to each where there is a an underline. (Giorgi, in Omery 1983:52 and Kerlinger, 1986 : 480). The numerical value was assigned to those sub-categories for example : S1, S2, S3, S4 for the strategy sub-category and E1, E2, E3, E4 for the expectations sub-category.

3.4.1.3 Identifying of units of analysis

In identifying the units of analysis, words and themes were also identified and underlined. Words and themes that reflected the same sentiments in each transcript were then interpreted as units of analysis.

3.4.2 VERIFICATION OF CATEGORISATION AND QUANTIFICATION

A meeting was again set between the researcher and the independent researcher. This was done to design a form for quantification purposes and also to discuss their independent efforts on categorisation. A form to indicate the frequency of identified units and themes was agreed upon. It has to indicate vertically all identified categories and sub-categories and the frequency of appearance horizontally. It was also agreed to quantify clusters of units with a similar meaning in order to exclude repetition.

3.5 PRESENTATION AND DISCUSSION OF RESULTS

The results of the three groups will be presented separately. According to the results obtained from the data analysis, two main categories emerged from responses. They are Expectations and Strategies.

3.5.1 EXPECTATIONS

These are then further clarified by their identified sub-categories which will then be substantiated in relation to the identified units or themes. From expectations, sub-categories emerged as:

* Ownership of services
* Structural change
* Attitudes.

For clarity purposes, the responses from all groups of respondents will now be presented in a table form, depicting expectations and strategies as the main categories. Sub-categories are reflected for each category (See Table 3.1).

TABLE 3.1 EXPECTATIONS OF SENIOR NURSES, FUNCTIONAL NURSES AND HEALTH CONSUMERS

3.1a Senior nurses

Ownership of services	Structural changes	Attitudes
Community involvement, community to take charge	Comprehensive health services	Reconstruction of attitudes and behaviours
Down-up consultation for policy review	Integrated 1-stop services	Commitment by top management staff community
Community upliftment and development	Industrial relations	
	Forums for changing mind sets	Need motivated staff
	Policy review	Dedicated staff and management
	Affirmative Action	Productivity and result orientated attitude
	Multidisciplinary management	Respect of diverse cultures and beliefs.
	Primary health care approach to supersede emphasis on curative aspect only	
	Implement national health insurance	

Table 3.1b Functional nurses

Ownership of services	Structural changes	Attitudes
Community involvement	Integration of fragmented services	Attitude change by staff and management
People driven primary health care	1-stop health service	Respect of communities diverse cultures and beliefs
Inclusive policy formulation	Primary health services to fall under Local Government	Non-responsive attitude not helpful
Right to health (Bill of Rights)		
Community development		Need dedicated and motivated management

Table 3.1c Health consumers

Ownership of services	Structural changes	Attitudes
Strengthen community links	Reconstruction of services in disadvantaged areas	Attitudes reconstruction
Community upliftment	1-stop health care to be accessible, equitable and affordable	Need committed health staff
Policy review to enhance people driven concept	Establish comprehensive services by linking all relevant departments together	Need more dedication from Government
	Establish health matters forums for multi-disciplinary management	

TABLE 3.2 RECOMMENDED STRATEGIES OF SENIOR NURSE, FUNCTIONAL NURSES AND HEALTH CONSUMERS.

Table 3.2a Senior nurses

Co-participation	Community and staff empowerment	Ideal Change Programme
Co-partnership with all stakeholders	Redistribution of skills	Equal employment opportunities for target groups
Co-determination	Informal education for the community	Popularise Bill of Rights
Consultation	Improve communication	Trust building for reconciliation
Resource sharing e.g with First Aiders, Traditional Healers	Customer friendly services	Staff security against criminals
RDP to be people driven	Meaningful health care	
Change management (participative style)	Employee advancement Affirmative Action Proper selection and recruitment processes	

Table 3.2b Functional nurses

Co-participation	Community and staff empowerment	Ideal Change Programme
Participative management	Develop available skills and redistribute them	More resources for training
Partnership with all stakeholders	Life skills training	Inclusive management through Trade Union participation
Co-determination by situational analysis	Health committee for staff and community to find each other	Information on the Bill of Rights
Consultation	Communicate new health plan	Improve communication network
People driven RDP	Improve communication strategies	Build trust for reconciliation
Change management which is participative in style		

Table 3.2c Health consumers

Co-participation	Community and staff empowerment	Ideal Change Programme
Work through elected Councillors	Community based RDP projects	Minimise staff shortage
Multi-disciplinary health committees	Develop available skills and resources	Staff availability 24 hours a day
People driven RDP	Improve communication systems	Reduce frequency of strikes
Consultation	Inclusion at Policy making level	Link all relevant operations, e.g. health, police and social workers
Co-determination	Accessible health ministers	

The responses will now be illustrated from all focus groups, with applicable verbalism quotations to reflect what emerged as expectations and strategies.

3.5.1.1 Expectations

a) Senior nurses on ownership of health services

"... and as the community will be developed or empowered, then it means that the community has to know that the health services belong to them, they are supposed to take charge of the very health services."

"But now with the present Government, there is a clear vision that we are going to work hand in hand with the community, and having quoted RDP as people driven, people say to themselves we are no longer going to be on the recipient side, we are going to receive what we have contributed..."

b) Functional nurses on ownership of services

"We still plan for the community and send out those ready packages to them which are obviously not effective, so we should start now to invite the community, to involve the community in planning, decision-making, implementing ..., people are not aware of the role they are supposed to play, to me they are an important stakeholder..."

"But it is amazing because in our clinics each room has these colourful charts about community involvement, community development, equity and so on but the community is still left out from influencing the policy formulation - this would make them feel that they have a say in health matters, then they would take health matters seriously because ownership goes a long way in sustenance..."

c) Health consumers on ownership of health services

"Yes, but now there is a thing called RDP, which should be people driven, meaning we must be contributing to planning, unlike before where plans were imposed."

"We have even identified sites where new clinics should be built, we have health authorities which have accepted our plans, to me they are slowly starting to realize that we are also important stakeholders ..."

"They must even train members of the community as first aiders in different blocks, so that people do not have to go to clinics or hospitals for minor problems, that should show you how much we are prepared to be part of this new health system."

3.5.1.2 Structural change

All groups stressed in no uncertain terms the need for authorities to embark on structural change if the expected changes are to be visible.

a) Seniors

"If there is commitment from the powers that be to effect changes, a strong commitment to transformation should be accompanied by structural changes, therefore our health department structure has got to change first ..."

"We need a comprehensive health service, where one can apply a one-stop service, that a client who enters the clinic will get the services under one roof."

"... it is the community who requests that services be integrated because all along patients are being referred to different services, now we should deliver comprehensive services under one body."

b) Functional nurses

"As we have said, concerning policy, there has to be reviewing or restructuring of the new ones into new policies including affirmative action and gender practices."

"We need to integrate our badly fragmented services for the community to buy into this vision of all inclusive; as it is, people are frustrated as they come to clinics only to be sent from pillar to post before they can eventually have their health problems solved."

"This integration must start from the top not from down - up, for it to be accepted. Changing from top structures will convince everybody that the time to implement change has come."

c) Health consumers on structural change

"We want to see the services that are comparable or which are the same as those of Whites because our services are so poor - to such an extent that even medicines are no longer available in clinic dispensaries."

"We have a problem of fragmented services. You find that there are clinics which cater solely for immunizations and family planning and there are those which only cater for ailments. The problem is that should you bring your child for immunizations and it is discovered that the child is sick, you will then be referred to a far away clinic for curative services which means that you must now pay another taxi fare --- so, all we are asking for is a one-stop health centre where all types of services will be offered on the same premises.

"The Government also must allow community delegations for health problems to be presented "up there". The problem with sending health personnel delegations is that messages can reach there distorted already and the urgency will not be felt. Therefore the Provincial Health Minister, Mr Masondo and National Health Minister Zuma must both come to meet us, the community, to get it from the horses' mouths ..."

3.5.1.3 Attitudes

All different focus groups identified the change of attitudes as the pillar for the expected change to effectively filter throughout the whole spectrum - that is the community, the health personnel and at Government level.

a) Seniors

"Things do not change but people within the organisation. All of us need to transform our mind sets, attitudes and the unwritten rules which we have adhered to so much. You can have the nicest policies about leadership, practices and so on, but if there is no attitude change, there will be no visible organisational transformation ..."

"Commitment, motivation and dedication can perform miracles for us. Attitudes .... this is the most important.

We have the attitudes of staff members to change, otherwise we cannot reach out to implement RDP unless those attitudes have changed. They should be dedicated to their work, committed to the community ..."

"Motivation of the staff, the staff have to be motivated towards being dedicated and committed towards patients, the community out there and the very community stakeholders have to be motivated too because you cannot go and motivate subordinates unless you are motivated yourselves, it has got to be intrinsic type of motivation, from inward."

b) Functional nurses

"Respecting the community, because even if the management stakeholder can be exemplary, if people do not respect the community, it will all be useless to change.

