Perceptions and experiences of nurses about the mobile clinic work environment

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DECLARATION

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ABSTRACT

Background: Concern for patients living in remote rural communities of the Western Cape Province who do not receive quality health care due to deficiencies in the work environment of mobile clinic health workers exists. The concern is especially for the wellbeing of the nurses who work in this environment.

Amidst a lack of scientific knowledge about the factors that have an influence on the quality of health provision in the mobile clinic work environment, the motivation to improve this work environment is hampered. Therefore, in striving towards excellence in mobile clinic health care by the year 2020, this study aimed to research the perceptions and experiences of nurses about the mobile clinic work environment.

Method: A qualitative approach with a descriptive design was followed to research the above problem**.** A purposeful sampling method was used for identifying five subdistricts in the Western Cape Province to which all mobile clinic nurses were invited to take part in (n=19). Permission was granted by the Health Research Ethics Committee at Stellenbosch University, the Western Cape Department of Health and the individual study participants.

Criteria for validity, namely credibility, conformability, dependability and transferability were applied to ensure trustworthiness. A pilot interview was conducted personally by the researcher in a neighboring district where she was not known, however to prevent bias a trained independent researcher conducted all other interviews.

Findings: Eight semistructured interviews were carried out of which three were individual and five were group interviews. During data analyses twelve themes emerged. A perception that the mobile clinic health services are indispensable in delivering primary health care to people living in remote rural areas was identified. However, several deficiencies with regard to the vehicles that are being used, such as the adverse conditions within which medicine are kept, *"I have asked many times about the medication on the bus because it reaches temperatures of 40 to 45 degrees",* emerged. An extreme workload and an extensive scope of practice that hamper the delivery of the desired health care, as well as a lack of in-service training to ensure greater competency in the mobile clinic work environment and a shortage of relief staff were also identified. Various stressors linked to deficiencies in occupational health and safety, such as the lack of telecommunication were identified, *"there is no communication, no-one that will go and search for you*". Lastly, various participant suggestions on how to improve the mobile clinic work environment were identified.

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Conclusion: The mobile clinic health care services fulfil an essential role in delivering primary health care to the dwellers in the rural communities of the Western Cape. However, occupational health and safety, as well as quality assurance are issues that need to be addressed urgently. It is thus recommended that policy makers take cognizance of the specific needs of every individual mobile clinic team.

Key words: remote rural communities, mobile clinic work environment, deficiencies, mobile clinic nurses, employee dissatisfaction, employee motivation, access to quality health care.

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OPSOMMING

Agtergrond: Kommer bestaan dat pasiënte woonagtig in afgeleë landelike gemeenskappe van die Wes-Kaap Provinsie nie gehalte gesondheidsorg ontvang nie weens leemtes in die werksomgewing van mobiele kliniek gesondheidswerkers. Daar is veral kommer dat hierdie werksomgewing nie die welsyn van die verpleegsters wat daar werk ondersteun nie.

Te midde van 'n gebrek aan wetenskaplike kennis betreffende die faktore wat 'n invloed het op gehalte gesondheidsorgvoorsiening in die mobiele kliniek werksomgewing, is motivering tot verbetering van hierdie werksomgewing belemmer. Daarom, in die strewe na uitmuntendheid in mobiele kliniek gesondheidsorg teen die jaar 2020, het hierdie studie ten doel gehad om die persepsies en ervaringe van verpleegsters rakende die mobiele kliniek werksomgewing te ondersoek.

Metode: 'n Kwalitatiewe benadering met 'n beskrywende ontwerp is gevolg om die bogenoemde probleem te ondersoek. 'n Doelgerigte steekproefmonster is gebruik vir die identifisering van vyf sub-distrikte in die Wes-Kaap Provinsie, waarna alle mobiele kliniek verpleegkundiges genooi is vir deelname aan die studie (n=19). Toestemming is van die Etiese komitee vir Gesondheidsnavorsing van die Universiteit van Stellenbosch, die Wes-Kaap Departement van Gesondheid en die individuele studie deelnemers verkry.

Kriteria vir geldigheid, naamlik geloofwaardigheid, gelykvormigheid, betroubaarheid en oordraagbaarheid is toegepas om betroubaarheid te verseker. 'n Loots onderhoud is persoonlik deur die navorser in 'n naby geleë distrik waarmee sy onbekend is uitgevoer, maar om vooroordeel te voorkom is alle ander onderhoude deur 'n opgeleide onafhanklike navorser uitgevoer.

Bevindinge: Ag semi-gestruktureerde onderhoude is uitgevoer, waarvan drie individueel en vyf groep-onderhoude was. Tydens data-analise het twaalf temas te voorskyn gekom. 'n Persepsie dat die mobiele kliniek gesondheidsdienste onontbeerlik is in die lewering van Primêre Gesondheidsorg aan mense woonagtig in afgeleë landelike gebiede, is geïdentifiseer. Desnieteenstaande het verskeie leemtes ten opsigte van die voertuie wat gebruik word opgeduik: "*Ek het al baie keer gevra na die medikasie in die bus, want dit raak 40 tot 50 grade*". 'n Uitermate werkslading en uitgebreide werksomvang wat gehalte gesondheidsorglewering belemmer, asook 'n gebrek aan indiensopleiding en aflospersoneel om groter bekwaamheid in die mobiele kliniek werksomgewing te verseker, is ook geïdentifiseer. Verskeie stressors verbandhoudend tot leemtes in beroepsgesondheid en

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veiligheid, soos die gebrek aan telekommunikasie is geïdentifiseer, *"daar is geen kommunikasie, niemand wat sal gaan om jou te soek nie*". Laastens is verskeie deelnemervoorstelle tot die verbetering van die mobiele kliniek werksomgewing geïdentifiseer.

Slotsom: Die mobiele kliniek gesondheidsdienste vervul 'n onontbeerlike rol in die lewering van primêre gesondheidsorg aan inwoners in die landelike gemeenskappe van die Wes-Kaap. Beroepsgesondheid en veiligheid, asook gehalte-versekering, is egter kwessies wat dringend in elke mobiele kliniek gesondheidsdiens ondersoek moet word. Dit word dus aanbeveel dat besluitnemers kennis neem van die spesifieke behoeftes van elke individuele mobiele kliniek verpleegspan.

Sleutelwoorde: afgeleë landelike gemeenskappe, mobiele kliniek werksomgewing, tekortkominge, mobiele kliniek verpleegsters, werknemer ontevredenheid, werknemer motivering, toegang tot gehalte-gesondheidsorg.

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DEDICATION

I dedicate this work to all the nurses working in the mobile clinic environment, for their devotion and dedication to the people of rural South Africa.

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Above all, I honour and thank God Almighty for bringing wonderful people into my life and providing the opportunity and skills to do this study. Thank you God, for loving me and always being there for me.

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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
CNP	Clinical Nurse Practitioner
EN	Enrolled nurse
ENA	Enrolled nurse auxiliary
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
NGOs	Non-governmental organisations
PHC	Primary Health Care
RN	Registered Nurse
SANC	South African Nursing Council
TB	Tuberculosis

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CHAPTER 1:
FOUNDATION OF THE STUDY

1.1 INTRODUCTION

The patient's need for excellence in health care delivery is the essence of the Western Cape government's comprehensive service plan for health care in the year 2020 (Western Cape Government, 2011:12). Excellence can only be achieved with the exceptional performance of every worker, of which the key element is *motivated employees* (Budica, Puiu & Budica, 2009:127). Even so, a supportive work environment is needed, one which will be conducive to higher productivity, harmonious interpersonal relations and reduced absenteeism of workers. If all the needed aspects are attended to, it will automatically improve the work experience of the workers (Schmalenberg & Kramer, 2008:2-8).

Given the shortage of research-based evidence and in striving for excellence in rendering mobile clinic health care services, the focus of this study is to explore the perceptions and experiences of nurses who work in the mobile clinic work environment.

This chapter includes the rationale, research problem, research question, purpose and objectives, conceptual theoretical framework and a brief description of the research methodology as applied.

1.2 BACKGROUND

Distance and a lack of transport were found to be the main barriers for patients from rural communities to access urban health services (Lindgren, Deutsch, Schell, Bvumbwe, Hart, Laviwa & Rankin, 2011:2). In the Provincial Government of the Western Cape, the provision of accessible health care, whether urban or rural, is a matter of high priority. People should be within walking distance of no more than 3 km to their nearest clinic (Western Cape Government, 2007:4). Therefore, to enable health workers to access even the most underserved rural communities, 90 mobile clinic units were deployed by the Western Cape Government (Krige, 2011:n.p.). In the Western Cape Province, a mobile clinic is the term used for a 16-seater vehicle, also called a minibus taxi, which has been converted and equipped to render PHC services. The terms mobile clinic and mobile clinic unit will be used interchangeably in the study.

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As a result, a much needed comprehensive health service can be taken directly to these people, enabling the nurse to view and treat them in their immediate home and work environment and thereby improving their chances to receive quality health care (Guasasco, Heuer & Lausch, 2002:168).

However, in the discussion document, *Re-engineering Primary Health Care in South Africa,* it is stated that the implementation of the Primary Health Care (PHC) approach has been inadequately dealt with in the past ten years (National Department of Health, 2010:1). Some aspects of the *2010 Comprehensive Service Plan* “proved to be over-ambitious” and consequently could not be implemented successfully (Western Cape Government, 2011:8). In learning from the past, the draft framework for dialogue on health care in the Western Cape by the year 2020 acknowledged the necessity to identify and address the factors that contribute to failure in the reaching of health goals (Western Cape Government, 2011:3). Furthermore, in the document on *Re-engineering of PHC in South Africa*, it is stated that there should be an integration of services at every level and in all fields of service delivery (National Department of Health, 2010:8). Thus, amidst a lack of scientific knowledge about the work environment of mobile health clinics, progress in the field of mobile health is hampered. Accordingly, it must be stressed that the Western Cape Government’s vision for client-centred quality of care for all by the year 2020 will not be accomplished without an understanding of the problems faced in mobile clinic health care.

In providing the optimal care for each individual, ethical decision making as a continual requisition in the nursing environment is essential. Nursing values, such as displaying compassion towards a patient, dedication to professional values and believing in the professional role of a nurse, would not have been fulfilled without the value of caring. Attitudinal values set the basis for maintaining the caring ethic, as it addresses nurses’ attitudes towards conditions in their work environment, their patients or everything that could have a negative effect on a person (Pera & van Tonder, 2011:11,13). Thus, the work environment of the mobile clinic nurses cannot be ignored any longer.

According to Schmalenberg and Kramer (2008:8), a satisfying work environment will automatically improve the work experience of the workers. When managers omit to look into foreseeable harmful conditions in the workplace, they are transgressing the ethical principle of beneficence (Pera & van Tonder, 2011:55).

Herzberg’s Two-Factor Theory on job satisfaction provided valuable guidance in addressing the factors that could influence job satisfaction in the mobile clinic work environment. The need for management to stress sufficiently the extrinsic factors to avoid employee

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dissatisfaction, as well as Herzberg's recognition of intrinsic factors as the true motivators in job satisfaction, were therefore included in the framework of the intended study. Extrinsic or hygiene factors refer to the circumstances in which a scope of practice is to be performed and include working conditions, supervision, organisational policies and administration, interpersonal relations, benefits and fairness in the workplace. Intrinsic or motivational factors on the other hand, address the psychological needs of employees and are inherent to the job. It refers to the work itself, opportunities for growth, responsibility, achievement, recognition and advancement (Herzberg, 2003:91-92).

1.3 SIGNIFICANCE OF THE STUDY

The perceptions and experiences of nurses who work in mobile clinics are unknown; however, these influence the delivery and the quality of care rendered to those whom they serve. It is mostly farm dwellers that attend the mobile clinic services. The findings of this study will assist policy makers in the public health sector to make decisions based on scientific evidence that will enhance the delivery of an efficient and effective mobile health service to the rural communities, taking cognizance of the nurses responsible to deliver these services.

1.4 RATIONALE

In the *Comprehensive Service Plan for the Implementation of Healthcare 2010,* PHC was identified as the foundation of an effective and efficient public health service. This perspective is grounded in the following motives: it is the first point of contact between the patient and the health service; a comprehensive and integrated package of essential PHC services need to be provided; efficiencies and inefficiencies at this level impact significantly on the entire health system (Western Cape Government, 2007:3).

Therefore, the significance of the mobile clinic health services in PHC is based on the extent to which it adheres to the above stated motives towards implementing the comprehensive service plan. A significant reduction in outstanding immunisations, skin and intestinal parasites, stunting growth and anaemia in young children when health services are delivered from mobile clinics in rural areas, were identified (Aneni, De Beer, Hanson, Rijnen, Brenan & Feeley, 2013:1). However, while many international studies focused on the health services delivered from mobile clinics, no published research studies could be found on the actual mobile clinic work environment of the staff that is expected to deliver a comprehensive health service to the populations they serve.

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The PHC package of care has changed considerably over the last 20 years. In concurrence with the expansion of PHC services, several new PHC facilities were erected and several more are in the planning in the Western Cape Province (Western Cape Government, 2011:7). However, progress in the mobile clinic work environment is debatable. Professionals in the field of public health care are of the opinion that most of the 90 mobile clinic units that are currently being used in PHC services in the Western Cape are not conducive to ensuring quality health care delivery (Krige, 2010:n.p.; Krige, 2011:n.p.).

The researcher, a Clinical Nurse Practitioner (CNP) with 15 years of experience in the PHC environment, identified that the nine different mobile clinic units she worked in, did not comply with basic pharmaceutical requirements for storage and safekeeping of medicine (South African Pharmacy Council, 2010:13-41). The mobile clinic units also did not provide in the basic needs of staff or the people they served. For instance, the lack of space and safe seating for additional health personnel on the mobile clinic units that have become essential for delivering the prolonged standard of care, hamper the expansion of the mobile clinic health care team. Many mobile clinic units do not have a toilet, running water, air-conditioning, effective ventilation or proper lighting. Concerns about the well-being of the nursing staff working in the mobile clinic units, the quality of health service delivered to people living in remote areas, and the lack of scientific evidence in terms of their work environment, are the reasons for this study.

1.5 PROBLEM STATEMENT

Over the last 20 years, the PHC package of care has expanded considerably. Nevertheless, there are indications that the current mobile clinic work environment is not conducive to the delivering of quality health care. Several factors in this work environment, known and unknown are raising concerns about the well-being of the nurses working in the mobile clinic units and the quality of health service delivered to the many people living in remote areas.

Furthermore, a gap in the knowledge base of the mobile clinic work environment exists. Consequently, in the absence of scientific evidence about the possible factors influencing the delivery of the desired health care, motivation for improvement is hampered.

Therefore, in striving for excellence in mobile clinic health in the Western Cape by the year 2020, it has become essential to explore scientifically the views of nurses about their work environment, address the factors that affect mobile clinic health service delivery negatively and build on the positive ones.

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1.6 RESEARCH QUESTION

The research question that guided this study is "What are the perceptions and experiences of mobile clinic nurses about the work environment of the mobile clinic?"

1.7 PURPOSE OF THE STUDY

The purpose of this study is to explore and describe the perceptions and experiences of mobile clinic nurses about the work environment of mobile clinics.

1.8 STUDY OBJECTIVES

The objectives of the study were to explore and describe:

- the perceptions of nurses about the mobile clinic work environment
- the experiences of nurses about the mobile clinic work environment
- job satisfaction in the mobile clinic work environment

1.9 CONCEPTUAL FRAMEWORK AND THEORETICAL UNDERPINNINGS

A study framework plays a very important role in guiding the development of a research study (Burns & Grove, 2009:126). Anfara and Mertz (cited in Burns & Grove, 2009:542) are of the opinion that a theoretical framework in qualitative research should be described in terms of its use and the effects it has on the qualitative research process.

In a study that is based on propositional statements that result from an existing theory, the framework is called a theoretical framework. However, a study based on a conceptual method is called a conceptual framework (Polit & Beck, 2010:198), where the researcher develops the framework through identifying and defining concepts and proposing relationships between these concepts (Brink, 2006:24).

For this study, Herzberg's Two-Factor Theory of job satisfaction was used to guide the researcher in the exploration of job satisfaction in the mobile clinic work environment. An in-depth discussion of the theory follows in section 2.9.2. Accordingly, his theory, as well as various other factors that could have an influence on the way patients experience mobile clinic health services in the Western Cape, have been identified and incorporated to form the conceptual framework of the study. All these factors are illustrated by means of a rotating cone-shaped figure (Figure 1.1).

Each factor has been ranked on a specific layer of the illustration presented in Figure 1.1 to reflect their weight and interdependence. For example, the outcome of the patient's experience is dependent on all the factors presented in Figure 1.1, and has therefore been

placed at the upper layer of this illustration. The factors related to legislation and ethics were placed at the base as they represent the foundation of the entire mobile clinic health service. Job satisfaction, which influences work performance and thus also the patient's experience, is dependent on the nurses' perceptions and experiences of motivational factors in the workplace.

The arrows in figure 1 indicate the constant interaction among the different layers, directly or indirectly, which eventually influences the quality of care.

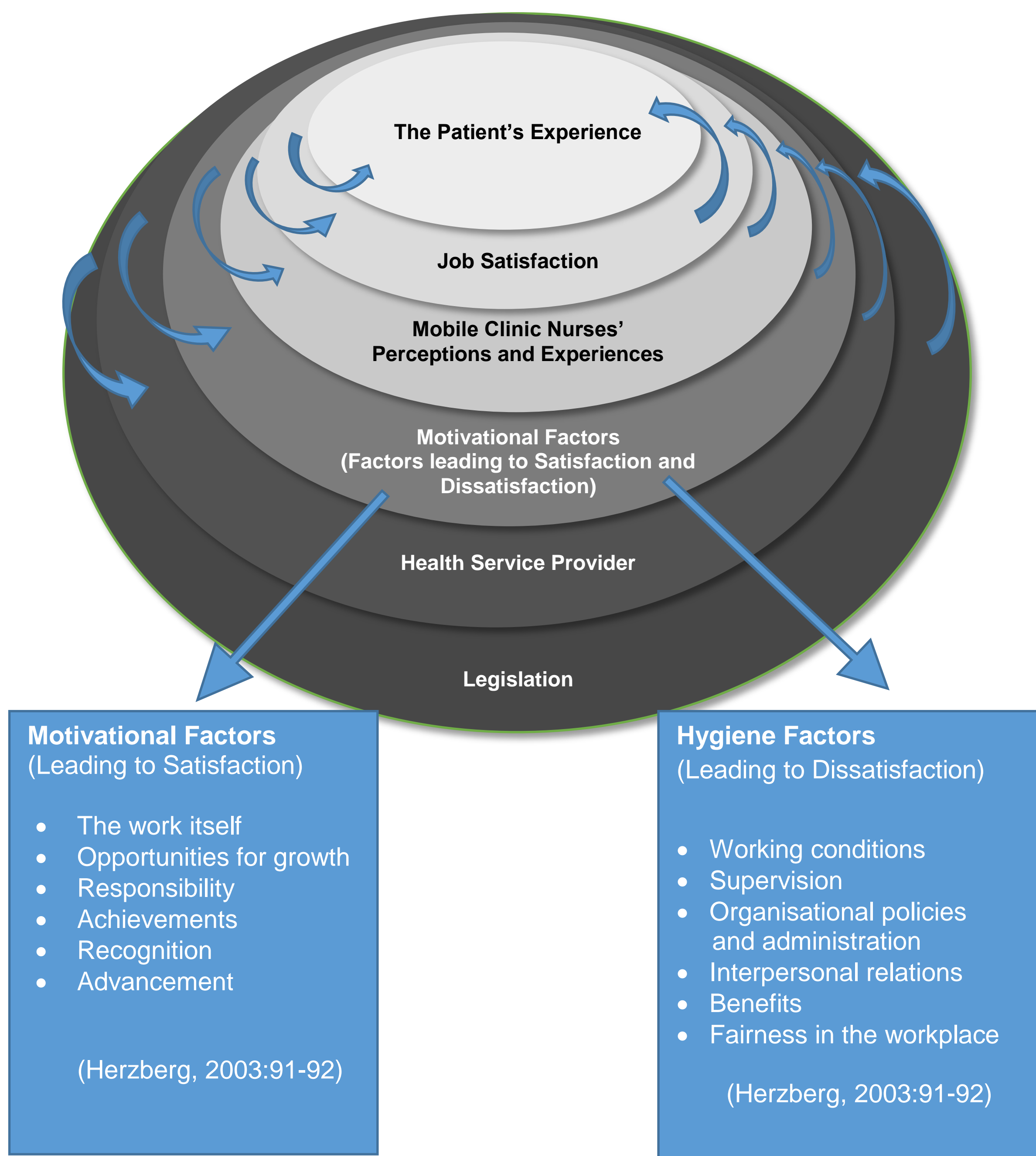

Figure 1.1: Conceptual map for the work environment of mobile clinics

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1.9.1 Conceptualisation of factors influencing the work environment of mobile clinics

1.9.1.1 Legislation

The Constitution is the highest law of South Africa. Thus, all other laws, actions and conduct are liable to the Constitution (McQuoid-Mason & Dada, 2011:70). Furthermore, basic values and principles, which originate from the Constitution, have been developed to support an acceptable policy and legislative framework for public service delivery. One of these principles is associated with the Constitutional ideals of promoting and maintaining high standards of professional ethics (Republic of South Africa, 2002:8). For these reasons, the legislation factors form the basis in conceptualisation of the factors influencing the mobile clinic work environment, as illustrated in Figure 1.1.

1.9.1.2 Health service provider

According to the Comprehensive Service Plan for the implementation of health care 2010 (Western Cape Government WCG, 2007:3), PHC is the foundation of an effective and efficient public health care service, stating that efficiencies and inefficiencies at this level have significant influence on the entire health system. For this reason, the *Health Service Provider* has been placed on the second layer of the illustration presented in Figure 1.1.

1.9.1.3 Motivational factors

According to Frederick Herzberg, there are certain factors in the workplace that, when inadequate, cause employees to be dissatisfied, however, when adequate, the satisfaction is only temporary. These factors are *physical working conditions, supervision, interpersonal relations, organisational policies and administration, and salary*. Herzberg called these “Hygiene factors”, since they are needed to set the foundation for the motivational factors, which are *the work itself, opportunities for growth, responsibility, achievements, recognition, advancement, and fairness in the workplace*. Herzberg called these “Motivational factors”, since they are the actual ones that lead to long-term satisfaction. Setting these factors right in the workplace are thus indispensable for a productive and satisfying work environment (Herzberg, 2003:91-92).

Herzberg’s Two-factor motivational Theory on job satisfaction provided valuable guidance in identifying the factors to be included in this study (see Figure 1.1). Herzberg advised that management should emphasise the factors leading to dissatisfaction to avoid employee dissatisfaction, and give recognition to the factors leading to satisfaction, as these are the true motivators to obtain job satisfaction (Herzberg, 2003:92-93). Due to the direct influence

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the employer has on these factors, it was placed in the layer directly above the layer reflecting factors related to the Health Service Provider.

1.9.1.4 Mobile clinic nurses' perceptions and experiences

The perceptions and experiences of nurses about the work environment of mobile clinics are the key that will unlock the knowledge base needed to fill the gap between current motivational factors and job satisfaction in the mobile clinic work environment. Therefore, exploring these factors is crucial to address the problem this study seeks to investigate.

1.9.1.5 Job satisfaction

According to Herzberg, satisfied workers are an asset to the workplace, while dissatisfied workers are less productive and less committed (Nichols, 2004:1). Herzberg's theory accentuates job enrichment as a motivator. Thus, managers need to ensure that work is stimulating and rewarding, since these factors inspire employees to work harder and perform better (Herzberg, 2003:92-93).

1.9.1.6 The patient's experience

In the striving for "client centred quality of care", as the first principle of the Western Cape Government's vision for quality health care by the year 2020 (Western Cape Government, 2011:12), it was necessary to identify all the components that could have an influence on the patient's experience. Therefore, the client-centred quality of care principle has been presented as a priority to strive for (Figure 1.1).

1.10 RESEARCH METHODOLOGY

In this chapter, a brief description of the research methodology is presented. A more in-depth discussion will follow in chapter three.

1.10.1 Research approach and design

A qualitative, descriptive study design was applied in this study.

1.10.2 Study setting

The study was conducted in three of the five rural health districts of the Western Cape Province which spans from the south-western across to the north-western parts of the province. Interview sites were approximately 260, 150 and 70 kilometres from Cape Town, respectively.

Figure 1.2: Map of the municipalities of the Western Cape (Mobile Health Map, 2009:n.p.)

1.10.3 Population and sampling

The target study population consisted of all the Nurses (approximately 60) who work in 30 mobile clinics in the public health services of the Western Cape Province. A purposive sampling method was used to identify the key informants who participated in this study.

- West Coast District: Cedarberg and Matzikama subdistricts (Figure 1.2)
- The Cape Winelands District: Langeberg and Witzenberg subdistricts (Figure 1.2)
- Overberg District: Theewaterskloof subdistrict (Figure 1.2)

1.10.4 Specific criteria

The only criterion for this study was that participants must have worked in the mobile clinic work environment.

1.10.5 Pilot interview

A pilot interview was conducted by the researcher in the Cape Agulhas subdistrict to test the interview guide as to ensure that the opening question and probes elicit the data required to meet the study objectives.

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1.10.6 Instrumentation and data collection

The data collection instrument included an opening question and probes to collect data during individual interviews and group discussions.

1.10.7 Trustworthiness

The criteria of credibility, conformability, dependability and transferability as proposed by Lincoln and Guba, were applied in this study (De Vos, Strydom, Fouché & Delport, 2011:419-421).

1.10.8 Data analysis and interpretation

For data analysis, a content-analysis approach was followed. Ritchie's steps for data analysis guided the researcher (Ritchie & Lewis, 2003:138-198).

1.11 ETHICAL CONSIDERATION

1.11.1 Consent and Informed Consent – The right to self-determination

Ethical approval for conducting the study was obtained from the Human Research Ethics Committee of the Faculty of Medicine and Health Sciences, Stellenbosch University (Ethics Reference number: S12/12/319) (Appendix 1). Permission to perform the study was obtained from the Western Cape Department of Health (Appendix 2). Each participant received a "Participant Information Leaflet" (Appendix 3) with sufficient background on the intended study to prepare them for informed consent (Appendix 3). The contact details of the researcher and study supervisor were provided in case participants had questions about the research. Participants were only interviewed once individual informed consent was obtained. This informed consent also included permission for interviews to be audio recorded.

