Experiences of primary health care nurses regarding the provision of free health care services in the Northern region of the Limpopo Province

VO Netshandama, MCur, University of Venda
L Nemathaga, MCur student, University of Venda
SN Shai-Mahoko, PhD, University of Venda

Abstract

The purpose of the study was to explore the experiences of primary health care nurses working in the clinics and health centres involved in the provision of free health care services. The research design followed was exploratory, descriptive and qualitative. The population of the study included all primary health care nurses working at the clinics and health centres in the Vhembe (northern) region of the Limpopo Province. The sampling method used was purposive for the samples of both the clinics and the nurses.

The inclusion criteria for the nurses included experience of two or more years in providing primary health care. The inclusion criteria for the selection of clinics included being a busy clinic (a minimum of 2000 patients per month) with a staff establishment of four or more primary health care nurses. In conducting this research, ethical principles were taken into account. Data was collected from 23 participants in the Northern Region. The research question read as follows:

What are your experiences regarding the provision of free health care services?

An open coding method consisting of eight steps provided by Tesch's (1990:140-145) eight-step method of analysing data was used. The research findings revealed that the primary health care nurses working in the clinics experience feelings of failure to provide adequate primary health care services due to the increased workload, misuse of the service, and fear associated with lack of security in the clinics and health centres. The conclusions drawn from this research are that on the one hand a poor mechanism exists for the monitoring of the implementation of free health services, and on another hand, there has been misuse of the facilities by the community. The concept "free health care service" has been misinterpreted.

Background and rationale of the study

The legacy of apartheid policies in South Africa created large discrepancies among racial groups in terms of socio-economic status, occupation, housing and health. The apartheid policies also created a fragmented health care system that was inequitable. The inequalities in health care were reflected in the health status of the most vulnerable groups (African National Congress 1994:19). There were, for instance, hospitals for whites only and those for non-whites. This was revealed by the Committee of Inquiry on Public Hospitals of 1925, the Loram Committee of 1928 and the Gluckman Commission of 1944. These commissions reflected the deteriorating conditions of health of the black populations in both rural and urban areas (Van Rensburg, Fourie & Pretorius 1992:61).

One of the recommendations of the Gluckman Commission, as cited in Van Rensburg et al (1992:61), was that all personal health services be rendered free of charge and financed by a national health tax. It is unfortunate that the recommendations made for improving health care provision were not implemented. The problems of fragmentation and maldistribution of health services thus remained unaddressed (Van Rensburg et al., 1992:60).

In 1980 the National Party government introduced the National Health Service Plan which aimed at bringing reforms in the health care system. These included aspects like addressing the inadequate health care provision to certain sectors of the population and the fragmentation of health services. However, these plans were not implemented in earnest as reflected in the following statement by the Director-General of National Health and Population Development in office in 1988: "my personal opinion is that these plans have not been implemented ... we have health plans, we have health goals. I feel the major shortcoming is that we have failed to employ a systematic, continuous process of national health planning" (Van Rensburg et al., 1992:72).

The ruling party was aware of the problems related to health care provision, but never implemented a policy that would ensure that the disadvantaged communities would benefit. As a result, the health care services remained inaccessible to the poor.

The 1990s, however, did actually produce signs of fundamental change in South Africa, e.g. a shift to primary health care, to preventive community-based care, the scrapping of numerous laws which maintained apartheid; but fundamental change like democratising the country was never effected. Deficiencies in the organisation of the health services, particularly in respect of co-ordination and integration, were never solved. More generous provision of basic requirements for whites and inequalities experienced by non-whites with regard to health care did not change. The more favourable distribution of health services and facilities in respect of urban areas rather than rural areas was never neutralised, and amidst greater accessibility, exclusion and discrimination were never removed (Van Rensburg et al., 1992:88).

