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REVISITING THE CHALLENGES CONCERNING CLEANLINESS OF THE PUBLIC HOSPITALS AT AMATHOLE DISTRICT IN SOUTH AFRICA

BY

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A MINI-DISSERTATION SUBMITTED TO THE FACULTY OF SCIENCE AND AGRICULTURE IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE MASTERS DEGREE IN PUBLIC HEALTH

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ABSTRACT

Most people lives are highly dependent on the quality of healthcare services rendered to them. One of the most important factors which people consider as a quality measure in hospitals is cleanliness. The National Health Service (2003) stresses "Cleanliness of institutions" as one of the six priority measures of quality. Although cleanliness means removal of unwanted materials from specific areas, it is not about maintaining the place spotless tidy, but ensuring that the physical surroundings do not affect the patients' psychological environment. This research sought to explore factors influencing cleanliness in the Public Hospitals of Amathole District in the province of the Eastern Cape, South Africa.

Both primary and secondary data sources were used in this study. This study adopted a quantitative research design through the utilization of survey method. The primary data was collected using a self-administered questionnaire. The population and sample for the study was drawn from five hospitals; - four from the Amathole District (Tafalofefe, Cathcart, Butterworth, and Nompumelelo) and one from Buffalo City Metropolitan Municipality (Bisho Hospital), which is the pilot hospital. Statistical Package for Social Sciences (SPSS) was used for data analysis. Statistical analysis tools such as the t-test, analysis of variance (ANOVA), factor analysis and chi-square were used.

The findings of this study established that, general support staff members in rural and urban public hospitals place much emphasis on availability of resources, institutional policy, work environment, work ethics and institutional support as crucial factors for maintaining a clean environment in hospitals. Thus, there is an observable relationship between the factors that influence cleanliness in public hospitals. The results of this study are important in identifying actions that would assist government, management and policy makers to develop and implement strategies that support cleanliness in public hospitals. Furthermore, this study will help to educate stakeholders of public hospitals on observing ethical issues that relate to cleanliness in public hospitals.

DECLARATION

I, Xolani James Tofu, hereby declare that this mini dissertation entitled, "Revisiting challenges concerning cleanliness of the public hospitals at Amathole District in South Africa", is my original work, and has not been and will not be submitted or presented for the award of any other degree, diploma, fellowship or other similar title.

XJ Tofu

Signature

03/10/2018

Date

DECLARATION ON PLAGIARISM

I, Xolani James Tofu student number 201415833 hereby declare that I am fully aware of the University of Fort Hare's policy on plagiarism and I have taken every precaution to comply with the regulations.

Signature: XJ Tofu **Date:** 04/10/2018

CERTIFICATION

This Mini-dissertation entitled" Revisiting the challenges concerning cleanliness of the Public Hospitals at Amathole District in South Africa" meets the regulation governing the award of the degree of MPH of the University of Fort Hare and is approved for its contribution to scientific knowledge and literary presentation.

Supervisor

04 October 2018

Date

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DEDICATION

This work is dedicated to my immediate family as well as my brother and sisters; you are so special to me.

LIST OF ABBREVIATIONS

ANOVA	: Analysis of Variance
CDCP	: Centre for Disease Control and Prevention
EICHF	: Environmental Infection Control in Health care Facilities
HST	: Health Systems Trust
ICNA	: Infection Control Nurses Association
NDOH	: National Department of Health
NHS	: National Health Service
NHSI	: National Health Surveillance Infostructure
NPSA	: National Patient Safety Agency
SPSS	: Statistical software package for social scientists

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CHAPTER ONE

INTRODUCTION AND BACKGROUND OF THE STUDY

1.1 INTRODUCTION

Sekaran (2003) described research as a scientific way of solving problems in order to get solutions through an intense study and analysis of the situational factors. Whilst decision-making, allows one to select an appropriate solution from alternative solutions in order to address a particular problem through a thorough, well planned and well executed research study. Knowledge of studies of this nature always assists one towards becoming a recipient concerning some outcomes discussed through providing recommendations for best practice. Research study is a useful decision-making tool (Sekaran, 2003). One of the most important factors which people consider as a quality measure in hospitals is cleanliness. It for this reasons that the National Health Service (2003) stresses on "Cleanliness of institutions" as one of the six priority measures of quality. Although cleanliness means removal of unwanted materials from specific areas, it is not about maintaining the place spotless tidy, but ensuring that the physical surroundings do not affect the patients' psychological environment (Mehta, 2012). This research sought to explore factors influencing cleanliness in the Public Hospitals of Amathole District in the Eastern Cape Province, South Africa.

