ASSESSING THE IMPACT OF THE MANDELA-CASTRO MEDICAL COLLABORATION PROGRAMME IN PROMOTING HEALTH CARE SERVICE DELIVERY IN THE FRANCES BAARD DISTRICT HOSPITALS, NORTHERN CAPE PROVINCE

by

ONKABETSE LEVY MOTSUMI

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Supervisor: Dr Pierre Juan de Montfort (D Tech Human Resource Management)

Co-Supervisor: Prof Tryna Van Niekerk (D Tech Public Management)

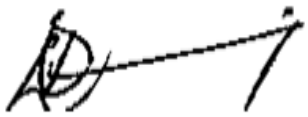
2019

DECLARATION OF INDEPENDENT WORK

DECLARATION REGARDING

INDEPENDENT WORK

I, ONKABETSE LEVY MOTSUMI, identity number and student number , do hereby declare that this research project submitted to the Central University of Technology, Free State for the Degree MAGISTER OF PUBLIC MANAGEMENT, is my own independent work; and complies with the Code of Academic Integrity, as well as other relevant policies, procedures, rules and regulations of the Central University of Technology, Free State; and has not been submitted before to any institution by myself of any other person in fulfilment (or partial fulfilment) of the requirements for the attainment of any qualification.



_____ **09 January 2020**

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ABSTRACT

The rural health care facilities have been facing the critical shortage of medical doctors where approximately 43% of the people in the rural areas often face greater health challenges such as having access to a mere 12% of the medical workforce in the Republic of South Africa (RSA) (Motala and Van Wyk, 2016:74). The reforms made after 1994 have thus, failed to bring about the necessary change in human resources for health (HRH) to improve access to health, especially in the rural areas. Various intervention measures such as the introduction of scarce skill allowance, rural allowance, community service, were among some of the interventions adopted by Northern Cape Department of Health (NDoH) intended to improve health care service delivery in the rural districts. One of the interventions, since 2000, to improve health care services in rural communities was to recruit candidates from poor communities to study medicine in Cuba through the Mandela-Castro Medical Collaboration Programme (MCMCP). The purpose of this study was to assess whether the MCMCP have assisted to promote health care service delivery in the small district hospitals in the Frances Baard (FBDM) area in the Northern Cape Province (NCP). To investigate the problem highlighted above, the research approach applied was deductive in nature and used quantitative data to generate propositions. The study was based on quantitative research and the non-experimental design namely an opinion-based survey in the form of a structured questionnaire to determine the attitude of hospital staff on the impact of the MCMCP in promoting health care service delivery in the FBDM hospitals, NCP was used. It was demonstrated that the provision of health care in the FBDM hospitals was mainly delivered by female health professionals and that the existing health professionals were aging. Although, it was concluded that RSA-Cuban trained medical doctors who took part in the MCMCP programme seemed to have a positive impact in the rural health care facilities, they had, however, demonstrated a degree of uncertainty to remain in the rural areas to alleviate the shortage of doctors. The suggested recommendations could be useful to improve the MCMCP and health care service delivery in FB district hospitals in NCP. The study also made a contribution to the theory of health care service delivery in the context of SA.

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LIST OF ABBREVIATIONS

AIDS:	Acquired Immune Deficiency Syndrome
APP:	Annual Performance Plan
CHCs:	Community Health Centres
CHCW:	Community Health Care Worker
DHS:	District Health System
DFA:	Diamond Fields Advertiser
DLM:	Dikgatlong Local Municipality
DoHA:	Department of Home Affairs
EPMDS:	Employee Performance Management and Development System
FB:	Frances Baard
FBD:	Frances Baard District
FBDM:	Frances Baard District Municipality
HISs:	Health information systems
HIV:	Human Immunodeficiency Virus
HRH:	Human Resources for Health
JTG:	John Taolo Gaetsewe
KHC:	Kimberley Hospital Complex
LC:	Local Municipality
LMICs:	Low- and Middle-Income Countries
MCMCP:	Mandela-Castro Medical Collaboration Programme
NCS:	National Core Standards
NCDoH:	Northern Cape Department of Health
NCP:	Northern Cape Province
NDP:	National Development Plan
NPC:	National Planning Commission
NGOs:	Non-Governmental Organisations
NHA:	National Health Act

NHC:	National Health Council
NDoH:	National Department of Health
NHI:	National Health Insurance
ICT:	Information and Communication Technology
OHSC:	Office of Health Standard Compliance
PHC:	Primary Health Care
PKS:	Pixley-Ka-Seme
RC:	Republic of Cuba
RSA:	Republic of South Africa
RUDASA:	Rural Doctors Association of South Africa
SA:	South Africa
SPLM:	Sol Plaatje Local Municipality
UHC:	Universal Health Coverage
USA:	United States of America
WHO:	World Health Organisation
WPToPS:	White Paper for the Transformation of the Public Service
WPToHS:	White Paper for the Transformation of Health System
ZFM:	Zwelentlanga Fatman Mgcawu

LIST OF FIGURES

LIST OF TABLES

TABLE OF CONTENTS

CHAPTER ONE: INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 INTRODUCTION

Access to health care is a basic right in South Africa**.** Section 27(1) of the Constitution of the Republic of South Africa, 1996 (hereinafter refers to as the Constitution, 1996) provides that everyone has the right to access health care services, including reproductive health care. The National Planning Commission (NPC) (2011:295) provides that access to medical care is one of the social determinants of health. According to the World Health Organisation (WHO) (2016:10), mere availability of health professionals (medical doctors, specialist, clinical practitioners, pharmacist, and radiographers) and other health workers (nursing staff, medical officers and emergency medical care officers) is not sufficient. This occurs only when they are equitably distributed and accessible by the population, when they possess the required competency, and are motivated and empowered to deliver quality care that is appropriate and acceptable to the socio-cultural expectations of the population, as well as when they are adequately supported by the health system with all necessary resources.

In contrast to what is advocated above, Wootton and Bonnardot (2015:35) states that the extreme shortage of doctors in sub-Saharan Africa is well documented, with 26 doctors per 100 000 people against a global average of 141 doctors per 100 000 people. The situation is no different in South Africa. South Africa has 77 doctors per 100 000 people. This includes retired and non-practicing doctors and those who have remained on the register but practice in other countries. The shortage of medical doctors is more apparent in rural areas where approximately 43% of people face greater health challenges, such as having access to only 12% of the medical workforce in South Africa (Motala and Van Wyk, 2016:74).

In light of the above Zelnick, Levenstein, Forrant and Wooding (2017:93) point out that district health has a significant shortage of physicians. Although 80% of patients in South Africa receive care in public hospitals, 70% of South African physicians work in the private sector. Wootton and Bonnardot (2015:28) states that health systems in Sub-Saharan low and middle-income countries (LMICs) face a particularly high burden of diseases with poor infrastructure and sanitary

equipment as well as scarce numbers of health professionals. These health professionals are mainly concentrated in urban areas and those in rural areas are professionally isolated. Due to fiscal constraints, both internally and externally imposed, South Africa reduced its tertiary academic medical facilities, including research and tertiary hospitals, in favor of primary care clinics, many of which exist on paper but not in practice. In addition, like many Southern African countries, South Africa struggles to provide health care services to its rural populations and to retain doctors and nurses across the country.

According to Matsoso, Fryatt and Andrews (2015:37), rural provinces such as the Eastern Cape, North-West, Mpumalanga, Limpopo, and Northern Cape have underdeveloped hospital services as well as fewer health professionals and facilities for the population they serve. Spooner and Ullman (2014:72), states that half of the medical graduates from South African medical schools end up working overseas. Of those South African doctors remaining in the country, only a quarter work in public health facilities, mostly in urban areas.

According to Renzaho (2016:153), local health staff are being poached by international Non-Governmental Organisations (NGOs) and staff are motivated to move from rural and regional service areas to urban centers with technologically advanced facilities. The increasing number of NGOs and their financial power mean that there are many opportunities for consultancies, which offer better remuneration than the government and result in taking highly qualified personnel away from their usual poorly paid work. South Africa has made some attempts to confine the movement of workers, but the inequities continue to persist as the remuneration potential involved with working overseas outweighs government attempts to keep health workers at home (Huish, 2013:72).

In an attempt to address the shortage of doctors, the South African government introduced various measures such as scarce skill allowance, rural allowance, community service, government-to-government agreements for the importation of doctors from Cuba as well as specific legislation designed to boost other forms of health care (Department of Labour, 2008:42). Despite the above measures, the Northern Cape Department of Health (NCDoH) lacks the adequate numbers and skills mix of human resources needed to deliver essential health interventions for a number of

reasons. These include limited production capacity, inadequate financing, poor socio-economic conditions of the province, a poor mix of skills and a lack of proper human planning (NCDoH, 2015:7-9).

Nelson Mandela and the former President of Cuba, Fidel Castro signed a bilateral agreement in 1996 (Parliamentary Monitoring Group, 2013:5). One of the key terms of the agreement was to address the critical shortage of medical doctors in the country. According to Hlakotsa (2018:1), the Mandela-Castro Medical Collaboration Programme (MCMCP) aims to provide primary health care, especially to health care facilities in rural areas. On completion of their studies in Cuba, students return to South Africa for their sixth year of study and do an additional eighteen months of medical training at any of the medical faculties of the eight South African universities. The successful candidates are then placed at designated facilities, as per contractual agreement.

The newly qualified South African Cuban (RSA-Cuba) trained doctors are deployed to various facilities to improve the quality of health care service. The province will continue with the MCMCP by sending young matriculates to Cuba to study medicine to alleviate the shortage of doctors (NCDoH, 2015:9). On the 25th May 2012 a further agreement between the governments of South Africa and Cuba to extend the training of medical students to 1000 students on an annual basis was concluded. This programme is referred to as the expanded training programme of the MCMCP. Bin-Abdulrahman, Minnin, Harden and Kennedy (2015:106) argue that MCMCP has proven very costly and has not gone a long way to resolve the country's lack of doctors. The government is, however, determined to considerably increase the number of Cuban-trained South African candidates. There is, however, little optimism amongst academics that this mobility will provide a short-term answer to a long-term problem.

Anon (2015) reports in the Diamond Fields Advertiser (DFA) that the Northern Cape Province (NCP) has the lowest number of general practitioners, medical specialist and surgical specialists (DFA, 01 November 2015). It was within this context that this study seeks to assess the impact of the MCMCP in promoting health care service delivery in the Frances Baard District Municipality (FBDM) hospitals in the NCP.

1.2 MOTIVATION FOR THE STUDY

The researcher was involved with the recruitment of South African students to study medicine in Cuba through the MCMCP. He has therefore seen and experienced the challenges that students in the MCMCP have to endure during the period of their studies in Cuba. According to Bin-Abdulrahman *et al*. (2015:106) students on the MCMCP are required to study medicine in Spanish and this process requires a tremendous amount of mind mobility and is often where students struggle most. Furthermore, students are also in a foreign culture, requiring them to adapt quicker than perhaps possible. Failure to adapt to this new setting will impact negatively on their studies.

A study was conducted by Motala in 2013 on the perceptions of training and perceived competence in clinical skills of the students who returned from Cuba after having taken part in the MCMCP (Motala, 2014). Motala also published a research paper in 2014 exploring the impact of experience-based medical learning on students' clinical preparedness, using the MCMCP as a case study. Another study, conducted by Bateman in 2013, on the projected growth of MCMCP projected that it would exert tremendous pressure on the under-resourced South African medical universities from 2018 onwards when about 1000 undergraduate RSA-Cuba trained medical students are to return to South Africa from Cuba to do the last phase of their training (Bateman, 2013).

There have been no studies conducted which emphasise the importance of assessing the impact of the MCMCP in promoting health care service delivery in the FBDM hospitals in the NCP. According to Abdulrahman *et al*. (2015:106), there is neither research that exists to show how well RSA-Cuban medical students perform as doctors nor whether they return to work in the regions of their origin.

1.3 CONCEPTUAL FRAMEWORK

According to Badenhorst (2012:21) a conceptual framework assists a researcher in unpacking the key concepts used in the research as well as in identifying the relationships between the concepts. The conceptual framework for this study, as illustrated in Figure 1.1 in the next page, was followed.

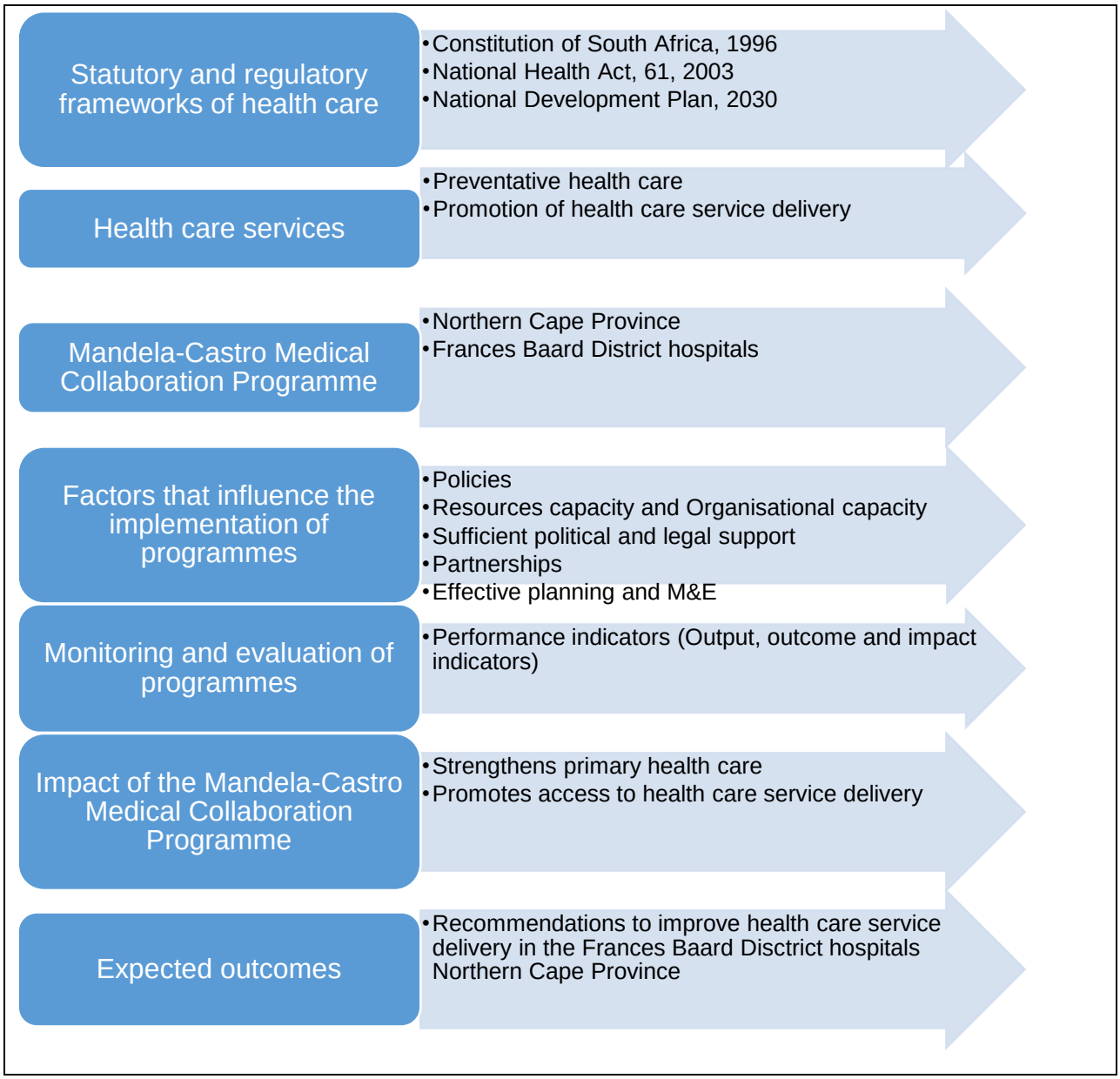

Figure 1.1: Conceptual framework of the study

(Source: Researcher's own interpretation)

1.4 BACKGROUND TO THE PROBLEM/PROBLEM STATEMENT

Since 1994 a decrease in the numbers of doctors and nurses qualifying along with a continued emigration of skilled health care personnel has increased the entrenched difficulty in encouraging

professionals to work in disadvantaged rural areas. Furthermore, low morale and burnout amongst health workers as a result of the Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) pandemic, has had a drastic impact on an overstressed public health care system, and worsened the situation further (Weindling, 2014:150).

According to van Rensburg (2014:5), the post-1994 reforms have thus largely failed to effect sufficient change in Human Resources for Health (HRH) distribution and in access to health care. Specifically, women, children and the aged from the poorest echelons and from rural areas continue to live less protected from health hazards, are more exposed to diseases of poverty, have to rely on health services of compromised quality, and have less access to services as a result of poverty-related barriers.

Green (2013:20) maintains that the Public Health Association of South Africa estimates that there is an overall shortage of 80 000 healthcare professionals in the country, and that 70% of doctors work in the private sector, which serves only 16% of the population. Green (2013:20) further states that South Africa is producing the same number of healthcare professionals as levels in the 1990s. Green (2013:20) states that the Head of the University of Cape Town's Medical School, Professor Bongani Mayosi, mentioned that South Africa is producing between 1 200 and 1 400 doctors annually. South Africa needs, therefore, to double the number of healthcare professionals that are currently being produced.

The NCDoH has since 2000 been a participant in the MCMCP, as depicted in Figure 1.2, in order to increase the number of medical doctors to improve health care service delivery.

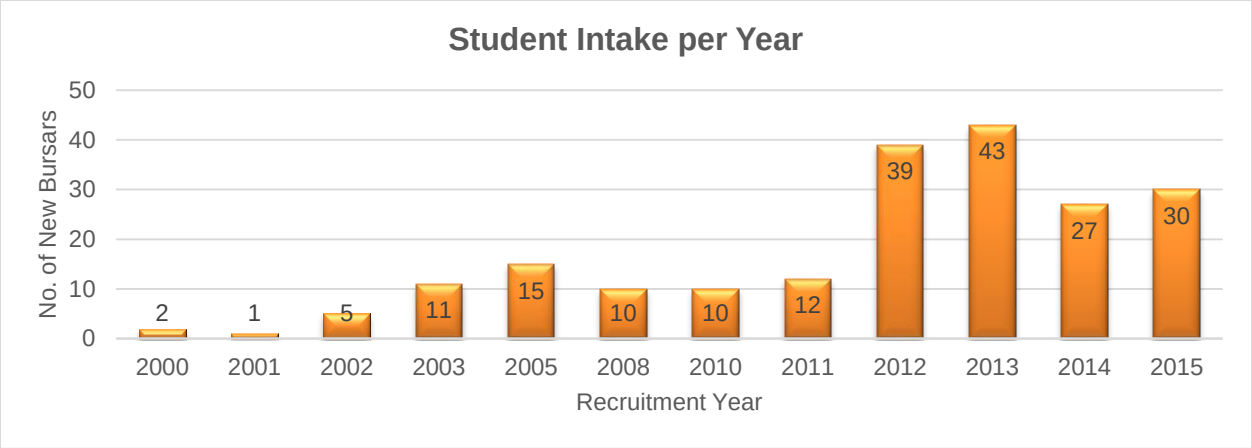

Figure 1.2: Student intake per year

(Source: NCDoH, 2017b:2)

The intention of the NCDoH has been to reduce the shortage of medical doctors in the province. Table 1.1 below provides a summary of RSA-Cuban student intake, who took part in the MCMCP programme from 2000 to 2015 in the five municipal districts of the NCP.

Table 1.1: Summary of the number of RSA-Cuban student intake from 2000 to 2015

Year	Beneficiaries per district in the Northern Cape Province					
	Pixley Ka Seme	Frances Baard	Namakwa	John Taolo Gaetsewe	Zwelentlanga Fatman Mgcawu	TOTAL
2000	0	0	0	2	0	2
2001	0	0	0	1	0	1
2002	1	4	0	0	0	5
2003	2	4	1	1	3	11
2005	4	5	1	1	4	15
2008	0	9	1	0	0	10
2010	3	2	1	4	0	10
2011	3	3	1	4	1	12
2012	7	21	1	5	5	39
2013	5	25	4	7	2	43
2014	4	13	1	6	3	27
2015	6	7	4	8	5	30
TOTAL	35	93	15	39	23	205

(Adopted from NCDoH, 2016:2)

It can be depicted from Table 1.1 on page seven that there are a total of 93 candidates from the FBDM area were selected to take part in the MCMCP. According to the NCDoH Annual Performance Plan, a total of 205 students from the Northern Cape Province were recruited as part of the MCMCP from 2000 to 2015 to study medicine in Cuba. From this number, 35 have qualified as medical doctors while the remainder are at different levels of their studies and 28 have dropped out (NCDoH, 2016:2). These doctors are obliged by the contractual agreement to serve in the NCDoH, and particularly in areas where there is a dire shortage of doctors. These doctors are placed across the five NCDoH municipal districts, as depicted in Figure 1.3.

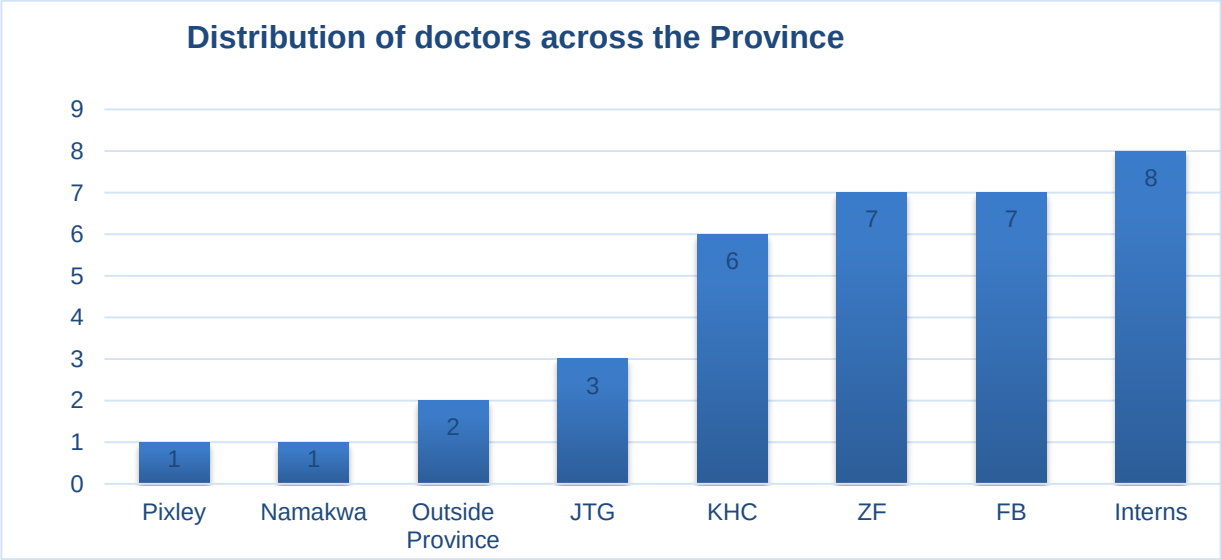

Figure 1.3: Distribution of MCMCP doctors across Northern Cape Province (NCP)
(Source: NCDoH, 2017b:2)

With regards to distribution of the doctors, seven are spread across the five small district hospitals in the FBDM area as follows: two in Galeshewe Day Hospital in Kimberley, two in ZK Mathews Hospital in Barkly West, one in Connie Vorster Hospital in Hartswater, one in Jan Kempdorp Hospital in Jan Kempdorp and one in Warrenton Hospital in Warrenton. With the exclusion of the eight medical interns, it implies that FBDM is comprised of 26% of South African-Cuban trained medical doctors. Another concern is the high rate of referrals of patients from these hospitals in the FBDM to Kimberley Hospital Complex, a tertiary health care service hospital in Kimberley (Pilane, 2016).

Benatar, Sullivan and Brown (2017:9) point out that the major weakness of health care in the context of South Africa is the inequitable health care services. In addition, the NPC (2011:331) states that the inability to get primary health care and the district health system to function effectively has contributed significantly to failure in the health system and has resulted in the high rate of referrals of patients from the district health care facilities to the tertiary health care facility. Patient care in many district hospitals is poor. Prevention, primary health care and the quality of care are neglected.

Specialised medical training is currently out of step with what South Africa needs. Training specialists to improve the quality of care in their field in district hospitals and surrounding health centers and clinics is the priority. They should also be trained to improve the planning, management, and monitoring of district services in their field (NPC, 2011:347). This study seeks to assessed the impact of the MCMCP in promoting health care service delivery in the FBDM hospitals in the NCP.

1.5. RESEARCH QUESTIONS

Emerging from the above the primary research question of this study was: Does the MCMCP assist to promote health service delivery in the small district hospitals in the FBDM area in the NCP? The secondary research questions of this study were:

- What are the statutory and regulatory framework requirements of the MCMCP?
- What is the attitude of health care professionals on whether enough competent doctors are produced by the MCMCP to reduce the shortage of doctors in the FBDM area?
- What is the attitude of the health care professionals on whether the doctors from the MCMCP improve the medical care services in the ZK Mathews District Hospital in Barkly West and the Warrenton Hospital in Warrenton in the FBDM area?
- What is the attitude of health care professionals on whether the MCMCP trained medical doctors are competent and motivated in their role as medical practitioners according to the perceptions of the hospital staff that they work with?

- What recommendations could be made concerning the impact of the MCMCP to promote health care service delivery in the small district hospitals in the FBDM area in the NCP?

1.6 AIM AND OBJECTIVES OF THE RESEARCH

The main aim of this study was to positively contribute by means of specific recommendations concerning the impact of the MCMCP to promote effective health care service delivery in the small district hospitals in the FBDM area in the NCP.

The primary objective of this study was to assess whether the MCMCP assists in promoting health service delivery in the FBDM hospitals in the NCP.

To further explore the primary research objective, the following were the secondary objectives of the study:

- To determine the statutory and regulatory framework requirements of health care service delivery and the purpose of the MCMCP.
- To determine the attitude of health care professionals on whether enough competent doctors are produced by the MCMCP to reduce the shortage of doctors in the FBDM area.
- To determine the attitude of the health care professionals on whether the doctors from the MCMCP improve the medical care services in the ZK Mathews District Hospital in Barkly West and the Warrenton Hospital in Warrenton in the FBDM area.
- To determine the attitude of health care professionals on whether the MCMCP trained medical doctors are competent and motivated in their role as medical practitioners according to the perceptions of the hospital staff that they work with.
- To determine what recommendations could be made concerning the impact of the MCMCP to promote health care service delivery in the small district hospitals in the FBDM area in the NCP?

1.7 RESEARCH METHODOLOGY

The purpose of this section was to provide a description of the research methodology used in the research study. Welman, Kruger and Mitchell (2005:2) state that research methodology explains the logic behind the research process. Bless, Higson-Smith and Sithole (2014:160) maintain that most research methods can be used in research based on either qualitative or quantitative methodologies. This study was based on quantitative research.

1.7.1 Research Philosophy/Paradigm

There are three major types of paradigms, namely positivism, post-positivism or interpretivist and pragmatism paradigms (Du Plooy-Cilliers, Davis and Bezuidenhout (2014:23-27). Welman, *et al*. (2005:6) state that the positivism paradigm (quantitative) underlies the natural-scientific method in human behavioural research and hold that research must be limited to what can be observed and measured. The positivism paradigm accepts knowledge to be true if it is created through scientific methods. On the other hand, the post-positivism paradigm or interpretivist (qualitative research) assumes that there are many ways to acquire knowledge besides using scientific methods. This study was conducted within the positivism paradigm (quantitative research) which focuses on the use of scientific methods and holds that research must be limited to what can be observed and measured objectively.

1.7.2 Research Approach and Design

The research approach applied was deductive in nature and used quantitative data to generate propositions. Cooper and Schindler (2003:149) state that the research design can be seen as a general plan or blueprint on how the researcher goes about answering the research questions. In this study a descriptive non-experimental design, namely an opinion-based survey in the form of a structured questionnaire to determine the attitude of hospital staff on the impact of the MCMCP in promoting health care service delivery in the Frances Baard District Hospitals, NCP was used. According to Welman *et al*. (2005:93) a survey design is a non-experimental research design used in quantitative research. Whereas, Salkind (2018:19-20) non-experimental research design refers

to research in which no manipulation of variables is involved and no cause and effect relationship is studied. Salkind (2018:20) further explains that non-experimental research methods include descriptive and correlational methods. Descriptive non-experimental research refers to any survey that assesses the current status of a phenomenon.

1.7.3 Population and Sampling

Welman *et al.* (2005:52) provide a definition of a population as the study object and consists of individuals, groups, organisations, human products, and events, or the conditions to which they are exposed. The target population of this study was comprised of health professionals working at the five small district hospitals in the FBDM area, namely the ZK Mathews Hospital in Barkly West, the Warrenton Hospital in Warrenton, the Connie Vorster Hospital in Hartswater, and the Jan Kempdorp Hospital in Jan Kempdorp and Galeshewe Day Hospital.

Neuman (2011:210) describes sampling as gaining a representative or small collection of units, or cases from a much larger collection of units, or cases from a larger collection of the population, such that the researcher can study the smaller group and produce accurate generalisations about the larger group. The simple random sampling method was used to select two of the five district hospitals to conduct the research. The simple random sampling method provides equal opportunity of selection for each element of the population (Bless *et al.*, 2014:167). A symbol was issued to each element of the population and placed in a container to select two of the five district hospitals to conduct the research. Probability sampling was also used by means of a random stratified sampling method to draw the sample of health professionals (unit of analysis) for this study from the ZK Mathews Hospital in Barkly West and the Warrenton Hospital in Warrenton as indicated in Table 1.2 and Table 1.3 on page 13 (Population frame; N = 134 and unit of analysis; n = 72).

Table 1.2: Health Professionals sample frame (N) and sample (n) ZK Mathews Hospital in Barkly West

Occupation of health professionals at the ZK Mathews Hospital in Barkly West	Total Population = Sample frame (N)	Sample (n)
Professional Nurse (General)	32	16
Clinical Nurse Practitioner	2	1
Staff Nurse	5	3
Nursing Assistant	18	9
Social Worker	1	1
Medical Officer	12	6
Dentist	3	2
Medical Specialist	2	1
Pharmacy Assistant Basic	2	1
Pharmacy Assistant Post Basic	1	1
Pharmacist	1	1
Pharmacy Supervisor	1	1
Emergency Care Officer	1	1
Speech Therapist	1	1
Environmental Health Practitioner	2	0
Occupational Therapist	4	2
Radiographer	1	0
Physiotherapist	3	2
Dietician	2	0
Clinical Nurse Specialist Practitioner	4	0
Total	**98**	**49**

Table 1.3: Health Professionals sample frame (N) and sample (n) Warrenton Hospital in Warrenton

Occupation of health professionals at the Warrenton Hospital in Warrenton	Total Population = Sample frame (N)	Sample (n)
Professional Nurse (General)	13	7
Staff Nurse	1	1
Nursing Assistant	5	3

Medical Officer	5	3
Dentist	1	1
Pharmacy Assistant Post Basic	1	1
Pharmacist	1	1
Emergency Care Officer	7	4
Occupational Therapist	1	1
Radiographer	1	1
Total	**36**	**23**

1.7.4 Data Collection

The researcher employed three methods to collect data, namely: a literature review, a pilot study and a survey in the form of a structured questionnaire (quantitative). The structured questionnaire was based on a 5-point Likert scale that consists of a collection of statements on the topic. In respect of each statement, respondents had to indicate the degree to which they agree or disagree with its contents on a five-point scale. Some statements represented a positive attitude whereas others reflected a negative attitude towards the attitudinal object.

To substantiate the validity and reliability of the measuring instrument, a pilot study was carried out at Dr Harry Surtie Hospital in Upington, using a total of 30 respondents. The researcher made sure that the instrument measured what it was supposed to measure, by referring to the objectives and literature relating to the area of study. Furthermore, to ensure reliability the researcher administered the measurement only once to a large, representative sample. Cronbach's coefficient alpha, a measure of internal consistency, was used to measure the degree of match between each item and every other item in the instrument. Also, the reliability coefficient that was obtained may be interpreted as an estimation of the parallel-forms reliability of the measurement (Welman *et al*. 2005:147).

To administer the questionnaire, an appointment was secured with the Central Executive Officer (CEO) of the ZK Mathews Hospital in Barkly West and the Operational Manager of the Warrenton Hospital in Warrenton to seek permission to distribute the structured questionnaire amongst the staff of the two small district hospitals. Once permission was granted, meetings with unit managers

took place to facilitate access to the respondents and to explain the rationale behind the significance of completing the questionnaires. Data was completed by means of group contact which put the researcher in full control of the completion of the questionnaires. Since the researcher was present, queries about the completion of the questionnaire could be answered immediately.

1.7.5 Data analysis

Henning, Van Rensburg and Smit (2004:6-7) maintain that the process of data analysis will assist the researcher in answering the research questions as well as in achieving the purpose of the research. Data was captured by using Multiple Regression Analysis. To measure data, the researcher used an interval measurement with a particular focus on the mean, frequencies and standard deviation. Most measures of human characteristics have interval properties. In interval measurement, the property of equal differences between consecutively higher numbers is used (Welman *et al*. 2005:139).

Welman *et al.* (2005:231) further explain the following statistics used for interval type:

- The mean is the average score for a group, and is equal to the total of individual scores divided by the number of scores.
- Frequencies determine if the distribution is even across the intervals or whether they cluster around one or two intervals.
- Standard deviation determines if the scores on a parametric test are evenly distributed and cluster closely around the mean.

The researcher used Moonstats statistical software to explore and describe data. Moonstats is a stand-alone statistical software programme that operates in Windows 95 or higher and allows for data entry of numeric values into a data sheet of up to 100 variables and 1000 cases (units of analyses) (Welman *et al.* 2005:319). An experienced statistician assisted the researcher to firstly, developed the structured questionnaire and secondly, to provide guidance in collating, interpreting and analysing the results from the data collection instrument.

1.8 ETHICAL CONSIDERATIONS AND LIMITATIONS OF THE STUDY

Maree (2013:306) states that it is essential that throughout the research process the researcher follows and abides by ethical guidelines. This study adhered to the following principles of ethical conduct:

- Informed consent and voluntary participation. The researcher obtained verbal informed consent from the stakeholders before implementing the structured questionnaire. The researcher ascertained whether or not the stakeholders would be available and willing to participate in interviews at a later stage. The researcher presented participants with a letter of consent (See Annexure A), in which the research process was described. The participants were requested to read the letter, ask questions to gain clarity, and sign the consent form if willing to be involved in the research.
- A letter of consent was submitted to the Chief Executive Officer (CEO) of the two district hospitals to create awareness of the research purpose and to get their consent to conduct the interview by means of a structured questionnaire (See Annexure B). and approval was granted to conduct the research (See Annexure C).
- Privacy, confidentiality and anonymity. All participants' information and responses shared during the study are kept private and the results have been presented in an anonymous manner in order to protect the identities of the participants.

The study contains certain conditions, such as the honesty, commitment and willingness of the participants to participate in the structured interviews.

1.9 CLARIFICATION OF KEY CONCEPTS

1.9.1 Francis Baard District Municipality (FBDM)

The district is one of five municipal districts in the NCP. The FBDM is the most populated of the five districts, estimated at 37% of the NCPs total population.

1.9.2 Mandela-Castro Medical Collaboration Programme (MCMCP)

The MCMCP is an agreement between the governments of South Africa and Cuba, in terms of which selected South African students are sent to Cuba to receive their initial medical training at a Cuban university. All costs of the programme are borne by the South African government including tuition, travel, accommodation, and subsistence. Students receive an initial five years of training in medicine in Cuba, in Spanish, and then complete their final year in English at a South African medical school. Most medical schools require the returning students to join a 6- or 12-month orientation programme before entering the final year. The design, duration and a need for a formal orientation programme are left to the discretion of each university as this exercise is not part of pass requirements but a platform for preparation of such students for a final year in the South African context (Donda, Hift and Singaram, 2016:1).

1.9.3 Policy and Legislative Framework of Health Care Service Delivery

According to Van Rensburg (2012:126) policies and legislation are implementation strategies. Policies are developed to guide the role-players in their endeavor to implement strategy whereas legislation is more prescriptive as to the process of implementing a strategy. Since 1994 legislation and policy have demonstrated government commitment to establishing a health service which meets the basic needs of all South Africans by pooling the use of public and private resources (Braithwaite, Matsuyama, and Johnson, 2017:59).

1.9.4 National Development Plan (NDP)

This is a plan for the entire of South Africa. It provides a broad strategic framework to guide key choices and actions (NPC, 2011:26). It is a plan for the country to eliminate poverty and reduce inequality by 2030 through uniting South Africans, unleashing the energies of its citizens, growing an inclusive economy, building capabilities, enhancing the capability of the state, and leaders working together to solve complex problems (NPC, 2011:1).

1.9.5 Universal Health Care Coverage

Universal Health Coverage (UHC) is central to achieving better health and well-being for all people of all ages. It delivers disease prevention, health promotion, and treatment for communicable and non-communicable diseases alike whilst ensuring that individuals are not driven into poverty due to high costs. The goal of UHC is to improve the chances of each individual attaining the highest level of health and well-being whilst also contributing to socio-economic and sustainable development (World Health Organisation (WHO), 2017).

1.9.6 Functions of Government

Governments supply services for managing order and protection, social welfare and economic welfare functions, which may be categorised as order and protection services, social welfare services and economic welfare services (Gildenhuys and Knipe, 2000:56).

1.9.7 District Health Care Services

Feucht (2013:124) points out that the district-based health care system includes primary health care (PHC) clinics, and community health centres (CHCs), as well as district hospitals. The primary and district health system should provide universal access, with a focus on prevention, education, disease management and treatment (NPC, 2011:51). The district health system embodies a decentralised, area-based, people-centred approach to health care (NPC, 2011:331).

1.9.8 Programme Management

Knipe in Van der Waldt, Van Niekerk, Doyle, Knipe and Du Toit (2001:210) define programme management as the co-ordinated management of a portfolio of projects to achieve a set of objectives.

1.9.9 Monitoring and Evaluation

Monitoring and evaluation systems are created specifically for the purpose of tracking performance and should, therefore, be equally able to reveal poor performance, satisfactory performance and good performance (Ile, Eresia-Eke and Allen-lle, 2012:92).

1.10 OUTLINE OF THE DISSERTATION

Further to this introductory chapter, this study was organised into four chapters:

Chapter 2, the literature review, contained the theoretical framework that has informed this research. The review involves health care service delivery with a particular focus on the definition of health care service delivery, policy and legislative framework on health care service delivery, Chapter 10 of the NDP, universal health coverage, functions of government in the provision of health care service, programme management and a detailed profile of MCMCP. Throughout the review, a theoretical basis for these constructs develop and it culminates in a summary from the material reviewed.

Chapter 3 discussed the methodology that formed the foundation of the research. The research strategy, sampling, measuring instruments, the data collection procedure, data analysis and limitations of the study are discussed.

Chapter 4 presented the research findings and results.

Chapter 5 presented the conclusion and recommendations of this study. It argued the main findings by drawing together the results from the previous chapters into a programming strategy.

1.11 SUMMARY

The aim of this study was to positively contribute by means of specific recommendations concerning the impact of the MCMCP in order to promote effective health care service delivery in the small district hospitals in the FBDM area in the NCP. Therefore, this chapter provides a guideline on how the study was set out. This chapter, therefore, highlighted the motivation of the research, the problem statement, objectives and research methods used. It further provides clarity on the concepts that form the foundation of the study. Chapter 2 provides a comprehensive theoretical overview of health care service delivery, the MCMCP and public programme management.

CHAPTER TWO: THEORETICAL OVERVIEW OF HEALTH CARE SERVICE DELIVERY, THE MANDELA-CASTRO MEDICAL COLLABORATION PROGRAMME (MCMCP) AND PROGRAMME MANAGEMENT

2.1 INTRODUCTION

In terms of Section 27(1) of the Constitution, 1996 everyone has the right to have access to health care services, including reproductive health care. One of the key objectives of National Health Act, 2003 (hereinafter refers to as the NHA, 2003) is to give effect to the constitutional right of people to have access to health care services. The former Minister of Health, Dr Motsoaledi emphasised in NDoH (2015b:4) that access to comprehensive quality health care services is an imperative to achieve health equity and to improve the quality of a healthy life for all people of South Africa. Therefore, MCMCP was identified as an alternative measure to improve access to health care service and to improve the quality of health care services in particular in rural areas. As mentioned in the previous chapter the study seeks to assess the impact of the MCMCP to promote effective health care service delivery in the small district hospitals in the FBDM area in the NCP.

This chapter contains the theoretical framework that has informed this study. The review is organised around the key constructs of health care service delivery with a particular focus on district health care services and in particular the MCMCP. The chapter commences with the conceptualisation of concepts, followed by a discussion about global challenges of health care services, the background of health care service delivery and challenges in the South Africa context. The statutory and regulatory framework of health care services were provided. The role of government on health care service delivery and MCMCP was outlined, followed by a discussion about district health care services. Lastly the chapter outlined the requirements concerning the management of programmes of which the MCMCP cannot be excluded.

2.2 CONCEPTUALISATION OF CONCEPTS

A good starting point for the purpose of this study was to first define service delivery before health care service delivery could be conceptualised. Theron and Mchunu (2016:188) refer to service delivery as a series of activities by various institutions that mobilise and process resources into services and present them to a target group of people in a satisfactory and sufficient manner. Alford and Flynn (2012:8) define service delivery as the production of outputs, which includes the provision of services to government agencies as well as their clients. Where the focus is on bringing about outcomes, or on the imposition of obligations, it should be referred to as implementation and, in some cases, to achieving outcomes. While the two definitions agree on the delivery of services, the former refers to the beneficiaries of these services as a target group, whereas the latter's definition tends to be more specific by mentioning the beneficiaries of services as government agencies and their clients. Furthermore, Theron and Mchunu (2016:188) indicate that the provision of services should be adequate and satisfactory to clients, while the latter does not draw attention to this distinction but rather stresses that services should lead to achieving outcomes.

Since 1994 the aim of service delivery in the context of South Africa is to address the needs of the community and therefore it requires specific policies and criteria to transform public service delivery. Service delivery refers to the provision of services or tangible public goods. Whereas basic municipal services refer to those services necessary to ensure an acceptable quality of life, and if not provided it could endanger public health or safety (Van Der Waldt and Du Toit, 1999:385; Van der Wadlt, Khalo, Nealer, Phutiagae, Van der Walt, van Niekerk and Venter, 2014:164). In addition, the White Paper on Transformation of Service Delivery, 1997 provides for principles known as "Batho Pele" principles, meaning "people first" which would enable national and provincial administrations to develop the strategies to promote continuous improvement in the quantity, quality and equity of service provision. Pertaining to the health sector, Roberts, Hsiao, Berman and Reich (2008:319) describe health as an important component of both opportunity and well-being for all individuals in society and thus, those who work to improve health status are doing genuinely important work from almost any ethical perspective.

According to Lane in Draai, Van Rooyen and Raga (2016:142) the South African government comprises a bureaucracy that is tasked with meeting the needs and the various expectations of a differentiated population from various socio-economic backgrounds. Section 195 of the Constitution, 1996 provides the principles that must guide the provision of public services of which health services could not be excluded. These principles entrust all spheres of government with the responsibility for the effective and efficient provisioning of public services to the community, and include the following; the promotion of a high standard of professional ethics; the needs of citizens must be responded to in an effective manner; service delivery must be delivered in an impartially fair and equitable manner without any bias, public participation should be promoted in all policy-making and development initiatives; and all government departments must deliver services in an accountable, transparent and developmental manner. Lane in Draai *et al*. (2016:143) state that the process of delivering services to the public should be a shared responsibility of a number of role players, including government, private sector, non-governmental organisations and communities, whereas, Gildenhuys and Knipe (2000:48-52) are of the opinion that governments have to execute a variety of functions and deliver a variety of services to realise their goals, objectives and short-term targets.

In terms of Section 1 of the NHA, 2003 health care services entail those services including reproductive health care and emergency medical treatment as required in Section 27 of the Constitution, 1996. It also includes those health care services as required in Section 28 of the Constitution, 1996 such as basic nutrition and basic health care services. In addition, health care services are an important component of social welfare that comprises the execution of personal health functions such as the prevention and combating of infectious diseases

2.3 AN OVERVIEW OF HEALTH CARE SERVICE DELIVERY CHALLENGES IN A GLOBAL CONTEXT

Most countries including wealthy countries are experiencing challenges to provide health care services, due to global economic challenges such as the global economic recession of 2008, and rapid growth in health care expenditures (Brill, Time Magazine, 4 April 2013). According to Benatar, Sullivan and Brown (2017:3) health care services are distorted and health care systems

and structures cannot keep up with the current burden of diseases. Global health care systems are dysfunctional, because of the insensitivity of commercial and bureaucratic considerations. In most countries, health care systems are unsustainable, in that the demands for health care services exceeded the ability to supply effective health care services. Naylor, Girard, Mintz, Jenkins, Power (2015) argue that attempts in most countries to control and standardise health care services, has led to more complex bureaucracies, which poses significant impairments on governments to deliver quality health care services of which South Africa cannot be excluded. In light of the above Arhete and Erasmus (2016:493) agree that across the globe there have never been more health care service challenges than experiencing currently that leads to unprecedented global reforms of health care systems. One of the major weakness in particular in Sub-Saharan African health care systems is the availability of health care workers. It is estimated that Africa has less than 1 health care worker per 1000 people in comparison with 10 health care workers per 100 people in Europe (Maphumulo and Bhengu, 2019:3).

Except for the above, Adams, Bakalar, Boroch, Knecht, Mounib and Stuart (2018:2) state that most countries including wealthy and developing countries experiencing the following health care service challenges:

- **Ageing populations**. According to Arhete and Erasmus (2016:493) the global population group of 60 years and over has tripled over the last half a century. It is estimated that the global population growth rate in this age group will reach two billion in 2050, which will place an additional strain on existing health care systems. A concern is that this growth rate will happen mostly in developing countries of which South Africa cannot be excluded. There is a global shift in the young and old age balance, throughout the world due to a rapid increase in the older age group, and a decline in fertility and mortality rates (Atallah, Lo and Yang, 2012:3; Arhete and Erasmus, 2016:493).
- **Chronic diseases**. Another challenge that has an impact on health care systems world-wide is a rapid increase in chronic diseases, which is typically of older age groups. These chronic diseases are among others, diabetes, hypertension, heart disease, cancer, mental disorder including Alzheimer and dementia and respiratory diseases. The latter led to an increase in the demand for health care services and reforms. As part of the reforms

countries across the world are offering global awareness campaigns, prevention and wellness programmes about chronic diseases (Deloitte, 2014:8: Arhete and Erasmus, 2016:493).

- **Access and cost of health care**. According to Deloitte (2014:4) both private and public health care funding systems are financially constrained by a rapid increase of the cost of health care. The continuing increase in the cost of health care and the increasing demand for access to health care services has become a challenge not in developing countries, but also in developed countries. The higher cost of health care does not necessarily mean good health care, countries all over the world face challenges with the quality of health care systems. Globally wide, both private and public health care facilities are introducing measures to cut costs, such as prescription drug price controls; physician incentive models, the use of generic drugs, and the introduction of affordable clinics among others (Arhete and Erasmus, 2016:493-494). According to Deloitte (2014:5) over a billion people world-wide lack access to health care facilities. Numerous countries invest in health care professional training programmes to increase the number of health care professionals. Examples of this are the General Practice training programme in Australia and the MCMCP in South Africa. Most countries invest in health care infrastructure improvement programs to increase access to health care facilities (Deloitte, 2014:5; Arhete and Erasmus, 2016:493).

In light of the above the rapid developing of medical technology and the availability of diagnostic and other high-tech medical equipment has changed the way in which health care is being delivered on a global scale. The evolving of medical technology led to an increase in the cost of health care services and the demand for robust information technology infrastructure (Arhete and Erasmus, 2016:493). Thus, one could argue that governments in most countries faces similar challenges such as the increase in an ageing population, chronic diseases, an increase in the demand and access of health care services, rapid increases in the cost of health care services and demand for the use of high-tech medical technology and equipment. The above challenges require more reforms from governments to change their health care policies and priorities to increase the demand of health care services and infrastructure of which the South African government cannot be excluded.

The focus of this study is primarily on health care service delivery in South Africa with emphasis on the impact of the MCMCP in the FBDM area in the NCP, therefore a brief overview of the provision of health care service delivery in Cuba is provided in the section below.

2.3.1 Provision of health care service delivery in Cuba

Whiteford and Branch (2008:43) aver that the Cuban national health care system is organised to provide health care at three levels. The point of entry in the first level is through the Basic Health Team which consists of the family doctor and auxiliary medical personnel (nurse). This team provide primary health care at the community level. The second level of care provides both secondary and tertiary health care and is comprised of acute care facilities, long term care facilities such as nursing homes and other specialities within the health area. The third level provides care for people whose needs require highly specialised treatment.

According to Plake, Schafermeyer and McCarthy (2016:502) the Cuban health care system is based on the following principles:

- Health care is a right.
- Health care delivery is the responsibility of the state.
- Prevention and curative services are integrated.
- The population participates in developing and maintaining the health care system.

The implementation of the above principles is driven by a primary health care service delivery framework, which depends on both governmental and citizen participation, an extensive network of family medicine practitioners, widespread preventative services and epidemiological surveillance (Whiteford and Branch, 2008:19).

Cuba places great emphasis on community based primary health care, prevention and citizens' active participation. Cuba has also one of the best health indices and all its services are government run (Bateman, 2013:603). In fact, Lundy and Janes (2009:401) maintain that because of the focus on primary care in the community, Cuba's main health indicators such as average life expectancy

and infant mortality are comparable to those of industrialised nations. However, the United States of America (USA) economic embargo on Cuba has had a detrimental effect on the health and nutrition of large numbers of Cuban citizens. The health care services on procedures such as organ transplant, other technology programs, surgical activity, the availability of medications and the acquisition and maintenance of medical equipment have also been affected by the embargo (Lundy and Janes, 2009:401). Thus, primary health care is the core of health care service delivery in Cuba.

Cuba's medical practitioners are produced by 25 medical schools from which 11 000 doctors graduate annually, and countries all over the world send students there. South Africa is one of the countries that have taken the advantage of the opportunity to train students there (Bateman, 2013:603).