1.11.2 Right to protection from discomfort and harm

A potential risk for breach of confidentiality within the Focus Group Discussions and possible victimisation by colleagues or management existed. This risk was minimised with all participants and the interviewer signing the informed consent form, agreeing to confidentiality.

Furthermore, participation was voluntary. All participants were assured that there would be no negative consequences if a participant did not want to be interviewed. They were also assured that they could withdraw from the interview at any time and discontinue participation without penalty. The interviewer would show compassion and kindness towards any participants suffering emotional distress during the interviews. Participation in the research study did not waiver any legal claims, rights or remedies.

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Study participants were not compensated for their participation. However, light refreshments were provided.

1.11.3 Right to confidentiality and anonymity

The rights of the participants were adhered to throughout the study. During the interviews, participants were anonymously addressed, implicating that their names were not to be mentioned in order to enhance the protection of identity and confidentiality. Participants were assured that all discussions were to be handled without referring to their names or any other identifier. All information shared during the interviews were used for the purpose of this study only. They were assured that all possible identifiers would be removed during transcriptions of the audio files and any publication or thesis resulting from the study.

All data is being kept locked and stored, accessible to the researcher only and will only be made available to the supervisor, co-supervisor and research ethics committee upon request. The identified data will be kept as long as possible if there are queries regarding the study method or findings. The original audio recordings will be destroyed as soon as the interviews are transcribed.

1.12 TERMINOLOGY PARTICULAR TO THIS STUDY

The following explanations are provided to assist in understanding the context within which these nurses function.

1.12.1 Mobile clinic

According to an international mobile clinic manufacturer, the term mobile clinic or mobile unit refers to a specific model vehicle, chosen according to the geographical setting where it will be utilised and the purpose of health care services to be delivered from it, e.g. dental care, women's health, diagnosis and screening, ambulatory surgery or primary health care. These factors will direct the engine capacity and the physical size of the vehicle (Mobile clinics international, 2009:1).

1.12.2 Work environment

According to Schmalenberg and Kramer (2008:2-8), a satisfying working environment is a multidimensional, integrated phenomenon. Such an environment will consist of care processes and relationships that are supportive to a physical setting, which will be conducive to higher productivity, harmonious interpersonal relations and reduced absenteeism of workers.

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1.12.3 Primary health care (PHC)

Primary health care, as declared by The Alma Ata, is essential health care "based on practical, scientifically sound and socially acceptable methods and technology", which should be accessible to all individuals and families in a community. It is the people's first contact with the national health system, "bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process" (World Health Organisation, 1978:428).

1.12.4 Comprehensive health services

According to the Comprehensive Service Plan for the Implementation of Health care, (Western Cape Government, 2007:34) the purpose of the Comprehensive Health Services component is the facilitation, implementation, coordination and evaluation of Health Programmes in the subdistricts. The component is subdivided into community-based services, facility-based services, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and tuberculosis (TB), and production units to assist with the execution of tasks.

1.12.5 Perceptions

Perceptions refer to the ability to see, hear or become aware of something through the senses. It is also the way in which something is regarded, understood or interpreted (Oxford Advanced Learner's Dictionary, s.a.:n.p.). One of the objectives of the study was to explore the perception of nurses about the mobile clinic work environment.

1.12.6 Experiences

The word experience refers to practical contact with and observation of facts or events. In the process, knowledge or skills are acquired by a period of practical experience, especially those gained in a particular profession (Oxford Advanced Learner's Dictionary, s.a.:n.p.). Another one of the objectives of the study was to explore the experiences of nurses about the mobile clinic work environment.

1.13 DURATION OF THE STUDY

The duration of the study was from the time of ethical approval, which was 01 August 2013, until completion of the research report, which was December 2015.

1.14 STUDY OUTLAY

Chapter 1: In this chapter the background and rationale of the study, the research problem, the study aim and objectives, as well as the research methodology and conceptual theoretical framework that guided the study, are described.

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Chapter 2: This chapter presents a literature review on issues relating to working in a mobile clinic unit that renders primary health care to indigent communities.

Chapter 3: This chapter describes the research methodology applied in the study.

Chapter 4: In this chapter the findings of the study are presented.

Chapter 5: In this chapter a discussion of the study findings, as well as the study conclusions and recommendations are presented.

1.15 SUMMARY

In this chapter the background, rationale and significance of the study were explained. The research problem, research question, purpose, objectives, conceptual framework and brief overview of the research methodology were described. In the following chapter a detailed literature review on all matters relevant to the study will be described.

1.16 CONCLUSION

Motivated employees are at the core of good performance. Moreover, it is the influence of quality leadership on team building and motivating employees which leads to the success of an organisation (Budica et al., 2009:127). In striving for excellence in mobile clinic health services in the Western Cape by the year 2020, the researcher recognised the need to identify the factors that influence job satisfaction and dissatisfaction and explore the influence of these factors on the functional abilities of mobile clinic nurses.

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CHAPTER 2:
LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter a literature review on mobile clinic health services – internationally, nationally and locally, is described. The value of mobile clinics and lessons to be learned, are emphasised. The types and design of mobile clinic vehicles are investigated. Known barriers in this field and possible factors that could influence job satisfaction and dissatisfaction of mobile clinic staff are described.

2.2 ELECTING AND REVIEWING THE LITERATURE

The aim of the literature review was to analyse and synthesise relevant literature to generate an image of mobile clinic health. Literature was obtained from electronic databases, such as PubMed; internet publications (through Google); journals; various government documents, books and searching through various reference lists. However, paucity of recent literature about the functioning, value and design of mobile clinic units was found, though, as far as possible, the researcher attempted to use literature that was published in the past 10 years.

2.3 MOBILE CLINIC HEALTH SERVICES IN PERSPECTIVE

The provision of health care is a major part of every government's responsibility to its citizens.

Penchansky and Thomas (1981:127) based 'access to care' on five principles: availability, affordability, accessibility, acceptability and accommodation. As each of these principles is intimately related, deficiencies in any one of them by definition, influences 'access to care'.

Access to health care often depends on where one lives. Amidst lower population densities, scarcity of infrastructure and resource-poor health departments, the majority of rural communities do not readily have access to health care. Furthermore, the health services of the rural areas are more generalist, while specialist services are concentrated in the bigger centres. With a tendency to focus only on those who are able to attend the health service facilities and not on all who require such service, access to health care becomes even more compromised (Gaede & McKerrow, 2011:54).

Mobile clinic units are one of the strategies utilised worldwide to seek to address these issues.

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2.3.1 International perspectives

Many disadvantaged people worldwide do not have access to regular health care because of their location. Some live in remote areas, some in slums or deprived regions and others in underserved communities (United Nations, 2010:10; Aneni et al., 2013:1). Many of these are provided sustainable, quality health care by means of properly designed and equipped mobile clinics (Guruge, Hunter, Barker, McNally & Magalhães, 2009:357; Hill, Powers, Jain, Bennet, Vavasis & Oriol, 2014:261).

2.3.1.1 Mobile clinic health services in the developed world

The literature accentuates that the main purpose of the mobile health services is to improve access to health care (McNeal, 2008:122). In this manner, people living in areas where there are no health facilities (Alam, Chongsuvivatwong, Mahmud & Gupta, 2013:228), or where they cannot afford the local health care (Carmack, 2010:1401), are provided with the needed care. Studies have shown that these facts apply in both the developed and the developing world.

a) The United States of America (USA)

In the USA, the world's fifth most developed country (Listovative, 2014:n.p.), in the striving towards improving access to health care, mobile clinics are used to overcome financial barriers, such as the need for health insurance and co-payments (Long & Masi, 2009:582-583). Mobile clinics also eliminate logistical constraints, such as complex administrative processes, difficulties in navigating the health system, making appointments, long waiting times at fixed clinics and problems with transportation (Campos & Olmstead-Rose, 2012:2, 4). Currently, an estimated 2 000 mobile clinics provide free health care to a projected 6.5 million people every year (Mobile Health Map, 2009:n.p.). In urban communities with poor health status, large mobile clinics are often utilized to take health support to the full spectrum of at-risk populations. An antenatal health service accommodated in one of these vehicles, for example, will consist of two examination rooms, lab collection services and an ultrasound machine (Edgerley, El-Sayed, Druzin, Kiernan & Daniels, 2007:235). Community health workers, health educators, nurses and doctors, respectively, staff these clinics (Song, Hill, Bennet, Vavasis & Oriol, 2013:36; Edgerley et al., 2007:235).

b) Australia

In remote rural parts of vast Australia, the world's second most developed country (*Listovative,* 2014:n.p.), technological advanced large mobile health clinics are utilized for improved access to specialist care (McNiece, 2014:1). For example, a routine mobile ear-screening service, which was established in an Aboriginal commune in central Queensland,

uses wireless telecommunication that enables city-based ear, nose and throat (ENT) specialists to assess children at a distance (Smith, Armfield, Wu, Brown & Perry, 2012:485).

Similarly, specialist cardiac and respiratory services are provided by means of a 25m-long semi-trailer with specialist diagnostic equipment and technology, staffed by medical specialists (Arthur, 2014:1). Despite these high technological mobile health services, small mobile clinics are utilized on this continent for the provision of culturally safe PHC with a focus on the early detection and prevention of non-communicable diseases (The University of Queensland*, 2013:1).*

c) Ireland

Whilst small geographically, in Ireland, the eleventh most developed country in the world (*Listovative,* 2014:n.p.), health profiles of the homeless indicate that more and more drug users are becoming homeless. Despite economic growth and a reduction of absolute poverty, the homeless are present with an increase in health needs (O'Carroll & O'Reilly, 2008:452). Subsequently, mobile health services have been established for the homeless and female sex workers of Dublin (Robinson, 2010:5; O'Carroll, 2012:1).

2.3.1.2 Mobile clinic health services in the developing world

a) Saudi Arabia

In Saudi Arabia, mobile clinic health services were established to provide PHC services to people living in the remote and rural parts of the country. However, according to Aljasir and Alghamdi (2010:1085), the Saudi Arabian public's awareness of the mobile clinic services needs to be improved.

b) China

In China, substantial obstacles hamper the provision of quality health care to impoverished and remote communities. Due to inadequate funding for rural health, 90% of the rural population lack health insurance (Brant, Garris, Okeke and Rosenfeld (2006:1). People must pre-pay for health care that is often provided by poorly trained Medici in poorly-equipped facilities. For many, obtaining medical treatment is impossible (Brant, Garris, Okeke & Rosenfeld, 2006:6). Jackson, Sleigh, Peng and Xi-Li (2005:137) stated that one third of farmers receive no medical treatment at all.

Mistrust in health care providers (acceptability), extended travelling times or unaffordable transportation (accessibility) remain realities faced by the people of rural China (Brant et al., 2006:2).

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In July 2003, 1 387 mobile clinics have been distributed in 30 provinces in an attempt to increase the accessibility of medical care for local women. Subsequently an additional 55 mobile clinics were allocated to 55 regions of China's northeast Heilongjiang Province to increase the accessibility of medical services for women and children in this province (Wenjun & Linfei, 2012:1).

c) India

In India, where many people live in extreme poverty, unable to afford food and clothes, health care is a luxury. In this country, 66% of the rural population do not have access to critical medicines and 31% of the population have to travel more than 30 kilometres to access health care. The rural health situation is critical. Moreover, when rural health services become available, they lack trained medical personnel.

It was only when the mobile clinic services reached their communities that people who suffered from illnesses for years, unaware that their condition is curable, received the necessary medical treatment. These commercially sponsored mobile clinic services, such as Wockhardt pharmaceutical company's Mobile 1 000 programme, has the vision of deploying 1 000 mobile clinics in rural India by the year 2017 (Mobile Medical Vans, 2013:1-2).

2.3.1.3 Mobile clinic health services in Africa

a) Egypt

In 1997, the Egyptian government launched a mobile clinic project in an attempt to strengthen its family planning programme. Staffed by a female doctor, two nurses and a driver, free basic health care, which included family planning, antenatal and postnatal care and immunization, were provided. However, according to a study by Al-Attar (2009:1-2) ten years later, mobile clinic usage in northern Egypt is low due to social norms, beliefs and underlying service misconceptions.

b) Ethiopia

Free PHC services, funded by non-profitable organisations, are delivered in this third world country by means of mobile clinics. According to the findings of a study by Stillman and Stong (2008:1) on pre-triage procedures in mobile health clinics in rural Ethiopia, it is essential to communicate the purpose of the mobile clinic service and the scope of services that will be available. Stillman and Stong (2008:7) stated that in setting expectations, it is advisable to involve the local community leaders.

c) Kenya

In rural Kenya, travelling is done on foot. Pregnant women, children and the elderly have to walk long distances in extreme weather conditions in search of medical care. Some forgo medical care or are taken by sick family members on donkeys and cows over rugged terrain to health centres. Frequently people cannot afford the medical service or drugs.

Non-profitable organisations, such as the Zakat Foundation of America, fund three mobile clinics in Kenya. These vehicles are staffed by local doctors and other health professionals who provide clinical examination, diagnosis, treatment and referrals; mobile pharmacy service; family planning, obstetrics and child immunisation; nutrition therapy; HIV-counselling and testing; malaria treatment services (Zakat Foundation of America, 2012:1).

d) Mozambique

In the rural areas of Mozambique, especially those with the highest HIV prevalence, the mobile clinic concept embodies a bold new approach for increased access to health care. The Elizabeth Glaser Pediatric Aids Foundation in co-operation with the US government launched the first three of five mobile clinics in May 2013 in southern Mozambique, the region hardest hit by the AIDS epidemic (Their HIV prevalence is 25.1%).

In central Mozambique, mobile clinics funded by the USA, are utilized for the prevention and treatment of communicable diseases, such as HIV care and treatment, laboratory services for testing CD4 count, syphilis, malaria, and tuberculosis (Manhice, 2013:1).

While many international studies focussed on the health services delivered from mobile clinics, no published research could be found on the evaluation of the physical and practical aspects of the mobile clinic vehicles themselves.

e) South Africa

Since 1994, the South African health sector underwent radical transformation in an attempt to improve the quality, accessibility and cost effectiveness of health care in the country. Yet, with high levels of poverty and unemployment, health care remains largely a burden of the government. About 80% of the population is reliant on public health care, while the government only provides for about 40% of all expenditure on health. Nevertheless, this expenditure consumes as high as 11% of the government's total budget (South African Government, 2012:4-6).

Health care delivery varies from basic PHC, offered free of charge by the government, to highly specialised, state-of-the-art services, offered by both the public and private sector. In some areas, the public health sector is stretched and under-resourced. Many non-

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governmental organisations (NGOs) in cooperation with the government's priority programmes make an indispensable contribution to HIV/AIDS, TB and cancer, disability, mental health and the development of PHC systems. From national to provincial and local level, their role in the individual communities is extremely important for the overall efficiency of the health system (South African Government, 2012:6).

Amid poor telecommunication, poor roads and shortages of doctors, therapists and medicine, access to affordable, comprehensive and good quality health care continuous to be an everyday struggle (Gaede & Versteeg, 2011:100). In contrast to the latter are well-functioning mobile health services that provide in the PHC needs of many people (Tladi, 2015:1). As illustrated in Limpopo and KwaZulu-Natal, the Provincial Government of Limpopo Province maintains 130 mobile clinics in the province's six municipal districts (District and Province Profiles, s.a.:145) and the KwaZulu-Natal Department of Health utilizes approximately 170 mobile clinics in its rural communities (Maxon, 2012:1).

Recently, four new solar-powered mobile clinics, funded by Samsung Electronics, were introduced in the Limpopo province. These units are equipped for specialized health care, such as eye care, dental care, malaria testing or mother-and-baby care (Lob, 2013:1).

In the remote rural areas of the Eastern Cape Province, NGOs work directly with the district health offices and communities to identify convenient locations to optimally utilise their mobile clinics. The original focus on HIV/AIDS and reproductive health has now been expanded to also provide immunization, the treatment of minor illnesses and chronic conditions. Each of these clinics operates with a family health team consisting of two professional nurses, a health promoter and community health workers, providing health education, screening, counselling, treatment or referrals to local health facilities (Miller, 2012:1).

In the Northern Cape Province, where areas with high rates of infant mortality, maternal deaths and HIV/AIDS infection occurs, access to health care is severely limited. Batho Pele health care units take essential health services to the heart of remote communities. Batho Pele is a partnership between the team at Kumba Iron Ore, Anglo American's iron ore business in South Africa, the Department of Health, the tribal council and the local municipality. Eye testing, dental care, surgery and screening services for diseases and infections are brought free of charge to the people. Off-road vehicles transport health units to four sites in the area on a one-week rotation basis. A free bus brings patients from the nearby villages to the health units. In September 2011, the first number of units went into

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operation. From that time, 1 948 patients made use of these services, demonstrating the need of the community (The Guardian, 2012:1).

In the Western Cape public health sector, 131 mobile clinics service people living in small villages and on farms (Abdullah, 2005:246). Recently, the Western Cape Government launched a fleet of five large mobile clinics, called the Wellness Mobiles, as part of their School Health programme. These state of the art vehicles are equipped with solar power, generators, water supply, air-conditioning, a kitchenette and toilet facilities. These wellness mobiles visit schools across the province to test Grade R and Grade 1 learners for TB, screen them for hearing, vision, speech or skin problems and assess their motor skills, mental health and oral health. Each vehicle, staffed by a school nurse, a dentist and an optometrist, is equipped with a consultation room, a dental unit and an optometry unit (Chowles, 2014:1).

2.4 EXPANDING THE ROLE OF THE MOBILE CLINIC HEALTH SERVICES IN ACCESS TO CARE

The literature however, does indicate an expanded role in providing access to PHC. Accordingly, the system of the ability of mobile units to operate independently, to react promptly, its mobility and universality, as well as the fact that it can access the most inaccessible and remote districts, were emphasized by the literature (Kucher, Ziniukov, Terliuk, Maksimets & Zalesskiĭ, 2012:1).

Research studies further indicate that well-functioning mobile clinic services promote the development of trusting relationships (Mayernik, Resick, Skomo & Mandock, 2010:227; Rodriguez, Appelt, Young & Fox, 2007:44; Guruge et al., 2010:350; Crouse, Macias, Cruz, Wilson & Torrey, 2010:227). Patients value the informal, familiar milieu of a mobile clinic with staff with whom they can easily talk to and that helps them to overcome barriers in access to care. A positive, trusting nurse-patient relationship that forms the basis for patient-motivation to make lifestyle changes is found in this scenario (Mayernik et al., 2010:227, 232). The value of the nurse being in the position to view, assess and treat the clients in their immediate home and work environment was already recognised more than 15 years ago (Guasasco et al., 2002:168).

2.5 VALUE OF HEALTH SERVICES PROVIDED BY MOBILE CLINICS

Various international studies concur that health outcomes are improved in cost-effective and culturally competent ways when delivered form mobile clinics (Mayernik et al., 2010:227; Hill et al., 2014:262; Edgerley et al., 2007:235; Smith et al., 2012:485).

The role of mobile clinics in the early detection and treatment of non-communicable diseases was highlighted in a study by Hill, Zurakowski, Bennet, Walker-White, Osman, Quarles and Oriol (2012:406). Their study specifically explains the significance of mobile clinics in the provision of cost-effective chronic disease prevention interventions to low-income men and women in underserved communities.

In South Africa, via the Phelophepa trains, almost 92 000 people have been treated at the PHC clinic (also see par. 2.6.1). More than 15 000 people received basic health education. Between 1994 and 2012, 348 000 children were screened by the dental clinic. More than half a million people received spectacles and more than 400 000 people received counselling at the psychology clinic. This is besides the training opportunities for students of each of the disciplines (The Phelophepa, 2015:1-2).

2.6 MOBILE CLINIC UNITS

2.6.1 Types

According to the literature, there are three major classes of mobile health facilities: mobile hospitals, large mobile clinics and small mobile clinics. Mobile hospitals usually consist of multiple tractor-trailers or oversized expandable semi-trailers, used when there is no established medical infrastructure, as is the case with natural disasters, civil unrest, or warfare. When one of these tractor-trailer containers is converted into a single unit mobile surgical hospital, it becomes much more mobile and accessible to remote geographical areas. These vehicles, however, are suited to areas with a smaller patient demand (Bosman, de Villiers, Froede and Lewis, 2012:21; Weatherhaven, s.a; Odulair, s.a.).

Large mobile clinics are converted busses, trucks, trailers or portable containers, and are generally equipped for specialized care, such as woman's health, dentistry, laboratory or educational health in more densely populated urban communities (Bosman et al., 2012:23; Odulair, s.a.). The combination of multiple rooms, water supply, electrical power and toilet facilities contribute to this class of mobile clinic being the most commonly utilized type worldwide. However, they are not considered as ideal for use in rural or underdeveloped areas (Bosman et al., 2012:23).

In the rural areas, where transportation is limited and a visit to the nearest clinic would take a whole day, small mobile clinics are most commonly utilized. These are usually converted panel vans or pick-up trucks that are equipped to accommodate a variety of PHC services (Bosman et al., 2012:23).

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Some unique interventions using mobile clinics have materialized. One such intervention are the Phelophepa ("Good, clean health") trains that operate as mobile healthcare hospitals in the rural parts of South Africa. Although the main purpose of these trains is the provision of health care. It also serves as training institutes for final-year nursing, optometry, psychology, dental and pharmaceutical students. Staffed by 20 permanent staff members, 16 contracted security officials, 40 students and numerous volunteers, a variety of health and educational services are provided (SA info reporter, 2012:n.p.). Apart from the six on-board clinics which deliver PHC, pharmacy, educational, dental, eye and psychology services respectively, each clinic has an outreach programme for surrounding schools and residential areas (The Phelophepa, 2015:1-2).

2.6.2 Unit design

No international literature dealing with research into the design aspects of mobile clinics could be found. In South Africa, many mobile clinic units in use to this day were designed in the 1980's. These are technically out-dated, incapable of travelling in the rough terrain and roads in rural areas and unable to accommodate the present range of PHC services to be provided. However, some health departments are in the process of replacing the older units with ones that are better equipped: having electrical power, water source, are ergonomically designed and are environmentally friendly. The fuel consumption is much improved and the vehicles are more manoeuvrable. Furthermore, two patients can be simultaneously examined (Maxon, 2012:1-2.).

Also in the Western Cape in South Africa, Public Health Services are working towards improving the current mobile clinic concept. Towards this end, the Western Cape Medical Research Council (MRC) and the Western Cape Department of Health in collaboration with Stellenbosh University and Global Engineering Teams (GET) redesigned and built a new mobile clinic unit during 2012 and 2013 (Bosman et al., 2012:1).The needs for future mobile clinics identified by Bosman et al. (2012:32) are set out in table 2.1.

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Table 2.1: Identified needs for future mobile clinics

Needs for future mobile clinics
Internal climate control
Ample work space and storage space
Improved ventilation and containment
Power steering
Cooled storage for medication
Increased range of health care services
Improved sanitation and ablutions
Robust internal clinic design
Self-sustained electrical supply
Provision for a third staff member
Improved patient privacy
Emergency communication equipment
Emergency first aid box
Access from cab to clinic

(Bosman et al., 2012:32)

The main objective during selection was to identify a vehicle that would accommodate the needs of the users, as listed in Table 2.1. Accordingly, when comparing the 18 candidate vehicles, the Volkswagen Crafter (35 2.0 TDI PV MWB SHR) scored the highest marks (Bosman et al., 2012:54, 60). This vehicle has been tested in the field of remote rural health during 2014 and 2015. The drivability of the vehicle, access from the driver's cabin to the clinic area and ample workspace were found to be major improvements. Likewise, the air conditioner in the clinic area and fridge were long-awaited contributions. However, various needs listed in Table 2.1 and described in the designers' report, were not followed when constructing the interior of the clinic area. It was thus recommended that a new vehicle be utilised for reconstruction of the interior and that futuristically, there should be more interaction with the nurses working in the mobile units and the people constructing the interior (Krige, 2015:n.p.).

2.7 BARRIERS

The barriers to quality health care in the mobile health clinic environment that were identified from the literature were staff shortages and shortcomings in the safekeeping of medicine.

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2.7.1 Shortages of Health Professionals

The shortage of skilled health care professionals in South Africa has been a well-stated issue for years. Shocking vacancy rates in the public health sector undermine strategies to improve health care delivery, such as the proposed national health insurance scheme. According to the South African Institute of Race Relations' 2012 survey on health and social security in South Africa, 56% of doctors' posts and 46% of nurses' posts were vacant. In the Eastern Cape, one of the poorest provinces in the country, 67% of nurses' posts were not filled. Even in the Western Cape, one of the wealthiest provinces, 40% of doctors' posts and 34% of nurses' posts were vacant (Kahn, 2013:1). Furthermore, of the 38 236 doctors registered with the Health Professions Council of South Africa in March 2012, 73% are working in the private sector (South Africa Government, 2012;1). The implications of these shortages on the public health sector is that there is only one doctor for every 4 211 people, which is significantly less than the projected doctor-to-population ratio of three doctors for every 4 000 people. There is also only one nurse for every 902 people (Kahn, 2013;1).

In a contrary view, Daviaud and Chopra (2008:46-47) state that the national shortage of professional nurses in PHC is only 6% and enrolled nurse auxiliaries, 17%. "The inefficient use of professional staff" is rather the problem according to them. Their research indicates an inequality in the allocation of "the right quantity of the right categories of staff" amongst PHC clinics. For example, some districts have no doctors at all in PHC settings, similarly, counsellors were found to be unequally allocated between facilities, with many health services having no counsellors at all.

Furthermore, with regard to poor health outcomes comparing peer countries, productivity levels, health strategies and the management of resources are under question (National Department of Health, 2011:9). It is thus more than just the availability of professionals in the health sector that requires attention.

Currently, the mobile clinic units in the Western Cape operate with one clinical nurse practitioner (CNP) or registered nurse and one enrolled nurse or enrolled nursing auxiliary each, as there are only two seats with safety belts in most of the vehicles (Heslop, 2010:n.p.). In the Winelands region of the Western Cape, approximately 4 800 people residing in some of the areas benefit from the mobile clinic services. At some of the mobile clinic service sites, a comprehensive package of PHC services is provided to an average of 76 people per day (Information Management, 2010/2011:2).

