HEALTH CARE WORKERS' EXPERIENCES OF THE IMPLEMENTATION OF THE NATIONAL CORE STANDARDS AT BERNICE SAMUEL DISTRICT HOSPITAL IN MPUMALANGA PROVINCE

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DECLARATION

I **Thembekile Majozi** declare that this research report is my original work. It is being submitted for the degree of Master of Public Health in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University. I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong. I confirm that the work submitted for assessment for the above degree is my own unaided work, except where I have explicitly indicated otherwise.

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03 June 2021

DEDICATION

To my daughter Motlalepule Leshoro, life with you has been that much sweeter. May this degree be testament to you that anything is possible with God.

ABSTRACT

Background

Quality of care is fundamental to the attainment of universal health coverage (UHC). In South Africa, the National Core Standards (NCS) set the expected level of performance for health establishments. The aim of the study was to explore the experiences of health care workers with the implementation of the NCS at the Bernice Samuel district hospital in Mpumalanga province.

Methods

This was a qualitative case study at the Bernice Samuel district hospital. Following informed consent, in-depth interviews were conducted with all health care workers (HCWs) who had experience of at least one NCS inspection. The questions focused on the context and process of implementation; knowledge of the NCS; HCWs' experiences of NCS implementation, and the factors that influenced the implementation of the NCS. The interviews were analysed using thematic analysis, supported by MaxQDA (Student Version).

Results

Sixteen in-depth interviews were conducted at the hospital. The context was influenced by the proposed national health insurance (NHI) system, community dissatisfaction with quality of care, and health ministerial priorities. Health care workers reported learning opportunities and role clarity as positive aspects. However, they highlighted the burden and perceptions of flawed implementation processes, exacerbated by insufficient district and provincial health support, financial and human resource constraints, and infrastructural challenges.

Conclusion

The implementation challenges need to be addressed to ensure the successful implementation of the NCS at hospital level.

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To my family and friends, thank you for your support and believing in me until I believed in myself.

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ACRONYMS/ ABBREVIATIONS

COHSASA	Council of Health Service Accreditation of Southern Africa
DoH	Department of Health
HCP	Health Care Provider
HCW	Health Care Worker
HCWs	Health Care Workers
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
ISQUA	International Society for Quality in Healthcare
LMICs	Low- and Middle- Income Countries
MDGs	Millennium Development Goals
MP	Mpumalanga
MPULEG	Mpumalanga Provincial Legislature
NCS	National Core Standards
NDoH	National Department of Health
NHI	National Health Insurance
OECD	Organisation for Economic Co-operation and Development
OHSC	Office of Health Standards Compliance
PERSAL	Personnel and Salary System
PHC	Primary Health Care
QA	Quality Assurance
QI	Quality Improvement
QIP	Quality Improvement Plan
RSA	Republic of South Africa
StatsSA	Statistics South Africa
SDGs	Sustainable Development Goals
TB	Tuberculosis
UHC	Universal health Coverage
WHO	World Health Organization

CHAPTER 1: INTRODUCTION AND LITERATURE REVIEW

1.1. Introduction

Quality of care is fundamental to the attainment of universal health coverage (UHC), and in preventing unnecessary deaths (1, 2). Estimates suggest that more than 8 million lives could be saved in low- and middle-income countries (LMICs) by the provision of high quality care (2). Existing evidence suggests that mothers and children in LMICs receive less than half of the recommended clinical care activities at any given visit to a health establishment (2). Furthermore, it has also been found that serious conditions are frequently misdiagnosed and that there is delayed action for conditions that require prompt action (2).

In South Africa, there have been numerous government initiatives since 1994 to improve quality of health care in the public health sector and to enhance health system responsiveness (3, 4). Among the most important initiatives has been the establishment of an independent quality of care regulator, the Office of Health Standards Compliance (OHSC) (5). The core mandate of the OHSC is the protection and promotion of the health and safety of health service users, through the effective management of patient complaints and the enforcement of compliance to prescribed norms and standards (5).

The norms and standards are known as National Core Standards (NCS). These NCS aim to define the structures and processes needed to provide safe, equitable, acceptable, and effective health services (6). Although the NCS implementation commenced in the public health sector, the NCS provide clarity on the performance expected from health establishments across the country (6). The compliance with the legislated standards and accreditation of health establishments are envisaged as prerequisites for the implementation of the National Health Insurance (NHI) system, which is South Africa's vehicle to achieve UHC (7). The OHSC measures compliance with the NCS through the inspection of different levels of health establishments (8). The goal for every inspected health facility is to obtain an overall acceptable level of quality and safety according to the NCS, thereby indicating that the facility is able to provide good standards of basic health care to the public (9). Quality initiatives, such as the NCS, have underscored the importance of every health worker in ensuring good quality healthcare and in complying with the minimum prescribed quality standards (10).

In 2015, the Bernice Samuel district hospital in Mpumalanga province obtained an overall NCS score of 44% during the OHSC inspection (11). In light of the crucial role of health care workers (HCWs) to the successful implementation of the NCS, this Master of Public Health (MPH) study focused on the experiences of health care workers (HCWs) of the implementation of the NCS at Bernice Samuel hospital. It is envisaged that the generation of locally, context-specific information on the NCS implementation at the hospital will enable the hospital management team to develop interventions to improve the quality of care, and to comply with the NCS at the hospital.

This chapter provides the context of and background to the study along with the literature review of research studies that focused on the implementation of quality improvement initiatives in health care. Section 1.2 defines the various terms used in the research report, followed by the global context of quality improvement initiatives in Section 1.3. Section 1.4 focuses on the South African context of quality improvement initiatives, including the NCS and the inspection process. Section 1.5 provides a summary of relevant studies on the implementation of quality of care initiatives. The concluding sections present the statement of the problem, study rationale, and the aims and objectives of the study.

1.2 Definition of terms

Accreditation	A formal process by which a recognised body assesses and certifies that a health care organisation or establishment meets pre-determined and published standards that are regarded as optimal and achievable (12).
Context	In this study, context refers to the environment in which health policy actors (in this case HCWs) operate. The context includes political, economic, and social factors that influenced the NCS implementation process (13).
Health Care Worker (HCW)	Any person employed in a health establishment to ensure that patients receive quality care, including

	front-line health care workers, supervisors, managers, and those that support and enable them to deliver quality care (6).
Health Establishment	A public or private organisation within South Africa that provides health care and related services. These include, but not limited to the provision of inpatient and outpatient care, diagnostic and therapeutic services, nursing care and equipment used for provision of health care services (6).
Implementation	The process of putting a decision, policy or plan into effect (14). In this study, implementation refers to the hospital's compliance with the NCS, determined through the inspection process.
Inspection	"On-site visits to health establishments for the purpose of gathering information and evidence to assess compliance or investigate breaches of prescribed norms and standards" (15, p.26).
National Core Standards	A set of standards developed in South Africa "which will assist in setting a benchmark of quality care to be delivered, and that are used in monitoring the delivery of health care services" (6, p.8).
Quality assurance (QA)	A systemic process of checking if the health services provided are meeting the set quality requirements or quality norms (16).
Quality of Care	A measurable process aimed at improving health, it reflects the desires and goals of key stakeholders including service users and communities (1, 17).
Universal Health Coverage (UHC)	Defined as "ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and

> palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship" (1. p.16)

1.3 Global context

There is a considerable body of literature on the quality of health care since the seminal conceptual framework of Donabedian that enables the evaluation of the quality of health care provided (17, 18). The Donabedian model proposes that quality of care can be assessed by focusing on structure (the context in which care is delivered, including resources and infrastructure), processes (the interactions between patients and health care providers), and outcomes (effects of healthcare on the health status of patients and/or populations) (17, 18).

It goes beyond the scope of this research report to review global quality of care initiatives since the publication of the Donabedian model. However, the global vision for UHC contained in Agenda 2030 of the Sustainable Development Goals (19) has reignited the emphasis on quality of care. During 2018, three global reports underscored the importance of high-quality health systems to the achievement of UHC (1, 2, 20). The first-ever joint global report from the World Health Organization (WHO), Organisation for Economic Co-operation and Development (OECD), and the World Bank Group emphasised that poor quality health services hamper progress in achieving population health improvements in all countries, regardless of income levels (1). The Lancet Global Commission report on high-quality health systems concluded that "providing health services without guaranteeing a minimum level of quality is ineffective, wasteful, and unethical" (2, p.1198). The Lancet Commission report also made a call for government investment in high-quality health systems, combined with public participation, accountability, transparency, and education of communities about their rights (2). The National Academies quality of care report highlights the progress made on the Millennium Development Goals (MDGs), but enormous gaps remain among and within countries and regions (20). The report points out that progress has been incomplete and unequal, and that a comprehensive effort is needed to improve the quality of health care services globally (20).

All three reports underscore the vulnerability of poor people to sub-optimal quality care in LMICs, exacerbated by resource constraints, the social determinants of health, and the actions or omissions of health care workers (21). All three reports emphasise the criticality of human resources for health (HRH) or health care workers to the quality of care provided and the achievement of high-quality UHC (Table 1.1). This is because health care workers are the implementers of quality of care initiatives and their knowledge, motivation, commitment, and level of involvement determines the impact of the quality of care initiatives (22). Hence, Table 1.1 summarises the key HRH findings from each of the global reports on quality, as well as the recommendations pertaining to health care workers.

Despite the global recognition of the importance of HRH, existing evidence suggests that there is insufficient consultation or involvement of frontline health care workers in health policy development, which in turn affects the subsequent implementation of policies (23, 24). This lack of involvement of frontline health workers may result in policy implementation failures or an inability to achieve the desired policy outcomes (23, 25). Lipsky, a policy implementation theorist, has argued that the actions and decisions of frontline service providers influence the nature and outcome of policy implementation (26). Given the importance of HRH to the successful implementation of health policies at all levels of the health system, this study explored the experiences of or health care workers in the implementation of the NCS at a small district hospital in Mpumalanga province.

1.4 South African context

1.4.1 Overview

South Africa's quest for a high quality-health system cannot be seen in isolation of the triple challenge of poverty, unemployment and health inequities in the country (27). This challenge is exacerbated by the quadruple burden of disease and the inequitable, racially-fragmented health system inherited at democracy in 1994 (28). The quadruple burden consists of a high prevalence of HIV & AIDS and tuberculosis; high maternal, neonatal and child morbidity and mortality; rising non-communicable diseases and high levels of violence and trauma (29).