2.4 AN OVERVIEW OF HEALTH CARE SERVICE DELIVERY IN SOUTH AFRICA

According to Maphumulo and Bhengu (2019:3) point out that many of the current health care service challenges in South Africa can be traced back to the apartheid period before 1994, in which health care systems was totally fragmented. Mayosi and Benatar (2014:23) contend that even after 1994 the health and well-being of the majority of the population of South Africa are burdened by continuing social disparities that hamper their access to quality health care services. Arhete and Erasmus (2016:495) agree that even decades after 1994 disparities, inequalities, and inequities continue to widen. These disparities hamper the distribution of resources, access to health care services, and access to quality health care services for the majority of the South African population. Mayosi and Benatar (2014:23) further explain that the public health sector, remains the sole provider of health care services to around 84% of the total population, which are staffed with approximately 30% of health professionals, while the remaining 70% of health professionals work in the private health care sector. These disparities between private and public health care services are deepening in particular between, socio-economic classes, between race, and between provinces and between urban and rural areas, which places a further constraint on access to effective health care services for all people. Another deepening disparity is that most of the public sector health care hospitals are deteriorating to such an extent that some are dysfunctional, due to lack of resources, adequate human resource, deteriorating infrastructure due to neglect, lack of equipment,

mismanagement, and corruption. Although, the South African government has made huge effort after 1994 to improve the quality of health care services the continuing deteriorating of public health care services cause the public to lose trust in the South African public health care system (Ataguba and Akazili, 2010:163; Maphumulo and Bhengu, 2019:2-3; Arhete and Erasmus, 2016:495).

Apart for the above the following major health heath care challenges place a burden on the South African health care systems:

- **Shortage of human resources/health care professionals and other health care workers**: One of the major challenges to provide health care services is the lack of adequate health care workers to provide for the rapid increasing population. Since 1994 the rapid increase in refugees and migrants into the country places a further burden on South African public health care services (Mayosi and Benatar, 2014:23-24). The continued unequal distribution of health professionals between public and private hospitals, provinces and urban and rural areas places a further burden on all public health care services to provide effective health care services (Maphumulo and Bhengu, 2019:3). The shortage of health care professionals leads to longer waiting time for patients in public hospitals, in worst cases patients are even turned away with devastating consequences for individuals. Many incidents were reported in the media of patients who died after they were denied access to health care services or turned away. Another concern is the shortage of medicine and equipment in public health care hospitals that leads to fatal delays and backlogs in urgent surgery. The lack of health care professional such as oncologist and equipment leads to delays for cancer patient urgent treatments (Maphumulo and Bhengu, 2019:2). The lack of other material, equipment, supplies and medicine is another concern, which led to prolonged patient stay in hospitals or prolonged waiting time to receive treatment (Maphumulo and Bhengu, 2019:2). One could argue that the shortage and unequal distribution of health professionals, the lack of equipment, supplies and medicine in public health care hospitals has an adversely negative impact on the constitutional right of all people to have access to health care services.

- **Health, well-being and poverty rates***:* According to Mayosi and Benatar (2014:23) the disparity between rich and poor in South Africa is the widest in the world. Furthermore, there is a direct and indirect link between wealth and health. When poverty affects a large proportion of the population the health of the majority of the people is affected by a lack of access to basic requirements of life, such as clean water, sanitation, adequate food, reasonable housing conditions, proper education and high rates of unemployment. The Poverty Trend Report, 2015 shows that there is an increase in the people living in poverty in South Africa. In 2011 a total of 53.2% (27.3 million) of the population lived in poverty, compared to 55.5% (30.4 million) people in 2015. The Poverty Trend Report of 2015 further shows that the Gini coefficient, which measures income inequality (0 representing perfect quality, while 1 represent perfect inequality), improved from 0.72 in 2006 to 0.68 in 2015 (Omarjee, Fin24 (Online), 22 August 2017). The majority of the population, which consist of black African still experienced the highest income inequality there was an increase of 0.01, in 2006 the Gini coefficient rate was 0.64, while it increased in 2015 to 0.65 (Omarjee, fin24 (Online), 22 August 2017). The persistence of such inequalities is incompatible with improvements in the health conditions of the majority of the South African population.

- **Maternal and child mortality and life expectancy at birth**: In a country where more than 50% of the population is living in poverty the life expectancy at birth is affected, children are the most vulnerable in such poverty conditions (Omarjee, fin24 (Online), 22 August 2017). In 2012/2013 the maternal mortality rate was 145, the infant mortality/1000 live births rate was 34, the under five-year mortality rate was 41, and the life expectancy rate in South Africa was 56 years. The increase in the expectancy at birth rate could be attributed to the roll out of antiretroviral therapy programme and prevention of mother-to-child transmission of HIV. (Benatar, *et al.* 2017:6; Mayosi, *et al.* 2014:23-24).

- **Predominance of HIV/Aids pandemic, tuberculosis and chronic diseases***:* For many years the South African government denied the link between human immunodeficiency virus (HIV) infections and immunodeficiency syndrome (AIDS), and minimal funding were provided for the treatment of the pandemic with devastating effects on the lives of

individuals, families, and society at large. After considerable local and international pressures, the NDoH rolled out a programme in 2003, to provide antiretroviral therapy (ART) to all patients with HIV infections in South Africa. Between 1999 to 2005 the National health HIV/AIDS expenditure increases at an average rate of 48.2% per annum and a total of 2 million people received ART treatment, which is also the largest in the world. The ART programme resulted in an increase in the life expectancy rate close to that of a person who are not infected. The ART programme together with claims that approximately 60 to 70 percent of hospital admissions in in the country are HIV/AIDS related places a further burden on health care expenditure, funding, and availability of health care professionals. As a result of the spread of HIV infections, South Africa has one of the highest rates of tuberculosis in the world, with an increase of 600 per 100,00 people in 2000's to 950 per 100,000 people in 2012 (Mayosi and Benatar, 2014:1345). South Africa also has the highest rate of extensively drug-resistant (XDR) tuberculosis cases world-wide with annual increases from 2005 to 2012. In 2017 tuberculosis accounts for 7.2% deaths (460, 236 deaths), while diabetes mellitus accounts for 5.45 of deaths. South Africa as elsewhere in the world experiencing a huge increase in the prevalence of chronic diseases such as diabetes mellitus, heart diseases, respiratory diseases among others (Arhete and Erasmus, 2016:493). Another concern is that approximately 4 million people are infected with sexually transmitted infections (STIs) each year that further place a burden on the health care services (Holtz and Elsawy, 2013:76; Arhete and Erasmus, 2016:495-496; Mayosi and Benatar, 2014: 1344-1353).

In light of the above, Matsoso *et al*. (2015:37) point out that during the five-year period from 2009 to 2014, a number of initiatives and interventions were introduced to improve access to service delivery and the quality of health care services. These interventions include the three components of primary health care reforms, namely the strengthening and expansion of primary and secondary school health services through the integrated school health teams' relaunch; the comprehensive approach to improve promotive and preventive health care at community level through the comprehensive ward-based primary health care outreach teams and; lastly, the move towards improved clinical governance through the introduction of the district clinical specialist teams. The aim of strengthening primary health care services at the district facilities would improve access to health care services. The health system is still facing many challenges with regards to poor quality

of health services and hospital based health care. Quality of health care has been associated with dissatisfaction amongst the users with respect to acceptability of the health care services and patient experience (NDoH, 2017b:12). Furthermore, Van Rensburg (2012:129) states that the introduction of free health care was originally not adequately planned and properly financed. The result led to severe overcrowding of patients, shortages of supplies and equipment, poor working conditions, poor staff morale, deteriorating quality of health care services in public hospitals.

In order to respond to the above challenges, the demand for health care services requires an adequate skilled workforce, essential health commodities such as material, equipment and medicines, the upgrade of health infrastructure, improvement of health information management systems, and quality and availability of service provision (Matsoso, *et al*. 2015: 36; World Health Organisation, 2011:23). All of these are to be considered within the context of providing both essential, preventative and, where appropriate curative health care services. The South African public health care systems can only function effectively with adequate health professionals, who are distributed equally and are accessible by the majority of the population, throughout the country. However, the mere availability of health professionals and other health workers is not sufficient. It is only when adequate and competent health professionals and other health workers are effectively supported by the health scare systems that health care services will be able to function optimally.

The statutory and regulatory framework of health care service delivery was discussed in the next section.

2.5 STATUTORY AND REGULATORY FRAMEWORK OF HEALTH CARE SERVICE DELIVERY

In terms of Chapter 2 (Bill of Rights) of the Constitution, 1996 access to health services is a basic right of all citizens of the country. Apart from the Constitution, 1996 there are a number of legislation that are directly relevant to health care service provisions, such as the Promotion of

Equality and Prevention of Unfair Discrimination Act, 2000 (Act 4 of 2000) and the Promotion of Access to Information Act, 2 of 2000.

Apart from the above, national health systems are a result of well-developed and implemented evidence-based policies to improve and safeguard the health of the population. These policies are based on and developed through detailed analysis and stakeholder consultations and dialogue. They define the way in which the health system works (World Health Organisation, 2011:20).

According to Mabidi (2013:20) the South African government has a constitutional obligation to provide health care services for everyone, to ensure that legislation and programmes are in place to provide these services, and to ensure that everyone is able to access these services. Van Rensburg (2012:126) is of the opinion that policies and legislation are implementation strategies. Policies are developed to guide the role-players in their endeavour to implement strategy whereas legislation, on the other hand, is more prescriptive as to the actual process of implementing a strategy. Legislation and policy since 1994 have demonstrated government commitment to establishing a health service which meets the basic needs of all South Africans by pooling the use of public and private resource (Braithwaite, *et al.* 2015:59). MCMCP was one of the policy statements that led to the first recruitment of young black students from mainly disadvantaged rural communities to study medicine in Cuba in 1997 (Reed, and Torres, 2008:49). The purpose of this recruitment was to alleviate and address the prevailing skills deficit in the rural health care facilities (Bateman, 2013:2).

2.5.1 Constitution of the Republic of South Africa, 1996

According to Hassim, Heywood and Berger (2007:96), Section 27(1)(1) of the Constitution, 1996 provides that everyone has the right to have access to health care services, including reproductive health care. Section 27(1)(3) of the Constitution, 1996 further provides that no person may be refused emergency medical treatment, while Section 28 (1)(c) states that every child has the right to basic health care services. In terms of Section 27 (2-3) of the Constitution, 1996 the state must

take reasonable legislative and other measures within its available resources to achieve the progressive realisation to achieve this right and that no one may be refused emergency medical care. Thus, health care service delivery needs to be prioritised by the South African government.

Section 195 of the Constitution, 1996 sets out the principles of public administration from which health care service delivery could not be excluded, namely: public administration of the three spheres of government must strive to promote a high standard of professional ethics; to provide impartial services to communities and to promote fairly, equitably and without bias, to use resources in an effective, efficient and economic manner, to respond to people's needs; to encourage the public to participate in policy making and public affairs; to be accountable and to ensure that transparency be fostered through the provision of timely, accessible and accurate information. In order to fulfil these requirements an effective system of health care services should be promoted to ensure that the services are provided within an efficient and effective public service that is responsive to the needs of its citizens. Malefane in Van der Westhuizen (2016:147) points out that the values and principles as provided in Section 195 of the Constitution, 1996 set out important standards against which the performance of public officials should be measured.

2.5.2 White Paper for the Transformation of Health System in South Africa, 1997

According to the White Paper for the Transformation of Health System (WPToHS) (1997:2) (hereinafter referred to WPToHS, 1997) it is the responsibility of the state to develop a unified health system capable of delivering quality health care to all citizens efficiently in a caring environment. Chapter 1 of the WPToHS (1997:5) states that the proposed health sector strategies are based on the following principles:

- The health sector must promote equity by developing a unified health system;
- The health system must focus on districts as the major role player in the implementation of the primary health care approach;
- All three spheres of government, NGO's and private sector have to work together to promote the shared goals;

- Each of the national, provincial and districts have to fulfil their unique as well as their complementary roles; and
- The health sector must ensure that they provide an integrated range of essential primary health care (PHC) services that must be available to the entire population at their first point of contact.

In addition to the above, Chapter 2 of the WPToHS (1997:6-7) sets out the roles, functions, and structures of the Department of Health at national and provincial spheres. Section 2.3 of the WPToHS (1997:7) sets out the principles, long-term goals and role of the district health system, and in particular the following implementation strategies:

- To ensure that each province is subdivided into a number of functional health districts;
- Each district will serve as a provider and purchaser of health services;
- To ensure that rural towns in a particular area will fall within the same health district to ensure that they have access to the closest economic and social links;
- To ensure uniformity in salaries and conditions of service for all public sector health personnel throughout the country to ensure that suitable health workers are encouraged to work in underserved areas;
- To ensure that financing mechanisms or formulae are devised and in place to finance district health services in an equitable and sustainable manner.

Apart for the above Section, 2.3.1(b) of the WPToHS (1997:6) provides that it is unlikely that a single system of governance can be implemented throughout the country, therefore the following health care options are available: firstly, the provincial option, where the particular province is responsible for all district health services through the district health manager; secondly, the statutory district health authority option (if there is no single local authority that has the capacity to render comprehensive health services the province may create through legislation a district health authority for each district); and lastly, the local authority option, where the local authority is responsible for all district health services. Thus, a district health care facility fulfils an important role in the provision of comprehensive health care services if the district has the capacity to render these services in an effective manner.

According to Van Rensburg (2012:31) the WPToHS (1997:5) provides that primary health care (PHC) is an essential health care service which is based on practical, scientifically sound, and socially acceptable methods, made universally accessible to individuals and families, and at a cost they can afford. Van Rensburg (2012:31) further mentioned that the WPToHS (1997:6) emphasises that district health systems are important because they are the locus where primary health care is planned and organised.

2.5.3 Other Health Policy Documents

According to Hassim *et al.* (2007:97) the South African NDoH issued before and even after the publication of the WPToHS, 1997 other important frameworks to guide health care systems and provision. These policy framework documents were the National Drug Policy, 1996; Health Sector Strategic Framework 1999-2004; the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa, 2003 and the Strategic Priorities for the National Health System 2004-2009. The first draft of the National Health Bill was published in 1998. The NDoH had to clarify the roles of the provision of health care services of provinces and that of district municipalities before an Act could be introduced. The NHA was only published in 2003, which gives effect to many of the aspects provided in the WPToHS, 1997.

2.5.4 National Health Act (NHA) (Act 61 of 2003)

According to Hassim *et al*. (2007:96) the aim of the NHA, 2003 as provided in the preamble of the Act include the following:

- To unite the various elements of the South African national health system to focus on a common goal to promote and improve the national health system;
- To give effect to the constitutional requirement to provide a system of cooperative governance and management of health services, within national guidelines, norms and standards, in which all provinces, municipalities and district health systems must promote and deliver quality health services;
- To establish a decentralised health system, recognised by international health standards which is based on the principles of equity, efficiency and good governance; and
- To promote a spirit of cooperation and shared responsibilities between private and public health sector providers.

The NDoH (2015b:11) maintains that the objectives of the NHA, 2003 as provided in Section 2 of Chapter 1 of the Act are to regulate national health and to provide uniformity in respect of health services across the nation as follows:

- By establishing a national health system which encompasses public and private providers to ensure that health services are provided in an equitable way that available resources can afford;
- The NHA, 2003 sets out the duties and the rights of health care providers, health care workers, health establishments and users; and
- The Act makes provision to protect, promote and fulfil the constitutional rights of the people to have access to health care services including reproductive health care.

In addition to the above Section 3(1) of the NHA, 2003 provides that the Minister of Health must within the available resources:

- Endeavour to protect, promote, improve and maintain the health of the population;
- Promote the inclusion of health services in the socio-economic development plan of the Republic;
- Determine the policies and measures necessary to protect, promote, improve and maintain the health and well-being of the population;
- Ensure the provision of such essential health services, which must include at least primary health care services, to the population of the Republic as may be prescribed after consultation with the National Health Council (NHC); and
- Equitably prioritise health services that the state can provide.

The NHA, 2003 gives effect to a public health system that is designed to function through the three spheres of government. At national sphere the NDoH is responsible to identify the national health goals and priorities, and to develop national standard's and norms for the provision of health services. Provincial governments are responsible to oversee public and private hospitals in the province, providing specialised hospital care, to ensure systems are in place to monitor the quality of health care, and to support district health systems in a province to ensure the provision of district health services (Hassim, *et al.* 2007:101).

In terms of Section 25 of the NHA, 2003 the Act provides for the general functions of the Provincial Departments of Health. Section 25(1) of the NHA, 2003 clearly provides that the relevant member of the Executive Council must implement national health policies, norms and standards in each province. Section 25(2) of the NHA, 2003 states that the head of the provincial department must, in accordance with the national and provincial health policies, provide specialised hospital services in each province. Section 25 (f) and (i) further provides that the head of the provincial department must plan, manage and develop human resources for the rendering of health services within the province and must participate in any inter-sectoral coordination and collaboration activities. In terms of Section 25(n) of the NHA, 2003 the head of the provincial department must ensure and control the quality of all health services and facilities. Section 25(o) of the NHA, 2003 states that the head of the provincial department must provide health services contemplated by specific provincial health service programmes while, Section 25(t) makes

provision for community participation in the planning, provision and evaluation of health services within the province.

Hassim *et al.* (20117:101) further points out that in terms of Chapter 5 of the NHA, 2003 district health structures as the centre of health care services, including provision of primary health care services through clinics. The boundaries of district health services are the same as that of the district and metropolitan municipal boundaries. It is within this context that health care service delivery needs to be available, accessible, and acceptable and of good quality (WHO, 2016:10).

2.5.5 National Health Amendment Act (Act 12 of 2013)

The National Health Amendment Act (Act 12 of 2013) (hereafter refers to as the NHAA, 2013) aims to make provision to insert, substitute or delete certain definitions and certain provisions as provided in the NHA, 2003. According to Gray and Vawda (2018:6) Section 81(1) of the NHAA makes provision for the appointment of an Ombud to the Director-General of NDoH. Whereas, Braithwaite *et al*. (2017:57) state that the NHAA, 2013 was passed by Parliament in 2013, resulting in the establishment of the Office of Health Standards Compliance (OHSC). The office will regulate the quality of health services using a set of National Core Standards (NCS). The OHSC is responsible to monitor and set standards for the health sector where public and private facilities comply with prescribed norms and standards (NCDoH, 2015:25).

According to Matsoso *et al.* (2015:94), the objectives of OHSC are to protect and promote the health and safety of the users of health services by:

- Monitoring and enforcing compliance by health establishments with prescribed norms and standards;
- Ensuring consideration, investigation and disposal of complaints relating to breaches of norms and standards.

The OHSC is, therefore, a significant referral point to measure quality of health care. Quality of health care refers to clinical quality that involves the skill and competency of health professionals,

correct diagnosis and treatment decisions. It also depends on whether the right inputs (e.g. drugs, equipment) are available to carry out appropriate care.

2.5.6 National Department of Health, Strategic Priorities for the National Health System over a Five Year Period

Matsoso *et al*. (2015:2) state that in 2008, the South African Health sector was in crisis with an estimated 300 000 deaths from a delayed response to HIV, increasing health inequities, and a public sector unable to cope with the huge burden of disease. Matsoso *et al*. (2015:2) further maintain that it was against this background that the government laid out a Ten Point Plan for transforming the health sector, announced a massive scale up of the response to HIV, and set ambitious targets with the presidency for improving health care and the health system. According to the NDoH (2010:3) the aims of the ten-point plan as provided in the Strategic Priorities for the National Health System 2004-2009 are as follows:

- To provide strategic leadership and to ensure the creation of a social compact for better health outcomes;
- The implementation of the National Health Insurance (NHI);
- To improve the quality of health services;
- Overhauling the health care system and to improve the management thereof;
- To improve human resource management, planning and development within the department;
- To revitalize the infrastructure;
- The acceleration and implementation of the National Strategic Plan of 2007, to manage HIV and AIDS and sexually transmitted infections and increase focus on TB and other communicable diseases;
- The mass mobilisation for better health for the population;
- The review of drug policy; and
- To strengthen research and development within the department.

According to Koch and Weingart (2016:267) the above ten- point plan outlined the top priorities for the sector. It emphasised the need to provide strategic leadership, implement NHI, improve the

quality of health services and accelerate the HIV/AIDS response. Koch and Weingart (2016:267) further indicates that the above commitments of the NDoH were later formalised in a Negotiated Service Delivery Agreement (NSDA) which entailed concrete targets to be achieved by 2014 such as increased life expectancy and reduced maternal and child mortality.

2.5.7 White Paper on the Transformation of the Public Service (WPTPS), 1997 (Batho Pele White Paper)

The purpose of this White Paper on the Transformation of the Public Service (WPTPS) (1997:11) (hereafter referred to as WPTPS, 1997) is to provide a policy framework and a practical implementation strategy for the transformation of public service delivery. It is primarily about how public services are provided, and specifically about improving the efficiency and effectiveness of the way in which services are delivered. Van der Waldt (2004:86) states that the WPTPS, 1997 principal aim is to transform the South African Public Service into a coherent, representative, competent and democratic instrument for executing government policies and meeting the needs of the people.

The White Paper on Transforming Public Service Delivery (1997:12-19) sets out the eight principles known as the Batho Pele principles for effective service delivery. These principles are determinants for the provision of service quality and include the following; consultation, service standards, access, courtesy, information, openness and transparency, redress and value for money. According to WPTPS (1997:8–9) these principles are briefly explained below:

- **Consultation** – citizens should be consulted about the level and quality of the public services they receive and, wherever possible, should be given a choice about the services that are offered;
- **Service standards** – citizens should be told what level and quality of public services they will receive so that they are aware of what to expect;
- **Access** – all citizens should have equal access to the services to which they are entitled,
- **Courtesy** – citizens should be treated with courtesy and consideration;

- **Information** – citizens should be given full, accurate information about the public services they are entitled to receive;
- **Openness and transparency** – citizens should be told how national and provincial departments are run, how much they cost and who is in charge;
- **Redress** – if the promised standard of service is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy, and when complaints are made, citizens should receive a sympathetic, positive response; and
- **Value for money** – public services should be provided economically and efficiently in order to give citizens the best possible value for money.

Draai *et al.* (2016:154) mention that the Department of Public Services and Administration (DPSA) adopted a service charter in 2013 that sets out the following guidelines for effective service delivery, namely:

- Continuous improvement of service delivery programmes and performance;
- Commitment of all role players to deliver services and programmes to all citizens in an effective and efficient manner;
- Acknowledge and reward excellent performance and quality service delivery;
- Clarify the rights, responsibilities and obligations of all stakeholders;
- Facilitate a process to set service standards in various sectors;
- Combat corrupt activities; and
- Promote delivering of effective, efficient and responsive public services.

All three spheres of government must strive to promote effective service delivery to the people of South Africa. Knipe in Van der Waldt *et al.* (2001:211) points to some of the approaches that influence the successful implementation of public service delivery programmes as follows: having a clear understanding of definitions and the terminologies involved, a clear sense of direction and purpose at which the programme is aimed and having a well-defined baseline. Bateman (2013:2) mentions that MCMCP is aimed at alleviating the shortage of medical doctors in the rural areas and enhances health care service delivery.

Knipe in Van der Waldt *et al.* (2001:218-219) further point out that there are five basic requirements that influence the successful implementation of public programmes, namely: sufficient resources and effective planning; programme definition; communication; alignment to the strategic objectives; adequate decision-making process; team work; organisational capacity and a supportive socio-economic environment.

Raga, Taylor and Albrecht (2011:149) maintain that the following factors have an influence on the quality of service delivery:

- Mission statements for service delivery, together with service guarantees;
- Priorities such as the principle of affordability, and the principle of redirecting resources to areas and groups previously under-resourced;
- Monitoring and evaluation mechanisms and structures designed to measure outcomes of a programme;
- Progress and the introduction of corrective action, where appropriate;
- Plans for staffing, human resource development and organisational capacity;
- Potential partnerships with the private sector, NGOs or communities;
- Development of a culture of customer care and of approaches to improved service; and
- Delivery that is sensitive to issues of race, gender and disability.

One could argue that if health professionals were adhering to the Batho Pele principles as enunciated above, tragedies such as Life Esidemeni, where 140 patients died in Gauteng due to negligence by health professionals, could have been avoided. Capri, Watermeyer, Mckenzie and Coetzee (2018:1) assert that the patients are not dead because they were mentally ill, or simply medically mismanaged; instead they died because we couldn't care less. Countless "Esidemenis" are currently happening to people who are still alive.

2.5.8 The National Development Plan (NDP), 2011

The NDP, 2011 provides a broad strategic framework to guide key choices and actions (NPC, 2011:26). In terms of health care services, the NPC (2011:295) states that access to medical care

is clearly one of the social determinants of health. The NPC (2011:332) further emphasises the provision of primary health care and indicates that health care should be focused on a more decentralised, area-based, people-centred approach of the district health system. The NPC (2011:334) acknowledges that the public health system needs to be focused on the promotion of enough trained health professionals to give effect to the constitutional rights that everyone must have access to health care services and that every child has the right to basic health care services.

Matsoso *et al*. (2015:262) point out that the NDP provides a broad strategic framework to guide key choices and actions within government and sets out to enable milestones and critical actions for the health sector. In terms of health care service, the NDP provides that by 2030 the following must be in place:

- The health system should provide quality care to all, free at the point of service, or paid for by publicly provided or privately funded insurance;
- The primary health care (PHC) approach and the district health services (DHS) should provide universal access, with a focus on prevention, education and disease management and treatment;
- Hospitals should be effective and efficient, providing quality secondary and tertiary care for those who need it, and more health professionals should be on hand, especially in poorer communities;
- There should be greater discretion over clinical and administrative matters at facility level, combined with effective accountability;
- There should be better patient information systems supporting more decentralised and home-based care models;
- There should be new forms of management authority and strengthened statutory structures for community representation.

In light of the above it is clear that the NPC (2011:51) emphasises that the DHS should play an important role in PHC services by providing universal access, as well as to focus on the prevention, education and disease management and treatment.

Theron and Mchunu (2016:190) aver that the NDP has been approved and adopted by government, and that it is receiving strong endorsement from various sectors of society, although labour unions and some political parties have been cautious in adopting it. The proposals as provided in the NPC (2011:28) are currently being incorporated into the existing activities of various government departments and strategically structured into the medium and short-term plans of government at all the three spheres of governance.

2.5.9 National Health Insurance Policy

According to the NDoH (2017b:viii), the WHO defines Universal Health Coverage (UHC) as ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship. South Africa is currently reforming its health system with UHC through developing the NHI programme (Fusheini and Eyles, 2016:2). The MCMCP will assist in strengthening the government's ability to ensure a better life for all South African citizens by increasing the number of qualified doctors and improving access to health care in support of the NHI system.

Fusheini and Eyles (2016:2) further point out that the NHI derives its mandate from the NDP of the country, the blueprint for the shape of South African society in 2030. The NPC (2011:334) points out that everyone must have an access to an equal standard of care, regardless of their income and that a common fund should enable equitable access to health care, regardless of what people can afford or how frequently they need to use the service. According to Mayosi and Benatar (2014:6), expectations that equity in health care delivery could be achieved at levels close to current private-sector levels appear to be unrealistic. As a health financing system, the NHI is designed to pool funds to provide access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socio-economic status (Fusheini and Eyles, 2016:2). For this to become a reality, a skilled workforce and appropriate infrastructure are needed (Jobson, 2015:13).

The system of medical aids is designed for only 16% of the population. According to this system, 84% of South Africans have no right to access to good quality health services and they can be served through alternative means (NCDoH 2017a:2). The realisation of NHI is mainly dependent on adequate health care professionals where medical doctors are key. Since the MCMCP strategic orientation is towards primary health care (Bateman, 2013:2); MCMCP trained medical doctors become necessary for the successful implementation of NHI to improve health care service delivery particularly focussing on the poor, vulnerable and disadvantaged groups (Matsoso *et al*. 2015:33).

2.6 ROLE OF GOVERNMENT ON HEALTH CARE SERVICE DELIVERY AND MANDELA-CASTRO MEDICAL COLLABORATION PROGRAMME (MCMCP)

The MCMCP was identified by the South African government as one of the alternative measures to assist in the successful implementation of the abovementioned interventions to improve access to service delivery and the quality of health care services because it places great emphasis on community-based primary care, prevention and citizens' active participation (Bateman, 2013:2). MCMCP was conceived by both the late President of the Republic of South Africa, Nelson Mandela and the late President of Cuba, Fidel Castro in 1995 as one of the options that could be used to recruit young black South Africans from poor families to study medicine in Cuba with the aim of strengthening primary health care at the district facilities to promote health care service delivery (Parliamentary Monitoring Group, 2013:5).

According to the agreement between the government of the Republic of Cuba (RC) and the government of the Republic of South Africa (RSA) on Training of South African Medical Students and Postgraduates in Cuba. In terms of Article 3, of the NDoH Agreement between the Republic of Cuba and the Republic of South Africa (NDoH, 2012b) it is the responsibility of the South African government to do the following:

- To select students in order to ensure that they meet the requirements in respects of qualifications and medical fitness;

- To furnish the student or doctor selected with a contract outlining the obligations of both parties;
- To assist students selected by it to obtain their passports to be issued by the Department of Home Affairs (DoHA) and the visas to be issued by the Embassy of the RC in the RSA;
- To notify the government of the RC, through diplomatic channels, of selected medical students one month prior to their departure for the RC;
- To submit authenticated documents (qualifications, birth certificate and medical certificate) together with Spanish translations of the documents before the arrival of the students in the RC;
- To pay the travelling expenses and insurance costs of selected students to and from the RC at the beginning and end of their studies or during any period as stipulated in their contract;
- To donate to the Cuban government annually an amount agreed upon according to the level of the students;
- To pay the total fees for the respective undergraduate and postgraduate studies and accommodation for the respective undergraduate and postgraduate students, whose amounts shall be determined by the parties and communicated through the diplomatic channel; and
- To pay equal monthly allowances to South African students while in the RC of an amount to be determined by the Minister of Health in the RSA in consultation with Members of the Executive Council for health of the provinces.

The programme (MCMCP) is managed on a decentralised but centrally coordinated basis. The NDoH is responsible for the overall coordination and management of the programme that includes development of legislative documents and related regulations whereas the provincial governments are responsible for funding and logistical arrangements. Upon the completion of their medical degrees, it is the responsibility of the RSA to facilitate the appointment of the newly qualified doctors and ensure that they serve their contractual obligations which is equivalent to the number of years funded by the department (NDoH, 2012a:4).

In order to execute the functions needed to realise their goals and objectives, governments are bound to supply and deliver public goods and services to their communities. Governments supply

services for managing their order and protection, social welfare and economic welfare functions, which may be categorised as order and protection services, social welfare services and economic welfare services (Gildenhuys and Knipe, 2000:56).

According to Roberts *et al.* (2008:29), governments often raise much of the revenue for the health system through taxes and directly operate a large part of the health-care delivery system. In such cases, governments can use their direct authority to influence what occurs such as changing hospital governance or by introducing a new financing scheme. Benatar, Sullivan and Brown (2017:2) are of the opinion social conditions conducive to render good health and access to proper health care facilities are only available to a small minority of the world's population. Benatar *et al.* (2017:30 further argue that health care services everywhere are distorted, dysfunctional, and unsustainable as a result funding mechanisms fail to focus on the value of care. The NDoH (2015b:4) provides that without concerted efforts and funding it will not be possible to improve health care services and in particular primary health care in South Africa.

In addition to the above Gildenhuys and Knipe (2000:52) emphasise that in order to secure good health for individuals, district municipalities and local municipalities must provide environmental health services such as sanitary services, street cleaning, removal of the carcasses of animals, control of rodents to prevent the outbreak of plagues and pestilence, inspections of industrial, business and residential premises in order to detect health hazards and dangers such as water, air and ground pollution, fuel inspections to secure its safety for human consumption, and slum and building control from the viewpoint of health. Health functions also include the execution of personal health functions such as the prevention and combating of infectious diseases, curative health functions, hospitalisation and control of medicines; these are examples of social welfare functions.

To ensure that government delivery outcomes on the delivery services are implemented, the President signs performance agreements with all cabinet ministers. In these performance agreements, ministers establish an implementation forum for each of the outcomes. In each implementation forum, ministers and all other parties responsible for delivering on an outcome, develop a delivery agreement. All departments, agencies and spheres of government involved in

the direct delivery process are required to achieve an output, and should be party to the agreement (Cloete, Rabie and De Coning, 2014:350).

With regard to provincial health services and general functions of provincial departments, Hassim, Heywood and Honnermann (2008:43) maintain that in terms of Section 25(1) of the NHA, 2003 the relevant member of the executive council must ensure the implementation of national health policy, norms and standards in his or her province. Hassim *et al.* (2008:43) further state that in terms of Section 25(2) of the NHA, 2003 the head of the provincial department must in accordance with national health policy and the relevant provincial health policy, in respect of or within the relevant province:

- Provide specialised hospital services;
- Plan and manage the provincial health information system;
- Participate in interprovincial and intersectional coordination and collaboration;
- Coordinate the funding and financial management of district health councils;
- Provide technical and logistical support to district health councils;
- Plan, coordinate and monitor health services and must evaluate the rendering of health services;
- Co-ordinate health and medical services during provincial disasters;
- Conduct or facilitate research on health and health services;
- Plan, manage and develop human resources for the rendering of health services;
- Plan the development of public and private hospitals, other health establishments and agencies;
- Control and manage the cost of financing of public health establishments and health agencies;
- Facilitate, promote the provision of health services, comprehensive primary health services and community hospital services;
- Provide and coordinate emergency medical services and forensic pathology, forensic clinical medical services and related services, including the provision of medico-legal mortuaries and medico-legal services;
- Control the quality of all health services and facilities;

- Provide health services advocated by the specific provincial health service programme;
- Provide and maintain equipment, vehicles and health care facilities in the public sector;
- Consult with communities regarding health matters;
- Provide occupational health services;
- Provide health and healthy lifestyle;
- Promote community participation in the planning, provision and evaluation of health services;
- Provide environmental pollution control services;
- Ensure health systems research; and
- Provide services for the management, prevention and control of communicable and non-communicable diseases (Hassim, *et al.* 2008:43).

In light of the above it is clear that the provision of health care service delivery and the successful implementation of the MCMCP are the responsibilities of all three spheres of government.

2.7 DISTRICT HEALTH CARE SYSTEM AND HEALTH CARE SERVICES

According to Theron and Mchunu (2016:254) prior to the establishment of a new dispensation in 1994 the health system in South Africa was fragmented. Since 1994 the NDoH introduced new policies to address the former fragmented health care system. As a result of this, the health care system was decentralised to the provinces, while the actual delivery of health care services is performed by the DHS. Theron and Mchunu (2016:255) further argue that the aim of the NDoH was to place all health care services under the ward-based health system to ensure that primary health care (PHC) teams were established in South Africa with the required number of medical professionals (medical specialist, physicians, medical doctors and nursing staff). The NPC (2011:71) supports the above by providing in Chapter 10 that PHC teams must provide health care services to families and communities, while each household within a ward must have access to a well-trained community health worker (CHW).

According to De Haan, Denhill, and Vasuthevan (2005:18) the DHS focusses on PHC and it is a more or less self-contained segment of the NHS. It comprises first and foremost a well-defined

population, living within a clearly delineated administrative and geographical area whether urban or rural. It includes all institutions and individuals providing health care in the district; governmental, private or traditional. A DHS therefore consists of a large variety of interrelated elements that contribute to health in homes, schools, workplaces and communities through the health and other related sectors.

Theron and Mchunu (2016:255) maintain that the DHS exemplifies a decentralised, area-based, people centred approach to health care. Feucht (2013:124) points out that the district-based health care system includes PHC clinics, and community health centres (CHCs), as well as district hospitals. Whereas, Le Roux, Du Preez and Couper (2015:440) point out that DHS is the vehicle that the NDoH has used in its attempt to provide comprehensive PHC to all SA citizens. Le Roux *et al*. (2015:440) further maintain that unless district hospitals are strengthened and enabled to function as an essential part of the DHS, and are seen to be part of the implementation of the PHC approach, the laudable aim of re-engineering PHC in South Africa is likely to fail (Le Roux, *et al.* 2015:440).

Apart from the above Van Rensburg (2012:144) states that the rationale for the introduction of the district-based primary health care (PHC) system in South Africa rests on five considerations and is aimed at redressing deficiencies of the pre-1994 dispensation:

- To meet the health care needs of everybody in the way that people want to receive care;
- To provide a simple, integrated and logical service, and thus to overcome inefficiencies in service delivery caused by undue fragmentation of the system;
- To ensure that local decisions are made locally, in terms of local needs, and by the very people who have to implement and will be affected by the decisions;
- To involve those people who use the services in planning and designing their own services by means of fully representative community health bodies;
- To shift the focus from administering health services towards improving health and quality of care at the local level.

Figure 2.1 below illustrates that mere availability of health workers is not sufficient: only when they are equitably distributed and accessible by the population, when they possess the required competency, and are motivated and empowered to deliver quality care that is appropriate and acceptable to the sociocultural expectation of the population and when they are adequately supported by the health system, can theoretical coverage translate into effective service coverage (Global Strategy on Human Resource Workforce, 2016:10).

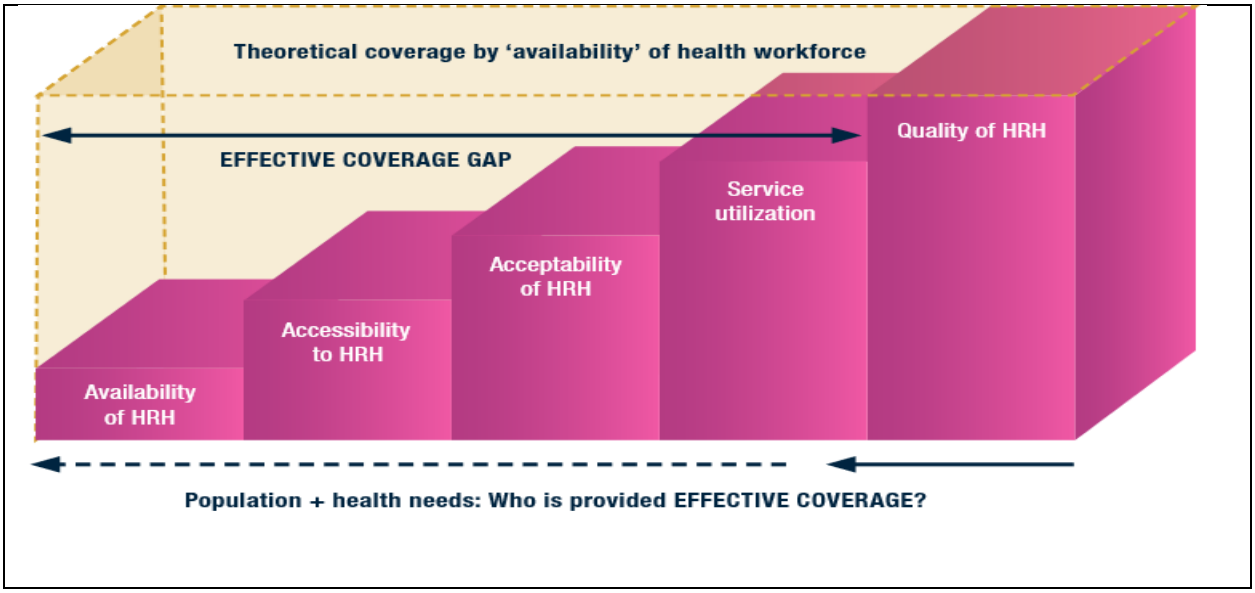

Figure 2.1. Human resources for health: availability, accessibility, acceptability, service utilisation and quality of HRH

(Source: Global Strategy on Human Resource Workforce, 2016:6)

Contrary to what is depicted in Figure 2.1, the NCDoH (2017a:72) points out that that the NCP was experiencing a shortage of both clinical and non-clinical personnel and that there was a need to fill vacant posts and to create new posts to meet the demand. Owing to financial constrains in the 2016/17 financial year, NCDoH was unable to recruit the 50 first year medical students it had targeted to study medicine in Cuba through the MCMCP (NCDoH, 2017:92). According to the Annual Performance Plan of NCDoH the vacancy rate of health professionals in the NCP was recorded as 38.12% and this implies that there were numerous facilities where quality health care was unavailable and inaccessible due to the shortage health professionals (NCDoH, 2016:30).

In light of the above the NCP comprised of five municipal districts which are Frances Baard, Zwelentlanga Fatman Mgcawu, Pixley-Ka-Seme, John Taolo Gaetsewe and Namakwa. The total population of the NCP is 1 191 997 and they are serviced by 251 primary health care facilities comprised of 74 non fixed clinics, 133 fixed clinics, 33 community health care centres and 11 district hospitals (NCDoH, 2016:64-65). The purpose of district health services is to provide a comprehensive, integrated and sustainable health care service that is preventive, promotive, curative and rehabilitative, based on the re-engineering primary health care approach through the district health system (NCDoH, 2016:67). The management of district health services should do the following:

- Ensure accessibility to health care services and the full implementation of the PHC and district hospitals packages;
- Improve the quality of health care services and safeguard high standard of care;
- Strengthen referral mechanisms within and between districts, and different levels of care, as well as minimising self-referrals to higher levels of care;
- Appointment of clinic supervisors, facility managers and district hospital managers;
- Establishment of PHC outreach, district specialist and school health teams, and;
- Monitoring and support of the pilot site and roll out to the other district (NCDoH, 2016:66).

The above objectives of the district health system are often compromised by policy implementation, human resources of health constraints and physical infrastructure (Matsoso, *et al*. 2015:81). It is therefore, within this context that the placement of MCMCP trained medical doctors in the district facilities becomes one of the relevant approaches to promote health care service delivery in the rural districts.

In light of the above the Report on the State of Readiness for the Return, Reception and integration of MCMCP students in July 2018 of the NCDoH showed that preparations for the reception and integration of 21 final year MCMCP students into the District facilities in July 2018 would be hampered by lack of clinical training sites, teaching facilities, accommodation, clinical supervision, availability of reliable transport and information and communication technology (NCDoH, 2018d:1).

Thus, while the DHS is aimed at improving the quality of life of the community, particularly those who have been marginalised in the past such as the vulnerable, the poor, women and the disabled (Theron and Mchunu, 2016:255), this may not be achieved as highlighted in the above paragraph. Table 2.1 below illustrates the District Health Facilities of the NCP.

Table 2.1: District Health Facilities

Health District	Facility Type				Population
	Non-fixed clinics	Fixed clinics	Community health centres	District hospitals	Total
Frances Baard	10	25	4	2	383 428
Zwelentlanga Fatman Mgcawu	29	15	6	2	254 349
Pixley-Ka-Seme	5	28	8	3	193 196
John Taolo Gaetsewe	5	39	5	2	241 836
Namakwa	25	26	10	2	119 188
Province	74	133	33	11	1 191 997

(Source: NCDoH, 2016:64)

The data as indicated in Table 2.1 above reveals that the biggest concentration of the population of the Northern Cape Province (NC) is located in the district of FBDM which makes up 33.2% of the total population of the province. It is within this context that the author seeks to assess the impact of South African Cuban trained doctors within the FBDM. Although the FBDM has the highest proportion of the population in the NCP, it possesses the smallest number of district health care facilities. On the contrary Namakwa contains the smallest proportion of the population, which is 10% of the total NCP population size, and has more district health care facilities (20.3% against 16.3%) of health care facilities in FBDM of the total health care facilities of the NCP.

It is within this context that the researcher seeks to assess the impact of MCMCP trained medical doctors within the FBDM. Therefore, in the discussion below more information is provided about

FBDM as well as the three local municipalities that falls within the jurisdiction of the district municipality.

2.7.1 Frances Baard District Municipality

FBDM is the smallest district in the NCP. Its area accounts for 3.4% of the total area of the province. However, the district municipality accommodates the largest proportion of the population of the province giving it the largest population density of (30.85 persons per square km) in the province. As illustrated in Figure 2.2 below the area of jurisdiction falling under FBDM includes the four local municipalities of Dikgatlhong, Magareng, Phokwane, and Sol Plaatje. The city of Kimberley, which is the seat of the District municipality and the NC legislature, is located in Sol Plaatje municipality, the largest of the four. The FBDM had a population of 383 428 in 2016. It has 34 clinics, 5 community health centres and 5 district hospitals (FBDM, 2018:3-6). In Chapter 1, Section 1.7.3 of this study mentioned that there five hospitals in the FBDM area, namely the ZK Mathews Hospital in Barkly West, the Warrenton Hospital in Warrenton, the Connie Vorster Hospital in Hartswater, and the Jan Kempdorp Hospital in Jan Kempdorp and Galeshewe Day Hospital.

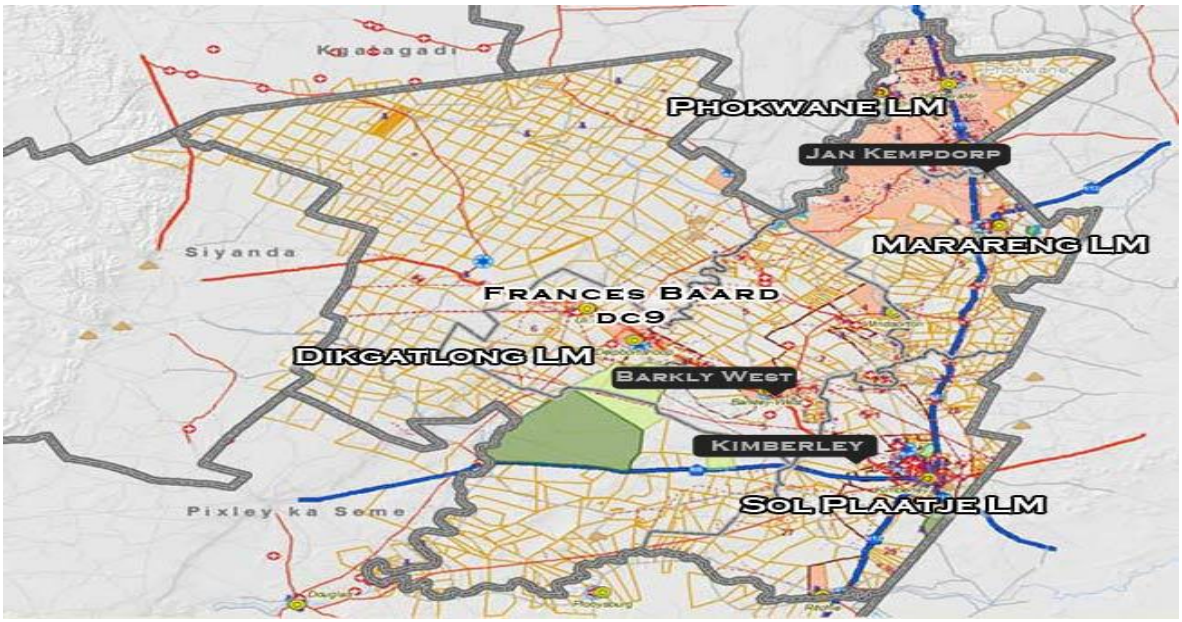

Figure 2.2: Map of Frances Baard District Municipality

(Source: Adopted from FBDM Integrated Development Review Planning- 2017-2021, 2018:5)

2.7.2 Dikgatlhong Local Municipality

Dikgatlong Local Municipality (DLM) is a Category B municipality in FBDM in the NC. It has seven wards. The municipal areas are Barkly-West, Windsorton, Delportshoop and a portion of the former Diamantveld District Council. The head office of the municipality is situated in the town of Barkly West that is approximately 35 km north-west of the city of Kimberley on the northern bank of the Vaal River. Barkly West is situated on the Kimberley-Postmasburg growth corridor. The municipal area covers approximately 7 315 km² and borders with the Magareng Municipality in the north-east and Sol Plaatje in the south-east. Agriculture and mining form the economic basis of the area (Census, 2011; FBDM, 2015:42-42).

2.7.3 Magareng Local Municipality

The name 'Magareng' is the Setswana word meaning 'the middle', and is derived from the fact that this region is literally in the middle of the country. It has five wards. Warrenton, a quiet agricultural town, is the administrative centre of the municipality and other communities include Ikhutseng, Warrenvale and Windsorton Road (FBDM, 2015:42). Magareng Local Municipality is situated in the NC and lies within the boundaries of the FBDM. Warrenton, the administrative centre of Magareng Local Municipality, is situated approximately 75 km north of Kimberley on the banks of the Vaal River (Census, 2011). According to FBDM (2015:42) the area is largely defined by agriculture, which is sustained by one of the largest irrigation schemes in the southern hemisphere. There are also a number of commercial farms which breed cattle, game, ostrich and goats. There are three historic stone blockhouses from the Anglo-Boer War still standing on the banks of the Vaal River, and an old railway bridge built in the 1920s – a line that still connects the NC and the North West Province.

2.7.4 Sol Plaatje Local Municipality

This municipality is named after Solomon 'Sol' Plaatje, a writer, politician and activist renowned for his incredible grasp of languages (fluent in seven). Sol was the first Secretary General of the

African National Congress and dedicated much of his life to the struggle and the liberation of African people (FBDM, 2015:43). The Sol Plaatje Municipality (SPLM) is in the capital city of the Northern Cape Province, Kimberley. It is where the Northern Cape legislature is located, as well as the Frances Baard District Municipality. SPLM has approximately 25% of the population of the Northern Cape, thus making it the biggest municipality in the province with 31 wards (Sol Plaatje, Local Municipality 2017:21-23). The N12 highway, which connects Gauteng to the Western Cape Province, runs through the city of Kimberley which is located in SPLM. The geographic area of SPLM is 1877.1 km². The SPLM includes the urban areas of Kimberley and Ritchie, in the southern eastern corner of the area.

According to the Sol Plaatje Local Municipality (2017:21-23), the municipality provides basic services directly, and it is only in Ritchie where Eskom is contracted to distribute electricity to approximately 5 000.00 customers of the municipality, including businesses and farms in the area. The main economic activities consist of retailers, industries as well as mining and farming (FBDM, 2017:10).