1.2 BACKGROUND OF THE STUDY

Quality is a progressively major measure in the people's existence, and as a result communities are frequently expecting superior care services. Excellent health care constitutes societal right, hence higher health care results in satisfaction of the clients (patients and community in general), employees, suppliers and better performance for the organisation. If quality health care services improve, costs decrease, productivity increases and a better service would be available for clients. In turn; it enhances organisational performance and provides long-term working relationships for employees and suppliers (Mosadeghrad, 2012).

The outlook of wards and public areas in a hospital varies; but this is not always associated with the level of cleanliness.

Audit Scotland (2002) suggest that, poor and inadequate maintenance of buildings and fabric, the need for re-decoration and dirty windows all contribute to a public perception that standards of cleanliness are poor. In some cases, poor maintenance and decoration can make it more difficult for some areas to be cleaned effectively. There is a clear need for improved co-ordination of domestic services and the facility management to identify and manage areas of risk collectively (AuditScotland, 2002).

Cleanliness in hospitals is more than just keeping the place clean. It speaks to patients and visitors about the attitudes of staff, managers and the Board of Trustee in terms of attention to detail level of care and the way the hospital is organised and run. This means that, it is not possible to have a good hospital without paying attention to cleanness (NHSI, 2001).

The office of Standards of Cleanliness UK (2003) proposed a need for processes and records to be in place in all health institutions to promote the potential for consistency in maintaining cleanliness (NHS, 2003). According to Nightingale's Environmental Theory's Model, cleanliness of the physical environment has a direct bearing on prevention of disease and mortality rates within the social environment of the community (Mehta, 2012). In addition, physical surroundings also strongly affect the patients' psychological environment.

Based on the grave trepidations raised by patients and the public, the National Department of Health through its office of Standard Compliance, developed National Core Standards for Health Establishments in South Africa, which assists in setting the benchmark of quality care against delivery of services which can be monitored (SouthAfrica, 2011). The Department of Health identified six priority quality areas within the Core Standards that need fast tracking or immediate improvement. Among these six priority areas is the cleanliness of the institutions. This priority area was informed by the hospitals and clinics that were often labelled as dirty, untidy and unhygienic, meaning that the staff neither cared for nor respected their patients or their own colleagues.

In some institutions, it was discovered that cleaning materials and equipment are often inadequate or unavailable because of limited budgets.

Lack of maintenance reinforces the impression of neglect (Health Standards Compliance Office, 2011). Compliance on this priority area was aimed at addressing the following:

- patients satisfaction with the cleanliness and hygiene of the facility, their accommodation, linen and amenities;
- the buildings, wards, toilets, public areas and grounds are kept clean and hygienic to maximise safety and comfort;
- cleaning materials and equipment are available, and staff and managers ensure their proper use in maintaining the cleanliness of the facility;
- general waste is managed to ensure general cleanliness and visual aesthetics; and
- healthcare clinical waste (e.g. soiled dressings) is handled and disposed off safely to reduce health risks to patients and protect the environment and the public from unnecessary exposure (Health Standards Compliance Office, 2011).

1.3 THE RESEARCH PROBLEM

A research problem is a statement about an area of concern, a condition to be improved upon, a difficulty to be eliminated, or a troubling question that exists in scholarly literature, in theory, or in practice which cause for meaningful understanding and deliberate investigation (Brayman, 2007). In other academic disciplines like science studies, the research problem is typically posed in the form of one or more questions. A research problem does not state how to do something, offer a vague or broad proposition, or present a value question (Brayman, 2007).

Public institutions in the Eastern Cape Province are reported to be dirty with poor sanitation. The District Hospital Management office that has an oversight function over District Hospitals of the province is overwhelmed by complaints from communities and other stakeholders concerning cleanliness of these institutions.

According to Charter (2016), local and national reporters are constantly reporting issues of cleanliness, and the challenges prevailing in the public hospitals, hence making the institutions not appealing to the communities. For this reason, the latter then tend to seek health care services in health care institutions in neighbouring

provinces, while other seek help in private institutions which are expensive for individuals without medical aid; while those on medical aid the government is subjected to incur high cost.

Most public hospitals in the province have resorted to outsourcing cleaning and maintenance services due to the fact that permanent workers entrusted with this responsibility seemed not to be failing as the hospitals remained poorly maintained. This move to outsource proved costly as large amounts of money were paid to the cleaning companies. Cleanliness of institutions is one of the six priority areas emphasized by the Department of Health under core standards. Irrespective of this, it has been observed that public hospitals are dirty, and this is compromising the health of the patients as well as lowering the staff morale (NDOH, 2011).This challenge is confirmed by the results of a patient satisfaction survey conducted at Nompumelelo District Hospital in Peddie at Amathole District on the 7th to 11th July 2014. During this period, 108 in-patients revealed that they were not satisfied with the cleanliness in the wards and toilets. The graph below presents the perception of these patients.

