A “PEOPLE-CENTRED APPROACH” TO REALISING HEALTHCARE BY FACILITATING, PATIENT PARTICIPATION IN HEALTH ATTAINMENT

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MASTER DEGREE IN BUSINESS INFORMATION AND ADMINISTRATION

by

PASHNEE NAICKER
(222886471)

SUPERVISOR: Professor Visvanathan Naicker

Date submitted: 10 May 2023

DECLARATION

I, Pashnee Naicker hereby declare that this research report is my own work, except to the extent indicated in the text and reference. It is being submitted in partial fulfilment for the degree of Master of Business Information and Administration at the Cape Peninsula University of technology. It has not been submitted before for any degree or examination in any other University.

Signed: P. Naicker **Date: 10 May 2023**

ABSTRACT

South Africa’s healthcare system faces a multitude of challenges that have resulted in inadequate access to quality healthcare for many citizens. These challenges include a shortage of healthcare workers, insufficient funding and resource allocation, a high burden of communicable and non-communicable diseases, and disparities in healthcare access and outcomes based on socioeconomic status and geographic location. As a result, many South Africans continue to experience poor health outcomes, limited access to essential health services, and a lack of trust in the healthcare system. Addressing these challenges is critical to improving the overall health and well-being of the South African population and ensuring equitable access to quality health services for all citizens.

This study offers insights into the patient experience from the patients’ perspective, which is crucial for improving the quality of healthcare. The study utilised Kolb's(1984) experiential learning theory as a model and employed qualitative and quantitative research methods, including a questionnaire administered to participants selected through convenience sampling at the HIV/AIDS unit of Chris Hani Baragwanath hospital. The data was analysed using Excel and SPSS to interpret and draw conclusions from the results.

The study's findings suggest a communication gap between healthcare workers and patients, highlighting the need for the Department of Health to provide training on communication and diversity. Additionally, the use of translators could help overcome language barriers between doctors and patients. Lastly, consistent patient feedback implementation can help healthcare institutes understand evolving patient needs and implement a "people-centred" approach to delivering quality healthcare services.

Keywords: People-centred, patient experience, quality healthcare, healthcare workers, HIV/AIDS

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DEDICATION

I dedicate this thesis to my husband, children and parents who have shown unwavering support to me throughout this journey.

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LIST OF ACRONYMNS

Abbreviation	Definition
AIDS	Acquired immune deficiency syndrome
ANOVA	Analysis of Variance
ARHAP	African Religious Health Assets Programme
ARV	Anti-retroviral
CEO	Chief Executive Officer
CPUT	Cape Peninsula University of Technology
DOH	Department of Health
ELT	Experiential Learning Theory
FREC	Faculty Research Ethics Committee
HBM	Health Belief Model
HIV	Human immunodeficiency virus infection
ICT	Information Communication Technology
IOT	Internet of Things
NQF	National Qualification Framework
PCC	Patient-centred Care
SCT	Social Cognitive Theory
SDG	Sustainable Development Goals
TBP	Theory of Planned Behaviour
UHC	Universal Health Coverage
UNAIDS	United Nations Aids
WHO	World Health Organisation

CHAPTER 1
INTRODUCTION

1.1 Introduction

The World Health Organization (WHO, 2015) is playing a key role in promoting quality healthcare for all. This aligns with the United Nations' Sustainable Development Goals (SDGs), which call for countries to achieve Universal Health Coverage (UHC) that includes financial risk protection and access to essential healthcare services of high quality. The South African Lancet Commission on High-Quality Health Systems, (South African Lancet Commission on High Quality Health Systems, 2019) found that Quality Health Care in South Africa is failing, and a 13-member consensus report provided a succinct diagnosis of the health system, demonstrating the impact of the failure of the private health sector on the already poor public health sector services. In the private sector, the lack of coordination among healthcare practitioners, a fee-for-service tariff system, and single-discipline practice models hinder the quality of care. Fragmentation of care delivery, over-servicing, and an oversupply of healthcare professionals compared to the number of funded patients further contribute to suboptimal care. On the other hand, the public sector struggles with ineffective management, poor accountability systems, and a shortage of healthcare professionals, especially at the primary care level. Overcrowding, limited resources, and supply chain constraints also impact the quality of care in the public sector. Overall, both sectors face significant challenges in delivering high-quality healthcare.

There is a shortage of most healthcare professions and a perception of higher income potential in the private sector. Most patients who cannot afford to pay the high medical premiums end up in the public sector, which is under-resourced and poorly managed. People-centred healthcare may only be successful through integrating services across the public and private sectors and all the levels of care, such as preventive, promotive healing and rehabilitation. Closely related to this discussion is a study by Summer Meranius, Holmstroem, Håkansson, Breitholtz, Moniri, Skogevall, Skoglund and Rasoal (2020), which highlights the following benefits of people-centred care (PCC): improved

health and well-being, improved mutual interaction in relationships, improved cost efficiency and improved working environment.
In the public-sector, quality of care is hampered by ineffective management and poor accountability systems to provide quality healthcare. Many factors contribute to poor quality of healthcare, such as overcrowding of facilities, shortage of professional units at the primary care level, poor clinical governance and supply chain constraints of equipment and medication.

Management and leadership styles vary across the health system and the nine provinces. Where quality healthcare is lacking, it may be one of the reasons for the loss of key staff. An outcome of the latter now exacerbates the low-staff-high-patient ratios and inadvertently causes low staff morale and a feeling of desperation. It was observed that there were significant problems in medical services which affected patient care. These problems are related to staff shortages, inadequate training, and poor staff attitude.

How can you improve performance in any situation? This cannot be done without understanding the service that the recipient receives. The recipient, in this context, is the patient. Once a benchmark is established, one can base the improvement on the patient's expectations. To conduct this research, patients' views are imperative regarding the quality of health services. To improve the health system overall, there needs to be a significant improvement in systems and processes to ensure that quality healthcare improvements are sustained. Hence, a clear plan of action should include training the management of health facilities to improve their performance in management and monitor their performance. Therefore, all nine Provincial health departments in South Africa must be held accountable for improving their healthcare systems to support their health establishments.

The latest United Nations AIDS (UNAIDS) 2021 global update reported that the AIDS pandemic took a life every minute in 2021. According to this report, there was a global decrease in new HIV infections in 2021. However, the reduction was only 3.6%, which represents the smallest decline since 2016. This has resulted in many countries being left to address the rising HIV infections alongside other crisis like COVID-19. Whilst a people-centred approach is being researched in healthcare overall due to sociological reasons, there is a gap in the HIV/AIDS field. The aspect of healthcare for HIV/AIDS patients

requires this approach due to the nature of the disease, the stigma attached to it and the overall management of lifestyle that is required. Additionally, a people-centred approach may assist in mitigating mortality rates and reduce the number of visits to the already strained healthcare facilities.

1.2 Thesis statement

To mitigate the well-being and health of patients, a people-centred approach to healthcare is essential globally, requiring a thorough understanding of the various stakeholders' roles, particularly healthcare workers who play a critical role in the success of this approach. This study investigates the influence of healthcare workers on patients' well-being and examines the feasibility of a people-centred approach to quality healthcare.

1.3 Problem statement

The healthcare system in South Africa is facing multiple challenges, including a shortage of human resources, insufficient funding, and ineffective leadership and management, all of which are exacerbating the already struggling system. The COVID-19 pandemic has further highlighted the vulnerability of the system. To mitigate this burden, a patient-centred approach to healthcare could be adopted to empower individuals to manage their health and lifestyles, reducing the number of visits to healthcare facilities. HIV/AIDS remains a significant global health issue with high mortality rates in several world regions. This approach aligns with the global shift towards patient-centred care and is particularly relevant in South Africa where healthcare resources are scare and the burden of disease is high.

1.4 Significance of the study

Globally, countries are investigating and implementing measures to ensure a "patient-centred" care is adopted.(Rosengren, Brannefors & Carlstrom, 2021). Understanding the patient's needs and wants is a foundation for achieving this. While there is extensive literature on patient-centred care worldwide, there is a lack of understanding of the needs and requirements of South African patients. South Africa's unique geographical location

and racial and cultural diversity contribute to patients' different requirements. South Africa has not implemented a patient feedback mechanism across all public hospitals and therefore has no benchmark for the service being provided to its citizens. National health insurance has hopes of bridging the gap between the private and public sectors healthcare. This requires an understanding of existing services and the gaps that are required to be filled. (World Health Organisation, Bridging the gap in South Africa 2010)

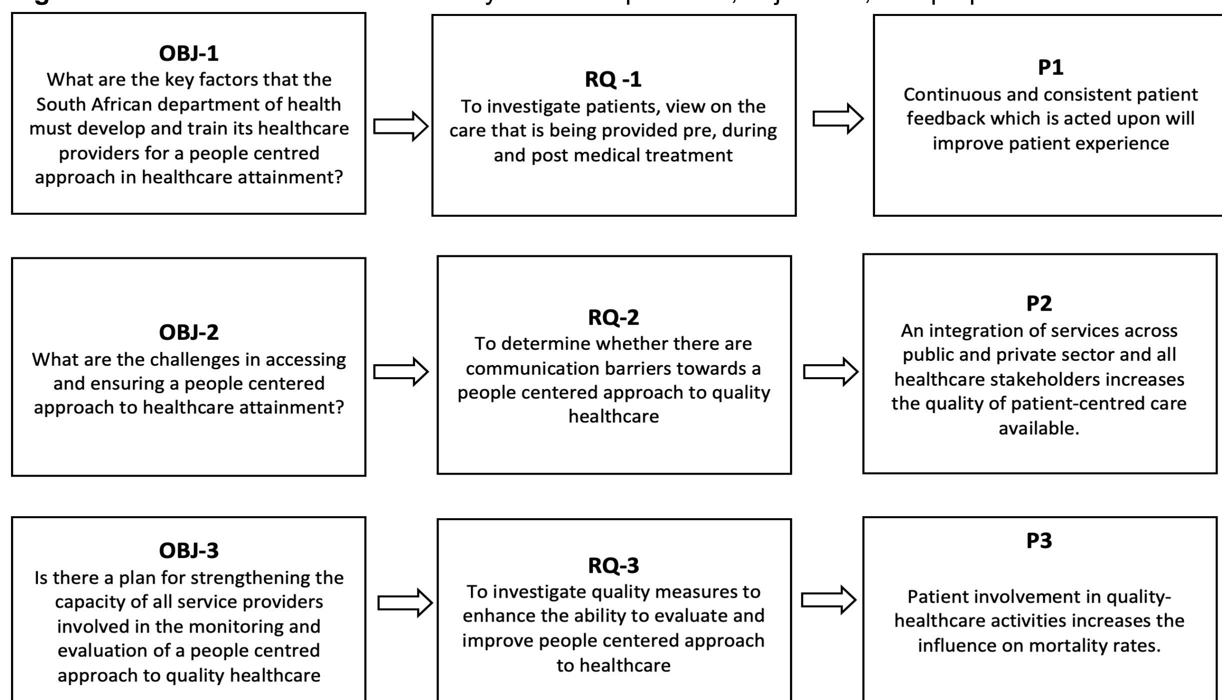
1.5 Main research objective

The main research objective was to determine what influence healthcare workers have on the HIV/AIDS patients' morale and general wellbeing and to investigate if a "people-centred" approach toward quality and efficient healthcare could be considered a viable approach as mitigation to the mortality rate. The following section illustrates how the research questions, objectives and propositions were linked.

1.5.1 Linking research questions, objectives and hypotheses

The secondary research questions, secondary objectives and propositions of the study were linked together to form the basis of the problem statement, as shown in Figure 1.1

Figure 1.1: Links between the secondary research questions, objectives, and proposition



Source: Author's own compilation

Table 1.1 displays the links between the secondary objectives, secondary research questions and propositions. Block one displays the objectives, block two the main research questions, and in block three it is clear how the research questions are linked to the three propositions.

1.6 Delineation

This study investigated patients' experiences visiting a public health institute in the Gauteng Province. It examined the interaction between public health workers and patients and their influence on patients and their wellbeing. In addition, this study explored any barriers that may exist in achieving a "people-centred" approach to healthcare.

1.7 Ethical considerations

Blumberg, Cooper and Schindler (2011) define ethics as the study of 'right conduct' and state that research should be conducted morally and responsibly. To comply with the specified ethical standards, the researcher applied for ethical approval from the Cape Peninsula University of Technology (CPUT) Faculty Research Ethics Committee (FREC), which was granted on 14 September 2021 (see Appendix B). Informed consent was obtained from the Department of Health to collect data from the unit of analysis (Appendix D).

The researcher ensured ethical considerations during fieldwork by adhering to the CPUT code of ethics, and data was collected with the respondents' consent. The privacy and anonymity of respondents were maintained throughout the study, and the respondents were duly notified about their entitlement to discontinue their participation in the research at any time.

The next section contains an abridged literature review.

1.8 Abridged literature review

The researcher compiled a literature review to ensure that the study was consistent with previous research studies and that the relevant theoretical frameworks applied to the phenomenon under study. This section focuses on the preparatory literature collected to set the context for this study.

The World Health Organisation (WHO), has urged countries to ensure universal health coverage (UHC) for their citizens through the Sustainable Development Goals (SDGs). (WHO, 2021) While progress has been made globally and in low-income countries, during the pandemic COVID -19 the focus was on survival, leading to conflicting priorities. World Health Statistics (2021) reports that the biggest threat to the 'triple billon' goal, which was designed to accelerate the achievement of the SDGs, is the cost of health care. Hence, the urgent need to remove all barriers to health care for all. Due to the cost of and access to healthcare in South Africa, priority in low-income households is moving down in the pecking order. The literature review highlighted all critical stakeholders and the important role filled by each one. It also revealed the need for cohesion between the various stakeholders.

The South African Department of Health (2020) has identified improving the quality of healthcare as one of the goals in its strategic plan for 2020/21-2024/25. This is in line with global efforts, as quality of healthcare is part of countries' Sustainable Development Goals, and South Africa is following suit. Another objective of the strategic plan is to consult citizens on the level and quality of public health services they receive. While medical treatment has improved in recent years, the psychological and emotional well-being of patients, and particularly the HIV/AIDS patients in this study, can still be negatively affected by the attitude and communication of medical staff. If these issues are recognised and addressed, health systems can improve the quality of care provided to patients, leading to better health outcomes and quality of life. The focus on value-based care in healthcare has intensified, necessitating healthcare organisations to enhance their quality and safety measures. In the current era of value-based care, the ability to improve processes is increasingly vital for building a successful healthcare business.

The research procedure is discussed in the following section.

1.9 Research procedure and methodology

On 15 September 2022, the researcher obtained signed consent from the Chief Executive Officer (CEO) of Chris Hani Baragwanath Academic Hospital to conduct the study. The CEO signed the consent (see Appendix C). Before the organisational approval, the researcher obtained ethical approval from CPUT FREC on 16 November 2021 and subsequently started conducting a pilot questionnaire study on 25 October 2022. The questionnaire was modified based on the responses from the pilot study. The researcher started collecting the questionnaire data through a survey (see appendix A) on 26 and 27 October 2022. The clinic is only open on a Wednesday and Thursday for booked appointments. During the rest of the week, the clinic accepts walk-ins. Data collection on these days was planned to ensure a sufficient sample size.

Burns, Grove and Gray (2015) argue that research methods are continuously evolving and that combining qualitative and quantitative research designs using mixed methods allows researchers to leverage the strengths of both approaches. A qualitative and quantitative approach was undertaken with questionnaire administration as the researcher administered the questionnaire. This was to ensure a comprehensive data collection. The quantitative aspect was in the form of the questionnaire that was administered to the patient. The qualitative aspect was applied at the data analysis stage when the data was categorised non-numerically. The sample size consisted of participants that attended the HIV/AIDS unit. It was envisioned to have a sample of 60 however the final sample was 71. Drawing on previous research with a similar focus, the researcher determines that a mixed methods design is advantageous in combining the strengths of quantitative and qualitative approaches. This aligns with Burns, Grove and Gray (2015) view that research methods are continuously evolving and that mixed methods offer researchers the flexibility to leverage the benefits of both qualitative and quantitative research designs. With mixed methods, researchers can gain a comprehensive understanding of complex research questions by collecting and analysing both numeric and narrative data. Therefore, adopting a mixed methods approach can enhance the rigor and validity of research findings.

The next section provides details on the research instruments used in this study.

1.10 Research instruments

The research instrument for this study was a structured questionnaire. The information was developed based on gathering a true reflection of patients' experiences. The structure of the questionnaire was designed to ensure that the responses are accurate and that the participants were given a fair opportunity to voice their opinion or suggestions. Consideration of the design of the questionnaire had been designed to ensure that the research questions will be answered. A statistician was employed to assist with the construction of the statements and to verify the data analysis.

1.10.1 Questionnaires

A survey was conducted using a questionnaire to answer the research questions. The questionnaires were given to the respondents who had consented at the HIV/AIDS department of Chris Hani Baragwanath Hospital. The questionnaire was filled out by the researcher personally with the assistance of a translator. An initial questionnaire was developed, a pilot test was conducted, and amendments were made to ensure that the research objectives were met. The survey comprised of three sections that pertained to the study's objectives, along with a final section that offered supplementary information pertinent to the research. The researcher distributed the questionnaire in person to the respondents.

1.11 Paradigm research philosophy

The researcher followed a pragmatic approach. Pragmatic research philosophy has been mainly concerned with application and solutions, with researchers focusing on the research questions and using all approaches available to comprehend the problem at hand (Creswell, 2017). The paradigm for this research adopted a quantitative approach which was best aligned with the questions and the context.

1.12 Qualitative and quantitative research

As noted by Creswell (2017), mixed methods data collection involves gathering both numeric and transcript information, which allows for a more complete analysis that is

based on empirical evidence. Researchers who adopt a mixed methods approach aim to better understand the research problem by using strategies of inquiry that combine both qualitative and quantitative methods. In the context of exploring factors that contribute to people-centred healthcare, contextual, exploratory, and descriptive research designs are commonly used to gather opinions and views of healthcare providers and professionals. Thus, the use of mixed methods is essential to obtain a comprehensive understanding of the research problem.

The quantitative content was captured by the researcher using Microsoft Excel and later transformed into statistical tables. The qualitative data, on the other hand, was captured, coded, and themed. The next section provides an overview of the research design.

1.13 Research design

As outlined by Mouton (2014), a research design refers to the blueprint that outlines how the study will be conducted. This encompasses the methodology and procedures that the researcher will utilise throughout the research process. According to Brink, Van der Walt, and Van Rensburg (2018), a research design is a series of coherent actions taken by the researcher to tackle the research question. This involves a systematic and structured approach to planning and executing the study, with the aim of producing valid and reliable results. Therefore, a well-designed research plan is crucial for ensuring the rigor and accuracy of research findings.

This study will follow the hypothetico-deductive approach. It will guide an experiential learning theory philosophy reasoning and the researcher will use a mixed methods approach to guide the research process. The hypothetico-deductive approach is a combination of deductive and inductive reasoning. It combines observation, experience, theory, and the proposition statement, which is being tested. It believes that a single approach (deductive or inductive) is incomplete reasoning to investigate a phenomenon and provide complete information that influences decision-making (Walliman, 2011).

1.14 Population and Sampling

Collis & Hussey (2014) maintain that a population is the complete group of members about whom a research intends to establish facts. Furthermore, it is the entire group of people who the researcher intends to target within the study consisting of male and female participants.

Acharya, Prakash, Saxena, and Nigam (2013) suggest that convenience and purposive sampling techniques are typically selected based on their ease of use for the researcher. Convenience sampling involves selecting participants who are readily available, which makes it a preferred technique due to its cost and logistical advantages (Taherdoost, 2016). Purposive sampling, also known as judgmental sampling, entails deliberately selecting specific settings, participants, or events to obtain essential data that may not be obtainable through other means (Taherdoost, 2016).

The study participants were chosen using a convenience sampling approach, which is among the most frequently used non-probability sampling techniques. This method is widely adopted since it enables researchers to select from any available pool of potential participants with ease. The methodology chapter will provide a comprehensive account of the criterion utilised in the selection of the study sample.

The target population was patients who had booked an appointment at the HIV/AIDS department of a Chris Hani Baragwanath Hospital in Gauteng Province, South Africa. The sample was determined by the number of consenting patients at the clinic. All patients were asked to participate in the survey, but only those who gave consent completed the survey. The sample size was 71.

The main reasons for choosing purposive sampling are:

1. The research was approved by the National Department of Health;
2. The data collection was completed over a period of 1 week and the data was collected by the researcher; and
3. All respondents are patients of the HIV/AIDS department.

1.15 Data analysis

According to Savenye and Robinson (2004), data analysis refers to the organised use of statistical or logical techniques to condense, depict, demonstrate, evaluate, and summarise data that has been collected. This procedure allows researchers to draw accurate conclusions and make well-informed decisions based on their study's findings. The data from the quantitative questions was inferentially analysed using Excel as an analysis tool, and thereafter the descriptive statistics was computed. The inferential analysis allows the researcher to interpret the data and draw conclusions.

SPSS version 28 was used to analyse the quantitative data for analysis such as analysis of variance (ANOVA) and T-tests.

1.16 Pilot testing

Prior to data collection, the researcher conducted a pilot test to ensure validity, reliability and overall understanding of the questionnaire. The pilot testing helped the researcher to ensure that the questionnaire was user-friendly and clear. The design of the questionnaire is explained in more detail in Chapter Four, the methodology. The next section deals with validity and reliability.

1.17 Validity and reliability

According to Clow and James (2014: 267), the concepts of validity and reliability are concerned with measurement and error. To establish the reliability and validity of the questions posed in this study, the researcher took measures to ensure that the questionnaire questions were tailored to the required data, comprehensible to the participants, and that the responses and data input were interpreted in the same manner as conveyed by the participants.

1.18 Outline of the research study

The structure of this study comprises six chapters, which are followed by references and appendices. The details of each chapter are as follows:

Chapter One: Background of the study

In this chapter, the report commences with an introduction, outlining the problem statement, research objectives and questions, research methodology, literature review, limitations, significance of the study, report layout, and concluding with a summary.

Chapter Two: Models and theories

This chapter presents and introduction, introduces the initial conceptual framework for this study, reviews applicable theories, the chosen theoretical framework for this study and concludes with a summary of the chapter.

Chapter Three: Literature review

Chapter three begins with an introduction, a discussion of the literature and concludes with a table summarising all literature reviewed. The key aspects of people-centred care (PCC), which include collaboration between all key stakeholders, accessibility to healthcare with a focus on emotional and physical well-being will be provided.

Chapter Four: Methodology

The chapter presents the methodology, including an introduction, a description of the research process and design, details about data collection, information about the population and sampling methods, a discussion of the research instrument, an explanation of the data analysis approach, and a summary.

Chapter Five: Research results and findings

The chapter presents a summary of the study's outcomes and findings, consisting of an introduction, a detailed discussion of the results, and a concluding summary.

Chapter Six: Conclusion and future research

The final chapter of this report summarises the study's conclusions, discusses its limitations, offers recommendations, and suggests possible avenues for future research.

1.19 Limitations of the research

Limitations refer to factors that are beyond the researcher's control. In the case of surveys, a drawback could be the respondents' reluctance to provide truthful and candid responses due to the fear of negative repercussions or social desirability bias, which may result in them providing answers that do not accurately reflect their actual thoughts or behaviours. Due to the sensitivity and nature of this survey, data was only collected in a public hospital focusing on the HIV/AIDS department. Therefore, the findings of this study cannot be generalised to all public facilities in South Africa.

1.20 Summary of chapter

This chapter provided a background for this study. This chapter also discussed the challenges faced by the South African health system, including the shortage of health workers, inadequate funding, and poor leadership and management. The COVID-19 pandemic highlighted the weaknesses of the system. The next chapter highlights the models and theories explored and chosen for this study.

CHAPTER 2
MODELS, THEORIES AND FRAMEWORKS

2.1 Introduction

The preceding chapter covered the study's background and thesis statement, followed by a problem statement, research objectives, and questions to be answered. The methodology for data collection, analysis techniques, and resources required were also presented. A concise overview of the current literature, the study's limitations, and its significance was also provided to offer a comprehensive understanding of the research project.