Table 1.1 Overview of key findings and recommendations on health care workers in global quality reports

	WHO/OECD/World Bank	Lancet Global Commission Report	National Academies of Sciences
Key findings	• Health workforce shortages • Inequities between urban and rural areas • Health workers ✓ Spend insufficient time with patients ✓ Many lack ability to make correct diagnoses, or prescribe inappropriate treatment • <50% of health care providers adhered to clinical guidelines • Major issues with health professional absenteeism, productivity and diagnostic accuracy • Sub-optimal primary healthcare provided in both public & private health sectors • Gaps in the care provided to elderly	• Many health providers do: ✓ Less than recommended evidence-based care activities ✓ Not follow clinical guidelines or examine patients systematically • Wide variations in clinical diagnostic accuracy • Lack of counselling and/or health education • Inadequate or poor quality care provided • ~ 50% suspected tuberculosis cases wrongly managed • < 10 % of people with depressive disorders receive minimally adequate care • Myocardial infarction, pneumonia, newborn-asphyxia frequently missed • Care for emergency conditions slow, reducing the chances for survival	• Need for skilled health professionals • Inequities among and within countries • 25-50% accurate healthcare for patients with asthma, tuberculosis, chest pain and diarrhoea • Lack of adherence to clinical guidelines/ evidence-based practice ✓ Insufficient knowledge or awareness of guidelines ✓ Competing priorities ✓ Sub-optimal infrastructure or care environment ✓ Poor accountability • Unnecessary/ ineffective care or services ✓ 6 million excess caesarean sections conducted every year ✓ Unnecessary antibiotic prescribing
Recommendations	Availability of high-quality health workforce ✓ National strategy ✓ Modernise training curricula ✓ Continuing professional development ✓ Skills, knowledge, attitudes ✓ Motivation ✓ Skills mix and teamwork ✓ Community health workers ✓ Enabling environments to support high-quality care	Transform the health workforce ✓ Competency-based pre-service health professional education and problem-based learning ✓ Early clinical exposure ✓ Improve quality of clinical education ✓ Address understaffing of health training institutions ✓ Positive practice environments	High-quality health care requires skilled health care workers ✓ Training of competent health workforce • Competency-based curricula • Digital health advances • Interpersonal skills for teamwork and person-centred care • Systems-based thinking ✓ Mainstream lay/community health workers (regulation, training) ✓ Improve work-life of health workers to enable quality

Original sources of content: WHO et al, 2018; Kruk et al 2018; National Academies, 2018 (1, 2, 20).

Summary of findings and recommendations adapted from: Rispel, 2019 (30).

Notwithstanding these challenges, there has been much progress in the country in the past 26 years. This progress includes an overall improvement in the health status of South Africans, notably a reduction in maternal and child mortality rates and an increase in life expectancy (27). The health system transformation initiatives include numerous structural and policy changes; removing access barriers through free PHC services and the clinic-building programme; and the implementation of priority health programmes (27).

Despite the progress in democratic South Africa, the health system continues to be plagued by huge inequities, between urban and rural areas, and between the public and private health sectors (27). The private sector, with its concentration of resources and health care providers, serves around 16% of the population with access to private health insurance (27). The results of these discrepancies in spending are evidenced by differences in the standard of care and infrastructure across the health care system.

Consequently, financing reforms are at the core of South Africa's efforts towards UHC, and are embodied in the National Health Insurance (NHI) System (8). Based on the Reconstructive Development Programme (RDP), the White Paper on Transformation of the Health System and other legislation, the NHI aims to transform the delivery of health care services (8). The transformation will be achieved through shifting the focus to health promotion, disease prevention and community empowerment (8). Furthermore, in pursuit of financial risk protection, the NHI will transform the financing of health care through eliminating fragmentation and pooling funds to purchase health care services for all citizens (8).

1.4.2 Summary of quality improvement initiatives

Quality of care has been a priority of the democratic South African government since 1994 (28). The Reconstruction and Development Programme (RDP), a socio-economic policy framework to achieve transformation of all sections of South African society, underscored the importance of quality public service delivery (31). The subsequent White Paper for the Transformation of the Health System in 1997 outlined a range of measures to improve quality of health care (32). At the same time, the White Paper on Transforming Public Service Delivery, commonly referred to as the Batho Pele White Paper, was published in 1997 (33). Batho Pele, a SeSotho word for "People First", emphasises eight principles of consultation,

service standards, redress, access, courtesy, information, transparency, and value for money (33).

Outside government, the Council for Health Service Accreditation of Southern Africa (COHSASA) was an important development (34, 35). COHSASA is a not-for-profit organisation that was established in 1995. Although COHSASA assists a wide range of healthcare facilities to meet and maintain quality standards, it is a voluntary process, with independent operations from government (34). In 2000, the Health Quality Assessment was established to analyse clinical data submitted by medical aid schemes, which is also a voluntary process that operates outside government (4).

Figure 1.1 shows a timeline of the most important quality of care initiatives (4). As can be seen from Figure 1.1, the majority of these initiatives have been legislative, policy or structural changes. The National Health Act provides the legal framework for health service delivery in South Africa, including a charter of patients' rights (36). The National Core Standards (NCS) set the expected level of performance or benchmark of quality for health establishments in South Africa (6). The amendment of the National Health Act makes provision for the establishment of the OHSC (5). The mandate of the OHSC is to ensure that both public and private health establishments in South Africa comply with the regulated health standards. The OHSC is part of a suite of health reforms to complement the implementation of the proposed NHI system (8).

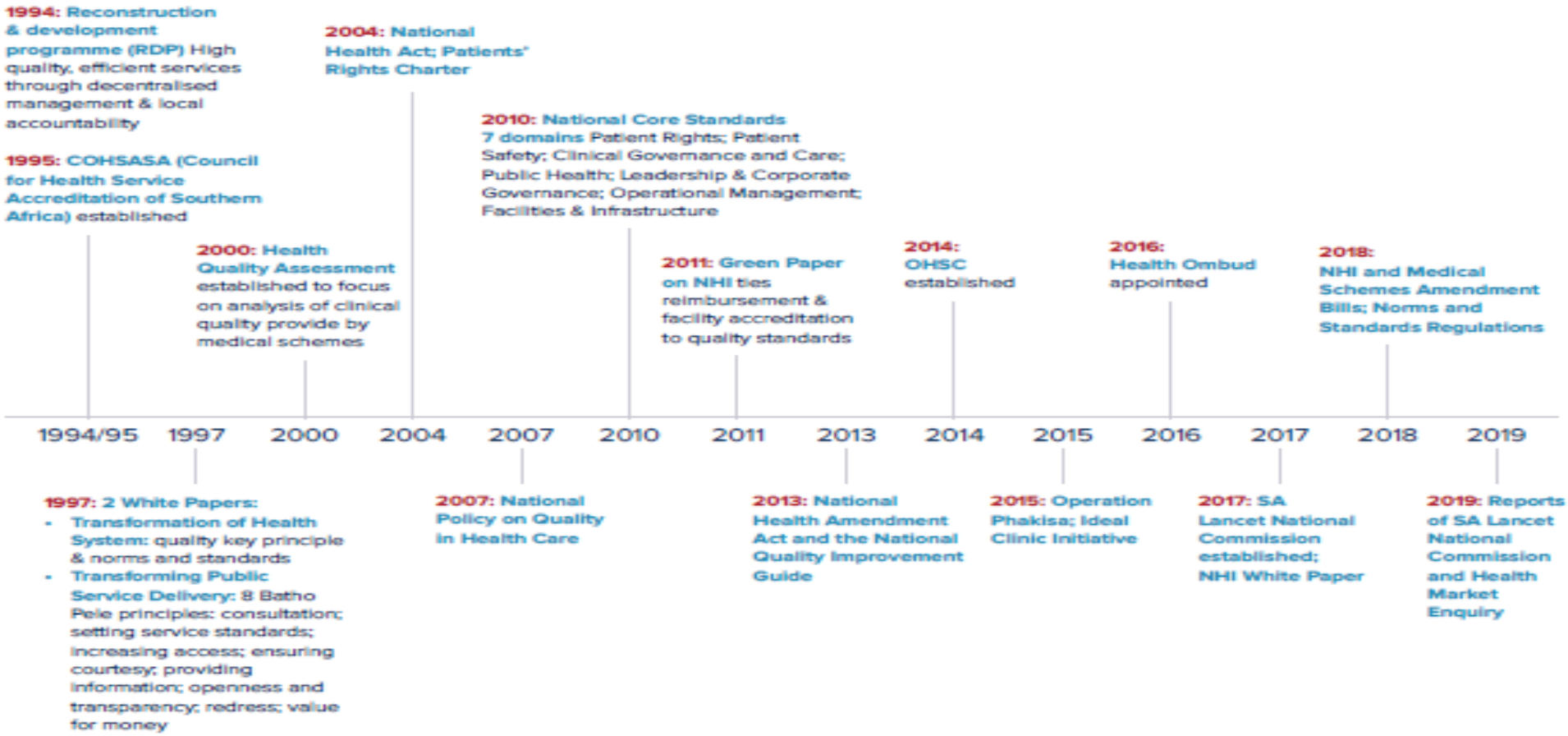

Figure 1.1: Key quality initiatives in South Africa.

Source: Rispel et al, 2019 (4, p.5).

1.4.3 Overview of the National Core Standards

The NCS consist of seven domains illustrated in Figure 1.2 (6). The first three domains: Patient Rights; Patient Safety, Clinical Governance and Care as well as Clinical Support Services are concerned with the core business of health establishments, which is to provide health care services to the public (6). The remaining domains: Public Health; Leadership and Corporative Governance; Operational Management along with Facilities and Infrastructure are seen as the support system that ensures the delivery of the Department's core business (6). The domains are further broken down into sub-domains. Within each sub-domain a set of standards define what is expected to be delivered in terms of best practice (6). Health establishments are expected to participate in self-assessments, supported by district assessment teams, before the external assessment by the OHSC (6). Both these assessments are geared at guiding health establishments towards meeting the set norms and standards.

Figure 1.2: Domains of the NCS

Source: National Department of Health, 2011 (6, p.10)

1.4.4 Overview of inspection process

The National Health Amendment Act mandates the OHSC to conduct inspections to ensure or enforce compliance with the regulated norms and standards (5). The OHSC's inspection strategy envisages voluntary compliance by health establishments (15). Hence, health establishments are encouraged to participate in self-assessments. These self-assessments provide a baseline of the establishment's performance against the NCS, and assist health establishments to get familiar with the assessment standards and tools, and to identify areas where improvements are needed, without the need of an external assessor (6).