This challenge therefore prompted the researcher to investigate the reasons for the poor state of the hospital in terms of cleanliness of toilets, wards and hospital bedding. The findings to this study might, therefore, help save huge amounts of money which can then be directed towards effective service delivery.

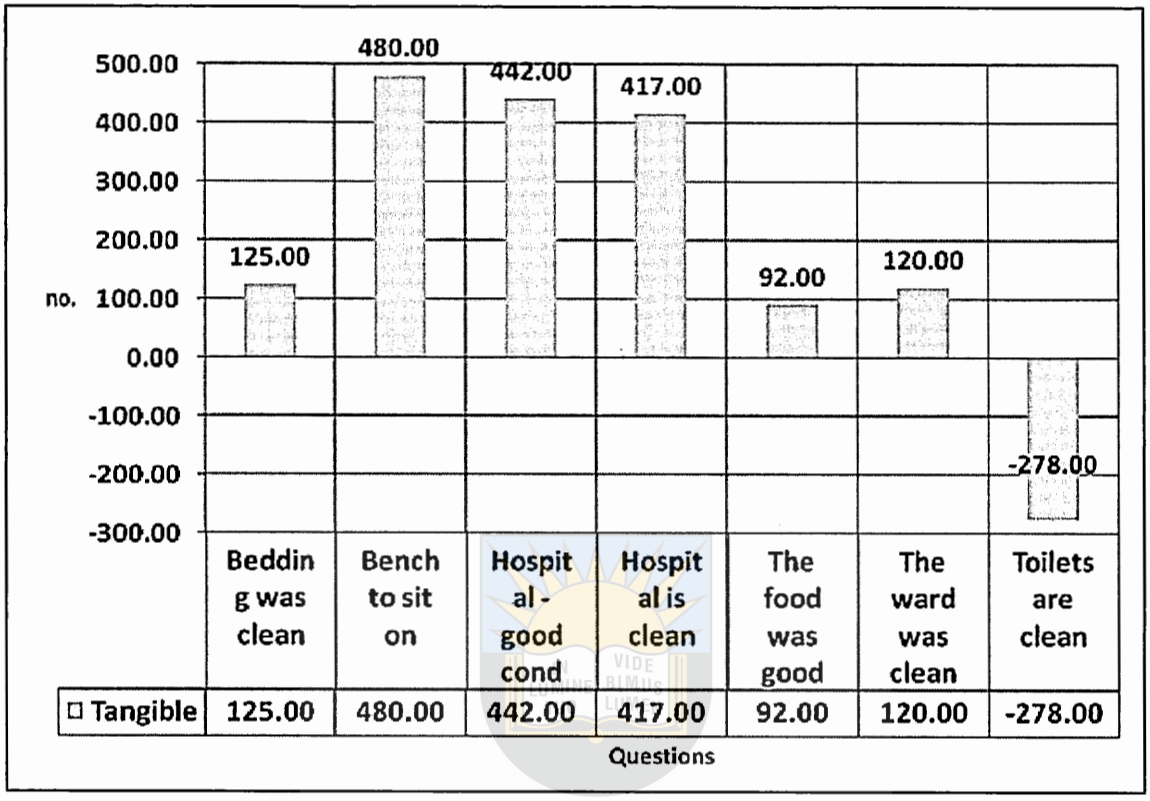

Figure 1:1 Nompumelelo Hospital Client Satisfaction Survey, July 2014

1.4 RESEARCH AIM

Aims are broad statements of desired outcomes or the general intentions of the research which 'paint a picture' of one's research project (Barney et al., 2001). They emphasise what is to be accomplished (not how it is to be accomplished). The aims address the long-term project outcomes, and thus they should reflect the aspirations and expectations of the research topic (Barney et al., 2001). The aim of the study was to explore factors influencing cleanliness in the Public Hospitals of Amathole District in Eastern Cape Province, South Africa with an objective of developing strategies for improvement.

1.5 RESEARCH OBJECTIVES

Objectives can (and usually do) state precisely intended outcome measures that will be used in a research. They are essential because they not only help guide the development of the protocol and design of study, but also play a role in sample size

calculations and determining the power of the study (Farrugia et al., 2010). The objectives of this study were:

- To explore factors that affect cleanliness in Public Hospitals in Amathole District, Eastern Cape Province, South Africa.
- To establish the attitudes and perception of General Assistants on job satisfaction and how to maintain hospital cleanness.

1.6 RESEARCH QUESTIONS

A research question is the fundamental and core component of a research project, study or review of literature. It shapes the study, determines the methodology and guides all the stages of inquiry, analysis and reporting (Farrugia et al., 2010).

