SC

THE SELECTION OF LEARNING OPPORTUNITIES FOR STUDENT NURSES ON THE APPLICATION OF PRIMARY HEALTH CARE IN THE TWO TRAINING HOSPITALS IN THE NORTH WEST REGION OF NAMIBIA

BY

HERMINE IITA

Submitted in fulfillment of the requirements for the degree of

Masters in Nursing Science
at the
University of Namibia

SUPERVISOR: PROF A VAN DYK (UNAM)
JOINT SUPERVISOR: DR U ALBERTS (UNISA)

Declaration:

I declare that "The selection of learning opportunities for students on the application of Primary Health Care in the two training hospitals in the North West Region of Namibia" is my own work and that all the sources that I have used have been indicated and acknowledged by means of complete references.

Signed by: .....
Hermine Iita

This ..... date of 2001

Dedicated to:

This study is dedicated to all Namibian Nurses who serve the communities of this country with commitment.

Acknowledgements:

I am grateful to the following people and institutions who did so much to make this study a success.

- My study supervisors, Professor Agnes van Dyk and Doctor U Alberts for their wisdom and consistent support. Through them, I learned not only how to do qualitative research but also that students need to be guided as humanly as possible.
- The University of Namibia, Faculty of Medical and Health Sciences, for approving my application for this study as well as for all logistical support.
- The Ministry of Health and Social Services of the Republic of Namibia for granting me permission to conduct this study and for all their input.
- The Regional Director, Dr N.T. Hamata for allowing me to conduct this research in his directorate.
- The Hospital Management of Oshakati and Onandjokwe Hospital for allowing me to conduct research in their facilities and for all the support offered.
- The Nursing Science Divisional heads of Oshakati and Onandjokwe University of Namibia division for allowing me to conduct research at their premises.
- The respondents for this study, for being co-operative and patient with me when I was collecting data.

- Mrs Suoma Kuugongelwa, a colleague, who has taken care of my students when ever I have had to attend to my educational consultation.

- Ms Ndapewa Shifiona, a colleague, who has always been unselfish in supporting me academically and morally throughout this study.

- Mrs Annalize Tsuses and Mr Imms Kalimba who assisted with the typing.

- My husband Ananias and my whole family for being patient and for giving me the necessary moral and financial support.

- All my friends, colleagues and relatives for all the support given.

- All the academic and administrative staff of the Faculty of Medical and Health Sciences, UNAM; at the Oshakati and Windhoek Campuses for all the support given.

Abstract:

Being a nursing lecturer the researcher had a question on whether appropriate learning opportunities and guidance for primary health care were selected and provided for nursing students in the two training hospitals in the Northern part of Namibia.

The study therefore focused on the following two objectives:

- to identify the factors that influence the selection of learning opportunities for primary health care in hospital units
- to determine how student nurses were guided and educated on primary health care in hospital units

A qualitative research design utilizing focus group discussions were used. The population consisted of purposively selected lecturers, student nurses and registered nurses. The same initial question was asked in each focus group to initiate the discussions. The data was analysed according to Tesch's method.

The results indicated that there is good commitment from the lecturers and registered nurses to be involved in selecting appropriate learning opportunities as well as to be involved in responsible guidance. The student nurses also demonstrated a willingness to learn and to be exposed to learning opportunities in primary health care. There were however certain constraints that emerged as themes: managerial constraints and educational constraints

Under the theme "Managerial constraints"
Categories such as workload, nursing staff shortages and communication problems were identified.

Under the theme "Educational constraints"
Categories such as a lack of conducive teaching, lack of guidance, the gap between the correlation of theory and practice emerged.

Recommendations based on this research report include improved inservice education on managerial and educational aspects to facilitate the primary health care approach in hospitals.

TABLE OF CONTENTS

PAGE

CHAPTER 2

RESEARCH DESIGN AND METHOD

CHAPTER 3

DISCUSSION OF THE FINDINGS

CHAPTER 4

SUMMARY OF THE FINDINGS, CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

Annexures

List of abbreviations

AIDS	-	Acquired Immune Deficiency Syndrome
ANC	-	Antenatal Care
BCG	-	Bacillus Calmette Guerine
HIV	-	Human Immunodeficiency Virus
MCH	-	Mother and Child Health/Maternal and Child Health
MOHSS	-	Ministry of Health and Social Services
PHC	-	Primary Health Care
TB	-	Tuberculosis
UNAM	-	University of Namibia

CHAPTER 1
INTRODUCTION AND BACKGROUND

Introduction

Health systems have taken generations to reform with the aim to improve health services, and governments are forever under pressure to meet the demands of the society concerning health needs. New approaches have also been suggested for the delivery of health care. Such attempts to improve the health of the world's population culminated in a conference held on September 6, 1978: in Alma Ata the International Conference on primary health care. The concepts used in PHC were defined during this conference and evolved from a meshing of ideas and experiences from various communities throughout the world (Tarimo & Webster 1996: 38). At the Alma Ata Conference the world community committed themselves to achievement of a health status consistent with a socially and economically productive life.

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (Monekosso 1994: 16).

For this strategy to be determined, first and foremost there must be political commitment to primary health care by the government in power. The government of Namibia declared its commitment to the equitable distribution of resources and to equity of access to basic services for the entire Namibian nation. As a result of this commitment the Ministry of Health and Social Services also adopted the primary health care approach as a strategy to achieve health for all by the year 2000 and beyond.

According to the national primary health care guidelines in Namibia primary health care should include at least

- education concerning prevailing health problems and the methods to prevent and control them;
- promotion of food supply and proper nutrition; adequate supply of safe water and
- basic sanitation
- maternal and child health care including family planning, immunization against major diseases, appropriate treatment of common diseases and injuries and provision of essential drugs, community participation in health and social matters.

(Official National Primary Health Care/Community based health care guidelines 1992: 4)

Although the shift of emphasis in primary health care is for the people in the community to become active participants in their own health care, hospitals still form part of the comprehensive approach that is needed for the implementation of primary health care.

Since hospitals are a major factor in providing health services, their role to contribute to primary health care services must not be under estimated. Hospitals also play a major role in the education of health personnel of which nurses are a vital part.

The role of hospitals in providing primary health care is:

- promotion of proper nutrition
- maternal and child care which include immunization of the newborn baby (BCG), antenatal care, foetal growth monitoring, family planning, treatment of common conditions associated with pregnancy
- general health education
- appropriate treatment of common diseases and injuries

(The Official National Primary Health Care/Community Based Health Care Guidelines MOHSS 1992: 4,67)

Analysis of the problem

It was clear that a shift in the emphasis of health care was necessary from curative hospital based care to community based care. This new approach to render health services required changes. Dr Mahler in his keynote address in Tokyo emphasized this by stating "Implementing of this new strategy, health for all, depends above all on people, their commitment to social equity, and on their understanding of the critical issues affecting the implementation of the strategy, and on their initiative to resolve these issues adequately" (Ntoane 1993: 37). It became clear that applying the Primary Health Care approach called for a reorientation of values,

attitudes and curricula of all health care workers. Furthermore, according to Dennil et al (1995: 2) the concept of primary health care encompasses a political philosophy that calls for radical changes in both the design and content of traditional health care services.

Kasonde & Martin (1994: 10) write about the experience with primary health care implementation in Zambia, which is a country that had a health care system containing elements of primary health care before the Alma Ata declaration on primary health care implementation in 1978. The government of Zambia decided to adopt a primary health care approach. A primary health care document was then developed and adopted after which, health workers were trained and reoriented. The problems according to the authors that were experienced in Zambia to develop primary health care were that;

- within the health sector itself, support for primary health care among doctors was very limited and this had a negative influence
- the emphasis on prevention of sickness and promotion of good health in primary health care had little genuine public appeal
- the public had been forcing health workers to provide curative services
- the financial difficulties forced managers to be reluctant to release funds
- team work among health personnel at all levels was poor, and at community level, difficulties were encountered in sustaining the primary health care activities.

According to Kazakhstan & Almaly cited in, 27-28 November 1998s' report of the World Health Organization's international meeting to celebrate 20 years after Alma-Ata declaration on primary health care, the discussions at that meeting revealed that primary health care implementation should be regarded as everybody's business if it is to be successful. It also needs political commitment. It was noticed that increases in communicable diseases like Tuberculosis and Acquired Immuno Deficiency Syndrome as well as non-communicable disease, violent trauma and substance abuse could be combated if all sectors could be actively involved in their prevention and control. To some extent, the deterioration in health status can be attributed to inadequacies in primary health care implementation.

To overcome this problem, the government in Namibia, started orientation progammes at training institutions and reviewed curricula to include primary health care concepts. Health workers, including registered nurses and lecturers were sent on courses to update their knowledge and skills on primary health care.

The nursing education curriculum of the University of Namibia for the registered nurse education was reviewed to include the primary health care approach. The content of the curriculum was re-organised in such a way that after completion of the course, the registered nurse will be able to provide and facilitate comprehensive health care (promotive, curative, preventive and rehabilitative) to individuals, vulnerable groups, families and communities at clinics and hospitals according to the policy

guidelines on primary health care and protocols of the Ministry of Health and Social Services (UNAM 1995: 8).

The revised curriculum for the education and training of professional nurses made provision for student nurses to be more exposed to field work and to participate in community projects. Lecturers and registered nurses were expected to guide and teach students in the clinical set up.

However, the time has come to ask how student nurses are prepared to meet the essential elements of a primary health care programme. All students apparently are able to say that primary health care must demonstrate equity, accessibility, affordability, acceptability, and community involvement. Yet there is not sufficient evidence that all concerned understand exactly how they have to function to ensure nursing contributions to the effective implementation of primary health care elements specifically within a hospital setup.

The creation and selection of learning opportunities and guidance of student nurses regarding the implementation of primary health care principles specifically in hospitals sometimes became problematic. One reason that is given is the strong emphasis on the community and community involvement in primary health care. Some nurses can't see the place of curative services, more specifically the role of the hospital in this regard. A second reason could be that hospitals do not view their responsibilities as extending to the population outside its walls, or consider its role in primary health care to include participation in the

characterization of the problems, resources, and needs of the population it serves. Also the problem of resistance to change is always present.

This leads to a situation where preventative, curative and rehabilitative services are seen as different pillars and not as a whole (Ebrahim & Ranken 1995: 12). Unfortunately, this attitude also creates stumbling blocks when it comes to the selection of learning opportunities for students, specifically in hospitals to develop their skills concerning the primary health care approach.

Hospitals as a health care facility is also important because nurses provide care at all levels namely, primary, secondary and tertiary. Nurses are frequently the main connection between the individual, family, other health professionals and the community.