In Nkangala where the Bernice Samuel district hospital is located, the District Office established district inspection teams to assist health establishments with the self-assessment process. After the self-assessment, the baseline is used to generate quality improvement plans to guide the institution in taking remedial actions towards the attainment of the set standards (6). Thereafter a formal, external assessment by an external body (OHSC) takes place at the health establishment (6). The results of the external assessment are also used to determine if the establishment is compliant with the regulated norms and standards and to guide further quality improvements (37).

1.5 Brief review of relevant research studies on quality of care initiatives and health workers' experiences

Several studies have demonstrated the gaps or differences between quality improvement initiatives and their actual implementation (38-41), which in turn influence the intended outcomes. HRH are critical to the implementation process as reiterated by the three global reports that focused on quality UHC (1, 2, 20).

Several studies across geographical settings have highlighted various facilitators and barriers to the implementation of quality improvement initiatives (42-47).

The 2018 report on quality of care of the National Academies found that unclear goals, poor training, unreliable supply chain processes, burdensome rules, inadequate information flows and inadequate systems impeded the implementation of quality improvement initiatives (42).

A study in Canada surveyed health care providers to examine the implementation processes of a large-scale, multi-year quality improvement initiative (43). Notwithstanding the high-income status of Canada, and significant investments in training and implementation, more than 75% of respondents complained about inadequate training and insufficient resources (43). Nurses were more likely to report that the quality improvement programme increased their workload. The survey also found significant differences in responses between health leaders and frontline health care providers (43). In Australia, a study explored the impact of collaboration among health care practitioners from different organisations and sharing of experiences of the Plan-Do-Study-Act (PDSA) cycles to achieve improvements (44). The study demonstrated mixed results on these collaborations, highlighting the design and reporting of these improvements as the main limitations (44).

In Hong Kong, a systematic review was done to identify the factors that influenced implementation of accreditation programmes in public hospitals. This review found that staff engagement and communication, multidisciplinary team building, positive changes in organisational culture, and enhanced leadership and staff awareness of continuous quality improvement enhanced implementation (45). In contrast, the barriers to implementation included organisational resistance to change, increased staff workload, lack of awareness or support for continuous quality improvement, and insufficient staff training (45).

In Thailand, a study that compared the opinions of health care professionals and surveyors (inspectors) on the implementation of hospital accreditation standards found that major obstacles included staff shortages, lack of integration and utilization of information, and inadequate discharge and referral processes (46).

In Lebanon, healthcare providers highlighted the perceived benefits of PHC accreditation as documentation, reinforcement of quality standards, and improved staff and patient satisfaction

(47). However, challenges encountered included limited financial resources, poor infrastructure and staff shortages (47).

Studies in Tanzania found that on-site mentoring and coaching visits to individual health facilities enhanced implementation. Challenges included competing or duplication of initiatives and insufficient health workers' knowledge (22, 48). In Uganda, a study on incentives and barriers to implementing national hospital standards found that staff expressed strong support for the development and implementation of these standards. The obstacles included lack of technical assistance, funding and training (49).

In Zambia, a study found that there was significant improvement in compliance with standards following the implementation of a national hospital accreditation programme (50). However, the accreditation programme had stalled due to insufficient funds, lack of legal standing of the Accreditation Council, difficulties in retaining qualified surveyors, and indecision on how to handle accreditation results (50).

In 2020, Holvid and colleagues reported that internal or mock inspections helped the HCWs to learn and to do better during the external inspection (51). This was because the HCWs were able to identify and close the quality gaps, leading to a better outcome during the external inspection. Twigg and colleagues found that staff shortages led to less time being spent on patients, resulting in patient dissatisfaction and HCWs being unable to implement quality standards (52).

The South African National Lancet Commission found that there is enabling legislation and several supportive policies for quality improvement (28). The Commission found that there are gaps in the coordination and implementation of the numerous quality improvement programmes, resulting in limited impact (28). The limited impact of these various initiatives is reflected in the results presented in the 2016/17 inspection report of the OHSC. The 2016/17 OHSC inspection report found that there were wide variations in the overall percentage scores achieved across the nine provinces and by type of health facility (53). Gauteng province achieved higher average percentage outcome scores, compared to the rural provinces of Eastern

Cape, Limpopo and Mpumalanga (53). In Mpumalanga, the OHSC found that the majority of health establishments inspected were critically non-compliant, and required follow-up inspections (53).

1.6 Problem statement and study rationale

In 2015, the Bernice Samuel district hospital, where the researcher is a speech therapist, obtained an overall NCS score of 44% during the OHSC inspection. The OHSC classifies a score of 40-49% as non-compliant, and recommends urgent intervention and re-inspection of the health facility (53). HCWs are essential to NCS compliance of a health establishment, both in the initial preparatory work prior to inspections, and subsequently as part of quality improvement teams to address the identified following inspection (6). The research questions that arose were, firstly whether the experiences of HCWs could contribute to the lack of compliance with the NCS, and secondly what could be done to enable HCWs to assist with NCS compliance at Bernice Samuel district hospital.

Hence, the rationale for this MPH study was to generate new knowledge on the experiences of HCWs on the actual implementation process of the NCS at the hospital. The study also set out to explore the factors that influence NCS implementation at a district hospital level. The researcher envisaged that information on the enablers and the constraints or bottlenecks to achieve NCS compliance could provide strategies and recommendations to deal with the NCS implementation gaps or shortcomings at the hospital level.

1.7 Aim and Objectives

The overall aim of the study was to explore the experiences of health care workers with the implementation of the National Core Standards (NCS) at the Bernice Samuel district hospital in Mpumalanga province.

The specific objectives of the study were to:

1. Describe the context of implementation of the NCS at Bernice Samuel District Hospital, specifically the political, economic, environmental, social, structural, and technological factors that influenced implementation.
2. Explore the knowledge of health care workers of the NCS.
3. Describe the process of implementation of the NCS at Bernice Samuel hospital.
4. Explore the experiences of health care workers with the implementation of the NCS at Bernice Samuel hospital.
5. Explore the factors that influenced the implementation of the NCS at Bernice Samuel hospital.

CHAPTER 2: METHODOLOGY

This chapter describes the approach and the methods used in the study to meet the objectives. Section 2.1 presents the study design and section 2.2 presents the study setting. Section 2.3 presents the population of interest, while Section 2.4 outlines the selection of the study participants. Section 2.5 describes the process of developing the data collection instrument. Sections 2.6 and 2.7 present data collection and data analysis respectively. Section 2.8 outlines the ethical considerations. Section 2.9 describes steps taken to ensure research rigor and trustworthiness and the concluding section 2.10 summarises the study limitations and steps taken to limit them.

2.1 Study design

This MPH study was a qualitative case study that sought to explore the experiences of health care workers (HCWs) of the implementation of a major policy initiative, namely the NCS, at a district hospital in Mpumalanga province. The case study methodology enabled a detailed exploration of the complex dynamics of NCS implementation within a real-life context (54).

2.2 Study setting

Mpumalanga is one of the nine provinces in South Africa and it is divided into three districts. Figure 2.1 shows Mpumalanga province in relation to the rest of the provinces and it also gives the demarcations of the three districts within the province. Nkangala is the smallest of the three districts in the province, comprising 22% of the total geographic area of Mpumalanga (55). Bernice Samuel hospital is one of seven district hospitals in Nkangala and is situated in Victor Khanye Local Municipality which borders the City of Ekurhuleni in Gauteng (55). Due to the rapid growth of the population being served by Bernice Samuel hospital, its capacity has steadily increased from ten beds at inception to the current 52 beds. However, the hospital has 39 approved beds (11). At the time of the study, the total staff complement according to the personnel and salary system (PERSAL) was 185 out of the 206 posts allocated to the hospital. Below is a map depicting the Bernice Samuel hospital in Nkangala district, Mpumalanga province.

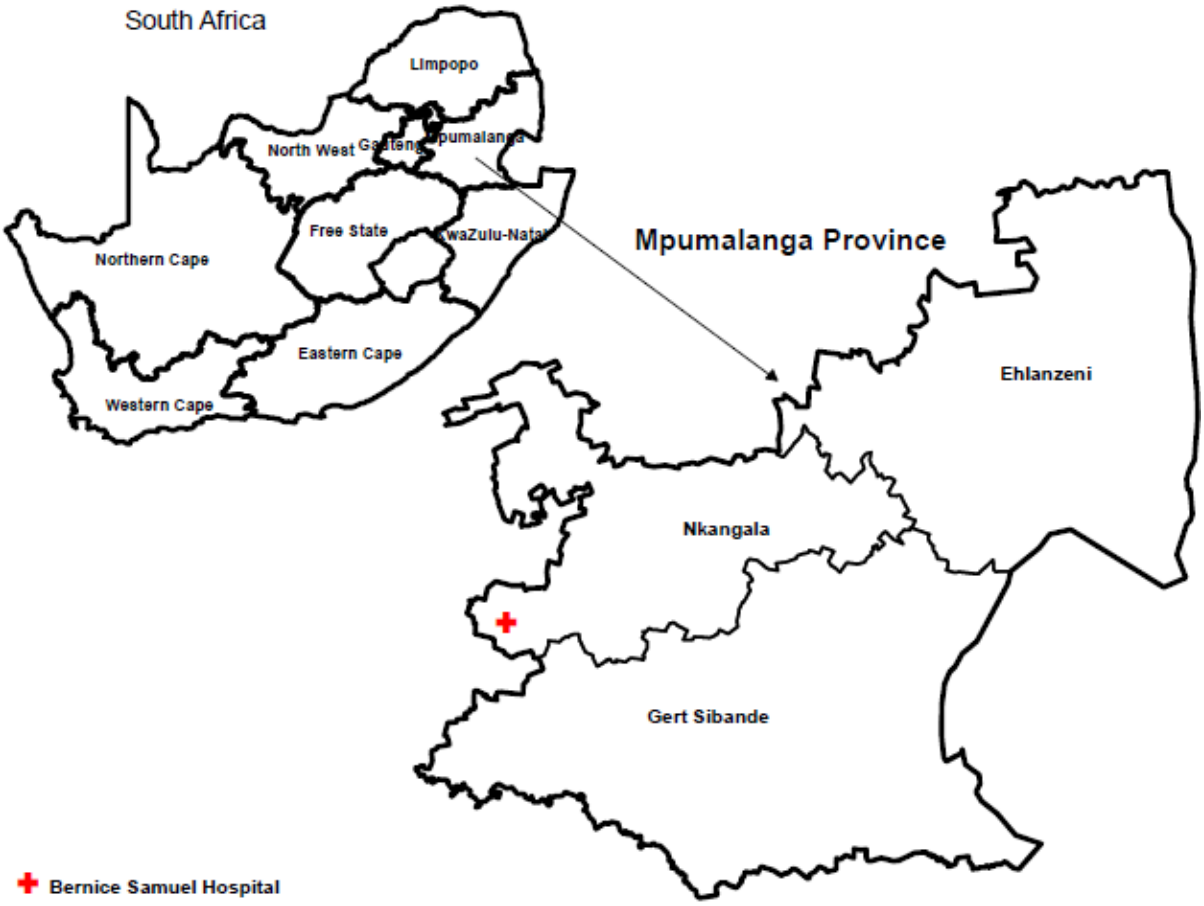

Fig 2.1: Map depicting study setting

Source: Health Systems Trust 2018/19 (55).