Worldwide, mid-level health workers, such as the Clinical Nurse Practitioners in South

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Africa, are increasingly utilized as a strategy to overcome physician shortages and improved access to health care in the remote rural areas of low- and middle income countries. Furthermore, the WHO identified this cadre as a possible solution to the health workforce crisis in achieving the health-related targets of the Millennium Development Goals. When adequately trained, supported and supervised, their role in the delivery of essential health services (including maternal and child health, HIV and other priority conditions), similar in quality standards as physicians, become profoundly recognised. Accordingly, the WHO commended that mid-level health workers should be included in the overall planning and management of health systems and that these workers should equally benefit from support, supervision, quality control and career development opportunities (World Health Organization (WHO), Global Health Workforce Alliance, 2010:5, 7).

In South Africa, within the national shortage of doctors, the Department of Health has introduced mid-level health care providers (South African Government, 2012;1). According to the WHO, mid-level health providers are trained at a higher education institution for at least 2-3 years. They are then qualified and authorized to work autonomously to diagnose, manage and treat illness, diseases and injuries (including surgery, if appropriately trained), prescribe medicines, as well as provide preventive and promotive care (WHO, Global Health Workforce Alliance, 2010:8). Mid-level health professionals' scope of practice varies significantly across countries, usually in response to the specific health needs of a country (Wildschut, Manamela, Huicho, Lassi, & Bhutta, 2013:2). Consequently, they have many different titles, e.g. physician assistant, clinical officer, pharmacist, or nurse practitioner (WHO, Global Health Workforce Alliance, 2010:8).

South Africa has a nurse-based health care system with 80% of the major group of health professionals consisting of nurses (National Department of Health, 2011:9). This nursing labour force is considered essential for the deliverance of quality health care (Oyetunde & Ayeni, 2014:599). As human resources are the most important resource in health service delivery, the National Department of Health indicated that concise and coherent policies and practices need to be put in place to develop and sustain the human resource capacity of the health sector (National Department of Health, 2011:6).

2.7.2 Safekeeping of Medicine

The Good Pharmacy Practice in South Africa guideline stipulates the minimum standards for mobile pharmaceutical services as follows: temperature, humidity and light in the unit must be in accordance with the requirements of storage of medicine (South African Pharmacy Council, 2010:26, 27). Temperature-sensitive medicines need to be stored according to the instructions of the manufacturer (South African Pharmacy Council, 2010:13). Most licences

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specify storage and transport of manufactured drugs at temperatures up to 25°C. If exposed to temperatures above that, the efficacy of medicine could be adversely affected (Crichton, 2004:n.p.). As an example, benzyl penicillin injections, ampicillin, erythromycin and furosemide for injection has shown significant reductions in activity after a year. The dissolution rate for diclofenac tablets was reduced significantly in as little as three months. Therefore, an air-conditioner in good working order must be installed in the dispensing area (South African Pharmacy Council, 2010:15, 38, 41).

To limit extreme temperatures, legislation makes it clear that the side panels and ceiling in mobile units must be insulated with double-sided panels and cross-ventilation (South African Pharmacy Council, 2010:27). Since temperature control inside a mobile unit is easily disrupted because of the large entrance door, it is important that medicine drawers be large enough to allow for orderly packing and proper stock rotation (South African Pharmacy Council, 2010:41).

The same requirements for working surfaces, cupboards, shelves and equipment in fixed clinics, are valid for mobile units (South African Pharmacy Council, 2010:27). Therefore, the walls, ceiling, window frames, floors and working surfaces must be of smooth waterproof, washable material – easy to be kept clean and to maintain in a hygienic condition (South African Pharmacy Council, 2010:37-38). There must be a hand washbasin with running water, as well as a closable rubbish bin with a lid, a bio-hazardous materials bin and sharps container (South African Pharmacy Council, 2010:23), placed in a safe, but easy accessible position.

For safekeeping of medicine and infection reasons, the mobile pharmaceutical service standards stipulate that medicine must not be kept on the floor (South African Pharmacy Council, 2010:58).

2.8 THE ADVANTAGES OF INVESTING IN MOTIVATED EMPLOYEES

Motivated employees are essential for goal realization in a company. When motivated, employees are more creative and willing to do their best. Moreover, when personnel believe a task is important and valuable, they will act with dedication and enthusiasm. When the balance between ability and willingness is achieved, increased productivity, lower operational costs and an improvement in efficiency results (Silberman, 2013:1-3).

Since motivation relates to the psychological processes that stimulate enthusiasm and perseverance in goal reaching, managers need to understand these processes to effectively direct employees towards organizational goals.

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In an attempt to identify the internal factors that motivate people, it is necessary to look at the needs (psychological or physiological inadequacies) of people that incite some type of behavioural response (Hartzell, 2013:2-3).

2.9 MOTIVATIONAL THEORIES

2.9.1 Maslow's hierarchy of needs theory

Abraham Maslow said that motivation is the outcome of a person's attempts to fulfill five basic needs: physiological, safety, social, esteem and self-actualization (McLeod, 2014:1-2). He defined growth as the incessant development of talents, abilities, creativity, wisdom and character, all processes that bring a person closer to self-actualization. Against this background Maslow explained that the higher needs only emerge when the lower needs are satisfied, which indicates that the higher needs are weaker than the lower ones. The deficit principle in this theory is that once a need is satisfied, it is no longer a motivator (Sengupta, 2011:103-104). The relevance of these needs in the workplace is as follow:

Physiological needs are essential for human survival and include air, water, shelter, food, clothing and sleep. In relation to the workplace, personnel require comfortable working conditions, reasonable working hours and time to eat, drink and use the bathroom.

Safety needs refer to a sense of security and well-being. They embrace personal and financial security, good health and protection from accidents, harm and their adverse effects. Safe working conditions include fair work practices, a stable emotional environment, job security and secure compensation, such as a salary, benefits and pension (Hartzell, 2013:2-3;Tanner, s.a:2).

Social needs signify the need for a sense of belonging and acceptance. It is beneficial for employees to get to know one another, experience cooperative teamwork, have accessible and kind supervision, and have a good balance between work and other aspects of daily life.

Esteem needs are the desire for self-respect, recognition and respect from others. Managers are required to attend to the esteem needs of their subordinates by giving praise and recognition for work well done and by offering further responsibility and advancements, and in this manner, demonstrating to subordinates that they are valued workers. Tanner (s.a.:2) added recognition for issues such as prestigious job assignments, job titles and nice workspaces.

Self-actualization needs refer to a person's need to reach his or her full potential. This need is met through challenging work, participating in decision-making and acknowledging insight.

It also embraces flexibility and autonomy in employment (Hartzell, 2013:n.p.; Tanner, s.a.:n.p.).

2.9.2 Herzberg's Two-factor theory

Frederick Herzberg said that the things that make people feel satisfied and motivated about their jobs are different in kind from the things that make them dissatisfied. These factors are thus not opposites of each other, but two different sets of factors causing job dissatisfaction (hygiene factors) or job satisfaction (motivational factors), respectively (Herzberg, 2003:91-92).

2.9.2.1 Hygiene factors

The hygiene factors refer to the job context, the circumstances in which a scope of practice is to be performed. When present, current levels of production and efficiency are maintained. However, when absent, it leads to dissatisfaction. It does not lead to satisfaction in the long-term (Herzberg, 2003:91-92).

i Organisational policies and administration

Policies are predetermined, consistent guides that reflect the core values and principles of an organization. It is the strategic linkage between the vision of a company and its day-to-day activities and is important as it offers a sense of autonomy in the workplace. It also provides uniformity and stability to the employee, as well as legal protection (Welling, 2011.1). For these reasons, health organizations should update their internal policies every time new patient protocols, technologies or other novelties are implemented (*Bianca, s.a.:1).*

ii Supervision

According to Schmalenberg and Kramer (2008:12), an excellent nurse working environment is one in which nurse leaders arrange for the right structures, practices and people. In such an environment clinical nurse practitioners will be able to do things correctly, meaning, producing desired outcomes for patients, staff and the organisation.

Supervision is about overseeing the doings of subordinates, to make sure that they are in line with the policies, objectives and goals of the organization (Jennings, 2010:n.p.). It is also about setting individual goals, evaluating performance and behaviour and helping employees grow and develop (Bock, 2009:n.p.). Supervision, as one of the essential roles that nurse managers have to fulfil, is vital for the overall growth and effectiveness of an institution. A lack of supervision in the workplace has a far-reaching negative impact on employees' feelings of safety, their morale and eventually job satisfaction and productivity (Jennings, 2010:1).

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iii Interpersonal relations

According to the findings of a study by Pitaloka and Sofia (2014:10), a good communication climate promotes social interaction with superiors and co-workers. Maslow classified it as a social need that signifies a need for belonging and acceptance. Billikopf (2006:1) sees it as crucial for the development and maintenance of trust and positive feelings in an organization and Nur Aisha, Hardjomidjojo and Yassierli (2013:605), regard working experience as one of the elements of working ability. The importance of good interpersonal relations in the workplace is thus clear.

However, according to Herzberg (2003:91-92) the value of good interpersonal relations in the workplace is to set the foundation for the motivational factors.

iv Working conditions

According to a study by Nur Aisha et al. (2013:605), working conditions and motivation have a statistical significant effect on employee performance. It was found that employees are not encouraged to work when facilities lack the necessary standards and support. When workers are confronted with an overload of work, the tendency is that the quality and quantity of their work performance will decrease. Furthermore, in these circumstances, employees lack motivation to show up for work or practise good time management.

Nur Aisha et al. (2013:609) recommend that managers maintain the optimal workload for each job with the necessary adjustments in the job description of the employees.

v Benefits

The majority of people in the world earn more or less a minimum wage. For some, even this might not be enough to cover their family's basic physiological, safety and even social needs. Therefore, the weight of money as motivator depends on the scope, the type of employees and how their basic needs are covered (Correa, s.a).

According to Maslow's hierarchy of needs, the presence of one need usually rests on the preceding satisfaction of another, more powerful need. Therefore, self-actualization and esteem needs cannot be satisfied with money (Maslow, 1943:370).

Herzberg's Two-factor Theory holds that an inadequate remuneration package may lead to employee dissatisfaction (Herzberg, 2003:91-92). In view of this, Van Wyk (2011:110-111) is of the opinion that employees should be encouraged to have discussions with management to address remuneration related concerns and to prevent dissatisfaction due to inaccurate expectations.

vi Fairness in the workplace

Fairness in the workplace is crucial to healthy employee-employer relationships. When people believe they are being treated fairly, feelings of happiness stimulate an increase in the levels of the 'feel good' neurotransmitter, dopamine (Soderland, 2010:1; Bergland, 2010:1). In such cases, people are less likely to reject requests that are of little value to themselves.

Soderlund (2010:1) states that there is a relationship between fairness and trust which will change with mood. Therefore, a person who is in a bad mood will be less tolerant of unfair treatment. Such a person will easily be emotionally aroused in which case stress hormones are released. When people are forced to control their emotions in the midst of inequity, their physical energy gets absorbed by coping with the emotional stress. This will negatively affect their ability to work effectively. They will lose devotion to do great work and will need intervention to calm their emotional state of mind. Therefore, the human mind is deeply affected by inequity. Fairness and communicating clearly without assuming something is fair will activate reward regions in people's minds. Soderlund (2010:1) emphasizes the need for greater attention on these matters.

2.9.2.2 Motivational factors

According to Beecham (2014:269), irrespective of where people work, it is the strength of their needs and the likelihood that these needs will be met by a given task that will determine the energy and enthusiasm they will disburse on the task. In view of this, managers need to balance three things: the task, the environment and the characteristics of the person.

Herzberg's Two-factor motivational theory implicates that an unfortunate work environment gives rise to dissatisfaction, while better working conditions seldom brought about improved attitudes. Instead, satisfaction often comes from factors intrinsic to the job, such as achievements, recognition, challenging and interesting work, and responsibility. Herzberg based his theory on various human needs that he applied to a strategy of job enrichment. This strategy has widely influenced motivation and job design strategies (Herzberg, 2003:91-92).

i Opportunities for growth and development

Van Wyk (2011:111) states that recruitment through the ranks is more desirable than external appointments. Therefore, employees should be prepared for a next position through on-going training, development and mentorship programmes. To create a sense of fairness amongst employees, they should receive equal opportunity for development and be informed about future opportunities to prevent a spirit of demotivation.

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Van Wyk (2011:114) further states that improvement of employees' skills will greatly enhance their expectation that effort will lead to desirable performance. Important though, effort cannot lead to performance if the skills and ability to transfer input into output is absent. It is thus imperative that every employee is continuously monitored and developed in all areas of employment. With on-going training their abilities and possibility of future advancement within the organisation will be enhanced.

ii The work itself

According to Bjerneld, Lindmark, McSpadden and Garrett (2006:49) the work itself relates to an employee's scope of practice. Walker and Miller (2009:184) added that the answer to motivation lies in the work itself. They said that when a job is enriched with opportunities for achievement and growth, employees are more motivated to perform better.

Consequently, the work must be stimulating and rewarding because, when job-enrichment is accentuated as a motivator, employees' skills and competencies are utilized to the maximum and the quality of work can be improved (Herzberg, 2003:91-92).

iii Responsibility

To be given responsibility gives rise to a sense of achievement and work satisfaction, as it puts a worker in the position to improve the work. It is the most lasting of all of Hertzberg's positive motivators (Blair, 1992:3).

iv Achievement

In order to motivate employees, there must be opportunities for achievement in the job (Herzberg, 2003:91-92). Usually, management sets the targets for achieving the provincial health goals. However, when these targets are too high, the subordinates may experience a feeling of failure, and when they are too low, the subordinates may lack motivation. Employees that are pressured to perform just a little bit better than average, will realise that their supervisor believes in their abilities to meet the departmental health goals. This *relationship of trust* is a motivator in itself. However, when management does not listen to the needs of the employees, the relationship of trust is broken and goal reaching becomes problematic (Blair, 1992:2).

v Recognition

According to Blair (1992:2) *recognition* is associated with feeling appreciated. When a task is performed well but is ignored, especially by management, the employee will not bother to do it so well the next time. The resulting message for the team will be that "no one cares".

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Van Wyk (2011:112) recommends that achievement which results from desired behaviour be recognised and praised. A standard recognition and praise process should be in place in the workplace that is to be applied consistently to prevent feelings of unfairness. Recognition can be intrinsic or extrinsic. It is the managers and supervisors' responsibility to determine what form of recognition the team will value. Furthermore, it is recommended that achievements be classified into different categories that are based on the overall value attached to each achievement (Van Wyk, 2011:112).

Thus, recognition, as is achievement, is considered crucial for team motivation and goal reaching.

vi Advancement

Long-term opportunities include salary raises, promotion and job prospects, whereas the acquisition of new skills, broader experience and increased responsibility, are categorized as short-term advancements. The team members will be looking for the former, but the manager needs to persuade them that the short-term matters are needed for the desired long-term advancement (Blair, 1992:3).

2.10 LEGISLATION

There are a number of Acts and regulations that govern the health practices within the mobile clinic work environment. This legislation applies to mobile clinic nurses at two distinct levels; firstly, as citizens and employees in their own right and secondly, as health professionals working within policies and scopes of practice.

2.10.1 Constitution of the Republic of South Africa (Act 108 of 1996)

The Constitution of the Republic of South Africa (Act 108 of 1996) is considered a cornerstone of democracy in South Africa. *The Bill of Rights*, as concluded in chapter 2 of the Constitution, protects the fundamental human rights of all people in the country and upholds the democratic values of human dignity, equality and freedom. The following rights in the Bill of Rights are of particular significance to the healthcare environment: fair and equal treatment, respect and protection of dignity, fair labour practices, freedom of conscience, a healthy environment, security of the person, access to health care within available resources, life, privacy and basic nutrition, health care and social services for children. Consequently, a breach of a patients' constitutional rights may result in a breach of the National Health Act, 2003 (Act 61 of 2003) or the common law and lead to possible legal action (McQuoid-Mason & Dada, 2011:33-34).

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2.10.2 National Health Act, 2003 (Act 61 of 2003)

The term 'health care personnel' as contained in the National Health Act, applies to all health care providers and health care workers in the Republic of South Africa. Accordingly, all nurses registered in terms of the Nursing Act, 2005 (Act 33 of 2005), are liable to the National Health Act (McQuoid-Mason & Dada, 2011:138).

2.10.3 Nursing Act, 2005 (Act 33 of 2005)

In South Africa, the Nursing Act governs the nursing profession by means of the South African Nursing Council (SANC). The Act consolidates and amends all laws related to the professions of PNs, midwives, ENs, ENAs and midwife auxiliaries and SANC governs all aspects of the nursing profession - from education to registration to professional practice. Nurses have a responsibility to keep up to date with the policies and regulations of the Council (McQuoid-Mason & Dada, 2011:205-207).

Nurses should realise that they have an obligation to provide nursing care within the legal framework. It is therefore crucial that they know their scope of practice and acts and omissions, as stipulated in SANC regulations 2598 and 767 (SANC, 1985 as amended).

2.10.4 Pharmacy Act, 1974 (Act 53 of 1974)

In the PHC environment, the Medicines and Related Substances Act, 1965 (Act 101 of 1965) (s 29(3)(a) of the Pharmacy Act and the Nursing Act, 2005 (Act 33 of 2005) (s 56(6) regulates the keeping of medicines and the supply of medicines to patients by nurses (McQuoid-Mason & Dada, 2011:217-218).

2.10.5 Public Service Act, 1994 (Proclamation 103 of 1994)

The conditions of employment regarding the public services are governed by the Public Service Act. The terms and conditions are approved by the Public Service commission. Thus, nurses working in the public services have to comply with the terms and conditions imposed by the Public Service Commission (Mason & Dada, 2011:237).

2.10.6 Labour Relations Act, 1995 (Act 66 of 1995)

The Labour Relations Act provides a framework within which employers and employees can negotiate on issues of common interest. It promotes orderly collective bargaining, worker participation in decision making in the workplace and effective solving of disputes. Its main purpose is to advance economic development, social justice, labour peace and democracy in the workplace. Accordingly, it protects workers against potential abuse by the employer. Thus, when nurses have disputes with their employer, they can solve these with assistance from their trade union, the Department of Labour, the local bargaining council or approach

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the Commission for Conciliation, Mediation and Arbitration's office for assistance (McQuoid-Mason & Dada, 2011:165-166).

2.10.7 Basic Conditions of Employment Act, 1997 (Act 75 of 1997)

As its name states, this Act regulates the basic conditions under which workers may be employed in South Africa. Accordingly, this Act reinforces the right to fair labour practices, as contained in the Constitution of the Republic of South Africa, 1996. Matters such as working hours, overtime and leave are covered by this act (McQuoid-Mason & Dada, 2011:29).

2.10.8 Skills Development Act, 1998 (Act 97 of 1998)

The Skills Development Act provides an official framework for the formulation of workplace strategies to develop and improve the skills of the employees. Thus, nurses may request skills training workshops which can be funded by the Sector Education and Training Authority (SETA) responsible for healthcare personnel.

2.10.9 The Occupational Health and Safety act

The Occupational Health and Safety Act regulates the health and safety of all workers in the workplace (McQuoid-Mason & Dada, 2011:208-209). Environmental Regulations for Workplaces (1987) addresses the physical conditions of the work environment, including thermal requirements, lighting, windows, ventilation, fire precautions and means of exit. Facilities Regulations (1990) dictate sanitary facilities, toilets, bathrooms, dining facilities, drinking water, as well as the conditions of these facilities, all part of the work environment. The General Administrative Regulations (2003) refer, among others, to health and safety committees, and the General Health and Safety Regulations (1986) refer to personal protective equipment and facilities and working in confined spaces (Boshoff, s.a:1).

2.10.10 Compensation for Occupational Injuries and Diseases Act, 1993 (Act 130 of 1993)

This Act provides compensation for disablement caused by occupational injuries sustained or diseases contracted by employees during the course of employment, or for death resulting from such injuries or diseases. Important though, is to report such injuries or diseases as soon as possible - verbally or in writing, proof of causality, identifying the source of injury and keeping to the prescribed timelines (McQuoid-Mason & Dada, 2011:56-57).

2.11 SUMMARY

The aim of the literature review was to analyse and synthesise relevant literature as to generate an image of mobile clinic health services. Accordingly, international and local perspectives have been viewed. Specific focus has been placed on the value of mobile

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clinics in the provision of health care and insights gained from other research. Known barriers in this field were addressed and possible factors that could influence job satisfaction and dissatisfaction were described according to the literature. Legislation relevant to the mobile clinic work environment has also been viewed.

2.12 CONCLUSION

'Access to care' is based on five principles: availability, affordability, accessibility, acceptability and accommodation. In reviewing the literature, it became evident that mobile clinics fulfil a crucial role in impoverished communities' access to essential health care. For many people living in the most inaccessible communities of the world, the mobile clinic services are their only means of access to sustainable health care.

With inadequate access to health care, treatable diseases such as HIV and TB, and non-communicable diseases will go undiagnosed, contributing to many people only receiving care at an advanced stage of disease. Accessible health care promotes health seeking and enables patients to become more active in their own health care plan.

The adequate design of vehicles for the tasks and services is an integral component of the success of mobile health clinic interventions. Also, imperative to quality service provision is job satisfaction, staff attitudes, motivation, training and the development of the personnel.

In the next chapter, the methodology applied to explore the perceptions and experiences of nurses about the mobile clinic environment, is set out.

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CHAPTER 3:
RESEARCH METHODOLOGY

3.1 INTRODUCTION

In this chapter the research plan, as set out in chapter one is discussed in more detail. This entails the research process that was followed to explore the perceptions and experiences of nurses about the work environment of mobile clinics. Subsequently, the purpose, objectives, research question and research methodology are described.

3.2 PURPOSE OF THE STUDY

The research purpose is generated from the research problem. According to Brink (2006:59), it defines clearly and concisely the aim of the study, and according to Burns and Grove (2009:78), it directs the development of the study.

The purpose of this study was to explore and describe the perceptions and experiences of nurses about the work environment of mobile clinics.

3.3 STUDY OBJECTIVES

Research objectives are clear, concise, declarative statements, the one-by-one steps that need to be taken to accomplish the purpose of a study (Brink, 2006:79; De Vos et al., 2011:94).

The objectives of the study were to explore and describe:

- the perception of nurses about the mobile clinic work environment
- the experiences of nurses about the mobile clinic work environment
- job satisfaction in the mobile clinic work environment

3.4 RESEARCH METHODOLOGY

3.4.1 Research approach and design

Since the purpose of this study was to explore and describe the perceptions and experiences of mobile clinic nurses about the mobile clinic work environment, a qualitative approach with a descriptive design was followed.

According to Burns and Grove (2009:51), qualitative research is a systematic, subjective approach that enables the researcher to describe and give significance to life experiences. It

also enables the exploration of the depth, richness and complexity inherent in phenomena and thus increases insight in the phenomena. The research design of this study is supported by De Vos et al. (2011:96) who state that in descriptive designs the specific details of a situation, social setting or relationship are presented, enabling the researcher to rigorously examine phenomena and the deeper meaning thereof. The researcher starts with a well-defined topic and conducts research to describe it accurately. The qualitative approach enables an even more intensive examination of phenomena, which leads to a more in-depth description.

3.4.2 Population and sampling

According to De Vos et al. (2011:223), *a population* is the totality of persons with whom the research question is concerned. The population for this study is thus the entire group of nurses who work in the 90 mobile clinics in the public health services of the Western Cape Province. The target population is the entire group of individuals who meet the sampling criteria (Burns & Grove, 2009:724). The target population for the purpose of this study consisted of all the nurses who worked in the mobile clinic sector of five subdistricts purposely chosen from three districts. The population was chosen on grounds of accessibility and sample characteristics. A purposive sample with a sample size of 19 mobile clinic nurses was thus drawn from five subdistricts that provide a wide range of geographical challenges to a mobile clinic. Purposive sampling provides the researcher with the richest data; therefore this was the most appropriate sampling method for the purpose of this study (De Vos et al., 2009:391-392).

The following five subdistricts were purposively chosen from the three districts:

West Coast District:

- Cedarberg subdistrict was chosen for its remote communities in a vast landscape of coast and mountain.
- Matzikama subdistrict was chosen to enlarge the data source of the West Coast District, which supports the vastness of the Western Cape Province.

Overberg District:

- Theewaterskloof subdistrict was selected for its densely populated farm communities and many seasonal workers.

The Cape Winelands District:

- Langeberg subdistrict was also chosen for its densely populated farm communities and to enlarge the geographical study area.

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- Witzenberg subdistrict, that combines the aspects of vastness and many seasonal workers, was chosen for the confirmation of data saturation in the study.

In this study the intention was to explore variety in the mobile clinic environment and not to compare the different subdistricts. Therefore, shortcomings were discussed as deficiencies in the mobile clinic work environment as a whole and not as that of a specific subdistrict.

3.4.3 Specific criteria

The only inclusion criterion for this study is that participants must be working in the subdistricts as defined for the purpose of this study.

3.4.4 Pilot interview

According to de Vos et al. (2011:237), a pretest or pilot interview is done to refine the methodology. It identifies problems with the design, determines whether the sample is representative of the population or whether the sampling technique is effective. It tests for reliability and validity of the instrument (interview guide) and refines the data collection plans.

The pilot interview was undertaken in the Cape Agulhas subdistrict (Overberg district) by means of a semistructured individual interview with a Clinical Nurse Practitioner who complied with the selection criteria. Since the data of the pilot interview was not to be included in the study, the researcher conducted the interview herself.

The pilot interview was valuable as it gave the researcher experience with the subjects, setting, methodology and method of measurement, especially the interview guide that is the data collection instrument. The inclusion of the various elements of Herzberg's Two-Factor Motivational Theory in the interview guide was found to provide a good foundation for guiding effective time management and eliciting data that supports the objectives of the study.

At the time of the pilot interview, no problems were found with the methodology as set out.

3.4.5 Study setting

The study was conducted in three of the five rural farming health districts of the Western Cape Province, stretching from the south-western to the north-western parts of the province. Interview sites were approximately 260, 150 and 70 kilometres from Cape Town, respectively.

The participants preferred to be interviewed during office hours. Accordingly, the interview venue that was most convenient to the study participants were the official offices of the nurses in the various towns from where they operated the mobile clinic services. It provided

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for an informal, non-threatening interview setting, where participants could participate in the interviews freely, uninterrupted and with confidentiality.

3.5 DATA COLLECTION

According to LoBiondo-Wood and Haber (2014:274), the data collection process is of critical importance to the success of the study. In the absence of high quality data collection techniques, the accuracy of the research conclusions is threatened. In planning the process, the researcher was guided by the following five questions: what data, how to collect it, who will collect it, where to collect it and when to collect the data? (Brink, 2006:141).