Based on the background discussed in the previous paragraphs, the ANC wanted to change the health situation in South Africa. In its attempt to reorganise health care service delivery, the African National Congress, with the help and technical support of the World Health Organisation and the United Nations Children's Fund, prepared a National Health Plan in May 1994. The policy proposed the provision of free health services for certain categories of consumers and treatments at the clinics and health centres. These include:

- children under six years of age;
- pregnant and nursing mothers;
- the elderly;
- the disabled and certain categories of chronically ill;
- promotive and preventive activities;
- school health services; and
- provision of contraceptives (African National Congress 1994:19).

This meant that all the above-mentioned categories should be attended to free of charge in all government clinics and health centres. This was done to address the issues of accessibility and affordability which are the pillars of the primary health care approach. The primary health care approach was adopted by the new South African health system because it is the most effective and cost effective means of improving the health of the population. The approach involves a health system led by primary health care services, which are at the base of an integrated district health system (RSA, 1997:36). One of the principles of primary health care is that care should be as simple as possible and affordable to individuals and the country. The introduction of the free health care policy by the government at all primary health care institutions was intended to ensure that care would be available to everybody, especially the disadvantaged. In the Limpopo Province, free health care was provided to everybody at the primary health care facilities without consideration of the specified categories. To encourage members of the community to make use of the primary health care facilities, patients are required to consult at the clinics or health centres before going to the hospitals. In some institutions patients who present themselves at the hospitals without a referral letter from the clinic or health centre, are turned back for the letter.

It is upon this basis that the researcher sought to explore the experiences of primary health care nurses regarding the free health care service delivery in the Northern Region of Limpopo Province.

Statement of the problem

Since the introduction of the policy on the provision of free health services, statistics in the primary health care facilities, namely clinics and hospitals, have shown an increase in the number of health care consumers seeking assistance as reflected in the statistics from these areas.

The introduction of the policy on free health service could be considered a good move by the government because this was addressing the issues of accessibility and affordability which were a problem before the democratisation of the country. The problem was, however, that no mechanism was put in place to monitor the implementation and there was no evaluation of it. It appears that the introduction of the policy on the provision of free health has presented those providing it with more challenges. The question of the researcher was, "What are the experiences of primary health care nurses in the provision of free health care services?"

The purpose of the study

The purpose of the study was to explore and describe the experiences of the primary health care nurses who provide free health services, with the intention of indicating the impact the policy has had on service provision.

Objectives

The objectives of the study were to:

- explore the experiences of primary health care nurses

working at the clinics and the health centres; and
- establish the impact that the provision of free health care services have had on service provision.

Research question

The following research question guided the study:
What are your experiences regarding the provision of free health care services at your clinic?

Research design and method

Research design

For the purpose of this study the research approach used was qualitative, descriptive and exploratory.

Qualitative

Qualitative research has been described differently by various researchers. Burns and Grove (1993:61) indicate that qualitative research is a way to gain insights through discovering meanings. Within a holistic framework, qualitative research is a means of exploring the depth, richness and complexity inherent in the phenomenon. Smith (1997:220), suggests that "qualitative research derives knowledge from subjective data about values, intuition, psychological and social forces and traditions".

In this study, the in-depth experiences of professional nurses working in the clinics and health centres regarding free health care services were explored. Inductive approaches were used. It was thus necessary to use the qualitative method to get detailed information regarding the experiences of primary health care nurses with regard to the provision of free health care services.

Exploratory

According to Polit and Hungler (1995:19) exploratory research aims at a phenomenon of interest and pursues factors affecting or relating to the phenomenon. According to Woods and Catanzaro (1988:150), to explore refers to "scrutinising the unknown with the purpose of discovering and gaining insight into the phenomena".

The study design chosen was exploratory in that the study intended to explore the depth, richness and complexity, and increase insight into the experiences of professional nurses regarding the provision of free health services (Burns & Grove 1993:16).

Descriptive

Polit and Hungler (1987:18) describe descriptive studies as a method in which a researcher selects a specific event, condition or behaviour and makes observations of the phenomenon and records them. Descriptive design includes the identification of a phenomenon of interest, identifying the variables within the phenomenon (Burns & Grove 1993:239). In this study, the experiences of the primary health care nurses are described.