"We have a responsibility for eradicating fear of health superiors by the community. I am saying this because an attitude of dominance whilst talking about change can be very detrimental. Trust building will take care of community fears then we can have meaningful input from those important stakeholders."

"We also need to change this attitude as nurses, of treating the community as our subordinates. You know, every nurse is talking about Bill of Rights. As nurses we will go on strike because we have our rights .... but we do not even want to know

how much our rights limit the rights of other people ... so I think attitude change must go together with respect for other people, whether it is respect for culture, beliefs or so but let us now adopt a productivity attitude as well as results oriented approach.

c) Health consumers

"We think you health people have this uncaring attitude whilst you are supposed to be the most caring of all professions. The case of the elderly people in these fragmented services is so pathetic. They even do not understand this fragmentation, to them any clinic is as good as the other. They are then tossed from pillar to post to relevant services which worsens their conditions. To show that you care, give us the one-stop service which will be ideal."

"Also we no longer have trust in them. They go on strike all the time ... so many lives have been lost during strikes, how are we then supposed to trust you? To me it shows that you treat us like nothing, you impose all the time with these strikes .... We are not saying you must not fight for your rights but can you try all available means of settling your problems first before going on strike?"

3.5.2 Strategies

Under this category, all the responses or inferences necessitated that three other subcategories be identified. These are co-participative strategy, community and staff empowerment as well as ideal programme of change.

3.5.2.1 Co-participation

It emerged from all focus groups that co-participation, co-determination and consultation and communication are the key to effective change in health related matters. This is participative style of management.

a) Senior nurses

"The ... looking at RDP, it is people driven and as it is people drive, we are looking at the community to take the lead ..."

"An example is that of the RDP, people now of late are no longer back seaters ... they have surfaced and have joined hands with service providers in whatever is of benefit to their health. It is for this reason that we are practising what we would regard as co-partnership in that we work with the community, especially community

representatives like the Civics ..."

"With our new Chief Executive Officer I can see he is applying strategic management as he told us when he appointed his strategic team "I do not want to call them my deputies, I want to call them my co-partners. Perhaps in this manner of co-partnership there will be some improvement.

b) Functional nurses

"One other wrong thing is to determine the standard of the agency without the efforts of the citizens. You have got to sit down with them, consult them, identify from them what they would like health to do for the citizens, as to how they can improve the health care delivery. Through brain storming you will be able to get ideas from them and together you can build or determine the standard that you would like to reach."

"I see major problems with implementation of integration of services as lack of communication ... Nobody is saying anything to us, we are just operating in limbo so we would like to have more communication and more information on that."

"You can have all these forums but if the actual people that need to be there are never informed about the changes that are introduced, they are not going to be successful ... even the National Health Policy should be communicated to different people who should be encouraged to read about it."

c) Health consumers

"Another request is that the community needs to be informed whenever the strikes are to be embarked upon ... it is so frustrating to us to come to the clinic and there is no service because workers are on strike. Why can't we be informed in time - because these strikes are planned - to allow us to make alternatives whilst there is still time."

"I now think the health personnel, doctors and nurses are the ones who suppress our input Not long ago they started telling us about primary health care which will be at our doorstep ... I must tell you that we know very little about primary health care - no one is prepared to give us more information..."

"Do you know that this place (clinic) was once a one-stop service that you young

ones are calling for? Yes, it had all kinds of services but as you know during those days, we were never consulted. Suddenly it changed to this useless setting without any explanation why to us the community."

3.5.2.2 Community and staff empowerment

For change to be felt as effective, there needs to be development of human resources, for both the staff and the community. Even the existing physical resources needs to be revamped to reflect the dictates for change. This was captured through the following responses :

a) Senior nurses

"The community has to be empowered with life skills and as the community will be developed or empowered, then it means that the community has to know that the services belong to them ..."

"... it is important that lay community health workers should be trained because community nursing is about that, so the community nurses must also be trained in as far as lay health workers are concerned so that people are able to look after their communities, so the community knows that they report the problems via these lay health workers to the community health nurses."

"And again, in order to bring change, people need to be orientated, as Mrs X has said. People need to know the advantages of comprehensive health services ... . It is through constant meetings with staff and community whereby effective communication, transparency and openness is displayed, so we should never get tired and say that the integration exercise has failed."

Our staff also needs to be trained; There is still a lot of staff who needs to be geared for change which we are all awaiting.

b) Functional nurses

"Constant, intensive and effective health education will update the community as to where we are at the moment. In order for this change to be initiated, we need their input, we need their co-operation and participation. I mean community participation, it has to be fully fledged and fully implemented."

"Community empowerment to me means we do not have to carry ourselves as superior people within the community, that we integrate with them, hold discussion

groups with the people, make ourselves available for questions and answers."

"We have a problem of training attached to ourselves as far as empowering the community. We have no skills in tackling some of the problems that are presented by the community and if you are not yourself knowledgeable, how are you going to empower others?

"I think it is important to be included during policy formulation when it comes to empowerment because at the end of the day you will be the one to implement those policies or agreements. If you are not involved, you will sort of distance yourself from those policies."

c) Health consumers

"At one time we were called into a meeting by the health staff and were told that they will be introducing a new type of lay health worker who will be selected from the community, will be trained to get certificates in order to relieve staff shortages. We do not know now where the blockage is, we need these lay health workers."

"I am emphasizing that all those who are in authority should find time to come and consult personally with the community so that the Government and RDP can be really people driven."

"To restore dignity to people living in hostels, they are also human beings but because of these no go areas which have become acceptable, these hostel residents are no longer accessible to health personnel, diseases will never be cured or detected there. The filth there is unbearable. Teach them personal and environmental hygiene and gardening."

"Train First Aiders in the community ... do not forget that traditional healers are our pride, allow them to make input in health matters."

3.5.2.3 Ideal programme of change

Quite a number of programmes were proposed by the focus groups to make meaningful change. The proposals by senior nurses, functional nurses and health consumers are discussed.

a) Seniors

Implement a National Health Insurance. Looking again at the National Health Plan where our Minister of Health Nkosazana Zuma recently established a health insurance, it is going to make the primary health care flourish and be fully fledged ... it should be implemented and not just lip service."

"We have got to have a clear mission for success of this transformation process: There has to be a clear vision as to where we are going. We must have clear goals."

"We are also looking at formulation of industrial relations committees whereby staff members are constantly made aware of what is expected of them. ... I am thinking of the strike that we are having at the present moment, we have essential services ... they should be educated as to what is expected of them as members of essential services."

"Implementation of affirmative action will address issues of representation in our workforce. There has to be proper selection and recruitment of staff ... There has to be reviewed or restructuring of policies into new policies which include affirmative action and gender practices."
"We need to have workshops on change management ... I was saying, can we also think about multidisciplinary management."

b) Functional nurses

"Health Matters Forums can be established to try and address communication problems. There was a Health Matters Forum where all health stakeholders are involved ... civic people, doctors and nurses."

"There is a process of change management so our management should involve themselves there and possibly do away with some of the bureaucracy which is not serving any purpose, maybe approach a different style of managing, participative probably but they need to explore different types of management."

"One role should be that of facilitators, we should mobilize our communities and participate in community projects and not expect the community to participate when we neglect their projects."

c) Health consumers

"Even this phoning for emergency vehicles is not very helpful. I suggest that even ambulances and fire-fighters must always be stationed in all clinics to save lives."

"They must even train First Aiders in different blocks so that people do not have to go to clinics or hospitals even for minor problems, that can alleviate so much overcrowding currently prevailing in health centres."

Another proposal will be to link all relevant departments together, like health linked to security, social work and education departments all linked to Local Government. In that way health will be meaningful as everything revolves around health."

"Mine would be to re-emphasize a multidisciplinary approach where social workers, teachers police and nurses can work together especially in curbing these horrible levels of child abuse."

3.6 CONCLUSION

In this chapter, the expectations of senior nurses, functional nurses and health consumers regarding the required nursing service change strategy have emerged. All focus groups presented the same expectations being:

* ownership of services through community involvement, community and staff development as well as meaningful and adequate consultation;

* structural changes to address fragmentation and duplication of services by establishing comprehensive health centres known as 1-stop health centres. Change management through multidisciplinary management teams to effectively implement new national policies in order to address the imbalances of the past, were mentioned repeatedly;

* reconstruction of attitudes by all stakeholders within the community emerged as a priority. This according to participants would assist in reconciliation endeavours that the nation is calling for. This would in turn enhance productivity, commitment and respect towards each other.