The questions that guided this study were as follows:

- What are the factors that affect cleanliness in the Public Hospitals in Amathole District, Eastern Cape, South Africa?
- What are the attitudes and perceptions of General Assistants towards their work?

1.7 SIGNIFICANCE OF THE STUDY

The findings of this study will assist in the development of recommendations that might subsequently help ensure good quality health care delivery to patients. The study will further assist the public institutions to comply with the National Core Standards on quality and cleanness.

Results of this study will also help to ensure that the District hospitals' environment is visually pleasing and informative, comfortable, relieves stress amongst patients and increases satisfaction with the quality of care provided, considering the potential ability of all people through creation of products and environment that everyone can use, regardless of age, physique and degree of disability.

The Department of Health stands to benefit from the study, since the results reflect gaps between expected and experienced service. This will create a basis for quality improvement programmes.

1.8 RESEARCH CONTEXT/DOMAIN

The Eastern Cape Province is predominantly rural than urban. It has about 66 district hospitals mostly situated in rural areas than in urban areas. The study aimed at exploring challenges affecting cleanliness in both rural and urban district hospitals. However, because of the vastness of the province, the research targeted only the Amathole District. The survey was done in only five hospitals, two urban and three rural hospitals so as to get perceptions from both the rural and the urban settings of the participants.

1.9 CHAPTER OUTLINE

- **Chapter one: Introduction and background to the study**

Chapter one sets out the research problems. The chapter looks at the research objectives and the significance of the research. Furthermore, the chapter presents a brief outlook of the research methodology and possible limitations of the study.

- **Chapter two: Literature Review and Conceptual Framework**

This chapter focuses on (literature review) the factors influencing cleanliness in Public Hospitals and suggests measures to enhance cleanliness in hospitals. The review of literature also focuses on the trends in terms of cleanliness in hospitals, government policies and regulation governing the process of maintaining a clean environment in public hospitals.

- **Chapter three: Theoretical Background of the study**

Chapter three of the research presents the research methodology. Thus, this chapter examines aspects of the study, including research design, data collection methods, data collection instrument and methods of data analysis.

- **Chapter four: Research Methodology and Design**

Chapter four focuses on the analysis and interpretation of research results. The research findings were explained according to the formats of the questionnaires for the determinants of cleanliness in public hospitals.

- **Chapter five: Data Analysis and Presentation**

This chapter reviews the research problem, revisits the objectives as well as the hypotheses of the research. It presents some concluding comments on the research and provides recommendations. It highlights the most significant findings from the study.

1.10 OPERATIONAL DEFINITION OF TERMS

Cleanliness of hospitals and clinics

The National Department of Health, through the office of health standards, defines cleanliness as the degree to which a health facility, its buildings, grounds, amenities, equipment and staff are spotlessly clean and tidy (National Department of Health, 2011).

Physical Environment

Physical environment refers to the physical surroundings and conditions affecting people's lives. In this study, it refers to hospital surroundings (Ivanov & Blue, 2008:254).

Mortality Rate

The mortality rate is the number of deaths in a given period (Ivanov & Blue, 2008:254).

Patient

A patient is a person receiving or registered to receive medical treatment (National Department of Health, 2011).

Hospital

According to the Concise Oxford dictionary (2011), a hospital is an institution providing medical and surgical treatment and nursing care for ill or injured people.

Ward

A ward is a separate room or a division in a hospital, for example, medical or surgical ward.

1.11 CONCLUSION

This chapter presented the background information relating to factors influencing cleanliness in public hospitals with the primary aim to develop strategies to ensure

that hospitals provide a clean environment. This chapter has also presented the research problems. More so, the chapter looks at the research objectives, research hypotheses as well as the significance of the research. Furthermore, the chapter stresses the importance of the research methodology, limitations of the study and the layout of the study. Finally, the motivation for the study lies in the fact that the results of the study will have implications on the way hospitals ensure a clean environment in a bid to improve the general work environment. This will help eliminate sanity-related illness and contamination of the environment that might affect visitors and guardians of patients. The following chapter provides an overview of the factors influencing cleanliness in Public Hospitals, both from the literature perspective as well as a theoretical point of view. The chapter will review literature with regard to suggested measures to enhance cleanliness in hospitals.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

The previous chapter focused on the background information of the research, which included the research gap, the research objectives, the research questions, and justifications of conducting this research. This chapter aims to bridge the gap between the research objectives and the literature. Hence, the chapter will provide a detailed analysis of existing body of knowledge to assist the process.

Literature review comprises a process of analysing the existing body of knowledge in order to make informed decisions about policies, resource allocation, practices and research direction. It is intended to "inform the information users about the current state of knowledge on a given subject, along with the strengths and limitations of the underlying research" (Joubert, 2007:66). A wide assortment of books, articles and reports were studied in order to establish other people's views on the topic.