Research methods

The population, study areas, and sample

Seaman (1987:233) defined population as "the total group of persons or objects that meet the designated set of criteria established by the researcher". Sampling refers to the process of selecting a portion of the population to represent the entire population. The sample has to be as representative as possible, i.e. the key characteristics should closely approximate those of the population (Polit & Hungler 1987:207).

The population in this study comprised of all the professional nurses working in primary health care settings in the

Table 1: Names of districts, location and the total number of PHC nurses interviewed per clinic.

NAMES OF DISTRICTS AND LOCATION	TOTAL NUMBER OF PHC NURSES INTERVIWED
Nzhelele/Tshipise (North of the Northern region: Clinic A and B)	5
Levubu/Mutale/Vhutswema (East of the Northern region: Clinic C and D)	4
Elim/Hlanganani (South of the Northern region: Clinic E and F)	4
Makhado (West of the Northern region: Clinic G and H)	5
Thohoyandou (Central to the Northern region: Clinic I and J)	5
TOTAL	23

Northern Region of the Limpopo Province which has six districts as indicated in the table. At the time of the study, the clinics in the study area had an average of 4 PHC nurses working 24 hours per shift.

The purposive sampling method was used to select both the clinics and the primary health care nurses. According to Brink (1996), purposive sampling is based on the judgement of the researcher regarding subjects or objects that are typical or representative of the phenomenon or topic to be studied. Wilson (1993) indicated that in purposive sampling, the researcher uses his/her judgement to decide who is representative of the population. The method was chosen because the researcher used her judgement to select the sample which would give reliable information.

The criteria for selection included being a busy clinic, that is, a clinic with a minimum of 2000 or more clients per month and with a staff establishment of four or more primary health care nurses. In addition, primary health care nurses working in the selected clinics should have had two or more years of experience rendering primary health care services at the clinic.

Data was gathered from twenty-three (23) primary health care nurses from five clinics that were selected according to districts. Two clinics were selected in each of the districts and at least two to three PHC nurses from each clinic were available and agreed to participate in the study. The sample size was determined by data saturation.

Ethical considerations

Participants were informed about the purpose of the study as well as the method and the procedure that would be followed when conducting the research. Permission to conduct research was obtained from the Limpopo Provincial Health Department and from the regional director. Consent was also obtained from the primary health care nurses working in the clinics and health centres. Throughout the research process the researcher ensured that the self- respect and dignity of the participants were respected and maintained (Brink 1996:52). Participants were allowed to exercise their choices, without coercion, regarding whether they wanted to participate in the study or not.

The participants were also informed of their right to withdraw from the study at any time without any fear of victimisation. Participants were also reassured that no link would be made to individuals in describing the findings. The researcher ensured that the anonymity of the participants was protected in that they were not required to mention their names and it was not possible to relate particular data to a particular person or clinic. Participants were also informed that the audio-taped information was confidential and would be done away with once it had been transcribed (Burns & Grove 1993:365).

Data collection methods

The data collection methods employed in this study were in-depth individual interviews and field notes conducted by the researcher. The interviews in this research ranged between 45 and 90 minutes duration. The interviews were conducted by the researcher, in a variety of settings including empty consulting rooms, under a tree or in an empty post natal ward as necessary.

Follow-up questions were then used to increase detail exploration. Additional prompting questions were used as probes to encourage the respondents to elaborate on what was being discussed. The interview was chosen because it is more free-flowing, with its structure limited only by the focus of the research. During the interviews data was tape-recorded for transcription within 48 hours after the interviews (Morse & Field 1996:107).

Field notes

According to Polit and Hungler (1987:271) field notes represent the participant observer's efforts to record information and also to synthesise and understand data. Field notes, according to Morse and Field (1996:91), are written accounts of the things that the researcher hears, sees, experiences and thinks in the course of collecting or reflecting on data in a qualitative study. Thus in this study the researcher jotted down field notes to supplement interview data. Participants' facial expressions varied when they were expressing certain aspects of their experiences. A feeling of discomfort was also picked up when talking about their employer or the government.