The strategies which could assist in developing a nursing service change strategy emerged uniformly from all focus groups. The following are the preferred strategies:

* participative management style through co-determination and co-partnership with all stakeholders in information and resource sharing. The R.D.P. projects should be people driven if they are to be meaningful;

* community and staff empowerment through human resource development was strongly proposed. This empowerment is aimed at both staff and the community members;

* The ideal programme of change emerged as equal employment opportunities for all target groups. Improving of communication strategy amongst all stakeholders is of paramount importance so that the long awaited change can be felt. Links to be strengthened in all public and civil service departments for easy access to all community forums.

In the next chapter, the results will be exposed to literature control.

LITERATURE CONTROL: A NURSING SERVICE CHANGE STRATEGY FOR HEALTH CLINICS

CHAPTER 4

4.1 INTRODUCTION

In the previous chapter, the results obtained from collected data were analysed and discussed. In this chapter, the research results will be compared with the relevant literature. The information from the literature will also be compared with findings from the present study to determine similarities and differences; after which the unique aspects of the results of this research will be highlighted.

Literature control in this study is done after data collection as this is a qualitative study. Qualitative researches believe the literature should be reviewed after data collection and analyses so the information in the literature will not influence the researcher's objectivity (Burns & Grove, 1993: 142). This literature control is part of the measures to ensure validity of the change strategy.

4.2 LITERATURE CONTROL

The results in comparison with literature control will be discussed according to the categories derived from results of the focus groups regarding expectations and strategies.

4.2.1 EXPECTATIONS

Comparisons concerning expectations from literature control are now discussed.

4.2.1.1 Ownership of health services

Community based projects emerged as a preferred route as long as the projects were agreed upon with the community elected councillors. "This is seen as an important mechanism for increasing local control and responsibility over their health matters" (African National Congress, 1994:21).

4.2.1.2 Community involvement

All respondents identified this aspect as important during transition. It is further supported by

the following extracts : When the process is managed in a manner that involved people, the content or the substantive aspects of change will not be resisted since those directly affected are making the decisions" (Michael, 1981: 185). Also on the community as stakeholders during the change process, Beckhard Harris (1977: 53-54) support the need for community involvement when they state that experience has shown that organizations and their managements often make erroneous assumptions about the current state of the organization when developing change strategies. "One of the first steps in looking at what parts of the system are most significantly involved... which specific subunits would be primarily affected by the change, the attitudes of those systems and their leaders towards the change. It is a fact more complex issue of planning, diagnosis of the total system and plans for getting "ownership" of the changes on the part of many people ... The changing expectations and demands of the users of the organization's products and services - all require that organizational leaders now begin developing strategies for coping with these demands and managing for organizational survival as well as for growth (Beckhard & Harris, 1977:15)".

Regarding community accountability, Boyle and Braddick (1981:12) refer to a trend of rethinking social accountability. The industry is now compelled by law to recognise, that they have social as well as economic obligations to the community they serve. If this is not adhered to, however, today's complex society finds other ways to apply social pressures and an important challenge, therefore is for top management to find an appropriate formula to resolve these dilemmas.

The concept of accountability is further supported by the African National Congress' Reconstruction and Development - A National Health Plan for South African (1994:21). "This is seen as an important mechanism for increasing local control and responsibility over health matters ... Effective community participation as envisaged in the PHC approach means that democratically elected community structures, integrated with representatives of the different sectors and stakeholders involved in health and community development, have the power to decide on health related issues".

4.2.1.3 Attitudes

Support for identified attitude change by all groups interviewed is supported in different sources. "In order for change to be effective, it is a given fact that change in attitudes is of fundamental importance. An assessment of the readiness of the various subsystems is an analysis of the attitudes of these systems towards change. It must be remembered that if traditions, norms and ways are locked in, the intervention will have to break people away from deeply held attitude of behaviours to ready them to try something else. This certainly requires

some "unfreezing" of attitudes" (Beckhard & Harris, 1977:37). Experience indicates strongly that in any complex change process, there is a critical mass of people, in all subunit - be it management, staff or the community - whose commitment is necessary to provide the energy for a change to occur. "A good principle to keep in mind is that if one can find an activity that loosens up the organisation or unfreezes frozen attitudes, one may be alleviating the process of creating those conditions necessary for incurring a change of attitude, an increase in energy and a greater commitment to change. The result is that less energy will be required than if one were to force the change on those who are resistant to it" (Beckhard & Harris, 1977: 53-54). Change of attitude during transition is seen by Beckhard and Pritchard (1992: 15-16) as a critical entry point in any organization undergoing change. To them change is a learning process and learning is a change process". This process involved : "Unfreezing" oneself from currently held beliefs of attitudes, absorbing new or alternative attitudes and "Refreezing" oneself into the new state". Concurrently, leaders must develop a strategy for unfreezing people and groups from existing attitudes and behaviours. Also according to Bernard (1985) organizational change involves the detection and correction of errors. For change to occur, the organization must "unlearn" previous beliefs and attitudes, be open to new inputs and relearn new assumptions and behaviour. An effective change strategy would be the one that takes account of the organization's memories, values and norms. "The normal "cascade" strategy for implementing change is usually ineffective because memories remain embedded in the way the organization works after the change" (Beckhard & Pritchard, 1992: 15 -16).

Commitment as cited by all respondents, is part of attitude change. This is supported by the following extracts from different sources : "There is a universal condition that wherever there is a change effort, there will be resistance. It may be caused situationally by the need to learn new things in order to destroy the old or familiar ones, or it may result from the individual dynamics of a fear of failing. To overcome such, management's strategy is to get rid of negative energy, to smooth things over by ushering in systems that lead to commitment by all involved with change. This is achieved by creating and stating clear goals, sharing the change strategy, appreciating contributions at all levels and rewarding group progress" (Beckhard & Pritchard, 1992: 74-75).

Change in attitude should have a basis, a purpose and incentives. "In order for employees to become motivated and committed to their work, their experience must justify their effort. They must either find intrinsic pleasure in their work enjoy a monetary benefit for doing it well, or have a sense that their participation in the organization is meaningful - that they are part of a community that needs them " (Niremburg, 1993 :108). The interviewees or

respondents raised some expectations which should trigger attitude change for the better. Some mentioned were training, equal employment opportunities, affirmative action, participative management and established career paths. From literature these are some expectations : "To be more specific about cultural cha nge in an organization, the direction of change is typically toward developing an organizational culture where, according to Michael (1981 : 186) these are :

* Managers exercise their authority more participatively than unilaterally and arbitrarily.
* Co-operative behaviour is more valued than competitive behaviour.
* The growth and development of organizational members is just as important as making the profit or meeting the budget.
* Equal opportunity and fairness for people abounds, in recruitment, promotions and in the organization's reward system.
* Organizational members periodically receive feedback on their performance.
* Organizational members are kept informed especially concerning matters that directly affect their jobs.

4.2.2 STRATEGIES

Strategies are also discussed in comparison with literature control. The three (3) main strategies identified are co-participation, community and staff empowerment and ideal programme of change.

4.2.2.1 Participative management

Communication forms the cornerstone in any organization, the flow of information from top management to other staff members into the community and vice-verse was identified by all groups of respondents.

This strategy is also captured from the following sources : "Since top managers normally manage through a structure, in other words they are not directly doing the job themselves, it is extremely important to influence and communicate with particularly well to his peers but also downwards. Increasingly, it is important to be able to communicate with all forms of stakeholders in the company. This is important as change in the organisation involves re-allocation of power and this is something which can normally only be achieved through exercise of power, and the ability to communicate such" (Boyle & Braddick, 1981:31).

Communication becomes absolute and meaningless if it is not carefully planned and executed well. "It must always be remembered that hierarchical decisions inhibit and dilute innovative

ideas and full communications. Time is a major concern. To limit each person's communication to written messages sent up through a line of bosses and them down the hierarchy again to the intended recipient is a tedious and time consuming procedure unsuited to today's extremely demanding and fast-paced business world. Decisions need to be made instantaneously and independently of succession shoots itself in the foot" (Niremburg, 1993:23). As part of community building everyone is involved in meaningful meeting opportunities which guarantees the employees and community rights to communicate freely and openly. This can include on the job discussions, informational meetings, consultations on training needs and assessment, company related social matters customer relations matters, grievances/fairness issues, governance issues or any member- initiated concerns at open forms" (Niremburg, 1993:131).

4.2.2.2 Consultation, co-determination and co-operation

These issues were strongly emphasized by all respondents as a very useful strategy in bringing about change. Where people, be it employees or community, acknowledge their participation and input in bringing about change through decision making, they tend to influence change positively.