For professional nurses to be able to respond with flexibility as well as to be pro-active and innovative practitioners they must get proper guidance, education and training on all levels of a comprehensive health care system. This is because the nurse has to play a major role in all aspects of the national developmental work which is the primary aim of primary health care.

In order to achieve learning that will enhance the practice of primary health care applicable learning opportunities must be selected in hospitals and students must be exposed to it, to gain experience and competence in it. Apart from the aspects that were mentioned where hospitals can

contribute to the implementation of primary health care, health promotion in general must be addressed. Learning opportunities are needed where students must get the opportunity to practice health promoting work with communities from out of the hospital set up. Learning opportunities where students get the opportunity to enhance personal and social development by providing health information to help patients to develop the skills they need to make healthy choices are vital (Dennill et al 1995: 11).

Problem statement

It is not clear if the learning opportunities that are needed to develop the necessary skills like social consciousness, flexibility in decision making, problem solving, health education, practical procedures, open communication intellectual skills, knowledge base attitudes which underlie the effectiveness of nursing practice are identified, selected and that students are educated and guided enough on the issues with regard to primary health care.

Research questions

Because of the abovementioned factors the researcher has come up with the following research questions:

- How are student nurses guided and educated for the Primary Health Care approach in the hospital units.
- How are learning opportunities selected by registered nurses and lecturers for student nurses, for the application of Primary Health Care in the hospital units.

Purpose of the study

It is because of the abovementioned facts that the purpose of the study is to explore and describe the experiences of registered nurses, lecturers and student nurses in selecting learning opportunities and guidance of students on primary health care in hospital wards.

Objectives of the study

The objectives of the study were:

- to identify the factors that influenced the selection of learning opportunities for primary health care in hospital units
- to determine how student nurses were guided and educated on primary health care in hospital units

Central statement

The exploration and description of the real life situation under which student nurses are being educated and guided will produce helpful information which lecturers, registered nurses and student nurses themselves might use for the purpose of efficient student nurses' education in primary health care.

Definitions

The following concepts and statements will be defined as follows:

Factors – are any of the conditions that act with each other to bring about a result (Longman new generation extended dictionary, 1982: 232).

Learning opportunities – are the possibilities for learning created by the registered nurse or midwife in the classroom and clinical teaching situation and could be used by the student to reach learning objectives (Mellish & Brink 1997: 118).

Registered nurse – is any person who is registered with the nursing board of Namibia as a registered nurse under Section 13 of the nursing professions Act, 30 of 1993. It also includes nursing lecturers who have an additional qualification as nurse educators (Nursing Act, 30 of 1993: 7).

A student nurse – is a person who is registered with a recognised training institution and with the registration authority to undergo training for 4 years in Comprehensive Nursing and Midwifery under Section 21 of the Nursing Professions Act, 1993 (Nursing Act, 30 of 1993: 7).

Training hospital – is an approved institution of training and education where sick people are treated, it should comply with the requirements of prescribed qualifications as contemplated in Section 18 of the Nursing Professions Act, 30 of 1993 (Nursing Act, 30 of 1993).

Clinical teaching – is the means by which student nurses learn to apply the theory of nursing so that an integration of theoretical knowledge and practical skills becomes the art and science of nursing (Mellish, Brink & Pera 1998: 207).

Primary Health Care (PHC) - is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford (Searle, Brink & Grobler, 1991: 141).

Methodological Assumptions

The scientific development and professional advancement in nursing should arise from a functional approach. Therefore, any scientific advancement in nursing is for contextual application of any knowledge gained, thus advancing the practice of nursing (Botes 1995: 19-23).

Summary

Because of changes in the health care delivery system in Namibia registered nurse students needed to be prepared in such a way that they could meet the demand for nursing care provision according to the primary health care approach as adopted by the government of Namibia to be the focal point of health care delivery to all communities in the Republic of Namibia. Nurse educators and clinical nurse practitioners have a responsibility to see to it that student nurses are prepared to suit the primary health care approach.

CHAPTER 2
RESEARCH DESIGN AND METHOD

Introduction

Qualitative research forms the basis of this research design and method. It is used as a vehicle for studying the empirical world from the perspective of the subject, not the researcher. Qualitative methods allow exploration of a human by humans in ways that acknowledge the value of all the evidence, the inevitability and worth of subjectivity, the value of a holistic view, and the integration of all patterns of knowing (Streubert & Capenter as sited in Shifiona 1998: 21).

In this chapter a description will be given of the rationale, research design and method for this study. Trustworthiness will also be addressed.

This method of research was used in this study to explore how learning opportunities have been created for student nurses to apply the Primary Health Care Approach in the clinical setup.

Research Rationale

Nurses have an important role to play in the provision of health care services with the emphasis on the primary health care approach. Student nurses need efficient clinical guidance and support from registered nurses and lecturers to be able to develop the necessary knowledge and skills that is needed in this regard.

Research design and method

Research design

A qualitative exploratory descriptive design that was contextual in nature, was used.

Qualitative research

This was a qualitative research study because it was meant to gain understanding of the context under which student nurses are being educated and practically guided. This helps to give meaning to the whole (Burns & Grove 1993: 28).

Qualitative research approach was considered to be suitable for this study because with this approach a systematic inquiry is implemented which is concerned with understanding human beings and the nature of their transactions with themselves and with their surroundings. The application of a qualitative research strategy is almost the natural results of interest in answers to specific type of questions guided by a researcher (Myburgh & Poggenpoel 1995: 5).

Exploratory research

The word "explore" implies scrutinising unknown regions for the purpose of discovery (Woods & Catanzaro 1988: 150). This study was exploratory because it was conducted to gain insight and understanding of the situation under which student nurses have being educated and practically guided at training hospitals in the North West with regard to primary health care approach.

The researcher thought that this study could enable her to depart from a position of "not knowing" and to enable her to gain an insight into the phenomenon (Burns & Grove 1993: 28).

Descriptive research

The study was descriptive because it was conducted to achieve a holistic understanding of the situation under which education and guidance of the student nurse following the four year diploma in comprehensive nursing and midwifery science course are being carried out at Oshakati and Onandjokwe. The researcher sought to obtain subjective information from the student nurses, lecturers and registered nurses in order to be able to describe the reality of the phenomenological experience (Woods & Catanzaro 1988: 134).

Contextual research

According to Burns & Grove (1993: 65) the body of knowledge, including the world concerns, unique to each person is the context within which that person can be understood. A contextual study was preferable because action related descriptions could only be given in a particular situation or context. Thus this study is contextual in nature as it was conducted to ascertain the different ways learning opportunities have been created for the student nurses and how student nurses perceived the learning opportunities created for them.

Research Method

The method that was used to conduct the study will be described. It includes data collection method, target population and sample, discussion of the method of sampling, discussion of results, data analysis, research context and setting, as well as methods in which the reliability and validity of the method used was be determined and ethical measures that was used.

Data collection method

Data was collected by means of focus group discussions. A focus group is defined by Krueger (1994: 6) as a carefully planned discussion designed to obtain perceptions of a defined area of interest in a permissive, non-threatening environment. It is conducted between four and twelve participants and an interviewer. The key principle in the formation of the focus group is homogeneity which is determined by the purpose of the study.

For this study, the respondents were interviewed at the hospitals premises and University of Namibia divisions at the venues which were agreed upon by the researcher and the respondents and as provided by the hospital management or heads of University of Namibia divisions.

The aim of using the focus group discussions in this study was to explore and describe the ways in which learning opportunities on primary health care have being selected for student nurses at the two training hospitals in the North of the country.

Techniques, skills and attitude of focus group facilitator

For the focus group discussions, it is emphasized by Burns & Groves (1993: 579) that the interviewer should take a non-directive role. She participates just enough to start the conversation and prevent the discussion from wandering too far from the question of the study. Emphasis is on the group interaction and on the latent significance of what is said. The interviewer's attitude has to be permissive. She should show interest in what is being said and should be objective. The interviewer should encourage all participants to say something and have to see to it that the interview is well co-ordinated.

Brotherson (1994: 12) writes that the beginning of an interview sets the tone and agenda for the rest of the procedure and it is therefore crucial that the researcher creates a thoughtful, permissive and friendly atmosphere so as to direct the focus group with limited intervention.

The interviewer used interviewing skills such as restating, validating, listening actively, conveying respect and minimal verbal response in order to ensure that discussions could proceed in a co-ordinated but self directed way of expressing ideas (Rawlins, Williams & Beck, 1993: 96).

The initial question to start the discussions was **"Tell me the factors that influence the selection of learning opportunities for students for primary health care in hospital units."** This question was used in all six focus group discussions.

Each discussion lasted at least one hour. Follow up interviews were conducted with some participants to validate the information. The reason for selecting this method was so that it could guide the researcher to collect descriptions of the life world of the interviewee, and respect the interviewer's interpretation of the meaning of the phenomenon that was to be described. It could make it possible for the interviewees to organise their own descriptions with emphasis on what they themselves felt was important in their situation in their own words (Kvale, 1983: 193).

Use of communication techniques

The following non directive communication techniques were used to ensure participants to express their views freely (Rawlins et al 1993: 97).

- Restating: the interviewer used her ability to repeat to the interviewees what has been said in the form of questions (Rawlins et al, 1993: 101).
- Validating: the interviewer used this technique to assist the respondents to achieve a more realistic view of the world, and creating in the respondent the experience of feelings understood (Rawlins et al, 1993: 101).
- Listening actively: the interviewer conveyed a real desire to hear what the respondents said (Rawlins et al, 1993: 97).

- Conveying respect: different points of views were used to show to the respondents that they were respected. The researcher also showed respect to respondents by being on time for appointments and by spending the right amounted time that had been agreed upon with respondents (Rawlins et al, 1993: 97).

- Minimal verbal response: the interviewer adopted a less active role and allowed more time for the respondents to talk (Rawlins et al, 1993: 100).

Stuart & Sundeen (1983: 122) also recommend that the interviewer should adopt a less active role and allow more time for the respondent to talk.

Field notes

The researcher kept written records of all the observations and ideas as observed and noticed with each group interview. These records were necessary to capture important events and behavior which could not be tape recorded but which could be of importance in making the phenomenon understandable (Streubert & Carpenter 1995: 199).

Focus group interview should be normally tape-recorded and field notes taken. Group members should be informed that the discussions are to be recorded (Devos 1998; 321).

Population and Sampling

Population

The research context for this study is about student nurses following the four years "Diploma in Comprehensive Nursing and Midwifery Science" course at two hospitals in the North of the country. Registered nurses who worked in the two training hospitals and who are involved in the education and guidance of student nurses and lecturers of the University of Namibia who teach the student nurses.