2.2 NATURE OF CLEANLINESS IN PUBLIC HOSPITALS

The National Patient Safety Agency, assisted by a group of experienced cleaning service managers together with members of the Infection Control Nurses Association from both NHS and private sector companies, developed and launched National Specifications for cleanliness in England in 2007 (NHS, 2007). These specifications were to produce "comparative framework" within which public hospitals in England can establish guidelines in the provision of cleaning services and evaluating their cleanliness. They were also designed to provide a simple, easy-to-apply methodology within which hospitals can assess the effectiveness of their cleaning services (NHS, 2007).

The specifications further postulated that, to achieve a high level of cleanliness, one should apply the following guidelines:

- there should be clear specification for cleaning services;
- staff attached to cleaning services should have proper training;
- there should be clear documented lines of accountability amongst staff members; and

- patients, as customers of care, should be actively involved in the cleaning services through continuous patient satisfaction surveys (NHS, 2007).

The study purported that a clean environment provides the right setting for good patient care practice and good infection control, and it is also vital for efficiency and effective health care. It further expounded that through the provision of clear standards, monitoring and auditing processes, hospital cleanliness was improved (NHS, 2007). All cleaning related risks were identified and managed in a consistent, long-term basis, irrespective of where the responsibility for providing cleaning services lies (NHS, 2007).

According to the Nursing Standard Guide by Wearmouth (2004), cleanliness in hospitals is not just cleanliness of the environment, but also exposes attitudes of staff and managers of the facility in the eyes of patients and visitors. The guide further elucidates that patients do rate cleanliness very high and as a result, they should be treated and cared for in a pleasing, spotless and risk-free environment. It also substantiates on the development of cleaning programmes that need to be appropriately focused and effectively devised, so as to continuously render high quality services that are within the expectations of customers (Wearmouth, 2004).

It states that when the introduction of housekeepers was instituted, a dramatic improvement in standards of cleanliness was observed. It further explains that since housekeepers work as part of the ward team, reporting on a day-to-day basis to the ward sister, they developed a sense of ownership which delivered real and visible involvement (Wearmouth, 2004). The impact of housekeepers in many hospitals on cleanliness standards showed a staggering improvement (Wearmouth, 2004).

The guide concluded by referring to a clean environment as the essential part of care, reiterating that nurses, have a significant role to play in ensuring that patient care areas are clean and tidy, thus setting exemplary standards for their wards or department. Cleaning a ward is a skill task that demands an understanding of what, how and when to clean. It is of great importance therefore, that nurses establish a good relationship with those who have the expertise, that is, cleaners, housekeepers and managers who can make a difference to the well-being of patients (Wearmouth, 2004).

Meldrum et al. (2002), with a view to improve cleanliness of hospitals in Scotland, published a document called 'a clean bill of health' that was to be used as a baseline review of hospital cleaning services. The bill made a number of recommendations that aimed at improving the quality and effectiveness of hospital cleaning as well as progress assessments that were to follow up these recommendations. The progress assessments were aimed at investigating the possible reasons for differences in the level of cleanliness, observing the issues set out in a clean bill of health document. The bill also looked at the following factors:

- Frequency of cleaning tasks;
- Staff input on cleaning and monitoring;
- Recruitment and retention of staff; and
- Management arrangements in the application of policies and procedures.

The method used to do the assessments involved organising local auditors together with domestic service managers acting as peer reviewers, and these visited 74 hospitals throughout Scotland between March and May 2002 (AuditScotland, 2002). They reviewed the level of cleanliness in a sample of wards and public areas against a number of specified criteria. Each area reviewed was rated as one of these categories: very good, acceptable, need for improvement. This scenario provided a snapshot of the level of cleanliness in hospitals in Scotland (AuditScotland, 2002).

The outcome of assessments was a very good or adequate level of cleanliness in over 70% of the wards and 80% of the public areas reviewed. Almost half of the hospitals had a very good or acceptable level of cleanliness in all areas reviewed. Only over 20% of hospitals showed a clear need for improvement, with the remainder in need of some minor improvements (AuditScotland, 2002).

The above study showed that even though there are clear guidelines on cleanliness in a given area, the level of cleanliness of the institutions in that particular area will not be the same due to various factors mentioned in this study (AuditScotland, 2002).A National Health Facilities Audit Report which was presented to the National Health Minister of the United Kingdom by the Independent Research Group from Health Systems Trust in February 2012, though it was comprehensively looking at

various health standards, revealed that, out of 82% of institutions audited, 74% of facilities failed dismally on cleanliness tests; while more than half of the institutions were reported to have no medication, 66% were found to be unsafe and almost 70% of staff at health care facilities were reported to be having negative attitudes (Trust, 2012). Though the minister relatively defended the institutions, alleging that the standard tool used for the audit was extremely high, he agreed that a lot of improvement is needed to uplift the standards of care (Health Systems Trust, 2012).