2.3 Population of interest

The population of interest included health care workers, namely professional nurses, medical officers and allied health professionals, as well as the managers of these health workers. At the time of the study in 2019, the hospital employed 46 professional nurses, 12 medical officers and 13 allied health professionals.

2.4 Selection of participants

The main inclusion criteria were: employment at the Bernice Samuel district hospital; previous involvement in the assessment or inspection of the hospital. The assessment or inspection could have been by the OHSC or by the District Assessment Team. This is because previous involvement in the inspection process is important, as the study investigated HCWs' experiences with the implementation of the NCS. Table 2.1 shows the profile of the participants invited to take part in the study.

Table 2.1: Profile of invited study participants

Hospital executive managers	Chief executive officer	5
	Nursing service manager	
	Corporate manager	
	Human resource	
	Finance managers	
Middle managers	Quality assurance manager	7
	Health information manager	
	Unit managers	
Frontline health care workers	Nurses	11
	Allied Health Professionals	
	Doctors	
Total Sample		**n=23**

2.5 Development of the data collection instrument

The principal researcher (PR) developed a detailed information sheet (Annexure 1) to provide an overview of the study, and consent forms for the interview and recording of the interview (Annexures 2 and 3). The PR developed a semi-structured interview schedule, in line with the study objectives (Annexure 4). The interview schedule consisted of two sections: context and knowledge of the NCS (four questions) and the process of the implementation of the NCS (nine questions). The section on context and knowledge section explored HCWs' previous involvement in quality of care initiatives; their opinions about the rationale for the NCS and the contextual factors that influenced the implementation of NCS at Bernice Samuel hospital.

The section on process of implementation focused on the HCWs role in the NCS inspection process, their overall experience of the NCS implementation as well as the challenges and constraints they experienced with the implementation of NCS at the hospital.

Healthcare workers were also asked what they would do to ensure compliance with NCS if they had the power to do so.

The PR piloted the interview schedule with HCWs from the District Office and another district hospital not part of the study. The aim of the pilot was to test the duration of the interview, clarity of questions, and the validity of the elements contained in the interview schedule. The pilot revealed that no changes were necessary to the interview schedule.

2.6 Data collection

The PR invited eligible study participants via email, and sent the information sheet (Annexure 1). The PR emphasised to all these individuals that their participation was voluntary. The eligible participants were then asked to indicate their availability for the interview and appointments were made with them.

After obtaining written informed consent (Annexures 2 and 3), the researcher conducted the interviews, using the semi-structured interview schedule (Annexure 4). Data collection took place between June 2019 and August 2019. All the interviews were conducted in English. The interviews took place during working hours, at convenient times for the participants. In order to maintain confidentiality, the participants' names were neither mentioned during the interview nor written on the interview schedule.

Each interview took an average of 25 minutes, but the time varied depending on the responses of the participant. Interviews were audio-recorded (with informed consent) to make it easier for the interviewer to capture the information discussed during the interviews. One participant refused to give consent for audio recording, therefore a dictation of the responses was taken. All recordings were uploaded to the researcher's laptop which is password protected. At the end of data collection the interview schedules were placed in an envelope and kept locked in a cabinet which only the researcher had access to in her office.

2.7 Data analysis

Each interview was allocated a unique study number using the following abbreviations for the study participants HCW1, HCW2 to HCW16. The PR transcribed the audio recordings verbatim. The process of transcribing forms the early stages of data analysis by the researcher, as it helps the researcher to develop a thorough understanding of the data (56).

The transcriptions were then imported into MaxQDA (Student Version) for thematic analysis (56). From the analysis of the data, inductive codes were generated. Code generation involves the identification of features of the data that may be of interest for the analyst (56). These are the most basic element of the raw data that can be assessed in a meaningful way (56). Inductive inferences are made from the collected data (57) and codes were based on the responses of the participants.

Two other coders, one of the supervisors, and a health systems researcher, were given three transcriptions of the same text to ensure inter-coder agreement. The PR and each of the other researchers applied the codes to the text data, first independently and then the coders had a meeting to discuss the codes that they had applied. The codes generated were then compared between and among the coders to check for inter-coder agreement (58). This process was used as a proxy for the validity of the themes that emerge from the text data (58).

Once there was inter-coder agreement, the deductive codes were used to develop themes and subthemes. The PR used the themes and sub-themes to analyse the rest of the data (56, 59).

2.8 Ethical considerations

The Human Research Ethics Committee (Medical) provided ethical approval for the study (#M190228) (Annexure 5). The study protocol was also submitted to the Provincial Health Research Committee (PHRC) at the Mpumalanga Department of Health through the National Health Research Database (NHRD), as well as the Institutional Head at Bernice Samuel Hospital. The Head of Institution signed a letter of support (dated 23 January 2019) (Annexure 6) for the study and the PHRC approved the study in May 2019(Ref: MP_201905_009) (Annexure 7).

The study was guided by the principles that are outlined in the Declaration of Helsinki (60), namely, voluntary participation, maintaining privacy and ensuring confidentiality, and ensuring that all potential participants were provided with information regarding the nature of the study, in order to give informed consent for participation.

All potential participants were approached through email and they were provided with information sheets about the study (Annexure 1) prior to participation. The information sheet

contains information about voluntary study participation as well as information about the study. This included what the study was about, why the study was conducted, confidentiality, and participant's rights in the study and potential benefits and/or risks.

In addition to the participant reading the information sheet, the researcher explained the voluntary nature of participation in the study and also answered any questions from potential participants. The researcher also emphasised that she was conducting the study as part of her MPH. Once potential participants agreed to take part in the interview, they were presented with consent forms to sign (Annexure 2 and 3). The consent forms acknowledge that participation in the study was voluntary as well as permission for audio recording of the interview.

No participant identifiers were collected. All data was kept in the researcher's laptop which is password protected. The completed interview schedules were kept in a locked office at all times. The audio recordings were also kept in a locked office and they will be destroyed after the period prescribed by the Ethics Committee.

2.9 Research rigour and trustworthiness

In qualitative studies, the researcher's subjectivity may cloud the interpretation of the research data, thus it is paramount that qualitative researchers consider rigour / trustworthiness of the data (61). Rigour is defined as quality or the state of strict precision, it is used to describe attributes related to the process of qualitative research; while trustworthiness talks to the degree of trust that readers must have in the study results (61). These terms have been used interchangeably throughout the literature (62). In order to ascertain trustworthiness in the current study, the researcher made use of the evaluation criteria that were proposed by Morse and others. These criteria are credibility; confirmability; meaning in context; recurrent patterning; saturation and transferability (63). Credibility was ensured by the researcher presenting the transcriptions back to the participants to ensure that data captured were representative of their experiences; they were also given a chance to make additions or corrections. Confirmability was met by taking detailed field notes during data collection, the researcher also maintained self-awareness of her role in the process as a researcher. Furthermore, the researcher ensured verbatim transcription of the interviews from the voice recordings (61).

2.10 Study limitations and mitigation

Some challenges that were encountered during the time of data collection included the unavailability of managers, due to meetings and other commitments. This was overcome by rescheduling appointments to fit the schedule of the executive managers. As social desirability was identified as a potential limitation of the study, the PR ensured all of the participants of voluntary participation, and the confidentiality and anonymity of the information provided.

The small number of HCWs who participated in the study is a limitation as the data collected reflect their experiences at a point in time. These views cannot be generalised to all HCWs. However, the number interviewed is a reflection of the HCWs who met the eligibility criteria. Notwithstanding these limitations, the study provides valuable insights into the experiences of these HCWs on the implementation of NCS at Bernice Samuel district hospital.

CHAPTER 3: RESULTS

3.1 Background of study participants

The researcher invited 23 potential study participants, four did not meet the inclusion criteria, and three declined to take part in the study. Hence, the final study number of study participants was 16. Table 3.1 summarises the background of study participants.

Table 3.1: Overview of study participants

Category	Number of participants	Gender		Mean years in portfolio	Range of years of service
		M	F		
Executive management	4	1	3	12	2 to 21
Middle management	8	1	8	13	7 to 16
Front line health care workers	4		4	7	7 to 21

The participants reported that they have been involved in various quality of care initiatives, including: maternal and child health; perinatal problem identification programme; alleviation of long waiting times; developing standard operating procedures to improve process flow of inpatients; and previous NCS inspections.

3.2 Themes and sub-themes

Although overlapping, Table 3.2 highlights the themes and sub-themes that emerged from the data. Each theme is described below.

Table 3.2: Study themes and sub themes

Themes	Sub-Themes
Context of implementation	• Planned NHI • NCS enforced by the Minister of Health • Community dissatisfaction • Uniformity in quality standards in health establishments for NHI readiness
Health worker support for quality improvements	• Learning opportunities • Clearly defined roles • New or final provincial policies • Staff appointments • Equipment purchase
Burden of implementation on HCWs	• Limited knowledge on the NCS domains • Lack of training of HCWs • HCWs overwhelmed by tasks • Insufficient HCW buy-in • NCS have not been internalised by HCWs
Flawed implementation of NCS	• Perceptions of NCS being punitive • Inspector discrepancies • Unsuitable inspection tool • Lack of consistency in facility performance after inspection • Window-dressing • Limited support from district, provincial and national health levels • Limited communication
Resource constraints	• NCS ideal but need resources • Lack of funding for implementation • Infrastructural challenges • Staff shortages • Lack of equipment

3.2.1 Theme 1: Context of implementation

The study participants reported that a combination of factors influenced the implementation of NCS at Bernice Samuel hospital. The proposed NHI system was a central theme in the context of the implementation of the NCS. Study participants believed that the NCS was part of a ministerial directive, where all health establishments had to implement the NCS in order to get ready for the planned NHI.