2.7.5 Phokwane Local Municipality

According to the Phokwane Municipality Integrated Development Plan 2012-2016/17 (2012:43), Phokwane municipality is located in the north-eastern extreme of the NCP, along the border of NWP, and close to the FSP. The municipality is made up of three main towns, namely, Hartswater, Jan Kempdorp and Pampierstad. It consists of 10 wards. Phokwane is defined by the lush Vaalharts valley and the many activities surrounding the harvesting and production of local produce such as olives, pecan nuts, peanuts, citrus, wine, cotton and stone.

2.8 PUBLIC PARTICIPATION IN HEALTH CARE SERVICE DELIVERY

The South African government regards public participation as the cornerstone of democracy and service delivery. It is not a privilege, but a constitutional right (Maphazi, Raga, Taylor and Mayekiso, 2013:56). Public participation plays an important role in providing people who may be affected by administrative action with an opportunity to engage and make representations. The

information obtained during such processes therefore serves to ensure that administrative decisions are made from an informed perspective (King and Reddell, 2015:947).

According to Maphazi *et al.* (2013:57) communities should be empowered to ensure effective and meaningful participation in matters of government, especially in the local spheres of government which is closest to communities. Theron and Mchunu (2016:257), view community participation in health care matters as having become widely established as a mechanism to negate the estrangement and oppression that resulted from the prolonged domination and exclusion of the apartheid era. Theron and Mchunu (2016:257) argue that community participation and intersectoral collaboration are cornerstones of the DHS.

Daniel (2013:318) argues that stakeholder involvement in policy formulation is an issue of concern in developing countries. He cites Kenya as an example where public participation in the development of Social Health Insurance policy formulation was low among all categories of people, namely patients, visitors, caretakers, health care providers and provincial administrators. According to Thinyane, Siebörger and Reynell (2015:243), prominent commentators have attributed the lack of delivery of basic services across the population to a lack of accountability at local government level, particularly with respect to lack of service delivery.

Williams (2008:32) suggests that meaningful participation should be viewed as participation that makes a visible and meaningful difference in the lives of ordinary people. He identifies the following interrelated aspects as evidence for meaningful participation.

- **Intervention by proposing specific policy framework**. For example, in relation to MCMCP, were the citizens allowed to intervene through specific policies towards the implementation of the MCMCP? This means that policy development on the MCMCP should not be confined to the ruling elite alone.
- **Origination of specific development programmes**. This implies the origin and development of policies on the MCMCP reflects the interest of the broader South African society (Williams, 2008:32).

- **Identification of specific policy issues**. The citizens are involved in the proposal of policies that inform the implementation of MCMCP and the marking out of factors that impact on health care service delivery.

- **Alignment or overriding perspectives**. The ideals, frames of reference and intended beneficiaries with regard to specific planning, policies or strategies on MCMCP reflects the broader participation of the South African society.
- **Authentication of particular development planning programme**. For example, is there co-determination of service related issues such as MCMCP in improving health care service delivery? (Williams, 2008:32)
- **Differentiation of context specific issues that impact on human development.** Is there acceptance of diverse interest groups, competing rights, and responsibilities? For example, are the views of South African Medical Schools on MCMCP considered or was this programme decided by a certain class of the ruling elites and forced on everyone? This implies that differences of opinion or debates towards the MCMCP on whether it is making an impact on health care service delivery should be embraced.
- **Authentication of development related information to validate the extent of development problems**. That is, were communities consulted and involved in the planning of the initial phase of the MCMCP? In brief, this means that the inputs or the views of the communities on the programmes such as the MCMCP should be considered (Williams, 2008:32).
- **Documentation of "consultation" processes and development proposals to ensure the existence of a careful index of community needs**. Is there a registry of community views and comments on the MCMCP? The registry of consultation is particularly essential in communities where doctors produced through the MCMCP were recruited so that those communities should not feel excluded or think that this programme was imposed upon them.
- **Legitimisation of the involvement of local communities and organisations to ensure that participation is inclusive, meaningful and regular during all phases of planning programmes**. For example, was the community informed about the first recruitment plans of South African students to study medicine in Cuba, during their studies in Cuba, their

return to South African Universities and their graduation leading to their appointment into health care facilities? (Williams, 2008:32).

- **Incorporation of specific development proposals from communities.** That is the alignment of statutory programmes such as MCMCP to the basic needs of the community.
- **Validation.** The endorsement of the MCMCP through public participation, critique, refinement of policy directions for delivery programmes at local level. The local community is allowed to engage regarding whether the MCMCP is effective or not at the district facilities.
- **Implementation**. That is the systematic monitoring of the delivery programmes compatibility with the expressed agreements between local communities with local authorities.
- **Affirmation**. That is measuring success through the actual lived experiences of local people (Williams, 2008:32). Within the context of this study, it is testing the attitudes of health professionals through the use of the five point summated scale to assess the impact of the MCMCP on health care service delivery in the FBDM.

The NPC (2011:301) stipulates that the fundamental importance of full community participation and the role of civil society has been underplayed and the focus on "people first-Batho Pele" has diminished. The culture of valuing and respecting the expressed needs of communities has faded, replaced by a top down approach.

It can therefore be deduced from the above that public participation can be encouraged with the level of understanding and literacy on health issues. According to Thutloa and Stroud (2012:120), health literacy is required for participation in the health care system and for people to understand their treatment options and decisions. Participation and a voice in health are important as they are the route towards encouraging health citizenship by empowering consumers to become involved in knowing their health risks and improving their health (Thutloa and Stroud, 2012:120). The principles of people centred development formulated as the building blocks of developmental local government, that is, public participation, social learning, empowerment and sustainability, feature strongly in the integrated, people centred approach advocated by the Reconstruction and Development Programme. Key to service delivery is the building of stable, long term, mutually

beneficial relations with stakeholders, especially with those who are critical or vital for the organisation to accomplish its vision and mission Maphazi *et al.* 2013:59).

2.9 OVERVIEW OF PROGRAMME MANAGEMENT IN THE SOUTH AFRICAN LOCAL GOVERNMENT CONTEXT

For the purpose of this study, it is important to have a theoretical discussion about programme management in the context of local government of which the MCMCP in the FBDM, NCP cannot be excluded.

According to Van Rooyen in Draai *et al*. (2016:219) programme management could be described as a management activity that contains processes that coordinate a group of related developmental projects such as a variety of development programmes within a municipality that consist of number of local economic development projects. Knipe in Van der Waldt *et al*. (2001:210) define programme management as the co-ordinated management of a portfolio of projects to achieve a set of objectives. These projects may run simultaneously within the organisation, each of which may or may not contribute towards the corporate strategic goals (Knipe in Van der Waldt, *et al.* 2001:211). For example, MCMCP trains undergraduate medical students to become doctors in Cuba (Lungelow, 2011:7), while medical professionals from Cuba are also recruited to teach medicine in South African universities to increase the current output of doctors, which is currently about 1 300 Cuban doctors per annum (Bateman, 2013:1). All these projects are aimed at providing quality health care in South Africa (NDoH, 2013:5).

Knipe in Van der Waldt *et al*. (2001:214) suggests that it is best to follow a specific method or process for programme management in any organisation. The steps that make up this method or process are mission, goals, and objectives, sense of direction, and purpose and definition of the baseline. Knipe in Van der Waldt *et al*. (2001:214) further aver that all stakeholders involved in a programme should have a clear understanding of the mission, goals and objectives of a particular programme to ensure that all involved strive to achieve the common goals and objectives.

In light of the above one could argue that the same is applicable to the MCMCP as a health care programme. The MCMCP programme will not be successful if all involved do not have a clear understanding of the programme's mission, goals and objectives. In addition, Knipe in Van der Waldt *et al*. (2001:214-216) point out that all public programmes including the MCMCP should have clearly defined roles, and responsibilities for all involved in the particular programme. Furthermore, the baselines from which to measure the cost and the benefits that result from the investments of the programme, terms of reference statements, the type of programme, the visible end deliverables, the risks, and benefits should be clearly defined and agreed upon by all stakeholders involved in such a programme. The baselines should form part of the contractual documents for a particular programme such as the MCMCP.

In terms of the roll out of health collaboration programmes such as the MCMCP, Mpofu (2014:325) points out that the World Health Organisation and several partners developed the Human Resources for Health (HRH) action framework which includes six action fields: human resources management systems, leadership, partnership, finance, education and policy, and an action cycle which illustrates the phases to follow in applying the framework that should assist with the development of health related programmes. The phases that should also be taken into consideration with the development of health related programmes such as the MCMCP consist of situational analysis, planning, implementation and monitoring and evaluation.

In light of the above Knipe in Van der Waldt *et al*. (2001:221) mention that there are seven stages in the planning process of any programme including the MCMCP, namely:

- **Planning stage.** During the planning stage the stakeholders have to thoroughly plan in terms of time and resource requirements for each project or programme.
- **Transmission stage.** If a programme consist of various projects the stakeholders have to ensure the transmission of the individual projects plans to a central point.
- **Consolidation stage.** During the consolidation stage the various individual project plans should be consolidated into a single programme plan.
- **Evaluation stage.** The stakeholders involved in a programme have to identify any challenges and conflicting situations during the evaluation stage to find alternative

strategies for optimal schedules for the future workload attached to a particular project and or programme.

- **Dissemination stage.** The dissemination stage involves the interpretation and dissemination of decisions taken back to individual project teams to ensure that individual project plans and or programme plans are modified.
- **Achievement measurement stage.** The achievement measurement stage requires the effective monitoring and evaluation of the individual projects attached to a particular programme.

Thus, effective planning, monitoring and evaluation are imperatives to ensure the success of any programme including health related programmes such as the MCMCP.

2.10 FACTORS THAT INFLUENCE THE SUCCESSFUL IMPLEMENTATION OF PUBLIC PROGRAMMES AND SERVICE DELIVERY

The WPTPS (1997:12-19) sets out the eight principles known as the Batho Pele principles for effective service delivery. These principles are determinants for the provision of service quality and include the following: consultation, service standards, access, courtesy, information, openness and transparency, redress and value for money. Draai *et al*. (2016:154) mentions that the Department of Public Services and Administration (DPSA) adopted a service charter in 2013 that sets out the following guidelines for effective service delivery, namely:

- Continuous improvement of service delivery programmes and performance;
- Commitment of all role players to deliver services and programmes to all citizens in an effective and efficient manner;
- Acknowledge and reward excellent performance and quality service delivery;
- Clarify the rights, responsibilities and obligations of all stakeholders;
- Facilitate a process to set service standards in various sectors;
- Combat corrupt activities; and
- Promote delivery of effective, efficient and responsive public services.

Therefore, all three spheres of government must strive to promote effective service delivery to the people of South Africa. Knipe in Van der Waldt *et al.* (2001:211) point out some of the approaches that influence the successful implementation of public service delivery programmes as follows: having a clear understanding of definitions and the terminologies involved, a clear sense of direction and purpose at which the programme is aimed and having a well-defined baseline. Bateman (2013:2) mentions that the MCMCP is aimed at alleviating the shortage of medical doctors in the rural areas and enhances health care service delivery.

Knipe in Van der Waldt *et al.* (2001:218-219) maintain that there are five basic requirements that influence the successful implementation of public programmes namely; sufficient resources and effective planning, good programme definition, effective communication, alignment to the strategic objectives, adequate decision-making process, team work, organisational capacity and a supportive socio-economic environment. Raga *et al*. (2011:149) maintain that the following factors have an influence on the quality of service delivery:

- Mission statements for service delivery, together with service guarantees;
- Priorities such as the principle of affordability, and the principle of redirecting resources to areas and groups previously under-resourced;
- Monitoring and evaluation mechanisms and structures designed to measure outcomes of a programme;
- Progress and the introduction of corrective action, where appropriate;
- Plans for staffing, human resource development and organisational capacity;
- Potential partnerships with the private sector, NGOs or communities;
- Development of a culture of customer care and of approaches to improved service; and
- Delivery that is sensitive to issues of race, gender and disability.

In light of the above one could argue that these factors could have an influence on any public service delivery programme of which the MCMCP cannot be excluded because a failure to plan strategically for human resources can lead to significant financial costs for any public programme (Van der Westhuizen, Wessels, Swanepoel, Erasmus, van Wyk and Schenk, 2011:122). This is

observable in the challenges faced by the NDoH to receive and integrate 720 final year MCMCP students into South African Medical schools in July 2018, due to limited space and the need to prepare the necessary training infrastructure such as training sites, teaching facilities, accommodation, transport and Information and Communication Technology (ICT). In a presentation about of the MCMCP in 2018 it was mentioned that the NCDoH needed about R 29 575 400.00 to budget for the integration of 21 final year MCMCP medical students in July 2018 (NCDoH, 2018e:1).

2.11 MONITORING AND EVALUATION OF PUBLIC PROGRAMMES

Mpofu (2014:118) is of the opinion that monitoring involves the supervision of activities in progress to ensure that they are meeting set goals and objectives within a defined time frame for the community in which these target goals are in use. Mpofu (2014:127) further maintains that monitoring and evaluation of health services across populations are required. Therefore, monitoring and evaluation systems are created specifically for the purpose of tracking performance and should therefore be equally able to reveal poor performance, satisfactory performance and good performance (lle, *et al*. 2012:92). Whereas, international health law focuses on regulation standards and regulations that must meet basic global standards for the purpose of promoting and preserving the community's health (Garner and Black, 2004).

According to Theron and Mchunu (2016:56) monitoring involves the collection of information about the programme while it is in progress whereas evaluation refers to a more specific process by which a programme, whether completed or not, is closely examined at a certain stage. Monitoring-and-evaluation systems are created specifically for the purpose of tracking performance of public programmes and should therefore be equally able to reveal poor performance, satisfactory performance and good performance (Ile, *et al*. 2012:92; Theron and Mchunu, 2016:193).

According to Cloete *et al*. (2014:345) in order to track the performance of public programmes, the National Treasury developed the system of departmental strategic plans and annual performance plans. In addition, departments were required to submit annual reports which provided

accountability for what they were undertaking. Cloete *et al.* (2014:345-346) further state that the Employee Performance Management and Development System (EPMDS) is a strategic approach to management which equips leaders, managers, employees and stakeholders at different levels with a set of tools and techniques to regularly plan, continuously monitor, and periodically measure and review the performance of the organisation in terms of indicators and targets for efficiency, effectiveness and impact.

Matsoso *et al.* (2015:200) point out that the promotion of effective monitoring and evaluation of any service delivery programme requires a well-functioning health information system that generates quality data for effective planning, and efficient resource allocation. Another pivotal component of an effective and responsive health system requires the monitoring of the population's health status. Matsoso *et al*. (2015:200) defines the health information system (HIS) as a system that integrates data collection, processing, reporting, and use of the information necessary for improving health service effectiveness and efficiency through better management at all levels of health services.

Matsoso *et al*. (2015:37) further state that a key impediment to the effective monitoring and evaluation of health care services is the lack of good-quality, reliable and incontrovertible data on South Africa's key health care. Cloete *et al*. (2014:346) point out that central to the improvement of service delivery will be the improvement of productivity within the public service. Strategies should therefore be developed by departments and provincial administrations, designed to promote continuous improvement in the quantity, quality and equity of service provision including the improvement of service delivery programmes.

Bateman (2013:1) states that Professor Steve Reid, the former director of the Centre for Rural Health at the University of KwaZulu-Natal, a founding member of the Rural Doctors Association of South Africa, (RUDASA) and current Chair of Primary Health Care at the University of Cape Town, called for a proper evaluation of Cuban-trained students to investigate if they remain in the public service or move to the private sector; and to also find out how many stay in the public service and how many end up in private practice, how many end up in underserved rural areas versus the city, and whether they are staying as generalists or going for specialisation. Thus, the

effective monitoring and evaluation of any service delivery programme, of which the MCMCP cannot be excluded has to take place to ensure the effectiveness and its contribution to health care service delivery.

2.12 AN OVERVIEW OF THE MANDELA-CASTRO MEDICAL COLLABORATION PROGRAMME

In this section the background about the MCMCP was outlined.

2.12.1 Origin of the MCMCP

Lungelow (2011:7) states that the participation in the MCMCP began in 1997 through the bilateral agreement signed by Cuba and South Africa. According to Spooner and Ullmann (2014:72) South Africa signed an agreement with Cuba in 1995 to send students to Cuban medical schools, as part of an effort to expand health services in the face of growing population and increasing number of patients with HIV/AIDS and related illnesses. According to the Parliamentary Monitoring Group (2013:5), the first bilateral agreement between the RC and RSA on cooperation in the fields of health and medical health services was signed on 30 October 1996, following the 1995 Declaration of Intent signed between the two countries under the leadership of the late Presidents, Nelson Mandela and Fidel Castro.

This agreement was extended in 2012, when Cuba increased students' intake from South Africa to 1000 from 80 to study medicine in Cuba. From 1996 to 2011, this programme was named the South African Cuban Medical Training Medical Collaboration Programme and in 2012 at the Joint Academic Meeting, it was renamed Nelson Mandela-Fidel Castro Medical Collaboration Programme known as the MCMCP. (NDoH, 2012c:1).

2.12.2 Purpose of the recruitment of South African students into the MCMCP

The purpose of the MCMCP agreement was firstly, to recruit doctors from Cuba to serve in the rural areas of South Africa as well as professors to teach medicine at Walter Sisulu University

(NDoH, 2013:5). According to Luginaah and Kerr (2015:125), in 2004 there were close to 500 Cuban doctors practicing in rural areas and townships around South Africa.

Secondly, the original agreement led to the participation in the MCMCP in 1997 where black and disadvantaged high school graduates are recruited to study medicine in Cuba (Lungelow, 2011:7). According to NDoH (2015:3), training of medical students in Cuba helps with scaling up production of doctors particularly in the rural areas.

Donda *et al.* (2016:2) state that South Africa suffers a serious imbalance between doctors employed in urban versus rural areas. It has been estimated that only about 35 of 1200 medical graduates produced annually will choose a rural career in the long term. Donda *et al.* (2016:2), further state that a major advantage of the MCMCP from the South African government perspective is that the Cuban medical curriculum is explicitly primary health care oriented. South Africa's national health planning is predicated on the centrality of primary, district based health care. Dr Ayanda Ntsaluba, Director General of Health when the Cuban-South African agreement was signed over a decade ago, notes that South African policy makers were also attracted to the Cuban emphasis on prevention, primary care and the bio-psycho-social approach that views patients holistically (Reed *et al.* 2008:50).

2.12.3 Duration of the study period of the MCMCP

The South African medical students that take part in the MCMCP have to study one year of Spanish and then five years of medicine before returning to South Africa to do their final clinical rotation and community service (Department of Labour, 2008:46). According to Spooner and Ullmann (2014:72), the purpose of clinical training in South Africa is for the graduates of Cuban medical schools to familiarise themselves with the country's burden of disease, including a very high prevalence of HIV/AIDS and tuberculosis.

Upon their return to South Africa, South African Cuban trained medical students are expected to spend 18 months, comprised of 6 month's orientation and 12 months of integration, in South

African Medical Schools before they could obtain their medical degrees (Van Wyk and Motala, 2016:7).

2.12.4 Factors that affect studies of MCMCP students

According to Bin-Abdulrahman *et al*. (2015:106) South African students studying medicine in Cuba are confronted with numerous challenges such as language and culture. On arrival in Cuba, students are required to learn Spanish which is the medium of instruction. On their return to South Africa, they must relearn medical terminology in English and this requires a tremendous amount of mind mobility. To succeed in their studies students must also adapt to a foreign culture. The culture of how students are taught and assessed in Cuba also differs substantially from South Africa.

Kooverjee (2017:12) elicits the following themes as some of the stressors that MCMCP students struggle with:

- **Inability to grieve when a parent or sibling passes.** They describe being flown to SA to attend the funeral the day after landing, and the very next day have to fly back to Cuba to write an examination the day after arrival.
- **Anxiety to perform and to be able to come back to SA was seen especially in those with high anxiety levels.** They are always under tremendous pressure to achieve high marks, for example, to obtain a score of 4 out of 5 is allegedly viewed as a failure in Cuba.
- **Poor residential facilities and lack of appropriate food as well as safety.**
- **Overcrowded public transport.** They noted being unable to focus or study due to the noise or disruptions caused by fellow students. Food choices are scarce and unhygienic at times.
- **Lack of communication with families in SA.** Data is too expensive and the telecommunication systems in Cuba are little to non-existent. This inability led to many feeling lonely and disconnected.

- **Identity crisis.** In Cuba, they are identified as South Africans whereas in South Africa they are identified as Cuban students. Owing to this, they feel rejected and discriminated against by both South Africans and Cubans.
- **High rate of pregnancy termination.** After termination of pregnancy, female students are not provided with counselling. They feel judged by the community and their peers as there is no concept of "patient confidentiality" in the Cuban health system.
- **Lack of psycho-social support.** They have been requesting psychological help for many years with no results. Unfortunate incidents such as students committing suicides, murders, and imprisonment could have been avoided if psychological intervention was provided.

According to Kooverjee (2017:14), the students lack professional support and this lead to the use of unhealthy coping mechanisms to maintain resilience and to safeguard their emotional functioning. She further points out unhealthy coping mechanisms include and are not limited to:

- Self-medicating with the use of alcohol,
- High rates of unprotected sex,
- Disconnect from others and isolating one's self, and
- Depression and complete avoidance of dealing with other issues.

Contrary to what is espoused above, the email sent by the South African Health Attaché based in Cuba to a Gauteng Department of Health official mentions that mental health support to the students is provided by psychologists and psychiatrists in Cuban health facilities (Kooverjee, 2017:25).

2.12.5 Decentralisation of undergraduate training in South Africa

Decentralisation of undergraduate training has become more urgent in the SA context owing to the growing numbers of senior medical students needing clinical training in the face of limited capacity at academic hospitals (Gaede, 2018:451). The increase is due in part to the MCMCP students returning from Cuba, whose programme includes a period of training at SA medical schools. The large numbers of students involved have made medical schools uneasy, fearing that

quality will be compromised for quantity, thus reflecting the dilemmas that have accompanied the growth of higher education more generally (Gaede, 2018:251).

Van Schalkwyk, Couper, Muller, Blitz and De Villiers (2017:74) suggest that the development of a vision for decentralised training that is shared by both the NDoH and educational institutions would allow such initiatives to be scaled up dramatically. This would benefit the students, the facilities where they train, and the health system at large. Van Schalkwyk *et al*. (2017:74) further state that initiatives around the placement of students who will be returning in significant numbers from September 2018 to complete their clinical training in South Africa as part of the MCMCP, may provide impetus towards achieving this.

2.12.6 Performance levels of MCMCP students in South African universities

According to Donda *et al*. (2016:2), the MCMCP students experience academic difficulties on their return to South Africa. In the final examinations, approximately 50% will have to repeat modules in order to qualify, resulting in a prolongation of training which in some cases may be substantial.

The MCMCP has come under a lot of fire in recent years with claims that South African doctors returning from Cuba are not adequately equipped for the South African context, being unable to treat illnesses such as tuberculosis (TB), HIV and complications associated with diabetes (Masters, Zondi, van Wyk and Landsberg, 2015:176). Upon the completion of their medical degrees they must commit to serve in a disadvantaged community (Bateman, 2013:2). According to the NDoH (2015b:3), the NDoH wants to make maximum use of MCMCP trained medical doctors to ensure a positive impact in rural health facilities.

2.12.7 The Integration and distribution of MCMCP trained medical doctors in the Northern Cape Province

The NCDoH (2017b:90) states that the NCDoH has been recruiting students from poor communities across the five districts since 2000 to pursue medical studies in Cuba through the MCMCP as depicted in Figure 2.3.

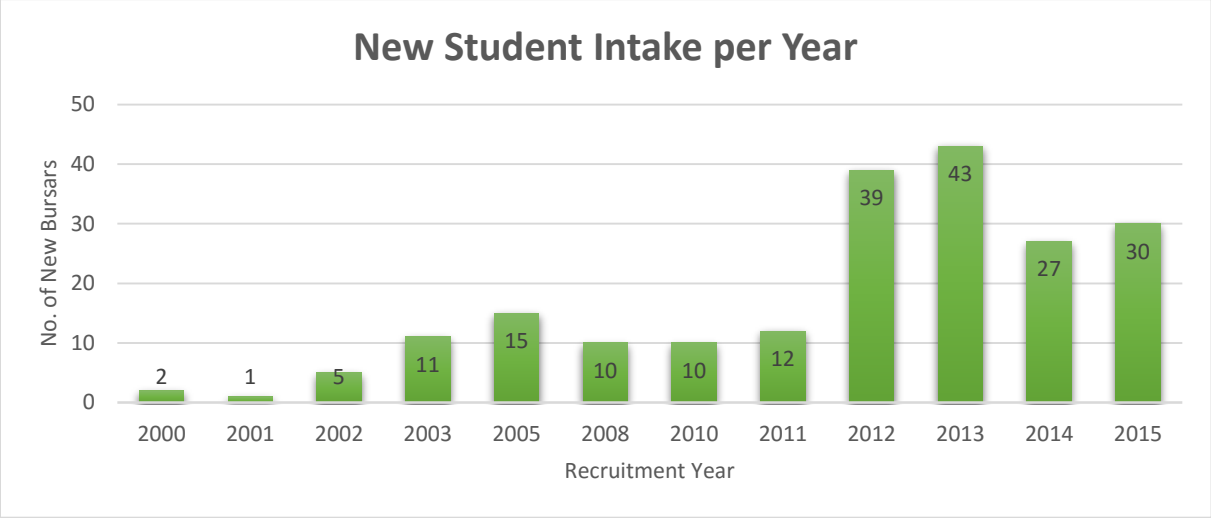

Figure 2.3: New student intake per year

(Source: NCDoH, 2017b:9)

Figure 2.3 depicts that the MCMCP started on a smaller scale in 2000 with only 2 students awarded the scholarship. This scholarship grew gradually over the years, with significant growth particularly in 2013. Eight years from inception, the scholarship was awarded to a new intake of 39 and 43 students in 2012 and 2013 consecutively.

The MCMCP is however, fraught with numerous challenges around the return, reception and integration of students recruited in 2012 (NDoH, 2017a:2). It is the responsibility of the provinces to make the necessary arrangements to ensure that clinical training sites, teaching facilities, accommodation, clinical supervision, transport costs, information and communication technology, tuition fees and other related costs are available for the training of MCMCP students (NCDoH, 2017a:2). According to Khan (2018:1), the former Minister of Health, Dr Aaron Motsoaledi,

conceded the MCMCP was more expensive than medical training in South Africa and said that this was one of the factors that counted against it. The proposal for funding of the above infrastructure was estimated around R 30 000 000.00 for NCDoH to cover the costs for the successful integration of 21 final year MCMCP students in July 2018 (NCDoH, 2018f:1). The NDoH invoice indicates that NCDoH was charged R 32 847 043.00 for 136 MCMCP students and this suggests that the RC of charges R 241 522.38 per student which is double the total amount of fees paid for medical students in South African Medical Schools.

The duration of the RSA-Cuban training course as stated by Motala and Van Wyk (2016:2) is eight years in total. One year is spent on the Spanish Language Course, five years is spent on medical training in Cuba and 18 months' orientation and integration in South African medical schools, and expenses on flight tickets after every two years in Cuba. When this is factored into the above costs it points to the exorbitant nature of this programme, which is likely to be three times the average cost of medicine in South Africa.

According to the NCDoH (2018e:1) of the 205 students recruited by NCDoH to study medicine in Cuba 33 have dropped out due to a variety of reasons such as pregnancy, medical conditions, academic exclusion and disorientation with the programme (NCDoH, 2018e:1-3). This results in the wastage of enormous sums of resources that could have been utilized on alternative developmental programmes to upskill and create employment for the poor deserving youth of this country.

Contrary to the above, the Annual Report of NCDoH indicates that between 2000 and 2017, this programme has produced 35 doctors, 71% of these doctors are serving in various health care facilities within the NCP, and those on internship are placed by NDoH to serve elsewhere outside the province (NCDoH, 2017a:90). Once the medical interns have completed their internship in other provinces they are expected to return to NCP to serve their contractual obligations. The newly qualified South African Cuban trained doctors are deployed to various facilities to improve the quality of health care service and that the province will continue with MCMCP by sending young matriculates to study medicine in Cuba in order to alleviate the shortage of doctors (NCDoH, 2015:9 and NCDoH, 2017a:90).

In Figure 2.4 below the distribution of doctors who are linked to the MCMCP in the NCP is indicated below.

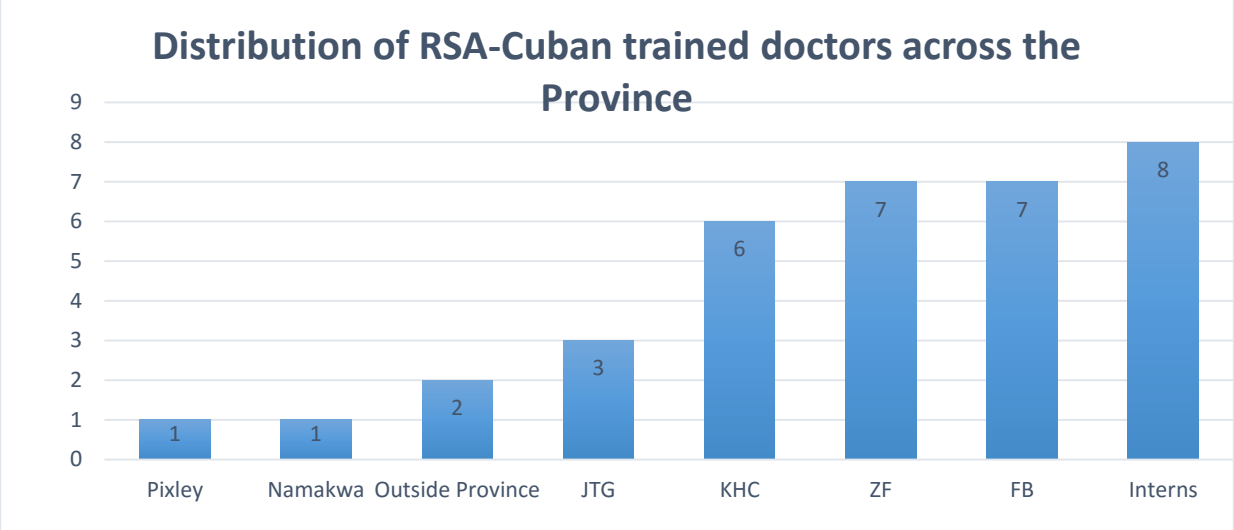

Figure 2.4: Distribution of MCMCP trained medical doctors
(Source NCDoH, 2017b:11)

From Figure 2.4, health care facilities in FBDM have seven of the 35 doctors produced. This means that 20% of these doctors are based in FBDM. This study seeks to assess the impact of MCMCP in promoting health care service delivery in FBDM.

2.13 PREVIOUS RESEARCH ON MANDELA-CASTRO MEDICAL COLLABORATION PROGRAMME (MCMCP)

Previous research about the MCMCP focussed on a variety of topics. A study was conducted by Motala in 2013-2014 about the perceptions of training and perceived competence in clinical skills of the students that returned from Cuba who took part in the MCMCP (Motala, 2014). Another study was conducted in 2008 about the specific clinical training that the students received who took part in the MCMCP (Reed *et al.* 2008). Motala also published a research paper in 2014 exploring the impact of experience-based medical learning on students' clinical preparedness and used the MCMCP as a case study.

Another study was conducted by Bateman in 2013 about the projected growth of MCMCP and that it will exert tremendous pressure in the under-resourced South African medical universities from 2018 onwards when about 1000 undergraduate MCMCP trained medical students return to South Africa from Cuba to do the last phase of their training (Bateman, 2013). No study was conducted to assess the impact of the MCMCP in promoting health care service delivery in the FBDM hospitals, NCP. This view is supported by Bin-Abdulrahman *et al*. (2015:106) and states that no research exists to show how well MCMCP trained medical students perform as doctors, nor whether they remain working in their regions of origin.

2.14 SUMMARY

This chapter discussed the theoretical overview of health care service delivery. It commenced with the conceptualisation of health care service delivery in the context of South Africa since 1994. Health care was described as an important component of both opportunity and well-being for all individuals in society. The discussion about health care service delivery in a global context showed that governments in most countries faces similar challenges such as the increase in an ageing population, chronic diseases, an increase in the demand and access of health care services, rapid increases in the cost of health care services and demand for the use of high-tech medical technology and equipment. These challenges require more reforms from governments to change their health care policies and priorities to increase the demand of health care services and infrastructure of which the South African government cannot be excluded.

The discussion about health care service delivery in the South African context emphasised that the majority of the population of South Africa are burdened by continuing social disparities that hamper the distribution of resources, access to health care services, and access to quality health care services for the majority of the South African population. The current reality in South Africa is that, the public health sector, remains the sole provider of health care services to around 84% of the total population, which are staffed with approximately 30% of health professionals, while the remaining 70% of health professionals work in the private health care sector. It was emphasised that the demand for health care services in the public health sector of which the district health sector cannot be excluded, requires an adequate skilled workforce, essential health commodities

such as material, equipment and medicines, the upgrade of health infrastructure, improvement of health information management systems, and quality and availability of service provision. The South African public health care systems can only function effectively with adequate health professionals, who are distributed equally and are accessible by the majority of the population, throughout the country. A concern was raised that, the mere availability of health professionals and other health workers is not sufficient. It was argued that only when adequate and competent health professionals and other health workers are effectively supported by the health scare systems that health care services will be able to function optimally.

Particular reference on the policy and legislative framework on health care service delivery was centred on Section 195 of the Constitution, 1996, WPTPS, 1997 (Batho Pele), the WPToHS, 1997, and the NHA, 2003 with its associated amendments, National Health Amendment Act, 2013. Section 195 of the Constitution, 1996 laid the basis for the principles that must guide the provision of public services which includes health care service delivery. It provides that everyone has the right to have access to health care services, including reproductive health care.

Section 2 of Chapter 1 of the NHA, 2003 states that the objectives of the Act are to regulate national health and to provide uniformity in respect of health services across the South African nation. In terms of this Act, the functions of the three spheres of government with respect to health care were outlined. The role of the Office of Health Standards Compliance (OHSC) with respect to the regulation of the quality of health services was provided by National Health Amendment Act, 2013. The Batho Pele eight principles stipulated in the WPTPS, 1997 were outlined. These included consultations, service standards, access, courtesy, information, openness and transparency, and redress and value for money were highlighted. The significance of these principles was seen as central to the transformation of the public service and in particular health care service in this context. The responsibility of the state to develop a unified health system in South Africa is provided in the White Paper for the Transformation of Health System in South Africa, 1997. The roles, functions and structures of the Department of Health at national and provincial levels were explained. Particular emphasis was placed on the role of the district health system in managing the primary health care.

The NDP was seen as a long term policy statement that provides a broad strategic framework to guide key choices and actions within government, and sets out to enable milestones and critical actions for the health sector. It was emphasised that the provision of primary health care should take precedence at the district facilities. It was argued that it was this policy directive that encouraged the recruitment of poor deserving students from the rural areas to participate in the MCMCP. It was further expressed that the medical graduates from the MCMCP were expected to be deployed in the rural districts so that health care should be focussed on a more decentralised, area-based, people-centred approach of the district health system. The MCMCP was viewed as one of the options that the South African government used to strengthen government's ability to ensure a better life for all South African citizens by increasing the number of qualified doctors and improving access to health care in support of NHI system. It was pointed that NHI provides for universal health coverage where everyone must have access to an equal standard of care, regardless of their income, and that a common fund should enable equitable access to health care, regardless of what people can afford or how frequently they need to use the service.

The role of the district health care system was discussed with particular emphasis on: the transformation of the health care system in SA after the 1994 advent of the constitutional democratic government; the role that government had played in decentralising the health care system through the adoption of primary health care; and the role that MCMCP had played towards the promotion of health care service delivery in FBDM. It was argued that government should ensure that health care should not only be available and accessible but should be of good quality and acceptable to its citizens. The description of the demographic layout of the four local municipal areas of FBDM areas was presented and illustrated with a map. The researcher had also indicated the total number of health care facilities such as clinics, community health care centres and district hospitals and their roles with respect to the MCMCP trained medical doctors to promote health care service delivery.

The significance of public participation in health care service delivery and how it contributes to democracy was discussed. The level of the involvement of public participation in the MCMCP was interrogated. While public participation was viewed as the cornerstone of democracy, on the contrary it was argued whether there was a deliberate attempt by the ruling elite to disregard the

views of the public unilaterally impose the MCMCP trained medical doctors on the broader South African society.

Discussions around the origin of the MCMCP were traced to the period when the late president Nelson Mandela of the Republic of South Africa and the late president Fidel Castro of the Republic of Cuba reached an agreement on health collaboration between the two countries in 1996. The terms of the agreement between the government of the RC and the government of RSA on the training of South African medical students and postgraduates in Cuba was outlined. The role of the three spheres of the government of the RSA on the recruitment of students into the MCMCP, the management of the programme until the attainment of degrees by the students, and their appointment was highlighted. The theoretical overview of the MCMCP was discussed in terms of its origin and why it was established in 1997 through a bilateral agreement signed by RC and RSA. It was argued that the MCMCP programme would not be successful if all involved did not have a clear understanding of the programme's mission, goals and objectives, particularly in the local government context of the FBDM. Factors that influence the successful implementation of public programmes and service delivery were discussed. The significance of Batho Pele principles as provided in WPTPS, 1997 were once again emphasised. Approaches that influence the successful implementation of public service delivery programmes were highlighted, such as having a clear understanding of the definitions and terminologies involved, a clear sense of the direction and purpose to which the programme is aimed, and having a well-defined baseline.

It was indicated that programmes including the MCMCP need to be monitored and evaluated while in progress, to ensure that they are meeting set goals and objectives within a defined time frame for the community in which these programmes are in use. In Chapter 3, the research methodology that formed the foundation of the research, the research strategy, sampling, measuring instruments, data collection procedure, data analysis and limitations of the study are discussed.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 INTRODUCTION

The previous chapter provided the theoretical overview about health care service delivery. An overview of the MCMCP was discussed in detail followed by a discussion about the requirements of public programme management in the context of local government of which the MCMCP cannot be excluded. This chapter considers the research methodology and explained the research paradigm, research design, study population and sampling procedures, data collection techniques, instrument validity and reliability and data analysis used in this study.

3.2 RESEARCH METHODOLOGY AND RESEARCH PARADIGM

Research methodology is a way to systematically solve research problems, while research techniques refer to the behaviour and instrument the researcher uses in performing research operations such as making observations, recording data, techniques of processing data and the like. Research methods refer to the behaviour and instruments used in selecting and constructing research techniques (Kothari, 2004:7-8). According to Welman *et al.* (2005:3), research methodology considers and explains the logic behind research methods and techniques. Bless *et al.* (2014:380) maintain that with the research methodology the researcher has to indicate whether the approach used was qualitative or quantitative. A qualitative approach is often used when the problem has not been investigated before, and this method requires smaller samples, from which findings are produced, while with quantitative studies the researchers rely more extensively on numbers and statistics in the analysis and interpretation to generalise findings (Bless *et al.* 2014:16). The research approach applied in this study is deductive in nature and quantitative data was used to generate propositions.

According to Welman *et al.* (2005:3), the term research paradigm refers to the progress of scientific practice based on people's philosophies and assumptions about the world and the nature of knowledge. Neuman (2011:94) defines a research paradigm as a general organising framework for

theory and research that includes basic assumptions, key issues, models of quality research, and methods for seeking answers. The most common research paradigms are positivism, interpretive or post-positivism and pragmatism paradigm (McGregor and Murnane, 2010:422). Welman *et al.* (2005:6) state that the positivism paradigm underlies the natural-scientific method in human behavioural research and holds that research must be limited to what can be observed and measured. In addition, Neuman (2011:95) maintains that the positivism paradigm refers to an organised method for combining deductive logic with precise empirical observations of individual behaviour to discover and confirm a set of probabilistic causal laws that can be used to predict general patterns of human activity. On the other hand, Maree *et al.* (2017:59) aver that post-positivism or interpretivist focusses on the subjective interpretations of human behaviour and their perceptions of a phenomenon. Du Plooy-Cilliers *et al.* (2014:28) mention that unlike the followers of positivism who explain causal relationships to control and predict a phenomenon, interpretivists only want to understand human behaviour. Du Plooy-Cilliers *et al.* (2014:78) further explain that pragmatic research or mixed method research utilise both quantitative and qualitative approaches. This study is conducted within the positivism paradigm that focuses on the usage of scientific methods that holds that research must be limited to what can be observed and measured objectively.

3.3 RESEARCH DESIGN

The design of a study concerns the plan to obtain appropriate data for investigating the research questions (Welman *et al.*, 2005: 102). Cooper and Schindler (2003:149) state that the research design can be seen as a general plan or blueprint on how the researcher goes about answering the research questions. Du Plooy-Cilliers *et al.* (2014: 93) agrees with the above definitions by stating that a research design refers to a procedural plan that the researcher adopted to answer the research questions. The study used a descriptive non-experimental design, based on an opinion-based survey to determine the attitude of hospital staff on the impact of the MCMCP in promoting health care service delivery in the FBDM hospitals, NCP. In Section 1.72 of this study it was mentioned that a survey design is a non-experimental research design used in quantitative research.

3.4 POPULATION AND SAMPLING PROCEDURES

According to Maree *et al.* (2016:164) the research questions of a study are always linked to a specific group or sampling units. The group that consist of all sampling units which are linked to the research question refers to the population. Whereas, Du Plooy-Cilliers *et al.* (2014:97) maintain that the study population consist of all the people or objects that possess all the characteristics or attributes in which the researcher is interested. Bless *et al.* (2014:162) agrees with the above definition by stating that the entire set of objects or people that is the object of the study an about which the researcher want to determine some characteristics refers to the study population.

The target population of this study is comprised of the four small district hospitals in the FBDM area namely, the ZK Mathews hospital in Barkly West, the Warrenton hospital in Warrenton, the Connie Vorster hospital in Hartswater, and the Jan Kempdorp hospital in Jan Kempdorp. The selected population or unit of analysis comprised of the health professionals within these district hospitals of the FBDM area of NCP.

3.4.1 Sampling and sample size

According to Bless *et al.* (2014:162) a subset of the whole population, which the researcher investigated by a researcher and in the case of quantitative research whose attributes or characteristics will be generalised to the entire population refer to the sample. Maree *et al.* (2016:164) agree with the above that the subset of the research population consisting of a predetermined number (sample size) is called the sample.

According to Maree *et al.* (2016:192) there are two sampling methods probability methods used in quantitative studies and non-probability methods used in qualitative studies. Probability sampling ensures that any unit of analysis of the population could be included in the sample (Du Plooy-Cilliers, 2014:136). Brynard and Hanekom (2006:57) concur that probability random sampling refers to a sampling method where everyone in the entire target population has an equal

chance of being selected. The advantage of probability sampling is that it indicates the probability with which sample results differ from the corresponding population. It also enables us to estimate sampling error (Welman, *et al.* 2005:57).

According to Bless *et al.* (2014:166) probability sampling methods include simple random sampling, interval or systematic sampling, stratified random sampling and cluster sampling. The simple random sampling technique provides an equal and independent opportunity that each object or member of the population can be selected to be part of the sample (Salkind, 2018:88). Systematic sampling is used to drawn a sample by using sample frame list. In this way each element of the sample is randomly chosen from the list by using a sampling interval which is the distance between each element selected from the sample (Du Plooy-Cilliers, *et al.* 2014:138-139). On the other hand, when using a stratified random sampling technique, one can be more certain of obtaining a representative sample from a population with clearly distinguishable strata. Also with a stratified random sample, one is ensured of sample representativeness, irrespective of size, because it has been built into the sampling strategy from the very beginning (Welman, *et al*., 2005:62).

In this study as explained in Section 1.7.3 of Chapter 2 of this study the simple random sampling technique as part of probability sampling was used to select two of the five district hospitals of the FBDM of NCP to conduct the research. The two district hospitals that were drawn are the ZK Mathews hospital and the Warrenton hospital. In addition, probability sampling by means of a random stratified sampling technique was used to draw the sample of health professionals for this study from the two selected district hospitals namely, ZK Mathews Hospital in Barkly West and the Warrenton Hospital in Warrenton as indicated in Table 3.1 and Table 3.2 on page 81.

Table 3.1 Health Professionals sample frame (N) and sample (n) ZK Mathew's Hospital in Barkly West

Occupation of health professionals at the ZK Mathew's hospital in Barkly West	**Total Population = Sample frame (N)**	**Sample (n)**
Professional Nurse (General)	32	16
Clinical Nurse Practitioner	2	1
Staff Nurse	5	3
Nursing Assistant	18	9
Social Worker	1	1
Medical Officer	12	6
Dentist	3	2
Medical Specialist	2	1
Pharmacy Assistant Basic	2	1
Pharmacy Assistant Post Basic	1	1
Pharmacist	1	1
Pharmacy Supervisor	1	1
Emergency Care Officer	1	1
Speech Therapist	1	1
Environmental Health Practitioner	2	0
Occupational Therapist	4	2
Radiographer	1	0
Physiotherapist	3	2
Dietician	2	0
Clinical Nurse Specialist Practitioner	4	0
Total	**98**	**49**

Table 3.2 Health Professionals sample frame (N) and sample (n) Warrenton Hospital in Warrenton

Occupation of health professionals at the Warrenton Hospital in Warrenton	Total Population = Sample frame (N)	Sample (n)
Professional Nurse (General)	13	7
Staff Nurse	1	1
Nursing Assistant	5	3
Medical Officer	5	3
Dentist	1	1
Pharmacy Assistant Post Basic	1	1
Pharmacist	1	1
Emergency Care Officer	7	4
Occupational Therapist	1	1
Radiographer	1	1
Total	**36**	**23**

3.5 DATA COLLECTION AND RESEARCH INSTRUMENT

According to Maree *et al.* (2017:174) a number of different methods can be used to collect data from the sample as determined by the purpose, aims and objectives of the study. Data collection entails a description of how the researcher intends to collect data to answer the research questions. There are numerous data collection techniques such as literature sources surveys, questionnaires, observations, interviews and document analysis Maree *et al*. (2017:37). In this study a structured questionnaire was used to collect data from the selected health care facilities of the FBDM area. In addition, both secondary and primary sources were also used to collect data. Salkind (2018:46) mentions that secondary sources include books on a specific subject and reviews of previous research, while primary sources refer to journals articles, scholarly books, educational resources.

According to Welman and Kruger (2005:150) the rationale for including a questionnaire by means of group contact is: (1) in working with captive audiences the procedure corresponds to the administration of a test; (2) since a single person is required to give instructions, in one location,

the cost per questionnaire is lower; (3) the researcher is in full control of the completion of questionnaires, so that no respondent has an excuse not to complete the questionnaire. Opinion based research methods generally involve collecting quantitative data. For this type of research, the measurements are usually arbitrary, following the ordinal or interval type (Welman, *et al.* 2005:139).

The measuring instrument used in this study to answer the research question was a structured questionnaire using an attitude scale with a five (5) point Likert scale that consists of a collection of close-ended statements and one open-ended question. In respect of each statement, respondents had to indicate the degree to which they agree or disagree with its contents on a five-point scale. Some statements represented a positive attitude whereas others reflected a negative attitude towards the attitudinal object (Welman, *et al*, 2005:156). The structured questionnaire used in this study consist of two Sections, namely; Section A comprised of the biographical data of respondents and Section B comprised of structured questions to collect data about the impact of the MCMCP in promoting health care service delivery in FBDM hospitals in NCP. Section B consist of the following sub-sections:

- Awareness of RSA-Cuba trained medical doctors;
- Competency;
- Relationship with their patients;
- Commitments;
- Motivation;
- Promotion of primary health care;
- Primary health care/curative;
- Leadership;
- Prejudice;
- Inclination to practice in rural areas; and
- Level of professionalism.

The theoretical chapter that informed this study was presented in Chapter 2 of this study based on the conceptual framework and problem statement as presented. The theoretical overview was

sufficient for a quantitative study and essential information resources including scholarly work, government documents and other relevant information based on health care service delivery and the MCMCP were used. The information obtained from the theoretical overview was used to draw up a structured questionnaire, which was used in the empirical study. Primary data comprised of a structured questionnaire using an attitude scale, to collect individual data to determine the attitude of hospital staff on the impact of the MCMCP trained medical doctors in promoting health care service delivery in the FBDM hospitals, NCP.

To administer the structured questionnaire, the researcher made appointments with the Central Executive Officers (CEO) of the hospitals in the FBDM to distribute the structured questionnaire amongst the staff of these district hospitals. Once permission was granted, meetings with unit managers were arranged to facilitate access to the respondents and to explain the rationale behind the significance of completing the questionnaires. Data was either completed individually or by means of group contact, which put the researcher in full control of the completion of the questionnaires. Consequently, a response rate of close to 100% was the general rule. Since the researcher was present, queries about the completion of the questionnaire were answered immediately. The researcher had initially secured meetings with the District Manager responsible for health care facilities in the FBDM. Once permission was given by the said district manager, the researcher informed the Central Executive Officer and Operational Manager of ZK Mathews' Hospital and Warrenton Hospital respectively of his intention to conduct the study.

On their consent of the study, various medical units at the hospital where health professionals such as nurses, radiographers, pharmacists, allied health professionals (physiotherapists, occupational physiotherapists and dieticians) and few administrative support staff are based were presented with structured questionnaires (Annexure B) to complete. The researcher was available at the hospital for a considerable period of time to explain and provide clarity on the questionnaires. The medical heads of various units were given questionnaires to hand to the staff who were working night shift. The researcher collected all completed questionnaires at both the selected hospitals namely, ZK Mathews' Hospital and Warrenton Hospital.

3.6 VALIDITY AND RELIABILITY

According to Neuman (2011:2008), reliability means dependability or consistency. It suggests that the same thing is repeated or recurs under identical or very similar conditions. He further states that validity suggests truthfulness. It refers to how well an idea fits with actual reality. Van Der Walt and Van Rensburg (2006:165) maintain that there is no point in using an instrument that is not valid, however reliable it may be. Similarly, if an instrument measures a phenomenon of importance but the measurements are not consistent, it is of no use. Validity and reliability are crucial aspects of quantitative research, but are often referred to as credibility and trustworthiness in qualitative research.