Data analysis

According to Polit and Hungler (1995:329), the purpose of data analysis is to impose some order on a large body of knowledge so that some general conclusions can be reached and communicated in a research report. Analysis of qualitative research is a hands-on process. A significant degree of dedication to reading, intuiting, analysing and synthesising was put into the data. The process of data analysis actually started when data collection began (Streubert & Carpenter 1995:24). Tesch's (1990:140-145) steps of qualitative data analysis were used. The researcher read through all the transcriptions carefully to get a sense of the whole. The researcher picked one interview document and went through it. Thoughts coming out were underlined with different coloured pens and notes were written in the margin.

This procedure was repeated for all the participants and a list of topics was then compiled. Similar topics were grouped together and arranged into major topics, unique topics and leftovers. Topics were abbreviated as codes and these were written next to the appropriate segments of the text. The researcher tried to find the most descriptive wording for the topics and these were turned into themes and subthemes. Related topics were grouped together to reduce the list of categories. A final decision was then made regarding the wording for each category/theme. Data belonging to each category/theme was assembled as presented in the table (Creswell 1994:155).

Table 2: Themes and sub-themes relating to the experiences of PHC nurses regarding free health service provision.

THEMES	SUB-THEMES
1. Failure to provide adequate primary health care due to increased workload	1.1 Frequent visits to the clinics by the community members. 1.2 Shortage of Primary Health Care nurses to provide adequate Primary Health Care services. 1.3 Lack of thorough assessment leading to symptomatic treatment. 1.4 Burnout, stress and strain related to increased workload.
2. Misuse of service by clients	2.1 Clients believe that medicines are diluted. 2.2 Clients move from one clinic to the other. 2.3 Clients do not use the services responsibly. 2.4 Clients demand medicine for hoarding purposes
3. Fear associated with lack of security in the clinics.	3.1 Lack of properly trained security staff

Measures to ensure trustworthiness

Lincoln and Guba's (1985:324) criteria and strategies to ensure trustworthiness were used in this study namely credibility, dependability, confirmability and transferability.

To ensure credibility in this study, the researcher remained in the field for a prolonged period. During the first contact the necessary information regarding the research was outlined in order to get consent from the participants. The information was collected and after transcribing, the data was taken back to the participants for them to verify the information. The other aspect that ensured credibility was the use of a variety of sources in data gathering. These included the use of a tape-recorder and field notes. At the end of data analysis the researcher went back to some of the clinics and discussed the findings with participants. This was done to present the study findings to the primary health care nurses to check the credibility of the analysis and to see whether the findings reflected the nurses' own experiences about the aspect of free health care services.

Lincoln and Guba (1985:324) note that dependability involves appropriateness of inquiry, decisions and methodological changes. Inquirer bias should be reviewed, and the extent to which decisions about the conduct of the inquiry may have been influenced by practical matters such as instability. Dependability was achieved by describing the research method fully and by discussing the research protocol with the research team and an independent co-coder. A tape recorder was also used to record all the interviews, thus increasing reliability. In an attempt to increase interviewer reliability a pilot study was done to develop interview skills, although the information gathered was not used in the main study.

According to Polit and Hungler (1995:433), confirmability is a criterion for evaluating data quality with qualitative data, referring to the objectivity or neutrality of data. Confirmability was ensured by making use of an independent co-coder. This was also accomplished by incorporating an audit procedure in the co-coding procedure. Sandelowski (1986 in Polit and Hungler 1995:433) argues that "auditability is achieved when the researcher leaves a clear decision trail concerning the study from its beginning to its end". In this study auditability has been attempted by the researcher's clearly describing each stage of the research process, explaining and justifying what was done and why.

Lincoln and Guba (1985:324) suggest that during data gathering, the description must be inclusive enough to be able to transfer the findings to other situations. Transferability was ensured by selecting the sample purposively and by complete description of methodology, including literature control and verbatim quotes from individual interviews (Brink 1996:124).

Discussion of findings

Themes and sub-themes emanated from the analysis of data as presented in table 2.