> *I think it's for political reasons, the Minister* [of Health] *is the one that initiated the whole idea, well I link NCS with the NHI and then before NHI there should be NCS. So it is the Minister that initiated that whole thing, for everyone to benefit in health care* (HCW3).

Participants understood that a key goal of the NHI is to ensure UHC, and improved access to quality health care for poor people.

> *I would say, maybe the economic factor, because it is gonna affect people in South Africa who maybe don't have funding for healthcare. If we comply, NHI would be implemented and people would have access to certain healthcare services* (HCW3).

> *It will help those who cannot afford to go to private* [health sector], *to be able to have better health* [care] (HCW13).

The role of the community in the decision on the implementation of the NCS was highlighted by most of the participants. They stated that they believed that the complaints and dissatisfaction of the community were part of the reason for the implementation of the NCS at Bernice Samuel Hospital.

> *…because as we are serving the community. Our community …they are having their own meetings. In most cases they will raise issues that in certain hospitals or clinics they are not getting the quality service that they want… you will find people waiting for a long time or some people will just return home without getting any help* (HCW4).

> *I think it's the issue of community… complaints from the community* (HCW6).

Participants also stated that the NCS aim to ensure that all health institutions were providing uniform standards of services across the country as a foundation for the planned NHI

> *Well the long and the short is to ensure that healthcare that is provided in Hospital A is the same as the healthcare that will be provided in Hospital B and it is the same as the health healthcare that will be provided in the private sector. So the NCS are the stepping stone to implementing the NHI* (HCW5).

> *Ok, from what I understand NCS is to try and see that all facilities comply with the basic minimum standards, so that everybody is ready for NHI…* (HCW11).

> *Isn't it that we are trying to move to the NHI and therefore now at least to make sure that we can have the same standard* (HCW14).

3.2.2 Theme 2: Health worker support for quality improvements

The sub-themes on health worker support for quality improvements included the positive aspects of NCS implementation, HCWs learning and clearly defined roles.

The positive aspects of heath care workers experiences included receipt of new or finalized provincial policies, appointment of additional staff, and the procurement of much needed equipment, because these were part of the NCS measurement criteria. Several participants commented on these aspects.

> *The problem was that some of the equipment we didn't have. At least it* [NCS] *helped us. The hospital actually got us equipment because the NCS needed it* (HCW13).

> *In terms of patient safety, adequate beds have been procured as well as equipment. The staff complement as well as resources have increased.* (HCW16)

> *Since I have started here, it was the first time the Provincial Office was involved with the policies. These days they are sending provincial policies* (HCW9).

Some participants highlighted that the NCS process was a learning process, they felt that they were being capacitated and there was a change in the way they worked after the NCS implementation.

They commented as follows:

> *So I think it keeps you on track, whatever you are doing at your office, will be in line with the NCS. It means you will be actually performing your work and you will have the documents in the office* (HCW1).

> *(It teaches you) to be always ready, to do your job properly and that if you are a manager, you need to assist your people under you* (HCW7).

> *What we have observed is that we weren't adhering to the policies, we were not doing the things correctly* (HCW12).

In terms of the process of implementation, study participants were clear on their respective roles.

> *My role was to give them all the necessary information that they are looking for, to make sure that whatever is on that file for the section it should be in the office. If not in the office, I should know where I can get it. So my role was to make sure that everything that they are inspecting is actually in the file* (HCW4).

3.2.3 Theme 3: Burden of implementation on HCWs

Notwithstanding the positive aspects of NCS implementation, many study participants highlighted the burden of implementation. Health care workers felt overwhelmed by the tasks of the NCS implementation.

> *Not everyone was pulling in the right direction, you also realise that it is because of a number of reasons…It could be that people are not willing, but I think the main reason is people were overwhelmed* (HCW8).

This was exacerbated by insufficient buy-in by some health workers, who did not participate in the NCS implementation. These health workers did not make any effort to implement any changes that the NCS required.

*Ok, I think the main challenge that I have seen is, you know, you are working with people and sometimes the attitude to participate, the positive attitude is not always there. Like I said before some other people, they don't feel involved so they don't have that attitude to partake, to answer, to comply cause they feel like "we are not even involved in this so why must I take part in it" (*HCW3).

Participants highlighted the lack or inadequate training of HCWs.

I think it's a good idea in assisting our government hospitals in rendering their quality health services on their patients. But I also feel that we need proper training about it. I think we need to have the workshops or the training prior to the implementation of NCS so that we all have the same understanding. We know that when the team comes for inspection what is it that they are expecting from us. (HCW6)

Before… actually we didn't even, actually understand what that inspection is? We were a little bit anxious (HCW15).

Although the seven NCS domains are the areas of potential risk to quality or patient safety, very few of the study participants were familiar with the NCS domains. Only one of the participants was able to name all of the domains, with most of them stating that they know that there are seven domains but they had not memorised them.

Ya, I know (laughing)… I know there's seven of them: patient's rights, public health, uhm… patient safety, clinical support services, leadership and corporative governance, facilities and infrastructure and operational management… sigh (HCW6).

There's seven domains… the first domain is patient's rights, everything about the patient, respect, dignity. Then there is uhm… it won't be in the following order, sorry… infrastructure uhm, managerial… uhm OPM managerial domain. I have forgotten the others… It's the OPM, infrastructure, patient care, patient safety, medicine and the last one… iya there are seven domains, it's all… there is subdomains, but it regulates what is underneath (HCW9).

Uhm… the domains, I don't know (HCW10).

3.2.4 Theme 4: Flawed implementation

Many participants highlighted the flaws in the NCS implementation at the hospital. These flaws included: perceptions that the implementation was punitive; unsuitable inspection tool; inspector discrepancy; lack of consistency of inspectors; lack of consistency in facility performance after inspection; window dressing; and lack of support from other spheres of government.

Some participants perceived the NCS implementation as punitive and said the following:

> *They* [inspectors] *press on your jugular vein… the assessment is not to say they must show you your stupidity, and to make you feel that when you are assessed you must be in the corner* (HCW15).

> *For some people who didn't know, they felt like it was a punishment on their work or they felt it is ousting them sort of… They are not doing their work well* (HCW3).

There was a perception that the inspection tool seems to be a blanket tool, inspecting all facilities in the same manner. The tool was not taking into account the level of the facility and the services that are rendered in that facility. The HCWs were of the opinion that the inspection tool was not tailor made for the different levels of health facilities.

> *…a rehab unit for instance… look at the questionnaire, does any of it, or does all of it make a relevant impact on the units? And if we can answer that "yes", then we can say that it is a good implementation. But if you look at the checklist for these units… equipment that you must have it's totally wrong* (HCW5).

> *There are some of the things that really I don't think they apply in my institution. Like the things of the patients' specialised care we always fail because the structure is failing us* (HCW15).

Most of the participants reported that there was inconsistency in the interpretation and use of the assessment tool, as the outcome weighed heavily on how the inspector understood the question or measure. The participants highlighted the need for uniform inspector training for those at the district level, as they felt that these inspectors did not always know what they were doing.

Self-assessment (by the District Assessment Team) should have been people that were trained and the assessments done by the same people in all facilities, because then they will give you a clearer picture of what is happening and it helps to make things consistent. I think we could have improved on that… that the same people do the assessments and not have different people. They [district inspectors] go around confusing people (HCW8).

The district team inspectors were HCWs from other health establishments within Nkangala District. The study participants were of the opinion that the district inspectors wanted to score their sections low so that it may appear that the inspectors' sections in their respective facility were doing better than the ones at Bernice Samuel hospital.

I was involved in two or three assessments sessions of the NCS. They were different. The assessors were not assessing the same way. Others would say we want this when you identify that as a gap then the next time when you produce it to somebody else, they would say to you "haai [no], it's not the one that is needed". They need something else. So the assessors, the assessment process is not standardised. (HCW12)

The OHSC team are strict, they are professional, but they also assist in how to improve. Whereas the District team (sigh), they are doing the inspection but somehow it gets biased. That is what I saw (HCW2).

When (district assessment team) inspectors are tired, they are no longer consistent… (HCW16).

Mostly in the district assessment team, it's different people who are doing the inspection. It seems like each person is using his or her own understanding and as a result, it creates confusion among the staff involved in the process (HCW6).

During the last self- assessment, we actually had a problem, because we were basically assessed by a colleague from another hospital. I think he came with the intention of putting us down, so there were things that were there which he said they weren't. Some of the things he had to observe. If he didn't see it, he would take it as if it wasn't there.

He didn't come and ask "do you have this?" One of the examples was the waiting time. We did have notice outside where it says what our waiting time is and he said no it wasn't there because he didn't see it (HCW11).

Due to the pressure that participants felt to comply with the NCS, they stated that they ended up borrowing equipment from other facilities in time for the assessment. This resulted in equipment being brought in for the purpose of the inspection and then returned to the lending institution. This led to participants questioning if getting the score was more important than giving the true reflection of what the facility has.

If managers, district managers come to say:"borrow a defibrillator from somewhere or another hospital, to have it in your unit when the assessment comes and then send it back after the assessment". What are we doing? (HCW6).

I think that when they come and you know they are coming, people window dress. I think you respect your work [and] you want everything good. But then it is window dressing because there is not enough equipment, there is not enough staff… there's not enough resources (HCW9).

The participants indicated that they did not think this was sustainable, as the facility should indicate what was lacking so that they may be assisted in procuring the necessary equipment. Furthermore, some believed it would not help to be certified while health outcomes would not change for the better, because of the gaps that would remain after everything goes back to normal.

Ok before the inspection we need to go outside and borrow things that we do not have, so that… I think to impress them (inspectors) because according to me we were supposed to leave it so they can see that we are struggling (HCW10).

Participants highlighted the lack of consistency in facility performance as they felt that the momentum is lost following the inspection. The perception was that HCWs adhere to the guidelines during inspection to impress the inspectors. This is evidenced by the dramatic improvements in the aspects of cleanliness and staff attitudes shortly before an inspection.