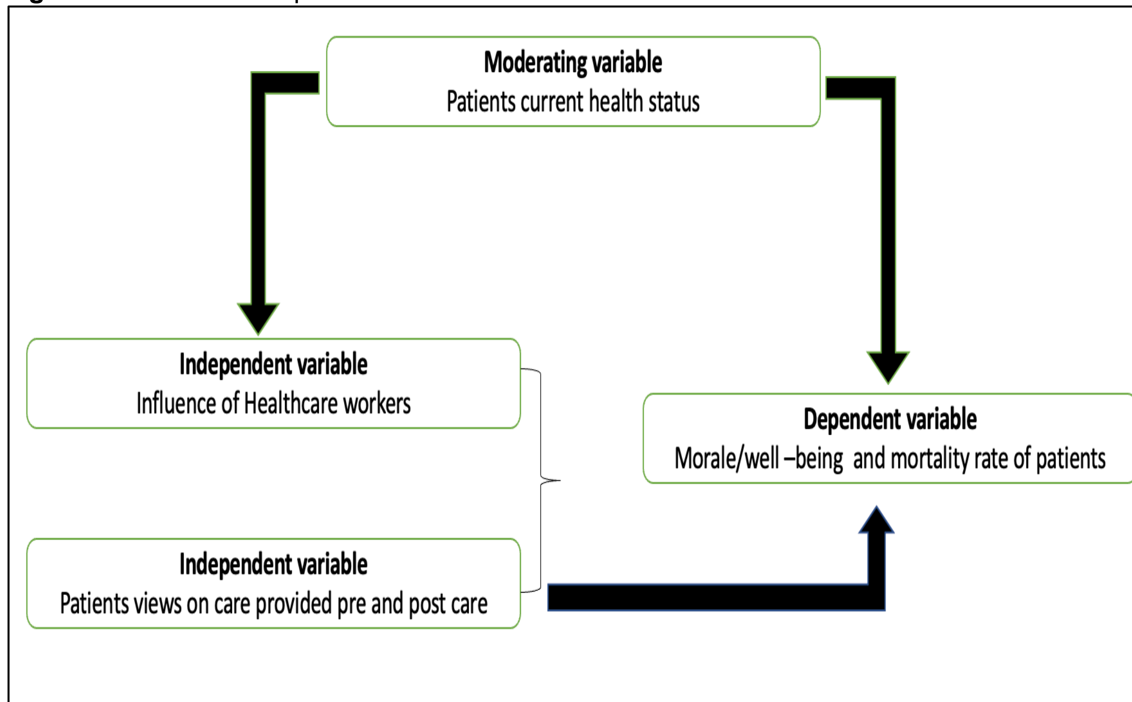
This chapter addresses the theoretical models that originated from the body of knowledge and therefore, were utilised to build the suggested conceptual model of this research. The chapter begins with the initial conceptual framework for this study. Thereafter, the Health Belief Model is discussed, and it is followed by the King Theory of Nurses. In the fourth section, the Theory of Planned Behaviour is discussed. Thereafter, in the fifth section, The Social Cognitive theory is explored. In the sixth section, The Experiential Theory by Kolb (1984) is discussed. This chapter concludes with the summary of the models and theories discussed. The next section discusses the conceptual framework for this study..

2.2 Conceptual Overview

In this study, the conceptual framework will focus on the impact of health workers on patients' morale, well-being and mortality rates and which of the three propositions put forward test them. According to the Cambridge Online Dictionary (1995), 'well-being' is the state of feeling healthy and happy. The dependent variable is the morale, well-being and mortality rate of patients. The independent variable is the influence of health workers and patients views on care provided pre and post care. The moderating variable is the patient's current health status. The researcher will investigate the influence of health workers on patients' well-being and morale and patients views on care provided pre and post care. From the patient's perspective, the researcher will look at how patients define the service and healthcare they receive and also how they feel about it. In addition, the

researcher will try to identify any barriers that exist in the provision of people-centred care. Figure 2.1 illustrates the researcher's initial conceptualisation of the relationships that exist between the variables.

Figure 2.1: Initial Conceptual Framework

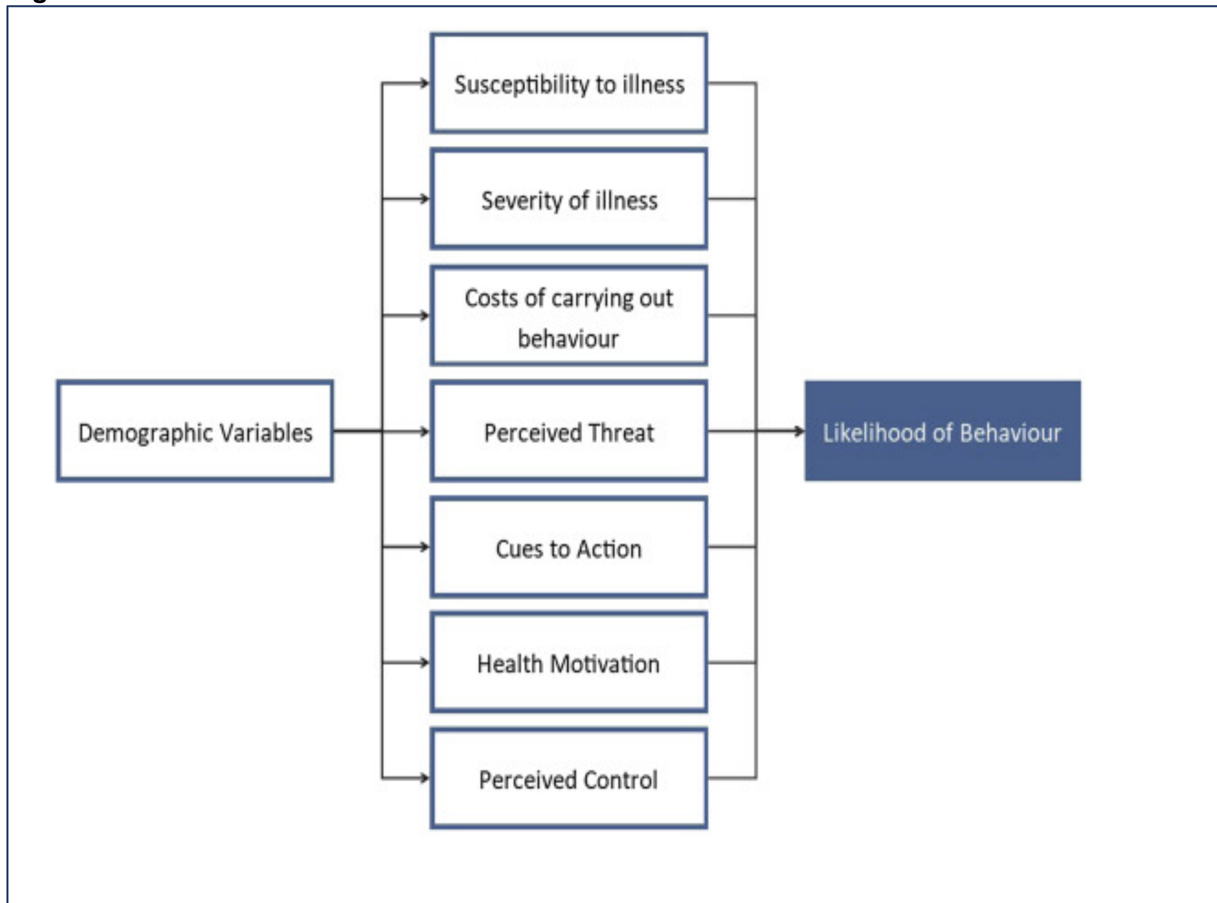


Source: Author's own Construction

2.3 The Health Belief Model

Roeckelein (2006) asserts that the most widely recognised model of health-related behaviour in health psychology is The Health Belief Model, Figure 2.2 below. This model proposes that individuals respond to cues or actions such as the onset of symptoms or an invitation to attend a health check-up, based on their beliefs regarding the pros and cons of taking a particular course of action. Consequently, individuals will be motivated to act or refrain from acting based on their perceptions of the benefits and drawbacks of the recommended health behaviour.

Figure 2.2: Health Belief Model



Source: Mckellar & Sillence (2020)

Abraham and Sheeran (2007) propose that beliefs are an ideal target for interventions aimed at modifying behaviour, as they are an enduring characteristic that influences behaviour and can potentially be altered. Furthermore, beliefs may vary across individuals due to differences in their socialisation history or demographic background. If interventions could successfully change beliefs linked to health behaviours, resulting in the desired behaviour change, it would provide a theory-based tool for health education. The Health Belief Model (HBM) focuses on two primary components of an individual's perception of health and health behaviour: Threat Perception and Behavioural Assessment. Threat perception includes two important beliefs, namely perceived susceptibility to disease or health problems and the likely severity of disease consequences. Behavioural assessment also includes two distinct beliefs: that of the benefits or effectiveness of a recommended health behaviour, and that of the costs or barriers associated with participating in a health behaviour.

According to Visser, Makin, Vandormael, Sikkema, and Forsyth (2009), HIV/AIDS infection rates in South Africa were significantly divided by race, with 13.6% of Black

Africans in South Africa being HIV-positive, while only 0.3% of Whites living in South Africa had the disease. In townships, false traditional beliefs about HIV/AIDS, combined with a lack of education and awareness programmes, contributed to the spread of the disease. Sexual violence and local attitudes towards HIV/AIDS further intensified the epidemic.

HIV/Aids stigmas, particularly those based on harmful myths, can have a profoundly negative impact on people living with HIV. This has also led communities to believe that the disease was only contracted by gay men and sex workers. However, that was not the only engagement that HIV/AIDS is contracted through, researchers have through time subsequently learnt that HIV/AIDS could pass through mother and child, sharing of needles in drug use and contaminated blood transfusions. However, the earlier understandings cannot be eradicated due to South Africa's social structures, therefore people are reluctant to share their HIV status for fear of being rejected or shunned or subjected to criticism by the communities.

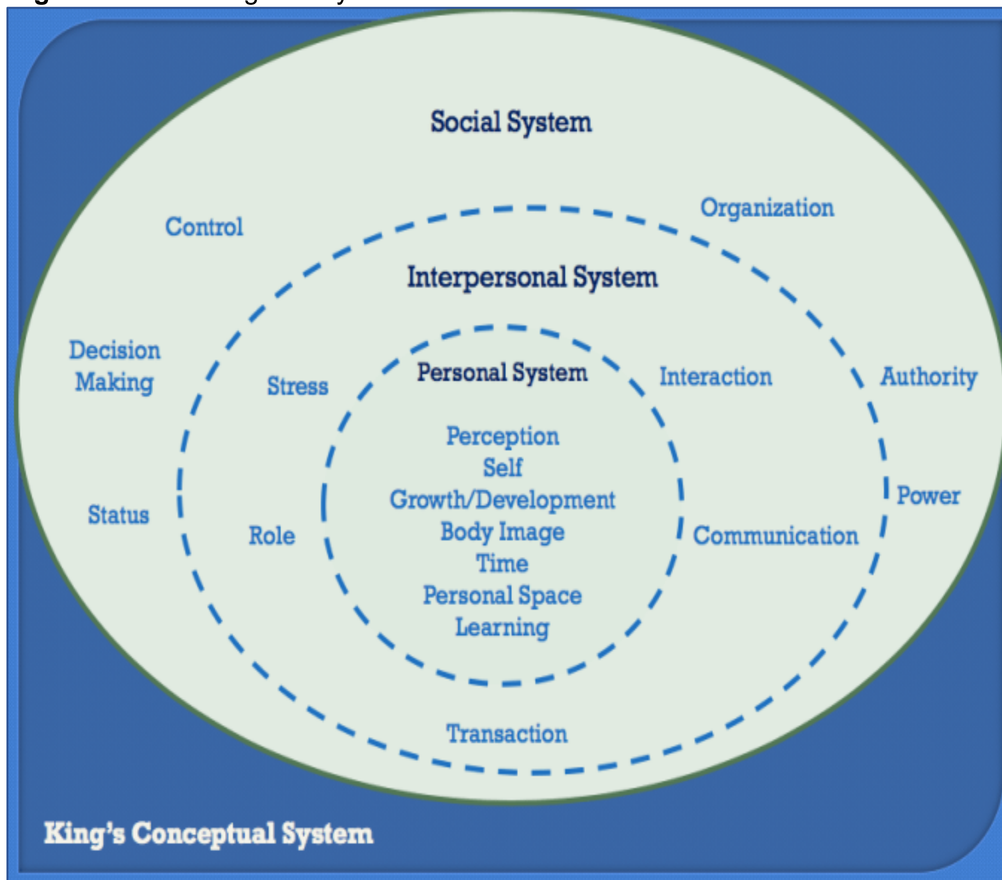
The African culture is steeped in rich cultural beliefs and their traditional healing is adopted over allopathic remedies and lifestyles. This is a dangerous path for a patient with HIV/AIDS as this disease is still being studied and there is no cure to date. Currently medical research has indicated that only Anti-Retroviral (ARV) medication combined with a healthy lifestyle ensures longevity. This too is dependent on how far the HIV virus has progressed, and the various treatments required at each stage.

The HBM may hinder the study as the cultural differences amongst the majority affected will not allow the patient to divulge his or her status let alone the honest feedback required to ensure a people-centred approach towards healthcare. Therefore, after a thorough investigation of the HBM and its suitability for this study it was established that this theory may not be suitable for this research topic. The next section discusses the second theory which is the King Theory of Nurses.

2.4 The King Theory of Nurses

King (1981) proposed a conceptual framework that includes three systems that interact with one another. The smallest of the systems is the personal system, which consists of individuals, such as nurses and patients. The interpersonal system is the second level, which consists of small groups, such as families, or the interaction between a nurse and patient. The largest level is the social system, which includes societies like religious organisations, universities, and hospitals. Figure 2.3 below illustrates the three systems and their interaction.

Figure 2.3: The King Theory of Nurses



Source: Fawcett, Kings Conceptual System 2018

King's (1981) theory of nursing includes the Theory of Goal Attainment, which is situated within her larger conceptual framework. The Theory of Goal Attainment posits that nurses and patients collaborate to establish and achieve mutually agreed upon goals. Communication and interaction between the nurse and patient are essential components of this process, and the transactional nature of their relationship is a key feature. Once a goal has been established, the nurse and patient work together to attain it, potentially involving other systems such as healthcare workers or the patient's family. King (1981)

identifies the main function of nursing as the improvement or restoration of the patient's health, thus highlighting the importance of health-related goals in the goal attainment process.

In line with this, King (1981) emphasises the importance of documentation in the goal attainment process, as it helps to streamline communication and facilitate coordination among healthcare workers. Documentation also serves as a means of assessing whether the goal has been achieved. Colby (2018) highlights the significance of this assessment stage as the culmination of the goal attainment process in King's theory.

The King's (1981) theory considers all stakeholders in the patient journey and is great when utilised in conditions that are working as intended. The healthcare system in South Africa is varied and unequal. The public healthcare system is hanging on by a thread. Both private and public healthcare system is being challenged with medical malpractice suits. This litigation amidst healthcare workers who are overrun by fatigue, lack of systems, equipment and processes adds more frustration than resolution. The essential aspect of King's (1981) nursing theory is the thorough and accurate documentation of goals, which may appear burdensome to healthcare workers as an additional process.

Whilst King's (1981) theory of nurses encompasses the relationships in a patient's journey, it is not possible to adopt on a large scale. In addition, with barriers of language and culture that exist in South Africa, personalising the goal per patient may add to the already strained healthcare system. Bärnighausen, Hosegood, Timaeus, and Newell (2007) conducted a longitudinal population-based study in rural South Africa, which led them to conclude that reducing poverty may not effectively reduce the spread of HIV/AIDS in the long-term (Lynda Fenton, 2005). Although poverty reduction is important, increasing educational attainment in the general population may be more effective in lowering HIV incidence rates, regardless of how it is achieved.

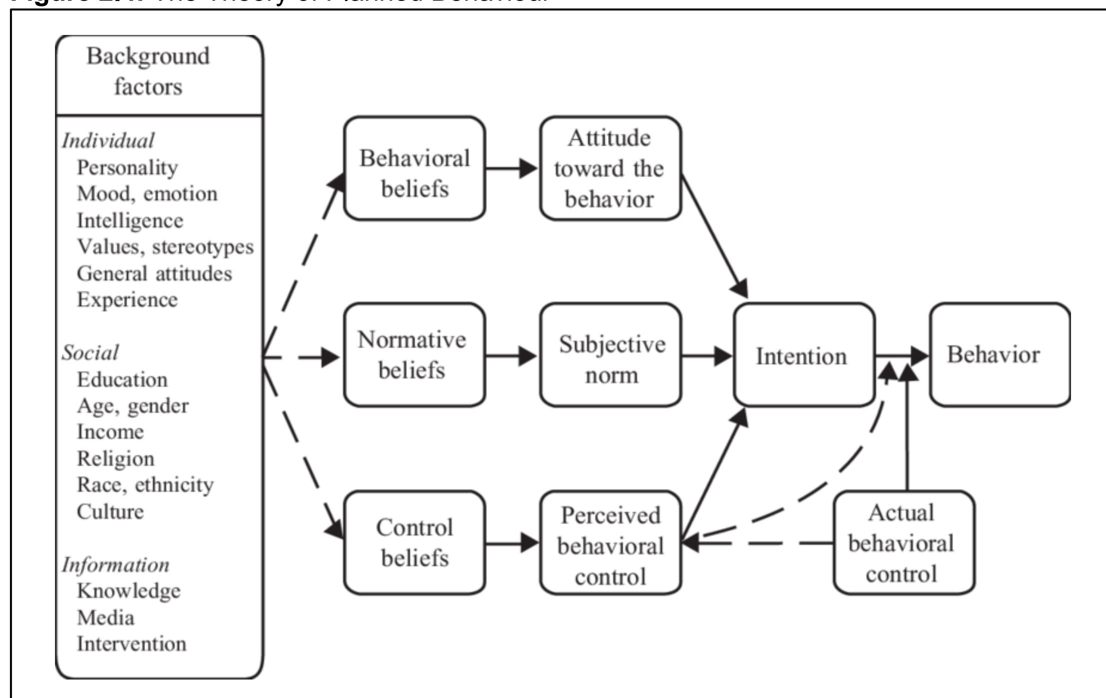
The King's (1981) theory of nurses require a certain level of understanding and education. The apartheid regime in South Africa has left the country with a huge divide in education levels. Some of the research indicated above shows that the reduction of poverty and increase in education is a critical factor in mitigating the spread of HIV. How would a patient who does not understand basic educational concepts be able to understand the

goal of healthy lifestyle maintenance or afford to sustain the suggested lifestyle balance required for HIV/AIDS maintenance? Hence, after careful consideration, the King Theory of Nursing (1981) is not a suitable model for this study. The next section discusses the Theory of Planned Behaviour.

2.5 The Theory of Planned Behaviour

Ajzen (1991) proposed the Theory of Planned Behaviour (TBP) which suggests that intentions to engage in a healthy behaviour are directly influenced by three factors: attitudes toward the behaviour, subjective group norms, and perceived behavioural control.

Figure 2.4: The Theory of Planned Behaviour



Source: Ajzen (1991)

A popular behavioural model that can help researchers understand how people's behaviour can change is the Theory of Planned Behavior (TPB), as explained by Arafat and Ibrahim (2018). The TPB assumes that behaviour is planned and predicts deliberate behaviour (Ajzen, 1991). This model has evolved from the earlier Theory of Reasoned Action (TRA) (Ajzen & Fishbein, 1975), which assumed that behaviour is voluntary and under control. As it was later discovered that behaviour is not always voluntary, the TPB

model was revised to include perceived behavioural control. The TPB considers three types of considerations that guide a person's action: behavioural beliefs, normative beliefs, and control beliefs. Behavioural beliefs lead to a favourable or unfavourable attitude towards a particular behaviour, normative beliefs lead to perceived social pressure or subjective norms, and control beliefs lead to perceived behavioural control. Greater favourable behaviour, subjective norm, and perceived control strengthen the person's intention to perform the behaviour in question (Ajzen, 1991).

According to Visser, Makin, Vandormael, Sikkema, and Forsyth (2009) even though the HIV/AIDS epidemic had extensively affected the South African communities under their study, stigmatising attitudes towards people living with HIV persisted. Their community-based research revealed that roughly one-third of participants expressed negative emotions or blamed individuals living with HIV, and one in five admitted to distancing themselves from them.

The Theory of Planned Behaviour is based on beliefs, normative beliefs which are expectations of other people that are acceptable in society. Societies in South Africa have a stigma associated with HIV/AIDS (UNAIDS, 2020) and this stigma influences all topics on HIV/AIDS. Until this is changed with an education process, the response from the participants in this study may be influenced in responding to the questionnaire. The other aspect of the TPB is behavioural beliefs which can be understood as presumed results of practised behaviour. The stigma in South African Communities is behaviour, if you are a person that is promiscuous then you will contract HIV/AIDS. This perceived behaviour is resulting in a presumed outcome (Eyawo, de Walque, Ford, Gakii, Lester, Mills, 2010).

Stangl and Nyblade (2007) emphasised the severe impact of HIV-related stigma and discrimination in various countries and communities. These consequences can be significant, including abandonment by family members, social rejection, loss of employment and property, expulsion from school, denial of medical services, lack of care and support, and violence. As a result of these consequences, people may be discouraged from seeking HIV testing, disclosing their HIV status, adopting preventive behaviour, or accessing treatment, care, and support due to the fear of stigma and discrimination.

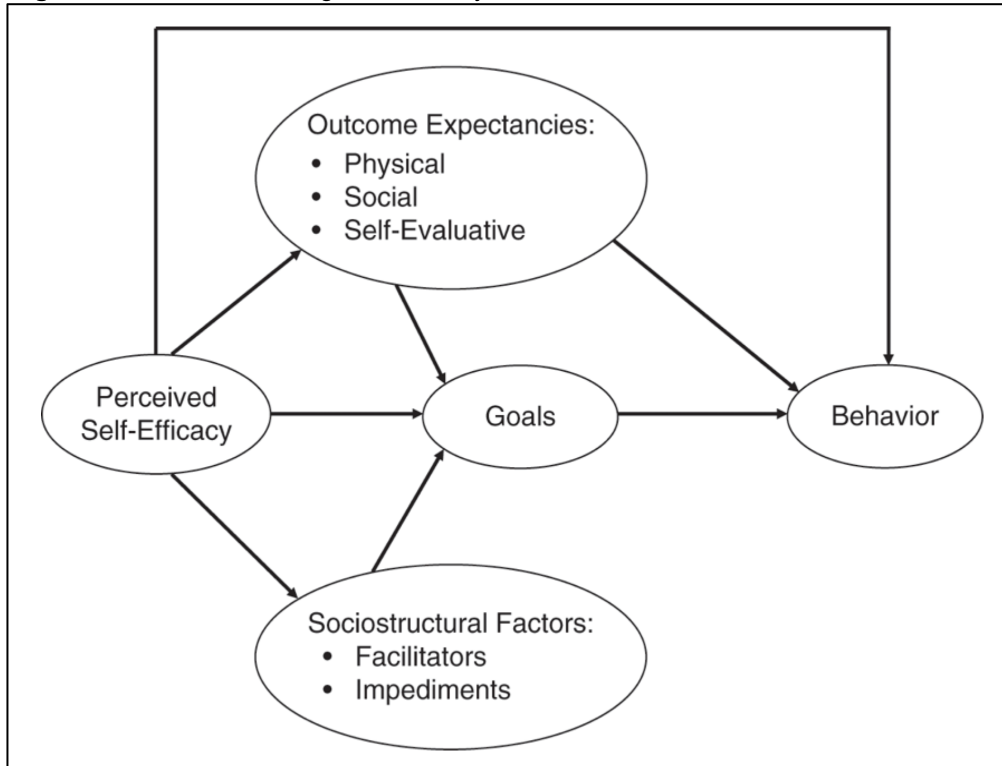
Topa and Moriano (2010) suggest that the Theory of Planned Behaviour (TPB) is an effective model for making changes in one's lifestyle, such as quitting smoking. The TPB incorporates attitudes, subjective norms, and perceived behavioural control, and has been applied extensively to forecast smoking behaviour. Researchers have also used the TPB to develop intervention programmes that are based on theory to decrease tobacco consumption. Many empirical studies have examined the TPB in relation to smoking behaviour antecedents, but the results have been variable. Therefore, a quantitative integration of this literature would prove valuable.

TPB has proven to be a great theory in healthcare behavioural changes which are required for a better lifestyle and effective management of disease. However, HIV/AIDS is a complicated disease due to the stigma attached. South Africa’s unique diversity of population with cultural beliefs still have a huge influence on beliefs, hence the TBP theory may be persuaded in a negative manner due to these beliefs. Some cultural beliefs include beliefs in traditional healers who are sought for advice and traditional medication. The latter hinders HIV/AIDS patients from taking Antiretrovirals and taking advice from doctors. Therefore, this theory was not adopted for this study. The Social Cognitive Theory is explored in the next section.