According to Du Plooy-Cilliers *et al.* (2014:254), reliability in quantitative research is concerned with the consistency of measures. It refers to the extent to which the observable or empirical measures are accurate and stable or consistent over repeated observations. They identify these different types of reliability in quantitative research:

- **Inter-rater or inter coder.** A measure of agreement that is established by using the same instrument with different participants. The structured questionnaire was distributed to health professionals at two different hospitals to collect data.
- **Test-retest.** It measures stability of the instrument and is established by using the same instrument with the same participants at different times. This method was not used in this study.
- **Parallel forms.** It measures equivalence and is established by using a different instrument with different participants at the same time.
- **Split halves.** It is a measure of equivalence that is established by splitting the instrument into two equivalent halves before scores are collated. This method was not used in this study
- **Internal consistency.** Internal consistency refers to how consistently each item measures the same construct and established by correlating the performance of each item with the performance across participants. In this study the Cronbach's alpha was used to ensure internal consistency of the structured questionnaire. The results of Cronbach alpha to

measure the internal consistency of the structured instrument were discussed in Sub-section 3.6.1.

According to Salkind (2018:105) validity focusses on the extent to which a research instrument measures what is supposed to measure. Below are five most important types of validity used in quantitative studies namely, face validity, content validity, construct validity and criterion validity:

- **Face validity.** Bless *et al.* (2014:234) maintain that face validity differs from the other forms of validity in that it focusses on the way the instrument appears to the participants.
- **Content validity.** Focusses on whether the measurement represent the specific content. In other words, content validity indicates the extent to which a test represents the universe of items or particular area of knowledge from which it is drawn (Salkind, 2018:106).
- **Construct validity.** Welman *et al.* (2005:142) explain that when a researcher measures something with an instrument, the instrument must measure what it is supposed to measure. In other words, the construct validity of an instrument such as a structured or semi-structured questionnaire refers to the degree to which it measures the intended construct rather than irrelevant constructs.
- **Criterion-related validity and convergent validity.** It is a measure of the extent to which a test is related to some criterion. Salkind (2018:106) explains that criterion-related validity is concerned with how well a test estimates present performance (concurrent validity) or how well it predicts future performance (predictive validity). Welman *et al.* (2005:144) aver that the relevant criterion refers to a specific variable that is to be diagnosed or whether it will become available only after the test is completed. Except for the above convergent validity refers to the relationships between a specific scale used and other scales that are intended to measure the same construct (Bless, *et al.* 2014:234).

3.6.1 Cronbach Alpha (α)

According to Pietersen in Maree *et al.* (2016:239), the Cronbach's alpha (α) that is used to measure the internal reliability of a research instrument. Bless *et al.* (2014:229) point out that the value of coefficient of reliability by using the Cronbach's alpha (α) always falls between 0 and 1. The closer the score to 1 the higher the internal consistency (reliability), while a score closer to 0 means the internal consistency or reliability of the instrument is unacceptable. In this study, Cronbach's alpha (α) was used to calculate the internal consistency of 43 items in the questionnaire. George and Mallery (2003:231) provide the following rules of thumb for the interpretation of internal consistency using Cronbach's alpha (α) of the structured questionnaire include the following:

- Internal consistency is excellent if (α) is > 0.9;
- Internal consistency is good if (α) is > 0.8;
- Internal consistency is acceptable if (α) is > 0.7;
- Internal consistency is questionable if (α) is > 0.6;
- Internal consistency is poor if (α) is > 0.5; and
- Internal consistency is unacceptable if (α) is < 0.5.

Table 3.3 on page 88, illustrated the reliability analysis of overall internal consistency of 43 items of the structured questionnaire tested for internal consistency and the Cronbach coefficient alpha (α) achieved.

Table 3.3: Cronbach's Alpha (α) with tested variables of 43 items of the structured questionnaire

Cronbach Coefficient Alpha with Tested Variables					
Deleted Variable	**Raw Variables**		**Standardized Variables**		**Label**
	Correlation with Total	**Alpha**	**Correlation with Total**	**Alpha**	
newQ_10_1_1	0.109569	0.935472	0.114594	0.942347	
Q_10_1_2	0.264624	0.934999	0.265712	0.941262	Q_10_1_2
Q_10_1_3	0.022270	0.937832	0.022574	0.943000	Q_10_1_3
Q_10_2_1	0.767182	0.929671	0.763111	0.937591	Q_10_2_1
newQ_10_2_2	0.737729	0.929814	0.739940	0.937766	
newQ_10_2_3	0.564171	0.931251	0.567462	0.939054	
Q_10_3_1	0.665235	0.930632	0.671780	0.938277	Q_10_3_1
Q_10_3_2	0.631627	0.930621	0.636363	0.938542	Q_10_3_2
newQ_10_3_3	0.624720	0.930847	0.636782	0.938538	
newQ_10_3_4	0.397665	0.932574	0.412679	0.940194	
Q_10_4_1	0.800669	0.929687	0.805950	0.937268	Q_10_4_1
Q_10_4_2	0.781000	0.929529	0.777619	0.937482	Q_10_4_2
Q_10_4_3	0.479471	0.931906	0.471980	0.939759	Q_10_4_3
newQ_10_4_4	0.549022	0.931280	0.551908	0.939169	
newQ_10_4_5	0.425042	0.932350	0.430544	0.940063	
Q_10_5_1	0.749294	0.929985	0.739839	0.937766	Q_10_5_1
Q_10_5_2	0.062460	0.935874	0.070194	0.942663	Q_10_5_2
Q_10_5_3	0.613835	0.930641	0.604821	0.938777	Q_10_5_3
newQ_10_5_4	0.727286	0.929805	0.730445	0.937837	
Q_10_6_1	0.638718	0.931111	0.641444	0.938504	Q_10_6_1

Cronbach Coefficient Alpha with Tested Variables					
Deleted Variable	**Raw Variables**		**Standardized Variables**		**Label**
	Correlation with Total	**Alpha**	**Correlation with Total**	**Alpha**	
newQ_10_6_2	0.173126	0.934050	0.168336	0.941963	
newQ_10_6_3	0.414816	0.932437	0.427244	0.940087	
Q_10_6_4	0.626757	0.930708	0.633888	0.938560	Q_10_6_4
Q_10_7_1	0.782539	0.929608	0.785143	0.937425	Q_10_7_1
newQ_10_7_2	0.441033	0.932246	0.440084	0.939993	
Q_10_7_3	0.244311	0.934140	0.239698	0.941450	Q_10_7_3
newQ_10_7_4	0.350934	0.932867	0.349359	0.940656	
Q_10_8_1	0.822418	0.929044	0.819061	0.937168	Q_10_8_1
Q_10_8_2	0.800604	0.929524	0.801897	0.937298	Q_10_8_2
newQ_10_8_3	0.511184	0.931647	0.508028	0.939493	
newQ_10_8_4	0.703975	0.929968	0.709142	0.937997	
Q_10_9_1	0.136766	0.934390	0.133710	0.942210	Q_10_9_1
newQ_10_9_2	0.024980	0.935943	0.039302	0.942882	
newQ_10_9_3	0.203108	0.934692	0.206038	0.941692	
Q_10_9_4	0.494285	0.931803	0.490174	0.939625	Q_10_9_4
Q_10_10_1	0.411642	0.932529	0.414511	0.940180	Q_10_10_1
newQ_10_10_2	0.326408	0.933041	0.331770	0.940784	
Q_10_10_3	0.310018	0.933317	0.299128	0.941020	Q_10_10_3
newQ_10_10_4	0.363931	0.932785	0.375176	0.940468	
Q_10_11_1	0.595084	0.930917	0.598065	0.938827	Q_10_11_1
Q_10_11_2	0.874186	0.928779	0.875620	0.936739	Q_10_11_2
newQ_10_11_3	0.742482	0.929871	0.752069	0.937674	
newQ_10_11_4	0.707311	0.930375	0.713707	0.937963	

Table 3.3 on page 89 illustrates the overall internal consistency of the questionnaire consisted out of 43 items used for the reliability analysis, resulted in a Cronbach's alpha (α) of 0.93. Items 1, 5, 6, 9, 10, 14, 15, 19, 21, 22, 25, 27, 30, 31, 33, 34, 37, 39, 42 and 43 were reversed for the analysis, so that the opposite is true. The subscale as illustrated in Table 3.3 had an excellent internal consistency ($\alpha > 0.90$) which, means high reliability.

3.6.2 Pilot study

To substantiate the validity and reliability of the data-collection instrument, a pilot study was carried out at Harry Surtie Hospital in Upington, using a total of 30 respondents. The researcher secured an appointment with the Central Executive Officer and explained the reasons for the visit and the significance of the study. A copy of the questionnaire was given to the CEO and explained for about 10 minutes. A request was tendered to the CEO to identify the heads of various medical units who would be willing to assist, to indicate the suitable time and distribute the questionnaires to the health professionals to complete. The study procedures for data collection had initially encountered some challenges at the casualty unit, where there was a degree of reluctance by the targeted respondents to participate due to work pressures resulting from the arbitrary emergencies at that unit. The researcher was advised to target other units with less pressure. The researcher spent the whole day at the hospital, moving from unit to unit, and spending about 20 minutes at each unit to allow the respondents to complete the questionnaires. The time spent by the respondents to complete the questionnaire was approximately 10 to 15 minutes. Some would miss one or two questions, seemingly due to misunderstanding of the terminology used in the question. Some of the questions were expunged out of the questionnaire as the researcher thought that they were more relevant to a qualitative study due to their subjective character. These included questions such as:

- What is your understanding of the MCMCP?
- Why was the MCMCP introduced by our government?

The term disdain in question 10.9 of the structured questionnaire was replaced with contempt. Every statement was numbered to make it easier to enter data on both an excel spreadsheet and MoonStats for statistical analysis.

The pilot study was significant in many ways. The researcher was able to gauge his time properly in terms of when to distribute the questionnaires. He was able to adopt a particular approach when communicating with health professionals. The researcher made sure that he was presentable and exercised caution particularly when approaching the casualty unit as there could have been an emergency that needed urgent collective attendance of all members of that unit including its Head. It was also discovered that there were a significant number of professionals who work night shift who could contribute to the study.

This pilot study had demonstrated that the study protocol was feasible. The project did not appear to be too disruptive to the hospital or have a significant impact on staff time. This study had demonstrated the effectiveness of a pilot study in identifying weaknesses in a questionnaire that after appropriate revisions can then be utilized in a full study. It has also provided a better understanding of how to implement the survey. Data entry was not problematic, although in the final study a statistician assisted with the data analysis.

3.7 DATA ANALYSIS

According to Henning *et al.* (2004:6-7) the process of data analysis will assist the researcher to answer the research questions, and to achieve the purpose of the research. Whereas, Welman *et al.* (2005:242) state that data analysis in quantitative studies such as in this study involves statistical analysis of obtained data. Specific statistical procedures can be applied depending on the level of measurement used for the variables of the quantitative study. To measure data, the researcher used interval measurement in this study. An interval scale has all the characteristics of both nominal and ordinal and scales, but provides additional information regarding the degree of difference between individual data items within a set or group. Most measures of human characteristics have interval properties. Interval measurement is the property of equal differences between consecutively higher numbers (Welman, *et al*. 2005:139). In addition to the above the

research applied certain procedures such as the mean, median, frequencies and standard deviations in the statistical analysis of the quantitative date of this study which are explained below.

- **The mean.** Maree *et al.* (2017:208) state that the mean is the most commonly used measure to describe the central tendency of data. Welman *et al*. (2005:230) maintain that the mean refers to the average score for a group which is equal to the total of individual scores divided by the number of scores.
- **The median.** According to Bless *et al*. (2014:255) the median refers to describe the middle value of a distribution. In other word the median splits the distribution into two halves in which 50% of the data is smaller than the median and 50% is bigger than the median.
- **Frequencies.** According to Welman *et al*. (2005:229) frequencies are used to determine whether distributions is even across all categories or interval or whether they cluster around one or two intervals.
- **Standard deviation.** The standard deviation is used to determine if the scores on a parametric test are evenly distributed and cluster closely around the mean. (Welman, *et al*. 2005:231).

There are two types of statistics that can be used in quantitative studies namely, descriptive statistics and interferential statistics. Descriptive statistics are used in quantitative studies to make a description or a summary of the data obtained from a group of individual units of analysis and to identified the range of the data and the central point of the data set used. On the other hand, interferential statistics is used in quantitative studies to draw conclusions or to draw inferences that one can make from the data (Du Plooy-Cilliers, *et al*. 2014:210-220; Welman, *et al.* 2005:231-236). In this study the researcher made use of descriptive statistics that were mainly mainly presented in pie charts and bar graphs.

In this study the data collected was loaded into MoonStats and analyzing by using descriptive statistics. MoonStats is a stand-alone statistical software programme that operates in Windows 95 or higher (Wellman *et al*. 2005:319). An experienced statistician assisted with the analysis of the data. The data was captured by using Multiple Regression Analysis.

3.8 ETHICAL CONSIDERATIONS AND LIMITATIONS OF THE STUDY

As explained in Section 1.8 of Chapter 1 of the study the following ethical considerations were taken into account throughout the research process.

- Informed consent and voluntary participation. The researcher presented participants with a letter of consent, in which the research process was described. The participants were requested to read the letter and ask questions to gain clarity, and sign the consent form if participants were willing to be involved in the research.
- A letter of consent was submitted to the Chief Executive Officer (CEO) of the two district hospitals to create awareness of the research purpose, and also to get their consent to conduct the interview by means of a structured questionnaire.
- Privacy, confidentiality and anonymity. All participants' information and responses shared during the study were kept private and the results presented in an anonymous manner in order to protect the identities of the participants.

3.9 SUMMARY

This chapter outlined the research methodology followed in the study and also discussed the research paradigm, research design, data collection and measurement instrument, validity and reliability, pilot study, and data analysis utilised in this study. This study was conducted mainly within the positivism paradigm (quantitative research) and had focused on the usage of scientific methods that hold that research must be limited to what can be observed and measured objectively. The validity and reliability of research instruments used to collect data aimed at assessing the impact of the MCMCP trained medical doctors in promoting health care service delivery was pre-tested through the pilot study on 30 respondents at Harry Surtie Hospital, in Upington. The researcher was always mindful of the significance of adhering to the principles of ethical conduct. The next chapter provided the findings and results of the empirical study.

CHAPTER 4: EMPIRICAL STUDY: FINDINGS AND RESULTS

4.1 INTRODUCTION

Chapter 3 provided a detailed discussion of the research methodology. It included a brief explanation of the research philosophy or paradigm that informed this study. This was followed with the research methodology which focussed on aspects such research design, study population and sampling procedures, data collection techniques, instrument validity and reliability, data analysis and ethical considerations. This chapter present a statement of findings and results of the analysis of data obtained from the structured questionnaire.

4.2. DATA ANALYSIS

It was articulated in Chapter 3 that Neuman (2011:383) states that the raw data collected needed to be reorganised into a form suitable for computer entry, presented in charts or graphs to summarise their features, as well as interpret or give theoretical meaning to the results. The data collected thereafter was analysed for the purpose of drawing certain conclusions that reflect on the issues that initiated the inquiry. It was highlighted in Chapter 3, Section 3.4 that the target population sample for ZK Mathews Hospital was 49 (n=49) whilst for Warrenton Hospital it was 23 (n=23) health professionals. The researcher received 64 (43 from ZK Mathews and 21 from Warrenton) completed structured questionnaires that were presented to the respondents based at the above two hospitals. The response rate was 88.8% (n=64) of the 72 structured questionnaires as some of the targeted participants had left the system. The structured questionnaire consists of Section A and Section B. Section A contained statements about the biographical information of the respondents relating to race, gender, disability, home language, age, occupation, hospital, experience and the highest level of education of the research participants. As expressed in Chapter 3, Section B contained statements captured on a five point Likert scale that were aimed at determining the respondents' attitudes towards the Mandela-Castro Medical Collaboration Programme (MCMCP). The presentation of findings and results from Section A of the structured questionnaire follows.

4.3 PRESENTATION OF FINDINGS AND RESULTS FROM SECTION A OF THE STRUCTURED QUESTIONNAIRE: BIOGRAPHICAL DATA OF HEALTH PROFESSIONALS

Section A of the questionnaire as pointed above, concentrated on the biographical details of respondents.

4.3.1 Race of the respondents

Question 1, in Section A asked about the race of the respondents in order to determine the number of participants from various races that completed the questionnaire. The results of the findings are presented in Table 4.1 below.

Table 4.1 Race of the respondents

Race of the Respondents				
Race	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Missing	1	1.56	1	1.56
Africans	44	68.75	45	70.31
Asians	1	1.56	46	71.88
Coloured	17	26.56	63	98.44
Whites	1	1.56	64	100.00

The findings in Table 4.1 above depict that of the 64 questionnaires received, only one of the respondents did not answer Question 1. The highest proportion of the respondents constitutes 68.8% of the population size of the research participants and these were of African descent. The second highest category consisted of 26.6% of the coloured population of the research participants. The combined response rate of the Whites and Asians was 3.2%, shared equally between the two races.

Gender of the respondents

Question 2 in Section A of the structured questionnaire aimed to determine the gender of the respondents who participated in the research study. The results of the findings are presented in Figure 4.1 below.

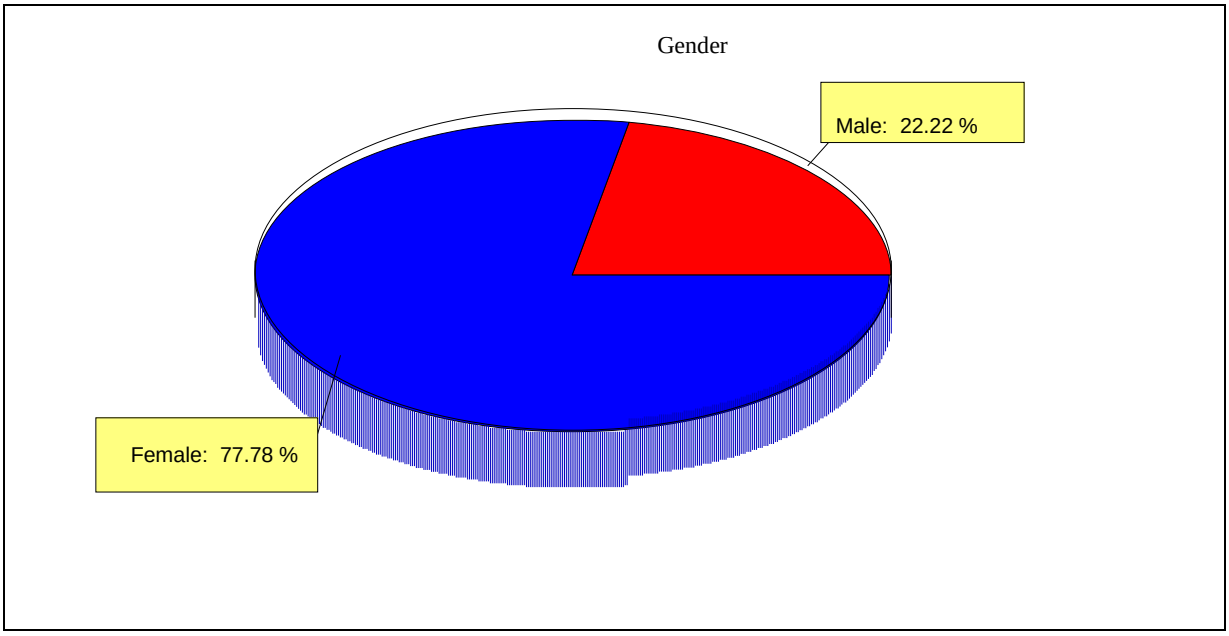

Figure 4.1 Gender of the respondents

The above graph in Figure 4.1 shows that 77.8% of the respondents were female while 22.2% of the respondents were male. This is consistent with the NCDoH PERSAL Report (2018b), retrieved in May 2018, which indicates that 72.3. % of health professionals are females whereas 27.7% are males. It can therefore, be deduced that this is a true representation of the gender distribution of the research participants.

4.3.3 Respondents living with disability

Question 3 in the structured questionnaire of Section A was asked to determine the disability of the respondents. The results are presented in Figure 4.2 on page 97.

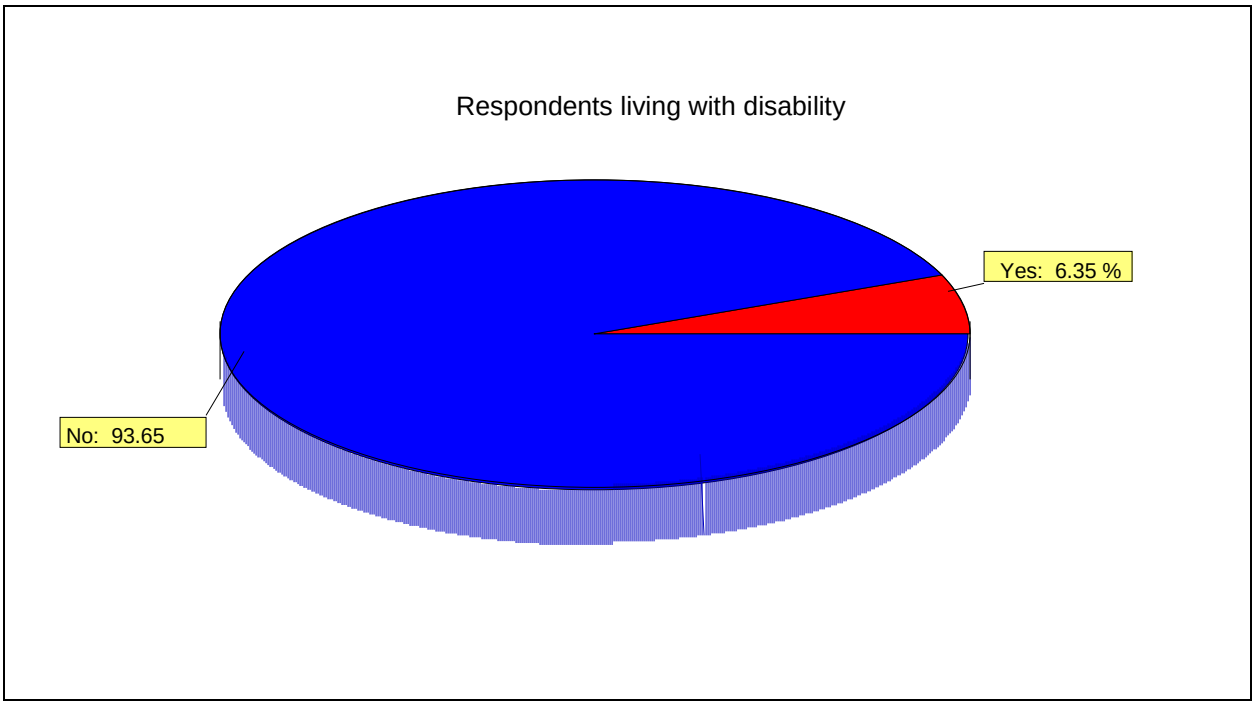

Figure 4.2 Respondents living with disability

The above graph in Figure 4.2 illustrates that a very low percentage, only 6.4%, of those who completed the questionnaire live with a disability versus 93.7% of research participants who do not have a disability.

4.3.4 Home language of respondents

Question 4 in Section A was asked to determine the respondents' home language. The results of the findings are presented in Figure 4.3 in the next page, on page 98.

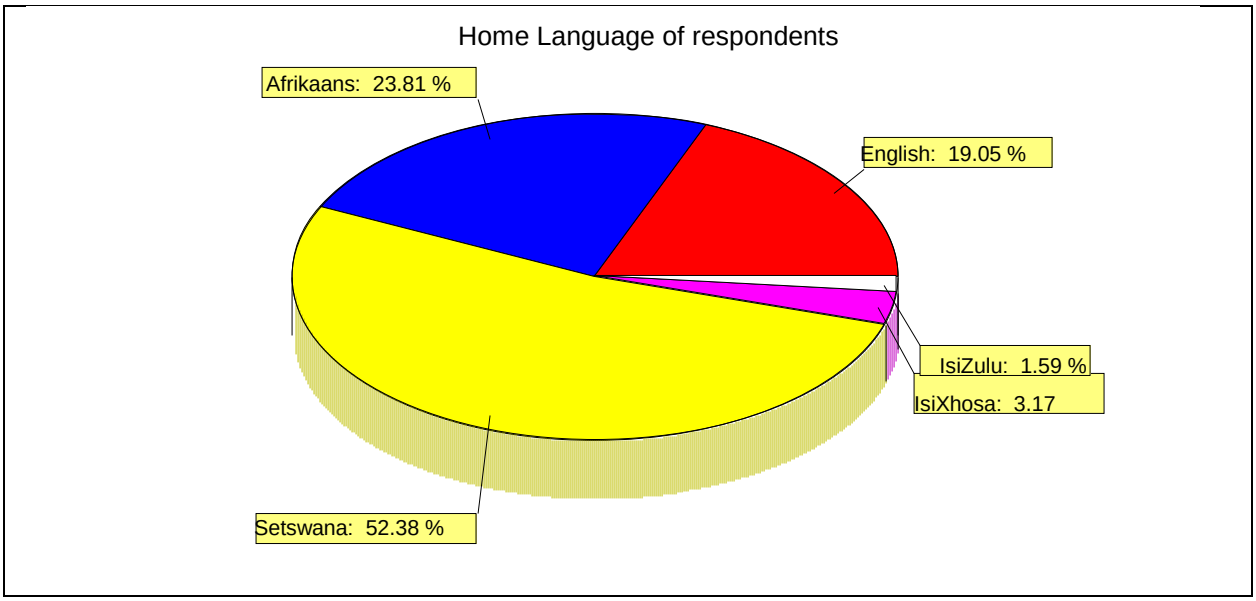

Figure 4.3 Home language of respondents

The above graph in Figure 4.3 demonstrates that the majority of respondents, 52.4%, were Setswana speaking. This was followed by Afrikaans, English, IsiXhosa and IsiZulu equaling 23.8%, 19.1%, 3.2% and 1.6% of the research participants respectively.

4.3.5 Age of research respondents

In Question 5 of Section A of the structured questionnaire, the researcher sought to determine the age of the respondents.

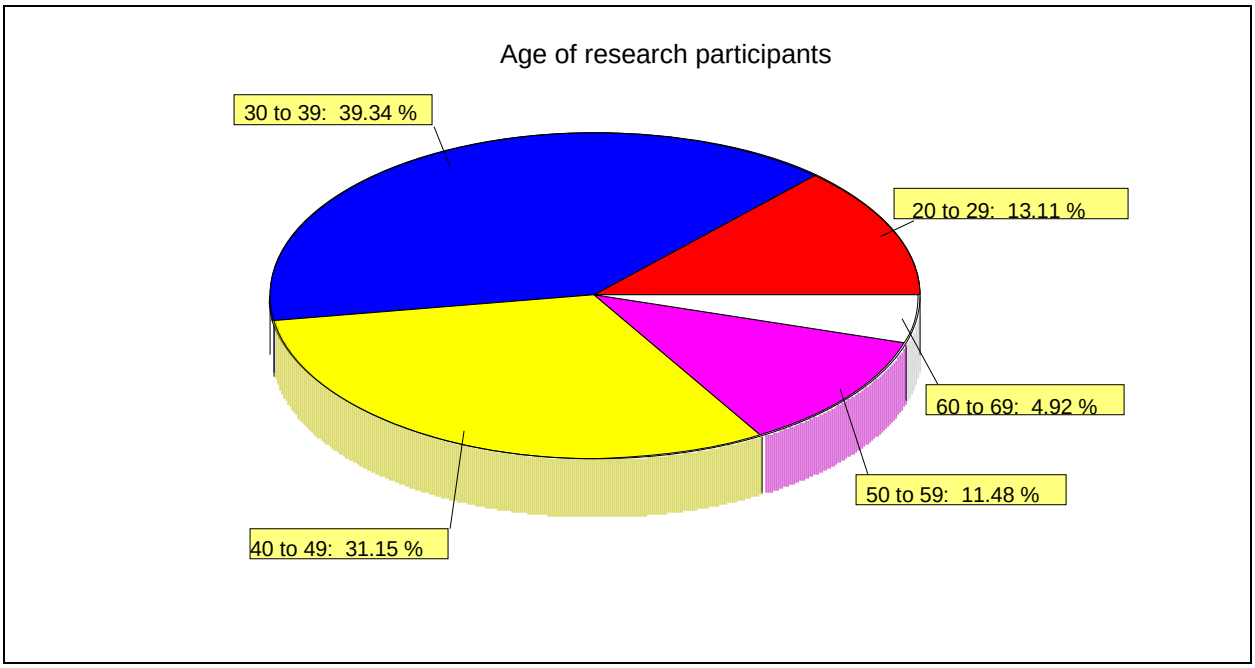

Figure 4.4 Age of research respondents

Figure 4.4 above depicts that the highest proportion of respondents, 39.3%, were between the age group 30 to 39 years. The age group between 40 and 49 constituted 31.2%, followed by the age groups between 20 to 29 and 50 to 59 constituting 13.1% and 11.5% respectively. The smallest proportion of participants was between 60 to 69 years constituting about 4.9% of the total population size of the participants.

4.3.6 Occupation of the respondents in the research study

Question 6 of Section A of the structured questionnaire was asked in order to determine the occupation of the participants in the research study. The results of the findings are presented in Table 4.2 below.

Table 4.2 Occupation of the respondent

Occupation of the respondents				
Occupation	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Nurse	34	53.13	34	53.13

Medical Officer	3	4.69	37	57.81
Pharmacist	5	7.81	42	65.63
Emergency Medical Care Officer	7	10.94	49	76.56
Radiographer	3	4.69	52	81.25
Allied Health Professionals	5	7.81	57	89.06
Other Health Professionals	1	1.56	58	90.63
Administrative Staff	6	9.38	64	100.00

From Table 4.2, it can be depicted that the largest number of respondents were nurses which makes about 53.1% of the total number of the research participants. These nurses were drawn from various medical units such as maternity wards, outpatients, surgery and health and wellness units. It is mainly in these wards where doctors trained through the MCMCP are based and interact with the nurses during their daily operational duties. The next bigger group of participants constituting 10.9% of the respondents was comprised of emergency health care professionals, who from time to time interact with these doctors.The response rate of pharmacists and allied health professionals was 7.8% for each. Medical officers and radiographers also shared an equal number of participants where the response rate for each was 4.7%. Other health professionals consisted of 2% of the total number of participants. The remaining 9% of participants was from the administration staff.

4.3.7 Hospitals where respondents are based

Question 7 in Section A was asked to determine the hospitals where the respondents were based. The results of the findings are presented in Figure 4.5 on page 101.

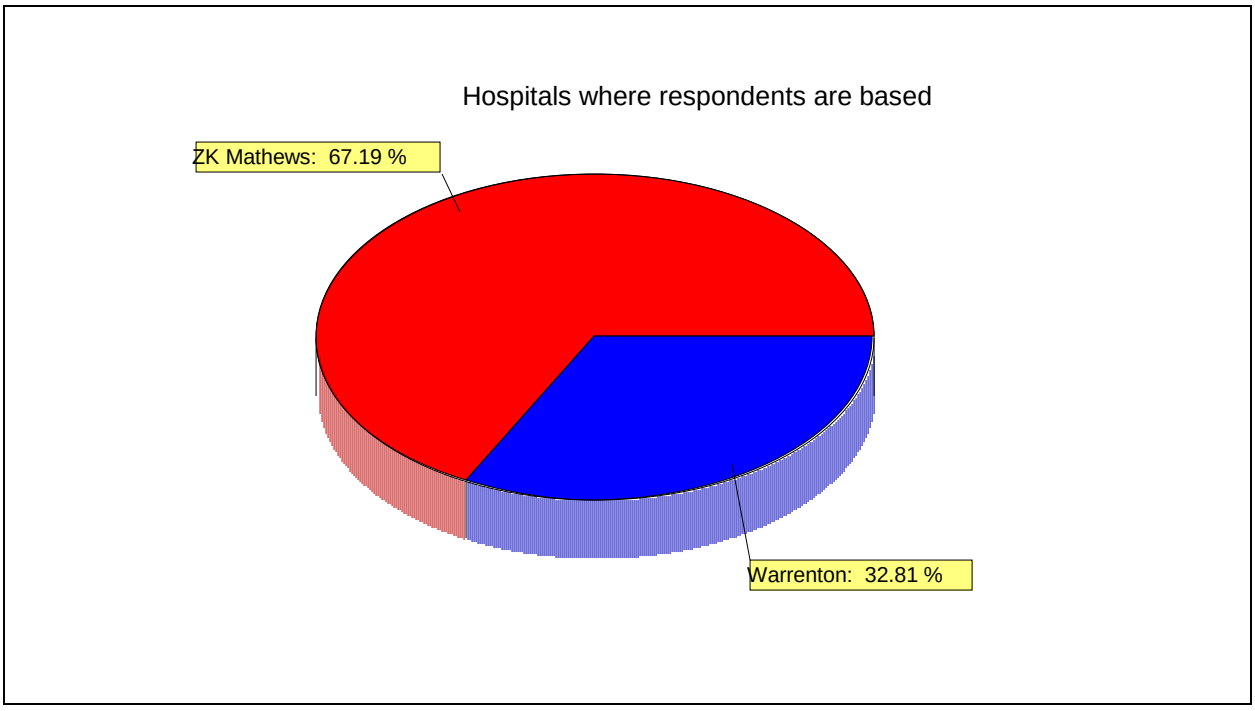

Figure 4.5 Hospitals where respondents are based

In Figure 4.5, the results of the findings indicate that of the two hospitals, 67.2% of the respondents are employed at ZK Mathews Hospital whereas 32.8% are employed at Warrenton Hospital. Chapter 3, Section 3.4.1 expressed that the above findings in Figure 4.7 were consistent with the the sample frames and samples of these hospitals (ZK Mathews: N=98, n=49; Warrenton: N=36, n=23).

4.3.8 The length of experience of the respondents

Question 8 of the structured questionnaire was asked to determine the length of experience of the participats in their respective posts. The results of the findings are presented in Table 4.3 below.

Table 4.3 The length of experience of the respondents

The length of experience of the respondents				
Experience	Frequency	Percent	Cumulative Frequency	Cumulative Percent
1-5 years	25	39.06	25	39.06

6-10 years	27	42.19	52	81.25
11-20 years	8	12.50	60	93.75
21 and more years	4	6.25	64	100.00

In Table 4.3 above, the graph depicts that the highest proportion of the participants was comprised of respondents whose experience was between six to ten years in the facility, constituting 42.2% of the total number of respondents. The next higher proportion of experienced staff who have been exposed to the facility at the hospital was between the period of one to five years and this constituted 39.1% of the respondents. Health professionals who have been working at this hospital for the period of 11 to 20 years constituted about 12.5% of the respondents while those with 21 and more years at the hospital were 6.3% of the total number of the research participants.

4.3.9 Highest level of education of the respondents

Question 9, in Section A of the structured questionnaire was asked to determine the qualifications that the respondents possess. The results of the findings are presented in Figure 4.6 below.

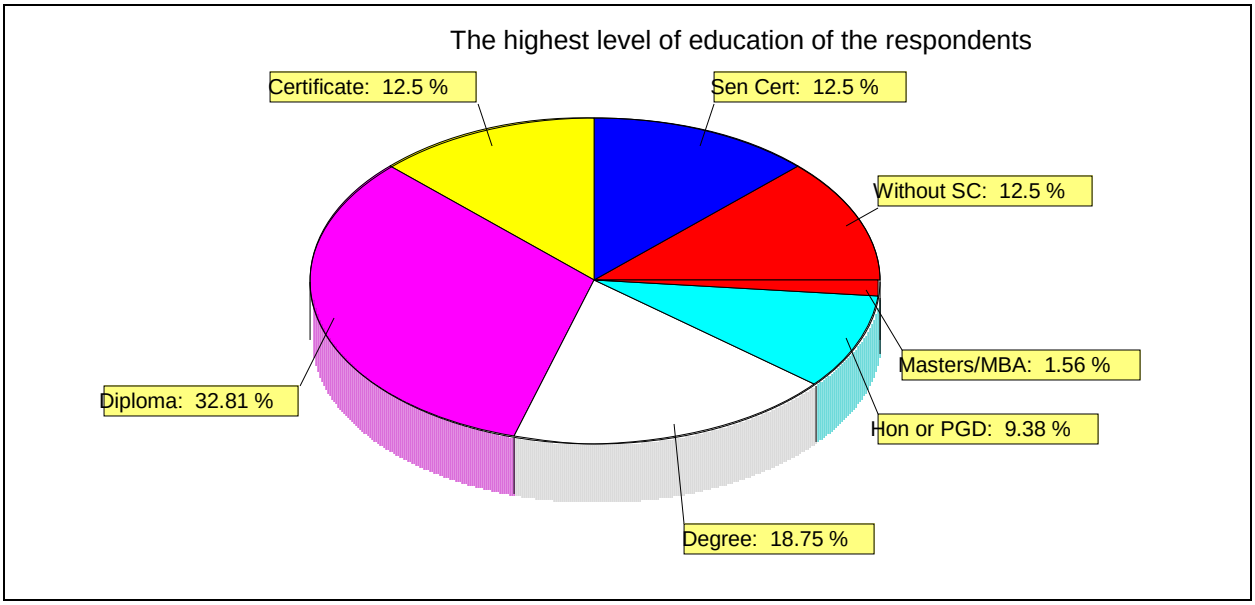

Figure 4.6 Highest level of education of the respondents

In figure 4.6 of the above graph, it can be depicted that the highest number of the respondents, constituting 32.8%, possess a diploma as a post matric qualification. The percentage of the number

of participants with degrees and post graduate qualification (Honors or Post Graduate Diploma) is about 18.8% and 9.4% respectively. The respondents without senior certificate, senior certificate and certificate shared an equal proportion of participation which was split at 12.5% for each category of respondents. The smallest number of the respondents was comprised of 1.56% of the respondents from Masters or Master of Public Administration degrees.

4.4 PRESENTATION OF FINDINGS AND RESULTS FROM SECTION B OF THE STRUCTURED QUESTIONNAIRE: ATTITUDES OF RESPONDENTS TOWARDS MCMCP TRAINED MEDICAL DOCTORS

Section B focused on questions that seek to collect information about the impact of the MCMCP trained medical doctors in promoting health care service delivery in FBDM hospitals, NCP.

Questions in Section B probed the respondents' attitude towards the MCMCP trained medical doctors who took part in the MCMCP. The five points summated or Likert scale (strongly disagree: 1, do not agree: 2, uncertain: 3, agree: 4, strongly agree: 5) was used by the researcher to assess the impact of the MCMCP trained medical doctors in promoting health care service delivery. The attitudes of the respondents were determined by assessing the degree of their agreement to each of the statements linked to an attribute as asked from Section 4.4.1 to 4.4.10.

As indicated in Chapter 3, Section 3.7, the researcher presented the results of the findings of the investigation and used tables to capture the findings and graphs to demonstrate the frequencies of the responses of the research participants. The findings illustrated in tables contained the following items: number of respondents, the mean, standard deviation, minimum and maximum, median and missing cases. Chapter 3, Section 3.5 highlighted that graphs depicted frequencies of responses to statements about the attitudinal objects. Here follows the presentation of findings and results from Section B of the structured questionnaire on attitudes of respondents towards the MCMCP doctors.

4.4.1 Awareness of MCMCP trained medical doctors

4.4.1.1 Findings on awareness of the MCMCP trained medical doctors

The questions from 10.1.1 to 10.1.3, Annexure B were asked to determine the state of awareness of the research participants towards the MCMCP trained medical doctors. In Table 4.4, the researcher depicts the number, the mean, standard deviation, minimum, maximum and missing cases of the research participants that took part in this study. The summary of the findings on the state of awareness of the research participants towards the MCMCP trained medical doctors are depicted in Table 4.4 below.

Table 4.4 The awareness of the MCMCP medical trained doctors

Statement in question:	N	Mean	Standard Deviation	Min	Max	Median	Missing Cases
10.1.1 The number of MCMCP trained medical doctors are more than RSA trained medical doctors.	64	2.56	1.11	1	5	3	0
10.1.2 MCMCP trained medical doctors are seen in every unit of the hospital.	63	3.05	1.33	1	5	3	1
10.1.3 It is difficult to identify MCMCP trained medical doctors from South African trained doctors.	63	2.67	1.36	1	5	3	1

Table 4.4 reveals that in all the above three statements, there was a general degree of uncertainty about the number, visibility and identification of MCMCP trained medical doctors at the hospitals of ZK Mathews and Warrenton. A breakdown of frequencies in terms of the research participants' degree of agreement or disagreement about awareness of the MCMCP trained medical doctors is shown in the graphs below.

4.4.1.2 Frequencies on the number of responses on the state of awareness of MCMCP trained medical doctors

In Question 10.1.1, the respondents were asked to indicate whether the number of MCMCP trained medical doctors is more than RSA trained medical doctors. The findings are presented in Figure 4.7 below.

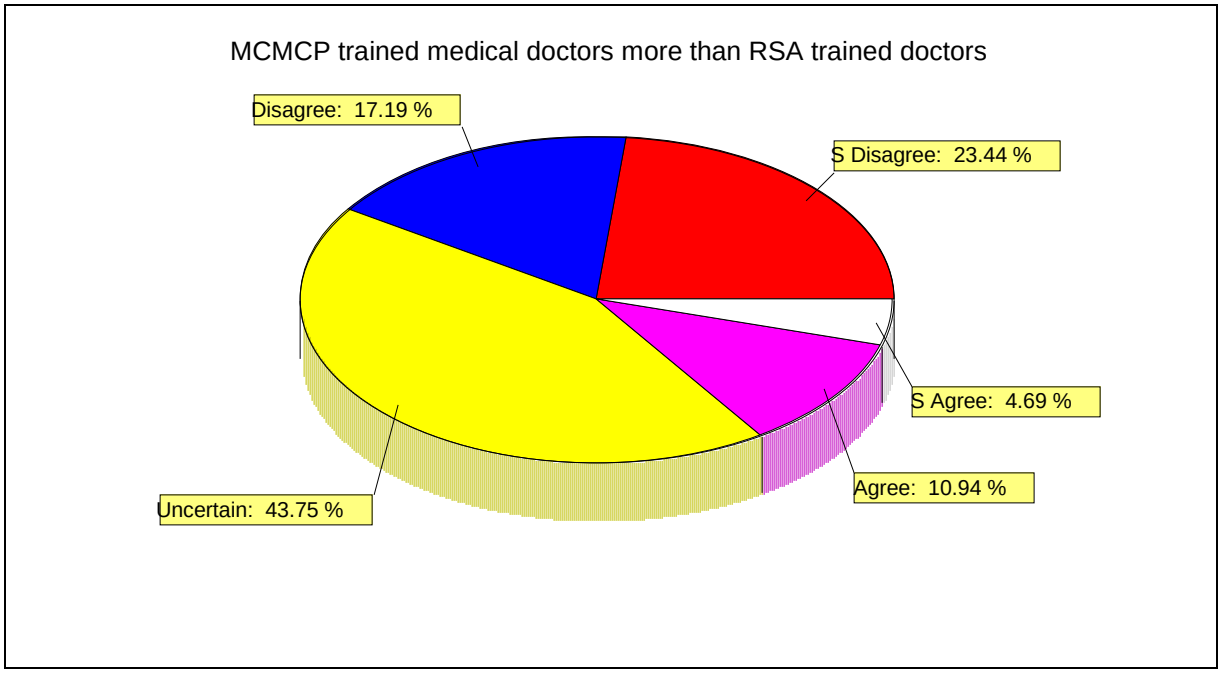

Figure 4.7 The number of MCMCP trained medical doctors is more than RSA trained medical doctors

In Figure 4.7, the results of the finding demonstrate that 43.8% of the respondents were uncertain if the number of MCMCP trained medical doctors who took part in the MCMCP is more than RSA trained medical doctors. Of the respondents, 17.2% and 23.4% respectively disagreed or strongly disagreed with the above statement. The remaining respondents either agreed or strongly agreed with the statement that there are more MCMCP trained medical doctors than RSA trained medical doctors, 10.9% and 4.7% respectively

Based on the results of the findings in Figure 4.7 and Table 4.4 it can be concluded that while the respondents were aware of the presence of MCMCP trained medical doctors at the hospital, there

was, however, a degree of uncertainty as to whether there are more or less than South African trained medical doctors.

In Question 10.1.2 the respondents were asked to indicate if MCMCP trained medical doctors (MCMCP) are seen in every unit of the hospital. The findings are presented in Figure 4.8 below.

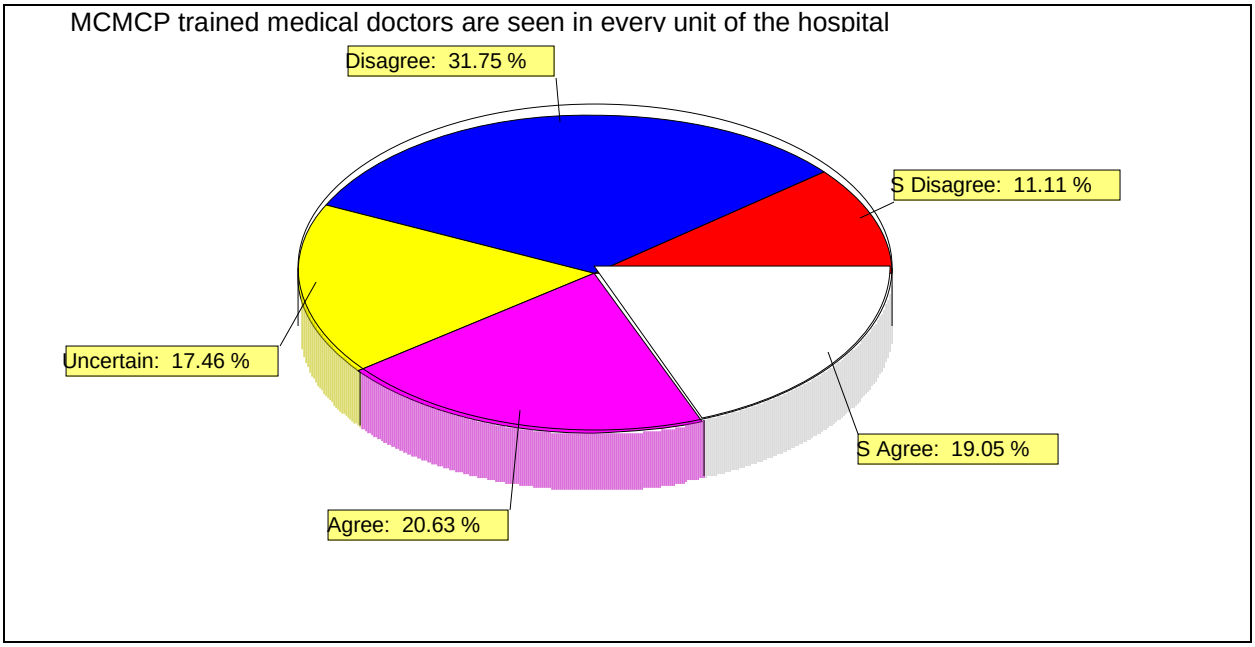

Figure 4.8 MCMCP trained medical doctors are seen in every unit of the hospital

In Figure 4.8, the graph indicates that the highest proportion of the respondents disagreed with the assertion that MCMCP trained medical doctors are seen in every unit of the hospital whereas 31.8% disagreed while 11.1% strongly disagreed. The combined sum of those that agreed and strongly agreed was 39.7% while the remaining group of participants constituting 17.46% was not certain if MCMCP trained medical doctors are seen in every unit of the hospital. It can, therefore, be deduced from these findings that more than a third of the respondents believed that MCMCP trained medical doctors were not visible enough to be identified in various medical wards of the hospital.

Question 10.1.3 asked if it is difficult to identify the MCMCP trained medical doctors from South African trained doctors. The results of the findings are presented in Figure 4.9 below.

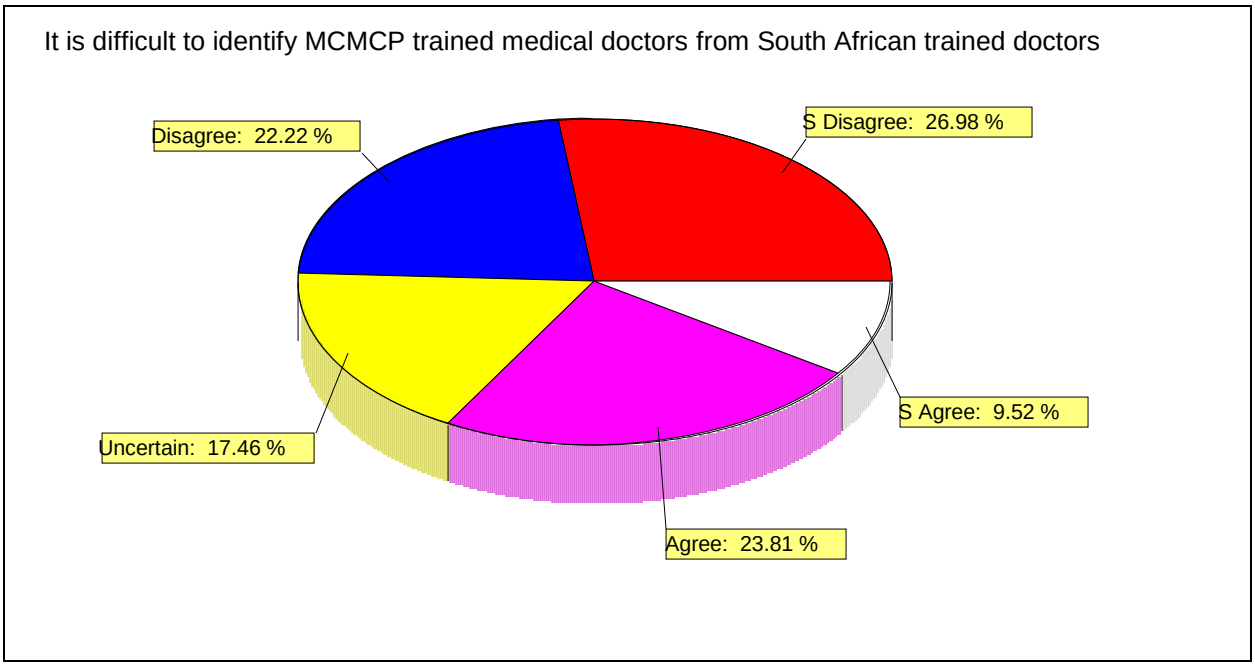

Figure 4.9 It is difficult to identify MCMCP trained medical doctors from South African trained doctors

The graph in Figure 4.9 depicts that 27.0% of the respondents strongly disagreed with the statement that it is difficult to identify MCMCP trained medical doctors from South African trained doctors whilst those who disagreed with the above assertion was 22.2%. The proportion of the respondents that either agreed or strongly agreed with the above assertion was 23.8% and 9.5% respectively. The respondents that were not certain if it is difficult to identify MCMCP trained medical doctors from South African trained medical doctors was 17.5%. It can, therefore, be concluded that almost 50% of the respondents do not believe that it is difficult to distinguish MCMCP trained medical doctors from South African trained medical doctors. It can also be concluded that almost a third of the respondents believe that it is difficult to distinguish MCMCP trained medical doctors from South African trained medical doctors.