And then during days, you know a couple of weeks before the assessment we are everywhere, we are like running around like headless chickens to try and cover up,

clean up. Few weeks ago, we were like running around trying to gather all the information (HCW1).

Whenever they (HCWs) know that it is an announced assessment, everybody brings their part, but once it is done it slacks (HCW12).

…we wait until they say visitors are here then we start fixing… it seems we work for percentages instead of for the patient. Percentages does not improve health outcomes, as we are not doing the things every day (that got us the high score) (HCW16).

HCWs believed that they did not receive support from higher levels of the health system in their attempts to meet the set norms and standards.

…how come you come assess me, but you are not able to provide? It's like a parent, you don't teach a child but you are able to reprimand a child (HCW1).

Because the health system is not well integrated so that challenges can move [be referred] *from your level to the highest level* (HCW8).

It was as if the NCS were the concern of the [health] f*acilities and not anyone else. The health system must start working together on the issue of the NCS* (HCW8).

3.2.5 Theme 5: Resource constraints

Participants highlighted resource constraints as a major obstacle for the implementation of NCS at Bernice Samuel hospital. They stated that even those who were willing to be part of the implementation process, could not do so due to insufficient resources. These constraints included the lack of funding for implementation, which lead to the lack of equipment, infrastructural challenges and staff shortages.

According to the participants, HCWs were under the impression that there would be a special budget for the implementation of NCS. Participants stated that after the gaps were identified and quality improvement plans (QIPs) were drawn up, any item that needed funding was rarely addressed. This surprised the participants because it seemed to them that the NCS implementation was being set up for failure.

Obviously the bad will be the allocation of budget, because where there is no money, there is no activity so the allocation of budget didn't meet the requirement of the NCS (HCW1).

My opinion is that in SA it (NCS) is not going to work. Why I am saying this is that if you look at the budget allocation to facilities currently, it's inadequate (HCW2).

To ensure compliance, again with the budget, you must avail the money and that budget must be in line with what it is that I require. If the big picture is NHI and then I want NCS to lead to that, so then the budget must be in line with that, it must correlate (HCW6).

The participants also felt that, in order to implement the NCS and to make a difference, it would be preferable if there were budgets set aside for addressing the gaps identified in the inspections. They further mentioned that it would be better if the identified gaps could be addressed promptly, rather than the Provincial Office stating that there was no budget to close the identified gaps following the inspection process.

I feel like they are going about it the wrong way, I feel like they first need to make sure there are funds available that the hospitals have the resources and then go about it the other way. First, make sure that things are available and then say ok now you need to comply. But now we are expected to comply and things are just not there (HCW11).

The participants highlighted that the hospital is a small facility with infrastructure challenges.

*In our facility some assessment (areas) were noncompliant because of infrastructure challenges and that part I find frustrating (*HCW1).

Even our hospital is so small, the community is big, like if you can look that side at maternity, our population is very big but the space is too small. Sometimes you know, you will find that you have to discharge someone before even… you see… the time. Because now we are overcrowded… (HCW15)

One participant gave an example of the lack of an isolation ward for psychiatric patients and this posed a safety risk to these patients, other patients and the staff members.

> *You find the Psych* [individual with mental illness] *patient must sleep alone, but now you find she is aggressive. We have to mix [her] with other patients. Yes, you see the structure is killing us. And it puts us at a risk. It puts the patients at risk, staff at risk even the (Psych) patients themselves at risk because we do not have the seclusion.* (HCW15)

Participants highlighted that the staff shortages exacerbated the feelings of being overwhelmed by tasks, as the vacant posts impacted negatively on NCS implementation.

> *If you look at our implementation of policies, there's no staffing to implement the policies. So we can have the best policies but if there's no people to implement those policies… what are we doing? Then… it's just a paper* (HCW5).

> *In terms of the shortage of personnel, I can make an example of OPD [outpatient department], there is a standard that says we need to have a helpdesk, manned by a professional nurse, but we do not have such a person so it is a disadvantage on our side* (HCW12).

> *I think the challenges we have are in terms of human resources so that we just meet the standard. Maybe that is still one of the reasons we are not at that par* [compliance], *but we are trying our level best* (HCW14).

HCWs interviewed also reported on the shortage of equipment, which hindered their efforts to meet the minimum standards set out in the NCS.

> *I can't say how many times we put requests in for staffing and for equipment, but nothing will come back. So forever we will be putting requests in and they are always saying the budget is centralised* (HCW5).

> *Take for instance the cleaner who is supposed to be given three different types of mops to work in three different areas, but you will find that the cleaner is working only with 1 mop. Sometimes there is also a shortage of trolleys for these cleaners* (HCW7).

CHAPTER 4: DISCUSSION

4.1 Introduction

Against the backdrop of the global goal of high-quality UHC (1, 2, 20) and the proposed NHI system in South Africa (8), this MPH research study aimed to explore the experiences of HCWs with the implementation of the NCS at the Bernice Samuel Hospital. This is because HCWs are vital to the implementation of health sector reforms (such as the NCS), the functioning of health systems, and the achievement of UHC (64)

In this chapter, the results are discussed in line with the study objectives and the relevant literature. The context of implementation is discussed in section 4.2, while 4.3 will discuss the experiences of HCWs in implementing the NCS. The process of implementation is the focus of section 4.4. and section 4.5 will discuss the reported factors that influenced implementation of the NCS at Bernice Samuel hospital.

4.2 Context of implementation

The three global reports on quality underscored recommended that quality improvement efforts should take into account and be adapted for local contexts (1, 2, 20).

This MPH study found that the context of implementing the NCS at Bernice Samuel district hospital was influenced by the proposed NHI system, community dissatisfaction with quality of care provided at the hospital, and the health ministerial priorities. All study participants were familiar with this broader context of NCS implementation. This is because the NCS are both critical to the successful implementation of the NHI, reflective of the health ministerial priorities, while responding to common community complaints about poor service delivery and/or negative health care experiences (4, 8). Another South African study, albeit focused on the primary health care (PHC) level, also found that the the drive to improve quality of care in preparation for the NHI system explained the broader context of implementing the ideal clinic realisation and maintenance (ICRM) programme (65).

Studies in other countries have found that context influences implementation of quality improvement programmes or initiatives, and could either be a barrier to implementation or be

a catalyst for positive changes (40, 41, 66, 67). Dixon-Wood et al analysed evaluation reports of five quality improvement programmes in the United Kingdom. The authors identified organisational cultures, capacities and contexts among the top ten challenges in improving quality (41). Avarado et al conducted 54 interviews with health professionals in England and found that context shapes the mechanisms through which national clinical audits enhance quality improvement (68). In Australia, a qualitative study among health system managers and frontline personnel found that adaptation of quality improvement initiatives to specific contexts contributed to successful implementation and sustainability (66).

The MPH study findings suggest that NCS implementation at the Bernice Samuel district hospital should build on HCWs knowledge and understanding of the broader context, while adapting the implementation of the NCS to take account of the local context at the hospital.

4.3 Health care worker experiences of the NCS

In this MPH study, HCWs reported mixed experiences of the implementation of the NCS at the hospital.

Overall, those interviewed expressed strong support for the NCS implementation at the hospital. The importance of staff support for accreditation and/or quality improvement was also found in studies in Lebanon (47) and Uganda (49). Some study participants highlighted several positive aspects. The NCS implementation benefited HCWs indirectly, through the appointment of additional staff, and the purchase of new equipment. Their new, clearly defined roles facilitated learning about quality improvement, namely compliance with the NCS. The participants' perceptions of clearly defined roles are encouraging as another South African study on the ICRM programme implementation at PHC level found that unclear roles resulted in unfulfilled responsibilities by different government spheres and disempowered frontline staff (65).

However, the positive aspects were marred by HCWs lack of knowledge on the NCS, and the perceived burden and flawed nature of implementation.

Although study participants were aware of the seven NCS domains, only one could list or describe the actual domains. Those interviewed reported that they did not receive training on NCS. This lack of knowledge on the NCS could explain the 2015 low score of 44% or non-compliance of Bernice Samuel hospital. The 2016/17 inspection report of the OHSC also flagged the lack of knowledge (which affects competencies) of staff as a problem and attributed poor leadership and management for this lack of knowledge (53). Further research is needed to quantify this knowledge gap on the NCS. Studies in Tanzania also found that insufficient health workers' knowledge hindered quality improvement (22, 48). In addition, the Lancet Global Report highlighted the importance of including quality in the pre-service training of all HCWs as well as refresher or in-service training on quality (2).

Various strategies are needed to ensure that HCWs at Bernice Samuel hospital are knowledgeable on the NCS. These include specific training workshops on quality improvement in general, and the NCS in particular, continuous professional development, improved management and supervision (53) and on-site mentoring and coaching as demonstrated by the experience in Tanzania (22, 48). Furthermore, education and training should emphasise ethical, respectful and compassionate care (2), while managers should encourage the notion of "the learning health system" that includes all HCWs, patients and communities (20).

4.4 Process of implementation of the NCS at Bernice Samuel hospital

HCWs at Bernice Samuel Hospital reported their perceptions of both the burden and flawed nature of NCS implementation. Although this perceived burden could partly be explained by their limited knowledge on the NCS due to lack of training, HCWs felt both overwhelmed by tasks associated with the NCS implementation, and insufficient buy-in from some of their colleagues. Muthathi and Rispel also found that the implementation of the ICRM programme was affected by insufficient involvement and buy-in from frontline staff (65). The 2018 report on quality of the National Academies emphasised the importance of a supportive and motivating culture for buy-in from staff, without which quality of care improvements or changes will be unsustainable (20). The corollary is that staff engagement and communication, a positive organisational culture, and leadership and staff awareness of continuous quality improvement could lead to successful implementation. This was found in a systematic review of public hospital accreditation in Hong Kong (45).

Almost all HCWs highlighted various flaws in the inspection process. A combination of inspector discrepancies, differences in the knowledge and behaviours between district and OHSC inspectors, and an unsuitable inspection tool for a small district hospital contributed to their perceptions that the NCS were punitive. This is in contrast to the findings of a study by Hovlid and colleagues Hovlid, Teig (51) where HCWs valued the internal inspection. The Lancet Global Report recommended that facility audits or inspections should include clear criteria for improvement and result in non-punitive responses, such as support for addressing deficiencies (2). Similarly, the South African Lancet National Commission underscored the need to be non-punitive and to partner with frontline health workers to create a quality of care revolution in the health system (28).