Failure to provide adequate primary health care due to increased workload

Discussions with the primary health care nurses revealed that the introduction of the policy on free health care service is frustrating because they feel they are not providing adequate primary health care due to increased workload. Most of the nurses felt that the introduction of the free health care services had brought more work because of

frequent visits by patients, shortage of staff, the introduction of the supermarket, and lack of support personnel.

Frequent visits to the clinic by patients

Participants indicated that the introduction of the free health care services has increased accessibility to the clinics and health centres. The poor and the rich visit the clinics as they wish. This is of benefit particularly to the poor who can now afford to seek assistance as soon as they feel sick. However, it also implies that primary health care nurses have to deal with large numbers that are coming to the clinics, thereby increasing their workload. This is evidenced by the following quotations:

"In the past you find that patient come being seriously ill and then the patient would say, I did not have money. After the introduction of the free health care service, these serious cases are no more coming."

"I think to me the statistics has gone high, very much high. You find that we are working very much hard because people are coming daily even if a person was treated yesterday."

Increased accessibility means that the primary health care services have to deal with large numbers that are coming to the clinics and this is putting a lot of strain on the primary health care nurses. The study conducted by the Child Health Unit of the University of Cape Town (2001) also revealed that the implementation of the free health service has led to a rise in the attendance of patients at most public sector health facilities. The study also suggested that the previous system of user fees was a deterrent to people using public health services.

Shortage of Primary Health Care nurses

Most of the health care clinics in Limpopo Province have suffered shortages of primary care nurses for some time. In fact, strategies have been put in place for training of such nurses all over the province so that each clinic should have PHC nurse(s). In some clinics the staff establishment of PHC nurses has remained the same despite the introduction of free health care services. The Child Health Unit of the University of Cape Town (2001) recommended that improving access to health services must be accompanied by improvement in the quality and effectiveness of the service. This cannot happen if there is a shortage of staff. Hence, the primary health care nurses fail to provide adequate primary health care services (Dennil, King, Lock & Swanepoel, 1995:17).

In the study conducted by Sibaya and Muller (2000:10), shortage of staff, medication as well as equipment and supplies were found to be among the greatest fears of PHC nurses during transformation of PHC services in Gauteng. This study confirmed the fears alluded to at the time. In addition, Tembani, van Rooyen and Strumpher (2003:67) found out in their study about clinic supervisory systems that lack of resources interfered with the effective clinic management and the therefore ineffective service provision.

Some of the participants felt that the introduction of the "supermarket approach" to service provision has also contributed to the increased workload. In this approach, one is expected to render all clinical services on a daily basis. The "supermarket approach" was introduced as a response to the government's request that comprehensive primary health care be provided to all people. Before the introduction of this approach, primary health care was not offered in a comprehensive way. Services were not integrated, and were offered on different days. There were specific days for under-five clinic, family planning, geriatric clinic, etc. If a client visited a clinic with a need for contraceptives, she would only get assistance if she visited the clinic on the family planning clinic day.

The "supermarket approach" is an excellent approach if used appropriately, and where there are no staffing problems. It is cost effective for the clients because they do not have to wait for a special day. However, while the approach seems to benefit the client, it sometimes leads to the primary health care nurse providing the care experiencing stress. According to Organ and Bateman (1996:388) an individual sometimes has to carry out many separate, essentially unrelated tasks like consulting a patient with chest pains, and then providing immunisation to the under-five, providing family planning, etc.

The disadvantage of the "supermarket approach" is that it makes it difficult for effective health education to take place as reflected in the following quotation:

"The supermarket is good for the patient but it prevent us from giving health education. Lets say just now I am having a patient, maybe a pregnant patient coming for ante natal care and I would like to give health education on minor ailments and there are thirty or fifty patients waiting outside, do you think I can give them health education?"

Another participant said, "Another disadvantage is that we do not have much time with the patients especially ante natal mothers. They are going to the labour ward without full orientation because they are coming one by one. If they are in a group, we can advise on what to expect in the delivery room. Usually one cannot have one song for the whole day, it is very much difficult."