The target population consisted of three groups:

- Student nurses following the four years "Diploma in Comprehensive Nursing and Midwifery Science" (course I-IV) at the two training hospitals in the North.
- Registered nurses, who were working in direct patient care at the two specific hospitals in departments where student nurses were allocated.
- All the lecturing staff of the Department of Nursing that were entrusted by the University of Namibia to educate student nurses.

Sampling

In this study purposive sampling was used in order to ensure contextuality. The aim was to select a homogenous stratum. Devos (1998: 198) suggests that the more homogenous the stratum of the population, the better the influence that can be made. Participants were purposively selected, meaning that cases that were judged to be typical of the population were picked. The researcher also sought for student nurses,

registered nurses and lecturers who were willing to describe their experience of the education and guidance to student nurses concerning the primary health care approach.

Description of sample

The sample for this study consisted of 41 respondents of the following categories: student nurses, registered nurses and lecturers. The discussion groups were as follows:

Group 1:	Registered nurses Hospital A	}	(7)
Group 2:	Lecturers	}	(4)
Group 3:	Student nurses	}	(9)
Group 4:	Registered nurses Hospital B	}	(9)
Group 5:	Lecturers	}	(3)
Group 6:	Student nurses	}	(9)

(The number in brackets indicates the total respondents present at the focus group discussion)

- "Student nurses" refers to those student nurses (course 1-4) following/attending the four year "Diploma in Comprehensive Nursing and Midwifery Science"
- "Registered nurses" include those registered nurses involved in the supervision and guidance of student nurses in the two hospitals
- "Lecturers" refers to those registered nurses employed by the University of Namibia to educate the student nurses under discussion.

The four groups of lecturers and student nurses preferred to have their focus group discussions conducted in English (Group 2,3,5 and 6) and the two groups for registered nurses preferred to have their focus group discussions conducted in Oshiwambo. The data of the latter was translated into English by the researcher.

All six focus group discussions were audiotaped. All respondents were encouraged to talk about their experiences on the creation and selection of learning opportunities for primary health care and guidance to the student nurses in this regard following the four-year "Diploma in Comprehensive Nursing and Midwifery Science." They were also asked to discuss their experiences concerning the factors that influence the selection of learning opportunities.

Frey & Fontana (1993: 365) recommend that the interviewer should see to it that group members are given a fair chance to express their views and discussions should be well co-ordinated.

Preparation

Participants were briefed on the purpose of the research and their consent was obtained prior to the focus group interview. Participants were notified of the date, time and venue where the focus group discussions were to be conducted. Venues were comfortable, non-evaluative and non-threatening environments with seats arranged in a circle to allow face to face interaction as little noise and disturbance as possible.

Data collection

The researcher used a tape recorder with a cassette with the permission of the participants, to tape record the discussions. The researcher did the tape recording and the interviewing, and facilitated the discussions. Information was collected till the data was saturated, as demonstrated by the repetition of themes (Burns & Grove, 1993: 247).

Data analysis

Data from the focus group interview was analysed according to Tesch's method in Cresswell (1994: 155). The eight steps suggested by Tesch and which the researcher followed are as follows:

Immediately after the interviews were completed. The researcher tried to:

- Get a sense of the whole by listening to the taped information on the cassette, transcribed all the taped interviews word by word and read through the transcriptions carefully, jotting down some ideas as they came to mind.

- Picked the most interesting and shortest interview tape, read through it and questioned its content. Thought of the underlying meaning and then wrote thoughts in the margin. This was also done with all other interviews. A list of all topics was made and similar topics were clustered together to form themes.

- The researcher took the list and went back to the data, abbreviated the topics as codes and wrote the codes next to the appropriate segments of the text. A scheme was organized to see whether new categories and codes would arise up.

- The most descriptive wording for the topics was found and topics were turned into categories. The total list of categories was reduced by grouping together topics that are related to each other and the lines were drawn to show the interrelationship between the categories.

- A final decision was made regarding abbreviation for each category.

- Data belonging to each category was assembled in one place and a preliminary analysis was performed.

In this study the study promoters who are knowledgeable in qualitative data analysis were engaged in the supervision of data analysis of the information that was collected. The researcher and supervisor did meet to discuss the results of the data analysis and consensus discussions on major categories and sub-categories were held.

Literature control

The results of the research study were discussed in the light of relevant literature. Referential checks were done to enhance the scientific trustworthiness of the study.

Trustworthiness

The researcher tried to adhere to the principles of trustworthiness throughout the research process. Trustworthiness is the method of ensuring rigor in qualitative research (Guba & Lincoln in Krefting, 1991: 215).

Because this study has used a qualitative approach, credibility (internal validity), transferability (external validity), dependability (reliability) and confirmability (objectivity) were used as aspects of ensuring trustworthiness (Lincoln & Guba, 1985: 300).

Credibility

Krefting (1991: 215) defines credibility as the truth value obtained from the discovery of human experience as it is lived and perceived by informants. The activities which increase the possibility of credible findings were observed by the researcher throughout the study. These include prolonged engagement, persistent observation, triangulation, member checks, structural coherence and establishing the authority of the researcher.

Prolonged engagement

In this study the researcher tried to spend time with all the respondents. Meetings were conducted whereby respondents were informed about the study proceedings. The researcher tried to establish rapport with the respondents and assured them that confidentiality would not be betrayed,

their interests were to be respected and anonymity was to be maintained. The researcher spent time listening to the tape recorded focus group interviews and familiarized herself with the content of the interviews.

Persistent observation

The researcher tried to identify crucial factors expressed by respondents and explored them in detail during all the interviews. This could be achieved through rephrasing and repeating questions focussed on issues of interest.

The researcher interviewed respondents using a tape recorder for contextual validation. Field notes on behaviors were recorded. The study supervisor was engaged in supervising the categorization of findings.

Member checks

Lincoln & Guba (1985: 314) writes that member checking is the most crucial technique to establish credibility.

Member checking was done to ensure that the themes that the researcher came up with were really reflective of what the respondents meant.
In this study the researcher ensured that the interviews on tape were played back to the focus group participants for their comment immediately after the interview. Follow up meetings were also conducted after the grouping into categories in order to confirm whether the information which the researcher came up with was real reflection of what the members meant.

Structural coherence

The researcher tried to make sure that there were no unexplained inconsistencies between the data and the interpretations.

Establishing the authority of the researcher

In this study, the researcher has applied principles of group dynamics and aimed to capture the contextual understanding of the respondents' experience.

→ Transferability

The researcher tried to provide the background information about the respondents as well as the research context and setting in order to allow others to assess how transferable the findings were and whether conclusions might be transferable or not.

→ Dependability

- The research methodology was fully explained
- field notes were kept and referred to
- all the materials used during the study were kept for any inquiry
- the study supervisor directed the researcher on how ambiguities could be clarified

→ Confirmability

- raw data was tape recorded
- field notes were taken by the researcher

- verbatim transcribed data was produced and presented to the study supervisor
- data was reconstructed
- category themes, interpretations and final report were produced

Ethical consideration

Burns & Groves (1993: 89) writes that conducting the research ethically goes from the identification of the research topic to the publication of the study results.

The respondents were oriented before the actual study was conducted. The researcher maintained good interpersonal relationships with the respondents. The respondents were given information on where and how to contact the researcher should they wish to do so.

Informed consent

This refers to the process whereby information is given to the respondents about the title, purpose, method, objectives, potential risks, benefits and input on the part of the respondents and to ensure that they agree to participate in the research without any element of force, fraud or other forms of constraint (Burns & Groves, 1993: 104).

For this study, a written consent was obtained from the office of the permanent secretary of the Ministry of Health and Social Services and also

from the office of the Regional Director, Northwest health directorate before the study could be carried out.

Gaining access

A formal letter was written to the management of the two training hospitals and also to the heads of University divisions in the North.

Free and voluntary participation

The respondents were informed that they had the freedom to participate or not in the research project after all the information was given to them. The respondents had the right to withdraw at any time, should they wish to do so and they were not expected to give their consent in writing for this study.

Anonymity and confidentiality

The respondents were informed that confidentiality would be maintained and personal information would not be disclosed. Permission was obtained by the researcher from the respondents to audiotape the discussions.

Statement of the research purpose

The respondents were informed about the purpose of the research and the expected benefits to both the researcher and the respondents.

Summary

In this chapter a description was given of the research rationale, research objectives, research design and method as well as research context and setting for this study.

Qualitative research formed the basis of this research design and method and it was used to study the empirical world from the perspective of the subject, not that of the researcher.

CHAPTER 3

DISCUSSION OF THE FINDINGS

Introduction

In the previous chapter, the methodology followed in conducting this study was discussed. In this chapter analysis of data will be discussed according to identified themes, categories and sub-categories. The identified themes will be verified with literature control.

Findings

The following themes, categories and sub-categories emerged from the participants' experiences concerning the creation of learning opportunities for the application of primary health care in hospitals.

Two main themes namely managerial and educational constraints were identified

THEME	CATEGORIES AND SUB-CATEGORIES
* Managerial constraints	• Working conditions influence learning and teaching as evident by: - workload and shortage of staff - lack of knowledge to select learning opportunities for primary health care - poor communication between registered nurses, lecturers and students - poor interpersonal relationships
* Educational constraints	• Lack of conducive teaching and learning environment as evident by: - lack of guidance by lecturers - lack of correlation between theory and practice - strengths and weaknesses of health education in practice

Discussion of the findings

Managerial constraints

Primary health care is an integral part of a country's comprehensive health care system and has been an inspiration for many in the world, and the momentum should be maintained as the goal of health for all is more relevant than ever before (Ntoane 1993: 36).

Therefore, effective management in the health sector is fundamental to greater equity, more efficient administration, more accountability to the people and improved quality and performance of services are called for (Renewing the health for all strategy consulting document WHO 1995: 24).

Working conditions

Workload and shortage of staff

During the discussions it was mentioned by participants that the workload of the staff creates a problem when it comes to teaching and guiding students on the primary health care approach. The following statements serve as evidence for this.

One participant said:

"In the hospital we have very few registered nurses. We don't always have the time to guide and teach students properly that are allocated to our wards."

Another participant stated:

"Our hospital is serving many patients, therefore time for teaching is limited. I doubt whether the learning climate is always conducive for learning of primary health care principles."

The findings correlate with those of a study that was done by Fish & Purr 1991: in Quinn (1998). In their evaluation of practice-based learning in continuing professional education in nursing, midwifery and health visiting, they concluded that supervisors had heavy workloads and their role was not well defined. They tended to lack status and demonstrated a striking lack of confidence about their teaching and facilitating roles.

Proper organisation of staff and time to supervise and guide students during clinical sessions is important. This is also emphasized by Quinn (1998: 186) who stated that students should be supervised and guided by first level nurses who received preparation for it, to ensure that relevant experiences are provided for students to enable learning outcomes to be achieved.