The perceptions of a punitive process appeared to have resulted in a number of unintended negative consequences, such as "window dressing" or creating the impression that the hospital complied with the NCS. HCWs reported that prior to the inspection, they would be on their best behaviour and carry out their duties as it is expected by the NCS, but after the inspection, they would revert back to their old habits. This "window dressing" could explain the poor hospital performance in 2015 when the OHSC inspection took place (11). Muthathi et al also found that PHC facility managers created the illusion of compliance, by buying and funding items to ensure that their clinics met the ICRM programme assessment criteria (25).

This MPH finding on "window dressing" underscores the need for quality in health to be brought to life to HCWs, through meaningful engagements, involving them in decision-making, supportive practice environments, training and supervision to ensure their continued commitment to quality of care (69). In addition, front line HCWs should be made aware of national quality policies and how to apply these to their daily work (2).

The study findings suggest that the District Assessment Teams should mainstream their operations and be supported by the Mpumalanga Provincial Health Department, through inter alia, training and support. The OHSC should also improve communication to ensure that all health facilities are aware of its mandate and the importance of NCS compliance.

4.5 Factors that influenced the implementation of NCS

The combination of the lack of support from district and provincial levels, insufficient communication, and resource constraints influenced the implementation of the NCS at Bernice Samuel hospital in an adverse manner. Hence, these issues could explain the very low score of 44% obtained in 2015.

The HCWs indicated that there was a lack of support from management at district and provincial levels of the health system. This was also found in a study in Tanzania, where HCWs stated that they did not receive equipment that they ordered from the district level (22). Once HCWs do not feel supported in their work environment, they experience frustration and exhaustion, constraining their ability to perform their work (20). All three global reports have outlined the importance of a supportive practice environment to enable HCWs to provide quality health care or to implement quality reforms (1, 2, 20).

The reported lack of communication, especially from other levels of government, was also highlighted by the study on the implementation of the ICRM programme in Gauteng and Mpumalanga (25, 65). Communication across all levels of the health system and between facilities needs to be improved in order to assist the health facilities and system as a whole to meet the quality standards (2). Therefore, the district and provincial health levels need to support the HCWs at Bernice Samuel Hospital. Improved communication on NCS does not require additional resources, which could be done through existing management and/or staff meetings.

The HCWs expressed both surprise and disappointment at the lack of resources and specific interventions following the inspections. The MPH study findings suggest that resource constraints are a major contributory factor to Bernice Samuel hospital's failure to comply with the NCS. Other studies in Thailand (46), Lebanon (47) and Uganda (49) have also demonstrated the debilitating effects of lack of funding, staff and/or equipment. Although resource constraints are a common problem in many LMICs, the misuse, misappropriation and/or corruption also contribute to resource constraints (20). This MPH study did not explore resource utilisation, or confirm the reported lack of resources. Further research on these aspects should be done.

4.6 Conclusion

Notwithstanding the potential and positive aspects of NCS implementation, the HCWs reported that they had limited knowledge and training on the NCS. These in turn affected HCW buy-in or commitment to the NCS. Resource constraints or deficiencies combined with insufficient district and provincial support, poor communication, and flaws in the inspection process reportedly contributed to the poor score at the hospital. All these were exacerbated by unmet HCW expectations that the inspection results would lead to changes at the hospital. The recommendations that flow from these study findings are presented in the final chapter of the research report.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The National Core Standards remain one of the most important initiatives to improve the quality of health care in South Africa, and to facilitate the implementation of the NHI system, which is the main vehicle for UHC (8). The recommendations that flow from this study are shown in Table 5.1, and elaborated below.

Table 5.1 MPH study recommendations

Recommendation	Department of Health (provincial, district)	Hospital manager	HCW
1. Prioritise implementation of the NCS as a prerequisite for the achievement of NHI and UHC in South Africa	**X**	**X**	
2. Issue clear guidelines and protocols, to all HCWs on NCS implementation, including each cadre's role on the implementation	**X**	**X**	
3. Advocate for additional resources for NCS (finances, staffing, infrastructure, equipment and all that will enable adherence to NCS.)	**X**	**X**	
4. Provide leadership on the NCS implementation and encourage a culture of honesty, rather than window dressing	**X**	**X**	
5. Develop and implement strategies to enhance supervision and management of frontline HCWs	**X**	**X**	
6. Streamline internal (district) inspection processes	**X**		
7. Facilitate and ensure engagement and communication with HCWs on the NCS, ask for their views on how to achieve compliance and to sustain change	**X**	**X**	**X**
8. Include NCS in the induction programme of all new staff		**X**	
9. Ensure education, training and continuing professional development on the NCS and quality improvement		**X**	**X**

5.2 Prioritisation of implementation

The Mpumalanga Provincial Department of Health should prioritise the implementation of the NCS, given the relatively poor performance of all facilities on the NCS (37). This is because of the importance of NCS compliance to the achievement of UHC through the NHI. Sustainable funding is needed, and a possible conditional grant should be considered for health establishments to implement the NCS.

The prioritisation of the NCS implies that all health facilities should receive clear guidelines and protocols, with an outline of the role and responsibilities of all HCWs on NCS implementation.

As was highlighted by the study findings, the NCS cannot be implemented without the requisite resources, namely budgets, staff, infrastructure, equipment, and other essentials. For example, the submission of the Bernice Samuel hospital budget should include the financial resources needed for NCS compliance. However, the hospital may require technical assistance to do the costing and prepare a detailed budget and motivation for the resources.

5.3 Leadership, management and supervision

Currently, health establishments such as hospitals have limited autonomy or delegations to effect infrastructural changes, or to purchase equipment (70). Coupled with resource shortages or constraints, such limited authority hinders the compliance with the NCS. These challenges suggest that provincial and district health levels need to work together with small hospitals (such as Bernice Samuel) in attaining the set norms and standards.

Higher levels of care should be responsive and small hospitals should be supported to comply with the NCS. There should also be open communication, so that staff do not feel that they have to create the false impression of compliance.

Existing evidence suggests that supportive management or good supervision of HCWs provide mechanisms for communication and feedback to improve performance (1, 2, 20, 28).

5.4 Standardisation and streamlining of the NCS inspection process

The HCWs complained about the discrepancies and inconsistencies in the district assessment process, as well as variations with the inspection team of the OHSC. The Mpumalanga Department of Health should ensure that there is there is a clear procedure manual on internal inspections and adequate training of the internal or peer inspectors. This procedure manual should include ethical conduct, independence of inspectors, and could draw on the OHSC processes, which are in the public domain (15).

HCWs highlighted the problems with the OHSC assessment tools for small district hospitals. Although there have been some revisions of all the inspection tools, the hospital and provincial managers should provide feedback on the tool to the OHSC. This could also assist with greater buy-in to the NCS and increased awareness of the kinds of evidence needed.

5.5 Communication and engagement

Stakeholder engagement is seen as one of the critical elements of policy development and implementation (20). The Lancet Global Commission underscores the importance of engagement, as well as clear mechanisms for engagement (2). In this study, HCWs were familiar with the broader context of the NCS, but complained about insufficient information on inspections, and the process of implementation. Provincial, district and hospital management should facilitate and ensure engagement and communication with HCWs on the NCS, ask for their views on how to achieve compliance and how to sustain changes in achieving compliance.

Communication and information on the NCS should also be included in the induction and orientation of all HCWs.

5.6 Education and Training on NCS

In the long-term, the pre-service education of all HCWs should include quality, as recommended by the South African Lancet National Commission (28). The HCWs reported that there was lack of training on the NCS. Hence, in the short-term hospital management and/or the provincial health department should ensure workshops, specific training on the NCS, as well as continuing professional development on the NCS and quality improvement. When

HCWs are more capacitated on initiatives, this will improve their understanding and ownership of the initiatives, and the implementation of NCS is also likely to improve. As this is an initiative that the national Department of Health (DoH) needs in order to achieve UHC, it is recommended that NCS training is carried out upon induction when new HCWs are appointed. Thereafter, periodic training to include updates on the policy are recommended for all staff who are already in the employ of the DoH. All HCWs should also be part of an inspection process, even if it is a mock inspection.

Health care workers should also be able to give feedback to the OHSC and the national DoH on any clarity that is needed or challenges that they encounter during implementation process. The OHSC and/or the national DoH should involve HCWs in the revision of subsequent versions of the NCS and the regulated standards. The recommended training and involvement will go a long was in closing the knowledge gap and feelings of not being involved in the NCS.

5.7 Areas for future research

This was a small qualitative study that provided valuable insights into the implementation of the NCS at a small district hospital. Further research should include a larger sample of hospitals and HCWs and attempt to quantify the constraints highlighted by study participants. This will establish whether the experiences are similar or different, and the reasons for the differences.

Other possible research studies are listed below:

- Quantifying the knowledge of HCWs on the different domains of the NCS;
- The association between management support and resource availability and NCS compliance;
- Explore the agency of individual health workers, and why they create the illusion of compliance (or window dressing);
- Costing of the resources needed to implement the NCS;
- Strategies to achieve sustainability of quality improvements, including compliance with the NCS.

5.8 Conclusion

This MPH case study has focused on the experiences of HCWs of the implementation of the NCS as Bernice Samuel district hospital. The context was influenced by the proposed NHI system, community dissatisfaction with quality of care, and health ministerial priorities. Health care workers reported learning opportunities and role clarity as positive aspects. However, they highlighted the burden and perceptions of flawed implementation processes. These were exacerbated by insufficient district and provincial health support, financial and human resource constraints, and infrastructural challenges.

The MPH has underscored the importance and contribution of HCWs to the success of the NCS in achieving quality service delivery. The implementation challenges need to be addressed to ensure the successful implementation of the NCS at hospital level. As hospitals are a critical part of the health care system, successful NCS implementation will also advance South Africa's goal towards UHC.

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ANNEXURE 1: Information Sheet

Health care workers' experiences of the implementation of the National Core Standards at Bernice Samuel District Hospital in Mpumalanga province

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Good Day,

My name is **Thembekile Majozi.** I am a master's student from the School of Public Health at the University of the Witwatersrand in Johannesburg. I am conducting research which seeks to explore health care workers' experiences of the implementation of the National Core Standards at Bernice Samuel Hospital in Mpumalanga. I would be most grateful if you would agree to participate in this study. The interview will be carried out by the researcher and it will take around 30 - 40 minutes of your time. With your permission your responses will be audio recorded, the recordings will be uploaded and saved on the researcher's laptop which is password protected. The recordings will be erased after 2 years, if there is a publication, or 6 years if no publication emanates from the study.