The findings from this research indicated that this integral aspect, health education, is not being given the attention it deserves. It is either not being given at all, or if given, it is done haphazardly because the primary health care nurses do not have enough time for this aspect. The main goal of health education is empowerment, i.e. the communities should be able to manage their health situation. Most of the participants felt that they are not able to give health education to the patients. This is supported by the following statement:

"You also give to conditions that you really think need health education eg. sexually transmitted diseases, diarrhea, etc. but with others you just prescribe treatment". Another participant said: "You know that the first treat-

ment is health education, but now because of this workload, you find that there are conditions, some of them we don't have time to give health education because of the queue which will be waiting for you."

According to Batho Pele principles (RSA, 1997:19), "information is one of the most powerful tools at the customer's disposal in exercising his or her right to good service. National and Provincial departments must provide full, accurate and up-to-date information about the services they provide, and who is entitled to them". Thus community members should be given full, accurate information about the services they are entitled to receive from the clinics. The limited time that the primary health care nurses are having is making it impossible for this principle to be attained."

Lack of thorough assessment leading to provision of symptomatic treatment.

Most of the primary health care nurses felt that patients are not examined thoroughly before medication is prescribed. This is supported by the following statement:

"Because sometimes we do not consult the patients and examine thoroughly, sometimes we can just listen for the symptoms and prescribe medication."

Another participant said: "Due to increased workload sometimes you just do a summary when you examine the patient because so many patients will be waiting for you. So you have to hurry, speed up in such a way that you cannot do a thorough examination which needs to be done."

The ALMA-ATA conference of 1978 identified eight elements to be the main focus of primary health care (PHC). The appropriate treatment for common diseases and injuries is one of the eight elements. In order to treat appropriately, one should take a good history from the client, conduct an examination based on the history taken, and then plan and give treatment. From the point of view of the primary health care nurses, thorough assessment is not done because of the increased workload. This leads to inadequate provision of primary health care services and compromising the quality of care provided. Most patients who seek health care have health-related worries or symptoms.

The physical examination may help both to identify such concerns and to explain the symptoms. It gives information with which to answer the patient's questions, offers opportunities for health education, provides baseline data for future use and increases both the credibility and the conviction of the clinician's advice and reassurance. Physical contact also enhances the clinician-patient relationship (Bates 1995:117). The experience of primary health care nurses reveals that this important aspect of examining the patients is not done, or if it is done, it is done haphazardly. Excluding this important aspect of physical examination will thus disadvantage the clients.

Some of the patients are too shy to divulge the information and unless a physical examination is conducted, the patient will go back with his/her problems unattended to.

Burnout, stress and strain related to increased workload

Most of the nurses felt that the increased workload also resulted in burnout, leading to stress and strain. Some nurses suffer from backache. Some even collapse on duty. One participant said,

"When I go off duty I am very tired, my legs are tired, even my mind is very tired. I need rest, but even if we are here for 24 hours there are still patients who come here at night, some only coming for condoms."

One participant put the issue in this way: "When we go home, we just want to sleep and we even sleep when we are still eating and at times you even fail to bath because of tiredness."

Cilliers (2003:62) wrote that research found burnout to correlate with pscychosomatic illness (Pettegrew, Costello, Wolf, Lennox & Thomas 1980), stress (Handy,1990; Hinshaw, Smeltzer & Atwood 1987) and organizational climate stress (Bedian, Armernakis & Curran, 1981) which imply in this study that the inputs of PHC nurses about the experience of burnout, stress and strain related to increased workload requires attention if service provision is to improve. Tembani, van Rooyen and Strumpher (2003:67) also found out in their study that nurses in charge of the clinics experienced elevated levels of stress due to their complex and challenging role in the clinic.