Data was collected during a six-week period from 14 February 2014 to 27 March 2014 at a time and venue most convenient to the study participants in the subdistricts defined for this study (as set out in par. 1.10.3). Most interviews were conducted in the morning before the participants departed on their various routes into the rural communities. In addition, interviews were also conducted on Fridays, a day set aside for non-clinical nursing obligations in the mobile clinic environment.

The number of participants that showed up at each data collection event influenced the decision of whether a group discussion or individual interview had to be used to collect the required data. Participants could select the one most preferable. Conversations were presented in both English and Afrikaans, however Afrikaans was dominating since most of the participants were Afrikaans speaking.

Finally, five groups discussions and three semi-structured individual interviews, supported by an interview guide (Appendix 5), based on the objectives of the study, were conducted. Probing words, included working conditions, supervision, organisational policies and administration, interpersonal relations, benefits, the work itself, opportunities for growth, responsibility, achievement, recognition, advancement and fairness in the workplace, derived from Herzberg's Two-factor Theory on job satisfaction, were applied. Intuiting guided the interviewer to probe and add additional questions to elicit in-depth discussions.

By means of the interviews, the researcher's aim was to provide a picture of the mobile clinic work environment from the participants' point of view, to unfold the meaning of their experiences and to uncover their lived world prior to scientific explanations. De Vos et al. (2009:342) describe an interview as a social relationship where the quantity and quality of information exchanged depend on the quick-wittedness and creativity of the interviewer in understanding and managing the relationship. It was therefore essential that the interviewer

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be competent in interviewing and communication techniques, as well as dealing with the pitfalls and process of interviewing (De Vos et al., 2009:342-347).

Since the researcher is acquainted with some of the participants and worked in the mobile clinic environment herself, bias was excluded by using an experienced independent researcher as interviewer. This person, a qualified Registered Nurse (RN) with mobile clinic work experience on farms and rural communities in South Africa and with a PhD qualification, collected all the data after being trained for best insight in the purpose and objectives of the study.

Interviews were conducted as follows: An information leaflet with sufficient background on the interviews was provided to participants to prepare them for informed consent before participation in the study. Participation was voluntary. Participants were assured that there would be no negative consequences if they did not want to be interviewed. No compensation for taking part in the study was offered, except for light refreshments to enhance the discussion milieu.

The demographic, educational and work experience information was collected (Appendix 4), using a self-administered questionnaire that the participants completed before the commencement of the interviews. Following the completion of the demographic data, participants were asked to describe their feelings, thoughts, perceptions and expectations about the mobile clinic work environment. Interviews were audio taped with permission from the participants. They were assured that all discussions would be treated with confidentiality. To ensure anonymity, there were no linkages to their identities. They were allowed to refuse answering questions that they did not feel comfortable with in answering. The ethical principles applied were discussed in more detail in chapter one.

3.5.1 Trustworthiness

The validity or trustworthiness of research findings in qualitative studies, as proposed by Lincoln and Guba (1985:29), is concerned with the credibility, confirmability**,** dependability and transferability of scientific findings. Subsequently, these criteria were applied to enhance the accuracy of the research findings and to support the rigour of this study.

3.5.1.1 Credibility

The credibility of the study data was enhanced by *triangulation*. According to Burns and Grove (2009:726), triangulation entails the “use of two or more theories, methods, data sources, investigators or analysis methods in a study”. In this study, a variety of sources from three vast districts in the Western Cape were included in the data collection. By using

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two different data collection methods, namely individual interviews and group discussions, the researcher could explore the experiences and perceptions of the mobile clinic nurses more thoroughly. Furthermore, credibility was ensured by *prolonged engagement in the field,* until data saturation occurred and by applying member checking with participants whether data was correctly understood (Appendix 6). Peer debriefing was applied through the continuous monitoring of the data collection process with the use of experts in the field of nursing research (De Vos et al., 2011:420).

3.5.1.2 Confirmability

Conformability was enhanced through the use of the two interview methods, as described under par. 3.5.1.1, continual evaluation for internal coherence in the raw data and the interpretation of study findings by research experts and finally by an internal and external examinator.

3.5.1.3 Dependability

In testing for the dependability of a research study, the researcher ensured that the research process was logical, well documented and audited (De Vos et al., 2011:420). At the same time, the methods followed to enhance credibility and confirmability added to the dependability of the study findings. In quantitative research, this construct is referred to as reliability (De Vos et al., 2011:420).

3.5.1.4 Transferability

According to De Vos et al. (2011:420), the transferability of qualitative study findings to other studies are more problematic than in quantitative research. However, the weaknesses can be overcome by including a conceptual theoretical framework, triangulating multiple sources of data and using a variety of data collection methods. Brink (2006:119) adds that by means of a thoroughly described investigator's report, the transferability of the study can further be enhanced. Using the purposive sampling method and staying in the field until data saturation occurred also contributed to transferability. The researcher deliberately strove to incorporate all these aspects to enhance transferability.

3.6 DATA ANALYSIS AND INTERPRETATION

According to Ritchie and Lewis (2003:219), data analysis in qualitative research is a continuous and interactive process. Creswell (2009:184) states that it starts with data collection. Ritchie and Lewis further indicate that two key platforms characterise its course: firstly, managing the data and secondly, making sense of it through descriptive or explanatory interpretations. Making sense of the data is not only dependent on the technique used to order and categorise data, but also on the conceptual and intellectual processes

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engaged by the researcher. Therefore, the researcher requires rigorous, creative and clearly derived concepts from the data set (Ritchie & Lewis, 2003:219-220).

Qualitative researchers now commonly use the analysis method framework of Ritchie and Lewis, which was developed in the 1980s. It facilitates rigorous and transparent data management and in this manner ensures that all the steps of the data analysis process are systematically executed. It also allows the researcher to move back and forth between the different themes derived from the data set, without losing sight of the "raw" data (Ritchie & Lewis, 2003:220). Thus, for the purpose of this study the model as prescribed by Ritchie and Lewis was applied for the analysis of the data.

3.6.1 Data management

The verbatim-transcribed interviews formed the data set. A transcriber did the transcribing. The researcher verified it with the audio-recorded interviews and simultaneously, got familiar with the feelings and emotions perceived in the transcribed interviews. The following steps guided the process of the data management:

Step 1: Identifying initial themes or concepts: The first phase of this step entailed the construction of a preliminary *thematic framework.* The researcher remained focused by reviewing the proposal, specifically the objectives of the study. For thorough familiarisation with the data set, the transcribed interviews were read and reread until it was felt that the variety of circumstances and characteristics within the data set were understood. During the process of theme identification the attitudes, behaviours, motivations and views of the participants, the general atmosphere of each interview and the ease or difficulty of matters raised during the interviews were considered. A long list of what appeared to be key themes and concepts within the data were identified. These were noted next to the corresponding data in a wide right-sided margin on the transcribed interview scripts (Ritchie & Lewis, 2003:221-222).

The next phase of step one was to derive a *conceptual framework* from the identified themes. The purpose at this early stage was to make sure that there was conceptual clarity within the framework and that no obvious overlapping or omission of concepts occurred. In this regard, the researcher looked for links between the themes, grouped these together thematically and sorted it according to different levels of similarity. Subsequently, a hierarchy of main and subthemes were formed. The distraction of analytical thinking was prevented by closely describing the themes in terms related to the language and terms used in the data set. Each theme was written on a small piece of paper, sorted and resorted on several A3

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paper sheets. These sheets of paper were then pasted against a wall to form a workable structure.

Eventually fewer, more comprehensive, higher ordered main themes were formed. These arrangements formed the conceptual framework of the analysed data (Ritchie & Lewis, 2003:221-222).

Step 2: Labelling or tagging the data: Once the initial conceptual framework was created, the next task was to apply it to the raw data. Ritchie and Lewis refer to this process as indexing (also called coding). Burns and Grove (2011:94) define coding as the process of reading the data, breaking it into subparts and labelling each part. Therefore each phrase, sentence and paragraph were read in finer detail to establish "what is this about?" The various parts of the thematic framework were linked to each section of the data. This was done electronically, e.g. Microsoft Word. According to Ritchie and Lewis (2003:224-225), it frequently happens that a section in the data contains references to more than one theme, and subsequently will be "multi-indexed". Therefore, interconnections between themes were noted for further analysis (Ritchie & Lewis, 2003:224-225).

Refinement of the preliminary *thematic framework* was required at this stage. Therefore, important categories that were missed previously were added and themes that repeatedly reflected differences in the material were subdivided. Tagging the data at this stage was only a first step in sorting the data for later retrieval (Ritchie & Lewis, 2003:225).

Step 3: Sorting the data by theme or concept: At this stage the material with similar content was placed together to form thematic sets, namely the detail and distinctions that lay within each theme were unravelled. This step also ensured that sections of raw data were not removed from its context in a way that it is irretrievable and thus destroyed, both its meaning and coherence (Ritchie & Lewis, 2003:228-229). Therefore, the electronic sorted thematic sets were printed and reapplied to a wall to get a complete view. These sets helped considerably in preparation for the next step.

Step 4: Summarising and synthesising the data: In the final stage of data management the raw data was summarised and synthesised electronically, not only to lessen the quantity of material to a more manageable level, but also to commence the process of filtering the original data.

Thematic charting was used, a process by which the key elements of each theme is summarised. The emphasis was on condensing without losing content or context. Thus, every word of the original data was inspected for meaning and relevance to the topic under

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investigation. At this stage, it was important to retain key words, expressions or phrases made by the participants as far as possible. The essence of the matter was to retain, without losing the language or voice of the respondent. Also, interpretations were to be kept to a minimum and material was not to be rejected as irrelevant only because it did not seem clear at this stage. Furthermore, it was important to include enough data and context so that there would be no need to return to the transcribed data, but to still keep it manageable. A page reference was applied to each section of the synthesised transcript (Ritchie & Lewis, 2003:229, 231).

3.6.2 Descriptive analysis

Descriptive analysis happens when the content and nature of a particular phenomenon are unpacked and illuminated. In describing the mobile clinic phenomenon, the researcher attempted to display the data in a way that was conceptually pure and meaningful. Three key steps were involved: *Detection,* where the fundamental content and magnitudes of the mobile clinic phenomena were identified; *Categorisation* in which categories (themes) were refined, supported by the appropriate descriptive data; *Classification* in which categories (themes) were grouped into more abstract conceptual classes.

According to Ritchie and Lewis (2003:237,244), it is essential that categorisation is performed comprehensively and that categorisations and classifications developed are conceptually coherent.

3.7 SUMMARY

In this chapter a more detailed description of the research methodology applied in this study was presented, which included the research approach, the descriptive design, the investigated population, the purposive sampling method and the data collection and data management process followed. Furthermore, the criteria followed to test for trustworthiness, and the various steps followed to ensure rigorous data analysis were described. The findings of the investigation are described in the following chapter.

3.8 CONCLUSION

According to LoBiondo-Wood and Haber (2010:131), qualitative research seeks to describe, understand and explain phenomena. Phenomena are the things perceived by the senses. Qualitative research also provides for the opportunity to give voice to those who have been unnoticed. The research process followed to explore the perceptions and experiences of nurses about the work environment of mobile clinics, contributed profoundly in describing,

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understanding and explaining the mobile clinic environment, and thereby, giving voice to the mobile clinic nurses about their work environment.

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CHAPTER 4:
FINDINGS

4.1 INTRODUCTION

The aim of chapter four is to describe the perceptions and experiences of the nurses who work in the rural communities of the Western Cape with regard to the work environment of the mobile clinic. Accordingly, this chapter presents a description of the findings of the study, supported by numerous verbatim-transcribed quotations to verify the trustworthiness of the findings. As explained in par. 3.6, data analysis was performed according to Ritchie and Lewis' data analysis model (Ritchie & Lewis, 2003:138-198). During the processes of theme identification, labelling, sorting, summarising and describing the data, the researcher applied inductive reasoning to assemble generalisations from the data set.

Subsequently, the data is presented in two sections. In section A, the biographical data that was gathered at the beginning of each interview is described and in section B, the twelve themes and subthemes that emerged during the process of data analysis are described.

4.2 SECTION A: BIOGRAPHICAL DATA

This study enrolled 19 study participants. Of these, fifteen were registered nurses (RNs), three were enrolled nurses (ENs) and one was an enrolled nurse auxiliary (ENA).

Of the fifteen RN participants, ten were additionally qualified as Clinical Nurse Practitioners (CNPs), a one-year post-basic qualification in Health Assessment, Treatment and Care. Three of these participants completed a Certificate in Health Assessment, Treatment and Care and seven upgraded to the post-basic Diploma in Health Assessment, Treatment and Care (SANC, 1982:1).

The ages of the fifteen RNs ranged from 20-65 years, with one in the 20-29 year age group; two in the 30-39 year age group; five in the 40-49 year age group and seven in the 50+ year age group.

The RN study participants' work experience on mobile clinic units in rural areas ranged from 3 months to 24 years: three having <3 years; six having 3-9 years; four having 10-19 years and two having 20+ years of work experience in this context.

All three participating ENs' work experience were <6 years and the ENA had 31 years of experience on the mobile clinics.

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Accordingly, the majority of the nurses working on the mobiles have experience in the mobile clinic work environment.

4.3 SECTION B: THEMES AND SUBTHEMES THAT EMERGED FROM THE INTERVIEWS

The perceptions and experiences of nurses about the work environment of the mobile clinic are presented in the following themes and subthemes (Table 4.1).

Table 4.1: Themes and subthemes that emerged from the interviews

Themes	Subthemes
The mobile clinic health services add value	
Appreciating the mobile clinic work environment	
Types of mobile units	The design of the pick-up trucks with pods Skills and competence to drive larger vehicles Fuel tank capacity
The structure of the mobile units	Physical space Poor ventilation
An excessive workload	The scope of practice of the mobile clinic nurse Too little time to complete tasks Working overtime due to poor staff allocation Too many patients, too few mobile clinics
Scope of practice	Enrolled nurses and enrolled nurse auxiliaries
Lack of in-service training	
Lack of relief staff to allow current staff further studies	
Additional stressors	Continued performance amidst perilous roads Responsibilities as driver of a vehicle Maintenance of mobile units Lack of acknowledgement Interpersonal relations and unfairness in the workplace
Occupational Health and Safety Issues	Exposure due to the absence of effective means of communication Trouble on the road Injury on duty No toilets
Concerns of delivering a Quality Service	The safety of medicine The accuracy and completeness of patient records and registers The frequency of mobile clinic routes Availability of CNPs on the mobile units The treatment of patients with dignity
Participant suggestions for the improvement of the mobile unit work environment	

During step 2 of data management, that is “labelling or coding the data”, each section of transcribed data was identified with one of the letters A – H, the page number of the specific transcribed interview and the line number on the page for easy retrieval later on, e.g. A3/7-9 (Interview A, page 3, lines 7 – 9).

Also during step 2, it repeatedly happened that a section in the data contained references to more than one theme and subsequently was discussed in more than one context. Interconnections between the various themes were therefore indicated in some of the paragraphs.

4.3.1 Theme 1: The mobile clinic health services add value

In all three districts where interviews were conducted, the participants agreed that mobile clinic health services are indispensable for people living in remote areas (A9/47-50; B1/20-24; C5/23-30, 42-43, 53-56; G7/7-8). Many farm dwellers are regarded as being poor in comparison with the rest of the population (A1/22-27) and are dependent on others for transportation to and from the clinics in town (C2/8-11, 28-30). When transportation is available, they do not always have the necessary funds to make use of it (A5/49-55; A6/34; A9/47-48; C2/9-11; E4/32-34; H27-8). These farm dwellers also cannot afford the loss of income when they miss a full day of work to visit the fixed clinic in town (D4/27-28). Reference to patients’ dependence on the health services offered by the mobile clinics was continuous throughout the interviews, specifically regarding the elderly and tuberculosis patients (G4/1-5; H8/52-53).

The participants regard mobile units as the medium from where preventative health care services should be delivered to people living in rural areas, as supported by the following: *“Many of the farms are far from town, and if you don’t take those patients’ chronic medication to them and give them their immunisations, they have no other way of acquiring it. Some of them only need their contraceptive injection”* D4/24-30*. “The same applies to Pap smears. I do a lot of those on the mobile clinic”* (H9/29-40).

One of the most valued services of a mobile health service, as highlighted by the participants, is to search for inaccessible people and provide the necessary care. One participant recounted how they searched for the children: *“We see many neglected and underweight children on the farms. When we get to the farms and I know where the mother lives and she does not show up with her child, we fetch the child, because they simply do not bring them”* (G7/8-11). Some of the participants have reported tuberculosis cure rates of a 100%, as the mobile unit staff actively look for patients to ensure treatment compliance (H8/52-53).

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There is more scope to observe the domestic and work environment of the patients and take the necessary steps to address health risks. *"I have a patient in one of those houses that is not satisfactory. It looks like a stable, its dark and there are no toilet facilities. There is a 3 year old boy. Both parents abuse alcohol. She shifts around a lot ... but the doctor does not know the circumstances like I do. The child arrives here* (at the fixed clinic), *dressed neatly and washed. They don't know what I see when I arrive there* (on the farm). *Then they say they cannot understand why the child should be taken into foster care. It doesn't seem as though there is a problem, but I know the true circumstances ... The social worker came out to the farm and recommended that the child be taken into foster care"* (B2/1-11).

In addition, the participants shared stories of how transportation problems to fixed clinics and water issues at the farm workers' houses were addressed after talks with the farmers: *"Then the patients ask, Sister, nothing is being done, can't you help? I will phone the owner and say that a few workers had asked if he could please look at the water", or otherwise I would say "I am sending out a health inspector"* (B1/41-45).

4.3.2 Theme 2: Appreciating the mobile clinic work environment

The participants described a complex entirety of difficult work circumstances, caring for the farm dwellers and achieving work satisfaction: *"Mobile clinics are not easy. You work in adverse conditions – fluctuating extreme temperatures"* (A1/28-30*). You are hot and sweaty* (A6/17) *and flies ... lots and lots of flies"* (A6/18). *"Time is a factor"* (A1/30). *"There is no space"* (B2/59), *"also no toilets"* (F4/52), *"there is dust everywhere"* (D1/54) and *"often the roads are bad" (A3/6). "There are times when I long to be able to work indoors"* (B1/30).

Nevertheless, the participants concurred that they enjoyed working in the mobile units (B1/11-16, 27, 30). They pointed out several positive aspects. There is the wonderful nature of the farm dwellers, the trust and respect the participants received from the patients and the appreciation the patients show for the services rendered to them (H1/51, 55-56): *"We are more restful with them. They do not argue, they do not fight with us. They are relaxed and are very appreciative of what we do"* (A4/60-62; A5/7). *"You know your patient personally and they tell you everything"* (B1/31). *"You get to know them and their circumstances so well that you look forward to going out to them"* (E6/4-6).

Furthermore, they enjoy the opportunity to practise independently, feeling that they achieve something as they interact with the patients whom they get to know on a personal level: *"It gives you a sense of freedom. It is satisfying to go to the farms and see your patients. You feel that you are achieving something"* (H10/4-8).

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It was also reported that they work together as a tightly knit team in the mobile units, carrying the boxes with medications and patient records: *"We are a team, we help each other. She takes one side, I take the other"* (H7/38-40). The mobile clinic nurses are supportive of one another and emphasised the importance of sound interpersonal relations within the confined space of the mobile clinic (D1/23-26; D3/56-58; H1/44; B7/33-51; G6/7-10): *"Every morning from half past seven to quarter to eight we get together to see whether everyone are still doing fine and are smiling. We chat for a while. We feel encouraged and free to talk to each other"* (B7/34-36). Humor is accredited for the good interpersonal relationships between the mobile clinic team members, as they shared different humorous experiences (F4/50-59).

4.3.3 Theme 3: Types of mobile units

The participants reported that they offer a mobile clinic health service from different types of mobile units. For the most part, modified panel vans are being used, but in a few cases a pick-up truck with a pod on the back (a canopy within which a clinic is installed), is utilised for this purpose. Various models of panel vans from Toyota and Volkswagen, as well as the Toyota Hilux 4X4 pick-up truck were described (C1/44-45; E1/34; F2/45; G5/60; H2/23-24).

4.3.3.1 The design of the pick-up trucks with pods

The participants named specific aspects regarding the design of the pick-up trucks with pods as unpractical and physically tiring. Apparently, there is a flap at the side of the vehicle that can open like a veranda. They experience trouble in opening these side flaps, since they do not have the physical strength to open it, especially for a nurse that is physically small in size. Furthermore, they prefer to work with the flaps closed, since *"everything is blown about"* (C1/38-42, 53).

These vehicles are also described as being high off the ground, which necessitates the use of a stepladder with three to five steps at the back of the vehicle that needs to be pulled down before staff and patients can enter the vehicles. They were described as unsteady and without side railings. Although some of these steps were replaced with more stable steel steps, the latter are heavy, which necessitates two staff members to lift it up when not required and onto the vehicle at stops when required.

Furthermore many patients, especially the aged, are not able to walk up the steps and staff has to go down to assist them outside the mobile clinic. Staff hurt themselves when they have to handle the heavy steps and the risk exists that staff and patients, especially children, could fall from the steps (E2/19-21; F2/48-63; F31-12; G2/55-62; G3/1-23).

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The participants shared their experiences regarding this matter: *"It is completely unpractical"* (G3/1). *"Yesterday our counsellor fell out of the bus."* (G3/4, 6-7). However, despite these inconveniences, some of the nursing staff still prefers the pick-up trucks to the panel vans. *"When we borrow someone else's bus* (panel van)*, we find them uncomfortable because we are not used to them"* (G2/16-19).

4.3.3.2 Skills and competence to drive larger vehicles

Participants who were used to smaller vehicles found it difficult to manoeuvre the larger vehicles on the challenging mountain tracks. One participant explained: *"We have to go to a farm in the mountain, so we have to drive zigzag among the stones and through ditches. If you are not a good driver, you will not make it there. The Toyota Quantum is very large and cumbersome, not like the old Volkswagens we had"* (H2/21-23).

4.3.3.3 Fuel tank capacity

In the case of areas with extensive routes, it was mentioned that some of the vehicles do not have large enough fuel tanks to complete the route in one day. As a result, some routes had to be divided and a second day allocated to complete the route (H2/46-48).

4.3.4 Theme 4: The structure of the mobile units

4.3.4.1 Physical space

4.3.4.1.1 Cabin space

Some vehicles are designed with three seats with safety belts in the driver's cabin. However, the participants mentioned that in the case of a fixed three-seater, the driver's space is very cramped. In their own words: *"Driving the vehicle is a big problem because all three of us have to sit in front – the Sister (RN), Staff nurse (EN) and the counsellor – and some of them are quite plump, then it is quite uncomfortable"* (G3/8-10). The participants explained that they find it difficult and risky to change gears when three people are sitting in front, since the gears are placed in the middle (G3/8-10). Furthermore, for drivers who are physically small built, the seat has to be moved forward, which creates discomfort for the others (E1/44-46). A further disadvantage of three seats in front, as described, is the absence of a passage to the work area at the back. As a result, the staff must get out of the vehicle at the various destinations, walk around the vehicles and enter via the side or back door. Specifically during adverse weather conditions this situation is experienced as problematic (A3/12; G2/15).

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4.3.4.1.2 Actual space in work environment

Amidst a total lack of space, too little floor space was pointed out during the interviews. However, this must be seen in combination with poor ventilation and extremely high temperatures inside the vehicles (see par. 4.3.4.2 on poor ventilation). A narrow gully of approximately 2.5 X 0.75 metres with cabinets on both sides, the registered nurse, enrolled nurse, occasionally a lay counsellor and the patient with one or two children, were illustrated (B2/27-29; F5/1-6; G2/1-40). Due to the lack of space and the unavoidable violation of patient privacy, it happens that some nurses do not feel comfortable with doing cervical smears in the mobile units. As a result, these patients are referred to the fixed clinics (E1/57-59; G1/50). Counselling sessions by the lay counsellors are also problematic. Most times the sessions take place in the driver's cabin or under a tree (F2/12; F3/20; D2/48).

Another inconvenience, as mentioned in all five subdistricts where interviews were conducted, is a total lack of storage space for the crates, filled with patient records and safe storage space for the boxes with chronic medication (A3/18-20, 26-29; B2/33-52; H3/1-36). Various ways of finding their way amongst the crates and boxes in the confined space of the vehicles were described. Some participants put the crates with the patient records on the floor while driving, but transfer it to the examination table when seeing patients (G5/1, 9-10; H3/35). Others leave it on the floor, because it is too heavy to pick up every time. They constantly have to bend down to find a document and file it again, frequently bumping into their colleagues (H3/5). As one participant described the situation: *"These things filled my bus completely yesterday. I had to help everyone outside while the wind was blowing. It was very unpleasant. Eventually, I moved into a room with my scales so that I can work with the children"* (H3/23-25).

In the absence of adequate space, predominantly in the pick-up trucks with pods, proper patient examination and recordkeeping are disrupted. Many participants reported a lack of space inside their work areas for staff, patients, equipment and clinical procedures (E1/21-23). Consequently, procedures cannot be performed as required. *"We cannot really do a proper examination"* (G6/11). *"Our examination bed is our desk, that's where our sharps are, where the statistics pages and files are kept, where the dustbin is. Therefore, when we examine a patient we have to take all those things off and find another place for it, which is impossible. In these circumstances I really examine the least number of patients. If it is not absolutely necessary I do not let them lie down"* (B2/35-39).

Several participants also mentioned that there is no place in their vehicles for the necessary registers and policy manuals. As a result, they leave it at their offices and complete the registers when they return to the office (B2/50-52).

In this paragraph, patient records and registers are described in a context of "too little space". In par. 4.3.5.2, the completion of records and registers are described again in a context of "too little time to complete tasks" and in par. 4.3.11.2 in a context of "concerns for delivering a quality service – the accuracy and completeness of patient records and registers".

On the other hand, the participants who only provide a preventative service felt that they could function effectively in the limited space if it is well-equipped. *"We can do everything there but it is only straight forward things like depots* (contraceptive injections), *drawing blood, immunisations and TBs"* (C4/33-37).