4.4.2 Competency of MCMCP trained medical doctors

4.4.2.1 The competency of MCMCP trained medical doctors

The questions from 10.2.1 to 10.2.3 in this section were asked to determine the competency of the MCMCP trained medical doctors. In Table 4.5, the researcher depicts the number, the mean, standard deviation, minimum, maximum, median and missing cases of responses to statements in question 10.2.1, 10.2.2 and 10.2.3. It was expressed in Chapter 2, Section 2.4.3 that quality of health care refers to clinical quality that involves the skill and competency of health professionals. The summary of the research participant's responses about the competency of MCMCP trained medical doctors is presented in Table 4.5 below**.**

Table 4.5 The competency of MCMCP trained medical doctors

Statement in question:	N	Mean	Standard Deviation	Min	Max	Median	Missing Cases
10.2.1 MCMCP trained medical doctors are good at what they are doing.	64	3.98	0.83	1	5	4	0
10.2.2 MCMCP trained medical doctors are sloppy and careless.	64	1.95	0.92	1	4	2	0
10.2.3 MCMCP trained medical doctors are not well trained and are unable to perform basic procedures such as delivery, setting drips etc.	63	1.7	0.84	1	5	2	1

The results of the findings captured in Table 4.5 on the competency of MCMCP trained medical doctors demonstrates that the respondents agreed with the statement in Question 10.2.1 and disagreed with statements in Question 10.2.2 and 10.2.3

The frequency on the number of responses to the above statements and the results of the findings are presented in graphs below.

4.4.2.2 Frequency of responses on the competency of MCMCP trained medical doctors

Question 10.2.1 was asked to determine if MCMCP trained medical doctors are good at what they are doing. The findings are presented in Figure 4.10 below.

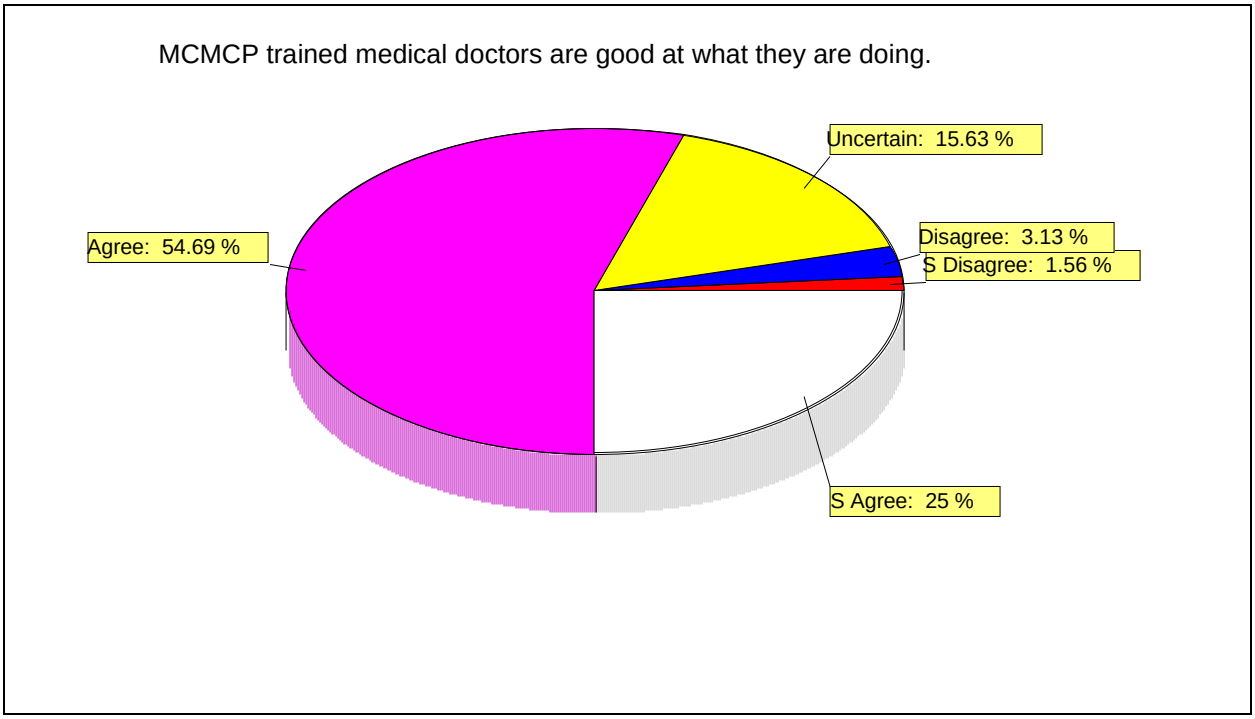

Figure 4.10 MCMCP trained medical doctors are good at what they are doing

In Figure 4.10 the graph depicts that 54.7% of the respondents agreed that MCMCP trained medical doctors are good in carrying out their duties whereas 25.0% strongly agreed. The smallest proportion of respondents range from those who strongly disagreed to those who disagreed at 1.2% and 3.1% respectively. It can, therefore, be deduced that a small fraction of the respondents think that MCMCP trained medical doctors are not good at executing their duties. There were, however, 15.6% of respondents who were not certain if MCMCP trained medical doctors are good at what they do. It can, therefore be deduced that while the majority of the health professionals, mainly comprised of the nursing staff, as indicated in Section 4.3 above, expressed a degree of confidence

in the doctors trained through the MCMCP. There was, on the contrary, a small fraction of respondents who do not have confidence in MCMCP trained medical doctors.

In Chapter 2, Section 2.12.6, it was highlighted that the MCMCP trained medical doctors have had high criticism in recent years with claims that South African doctors returning from Cuba are not adequately equipped for the South African context, being unable to treat illnesses such as tuberculosis (TB), HIV/AIDS and complications associated with diabetes (Masters, *et al*. 2015:176). It was also indicated in Chapter 2, Section 2.4 that the mere availability of health workers is not sufficient; it is only when they are equitably distributed and are accessible by the population, when they possess the required competency and are motivated and empowered to deliver quality care that is appropriate and acceptable to the socio-cultural expectation of the population and when they are adequately supported by the health system.

In Question 10.2.2, the researcher asked if MCMCP trained medical doctors are sloppy and careless. The results of the findings are presented in Figure 4.11 below.

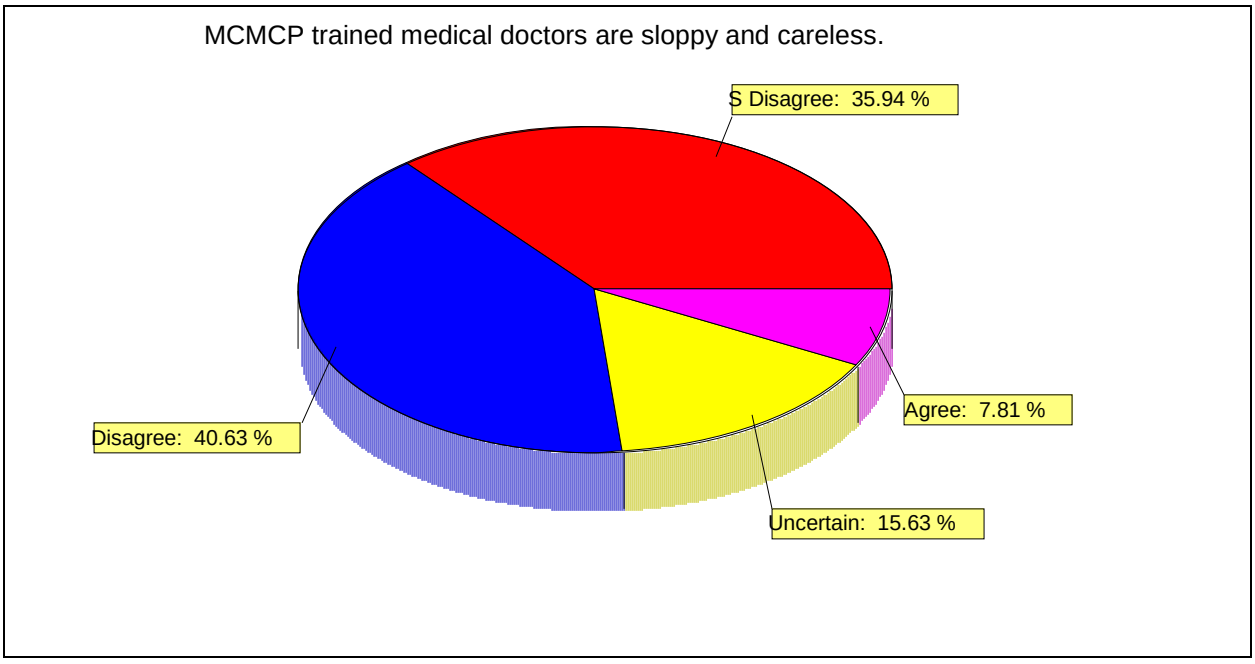

Figure 4.11 MCMCP trained medical doctors are sloppy and careless

From the findings depicted in Figure 4.11, the majority of the respondents (40.6%) disagreed with the statement that MCMCP trained medical doctors are sloppy and careless whereas 35.9% of the

respondents strongly disagreed. A small proportion, constituting 7.8% of the respondents, agreed that MCMCP trained medical doctors are sloppy and careless while 15.6% were uncertain about this assertion. The outcome of this investigation on the above statement indicates that the majority of respondents disagree with the above statement.

In Question 10.2.3, the respondents were asked to indicate if MCMCP trained medical doctors are not well trained and are unable to perform basic procedures such as delivery and setting drips, as examples. The findings are presented in Table 4.6 below.

Table 4.6 MCMCP trained medical doctors are not well trained and are unable to perform basic procedures

Level of agreement	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Strongly disagree	30	47.62	30	47.62
Disagree	25	39.68	55	87.30
Uncertain	6	9.52	61	96.83
Agree	1	1.59	62	98.41
Strongly agree	1	1.59	63	100.00

Frequency Missing = 1

Table 4.6 illustrates that 47.6% of respondents strongly disagreed with the statement that MCMCP trained medical doctors are not well trained and are unable to perform basic procedures such as delivery and setting drips, amongst others. This sentiment was also shared by the next category of respondents where 39.7% disagreed with the above assertion. A small proportion of respondents had either agreed (1.59%) or strongly agreed (1.59%) that MCMCP trained medical doctors are not well trained and are unable to perform basic procedures. The remaining category of respondents, constituting 9.5% of participants, were uncertain as to whether MCMCP trained medical doctors are well trained or not regarding being able to perform basic procedures such as delivery and setting drips, among others.

The literature reviews in Chapter 2, Section 2.12.6 of this study highlighted that the MCMCP trained medical doctors has come under fire in recent years with claims that South African doctors returning from Cuba are not adequately equipped for the South African context, being unable to treat illnesses such as tuberculosis (TB), HIV/AIDS and complications associated with diabetes (Masters, *et al.* 2015:176). It was also emphasized in Chapter 2, Section 2.13.3 that RSA-Cuban trained medical students have to do an additional 18 months medical training in South Africa before they could obtain their medical degrees. The 18-month training, comprise of a 6 month's orientation programme and a 12-month integration programme at a South African Medical School before they could obtain their medical degree. From the latter one could interpret that the MCMCP trained medical doctors are well trained and well integrated into the South African health care system. It also corresponds with the findings of the respondents as illustrated in Table 4.6.

4.4.3 Relationship of MCMCP trained medical doctors with patients

4.4.3.1 Findings on how MCMCP trained medical doctors relate with their patients

The respondents were asked to indicate how MCMCP trained medical doctors relate with their patients. In Table 4.7, the researcher depicts the number, the mean, standard deviation, minimum, maximum and missing cases of the research participants that took part in the study. The summary of the research participant's responses on the relationship that MCMCP trained medical doctors have with their patients is presented in Table 4.7 below.

Table 4.7 How MCMCP trained medical doctors relate with their patients

Statement in question:	N	Mean	Standard Deviation	Min	Max	Median	Missing Cases
10.3.1 MCMCP trained medical doctors are loved by patients.	64	4.08	0.78	2	5	4	0
10.3.2 MCMCP trained medical doctors dedicate more time talking to their patients.	64	3.94	0.89	2	5	4	0

10.3.3 Patients do not welcome the idea of being attended to by MCMCP trained medical doctors.	64	1.78	0.79	1	4	2	0
10.3.4 MCMCP trained medical doctors are always talking bad about their patients.	63	1.67	0.86	1	5	1	0

Descriptive statistics in Table 4.7 indicate that the respondents agreed with the statements in Question 10.3.1 and 10.3.2 while they disagreed with statements in Question 10.3.1 and 10.3.4. Here follow questions and the presentation of findings on how the MCMCP trained medical doctors relate with their patients to corroborate the above statistics.

4.4.3.2 Frequencies of responses on how MCMCP trained medical doctors relate well with their patients

Question 10.3.1 was asked to determine if MCMCP trained medical doctors are good with and liked by their patients. The results of the findings are presented in Figure 4.12 below.

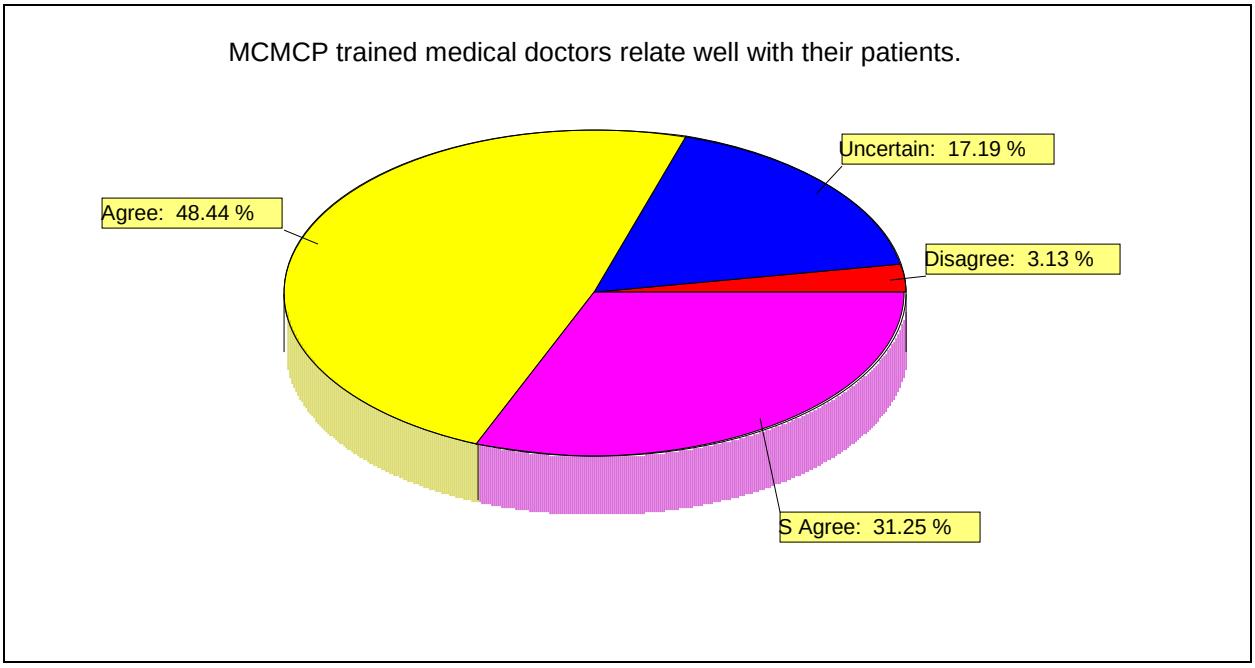

Figure 4.12 MCMCP trained medical doctors relate well with their patients

The findings in Figure 4.12 demonstrate that 48.4% of the respondents agreed that MCMCP trained medical doctors relate well with their patients while 31.2% of the respondents strongly agreed with the statement that MCMCP trained medical doctors relate well with their patients. On the contrary 3.1% disagreed with this assertion. It was also depicted in Figure 4.15 that 17.2% were uncertain if MCMCP trained medical doctors relate well with their patients. In Chapter 2, Section 2.5.8 it was mentioned that the NPC (2011:332) emphasising that the provision of primary health care must focus on a more people-centred approach of the district health system. It was further highlighted in Chapter 2, Section 2.5.2 that in terms of the WPToHS, 1997 it is the responsibility of the state to develop a unified health system capable of delivering quality health care to all citizens efficiently in a caring environment.

Question 10.3.2 was asked to determine if MCMCP trained medical doctors dedicate more time talking to their patients. The findings are presented in Figure 4.13 below.

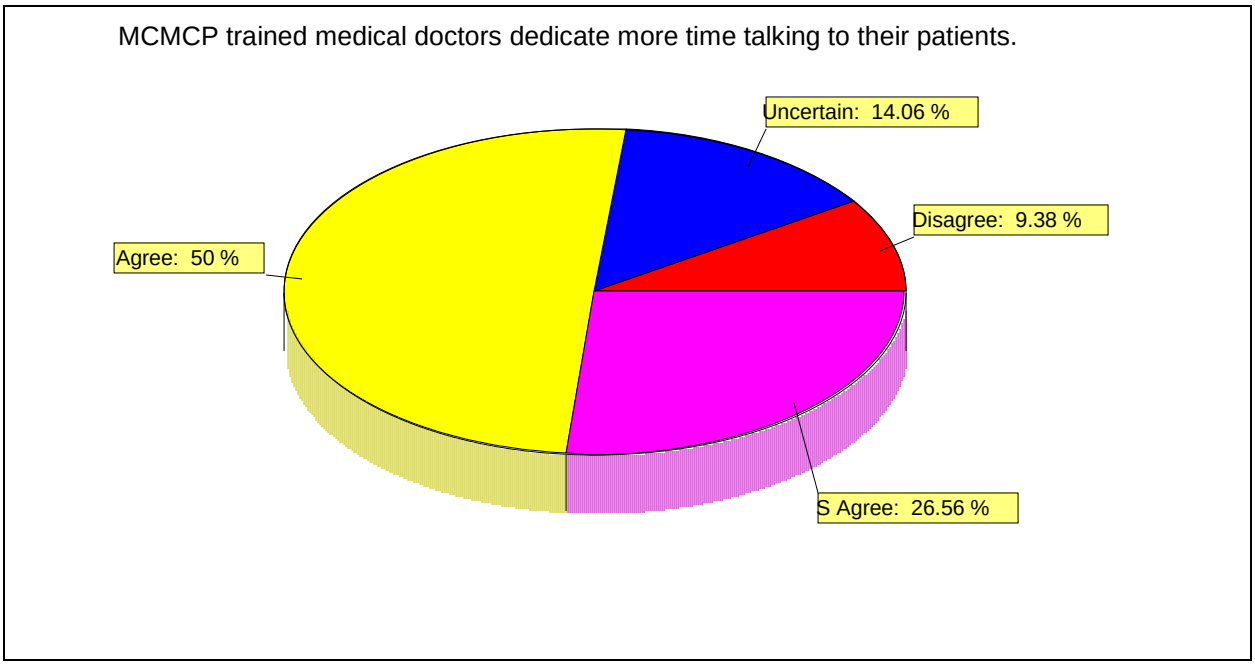

Figure 4.13 MCMCP trained medical doctors dedicate more time talking to their patients

The results of the investigation in Figure 4.13 indicate that 50.0% of the research participants agreed that MCMCP trained medical doctors dedicate more time talking to their patients. The next proportion of respondents strongly agreed (26.6%) while 9.4% disagreed with the assertion that MCMCP trained medical doctors dedicate more time talking to their patients. It was only 14.1% of respondents who were not certain whether MCMCP trained medical doctors dedicate more time talking to their patients.

Question 4.10.3 was asked to determine if patients do or do not welcome the idea of being attended to by MCMCP trained medical doctors. The findings are presented in Figure 4.14 below.

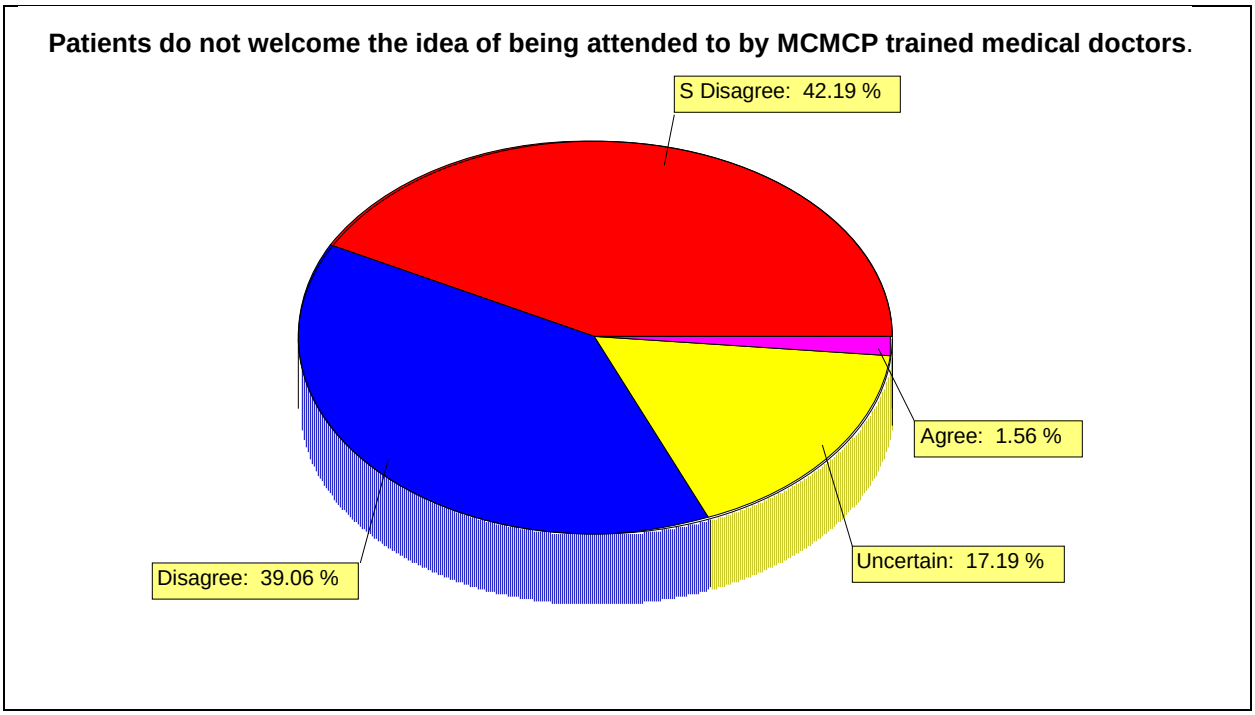

Figure 4.14 Patients do not welcome the idea of being attended to by MCMCP trained medical doctors

The findings presented in Figure 4.14 of the pie chart indicate that an overwhelming majority of the research participants were opposed to the statement that patients do not welcome the idea of being attended to by MCMCP trained medical doctors. Of those who were opposed to the above statement, the highest proportion constituted 42.2% who had strongly disagreed while the next highest percentage at 39.1% disagreed. The next proportion was made of 17.2% of the research

participants who were uncertain while the smallest fraction was made of 1.6% of those who had agreed with the statement that patients do not welcome the idea of being attended to by MCMCP trained medical doctors.

Question 10.3.4 was asked to determine if MCMCP trained medical doctors are always talking badly about their patients. The results of the investigation are presented in Figure 4.15 below.

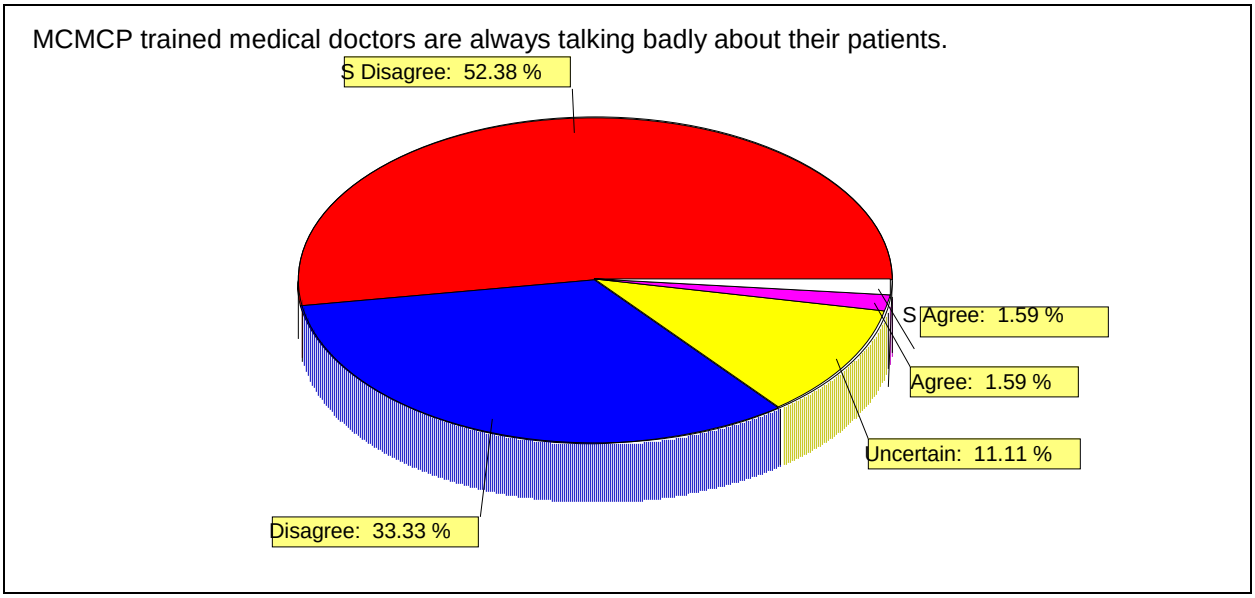

Figure 4.15 MCMCP trained medical doctors are always talking bad about their patients

The above graph in Figure 4.15 shows that the majority of respondents were opposed to the statement that MCMCP trained medical doctors are always talking badly about their patients. The total proportion of the research participants that had strongly disagreed with the above statement was 52.4% while 33.3% disagreed. The combined percentage of those who had either agreed or strongly agreed was 3.2% of the research participant. There was, however, a group of respondent (11.1%) of the total percentage of the research participants that were uncertain if MCMCP trained medical doctors are always talking badly about their patients.

4.4.4 Commitment of MCMCP trained medical doctors

4.4.4.1 Findings on the commitment of MCMCP trained medical doctors

The questions from 10.4.1 to 10.4.5 in this section were asked to determine the commitment of the MCMCP doctors. In Table 4.8, the researcher depicts the number, the mean, standard deviation, minimum, maximum, median and missing cases of responses to statements in Question 10.4.1 to10.4.4. The summary of the research participant's responses about the commitment of MCMCP trained medical doctors is presented in Table 4.8 below.

Table 4.8 Commitment of MCMCP trained medical doctors

Statement in question:	N	Mean	Standard Deviation	Min	Max	Median	Missing Cases
10.4.1 MCMCP trained medical doctors are committed to their work.	63	4.08	0.77	1	5	4	1
10.4.2 MCMCP trained medical doctors are hard workers.	64	3.94	0.81	1	5	4	0
10.4.3 MCMCP trained medical doctors work overtime.	63	3.83	0.96	1	5	4	1
10.4.4 MCMCP trained medical doctors come late to work.	63	2.43	1.06	1	5	3	1
10.4.5 MCMCP trained medical doctors respond late to calls.	63	2.52	0.91	1	5	3	1

It can be deduced that there was a general degree of agreement with statements in 10.4.1 to 10.4.3 while there was a degree of uncertainty with statement 10.4.5 in Table 4.8.

The frequency of the number of responses to the above statements and the results of the findings are presented below.

4.4.3.2 Frequencies of responses about the commitment of MCMCP trained medical doctors to their work

Question 10.4.1 was asked to determine if MCMCP trained medical doctors are committed to their work. The results of the findings are presented in Figure 4.16 below.

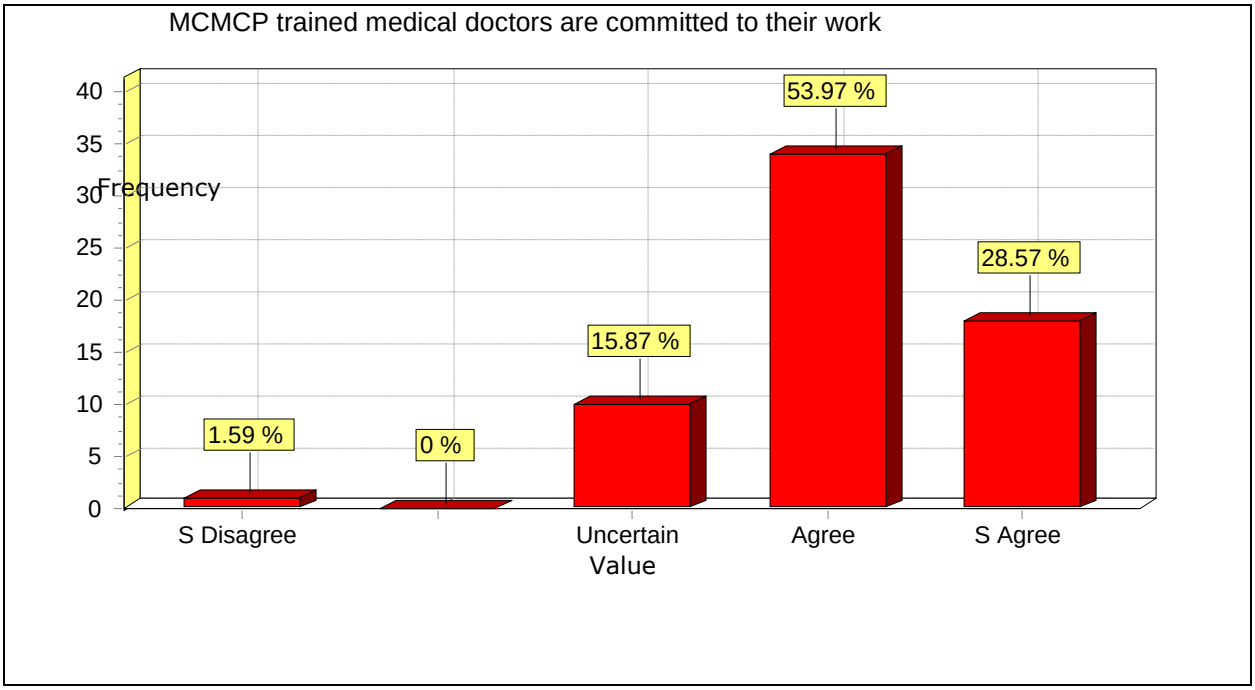

Figure 4.16 MCMCP trained medical doctors are committed to their work

There was an overwhelming majority of the research participants who thought that MCMCP trained medical doctors are committed to their work. This assertion is demonstrated in the above bar graph, Figure 4.16, where 54.0% agreed while 28.6% of respondents strongly agreed with the above statement. Some of the respondents, constituting 15.9%, were not certain if MCMCP trained medical doctors are committed to their work. It was only a small fraction (1.6%) who disagreed with the above assertion.

It was stipulated in Chapter 2, Section 2.10 that the commitment of all role players to deliver services and programmes to all citizens in an effective and efficient manner is one of the core requirements provided in the service charter, adopted by DPSA in 2013 of which health care service delivery cannot be excluded. Both the results of the findings in the graph in Figure 4.16 and Table 4.8 show a positive attitude of respondents towards the level of commitment of MCMCP trained medical doctors towards their profession.

Question 10.4.2 was asked to investigate if MCMCP trained medical doctors are hard workers. The results of the findings are presented in Figure 4.17 below.

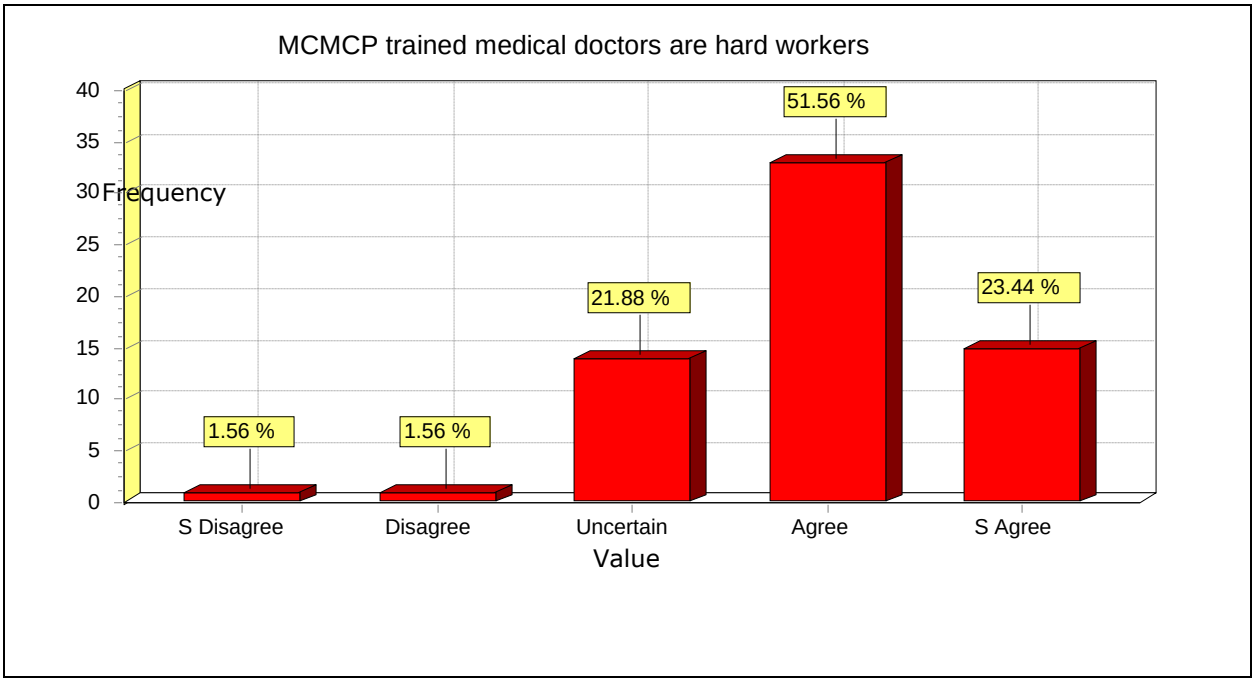

Figure 4.17 MCMCP trained medical doctors are hard workers

The results of the findings presented in Figure 4.17 illustrates that the proportion of respondent who agreed with the statement that MCMCP trained medical doctors are hard workers was 51.6% whereas 23.4% strongly agreed. The percentage of the research participant that had a contrary view to the above was 3.2% and this was shared equally between those who strongly agreed and agreed. The remaining 21.88% of the respondents were uncertain if MCMCP trained medical doctors are hard workers.

Question 10.4.3 sought to find out if MCMCP trained medical doctors work overtime. Here follow the results of the findings in Figure 4.18.

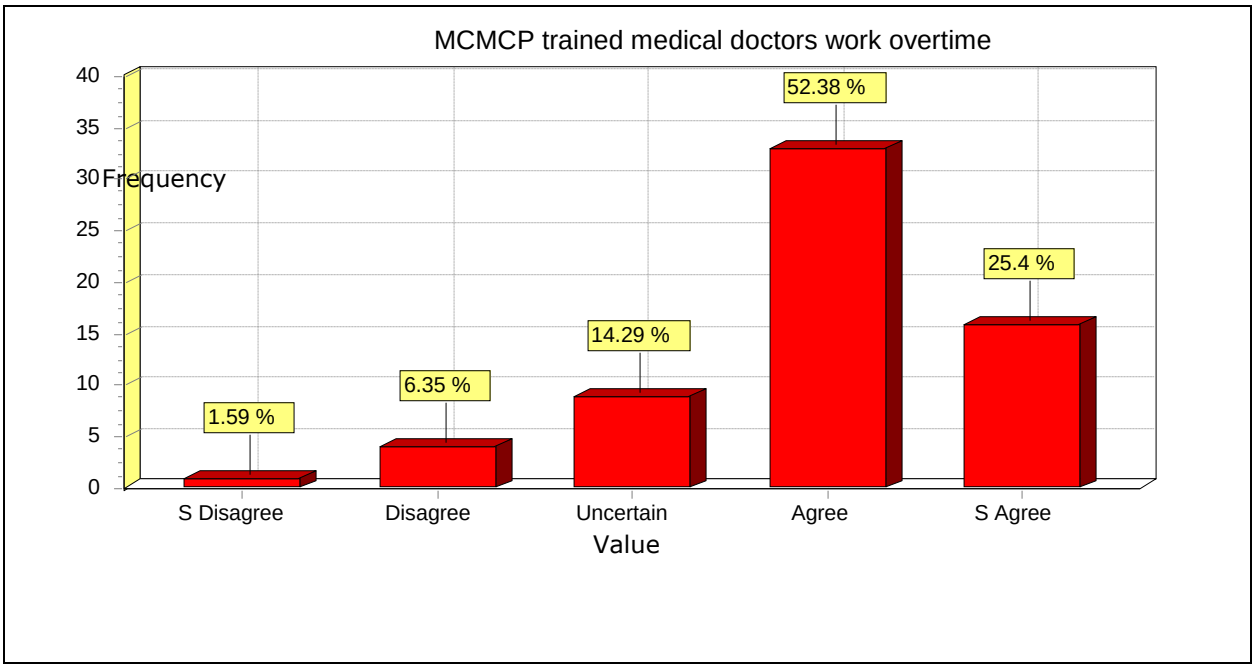

Figure 4.18 MCMCP trained medical doctors work overtime

The majority of respondents, 52.38% of the research participants, agreed that MCMCP trained medical doctors work overtime while 25.4% of respondents strongly agreed with this assertion. The overall proportion of the research participants that did not agree with the above assertion stood at 7.9% whereas 14.3% were uncertain.

Question 10.4.4 was asked to determine if MCMCP trained medical doctors come late to work. The results of the findings are presented in figure 4.19.

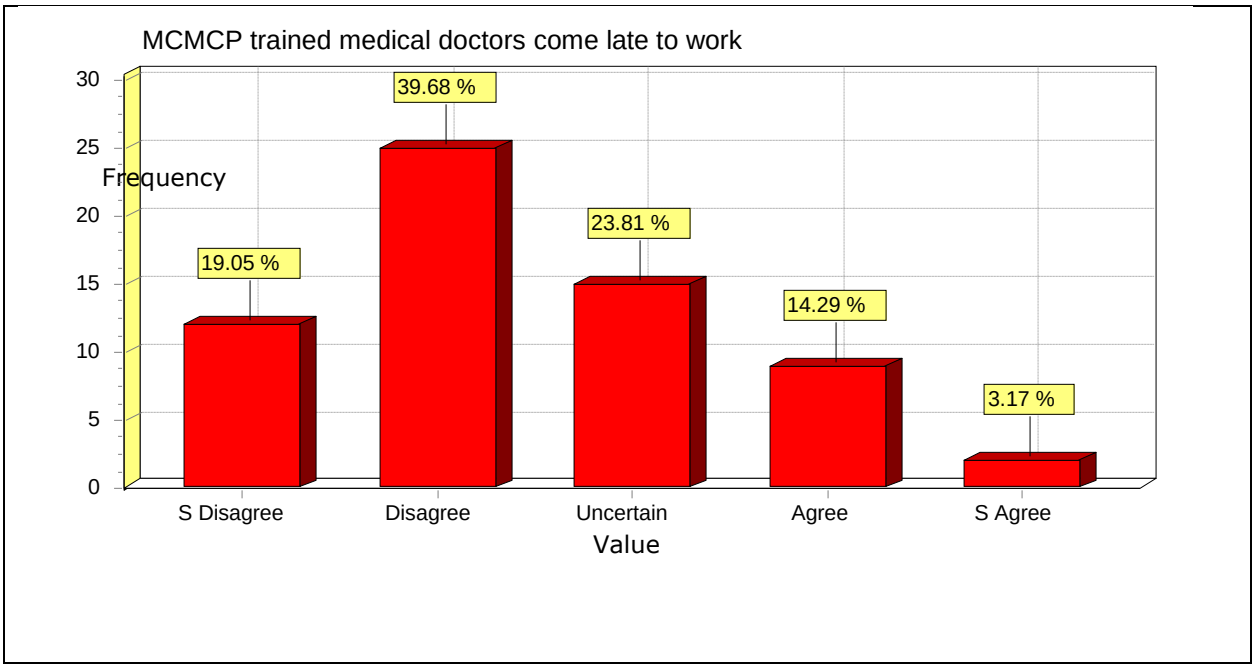

Figure 4.19 MCMCP trained medical doctors come late to work

In Figure 4.19, a combined proportion of respondents constituting 58.8% had either disagreed or strongly disagreed that MCMCP trained medical doctors come late to work. On the contrary, 14.3% agreed that MCMCP trained medical doctors come late to work while 3.17% had strongly agreed with this statement. The remaining 23.8% of the research participants were not certain if MCMCP trained medical doctors come late to work.

Question 10.4.5 was asked to determine if MCMCP trained medical doctors respond late to calls. The findings are presented in Figure 4.20.

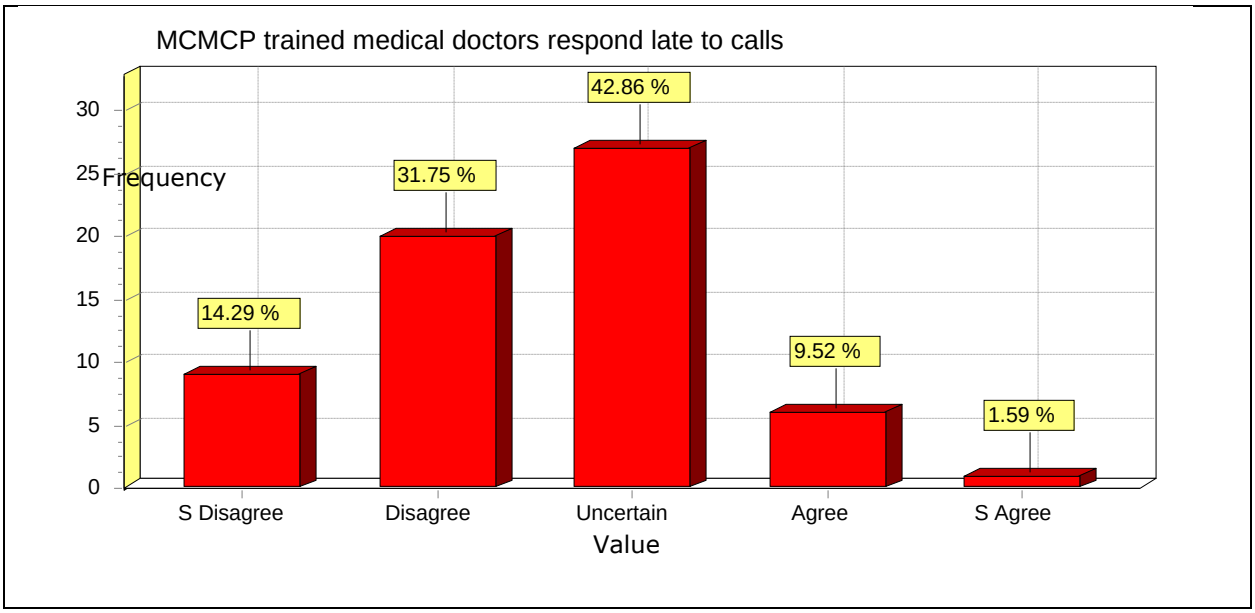

Figure 4.20 MCMCP trained medical doctors respond late to calls

The above bar graph, in Figure 4.20, depicts that the highest percentage of respondents (42.9%) were not certain if MCMCP trained medical doctors respond late to calls. The research participants who opposed the statement that MCMCP trained medical doctors respond late to calls consisted of 31.8% of those who disagreed while 14.29% of respondents strongly disagreed with this statement. In contrast to the above assertion, 9.5% of respondents agreed while 1.6% had strongly disagreed that MCMCP trained medical doctors respond late to calls to attend to patients.

4.4.5 Motivation of MCMCP trained medical doctors

4.4.5.1 Findings about the level of motivation of MCMCP trained medical doctors

The questions from 10.5.1 to 10.5.4 in this section were asked to determine the level of motivation of the MCMCP trained medical doctors. In Table 4.9, the researcher depicts the number, the mean, standard deviation, minimum, maximum, median and missing cases of responses to statements in question 10.5.1 to 10.5.4. The summary of the research participant's responses about the level of motivation of MCMCP trained medical doctors is presented in Table 4.9 below.

Table 4.9 The level of motivation of MCMCP trained medical doctors

Statement in question:	N	Mean	Standard Deviation	Min	Max	Median	Missing Cases
10.5.1 MCMCP trained medical doctors are motivated.	63	3.97	0.76	1	5	4	1
10.5.2 MCMCP trained medical doctors are pessimistic about their role.	63	3.25	1.02	1	5	3	1
10.5.3 MCMCP trained medical doctors are eager and enthusiastic to share their knowledge and skills.	64	3.75	1.02	1	5	4	0
10.5.4 MCMCP trained medical doctors seem to doubt the knowledge they obtained in Cuba.	64	2	0.93	1	5	2	0

Table 4.9 above indicated that the respondents agreed with the statements in question 10.5.1 to 10.5.3 and disagreed with the statement in 10.5.3. The frequency on the number of responses to the above statements and the results of the findings are presented below.

4.4.5.2 Frequencies of responses about the motivation of MCMCP trained medical doctors

Question 10.5.1 was asked to determine if MCMCP trained medical doctors are motivated. The results are presented in Figure 4.21.

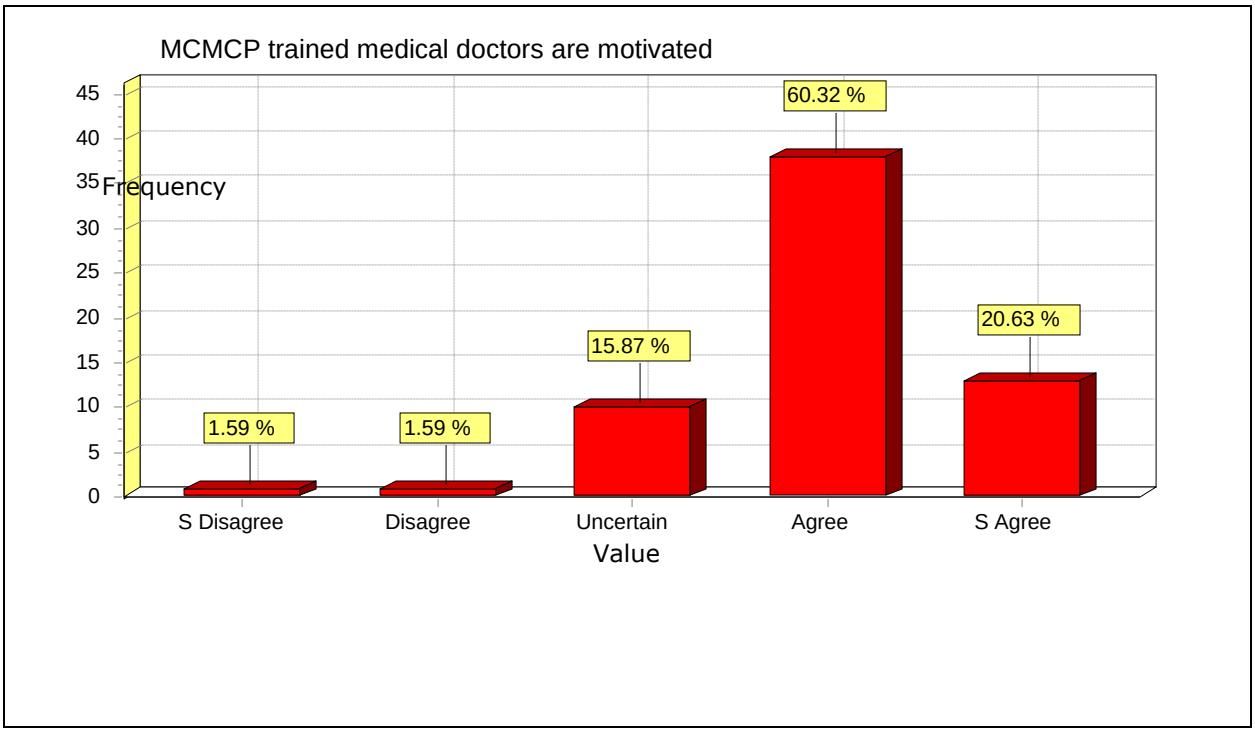

Figure 4.21 MCMCP trained medical doctors are motivated

In Figure 4.21, it was demonstrated that 60.3% of respondents agreed that MCMCP trained medical doctors are motivated while 20.6% of respondents strongly agreed with this statement. A small fraction of 3.2% of respondents either disagreed or strongly disagreed with the above statement while only 15.9% of the research participants were uncertain. In Chapter 2, Section 2.2, it was stated that mere availability of health workers is not sufficient; it is only when they are equitably distributed and are accessible by the population, when they possess the required competency and are motivated and empowered to deliver quality care that is appropriate and acceptable to the sociocultural expectation of the population and when they are adequately supported by the health system.

Question 10.5.2 was asked to determine if MCMCP trained medical doctors are pessimistic about their role. The results of the findings are depicted in Figure 4.22.