Misuse of free health service and medicines by the clients

On the one hand, abuse of medicines involves visiting the clinic more frequently and demanding the medication even if it is not necessary. On the other hand, it has to do with procedures that have to be followed when visiting the clinic, e.g. visiting the clinic at awkward times like taking a child with a minor ailment at night. Visiting the clinics/health centres at awkward times raises issues around the security of the PHC nurse. Most of the nurses felt that they are not secure in the clinics, especially at night. The introduction of free health services has made it possible for free movement of the communities in and out of the clinics. Even those who are drunk and dangerous can come in as reflected in the following statement:

"Some people do come to the clinic when they are drunk demanding to be treated."

In addition, the communities' ignorance about the free health care service has been identified as a factor contributing to the misuse of the service. From the interviews with the primary health care nurses, it appears that the public has several misconceptions or myths regarding the implementation of the free health care policy. Some of the myths are reflected in the following statements and behaviours:

Clients believe that medicines are diluted.

"Patients say sometimes that since the free health service was started the medicines have been diluted and that is why they are not paying, and when they want special medication they will rather go to a special doctor."

Clients move from one clinic to another.

The introduction of the free health care service has led to people visiting different clinics at the same time. A person will not wait to complete the course of treatment before returning to the clinic or going to another clinic. A patient consults at one clinic and after two or three days he/she goes to another clinic with the same complaints, more especially where personal health record booklets are not used. This is supported by the following quotations:

"They come now and then, maybe twice or three times a week."

"They usually come and say, I am coughing, and you can see that the person is not actually ill, they are just coming because the treatment is free and when you go out you see medicines lying outside, good medicine like brufen."

Clients do not use the services responsibly.

Instead of bringing minor ailments to the clinic during the day when there are more nurses, community members have a tendency of coming during the night, when the staff is reduced, for services like family planning. The following quotations evidence the findings in this regard:

"They misuse it, because some people come during the day and find the clinic being full, so they tell themselves that they will come during the night, even if it is not an emergency."

"Some parents send their children alone, some come here from the age of nine, ten being alone and that can always bring a problem with prescribing..."

This shows that the communities do not see anything wrong in sending their children alone to the clinic. It might be difficult for a child to understand how medicines should be taken. The possibility of mixing the treatment is very great and this can lead to serious complications like poisoning. Another participant indicated: "When they reach home the mother will come back with calamine lotion which is not supposed to be taken internally but externally, the one who brought the child did not explain well how the treatment is supposed to be taken or they just mix those treatment."

In addition, it was found out that some clients demand medicine for hoarding purposes. The following quotation provides evidence of this finding:

"They just collect the medicines and keep them at home. One patient said that we are keeping the panado at home so that if my child can have temperature I will just give him."

The discussed statements show lack of responsibility and also lack of commitment by community members. In addition, most of the participants felt that the introduction of the free health care service has lead to a shortage of medicines in most of the clinics. Most of the commonly-used medicines like panado are out of stock most of the time. This may be due to frequent consultations and patients who demand medicines even if there is no need for medication. This can be supported by the following statement:

"Other problems are like shortage of medicines, because when they come to the clinic they do not want to leave the clinic without medication." Another participant said: "Up to so far we have shortage of medicines. The medication can get finished before the next stock comes."

The Health Summit held in Johannesburg from 18 – 20 November 2001 also identified shortage of medicines as an issue of concern (Sowetan 2001:20). The aspect of shortage of medicines can be interpreted in various ways. The shortage of medicines could be the result of abuse by the clients as explained in the previous section. Another reason could be lack of planning by the primary health care nurses. It is necessary for the primary health care nurses to make good estimates when ordering drugs to avoid unnecessary shortages. To be able to do this, ongoing research is necessary to determine the kind of conditions often present at the clinic. The findings of this research revealed time constraints, and conducting research will definitely need time. This means that unless something is done about staffing, the problem of the shortage of medicines will continue to be a problem.

In an effort by the government to provide cost-effective drugs, it appears that certain effective drugs have been removed from the essential drug list. This can be supported by the following statement:

"We use to get voltarin for management of pain in patients with arthritis and also indocid for patients with rheumatic arthritis, but we are no longer getting these treatment."