These are extracts in support of co-determination :

* Involve in the planning process those persons who will be affected by the change.
* Allow time for discussion among group members.
* Initiate follow-up to ensure that communication is implemented.
* After a period of time, allow the people affected by change to evaluate change.
* If the change project proves to be a mistake, honestly acknowledge this to all affected and replan together.
* People will change when they know WHY and HOW, and WHEN, they are involved in a process. This leads to empowerment of stakeholders. Empowerment refers to the recognition of power already present in a role and allowing it to be expressed (Porter-O'Grady, 1996: 49) It is a fact that change brings about fear, anxiety, doubt and uncertainty, those in power should take it upon themselves to ease the pain brought about by change by consulting and co-determination. All groups of interviewees reflected that the manner in which change occurs influences the kind and degree of resistance. On the other hand people are more likely to accept change that they perceive as inevitable, if such is communicated to them in an acceptable manner. Other ways of consulting this resistance are cited by Lancaster & Lancaster (1982: 112) as generally accepted techniques by (1) "Paving the way for change as far in advance as possible; (2) be clear about the need for change and kinds of change under consideration; (3) involve those affected by potential change in order to tap their ideas and (4) design training opportunities to provide newly

needed skills, insight and attitudes".

4.2.2.3 Communication

Communication was seen by respondents as process of passing information and understanding from one to another as another prerequisite for the change process. Whilst communicating, the change agents should be keenly aware of the personal and subjective nature of understanding therefore both formal and informal communication channels within the organization should be utilised. "Creating such a communication channel and climate requires that concepts such as trust, respect and empathy be a part of the communication process" (Lancaster & Lancaster, 1982: 112). It is therefore clear that without trust, neither the sender nor receiver will risk the transmission of an honest message. Respect takes into consideration that each person is unique, whether junior or senior. If communication is to be effective, respondents stated that each person must feel accepted and respected whilst undergoing change implications. For empathy the senders should be attentive to both verbal and non-verbal responses so that confusion and misunderstanding are not the order of the day which can end up negatively influencing the change process.

4.2.2.4 Reconstruction of attitudes by all stakeholders

The respondents felt that with the necessary support from all stakeholders, that is, management, staff and community, change can be as smooth as possible. The positive attitudes go a long way towards effective reconstruction. Leaders need to be available all the time for purposes of giving feedback for stakeholders to continuously assess if they show commitment, are motivated and thus increasing productivity level towards implementing change because change support helps groups to continue with their brief with confidence. Supportive comments serve several functions. (1) They inform persons about behaviours which are no target and helpful; (2) create a climate of greater confidence for expressing unpopular ideas and (3) help the silent of the mor fearful members feel that if they speak there will be someone who will recognize and respond to them. Thus being supportive, the leader can facilitate greater member participation.(Sampson & Marthas, 1981:236).

4.2.2.5 Community and staff empowerment

Whilst the new National Health plan as well as the Reconstruction and Development programme indicate that reconstruction should be "people driven", this can only take place effectively if people are empowered with knowledge, skills and insight. Both staff and the community stressed in no uncertain terms, over and over gain their need to be helped to develop. Training and development of all are a core of wholesome health. To develop communities would be to invest as health providers are recruited from the very community.

Developing those within the health fraternity was seen as an even bigger investment if primary health care was to be effectively implemented. It is therefore imperative that a change model requires a continuos production line of nurses to produce advanced nursing. This kind of nurse to which the patient is entitled if his needs as a whole person are to be met. Those in positions of management and education have a responsibility to ensure that continuous learning happens.

For the community, same can be said. To educate the community is to improve their health status. "Literacy is of major importance to health : it enables people to understand their health problems and to find ways of solving them ... In considering education in relation to health, it would seem more sensible and realistic to think much more in terms of communication by all available media or whatever is felt to be appropriate to the culture of a particular society" (Stephen, 1992:13-14). It must therefore always be remembered that planning for people is not most effective in a long run. Communities are most important members of the health team therefore there is a need to empower them. "Clients are the most important members of the health care team. Without them, there would be no reason for the team to exist. And without their active participation, health care goals cannot be fully met. It is therefore the responsibility of other health members to inform clients of the importance, to teach and develop them and to help them take a position of active responsibility in their own behalf" (Fromer, 1983:94).

Whilst the RDP policy clearly suggests that an education and training programme is crucial, it emphasises that education and training should be available to all from cradle to grave. The challenges of RDP can be met through the extensive development of our human resources. "The RDP takes a broad view of what happens in schools or colleges, but in all areas of our society - houses, workplaces, public works programmes, youth programmes and in rural areas... this emphasis and with the emphasis on affirmative action throughout the RDP, we must unlock boundless energies and creativity suppressed by racism and discrimination" (The Reconstruction and Development Programme, a policy framework, 1994: 8-9). The National Health Plan summarizes problems posed by the unacceptable uneven members of personnel throughout South Africa within the health fraternity why and how reconstruction should take place. "These figures reflect a number of prominent problems in human resources development that need to be addressed, some of which are :

* insufficient personnel within the necessary training or skills to manage change in accordance with the PHC approach,
* insufficient or inappropriately trained staff in fields such as environmental health, health

education and promotion, advocacy and management" (African National Congress, 1994:32).

4.2.2.6 Reconstruction of services in disadvantaged areas

As change evolves, so do needs of the communities. Reconstruction and Development is aimed at upliftment of standards for those previously ignored; health is no exception. The analysis of results indicate the following :

* Primary health services to fall under Local Government at present health provision is from different levels of government, including first level (primary)health care. There is now, according to respondents, a need for Primary Health Care to be provided by Local Government which is closer to people, for effective input and feedback purposes of health matters.

These are substantiated by the following extracts : (1) "Health and politics are inseparable because health is as influenced by socio-economic development as by the treatment and prevention of disease... Following the Alma Ata Conference, the importance of community participation at Local Government level was approved by all member countries of the WHO though many problems still remain" (Stephen, 1992: 249-250). (2)" The large city health departments are besetted by tremendous problems resulting from the increase in children and senior citizens which has produced a growing demand for health services. Thus the city health departments must develop extensive health care services for increasing number of economically deprived persons unable to provide these services for themselves"
(Grant, 1987: 266).

4.2.2.7 Ideal programme of change

Bringing together all responses from all groups interviewed, the following emerged as ideal situation in a changing environment:

* This should be a way of providing a framework within which health services could be looked into when determination health problems and identifying health needs. Problems arose from one badly fragmented services currently prevalent in this country. For health care to be continuos and co-ordinated, PHC needs to be allocated to Local Government for its accessibility and availability. This would only happen in a comprehensive setting which is an acceptable form of health delivery. " To be comprehensive as the term implies, they should provide health care for all the people in the community who need it whenever they need it - in hospitals, clinics, outpatient departments, extended care facilities, in schools, in

places of work or in the home" (Tinkham & Voorhies, 1982: 221).

4.2.2.8 Multi - disciplinary approach

The present fragmentation resulted in excessive specialization which led to impersonalised health care which is harzadous and contrary to wholesome health giving. Each health division like medical, nursing or environmental, ended up in increased specialization of health workers, with each concentrating on one aspect of health in the individual or community. To emphasize this, these are the following extracts : 'Services will be provided by multidisciplinary teams. Many health professionals and consumers will be involved as members of the health team...Health care will be organised in such a way that entrance into it and orderly progression within it will be facilitated" (Tinkham & Voorhies, 1982: 270).

Health provision is not a prerogative of the medical profession. Medical students need to train with and work alongside other members of the health care team : nurses, social workers, dieticians, physiotherapists, occupational therapists, primary health care workers and so on... Health is not a prerogative of a medical profession - clean water, adequate food, proper shelter appropriate education, good sanitation are all of tremendous importance" (Ross, 1994: 14-15). This can be achieved by creating awareness among the different sectors about the importance attached to intersectoral collaboration or the importance of their influence on health care and health improvements. This on the other hand, needs a lot of joint planning. Health should be expanded to include socio-economic environment, it is also important to identify the precise nature of this environment and the sectors that have resources to improve the situation. "The health sector could set up new health service units, but problems of poor nutrition also need to be addressed by the agricultural sector, problems of water and sanitation by water resources and problems of health education by departments of education and community development" (Streefland & Chabot, 1990:16).

4.2.2 9 Structural change

Input from all groups of respondents emphasized a need for structural change to enhance changing from the old to the new practises, if change is to be visible. The input included amongst others :

* policy review to accommodate the WHO declaration for the attainment of health for all the people of the world by the year 2000, a level of health that will permit them to lead a socially and economically productive life (Lancet : 1978).

* equity of distribution of health resources and resource allocation. "To return to the WHO

indicators of health for all, another health policy indicator suggested is the degree of equity of distribution of health expenditure. South Africa has a lower percentage of expenditure on health than any of the 19 low and middle income countries listed in the world development report of 1981. Only 2% was spent on preventive medicine and according to a policy decision of the Department of Health and Welfare of South Africa, this was to have increased by 15% by year 2000, if Primary Health Care is to be successfully implemented" (Ross, 1984:5).

Policy review to influence structural change should be influenced by the National Health System (NHS). "The whole NHS must be driven by the Primary Health Care approach. This emphasizes community participation and empowerment, intersectoral collaboration and cost effective care as well as integration of preventive, promotive, curative and rehabilitative services" (ANC, 1994:45).