According to Mellish, Brink & Paton (1998: 140) teachable moments for guiding students and correcting mistakes on the spot during real patient care are very important. Teachable moments occur many times during a nursing care day of which many are wasted but many more are used often subconsciously. A teachable moment occurs in real life situation without serious planning. No preparation is needed, other than that acquired in daily practice and keeping up to date. It is one of the teaching tools most

to be readily available to the trained unit staff in a unit than to the nurse educator from outside.

However, despite the problems of work overload and staff shortage participants at Hospital A indicated there are some initiatives from the service site in order to facilitate the education and guidance of student nurses in the practical set up. It was mentioned that teaching programmes with emphasis on the primary health care approach are set up in various departments and are also being adhered to. Some registered nurses are said to have been selected as clinical instructors for each department in order to see to it that the teaching of student nurses and other nursing staff in the unit is co-ordinated. It was said that the aim of selecting clinical instructors is to bring about uniformity and to reduce confusion in the performance of different nursing procedures in the hospital.

It is clear from the discussions that the workload of staff has an influence on student guidance and therefore on the creation of learning opportunities to apply the primary health care approach.

Lack of knowledge to select learning opportunities (uncertainty)

According to Mashaba & Brink (1994: 131) one of the important issues in creative management in the practice setting is the types of knowledge and skills that are selected to be developed. However, in order to fulfill the intentional objectives the supervisor should draw up a plan in this regard which could act as an implicit guide.

Registered nurses and lecturers are considered to be the resource persons who could take a lead in the coordination of student nurses' education and guidance. Unfortunately it was reported from the participants (registered nurses, lecturers and students) that this guidance is not always sufficient. It was also revealed that not all concerned are sure about how to select primary health care learning opportunities in the wards. This is evident from the following accounts:

One student nurse said:

"On the primary health care approach, concerning the wards, it seems as if primary health care approach is really known by people who are working in primary health care departments like the antenatal clinic, but as far as the general hospital departments are concerned, I think they are just concerned with treatment of patients."

Another student nurse said:

"In the case of primary health care, we are being taught by registered nurses in the wards how to do the service according to the information they have which is not always sufficient."

According to Palmer et al (1994: 15) the practical set up focus on competence and the development of reflection, therefore, then, that the approaches to learning must be congruent with thus. But it seems that students also don't always have the courage to ask. This was reflected by a student who said:

"Some learning opportunities are not utilized because we don't really ask registered nurses to teach us some primary health care procedures when they are not busy."

A lecturer expressed herself as follows:

"Implementing the primary health care approach and guiding students was and still is a challenge to me. I am using the word challenge because first of all I do not have it clear how to integrate primary health care approach during clinical sessions with students."

Another lecturer said:

"I don't think we are all really clear about how to implement or how to integrate the primary health care approach in the subjects that we teach during clinical sessions."

This however is a problem because according to Mellish & Brink (1990: 94) the one thing that makes a person a successful teacher is that one should among all other requirements be knowledgeable and up to date with his subject and be able to bridge the gaps between the world of the student and the real world, theory and practice.

It was reported that some departments like antenatal clinic and maternity wards are really doing their best in providing primary health care services.

Poor communication between registered nurses, lecturers and students

Some participants indicated that poor communication is sometimes a stumbling block in the guidance of students. It seems that this resulted in a situation where lecturers and registered nurses did not always communicate with each other and with students about what they should learn and practise. This was evident in the following accounts.

One participant stated:

"Sometimes there is no communication between lecturers and registered nurses in the clinical situation. This creates problems for students in achieving objectives in the clinical setting."

Communication is the activity that influences all the other activities and effective management of any unit. Communication forms a crucial part of the effective management of the unit, because without effective communication none of the steps of the management process can be implemented effectively (Naude et al, 1999: 192).

Horne & Cowan (1992: 1) also write that effective communication is an undeniable element of every situation for goals to be achieved.

According to Booyens (1998: 274) it is far more effective if the nurse manager, in her communication, focuses on the aspirations, values, motivations and needs of her personnel than on what she wants to get across to them. By giving feedback to employees the communication cycle is completed, making it a two-way communication.

The student participants also indicated that their progress on activities is not always communicated to them by means of proper feedback. According to Ewan & White (1996: 120) the main purpose of feedback is to assist the ways of surrounding difficulties. Feedback should be descriptive rather than evaluative. Constructive feedback is an important step towards authenticity.

Van Hoozer et al (1987: 120) stated that feedback which may be done orally, telling a learner that a response is correct or incorrect and explaining why, is very important for re-enforcement. He further explained that feedback should be done immediately after the response and it should focus on the quality or accuracy of a response and the nature of the mistake should be made clear to the learner because it won't help a learner just to tell him or her that the response is right or wrong without clear explanations which can help the learner to improve for the better.

Another participant stated:

"I think a good interpersonal relationship between student nurses and other members of the nursing staff in a unit is important in order for students to learn and to be free to ask questions."

Burnard (1992: x) also stated that effective communication can only be accomplished in an atmosphere of mutual respect and confidence. In such an atmosphere, where suggestions are given and received an effective exchange of opinions and information is accomplished.

Morrison & Burnard (1991: 40) also write that a caring communication is the one in which both parties listen, showing respect of what is being said and give the necessary support.

Poor interpersonal relationships

It was mentioned by the student participants that the interpersonal relationship between registered nurses in the wards and students is not always what it should be. This has a destructive implication when it comes to teaching and learning.

It is evident from the following accounts:

A student said:

"The attitudes of registered nurses in the wards do sometimes cause frustration for the students. Because they will shout at you in front of a patient if you make a mistake."

Another student said:

"If you see a registered nurse do a procedure on a patient and you asked to be involved the registered nurse says go away I don't want to be surrounded by students."

Strassen (1992: 56) cited that a good interpersonal relationship and communication is needed in every situation where more than one person work for benefits. Every nurse has the responsibility to do everything possible in order to make all nurses working in their unit happy because

happy nurses mean happy patients. She further writes that because nursing students who are about to enter the labour market for the first time are already recruits, they should be vigorously courted and eased into their first professional assignments gently. A facility that develops a reputation as a good place to launch a career can be regarded as a suitable host for student nurses education and guidance by any nursing school.

McGee (1998: 78) writes that nursing is a caring profession, and caring in nursing refers to the direct or indirect skilful activities, process and decisions related to assist people in such a manner that reflects behavioral attributes which are emphatic, supportive and also educationally dependent on the needs of the individual being assisted.

Registered nurses also complained about the attitudes of students towards them in the wards.

One participant said:
"I really don't know whether students are taught ethics anymore, because I don't see them applying it to practice."

According to Mellish & Brink (1990: 57) good interpersonal relationship skills, loyalty, high moral code, patience and tolerance should be developed in students for them to become good nurse practitioners.

Quinn (1998: 421) emphasizes the importance of interpersonal effectiveness in nursing education which calls for both parties involved to

examine their behaviors and to change accordingly, but it is said that for change to occur one needs first to be aware of the negative behaviour which he/she is having and can then change accordingly.

Ewan & White (1996: 144) stated that for students and clinical teachers, a range of emotions through pain, frustration, fear, helplessness, anger, shame, guilt as well as joy, wonder and love can be experienced. Sometimes interpersonal conflict arises between patients and students, students and clinical staff or students and clinical teachers. Accepting that there will be clashes of personality from time to time regardless of the skills of the clinical instructor is being realistic. Several reasons for that includes the physical and emotional health of either party in the relationship. Having an understanding of the pressures on the students who are learning, studying and practising as well as coping with developmental stages of their age group may enable the clinical teacher to arrive at a reasonable response and thus avoid a breakdown of the relationship. Quinn (1998: 182) suggested that students should be treated with kindness and understanding by qualified staff.

Chenevert (1997: 63) also cited that nurses, especially junior nurses and nursing students, need encouragement from senior nurses in order for them to find interest in nursing and to stay longer in the profession. This also helps to prolong life for the nursing profession.

Soothhill, Henry & Kendrik (1992: 4) did a research in England on recruitment and staff wastage and their study revealed that difficulties in

communication between nurses and doctors, especially junior, assistants and student nurses was reported to have caused a lot of wastage of energy and time, and patient care suffered.

Educational constraints

Concerning educational constraints the following categories were identified:
The lack of conducive teaching and learning environments exists due to several factors, as will be indicated in the sub-categories.

The practical setting by its nature should be an environment that is conducive to learning. It has been suggested that it should be safe, organized and structured in order to facilitate learning (Palmer et al 1994: 15).

White & Ewan (1997: 155) write that no matter how much clinical exposure students have, the quantity does not necessarily ensure that the experience will promote the students' personal and professional growth. The quality of the experience is related to the opportunity students have for understanding what the experience means and for coming to terms with issues such as life and death, ethical dilemmas, personal responsibility and accountability for one's own actions. The clinical teacher can assist to ensure that the students have sufficient experience of quality to allow them to engage the issues.

According to Woolfolk (1995: 401) a positive learning environment, if not existing, must then be established and maintained. Factors that contribute to a positive learning environment is that students need time to practice and to learn, opportunities for self-management, students must be respected as human beings and students should know and understand what is expected of them. Bernhard & Walsh (1990: 108) also recommend that, when teaching a practical skill such as administration of medicines for example, the nurse leader or teacher should use the behaviourist concepts of motivation, repeated practice and re-enforcement. The following sub-categories were identified in this regard.

Lack of guidance to registered nurses and students

On accountability and responsibility in nursing education, Watson (1995: 233) wrote that since nursing education has become a part of higher education programmes, being offered in universities and higher learning institutions, these institutions have an obligation to demonstrate accountability to the funding institutions and to the purchaser of the necessary services being provided by nurses graduating from such institutions. It is expected that universities and higher education institutions must see to it that they produce nurses who can function in a way that meets service requirements. Nevertheless, decisions should be made between educational institutions and services as to how the agreed learning outcomes will be assessed through theoretical and clinical assessment.

Karlowicz (2000: 82) wrote about accountability in the outcome of the education program that a "student portfolio" is a method that is used to evaluate the effectiveness of the outcome of education program. It also helps to prove the competence of graduates for prospective employment. This is a documented evidence of learning.

Lecturers are seen as the educational leaders and resource persons but it also became evident that they don't provide the necessary guidance to the registered nurses in the wards concerning the programme that the student should follow.

Some participants indicated that lecturers are not always available to guide students and registered nurses concerning learning experiences for primary health care in the wards.

One registered nurse said:
"Why don't lecturers come more often to the clinical setting to spend time together with students and registered nurses to guide us in the selection of learning opportunities for primary health care?"