The advantage of removing effective medicines and replacing these by less effective medicines is that of saving money, because effective medicines are more expensive and it would be difficult for the government to purchase these medicines. The disadvantage is that it might take a long time when managing a patient with a chronic disease like arthritis to be cured.

Fear associated with lack of security at the clinic

Most of participants felt that they are not secure in the clinics, particularly at night. The introduction of free health services has made it possible for free movement of the communities in and out of the clinics. Even those who are drunk and dangerous can come in as reflected in the following statement:

"Some people do come to the clinic when they are drunk demanding to be treated."

Lack of properly trained security staff.

Another complicating issue around security is that there is no properly trained staff. The security services are provided by watchmen who in most cases have never undergone any form of training. One participant put it this way: "We are always being threatened and we are afraid. There is an old man and I don't think he can secure me ..." Another participant said: "The nurses' home is not having burgler proof and some of the doors are not having security gates. This allows free movement of people in and out the nurses home." The above statements show that the nurses' home cannot be a safe place to stay under the present circumstances.

As indicated by participants, there are no properly trained security guards at the clinics and health centres and at some clinics there is no proper fencing. This is a very serious problem to the nurses who are expected to render 24-hour service. In one of the clinics a man came in carrying a gun during the night and he wanted a sister whom he did not mention by name. This shows how unsafe clinic nurses are during the night. One participant said: "Last week a night nurse had a problem, a man came in carrying a gun and just said I want a sister, I want a sister. People started to run in all directions and the watchman also ran away and he was actually the first person to run."

According to Maslow's hierarchy of needs as cited by Jordaan and Jordaan (1998), the needs are placed at different levels, like placing these at the different steps of a ladder starting from the most basic to the most sophisticated need. Security needs are second from the first step of the ladder. Maslow identified seven groups of needs and according to him a higher need will not be experienced until the preceding lower need has been at least partially satisfied and the person feels assured of regular future satisfaction. This implies that the primary health care nurses who are experiencing a deficiency in their need for security will not strive towards self-actualisation which is the basic motive linking all these needs (Jordaan & Jordaan 1998:581). The issue of security therefore affects the provision of quality free health care services to the communities.

The issue of security has led some of the clinics to abandon working during the night, which impacts on the principle of accessibility to the community of service provision. When it comes to the maternity cases, they are forced to hire transport to the hospital which is very expensive for some community members. This can result in some of the expectant mothers delivering unattended at home, which adds another dimension to the problem.

Conclusions and recommendations

Findings in this study indicated that although the primary health care nurses are implementing the free health care policy, they are dissatisfied with their performance because of the problems that are associated with the implementation of the free health care policy.

The findings in the above discussion indicate that the primary health care nurses appreciate what the government has done, namely, increasing the accessibility of the health care services. However, there are indications that participants are experiencing problems like increased workload due to increased accessibility and shortage of staff. They are also experiencing problems of shortage of medicines at the clinics, and misuse of the medicines and the services by the clients. The research findings also revealed fear due to lack of security at the clinics. All these problems are contributing to the primary health care nurses' failure to provide adequate primary health care services and it also contributes to their dissatisfaction and disappointment.

The Ministry of Health should institute a programme whose main focus should be education of the community regarding the free health care services. The communities should be made aware of the fact that the government is actually buying the medicines from the pharmaceutical companies. The government is making use of tax money collected from the public servants and the business communities. It therefore has a duty to keep the tax-payer informed. Education should also include how medicines work in the body as well as problems that could arise if the course of treatment is not completed. The media, community structures like civic organisations, traditional leaders, churches, etc., can be used to disseminate the information. Emphasis should be placed on co-operation between the communities and the clinics if the policy on free health care service is to be effective.

Finally, the discussions with the primary health care nurses show that no mechanisms were put in place to monitor the effectiveness of the free health care policy. It was also found that no feedback mechanism was put in place to inform the government with regard to the impact of the policy on the people implementing it and also to get the viewpoints of the health care consumers.
Monitoring mechanism should be put in place on a continuous basis so that the shortfalls of free health services are identified in time and remedial actions put in place to improve the effectiveness of service provision.

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