4.2.2.10 Change management

Whilst change is brought about by a multitude of factors making a change process inevitable, managers in organizations undergoing change should consider the impact of change on the quality of life of all citizens affected, be able to jointly develop new way to help employees and the society cope with change and its implications. This will ensure that change is meaningful, purposeful and bearable. Planned change therefore means that all steps leading to meaningful change should be a process that is planned, implemented, controlled and evaluated.

All respondents cited a change management concept as part of a successful change process. To this effect, leadership styles of participative management were emphasized. "The process of change is complex as a result of the interaction among the myriad of influencing forces. In general, planned change is a process by which new ideas are created or developed, communicated to all participants and adopted" (Lancaster & Lancaster, 1992 : 7).

According to Tinkham & Voorhies, (1982: 221) the implementation of change carries with it grave responsibility and one of the most strategic parts of the whole process. Therefore, its management should strive for flawlessness. Change can be threatening and anxiety- producing as well as exciting and rewarding. It must always be kept in mind that those who are most affected by change are more willing to change when they see the ultimate goal as desirable and consistent with their own value systems and interest.

Most of the issues raised as positive strategies to successful change management were:

* participative management

* consultative, co-operation and co-determination
* effective communication
* transparency
* constant evaluation of a change process.

Change management can then be summarised as quality and value within the organisation. As role players are different, their different understanding of quality and value is captures as follows :

* For employees - a quality and valued company is the one which acknowledges their contribution and their intelligence, meaning any job should offer fulfilment or job satisfaction.

* For health consumers - value and quality has a combination of features. According to Chinn (1991) these features are reliability, for value for money, service delivery that meets or exceeds their expectations.

* For employer - quality refers to measurable productivity, visible improvement in service delivery, time management, cost effectiveness at the end of the day.

Change management therefore refers to total plan of strategy which seeks to bring about improvements within an organisation, not as a once- off procedure embarked upon but as a continuos process which is inclusive. A process of change management for this research includes a structured means of plan, assessment, implementation, control and evaluation. This will enable those in control as well as employees to measure productivity as to how well they have fulfilled their customer service delivery objectives.

4.3 SIMILARITIES

The similarities between focus groups results and literature control are now discussed.

4.3.1 SIMILARITIES FROM EXPECTATIONS

The expectations have been confirmed through literature versus the verbalised responses by the respondents. These are ownership of services and structural change.

4.3.1.1 On ownership of services

It is confirmed by reviewed literature that for services to be regarded as useful by the community, the following principles need to be upheld, if change is to be meaningful:

* community involvement through communication, co-determination, consultation and staff development;

* development programmes to cope up with change.

This approach will help bring about Total Quality Management as proposed by the National Health Service Management Executive (1993b) which states that: (In an organisation when Total Quality Management strategy is utilised);

* everything is driven by customers needs;
* a highly trained and motivated workforce continually seeks better ways of working;
* change is based on measured fact and monitored in a continuos cycle of improvement;
* errors are relentlessly traced and eliminated.

4.3.1.2 On structural change

For change to be felt as moving from the old to the "new" era, structural change has been confirmed by literature as a necessity within any changing and learning organization. New structures will enable re-organization and development of resources to where they are mostly needed. Change structure will also enable new definitions of job activities for impact, new responsibilities and new accountable bodies.

Structures that need to change concern effective change at:

* policy making level, in the health system it means adhere to National Health Service requisites
* operational level, meaning a shift towards Primary Health Care instead of fragmented services. This shift will influence 1-stop health services in order to provide comprehensive health care through multi-disciplinary teams approach. Change in human resource management will help in review to implement the following principles:

* Affirmative Action
* Equal employment opportunities
* New Labour Relations Act no. 66 of 1995

* New National Health Insurance Plan
* New Constitution.

The National Health Service objective is to reform and strengthen healthy care delivery system. It is stated in (DHA, 1989) as "Being a service that puts patients first".

* the idea of working through a comprehensive 1-stop health centre was strongly suggested by respondents, not only referring to health personnel but to other relevant disciplines like Police, Social Workers and Non-governmental organisations to be able to address all stresses of life which have a bearing to health. Reviewed literature supports this viewpoint in an attempt to inform policy review where a need is felt

* the idea of reducing the frequency of strikes which was upheld by health consumers is strongly supported in the new Labour Relations Act which compels employers and employees to resolve their conflicts instead of resorting again and again to strikes and lockouts

* the concept of people-driven projects as raised by respondents is well captured in the RDP framework

* staff and health consumers captured very explicitly the need to reconstruct attitudes by all stakeholders if change in health services is to be felt and noticed. Attitude should be reformed to cater for cultural diversity to bring about service delivery oriented personnel, to effectively deal with stresses and strains between employer and employees, also between senior staff to enable reconciliation and trust in the workplace. The literature supports this notion in no uncertain terms

* understanding what is behind change motivate most of the stakeholders in helping bringing about the desired change. Literature confirms this principle, still emphasizing the need for communication, good interpersonal skills and transparency.

4.3.2 SIMILARITIES ON STRATEGIES

The emphasis towards change management as a strategy to bring about change and sustain it has been confirmed through literature review which supports change management as it leads not only to crafting a vision but to the implementation process itself.

With change management, the respondents' responses clearly states that change should be brought about through an "all inclusive" change strategy. This inclusivity refers to the employer, staff and the health consumers. This was verbalised by calling for the following management principles:

* involvement of all stakeholders (participative management style)
* consultation, co-determination and co-operation
* effective human resource development
* resource allocation and sharing
* effective communication strategy from employer to employees and to health consumers.

This strategy is supported by Goodman (1982) who states that change succeeds only when an entire organization participate in the effort. He divides an organization into three broad role - players namely

* change strategists (management)
* change implementors (staff)
* change recipients (society).

The change strategists are responsible for the early work of identifying the need for change, creating a vision of the desired outcome and who should sponsor and defend change.

Change implementors develop the implementation plan and manage the day to day process of change. They respond to demands from above whilst attempting to co-operate with those below.

Change recipients should inform and support the change process through constant evaluation through a clear feedback channel. The mission statement for the purpose values and beliefs of the organisation should always be clearly spelt out for the sake of security to all stakeholders.

4.3.3 DIFFERENCES FROM LITERATURE

What did not come out of the input by respondents was identification of pitfalls associated with bringing about change. Literature review steered the researcher to capture some of the dangers associated with change. The dangers associated with change are the following, according to Jick (1993: 193).

* The echo of well intentioned advice fades as the practical hard work of change begins.

* Both the press and academic literature tend to depict organizational change as a step-by-step process whilst the reality is that different forces associated with change should in for the planners to continuously react to barriers and frustrations brought about by human errors.

* There will always be internal and external forces which are uncontrollable and which should never be underestimated but tackled as they emerge. Those who make change happen must also grapple with unexpected forces both internally and outside the organization. No matter how carefully these implementors prepare for change, and no matter how realistic and committed they are, there will always be factors outside of their control which may have profound impact on the success of the change process.

* Whilst most literature reviewed supported the respondents that change is a process which is initiated through assessment and planning, Literature states that the quality transformation process really begins with communication. This is done to inform the formulation of the theory about change for quality-consciousness.

* Conflict handling is not yet viewed as collective employer/employee responsibility. It is still regarded as top managements' responsibility whenever disputes arise. Whilst Unions are there, both management and junior staff are still reactive instead of being proactive in their approach. Management still views itself as a power base as far as planning is concerned and the rest of the staff feel left out, leading to loss of precious time in arguments and counter strategies instead of working as a unit. Reviewed literature supported all inclusive approach towards planning for change.

* There was, from health consumer respondents, an inclination to confuse roles between expected outcomes based on their differing abilities. Input was made based mostly on their experience, perception and values. Literature clearly states that there will always be initial reactions to change. The change agents and initiators will always be in conflict if proper motivations for change are imposed. It should always be remembered that the "comfort zone" gives a feeling of security.

First come up with a team to look at possible hurdles to the change at an early stage (only those who are supportive of change of course). The team will consider "change acceptance factors", that is are stakeholders willing to accept and participate in the change process.

These are traps that could sabotage the process if the initiators are insensitive to internal and external pressures as presented by Candlin (1992: 445-451):

* are opinions about change clear and non conflicting?
* is communication from management adequate and convincing?

The following are differences between health consumers and professional staff (see figure 4.1)

Figure 4.1 Differences between professional staff and health consumers

Health Consumers	**Nurses or Health Staff**
knowledge	skill
experience	knowledge
perception	motivation
trust	empathy

This suggests that input from the different role players should compliment each other to end up with an ideal situation which satisfies and reciprocates different needs. Emphasis is therefore still placed on consultation and co-determination which accompanies a participative management style. Figure 4.2 reflicts factors influencis mutual goal setting.