Research shows that coverage of students' clinical experience by lecturers is a contemporary issue. It seems that clinical practice guidance by lecturers does not always function optimally. Campbell (1991: 39) showed that correlation of theory and practice was unsatisfactory and that clinical teaching was usually done in an disorganized manner.

Another registered nurse said:

"Practice programmes for student nurses are not always clear for us in the wards. What is not clear is what students on different levels should know and learn regarding primary health care."

Transition from classroom or simulated nursing laboratory into the real setting is the point at which many of the previously mentioned problems in clinical education arise. Some of those problems can be avoided by adequate prior planning and preparation of both students and clinical staff and some of them can be avoided by improving knowledge and practice of the clinical supervision role (van Hoozer et al 1987: 120; Ewan & White 1996: 116).

A student said:

"Some of the information that is given by lecturers on primary health care is not always known by the staff in the wards. Because of this registered nurses find it difficult to guide us the students."

From the discussions it was also clear that during guidance some registered nurses don't allow for free discussions and questions from students, especially when it comes to suggestions on patient care.

One student said:

"Registered nurses ignore the information what we have. They may tell you – do you think you know more than us, I have many years of experience."

This environment then leads to a situation where students are not willing to ask questions if they don't understand something. It is then questioned how students will learn to take decisions and to solve problems. According to Sullivan & Decker (1992: 243) a realistic approach, good management climate, and an environment conducive to hard thinking and evaluation are all important to develop creativity and decision making skills.

However, there were also positive remarks expressed by participants.

A lecturer expressed it as follows:

"It is not always that we are only having negative influences, but we are also having positive influences. In most cases when student nurses are allocated in certain units, registered nurses are really willing to help if they are given information as to what they have to teach the student nurses. Registered nurses in different nursing departments have good materials in the wards and clinics which they can use to teach student nurses. The problem is only that maybe they don't have time or motivation or encouragement to teach student nurses."

According to the attribution theory of motivation formulated by Weiner (1979) in Quinn (1998: 24) individuals search for understanding is seen as the key factor in motivation. The person's success is said to be attributed to various factors such as typical effort, ability, teacher bias, unusual help from others and luck. People are less likely to undertake tasks when they feel that such a task is uncontrollable by their own efforts. The greater

problems of motivation arise when people attribute their lack of success to internal, uncontrollable factors, such as their own ability which is perceived as beyond their power to change.

Lack of correlation between theory and practice

The patient is the focus of nursing practice. According to Wilkinson (1996: 89) correlation between theory and practice is important because one aspect of it is nurses use diagnostic reasoning to analyze data and draw conclusions about the patient's health status. Therefore, fundamental knowledge and insight into the theoretical basis of practice is important, practice should be based on the fundamental cornerstones of the nursing profession.

Ross & Cobb (1990: 2) also assert that regardless of the type of health care setting, the nurse in primary health care has the responsibility to assess, analyse, diagnose, implement and evaluate nursing care of clients, taking into consideration the total person and assist them to cope well with the catastrophe caused by illnesses.

Ntoane, C. (1993: 35) writes that primary health care is not limited to primary prevention or treatment to the initial contact or primary settings, but it includes secondary and tertiary levels of prevention or treatment of diseases and injuries as well as the provision of essential drugs.

However, the students who participated in the study indicated that they experience a problem of correlation between theory and practice with

specific reference to practical procedures and health education. The following statements are accounts of this:

One student said:

"When we as student nurses try to do things as we were taught in the class the staff in the wards felt that we are wasting time, while there is still much to do for example if you want to apply family planning protocols for instance."

Another lecturer expressed herself as follows:

"Student nurses are being taught how to do the correct procedures at the college, but the time they go to the clinical situation, they start again to learn other methods of doing procedures incorrectly and it seem as if they get confused as they don't know anymore which is the correct way of doing procedures. Student nurses don't do procedures as they were taught at the college when they in at the clinical situation resulting in two ways of doing things."

Another point mentioned which causes the gap between theory and practice is the lack of equipment. One student gave the following example:

"I think also .. some of the problems are just coming from the equipment especially when they are teaching you how to make ... hot to prepare a feeding for the baby pack. They (at the ward) just prepare the feeding without a gown, without a cap, without a mask, then you must only

learn the procedure which is not systematic, and there is also not even a spatula to mix the milk there."

A registered nurse participant explained:
"Another thing is that we don't have enough or all equipment in the hospital which is necessary to teach these student nurses. It may happen that I am teaching the student nurses a certain procedure but I may find that some of the instruments listed in the instrument bundle to be used are not all available in our hospital."

Quinn (1998: 185) indicated that for any environment to be good for proper student learning during their practical placements, it should be adequate in terms of space and necessary equipment as well as safety so as to facilitate development of competency.

Rolfe (1996: 1) stated that the problem of the theory practice gap is one of the most problematic and enduring issues for nursing. The observation that what happens in the clinical situation rarely, if ever, matches what the text books say ought to happen. This so called "theory practice gap" is probably felt most accurately by student nurses, who often find themselves torn between the demands of their tutors to implement what they have learned in theory and pressure from practising nurses to conform to the constraints of real life clinical situations. When one attempts to perform a particular technique or nursing intervention read about in a text book or a journal, only to be told that "we have already tried that and it doesn't work." Lathlean and Vaughan (1994: 15) also

writes that research has repeatedly shown that very often what was taught in the classroom or what ought to be done does not match what is being done in the clinical situation. Students often considered that their training lacked integration. This is because the theory taught was not always followed with relevant practice.

Correlation of theory and practice is not only applicable to procedures in the clinical situation. The core of nursing which is also applicable to primary health care elements, which is concern, care, cure, competence, comprehensiveness and coordination are important to apply during correlation of theory and practice (Searle & Pera 1995: 202).

According to Searle and Pera (1995: 202) the personal and professional philosophy of individual registered nurses determine how they will develop their expertise and how they will apply expertise to meet the patients' needs. It was mentioned by the group of participants that this is a vague area which doesn't get the attention it should.

If registered nurses accompany students in a successful manner they need to be able to correlate theory and practice. Theoretical knowledge is imperative for taking care of patients. It is important to realise that a sound theoretical background forms the basis for all future practice.

Strengths and weaknesses of health education in practice

Health education is an essential ingredient of primary health care, and should be implemented in the hospital wards. The fact that patients are

discharged earlier places more responsibilities onto the patients themselves, their families and home-based caretakers. According to Canobbia (1996: vi) this means health care providers need to conduct all the relevant discussions with patients and their families before discharge.

Health workers have to be prepared to provide the patients and families with information that will enhance the knowledge and skills necessary to promote recovery and improve functions, encourage patients participation in decision making and include the family in the teaching process; use education programme that starts with assessment, educate patients about effective use of medicine, equipments and other suppliers, counsel patients regarding food and diet and give information for follow up care.

McKenzie; Ngobeni & Bonongo (1992: 26) write that health workers are not modeling what they say, not enough time is given to health education, junior people are mostly used for health education and their health education is not evaluated. No attention is given to whether health education messages are correct, whether they are given using appropriate methods and whether the health education has any impact.

Although the participants indicated that health education is done, some shortcomings were also pointed out. This of course creates stumbling blocks in learning opportunities for students. The following statements are evidence of the shortcomings:

One student said:

"In the medical ward we provide information to the patients in terms of their treatment but we really don't include the families of our patients as it is being emphasized."

According to Canobbio (1996: xxiv) patients often may not feel prepared for or physically capable of performing self-care activities. Consequently, family members are the vital links in the transition from hospital to home care. Families must be included in all discussions and demonstrations. Family in this context is considered to include any person who plays an important role in the patient's life. The family member may not be an individual who is legally related to the patient but simply the one who will assume the primary responsibility for the care of the patient at home.

Neill (1994: 126) quotes a study that was done by Hartman & Becker (1978) on the health belief model for non compliance with a prescribed regimen for chronic haemodialysis patients. Results from this study revealed that the problem in health professional – patient relationships, and individual's family and friends as well as his or her health beliefs and personality all contribute to determine patient behaviour in response to medical advice. It further revealed that social support in the form of emotional support from family and friends and physical assistance is an important factor in medical compliance. Patient education can increase compliance. It is important to provide the patient with feedback after getting diagnostic information so as for him to be able to know the nature of their condition, how it was caused and what may be done about it.

Therefore, there should be a proper system concerning health education in place through which students can get enough opportunities and experience to give proper health education. Patients need to be prepared well in advance on the nature of the disorder, symptoms to report, diet counselling, medications and activities, any specific instructions related to the disease, disorder or procedure that was done or needs to be done.

One student remarked:

"Health professionals pay much attention to patients with communicable diseases like plague to prepare them for discharge but not for all the other diseases. That is why I am saying primary health care in the hospital is poor."

Guidelines for patient education include: assessment of the environment, educational and information level as well as preparation of patient education materials and family preparation. To maximise patient self-care skills, the health care provider must permit sufficient time and opportunity for the patient to practice the skills. Practice should be integrated into all encounters with the patient, not saved up until discharge. Every effort must be made to ensure that learning takes place in incremental steps and that patients are not overwhelmed with too much information at one time (Canobbia 1996: xxv).

Another point that was raised by participants was that the health education that is given concentrates on diseases like malaria, diarrhea and immunization. It was also indicated that it seems as if the communities

understand these conditions well. But if it comes to other diseases they are totally ignorant most of the time.

A student said:

"If you ask the community during health talks about diabetes mellitus, tuberculosis, cancer and respiratory diseases, to name a few, they don't know what you are talking about."

Participants also expressed their responsibility and desire to give more information to the public concerning their health, and through that create learning opportunities. This was evident in the following accounts.

One participant said:

"What I can tell you is that health education is a very important thing in patient care, because if you just treat the patient without health education you may end up treating the patient four times a month."

Another participant stated:

"We would really like to go to the community everyday to enlighten them about how to prevent and how to promote mental health for instance but we don't always have the means and resources to do so."

According to Jeffree (1990: 105) health education aims to provide information and ensure that all members of the public can with competence act upon the knowledge provided. Use all the facilities of the

health care system and understand those factors which can affect health such as smoking, alcohol abuse, nutrition and stress.

Hubley (1994: 16) stated that information and education provide the informed base for making choices. They are necessary and co-components of health promotion, which aims at increasing knowledge and disseminating information related to health. This should include the public's perception and experiences of health and how it might be sought; knowledge from epidemiology, social and other sciences on the patterns of health and diseases and factors affecting them, and descriptions of the total environment in which health and health choices are shaped. Health education is one of the most important components of health promotion and involves a combination of the following: motivation to adopt health promoting behaviors, helping people to make about their health and acquire the necessary confidence and skills to put their decisions into practice.

Field notes

Field notes were described according to the stages of data-collection.

Appointment

The researcher did not experience practical problems with the arrangement of the date of the focus group discussions.