4.3.4.2 Poor ventilation

The study participants unanimously reported extreme temperatures, both inside and outside the vehicles (A1/29-30; B1/28; C1/27-28; D1/16-18; E2/35-36, 51-52; G1/1-5; H2/50). Temperatures of up to 45˚C were mentioned. None of the vehicles described were fitted with air conditioning in the work area. Windows can only open partially (G1/27-45) and there is a small fan at the back of the vehicles that alleviates the heat a little (C1/27). The participants stated that their work areas become unbearably hot due to the poor ventilation (F5/1-23). In order to be able to function in these vehicles on such hot days, a choice must be made between the scorching heat and the privacy of the patients. One participant said*, "It is so hot, you cannot close the door. To allow some air to flow through, we leave the door open"* (G1/6-9). Participants in other districts made similar remarks*. "It feels as though my glasses are washed from my face. It is worse than being outside. It makes me realise that we are working in a car which is parked outside in the sun"* (B2/30-33).

Some of the vehicles have air conditioning in the driver's cabin, which they experience as wonderful while they are driving, but as soon as the vehicle stops, the intense heat and stuffiness take over the vehicles, making conditions unbearable (A2/60-62). The participants who travel in vehicles without air conditioning, however, have no choice but to open the windows to get some cool air, inhaling a cloud of dust from the dirt roads in the process (D1/52-54).

Then again, in winter it is extremely cold. *"When the door opens the wind and rain get in and blow all your papers up into the air"* (B1/29-30).

4.3.5 Theme 5: An excessive workload

One aspect that received much disapproval from the participants was their excessive workload. This matter is divided into the following subthemes: the scope of practice of the

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mobile clinic nurse; too little time to complete tasks; working overtime due to poor staff allocation; too few mobile clinics.

4.3.5.1 The scope of practice of the mobile clinic nurse

A variety of functions were identified from the interviews.

4.3.5.1.1 Managerial function with regard to a health care facility

The registered nurses that manage the mobile clinic health services are being held responsible for the achievement of Department of Health goals (A4/8-12; A85-8). In co-operation with subdistrict nursing service managers, they are also responsible for planning and organising the routes (D3/40; E4/19).

4.3.5.1.2 Nursing functions

Various preventative services were identified from the transcribed interviews (A1/48; D4/30,36; F1/58; F6/21): Women's health services such as family planning (A1/49; B10/21; F6/23), antenatal care (first visit) (B10/24; D3/49), follow-up visits (A1/49; A2/48; D3/6; G5/3,16) and postnatal care (B10/24) were mentioned. Cervical and breast cancer screening (B10/25; E1/57) were also mentioned. HIV and TB screening, especially the detection of TB contacts (A1/48; B10/22; G1/7; G7/28) was portrayed. Child Health was described in terms of the weighing of children, the interpretation of the Road to Health Chart, immunisations and the referral of children (A1/49, 58; B4/38; B10/21; D1/25; E2/17; F2/32; F6/25; G2/7). Chronic disease discussions concentrated on screening for diseases such as diabetes and hypertension (A1/50), routine evaluations, renewal of chronic medication scripts, referrals (B3/11; B8/40; E3/48-49) and the preparation (D2/61) and provision of the chronic medication (A1/35; A1/50; B9/47; B10/25; D2/60-61; D5/55; D6/2; E3/58; F2/24; F6/23). Added to the preventative services are the detection, preparation and referral of HIV positive patients for highly active antiretroviral therapy (HAART) (A1/49; A3/2). Included in many of the above discussions were record-keeping.

Specific curative services identified were: the detection and treatment of TB patients (B3/55; B8/18; B10/21; G4/1; G7/27) and the examination, categorisation, diagnosing, treatment and referral of acutely sick patients (A2/49; A3/1; B1/25; B2/38; D4/37; E5/30; F6/21; G4/3; G6/19; G7/25).

Other nursing functions identified from the interviews were the collection and documentation of laboratory specimen results (D1/39-41; G1/19; H5/13), wound care (restricted to small wounds) (D7/38; E7/7) and emergency care in terms of the establishment and maintenance of emergency equipment and supplies and the handling of emergencies (E7/28).

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4.3.5.1.3 Administrative function

The recording of statistics on a daily and monthly basis (A2/11-18; D5/13; F4/38) was the only administrative function identified that relates to the nurses' scope of practice.

4.3.5.1.4 Pharmaceutical function

The following pharmaceutical functions were identified from the interviews: the establishment and maintenance of a mini pharmacy (a limited supply of medicine in the mobile units, regulated in accordance to the relevant mobile clinic nurse manager's scope of practice) (A1/48-51; D424-30; E3/2-6; F2/40-43), preparing and providing medication to acutely sick patients (A1/43-44; A1/53-58), organising and providing prepacked chronic medication (A1/34-35; A3/18-19; D2/56-63; D3/1-2; H3/7-8) and the establishment and maintenance of the "cold chain" for immunisations (E2/40-41; F2/32-33).

4.3.5.1.5 Responsibility with regard to the vehicles

The participants expressed their responsibilities with regard to the vehicles as safe driving of the vehicles and the safety of the passengers (colleagues and patients) (B4/18; E5/8). They are also held responsible for the safety of the vehicles in terms of checking and reporting defects (F3/24-25; H3/61-62).

4.3.5.1.6 Tasks of other category workers executed by nursing staff

Several functions were identified that do not fit into a nurse's scope of practice, but which, in the absence of the allocated personnel, are performed by the mobile clinic nurses. With reference to infection prevention control, the cleaning of vehicles on the inside (B3/43) and organising washing of the exterior are performed by them. They also fill up the water tank for washing their hands (G5/13).

Furthermore, they carry the heavy boxes with patient records to and from the mobile units on a daily basis (B4/1; F6/1; H7/39-40). In case of a flat tyre, they are expected to change the tyre themselves (D2/23; F3/35). In some areas, the nurses also see to it that the vehicles are serviced (F3/24).

In the absence of clerks, they make appointments for patients themselves. They also do the maintenance of a filing system for patient records (R1/58 G2/48 W5/9, 3). Moreover, they do the electronic import of patient details on a template for the preparation of chronic medication themselves (B10/3-6).

4.3.5.2 Too little time to complete tasks

The policy for chronic patients: According to the participants, there is not enough time in a mobile clinic workday to incorporate the latest chronic policy as provided within a polyclinic

health service. It was explained that each chronic disease has a flow chart which stipulates the needed observations, lifestyle questions, relevant blood tests, eye test, feet examination, body mass index calculation and every six months, or more frequently in case of unstable chronic conditions, a chronic medication script must be reissued (C8/37-40; D1/26-31,39-41). One participant expressed her experience with the previous chronic policy compared to the current policy as follows: *"So where you previously saw the patient for 5 minutes to take the blood pressure and check the patient's medication you now have a full work-up to do"* (D1/30-31). It was said that a work-up with the new policy takes about 15 minutes (D1/39), but when 20 to 40 chronic patients are seen (D1/45-47), together with all the other patients that need to be helped, it becomes an enormous workload (B8/34). Although the participants expressed their dissatisfaction at the degree to which they are forced to complete nursing tasks after hours, their commitment to their work was evident. One participant recounts: *"What must we do with the files? You have boxes and boxes of them. So you take it home over weekends. You start on a Friday night. On Saturday you take a rest. Sundays you work on it again. Come Monday you can go to work knowing your files have been updated. You have to work something out for yourself to stay in control"* (B8/48-51).

Additional to the latest chronic policy, an increasing number of HIV positive patients are to be transferred onto the antiretroviral programme. According to the participants, it is no longer just a simple referral, but a complete work-up with flow charts and laboratory tests that need to be done prior to referral to the "infection clinic" (B10/7-11; D4/8-12). Moreover, there are currently plans for the decentralisation of farm dwellers that need antiretroviral treatment to the mobile clinic health services (A3/2-5).

Administrative tasks: In all the subdistricts the participants complained about a lack of time to complete administrative tasks during working hours (B3/1-17; C5/1-14; C4/62-63; E3/35-42; E3/46-49; H7/34-36). In this context, the completion of daily and monthly statistics (A2/11-20), the making of patient appointments, the completion of registers and nursing records, and the renewal of chronic medication scripts were elicited. The various programmes for TB, HIV and chronic disease management were accentuated more than others.

Record-keeping: A variety of aspects regarding record-keeping were described in a mood of frustration and dissatisfaction (A3/24-26; B8/33-56; E5/17-48; H4/46-55). In addition to the lack of time to complete nursing records while on routes, there was concern from the nurses about the lack of shelter for waiting patients at some of the clinic stops (B8/33-34; H4/48): *"If you don't write these things down while the patient is in front of you, you forget"*, though *"it is not just writing it down, you have to concentrate".* Their dilemma, however, is*: "You see the*

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patients standing outside in the heat and the rain, and then you write it down in your diary so long" (B2/61-63; B8/31-59).

Some of the participants were unhappy because, over and above their own tasks, they have to help in the fixed clinics. This means that they have to complete their administrative tasks after hours, including the incomplete patient records (E5/35-38; H5/7-15).

Accordingly, in this section, record-keeping was described in the context of "too little time to complete tasks". In par. 4.3.4.1.2 record-keeping is described in a context of "inadequate space for proper record-keeping". In par. 4.3.5.3, this is described in the context of "overtime due to poor staff allocation" and in par. 4.3.11.2 in the context of "concerns for delivering a quality service".

Mobile clinics vs fixed clinics: During the interviews substantial differences between fixed and mobile clinics with regard to the amount of time and number of staff members available to complete tasks came to the fore. At the mobile clinics, where only two nurses work, it happens that only 20 minutes are available per stop, regardless of the type of health service a patient needs (E3/55). On the other hand, fixed clinics have considerable more time and staff available per patient. The participants relay their experiences in this regard*: "An antenatal booking with HIV counselling can take up to an hour in a normal clinic"* (A3/2-4). *"If you go next door for a psychiatry booking, you have to enter there, for chronic you enter there, for infections at another door and each time a different Sister and nurse are on duty. At the mobile we do everything and we have to stay abreast of all the changes"* (B10/30-33; H5/20-21). Sometimes it is a case of crisis management at the mobile clinic. As described, it happens that a large number of women will show up for family planning at one specific stop. Then everything needs to be done in a hurry, with no time for routine observations. This includes antenatal bookings: "*It is quick bookings, everything is done in haste"* (H8/33-35).

Acutely sick patients: The clinical nurse practitioners that manage the mobile clinic services are not only confronted by a lack of time for a thorough clinical examination, they also have to prepare and issue medication themselves (A1/34-37; A2/2-6). One of the clinical nurse practitioners expressed her perspective on quality patient time as follows: *"If your route is already full and you have to see sick patients as well, you will probably have too little time. I think each patient, especially when he is sick, deserves a thorough examination"* (D4/35-48). As a solution to the problem of insufficient time and space for proper patient examination, the participants are of the opinion that with the devolution of chronic medication, more time will be made available for the rendering of a quality service from the mobile units (A8/21-26).

In this paragraph, "clinical examination" is described in the context of "too little time". In par. 4.3.4.1.2 it is also described in a context of "too little space".

No proper rest periods: In the following quotes the participants explained why they do not take lunch breaks. They realise that this is detrimental to themselves and the patients, because they sometimes become agitated when they do not take a break. In reality, however, they are confronted with the plight of the patients who would then not be helped. It is therefore often their sense of duty towards their patients that motivate them to sacrifice lunch times. *"It is no good saying to people: 'It is now 12 o'clock, I am now going to eat. We will be back in half an hour.' It is very hard to drive away from mothers with babies who are also hungry. So what happens is ... you just bear through with it"* (A4/48-50; F2/1-15). *"We eat while we travel – as we drive from one farm to the next. If I take lunch and I stop working at 16:30 several people will not be examined"* (C3/17-20).

4.3.5.3 Working overtime due to poor staff allocation

Due to their extreme workload and a lack of relief staff when the mobile clinic staff are scheduled for leave or attends courses, the working of overtime cannot be avoided. Mobile clinic staff often have to go back to the farms on following days to complete their routes (C4/62-63; C5/1-24). One participant said that she is in her office at 07:00 in the morning and is never done before 17:00 or 17:30 (H4/1). Various participants from all three districts verified this tendency.

In addition, the mobile clinics are dependent on the fixed clinics for the provision of relief staff: *"To take a sister off a mobile you have to have relief, and there's not always relief. If the clinics have an extra hand, they will give it. If the mobile clinics have someone going on course or on leave, that bus gets closed"* (A8/44-50). As a result, the first few days after leave, where no relief staff was available, is experienced as a very stressful time. The participants recalled their experiences: *"You have to catch up"* (H6/23). *"I have been through three days of hell, where I went out every morning and came back late afternoon because I had to do all my immunisations"* (H6/15-18).

It is especially when staff returns from sick leave or is still ill, that the workload takes its toll (E2/20-27). *"Then it gets too much for you as a person, you become irritated and very tired. It is terrible for me, because you are at work, you want to do your best, but you cannot do so if you are exhausted. Then we sometimes snap at our colleagues and at the end of the day I feel totally drained because there was not one moment where we could just relax for a minute"* (E3/29-38).

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Moreover, they described a disregard for after hours work at the office as overtime: *"It is very frustrating that they do not acknowledge the time we work here. They say the only overtime we are allowed to claim is when we are physically on the mobile"* (A2/18-20; B8/35, 55, 48-51; E5/17-48).

Overtime was also discussed in par. 4.3.5.2 in the context of "too little time for record-keeping".

Other participants however, experienced more support with relief staff: *"The Sister in control of our unit sends someone out, someone who can do immunisations and do the basics, even if only for a short while"* (W6/6-31). Nevertheless, the general feeling of the participants was that too much is expected from the two nurses who work in a mobile clinic: *"In the mobile clinic everything is expected from those 2 people"* (H5/21).

During the interviews, it became evident that in some areas, apart from helping out in the fixed clinics after completion of the day's route, mobile clinics' nurses are expected to assist the patients from their service area who turn up at the fixed clinic in the morning before they leave on the day's route. This tendency is the cause of a lot of unhappiness, since the mobile clinic staff then go on routes too late, cannot complete the day's route and subsequently have to work overtime. In some areas a distinction is made between "farm patients" and "town patients", which contributes to the participants' perception that the staff at the fixed clinic lack co-operation. Also, a lack of uniformity in the way mobile clinic staff is applied in the subdistrict is experienced by the participants (H5/20-57; H6/1-62). One participant describes her unhappiness as follows: *"What makes me unhappy is that none of them will come to us and enquire whether they can assist us in some way. It doesn't happen. It's the unfairness that angers me"* (H7/55-59). These participants said they often feel abused and experience a lack of insight into their workload (H7/24-28).

There were, however, other clinics where good co-operation between mobile and fixed clinics were evident and where patients from farm areas were well supported at the fixed clinics (H6/29-31, 43-46, 51-53).

Self-sacrifice: Whenever the participants raised the difficult working conditions on the mobile units, the sacrifices they made in order to deliver the best possible health care in their working conditions became evident. From the transcribed interviews, compassion with the situation of the farm dwellers were noticed, where the participants put themselves in the shoes of their patients and find it difficult to break themselves away from the hardship of their patients.

The inner conflict that nurses and nurse managers have to cope with in dealing with an unbearable workload was noticed. Accordingly, they often have to refer patients with less serious medical conditions to the fixed clinics in town, knowing that the patient does not have transport to go there. They are obliged to take these steps so as to accommodate patients with more serious illnesses. One of the participants posed the following question, as if she was in the shoes of her patient that has "*too many children*" and in this way expressed her empathy: *"I wonder ... what it feels like to be poor? I do not have a car, my children have to be somewhere, and the farmer is not on the farm. I have to piggyback one and take one on the arm ... and I have to walk 5 km and back ..."* (A7/53-59). *"My superior rebukes me, helps me to think differently ... because 'you must work smarter and not harder'"* (A7/59-61).

The dilemma of managers are that they are pressured to reach departmental goals, but statistical instruments only measure selective aspects of health care and do not provide a true picture of the time spent on sick people at clinics (A9/28-37).

4.3.5.1 Too many patients, too few mobile clinics

Seasonal workers: According to the data, the impact of seasonal workers on the mobile clinic health services is overwhelming. Up to 26 000 people may enter a specific valley during the fruit harvesting season (C3/13). Despite the increase in numbers, these areas are still served by only one or two mobile clinics (C3/4-6). It is against this background that mobile clinic nurses perceive their employer as not being really concerned about their well-being. They feel that they are making a huge impact on health in densely populated farm communities (C8/34-40). This is demonstrated by the workers' preference of the mobile clinic health services that stop on the farms, rather than go to the town clinics. However, their hard work is going unnoticed. One of the participants had this to say: *"If you don't have compassion in your heart and you do not care about the community, it would have collapsed a long time ago"* (C7/18-25).

The continuous migration of people between their place of origin and the fruit areas causes much frustration and problems for the staff of mobile clinics, especially TB patients from other provinces who appear and disappear before they have completed their treatment. Sometimes HIV positive parents arrive with sick children and the parents do not realise the importance of keeping up the child's immunisation programme. Nevertheless, the nursing staff goes to great lengths to interpret the importance of continued treatment to those workers who can only speak an ethnic language, but it still results in poor compliance. The participants indicated that these patients do not keep their appointments at the mobile units; neither do they attend the clinics in their hometowns (B9/25-41).

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4.3.6 Theme 6: Scope of Practice

4.3.6.1 Enrolled nurses (ENs) and enrolled nurse auxiliaries (ENAs)

The whole concept around mobile clinic health services is to make quality health care more accessible to people who live far from fixed clinics. However, during the interviews a potential malpractice situation was identified. When CNPs go on leave and no relief staff is available, unqualified nursing staff are being trained by their supervisors to carry on with the mobile clinic health services. Accordingly, they are trained to look between the percentile lines at the baby's weight. *"We train through example. If we don't do that, everything stops when we are not there"* (B4/19-25). This situation exposes them to act outside their scope of practice.

A clinical nurse practitioner explained how subtle this malpractice happens: *"Because we work so closely together, they know how to do our work. They have all the experience"* (B5/29-34). Moreover, when less qualified nursing staff are alone on the mobile routes, the temptation to help might just as well become too much to tolerate: *"You who are asked to help is constantly under pressure, because you really want to help this person. Can't I just give her the pain medication so that she can be helped?"* (B5/25-27).

Accordingly, in the absence of qualified relief staff for RNs and CNPs, nurse managers require ENs and ENAs to manage mobile clinics' scheduled visits to rural communities without the needed supervision. In the process, ENs and ENAs are exposed to work outside their scope of practice, resulting in malpractice: *"I want to paint another picture of someone who worked on a mobile. They do not have a Sister, only a staff nurse* (EN) *who has a* [driver's] *licence. She has to do absolutely everything. She has to perform a Sister's duties in order to keep her mobile running. She is completely out of her scope of practice. The superiors know about it, but she still has to do it"* (A8/41-55; B4/37-49; B5/13-17).

4.3.7 Theme 7: Lack of in-service training

On the mobile units the nurses are working more independently. For this reason it is important that they are well equipped with the necessary knowledge and skills required to provide a safe service to the patients.

Registered nurses who were not qualified as CNPs said that their first encounter with the mobile clinic work environment left them feeling exposed and at the mercy of whatever the day brings, especially after coming from a protective hospital environment with doctors and colleagues surrounding them. A RN, who had only three months exposure to the PHC environment at the time of the interviews, gave an alarming description of how vulnerable

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and exposed she felt: *"I have been asked to help out only for this year but there is no guidance. I received orientation for one day and that was so overwhelming that I did not know what was happening. On the mobile you are on your own, you do not know, you are vulnerable. I have not done many courses. I have to struggle and learn as I go and my nurse has to teach me, which is not fair"* (H8/1-20).

4.3.8 Theme 8: Lack of relief staff to allow current staff further studies

Clinical Nurse Practitioners (CNPs): As explained by the participants, CNPs who are working in the mobile clinic environment do get the opportunity to be promoted to the position of Operational Manager of a fixed clinic, whenever such a position becomes available. However, they need to hold a Diploma in Clinical Nursing Science, Health Assessment, Treatment and Care. Thus, should CNPs with only a certificate in Health Assessment, Treatment and Careprefer not to upgrade to the Diploma in Health Assessment, Treatment and Care, they disqualify themselves from any possible promotion opportunities (A8/41-55; F5/44).

In view of that, participants who completed the certificate course explained that they found it extremely difficult to manage the mobile service and meet the demands of their studies (B6/28-58; B6/1-20). Some had emotional breakdowns, others suffered from depression during and after the course. The experience was too disruptive and accordingly they have no motivation for upgrading to the diploma in diagnostic, assessment and treatment: "*That left me with two days a week to run my clinic. It was absolute chaos, physically impossible. I received assistance at the end of May, but it was already too much of a burden. That is why I cannot go through the stress again"* (B6/28-58).

Professional nurses (PNs): PNs in the mobile clinic environment do get the opportunity to be trained as CNPs. Even so, it is expected of them and their supervisors that they should be trained. However, the tight schedules of the mobile clinics make it difficult for them to further their studies, as relief staff is problematic. Accordingly, they are also expected to undergo training and deliver a mobile clinic health service at the same time (A8/41-44; B4/55-59). The participants had the following to say about the procedure during course days: *"If the mobile clinics have someone going on course or on leave, that bus gets closed, there's no continuation of that service ... Last year quite a few times we had to send out a nurse and a clerk to just go and hand out the chronic medicine and do the family planning, because there was no sister (RN) to send with the mobile. So that is a bit of an issue"* (A8/46-50).

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Since no services are delivered when staff is on leave or attending courses, health goals are hardly met during these periods (A/46-50).

Enrolled nurses (EN): According to the participants there are no opportunities within the mobile clinic environment for ENs to improve their qualifications and thus their chances for promotion are curtailed. They are forced to resign from their positions to study on their own expenses and then apply for a vacant position, or with the bridging course in mind, apply to be transferred to another institution. Once again, the lack of relief staff on mobile units was presented as the reason for these drastic measures (B5/38-62; F5/47; F7/30-50). An EN recounts *"... I also plan to resign. I have spoken to the superior a few times and she says that we are not replaced. They won't get others in our place and they cannot allow the Sister (PN) to work alone"* (B5/56-58).

A significant loss for the mobile clinic health services occurs when staff resign, taking with them a wealth of knowledge and experience. Some enrolled nurses have been working on the mobile units for many years, "carrying" the younger registered nurses with their expertise: *"At the moment the staff nurse (EN) is teaching me so many things because she has years of experience. She would love to study but the opportunity is not there"* (B5/42-45). As a result, new nurses have to be appointed and trained (B7/12-17).

Enrolled nursing assistants (ENA): Due to the lack of relief staff, the ENAs are in the same unfortunate position as the ENs and thus have no opportunity for furthering their studies while working in the mobile clinic environment. A PN shared her perceptions on this matter: *"I feel sad because they are in this position. So many of them would like to study and improve themselves but they cannot. My previous assistant nurse (ENA) had to resign and use her own money to pursue her studies"* (B5/39-42).

4.3.9 Theme 9: Additional stressors

4.3.9.1 Continued performance amidst perilous roads

Apart from shortcomings in the design of vehicles and availability of staff, there is constant pressure on the participants to explain why goals have not been met: *"...you do have a minimum and maximum of how many family plannings you should do in a month, and how many pap smears. Immunisations, TBs also have a minimum and maximum, and if it falls below or above, you have to give an explanation why that is"* (A4/8-12). Moreover, it happens that environmental factors disrupt their work schedules: *"Often the roads are impassable, especially during winter"* (E3/12-13). They are confronted with relentless rain, overflowing rivers and slippery roads, *"but we have to go".* Sometimes they get stuck in the

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mud and have to wait for somebody from the community to come and pull them out (E3/18-2).

4.3.9.2 Responsibilities as driver of a vehicle

One of the participants summarised the additional responsibility of driving the vehicle as follows: "You are afraid of making an accident because people's lives are in your hands. If there is any damage to the vehicle you are responsible, you have to write a report. You carry all the responsibility" (E5/8). Especially the older vehicles were singled out as a source of great uneasiness and bigger responsibility. This is further discussed under the next heading.

4.3.9.3 Maintenance of mobile units

Service of vehicles, repairs and relief vehicles: The participants had varying experiences of who takes responsibility to see that vehicles are serviced. In general, the vehicle departments of the various subdistricts see that vehicles are serviced and licenses renewed, but apparently, in some areas, this responsibility also resorts under the mobile clinic nurse (B9/20-21; F3/24-31).

It was also said that there is no one who takes responsibility for the roadworthiness of vehicles in between services, apart from the nursing staff: *"There is no one who takes physical responsibility for checking the buses to ensure that they are in good condition. I leave here at 7 o'clock in the morning, and I never return before five o'clock, half past five. Where do I find the time to go to a garage to have those things checked for me?" (H3/61-62; H4/1-2). "They forget that we are women"* (H4/9). Once again it was the older vehicles that were depicted as a source of frustration. The participants described incidents where the shock absorbers of vehicles caused intermittent problems, due to the dirt roads (D2/22-24), axles of buses broke (H2/54) and hand-washing facilities were out of order (H5/7). It was said that these things constantly break; however, they are simply repaired and never replaced (H2/53-54).

From the transcribed interviews, the only comment on relief vehicles was that they are available when a vehicle goes for repairs, but are less comfortable than the usual vehicles D2/41.

Cleaning of vehicles: Participants of all the subdistricts mentioned that they have to clean the interior of the vehicles themselves. It was also mentioned that a cleaner was hired privately to clean the mobile unit (B2/34). In some of the subdistricts the exterior of the vehicles are washed at the hospital in town every second Friday, but the nurses have to take the time to drive the vehicle to the hospital (D2/1-3). In contrast to this, the fixed clinics,

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where the mobile clinics are parked, have cleaners who clean the offices of the mobile clinics' staff, but not the vehicles (B3/46-47).

Safe parking for mobile units: It often happens that lock-up garages are not available for the mobile units. Various participants mentioned that the vehicles are mostly parked outside the fixed clinics or hospital in town, but without the proper measures to ensure the safety of the equipment and supplies inside the vehicles. Some vehicles, like the pick-up trucks with flaps on the sides that can open and drawers that can open inwards and outwards, are especially exposed. One of the participants expressed her concern: *"The mobile has to stand outside at the mercy of the elements. When we get to the mobile during winter, it has rained in. This makes it difficult because the equipment gets rusty and breaks"* (D1/32-46; D2/1-5).

4.3.9.4 Lack of acknowledgement

Throughout the interviews participants expressed their gratitude towards their colleagues for good co-operation, hard work, after-hour tasks and the achievement of departmental goals.

Managers praise them for good statistics achieved, but as one participant noted*: "If I look at the audits that are done, no recognition is given because only the fixed clinics are audited without as much as a glance at the mobile clinics"* (F7/41-4, F7/3). According to the participants, the structures for acknowledgement are very limited. Furthermore, it appeared as though they do not really believe that the conditions on the mobiles would improve. The following was said in support of the above opinion: *"I think the structures for recognition are very limited. They often say, 'We see that you are working hard', but our work conditions never improve. Words are spoken but they are never followed by actions"* (B8/16-23).