Figure 4.2 Factors influencing mutual goal setting.

Patients		**Nurses**
values		values
perception		motivation
experience		knowledge
expectation	mutual goal setting	experience
knowledge		skill
resources		resources
trust		empathy

The implication is, for example that a suggestion may come from Traditional Healers on how to deal with certain ailments. The nurses or health professionals, should not dismiss such a idea but influence it based on their knowledge of drawn from biological, behavioural and scientific principles. In this manner, all stakeholders have contributed to problem- solving.

Whilst all respondents supported the implementation of Primary Health Care based on emphasis to free health services for all as being implemented Nationally in a staggered approach for those who are disadvantaged, Mason (1991: 7-13) suggests that the directly managed health units should provide services which are subject to contract with purchasers. These are established to secure sufficient income to cover some of the expenditure incurred in providing health care thus offering "quality service and value for money". Whilst respondents at management level felt the mission statement of the organization should be an all inclusive exercise. Beckhard & Harris (1977: 37) suggest that a mission statement should reflect the purpose of an organization based on the values and beliefs of its members.

4.4 NEW KNOWLEDGE GAINED FROM LITERATURE

Scores of books were read to qualify the title of the researcher. As this study is qualitative in nature, the results through analysis were verified only at the end of the study.

Most of the literature reviewed confirmed the responses of the respondents. The next effort was to try and refine the steps that lead to affirming with "The nursing service change strategy for health clinics". What comes out clearly is that basically there are six steps in bringing about change and managing it properly. Some books use different terms to qualify these steps but eventually the following steps were captured by the researcher as the backbone (see figure 4.2).

4.4.1 Steps for change: a nursing service change strategy for primary health care clinic.

The steps for change are reflected in figure 4.3.

4.4.1 FIGURE 4.3 STEPS FOR CHANGE

STEP 1: CLARIFY THE NEED FOR CHANGE
Identify the need and determine its potential for change, gauging emotional reactions of all concerned, communicate benefits to this change, threats and advantages.
STEP 2: DEFINE THE RESULTS
As a leader, define clearly the desired outcome and collectively determine who will be affected.
STEP 3: PRODUCE THE PLAN
Consider the stakeholders' responses and their input to the plan. Jointly decide, through proper guidance, on the tasks by collective development of an action plan.
STEP 4: IMPLEMENT THE PLAN
Before putting it in motion, decide who and how it will be monitored thus encouraging ownership provide all necessary resource needed for effective implementation.
STEP 5: STABILIZE THE OUTCOME
Communicate throughout, assess grassroots support and encourage it. Solicit support, not through coercion, so that change remains in place.
STEP 6: ASSESS AND EVALUATE THE PROCESS
Evaluate continuously and establish ways to encourage innovation. If there are hitches, re-plan.

4.4.2 INITIAL REACTIONS TO CHANGE

There will always be initial reaction to change .These reactions are :

* the change agents and initiator will always be in conflict if improper motivations for change are imposed. It should always be remembered that the comfort zone gives a feeling of security.
* first come up with a team to look at possible hurdles to change at an early stage (only those who are supportive of change of course).The team will consider change acceptance factors,

that is are all stake holders willing to accept and participate in the change process;

* there are traps that could sabotage the process if the initiators are insensitive to internal and external pressures as presented by Margerison (1995):

a) are opinions about change clear and non conflicting ?
b) is communication about the need for change existent or is management assuming that the need for change is "Obvious" ?
c) is communication from management consistent and supportive of change ?
d) are desired outcomes specifically defined ?
e) is there a lack in the system to monitor issues identified as potential problems ?
f) is there adequate determination of resources needs ?
g) are there contingency plans for unanticipated changes ?
h) are there time frames set to publicity announce if the desired outcome has been attained?

It is helpful at any early stage of change for implementors to systematically examine the forces for and against change. This is necessary because change will not occur unless the forces driving it are stronger than those resisting it. If the forces against change appear dominant, implementors should consider what additional forces they can muster for example, in the form of committed followers, or of better proof for the need for change before launching a change plan (Margerison,1995). Lining up the political sponsorship and support appear to be a pivotal role around which successful change can be based. Political support where the community, which is the politicians' constituency, cannot be overlooked as critical issues in implementing and managing change has undeniable political dynamics. This will help the researcher in motivating constructive behaviour in the face of the anxiety created by change and to manage the state of transition. Avoid the "Magic Leader Principle". Whilst individual leaders can serve as a focal point for the change, whose presence has some special "feel" or "magic" to help mobilize and articulate the need for change, continued dependence on such leaders has disastrous effects. Change become too personalized, nothing proceeds unless these leaders take leading role.

When these leaders make mistakes, the magic fades away because no leader can live up to the fantasies that the subordinates create. This means that the organization should be allowed to grow beyond the current leaders. Change requires the combination of both science and art. This combination will help with provision of a useful blueprint for embarking on change. Care should be taken not to stick rigidly to the proposed blueprint as change is a process that is dynamic. The blueprint will only serve as a guideline to evaluate through continuously asking

these questions:

* Are we addressing the real needs of an organization ?
* How shared is our vision and mission ?
* Are we not discarding the useful anchors of the past whilst moving to the future?
* Is everybody involved feeling the same sense of urgency and commitment?
* Are we able to positively impact on those negating the change process?
* Are we moving within the expected time frames - not too slowly ?
* Is there visible progress or improvements brought about by change implementors ? etc. If answers are more towards the negative, obviously the action plan has gone wrong, indicating the need for review of the strategy collectively.
* Failures in coping with change brought about by the latest political reality in our country is that no one, according to Tim Porter-0'Grady (1996: 46-51) can really cope with the change rate, scope and its intensity. This is because whilst these are a reality, they were never expected or desired to become the conditions of life for those who were advantaged by the past powers used to rule.

These changes even impact on some peoples' values. The bottom line is that they must accommodate all these expectations.

* These new realities are affecting even the old work structures, designs and procedures. There is now an undeniable need for:

(1) information technology and systems in the workplace to connect people in all kinds of environments;
(ii) building different working relationships on the people, systems, processes and outcomes are managed;
(iii) redesigning new yet fewer leadership roles which require a higher level of competence and confidence to what was a norm in the old paradigm;
(iv) leaders producing sustainable change which reflects a commitment to consistent application of the principles and rules of good change and its management.

4.5 CONCLUSION

In this chapter, literature control was done in order to compare literature information with data from focus groups to determine if there are similarities or differences in order to highlight the unique aspects of the results of this research. This is done to ensure trustworthiness.

Literature control actually endorsed the expectations of all respondents on ownership of services, community involvement as well as community and staff empowerment. On change of attitudes it also emerged from literature that positive change from all stakeholders creates conditions necessary for change thus allowing commitment from all involved. Towards confirming strategies that lead to nursing service change strategy , literature review did confirm the following principles as cited by respondents: co-participation, community and staff empowerment as well as an ideal programme of change. These were also captured by literature as having underlying principles like communication, consultation, participative management style and reconstruction of services in disadvantaged areas. Structural change especially to allow for policy reviewal was frequently found in literature to support the participants views and proposals.

The differences were also captured through literature review, which helped in gaining of new knowledge by the researcher. These emerged as factors that could either support or sabotage change. The new knowledge gained as well as input from respondents assisted the researcher to formulate the conceptual framework for a nursing service change strategy required for health clinics. These are illustrated in figure 4.3. In the next chapter, the overview, conclusion, guidelines and recommendations will be outlined.

THE OVERVIEW, GUIDELINES, RECOMMENDATIONS AND CONCLUSION

CHAPTER 5

5.1 OVERVIEW

The first democratic national elections in South Africa in 1994 led to inevitable and dramatic changes. Firstly the Government of National Unity was born. With the Government of National Unity came the Reconstruction and Development Programme (RDP). This RDP (ANC, 1994 :43-46) promoted the National Health System (NHS) both of which necessitated the complete transformation of the health care system.

This transformation meant a totally different approach from the former Government which obviously necessitated major political, social, economical and technological changes. The impact therefore was nationally felt within the health discipline as there needed to be review and restructuring of all relevant legislation, statutory bodies, institutions and organisations affecting health in order to reflect and effectively cater for diversity of people of South Africa. As the RDP advocates major changes of basic aspects such as meeting basic needs, democratising the society and building the economy of the country and developing human resources, there needed to be changes on the nursing service as an element of health care delivery. The traditional nursing management and leadership practices got outdated and there was some measure of instability amongst the nursing staff, senior and junior, and this was felt by the community. As a coping mechanism, there was blame shifting as to why primary health care had not effectively taken off the ground within Soweto Primary Health Clinics, hence the need was felt by the researcher to undertake this research project in order to hopefully come up with a suitable and acceptable nursing service change strategy. For acceptability of the strategy, the researcher then chose to involve the nursing staff and health consumers as respondents in order to inform such a strategy. The research questions are as follows:

* What are the expectations of the selected stakeholders concerning change that has to be implemented in relation to effective health care?