2.6 The Social Cognitive Theory

Conner, Norman, Schwarzer, and Lucszczynska (2015) state that the Social Cognitive Theory (SCT) emphasises the importance of forethought in human motivation and action. This anticipatory control mechanism involves expectations that refer to the outcomes of taking a specific action. The theory outlines several crucial factors that influence behaviour, including perceived self-efficacy, which concerns people's beliefs about their ability to perform a specific action required to achieve the desired outcome, and outcome expectancies, which are people's beliefs about the possible consequences of their actions (Bandura, 1986). SCT also considers goals, perceived obstacles, and facilitators. These constructs are illustrated in Figure 2.5, showing their interplay throughout the behaviour change process.

Figure 2.5: The Social Cognitive Theory



Source: Bandura (2000a)

Bandura (1998) examines health promotion and disease prevention through the Social Cognitive Theory (SCT) and notes the overlap with other psychosocial health models. The approach to health promotion has shifted over time from fear-based tactics to encouraging healthy behaviour, self-regulatory skills, and social support. This multifaceted approach considers the interplay between personal and environmental determinants of health behaviour. SCT addresses socio-structural and personal determinants, highlighting the need to address harmful social systems and individual habits for comprehensive health promotion. To achieve progress, new structures and systems for health promotion, risk reduction, and policy initiatives are needed. Bandura (1998) further highlights the importance of collective efficacy beliefs in shaping public health approaches to health promotion and disease prevention. The Social Cognitive Theory is based solely on a person's belief in self-capabilities, these beliefs can originate from perceptions built over a period of time. For example, if a person believes that they have a strong sense of willpower to maintain a balanced and healthy lifestyle to ultimately meet a goal weight, then he would embark on the diet and maintain it successfully. The ultimate goal is looking good and recognition by society. The individual practises self-

efficacy and control and realises the goal. The acknowledgement from society increases self-efficacy and motivates the person.

Bandura (1997) defines perceived self-efficacy as an individual's belief in their ability to control challenging demands and their own functioning. Conner et al. (2015) state that Bandura's unifying theory of behaviour change hypothesizes that expectations of self-efficacy are self-regulatory cognitions that determine the initiation, effort, and persistence of instrumental actions despite obstacles and failures. Self-efficacy is a significant factor in the motivation process, which can either enhance or impede motivation and is directly related to behaviour. It represents confidence in one's ability to resist temptation, cope with stress, and mobilise resources to meet situational demands. Self-efficacy beliefs can influence the amount of effort to change risk behaviour and persistence in continuing to strive for change. These beliefs are formed based on various sources (Bandura, 1997).

Bandura (1997) proposed four sources of self-efficacy beliefs that can enhance an individual's confidence in their ability to exercise control over challenging demands and their own functioning. The first source is personal accomplishment or mastery, which can enhance self-efficacy beliefs if success is attributed internally and can be repeated. The second source is vicarious experience, where observing a model person, someone similar to the individual, successfully mastering a difficult situation can enhance self-efficacy beliefs through social comparison processes. The third source is verbal persuasion, where others can enhance self-efficacy beliefs through positive feedback or encouragement. For example, a health educator may reassure a patient that they will perform cancer screening properly due to their competence. The last source of influence is emotional arousal, where experiencing no apprehension in a threatening situation can lead to feeling capable of mastering the situation (Conner et al., 2015).

For this study, this theory cannot be utilised due to the nature of the study. The research questions intended to be answered will be influenced by the person's self-efficacy beliefs. Measurement of patient and healthcare workers' views of quality healthcare from a people centredness aspect needs to be based on actual experiences and not influenced by self-efficacy beliefs. Additionally, societal change on views of HIV/AIDS needs to change to add to the self-efficacy and to motivate a person to disclose HIV/AIDS status and prompt healthy lifestyle. Until this change occurs communities continue to ensure that HIV/AIDS

patients feel alienated. If the person believes this, the patient will not have a neutral view on what care and healthcare he deserves and needs. The final theory in this chapter is the Experiential Learning Theory which is explored next.

2.7 The experiential learning theory

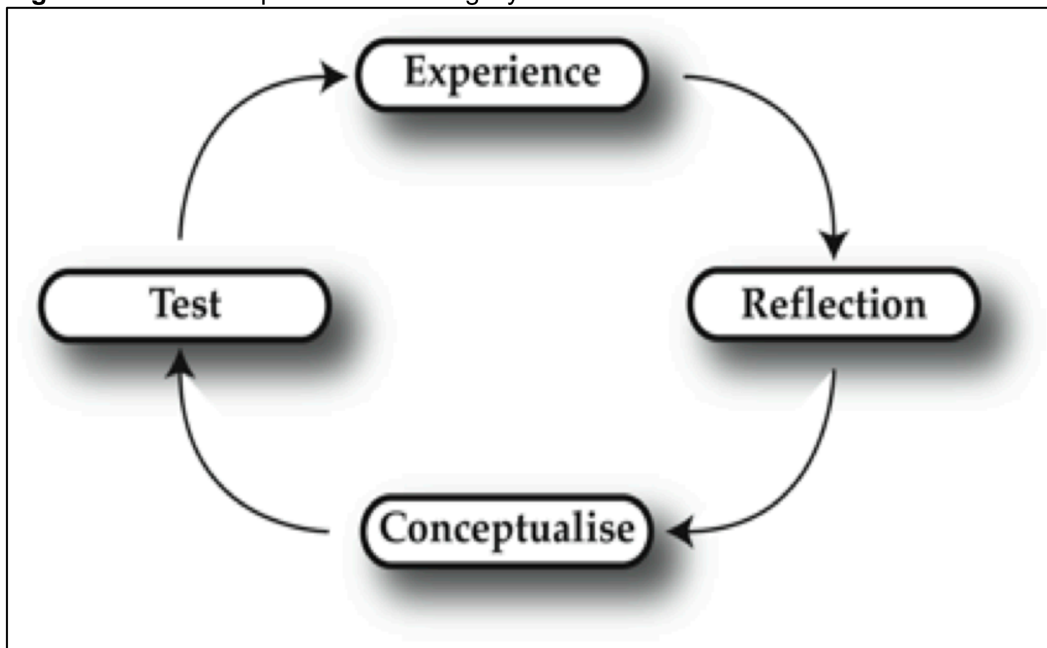
Sternberg and Zhang (2014) describe the Experiential Learning Theory (ELT) as a model of the learning process and adult development that emphasises the importance of experience. This sets ELT apart from other learning theories that focus only on cognition or exclude subjective experiences. ELT draws inspiration from the works of Dewey, Lewin, and Piaget, specifically Dewey's philosophical pragmatism, Lewin's social psychology, and Piaget's cognitive-development genetic epistemology (Kolb, 1984). By emphasising the role of experience in learning, ELT provides a comprehensive understanding of the learning process and adult development that is consistent with current knowledge of human learning and development (Sternberg & Zhang, 2014).

Most organisations have transformed from selling products and solutions to selling complete experiences. From the moment you step foot into a retail store, the seamless user experience, effective communication of promotions, and integration of technology have elevated this encounter into an immersive journey. The Amazon store serves as a prime illustration of this phenomenon, where entering the premises evokes a sense of entering a well-managed workspace with controlled access. It allows customers to effortlessly pick up desired items from the shelves and proceed with their shopping, creating a frictionless experience. This entire experience is strange, you may feel like you have shoplifted, as there are no tellers or queues. But the due amount is deducted from your credit card. In order to build this experience, engagement with consumers to understand their experiences and what makes them frustrated and what they would like to see was important. Experience is what our daily lives are made up of.

A people-centred approach is based on emotion and what the person felt during the experience at the healthcare facility, therefore an experiential model was more suited. To understand a people-centred approach to healthcare it is imperative to understand the individual's experience which provides researchers with a basis to set a benchmark.

The theoretical framework selected is experiential, as expressed by key theorist Kolb (1984). The basis of this theory is that people learn through experiences. The cycle in Figure 2.6 depicts the stages, beginning with experience, reflection or observations of this experience, key take-away points are extracted and these take-aways are applied or tested in practice. The entire framework is built upon experiential foundations; however, it operates as a cyclical process. Once implemented and tested, adjustments can be made as necessary to ensure the achievement of desired outcomes and ongoing success.

Figure 2.6: Kolb's Experiential Learning Cycle



Source: Kolb's Experiential Learning Cycle (McLeod, 2017)

Evolution is forcing consistent change and adaption and therefore this theory fits perfectly to a "people centred approach" to healthcare. Additionally, "people" are the basis of this study and therefore experiences are essential to this foundation. According to Kolb and Kolb (2006), the Experiential Learning Theory (ELT) is built upon the contributions of influential 20th-century scholars who highlighted the significance of experience in their theories of human learning and development. These scholars include John Dewey, Kurt Lewin, Jean Piaget, William James, Carl Jung, Paulo Freire, and Carl Rogers. ELT takes a holistic approach to the experiential learning process and offers a multi-linear model of

adult development, which was developed based on the foundation provided by these scholars (Kolb, 1984).

Murray (2018) highlighted the key principles of experiential learning identified by Dewey (1938). Firstly, education and experience must be related, and educational lessons must have an experiential component. Secondly, experiences must show continuity and interaction, and they must be planned to be significant for learners. The meaningful experience allows learners to build on their experiences and connect what they learned from their new experiences, enabling them to see future consequences. Finally, the environment and the learner's interaction with the environment, affect the experience, and the environment must be comfortable and conducive to learning. According to Dewey's theory, experiential learning is personalised and individualised for each learner based on their past experiences, and learners may have different views of the same concept (Kolb, 1984).

Merriam, Caffarella, and Baumgartner (2007) emphasised the importance of connecting learners' past and future experiences in order for learning to occur. They also highlighted the need for productive and genuine experiences. The authors recommend that to facilitate adult learning, a welcoming environment must be created, appropriate materials must be provided, and those materials should be linked to learners' past and future experiences.

A people-centred approach to improving the quality of healthcare provided to HIV/AIDS patients will be measuring the variables of how personalising the service or healthcare to the patient will enhance the patient's quality of life. Patients living with HIV/AID's are faced with various challenges from access to healthcare facilities, affordability for healthcare as well as basic understanding of what their healthcare workers are communicating to them. South Africa has a diverse landscape with eleven official languages and many more religious beliefs and this diversity leads to challenges that require a deeper understanding. Understanding these barriers and being able to overcome this to ensure that a patient understands the healthcare services provided is critical to the success of a people-centred approach to healthcare.
Stiernborg, Zaldivar and Santiago (1996) conducted a study comparing the effectiveness of didactic teaching and experiential learning in HIV/AIDS education for nursing students

in the Philippines. The study used a quasi-experimental pre-test-post-test design involving three groups of nursing students: a didactic group, an experiential learning group and a control group. Both the didactic group and the experiential learning group covered the same content, including AIDS epidemiology, infection control, socio-ethical issues related to HIV infection and caring for patients in the hospital and community. The study found that while both groups had significant knowledge gains, the experiential learning group had significantly higher knowledge scores and more consistent positive attitude changes. The authors concluded that the experiential learning approach was more effective than the didactic approach in knowledge acquisition because it encouraged active participation of the participants, introspection, implementation, adaptability and student centredness. Patient interactions were also integrated as an essential part of the learning process. Kolb and Kolb (2006) further support the idea that experiential learning is an effective approach for knowledge acquisition and personal growth.

According to the Institute of Medicine (2001), nurse practitioner Mary Chao's experience in working with newly diagnosed diabetes patients demonstrates that people learn better through multiple experiences. Chao gives each new patient a diary to record their meals and blood sugar levels. She explains, "Don't worry about anything. Just write down your meals and blood sugars. At the next visit we will look at it." Patients are able to draw connections between their meals and blood sugar levels by using the diary. Even patients with little formal education are active participants in their self-management. One patient compared his self-management to being like an athlete in training. Elderly patients who had previously struggled to manage their blood sugar levels have successfully monitored and managed their diabetes by generating their own clinical information, which is available to them and their clinicians on their own websites in graph and chart forms.

Avert (2021) suggests that beginning antiretroviral treatment promptly, and adhering to it as a regular part of one's routine, is the most effective means of preserving the strength of the immune system. Maintaining good health involves engaging in regular exercise, consuming a nutritious diet, and getting sufficient rest and quality sleep. One's mental health is equally essential as one's physical health, and discussing concerns with family, friends, or a support group, can be highly beneficial. The above research reiterates that patients with HIV/AIDS can live long and fruitful lives if the disease is managed

appropriately. However, the lack of understanding of a proper diet, lifestyle and treatment deters longevity. This research aims to investigate a people-centred approach to healthcare and specifically HIV/AIDS patients can lead to high mortality rates. The understaffed healthcare system in the country will be under less pressure once the patient is educated on the management of diseases appropriately within their specific lifestyle and budget.

The research will explore how patients define the healthcare they receive currently and what in their opinion can be changed to accommodate their individual requirements.

2.8 Review Models, Theories and Frameworks

To summarise, the below table indicates the theory and how it relates or does not to this research study.

Table 2.1 Evaluation of models and theories

Theory	Author	Advantages	Disadvantages	Suitability
The Health Belief Model	Irwin M. Rosenstock, Godfrey M. Hochbaum, S. Stephen Kegeles, and Howard Leventha, 1950's	HBM has seemed effective in reduction of risk of disease HBM Model has shown success when applied to understanding decisions on healthcare	HBM fails to consider the impact of individual factors such as attitudes and beliefs on a person's decision to adopt a particular health behaviour. HBM fails to consider habitual behaviours that may influence an individual's decision to accept a recommended action, such as smoking HBM does not consider external factors such as economic or environmental influences that can either facilitate or hinder the adoption of the recommended behaviour. HBM assumes that individuals have equal access to	Not used in this study due to the beliefs of HIV/AIDS and the stigma in the South African population. This may negatively impact the participants response.

			information about an illness or disease. HBM assumes that cues to action are abundant and effective in encouraging people to engage in health-promoting actions, and that individuals prioritize “health” actions in their decision making process.	
The King Theory of Nurses	Dr.Imogen King 1971	Communication enhances patient experiences and this theory is based solely on consistent communication.	The King theory of Nurses focuses on only the nurse-patient relationship and excludes the entire ecosystem involved in the healthcare Communication is the foundation of the theory. South Africa’s variety of languages acts as barrier.	Not used in this study due to barriers the different languages in South Africa bring.
The Theory of Planned Behaviour	Icek Ajzen 1991	TBP has been successful in explaining health behaviours TBP is useful in making predictions TBP assists in identifying barriers to change	TBP does not address the discrepancy that can occur between a person’s intention to engage in behaviour and their actual behaviour. TBP presupposes that an individual possesses the resources and opportunities necessary to successfully execute the intended behaviour, irrespective of their intention. TBP does not consider emotional factors that may influence behaviour. TBP does not provide a method for identifying specific actions that lead to behaviour change.	Not used in this study due to the beliefs of HIV/AIDS and the stigma in the South African population. This may negatively impact the participants response.

The Social Cognitive Theory	Albert Bandura 1960's	SCT has addressed the underlining determinants of health behaviour SCT focuses on promoting change based on the interaction between individuals and environment.	SCT presupposes that an environmental changes will result in corresponding changes in an individuals behaviour. SCT does not prioritise the long-term sustainability of a behaviour change once it has been achieved. SCT emphasis on the learning process and may overlook the potential influence of biological and hormonal predispositions on behaviours, which may persist regardless of past experiences and expectations.	Not used in this study due to self-efficacy beliefs that may influence the results of the research.
The Experiential theory	David Kolb 1984	Emphasises personal involvement through experiences Experiential learning is flexible and patient-centred Reflective observation is a key aspect of this theory which provided a holistic view and not one event	Goals are not included in this theory Requires patience from researcher	Suitable for this study due to patient centred approach to healthcare being the main research area

Source: Author's own compilation

2.9 Summary of Chapter Two

After investigating the five models above, the chosen model for this research project is The Experiential Learning Theory. Understanding the patient experience is critical to the success of patient centred healthcare. According to the definition provided by the Agency for Healthcare Research and Quality (2016), patient-centred care involves the provision of healthcare services that are responsive and respectful to individual patient preferences, values and needs, with the goal of ensuring that patient values guide all clinical decisions. Patient-centred care has been identified as a key element in improving quality management in healthcare. Therefore, ELT was chosen based on the subject matter as well as to ensure that the gaps that required to be covered would be addressed adequately.

Based on the models and theories reviewed in this chapter the researcher has utilised a pragmatic view for this study. The next chapter, which is Chapter Three, will focus on the literature review which is linked to the research questions and research objectives.

CHAPTER THREE
LITERATURE REVIEW

3.1 Introduction

In the previous chapter, the focus was on the theoretical aspects of this study, and various models and theories were explored. This chapter focuses on the literature on patient-centred healthcare, perceived benefits, and uses. The importance of patient-centric healthcare thereby exploring the various research studies previously completed in different countries relating to this study and reveals research gaps which this study helps to address.

In the first section, patient-centred care is defined. This is followed by why patient-centred care is essential. The subsequent section explores the role of nurses in patient-centred care. The role of doctors in patient-centred care follows this. After that the researcher delves into the role of communication in patient-centred care. The subsequent section highlights the healthcare system and its alignment with patient-centred care. The meaning of care for patients follows this. The next section expands on physical comfort and emotional well-being in patient-centred care. The next section discusses the importance of involving patients, families, and communities in healthcare. Thereafter, the researcher highlights how the fast delivery of information with transparency is imperative to care. This is followed by the role leadership plays in patient-centred care. The next section expands on how the role of spirituality, religion, and culture affects patient-centred care. The penultimate section focuses on how critical the patient experience is to care. Finally, the chapter concludes with how technology affects patient-centred care.

3.2 A brief overview of patient-centred healthcare

According to Wolf (2021), healthcare workers, patients, family caregivers, and care partners are all engaged in the work of caring, curing, or helping others live with dignity and respect. This fundamental human need is a common ground that brings people together in the healthcare experience. Despite the vast diversity of stories and experiences in the world, this basic need remains constant for everyone. Healthcare,

unlike other industries, has more at stake due to the infinite value of the cost of a life. Ensuring that the healthcare experience is personalised and not just mechanical with a 'one-size-fits-all' fit, is the essence of getting healthcare to work optimally. According to Catalyst (2017), patient-centred care has several common elements that influence the design, management, and delivery of healthcare services. These elements include:

1. Ensuring that the healthcare system's objectives, vision, principles, leadership and initiatives for quality improvement are in harmony with patient-centred goals.
2. The delivery of healthcare services that are coordinated, collaborative and easily accessible, and are provided at the appropriate time and location.
3. Care that attends to both the physical comfort and emotional well-being of the patient.
4. Recognition and consideration of the patient and their family's preferences, values, cultural background, and economic status.
5. The belief that patients and their families are integral members of the care team and participate in making decisions related to the patient and the healthcare system.
6. Encouragement and facilitation of family member presence in the care setting; and
7. Full and prompt sharing of information with patients and their families to enable informed decision-making.

Figure 3.1: Patient-Centred Care

Source: Catalyst (2017)

Figure 3.1 illustrates that the patient is at the heart of the healthcare provided. Family and patient are included in the entire process. The care that is provided is collaborative. Respect, transparency, and fast information delivery are critical criteria for patient-centred care. Physical and emotional well-being is a focal point of the care. Goals are mutually aligned with the clinician and the patient's needs.

In the following section, the researcher elaborates on why patient care is essential and how Patient-Centred Care [PCC] will assist in reducing the fragmentation of care.

3.3 The importance of patient-centred care

According to the WHO (2015), health care that lacks a people-centred and integrated approach risks becoming increasingly fragmented, inefficient, and unsustainable. The absence of people-centred and integrated health services can hinder individuals from accessing top-notch healthcare services that cater to their requirements and preferences. Conversely, incorporating people-centred and integrated health services can improve the quality of healthcare services, enhance financial sustainability, and be more receptive to the needs of individuals and communities. Therefore, adopting a people-centred approach for South African healthcare organisations is critical. The fragmentation of care provided today causes frustration to patients and healthcare workers. According to the WHO (2015), a fragmented healthcare system is often characterised by the presence of vertical, disease-oriented programmes such as those for HIV/AIDS, malaria, tuberculosis, and other infectious diseases, as well as some chronic care management programmes. However, this approach can lead to duplication, inefficient use of resources, and gaps in patient care for those with multiple health conditions. Furthermore, the emphasis on single diseases often leads to a reduction in overall healthcare sector capacity as the best healthcare workers focus on a single disease. This approach also leads to inequities for patients who do not have the "right" condition. Thus, there is a need for a new strategy that rebalances healthcare service delivery and addresses the problem of ‘inequity by disease’ (WHO, 2015).

According to Burton-Hughes (2021), the growing demand for healthcare can cause caregivers to overlook the person behind the medical condition they are treating.

Therefore, patient-centred care is essential in order to help caregivers refocus on fulfilling the needs of the patient beyond their disability or ailment. Healthcare, unlike other services, is personal, and the effects of not administering and managing healthcare services effectively cannot be undone. Burton-Hughes (2021) highlights the importance of patient-centred care for both patients and healthcare facilities. Patient-centred care offers numerous benefits such as enhancing patients' comfort and confidence in healthcare services by upholding their dignity and independence, thereby promoting mutual respect. Patients tend to trust clinicians more, and clinicians are better able to meet patients' emotional, social, and practical needs, which help maintain a high quality of life for the patient. Moreover, people-centred care helps patients who have difficulty communicating their wants and needs, thereby maximising their quality of care. The patient's independence is improved, raising their engagement, and encouraging them to take part in decisions, which helps clinicians reach patients with better, more suitable choices for their care.

According to Burton-Hughes (2021), healthcare institutions can also benefit from patient-centred care. Patients who feel respected, involved, and in control of their treatment plans are more likely to adhere to them, which can reduce the burden on the healthcare system by avoiding repeated checks and wasted medication. Furthermore, patient-centred care enhances patients' understanding of their condition, reducing unnecessary admissions and motivating patients to adopt positive health behaviours that improve their overall health management.

Burton-Hughes (2021) emphasises that UK hospitals are currently facing significant strain due to the number of patients who are unnecessarily admitting themselves. However, personalised and enabling care can address this issue by ensuring that patients receive appropriate medication and engage in the right services, ultimately reducing the burden on the healthcare system. This is especially crucial for patients with long-term conditions who depend heavily on healthcare services.

The following section highlights the pivotal role that nurses play in PCC.

3.4 Nurses' role in patient-centred care

The International Council of Nurses (2022) highlights the role of nursing as a fundamental component of the healthcare system. Nurses are responsible for promoting health, preventing illness, and caring for individuals of all ages who have physical or mental health problems, as well as disabilities, across various healthcare and community settings. In the context of nursing, "responses to actual or potential health problems" among individuals, families, and groups are of particular concern (American Nurses Association, 1980). These human responses can include a broad range of issues, from addressing individual episodes of illness and restoring health, to developing policies and promoting long-term health within populations. A significant aspect of health promotion is the management of chronic diseases, which accounted for 28% of all deaths in South Africa in 2002 (Project HOPE, 2019).

"Chronic diseases are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both" (Centres for Disease Control and Prevention, 2022). Davis, Eckert, Hutchinson, Harmon, Sharplin, Shakib, and Caughey (2021) provide an authentic insight into the engagement and advice from nurses which educate patients on managing chronic diseases appropriately, ultimately leading to a reduction in hospital visits. This reduction in visits alleviates the burden of the healthcare system.

As per the WHO (2020), nurses have a crucial part in accomplishing the Sustainable Development Goals (SDGs) and guaranteeing that everyone is included. The WHO affirms that nurses significantly contribute to attaining both national and global objectives related to various healthcare priorities, such as universal health coverage, mental health, non-communicable diseases, emergency preparedness and response, patient safety, and the provision of integrated, patient-centric care. Nurses are an integral part of the healthcare system. The COVID-19 pandemic accentuated this. According to the WHO (2020), the nursing workforce is a substantial presence in the healthcare sector, comprising a global total of 27.9 million personnel, among which 19.3 million are professional nurses. This indicates a growth of 4.7 million in the total number of nurses between 2013 and 2018, making nursing the largest occupational group in the health sector, accounting for about 59% of the health professions. Among the 27.9 million

nursing personnel, professional nurses represent 69% (19.3 million), while associate professional nurses and unclassified nurses account for 22% (6.0 million) and 9% (2.6 million), respectively.

The above statistics confirm that nurses constitute half of the healthcare workforce which reaffirms how integral nurses are to achieving patient-centred healthcare. Nurses' availability to patients is more prevalent as they carry out the recommended care from doctors. According to the WHO (2020), nurses hold diverse roles and responsibilities as advanced practitioners, clinicians, leaders, policymakers, researchers, scientists, and educators, and are critical to the proper functioning of health professionals' education and practice. The nursing profession's contributions to industry, innovation, and inspiration have resulted in improvements in population health and well-being. The WHO highlights that effective communication is crucial for the nursing profession to achieve its objectives.