The minister allegedly blamed the staff entrusted with the cleaning responsibility for not being dedicated to their job, thus leading the institutions to rather hire private companies to do the cleaning (NHS, 2003; Trust, 2012). The minister further put the blame for poor health standards on poor implementation of health policies, poor supervision of primary health care and inadequate systems for oversight and governance of clinical care (HST, 2012).

Khumalo (2013), in her study, managed to look at this topic but at a more different angle. She studied factors that influence patients' satisfaction with peri-partum care at Germiston Hospital maternity unit. The study was carried out on 260 women aged 18 years and above during the first three days of the post partum period. In this study, she looked at multiple factors that included cleanliness on this maternity ward. The results of the study showed that about 90% of the women were satisfied with the cleanliness in the maternity ward, and that meant that a few (10%) were not satisfied with the cleanliness in the maternity ward (Khumalo, 2013).

A report by Dave Prentis (2004) gives a clear indication that during its publication, it was a time of intense media and public concern around standards of hygiene in public hospitals. It also lifted the veil on the day-to-day reality of working life for hospital cleaners who were struggling against all odds, in the face of desperate under-resourcing to sustain ever-minimum cleaning standards. UNISON used the content of the publication to ensure that the findings of experts, the opinions of cleaners themselves, was received cordially by policy makers, most importantly the government. In order to unveil the reality in terms of cleaning services in many public hospitals, UNISON opted for a more direct methodology. Instead of seeking the opinions of patients, Trust Chief Executive, matrons, nurses, or non-executives they sought to find answers from cleaning staff themselves in nine critical hospital Trusts

covering twelve hospitals in England, Wales and Scotland (Prentis, 2004; NHS, 2003).

The report further explained that out of those twelve hospitals, five were currently having their domestic services provided by private contractors. Four were just brought back in-house after a period of privatisation. Two remained in-house but have had the level and quality of services disrupted and standards affected by repeated rounds of competitive tendering (Mulholland, 2005). Only one had a high quality service in-house. All the interviews with staff was conducted in December 2004. The responses were 'reproduced verbatim from conversations tape recorded in the hospitals by Dr John Lister of Health Emergency who was researching on behalf of UNISON (NHS, 2007).

It is further deduced that many of the hospital cleaners were left frustrated with their inability to deliver quality patient care and being ignored, even on issues where they had expertise, in a system based on professional elitism that places them at the bottom of the hierarchy" (Prentis, 2004). Adopted from the responses of the cleaners are the following ten key steps as priorities needed to make cleaner hospitals a reality.

2.3 PRIORITISE CLEANING SERVICES

The cleaning staff through the NHS wanted to see the hospital cleaning services made a genuine priority for NHS Trusts, from the top most level of management downwards, including medical and professional staff (Mulholland, 2005). They further expounded that, without proper standards of hygiene in wards, clinics and operating theatres, it was impossible for clinical professionals to deliver high quality, hi- tech medicine. The message was loud and clear that it required a complete break from the culture that had largely prevailed at management level since the competitive tendering of the mid 1980s, which branded cleaning and non-cleaning services as hotel services and saw them as legitimate targets for contracts which slashed back hours of work and quality of care in persuit of the lowest cost (NHS, 2007).

2.4 MORE STAFF, MORE HOURS

Hospital cleaning was seen as a hard, labour-intensive duty in which technology has provided little influence in the last 20 years.

Any enhancement of the cleaning standards, consequently, required a significant increase in the number of hours worked, which in turn, meant an increase in the number of cleaning staff (Prentis, 2004).

2.5 MORE AND BETTER RESOURCES

Cleaners also needed the relevant physical resources helpful to their work. This meant adequate supplies of properly maintained equipment and high quality cleaning materials, along with proper provision of staff rooms, changing rooms and sufficient uniforms and protective clothing to enable all staff to comply with good practice in infection control (NHS, 2003; Mulholland, 2005). Futhermore, the cleaning staff needed to be consulted in advance regarding proposed purchases of new equipment; they also felt that staff concerns on the poor quality of the cleaning fluids and materials that they are using must also be taken seriously (Prentis, 2004).