Some of the participants described the top management as critical, dictatorial and unthankful for what is done on ground level: *"When our superiors get here it feels as if they are only here to criticise. They only bring more work and tell you how to do your work. Never a 'thank you, you've done well so far, now let's try another way'. It feels as though they only criticise"* (F7/5-15).

As already described under 4.9.2, there is a lack of recognition for the many hours spent in the evenings and over weekends to update registers, statistics and patient files (G8/55-56), as well as for lunch breaks not taken, but rejected as overtime (D5/2; H4/41-62; H5/1-15).

Some participants said that they experience the gratitude and appreciation of patients for services rendered as their acknowledgement: *"I don't think anyone knows what we really do. I actually only work for the sake of my patients"* (B8/6-7).

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4.3.9.5 Interpersonal relations and unfairness in the workplace

In general the data reflected a sense of true cohesion and excellent interpersonal relations among the mobile clinic staff (see par. 4.3.2 on “appreciating the mobile clinic work environment”).

The participants had strong arguments against the decision that mobile clinic staff should, over and above their own tasks, have to help at the fixed clinics where considerable larger numbers of workers are employed. Their unhappiness is rooted in the consequences of such a decision, when they then have to work after hours to finish off the mobile clinic’s administrative obligations, hours that they are not compensated for. They felt that there is a lack of insight into the extent of their workload and working conditions. This adversely affects the team spirit and relationship between the staff of the mobile clinics and the fixed clinics (H4/41-47, 61-62; H5/1-5, 9-10, 12-13; H6/8-10). The following is an example of their perceived lack of insight in their circumstances: *“When there is sickness in the fixed clinic you have to leave your route to help out in the clinic, which means that somewhere you have to make time for that route, and that is hell because it means you have to do two routes in one day”* (H6/23-27; H7/11-20).

Then again, in other interviews the participants acknowledged excellent interpersonal relations and team co-operation between the staff of the fixed and mobile clinics (H6/61-62; H7/1-2, 6-7).

Supervisors: With the exception of a few cases it was deducted from the interviews that good relations between mobile clinic staff and their supervisors do exist. Meetings are held at regular intervals and their suggestions regarding route planning and the development of mobile clinic services are considered. They felt that they and their supervisors form a good team (D6/52-54; G6/7-10). When one of the mobile clinic’s staff members goes on leave, there are efforts to ensure a relief nurse. If this is not possible, a driver accompanies the EN on the route in order to provide the most essential services, while the rest of the patients are accommodated at the fixed clinic in the area (H6/61-62; H7/1-2).

Top management: Only limited data was provided with regard to the participants’ experiences with health service managers at subdistrict and district level. The only two issues mentioned was the attainment of departmental goals and how they express recognition.

Accordingly, feelings of hopelessness were noted when the participants talked about goals that must be reached, quality care that must be provided and crowds of patients that need to

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be treated, despite the limited staff and time. It was said that the routine monthly report that reflects the achievement of departmental health goals, does not measure the full scope of service delivery at clinic level and that managers do not show understanding in the daily challenges that mobile clinic staff has to face. The participants agreed that unrealistic targets are set: *"...when you go to monitoring and evaluation meetings, they say: 'You are not giving out condoms.' They do not look at how many colics (sick children) or PGSs* (curative nursing) *you see, how many children you refer to OT* (occupational therapy). *They just look at family planning and certain targets"* (A8/1-12).

The participants felt that managers place unreasonable expectations regarding health targets that need to be reached, thereby showing a lack of insight into the working conditions of mobile clinic nurses: *"Sometimes it is unreasonable that we are expected to reach the targets ... but the people at the top do not know what we are doing. It is a tough road ahead"* (A9/36-37). In this context, although a comprehensive service is offered by the mobile clinic services, it does target individual goals, e.g. HIV/AIDS care.

Farmers: Some of the participants acknowledged that they do not always have the frankness to sort out problems with the farmers. It sometimes happens that routes have to be cancelled due to training, staff that is ill, or adverse weather conditions. When those routes have to be serviced on a non-scheduled day, it does not necessarily fit into the farmer's schedule, forcing him to arrange special transport to get the workers to the mobile clinic. Apparently, in the past, conflict had developed between mobile clinic staff and farmers when farmers were not notified in advance of changes in mobile clinic route schedules, causing the farmers to be uncooperative with the transportation of farm workers to the mobile clinic (E6/18-47).

However, several participants stressed good relations with the farmers as being an important factor in sustained treatment. One of the participants explained her experience on the importance of farmers' involvement in continued TB treatment as follows: *"In the area where I used to work the farmers were my mouthpiece. If I had a problem with a patient, I could phone and ask, 'Please help me with this patient'. In the area where I work now, there is a communication gap. How can I treat a patient successfully? A problem patient? I need someone. So communication is what often saves the day"* (A7/16-30; H9/42-56).

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4.3.10 Theme 10: Occupational Health and Safety Issues

4.3.10.1 Exposure due to the absence of effective means of communication

The participants were unanimous in stating that currently, their only means of communication while on routes is their private cell phones; however, cellular reception is not always available (H4/27). Previously, each mobile unit was equipped with a two-way radio that used the same frequency as the local ambulance service: *"...so there was constant communication between the clinic and the ambulance services"* (H4/39).

In the event of an adversity when out on their routes, the participants felt abandoned in the thought that nobody will know what happened to them (H4/16). *"We are left to our own devices"* (H4/34). They also expressed feelings of anxiety in the current violent South African climate: "*Two women out in a mobile. It's generally safe, but the world is changing and you have no way of calling someone if something happens"* (A10/33-36).

4.3.10.2 Trouble on the road

Flat tyres and getting stuck: According to the participants it often happens that vehicles get stuck or develop flat tyres along the routes, but not everyone feels that they are able to change the tyres. The tyres are too big and heavy and there has always been help from the community, whether it is a farmer, workers or passers-by (G5/24). One of the participants encountered a flat tyre on a busy national road. In the absence of a safe place to pull off the road, she slowly drove to the nearest garage, where the tyre could be changed in safety. A participant who drives a 4X4 vehicle, but who is not willing to change the tyres, because of the size of it, expressed her fears: *"I don't know what would have happened if we had been in the mountains where we were earlier. The tyres are too big"* (D7/49-62; D8/1-22).

There was an overall feeling of uneasiness noticeable during the interviews about the lack of effective means of communication on the mobile clinics, not just due to the nurses' own safety, but also that of their patients.

Exposure to unsafe roads: Dirt roads and national roads were singled out by the participants as being the most unsafe.

Their tales bore witness to roads that are in a bad condition, often slippery and muddy after heavy rains and full rivers, which force them to take detours. The following was relayed about a road that was washed away: *"I've had the experience where we had to climb out and ... put some rocks there so we can drive out, because the road was washed away. That's time-consuming and it's an issue, because now you're late"* (A3/6-9). Dangerous road

crossings on national roads, especially when thousands of city dwellers migrate to coastal towns during the holidays, were also depicted as a problem (B4/11-29).

Delays on route: Slow heavy vehicles and series of roadblocks due to road works on national roads disrupt traffic flow and cause mobile clinics to arrive late at farm stops and returning late from their routes in the afternoons*: "Nowadays they transport such big things via road .... If you land behind one of those, you will drive at 20 km/h and you have to wait at the road stops (due to roadworks). You have no choice but to sit and wait"* (D3/28-36).

4.3.10.3 Injury on duty

All the participants from the districts complained about daily loading and unloading of heavy crates or boxes with patient records, registers and medication as physically exhausting. The nurses were experiencing difficulty and were injuring themselves when carrying these. One participant recounts*: "For each route you have at least 3 to 4 big, heavy boxes which you have to carry in and out of the mobile"* (B4/1; D6/3-4; F6/1-4; G4/9-17). *"We have to carry the boxes down an unsteady step at the back of the fixed clinic to the mobile. I developed carpal tunnel syndrome on the mobile, then I could not drive anymore. Now I refuse to carry any boxes."*

A lack of safe storage space for the crates with patient records inside the mobile units is a further source of injury (H3/1). As depicted in par. 4.3.4.1 (*Physical Space*), the nurses hurt themselves due to deficits in the ergonomic outlay of the mobile clinics.

Furthermore, the participants who work in vehicles with no passage between the driver's cabin and the clinic area expressed their dissatisfaction with their situation: *"When it rains, we cannot move from the front to the back, then we have to get out and climb in at the back and we get wet and sick"* (H2/51).

4.3.10.4 No toilets

All the participants put emphasis on the unbearable heat in the vehicles during the summer months. They become irritated due to the heat, which is worsened by the fact that, in the absence of toilet facilities, they compensate by not drinking enough water*: "It's hot, you are irritated, and you cannot drink water because there are no toilets"* (F4/51) (see par. 4.3.4.2 about poor ventilation).

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4.3.11 Theme 11: Concerns of delivering a quality service

4.3.11.1 The safety of medicine

Concern for the extremely high temperatures to which medicine is exposed in the mobile units was expressed. Although this problem has been repeatedly reported to their managers, it is still unsolved. The participants stated that they have no other choice than to provide this heat-exposed medication to the patients: *"I have asked many times about the medication on the bus because it reaches temperatures of 40 to 45 degrees. That is unacceptable, but what must we do?"* (F2/13-28.)

Another problem is what to do with the boxes with prepacked chronic medication while patients are being seen at the various farm stops. Some of the participants stated that when they reach their stops, they have to store these boxes in the driver's cabin where temperatures often reach 50˚C, but as one participant explained: *"There is no other space"* (A3/20; H3/1-20) (see par. 4.3.4.1 in the context of "physical space")**.**

4.3.11.2 The accuracy and completeness of patient records and registers

Different reasons on why patient records and registers are not being completed during consultation sessions have been identified during the interviews. It was mentioned that the large size of some registers and a lack of storage space in the mobile units prevent the staff from taking manuals and registers with on routes (see par. 4.3.4.1 in the context of "physical space"). In addition, due to a lack of consultation time, they have to choose between complete record-keeping and attending to the patients (A3/26-32; B2/50-52, 61-63; B3/1-4).

In some areas, the fixed and mobile clinics share the patient records. Consequently, it has happened that records were not available at the time of consultation and subscriptions needed to be done afterwards. Some of the participants described their record system as chaotic. All these factors contribute to incomplete and inaccurate record-keeping (B2/48-52 H5/9-10, 25-27), (see par. 4.3.5.2 on "too little time to complete tasks - record-keeping").

4.3.11.3 The frequency of mobile clinic routes

As discussed in par. 4.3.5, in several subdistricts the participants were verbalising an unmanageable patient load and too few mobile clinics. In par. 4.3.6 and 4.3.11.4, a lack of trained CNPs, the only ones who can deliver the full package of a comprehensive PHC service, are discussed (A2/2-6). As a result the frequency of mobile clinic visits has been decreased to once every four to six weeks in some of the subdistricts.

When rural areas are not visited frequently enough, the quality of health care is adversely affected, as pointed out by the participants. Some of these problems are to obtain sputum

samples in time for monitoring of the progress of TB patients' sickness; chronic treatment that needs to be provided 2-weekly; the monitoring of children on the PMTCT programme and challenges in the reaching of departmental health goals. Some of the descriptions of such problems are as follows: *"Unfortunately nowadays we only visit a farm once per month, which I regard as a problem. If you have a patient with TB who needs medication and he does not pitch you will only see him in a month's time. We need his sputum"* (A7/32-43). *"There was one patient that missed his TB medication because he couldn't walk the distance. He should also be getting his psychiatric injection twice a month, but the bus only goes out once a month, so he is in hospital. He had a psychotic episode, so you are back to square one again. How do you deal with those types of patients?"* (A8/57-62; A9/1-2; H5/54-57).

4.3.11.4 Availability of CNPs on the mobile units

During the interviews it became evident that the scope of PHC service offered at the various mobile units differs from area to area. Where a CNP offers the mobile service the full package of preventive and curative care is being provided, but in the case of RNs without the qualification, only a limited curative service is offered. CNPs participating in the study were concerned that CNPs will be replaced by RNs, since the latter will not be able to treat major illnesses (*A*2/45-55). Apparently, health care managers have the perception that CNPs can be better utilised in fixed clinics than in mobile units (G7/50-53). Their argument is that on days that the mobile clinics are not on route in specific areas, sick patients have to go to the fixed clinics anyway. They argue that sick patients might just as well go to the fixed clinics all the time (F6/21-24).

4.3.11.5 The treatment of patients with dignity

The participants have named a variety of cases in the mobile clinic work environment that impair patients' dignity. It was mentioned that in the absence of toilet facilities, patients are sent *"into the bushes"* to obtain a urine sample (D8/48). At most of the stop points there is not sufficient protection against the natural elements (A3/10-11). A lack of privacy during the execution of cervical smears, HIV counselling and other sensitive conditions were concerns in ensuring that patients are treated with dignity. In addition, a number of deficits in the mobile work environment hamper the quality of care being provided to patients. A lack of lighting for safe patient examinations, nurses who have to look down on patients during consultation sessions since they have to stand in the absence of seating, patients being treated by staff that are irritable due to the excessive heat and stuffiness in the mobile units and a clinic environment that swarms with flies, have been described by the participants (A6/7-15).

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4.3.12 Theme 12: Participant suggestions for the improvement of the mobile unit work environment

When PNs or CNPs go on leave or on course, nurses equal in rank must relieve them to manage the mobile service, since ENs and ENAs are confronted with clinical situations, e.g. uncontrolled blood pressures or child immunisations that necessitates them to work outside their scope of practice when working without PNs and CNPs on the mobile units (B7/53-63).

Furthermore, in the mobile clinic environment, the ENA must be substituted by an EN to ensure continuity of preventive services in the absence of PNs and CNPs, since mobile clinic services come to a halt when these nurses go on leave or on a course (B4/35-49; B5/1-4).

After hours work, such as the semi-annual renewal of chronic medication scripts and working through lunchtimes, should be recognised as overtime. It happened that mobile clinic nurses' excessive patient load prevented them from managing all nursing functions during duty hours. For the same reason they are not taking lunch breaks. These are personal times for which the mobile clinic nurses are not remunerated (B8/25-59; D5/2-7). A suggestion was made that these times be given back on a Friday afternoon (D5/2-7).

The participants felt it is unfair that over and above their own responsibilities and workload they have to help in the fixed clinics. They would like to see that this tendency be stopped in future. "*They* (managers and fixed clinic staff) *musn't expect of us to help them with their tasks"* (H5/13-15).

Furthermore, given that ENs and ENAs currently have to resign from their positions on the mobile clinics to be able to study further, more opportunities for courses such as bridging courses for ENs and ENAs must be created (B5/38-58).

It was also suggested that the Community Based Services be extended to the farming communities. According to Tsolekile, Puoane, Schneider, Levitt and Steyn (2014:1), community health workers have a crucial role in linking communities with health facilities, providing health support and empowering communities. Since the mobile clinic staff do not always have the time or effective means of communication to reach patients in between scheduled clinic visits, they need someone on the farms that could start active case finding, e.g. when concerned about a patient with abnormal blood results, or when they need to inform newly diagnosed tuberculosis patients to come to the mobile clinic at the next scheduled visit.

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Amidst the feeling that mobile clinic nurses are being neglected and considering the extreme patient loads in some areas, a second mobile clinic was highly recommended. *"If mobile clinic staff are truly looked after, an additional mobile unit is a necessity"* (C7/16-27).

Considering the condition of some of the mobile clinics being utilised in the health services of the Western Cape Province, the participants felt that it is unfair that nurses in other provinces are privileged to work from bigger, more advanced mobile units while the same does not happen here. Accordingly, they wished for more spacious mobile units that will bring greater equality in the mobile clinic environment (B9/55-62).

Moreover, due to a lack of computers in the mobile clinic health services, the nurses find it difficult to manage the importing of chronic patients' prescriptions during duty hours (B10/3-7).

4.4 SUMMARY

The perceptions and experiences of 19 nurses working in the mobile clinic health services of five subdistricts across a vast area of the Western Cape Province were described in this chapter; these included 15 registered nurses of which 10 were additionally qualified as CNPs.

In all the districts, i.e. The Cape Winelands, Overberg and West Coast districts, the participants agreed that mobile clinic health services are indispensable to people living in remote areas in affording them access to PHC. Participants experience the mobile clinic health services as the answer to reaching health goals in the prevention of disease and promotion of health.

Complex, difficult working conditions and living the values of caring and job satisfaction, as shared by the participants, were described in this chapter. A number of themes and subthemes were described which included the following: shortcomings of the vehicles, especially the design of the mobile clinic areas in relation to space and temperature control; several demotivating experiences concerning an excessive workload, a lack of relief staff to allow current staff further training, nurses obliged to work outside their scope of practice, exposure due to the absence of effective means of communication and the dangers of working on the roads. Issues on fairness in the workplace and the concerns of the participants about the quality of health care to their patients were also captured.

Several positive aspects on mobile clinics were pointed out by the participants, accentuating it as a work environment of choice for many nurses.

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4.5 CONCLUSION

In this chapter the depth, richness and complexity of the mobile clinic work environment was described. Ritchie's approach to data analysis provided valuable guidance in unravelling the specific details and relationships of these phenomena, as presented in the verbatim-transcribed interviews that formed the data set. From the data set the researcher could do an intensive examination of the perceptions and experiences of nurses about the work environment of mobile clinics in the Western Cape Province and capture their life experiences in various themes and subthemes.

In the next chapter the researcher will discuss the themes and subthemes described in this chapter, form appropriate conclusions and make the necessary recommendations to enhance the quality of health care in the field of mobile clinic health service. The limitations identified in the previous chapters will also be addressed in chapter five.

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CHAPTER 5:
DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

The future character and culture of the South African health sector in 2030 will be defined by decisions and actions taken in the forthcoming five years. Every error or failure to act appropriately might take many years to rectify. Therefore, succinct and coherent policy and practice need to be put in place (National Department of Health, 2011:6).

Amidst a paucity of published research findings about the public health mobile clinic work environment in South Africa, a need existed for exploration of this work environment. Therefore, this study aimed to explore the perceptions and experiences of nurses about the mobile clinic work environment in the rural areas of the Western Cape Province of South Africa.

In this chapter, the researcher will look beyond the themes that emerged from the study data presented in chapter four, to get an understanding of the wider meaning of the findings of this study (Creswell, 2013:187). Likewise, recommendations related to the mobile clinic health services of the Western Cape Province will be proposed, based on the study data.

5.2 DISCUSSION

The purpose of this study was to explore the perceptions and experiences of nurses about the work environment of mobile clinics. This exploration was guided by the factors from Herzberg's Two-factor motivational theory as fully presented in par. 2.7.2. Content analysis, according to Ritchie and Lewis (par. 3.6.1), was used to analyse the data collected during individual interviews and group discussions. Chapter four presents the study findings.

A discussion on these study findings in relation to the objectives of this study are presented in this chapter.

5.2.1 Objective 1: The perceptions of nurses about the mobile clinic work environment

5.2.1.1 The mobile clinic health services add value

The mobile clinic nurse study participants perceive the mobile clinic health services as a field in health service delivery that adds value to the lives of people living in the rural environment. It is regarded as a means from where to provide preventative health care to

people living in the remote rural areas: *"Many of the farms are far from town, and if you don't take those patients' chronic medication to them and give them their immunisations, they have no other way of acquiring it. Some of them only need their contraceptive injection"* (D4/24-30).

5.2.1.2 Appreciating the mobile clinic work environment

Another perception of participants found is appreciation for the mobile clinic work environment: *"You get to know them* (the patients) *and their circumstances so well that you look forward to going out to them"* (E6/4-6). Working autonomously adds to their appreciation of the mobile clinic work environment: *"It gives you a sense of freedom. It is satisfying to go to the farms and see your patients. You feel that you are achieving something"* (H10/4-8).

5.2.1.3 Concerns for delivering a quality health service

However, the study participants revealed several concerns for delivering a quality health service. Accordingly, they were not comfortable with the unsafe conditions within which medicine is kept in the mobile units and were therefore worried about the potential harmful effects of these medications: *"I have asked many times about the medication on the bus, because it reaches temperatures of 40 to 45 degrees"* (F2/13-28). These temperatures are inconsistent with pharmaceutical legislation, which stipulates that the temperature in a mobile unit must be in accordance with the requirements of storage of medicine (South African Pharmacy Council, 2010:27). Accordingly, medicine should be stored at temperatures between 20˚C and 25˚C and never higher than 30˚C. Exposure to periods of excessive heat can cause medicine to change physically, lose its potency or become unsafe for human usage (Orr, 2013:26).

Furthermore, study participants were concerned about the tendency of rescheduling mobile clinic services to visit farm communities less frequently within challenges of unmanageable patient loads, a lack of trained CNPs and too few mobile clinics: *"There was one patient* (who) *should be getting his psychiatric injection twice a month, but the bus only goes out once a month, so he is in hospital. He had a psychotic episode, so you are back to square one again"* (A8/57-62; A9/1-2; H5/54-57). Thus, this practice has the possibility to compromise treatment compliance and managing certain medical conditions.

Key informants were also concerned about the accuracy and completeness of patient records and registers (par. 4.3.11.2). According to the literature, inaccurate or omitted data can have several harmful consequences. Not only does it negatively affect quality of care, it also concerns the patient's rights, increases costs and inefficiencies, and gives rise to liability risks (Verhulst, 2006:4).

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Moreover, participants were concerned that patients are not treated with the necessary dignity (see par. 4.3.11.5). Their concern is grounded in the belief that every person is born with an inherent dignity that should be respected and protected (Republic of South Africa, 1996:6).

Mobile clinic nurses appreciate that their work adds value to the lives and health of the indigent. However, the PNs working in the mobile clinic environment have concerns regarding the safety of the medication exposed to high temperatures in the mobile clinic units. Furthermore, should the mobile clinic work environment remain unchanged, there is a great possibility that PNs working on mobile units inadvertently open themselves to medico-legal risks, as they do not have sufficient time to ensure adequate recordkeeping.

In conclusion, in view of the findings on the perception of nurses about the mobile clinic work environment, the mobile clinic nurses find themselves in a dilemma as they desire to render a safe and quality health service. However, their work environment lacks the necessary resources to do so. These findings show that the Provincial Government of the Western Cape's vision to offer client-centred quality health care and improved access to quality health care to all by the year 2030 is unlikely if the mobile clinic work environment remains unchanged (Western Cape Government, 2011:30).

5.2.2 Objective 2: The experiences of nurses about the mobile clinic work environment

5.2.2.1 The mobile clinic units

This study also found that even though different types of small mobile units are being utilized, participants reported that these vehicles do not address the needs of staff and patients: "*It is so hot, you cannot close the door"* (G1/6-9). Moreover, the physical space in the work area does not meet the needs in terms of the actual space required to perform nursing activities: *"Our examination bed is our desk, that's where our sharps are, where the statistics pages and files are kept, where the dustbin is. Therefore, when we examine a patient we have to take all those things off and find another place for it, which is impossible. In these circumstances, I really examine the least number of patients. If it is not absolutely necessary I do not let them lie down"* (B2/35-39). Thus, the inappropriate working conditions in the mobile clinics adversely affect the patients' right to privacy and safe patient care. Furthermore, a lack of space and deficiencies in the design of work areas affect the quality of care being provided to farm dwellers.

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Penchansky and Thomas (1981:127) based 'access to care' on five principles: availability, affordability, accessibility, acceptability and accommodation. As each of these principles is closely related to one another, deficiencies in any one of them by definition, influences 'access to care' (Brant et al., 2006:2). In reflection to the mobile clinic work environment, a lack of privacy during consultation sessions (acceptability) and incomplete patient examination (accessibility) are realities that limit access to care.

5.2.2.2 Working conditions

This study found that mobile clinic nurses have an excessive workload. Despite their job related functions, they also have responsibilities with regard to the vehicles and various tasks that are usually performed by different categories of workers (par. 4.3.5.1.6).

Besides this workload, it was found that participants experience additional stress with regard to expectations of continued performance amidst perilous roads, as driver of a mobile unit, especially the older vehicles and maintenance of the vehicles: *"There is no-one who takes physical responsibility for checking the buses to ensure that they are in good condition. I leave here at 7 o'clock in the morning, and I never return before five o'clock, half past five. Where do I find the time to go to a garage to have those things checked for me?"* (H3/61-62; H4/1-2) (par. 4.3.9).

In conjunction with the above findings, it was found that the current mobile clinic work environment lend itself to unfair labour practice. Over and above poor staff allocation (par. 4.3.5.3), too many patients and too few mobile clinics (par. 4.3.5.4), this study found that mobile clinic nurses are not compensated for overtime work to ensure completion of nursing tasks: *"It is very frustrating that they do not acknowledge the time we work here. They say the only overtime we are allowed to claim is when we are physically on the mobile"* (A2/18-20; B8/35, 55, 48-51; E5/17-48).

Due to a lack of relief staff, the mobile clinic work environment lacks opportunity for in-service training (par. 4.3.7), or allowing current staff to study further (par. 4.3.8). Even more, participants experienced that management did not acknowledge them for the work they do: *"I don't think anyone knows what we really do. I actually only work for the sake of my patients"* (B8/6-7) (par. 4.3.9.4).

Despite all of this, they are still committed to the communities they serve: *"You get to know them and their circumstances so well that you look forward to going out to them"* (E6/4-6) (par. 4.3.2).

However, being committed does not justify the adverse working conditions of mobile clinic nurses. According to Lavagnini and Mennella (2014:222), work overload is unhealthy and stressful, as it holds risks of work related illnesses, working accidents due to hazardous moments of poor concentration and interference with workers' personal life. Hughes and Ferrett (2016:72) defined the individual factors that affect health and safety at work as any condition or characteristic of a person, physical, cognitive or psychological that could influence that person to act in an unsafe manner. Accordingly, low skill and competence levels, tiredness, boredom, low morale and individual medical problems were identified as the most common individual factors that contribute to accidents at work (Hughes & Ferrett, 2016:72-73).

Concerning fairness in the workplace, people expect others to treat them fairly. According to Rupp (2015:1), employees have a tendency to be committed, loyal and in good health when believing their job is just, whereas injustice may trigger hostility, aggression, feelings of resentment, counter productivity, absenteeism and even contribute to employees resigning from their posts.