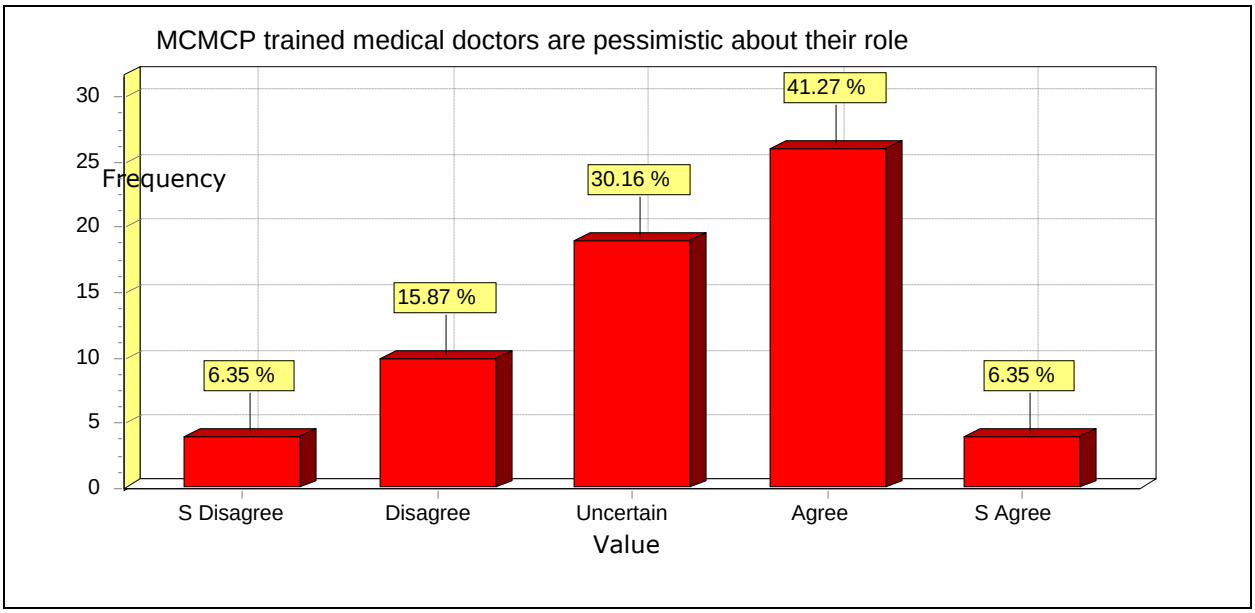

Figure 4.22 MCMCP trained medical doctors are pessimistic about their role

The graph in Figure 4.22 depicts that the highest proportion of respondents of 41.27% agree with the statement that MCMCP trained medical doctors are pessimistic about their role while 6.35% of respondents had strongly agreed with this statement. The next highest proportion of respondents (30.2%) of the research participants were not certain about the above statement. The combination of the respondents that had either disagreed or strongly disagreed with the statement that MCMCP trained medical doctors are pessimistic about their role constituted 22.3% of the total percentage of the research participants.

Question 10.5.3 was asked to determine if MCMCP trained medical doctors are eager and enthusiastic to share their knowledge and skills. The results of the findings are presented in Figure 4.23.

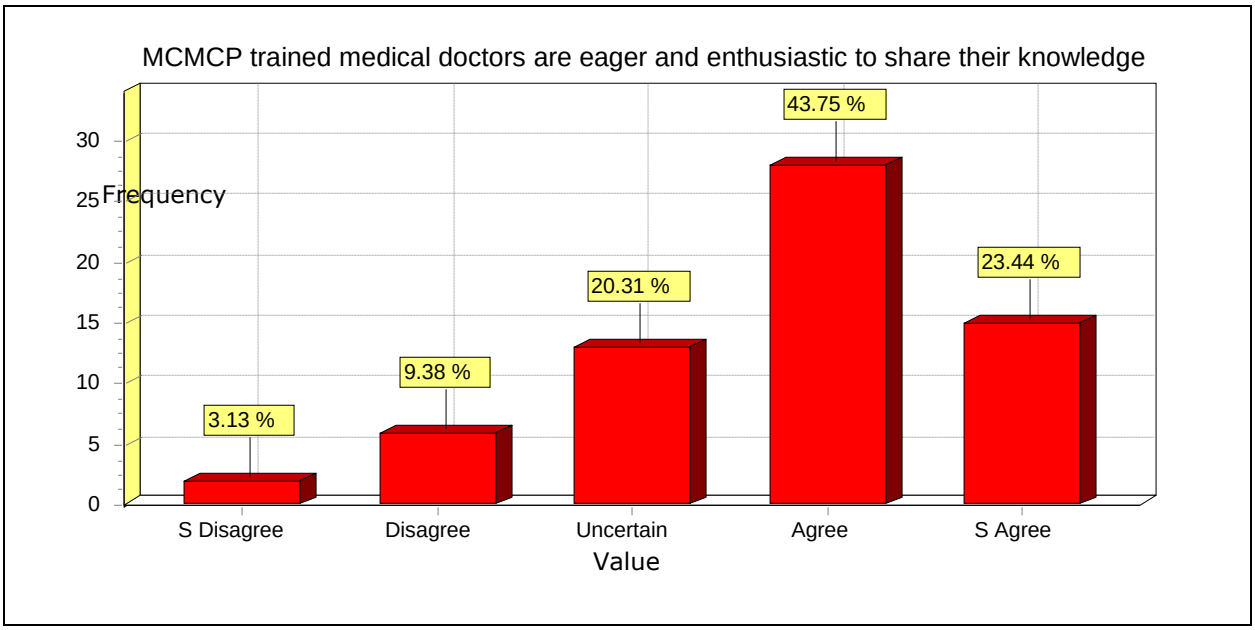

Figure 4.23 MCMCP trained medical doctors are eager and enthusiastic to share their knowledge and skills

The findings in Figure 4.23 depicts that 43.8% of respondents agreed that MCMCP trained medical doctors are eager and enthusiastic to share their knowledge and skills. It was also demonstrated that 23.4% of respondents had strongly agreed with the above statement in Figure 4.23. The above graph also demonstrates that 20.3% of respondents were uncertain whether MCMCP trained medical doctors are eager and enthusiastic to share their knowledge and skills. The percentage of respondents that opposed the above statement was 12.5% of the research participants.

Question 10.5.4 was asked to determine if MCMCP trained medical doctors seem to doubt the knowledge they obtained in Cuba. The results of the findings are presented in Figure 4.24.

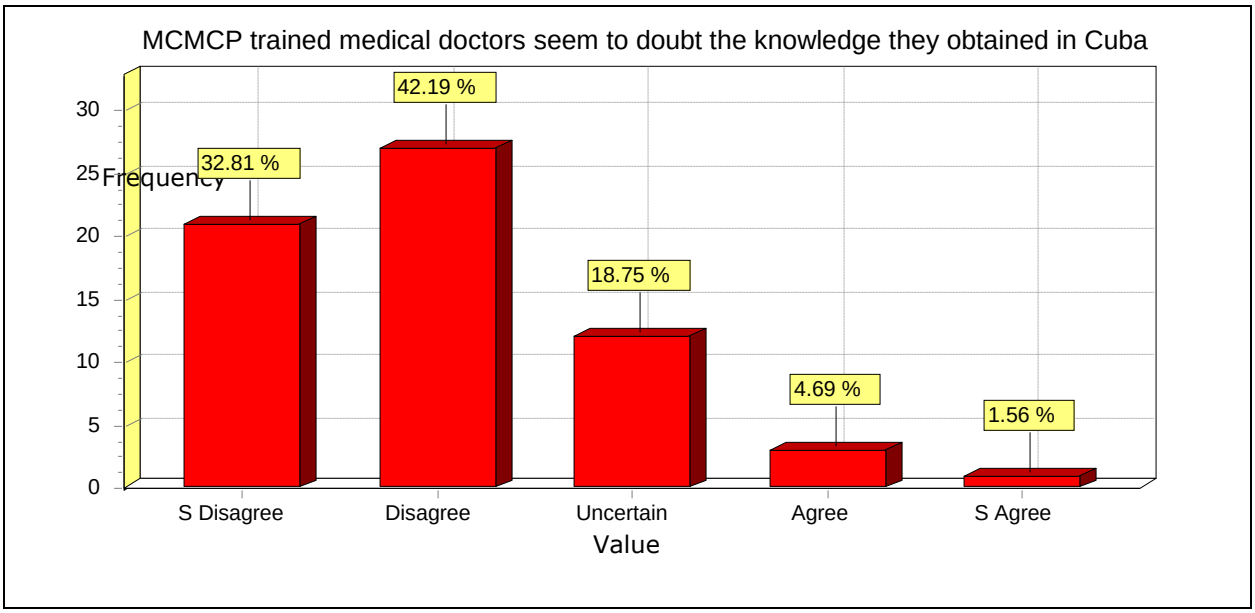

Figure 4.24 MCMCP trained medical doctors seem to doubt the knowledge they obtained in Cuba

The graph in Figure 4.24 depicts that 42.2% of respondents disagreed with the statement that MCMCP trained medical doctors seem to doubt the knowledge they obtained in Cuba while 32.8% strongly disagreed with this statement. The next higher percentage, 18.8% of respondents, demonstrated a degree of uncertainty about the above statement. The combined smallest percentage of respondents that agreed with the above statement constituted 6.3% of the research participants.

4.4.6 Promotion of Primary Health Care

4.4.6.1 Findings on how the MCMCP trained medical doctors promote primary health care

The questions from 10.6.1 to 10.6.4 in this section were asked to determine if the MCMCP trained medical doctors promote primary health care. In Table 4.10, the researcher depicts the number, the mean, standard deviation, minimum, maximum, median and missing cases of responses to statements in question 10.6.1 to10.6.4. Chapter 2, Section 2.5.2. mentioned that according to Van Rensburg (2012:31) primary health care (PHC) is an essential health care service which is based on practical, scientifically sound, and socially acceptable methods, made universally accessible to

individuals and families, and at a cost they can afford. The summary of the research participant's responses about the commitment of MCMCP trained medical doctors is presented in Table 4.10 below.

Table 4.10 Findings on the promotion of primary health care

Statement in question:	N	Mean	Standard Deviation	Min	Max	Median	Missing Cases
10.6.1 MCMCP trained medical doctors promote primary health care.	64	4.05	0.63	3	5	4	0
10.6.2 MCMCP trained medical doctors despise the curative approach.	62	2.4	0.73	1	4	2	2
10.6.3 MCMCP trained medical doctors believe that primary health care is not practical for South African setting.	63	2.14	0.9	1	5	2	1
10.6.4 MCMCP trained medical doctors are always advising the significance of a good lifestyle.	64	3.98	0.86	2	5	4	0

The findings in Table 4.10 above demonstrates that the respondents agreed with the statements 10.6.1 and 10.6.4 while in 10.6.2 and 10.6.3 statements they showed a degree of disagreement. The frequency of the number of responses to the above statements and the results of the findings are presented in the next page.

4.4.6.2 Frequencies on responses about how MCMCP trained medical doctors promote primary health care

The respondents were asked in question 10.6.1 to find out whether MCMCP trained medical doctors promote primary health care. The findings are presented in Figure 4.25.

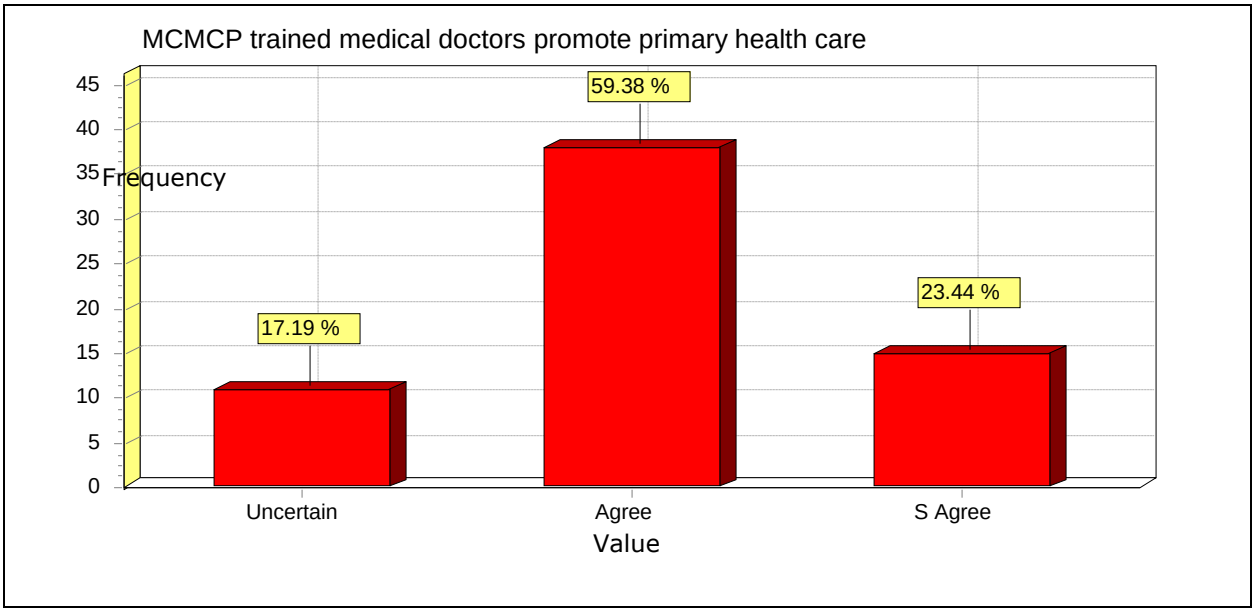

Figure 4.25 MCMCP trained medical doctors promote primary health care

The above graph, in Figure 4.25 demonstrates that 59.4% of respondents agreed while 23.4% strongly agreed that MCMCP trained medical doctors promote primary health care. Only 17.9% of respondents demonstrated a degree of uncertainty towards the above statement while no one agreed or strongly agreed with the above statement. It was stated in Chapter 2, Section 2.12 that MCMCP was conceptualised by both the late President of the RSA, Nelson Mandela and of Cuba, the late Fidel Castro in 1995 as one of the options that could be used to recruit young black South Africans from poor families to study medicine in Cuba with the aim of strengthening primary health care at the district facilities to promote health care service delivery (Parliamentary Monitoring Group, 2013:5).

It was also highlighted in Chapter 2, Section 2.7 that the aim of strengthening primary health care at the district facilities was to improve access to health care services. It was further expressed in Chapter 2, Section 2.5.8 that the NPC (2011:295) further emphasises the provision of primary health care and indicated that health care should be focused on a more decentralised, area-based, people-centered approach of the district health system.

The respondents were asked in question 10.6.2 to determine whether MCMCP trained medical doctors despise the curative approach. The results of the findings are depicted in Figure 4.26.

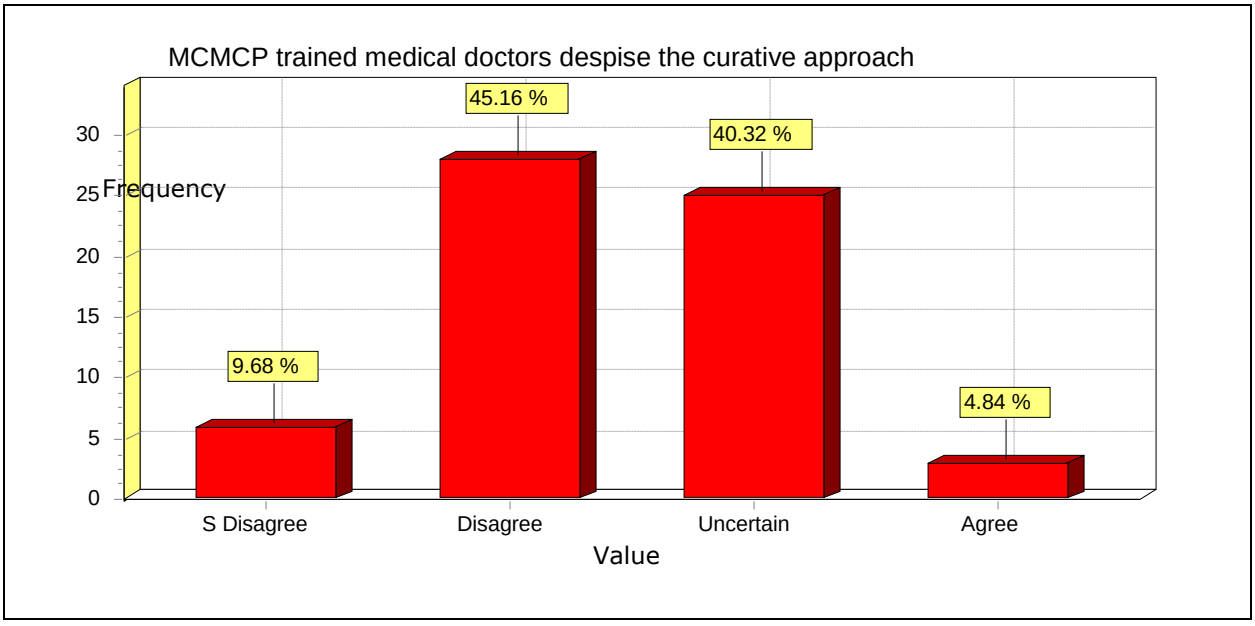

Figure 4.26 MCMCP trained medical doctors despise the curative approach

In Figure 4.26, the highest proportion of respondents constituting 45.2% of the research participants disagreed with the statement that indicates that MCMCP trained medical doctors despise the curative approach. The above graph also indicates that 40.3% of respondents were uncertain whether MCMCP trained medical doctors despise the curative approach. The findings depicted in Figure 4.26 further reveal that 9.7% of respondents had strongly disagreed with the above statement while 4.8% agreed with it.

Chapter 2, Section 2.7 reveals that the purpose of district health services is to provide a comprehensive, integrated and sustainable health care service that is preventive, promotive,

curative and rehabilitative based on re-engineering the primary health care approach through the district health system (NCDoH, 2013:67).

In question 10.6.3, the respondents were asked to determine if MCMCP trained medical doctors believe that primary health care is not practical for the South African setting. The results of the findings are presented in Figure 4.27.

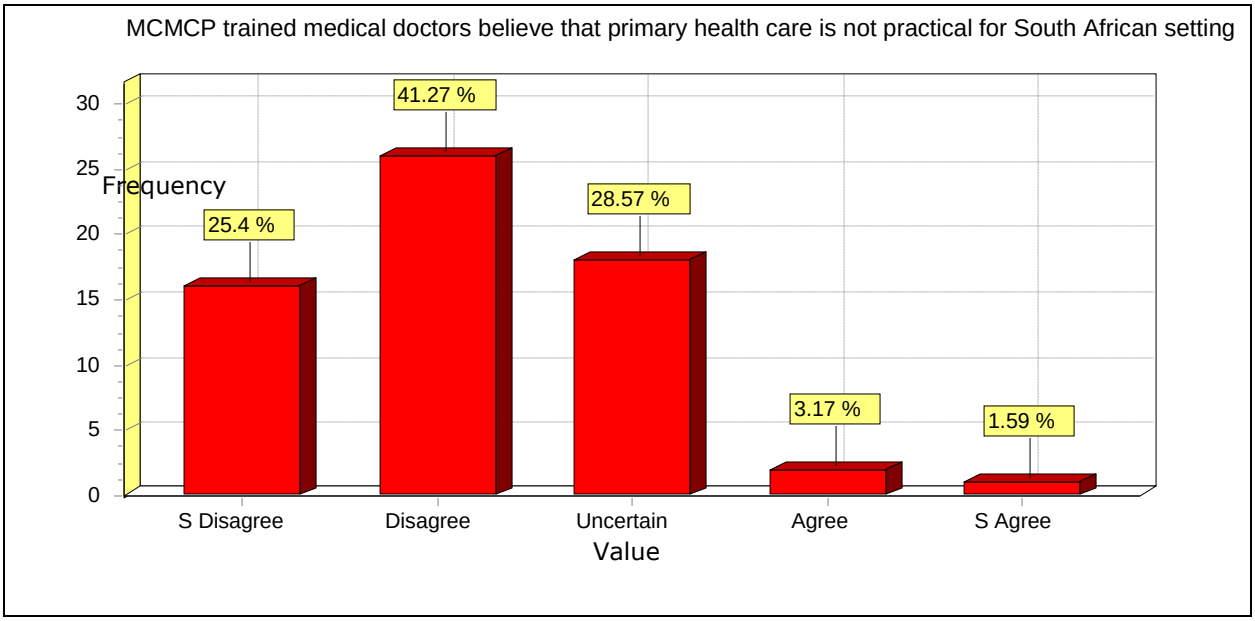

Figure 4.27 MCMCP trained medical doctors believe that primary health care is not practical for South African setting

The results of the findings in Figure 4.27 shows that 41.3% of respondents disagreed with the statement that MCMCP trained medical doctors believe that primary health care is not practical for the South African setting. The findings in the above graph also indicate that 28.6% of respondents were uncertain while 25.4% of respondents disagreed with the statement that MCMCP trained medical doctors believe that primary health care is not practical for the South African setting. The total proportion of respondents who agreed and strongly agreed was 4.8% of the total percentage of the research participants.

In question 10.6.4, MCMCP trained medical doctors are always advising the significance of a good lifestyle. The findings of the results are depicted in Figure 4.28.

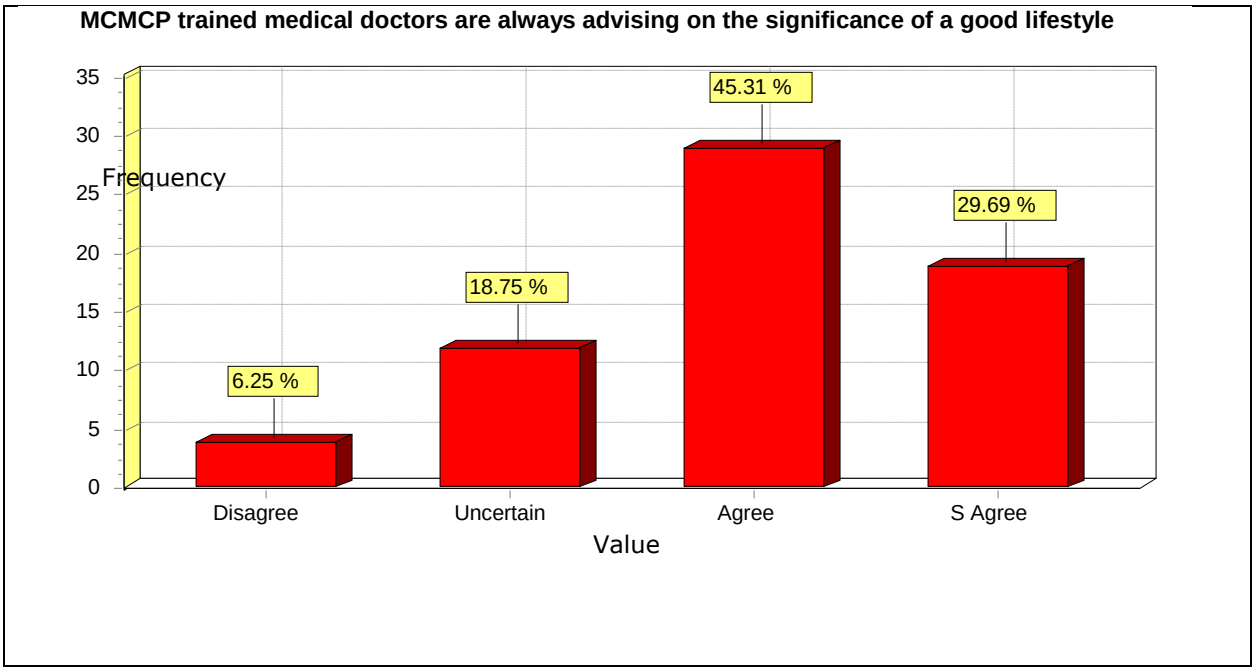

Figure 4.28 MCMCP trained medical doctors are always advising on the significance of a good lifestyle

The above graph in Figure 4.28 illustrates that 45.3% of respondents agreed with the statement that MCMCP trained medical doctors are always advising on the significance of a good lifestyle while 29.7% of the research participants strongly agreed with this statement. The other category of respondents that constituted 18.8% of the research participants were uncertain whereas 6.3% disagreed with the statement that MCMCP trained medical doctors are always advising on the significance of a good lifestyle. It was stated in Chapter 2, Section 2.5.4 that a healthy lifestyle is one of the provisions included in Section 25 (1) of the NHA, 2003.

The conclusion that can be drawn from the above quantitative analysis is that the majority of health professionals who completed the structured questionnaire believe that MCMCP trained medical doctors are mindful of the significance of a healthy lifestyle.

4.4.7 Primary Health Care versus Curative

4.4.7.1 Findings on primary health care versus curative care

The questions from 10.7.1 to 10.7.4 in this section were asked to determine how the MCMCP trained medical doctors are able to practice primary health care against curative care. In Table 4.11, the researcher depicts the number, the mean, standard deviation, minimum, maximum, median and missing cases of responses to statements in question 10.7.1 to10.7.4. The summary of the research participant's responses about primary health care versus curative care is presented in Table 4.11 below.

Table 4.11 Primary health care versus curative care

Statement in question:	N	Mean	Standard Deviation	Min	Max	Median	Missing Cases
10.7.1 MCMCP trained medical doctors are able to blend and implement both preventative and curative models successfully.	64	3.89	0.8	1	5	4	0
10.7.2 MCMCP trained medical doctors' show less interest on preventative approaches.	62	2.27	0.94	1	5	2	2
10.7.3 There are no observable differences between locally trained and MCMCP trained medical doctors at the level of their approaches around their practice.	63	3.13	1.07	1	5	3	1
10.7.4 MCMCP trained medical doctors believe that they are not provided space to practice	64	2.48	0.8	1	4	3	0

preventative primary health care.							

The findings as indicated in Table 4.11 above showed that the respondents agreed with the statement in question 10.7.1 while they disagreed with the statement in 10.7.2. While the statement in question 10.7.4 shows that the respondents were uncertain about this statement, the response of the research participants to the statement in 10.7.3 was skewed towards the degree of agreement.

The frequency on the number of responses to the above statements and the results of the findings are presented below.

4.4.7.2 Frequencies about how primary health care versus curative care

In question 10.7.1, the respondents were asked to indicate if MCMCP trained medical doctors are able to blend and implement both preventative and curative models successfully. The results of the findings are presented in Figure 4.29.

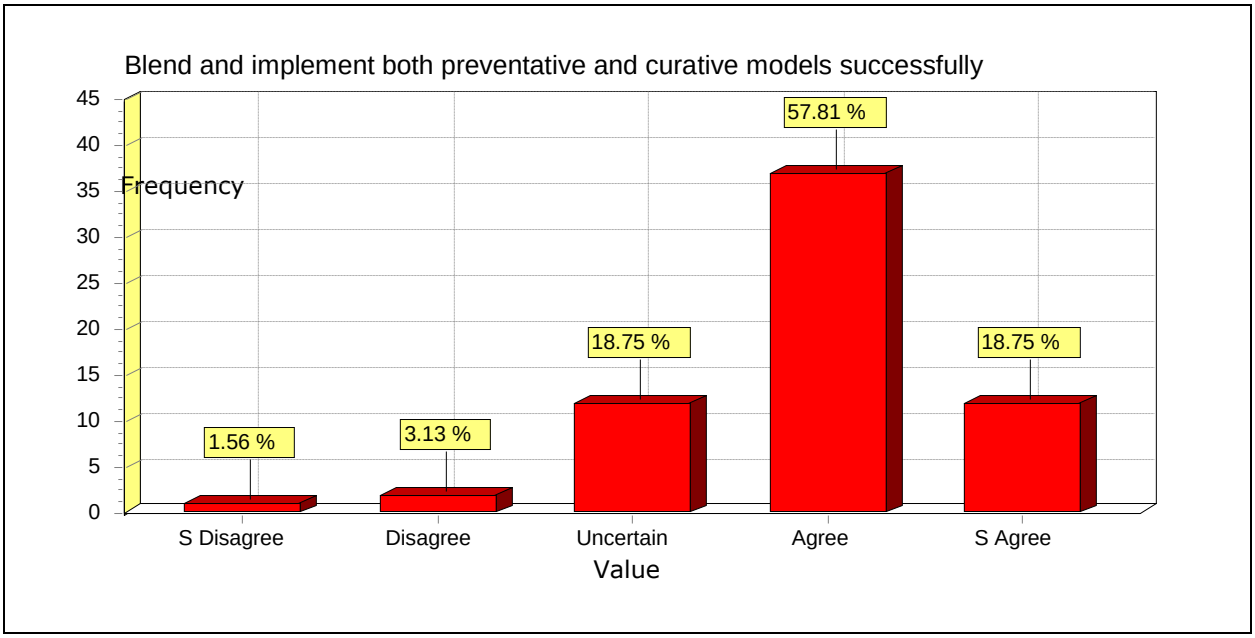

Figure 4.29 MCMCP trained medical doctors are able to blend and implement both preventative and curative models successfully

According to the results of the findings presented in Figure 4.29, 57.8% of respondents agreed that MCMCP trained medical doctors are able to blend and implement both preventative and curative models successfully while 18.8% of the research participants agreed with this statement.
Contrary to this, a small proportion of respondents made of 4.7% of the research participants had either disagreed or strongly disagreed with this statement. Those who were uncertain about the above statement constituted 18.8% of the research participants. Chapter 2, Section 2.7 articulated that the purpose of district health services is to provide comprehensive, integrated and sustainable health care services that are preventive, promotive, curative and rehabilitative based on the re-engineering of the primary health care approach through the district health system (NCDoH, 2013:67).

In question 10.7.2, the respondents were asked to indicate if MCMCP trained medical doctors' show less interest in preventative approaches. The results of the findings are presented in Figure 4.30.

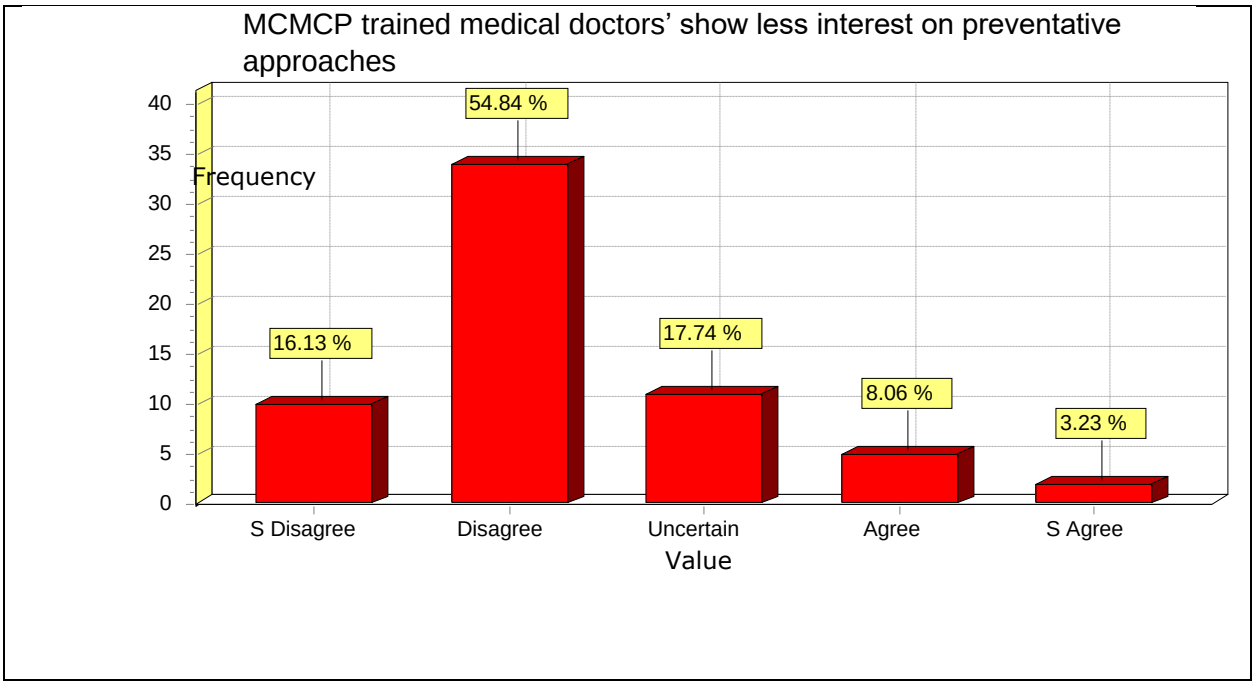

Figure 4.30 MCMCP trained medical doctors' show less interest on preventative approaches

The above graph shows that 54.8% of the respondents disagreed while 16.3% strongly disagreed with the statement that MCMCP trained medical doctors show less interest in preventative

approaches. The graph also depicts that 17.7% of respondents were uncertain while a combination of those who agreed and strongly agreed was 11.3% of the research participants. Chapter 2, Section 2.4 expressed that preventive health care at community level through the comprehensive ward-based primary health care outreach teams is significant. It was also stated in Chapter 2, Section 2.12.2 that the major advantage of the MCMCP from the South African government perspective is that the Cuban medical curriculum is explicitly primary health care oriented. South Africa's national health planning is predicated on the centrality of a primary, district based health care system. It was further expressed in Chapter 2, Section 2.12.2 that Dr Ayanda Ntsaluba, Director General of Health when the RSA-Cuban agreement was signed over a decade ago, notes that South African policy makers were also attracted to the Cuban emphasis on prevention, primary care and the bio-psycho-social approach that views patients holistically (Reed and Torres, 2008:50).

In question 10.7.3, the respondents were asked to indicate if there are any observable differences between locally trained and MCMCP trained medical doctors in their approaches to their practice. The results of the findings are presented in Figure 4.31.

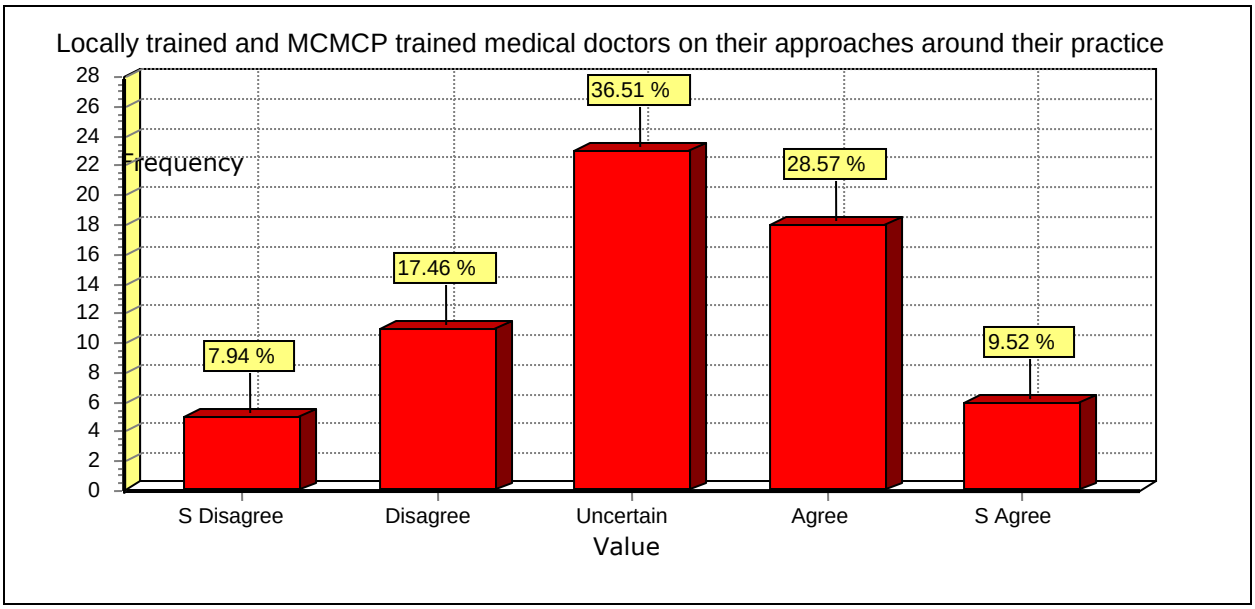

Figure 4.31: There are no observable differences between locally trained and MCMCP trained medical doctors on their approaches around their practice

The above graph in Figure 4.31 demonstrates that the highest proportion of respondents, 36.5% of the research participants, were uncertain about the statement that there are no observable differences between locally trained and MCMCP trained medical doctors on their approaches around their practice. It was only 9.5% of respondents that strongly agreed while 28.6% agreed with the above statement. The graph, in Figure 4.31 also demonstrates that 17.5% of the respondents disagreed while 7.9% of the respondents strongly disagreed with the above statement. Chapter 2, Section 2.6.4 stated that the culture of how students are taught and assessed in Cuba also differs substantially from South Africa. In question10.7.4, MCMCP trained medical doctors believe that they are not provided space to practice preventative primary health care. The results of the findings are presented in Figure 4.32.

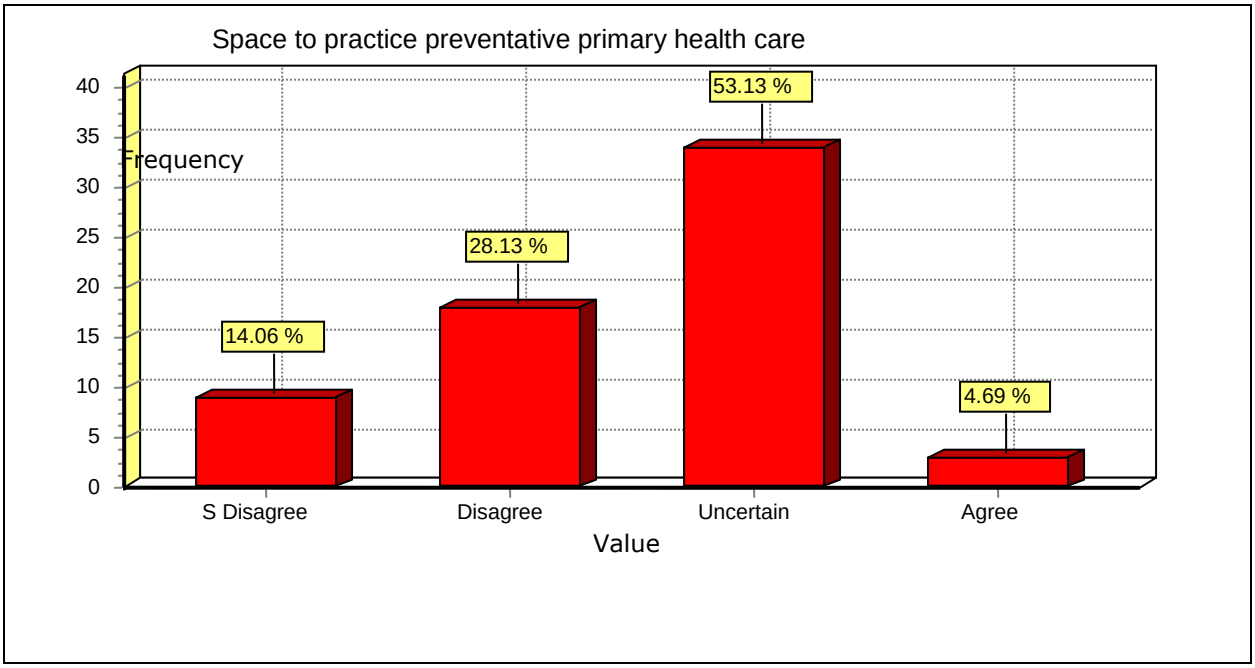

Figure 4.32 MCMCP trained medical doctors believe that they are not provided space to practice preventative primary health care

The above graph, in Figure 4.32 illustrates that 53.1% of the respondents were not certain whether MCMCP trained medical doctors believe that they are not provided space to practice preventative primary health care. The graph also indicates that 28.1% of the respondents disagreed whereas 14.1% of the respondents strongly disagreed with the above statement. It was only 4.7% of the

respondents that agreed that MCMCP trained medical doctors believe that they are not provided space to practice preventative primary health care.

It can be deduced from these findings that most of the South African doctors trained in Cuba are doubtful whether they are afforded the opportunity by the South African government to practice preventative primary health care.

4.4.8 Leadership of MCMCP trained medical doctors

4.4.8.1 Findings on the leadership of MCMCP trained medical doctors

The questions from 10.8.1 to 10.8.4 in this section were asked to determine how the MCMCP trained medical doctors are able to demonstrate leadership. In Table 4.12, the researcher depicts the number, the mean, standard deviation, minimum, maximum, median and missing cases of responses to statements in question 10.8.1 to 10.8.4. The summary of the research participant's responses about the commitment of MCMCP trained medical doctors is presented in Table 4.12 below.

Table 4.12 Leadership of MCMCP trained medical doctors

Statement in question:	N	Mean	Standard Deviation	Min	Max	Median	Missing Cases
10.8.1 MCMCP trained medical doctors are good leaders.	64	3.84	0.86	1	5	4	0
10.8.2 MCMCP trained medical doctors are self-driven.	63	3.92	0.79	1	5	4	1
10.8.3 MCMCP trained medical doctors are not proactive.	63	2.32	0.86	1	4	2	1
10.8.4 RSA-Cuban doctors always wait for their South	64	2.06	0.92	1	4	2	0

African locally trained counterparts to take decisions on their behalf.							

The findings in Table 4.12 depict that the research participants agreed with the statements in question 10.8.1 and 10.8.2. On the contrary, they disagreed with the statements in questions 10.8.3 and 10.8.4. The frequency on the number of responses to the above statements and the results of the findings are presented below.

4.4.8.2 Frequencies on the leadership of MCMCP trained medical doctors

In question 10.8.1, the respondents were asked to determine if MCMCP trained medical doctors are good leaders. The findings are presented in Figure 4.33.

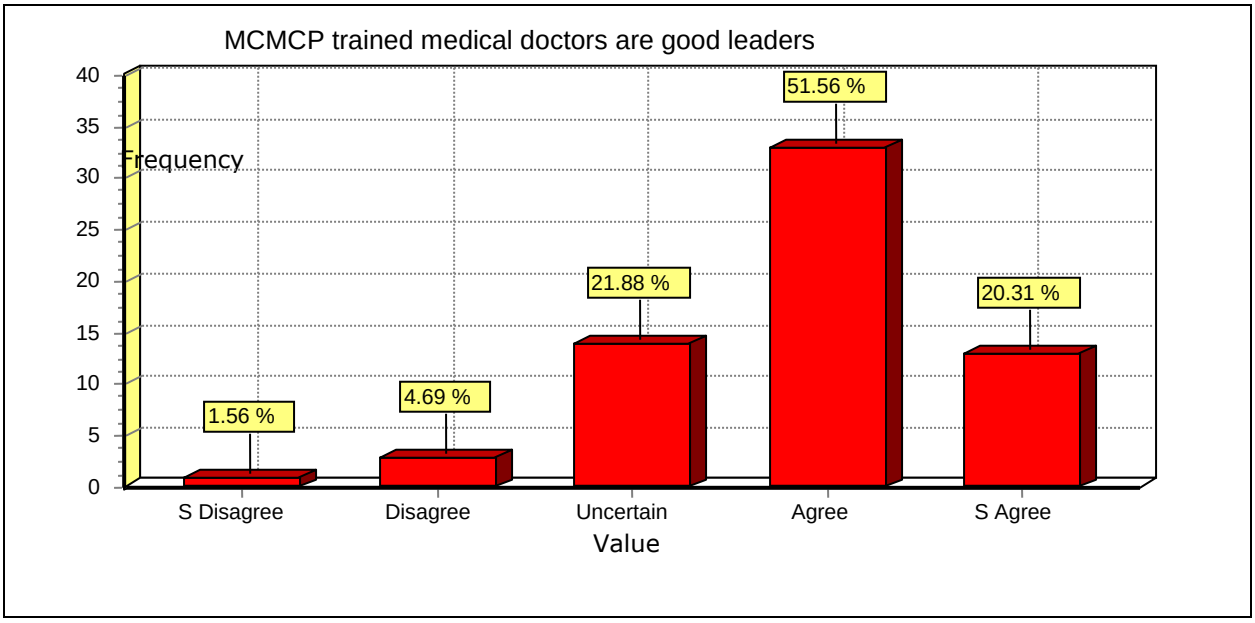

Figure 4.33 MCMCP trained medical doctors are good leaders

The results of the investigation, in Figure 4.33 indicate that 51.6% of the respondents agreed whereas 20.3% strongly agreed that MCMCP trained medical doctors are good leaders. It was also shown that 21.9% were not certain about the above statement. A combined small fraction of those who had disagreed and strongly disagreed made the sum total of 6.3% of the research participants.

In question 10.8.2, the respondents were asked to indicate if MCMCP trained medical doctors are self-driven. The results of the findings are presented in Figure 4.34.

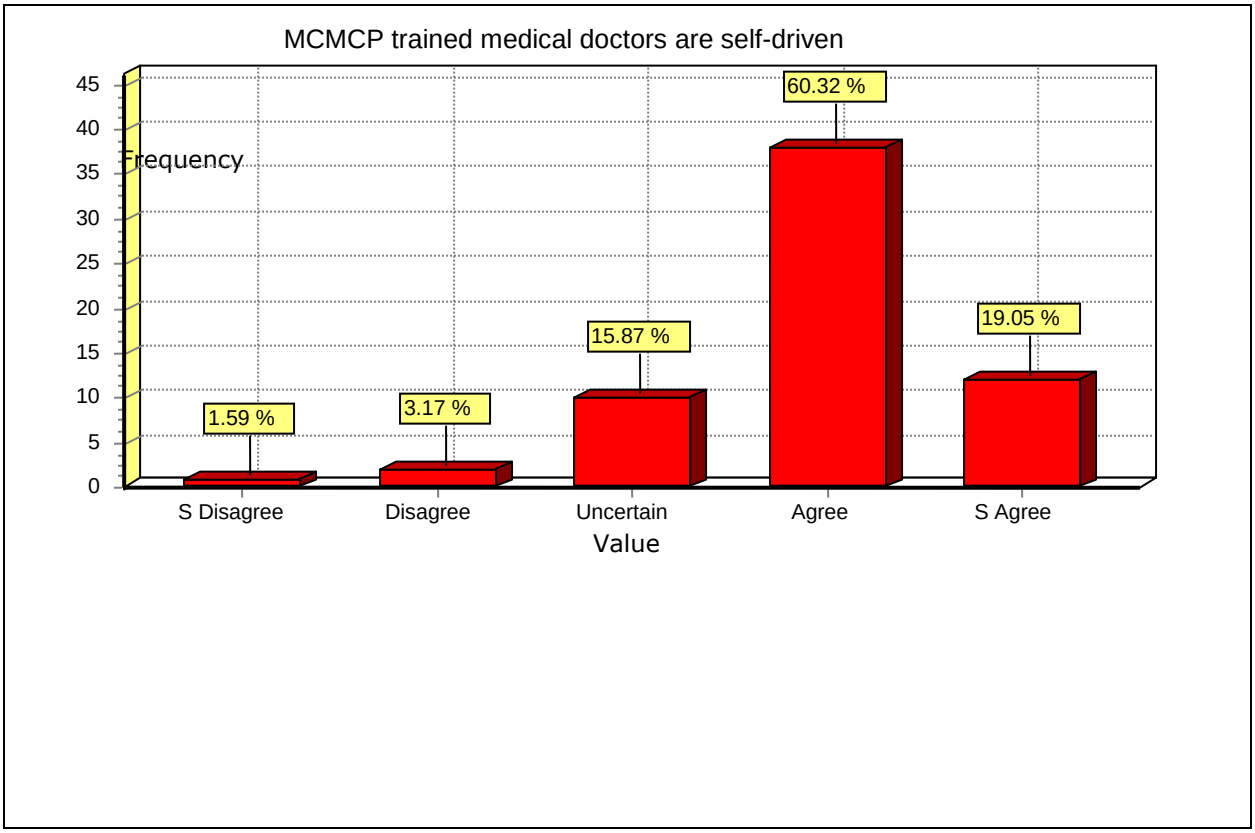

Figure 4.34 MCMCP trained medical doctors are self-driven

The above graph in Figure 4.34 demonstrates that there was an overwhelming affirmation of 79.4% between the respondents who agreed and strongly agreed that MCMCP trained medical doctors are self-driven. It was only 4.8% of the respondents that disagreed with the above statement. The remaining fraction of 15.9% of the respondents were uncertain if MCMCP trained medical doctors are self-driven.

In question 10.8.3 the respondents were asked to indicate if MCMCP trained medical doctors are not proactive. The results of the findings are presented in Figure 4.35.

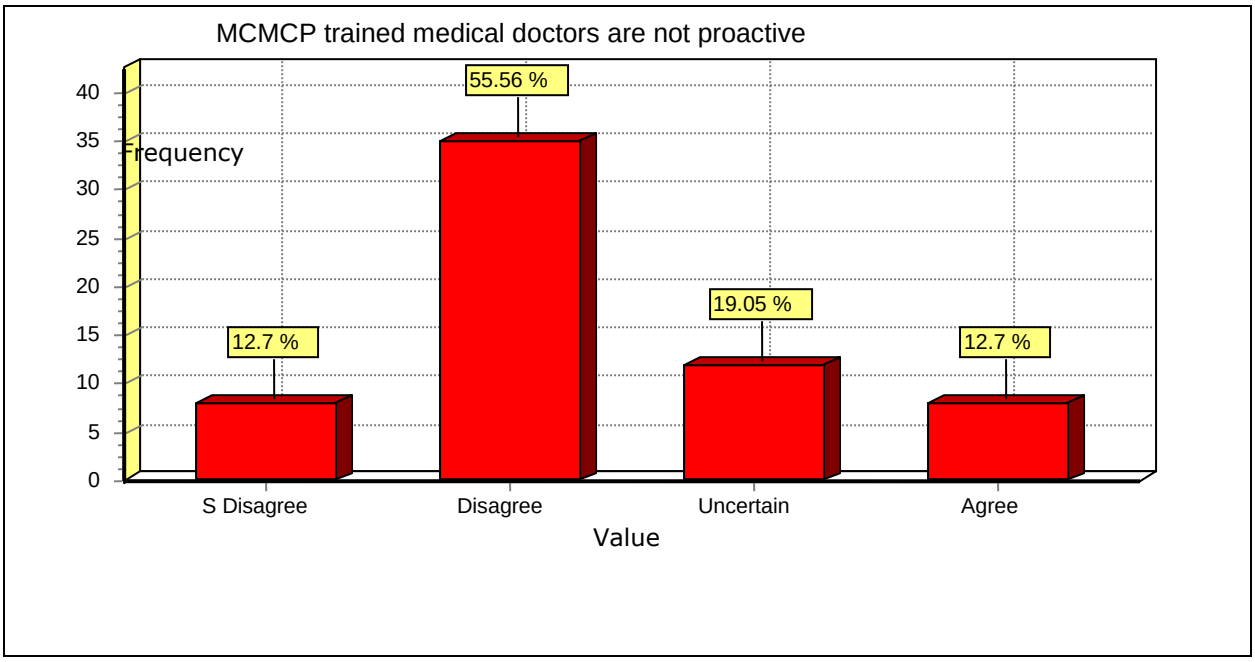

Figure 4.35 MCMCP trained medical doctors are not proactive

The graph in Figure 4.35 demonstrates that 55.6% disagreed while 12.7% strongly disagreed with the statement that MCMCP trained medical doctors are not proactive. While none of the respondents strongly agreed, it was demonstrated that 12.7% agreed whereas 19.1% of the respondents were uncertain if MCMCP trained medical doctors are not proactive.