Interview

All the respondents were open and keen to express themselves about their experiences with learning opportunities in primary health care in hospitals.

Data analysis

Because both the researcher and the independent coder are familiar with primary health care principles and education of student nurses it was not difficult to analyse the data. The discussions were conclusive for both the researcher and the coder and no major dissimilarities were experienced.

Summary

In response to the question "What are the factors that influence the creation of learning opportunities for primary health care in the hospital units?" a rich description of the persons concerned, experiences was made available from the obtained data. This was developed into two major themes, categories and subcategories illustrating the factors that influence the selection of learning opportunities for students in hospital units.

The first theme dealt with managerial constraints in creating learning opportunities for students concerning primary health care. A number of factors were mentioned within daily practice which were regarded as core main problems. These factors include among others, workload and shortage of staff, uncertainty about the implementation of primary health care principles, poor communication and interpersonal relationships.

The second theme describes the factors that influence the teaching learning environment. Factors that were mentioned were lack of guidance by lecturers, gap between theory and practice and strengths and weaknesses of health education practice.

In this chapter the analysis of data was discussed according to the identified themes, categories and sub-categories. Two main themes namely: managerial constraints and educational constraints were identified. Quotes from transcriptions were included and reference was made to the relevant literature.

CHAPTER 4

SUMMARY OF FINDINGS, CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

Introduction

In the previous chapter the findings of the study were presented and discussed in detail. These findings centred around the following aspects:

- the way students are guided during clinical sessions in the wards concerning the application of primary health care
- the factors that influence the selection of learning opportunities and experiences in the hospital wards concerning primary health care

In this chapter, a summary of the study and the findings is presented. Conclusions are also drawn on which recommendations are based.

Summary of the study

The purpose of the study was to

> Explore and describe the experiences of registered nurses, lecturers and student nurses in selecting learning opportunities on primary health care in hospital wards.

To achieve this the researcher conducted focus group discussions consisting of the following participants: registered nurses from the wards,

lecturers and student nurses. The central question that was posed to them was. Tell me the factors that influence the selection of learning opportunities for students for primary health care in hospital units.

During data analysis, bracketing, intuiting reflection and content analysis were implemented as the basis for analysis. Guba's model of trustworthiness of qualitative research was used to ensure that all the data obtained was trustworthy. Several practical strategies appropriate to the four criteria of trustworthiness namely credibility, transferability, dependability and confirmability were applied.

Summary of the findings

The findings are presented in relation to the objectives of the study.

Objective One

To identify the factors that influenced the creation of learning opportunities for primary health care in hospital units.

Conclusion

It was stated by registered nurses that they are willing to take part in the education and guidance of students. They want students to eventually become competent and self-directed registered nurses. However, they revealed that there are some managerial problems which cause problems when it comes to education and guidance of students. Participants expressed the problem of workload and shortage of staff, uncertainty

about implementation of primary health care in hospital units, poor communication between registered nurses, lecturers and students and poor interpersonal relationships between the concerned groups were also mentioned.

Lecturers also are aiming to produce registered nurses who can function within the framework of primary health care. It was evident that the environment is not always conducive for learning and teaching. This is caused by a lack of guidance on how learning opportunities should be selected to emphasize primary health care. A gap between the correlation of theory and practice as well as weaknesses concerning health education were mentioned.

Objective Two

To determine how student nurses are guided and educated on primary health care in the hospital units.

Conclusion

It was evident that registered nurses in the wards are not always sure how to guide the students concerning primary health care. It was also pointed out that lecturers did not provide enough guidance to registered nurses in this regard.

However, there were also positive remarks on certain wards where primary health care education was done effectively. The example of maternal child health departments was mentioned.

Recommendations

The recommendations from this study were made with specific reference to nursing education and the management of primary health care implementation in the hospital wards. The recommendations are based on suggestions made by participants during the focus group discussions.

- **Nursing education**

  An environment conducive do learning during clinical sessions must be established. The lecturers and registered nurses must establish a climate conducive to learning by ensuring a safe physical and psychological environment (Quinn 1998: 182). A psychological environment where good interpersonal relationships are fostered by mutual trust, respect, helpfulness support, freedom of expression, acceptance of differences - especially with cultural differences, are promoted (Lathlean & Vaughan 1994: 55).

- **The content, objectives and expectations of educational programmes must be explained to registered nurses in the wards.** This can be done through discussion, orientation sessions or regular meetings between the concerned parties. This statement is also emphasized by Ewan & White (1996: 110) who stated that if clinical supervisors are not fully aware of the objectives of the

placement of the background knowledge and skills of students, then students have little opportunity to achieve the objectives for which the placement was intended.

Therefore, supervisors must be informed about the content and objectives of the curriculum of students (Mellish, Brink & Paton 1998: 209).

- **Registered nurses in the wards should be guided on the selection of learning opportunities for students in the wards:**
  Registered nurses must be guided on selection of learning opportunities in the hospital according to the specific level of the student. Learning opportunities such as furthermore, to explore on how learning experiences may enrich the development of the student. Opportunities must also be provided for reflection and dialogue on experiences such as making errors, discovering diversity and future actions. According to (Rolfe & Fulbrook 1998: 231) students must feel free to make mistakes and to voice their misconceptions.

  Activities have to be structured so that students can discover solutions, alternatives and consequences for herself concerning primary health care. Engage the student in higher thinking modes such as analysis, critiquing, evaluating, assumptions and inquiring into the nature of things (Karlowitz 2000: 82) concerning primary health care. Students should be motivated to be actively involved in their education. This can be done if lecturers and registered

nurses acquire the general attitude that all students can show creativity by allowing them freedom to learn in ways that are important to them, and allow students to be self-directing (Palmer et al 1994: 124).

Lecturers and registered nurses must also encourage students to develop creative approaches to the application of primary health care in the hospital units. Lecturers and registered nurses must update their knowledge and skills concerning the primary health care approach to enable them to guide students accordingly. According to Bevis & Watson (1989: 379) the teachers can use their knowledge and self image as a positive force to produce an atmosphere that fosters creativity. Therefore it is recommended that lecturers and registered nurses be given structured sessions of inservice education in this regard. Registered nurses who practise in primary health care departments should be used in the inservice education programmes to guide registered nurses how to apply primary health care in hospital wards.

- **Nursing management of primary health care in hospitals**

  Effective communication and co-operation: lecturers and registered nurses need good co-operation and collaboration in order to be able to guide the student nurses as should be. In order to achieve these, proper channels of communication need to be kept open and there need to be a proper regular forum established whereby lecturers and registered nurses in both divisions can come

together and discuss matters related to student nurses education and guidance.

The clinical setting must be managed so that students can plan their own learning. To allow this the placement must give enough flexibility to allow individual student projects but also enough structure and guidance so that students don't get lost (Ewan & White 1996: 117). Health education needs to be strengthened within the hospital set-up. More attention needs to be given to the inclusion of patient's families during health education. Family members or caretakers need to be involved to ensure that they know how to help the patients at home after discharge. Invite community members to take part in health education sessions in the wards. Strategies on how to improve the staff - patient ratio should be looked into by the management of hospitals.

Limitations of the study

Limitations applicable to this study are participant effect, and data collection and analysis.

Participant effect:

Although the assumption was accepted that participants would answer honestly and with integrity to reasonable questions posed during the focus group discussion, participants may have answered questions in a manner which they perceived as being more polite and not really as they felt about or perceived them. This participant effect, where the informants

may have given the answers they thought the researcher expected, is commonly referred to as the Hawthorne effect (Polit & Hungler 1987: 129-130; 196; Mouton & Marais 1990: 86; Wilson 1993: 10; Parahoo, K. 1997: 313).

Data collection and analysis

- For two out of six focus group discussions conducted, the discussions were conducted in Oshiwambo and since this study is conducted in English, it was then necessary to translate the data into English. This translation might have resulted in distorting the originality of the participants experience as expressed in their original language.

- Although the researcher did manage to conduct member checking by means of debriefing of the results with all six groups, for two groups of registered nurses it was only possible for about half the number of the initial group to attend, due to other commitments at the nursing departments.

Final Conclusion

The study focused on how learning opportunities on primary health care are selected in the hospital units and how students are guided to master the necessary skills in this regard. The study provided a lot of useful information about applying primary health care in hospitals. Constraints which hindered the implementation of primary health care in hospitals

were identified , and recommendations to facilitate application of these principles were made.

It is trusted that the findings of this study will ensure that nurses are indeed educated to serve the community by providing quality nursing care either inside or outside a hospital.

Bibliography

1. Bernhard, L.A. & Walsh, M. 1990. Leadership. The key to the professionalization of nursing. Second Edition. Philadelphia: The C.V. Mosby Company.
2. Bevis, E.M. & Watson, J.E. 1989. Toward a caring curriculum: A new pedagogy for nursing. New York: National League for Nursing.
3. Booyens, S.W. 1998. Dimensions of Nursing management. Cape Town: Juta.
4. Botes, A.C. 1995. The operationalization of a research model in qualitative methodology. Raucur. 1(1) July 1995: 4-9.
5. Brotherson, M.J. 1994. Interactive focus group interviewing: A qualitative research method in early intervention. Topics in early childhood special education, 14 (1) 101-118.
6. Burnard, T. 1992. Effective Communication Skills for Health Professionals. London: Chapman & Hall.
7. Burns, N.L. & Grove, S.K. 1993. The practice of nursing research. Second Edition. USA: W.B. Saunders Company.
8. Campell, C. 1991. Improving Staff nurse participation. Nursing Administration Quarterly. Vol. 16, No. 1 56-60.
9. Canobbia, M.M. 1996. Handbook of Patient Teaching includes home care. University of California: Mosby.
10. Cresswell, J.W. 1994. Research design: Qualitative and quantitative approaches. London: Sage Publications.

11. Chenevert, M. 1997. The Professional Nurse Handbook. Designed for the nurse who wants to survive professionally. Third Edition. Boston: Mosby.

12. Dennil, K.; King, L.; Lock, M.; Swanepoel, T. 1995. Aspects of primary health care. Halfway House: Southern Book Publishers.

13. Devos, A.S. 1998: Research at Grass Roots. A primer for the caring professions. Pretoria: J L van Schaik.

14. Dietz, G.R. & Brandrup-Lukanow, A. 1993. Maternal health and family planning. A handbook for health and family planning projects. London: Macmillan.

15. Ebrahim, G.J. & Ranken, J.P. 1995. Primary Health Care: Reorienting Organisational support. First Edition. London: Macmillan Education. LTD.

16. Ewan, C.L. & White, R. 1996. Teaching Nursing. A self instructional handbook. London: Chapman & Hall.

17. Frey, J.H. & Fontana, A. 1993. The group interview in social research. Morgan, D.L. (ed) Successfully focus groups. Advancing the state of the art. Newbury Park; CA: Sage Publications, 20-34.