For the sake of staff and patient safety, it is thus crucial that public service managers at all levels take cognizance of individual factors, such as attitude, motivation, training and human error in the mobile clinic work environment, all factors that could have a significant effect on the health and safety of mobile clinic nurses.

5.2.2.3 Occupational health and safety

Study participants also pointed to many external occupational health and safety related issues in the mobile clinic environment. For example, participants experienced feeling unsafe due to the absence of effective means of telecommunication, especially when working in vast areas where there is no cell phone reception (par. 4.3.10.1). In case of trouble on the road, such as developing a flat tyre, being stuck or delayed because of dangerous roads, the realities of the participants were revealed by this study: *"I've had the experience where we had to climb out and ... put some rocks there so we can drive out, because the road was washed away. That's time-consuming and it's an issue, because now you're late"* (A3/6-9) (par. 4.3.10.2).

Furthermore, deficiencies in the ergonomic outlay of work areas (par. 4.3.10.3), the lack of sufficient cross ventilation in the mobile unit workspace (par. 4.3.4.2) and the lack of toilet facilities in the mobile units (par. 4.3.10.4), were reported as occupational health and safety risks for the staff that have to work in these units: *"When it rains, we cannot move from the*

front to the back, then we have to get out and climb in at the back and we get wet and sick" (H2/51).

According to Hughes and Ferrett (2016:71) ergonomically designed work areas are to accommodate comfort and the health of the worker. When workers working in such an environment are appropriately trained and are experienced, the risks for human error and thus medical-legal risks are minimised. Workspace, lighting, noise and heating conditions, access to maintenance, control of fatigue and stress and efficient communication are all matters included in the concept of ergonomics.

In conclusion, the objective was to explore the experiences of nurses about the mobile clinic work environment. The findings revealed that despite having different types of mobile clinics, the expectations of both the mobile clinic nursing teams who manage the mobile clinic health services and their patients, are not met. Accordingly, patients' rights to privacy and safe health care are being violated in the current mobile clinic work environment, as well as nurses' rights to safe working conditions and fair labour practices.

The study also revealed that health management do not recognize the complexities of delivering a health service from a mobile clinic and therefore, do not take cognizance of the time of additional administration and recordkeeping on mobile clinics, as well as occupational health and safety issues.

5.2.3 Objective 3: Job satisfaction in the mobile clinic work environment

According to the literature, satisfaction is the fulfilment of wishes, expectations or needs. Thus, patients will be satisfied through the health services provided of which satisfied employees form an integral part. However, employees' performances are largely influenced by their level of motivation and job satisfaction (Hossain, 2015:95, 98).

5.2.3.1 The mobile clinic health services add value

According to the findings of this study, the participants derive satisfaction from their perception that the mobile clinic health services add value to the lives of the indigent. A feeling of personal achievement is experienced when they are able to attain above average health goals (par. 4.3.1).

According to Herzberg (2003:93), the ability to achieve contributes to experiencing psychological growth. The stimuli for the growth needs are tasks that induce growth, such as the job contentment. Cuthie (s.a.:1) stated that intrinsic incentives are those factors that descend from performing the work itself. They include feeling successful or important,

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learning valuable skills and enjoying the outcomes of work accomplished, such as helping other people.

When looking at 'the mobile clinic health services add value' in context of Herzberg's motivation theory and more specifically, 'the work itself' (par. 2.7.2.2), the conclusion is that the scope of nursing in the mobile clinic work environment is interesting and stimulating, holding ample opportunities for personal achievement and satisfaction. For this reason 'the work itself' in the mobile clinic environment is regarded as a strong motivator for ongoing quality work.

5.2.3.2 Appreciating the mobile clinic work environment

This study found a perception of good nurse-patient relations and good team cohesion amongst the two nurses that are working per mobile unit. Within these perceptions, despite difficult work circumstances, much appreciation for the mobile clinic work environment was detected.

However, Bakotić and Babić (2013:209) stated that working conditions, one of the factors that influence job satisfaction, do not determine overall job satisfaction. Accordingly, employees working in difficult conditions experience less job satisfaction than employees who work in normal working conditions. They therefore put emphasis on the importance of improved working conditions for workers who work in difficult circumstances.

Furthermore, according to Bakotić and Babić (2013:207), difficult working conditions refer to external factors, such as temperature, humidity, lighting, interference and dust. These also refer to subjective factors that include the gender and age of the worker, fatigue and unfavourable posture during work. Additionally, difficult working conditions are related to the organization of production, such as the work schedule, work pace and excessive strain. It is thus clear that difficult working conditions will influence employees' ability to perform.

The literature also indicates that good interpersonal relations contribute to a relaxed work atmosphere (Sabbag, 2009:68). However, good interpersonal relations as a hygiene factor only contribute to the avoidance of job dissatisfaction, not job satisfaction in the long run (Herzberg, 2003:91-92).

5.2.3.3 Types and structure of mobile units

In analysing the perceptions and experiences of nurses about their working conditions, the overall impression was that the shortcomings of the vehicles and more specifically deficiencies in the design of workspaces are major factors contributing to mobile clinic nurses being dissatisfied with their work environment.

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According to Herzberg's Two-factor Theory (Herzberg, 2003:91-92), working conditions as a dissatisfaction-avoidance (Hygiene) factor, represents the environment in which a scope of practice is to be performed. When inadequate, it can cause serious dissatisfaction. Therefore, when managers want to get rid of dissatisfaction in the workplace, they will have to attend to the factors that make employees feel unsafe, unhappy and uncomfortable in the workplace (Hartzell, 2013:n.p.).

5.2.3.4 An excessive workload

Amid shortcomings in the vehicles (par 4.3.3 - 4.3.4) and an excessive workload (para 4.3.5), mobile clinic nurses struggle to meet the set standards for excellence in health service delivery. Frustration, arising from a state of insecurity and dissatisfaction due to unresolved problems or unfulfilled needs (Merriam-Webster, s.a.), was found to be experienced by the participants of this study. Accordingly, much frustration were experienced regarding a lack of time for safe quality nursing care and administrative tasks, inequities in staff allocation between the fixed and mobile clinics and the extent to which they have to work overtime to complete tasks. Amid concern about the fate of sick patients whom have to be shown away at the mobile clinics due to excessive patient loads, the participants' emphasised that the nursing code of ethics are being violated. Similarly, dissatisfaction regarding various tasks beyond nurses' job description that are to be performed by mobile clinic nurses were detected, holding them from their nursing obligations. Moreover, a lack of support regarding the seasonal workers phenomenon, a lack of relieve staff when mobile clinic nurses went on leave and a disregard for after hour work as overtime, were identified as sources of extreme dissatisfaction among participants.

These findings are in agreement with the findings of a study by Nur Aisha et al. (2013:605) that working conditions, incentives and motivation have a statistical significant effect on employees' performance. Accordingly, performance refers to the concepts of ability, opportunity and motivation. Ability is a function of education, experience and training. Opportunity refers to the infrastructure and facilities that are to accommodate a job and motivation to a psychological process that concerns arousing, directing and affecting persistence in a certain course of action to achieve a goal (Nur Aisha, et al., 2013:605).

Consequently, good performance is expected when employees have the ability to do their job, the infrastructure and facilities to accommodate the job and the motivation to achieve a goal. Conversely, with deficiencies in any of these, as portrayed by the participants of this study, work performance are compromised.

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In conclusion, due to the shortcomings of the vehicles and an excessive workload, mobile clinic nurses struggle in living up to the set standards for excellence in health service delivery. These are major factors contributing to mobile clinic nurses being dissatisfied with their working conditions.

5.2.3.5 Lack of in-service training

Participants, who did not receive the required in-service training, are exposed and vulnerable in their ability to adhere to the work activities of the mobile clinic.

At a first glance, the primary shortcoming identified was a lack of in-service training, however, when looking at this matter in relation to job satisfaction, much more are at stake. According to the Turner (2006:27) people tend to feel vulnerable when they are exposed to the possibility of being harmed, either physically or emotionally. Thus, when nurses lack in-service training, their vulnerability is directed towards the possibility of emotional harm, since they fear treating patients wrongly and putting their career at risk. Accordingly, Maslow referred to all necessities that provide a sense of security and well-being as safety needs (Hartzell, 2013:n.p). Managers are attending to the safety needs of their subordinates if they provide safe working conditions, fair labour practices, a stable emotional environment and job security (Hartzell, 2013:1; Tanner,s.a.:1).

Underlying to the matter of a lack of in-service training in the mobile clinic environment is supervision of subordinates. The literature indicates that a lack of supervision in the workplace has a far-reaching negative impact on employees' feelings of safety, their morale and eventually job satisfaction and productivity (Jennings, 2010:1).

All these factors are environmental factors that when absent, Herzberg (2003:91-92) found to be causes of dissatisfaction in the work environment. Herzberg's findings are found to be in agreement with the findings of this study.

In conclusion, amid a lack of in-service training, mobile clinic nurses lack the ability to adhere to the nursing activities of the mobile clinic work environment. This situation not only subjects itself to risks in treating patients wrongly, nurses are also placing their careers at risk. In these unsafe working conditions nurses felt profoundly dissatisfied with their working conditions.

5.2.3.6 Lack of relief staff to allow current staff further studies

This study also found that, due to shortages in relief staff, participants experienced a lack of opportunities for growth. Accordingly, it was found that participants have to resign from their posts, taking with them a wealth of expertise, to be able to further their studies. Others suffer

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emotional breakdowns and depression when expected to adhere to both job and study obligations.

Herzberg (2003:91-92) states that opportunities for growth in the workplace address a unique human characteristic, the ability to achieve and thereby to experience psychological growth. His research indicates that employees are highly motivated and satisfied in the presence of opportunities for growth, thereby providing an explanation why study participants lack job satisfaction in relation to opportunities for growth in the mobile clinic work environment.

Furthermore, compared to their colleagues in the fixed clinics, the consequences of a lack of relieve staff in the mobile clinic environment lend itself to inequality between the mobile and fixed clinics, which encompass elements of unfair labour practice. (Fairness in the workplace is discussed in par. 2.9.2.1). According to Nur Aisha et al. (2013:609), fairness in the workplace plays a significant role in employee motivation. Motivation has a significant effect on an employee's ability to perform. Thus, goal achievement becomes compromised when employees lack opportunities for growth.

In conclusion, the mobile clinic work environment lack opportunities for nurses to further their studies, since ENs and ENAs have to resign from their posts to further their studies. PNs suffer extreme emotional stress when expected to adhere to both job and study obligations. Mobile clinic nurses thus lack motivation to further their studies. Moreover, these matters compromise health goal achievements.

5.2.3.7 Additional stressors

It was further found that the participants do not always have confidence in the roadworthiness of the mobile units, especially the older vehicles. Irrespective of constant breakdowns, perilous roads and poor means of communication, it also became clear that the participants were constantly under pressure to reach health targets.

Inequality between the mobile and fixed clinics regarding the cleaning of work areas, the misuse of mobile clinic staff regarding the maintenance of mobile units, sluggishness in the establishment of proper mobile health facilities and safe parking for mobile units, were other adversities identified by this study. Regardless of all these, a lack of insight in the extent of the participants' workload and working conditions and concurrently, a lack of recognition and support from top management was found to be the grounds for poor interpersonal relations between the participant, their colleagues at the fixed clinics and top management. All of

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these matters were found to be causing a lot of frustration and dissatisfaction in the everyday lives of the study participants.

In view of the above findings and in accordance with Herzberg's theory, the mobile clinic work environment lack supervision, security, healthy interpersonal relations and fair labour practices (par. 5.2.3.7). These factors address the dissatisfaction-avoidance or hygiene factors of Herzberg's theory, the circumstances in which a scope of practice is to be performed (Herzberg, 2003:92). Thus, since they represent the physiological wants of employees in the workplace, they are needed to avoid dissatisfaction (Herzberg, 2003:92).

The findings of this study also revealed a lack of recognition for achievement within difficult working conditions in the mobile clinic environment. As one of the motivational factors in Herzberg's theory, recognition addresses a psychological need that Blair (2009:2), associates with feeling appreciated. Thus, when work is done well but ignored by management, the resulting message will be that "no one cares". Moreover, when management does not listen to the needs of the employees, their relationship of trust is violated (Blair, 1992:2).

In conclusion, various stressors experienced by mobile clinic nurses stem from a lack of supervision, security, healthy interpersonal relations and fair labour practices. Furthermore, amid a lack of recognition for achievement within their difficult working conditions, the relationship of trust between them and top management is compromised. All these factors relate to the circumstances in which a scope of practice is to be performed and were found to be causing a lot of frustration and dissatisfaction in the everyday lives of the mobile clinic nurses.

5.2.3.8 Occupational Health and Safety issues

In par. 5.2.2.3 the findings on the experiences of nurses about occupational health and safety in the mobile clinic work environment have been discussed. These findings revealed concerns regarding the risks pertaining to the absence of effective means of telecommunication, deficiencies in the ergonomic outlay of work areas that contribute to staff becoming sick and injuring themselves, a lack of sufficient cross ventilation in the mobile unit workspace and a lack of toilet facilities in the mobile units. When viewing these aspects in accordance with job satisfaction, this study found that study participants experienced considerable dissatisfaction with regard to the lack of occupational health and safety measurements in the mobile clinic work environment.

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These findings are in agreement with Herzberg's findings on security matters. According to Herzberg's Two-factor Theory, a lack of security stems from the human instinct to avoid pain from the environment. Thus, people will experience dissatisfaction when their work environment lacks the necessary security measurements (Herzberg, 2003:92).

In conclusion, the occupational health and safety issues that were identified in this study are the cause of considerable job dissatisfaction. It is of great concern for staff wellness and quality patient care in the current mobile clinic work environment.

5.3 LIMITATIONS

The views of nurse managers were not sought during data collection, thereby limiting the objectivity of matters, such as the lack of acknowledgement as being experienced by the participants (par. 4.3.9.4).

5.4 RECOMMENDATIONS

The recommendations for this study emerged from the scientific evidence as discussed in this study. The evidence indicates that the mobile clinic health services have a crucial role to play in the field of rural health. However, pertaining medical-legal risks, employee dissatisfaction and a lack of employee motivation in the mobile clinic work environment raised deep concerns whether the Provincial Government of the Western Cape's vision to offer client-centred quality health care and improved access to quality health care to all by the year 2030 will be reachable. The following are recommended:

5.4.1 Working conditions

At provincial level, decision makers should investigate the possibility of developing at least three prototype mobile clinic work areas from which the PNs managing the mobile health services can select. However, decision makers should take cognizance of the particular needs of the individual mobile clinic service nursing teams. Therefore, all relevant managers need to engage with mobile clinic health teams when the need arises.

For instance, managers from the Department of Transport and Public Works, together with the engineer who are responsible for converting the vehicle into a mobile clinic, need to engage with individual mobile clinic health teams before procurement of new mobile clinic units. Furthermore, when evaluating the vehicle, these managers need to communicate directly with the individual mobile clinic health teams. This is to ensure that all reasonable ergonomical aspects are communicated first hand and properly addressed (see par. 5.2.2.3 on ergonomically designed work areas).

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Then again, nurse managers need to meet monthly with mobile clinic nursing teams and proactively address their needs as far as possible. The allocation of vehicle maintenance tasks, clerical tasks or cleaning tasks to the appropriate staff categories need to be taken up with the relevant departments. However, should obstacles such as cleaners' job descriptions that do not include the mobile clinic services arise, managers need to take the necessary steps to assure equality in dividing resources.

This approach would amongst others, complement motivational issues as reflected by Herzberg's Two-factor Motivational Theory.

5.4.2 Occupational health and safety

When investigating different prototypes, consideration should be given to occupational health and safety legislation to ensure compliance to the law. Moreover, an occupational health and safety risk assessment needs to be conducted in all mobile clinic work areas to ensure the Western Cape Department of Health is occupational health and safety compliant.

5.4.3 Quality assurance in the mobile clinic environment

Health managers need to take cognizance of the various concerns of study participants. Concerning the accuracy and completeness of patient records and registers, quality insurance audits need to be performed in the mobile clinic environment, as being done in the fixed clinics, followed by the needed affirmative actions to address barriers in quality insurance. Likewise, the availability of CNPs on the mobile units should be considered in agreement with the Western Cape Province's mission of providing a comprehensive package of care to improve health outcomes (Western Cape Government, 2011:12).

Furthermore, health managers need to address the dilemma of inadequately trained professional nurses in the mobile clinic work environment. They need to understand that due to the autonomous nature of mobile clinic nursing within shortcomings such as a lack of telecommunication, these nurses need to be properly skilled. However, considering the lack of relief staff to allow mobile clinic staff further studies or the needed in-service training, the need for properly skilled nurses in the mobile clinic work environment needs to be prioritised.

On national and provincial level, policy makers need to consider the achievability of policy amid staff shortages on clinic level. This study described the enormous implications of a lack of relief staff on the well-being of mobile clinic nurses, as well as on health care provision. Managers together with mobile clinic teams therefore should develop a standardised contingency plan to address staff shortages in the mobile clinic environment within the necessary legal framework to ensure staff wellness, as well as safe patient care.

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5.4.4 Further research

The current mobile clinic environment lends itself to the need for various further research studies:-

- An objective opinion needs to be sought as to the particular requirements a mobile clinic health service needs to adhere to in rendering an optimal health service to the different communities situated in different rural terrains in the Western Cape. This is to address the looming ethical dilemmas in the mobile clinic work environment. Therefore, management needs to seriously consider the problem areas identified by the study participants of this study. Further to this, it is recommended that the Western Cape Health Department investigates how the prototype mobile unit designed in a previous study in the Western Cape and built by the Department of Health (Bosman et al., 2012), can be adjusted and changed until it is fit for purpose.
- Identify and describe medical legal risks pertaining to an excessive workload amid a lack of time for proper recordkeeping and administration in the mobile clinic work environment.
- An exploration of health management's perceptions on mobile clinic health service delivery.
- The perceptions and experiences of nurses in the other provinces of South Africa about the mobile clinic work environment.
- The perceptions and experiences of patients about the mobile clinic health services.
- For reasons of accessibility, this study was only conducted in the three health districts of the Western Cape Province. The opinion of mobile clinic nurses in the two excluded districts, Eden and Central Karoo, which are also the furthest from the Cape Metropole, might contribute significantly to the knowledge base of mobile clinic services in the whole of the Western Cape Province.

5.5 DISSEMINATION

The researcher plans to publish these findings of this study in an accredited, peer-reviewed health care journal. Furthermore, opportunity will be sought to present the findings at a meeting of the Forum for Professional Nurse Leaders in the Western Cape.

5.6 FINAL CONCLUSION

In this chapter, the study findings were discussed in relation to the specific objectives set for this study. These were thoroughly explored to answer the research question, which is consequently answered.

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The findings urge the necessity for decision makers to take cognizance of the needs of mobile clinic nurses, in so doing revealing that they are committed to the optimum development, motivation and utilisation of personnel and the promotion of sound labour and interpersonal relations (RSA, 2002:31).

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APPENDICES

Appendix 1: Ethical approval from Stellenbosch University

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot • your knowledge partner

Approval Notice
New Application

01-Aug-2013
STEMMET, Charlotte Louise

Ethics Reference #: S12/12/319
Title: **Clinical Nurse Practitioners' perceptions and experiences of the mobile clinic work enviroment.**

Dear Ms Charlotte STEMMET,

The New Application received on **06-Dec-2012**, was reviewed by members of **Health Research Ethics Committee 1** via Expedited review procedures on **31-Jul-2013** and was approved.
Please note the following information about your approved research protocol:

Protocol Approval Period: **31-Jul-2013 -31-Jul-2014**

Please remember to use your **protocol number** (S12/12/319) on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:
Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired.
The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.
Translation of the consent document to the language applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.
For standard HREC forms and documents please visit: www.sun.ac.za/rds

If you have any questions or need further assistance, please contact the HREC office at 0219389657.

Included Documents:
CV'S
Consent Form
Application Form
Investigators declaration
Protocol
Synopsis
Checklist

Sincerely,

Franklin Weber

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Appendix 2: Permission obtained from Department of Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6857; fax: +27 21 483 9895
5th Floor, Norton Rose House,, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: RP 122/2013
ENQUIRIES: Ms Charlene Roderick

Disa Street 16
Fairy Glen
Worcester
6850

For attention: **Charlotte Louise Stemmet**

Re: Clinical Nurse Practitioners' perceptions and experiences about the mobile clinic work environment

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following people to assist you with any further enquiries in accessing the following sites:

Cape Winelands CHC	**Ms S Neethling**	**Contact No. 023 348 8120**
Overberg District	**Ms R Zondo**	**Contact No. 028 212 1512**
West Coast CHC	**Dr D Schoeman**	**Contact No. 022 487 9267**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.

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2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR NT Naledi
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 10/12/2013

CC	**DR L PHILLIPS**	**DIRECTOR: CAPE WINELANDS**
CC	**MS W KAMFER**	**DIRECTOR: OVERBERG**
CC	**DR H SCHUMANN**	**DIRECTOR: WEST COAST**

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Appendix 3: Participant information leaflet and consent form

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT:
Perceptions and experiences of nurses about the mobile clinic work environment

REFERENCE NUMBER: S12/12/319

PRINCIPAL INVESTIGATOR: Charlotte Louise Stemmet

ADDRESS: 16 Disa Street
Fairy Glen
Worcester
6850

CONTACT NUMBER: 084 207 1400 **e-mail:** charlottestemmet@telkomsa.net

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the interviewer any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is entirely voluntary and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Human Research Ethics Committee of the Faculty of Medicine and Health Sciences at Stellenbosch University** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

In the Re-engineering of Primary Health Care in South Africa document, under core standards for clinics and community health centres, significant deficiencies in the mobile

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clinic work environment have been identified. In addition, the well-being of mobile clinic nurses and the mobile clinic work environment have never been scientifically investigated.

In striving for excellence in mobile clinic health services in the Western Cape by the year 2020, the researcher recognised the need to identify the factors that influence job satisfaction negatively and to explore the effect of these factors on the functional abilities of the mobile clinic registered nurses.

The purpose of this study will therefore be to explore the perceptions and experiences of nurses about the mobile clinic work environment.

This study will be conducted in the three districts: West Coast, Cape Winelands and Overberg in the Western Cape Province. Nurses working in the mobile clinic work environment will be invited for an interview. In total, 14 (or more) nurses will be interviewed (until data saturation occurs).

Interview procedure:

1. All nurses working on mobile clinics in the selected subdistricts, will be traced via the Primary Health Care nurse managers of the subdistricts.
2. An appointment date will be scheduled with all interested participants to conduct a focus group interview or a one-to-one interview at a venue of the participants' choice.
3. Interviews will be audio-recorded and transcribed.
4. All participants will be interviewed anonymously in order to enhance protection of identity and confidentiality, and thus ensure anonymity.
5. Participation is voluntary and may be terminated at any time.

Why have you been invited to participate?

You are an expert in this field and you posses valuable information that could influence the development of mobile clinic health services in the future.

What will your responsibilities be?

1. Read this leaflet.
2. Think about and reflect honestly on your perceptions and experiences of the mobile clinic work environment and how it affects your functional abilities as a registered nurse or clinical nurse practitioner in a mobile unit.
3. Complete and sign this consent form in duplicate. Keep one form for yourself and give the other to the researcher.

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Will you benefit from taking part in this research?

Mobile clinic nurses and patients in the Westen Cape will only benefit from this study once the study findings are considered in the development of an operational plan for mobile clinics in the province.

Will you be paid to take part in this study and are there any costs involved?

No, you will not be paid to take part in this study. However, you will receive compensation for transport expenses to the interview site. Light refreshments will also be served at the interview site.

Are there any risks involved in your taking part in this research?

There is the potential risk for breach of confidentiality within the focus group discussions and possible victimisation by colleagues or management. This is minimised by all participants and the interviewer signing this consent form, declaring that they will keep confidential all information shared with them during interviews or any other discussions.

If you do not agree to take part, what alternatives do you have?

There are no alternatives – either you participate or not. You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study.

Who will have access to the audio-recorded and transcribed records?

All information collected during interviews will be treated as confidential. The identity of the participant will remain anonymous at all times, including in any publication or thesis resulting from the study. All data will be locked up in a safe for a period of five years and will only be made available to the supervisor, co-supervisor and research ethics committee upon request.

Is there anything else that you should know or do?

- You can contact the ***Human Research Ethics Committee of the Faculty of Medicine and Health Sciences at 021-938 9207*** if you have any concerns or complaints.
- If you have questions regarding your rights as a research participant, contact ***Ms Danine Kitshoff [danenek@sun.ac.za; 021 938 9823] at the Division of Nursing, Stellenbosch University.***

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Declaration by participant

By signing below, I …………………………………...………… agree to take part in a research study entitled: Perceptions and experiences of nurses about the mobile clinic work environment.

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is voluntary and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the interviewer feels it is in my best interests, or if I do not follow the study plan, as agreed to.
- I confirm that I will keep confidential all information shared with me at the focus group or other discussions

Signed at (place) ....…........………… on (date) …………....……….. 2014.

....	…………………………………………..
Signature of participant	**Signature of witness**

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Declaration by interviewer

I (name) ……………………………………………..…………………….. declare that:

- I have explained the information in this document to ……………………..............
- I have encouraged him/her to ask questions and have taken adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above.
- I confirm that I will keep confidential all information shared with me at focus groups or any other discussions.

Signed at (place) .... on (date) …………..……….......... 2014.

....	…………………………………………..
Signature of interviewer	**Signature of witness**

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Appendix 4: Demographic data

Perceptions and experiences of nurses about the mobile clinic work environment.

Interview date:……………………………………………………………………………

Subdistrict:…………………………………………………………………………………..

Mobile clinic service area:……………………………………………………………..

Age of paritcipant: (indicate with an X)

25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-65

Nursing qualification:

Basic (encircle)	R48 (CNP) (encircle)	Other
Diploma / Degree	Sertificate / diploma	Qualification:………………………….

How long have you been working on a mobile clinic?..

How many days a week does "your" mobile clinic service deliver a health service in the community?...

Please note that your identity will not be made known with regards to any information shared during the interviews. Dificiencies in the mobile clinic work environment are to be addressed as a whole and no emphasis will be placed on a specific subdistrict.

Thankyou for your participation.

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Appendix 4:Semi-structured interview guide

Question: What are your perceptions and experiences of the mobile clinic work environment?