In question 10.8.4, the respondents were asked to indicate if MCMCP trained medical doctors always wait for their South African locally trained counterparts to take decisions on their behalf. The results of the findings are presented in Figure 4.36.

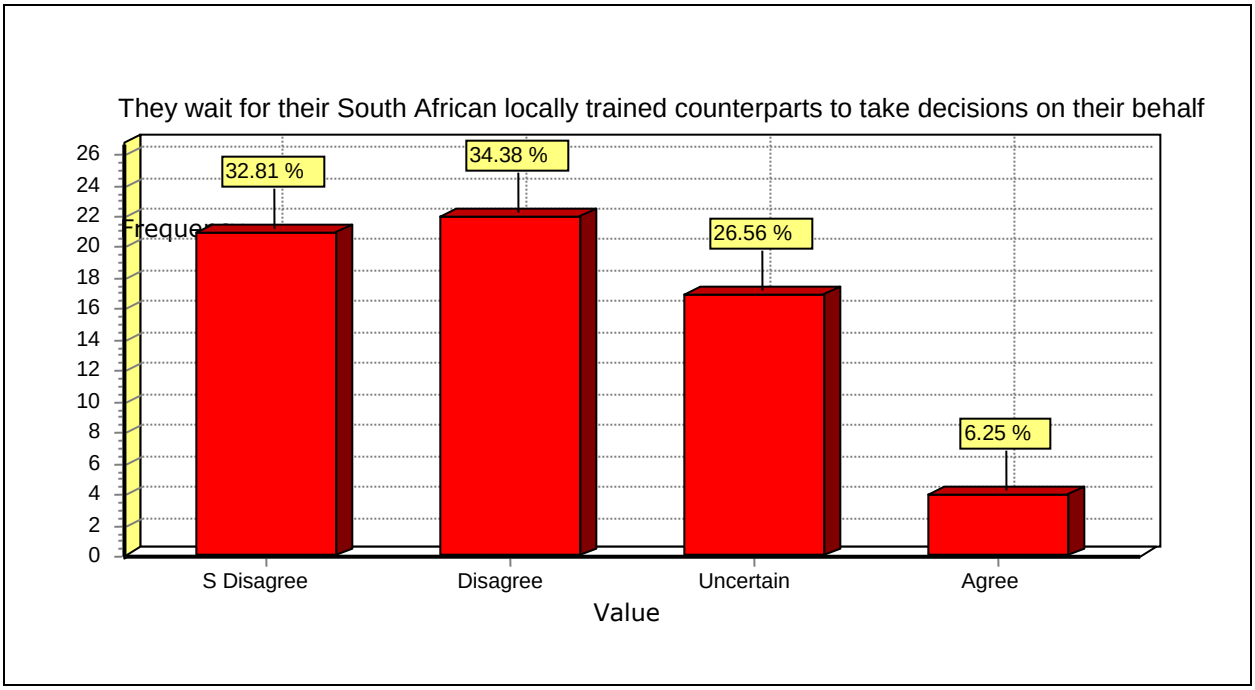

Figure 4.36 MCMCP trained medical doctors always wait for their South African locally trained counterparts to take decisions on their behalf

In Figure 4.36, it was demonstrated that there is a small margin of difference between the respondents who disagreed and those who strongly disagreed with a response rate of 34.4% and 32.8% respectively on the above statement. None of the respondents had strongly agreed while 26.6% remained uncertain whether MCMCP trained medical doctors always wait for their South African locally trained counterparts to take decisions on their behalf.

4.4.9 Prejudice towards MCMCP trained medical doctors

4.4.9.1 Findings about the level of prejudice towards MCMCP trained medical doctors

The questions from 10.9.1 to 10.9.4 in this section were asked to determine the level of prejudice towards the MCMCP trained medical doctors. In Table 4.13, the researcher depicts the number, the mean, standard deviation, minimum, maximum, median and missing cases of responses to statements in question 10.9.1 to10.9.4. The summary of the research participants on prejudice towards the MCMCP trained medical doctors is presented in Table 4.13 on page 143.

Table 4.13 The level of prejudice towards MCMCP trained medical doctors

Statement in question:	N	Mean	Standard Deviation	Min	Max	Median	Missing Cases
10.9.1 Locally trained South African health professionals treat MCMCP trained medical doctors with contempt.	62	3.11	0.75	1	5	3	2
10.9.2 MCMCP trained medical doctors are referred to as 'Cubans' by their locally trained South African counterparts.	64	2.56	1.01	1	5	3	0
10.9.3 Locally trained South African health profession looks down upon the Cuban health system.	64	2.53	1.08	1	5	2	0
10.9.4 Locally trained South African health professional respect the Cuban health system.	63	3.24	0.89	1	5	3	1

Table 4.13 above indicate that the respondents showed a degree of uncertainty towards the statements in question 10.9.1 10.9.2 while they disagreed with the statement in 10.9.3. While there was a high degree of uncertainty towards the statement in 10.9.4, there were a considerable number of respondents that agreed with this statement.

The frequency of the research participants' responses in terms of the degree of agreement or disagreement on the Summated scale to the above statements and the results of the findings are presented on page 144.

4.4.9.2 Frequencies about the level of prejudice towards the MCMCP trained medical doctors

In question 10.9.1, the respondents were asked to indicate if locally trained South African health professionals treat MCMCP trained medical doctors with contempt. The results of the findings are presented in Figure 4.37.

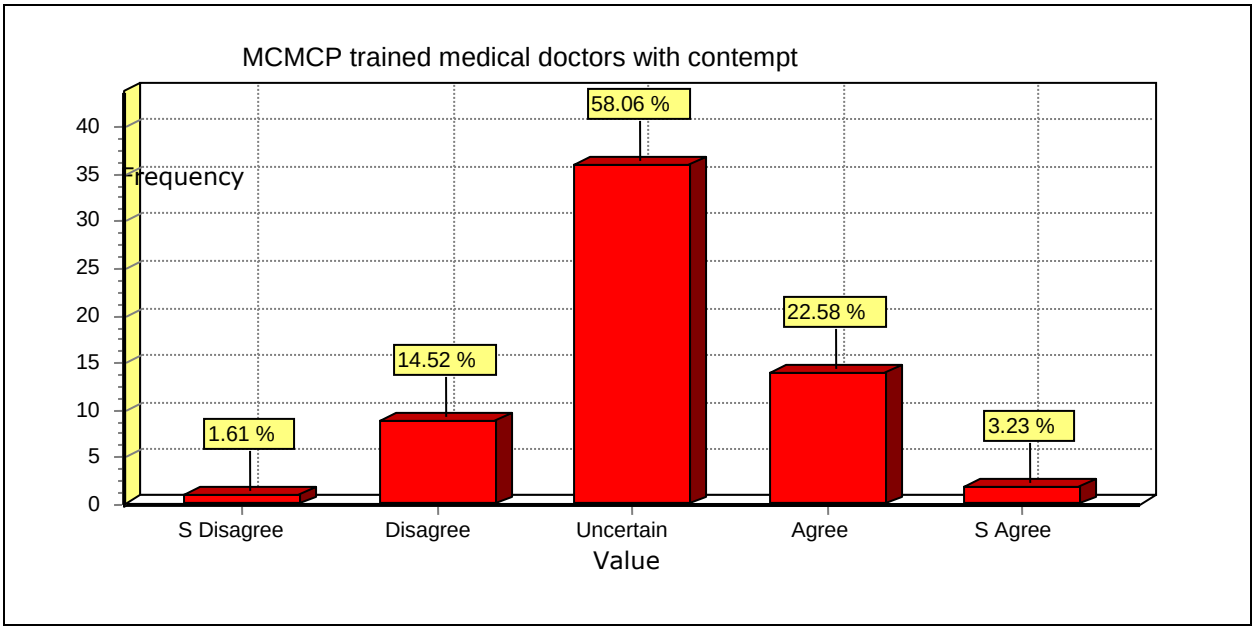

Figure 4.37 Locally trained South African health professionals treat MCMCP trained medical doctors with contempt

The findings of the investigation in Figure 4.37 demonstrates that the highest proportion of the respondents, 58.1%, were uncertain if locally trained South African health professionals treat MCMCP trained medical doctors with contempt. There was, however, a category of respondents who either agreed or strongly agreed with a response rate of 22.6% and 3.2% respectively towards the above statement. On the contrary, 14.5% disagreed while 1.6% strongly disagreed with the statement that locally trained South African health professionals treat MCMCP trained medical doctors with contempt.

In question 10.9.2, the respondents were asked to indicate if MCMCP trained medical doctors are referred to as 'Cubans' by their locally trained South African counterparts. The results of the findings are presented in Figure 4.38.

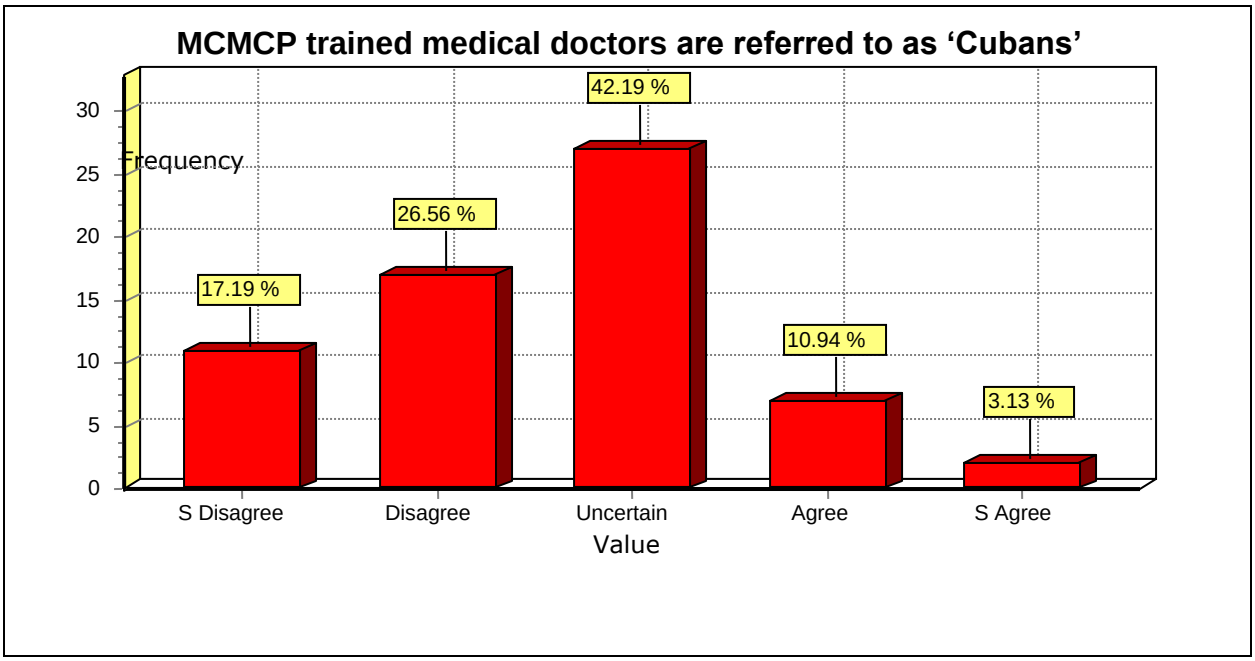

Figure 4.38 MCMCP trained medical doctors are referred to as 'Cubans' by their locally trained South African counterparts

The above graph in Figure 4.38 indicates that 42.2% of respondents were uncertain if MCMCP trained medical doctors are referred to as 'Cubans' by their locally trained South African counterparts. The graph also shows that 26.6% disagreed while 17.2% strongly disagreed with the above statement. The total sum of the respondents that agreed and strongly agreed that MCMCP trained medical doctors are referred to as 'Cubans' by their locally trained South African counterparts was 14.0% of the research participants. In Chapter 2, Section 2.12.4, it was expressed that an identity crisis can be seen as one of the factors that affect studies of MCMCP students. It was mentioned that in Cuba, they are identified as Africans whereas in South Africa they are identified as Cuban students. This situation leads to them feeling rejected and discriminated against by both South Africans and Cubans.

In question 10.9.3, the respondents were asked to indicate if locally trained South African health professionals look down on the Cuban health system. The results of the findings are presented in Figure 4.39.

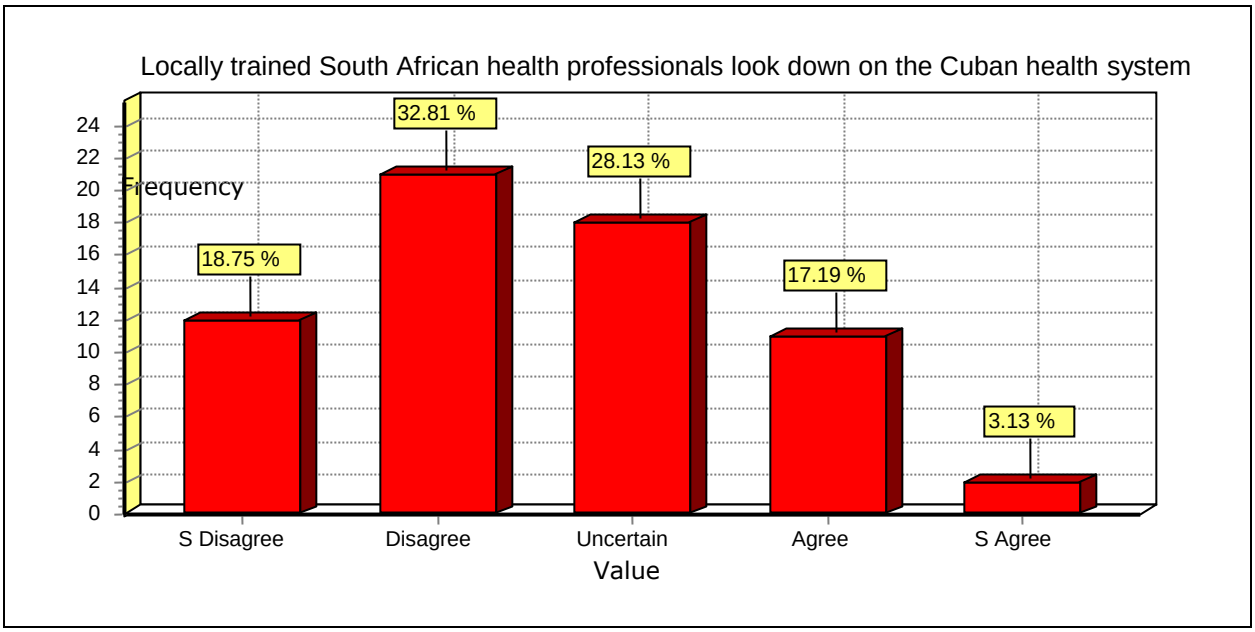

Figure 4.39 Locally trained South African health professionals look down upon the Cuban health system

The findings in Figure 4.39 illustrates that 32.8% of the respondents disagreed while 18.8% strongly disagreed that locally trained South African health professionals look down on the Cuban health system. The results of the investigation also indicate that 28.1% were uncertain while a combined response rate of those who agreed and strongly agreed was 20.3% of the research participants.

In question 10.9.4, locally trained health professionals respect the Cuban health system. The results of the findings are presented in Figure 4.40.

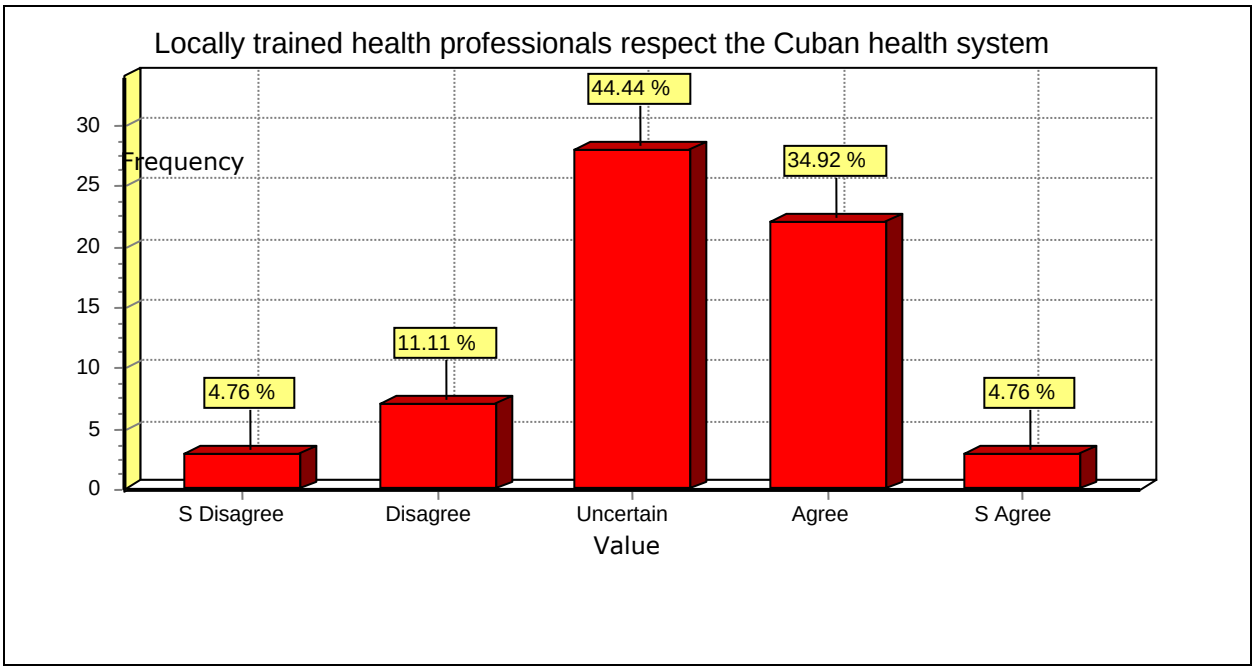

Figure 4.40 Locally trained health professionals respect the Cuban health system

In Figure 4.40, the findings of the investigation demonstrate that 44.4% of the respondents were uncertain if locally trained health professionals respect the Cuban health system. The above graph also shows that 34.9% of the respondents agreed while a small fraction of 4.8% of the respondents strongly agreed with the above statement. It was also shown that a combined response rate of those who agreed and strongly disagreed was 15.9% of the research participants.

4.4.10 Inclination to practice in the rural areas

4.4.10.1 Findings on the inclination of MCMCP trained medical doctors to practice in the rural areas

The questions from 10.10.1 to 10.10.4 in this section were asked to determine whether MCMCP trained medical doctors are inclined to practice medicine in rural areas. The summary about the inclination of MCMCP trained medical doctors to practice medicine in rural areas is presented in Table 4.14 below.

Table 4.14 The MCMCP trained medical doctors' inclination to practice in rural areas

Statement in question:	N	Mean	Standard Deviation	Min	Max	Median	Missing Cases
10.10.1 MCMCP trained medical doctors prefer practicing in the rural areas.	64	3.28	0.93	1	5	3	0
10.10.2 MCMCP trained medical doctors do not intend practicing in the rural areas for long.	64	2.89	0.78	1	5	3	0
10.10.3 MCMCP trained medical doctors are always encouraging their colleagues to remain in the rural facilities	64	2.94	0.89	1	5	3	0
10.10.4 MCMCP trained medical doctors are against doctors being trained in the rural district hospitals	64	2.5	0.8	1	5	3	0

In Table 4.14 above, the researcher depicts the number, the mean, standard deviation, minimum, maximum, median and missing cases of responses to statements in question 10.10.1 to10.10.4. The

findings from Table 4.14 depicts that the respondent agreed with the statement in question 10.10.1 while there was a general degree of uncertainty towards the statements in questions 10.10.2, 10.10.3 and 10.10.3.

The frequency of the number of responses to the above statements and the results of the findings are presented below.

4.4.10.2 Frequencies on the MCMCP trained medical doctors' inclination to practice in rural areas

In question 10.10.1, MCMCP trained medical doctors prefer practicing in rural areas. The results of the findings are presented in Figure 4.41.

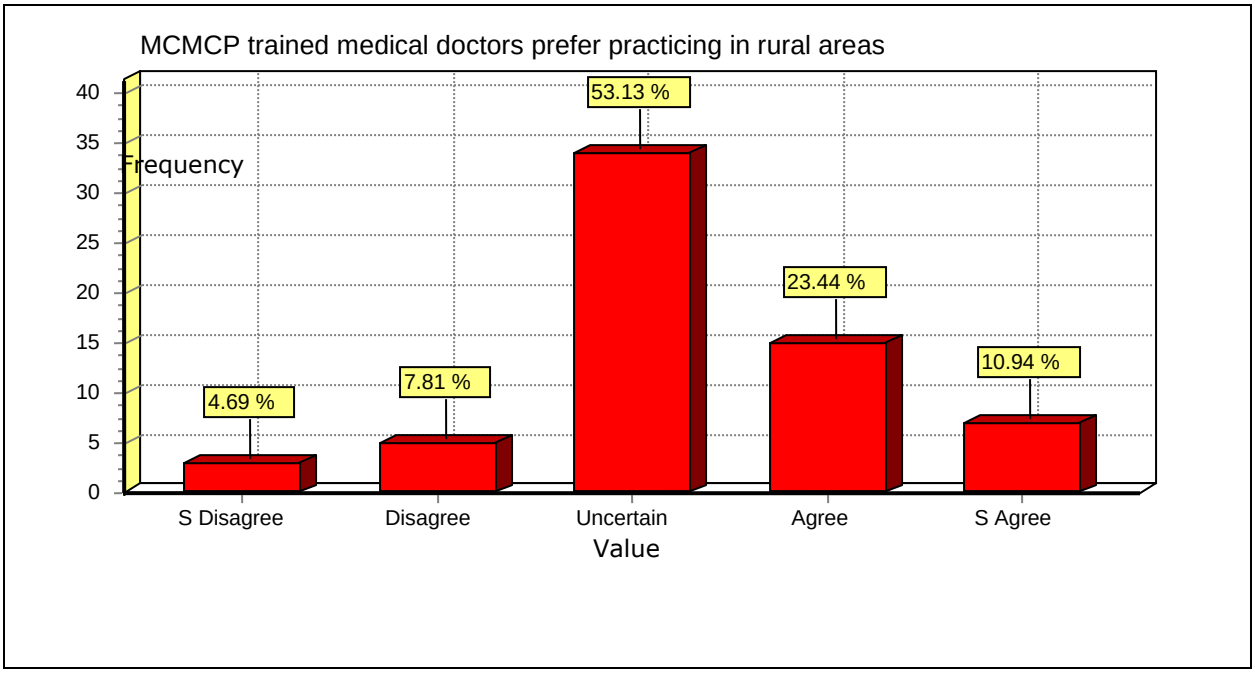

Figure 4.41 MCMCP trained medical doctors prefer practicing in the rural areas

The above graph, in Figure 4.41 depicts that 53.1% of respondents were uncertain if MCMCP trained medical doctors prefer practicing in rural areas. The results of the findings show that 23.4% of the respondents agreed while 10.9% of the respondents strongly agreed with the above statement. The combined score of the response rate who disagreed and strongly disagreed constituted 12.5% of the research participants. Chapter 2, Section 2.12.2 articulated that the

purpose of the MCMCP agreement was firstly, to recruit doctors from Cuba to serve in the rural areas of South Africa. It was further mentioned that in 2004 there were close to 500 Cuban doctors practicing in rural areas and townships around South Africa. Secondly, the original agreement led to the participation in the MCMCP in 1997 where black and disadvantaged high school graduates are recruited to study medicine in Cuba. It was further emphasised that the training of medical students in Cuba, helps with scaling up production of doctors particularly in the rural areas.

In question 10.10.2, the respondents were asked to indicate if MCMCP trained medical doctors do not intend practicing in rural areas for long. The results of the findings are presented in Figure 4.42.

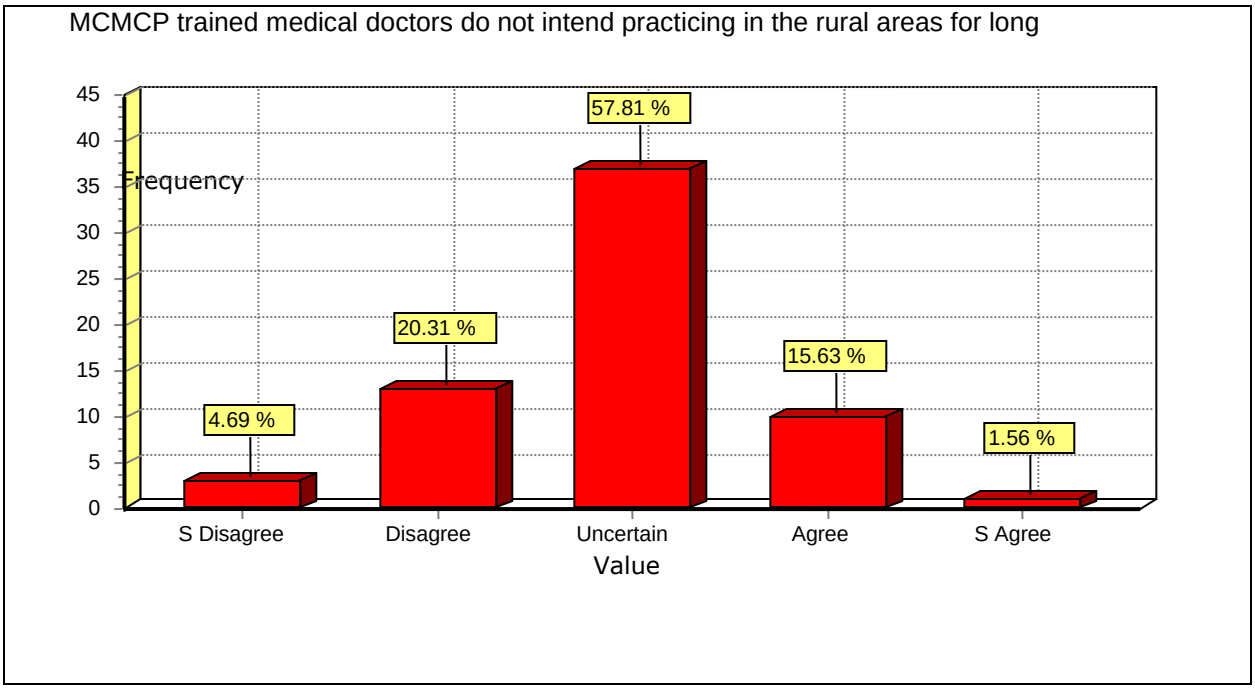

Figure 4.42 MCMCP trained medical doctors do not intend practicing in the rural areas for long

The graph in Figure 4.42 demonstrates that 57.8% of the respondents were uncertain if MCMCP trained medical doctors do not intend practicing in rural areas for long. The total percentage of the respondents that agreed and strongly agreed with the above statement was 17.2% of the research participants. On the contrary, the findings depict that 20.3% of the respondents disagreed while 4.7% strongly disagreed that MCMCP trained medical doctors do not intend practicing in

rural areas for long. In Chapter 2, Section 2.12.2 it was mentioned that the purpose of the MCMCP agreement was firstly, to recruit doctors from Cuba to serve in the rural areas of South Africa. In Chapter 2, Section 2.12.2 it was mentioned that South Africa experiences a serious imbalance between doctors employed in urban versus rural areas. It has been estimated that only about 35 of 1200 medical graduates produced annually will choose a rural career in the long term.

In question 10.10.3, the respondents were asked to indicate if MCMCP trained medical doctors are always encouraging their colleagues to remain in rural areas. The results of the findings are presented in Figure 4.43.

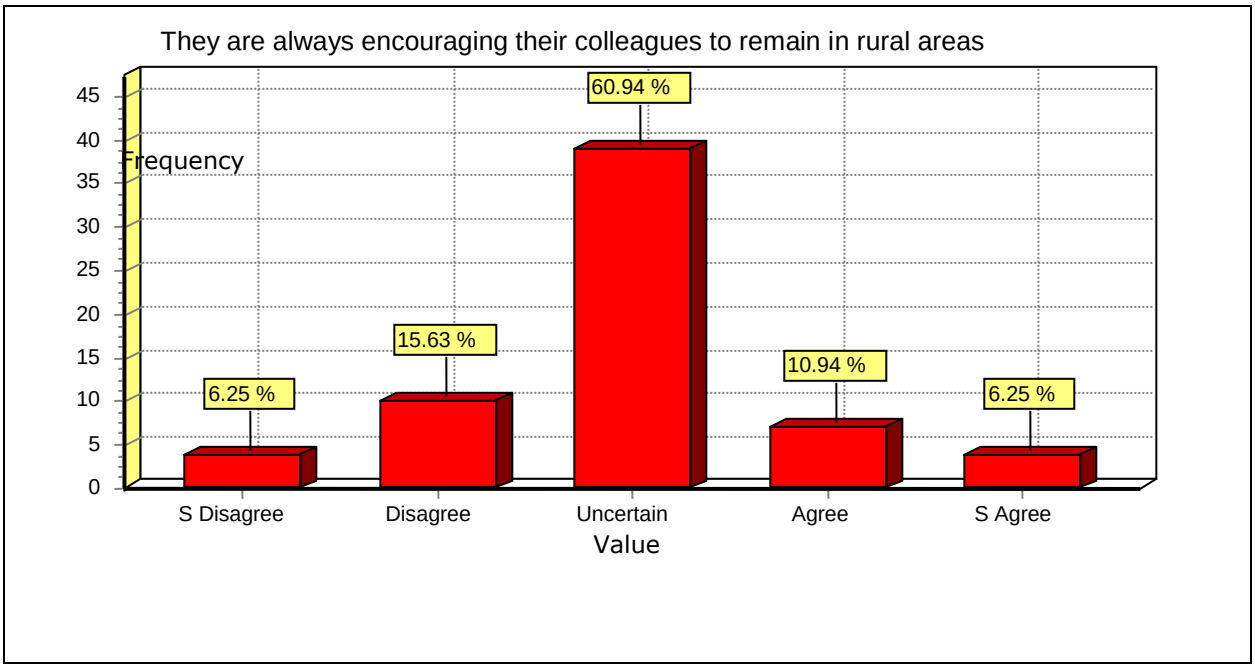

Figure 4.43 MCMCP trained medical doctors are always encouraging their colleagues to remain in the rural facilities

The graph in Figure 4.43 demonstrates that 60.9% of the respondents were uncertain if MCMCP trained medical doctors are always encouraging their colleagues to remain in rural areas. The total percentage of the respondents that agreed and strongly agreed with the above statement was 17.2% of the research participants. On the contrary, the findings depict that 15.6% of the respondents disagreed while 6.3% strongly disagree that MCMCP trained medical doctors are always encouraging their colleagues to remain in the rural areas. In question 10.10.4, the respondents

were asked to indicate if MCMCP trained medical doctors are against doctors being trained in the rural district hospitals. The results of the findings are presented in Figure 4.44.

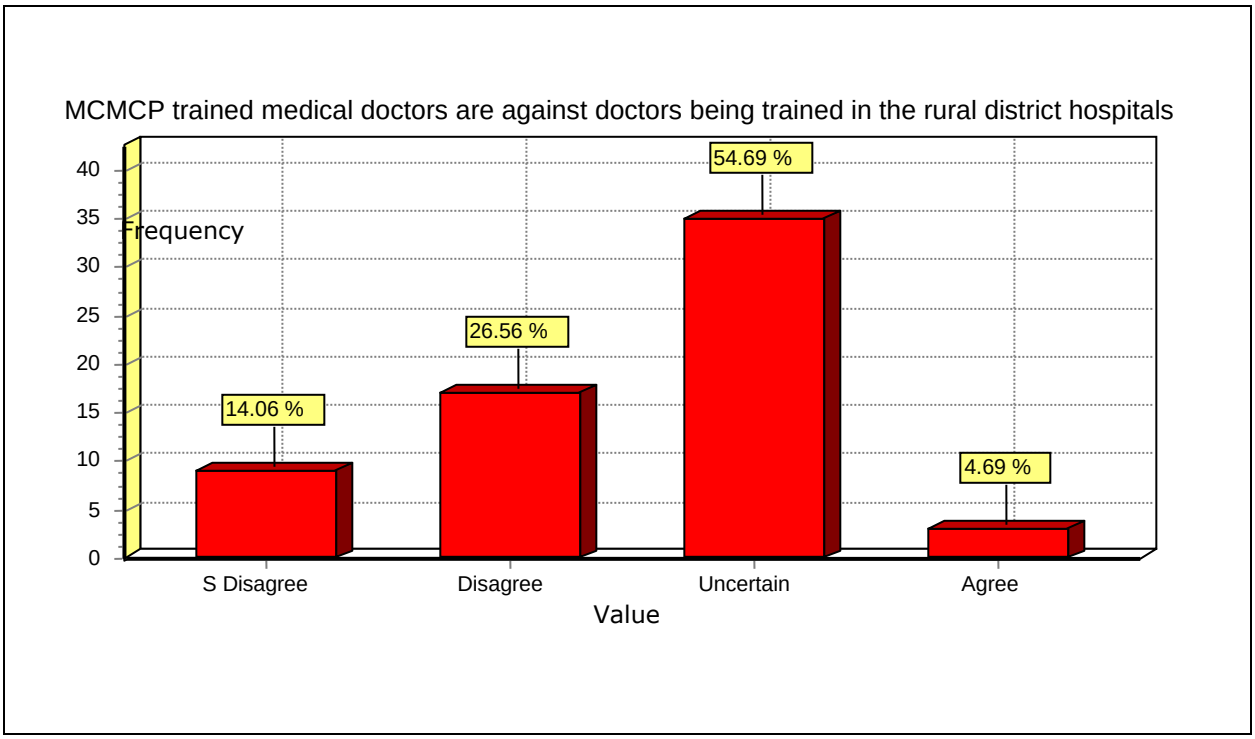

Figure 4.44 MCMCP trained medical doctors are against doctors being trained in the rural district hospitals

The results of the findings in Figure 4.44 illustrates that 54.7% of the respondents were uncertain if MCMCP trained medical doctors are against doctors being trained in the rural district hospitals. The graph also depicts that 26.6% of the respondents disagreed while 14.1% strongly disagreed that MCMCP trained medical doctors are against doctors being trained in the rural district hospitals. Only a small fraction of the respondents, 4.7% of the research participants, agreed that MCMCP trained medical doctors are against doctors being trained in the rural district hospitals.

4.4.11 Level of professionalism of MCMCP trained medical doctors

4.4.11.1 Findings on the level of professionalism of MCMCP trained medical doctors

The questions from 10.11.1 to 10.11.4 in this section were asked to determine the level of professionalism of MCMCP trained medical doctors. In Table 4.15, the researcher depicts the number, the mean, standard deviation, minimum, maximum, median and missing cases of responses to statements in question 10.11.1 to 10.11.4. The summary of the research participants on the level of professionalism of MCMCP trained medical doctors is presented in Table 4.15 below.

Table 4.15 The level of professionalism of MCMCP trained medical doctors

Statement in question:	N	Mean	Standard Deviation	Min	Max	Median	Missing Cases
10.11.1 MCMCP trained medical doctors are professional on how they conduct themselves.	62	4.11	0.89	1	5	4	2
10.11.2 MCMCP trained medical doctors are good ambassadors of the medical profession.	63	3.95	0.83	1	5	4	1
10.11.3 MCMCP trained medical doctors behave unprofessionally towards their profession.	63	1.87	0.81	1	4	2	1
10.11.4 MCMCP trained medical doctors misrepresent the medical profession.	63	1.83	0.75	1	3	2	1

From Table 4.15, the researcher demonstrates that the respondent's agreed with the statements in questions 10.11.1 and 10.11.2 whereas they disagreed with the statements in 10.11.3 and 10.11.4.

The frequency of the number of responses to the above statements and the results of the findings are presented below.

4.4.11.2 Frequencies about the level of professionalism of MCMCP trained medical doctors

In question 10.11.1, the respondents were asked to indicate if MCMCP trained medical doctors are professional in how they conduct themselves. The results of the findings are presented in Figure 4.45 below.

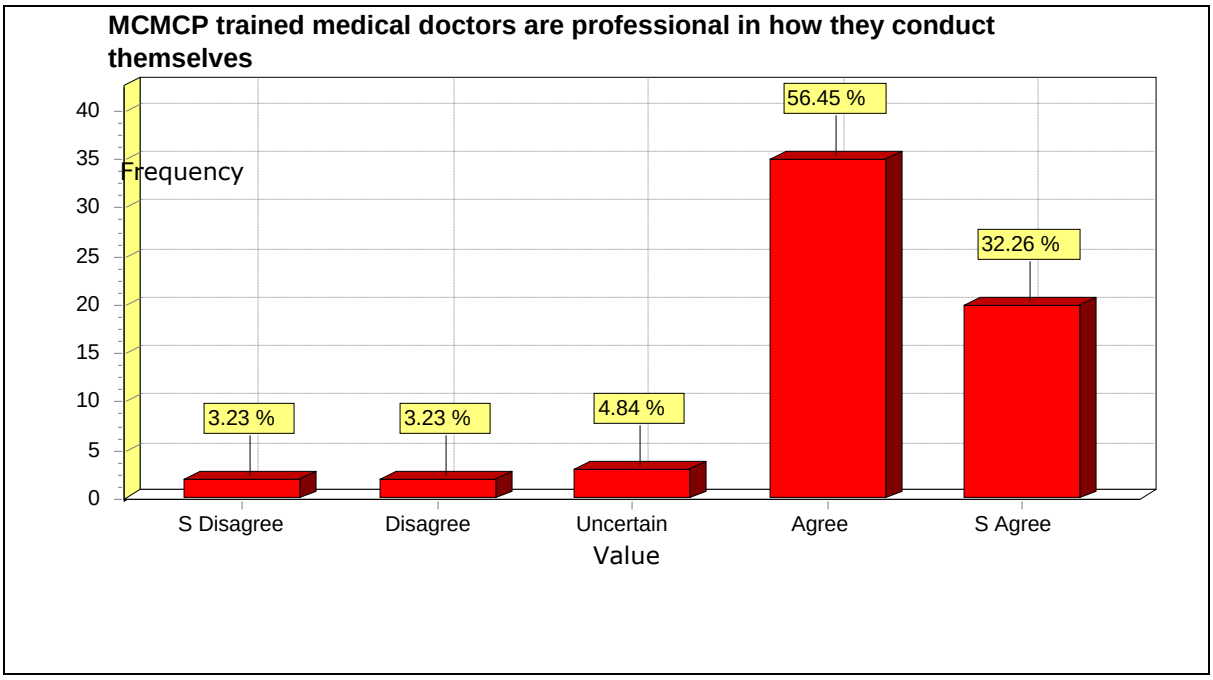

Figure 4.45 MCMCP trained medical doctors are professional on how they conduct themselves

The above graph in Figure 4.45 shows that the majority of the respondents believed that MCMCP trained medical doctors are professional in how they conduct themselves. The findings in Figure 4.45 prove that 56.5% agreed while 32.3% strongly agreed with the above statement. It was also indicated that an equal proportion of respondents where 3.2% of each category of the research

participants had either disagreed or strongly disagreed with the research participants. It was only a fraction (4.8%) of the respondents that were uncertain if MCMCP trained medical doctors are professional in how they conduct themselves.

In question 10.11.2 the respondents were asked to indicate if MCMCP trained medical doctors are good ambassadors of the medical profession. The results of the findings are presented in Figure 4.46 below.

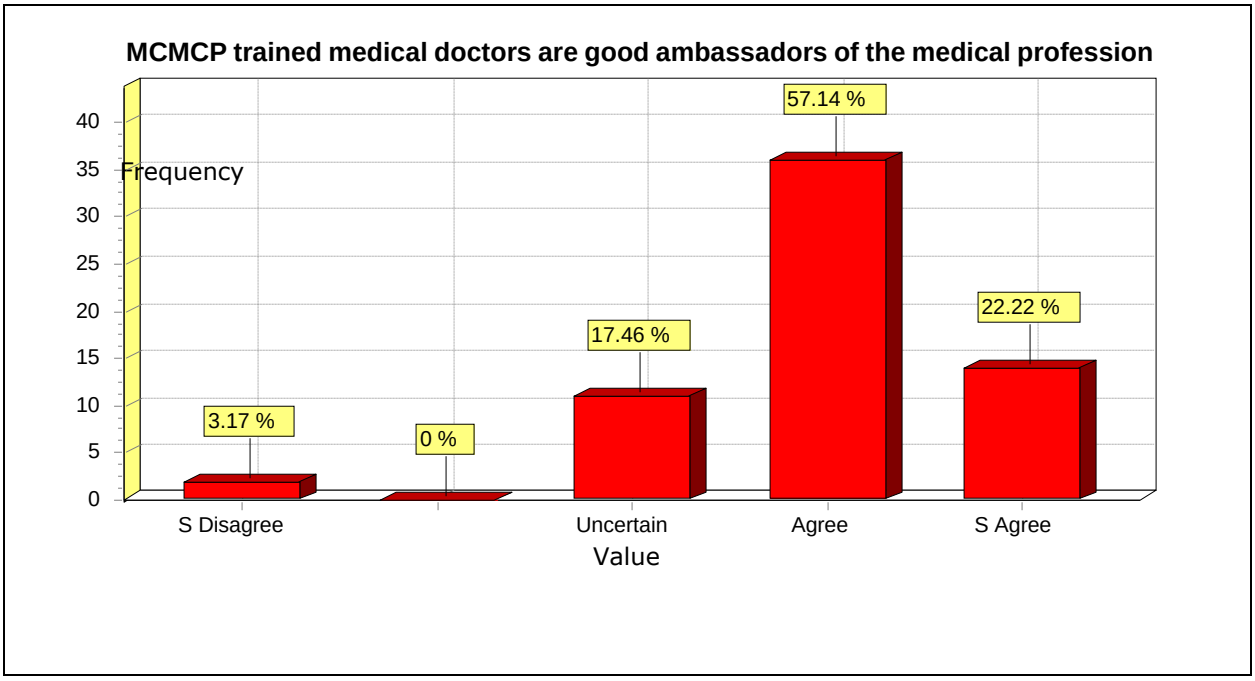

Figure 4.46 MCMCP trained medical doctors are good ambassadors of the medical profession

The above graph in Figure 4.46 indicates that the majority of the respondents believe that MCMCP trained medical doctors are good ambassadors of the medical profession. The findings in Figure 4.49 demonstrate that 57.1% agreed while 22.2% strongly agreed with the above statement. It was also shown that 17.5% were uncertain while 3.2% had strongly disagreed with the above statement.

In question 10.11.3, the researcher asked the respondents to indicate if MCMCP trained medical doctors behave unprofessionally towards their profession. The results of the findings are presented in Figure 4.47 below.

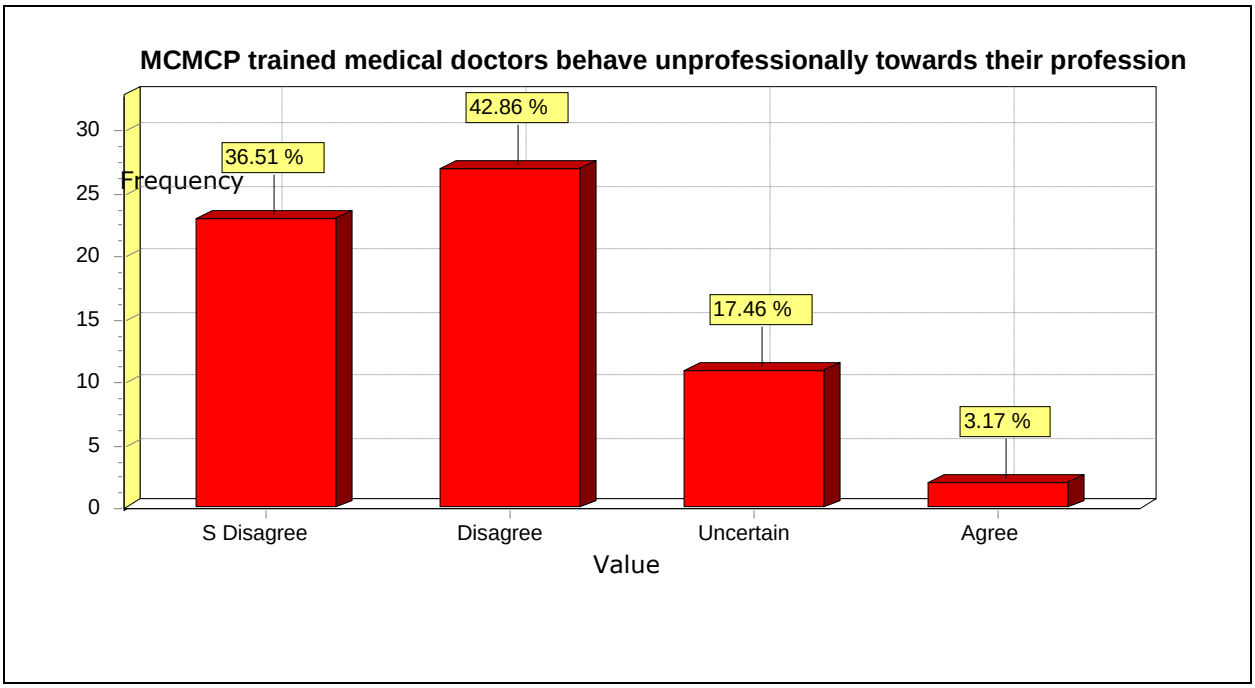

Figure 4.47 MCMCP trained medical doctors behave unprofessionally towards their profession

The results of the findings in Figure 4.47 demonstrate that the highest proportion of the respondents did not agree with the assertion that MCMCP trained medical doctors behave unprofessionally towards their profession. The findings in Figure 4.47 indicate that 42.9% of the respondents disagreed while 36.5% had strongly disagreed with the above statement. It was also shown that 17.5% were uncertain whereas 3.2% agreed that MCMCP trained medical doctors behave unprofessionally towards their profession.

In question 10.11.4, the respondents were asked to indicate if MCMCP trained medical doctors misrepresent the medical profession. The results of the findings are presented in Figure 4.48 below.

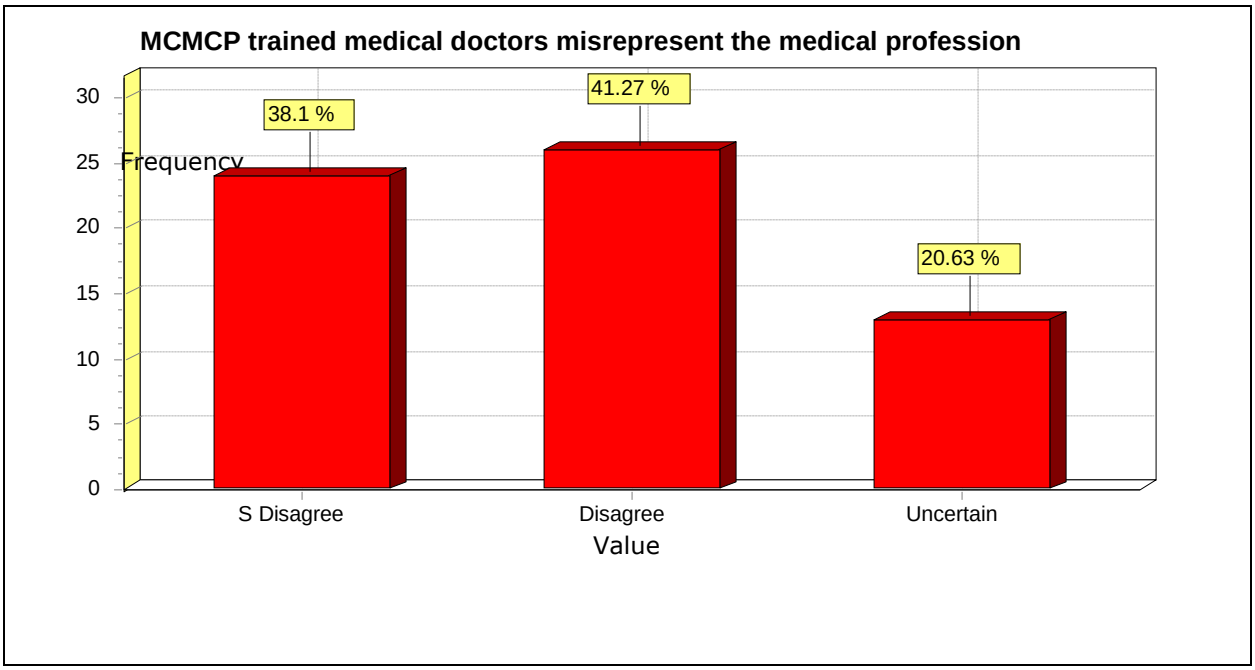

Figure 4.48 MCMCP trained medical doctors misrepresent the medical profession

The graph in Figure 4.48 indicates the majority of respondents were against the statement that asserts that MCMCP trained medical doctors misrepresent the medical profession. The findings of the investigation demonstrate that 41.3% disagreed while 38.1% strongly disagreed with the above statement. It was only 20.6% of the research participants who were uncertain if MCMCP trained medical doctors misrepresent the medical profession.

4.4.12 How does the MCMCP trained medical doctors affect health care service delivery in the NCP?

The above question was asked to determine if MCMCP trained medical doctors had any effect on health care service delivery in the NCP. The respondents were asked to indicate their preferred answer from the following three possible answers if this programme has had a positive effect, no effect or a negative effect. The results of the findings are presented in Table 4.16.