Abdulla, Naqi, and Jassim (2022) highlight the significance of communication between nurses and patients, as well as its impact on healthcare quality and patient satisfaction. The authors emphasise that effective communication skills are critical in alleviating patient anxiety and discomfort, improving satisfaction levels, and preventing negative health outcomes. The following section focuses on Doctors' imperative role in Patient Centred Care.

3.5 Doctors' role in patient-centred care

Kaba and Sooriakumaran's (2007) discussion of the evolution of the doctor-patient relationship is supported by Parsons' (1951) concept of the asymmetrical or imbalanced interaction between doctor and patient, where the doctor is seen as the dominant decision-maker, and the patient complies with the doctor's choices. However, critics have challenged this model, proposing a more patient-centred approach where patients are more autonomous and actively participate in decision-making. McWhinney (1989) advocates for a patient-centred approach, where physicians should aim to comprehend the illness from the patient's viewpoint. This approach has become the predominant model in clinical practise today. Critics have suggested a more active and autonomous role for patients, with more control by the patient, less dominance by the doctor and more

mutual involvement. This evolution of the patient-doctor relationship, and patients having information at their fingertips, adds more complexity. Carlile and Sefton (1998) argue that healthcare workers are facing unprecedented demands due to the information age, characterised by the explosion of information technology and the exponential growth of biomedical and clinical data. They also assert that the doctor-patient relationship has undergone significant changes due to this revolution. As a result, they suggest that medical education needs to take a new approach to address these challenges. They propose several imperatives for medical education and suggest practical changes to the medical curriculum.

A patient-centred approach is rationalised with more informed patients, as patients will receive complete transparency and fast information delivery. Open communication will allow patients to validate the information read and understand why the doctor has chosen a particular course of treatment. Dowrick, Frith, May and Mead (2012) advocate that the patient-as-a-person is given enormous significance as a partner during consultations. Sometimes these consultations result in complex negotiations. A proxy of measure for quality of care and patient-centredness is expressed in the creation of formal models of doctor-patient interaction. It is increasing as a measurement of the interaction between doctor-patient. Law and Britten (1995) assert that patient-centred consultations lead to higher levels of patient satisfaction compared to doctor-centred consultations. They also suggest that patient-centred consultations have a positive effect on certain health outcomes. These patient-centred consultations involve actively listening and communicating in a way that the patient understands. The following section highlights the critical role communication plays in Patient Centred Care.

3.6 The role of communication in patient-centred care

Duffy, Gordon, Whelan, Cole-Kelly and Frankel (2004), explain that communication and interpersonal skills are two linked competencies. Communication skills consist of particular tasks and behaviours, such as acquiring a medical history, explaining a diagnosis and prognosis, providing therapeutic instructions, and offering counselling. Interpersonal skills are more relational and process-oriented, emphasising the impact communication has on another person, such as reducing anxiety or establishing a trusting

relationship. According to the Institute of Medicine (2001), patients are concerned about various communication aspects concerning their health. They want to know their diagnosis, how to stay healthy, their prognosis, and how it will affect them. Patients need accurate answers and explanations in a language they understand. Patients are diverse in their preferred way of interacting with healthcare providers. Some prefer personal face-to-face relationships, while others only interact with the healthcare system when necessary, which may not include an interpersonal relationship. Some are comfortable with e-mail and other web-based communication technologies. However, all patients desire trustworthy information that is attentive, responsive, and tailored to their individual needs, often from an individual clinician.

Communication in a country like South Africa adds additional complexities, as described by Christopher (2004). The patient may not understand the basic communication form of speaking due to the country having eleven official languages. This multilingualism has resulted from a complex political history of apartheid. The Afrikaans language has left a stigma among Black South Africans who prefer to speak in their native language (Broeder, Extra and Maartens, 2002). If clinicians cannot communicate in one of these native languages, patients may not understand the diagnoses or the treatment, resulting in patients returning for another consultation.

A similar conclusion appears to have been reached in the study by Chimbindi, Bärnighause and Newell (2014) where the results indicated a high level of patient satisfaction in a rural area of KwaZulu-Natal. All patients, doctors and nurses in this area spoke the isiZulu language. Kee, Khoo, Lim, and Koh (2017) found four primary areas where communication errors occur in their study. These are nonverbal cues (e.g., eye contact, facial expression, and tone of voice), verbal communication (e.g., active listening and improper choice of words), content of the message (e.g., inadequate quality or quantity of information provided), and negative attitudes (e.g., lack of empathy and respect). Their study shows multilingualism may not be the only barrier to successful patient communication. Non-verbal communication and general body language are equally important to the success of PCC.

Abdulla et.al (2022) caution that communication errors in healthcare systems have been cited as the primary reason behind many reported incidents and complaints. These communication errors and misunderstandings may result in further damage, like the rising

medical negligence claims. The Auditor General of South Africa (2021) found that the majority of the country's departments, at 87%, had claims against them at year-end, which totalled R147,12 billion. These claims are a result of litigation for compensation due to a loss caused by the department, with medical negligence claims against provincial health departments being the most frequent. The R105,8 billion worth of claims against provincial health departments, including medical claims, puts further pressure on their budgets, as they have to allocate funds to pay successful claims. This situation negatively impacts service delivery, as budgets for other strategic priorities will be affected. The financial sustainability of these departments is further weakened, with over a third of them having claims against them exceeding 10% of their next year's operational budget. In some cases, unpaid claims at year-end exceeded the entire operating budget for five health departments. Communication skills can assist in reducing these medical negligence claims, which will alleviate the financial burden the healthcare system is currently experiencing.

The subsequent section focuses on the South African healthcare system and its alignment with patient-centredness.

3.7 Healthcare system and alignment to patient-centredness

The South African Government (2019) introduced the Presidential Health Summit Compact, which includes nine pillars aimed at strengthening and transforming the healthcare system into an integrated and unified system which will be achieved through the following nine pillars:

1. Increasing a more equitable distribution of human resources for healthcare.
2. To enhance access to essential medicines, equipment, and supplies by improving the management of the supply chain.
3. Implementation of the health infrastructure plan.
4. Involving the private sector in the healthcare system.
5. The fifth pillar is centred on community involvement.
6. Enhancing the quality, safety, and quantity of the healthcare system.

7. Enhancing financial sustainability, focusing on increasing efficiency in financial management.
8. Create national health information systems that can inform policies, strategies and investments, and guide decision-making.
9. To ensure accountability, it is important to strengthen governance and leadership.

These nine pillars contain some aspects of PCC with specific reference to the involvement of the community, however, the patient and individualised care are not considered. It is justified, as the South African healthcare system requires a massive shift from the foundation up, and the basics must be achieved first. According to Maphumulo and Bhengu (2019), despite considerable efforts to enhance healthcare delivery quality in South Africa since the 1994 elections, public institutions have been subject to criticism by the public on several issues, including prolonged waiting times caused by a lack of human resources, inadequate hygiene and infection control measures leading to adverse events, avoidable errors resulting in increased litigation, and shortages of medicine and equipment and inadequate record-keeping. The success of PCC requires complete alignment with the government; whilst some aspects exist, a dialogue would need to occur.

The following section discusses the meaning of care and what it means to patients.

3.8 The meaning of care for patients

According to McLaren, Ardington, and Leibbrandt (2014), poor access to healthcare is a significant concern as it perpetuates poverty and inequality. Despite efforts to increase the number of health facilities in South Africa, even in remote rural areas, large racial disparities in access remain, due to the country's apartheid history. The authors note that even when health services are provided free of charge, vulnerable segments of the population may face significant monetary and time costs associated with travel to a local clinic, which can be a significant barrier to accessing healthcare and lead to overall poorer health outcomes. Omogbadegun (2013) defines collaborative healthcare, as consisting of healthcare service providers and physicians that utilise complementary skill sets, and patients based on trust and with deep respect and understanding of each other's skills

and knowledge. This also entails mutually approved roles and responsibilities, which take into consideration the personalities and skill sets of the individual role players. The basis of the collaboration must be mutually beneficial to all parties involved.

Collaboration in the South African healthcare system requires depth and extensive reach, largely due to the disparity of the healthcare system. (McLaren et.al 2014). Collaboration is required between the following stakeholders:

1. Private sector
2. Public sector
3. Medical insurance companies
4. Pharmaceutical companies
5. Doctors, nurses and all administrative staff
6. Academic research councils
7. Science councils
8. Patients and communities
9. Medical Technology companies

The South African Government (2019) notes that the health system in South Africa is distinct from most countries worldwide, as it includes both public and private sectors. According to data from the World Health Organization (WHO), in 2016, about 52% of health expenditure in 186 countries was funded by governments, while 39% was privately funded, with the remainder mostly derived from external aid. In South Africa, the private sector funds about 44% of health expenditure, which is higher than other upper-middle-income countries where private sector funding is at 37%. While the percentage is not substantially different from other countries, the composition of South Africa's health spending sets it apart from others. The South African Government (2019) highlights the impact of the history, whilst there has been a significant change in the current healthcare system from the system in the apartheid era, which consisted of fourteen public sector health departments. Each of these departments was serving different ethnic and population groups. This design is a major contributing factor to the massive inequalities in today’s system. The most concerning is that the share of spending contributing to private voluntary medical schemes remains the highest in the world, at over 47% in 2016. This percentage only services 16% of the population with medical scheme coverage. The

above disposition exhorts the need for collaboration between all healthcare stakeholders in South Africa, with the goal of bridging the healthcare divide in the country.

In the subsequent section, the researcher shows the role of physical comfort and emotional well-being affecting Patient Centred Care (PCC).

3.9 Physical comfort and emotional well-being

Hamilton (1989) conducted a study on the topic of disease process and comfort, in which patients defined comfort in terms of pain, bowel function, and disabilities. The study concluded that patients associated comfort with pain relief, and medication was the only intervention that helped them achieve comfort. In addition, patients considered regular bowel function as an important component of their comfort. Moreover, patients identified their illness or loss of function of their limbs or eyes as a hindrance to their comfort, and many described these losses as disabilities. The patients suggested that better pain management could improve their comfort levels.

According to Malinowski and Stamler (2002), the desire for comfort is innate in human beings from birth. This is demonstrated when a newborn quiets down when held and rocked, or a child stops crying when his or her hurt knee is kissed. Additionally, comforting actions such as gently stroking a sick or elderly person's hand and speaking soothing words can bring them peace. Therefore, comfort should be recognised as a crucial component of holistic nursing care, as it remains an essential need throughout life. This idea is not new and has been previously acknowledged by influential leaders such as Florence Nightingale (1982). According to Chałdaś-Majdańska, Bieniak and Karska (2020), patients experience great discomfort as a result of a negative change in their health condition, which can lead to anxiety, stress and other negative emotions. Effective communication can help alleviate these feelings and reduce anxiety and stress. Communication involves establishing proper information exchange and contact between the clinician and the patient, which helps the patient feel secure and understood.

Emotional well-being and physical comfort are imperative to the success of PCC, as comfort, physical or mental, cannot be overlooked if the patient is meant to be at the

centre of care. According to Neoteryx (2018), patients must confront difficult and often scary situations that cause pain, loneliness, and discomfort. Effective pain management and ensuring a comfortable environment are crucial for improving the patient's experience. To achieve this, healthcare providers need to create an environment that is conducive to healing and instils a sense of security and comfort for patients. However, Neoteryx (2018) warns that the challenges of illness can impact the patient's emotional and mental wellbeing. To provide patient-centred care, healthcare providers must recognise that patients are complex individuals with unique needs that extend beyond just their physical condition. Therefore, a comprehensive approach that considers the patient's mental and emotional health, as well as their physical wellbeing, is necessary to ensure optimal patient outcomes.

The following section discusses how involving patients, family and communities in healthcare is important.

3.10 Involvement of the patient, family and community in care

According to Frampton, Charmel, and Guastello (2013), research and field experience confirm that involving patients and their family members in the care process and supporting healthcare professionals to establish partnerships with them can lead to better outcomes, including reduced errors and re-admissions and higher patient and family satisfaction.

The importance of including patients' and families' perspectives in healthcare is emphasised by the Institute for Patient and Family-Centred Care (2016), as a key factor in improving healthcare quality and safety. This perspective has been missing from the healthcare equation for a long time. Healthcare leaders are now recognising the need to directly involve patients and families in planning, delivering, and evaluating healthcare to enhance patient-centred care.

South Africa is a country steeped in community living and culture, stemming from African cultural concepts.

“Philosophically, the term Hunhu or Ubuntu emphasises the importance of a group or community. The term finds a clear expression in the Nguni/Ndebele phrase: umuntu ngumuntu ngabantu (a person is a person through other persons). Hunhu/Ubuntu is also a key theme in African philosophy as it places an imperative on the importance of group or communal existence as opposed to the West’s emphasis on individualism and individual human rights.” (Mangena,2016)

The concept of Hunhu or Ubuntu emphasises community. This African traditional philosophy focuses on the concept that a burden and benefit should be shared equally and no one should be discriminated against. With this philosophy in mind, it is imperative to involve the family/community as part of the process with the patient in healthcare discussions. Another aspect of African tradition is family decisions; all important decisions are made within the family. There appears to be a strong sense of community and collectivism in Black South Africans, as highlighted by Mhlongo and O’Neil (2013) in their study of family influences on career decisions by black first-year students. Western influences focus on individualism however, black communities’ foundation is collectivism.

In a study by Durrance-Bagale, Marzouk, Tung, Agarwal, Aribou, Ibrahim, Mkhallati, Newaz, Omar, Ung, Zaseela, Nagashima-Hayash and Howard (2022) the authors revealed that community engagement in decision making and implementing and evaluating possible solutions encourages a sense of ownership. This also led to success to healthcare interventions. A key component of Patient-centred Care (PCC) is personalisation or customisation, taking into consideration the collectivist aspect of the African culture; this should be included in PCC in South Africa.

The next section highlights the consequence of the lack of transparency and fast information delivery.

3.11 Full transparency and fast delivery of information

With the dawn of the information age and the internet, easy access to Information Communication Technology (ICT) has made accessing information easier. It is more important now for clinicians to react with haste to ensure that patients are provided with

timeous and accurate delivery of their healthcare state. Previously, patients' diagnoses and healthcare advice only source was the healthcare professionals' view; however, the research by Coiera (1996) indicates gravitation toward the Internet as a source of information. The potential danger could lead to misdiagnosis and self-treatment. Should the patient's condition not be attended to by a medical professional, long-term effects could be realised.

With the staggering number of existing litigation and malpractice cases in South Africa, Coeira (1996) cautions that the internet may significantly increase these cases, due to the easily accessible and available literature. The Institute of Medicine (2001) features an important caveat that the patient should be given the necessary information, which is free-flowing, with an option of some autonomy to control healthcare decisions that affect them. There should be shared knowledge and a free flow of information consistently. Healthcare professionals need to expedite the delivery of information with full transparency due to the advancement in technology. Patients can collaborate with their fingerprints with the information they receive with access to smartphones. Carlile and Sefton (1998) highlight the impact of the Internet. The Internet is now the largest repository for information which is consistently being updated. This suggests that patients are increasingly able to access and contribute to health information resources, which has significant implications for the field of medicine. Healthcare leaders and professionals would need to regularly review and evaluate relevant websites to understand the content and new practises available and to help patients who want to be better informed find accurate and relevant information.

Closely related to the above discussion Wald, Dube and Anthony (2007) highlight the advantages and disadvantages of the internet's impact on healthcare. However, in both instances, the physician would have to be equipped to demystify and address the validity of concerns originating from the information on the internet. Healthcare leaders would also need to acknowledge the changes technology is bringing to this age-old practice of medicine and navigate accordingly.

The subsequent section highlights the critical role leadership plays in PCC.

3.12 The role of leadership in patient-centred care

Edgman-Levitan and Schoenbaum (2021) point out that the purpose of healthcare and healthcare systems are to enhance the health and well-being of individuals and populations, which necessitates patient participation in these efforts. Despite this, many healthcare leaders and clinicians are still resistant or see no need for such involvement. PCC is still a relatively new concept in healthcare, especially in Africa as basic healthcare issues are still being addressed, as advocated by McLaren et al (2014). This leads to myths and fears that leaders experience about patients being partners in healthcare activities. Some of these fears are “showing our dirty laundry” or inappropriate expectations, clinicians and staff may be subjected to anger and, patients will have nothing of value to add to the partnership as stated by Levitan and Schoenbaum (2021).

According to the Institute of Medicine (2001), effective healthcare leadership is crucial as the need for transforming the healthcare system has become increasingly pressing. Although the process will be challenging, the potential benefits are significant, as narrowing the quality gap can allow medical science and technology to benefit all individuals and communities, resulting in reduced pain, suffering, disability, improved longevity, and a more efficient workforce.

In a review of South African health, the Health Systems Trust (2005) realised the magnitude of good management and leadership in boosting staff morale, productivity and ultimate quality of care was emphasised. The review urges the need for political leadership and managers in the health sector to articulate a clear vision, mission and goals that resonate with all those working there, ultimately resulting in clear operational strategies. Once frontline workers adopt the mission and objectives, accountability can be implemented in key performance areas.

One of the 9 pillars of the South African Government (2019) Presidential Health Summit is "strengthening governance and leadership to ensure accountability". With this key focus area, healthcare leaders have a responsibility to ensure proper governance and accountability are enforced and managed. The WHO (2016) affirmed that a collaborative leadership style is required to bridge and bring the multiple stakeholders in the healthcare system towards reform of health services. Collaborative leadership will assist in

transforming the healthcare service provided to patients and communities. Leadership must include clinicians and all healthcare professionals in management decisions and continuous community participation to ensure strategies and processes are aligned with people-centred care. Collaboration should include spiritual organisations as they form a key role in South Africa’s cultural influence.

The role of spirituality, religion and culture in PCC is considered in the next section.

3.13 The role of spirituality, religion and culture in patient-centred care

As the health system evolves, consideration is given to recognising the patient as a person, a holistic approach to health care. Spirituality, religion and culture play an important role in people’s lives, sometimes, it defines decisions on taking a course of medication. Therefore, healthcare professionals need to understand spirituality, religion and cultural elements to help facilitate healthcare services effectively. The World Health Organisation (1998) explored the role of spirituality, religion and belief in peoples’ health. The review supported the notion that spirituality and the belief in a higher being, fulfilment of life, and the need for hope contribute to hope and the will to live. If a person does not have these factors, it may delay the healing process resulting in distress due to feelings of emptiness and despair.

“The experience of the illness may reduce their ability to seek fulfilment for their spiritual needs, which in turn increases their chance of experiencing spiritual distress, and this may have adverse effects on their state of health” (WHO,1998). The beauty of South Africa's diversity also adds complexity to the various religious and cultural beliefs. Storytelling is an essential part of African culture. Information passed down from generation to generation still uses this method today. De la Porte (2016) emphasises the significance of a narrative-hermeneutical approach in multicultural contexts, especially in South Africa where the medical environment and healthcare culture coexist with diverse cultures. Patients may find the medical environment overwhelming due to its language, principles, and interpretive systems, which can result in breakdowns in their interpretive systems.

There needs to be an acknowledgement of the role of spirituality and religion in African life, which the African Religious Health Assets Programme (ARHAP) (2006) have urged healthcare and religious leaders to understand. Healthcare leaders and religious leaders should be united in the significance religion and spirituality play in healthcare. They are important allies to the success of PCC. Spirituality and religious beliefs ultimately contribute to the overall patient experience because they influence a patient's perception and beliefs.

In a multicultural and diverse nation, spiritual and religious beliefs must be considered when delivering patient care as this lends to the overall patient experience.

The next section discusses the patient experience.

3.14 The patient experience

The Agency for Healthcare Research and Quality (2016) defines the patient experience as the various interactions patients have with the healthcare system, which encompasses treatment received from healthcare providers such as physicians, nurses, staff in hospitals, physician practices, and other healthcare facilities. De Man, Mayega, Sarkar, Waweru, Leys, Van Olmen, Criel (2016) further emphasise that a patient's response to treatment is influenced by their past and present experiences. For instance, the researchers provide an example of a patient who experiences anxiety when feeling pressure on the chest, which may be derived from their prior experiences and beliefs about the healthcare system's responsiveness. Mashego and Peltzer's (2005) study found discrimination towards patients. The research was conducted through focus groups with communities in Limpopo on patient experiences in local community clinics and hospitals. One of the results of this study indicated that patients experienced discrimination from nurses depending on the patients' class. The higher the patient's class, the better the service received. The above experience led the patient to prefer traditional healers, as patients were treated with more dignity when interacting with a traditional healer. The COVID-19 pandemic highlighted the importance of seeing a healthcare professional who was also unsure how to treat the virus. The virus continued

to mutate and posed additional challenges for doctors. The pandemic challenged people's traditional ways of life.

The pandemic has forced evolution in almost every aspect of our lives, from online teaching, online shopping and virtual consults have become a reality. With this evolution, patients have expectations of service and are expecting experiential experiences as suggested by Pietig (2021). He asserts that patients expect services that are convenient, and accessible whilst still being personalised and meaningful. He adds that the following qualities need to be present in the experience: experiential, transparent, personalised, self-service, care-anywhere, shoppable and holistic. With other sectors are making experience the main priority, this forces sectors like healthcare to consider every touchpoint of the healthcare system.

Patients are more informed due to the easy access to information which Carlile and Sefton (1998) described in rich detail. This information has shaped their views and perceptions. Peltzer (2009) asserts that there has been a shift towards considering patients' views and giving them more weight in policy-making. According to Peltzer, it is crucial to understand the population's perceptions of the quality of care to develop measures that can increase the utilisation of healthcare services. The ease of access to information is driven by the evolution of technology and how entwined in daily life it has become. The following section explores technology’s effects on healthcare and how it contributes to PCC.

3.15 The effects of technology on patient-centred care

Technology is embedded in daily activities, from the minute a person may wake up and sometimes begin before, as smartwatches may alert the number of hours of sleep an individual should get in a day. Turner (2022) focuses on seven integral ways technology impacts our daily lives. One of these effects is communication; the standard telephone call has evolved into a video call which has further evolved into multiparty video calling across any destination in the world. Shopping physically in a mall has been revolutionised to online shopping; the COVID-19 pandemic accelerated this as the no-contact aspect became a life-saving feature. Flexible working, working from anywhere and anytime, is a

reality. This new way of life was only possible through the evolution of technology. Turner (2022) further expands on smart health tracking and how a person can track and monitor heart rate, exercise, breathing and even oxygen levels.

With the advancement of technology and technology playing such a critical aspect in daily life, it is not surprising that this would form a critical component of PCC. Patients expect technology to be available and present in interactions with clinicians. Smart devices like smartwatches are driven by the Internet of Things (IoT). Javed, Sarwar, Beg, Asim, Baker and Tawfik (2020) describe how IoT has driven the development of collaborative healthcare frameworks. In this study, the authors propose an IoT healthcare framework to enhance team communication between key stakeholders like doctors, patients and communities. Additionally, the authors advocate that IOT may assist patients in continuous health management.

Omogbadegun (2013) asserted that the disparities in healthcare could be addressed with the effective use of Information and Communication Technologies (ICTs). It is further suggested by Omogbadegun (2013) that technology-based solutions like telemedicine and mobile health can improve access to high-quality care and reduce the cost of healthcare delivery. The possibility of utilising medical skills from first-world countries may be bridged with telemedicine. South Africans may still have access to global healthcare standards without the additional cost of physical travel, whilst local clinicians witness and learn through skills transfer.

Mateus, Allen-Ile and Iwu (2014) elicited information through a literature review on the skills shortage in South Africa. The authors highlighted that nurses and doctors are two of the four major skill shortages experienced in South Africa. Their research highlighted the impact of nurse shortage “a ratio of 451 people for every registered nurse.”

The technology could easily address this shortage of skills whilst providing skills transfer to local clinicians.

3.16 Summary of this chapter

This chapter began with defining what patient-centred care encompasses and the aspects involved in constructing PCC effectively. It highlighted the importance of PCC not just from a global perspective but from a South African context. The chapter expanded on the critical role nurses and doctors play in the success of PCC. Communication is an age-old skill that began in the caveman days. This skill consistently evolves. The need to communicate effectively and efficiently to patients and their families about their health status is not just a requirement for PCC but healthcare in general. This chapter highlighted how effectively communicating the status of a patient's health and the required maintenance assists with reduced repeat visits which monopolise clinicians' time. This chapter expanded on what care means to patients and how care is individualised per patients' perceptions and expectations. The role of physical comfort was discussed next, emphasising pain management and its effect on PCC. In a South African context, the role of family and community is the foundation of culture, and the involvement of family and community is an aspect that clinicians need to consider. This chapter highlighted the concept of Ubuntu/Hunhu and the need to involve patients, families and communities in all healthcare decisions. Thereafter it discusses how the evolution of technology has resulted in easy access to information which may result in inaccurate information being taken as a diagnosis resulting in a delay in treatment. The need for fast, accurate delivery of information to patients has never been greater since the birth of the Internet. PCC will never be successful without the support of leadership in healthcare, the researcher elaborated on the importance of leadership in PCC. The relationship between clinicians and patients has evolved from transactional to holistic healthcare, recognising a patient as a person. Spirituality is a major factor in a person's identity; spirituality and culture affect how patients react to treatment and diagnosis. This consideration, therefore, plays a critical role in PCC. An exceptional patient experience is an ultimate objective and understanding the personalised requirements of patients is challenging however, tailoring care edges closer to PCC than generic care, which the chapter highlighted. The chapter concluded with how technology effects have influenced patients' expectations. Technology advancement and utilisation in our daily lives has evolved the expectations of care or service given and is the evolving factor that will keep changing. Table 3.1 below summarises the articles reviewed in this chapter.