Prompting words:

- working conditions
- supervision
- interpersonal relations
- organisational policies and administration
- benefits
- the work itself
- opportunities for growth
- responsibilities
- achievements
- advancement
- fairness in the workplace

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Appendix 5: Confidentiality agreement with data transcriber

TIK & TAAL

Eienaar/Owner: Niny West

TO WHOM IT MAY CONCERN

This letter is confirmation that I,

Niny West,

have transcribed the audio recordings used in the research for the thesis of **Charlotte Louise Stemmet**.

I confirm that I have kept and will keep confidential all information acquired during transcription of the interviews.

Yours faithfully

Niny West
November 2015

FOR: CHARLOTTE LOUISE STEMMET

TITLE: PERCEPTIONS AND EXPERIENCES OF NURSES ABOUT THE MOBILE CLINIC WORK ENVIRONMENT

Niny West *Quelleriestr. 34* *023-347 0373*
TIK & TAAL *WORCESTER. 6850* *082 667 1383*
Email: ninywest@telkomsa.net

Stellenbosch University https://scholar.sun.ac.za

Appendix 6: Extract of a transcribed interview

ONDERHOUD E

Prof: Dis die 26ste Februarie en ek is op (dorp). Ek gaan 'n onderhoud voer met 'n verpleegkundige en stafverpleegkundige wat op 'n mobiele eenheid in die gebied werk.

Môre, baie dankie dat julle deel is van hierdie onderhoud en dankie dat ek dit mag opneem. Ek wil vra dat julle asb nie mekaar se name noem nie.

Wat ek vir u wil vra is om vir my te vertel van u ondervinding van die mobiele eenheid as 'n werksomgewing.

Deelnemer: Vir my persoonlik is die mobiele eenheid 'n goeie eenheid wat gebruik kan word, dit kan goed funksioneer as dit voldoen aan die vereistes vir die persoon wat dit bestuur of in beheer is.

Prof: Waaraan dink u as u praat van die vereistes waaraan dit moet voldoen?

Deelnemer: Soos bv. daar is nie genoeg spasie in ons bussie nie, 'n Toyota Hilux, en die ruimte aan die agterkant is baie klein. Daar is bokse met lêers wat agterin moet kom en Suster en 'n stafverpleegster en 'n berader, so daar is nie genoeg staanplek vir ons almal nie, en ook nie privaatheid nie. Gewoonlik sit die pasiënt wat inkom daar en die Suster doen haar verpleegaksies en die stafverpleegster doen sekere dinge en so ook die berader op dieselfde pasiënt, en soms staan daar mense om die bussie rond en hulle kan als hoor wat gesê word. Persoonlike dinge kom uit en daar word van jou verwag om die pasiënt te ondersteun en bietjie meer uit te vind en inligting aan die pasiënt te gee.

Prof: So soms sê u is die ruimte bietjie beperk want dis die pasiënt, die stafverpleegster, Suster, die berader. Het die pasiënt soms 'n baba wat sy gekry het?

Deelnemer: Ja.

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Prof: So dis redelik beperk om agter in die Hilux bakkie se canopy te werk. So u moet uitklim uit die bakkie uit en agter ingaan. U praat van 'n berader. Het u elke keer drie mense wat uitgaan met die mobiel?

Deelnemer: Nie altyd nie. Dit hang af van die omstandighede, as daar 'n behoefte is dat daar 'n berader moet wees. As gevolg van iemand wat nie aan diens is nie, bly die berader soms binne, dan gaan die Suster en stafverpleegster alleen uit.

Prof: Sit u al drie voor in die mobiel?

Deelnemer: Ja, ons sit al drie in die voorste sitplek. Ek is kort, dis nou een ding van die mobiele eenheid. Dit is ook 'n ongemaklikheid, want die sitplek moet vorentoe geskuif word, so almal is ongemaklik om my te akkommodeer.

Prof: Het julle almal veiligheidsgordels?

Deelnemer: Ja, daar is drie veiligheidsgordels, so almal is veilig.

Prof: Goed. U moet nou vir my 'n bietjie meer verduidelik, want die spasie lyk vir my na 'n meter en 'n half agterin waar julle werk. Hier moet nou die verpleegkundiges, die berader, die pasiënt en moontlik 'n baba inpas, en die ruimte klink vir my baie beperk. Kan jy die mense ondersoek in so 'n beperkte ruimte?

Deelnemer: Jy kan mense ondersoek, maar as dit by 'n papsmeer kom, is dit ongemaklik, want die persoon moet mos 'n sekere liggaamsposisie inneem vir 'n papsmeer. Die venster aan die bokant sal mos nou oop wees, so dis weer die kwessie van privaatheid.

Prof: Dis weereens 'n probleem. Die dame moet 'n papsmeer kry, en behalwe die ruimte wat beperk is, luister die mense rondom die mobiel en bly die stafverpleegkundige en die berader in die eenheid terwyl jy 'n papsmeer moet doen.

Deelnemer: Nee, hulle gaan gewoonlik uit, veral as dit 'n swaar pasiënt is wat ondersoek word. Dan trek ons sommer die gordyn toe en trek die deur toe en ons staan buite of in die deur dat die ander mense nie kan sien nie. *6:23*

Prof: Maar dit beperk tog die privaatheid van die pasiënt wat die ondersoek moet hê.

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Deelnemer: Veral by jou vroulike pasiënte as sy 'n inspuiting moet kry, dan moet jy tog 'n gordyn daar hê. As dit ons al drie is, moet een van ons uitklim. Die reg van die pasiënt word ook geskend.

Prof: So die privaatheid. Ek was gister in (dorp) en (dorp) en dit lyk my dit kan baie warm word. Toe was ek gistermiddag hier. Al 4 of 5, afhangend of daar 'n kindjie by is of 2, is agterin en jy moet 'n spuit gee. So dis die privaatheid van die pasiënt wat geskend word, enigiets anders? U praat ook van 'n gordyn en nie genoeg ruimte nie.

Deelnemer: Nie genoeg ruimte nie, As ek die baba moet inspuit, lê hy hier, ek moet my koelboks daar oophê, die berader is dalk ook hier, die ma is hier, dalk nog 'n kindjie en Suster. Veiligheid t.o.v. die kind self. Die toesighouer moet nou die baba en die kindjie dophou terwyl ons die immunisasie gee, want die trappie wat aangehak word, is hoog en kinders kan daar afval. Die mense buite is ook nie vreeslik behulpsaam nie, so hulle sal nie help kyk nie. Die kind is dalk ook bang vir die ander mense en wil nie by die ander mense staan nie, afhangend van die ontwikkelingsfase waarin die kind is. Jy kan ook nie altyd die ander mense vertrou en jou kind vir enige persoon gee om dop te hou nie. Die kind kan dalk verdwyn of voor in die bakkie klim en die handbriek losmaak. Enigiets kan gebeur. Jyself voel dalk siek en dit reën, maar jy gaan steeds uit op die bus. Mens weet ook nie altyd of die pasiënte geestesgesond is nie.

Prof: So wat u vir my sê, is die veiligheid van die pasiënt en die pasiënt se kinders, want u voel verantwoordelik vir die veiligheid van die klein kindertjies wat rondhardloop en alles wil verken. En vir uself as personeel is dit ook nie altyd veilig nie, met betrekking tot die vasstaan van die bakkie, die handbriek aansit, spesifiek wanneer dit reën. Vertel my meer van die weersomstandighede binne die mobiel.

Deelnemer: As dit voorin is, is dit okay, want ons het mos nou aircon, maar agterin is dit verskriklik warm en bedompig, veral as ons drie en die pasiënt daarin is.

Prof: En die immunisasie en wat van die cold chain?

Deelnemer: Ons het mos nou 'n yspak onderin, dan karton, dan die immunisasie, dan weer karton en 'n yspak bo-op. Dit hou die immunisasie koel.

Prof: En dan laai u dit agterin?

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Deelnemer: Agter in die bus, ja.

Prof: So die cold chain word behou, maar deur middel van cooler bags – is that right, with an ice pack, cardboard, immunisations, cardboard and ice pack. Daarmee is u heeltemal tevrede dat die cold chain behou word.

Deelnemer: Ja, maar somtyds voel dit asof die temperatuur in die mobiel 2 keer meer is as wat dit buite is. Die spasie is ook baie bedompig.

Prof: U het nie 'n termometer in die mobiel nie?

Deelnemer: Daar is 'n termometertjie in die ice pack, maar nie agter in die bus nie.

Prof: Maar u voel omdat daar mense is, is dit eintlik baie warmer as buite, en buite is dit baie warm.

Deelnemer: Dis reg, ja.

Prof: Goed, u het begin sê van medikasie?

Deelnemer: Die medikasie word aan die humiditeit blootgestel. Die medikasie is in die binnekant van die bussie en ek weet nie of dit so goed is nie, want dit moet mos 'n sekere temperatuur wees en daardie temperatuur moet gehandhaaf word. Die medikasie word vervang deur ons apteker en ons hou dit in kartonboksies aan. Daar is boksies waarin ons die medikasie sit, maar ek weet nie ...

Prof: U twyfel of die blootstelling aan die hitte van die medikasie goed is. Dit vernietig dalk die effek van die medikasie. Nog iets oor die mobiel en die werksomstandighede wat u wil noem? *13:17*

Deelnemer: Die paaie is baiekeer onbegaanbaar, veral in die winter. Dit is dan glyerig en glad en ons moet soms uitgaan met die bussie, wat gevaarlik is vir ons.

Prof: So u praat van die gevaar vir u as personeel, wanneer u moet uitgaan wanneer die paaie nat en glad is.

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Deelnemer: Somtyds kan dit vir dae aaneen reën. Ons het die ondervinding gehad op 'n plaas waar die paaie onbegaanbaar was. Ons kon nie eintlik daar ry nie, want jy het meer gegly van die een kant na die ander, maar ons moes gaan. Ons het vasgeval en moes toe van die plaasboere vra om ons te kom uittrek en ons te help. Soms is daar ander roetes wat ons kan volg. Soms is die rivier vol, maar soms is dit 'n maklike roete om te volg.

Prof: Ek hoor u sê u voel onveilig wanneer u moet ry wanneer die paaie nat en glyerig is. Die boere help u om die bakkie te bestuur tot by 'n veilige punt, maar dit gebeur wel soms dat u nie deur die loop van die rivier kan ry nie, want die rivier kom af. Is daar nog iets wat u wil sê in terme van die werksomstandighede?

Deelnemer: Soms as die personeel siek is, moet jy die roetes inry, want die roetes is agter. Dan werk dit in op jou as persoon, jy raak kort van draad en jy is moeg, want alles moet binne 'n sekere tyd gedoen word. Vir my is dit verskriklik, want jy is by die werk, jy wil altyd jou beste gee, maar jy kan nie jou beste gee as jy moeg en vermoeid is nie. Ons is mense, nie masjiene nie, ons het elkeen ons eie persoonlikhede en dinge waarmee ons gemoeid is en dan kom dit soms dat ons met mekaar haaks is en dan voel ek aan die einde van die dag ek is ooreis, want jy kon nie vir 'n oomblik afskakel nie. Dan wens jy jy kan die dag in die kliniek bly en administrasie op datum kry, want dít kan ook 'n ding wees wat aan jou torring want jy het net nooit tyd om jou administrasie af te handel nie. Daar is net nie tyd om aandag te gee aan die prioritite nie.

Prof: Soos watter prioriteite?

Deelnemer: Administrasie wat jy op datum moet kry.

Prof: Vertel my van die administrasie. Wanneer doen u dit?

Deelnemer: Ons kry een keer op 'n Woensdag tyd om administrasie te doen, maar twee ure is nie genoeg om die administrasie op datum te kry nie. As jy op die plaas is, is daar soms voorskrifte wat verval het, en hulle verwag van jou om observasievorms sesmaandeliks te doen. Die persoon wat stabiel is, se vorms word sesmaandeliks gedoen. Die persone wat nie stabiel is nie, word meer gereeld gedoen, en daar word sekere dinge van jou verwag om te doen. Jy moet bv. bloed trek, die man se urine toets vir sekere proteïene. Dan is daar nog klein goedjies wat bykom wat nie altyd sin maak nie. En jy móét gesondheidsvoorligting gee, oor en oor en oor. Al sê jy dit ook vir een pasiënt vir die vierde keer, jy moet die

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gesinsvoorligting indril. Jy kan nie net 5 minute met 'n pasiënt spandeer nie en dit vat baie tyd. En hulle verwag jy moet 20 minute per plaas staan. Dis te kort.

Deelnemer: Dis te kort. Ons het nou die keer baie pasiënte gespuit, ons het nie eers die chroniese medikasie uitgedeel nie, ons het net die gesinsbeplanning gedoen.

Deelnemer: Ons het omtrent meer as 'n uur daar gestaan.

Prof: So die skedule is dat julle nie meer as 20 minute per plaas behoort te staan nie.

Deelnemer: Ons staan 20 minute, maar dis te min.

Prof: Dis wat ek probeer sê. Die werksplan word so uitgewerk dat u 20 minute per plaas het. Maar u vind dat wanneer u daar kom, dit soms nodig is om 'n uur daar te staan. U werk vas, maar u het nog nie alles gedoen nie, dan moet u inhaal, en u word hakkerig met mekaar en die pasiënte omdat u moeg is. Wat u sê, is dat u ook nie dan kan opvang met u administrasie nie, so dit wil voorkom asof dit u ook pla, want u werk kom nie klaar nie. Is dit wat u vir my sê?

Deelnemer: Ja, dis reg.

Prof: Nou wie werk dan die roetes en die tye uit?

Deelnemer: Dit word uitgewerk deur die Bestuurder van die kliniek. Maar dit word lank voor die tyd uitgewerk, dis vaste roetes. *20:32*

Prof: Maar kan u nie daar 'n voorstel maak nie?

Deelnemer: Ja, ons kan. Die verpleegbestuur doen die beplanning van die roetes, maar ons kan voorstelle maak. Dit is vasgestelde roetes, maar ons het laasjaar gevra dat van die roetes weggeneem of bygesit word.

Prof: En het dit so gebeur?

Deelnemer: Ja, roetes is weggeneem, want ek dink die verpleegbestuurder het besluit dat plase wat na aan die kliniek is binne loopafstand, word weggeneem.

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Prof: So u sê die bestuur het tog na u voorstel geluister, waar mense wat binne loopafstand van die vaste kliniek is, eerder loop soontoe as om nog las op die mobiel vir daardie stoppunt te sit.

Deelnemer: Maar daar is een roete, wat nader is aan (dorp A) as aan (dorp B). Die mense voel hulle moet meer geld uitgee na (dorp B) as na (dorp A). Die mense is arm en kan nie altyd bekostig om die taxigeld te betaal nie, so hulle kies om na die naaste kliniek te gaan en (dorp A) is nader. Die personeel by (dorp A) voel natuurlik (roete) is (dorp B) se mense. Dit maak eintlik dat die gevoelens nie lekker is tussen (dorp A) se personeel en (dorp B) se personeel nie.

Prof: Want dis 'n grensplaas, so aan wie behoort hy?

Deelnemer: Ja. (roete F) ook. Ek voel (roete F) behoort eerder aan (dorp C), want dis nader aan (dorp C) as aan (dorp B), ook as jy na die grense kyk.

Prof: So wat ek hoor, is dat u sê bepaling van grense en watter plase deur watter mobiel ingesluit word of nie, kan krapperigheid veroorsaak tussen gebiede, tussen u eie bussie en die bussies op die naburige dorpe.

Deelnemer: En aan die einde van die dag kry die pasiënt dan nie die voldoende dienslewering nie.

Prof: So die pasiënt trek aan die kortste ent.

Deelnemer: Beslis.

Prof: Het enige van u die R48?

Deelnemer: Ja, ek het die R48.

Prof: Toe u dit gedoen het, het u darem bietjie afgekry of het u dit gehad voordat u op die mobiel begin het?

Deelnemer: Voordat ek op die mobiel begin het.

Prof: Goed. So dit was hulle geluk, né?

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Deelnemer: Hulle geluk, ja.

Prof: En u sê 'n nat pad neem baie langer om te bestuur as 'n droë pad. So as dit nat en koud is, het u spanning om te bestuur, want die pad is glyerig, dit neem langer en alles moet nog steeds binne 'n sekere tyd gedoen word. Is dit reg?

Deelnemer: Ja. Jy is bang om 'n ongeluk te maak, want mense se lewens is in jou hande. As daar skade aan die voertuig is, is jy verantwoordelik, jy moet 'n verslag skryf. Alle verantwoordelikheid kom na jou toe.

Prof: So die verantwoordelikheid om hierdie bussie te bestuur en veiligheid in jou gedagtes te hê, al die verantwoordelikheid op jou te neem, is baie stremmend. Is daar nog iets?

Deelnemer: Sy bestuur maar altyd die bussie, so sy het al die verantwoordelikheid daarvan.

Prof: Dan het u gesê u kry Woensdae tyd vir administrasie, maar u vind dit is te min tyd.

Deelnemer: Dit is te min tyd, ja. *25:34*

Prof: Is die roetes so dat u na die tyd van elke dag die administrasie sal kan afhandel?

Deelnemer: Ek ry nie altyd sulke lang roetes nie, maar hulle roetes is baie lank en hulle kom uitvaltyd eers hier aan, dan is daar nie tyd om nog administrasie te doen nie.

Prof: Wanneer doen julle dit dan?

Deelnemer: Soos ons gesê het op 'n Woensdagmiddag as alles stil is, soms op 'n Vrydag. Dit hang ook af, soms as die kliniek baie vol is, moet ons daar help. In die somer is 'n mens baie moeg, jy doen baie werk, skryf jou ondersoeke en bevindinge in. Daar is nie altyd kans om dit alles te doen nie.

Prof: Wanneer kry jy dit dan gedoen, want dit moet gedoen word?

Deelnemer: Dan kom ek terug, hou my lêers in my boks en kom sit dit hier, dan hoop dit mos nou op. Dan kom die verpleegsters my aanspreek, want hulle soek lêers en hulle kry dit

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nie in my kamer nie, en wanneer maak ek dit klaar. Dan kom opleiding, soms is jy af siek, jy haal net nooit in nie.

Prof: Jy haal net nooit in nie. Neem jy ooit die goed huis toe?

Deelnemer: Daar was 'n tyd wat ek die goed huis toe geneem het, maar toe het ek besluit om dit nie te neem nie, want dit neem my eie tyd, ek moet mos tyd aan my eie mense ook spandeer.

Prof: Maar u kry dit nie in die gegewe tyd gedoen nie.

Deelnemer: Nee, die werk is te veel.

Prof: Maar dan veroorsaak dit ook spanning. Is daar enige voordele aan die werk in die mobiel?

Deelnemer: Ja, soms is dit mos baie bedrywig in die kliniek, dan is dit rustiger op die mobiel as in die kliniek self. Jy ken ook die pasiënte daarbuite se omstandighede, hoe hulle leef en so aan. Jy is na aan hulle, jy ken die name, ek werk eintlik lekker met hulle. Hier in die kliniek het jy net 'n paar minute, buite het jy meer tyd om te gesels, omstandighede te luister en voorligting te gee.

Prof: So u voel dis 'n groot voordeel om uit te gaan van die vaste kliniek, want u ken die pasiënt se naam en omstandighede. U kan voorligting gee binne daardie konteks en u kan hulle ondersteun en vir hulle leiding gee, en dis vir u lekker om ook so 'n bietjie uit te kom.

Deelnemer: Ja, so 'n bietjie.

Prof: Reg.

Deelnemer: Die ander ding is die plaasarbeiders waardeer jou as verpleegkundige meer vir die diens wat jy verskaf, hulle het meer respek en erken jou en wat jy vir hulle doen. Hulle is baie nederig en waardeer dit.

Prof: Is dit vir jou lekker?

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Deelnemer: Ja, dit is vir my lekker om op die bussie te werk, behalwe as daar so verskriklik baie goed is. Jy raak so bekend met die persone se omstandighede dat jy dit geniet om uit te gaan en die beste vir hulle te gee.

Prof: So die voordeel wat ek hoor is dat die plaasmense nederig is en u waardeer en respekteer vir wat u bring, en dit maak dit lekker en die moeite werd.

Deelnemer: Dit maak dit regtig die moeite werd en om 'n diens aan hulle te lewer. Die ander ding is, daar is nie lekker komunikasie tussen ons en die plaasboere nie. Mens voel nie gemaklik om, dit hang af watter persoon dit is, na hulle toe te gaan en met hulle te praat en te sê, Dis die probleem, is daar enigsins 'n manier hoe ons vir u tegemoet kan kom of u vir ons tegemoet kan kom? Daar is nie altyd daardie kommunikasie nie. Ons kom ook nie altyd op die tye wat op die blaaie uitgewerk is nie.

Prof: Wat is die rede dat u nie by die tyd hou nie? *30:45*

Deelnemer: Dit is mos wanneer ons opleiding kry of wanneer daar te min mense is of mense siek is, of die weersomstandighede.

Prof: Veroorsaak dit wat u gesê het, dat u nie altyd by die tye hou nie, die swak verhouding tussen u en die boere? As u bv sê u kom 10:00 en u kom 12:00 ...

Deelnemer: Nee, op die datums.

Prof: O, op die datums. U kan nie by die datums hou nie vanweë die opleidingsdae en dit veroorsaak probleme met die bestuur op die plaas.

Deelnemer: Ja, sommige boere het verskeie plase en dan het hulle reeds 'n dag uitgesit. Hy wil op die ander dae sy werkers op 'n ander plaas gebruik. As ons daar aankom, sê hy, Julle moes al gister gekom het, hoekom kom julle dan vandag? Ons werkers is nie vandag hier nie, want ons werksprogram lyk só. Dan moet hy óf die plaaswerkers gaan haal met spesiale vervoer óf ons moet tot daar gaan om die werkers te sien. Dan is daar eers 'n woordewisseling voordat enigiets anders gebeur.

Prof: En daardie woordewisseling lei tot erge spanning. U het vroeër gesê die pasiënte ly daaronder, kan ek dit nou maar sê?

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Deelnemer: Ja.

Prof: Goed. Wat dink u het u al bereik op die mobiel? ... [Stilte] ... Julle het al baie bereik, julle het kindertjies geïmmuniseer, julle het mense gehelp ...

Deelnemer: Dis reg ja.

Prof: Kry julle darem erkenning van die mense op die plase? Enigsins ander erkenning as van die pasiënte?

Deelnemer: Ons kry darem van die boere ook erkenning. Hulle gee dikwels 'n boks druiwe of gee vir ons 'n sak aartappels of so iets.

Prof: Dis fantasties. So julle kry wel erkenning daarvandaan. In die werksplek, dink u die verwagtinge van hoeveel mense gesien moet word tussen die vaste kliniek en die mobiel is billik?

Deelnemer: Dis nie dieselfde nie.

Prof: Wat bedoel jy met nie dieselfde nie?

Deelnemer: Die behoeftes van die dorpsmense en die plaasmense verskil. Op die bus is daar nie altyd alle voorrade nie. Jy vat die pleisters en salwe, ens saam, maar soms is dit 'n groot wond, dan kan jy dit nie daar hanteer nie, dan voldoen jy nie aan die persoon se verwagtinge nie, dan moet jy hom in dorp toe verwys. By die kliniek self word die groot brandwonde bv direk en onmiddellik gedoen, hy hoef nie per ambulans dokter of hospitaal toe te gaan nie. Op die plaas moet ons hom verwys of ons moet 'n ambulans bel en vra, as daar nie een beskikbaar is nie, moet die persoon self op eie koste inkom Klawer toe.

Prof: En dit is kostes. Wat is die gemiddelde koste vir die pasiënt per taxi min of meer?

Deelnemer: Ek dink uit (dorp A) uit is dit R30 om in (dorp B) te kom, maar privaat mense vra mos meer.

Prof: So dit kan baie geld kos om in te kom kliniek toe. En vir arm mense is dit onmoontlik om te betaal.

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Deelnemer: Ons moet ook kyk na die tyd hoe lank dit vir plaasmense vat om in te kom. Die taxibestuurder staan mos nou en wag tot sy taxi vol is voordat hy gaan beweeg van punt A tot by punt B. Dis hoekom die mense van privaat vervoer gebruik maak, wat baie meer kos as om 'n taxi te neem.

Prof: Is daar nog iets wat julle vir my sê t.o.v. die werksomstandighede in 'n mobiele eenheid?

Deelnemer: As ons nou 'n noodgeval moet kry, is ons skedulegoed en dit wat ons gebruik, ook nie altyd op datum nie. Ons kan regtig nie dan tyd spandeer om alles in te skryf nie, want ons gebruik die tyd om die persoon te help. Soms het ons ook nie al die hulpmiddels om die persoon te kan help nie. *36:48*

Prof: So dit bly ook in gebreke. Is daar 'n noodplan?

Deelnemer: Ja, ons het 'n noodplan op ons bussie.

Prof: Kan ek gou vir u vra, kry u ooit pap bande?

Deelnemer: Ja, ons het gereeld pap bande gekry.

Prof: Wat maak u dan? U is so klein?

Deelnemer: Nee, ek ruil nie bande om nie. Ons bel in na Namakwadienste en vra of hulle ons kan help.

Prof: So u het altyd kontak met die dorp. Het u 'n tweerigting radio?

Deelnemer: Nee, ons het nie 'n tweerigting radio nie. Dit was nogal 'n voorstel gewees laasjaar, maar ek weet nie wat daarvan geword het nie. Hulle sou begin het met 'n projek waarmee ons 'n tweerigting radio sou kry, 'n selfoon sou kry, ek weet nie wat daarvan geword het nie.

Prof: En as julle inbel, wat gebruik julle dan?

Deelnemer: Ons eie selfone, en ook om afsprake te maak.

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Prof: Gebruik julle jul eie selfone om afsprake te maak?

Deelnemer: Ja, ons bel die klerk, dan bel hy terug.

Prof: Maar die eerste kontak is met jou eie persoonlike selfoon, dan as jy 'n pap wiel het, bel jy in en mense kom uit. Reg. Maar dit gebeur nie baie nie, nie met hierdie bakkie se bande nie.

Deelnemer: Dit kan baie gebeur, want waar ons ry, is dit nogal skerp klippe en die afval van die mense wat hulle rondom die huise gooi. Soms staan ons naby of tussen die huise, dan sien jy nie altyd draadheinings, bottelstukke, skerp voorwerpe, ens nie.

Prof: Goed, as daar daar niks meer is nie, sê ek vir u baie dankie vir u deelname.

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Appendix 7: Declarations by language editor

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TO WHOM IT MAY CONCERN

This letter serves to confirm that the undersigned

ILLONA ALTHAEA MEYER

has proof-read and edited the document contained herein for language correctness.

(Ms IA Meyer)

SIGNED

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