* What change strategy is required with the clinics to implement this Primary Health

Care approach?

The objectives of this study are:

* to explore and describe the expectations of nursing managers (seniors) and functional nurses context concerning the required nursing service change strategy for Soweto primary health clinics;
* to explore and describe the expectations of health consumers contact concerning the required nursing service change strategy for Soweto primary health clinics;
* to describe the required nursing service change strategy for the Soweto primary health clinics.

5.2 THE RESEARCH DESIGN

An exploratory and descriptive research strategy was used to explore the expectations of senior nurses, functional nurses and health consumers regarding the required nursing service change strategy for primary health clinics, and to also describe the ideal nursing service change strategy which will be implemented effectively and meaningfully within the primary health clinics. The context is ten (10) Primary Health care clinics. This study is qualitative in nature where a phenomenological approach is undertaken in order to understand the responses of participants as whole human beings, not just the specific parts or specific behaviour.

The method included data gathering through three (3) focus groups interviews with the semi-structured interview through open-ended questions were aimed at allowing free expression of ideas by the participants. To attain these objectives, these are the questions that were asked for both senior, functional nurses and health consumers during the focus group interview:

1) What are your expectations regarding the required nursing service change strategy for Primary Health Care clinics?
2) What nursing service strategy is required for change realisation?

Data management included audio-taping of different focus groups and transcribing of some which were then sent to the independent coder for analysis. The method for content analysis aimed at identifying the main categories, sub categories and units of analysis.

The sampling methods used was stratified purposive sampling in order that all levels of identified variables are represented in the sample so that increased theoretical understanding is achieved.

5.3 THE RESEARCH RESULTS

From the focus groups interviews, data was analysed and two (2) main categories emerged from the responses. These categories are Expectations and Strategies. From these emerged the sub categories. The sub categories which emerged from expectations are ownership of services, structural changes and reconstruction of attitudes. From the strategies, the sub categories which emerged are co-participation, community and staff empowerment as well as the ideal programme of change (refer figure 3.1).

5.3.1 THE PROVISIONAL CONCEPTUAL FRAMEWORK

The provisional conceptual framework is based on what evolved from expectations and strategies as motivated for by all focus groups.

Figure 5.1 The provisional conceptual framework: Nursing service change strategy

Expectations	Strategies
* community up-liftment * community involvement * community and staff development * comprehensive health services	* participative management style * equitable distribution of available resources * effective communication strategy * implementation of new national policies to address imbalances of the past :- -Affirmative action -Equal employment opportunities -New Labour Relations Act no. 66 of 1995 -New constitution
* comprehensive health service through one (1) stop health centres * establishment of health matters consultative forums * review of health policy * reconstruction of attitudes by all stakeholders * clear goals * shared vision of the organisation.	* multi-disciplinary management * people driven, community based RDP projects.

5.3.2 LITERATURE CONTROL

As this is a qualitative study, literature control was only undertaken at the end of the study for comparing and contrasting findings of the qualitative study. From literature review there were similarities, differences and new knowledge was therefore gained. The similarities were confirmed on the expectations of focus groups. They concern ownership of services, structural change and reconstruction of attitudes. Also the strategies were confirmed through literature control concerning participative management, community and staff empowerment as well as change management. New knowledge gained added onto what was proposed by the focus groups in the sense that adding onto the three (3) familiar concepts of organisational management which are structure, strategy and systems, four (4) others are now added which are skills, style, staff and super goals.

5.3.3 THE FINAL CONCEPTUAL FRAMEWORK

Throughout the process of data collection, analysis and refining of methods, certain concepts were selected up and grouped as fundamental to infer the conceptual framework of this study. The following framework (Figure 5.2) has been formulated by the researcher as relevant to this study and based on the input by the respondents.

Figure 5.2 The conceptual framework: Nursing strategy for change for Primary Health Clinics.

ROLE PLAYERS
(Employer, Employee, Community)

GOALS

EXPECTATIONS	STRUCTURE	STRATEGY	PROCESS
*Integration of all fragmented health services	1-stop health centres	*Participative management through multi sectoral management committees e.g. housing agriculture, social welfare	*Joint assessment planning through collection, collation and joint analysis of health related data to inform the strategy
*Staff and community involvement for ownership of services through acceptable communication channels	*Community health committees and inter sectoral coordinating body	*Interface between the community and the health system for a consultative process	*Joint agreements on plans of action
*Staff and community development and training	*Human resources management committees	*Planning provision of health services as part of the human resources development and training for the implementation of new policies like Equal Employment opportunities New Labour Relations Act	*Implementation of policy agreement and procedures based on joint monitoring
*Equitable distribution of available health services	*Support services	*Sufficient stock proper storage, distribution and stock control equipment, staff laboratories pharmaceuticals etc	*Joint evaluation co-ordination and control of policies administrations and finances, training centre and health centres *Continuous research for provision and implementation of acceptable, affordable and equity in health care

5.4 GUIDELINES FOR THE NURSING SERVICE STRATEGY FOR CHANGE FOR PRIMARY HEALTH CLINICS.

5.4.1 The context

The change strategy for nursing service is meant for Soweto Primary Health Clinics. The 10 clinics are run by the local Authority called Greater Johannesburg Transitional Metropolitan Council (GJTMC).

5.4.2 The role-players.

As this is Local Government the role players involved within GJTMC are the following:

* Employers (the Councillors)

* Employees (the nursing staff)
* The community (the clinic attendants).

5.4.3 The goal of the change strategy

The goal is transformation of the nursing service to be in line with the National Health Plan which includes complete transformation of health services to deliver a comprehensive primary health care service in accordance with community needs.

5.4.4 The procedure for change

The guidelines are directed at addressing the identified four (4) expectations from interviewed focus groups. The expectations are as follows:

* integration of fragmented services;
* staff and community involvement;
* human resource development;
* equitable distribution of resources (see figure 5.2 and 5.3).

FIGURE 5.3

EXPECTATION 1	OBJECTIVE	ACTION	STRATEGY
Integration of fragmented services.	To create 1-stop or comprehensive health centres.	* Create a transfor-mation multi sec-toral health committee to link up with District Health Authority which will provide coherent and co-ordinated recommendations within which the nursing fraternity can function; * perform needs assessment as to how many 1-stop health centres will be needed, and clearly; * motivate where and why each centre should be built in identified areas.	* The process of wide consultation among the role players who are employer, employees and the community for recommendations towards joint policy formulation through consultative forums; * adhere to joint assessment, planning and joint analysis of health related data to inform the nursing service change strategy; * use open com-munication for feedback purposes to role players.
EXPECTATION 2	OBJECTIVE	ACTION	STRATEGY
Staff and community involvement for ownership of services.	To implement a people driven process	* Establish multi sectoral community development committee with members elected from role players and sectors; * propose and recommend a way to help co-ordinate all aspects of development to ensure that all available and planned resources are used to the best advantage of the community; * liaise with those employed and responsible for the running of health facility, in order to be inclusive examining and proposing effective budget; * identify and prioritise community health needs in order to present them to the District Health Authority; * identify projects that can be people or community driven; * guide work programming, target, priorities and time frames ensuring priority-based budgeting.	* ensure a participatory process; * ensure collaborative, integrated planing and decision making; * develop inclusive criteria for assessing targets and time frames; * publicly motivate all decisions with sound reasons so that affected parties must be able to object against decisions before they are forwarded to District Health Authority.
EXPECTATION 3	OBJECTIVES	ACTION	STRATEGY
Human Resource development (staff development and training)	* to implement staff and community training and development programmes that will allow development to fill potential; * to deal with training in formal training institutions and at the workplace.	* Establish human resource management committees from all roleplayers and health related sectors; * make recommen-dations taking into consideration the following aspects:- - the current education framework and its guidelines; - the South .African Nursing Council training and development curriculum; - reorientation and retraining of existing health personnel; - review training programmes, recruitment and selection procedures for recommendations to District Health Authority and the South African Nursing Council; - make needs assessment in training so that proposals are problems oriented and community based in character; - recommendations to take into consideration the equal employment opportunities, affirmative action, constitution and Patients Charter, as well as the new Labour Relation Act; - review health information systems for effective data gathering.	* ensure community and staff involvement through multi-disciplinary committees; * consult affected parties and role players on all proposals before forwarding those to all relevant authorities.
EXPECTATION 4	OBJECTIVE	ACTION	
Equitable distribution of available health services	To address the inequitable access to health care caused by the past fragmented health system.	* Establish a co-ordinating committee to address effective resource reallocation where there is great need; * perform needs analysis pertaining to health care facilities and personnel as well as support services like pharmaceutical laboratories, radiological services and emergency services; * recommend for reallocation of human resources based on research to address imbalances; * identify problem areas in health information system and technology to ensure that accurate data is collected from all parts of the health system for diagnostic purposes; * ensure that support services like sufficient stock and equipment reflect acceptable proportions * ensure joint strategy formulation by encouraging community and staff to participate actively in the planning, managing ,delivery, review and evaluation of health services; * set targets and time frames for evaluation purposes.	* ensure joint strategy formulation by encouraging community and staff to participate actively in the planning, managing, delivery, review and evaluation of health services

5.5 CONCLUSIONS

The conclusions are based on the objectives of this study which are the following:

a) The explorations and description of the expectations of the nurse managers and functional nurses concerning the required nursing service change strategy for primary health clinics.