Table 3.1 Summary of articles reviewed

Author	Title	Strength	Weakness
De Man et al 2016	Patient-centred care and people-centred health systems in Sub-Saharan Africa: Why so little of something so badly needed?	Three of the authors are medical doctors with many years of experience. The research revealed a need for PCC in sub-Saharan Africa. It also highlighted the barriers and provided a rudimentary framework	The research was from an outside view as it was not conducted by Africans. The majority of the researchers' exposure was European. There was no involvement with local actors (community, patients, healthcare providers, policymakers)
De la Porte (2016)	Spirituality and healthcare: Towards holistic people-centred healthcare in South Africa.	The author explored extensively the impact of spirituality on healthcare in Africa specifically how it affects patient-centred care. The author additional clearly stated the need to include spirituality and religion in PCC to ensure its success.	PCC comprises multiple aspects and only the spiritual and religious aspect was explored in this study.
Mashego and Peltzer (2005)	Community perception of quality of (primary) health care services in a rural area of Limpopo Province, South Africa: A qualitative study	The researchers included the local communities and the results highlighted the need for interpersonal skills training for nurses and doctors in this area. Drug availability was another issue highlighted which requires government support.	The results are evidence of a small Limpopo sample and not the greater Limpopo area. Which may have provided more focus areas.
Peltzer (2009)	Patient experiences and health system	The author was able to gather a large sample across public/private	The respondents to the survey were requested to advise

	responsiveness in South Africa	entities and in and out-patient.	on their experience in the past 5 years prior to the survey. The time-lapse could have affected the respondents' details of the experience as it may not have been a recent visit. The results on ambulatory care sample size was small which may not reflect representative of the general population.
Maphumulo and Bhengu (2019)	Challenges of quality improvement in the healthcare of South Africa a post-apartheid: A critical review	The extensive literature study revealed multiple challenges however 7 focus areas were highlighted for improvement.	The study left out any research before 2004. A post-apartheid review should have included research from 1994 onwards to ensure all healthcare programmes after apartheid were evaluated.
McLaren, Ardington and Leibbrandt (2014)	Distance decay and persistent health care disparities in South Africa	The study included a holistic view across South Africa based on the information received from the National Income Dynamics Study.	The information received from the National Income Study did not include the cost of transportation and mode of transport. Additionally, the individual health status was not included in the study which may influence the living distance to

			the nearest healthcare facility.
Edgman-Levitan and Schoenbaum (2021)	Patient-centred care: Achieving higher quality by designing care through the patient's eyes.	The study highlighted the importance of achieving higher healthcare quality through the eyes of the patient rather than through healthcare staff and doctors.	The study focused on one piece of information extracted internationally and excluded Africa.
Kaba and Sooriakumaran (2007)	The evolution of the doctor-patient relationship	The authors have researched extensively the doctor-patient relationship through the ages. Analysis of a timeline of the relationship.	The research only focused on the doctors' role in PCC and not all key actors.
Omogbadegun (2013)	Development of a framework for collaborative healthcare services delivery	The researcher highlighted the need for collaboration of various hospitals through ICT technologies to increase healthcare quality. The Nigerian landscape was considered in the framework suggested.	The framework is very specific to Nigeria and its legislation and political situation. The study only focuses on technology in PCC and not the other components.

Source: Author's own compilation

The literature review revealed that some of the above studies were conducted worldwide and excluded South Africa and included additional limitations as listed above. After an extensive review of the literature, a gap was identified: The views of local South Africans in a public hospital have not been thoroughly researched, which is the main research question of this study.

CHAPTER 4
METHODOLOGY

4.1 Introduction

In the previous chapter, Patient-Centred Care (PCC) was defined in detail. PCC comprises of various elements which were explored further. Some of the elements discussed were: the critical role doctors and nurses play in PCC as well as the importance of PCC from a global and local perspective. This research project is based on the views of the patient therefore all patient needs and requirements were explored in depth.

This chapter focuses on several research paradigms from which the researcher selected the most suitable for the study. These paradigms were guided by the literature review and supporting theories discussed in Chapter Two. The ultimate objective is to achieve the research objectives and answer the research questions. In the first section, the research problem is restated and this is followed by the research questions, objectives and proposition. The following section discusses the research process that was undertaken. Thereafter the research design is explained which is followed by how the data was collected, population and sampling size. Thereafter, the research instrument utilised is described in terms of design and structure. The researcher concludes this chapter with a summary of the methodology applied to this study.

4.2 Research problem restated

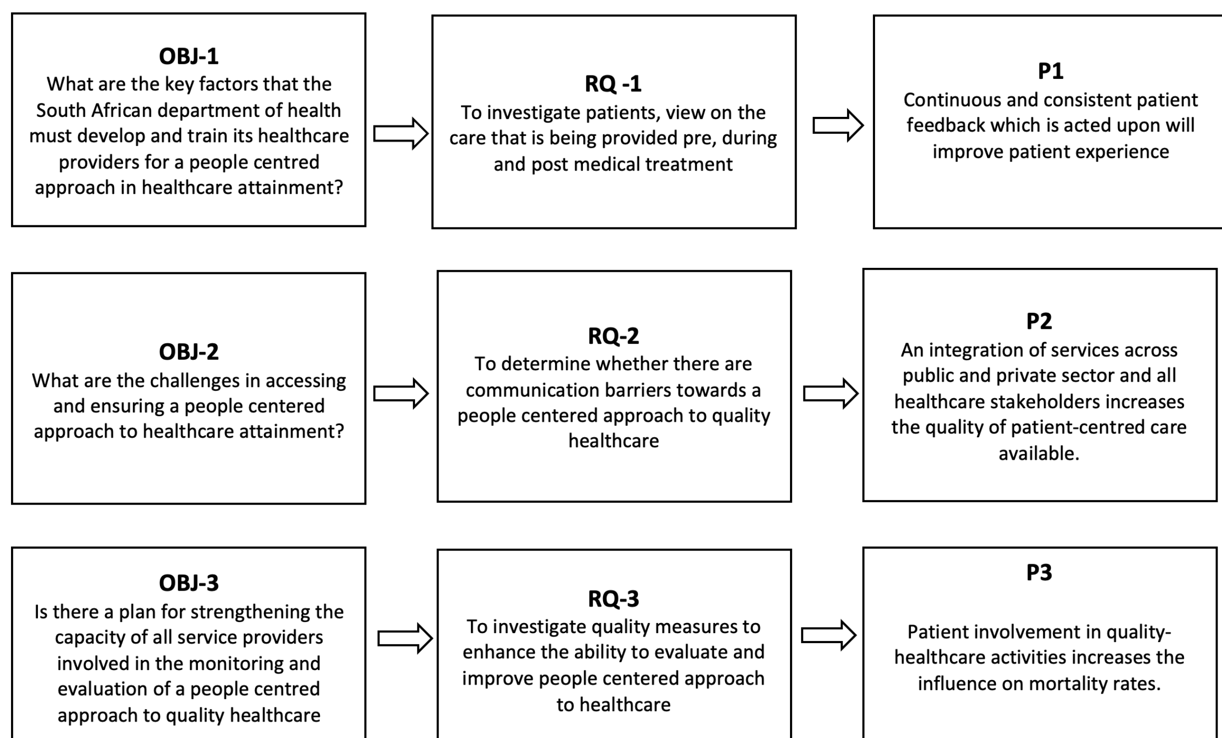
The focus on value-based care in healthcare is increasing, and organisations need to improve quality and safety outcomes to succeed in this environment. However, South Africa has seen a steady increase in medical malpractice claims, leading to a shift from compassionate medicine to defensive medicine and mistrust. This has put pressure on provincial health departments, who struggle to provide services while paying out billions in claims. Additionally, medical specialists in the private sector are facing high insurance premiums, which increased healthcare costs and directly impact their practices. The national contingent liability for litigations is estimated to be at R90 billion, representing

15% of operating budgets. (South African Lancet Commission on High Quality Health Systems, 2019)
The COVID-19 pandemic highlighted the fragile healthcare system and exposed the lack of equipment, staff and burnout the healthcare workers are experiencing. This essential service which is a basic need requires continued focus and efforts to improvement. Why continuous? Evolution is forcing all entities to grow or collapse. A pandemic could never have been foreseen. However, with strengthening the healthcare system to a people-centredness approach could provide the resilience required to address future issues that may arise.

4.3 Research objectives, questions and propositions restated

The aim of this study is to explore the influence of healthcare workers on the HIV/AIDS patients' morale and general wellbeing, as well as to investigate if a "people-centred" approach towards quality and efficient healthcare could be considered a viable approach as mitigation to the mortality rate. The following research objectives, questions and propositions below guided the study.

Figure 4.1: Relevance between research objectives, questions & propositions



Source: Author's own compilation

The following section discusses the research methodology adopted in this study.

4.4 Research method

Saunders, Lewis and Thornhill (2009) explain that in research, there are two main types of data collection techniques and data analysis procedures: quantitative and qualitative. Quantitative research involves collecting and analysing numerical data, such as through the use of questionnaires or statistical analysis. On the other hand, qualitative research involves collecting and analysing non-numerical data, such as through interviews or categorising data. A mixed methods approach combines both quantitative and qualitative methods in the research method.

4.4.1 Mixed methods research methodology

Mixed methods research methodology, as defined by Saunders et al. (2009), involves the integration of both quantitative and qualitative techniques in data collection and analysis for research design. The combination of these methods can be used in parallel, where both types of data are collected simultaneously, or sequentially, where one type of data is collected first and used to inform the collection and analysis of the other type of data. For the purpose of this study, a mixed methods approach was adopted to ensure that the research objectives were met. The quantitative aspect will be in the form of the questionnaires that will be administered to the patient. The qualitative aspect will be applied at the data analysis stage when the data is categorised non-numerically.

The next section highlights the research philosophy underpinning this research.

4.4.2 Research philosophy

Saunders et al. (2009) argue that the research philosophy a researcher adopts has significant implications for the way they view the world. The two foremost ways of thinking of research philosophy: ontology and epistemology. The researcher adopted a pragmatic philosophy for this study. The following section provides an explanation of ontology.

4.4.3 Ontology

Saunders et al. (2009) describe ontology as a branch of philosophy concerned with the nature of reality. Ontology can be divided into two aspects: objectivism and subjectivism. Objectivism can be defined as social entities' existence is not dependent on social actors. Irrelevant to the social actor the process and function of the social entity are static. Subjectivism viewpoint is from the social actors. Subjectivism phenomena are based on the perceptions and subsequent views of the social actors which are constantly changing.

4.4.4 Epistemology

Saunders et al. (2009) states that epistemology focuses on what constitutes acceptable knowledge in a field of study. The two main philosophies in epistemology are positivist and interpretivist. Positivist takes a stance of a natural scientist. Only a social reality that can be observed can lead to credible data. The interpretivist view is that it is important to understand the role of social actors and their differences.

4.4.5 Pragmatic research philosophy

Based on the nature of the study, the most appropriate research philosophy is one that prioritises practical considerations and operational decisions aimed at providing the best solutions to the research questions. Therefore, the researcher will follow a pragmatic approach. Pragmatic research philosophy has been mainly concerned with application and solutions, with researchers focusing on the research questions and the use of all approaches available to understand the problem at hand (Creswell, 2017).

Pragmatism is a perfect marriage with a mixed-methods approach. This is largely due to the flexibility of pragmatism to solving research problems. Pragmatism does not lock you into one view, it promotes that there are different ways to understandings because of multiple realties. Understanding these multiple realities requires mixed methods like quantitative and qualitative methods.

Pragmatism advocates for a mixed approach to problem-solving (Creswell, 2017).

4.4.6 Main principles of pragmatism

The following are the three principles: (1) prioritising practical knowledge, (2) acknowledging the interdependence among experience, knowledge, and action, and (3) perceiving research as a process based on experience.

4.4.7 Emphasis on actionable knowledge

The data resulting from the questionnaires will provide healthcare institutes the evidence required to make customised changes to address patients' needs. The feedback from these questionnaires could be utilised to train new and existing staff therefore providing PCC.

4.4.8 Interconnectedness of experience and knowing

The questionnaire has been designed with the patient's recent experience and knowledge. The theory applied to this research study is the experiential theory as the experience of the patient underpins PCC. The action on the knowledge of the data gathered provides a sound benchmark.

4.4.9 View of inquiry as an experiential process

This research study and the tool chosen, in the form of a questionnaire, is the view of inquiry into the patient experience during the hospital visit. The questionnaire consists of possible interactions during the hospital experience.

4.4.10 Pragmatism and the use in mixed methods research

Holloway and Todres (2003) assert that utilising pragmatism as a paradigm ensures rigor by establishing consistency and coherence between the researcher's worldview and the knowledge claims drawn from the results of mixed methods research.

Table 4.1: Pragmatism Research Philosophy

	Research approach	**Research strategy**
Positivism	Deductive	Quantitative
Interpretivism	Inductive	Qualitative
Pragmatism	Deductive/Inductive	Qualitative and/or quantitative

Source: Author's own compilation

The pragmatic research philosophy has symbiotic relationship with a mixed methods methodology as depicted in Table 4.1. It complements the final object of ultimately answering the main research question. Pragmatism is appropriate to this study in terms of understanding the patient experience.

The following section describes the research design that was utilised for this study.

4.5 Research design

Mouton (2014) defines a research design as a plan for conducting research, while Brink, Van der Walt, and Van Rensburg (2018) describe it as a set of logical steps taken by the researcher to answer the research question. Based on a review of literature on similar research, the researcher agrees that a mixed methods design is advantageous for combining the strengths of both quantitative and qualitative approaches. Burns, Grove and Gray (2015) support this approach by suggesting that research methodologies are continually evolving, and mixed methods research provides researchers with the flexibility to harness the strengths of both quantitative and qualitative research designs.

4.5.1 Deductive approach

Blumberg, Cooper and Schindler (2011) described a deductive approach as a method where the conclusion is derived from the reasons given and moves from general social theory testing to a more focused theory. However, this research project did not adopt this approach.

4.5.2 Inductive approach

Sheppard (2020) explains that the inductive approach to research is vastly different from the deductive approach. Blumberg, Cooper, and Schindler (2011) define the deductive approach as the one that derives a conclusion from evidence, where the evidence supports the conclusion. On the other hand, the inductive approach begins with the collection of relevant data, followed by the identification of patterns to develop a theory to explain them. However, the current research project did not adopt the inductive approach since data collection did not come first.

4.5.3 Hypothetico-deductive approach

This research study followed the hypothetico-deductive approach. It was guided an experiential learning theory reasoning and the researcher utilised a mixed methods approach to guide the research process. The hypothetico-deductive approach is a combination of the deductive and the inductive reasoning. It combines observation, experience, theory, and the hypothesis statement, which is being tested. It believes that a single approach (deductive or inductive) is incomplete reasoning to investigate a phenomenon and provide complete information that influences decision-making (Walliman, 2011).

As the name suggests, there are two parts to this approach, hypothetico where a hypothesis or proposition is identified and predications are generated by the hypothesis. The deductive aspect tests the predictions and if correct, the hypothesis or proposition is correct. If not, then the hypothesis is disconfirmed.

The pragmatic research philosophy has deductive features like actionable knowledge as well as components of experiential. The hypothetico-deductive approach combined with the pragmatic research philosophy for this study ensured that that the main research question would be answered.

4.5.4 Sampling and population

Collis & Hussey (2014) explain that a population is the complete group of members about whom a research intends to establish facts. Furthermore, it is the entire group of people who the researcher intends to target within the study consisting of male and female participants. This research concentrates on the quality of health and patient care and how the philosophy of a people centred approach may ease some of the problems the South African Department of Health is confronted with.

The selection of participants for this study followed a convenience sampling approach, which is a commonly used type of non-probability sampling (Blumberg et al., 2011). This technique was deemed advantageous due to its practicality and simplicity in obtaining a sample in a cost-effective manner. In addition, purposive (or judgmental) sampling was used to deliberately choose certain settings, participants or events to provide crucial data that could not be obtained through other sampling techniques (Taherdoost, 2016).

The targeted population is the patients that attend the clinic days at the HIV/AIDS unit at the Chris Hani Baragwanath Hospital. The sample was determined by the exact number of patients that consent to participate in the survey. The initial intended sample size was 60, however, 71 patients consented to partake in the survey.

4.5.5 Sampling techniques

It is impractical to survey the entire population. This could be due to budget or time constraints. Researchers have a choice between probability and non-probability sampling. Saunders et. al (2009) describes the five different sampling approaches which fall under non-probability these are: snowball, convenience, quota, purposive and self-reflection. The sampling types that fall under probability are; simple random, systematic, stratified random and cluster. The sampling technique chosen for this study is convenience sampling which is detailed below.

4.5.6 Convenience sampling

Acharya, Prakash, Saxena, and Nigam (2013) explain that convenience and purposive sampling techniques are commonly used in research due to their convenience for the researcher. Taherdoost (2016) further clarifies that convenience sampling involves selecting participants based on their availability and accessibility. In this study, convenience sampling was utilised to select participants from the HIV/AIDS ward, with all available patients during the granted period being targeted.

4.5.7 Data collection

Burns, Grove and Gray (2015) define data collection as "the precise and systemic gathering of information relevant to the research purpose or the specific research objective, question, or hypothesis of the study." The questionnaires were distributed and administered by the researcher and an assistant for translation purposes. A statistician was employed to assist with the construction of the statements and the analysis of the data. All validity and reliability procedures were conducted to ensure the relevant methodological procedures to the research questions and objectives were computed.

4.6 Research instrument

The primary source of data were questionnaires' and researcher observations. To attain qualitative and quantitative data input from participants a questionnaire with open and closed questions was utilised. The following section will discuss the questionnaire structure in more detail.

4.6.1 Questionnaire

The questionnaire was designed to include a five-point Likert scale to establish the participants' attitudes and feelings toward the healthcare engagement. Due to multiple role players playing a part in the patient's visit like administrators, nurses and doctors, the questions covered the entire process. The questionnaire included open ended questions which allowed participants to provide insight and any feedback without restriction. In

addition, a rating scale was included in the questionnaire which established the participants overall views of the hospital. The Table 4.2 below illustrates how the research sub-questions are linked to the relevant propositions.

Table 4.2: Linking questions from questionnaire to propositions

During this treatment,		**Proposition 1** Continuous and consistent patient feedback which is acted upon will improve patient experience	**Proposition 2** An integration of services across public and private sector and all healthcare stakeholders increases the quality of patient-centred care available.	**Proposition 3** Patient involvement in quality-healthcare activities increases the influence on mortality rates.
1.	How often did nurses treat you with courtesy and respect?	X		
2.	How often did **nurses** listen carefully to you?		X	
3.	How often did **doctors** listen carefully to you?		X	
4.	How often did **nurses** explain things in a way you could understand?		X	X
5.	How often did **doctors** explain things in a way you could understand?		X	X
6.	How often did you get help as soon as you requested it?	X	X	
7.	How often were your room and bathroom kept cleaned?	X	X	
8.	How often did you get help from a nurse in getting to the bathroom or in using a bedpan as soon as you wanted?		X	X

9.	How often did the nurses assist you to control your pain?		X	X
1(	How often did the hospital staff do everything they could to help you with your pain?		X	X
1	Before giving you any medicine, how often did nurses tell you what the medicine was for?		X	X
1(	Using any number from 0 to 10, where 0 is the worst treatment possible and 10 is the best treatment possible, what number would you use to rate the **nurses** during your stay?	X		X
1(	Using any number from 0 to 10, where 0 is the worst treatment possible and 10 is the best treatment possible, what number would you use to rate the **doctors** during your stay?	X		X
1	Please provide reasons why you would recommend or not recommend the **nurses** at this facility?	X	X	X
1!	Please provide reasons why you would recommend or not recommend the **doctors** at this facility	X	X	X

Source: Author's own compilation

4.6.2 Pilot testing

Prior to the data collection, the researcher conducted a pilot test to establish if the questionnaire was easy for the patients to understand additionally ensuring that there would be no problems recording the data. This process assisted the researcher to understand the sample population as well as being completely satisfied that the questionnaire was designed and structured well. The researcher conducted a pilot with 5 patients, one change was made to question 16, as the nurses do not administer the

medication, this is processed by the pharmacist. The word ‘nurses’ was changed to ‘pharmacist’.

4.6.3 Researcher as an Observer

Observation alone can capture the whole event as it occurs in its natural environment (Blumberg et.al., 2011). Whilst observation is time consuming for a researcher, in experiential learning it provides great context of the experience the researcher is trying to understand further. In this study, the researcher administered the questionnaire therefore played a role of observer.

4.7 Data analysis

According to Savenye and Robinson (2004), the term ‘data analysis refers to the systematic use of statistical or logical techniques in order to condense, describe, illustrate, evaluate, and summarise captured data. The data from the quantitative questions was inferentially analysed using Excel as an analysis tool, and thereafter the descriptive statistics were computed. The inferential analysis allows the researcher to interpret the data and draw conclusions. SPSS Version 28 was used to analyse the quantitative data for analysis such as analysis of variance (ANOVA) and T-tests.
The data was coded numerical with no patient detail that can identify the patient on the questionnaires.

4.8 Validity and Reliability

Even though the results and quality of data are addressed in both qualitative and quantitative research designs, the validity and reliability will differ even if the quality of data and the results in both methods are assessed (Creswell and Clark, 2007). The research design for this study was deemed appropriate for these reasons and the analysis of the results was performed in line with ethical standards and without bias. Zhang and Wildemuth (2009: 7) maintain that dependability can be determined by checking the study process consistency, and “confirmability is determined by checking the internal coherence of the research product, which includes the data, findings, interpretations and recommendations”. Furthermore, the researcher used original data in the analysis of the

research study results. The data collected during the interviews were transcribed, and care was taken not to omit any important information that could contribute to the study. Coding and thematic analysis were used for the qualitative data analysis and Microsoft Excel was used for the data transcription of quantitative and statistical results. The limitations to this study will be covered in the next section.

4.9 Limitations to the study

The following limitations have been identified as events that could have an impact on this study.

- The questionnaire was only available in English, which although understandable to all respondents, might have caused some interpretation issues for respondents whose home language was not English.
- Load shedding schedules might have had an impact on the completion of questionnaires and interviewees.
- Owing to the prevailing stigma surrounding HIV/AIDS and the potential influence of the entrenched beliefs, participants response to the questionnaire was possibly affected.

4.10 Ethical considerations

Blumberg et.al., (2011) describe ethics as the 'right behaviour' and a way to conduct research in a moral and responsible way. A consent letter from the Department of Health (DOH) had been provided to collect the data from the unit of analysis. A letter of permission was sent to the office of the CEO of Chris Hani Baragwanath hospital. In addition, ethics permission was applied for and received from the Faculty of Business Management and Sciences – Ethics committee. The researcher adhered to all the rules as guided by the CPUT ethics policy on collecting data. Informed consent was requested from the selected respondents. Respondents had the option to withdraw from participating at any time during the study and ethical conduct during the study was to facilitate survey results that are accurate, true, ethical, and original. The researcher abided by the Cape Peninsula University of Technology's guiding principles for Research

Ethics and the Code of Ethics for Research on Human participants as required by the Health and Wellness Sciences Research Ethics Committee.
Additionally the data set derived from this study was coded numerical and will be stored in the universities repository for safekeeping.

4.11 Summary of this chapter

This chapter began with the research problem being restated. This was followed by the research objectives linked to questions and propositions. The main research question being what influence healthcare workers have on HIV/AIDS patients' morale and general wellbeing, as well as to investigate if a "people-centred" approach towards quality and efficient healthcare could be considered a viable approach to mitigation to the mortality rate. Thereafter, the methodology adopted for this study which is the mixed method was discussed. This was followed by the research philosophy of pragmatism being explained with its relevance to this study. This was followed by various research designs which were explored for this study, the chosen research design of hypothetico-deductive will ensure that the main research question will be answered. Thereafter, the population and sampling approaches were explained, the elected approach was convenience sampling for this research project. Following this, the data collection and research instrument were discussed in detail, the questions from the questionnaire were linked to the propositions and the design of the questionnaire was highlighted. This was followed by data analysis, validity, reliability and limitations to study. This chapter concluded with discussing ethical considerations.