Table 4.16 Effect of MCMCP trained medical doctors on health care service delivery

Effect of MCMCP trained medical doctors on health care service delivery in the NCP.				
Value	**Frequency**	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
Missing	**6**	9.38	**6**	9.38
Positive effect	53	82.81	59	92.19
No effect	4	6.25	63	98.44
Negative effect	1	1.56	64	100.00

The results of the findings depicted in Table 4.16 indicate that of the 64 questions six respondents did not answer question 11.1. Furthermore, the highest proportion of the research participants, 82.8%, believed that the MCMCP had a positive effect whereas 7.8% believed that this programme had no effect in the FBDM health care facilities. It was stated in Chapter 1. Section 1.4 that the study seeks to assess the impact of the MCMCP trained medical doctors in promoting health care service delivery in the FBDM hospitals, NCP.

It was also expressed in Chapter 2, Section 2.12.2 that South Africa has an imbalance between doctors employed in urban versus rural areas. It has been estimated that only about 35 of 1200 medical graduates produced annually will choose a rural career in the long term. Donda *et al.* (2016:2) further state that a major advantage of the MCMCP from the South African government perspective is that the Cuban medical curriculum is explicitly primary health care oriented. South Africa's national health planning is predicated on the centrality of primary, district based health care. Dr Ayanda Ntsaluba, Director General of Health when the Cuban-South African agreement was signed over a decade ago, notes that South African policy makers were also attracted to the Cuban emphasis on prevention, primary care and the bio-psycho-social approach that views patients holistically (Reed and Torres, 2008:50).

4.5 SUMMARY

This chapter revealed that the provision of health care in the FBDM area is mainly delivered by female health professionals. It was discovered in Section 4.3 of this Chapter that 77.8% of the respondents were females while 22.2% of the respondents were males. This is consistent with NCDoH PERSAL Report (2018) retrieved in May 2018 which indicates that 72.3. % of the health professionals were females whereas 27.7% of the health professionals were males. There was also an indication that a significant number of health professionals do not have post matric qualifications. In fact, combined categories of respondents who possess a certificate, senior certificate constitute 25% while those without a senior certificate constitute 12.5%.

It was also exposed that the majority of the health professionals is aging. The age group between 40 and 49 constituted 31.2% while between 50 and 59 constituted 13.1% of the research participants. This implies that 44.3% are nearing retirement age and will need to be replaced in the near future.

Against this backdrop, the MCMCP trained medical doctors seem to be invisible according to the results of the findings in Section B above where it was demonstrated that there was a general degree of uncertainty about the number, visibility and identification of MCMCP trained medical doctors at the ZK Mathews Hospital and Warrenton Hospital. It was, however, indicated that their level of competency is satisfactory as the majority of the respondents believed that they were executing their duties as required. It should, however, be stated that in Chapter 2, Section 2.12.6 it was highlighted that the MCMCP has come under a lot of fire in recent years with claims that South African doctors returning from Cuba are not adequately equipped for the South African context, being unable to treat illnesses such as tuberculosis (TB), HIV and associated complications.

The results of the findings have also revealed that MCMCP trained medical doctors are committed and motivated to deliver health services in the FBDM health care facilities. It should also be noted that there was a significant number of respondents constituting about 24.5% who were uncertain if RSA-Cuban doctors were committed or motivated to deliver health care service in rural

hospitals. It can also be argued as to whether this programme is sustainable as the results of the findings indicate that there was a great sense of uncertainty on whether MCMCP trained medical doctors will remain in the rural areas to improve health care service delivery. Chapter 2, Section 2.6 articulated that the MCMCP trained medical doctors was one of the policy statements that led to the first recruitment of young black students from mainly disadvantaged rural communities to study medicine in Cuba in 1997 (Reed and Torres, 2008:49). It was also articulated in Chapter 2, Section 2.10 that Bateman (2013:2) mentions that the MCMCP is aimed at easing the shortage of medical doctors in the rural areas and enhances health care service delivery.

Accessibility to primary health care has to a certain degree been compromised by the language barrier. Section 4.3 in this chapter attests to the fact that the dominant languages in FBDM are Setswana and Afrikaans whilst most doctors, according to the PERSAL report, are foreigners who are not conversant with these two languages. It is within this context that the MCMCP trained medical doctors tend to yield a degree of approval from their colleagues. ZK Mathews Hospital for the past three years has been serviced by three South African trained doctors versus the eight that were all foreigners.

It was also shown that there was a general degree of uncertainty by the respondents on whether MCMCP trained medical doctors are suffering from an identity crisis (referred to as ‘Cubans’ by their locally trained South African counterparts). While it was demonstrated that the South African trained health professionals do welcome the contributions that MCMCP trained medical doctors are making, they, however, displayed a degree of uncertainty on whether the Cuban health system needs to be respected.

Chapter 5 focused on the conclusions drawn, from the empirical study as presented in this chapter followed by recommendations and indications for further study.

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter is the final chapter in the study. The chapter begins by focusing on a summary of the literature review chapters. The primary research question of this study as provided in Chapter 1, Section 1.6 of this study was as follows: **"**Does the MCMCP assist to promote health service delivery in the small district hospitals in the FBDM area in the NCP?**"** The main aim of this study was to positively contribute by means of specific recommendations concerning the impact of the MCMCP to promote effective health care service delivery in the small district hospitals in the FBDM area in the NCP. This chapter reiterates the research objectives as proposed in Chapter 1. Finally, the chapter concludes by making specific recommendations on the findings of the literature review and the empirical chapter of this study, and is followed by suggestions for future research.

5.2 SUMMARY OF THE CHAPTERS

A summary of the Chapters 1 and 2 are outlined below:

Chapter 1 provided the orientation of the study, the conceptual framework of the study, the background to the research problem, the aim of the study, the primary and secondary research questions and research objectives, research methodology, ethical considerations and limitations of the study.

Chapter 2 provided a theoretical overview of health care service delivery, the MCMCP and public management programmes. The chapter outlined the challenges of health care in a global context followed by a discussion about health care service delivery in the South African context. It was mentioned that most countries face similar challenges such as the increase in an ageing population, chronic diseases, an increase in the demand and access of health care services, rapid increases in the cost of health care services and demand for the use of high-tech medical technology and equipment. In the context of South Africa it was mentioned that the demand for health care

services requires an adequate skilled workforce, essential health commodities such as material, equipment and medicines, the upgrade of health infrastructure, improvement of health information management systems, and quality and availability of service provision. It was further emphasised that the South African public health care systems can only function effectively with adequate health professionals, who are distributed equally and are accessible by the majority of the population, throughout the country. A concern was raised that the mere availability of health professionals and other health workers is not sufficient. It is only when adequate and competent health professionals and other health workers are effectively supported by the health care systems that health care services will be able to function optimally.

The above challenges require more reforms from governments to change their health care policies and priorities to increase the demand of health care services and infrastructure of which the South African government cannot be excluded. Health care was described as an important component of both opportunity and well-being for all individuals in society. The health professionals that work to improve the health status of the community were viewed as involved in important work. Health care service delivery was further narrowed down to the FBDM where the MCMCP contribution to health care was discussed. Discussions around the relevancy of the MCMCP with respect to improving health care service delivery were interrogated. An overview of the provision of health care service delivery in Cuba was provided. In the discussion about statutory and legislative frameworks on health care service delivery, it was emphasised that in terms of Section 27(1) (1) of the Constitution, 1996 everyone has the right to have access to health care services, including reproductive health care. Section 195 of the Constitution, 1996 sets out the principles of public administration including the health care service delivery. The responsibility of the state to develop a unified health system in SA is provided in the WPToHS in SA, 1997. The roles, functions and structures of the Department of Health at national and provincial levels were explained. Particular emphasis was placed on the role of the district health system in managing the PHC. It was further emphasised that the objectives of the NHA, 2003 as provided in Section 2 are to regulate national health and to provide uniformity in respect of health services across SA. In terms of the National Health Amendment Act, 2013 the OHSC was established. The OHSC regulates the quality of health services using a set of NCS. The OHSC is responsible to monitor and set standards for the health sector where public and private facilities comply with prescribed norms and standards. It

was further highlighted that the WPToHS (1997:5) provides health sector strategies based on principles such as: the health sector must promote equity by developing a unified health system; the health system must focus on districts as the major role player in the implementation of the PHC approach; all three spheres of government, NGO's and private sector have to work together to promote the shared goals; each of the national, provincial and districts have to fulfil their unique as well as their complementary roles; and the health sector must ensure that they provide an integrated range of essential PHC services that must be available to the entire population at their first point of contact. Except for the above it was highlighted that the WPToHS, 1997 provided the responsibility of the state to develop a unified health system in SA.

Chapter 2 further emphasised that the NDP was seen as a long term policy statement that provides a broad strategic framework to guide key choices and actions within government and sets out to enable milestones and critical actions for the health sector. It was emphasised that the provision of PHC should take precedence at the district facilities. It was argued that it was this policy directive that encouraged the recruitment of poor deserving students from the rural areas to participate in the MCMCP. It was further expressed that the medical graduates from the MCMCP were expected to be deployed in the rural districts so that health care should be focussed on a more decentralised, area-based, people-centred approach of the district health system. The MCMCP was viewed as one of the options that the South African government used to strengthen government's ability to ensure a better life for all South African citizens, by increasing the number of qualified doctors and improving access to health care in support of NHI system. It was pointed out that the NHI provides for universal health coverage where everyone must have access to an equal standard of care, regardless of their income, and that a common fund should enable equitable access to health care, regardless of what people can afford or how frequently they need to use the service. The role of the district health care system was discussed with particular emphasis on: the transformation of the health care system in SA post the 1994 advent of the constitutional democratic government; the role that government had played in decentralising the health care system through the adoption of PHC; and the interrogation of the role that MCMCP had played towards the promotion of health care service delivery in FBDM. It was argued that government should ensure that health care should not only be available and accessible but should also be of good quality and acceptable to its citizens. The description of the demographic layout of the four

local municipal areas of the FBDM was presented and illustrated with a map. The researcher had also indicated the total number of health care facilities such as clinics, community health care centres and district hospitals, and their roles with respect to the MCMCP to promote health care service delivery. The significance of public participation in health care service delivery and how it contributes to democracy was discussed. The level of involvement of public participation in the MCMCP was interrogated. While public participation was viewed as the cornerstone of democracy, on the contrary it was argued whether there was a deliberate attempt by the ruling elite to disregard the views of the public and decide to unilaterally impose the MCMCP on the broader South African society. Discussions around the origin of the MCMCP were traced to the period when the late president Nelson Mandela of the Republic of SA and the late president Fidel Castro of the Republic of Cuba reached an agreement on health collaboration between the two countries in 1996. The terms of the agreement between the government of the RC and the government of RSA on the training of South African medical students and postgraduates in Cuba was outlined. The role of the three spheres of the government of the RSA on the recruitment of students into the MCMCP, the management of the programme until the attainment of degrees by the students, and their appointment was highlighted. The theoretical overview of the MCMCP was discussed in terms of its origin and why it was established in 1997 through a bilateral agreement signed by RC and RSA. It was argued that the MCMCP programme would not be successful if all involved do not have a clear understanding of the programme's mission, goals and objectives, particularly in the local government context such as the FBDM. Factors that influence the successful implementation of public programmes and service delivery were discussed. The significance of Batho Pele principles as provided in WPTPS, 1997 were once again emphasised. Approaches that influence the successful implementation of public service delivery programmes were highlighted: having a clear understanding of definitions and the terminologies involved, a clear sense of direction and purpose to which the programme is aimed, and having a well-defined baseline. It was indicated that programmes including the MCMCP need to be monitored and evaluated while in progress to ensure that they are meeting set goals and objectives within a defined time frame for the community in which these target goals are in use.

Chapter 3 provided the research methodology used in this study. This study was conducted mainly within the positivism paradigm (quantitative research) and had focused on the usage of

scientific methods that hold that research must be limited to what can be observed and measured objectively.

Chapter 4 provided the findings and results of the empirical study. The findings and results of the empirical study demonstrated there was a general degree of uncertainty about the number, visibility and identification of MCMCP at the hospitals of ZK Mathews and Warrenton, FBDM, NCP. The respondents' sense of awareness about the number of MCMCP trained medical doctors is consistent with what was depicted in Figure 1.2 in Chapter 1, Section 1.3. where, it was indicated that the total population of MCMCP trained medical doctors who took part in the MCMCP constituted 26% of doctors in the FBDM. Chapter 4 further illustrated that the level of competency of the MCMCP trained medical doctors deployed at ZK Mathews District Hospital in Barkly West and the Warrenton Hospital in Warrenton in the FBDM area is satisfactory. The majority of the respondents believed that they were executing their duties as required. The results of the findings have also revealed that MCMCP doctors are committed and motivated to deliver health services in the FBDM health care facilities. It should also be noted that there was a significant number of respondents constituting about 24.5% who were uncertain if MCMCP, trained medical doctors were committed or motivated to deliver health care service in rural hospitals. It can also be argued as to whether this programme is sustainable as the results of the findings indicate that there was a great sense of uncertainty on whether MCMCP trained doctors will remain in the rural areas to improve health care service delivery. Accessibility to primary health care has to a certain degree been compromised by the language barrier. Section 4.3, Chapter 4 attests to the fact that the dominant languages in FBDM area, are Setswana and Afrikaans whilst most doctors, according to the PERSAL report, are foreigners who are not conversant with these two languages. It is within this context that the MCMCP trained medical doctors tend to yield a degree of approval from their colleagues. ZK Mathews Hospital for the past three years has been serviced by three MCMCP trained medical doctors versus the eight that were all foreigners.

It was also shown that there was a general degree of uncertainty by the respondents on whether MCMCP trained medical doctors are suffering from an identity crisis (referred to as 'Cubans' by their locally trained South African counterparts). While it was demonstrated that the South African trained health professionals do welcome the contributions that MCMCP trained medical doctors

are making, they, however, displayed a degree of uncertainty on whether the Cuban health system needs to be respected.

5.3 RESEARCH QUESTIONS/OBJECTIVES

In this discussion an attempt is made to reflect on the extent to which the research questions/objectives have been realized and the corresponding research questions proposed in Chapter 1 have been answered. The main aim of this study was to positively contribute by means of specific recommendations concerning the impact of the MCMCP to promote effective health care service delivery in the small district hospitals in the FBDM area in the NCP.

The following were the research questions and objectives of the study:

The primary research question of the study was as follows: Does the MCMCP assist to promote health service delivery in the small district hospitals in the FBDM area in the NCP? Based on the primary research question and the above aim of the study the primary research objective of the study was as follows; to assess whether the MCMCP assists to promote health service delivery in the small district hospitals in the FBDM area in the NCP.

The secondary research questions were posed in Chapter 1 of this study:

- What are the statutory and regulatory framework requirements of the MCMCP?
- What is the attitude of health care professionals on whether enough competent doctors are produced by the MCMCP to reduce the shortage of doctors in the FBDM area?
- What is the attitude of the health care professionals on whether the doctors from the MCMCP improve the medical care services in the ZK Mathews District Hospital in Barkly West and the Warrenton Hospital in the FBDM area?
- What is the attitude of health care professionals on whether the MCMCP trained medical doctors are competent and motivated in their role as medical practitioners according to the perceptions of the hospital staff that they work with?

The following secondary objectives were posed in Chapter 1 of this study:

- To determine the statutory and regulatory framework requirements of the health care service delivery and the purpose of the MCMCP.
- To determine the attitude of health care professionals on whether enough competent doctors are produced by the MCMCP to reduce the shortage of doctors in the FBDM area.
- To determine the attitude of the health care professionals on whether the doctors from the MCMCP improve the medical care services in the ZK Mathews District Hospital in Barkly West and the Warrenton Hospital in Warrenton in the FBDM area.
- To determine the attitude of health care professionals on whether the MCMCP trained medical doctors are competent and motivated in their role as medical practitioners according to the perceptions of the hospital staff that they work with.
- To determine specific recommendations concerning the impact of the MCMCP to promote health care service delivery in the small district hospitals in the FBDM area in the NCP.

5.3.1 Objective 1: To determine the statutory and regulatory framework requirements of health care service delivery and the purpose the MCMCP.

This objective finds expression in Chapter 2, Section 2.5 where it was discussed that policy and legislative framework on health care service delivery was centred on Section 195 of the Constitution, 1996, the WPTPS, 1997 (Batho Pele), WPToHS in SA, 1997 and NHA, 2003 with its associated amendments, the National Health Amendment Act, 2013.

Section 195 of the Constitution, 1996 stipulates that everyone has the right to have access to health care services, including reproductive health care. Section 27(1) (3) of the Constitution, 1996 provides that no person may be refused emergency medical treatment, while Section 28 (1)(c) states that every child has the right to basic health care services. This implies that quality health care should be available to all the citizens of this country.

Section 25 of the NHA, 2003 outlines the general functions of the Provincial Departments of Health. Section 25(1) of the NHA, 2003 clearly provides that the relevant member of the Executive

Council must implement national health policies, norms and standards in each province. Section 25(2) of the NHA, 2003 states that the head of the provincial department must, in accordance with the national and provincial health policies, provide specialised hospital services in each province.

Chapter 2, Section 2.5 of this study further elaborates that, in order to execute the functions needed to realise their goals and objectives, governments are bound to supply and deliver public goods and services to their communities. Governments supply services for managing their order and protection, social welfare and economic welfare functions, which may be categorised as order and protection services, social welfare services and economic welfare services (Gildenhuys and Knipe, 2000:56). For example, the programme (MCMCP) is managed on a decentralised but centrally coordinated basis. The NDoH is responsible for the overall coordination and management of the programme that includes development of legislative documents and related regulations, whereas the provincial governments are responsible for funding and logistical arrangements (NDoH, 2012a:4).

It was expressed in Chapter 2, Section 2.7 that at local government level, the purpose of district health services is to provide comprehensive, integrated and sustainable health care services that are preventive, promotive, curative and rehabilitative based on the re-engineering PHC approach through the district health system (NCDoH, 2013:67). It is within this context that the South African policy makers were also attracted to the Cuban emphasis on prevention, primary care and the bio-psycho-social approach that views patients holistically (Reed and Torres, 2008:50)

Chapter 2, Section 2.5.2 further highlighted that for the effective implementation of government policies, public servants need to adhere to certain mandatory principles and these are provided in the WPToHS in SA. These principles include consultations, service standards, access, courtesy, information, openness and transparency, redress and value for money. The significance of these principles was seen as central to the transformation of the public service and in particular health care service in this context.

Matsoso *et al*. (2015:262) point out that the NDP provides a broad strategic framework to guide key choices and actions within government, and sets out to enable milestones and critical actions

for the health sector. The NPC (2011:334) acknowledges that the public health system needs to be focused on the provision of enough trained health professionals to give effect to the constitutional rights that everyone must have access to health care services and that every child has the right to basic health care services. On the contrary access seems to be far-fetched as was indicated in Chapter 2, Section 2.12.2, which states that SA suffers a serious imbalance between doctors employed in urban versus rural areas (Donda, Hift and Singaram, *et al.* 2016:2). It has been estimated that only about 35 of 1200 medical graduates produced annually will choose a rural career in the long term. Donda *et al*. (2016:2), further state that a major advantage of the MCMCP from the South African government perspective is that the Cuban medical curriculum is explicitly PHC oriented. It was pointed out that the deployment of these doctors in the rural areas would assist to alleviate this shortage and thus to enhance accessibility at the district hospitals such as ZK Mathews and Warrenton hospitals among others in FBMD.

It was also expressed in Chapter 2, Section 2.12.4 that South African students studying medicine in Cuba are confronted with numerous challenges such as language and culture. On arrival in Cuba, students are required to learn Spanish which is the medium of instruction. On the return to SA, they must relearn medical terminology in English and this requires a tremendous amount of mind mobility (Bin-Abdulrahman, *et al.* 2015:106). According to Kooverjee (2017:14), the students lack professional support and this leads to the use of unhealthy coping mechanisms to maintain resilience and to safe guard their emotional functioning. She further points out that unhealthy coping mechanisms include and are not limited to:

- Self-medicating with the use of alcohol
- High rates of unprotected sex
- Disconnect from others and isolating one's self, and
- Depression and complete avoidance of dealing with other issues.

Chapter 2, Section 2.12.4 further pointed out that these challenges extend to the last phase of their training in SA. According to Donda *et al*. (2016:2), the MCMCP students experience academic difficulties on their return to SA. In the final examinations, approximately 50% will have to repeat

modules in order to qualify, resulting in a prolongation of training which in some cases may be substantial.

In Section 2.12.6, Chapter 2 of this study it was mentioned that, the MCMCP has come under a lot of fire in recent years with claims that South African doctors returning from Cuba are not adequately equipped for the South African context, being unable to treat illnesses such as tuberculosis (TB), HIV and complications associated with diabetes (Masters *et al*. 2015:176). It was also mentioned in Chapter 2, Section 2.6.7 that the MCMCP faces challenges around the return, reception and integration of students recruited in 2012 (Second National Consultative Workshop on Preparations for the Reception of South African Students Studying Medicine in Cuba, 2017:2). According to the Report on the State of readiness for the return, reception and Integration of MCMCP Students (NCDoH, 2018d:1-5) and the NDoH submission on the Third Consultative Workshop in Pretoria (NCDoH, 2018a:2), it is the responsibility of the provinces to make the necessary arrangements to ensure that clinical training sites, teaching facilities, accommodation, clinical supervision, transport costs, information and communication technology, tuition fees and other related costs are available for the training of MCMCP students. According to Khan (2018:1), the Minister of Health, Dr Aaron Motsoaledi conceded the MCMCP was more expensive than medical training in SA and said that this was one of the factors that counted against it. The proposal for funding of the above infrastructure was estimated at around R 30 000 000.00 for NCDoH to cover the costs for the successful integration of 21 final year MCMCP students in July 2018 (NCDoH, 2018g:1). Section 2.12.7, Chapter 2 of this study states that the NDoH 2017 invoice indicates that NCDoH was charged R 32 847 043.00 for 136 MCMCP students and this suggests that the Republic of Cuba charges R 241 522.38 per student which is double the total amount of fees paid for medical students in South African Medical Schools.

5.3.2 Objective 2: To determine the attitude of health care professionals on whether enough competent doctors are produced by the MCMCP to reduce the shortage of doctors in the FBDM Area.

This objective finds resonance in Chapter 4, Section 4.4.2 as highlighted in the following paragraphs. In Chapter 4, Section 4.4.2 it was deduced that while the majority of the health

professionals (54.69% agree and strongly 25% agree), that were mainly comprised of nursing staff, expressed a degree of confidence regarding the competency in the doctors trained through the MCMCP. There was, on the contrary, a small fraction of respondents that did not have confidence in MCMCP trained medical doctors and believed that they were not competent enough to deliver health care service delivery.

The results of the findings as presented in the descriptive statistics in Chapter 4 in Section 4.4 showed that there was a general degree of uncertainty about the number, visibility and identification of MCMCP at the hospitals of ZK Mathews and Warrenton.

5.3.3 Objective 3: To determine the attitude of health care professionals on whether the doctors from the MCMCP improve the medical care services in the ZK Mathews District Hospital in Barkly West and the Warrenton Hospital in Warrenton in the FBDM area.

This objective finds resonance in Chapter 4, Section 4.4.5, Section 4.4.6 and 4.4.7. Figure 4.21 illustrated that 60.32% agree and 20.63% of the respondents strongly agree that the MCMCP trained medical doctors are motivated to deliver health care services. The sub-statements as illustrated in Table 4.9 namely, "MCMCP trained medical doctors are pessimistic about their role" and "MCMCP trained medical doctors are eager and enthusiastic to share their knowledge and skills" are directly linked to the MCMCP trained medical doctor's attitude. In addition, to the above Figure 4.25 illustrated that 59.38% of the respondents agree and 23.44% strongly agree that the MCMCP trained medical doctors promote primary health care in the FBDM hospitals. While only 17.9% of the respondents demonstrated a degree of uncertainty towards the statement. In Figure 4.29 and Table 4.11 a total of 57.8% agree and 18.75 strongly agree that the MCMCP trained medical doctors are able to implement both preventative and curative primary health care in the FBDM hospitals. Thus, the majority of the respondents are in agreement that the MCMCP trained medical doctors contribute to the improvement of medical care services in ZK Mathews District Hospital in Barkly West and the Warrenton Hospital in Warrenton in the FBDM area.

Responding to the above objective, a theoretical overview was also explored in Chapter 2 in numerous sections as expressed on page 172. Chapter 2, Section 2.5.4 it was emphasised that the

preamble of the NHA, 2003 aims to give effect to the constitutional requirement rights of the people to have access to health care services, in an equitable way which is based on principles of equity, efficiency and good governance. In Chapter 2, Section 2.12.2 it was stated that MCMCP trained medical doctors would be deployed to various facilities to improve the quality of care of patients in rural areas of which the FBDM hospitals cannot be excluded. In Section 2.5.9, Chapter 2 of this study it was further mentioned that the MCMCP trained medical doctors are necessary for the successful implementation of NHI to improve health care service delivery, particularly focussing on the poor, vulnerable and disadvantaged groups (Matsoso *et al*., 2015:33).

5.3.4 Objective 4: To determine the attitude of health care professionals on whether the MCMCP trained medical doctors are competent and motivated in their role as medical practitioners according to the perceptions of the hospital staff that they work with.

This objective was explored in the theoretical overview of Chapter 2 as highlighted in the following excerpts derived from Chapter 2. Chapter 2, Section 2.4 pronounced that mere availability of health workers is not sufficient; they should be equitably distributed and accessible to the population, they should possess the required competency and be motivated and empowered to deliver quality care that is appropriate and acceptable to the socio-cultural expectation of the population, and be adequately supported by the health system. The results of the findings are presented in the descriptive statistics of Table 4.6, Chapter 4. Section 4.4.5 indicates that the respondents believed that MCMCP trained medical doctors are motivated and are eager and enthusiastic to share their knowledge and skills. Figure 4.21 illustrated that the majority of the respondents agree and strongly agree that the MCMCP trained medical doctors of the ZK Mathews District Hospital in Barkly West and the Warrenton Hospital in Warrenton in the FBDM area are motivated. While figure 4.10 illustrated that 54.69% of the respondents agree and 25% strongly agree that the MCMCP trained medical doctors are competent.

5.3.5 Objective 5: To determine specific recommendations concerning the impact of the MCMCP to promote health care service delivery in the small district hospitals in the FBDM area in the NCP.

Section 5.4 of this chapter provides the recommendations based on the literature chapters and the findings of the empirical study.

5.4 CONCLUSIONS DRAWN FROM THE EMPIRICAL FINDINGS

Firstly, Chapter 3 provided a detailed discussion of the research methodology with a focus on study design, study population and sampling procedures, data collection techniques, instrument validity and reliability, pre-test, ethical considerations and data analysis.

These conclusions were reached after an analysis of the results of the findings of the structured questionnaires. The questionnaires were presented to 64 research participants where 43 and 21 of these respondents were based at ZK Mathews Hospital and Warrenton hospital respectively. The purpose of this study was to assess whether the MCMCP have assisted to promote health care service delivery in the small district hospitals in the FBDM area in the NCP. The following findings and conclusions were reached after the research analysis as presented in Chapter 4 were conducted.

5.4.1 Conclusions drawn from the empirical findings of the biographical data presented in Chapter 4, Section 4.3.

- It was discovered that the provision of health care in the FBDM was mainly delivered by female health care professionals. The findings of the results of the research presented in Chapter 4, Section 4.3 indicate that 77.8% of the respondents were females while 22.2% of the respondents were males. This is consistent with the NCDoH (2018b) retrieved in May 2018 which indicates that 72.3% of the health professionals were females whereas 27.7% of the health professionals were males. It can be inferred from this that there was a very small population of males who have shown interest in the health care profession. Health care service delivery was implemented by two thirds of the female health professionals.

- It was also deduced that Afrikaans and Setswana were the two dominant languages spoken in FBDM hospitals.

- There was also an indication that a significant number of health professionals do not have post matric qualifications. In fact, a combined category of respondents who possess a certificate or senior certificate constitute 25% while those without a senior certificate constitute 12.5%.

- It was also exposed that the majority of the health professionals were aging. The age group between 40 and 49 constituted 31.2% while between 50 and 59 constituted 13.1% of the research participants. This implies that 44.3% are nearing retirement age and will need to be replaced in the near future.

- The nursing staff (53.1%) and emergency health care (10.9%) professionals constituted the majority of the staff in FBDM hospitals. The remainder of health professionals and support staff constitute 40.0% of the employees. It can, therefore, be deduced that health care service delivery in FBDM hospitals was mainly driven by nurses and emergency care workers.
- It can also be concluded that, the majority of experienced health care professionals that have been employed by the facility of FBDM hospitals was between one to five years (39.1%) and five to ten years (42.2%).

- There was a small proportion of health care professionals who possessed a post-graduate qualification in the FBDM hospitals. It was only 1.6% of professionals who had obtained a master degree qualification whereas 9.6% were in possession of an Honours or a Post Diploma qualification. There was, therefore, limited scope for research-based studies for these professionals.

5.4.2 Conclusions drawn from the analysis of the data collected from the structured questionnaire in Chapter 4, Section 4.4

- It was also concluded that there was a general degree of uncertainty about the number, visibility and identification of MCMCP trained medical doctors at the hospitals of ZK Mathews and Warrenton. The respondents' sense of awareness about the number of MCMCP trained medical doctors is consistent with what was depicted in Figure 1.2 in Chapter 1, Section 1.3. Here, it was indicated that the total population of MCMCP trained medical doctors who took part in the MCMCP constituted 26% of doctors in the FBDM.

- It was indicated that their level of competency is satisfactory as the majority of the respondents believed that they were executing their duties as required. It should however, be stated that in Chapter 2, Section 2.12.6 of this study it was highlighted that the MCMCP trained medical doctors has come under a lot of criticism in recent years with claims that South African doctors returning from Cuba are not adequately equipped for the South African context, being unable to treat illnesses such as tuberculosis (TB), HIV and complications associated. The respondents had, however, displayed positive attitude towards the level of competency of the MCMCP trained medical doctors.

- It can also be established that the MCMCP trained doctors related well to their patients. The sound interpersonal relations they established with their patients allowed them to be accessible and this would enable the patients to reveal or open up about their medical conditions and lead to better diagnoses.

- The results of the findings presented in Chapter 4, Section 4.4.4 have also revealed that the respondents believed that MCMCP trained medical doctors are committed and motivated to deliver health services in the FBDM health care facilities.

- It was also established that the MCMCP trained medical doctors were motivated, eager and willing to share their knowledge with their South African trained counterparts.

- PHC was viewed as the primary focus of the Cuban health care. There was a degree of uncertainty if the doctors trained through the MCMCP despise the curative model of health. It was also concluded that the doctors trained through the MCMCP were doubtful

whether they were afforded the opportunity by the South African government to practice preventative medicine that informed the better part of their studies in Cuba.

- Conclusions were also drawn that the RSA doctors trained through the MCMCP were not prejudiced against but were instead treated well by their South African counterparts. There was, however, a degree of uncertainty whether they were labelled as "Cubans" by the South African trained counterparts.

- It was also discovered that a significant number of the MCMCP trained medical doctors demonstrated a degree of reluctance to remain in the rural areas for too long. It was therefore concluded that the purpose of the MCMCP of alleviating the shortage of doctors in the rural areas did so to a certain degree, but did not reach its intended purpose.

- There was, however, a general consensus that the MCMCP trained medical doctors was effective in FBDM hospitals.

5.5 RECOMMENDATIONS

These recommendations were mainly informed by the conclusions drawn from results of the findings of the investigation as presented in Chapter 4.

- It was discovered that the majority of health care professionals were females as expressed in Section 5.4 above. In order to comply with the developmental transformative priorities (equitable distribution of health care professionals in terms of race, gender etc.) of the government of SA, it is advisable, as advocated in Chapter 2, Section 2.5.2 that strategies should therefore be developed by departments and provincial administrations, designed to promote continuous improvement in the quantity, quality and equity of service provision, including the improvement of service delivery programmes.

- In order to strengthen health care service delivery, it is important that health care professionals should have the basic understanding of the languages spoken by the

inhabitants of the area. In Chapter 4, Section 4.4.3, it was discovered that the dominant languages spoken in FBDM hospitals is Afrikaans and Setswana and would therefore be advisable that health care professionals have a basic understanding of these languages. This will enhance the accessibility of health care service delivery as the language can be a barrier. For example, it was stated in Chapter 2, Section 2.12.4 that RSA students studying medicine in Cuba, as part of the MCMCP programme are confronted with numerous challenges such as language and culture.

- To complement the service rendered by doctors, the supporting staff and other health care professionals should possess the requisite skills relevant to their professions. It was indicated in Section 5.2 that in the FBDM hospitals, the combined categories of respondents who possess a senior certificate constitute 25%, while those without a senior certificate constitute 12.5%. In Chapter 2, Section 2.4 it was pointed out that the mere availability of health professionals and other health workers is not sufficient. It is only when adequate, qualified and competent health professionals and other health workers are effectively supported by the health care systems that health care services will be able to function optimally. Therefore, it is recommended that skills development and training strategies for both clinical and support staff should be implemented by the Department of Health at national and provincial sphere to alleviate the shortage of scarce and critical skills in the FBDM hospitals.
- There is a need to establish a clear succession plan and a retention strategy for rural hospitals. This will not only assist in the replacement of the aging staff but also assist in the equitable distribution of doctors, thus ensuring that health care service delivery is accessible and available to communities that were previously disadvantaged. It was stated in Chapter 2, Section 2.12.7 that the MCMCP grew gradually over the years and this would mean that without a properly drawn out retention strategy the aging staff that is about to retire from FB district hospitals as demonstrated in Chapter 4, Section 4.4.3 may not be replaced, and the doctors produced through the MCMCP may also relocate elsewhere. As expressed further in Chapter 2, Section 2.12.7, this would result in the wastage of enormous sums of resources that could have been utilized on different developmental programmes to upskill and create employment for the poor deserving youth of this country.

- The NCDoH should institute a comparative study between the impact made by the nurses in FBDM hospitals and the MCMCP trained medical doctors in terms of health care service delivery, and map a way forward on the relevancy of this programme and whether it's worth investing into for the future.

- According to Khan (2018:1), the former Minister of Health, Dr Aaron Motsoaledi conceded that the MCMCP was more expensive than medical training in SA and said that this was one of the factors that counted against it.

- There was a need for the promotion of post-graduate studies for health care professionals in the FBDM hospitals in order to enhance research studies for these professionals. For example, there is wide scope for research on the MCMCP, as suggested by Bin-Abdulrahman, *et al*. (2015:106), who state that no research exists to show how well MCMCP trained students perform as doctors, nor whether they remain working in their regions of origin.

In view of the challenges that the students grapple with in Cuba and the exorbitant costs incurred by the South African government to manage the MCMCP as articulated in Chapter 2, Section 2.12.7 it would further be suggested that:

- A comparative study between locally trained medical doctors and MCMCP trained medical doctors be carried out. This comparison should focus on the outcomes of both programmes with respect to compliance with the norms and standards as stipulated in the NHA, 2013, amended in 2013.
- The progress of this programme should be measured on how it contributes to health care service delivery in the rural districts. It was indicated above in Section 5.3.1 that the doctors trained through the MCMCP were reluctant to practice medicine in the rural areas. Progress should also be measured against the targets of the NDP as pointed out in Chapter 2, Section 2.5.8. It should also incorporate its achievements against the outcomes and output of the departmental strategic plans.

- Improve the infrastructure of rural hospitals and enact legislation for the compulsory deployment of MCMCP trained medical doctors to rural health care facilities for a determined period of time as would have been stipulated in contract. Devise an electronic system that would track the movement of doctors trained through the MCMCP for better management.
- Create the necessary capacity in local South African universities and divert the funding that would have gone to Cuba to train students locally. It was expressed in Chapter 2, Section 2.12.7 that the MCMCP was more expensive that the medical training in SA. It was indicated that the cost of training in Cuba is likely to be three times the average cost of medicine in SA. For example, newly established universities such as the Sol Plaatje and Mpumalanga universities could introduce medical faculties with an adapted standardized curriculum who would train students that would have gone to Cuba for training.

5.6 CONTRIBUTION OF THE STUDY

The study assessed the impact of the MCMCP in promoting health care service delivery in the FBDM hospitals, NCP. Based on the findings of the study, suggested recommendations were made in terms of the impact of the MCMCP to improve or to promote health care service delivery in FBDM hospitals. The suggested recommendations could be useful to improve the MCMCP and health care service delivery in FBDM hospitals in NCP. The study also made a contribution to the theory of health care service delivery in the context of South Africa.

5.7 RECOMMENDATIONS FOR FURTHER STUDY

This study has revealed that there are ample opportunities for this topic to be explored further in future. In Chapter 2, Section 2.13, Bin- Abdulrahman, *et al*. (2015:106) maintain that no research exists to show how well MCMCP trained medical students perform as doctors, nor whether they remain working in their regions of origin. While the purpose of this study was to assess whether the MCMCP has assisted in promoting health care service delivery in the small district hospitals in the FBDM area in the NCP, the study has the potential to expand discussions on topics related

to the above. For example, an impact assessment of the MCMCP to improve health care service delivery in the NCP or in SA could be explored as a possibility for further research.

5.8 SUMMARY

The purpose of this chapter was to present the conclusions and recommendations of this research study with respect to assessing whether the MCMCP has assisted to promote health care service delivery in the small district hospitals in the FBDM area in the NCP. A particular focus on whether the results of the findings as presented in Chapter 4 were aligned to the objectives of this study was also interrogated. All the above aspects of this study culminated in conclusions derived mainly from the empirical findings presented in Chapter 4. This was followed with a detailed outline of the recommendations. This brings the dissertation to completion with the hope that it will be beneficial to the NCDoH and particularly to the district hospitals in the FBDM area in the NCP and that there are further prospects for research on this topic.

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ANNEXURE A- CONSENT LETTER

To: Dr E Worku
Northern Cape Department of Health: Research Committee

From: Mr OL Motsumi
Master of Public Management

Research Study: Title: Assessing the impact of the Mandela-Castro Medical Collaboration Programme in promoting health care service delivery in the Frances Baard district hospitals, Northern Cape Province.

I am Mr. OL Motsumi, a Master of Public Management student at Central University of Technology, Free State. I hereby request permission to conduct structured interviews with health professionals in the Frances Baard district hospitals. I also wish to request permission to conduct a pilot study at Harry Surtie Regional Hospital using a similar structured questionnaire as above with health professionals. I wish to also confirm that I will make every effort to safeguard the confidentiality of the respondents with whom I will conduct interviews.

The purpose of this study is to assess whether the Mandela-Castro Medical Collaboration Programme has assisted to promote health care service delivery in the district hospitals and in the Frances Baard District area in the Northern Cape Province.

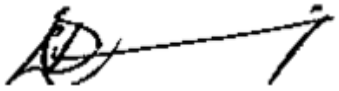
To further explore the main research, question the following objectives will frame the research:

- To determine the attitude of health care professionals on whether enough competent doctors are produced by the Mandela-Castro Medical Collaboration Programme (MCMCP) to reduce the shortage of doctors in the Francis Baard District Area.

- To determine the attitude of health care professionals on whether the doctors from the MCMCP improve the medical care services in the ZK Mathews District Hospital in Barkly West and the Warrenton Hospital in Warrenton, in the Frances Baard district area.
- To determine the attitude of health care professionals on whether the South African-Cuban trained doctors are competent and motivated in their role as medical practitioners according to the perceptions of the hospital staff that they work with.

The target population of this study will be comprised of health professionals working at the five small hospitals in the Frances Baard district municipal area namely, the ZK Mathews Hospital in Barkly West, the Warrenton hospital in Warrenton, the Connie Vorster Hospital in Hartswater, and the Jan Kempdorp hospital in Jan Kempdorp and Galeshewe Day Hospital.

Kind Regards



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Mr OL Motsumi

ANNEXURE B – RESEARCH STRUCTURED QUESTIONNAIRE

Respondent Number: ☐

Purpose

I, Mr Onkabetse Levy Motsumi a Masters of Public Management student at the Central University of Technology, am conducting an academic research study in fulfilment of my master's degree.

The purpose of this research questionnaire is to assess the impact of the Mandela-Castro Medical Collaboration Programme in promoting health care service delivery in the Frances Baard district hospitals, Northern Cape Province

Your contribution to this questionnaire will remain private and all information will be considered confidential and that no personal information will be published. Your identity will also remain anonymous and no information that can identify you will be on the questionnaire.

Instructions

- Your responses should be as accurate as possible to the situation in your hospital.
- Please use **X** mark where applicable and please use a black ink pen.

Thank you for your participation.

RESEARCH STRUCTURED QUESTIONNAIRE

Section A

Biographical Data of Respondents

1. What is your race?

African	
Asian	
Coloured	
White	

2. What is your gender?

Male	
Female	

3. Do you have a disability?

Yes	
No	

4. What is your home language?

English	
Afrikaans	
Setswana	
IsiXhosa	
IsiZulu	
Other, please specify:	

5. What is your age? _____years

6. What is your occupation?

Nurse	
Medical Officer	
Pharmacist	
Emergency Care Officer	
Radiographer	
Allied Health Professional (Occupational therapist, Physiotherapist)	
Other Health Professional, please specify:	
Administrative Support staff	

7. What is the district hospital where you are currently employed?

Galeshewe Day Hospital	
Warrenton Hospital	
ZK Mathew's Hospital	
Jan Kempdorp Hospital	
Connie Vorster Hospital	

8. How long have you worked in this hospital?

1-5 Years	
5-10 Years	
10 – 20 Years	
20 Years and more	

9. What is your highest level of education?

Without Senior Certificate	
Senior certificate	
Certificate	
Diploma	
Degree	
Honours/Post Graduate Diploma	
Masters/MBA	
Doctorate/PHD	

SECTION B

This section is comprised of questions that seek to collect information about the impact of the Mandela-Castro Medical Collaboration Programme in Promoting Health Care Service Delivery in the Frances Baard District Hospitals, Northern Cape Province.

Attitude-Scale Questionnaire

Circle or mark a cross on the option you are choosing from the list of possible answers below.

Note: Strongly agree = 5, Agree = 4, Uncertain = 3, Do not agree = 2, strongly disagree = 1

10.1 Awareness of MCMCP trained medical doctors					
	Strongly Agree	Agree	Uncertain	Do not agree	Strongly disagree
10.1.1 The number of MCMCP trained medical doctors is more than RSA trained medical doctors.	5	4	3	2	1
10.1.2 MCMCP trained medical doctors are seen in every unit of the hospital.	5	4	3	2	1
10.1.3 It is difficult to identify MCMCP trained medical doctors from South African trained doctors.	5	4	3	2	1

10.2 Competency					
	Strongly Agree	Agree	Uncertain	Do not agree	Strongly disagree
10.2.1 MCMCP trained medical doctors are good at what they are doing	5	4	3	2	1
10.2.2 MCMCP trained medical doctors are sloppy and careless.	5	4	3	2	1
10.2.3 RSA-Cuban doctors are not well trained and are unable to perform basic procedures such as delivery, setting drips etc.	5	4	3	2	1

10.3 Relationship with their patients.					
	Strongly Agree	Agree	Uncertain	Do not agree	Strongly disagree
10.3.1 MCMCP trained medical doctors are loved by patients.	5	4	3	2	1
10.3.2 MCMCP trained medical doctors dedicate more time talking to their patients.	5	4	3	2	1
10.3.3 Patients do not welcome the idea of being attended to by MCMCP trained medical doctors.	5	4	3	2	1
10.3.4 MCMCP trained medical doctors are always talking bad about their patients.	5	4	3	2	1

10.4 Commitments					
	Strongly Agree	Agree	Uncertain	Do not agree	Strongly disagree
10.4.1 MCMCP trained medical doctors are committed to their work.	5	4	3	2	1
10.4.2 MCMCP trained medical doctors are hard workers.	5	4	3	2	1
10.4.3 MCMCP trained medical doctors work overtime.	5	4	3	2	1
10.4.4 MCMCP trained medical doctors come late to work.	5	4	3	2	1
10.4.5 RSA-Cuban trained medical trained doctors respond late to calls.	5	4	3	2	1

10.5 Motivation					
	Strongly Agree	Agree	Uncertain	Do not agree	Strongly disagree
10.5.1 MCMCP trained medical doctors are motivated.	5	4	3	2	1
10.5.2 MCMCP trained medical doctors are pessimistic about their role.	5	4	3	2	1
10.5.3 MCMCP trained medical doctors are eager and enthusiastic to share their knowledge and skills.	5	4	3	2	1
10.5.4 MCMCP trained medical doctors seem to doubt the knowledge they obtained in Cuba.	5	4	3	2	1

10.6 Promotion of Primary Health Care					
	Strongly Agree	Agree	Uncertain	Do not agree	Strongly disagree
10.6.1 MCMCP trained medical doctors promote primary health care.	5	4	3	2	1
10.6.2 MCMCP trained medical doctors despise the curative approach.	5	4	3	2	1
10.6.3 MCMCP trained medical doctors believe that primary health care is not practical for South African setting.	5	4	3	2	1
10.6.4 MCMCP trained medical doctors are always advising the significance of a good lifestyle.	5	4	3	2	1

10.7 Primary Health Care/ Curative					
	Strongly Agree	Agree	Uncertain	Do not agree	Strongly disagree
10.7.1 MCMCP trained medical doctors are able to blend and implement both preventative and curative models successfully.	5	4	3	2	1
10.7.2 MCMCP trained medical doctors' show less interest on preventative approaches.	5	4	3	2	1
10.7.3 There are no observable differences between locally trained and MCMCP trained medical doctors at the level of their approaches around their practice.	5	4	3	2	1
10.7.4 RSA-Cuban trained medical believe that they are not provided space to practice preventative primary health care.	5	4	3	2	1

10.8 Leadership					
	Strongly agree	Agree	Uncertain	Do not agree	Strongly disagree
10.8.1 MCMCP trained medical doctors are good leaders.	5	4	3	2	1
10.8.2 MCMCP trained medical doctors are self-driven.	5	4	3	2	1
10.8.3 MCMCP trained medical doctors are not proactive.	5	4	3	2	1
10.8.4 RSA-Cuban doctors always wait for their South African locally trained counterparts to take decisions on their behalf.	5	4	3	2	1

10.9 Prejudice					
	Strongly Agree	Agree	Uncertain	Do not agree	Strongly disagree
10.9.1 Locally trained South African health professionals treat MCMCP trained medical doctors with contempt.	5	4	3	2	1
10.9.2 MCMCP trained medical doctors are referred to as 'Cubans' by their locally trained South African counterparts.	5	4	3	2	1
10.9.3 Locally trained South African health profession look down upon the Cuban health system.	5	4	3	2	1
10.9.4Locally trained South African health professional respect the Cuban health system.	5	4	3	2	1

10.10 Inclination to practice in the rural areas					
	Strongly Agree	Agree	Uncertain	Do not agree	Strongly disagree
10.10.1MCMCP trained medical doctors prefer practising in the rural areas.	5	4	3	2	1
10.10.2 RSA-Cuban doctors do not intend practising in the rural areas for long.	5	4	3	2	1
10.10.3 MCMCP trained medical doctors are always encouraging their colleagues to remain in the rural facilities	5	4	3	2	1
10.10.4 MCMCP trained medical doctors are against doctors being trained in the rural district hospitals	5	4	3	2	1

10.11 Level of professionalism					
	Strongly Agree	Agree	Uncertain	Do not agree	Strongly disagree
10.11.1 MCMCP trained medical doctors are professional on how they conduct themselves.	5	4	3	2	1
10.11.2 MCMCP trained medical doctors are good ambassadors of the medical profession.	5	4	3	2	1
10.11.3 MCMCP trained medical doctors behave unprofessionally towards their profession.	5	4	3	2	1
10.11.4 MCMCP trained medical doctors misrepresent the medical profession.	5	4	3	2	1

11.1 In your opinion, how does the Mandela-Castro Medical Collaboration Programme affect health care service delivery in the Northern Cape?

Positive effect	
No effect	
Negative effect	

11.1.1 Please elaborate on your answer above:

……

……

ANNEXURE C - APPROVAL LETTER TO CONDUCT RESEARCH

DEPARTMENT OF HEALTH
LEFAPHA LA BOPHELO BO BOTLE
DEPARTEMENT VAN GESONDHEID
ISEBE LEZEMPILO

Research and Development Unit
Executive Offices
Northern Cape Department of Health
Du Toit Span Road, Belgravia
P/Bag X5049, Kimberley, 8300
Tel: 053 830 2134
Fax: 086 485 3243
Email: BMashute@ncpg.gov.za/
EWorku@ncpg.gov.za

Enquiries: Dipatlisiso: Imibuzo: Navrae : Dr. E Worku

Date: Leshupelo: Umhla: Datum: 28 June 2018

Reference: Tshupelo: Isalathiso: Verwysing: *NC_2018_RP003*

Mr. OL Motsomi
16648 Khutsanong Street
Kutlwanong, Mankurwane
Kimberley
8345

Dear Sir

Project Title: ***Assessing the impact of the Mandela-Castro Medical Collaboration Programme in promoting health care service delivery in the Frances Baard District Hospitals, Northern Cape Province.***

The application requesting permission to conduct the above-mentioned research study was received and has been reviewed by the Provincial Health Research and Ethics Committee (PHREC) for gate-keepers' permission.

Approval is granted to conduct this research study at Prof ZK Matthews hospital, Warrenton hospital, Connie Voster hospital and Jan Kempdorp as indicated in your application form, in Northern Cape Province.

Your Provincial Ethics Reference Number is ***NC_2018_RP003,*** kindly use that reference number in correspondence with the PHREC administration

Please note the following:

Please note the following conditions:

1) This project must be conducted at no cost to the Northern cape Department of Health
2) This approval is limited to the research proposal as submitted in the application
3) No variation or modification on the research project
4) PHREC may monitor the research progress at anytime
5) At the completion of this study, a copy of the final report must be submitted to the Research and Development Unit
6) The Northern Cape Department of Health Senior Management Committee shall be briefed on the outcome of the study prior publishing

The committee wishes you success on your research study

Kind regards

C

28 06 2018

Dr. E Worku
Chairperson of PHREC
Tel: 053 830 2134
Cell: 072 703 8037
Email: EWorku@ncpg.gov.za

Date