18. Horne, E.M.R.; Cowan, T. 1992. Second Edition. The professional development series. Effective Communication. Some nursing perspective. England: Wolfe Publishing LTD.

19. Hubley, J. 1994. Communicating Health. An action guide to health education and health promotion. London: Macmillan. Press LTD.

20. Jeffree, P. 1990. The Practice Nurse. First Edition. London: Chapman & Hall.

21. Karlowitz, K.A. 2000. The value of student portfolios to evaluate undergraduate nursing programs. In Nurse Educator March/April 2000. Vol. 25 No. 2. School of Nursing and Public Health: Australia: Lippincott 82-87.

22. Kasonde, M. & Martin, J.D. 1994. Public Health in Action. Experience with Primary Health Care in Zambia. Geneva. Switzerland: WHO Publishers.

23. Krefting, L. 1991. Rigor in qualitative research. The assessment of trustworthiness. Volume 45. Number 3. March 1991.

24. Krueger, R.A. 1994. Focus groups. 2nd Edition. Thousand Oaks. Sage Publications.

25. Kvale, S. 1983. Interviews. An introduction to qualitative research in interviewing. London: Sage Publications.

26. Lathlean, J. & Vaughan, B. 1994. Unifying Nursing Practice and theory. Oxford: Butterworth – Heinemann.

27. Lincoln, Y.S. & Guba, E.G. 1985. Naturalistic Inquiry. Beverly Hills; Sage Publications.

28. Longman New Generation Extended Dictionary. 1982. London.

29. Mashaba, T.G. & Brink, H.I. 1994. Nursing Education. An international perspective. University of South Africa: Juta & Co LTD.

30. McGée 1998. Models of Nursing in Practice. A pattern for practical care. First Edition: Birmingham UK: Stanley Thomas Publishers.

31. McKenzie, A.; Ngobeni, O. & Bonogo, T. 1992. Is Health Education Effective? In Nursing RSA. July 1992. Vol. 7, No. 7 p. 26-27.

32. Mellish, J.M. & Brink, H. 1990. (1997) Teaching the practice of Nursing. A text in Nursing Didactics. Third Edition. Durban: Butterworths.

33. Mellish, J.M.; Brink, H. & Pera. 1998. Teaching the practice of nursing. A text in nursing didactics. Durban: Butterworths.

34. Mellish, J.M.; Brink, H. & Paton, F. 1998. Teaching and learning the practice of nursing. Johannesburg: Heinemann.

35. Monekosso, G.L. 1994. District Health Management Planning, implementing and monitoring a minimum health for all package. Regional office for Africa of the World Health Organization.

36. Morrison, P. & Burnard, P. 1991. Caring & Communicating. Towards 2000. London: Macmillan Education LTD.

37. Mouton, J. & Marais, H. 1990. Concepts in the methodology of social sciences: Human science research council. Pretoria.

38. Myburgh, C.P.H. & Pogenpoel, M. 1995. A qualitative research strategy and what now? Rand Afrikaans University. Volume 1, No. 2.

39. Naude, M.; Meyer, S.M. & van Niekerk, S.E. 1999. The Nursing Unit Manager: A comprehensive Guide. Hernemann: Sandton.

40. Neil, N. 1994. Second Edition. Health Psychology. An introduction for nurses and other health care professionals. New York: Churchill Livingstone.

41. Ntoane, C. 1993. The challenge of primary health care in nursing. RSA. Volume 8. No. 10 p. 35-43.

42. Nursing Act, 30 of 1993.

43. Official National Primary Health Care/ Community Based Health Care Guidelines 1992. Ministry of Health and Social Services, Namibia.

44. Parahoo, K. 1997. Nursing Research principles, process and issues. London: Macmillan Press LTD.

45. Palmer, A.M., Burns, S.I. & Bulmon, C. 1994. Reflective practice in nursing. London: Blackwell Scientific Publications.

46. Polit, D.F. & Hungler, B.P. 1991. Nursing Research. London: J B Lippincot.

47. Quinn, F.M. 1998. The principles and practice of nurse education. London: Chapmann and Hall.

48. Rawlins, R.P.; Williams, S.R. & Beck, C.K. 1993. Mental Health Psychiatric Nursing. A Holistic Life Cycle.

49. Renewing the health for all strategy. Consulting Document. WHO 1995.

50. Rolfe, G. 1996. Closing the Theory - Practice Gap. A new paradigm for nursing. Oxford: Butterworth.

51. Rolfe, G. & Fulbrook, P. 1998. First Edition. Advanced Nursing Practice. Oxford: Butterworth.

52. Ross, B. & Cobb, K. 1990. Family Nursing. A nursing process approach. California: Addison Wesley.

53. Searle, C. & Pera, S. 1995. Professional Practice. A South African Nursing Perspective, Durban: Butterworths.

54. Searle, C., Brink, H.I. & Grobbelaar, W.C. 1991. Aspects of Community Health. Cape Town: King Edward VII Trust.

55. Shifiona, N.N. 1998. Life stories of adult depressed women in peri-urban Namibia. Unpublished Thesis Rand Afrikaans University. Johannesburg.

56. Strassen, L.L. 1992. The image of professional nursing. Strategies of Action. London: JCB Lippincott.

57. Soothhill, K.; Henry, C. & Kendrick, K. 1992. Themes and perspective in Nursing. First Edition. London: Chapman & Hall.

58. Streubert, H.J. & Carpenter, D. 1995. Qualitative Research in Nursing. Advancing the Humanistic Imperative. Philadephia: J.B. Lippincott Company.

59. Stuart, G.W. & Sundeen, S.J. 1983. Principles and practice of psychiatric nursing. St Louis: C.V. Mosby.

60. Sullivan, E.J. & Decker, P.J. 1992. Effective leadership and management in Nursing. New York: Addison-Wesley.

61. Tarimo, E. & Webster, E. 1996. Primary Health Care concepts and challenges in changing world. Geneva. WHO.

62. University of Namibia. Faculty of Medical and Health Science. 1995. Diploma in Comprehensive Nursing and Midwifery Science (Updated Curriculum). Windhoek. University of Namibia.

63. Van Hoozer, H.L.; Bratton, B.D.; Ostmore, P.M.; Weinholtz, D.; Craft, M.J.; Gjerde, C.L. & Albarese, M.A. 1987. The teaching process. Theory and Practice in Nursing. The University of Iowa, College of Nursing: Appleton-Century-Crafts/Norwalk, Connecticut.

64. Watson, D. 1992. The changing shape of professional education in: Developing Professional Education. Buckingham: Society for Research in Higher Education and Open University.

65. Watson, P. 1995. Accountability in Nursing Practice. London: Chapman and Hall.

66. White, R. & Ewan, C. 1997. Clinical Teaching in Nursing. Cheltenham. United Kingdom: Chapman and Hall.

67. Wilkinson, J.M. 1996. Nursing Process – A critical thinking approach. California: Addison-Wesley.

68. Wilson, H. 1993. Research in Nursing. New York; Addison-Wesley. Publishing Company.

69. Woods, N.T. & Catanzaro, M. 1988. Nursing Research: Theory and Practice. ST Louis: Mosby.

70. Woolfolk, A.E. 1995. Educational Psychology. New York : All YN & Bacon.

ANNEXURE 1

Request for consent to conduct research

UNAM:OSHAKATI DIVISION
P.O. BOX 1549
OSHAKATI
9000
04 NOVEMBER 1998

THE RESEARCH COMMITTEE OF
THE MINISTRY OF HEALTH AND SOCIAL SERVICES
PRIVATE BAG 13198
WINDHOEK
NAMIBIA

SIR/MADAM

REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY IN OSHAKATI AND ONANDJOKWE HOSPITALS.

TOPIC: *A STUDY TO IDENTIFY FACTORS THAT INFLUENCE THE CREATION OF LEARNING OPPORTUNITIES IN PRIMARY HEALTH CARE IN PRIMARY HEALTH CARE IN THE TWO TRAINING HOSPITALS (OSHAKATI AND ONANDJOKWE)IN NORTH WEST HEALTH DIRECTORATE-NAMIBIA*

I hereby would like to ask permission to conduct the above mentioned study in the two hospitals as mentioned above.

I am a registered nurse, currently employed by the University of Namibia: Faculty of Medical and Health Sciences, as a Junior Lecturer.

I would like to further my study by following a course: Masters in Nursing Education through the University of Namibia.

It is required that I have to carry out a research project as a part of my study.

The study population will be:

1. All the registered nurses in the two hospitals as mentioned above.
2. All student nurses in the two hospitals.

This letter serve to ask permission to be allowed access in the two hospitals's premises for this study and also to be allowed to conduct personal interviews as well as some two to four focussed group discussions with registered nurses and student nurses in each of the two training hospitals.

The estimated period for data collection is as from 1 February to 30 September 1999.

I enclosed (1) a copy of a letters from Prof. A. van Dyk, Dean -Faculty of Medical and Health Sciences: Unam which authorises me to register for the course and

(2) a copy of the research proposal.

Thank you in advance for your consideration.

Yours faithfully

Hiita

Hermine (Nambinga) Iita

ANNEXURE 2

Letter of Permission from Ministry

9-0/00

REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

DIRECTORATE NORTH WEST HEALTH REGION

Office of the Director
Private Bag 5538
OSHAKATI

Tel. No: (09 264 65) 220211
Fax. No: (09 264 65) 220303

Enquiries: Dr N.T. Hamata

26 April 1999

TO: Medical Superintendents of Oshakati
Regional Hospital and Onandjokwe Hospital

FROM: Regional Director

PERMISSION TO ALLOW MRS HERMINE (NAMBINGA) IITA TO CARRY OUT AND START THE RESEACH AT YOUR HOSPITALS

Attached find two copies of letters one from Mrs Iita dated o4 November 98 and the 2nd one from the Permanent Secretary permitting Mrs Iita to do the research.
For Onandjokwe, I do not know if the request was ever received. If not, the request is now being made and permission for her to start.

For Oshakati, it is to inform that Mrs Iita will start shortly.
For both hospitals, as the research was planned for eight months, permission is also requested to extend it beyond the 30 September 1999(The starting date has changed).

Trusting on your usual co-operation.

Kind regards

Dr N.T. Hamata Regional Director
cc. Mrs Hermine (Nambinga) Iita.