In the next chapter, the research results will be discussed in detail.

CHAPTER 5
RESEARCH RESULTS AND FINDINGS

5.1 Introduction

In the preceding chapter, the research methodology was explained in detail, outlining the research design, data collection methods, sample size, research instrument, and data analysis techniques. In this chapter, the researcher discusses the research results and key findings that became evident from the research. This study aims to explore what influence healthcare workers have on the HIV/AIDS patients' morale and general well-being, as well as to investigate if a “people-centred” approach towards quality and efficient healthcare could be considered a viable approach as mitigation to the mortality rate. The researcher analysed the collected data without altering the essence of the responses.

The following section provides an overview of the respondents’ descriptive data. The results of the qualitative analysis follow this. Thereafter, the discussion on the data collated is highlighted. The chapter concludes with a summary of the findings aligned to the research questions and objectives.

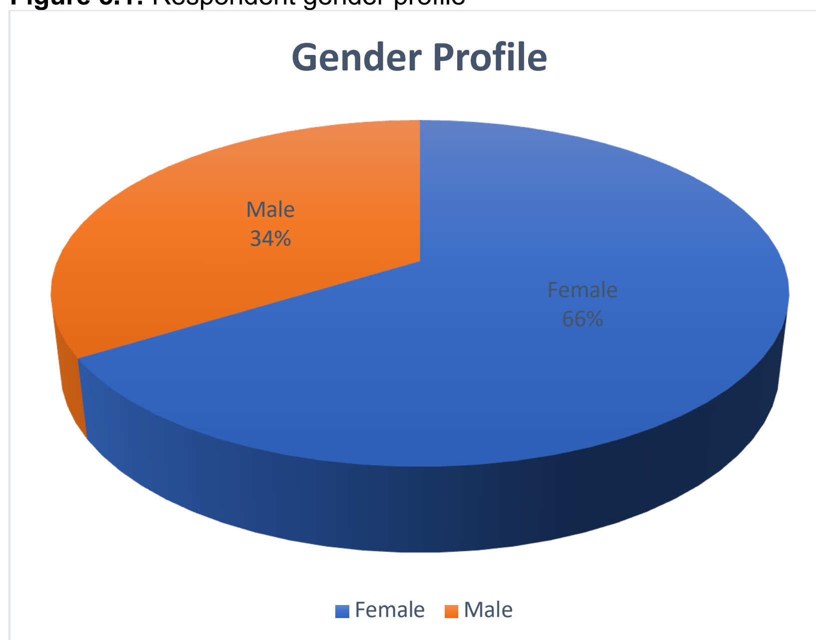
5.2 Descriptive data

The descriptive data is inclusive of 71 surveys and interview respondents.

5.2.1 Respondent gender

The respondents’ gender classification is illustrated below in Figure 5.1

Figure 5.1: Respondent gender profile



Source: Author’s own compilation

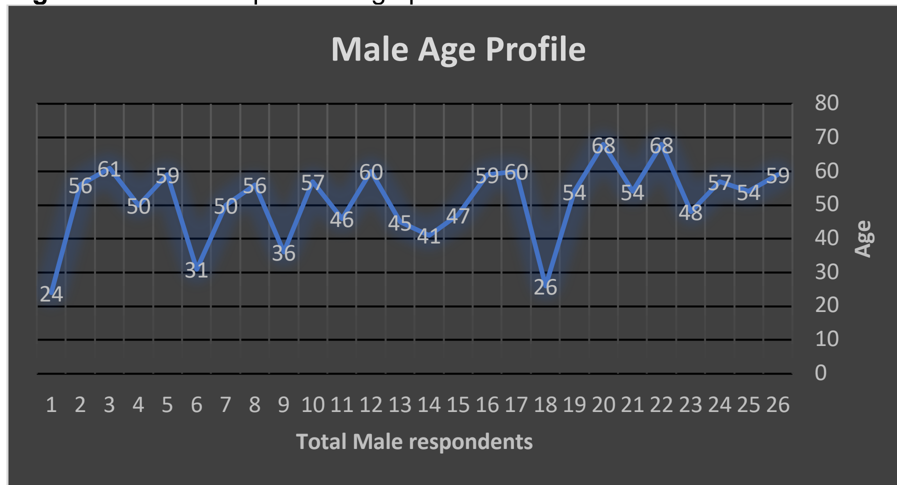
Sixty-six percent (66%) of the respondents were female, and thirty-four (34%) were male. This indicates that the majority group of respondents were female.

According to United Nations Women (2018), in sub-Saharan Africa, women comprised 56% of new infections among adults (15 and older); the proportion was higher among young women aged 15-24, who made up 67% of new infections among young people. In a study conducted in West, Central, Eastern and South Africa by Hegdahl, Fylkesnes and Sandøy (2016) the female: male HIV prevalence ratio was above one in all countries in at least one survey round for both ages 15–24 and 25–49 years. In 13 out of 18 countries, the prevalence ratio was higher for the younger age group compared to the age group 25–49 years (3 significant). This difference in prevalence ratios between the age groups did not change over time. The above-stated study highlighted the need to include age in this research project. The following section will provide the respondents’ age profile per gender to establish if a similarity exists.

5.2.2 Respondent age profile

The male respondents’ age categories are indicated in Figure 5.2.

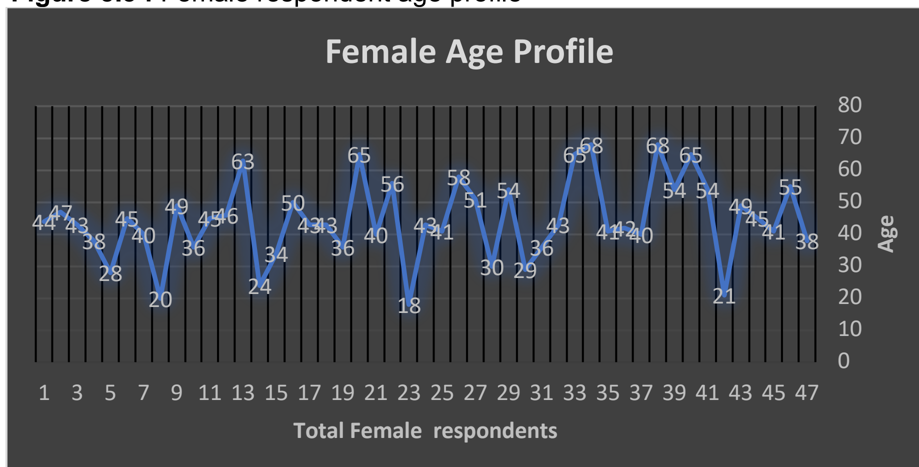
Figure 5.2: Male respondent age profile



Source: Author's own compilation

The above figure illustrates the age of the male respondents. The total sample size was 71, of which 26 respondents were male. The youngest male respondents were 24 years and the oldest was 68 years. The mean referred to is the average of the dataset analysed. Concerning the male respondent age, the mean was fifty-one. Figure 5.3 illustrates the age of the female respondents. Seventy-one was the total sample and forty-one were female. The youngest female was 18 years and the oldest 68 years. The mean for the entire female respondents was 44,34 which is lower than the male respondents. This result indicates that females are being infected at a younger age than males. The biggest age group was 46-60 years with 39,4%; this applied to both genders.

Figure 5.3 : Female respondent age profile

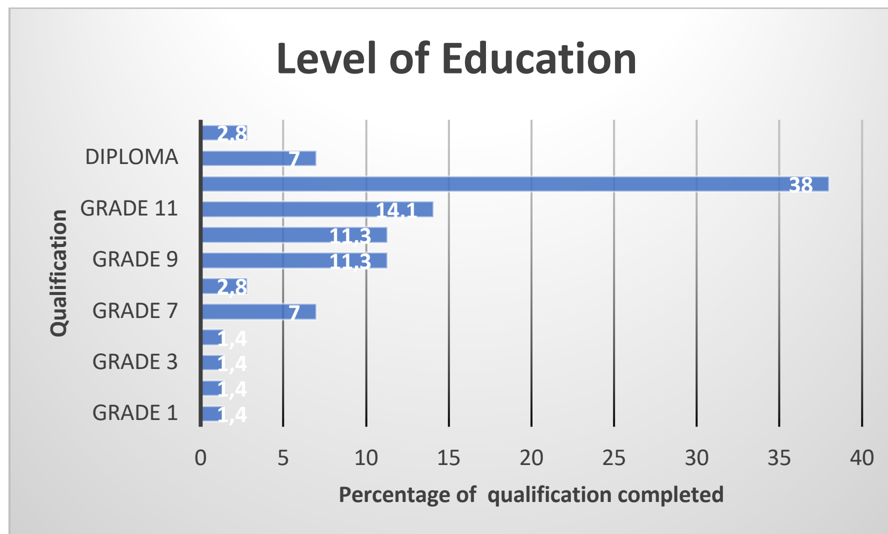


Source: Author's own compilation

5.2.3 Respondents’ level of education

The respondent’s level of education is illustrated in Figure 5.4 and the blue areas indicate the percentage applicable to each education category.

Figure 5.4: Respondents’ level of education



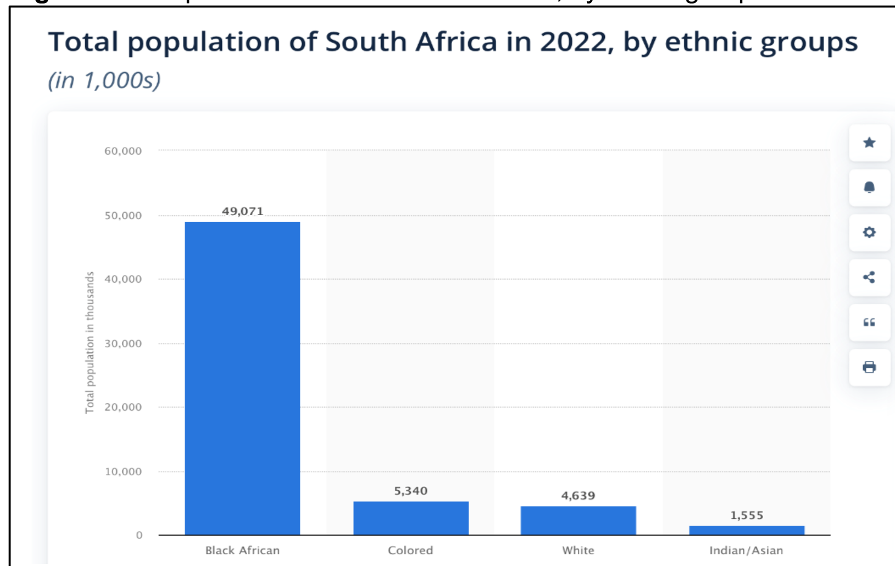
Source: Author’s own compilation

To gauge the level of respondent education, the respondents were asked what was the highest grade or qualification they had passed. The results indicated that 38% of respondents had a Grade 12 qualification. From the total respondents, 7% had completed a diploma qualification, and 2.8% of respondents indicated they had a National Qualification Framework (NQF) Level 4 qualification. The level of education varied from Grade 1 to NQF Level four. The results indicated that none of the respondents had furthered their education past the NQF Level four, whilst the majority of the respondents have only completed Grade 12 qualification.

Tuntufye (2014) asserts that education serves as the social vaccine in the absence of a cure for HIV/AIDS.

South Africa has four main race classifications, White, Indian, African and Coloured. Statistics South Africa reported in 2022 the population by ethnic group which is indicated in Figure 5.5:

Figure 5.5: Population of South Africa in 2022, by ethnic groups

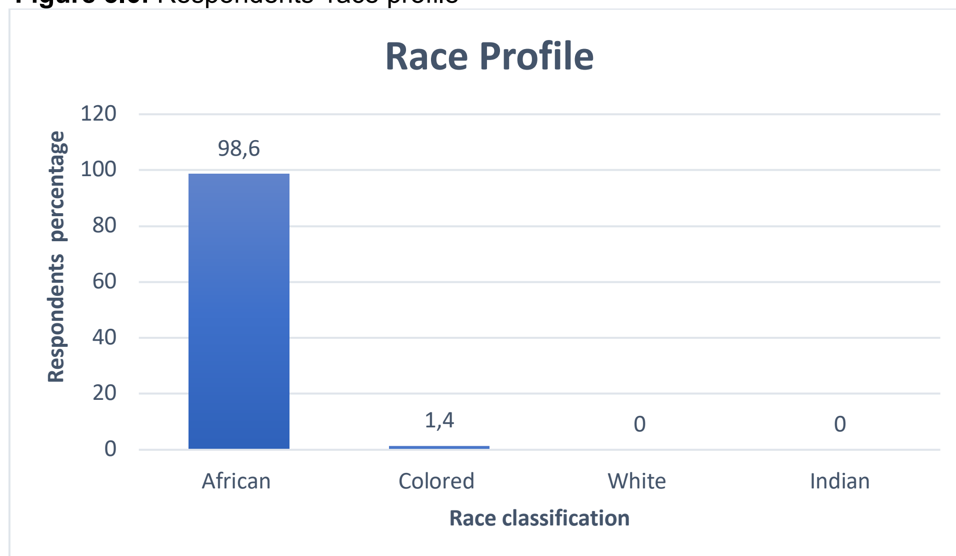


Source: Statistics South Africa (2022)

The following section will now provide the race of the respondents.

5.2.4 Respondents Race

Figure 5.6: Respondents' race profile



Source: Author's own compilation

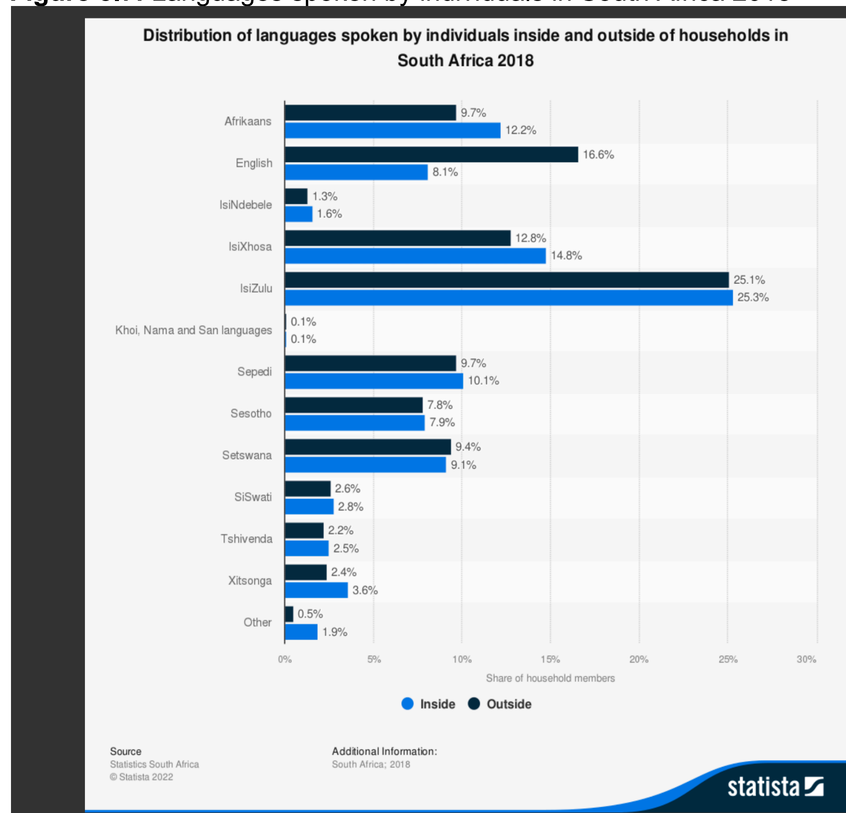
To gauge the race of the respondents, they were asked to select their appropriate race from a predetermined group of options. The options listed on the survey were African,

White, Coloured and Indian. Results indicated that 98,6 % were African and 1.4 % were Coloured.

5.2.5 Respondents Language

In a study conducted by Brenzinger (2017) he highlighted that the language policies of the new South Africa in 1994 were to transform the nation into a multilingual country, affording eleven languages equal status. These eleven languages are Afrikaans, English, isiXhosa, isiZulu, Sesotho, Setswana, Northern Sotho, Xitsonga, Tshivenda, siSwati, Ndebele. In Figure 5.7 extracted from Statistics South Africa (2018), isiZulu is the most common language prevalent in the country, inside and outside the household.

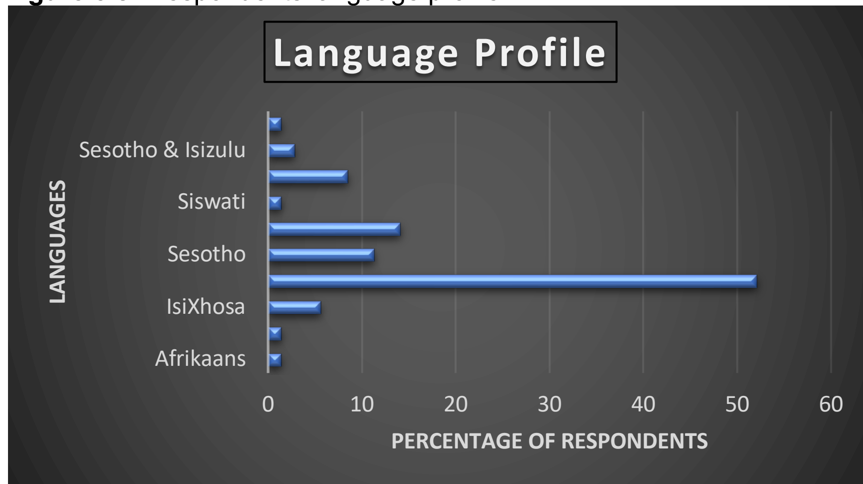
Figure 5.7: Languages spoken by individuals in South Africa 2018



Source: Statistics South Africa 2022

The following graph shows the language profile of the 71 respondents.

Figure 5.8: Respondents language profile

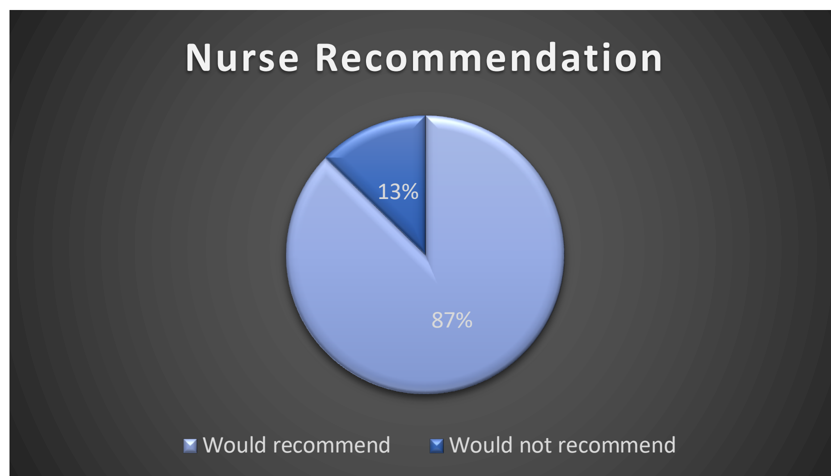


Source: Author's own compilation

To establish the home language spoken by the respondents, a question was asked on what language was mainly spoken in the household. South Africa has eleven official languages, so the question was left open-ended. The results indicated that the majority are isiZulu at 52,1%, followed by Setswana at 14,1%, Sesotho with 11,3%, Xitsonga at 8,5%, and isiXhosa at 5,6%. The results also indicated a few multi-lingual households speaking Sesotho and isiZulu with 2,8% and English and isiXhosa at 1,4%. The respondents who spoke English at home were computed at 1,4%.

5.2.6 Indicator of respondents' recommendation of nurses

Figure 5.9: Respondents nurse recommendation



Source: Author's own compilation

The respondents were asked, “Please provide reasons why you would recommend or not recommend the nurses at this facility?” Figure 5.9 indicates that 87,3% of all respondents recommend the nurses at the facility; however, 12,7% indicated that they would not. Below are some of the comments which were extracted from the interview of the respondents:

Table 5.1: Respondents’ response on Nurse recommendation

Question	Response
Please provide reasons why you would recommend or not recommend the nurses at this facility?”	**Respondent 1:** Nurses can be helpful at times but can be dismissive at times **Respondent 2:** Nurses can be disrespectful to patients **Respondent 3:** The nurses are very good at providing care to patients **Respondent 4:** Nurses are professional and helpful **Respondent 5:** Nurses are supportive and make you feel comfortable. Patient feels comfortable asking nurses questions **Respondent 6:** Nurses are always helpful and ready to assist **Respondent 7:** Nurses are considerate and are always explaining things **Respondent 8:** Nurses provide good care **Respondent 9:**

	Nurses are very helpful in getting a diagnosis and were very caring throughout the process **Respondent 10:** Nurses are willing to listen **Respondent 11:** Nurses are very helpful and caring **Respondent 12:** Nurses are very helpful and offer the best treatment **Respondent 13:** Nurses are helpful and treat patients well **Respondent 14, 17, 31, 40, 53, 54, 63:** Nurses are helpful **Respondent 15:** Nurses aren't helpful and considerate, they barely listen to people **Respondent 16:** Nurses are very helpful and respectful **Respondent 18:** Nurses treat patients very nice and explain everything nicely **Respondent 19:** The nurses treat the patients right **Respondent 20:** Nurses give excellent treatment **Respondent 21:** Nurses treatment is good **Respondent 22:**

	Nurses are too cheeky, do not want to listen **Respondent 23:** Nurse need to change attitude to patients. Nurses do not listen and don't care about the patients **Respondent 24:** Nurses do not explain side effects **Respondent 25:** The nurses are trying their best under the challenges they face **Respondent 26:** The nurses are courteous and have good communication. They use simple language that patients understand **Respondent 27, 30, 36, 47:** Nurses are good **Respondent 28:** Nurses are always available and explain medication **Respondent 29:** Nurses helps a lot **Respondent 32:** Nurses and staff are very helpful **Respondent 33:** Everything is great **Respondent 34:** Very professional, caring and observant **Respondent 35:** Nurses provide good treatment and healthcare

	Respondent 37: Nurses are nice **Respondent 38:** Nurses are very patient. Patient feels very welcome at the HIV/AIDS unit **Respondent 39:** Excellent service from nurses **Respondent 41:** Nurses give the best service **Respondent 42:** Nurses are helpful and always ready to assist **Respondent 43 and 44:** Nurses are helpful and respectful **Respondent 45:** Nurses give very good treatment and are helpful **Respondent 46:** Nurses are helpful and patient **Respondent 48:** Nurses are very helpful and good **Respondent 49:** Nurses are explaining and are very good **Respondent 50:** Nurses do not listen and sometimes are rude to patients **Respondent 51:** Nurses are very helpful and considerate

	Respondent 52: Some nurses treat patients well and with respect and some are not considerate **Respondent 55:** Nurses are respectful and give advice and treatment according to the patients need **Respondent 56:** Nurses always provide information when required. Are always friendly and willing to assist **Respondent 57:** Nurses understand patients' needs and assist according to your needs **Respondent 58:** Bara is the best and much better than the local clinics. Nurses at Bara are better than the local nurses **Respondent 59:** Nurses are impatient and do not treat patients well **Respondent 60:** Nurses are at times rude and do not listen to the patient **Respondent 61:** Nurses are respectful and treat patients with dignity **Respondent 62:** Nurses always advice on diet and treatment that can lead to better health **Respondent 64:** Bara is very good. Patient is happy

	Respondent 65 and 70: Nurses are very good **Respondent 66:** Nurses are good sometimes **Respondent 67:** Nurses are sometimes not patient **Respondent 68:** Nurses do not always explain medication when it is changes and the side effects they have **Respondent 69:** Bara is the best. Nurses are sympathetic and kind **Respondent 71:** Nurses are not approachable and are only if doctors are around. No nurse-patient relationship. Nurses are very hostile. Patients cannot ask questions.