2.6 STAFF INVOLVEMENT TO ENSURE CONTRACTS MATCH NEEDS

As perceived by cleaners, the cleaning contracts, especially those that have emerged after a period of privatisation, must be re-drawn to ensure sufficient staff and resources that meet the clinical needs of each Trust. They also complained about the poor quality of monitoring and quality control, and that meant poor standards had been allowed to continue in many Trusts. New external supplier contracts to be properly resourced and strictly monitored by suitably qualified staff to ensure that the stipulated hours are being worked and that the specific standards are being consistently delivered (Mulholland, 2005; Prentis, 2004).

2.7 EFFECTIVE TEAMS

It was stressed by the cleaners that, cleaner hospitals could not be secured simply through the existing cleaning staff working harder, and any improvement had to be a team effort. Cleaner hospital teams should include representatives of cleaning staff whose specialist knowledge, commitment and professionalism is vital for day-to-day cleanliness on wards and throughout each hospital (Prentis, 2004).

2.8 RESPECT AND IMPROVING COMMUNICATION

It was envisaged that steps needed to be taken by the Trust and Ward Level management to combat conflict-ridden or discriminatory attitudes towards cleaning,

for example, issues that often lead to domestic staff being invinsible. NHS (2003) also posit that nursing and medical staff must in particular, be educated on the importance of ensuring cleaning staff are viewed and treated as part of the health care team. This will unquestionably mean enhanced communication on the important role of every member of the team. More specifically, it means improved communication with non-clinical staff over potential infection-risks and specific cleaning and hygiene regulations (Prentis, 2004).

2.9 TRAINING FOR ALL

In order to deliver supreme quality cleaning services and to gain recognition as well as to win the respect of experienced cleaning staff, it was necessary for the management and supervision within those services to be appropriately trained in cleaning techniques, health and safety, infection control and in management skills. Improved training opportunities for cleaning staff would allow them to develop their skills and also open up possibilities to improve the quality of domestic services management through internal promotion and bring better recruitment and retention (NHS, 2007; Prentis, 2004).

2.10 GIVING SCOPE TO RESPOND TO CRITICISM

The potential for conflicts of interest between patients and their visitors exercising their rights, on the one hand, and cleaning staff in busy wards seeking to carry out their duties, on the other, needed to be taken more seriously by managers and by cleaning schedules and ward routines.

Any system which urged more members of the public to complain about standards of cleanliness and other services must be balanced by a procedure that ensures that the staff in the affected service area are given genuine opportunities to respond to criticism and encouraged to work with other sections of staff to reshape services to improve standards (Prentis, 2004).

2.11 BRINGING CLEANING SERVICES BACK IN-HOUSE

Experience in the NHS showed 20 years of failure as a result of a system of market testing which had led to drastic cost cutting, decline and unacceptable levels of cleaning standards in hospitals.

Competition for contracts within that system had reduced even in-house services to the lowest common denominator. The answer is not to provide more guidance in terms of bringing about quality services: private companies would certainly not take blame when things go wrong nor would give Matrons powers to refuse to give money to underperforming contractors in order to solve the problem.

Rather than transferring risks, all that was achieved by continuing with contracting-out was losing control (NHS, 2007). Cleaning staff argued tremendously that their services should be in-house within the NHS. Thus bringing services back in-house should be seen as a vital first step towards restoring lost standards of care through team working. Unless staffing levels and hours of work were also raised, there was little chance that services will genuinely improve (Prentis, 2004).

2.12 BETTER PAY AND CONDITIONS

As much as there is need to increase staffing establishments, serious attention was needed to address the high turnover and intolerable vacancy levels, evident from many cleaning services, both in-house and external services (Mulholland, 2005). Providing decent rewards and conditions of employment was one way to show staff that they are valued. The introduction of the Agenda for Change in the NHS ensured that domestic staff was on the same pay and conditions as other NHS staff.

The knowledge and skills framework required all staff to have personal development plans and access to further training and development. Those were important advances that should apply to all cleaning staff. The Secretary of State had given a commitment to UNISON to end the two-tier workforce in health. Urgent attention should be given to ensure that Agenda for Change becomes a reality for all cleaning staff (Prentis, 2004). Guh (2010), in her study, concluded that the transmission of many health care pathogens was related to the contamination of near-patient surfaces and equipment; therefore, all hospitals were encouraged to develop programs to optimize the thoroughness of high touch surface cleaning as part of terminal room cleaning at the time of discharge or transfer of patients. Hospitals were, therefore, urged to develop dedicated resources to implement objective monitoring programs (Guh & Carling, 2010).

Carling and Bartley (2010), in their report, stressed that studies that used direct covert observation or a fluorescent targeting method had constantly confirmed that patients admitted to rooms previously occupied by patients with hospital infections had a considerably greater risk of getting the same infections than patients not occupying such rooms. The findings showed that disinfection cleaning could be improved, on average, more than 100% over baseline, and that such improvements have been associated with a decrease in environmental contamination of high touch surfaces (Carling & Bartley, 2010).