The exploration and the description of this objective revealed the following expectation:

* staff and community involvement;
* improved staff training and development programmes;
* equitable distribution of available health services.

b) The exploration and description of expectations of health consumers concerning the required nursing service strategy for change for Soweto Primary health clinics.

The exploration description of this objective revealed the following expectation:

* community involvement;
* community and staff development programmes;
* equitable distribution of available health services.

c) A description of the change strategy for nursing service required for Soweto Primary Health Clinics.

The description of the change strategy for nursing service within Soweto Primary Health Clinics was described focusing on the following aspects:

* the context (Soweto primary health clinics);
* the role players (the employer, employee, community);
* the goal of the change strategy; the guidelines;
* the recommendations.

d) The guidelines for the nursing service change strategy were described.

5.6 RECOMMENDATIONS

Recommendations will be made based on the findings of this research but reference will be made to Nursing for the Whole Person Theory for purposes of applicability of this research in terms of nursing education, nursing management and research based on Primary Health Care. The recommendations are aimed at promotion, prevention, maintenance and restoration of health towards the quest for wholeness.

5.6.1 NURSING SERVICE MANAGEMENT

For purposes of primary health care, transformation and change is advocated by the RDP and the National Health System in all areas of health delivery service. The principle to be followed include community participation and involvement in health related matters. Nursing service managers should therefore adhere to this priciple and involve all role players like representatives of community health committees, community based organisations, trade unions and all available professional bodies in the area.

It is recommended that the results of this project be implemented as a pilot project within all primary health clinics within the Transitional Metropolitan Council of Greater Johannesburg, to facilitate change.

5.6.2 NURSING EDUCATION

The following recommendations are made regarding nursing education:

* Promotion of this research project by means of publication in journals, presentation at conferences and seminars as a refresher course to already qualified nursing service managers and nurse educators to popularise this change strategy.

* These results could also be included in the formal post basic curriculum or courses for all nursing service leaders like prospective nurse managers and educators.

* Transformation of staff attitude towards change by means of professional development programmes.

* This project can also be referred to the Gauteng health ministry for critique by health strategists who influence policy decisions.

5.6.3 NURSING RESEARCH

As this qualitative, descriptive study was only done within the context of Soweto, its success as a nursing service change strategy can still be measured through further extensive qualitative, exploratory and descriptive studies to provide more supportive evidence. It can still be verified on a national basis.

The following hypothesis is stated: the implementation of this change strategy for nursing service in Soweto primary health clinics improves the following :

* participative management ;
* comprehensive primary health services;
* community and staff involvement for ownership of services;
* human resources training and development;
* equitable distribution of available health resources.

5.7 EVALUATION OF THE STUDY: STRENGTHS AND WEAKNESSES

The study is evaluated through the following weaknesses and strengths:

5.7.1 WEAKNESSES

The following were identified by the researcher as shortcomings or stumbling blocks which in a particular way posed threats and limitations:

a) SAMPLE

Whilst the researcher had successfully received confirmation from prospective respondents, there was unfortunately a strike throughout Municipal institutions within

Gauteng Province which lasted for several weeks, thereby disrupting all normal routines within Soweto Clinics. Clinics were run by skeleton staff and few of the respondents could no longer participate. Fortunately all clinics were represented in focus groups as well as all levels of functional nurses and community representatives.

b) SCARCITY OF RESOURCES

The researcher works where libraries are a rare commodity and barely equipped. This necessitated long trips to university libraries for referencing during literature control.

5.7.2 STRENGTHS

As this project has not been conducted within Greater Johannesburg Transitional Metropolitan Council, it can help to empower all surrounding primary health care clinics where nursing service managers are still struggling to formulate a change strategy.

5.8 CONCLUDING COMMENTS

In this final chapter, the study was evaluated, conclusions and recommendations were made for the nursing service change strategy for purposes of recommending towards nursing management, nursing education and nursing research.

The overall aim of this study was to describe a nursing service strategy for change, with guidelines for implementation of same within the primary health clinics. The described change strategy will be recommended for validation through further research and for possible implementation in the clinics to test its applicability.

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ANNEXURE A

GREATER JOHANNESBURG
TRANSITIONAL METROPOLITAN COUNCIL
SOWETO ADMINISTRATION

Shanty Clinic
C\O Soweto City Health
Department

10 August 1995

The Senior Nursing Service Manager
Chiawelo Clinic
Soweto City Health Department

Dear Madam

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

As a student at Rand Afrikaans University doing M.Cur, the requirement for compliance in obtaining a degree is that a dissertation needs to be submitted by myself. This necessitates that I conduct the research.

For my project, I need permission to conduct this rearch within the clinics of Soweto City Health Department. The theme is 'A change strategy required in Soweto City Health Clinics.' The purpose is to describe and explore from nurses and health consumers of Soweto the ideal change strategy that can bring about meaningful transition to fit in with the dictates of the Reconstruction and Development Programme in bringing about effective Primary Health Care. The findings will be used to develop guidelines in developing the implementation policy necessary for the envisaged comprehensive health service delivery constructively,thus facilitating the staff and health consumers' quest for health.

The method to be used will be focus groups interviews lasting between 1-1half hours per group, approximately 5 groups of 10 in all will be necessary.

For more information kindly contact me at Shanty Clinic or the Nursing Science Department at R.A.U.

Yours faithfully

Gumede

Ntokozo Rosemary Gumede
RESEARCHER

Permission granted
23/08/95

GREATER JOHANNESBURG
TRANSITIONAL METROPOLITAN COUNCIL
SOWETO ADMINISTRATION

Shanty Clinic
C\O Soweto City Health
Department

10 July 1995

MR/MS .....

.....Clinic

INFORMED CONSENT FORM FOR PARTICIPATION IN QUALITATIVE RESEARCH.

RESEARCH TITLE : A strategy for change in Soweto Municipal Clinics.

RESEARCHER : Ms N. R. Gumede

The researcher is a Senior Community Health Nurse studying at Rand Afrikaans University (R.A.U.) for M.Cur Degree purposes. The aim of the research is to describe and explore from nurses and health consumers of Soweto, the ideal 'change' strategy towards a meaningful transition to fit in with the dictates of Reconstruction and Development Programme in bringing about effective Primary Health Care. The findings will be used to develop guidelines necessary to implement the awaited comprehensive health service delivery constructively where policy makers are professionals and consumers of care in partnership.

Should you consent to be interviewed, the interviews will be in small groups form, lasting about one to one & half hours at the clinic. The interview will be audio/video taped for the panel of independent experts to verify my findings. Your identity will be protected as well as confidentiality ensured by erasing the tapes after the information has been analysed by the researcher and independent experts.

Permission granted

28/09/95

S. Ra-a

GREATER JOHANNESBURG
TRANSITIONAL METROPOLITAN COUNCIL
SOWETO ADMINISTRATION

Shanty Clinic
C\O Soweto City Health
Department

10 July 1995

MR/MS .....

.....Clinic

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Should you consent to be interviewed, the interviews will be in small groups form, lasting about one to one & half hours at the clinic. The interview will be audio/video taped for the panel of independent experts to verify my findings. Your identity will be protected as well as confidentiality ensured by erasing the tapes after the information has been analysed by the researcher and independent experts.

Permission granted

28/09/95

S. Ma-a

ANNEXURE C

03 January 1996

The Independent Researcher/ Coder

Dear Colleague

Thank you for your input as independent researcher. The next step now is data analysis.

As you would recall, there are 3 casettes transcripts. One is interview of the Nurse Managers and Chief Professional Nurses, the second one is interview of Functional Nurses and the third casette is interview of Health consumers.

Kindly follow the steps below to analyse the data of the 3 focus group interviews:

1. Analyse the 3 casettes transcripts separately

2. Read through them to gather an overview of the whole to familiarise yourself

3. Identify and classify the main themes or categories under:

4. Expectations (E) and Strategies (S)

5. Read through all transcription and underline words and themes

6. Identify subcategories under each theme by clustering words or themes

7. Classify themes or categories into 2 tables by ;

   (a) Calculating the number of each main category E and S extracted from the total number of scripts and

   (b) Award a numerical value (e.g. S1, S2,E1,E2)

Thank you

N. R. GUMEDE
(M. Cur Student)