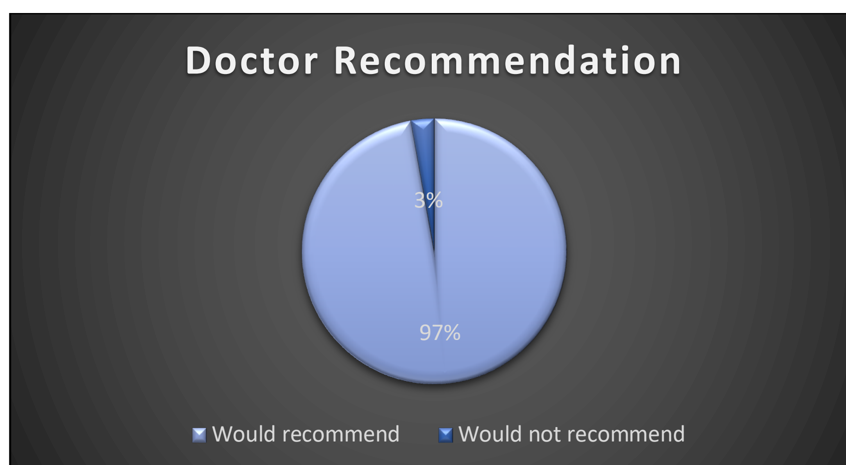
Source: Author's own compilation

From the 71 completed surveys, 12 were negative comments, and the respondents would not recommend the nurses from this institute. The common theme of the negative comments was that nurses could be disrespectful and not listen to patients. Upon inspection of the age of the respondents that felt this way, 9 of the 12 were over 45. Globalisation affects African culture, and respect for elders is a crucial aspect of African culture today (Precious, 2010).

From the 59 positive responses, two respondents said "Nurses are very good", seven respondents said "Nurses are very helpful" and four respondents said "Nurses are good." From the above feedback, the researcher deduces that the service received from the nurses at this facility is generally good, however, there are incidents were service is not acceptable.
The next section provides the respondents' feedback on the doctor's recommendation.

5.2.7 Indicator of respondents' recommendation of doctor

Figure 5.10: Respondent's doctor's recommendation



Source: Author's own compilation

The respondents were asked "Please provide reasons why you would recommend or not recommend the doctors at this facility?" Figure 5.10 above indicates that 97,2% of all respondents would recommend the doctors at the facility, however, 2,8% indicated that they would not. The reasons provided for recommendation were: "Doctors are very helpful." "Doctors are experienced and willing to explain everything properly", "Doctors give information and check on well-being." Table 5.2 below summaries all 71 respondents' feedback on doctors.

Table 5.2: Respondents' response on Doctors recommendation

Question	Response
Please provide reasons why you would recommend or not recommend the doctors at this facility?"	**Respondent 1, 2, 35, 42, 45:** Doctors are very helpful **Respondent 3:** Doctors are helpful and always explaining everything. **Respondent 4:** Doctors are helpful and supportive. **Respondent 5:**

	Doctors are easy to talk to and are always ready to assist **Respondent 6:** Doctors are experienced and willing to explain everything properly **Respondent 7:** Doctors are very helpful and supportive **Respondent 8:** Doctors can care for the sick really well **Respondent 9:** Doctors are very helpful and passionate **Respondent 10:** Doctors give good advice and care **Respondent 11:** Doctors always offer clarity and care **Respondent 12:** Doctors keep very good records and understand the patient's needs **Respondent 13:** Doctors are very helpful and understanding **Respondent 14:** Doctors are helpful and considerate **Respondent 15:** Doctors are helpful and listen to patients **Respondent 16:** Doctors give good treatment to patients **Respondent 17:** Doctors explain in detail

	Respondent 18: Doctors treat very well and explain how to take medicine. **Respondent 19:** Patient has started attending the facility since 2011. The doctors changed tablets which agrees with patient **Respondent 20:** Doctors have excellent communication **Respondent 21,22,36,40:** Doctors are good **Respondent 23:** They take notice of their patients **Respondent 24:** The doctors are the best, very helpful **Respondent 25:** Doctors give information and check on wellbeing **Respondent 26:** Doctors explain things properly **Respondent 27:** The doctors are always alright **Respondent 28:** Doctors are very supportive, encourage patients to take medicine no matter how hard **Respondent 29:** Doctors help a lot **Respondent 30:**

	Sometimes doctors and good and sometimes not **Respondent 31:** Doctors give advice **Respondent 32:** Doctors are great and are always ready to assist **Respondent 33:** Everything is great **Respondent 34:** Very good, very caring and considerate **Respondent 37:** Doctors are nice **Respondent 38:** Doctors are very patient **Respondent 39:** Excellent service from doctors **Respondent 41:** Doctors are great **Respondent 43:** Doctors are helpful and understanding **Respondent 44:** Doctors are very considerate and helpful **Respondent 46:** Doctors are very effective and administer treatment while explaining everything **Respondent 47:**

	Doctors are good however institution not forward thinking and innovative **Respondent 48, 59, 63, 64, 65:** Doctors are very good **Respondent 49:** Doctors are very difficult **Respondent 50:** Doctors always explain and provide information. **Respondent 51:** Doctors consider your living environment when making recommendations. They are always ready to help **Respondent 52:** Doctors are very respectful and understanding **Respondent 53:** Doctors are ready to help and always check to see if you understand **Respondent 54:** Patient has not interacted with any doctors **Respondent 55:** Doctors are always ready to explain and administer treatment **Respondent 56:** Doctors always advice on treatment and effects and always try to provide information at every point **Respondent 57:** Doctors are respectful and try to understand requirements and patients' needs

	Respondent 58: Doctors are the best **Respondent 60:** Doctors are patient and make you feel comfortable. Always ready to explain and are ready to listen and understand **Respondent 61:** Doctors always explain how medication works and explain and listen to questions **Respondent 62:** Some of the doctors are really helpful and administer treatment as required **Respondent 66:** Doctors are good sometimes **Respondent 67:** Doctors are good and patient **Respondent 68:** Doctors at the start of the treatment explain very well **Respondent 69:** Doctors are patient and good at heart **Respondent 70:** Doctors are always smiling and are good **Respondent 71:** Doctors are more approachable. Language barrier with doctors sometimes no communication with doctors.

Source: Author's own compilation

From the 71 surveys completed, three respondents had negative comments. There was no specific theme established from these three comments. The one comment was "Doctors are more approachable. Language barrier with doctors sometimes no communication with doctors." Upon further inspection, most doctors were not African, and English was the primary language utilised during consultations. However, this respondent preferred the Doctors at this institute to the nurses. One respondent said that no interaction with Doctors had taken place and, therefore, could not comment. The last negative comment "Sometimes Doctors are good and sometimes not." The service received from doctors differs with every interaction. The majority of the respondents were positive, and a few responses were that the Doctors at this institute are great and they provide good service and advice.

The following section reviews the quantitative statistics.

5.3 Quantitative analysis

T-tests are used to determine if there is a significant difference between the means of two groups, helping to determine the relationship between them.
As part of the quantitative analysis T-tests were computed between the male and females to understand if there were any significant differences.

Table 5.3: T-test results

		Levene's Test for Equality of Variances		T-test for Equality of Means							
						Significance				95% Confidence Interval of the Difference	
Independent Samples Test		F	Sig.	t	df	One-Sided p	Two-Sided p	Mean Difference	Std. Error Difference	Lower	Upper
Q6 How often did nurses treat you with courtesy and respect?	Equal variances assumed	.107	.744	-.008	68	.497	.994	-.002	.235	-.471	.468
	Equal variances not assumed			-.007	39.142	.497	.994	-.002	.251	-.510	.506

Independent Samples Test		Levene's Test for Equality of Variances		T-test for Equality of Means							
						Significance				95% Confidence Interval of the Difference	
		F	Sig.	t	df	One-Sided p	Two-Sided p	Mean Difference	Std. Error Difference	Lower	Upper
Q7 How often did nurses listen carefully to you?	Equal variances assumed	2.867	.095	.875	69	.192	.384	.243	.277	-.311	.796
	Equal variances not assumed			.988	63.288	.163	.327	.243	.246	-.248	.734
Q8 How often did doctors listen carefully to you?	Equal variances assumed	.201	.655	-.211	68	.417	.834	-.050	.237	-.523	.423
	Equal variances not assumed			-.205	40.794	.419	.839	-.050	.244	-.542	.442
Q9 How often did nurses explain things in a way you could understand?	Equal variances assumed	5.305	.024	1.274	69	.104	.207	.303	.238	-.172	.778
	Equal variances not assumed			1.566	68.884	.061	.122	.303	.194	-.083	.690
Q10 How often did doctors explain things in a way you could understand?	Equal variances assumed	5.918	.018	-1.552	68	.063	.125	-.353	.228	-.808	.101
	Equal variances not assumed			-1.400	34.098	.085	.171	-.353	.252	-.866	.160
Q11 How often did you get help as soon as you requested it?	Equal variances assumed	.860	.357	.241	68	.405	.810	.083	.345	-.606	.772
	Equal variances not assumed			.252	52.659	.401	.802	.083	.331	-.580	.747
Q12 How often were your	Equal variances assumed	9.543	.003	3.588	65	<.001	<.001	1.382	.385	.613	2.151

Independent Samples Test		Levene's Test for Equality of Variances F	Sig.	T-test for Equality of Means t	df	Significance One-Sided p	Two-Sided p	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference Lower	Upper
bathroom kept clean?	Equal variances not assumed			3.980	54.728	<.001	<.001	1.382	.347	.686	2.078
Q13 How often did you get help from a nurse in getting to the bathroom or in using a bedpan as soon as you wanted?	Equal variances assumed	.527	.471	.459	46	.324	.648	.206	.449	-.697	1.109
	Equal variances not assumed			.428	23.209	.336	.672	.206	.481	-.788	1.200
Q14 How often did the nurses assist you to control your pain?	Equal variances assumed	4.804	.033	1.489	53	.071	.142	.539	.362	-.187	1.266
	Equal variances not assumed			1.617	52.060	.056	.112	.539	.333	-.130	1.208
Q15 How often did the hospital staff do everything they could to help you with your pain?	Equal variances assumed	.175	.678	-.126	54	.450	.900	-.042	.334	-.711	.626
	Equal variances not assumed			-.128	49.542	.449	.899	-.042	.329	-.704	.619
Q16 Before giving you any medicine, how often did pharmacists tell you what the medicine was for?	Equal variances assumed	.645	.425	-.333	66	.370	.740	-.061	.183	-.426	.304
	Equal variances not assumed			-.290	31.548	.387	.774	-.061	.210	-.489	.367

Independent Samples Test		Levene's Test for Equality of Variances		T-test for Equality of Means							
						Significance				95% Confidence Interval of the Difference	
		F	Sig.	t	df	One-Sided p	Two-Sided p	Mean Difference	Std. Error Difference	Lower	Upper
Q17 Using any number from 0 to 10, where 0 is the worst treatment possible and 10 is the best treatment possible, what number would you use to rate the nurses during your stay?	Equal variances assumed	.420	.519	-.585	69	.280	.560	-.349	.597	-1.540	.841
	Equal variances not assumed			-.581	45.556	.282	.564	-.349	.601	-1.559	.861
Q18 Using any number from 0 to 10, where 0 is the worst treatment possible and 10 is the best treatment possible, what number would you use to rate the doctors during your stay?	Equal variances assumed	6.854	.011	1.428	69	.079	.158	.575	.403	-.229	1.379
	Equal variances not assumed			1.108	26.356	.139	.278	.575	.519	-.492	1.642

Source: Author's own compilation

A significant difference in the variances was found in the following question: How often was your bathroom cleaned? The result of the T-test for unequal variances (F=9.543, p-

value <0.001), the t-test for unequal variances was utilised. The result of the t-test for unequal variances shows a significant difference between the males and the females. (t= 3.980, difference = 54,728, p-value < 0.001). Thus, the average of the females (3.2-> between sometimes and rarely) is significantly different from the male's average (1.82 -> between very often and always). Thus, the females say that the bathroom is not kept clean that often.

A significant difference was established in the following question: How often did the nurses assist you in controlling your pain? The significant difference in the variances (F=4.804, p-value = 0.033), the t-test for unequal variances was used. The result of the t-test for unequal variances shows that the average of the females (2.21) was notably higher (t=1.617, difference = 52.060, p-value = 0.056) than the average for the males (1.67). Thus, the average of the females (2.21 -> between very often and sometimes is notably more than the average of the males (1.67-> between very often and sometimes. Therefore, the females say that pain is controlled between sometimes and very often, whilst the males say the pain is controlled very often to always.

ANOVA tests are employed in statistical analysis to determine if there is a significant difference between two or more categorical groups. These tests evaluate differences of means using a variance.

The data was categorised into the following age categories; 18-30; 31-45; 46-60, and 61 years and over. ANOVA tests were run to understand if there are significant differences between the responses based on age categories. There was one notable difference for Question 8; How often did the doctors listen carefully to you? Over 61 years were between very often to sometimes. The age categories 18-30 responded always to this question however, the age categories 31 to 35 were between always and sometimes. Based on the results, there was a notable contrast in the responses between the younger age groups (30 or under and 31-45) and the older age group (61 or over) for Question 8, indicating that doctors listened carefully more frequently for the younger groups compared to the older group.

5.4 Researcher Observation

In conducting the survey, the researcher found that respondents who made positive comments about the service provided by health workers were overall helpful and happy to provide feedback. However, respondents who made negative comments were despondent and a few were angry.

5.5 Discussion

This study aimed to explore what influence healthcare workers have on the HIV/AIDS patient's morale and general well-being, as well as to investigate if a "people-centred" approach toward quality and efficient healthcare could be considered a viable approach as mitigation to the mortality rate. Whilst there are areas of improvement to ensure a people-centred feedback is achieved, overall results were positive. From the above results, 97% of respondents would recommend the doctors at this facility, and 87% would recommend the nurses from this facility. Some of the common themes for a recommendation of Doctors were; Good Doctors – 12,76% of the respondents; Helpful doctors – 21,12%, Doctors give a good explanation – 16,90%. Some common themes for a recommendation of Nurses were; Helpful Nurses – 19,71%, Good Nurses – 16,09%, Caring nurses – 5,63%. The overall positive response indicates the good morale of the patients, majority have indicated that they have been attending this facility for many years and they were happy. The biggest age group was 46-60 years with at 39,4%, which applied to both genders. The HIV/AIDS patients at this institute were overall happy with the healthcare workers service and their mortality rate indicating this as well.

The following section summarise the findings.

5.6 Summary

For ease of reporting, the summary of findings will be presented in a table format, with a list of the research objectives, the research questions, and the results for each of them.

Table 5.4 Summarised findings linked to research questions and objectives

Research objectives		Research questions		Summarized findings
Objective 1	To investigate patients views on the care that is being provided pre, during and post-medical treatment	**Question 1**	What are the key factors that the South African health department must develop and train its healthcare providers for a people-centred approach in healthcare attainment?	The feedback received, indicated 12,7% of the respondents would not recommend the nurses at this institute due to the following reasons: Nurses need to listen to the patients; nurses are not approachable; nurses are disrespectful or dismissive at times; nurses are sometimes cheeky.
Objective 2	To determine whether there are communication barriers towards a people-centred approach to quality healthcare.	**Question 2**	What challenges exist in accessing and ensuring a people-centred approach to healthcare attainment?	The findings indicated that 52,1 % of the respondent's home language was isiZulu, followed by Setswana at 14,1% and Sesotho at 11,3%. Language is a barrier to people-centred healthcare. The majority of the doctors were not of African origin and did not speak the local languages, which is the patient's home spoken language.

Objective 3	To investigate quality measures to enhance the ability to evaluate and improve people-centred approach to healthcare	Question 3	Is there a plan for strengthening the capacity of all service providers involved in the monitoring and evaluation of a people-centred approach to quality healthcare	There needed to be a clear plan for monitoring and evaluating a people-centred approach to healthcare at the facility. The respondents were surprised to be involved in feedback on the service received as the perception was that you take the service you are given as this is a free service.

Source: Author's own compilation

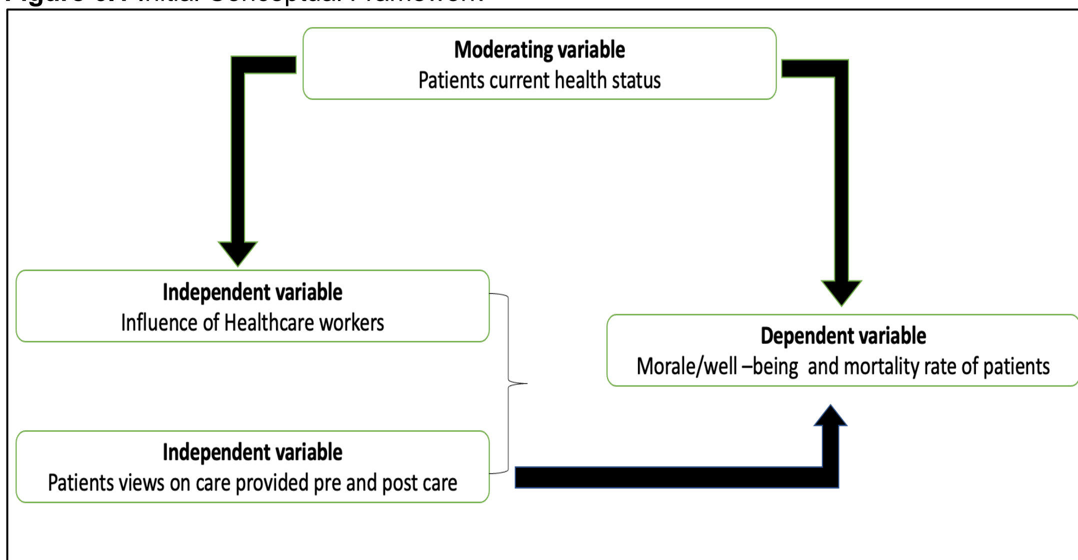
The final chapter is the concluding chapter for this research. It will contain an overview of the study, relevance of the study, recommendations, and future research insights.

CHAPTER 6
CONCLUSIONS AND FUTURE RESEARCH

6.1 Introduction

This study aims to explore what influence healthcare workers have on the HIV/AIDS patient's morale and general well-being, as well as to investigate if a "people-centred" approach toward quality and efficient healthcare could be considered a viable approach as mitigation to the mortality rate. To achieve the above-stated objective, three research questions and three objectives were established. These research questions and objectives provided the foundation for the survey questions that were developed. These questions were aligned with the phenomena under study. In chapter five, the researcher discussed in detail the achievement of the stated research objectives and the research results. The purpose of this chapter is to summarise this study. It includes the following topics: an overview of the previous chapters, a restatement of the research questions and objectives, the summarised findings, concluding remarks including the results of the hypotheses, limitations encountered in this study, recommendations for future research, and finally, an explanation of how this study could contribute to the existing body of knowledge. The initial conceptual framework is restated below, showing the relationship between the variables.

Figure 6.1 Initial Conceptual Framework



Source: Author's own compilation

6.2 Recap of the previous chapters

Chapter 1 – Introduction

The first chapter introduced the study by detailing how the South African health system struggles with a lack of resources, accountability, and poor management. It explained the importance of this study, outlined the problem statement, and stated the three research questions and objectives. This chapter also discussed the ethical considerations and provided a brief literature review. The research methodology, research instruments and design were then explained.

Chapter 2 – Models, theories and frameworks

Chapter Two examined the models, theories and frameworks relevant to this study. Five models were examined: the Health belief model, the King theory of nurses, the Theory of Planned Behaviour, the Social Cognitive theory and Kolb's experiential theory. After thoroughly analysing these theories, Kolb's experiential model was selected for this study. The researcher chose this model because it is based on experiential learning. To understand patients' expectations can only be understood through their feedback about past and present experiences and future expectations. Chapter Two concluded with the initial conceptual framework for this study. The researcher identified the variables as follows: Independent variable: influence of healthcare workers and patients views on care provided pre and post-care; moderating variable: current health status of the patient; dependent variable: morale/well-being and mortality rate of patients.

Chapter 3 – Literature Review

Chapter Three contained an extensive and focussed literature review. This chapter defined patient-centred care and explained why it is essential in healthcare. It focused on the roles that different stakeholders play in patient-centred care. The chapter introduced the different elements that impact patient care and concluded why the patient experience is essential for personalising patient care.

Chapter 4 - Methodology

Chapter Four provided a detailed account of the methodology, outlining the research design, which comprised of sampling techniques, data collection instruments and methods, data analysis approach, and ethical considerations. The chapter also

established a connection between the research questions and objectives, and the researcher's systematic approach to data collection was elucidated.

Chapter 5 - Research results and findings

Chapter Five presented the research findings and critical findings resulting from this study. The descriptive data of all respondents were presented, followed by the detailed results and an interpretation of the findings. This chapter concluded with a summary of the findings and the achievement of the research objectives.

Chapter 6 – Conclusions and recommendations

The sixth chapter of the study establishes a connection between the results and the research objectives. It begins with a review of the preceding chapters, followed by restating the research questions and objectives. The chapter presents a summary of the findings, concluding remarks, and a discussion of the limitations encountered. Recommendations for future research are also presented, along with suggestions on how the study's results could contribute to the existing body of knowledge.

The research questions, objectives and hypotheses will be restated in the following section.

6.3 Research objectives restated

The research objectives were:

1. To investigate patients views on the care that is being provided pre and post-medical treatment;
2. To determine whether there are barriers towards a people-centred approach to quality healthcare;
3. To investigate quality measures to enhance the ability to evaluate and improve a people-centred approach to health care.

The study was based on the following research questions:

1. What are the key factors that the South African department of health must develop and train its healthcare providers for a people centred approach in healthcare attainment?
2. What are the challenges in accessing and ensuring a people centred approach to healthcare attainment?
3. Is there a plan for strengthening the capacity of all service providers involved in the monitoring and evaluation of a people centred approach to quality healthcare?

The study was based on the following propositions:

1. Continuous and consistent patient feedback which is acted upon will improve patient experience.
2. An integration of services across public and private sector and all healthcare stakeholders increases the quality of patient-centred care available.
3. Patient involvement in quality-healthcare activities increases the influence on mortality rates.

After restating the research objectives, questions and hypotheses, the following section discusses the findings. The research questions were answered, and the research objectives were achieved. In the following section, the research findings are discussed.

6.4 Results

This section summarises and discusses the research findings about the aims of the study.

6.4.1 Research objective one

The first research objective was to establish the critical factors that the South African Department of Health needs to develop and train its providers for a people-centred approach in healthcare attainment. From the respondents' feedback it was established that the listening skills of the nurses were lacking. Nurses are not approachable and are

disrespectful or dismissive. This was a minority finding, however it still indicates a gap in communication skills with the patients. Chapter Three highlighted that respecting patient and family preferences, values, cultural traditions, and socioeconomic conditions is one of the seven critical elements of patient-centred care. In Chapter Five, the results indicated that 9 of the 12 respondents who found the nurses disrespectful were over 45. The majority of the respondents' demographic were African; this aligns with the African culture of respect for elders being a critical aspect.

The gap identified can be addressed with diversity and communication training. Healthcare workers can be trained on African culture and how to communicate with empathy and understanding. This will ensure that the patient feels heard and seen.

6.4.2 Research objective two

The second objective of this study was to discover what the challenges are in accessing health care and ensuring a people-centred approach. Judging from the responses, isiZulu is the most common mother tongue with 52.1%. It is followed by Setswana with 14.1% and Sesotho with 11.3%. Language is a barrier to people-centred health care. It was found that most doctors in the department were either of foreign or non-African origin and did not speak the local languages. According to a report by Business Tech (2022), South Africa is currently grappling with a shortage of doctors. To address this issue, the South African Department of Home Affairs has recently expanded the critical skills list by incorporating 39 additional skills.This list includes public health medics and registered nurses. This would explain why foreign doctors are employed in public health facilities. However, this does not solve the problem of the language barrier. A recommendation for the use of interpreters in these cases will ensure that the patient feels that their needs are being addressed. They will also learn how to manage their condition effectively. This can lead to fewer visits to the doctor and a reduced burden on the health system.

6.4.3 Research objective three

The third research objective was to investigate if there is a plan to strengthen the capacity of service providers involved in monitoring and evaluating a people-centred approach to

quality health care. It was found that respondents were surprised that they were involved in providing feedback on the services they received. The impression was that one takes what one gets as it is a "free service". A process of continuous feedback needs to be introduced. This could be in the form of a survey. Patients at the clinic wait in queues for hours and meanwhile can easily fill out a survey with three questions about the service they received. The feedback from this survey will help implement a service that puts people first. Other relevant findings from this study are discussed in the following section.

6.5 Consistent service

Respondents indicated that nurses and doctors were sporadic. Some of the comments in the open-ended questions were, "The doctors are sometimes good and sometimes not." The same applied to the nurses. For people-centred healthcare to be successful, the right care needs to be delivered at the right time and in the right place. The health sector has been under more strain than other sectors in recent years.

While the challenges in healthcare are great, the right use of skills, resources and technology can help to reduce them. The department of health may explore the possibility of shorter and more frequent shifts to counteract possible burnout and increasing administrative staff that can be filled by non-medical staff. It is also important to ensure that the skills of doctors and nurses are used effectively.