9-0/001

REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198 | Ministerial Building | Tel: (061) 2032824
Windhoek | Harvey Street | Fax: (061) 227607
Namibia | Windhoek | E-mail: namrcu@iwwn.com.na

Enquiries: T. Hoffmann | Date: 11 April 1999

OFFICE OF THE PERMANENT SECRETARY

Ms. Hermine Nambinga-Iita
University of Namibia
Oshakati Division
P.O.Box 1549
OSHAKATI

Dear Ms. Nambinga-Iita

A STUDY TO IDENTIFY FACTORS THAT INFLUENCE THE CREATION OF LEARNING OPPORTINITIES IN PRIMARY HEALTH CARE IN THE TWO TRAINING HOSPITALS (OSHAKATI AND ONANDJOKWE) IN NORTHWEST REGION, NAMIBIA.

1. The Research Management Committee has reviewed the above mentioned research proposal submitted to the Ministry.

2. It has been evaluated as having merit and you are hereby granted approval for the execution of the project. Kindly, take note that the approval is subject to the following conditions:

2.1. Progress reports to be submitted to the Ministry.
2.2. Preliminary findings to be presented to the Ministry.
2.3. The final report submitted to the Ministry upon completion of the project.
2.4. Written approval be sought from the Permanent Secretary for publications.

3. Wishing you all success in the project.

Yours sincerely

DR. K. SHANGULA
PERMANENT SECRETARY

MINISTRY OF HEALTH AND SOCIAL SERVICES
REPUBLIC OF NAMIBIA

ANNEXURE 3

Copy of transcript (one)

Annexure 3

Focus group transcript

Date: 21.05.1999

Researcher: "Good morning everybody? First of all I would like to thank you all for coming to attend this meeting where we are going to discuss matters related to the education of student nurses following the four year course which is leading to Registration as nurses with Diploma in Comprehensive Nursing and Midwifery Science with special emphasis on the primary health are approach which should be applied in all hospitals. The question that is going to guide our discussion is; "What are your experiences on selecting learning experiences for students concerning the primary health care approach in your hospital units.

Silence .....

Registered nurse 1: "I noticed that the time table for the four year course student nurses is making it difficult for these student nurses to be able to master all the required practical experiences because the time student nurses are allocated in the practical situation appears to be short or enough or may be if the time allocated for the clinical practice is not enough, maybe is not properly distributed. I say this because at times a student nurse is just staying in the department up to one o'clock in the afternoon. Sometimes it happens that I as a registered nurse is busy teaching the student nurse a certain procedure but before I am satisfied that the student is really competent in whatever I have been teaching her or him, then she is already leaving the department to go back to the classroom."

Registered nurse 3: "Another thing is that we don't have enough of all equipments in the hospital which are necessary to teach these student nurses. It may happen that I am teaching the student nurses a certain

procedure but I may find that some of the instruments listed in the instrument bundle to be used are not all available in our hospital."

Researcher: "Can you name some examples of equipments which are not available in the hospital and which are making your teaching difficult?"

Registered nurse 3: "I would like to say that procedure packs which are being prepared in the hospital are not prepared to meet the standard of carrying out procedures being demonstrated to these student nurses. In most cases if you have to demonstrate a procedure to these student nurses, you have first to go to the sterilization department here in the hospital and tell the staff who are working there that you need is these and that instrument to be included in the pack you are going to use and they have then to try by all means to find those instruments for you. I can mention an example of the delivery pack which is being used in labour room. They don't usually include draping cloth in this pack. They used to put papers in this pack and these papers are used to cover the patients. The problem is that the papers are short in diameter and they are not usually enough for the purpose. It is really difficult to teach students and also when students have to practise, they do find it difficult to drape the patients with those papers."

Researcher: "I see .....!!"

Registered nurse 5: "I would like to add on the point which was just mentioned in connection to lack of equipments. It happens many times that when the lecturer at the college is demonstrating a certain procedure to the student nurses, she may prepare all the necessary equipments but when student nurses come to practice the same procedure at the clinical situation, they are not going to find the same thing or equipments as the lecturer has prepared when she/he demonstrated a procedure to them. It is really difficult for student nurses to practise here."

Registered nurse 1: "Another thing which I have also noticed is that we are having a serious shortage of staff in the hospital. This has caused the situation that we don't let student nurses to work or to practice as student nurses anymore, but we are forced to use them as members of the working force. Sometimes they have to do a certain job alone without direct supervision by a registered nurse. An example which I can give is that sometimes you may find student nurses doing screening of patients alone or they may be left alone to attend the doctor without a registered nurse around. In such circumstances it is very difficult to tell... one may say that this practice may help student nurses to learn nursing skills, but is difficult to tell whether they are learning in the correct way as they should."

Registered nurse 3: "Let me add something briefly concerning the shortage of staff. Shortage of staff also sometimes causes that some student nurses may leave a certain department without them having been evaluated on how they are performing certain procedures which they are expected to know. Sometimes you are only having one registered nurse in a certain department and very often student nurses have to do the work alone without a registered nurse supervising them, so it is difficult for all student nurses to be evaluated by a registered nurse in our hospital."

Researcher: "I see...!!"

Registered nurse 5: "Another thing which I have also noticed as far as student nurses in our hospital are concerned is that the practice programme for student nurses is not always clear when they are coming to us in various departments. I mean that registered nurses who have to evaluate the student nurses during their practice are not always informed as what a group of student nurses should know at a certain stage."

Registered nurse 2: "Sometimes we as registered nurses get doubt as to do we have to teach certain student nurses when they are allocated in our

departments for practical purposes. I can give an example of the screening area situation. At times you may just decide to teach a student nurse whatever you feel like teaching him or her but it might be possible that you are not targeting the real aim why that student nurse is placed in the department. It means that we do need a clear guideline from the school of nursing that for example: we are sending you this group of student nurses and they need to be guided about this and that."

Registered nurse 1: "Again we are having a problem of patient flow! The flow of patients into our hospital is very heavy! Our hospital is serving many patients and I doubt whether the nursing care or treatment is really being done in the way that can help a student nurse to learn doing things properly. If I can give an example of the practice in the screening area consulting rooms. At times you may find three patients being consulted in one consulting room but you know that normally we need to see not more than two patients in one consulting room at the same time. There is no privacy at all!"

Registered nurse 6: "The study of theory does not always go together with the allocation of student nurses to certain practical areas. If I can give an example of what I have noticed in the labor ward. A student nurse might be allocated in the labour ward in January or February month but it was noticed at the classroom she is only taught the theory on the anatomy of the pelvis. It is difficult for the registered nurse to teach that student nurse how to conduct a delivery because she is not familiar with the theory on the stages of labour."

Registered nurse 3: "Another thing which I feel I have to mention is that .... I noticed that the follow up of student nurses by lecturers in the clinical situation is very much limited and I feel that we as registered nurses in wards are not teaching student nurses enough because of the serious shortage of staff which we are experiencing here in the hospital."

Registered nurse 1: "I feel that the hospital setting or the environment of our hospital is not conducive to learning. There are no procedure rooms in some wards where one can organize the teaching for the student nurses. There is no privacy because there is no suitable place where you can take the patient in order to teach student nurses a certain procedure."

Researcher: "Although we have discussed many issues here which are affecting the creation of learning opportunities, can you now come up with more suggestions as what can be done to improve the teaching and guidance of student nurses in the hospital?"

Silence .....

Registered nurse 3: "I think it could be better if we are please well informed about practical programmes for student nurses being placed in our departments so that we can be in a position to guide them accordingly."

Registered nurse 1: "If it could be possible for student nurses to be allocated in a certain department for the whole month and they spend another full month in the classroom so as to allow registered nurses enough time to teach student nurses they necessary practical skills and also for student nurses to have enough time in the department to learn the required practical skills at their level of study. UNAM student nurses don't have enough time in wards to practise!"

Registered nurse 2: "One needs a certain time period to know a person with whom you are working. It is necessary for a registered nurse to learn and to know a student nurse who is allocated in her department so that she can find a way how to help that student nurse better. Student nurses also do need time to know the registered nurses in departments where they are being allocated. What I have noticed is that UNAM student nurses and registered nurses in our departments don't have enough time to learn and to know each other."

Silence .....

Registered nurse 5: "Lecturers need to clarify the clinical teaching programme for all their student nurses to all registered nurses in various departments and it is also very much necessary that lecturers do regular follow up in order for them to see how student nurses are performing in the clinical situation."

Registered nurse 1: "I suggest that it could be better if in future the hospital setting should be considered before allocating student nurses to do their practice at such hospital. When I look at the setting of our hospital ... it looks so bad and I doubt whether in such hospital environment the student nurses are really learning to do the correct nursing procedures."

Silence .....

Researcher: "Let me take a chance to thank you all for allowing me to discuss with you the issues related to the guidance of student nurses in the hospital. I thank you all for your contributions."

ANNEXURE 4

Group of Categories

Table 3.4.1 *Student nurses, registered nurses and lecturers experience of the education and guidance of the student nurses following the four years diploma in comprehensive nursing and midwifery course.*

Table 3.4.1

	Group 1	*Group 2*	*Group 3*	*Group 4*	*Group 5*	*Group 6*	*Total counts*
Lack of principles for integrating for theory into practice							
* Lack of proper guidance							
- by lecturers	Y	Y	Y	Y	N	Y	5
- by registered nurses	Y	Y	Y	Y	Y	Y	6
* Poor communication	Y	Y	Y	Y	Y	Y	6
* Lack of uniformity	Y	Y	Y	Y	Y	Y	6
* Uncertainty	Y	Y	Y	Y	Y	Y	6
* Teaching of theory does not always go with practice	Y	N	N	Y	N	Y	3
* Lack of motivation and interest by student nurses	N	Y	Y	Y	N	Y	4

Obstacles in the management of primary health care delivery including practical and theoretical aspects in the guidance of student nurses.							
* Work overload (registered nurses)	Y	Y	Y	Y	N	Y	5
* Nursing staff shortage	Y	Y	Y	Y	N	N	4
* Student nurses being used as members of the working force	Y	Y	Y	Y	N	Y	5
* Student nurses not sufficiently exposed in the practical situation	Y	Y	Y	Y	N	Y	5
* Confusion for who is responsible for the guidance of student nurses in the clinical situation.	Y	N	Y	Y	N	Y	4
* Lack of proper facilities and prescribed materials.	Y	Y	Y	N	Y	Y	5
* Primary health care not adequately implemented within the hospitals.	Y	Y	Y	N	N	Y	4
* Poor interpersonal relationship between student nurses and registered nurses in the hospitals	Y	Y	Y	Y	Y	Y	6
* Health education not sufficiently given	y	y	n	y	y	n	4
*Patients' families not involved in the care	y	y	n	y	y	n	4
* Less attention given to mental illnesses and other chronic diseases	y	y	y	n	y	n	4

ANNEXURE 5

Map of Namibia's Health Directorates

REPUBLIC OF NAMIBIA

HEALTH DIRECTORATES (4), ADMINISTRATIVE REGIONS (13)