Why am I doing the study?

This study is part of the requirements of my post-graduate studies. In this study, I wish to explore the knowledge and experiences of health care workers with the implementation of the National Core Standards at a district hospital in Mpumalanga province.

What am I asking you to do?

You are invited to take part in an interview. Your participation is voluntary. Your inputs, opinions and experiences are important to the study. You may refuse to answer any questions that you don't feel comfortable answering. The interview will take place during working hours in the Hospital Boardroom.

How do I know that the information I give you will not get out to others?

The information that you give in the interview will be kept confidential. All interviews will be assigned a code. The answers given will be analysed and reported as group data.

Did I get permission to do the study?

Permission to carry out this study was obtained from the University of the Witwatersrand, Human Research Ethics Committee as well as from the relevant health authorities.

Are there any benefits and risks of participation?

Participation in this study is voluntary and there will be no direct benefits to anyone who takes part in the interview. Similarly there will be no negative consequences for individuals who do not want to take part. You will not be compensated for taking part in the study. You have the right not to answer any questions that make you feel uncomfortable or that you do not want to answer.

Whom do you contact if you want more information?

If you have any questions about your rights as a study participant, you may contact:

Human Research Ethics Committee (HREC) chair
The University of the Witwatersrand,
Prof C. Penny
Email: Clement.Penny@wits.ac.za

Tel (011) 717-2301

Administrative officer
Ms Z Ndlovu
Email zanele.ndlovu@wits.ac.za
Tel 011 717-1234

If you have questions about the research, you may also contact me or my supervisors:

Thembekile Majozi
Bernice Samuel Hospital
Tel: (013) 665 8261
Cell: 0720753115
Email: majozitp@gmail.com

Janine White
School of Public Health
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ANNEXURE 2: Consent form for Health Care Workers

Health care workers' experiences of the implementation of the National Core Standards at Bernice Samuel District Hospital in Mpumalanga province

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I agree to participate in the study entitled: **Health care workers' experiences of the implementation of the National Core Standards at Bernice Samuel District Hospital in Mpumalanga province**

The goals, methods and the purpose of the study have been explained to me and I have been given the opportunity to ask questions. I understand that the study will involve participating in an in-depth interview. I understand that I have the right to refuse participation in the study.

I agree to participate in the study on condition that:

1. I can withdraw from the study at any time voluntarily and that no adverse consequences will follow on withdrawal from the study.
2. I reserve the right not to answer any/or all questions posed in the survey.
3. The Mpumalanga Department of Health Research unit has approved the study.
4. The Human Research Ethics Committee (Medical) at the University of the Witwatersrand has approved the study protocol and procedures.
5. My name will not appear anywhere on this interview guide. All results will be treated with the strictest confidentiality.
6. The Researcher is committed to treating participants with respect and privacy throughout the procedure.

PARTICIPANT

Signature/Initial **Date and Time**

RESEARCHER:

Printed Name **Signature** **Date and Time**

ANNEXURE 3: Consent Form for Audio-recording

Health care workers' experiences of the implementation of the National Core Standards at Bernice Samuel District Hospital in Mpumalanga province

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I have read and understood the information sheet. I am aware that I may choose whether to allow my interview to be recorded. The reason for audio-recording the interview has been explained to me and I am aware that I may stop the interview at any point without prejudice.

I acknowledge that the researcher **will** ensure that the recording is kept confidential and safe.

I consent to having the interview audio recorded.

Participant

Signature or initial: _____

Date: _____

Researcher

Signature: _____

Date: _____

ANNEXURE 4: Interview Schedule for Health Workers

Health care workers' experiences of the implementation of the National Core Standards at Bernice Samuel District Hospital in Mpumalanga province

1. **Category of Health Care Worker**
    a. Executive manager
    b. Middle manager
    c. Front-line health worker
2. **Date of interview** _____

3. **Result codes**

01 = Completed , 02 = Respondent not available, 03 = Respondent refused; 04 = Partially completed
05 = Other .....

NB:

- ***Circle all that apply***
- ***Write information required on the space provided***

CONTEXT AND KNOWLEDGE

1. How long have you been working at Bernice Samuel District Hospital?
2. Could you tell me about the quality of care initiatives that you have been involved at the hospital in the past two years?
    a. Were you part of the last inspection at Bernice Samuel Hospital?
3. In your opinion what is the rationale or reason for the National Core Standards (prompt)?

    a. What are the goals of the NCS?

    b. Are you familiar with the NCS domains?

    c. What do you personally think about the NCS?

4. In your opinion what are the contextual factors that influenced the implementation of the NCS at Bernice Samuel Hospital? (Prompt: political e.g. MEC or Premier, economic e.g. funding, environmental, social, structural, technological factors)

PROCESS OF IMPLEMENTATION OF THE NCS

5. Could you share with me the process of implementation of the NCS at the hospital during the last inspection?
    a. What happened before the inspection?
    b. What happened during inspection?
    c. What happened after inspection?

6. Could you tell me what your role was in the inspection process?
7. How would you describe your overall experience of the NCS implementation process at the hospital?
8. Are there any changes that you would make to the way the NCS were implemented? Please share the reasons with me?
9. In your opinion, what are the main achievements since the NCS have been implemented?
10. What are the challenges or constraints experienced with the implementation of the NCS at the hospital?
11. What are the lessons that you have learned about implementing the NCS?
12. If you were the chief inspector of the OHSC, what would you do to ensure compliance with the NCS in health facilities in South Africa?
13. Is there anything else that you would like to add about your experiences regarding the implementation of NCS?

Thank you for taking the time to participate in this study.

ANNEXURE 5: Human Research Ethics Committee Ethics Approval

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

R14/49 Ms T Majozi

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
CLEARANCE CERTIFICATE NO. M190228

NAME: (Principal Investigator)	Ms T Majozi
DEPARTMENT:	School of Public Health Medical School University
PROJECT TITLE:	Health care workers experiences of the implemention of the National Core Standards at Bernice Samuel District Hospital in Mpumalanga Province
DATE CONSIDERED:	2019/02/22
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Professor L Rispel and Ms J White
APPROVED BY:	Dr CB Penny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	2019/05/21

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on the 3rd Floor, Phillip Tobias Building, Parktown, University of the Witwatersrand, Johannesburg.
I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to submit details to the Committee. **I agree to submit a yearly progress report**. When a funder requires annual re-certification, the application date will be one year after the date when the study was initially reviewed. In this case, the study was initially reviewed in **February** and will therefore reports and re-certification will be due early in the month of **February** each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature

23/05/2019
Date

PLEASE QUOTE THE CLEARANCE CERTIFICATE NUMBER IN ALL ENQUIRIES

ANNEXURE 6: Head of Institution Support Letter

Department of Health
Bernice Samuel Hospital

Hospital Street Delmas, 2210, Mpumalanga
Private Bag X 1006, Delmas 2210, Tel: 013 665 8200, int: +27 13 665 8200, Fax: 013 665 1455, int: +27 13 665 1455

Litiko Letemphilo | Umnyango WezaMaphilo | Departement van Gesondheid

ENQ: DR. C. M. KHOZA
0136658201

Ms. Thembekile Majozi

Speech and Hearing Therapist

Bernice Samuel Hospital

Dear Ms. Majozi

PROVISIONAL APPROVAL PF A STUDY ON HEALTH CARE WORKERS' EXPERIENCES OF THE IMPLEMENTATION OF THE NATIONAL CORE STANDARDS AT BERNICE SAMUEL DISTRICT HOSPITAL IN MPUMALANGA PROVINCE

- The above matter bears reference;
- The request for Hospital support (**not financially**) in relation to the above mentioned research is hereby approved in principle, provided that you supply the Provincial Department of Health with ethical clearance from your University
- Please use this letter to release your ethics certificate
- The onus is on the researcher to seek ethical approval from his/her University

Please do not hesitate to contact me, should you require additional assistance

Kind Regards,

Dr. C. M. Khoza
Acting CEO

01/08/2019
Date

MPUMALANGA
THE PLACE OF THE RISING SUN

ANNEXURE 7: Provincial Health Research Committee Approval

health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

Indwe Building, Government Boulevard, Riverside Park, Ext. 2, Mbombela, 1200, Mpumalanga Province
Private Bag X11285, Mbombela, 1200, Mpumalanga Province
Tel I: +27 (13) 766 3429, Fax: +27 (13) 766 3458

Litiko Letemphilo | Departement van Gesondheid | UmNyango WezeMaphilo

Enq: 013 766 3766/3511
Ref: MP_201905_009

Provincial Research Approval Letter

TO: **Ms Thembekile Majozi-Leshoro**
69 SECOND AVE
WELGEDACHT
SPRINGS
1559

TITLE: HEALTH CARE WORKERS' EXPERIENCES OF THE IMPLEMENTATION OF THE NATIONAL CORE STANDARDS AT BERNICE SAMUEL DISTRICT HOSPITAL IN MPUMALANGA PROVINCE

The provincial health research committee has approved your research proposal in the latest format you sent.

- Approval Reference Number: MP_201905_009
- Data Collection Period: 30 May 2019 – 31 December 2019
- Approved Data Collection Facilities: Bernice hospital

Kindly ensure that the study is conducted with minimal disruption and impact on our staff, and also ensure that you provide us with a soft or hard copy of the report once your research project has been completed.

Kind regards

MR. JERRY SIGUDLA
MPUMALANGA PHRC

MPUMALANGA PROVINCE
DEPARTMENT OF HEALTH
27 -05- 2019
PRIVATE BAG X11285
NELSPRUIT 1200

27/5/2019
DATE

MPUMALANGA
THE PLACE OF THE RISING SUN

ANNEXURE 8: Plagiarism Declaration

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

FACULTY OF HEALTH SCIENCES

PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

SENATE PLAGIARISM POLICY: APPENDIX ONE

I THEMBEKILE LESHORO (Student number: 0502057X) am a student registered for the degree of MASTER OF PUBLIC HEALTH in the academic year 2.

I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
- I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.
- I have included as an appendix a report from "Turnitin" (or other approved plagiarism detection) software indicating the level of plagiarism in my research document.

Signature: _____ Date: 02/11/2020

ANNEXURE 9: Plagiarism Report - Turnitin

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