6.6 Better service than local clinic

Patients are referred to the hospital only when treatment at local clinics is not effective. Patients compare the services of the local clinics with those of the hospital. One comment from the open question was "Bara is the best and much better than the local clinics, the nurses in Bara are better than the local nurses".

6.7 Observations

Patients wait a long time to be seen by doctors and nurses. There are different waiting areas to see the nurses and then the doctors.

An overview of the conditions during the waiting time.

The waiting areas are outside the building and are exposed to the weather. Access and permission from the nurses are required to unlock the toilets, while the toilets available for public use lack essential amenities such as toilet paper and hand soap.

6.8 Conclusions

Based on the research findings in Chapter Five, the research questions were answered and the research objectives were achieved. Based on the research results and findings discussed in Chapter Five, Table 6.1 reports the results of the 3 research propositions used in this study.

Table 6.1: Propositions linked to findings and outcomes

Propositions		Summarised Findings	Outcome
Proposition 1	Continuous and consistent patient feedback which is acted upon will improve patient experience.	The feedback received, indicated 12,7% of the respondents would not recommend the nurses at this institute due to the following reasons: Nurses need to listen to the patients; nurses are not approachable; Nurses are disrespectful or dismissive at times; nurses are sometimes cheeky.	Based on the findings, there is room for improvement. Research proposition 1 is supported.

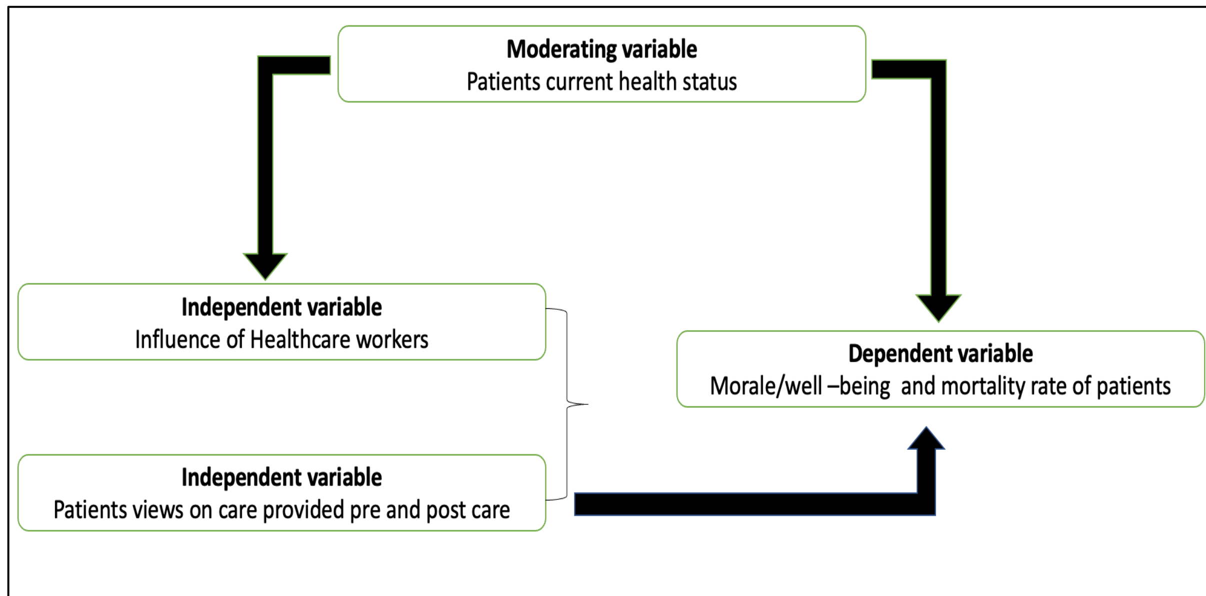
Proposition 2	An integration of services across public and private sector and all healthcare stakeholders increases the quality of patient-centred care available.	The findings indicated that 52,1 % of the respondent's home language was isiZulu, followed by Setswana at 14,1% and Sesotho at 11,3%. Language is a barrier to people-centred healthcare. The majority of the doctors were not of African origin and did not speak the local languages, which is the patient's home spoken language.	Based on the findings, establishing partnerships between healthcare institutions (Public and Private) and local community organisations to bridge the language gap. These collaborations can help facilitate better communication and understanding between healthcare providers and patients, ensuring that patient needs and preferences are effectively addressed. there is a requirement for cohesive Research proposition 2 is supported.
Proposition 3	Patient involvement in quality-healthcare activities increases the influence on mortality rates.	There needed to be a clear plan for monitoring and evaluating a people-centred approach to healthcare at the facility. The respondents were surprised to be involved in feedback on the service received as the perception was that you take the service you are given as this is a free service.	Based on the findings, patients are not involved in any feedback mechanism. Research proposition 2 is supported.

Source: Author's own compilation

At the outset of this study, the researcher designed an initial conceptual framework based on variables identified through the dissemination of existing literature. The initial conceptual framework was presented in Chapter Two of this study. In the initial conceptual framework, the researcher identified the influence of health workers on patients and patients' views are provided pre and post care as the independent variables, the dependent variable the morale/wellbeing and mortality rate of patients and the moderating variable the current health status of patients. The aforementioned independent variables have an influence on the patients' morale/well-being and mortality rates. The modifying variable of the patients' health status modifies this effect. The

researcher assumed that all of the above variables have an effect on the morale/well-being and mortality rate of the patients. Figure 6.2 is an illustration of the original conceptual framework as described in the second chapter of this study.

Figure 6. 2: Initial conceptual framework



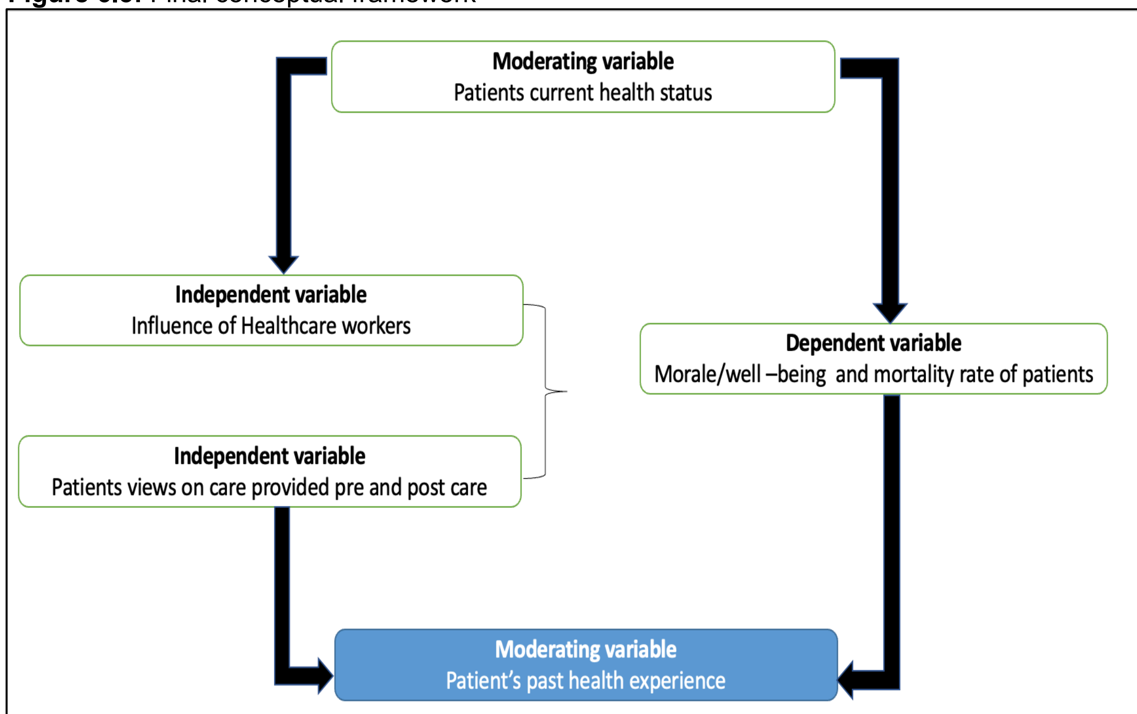
Source: Author's own compilation

6.9 Final Conceptual framework

Against the background of the initial conceptual framework as shown in Figure 6.2, the researcher designed a final framework informed by the findings of this study. It should be noted that the final framework was shaped by the researcher's interpretation of the findings and could be different if interpreted by another party. The researcher found that respondents that provided positive comments about the service received from healthcare workers were overall eager to assist and provide feedback. However, the respondents that provided negative comments were despondent and a few were angry in nature. In Chapter Three the researcher highlighted examples where patients felt more respected when seeking a traditional healer as opposed to healthcare institute. The danger this presents is that the patient may decide to adopt traditional healing instead of allopathic guidance. In the context of HIV/AIDS, the absence of a cure poses significant risks for patients. Extensive research has demonstrated that the utilization of antiretroviral medications (ARVs) and the adoption of a healthy lifestyle management approach remain the sole viable solutions. The model chosen for this study is Kolb's experiential model.

The model is based on learning through experience. The respondents were able to compare the service they received in the local clinics with the service they received in the hospital. The patients made a comparison and on this basis were able to determine whether the service they received was good or bad. It may be that not all respondents used this yardstick and used other facilities that may have offered a good service and therefore felt that the service at the hospital was insufficient. Therefore, the researcher found that an additional moderating variable of past experience influences the morale/well-being of patients. A significant question is: What has the institution done to help patients during their visit. Special consideration should be given to fast track elderly patients or those with infants accompanying them on clinic days. Unfortunately, these patients often endure lengthy queues, waiting for hours before they can receive medical attention, and subsequently have to proceed to the pharmacy for medication collection. This entire process, spanning the entire day, is not only exhausting but also necessitates the use of public transportation for the journey back home. Therefore, the researcher found that an additional moderating variable, namely previous experience, has an impact on patients' morale/well-being. An important question is what the facility did to help patients during their visit. Figure 6.3 shows how the researcher interpreted the final framework for this study.

Figure 6.3: Final conceptual framework



Source: Author's own compilation

6.10 Limitations

The following section discusses the limitations, including shortcomings or consequences that were beyond the researcher's control in conducting this study.

6.10.1 Sample size

This study was conducted only in the HIV/AIDS department with a sample size of 71. A larger sample was intended, but only respondents who gave consent were interviewed. In addition, the study could only be conducted on clinic days, which are twice a week on a Wednesday and Thursday. The other days are for walk-ins with unforeseen circumstances. This sporadic service might bring only 5 to 10 patients and the numbers are not guaranteed. Interviewing the other departments in the hospital, not just the HIV/AIDS outpatient department, as well as other public hospitals, could provide additional insights.

6.10.2 Restricted schedule

The researcher studies part-time and works full-time. The researcher had to take study leave and annual leave to spend time collecting research data, analysing and finalising the research paper as working after hours and on weekends was not always enough to meet the set milestones.

6.10.3 Demographical profile

The majority of respondents were African, with 1 respondent being coloured, other populations were not fully represented in this study. The interpretation of these results should not be generalised to other racial groups.

6.10.4 Age

Children are also infected with HIV/AIDS, but did not participate in the survey. The unit where the survey was conducted is an adult only facility.

6.11 Recommendations

The following section discusses the recommendations arising from this study.

6.11.1 Waiting areas

Consideration should be given to a waiting area inside the building that can accommodate all patients and make it easier for patients to get around. A patient goes to the nurse to check their vitals and then immediately to the next room to see the doctor.

6.11.2 Bathroom facilities

In the survey, most women said that the toilet was not kept clean. Regular cleaning staff who ensure that bathrooms are clean and tidy and that the necessary hand soap and toilet paper are available will immediately increase patient satisfaction. This may seem very simple, but according to the survey results, it is a crucial aspect of patient satisfaction.

6.11.3 Doctor assistance

While most of the respondents stated that the doctors at this facility are good, there were 4 negative comments – "The service is sporadic, sometimes good and sometimes not". The one negative comment was that the doctors do not speak the local language, and this could be remedied in the form of a translator. This would ensure that the patient understands the advice. Doctors cannot be expected to speak every language. Given the shortage of doctors locally, finding doctors who speak the local language can be a challenge. Technology may also be utilised to address this. Google translate can translate English into isiZulu and isiXhosa. According to the results, 52.1% of the respondents spoke isiZulu and 5.6% spoke isiXhosa. This is where integration between the public and private sector will be beneficial as private sector may have use of technology for translation.

6.11.4 Training of nurses

Nurses received more negative feedback than doctors. Out of the 12 negative comments received, it is evident that the feedback was predominantly characterized by disrespect, dismissiveness, lack of attentiveness, excessive impertinence, inconsistent attitudes, rudeness, impatience, and a tendency to exhibit kindness solely in the presence of doctors. The researcher recommends training for nurses based on soft skills. A "people-centred" healthcare is based on patients' experiences and how they feel. A process needs to be put in place to ensure that training is embedded in the daily service and there need to be accountable for the absence of these elements in services. HIV/AIDS patients are subject to stigma and judgement and do not need further feelings of injustice. Of the negative comments received from patients, 9 of the 12 were from patients who were over 45 years old. African culture has a deep respect for older people. A training module on African culture will help nurses understand expectations. These cultural aspects are an important aspect of ‘people-centred' health care.

6.11.5 Patient feedback

The patient's perspective is valued in person-centred care. It is important that consistent feedback is introduced in public health facilities. It is recommended that an anonymous survey with questions about the service and experience is completed at the end of treatment to ensure a consistent level of service. This proactive response shows the patient that the facility cares and values them. Furthermore the survey should not be too long as patients need to also collect their medication from the pharmacy. Upon departing the premises, three key questions can be posed to determine the adequacy of the service received.

6.12 Relevance of the research study

One of the main objectives of research is to build knowledge. In this context, this study could help to provide insights on management in the public sector health, as well as management in non-public sector health facilities, to understand the patient experience. WHO calls on all countries to improve the quality of care through the Sustainable Development Goals. Some private sector health facilities focus on patient feedback, while

public sector facilities do not have the bandwidth and capacity to focus on this. In this context, this study could help provide insights that health facilities can use to improve the quality of health care. This study provides a better understanding of the value of healthcare from the patient's perspective.

The next section makes recommendations for future research.

6.13 Areas of further research

The researcher strongly recommends that further research should be conducted based on the findings and interpretation of this study. This study has provided insights into issues that are specific to the South African context. It has also shown the need to understand African culture and receive services in a language that can be understood. However, there is a gap in the existing body of knowledge because the family is not involved in the process. African culture has a 'communal' rather than an ‘individualistic’ approach. Understanding the family's views on the health services received provides a complete view of the patient experience. In addition, a complete patient experience of inpatients and outpatients in all departments of the hospital will provide a better insight. Another suggestion is to include the major hospitals in all provinces as this will provide a complete South African patient experience.

Peltzer (2009) conducted a study on patient experience and health system responsiveness in South Africa. However, no updated study has been conducted since then. People's perceptions and demands change and evolve over time.

6.14 Contribution to the existing body of knowledge

This study contributes new insights into how South African HIV/AIDS patients feel about the service received. Even though the study did not extend to the local clinics, the patient was able to make a comparison between the service received in the clinic and compare this to the hospital. Of the 71 respondents, only 38% had completed Grade 12. Despite this the respondents provided feedback based on experiential learning.

This study could make a meaningful contribution to building a benchmark for the training of nurses and a 'voice of the patient' project. Kolb's experiential learning theory has been applied mainly to the education sector, however healthcare studies and research may benefit from this as well.

The researcher believes that the following factors could have an impact on patient experience:

1. Influence of healthcare workers
2. Patients' current health status
3. Patients' past health experiences
4. Cultural expectations
5. Language preference

Based on observations, the researcher believes that the above factors need to be considered in the field of patient experience at present and in the future.

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APPENDIX A – QUESTIONNAIRE

1. What is your age

____

2. Place a tick next to your gender

Male	
Female	
Transgender female	
Transgender male	
Gender variant/non-conforming	
Prefer not to answer	
Other	

3. Place a tick next to your race

African	
White	
Indian	
Coloured	

4. What is the highest grade or level of school that you have completed?

____

5. What language do you speak at home?

____

Please read each of the following statements carefully and refer to your stay and treatment during this hospital visit:

	During this treatment,	Always	Very often	Sometimes	Rarely	Never
6	How often did nurses treat you with courtesy and respect?					
7	How often did **nurses** listen carefully to you?					
8	How often did **doctors** listen carefully to you?					
9	How often did **nurses** explain things in a way you could understand?					
10	How often did **doctors** explain things in a way you could understand?					
11	How often did you get help as soon as you requested it?					
12	How often were your room and bathroom kept clean?					
13	How often did you get help from a nurse in getting to the bathroom or in using a bedpan as soon as you wanted?					
14	How often did the nurses assist you to control your pain?					
15	How often did the hospital staff do everything they could to help you with your pain?					
16	Before giving you any medicine, how often did the pharmacist tell you what the medicine was for?					

17. Using any number from 0 to 10, where 0 is the worst treatment possible and 10 is the best treatment possible, what number would you use to rate the nurses during your stay?

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

18. Using any number from 0 to 10, where 0 is the worst treatment possible and 10 is the best treatment possible, what number would you use to rate the doctors during your stay?

0	1	2	3	4	5	6	7	8	9	10

19. Please provide reasons why you would recommend or not recommend the nurses at this facility?

____

____

____

____

20. Please provide reasons why you would recommend or not recommend the doctors at this facility

____

____

APPENDIX B – ETHICAL CLEARANCE CERTIFICATE

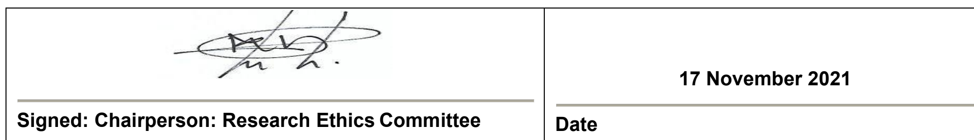
P.O. Box 1906 | Bellville 7535
Symphony Road Bellville 7535
South Africa
Tel: +27 21 4603291
Email: fbmsethics@cput.ac.za

Office of the Chairperson Research Ethics Committee	FACULTY: BUSINESS AND MANAGEMENT SCIENCES

The Faculty's Research Ethics Committee (FREC) on **16 November 2021**, ethics **APPROVAL** was granted to **Prof Visvanathan Naicker** for a research activity at the Cape Peninsula University of Technology.

Title of project:	**National Health Quality Improvement Plan in South Africa [NHQIP]** Researcher (s): Prof V Naicker/ Prof R Tengeh/ Prof R Rampersad

Decision: APPROVED



Signed: Chairperson: Research Ethics Committee	**17 November 2021** **Date**

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the CPUT Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study requires that the researcher stops the study and immediately informs the chairperson of the relevant Faculty Ethics Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the confidentiality of the data, should be reported to the Committee in writing accompanied by a progress report.
5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines, and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, notably compliance with the Bill of Rights as provided for in the Constitution of the Republic of South Africa, 1996 (the Constitution) and where applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003 and/or other legislations that is relevant.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data requires additional ethics clearance.
7. No field work activities may continue after two (2) years for Masters and Doctorate research project from the date of issue of the Ethics Certificate. Submission of a completed research ethics progress report (REC 6) will constitute an application for renewal of Ethics Research Committee approval.

Clearance Certificate No | 2021_FBMSREC 078

APPENDIX C – CEO CONSENT APPROVAL

CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL

Directorate: Office of the CEO
Enquiries: SMO Masote
Tel: 011 933 0181/ 9145
Email: Selaelo.masote@gauteng.gov.za

To : **Ms Pashnee Naicker**

From : **Dr MM Lesia**
CEO CHBAH

Date : **15 September 2022**

Subject : **Application for permission to conduct research at Chris Hani Baragwanath Academic Hospital**

Dear Ms Pashnee Naicker

This serves as confirmation that your email request regarding the following research was received by the Office of the CEO at Chris Hani Baragwanath Academic Hospital.

Research Topic: A "people-centred approach" to realising healthcare by facilitating, patient, provider, and community participation in health attainment

Approval is granted for you to conduct the research according to the approved protocol. Please note the ethical clearance certificate should be submitted to the office of CEO before the data is collected.

Best wishes with the study

Kind regards

Dr MM Lesia
CEO: Chris Hani Baragwanath Academic Hospital
Date: 16/09/2022

APPENDIX D – DEPARTMENT OF HEALTH LETTER

DIRECTOR GENERAL
HEALTH
REPUBLIC OF SOUTH AFRICA
PRETORIA
Private Bag X828, PRETORIA, 0001, Dr AB Xuma Building, 1112 Voortrekker Rd, Pretoria Townlands 351-JR, Pretoria, 0187, Tel (012) 395 8000
CAPE TOWN
P.O. Box 3875, CAPE TOWN, 8000, 103 Parliament Towers, Room 615, Plein Street, CAPE TOWN, 8000 Tel (021) 461 2040 Fax (021) 461 6864

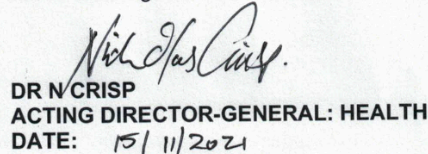
To Whom it may concern

Letter of Support: National Quality Health Implementation Plan – Research Project to be conducted in the nine provinces of South Africa

The National Department of Health supports the conduct of following nine studies that will be conducted by Masters and Doctor students based at Cape Peninsula University of Technology under the leadership of Professor Visvanathan Naicker

1. A study of Healthcare Quality and Patient safety capacity building interventions in South Africa. A national sectoral analysis.
2. Bridging the Competency Gap in Quality Patient Care Amongst Clinicians and Clinical Managers.
3. Translation of knowledge during the training into tangible improvements in the quality of care provided for Emergency Medical Services.
4. Towards High Reliability Healthcare in RSA: A Study of capacity building of non-clinical managers and leaders in South Africa.
5. Translation of knowledge from the Healthcare Quality Management training into tangible improvements in healthcare social work services.
6. The lack of strategic management of health services and its effect on quality health care.
7. A "people-centred approach" to realising health care by facilitating patient, and community participation in health attainment.
8. The effect of critical staff shortages, inadequate training, and poor attitudes of staff on health care.
9. Delivering Emergency Medical Services in resource constrained circumstances

The benefit derived from this research will inform the health sector on where and what the problematic areas are - pre and post the training around the various topics the 9 students have chosen in quality healthcare. Evidence from this research and training will further encourage a strong stewardship and leadership for high quality universal health coverage for all South Africans



DR N CRISP
ACTING DIRECTOR-GENERAL: HEALTH
DATE: 15/11/2021

APPENDIX E – TURN-IT-IN REPORT

A people-centred approach to healthcare

ORIGINALITY REPORT

11%	9%	5%	5%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

#	Source	%
1	Submitted to CSU, Dominguez Hills Student Paper	1%
2	etd.cput.ac.za Internet Source	<1%
3	uir.unisa.ac.za Internet Source	<1%
4	www.researchgate.net Internet Source	<1%
5	repository.up.ac.za Internet Source	<1%
6	zenodo.org Internet Source	<1%
7	Conner, Mark, Norman, Paul. "EBOOK: Predicting and Changing Health Behaviour: Research and Practice with Social Cognition Models", EBOOK: Predicting and Changing Health Behaviour: Research and Practice with Social Cognition Models, 2015 Publication	<1%

APPENDIX F – EDITING CERTIFICATE

NERESHNEE GOVENDER COMMUNICATIONS (PTY) LTD

REGISTRATION NUMBER: 2016/369223/07
DR NERESHNEE GOVENDER (PhD)
neresh@ngcommunications.co.za
0847022553
WRITING PRACTITIONER • EDITOR • COPYWRITER • TRAINER

PhD-Management Sciences: Marketing (gender and media); *PG DIP - Higher Education - Academic Developers (Cum laude;)* M-Tech Public Relations; B-Tech Public Relations *(Cum laude)*; B-Tech Journalism *(Cum laude)*; *N-Dip Journalism*

09/06/2023

PASHNEE NAICKER
CPUT

RE: EDITING CERTIFICATE

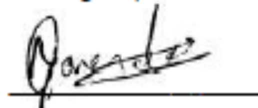
FOCUS AREA: A "PEOPLE-CENTRED APPROACH" TO REALISING HEALTHCARE BY FACILITATING, PATIENT PARTICIPATION IN HEALTH ATTAINMENT

Submitted in fulfilment of the requirements of the Faculty Business and Management Sciences, Cape Peninsula University of Technology, in partial fulfilment of the requirement for the MASTER DEGREE IN BUSINESS INFORMATION AND ADMINISTRATION

Student number: 222886471

This serves to confirm that this research has been edited for clarity, language and layout.

Kind regards,



Nereshnee Govender (PhD)