Centres for Disease Control and Prevention (CDCP) Guidelines for Environmental Infection Control in Health care Facilities recommended that hospitals should clean and disinfect high-touch surfaces. The report went on to recommend that hospitals should monitor cleaning performance to ensure consistent cleaning and disinfection of surfaces in close proximity to the patient and likely to be touched by the patient and health care professionals. It confirmed that the constant evaluation and constant monitoring of cleaning interventions reduce the risk of transmission of environmental pathogens through defined procedures and have been elements of infection prevention and control practice in many hospitals (Carling & Bartley, 2010).

2.13 CONCLUSION

This chapter provided an overview of the factors influencing cleanliness in the Public Hospitals, both from the literature perspective as well as the theoretical point of view. The chapter also discussed information from literature with regard to suggested measures to enhance cleanliness in hospitals. Perspectives from various researchers gave the researcher in this study the understanding of other people's perceptions on issues related to the topic under inquiry. Importantly. It gave the researcher the direction to take based on the limitations that other researchers encountered. The next chapter focuses on the description of the research methodology used, with particular focus on the study design, the popuplation, the sample and the instrument used to collect data.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter focused on the description of research methodology used and the context wherein the study took place. It further describes the study design, the target population and the sample, and data analysis. The issues of validity and reliability as well as ethical considerations are also discussed.

The research aim was to explore factors influencing cleanliness in the Public Hospitals of Amathole District in the Eastern Cape Province, South Africa so as to develop strategies for improvement.

3.2 RESEARCH DESIGN

A quantitative research design was employed in this study. Wyse (2011) describes quantitative research as an approach used to quantify the problem by way of generating numerical data that can be transformed into usable statistics. It is used to give meaning to attitudes, opinions, behaviours and other defined variables and generalize results from a larger sample population.

Burns and Grove (2005:23) define quantitative research approach as "a formal, objective, systematic process in which numerical data are used to obtain information about the world". It is used to describe variables, examine relationships among variables and determine cause and effect interactions between variables (Burns & Grove, 2005).

A research design is described by Durrheim and Terre Blanche (2002:29) as a "strategic framework for action that combines research questions and the execution of the research". The research design guides the procedure of conditions for collection and analysis of data in a manner that links relevance to the research purpose. Its' designed and planned nature distinguishes research from other forms of observation (Terre Blanche & Durrheim, 2002).

The design basically seeks to include vital techniques that will be employed in the implementation of the research and, thereby, provide details and comprehensive

information about all three aspects of research (Terre Blanche & Durrheim, 2002). The descriptive approach was followed. It sought to describe the factors affecting cleanliness as well as attitudes and perceptions of general assistants in public hospitals. The study was investigated the respondents in a natural environment (hospital) and was not manipulative, as the respondents were observed as they were (Brink, 2000).

3.3 RESEARCH SETTING

The study was conducted in five district hospitals, namely: Butterworth, Tafalofefe, Nompumelelo and Cathcart hospitals which are under Amathole District in the Eastern Cape Province in South Africa. From Buffalo City Municipality, Bisho Hospital was included in the research. Butterworth and Cathcart hospitals were categorised as urban institutions, while both Nompumelelo and Tafalofefe hospitals are rural institutions. All these hospitals are level1 district hospitals and render level 1 district hospital package. They get clients and patients that are referred from Community Health Centres and feeder clinics while some clients are self-referral.

3.4 DATA COLLECTION METHOD

A structured questionnaire that was in vernacular (*IsiXhosa*) was used as the targeted group literacy rate was very low. However, the responses were translated in English for reporting purposes. In order to ensure that there was consistency and accuracy in interpreting the responses, the researcher sought the services of the translator from Language Department of the University of Fort Hare.

3.5 TARGET POPULATION

The target population for this research consisted of all general assistants (both males and females) of different ages with or without any level of training and working in medical and surgical general wards. However, other general assistants from other clinical sections were also included in the research as it was initially debated and ultimately confirmed that there is rotation of all general assistants from one section to another due to staff shortages in all the district hospitals visited. All these people are the workforce assigned to the cleaning unit. General Assistants' experience has been found to be an important determinant of cleanliness in a hospital setting. A research population is also known as a well-defined collection of individuals or

objects known to have similar characteristics. All individuals or objects within a certain population usually have a common, binding characteristic or trait (Castillo, 2009).

3.5.1 Inclusion Criteria

The research sought to find opinions from day staff (male and female), general assist staff and housekeeping staff. These were hospital employees working in medical, surgical wards and in all other clinical areas present at work on the days of the visit. The researcher had enough time to visit the institutions during the day time.

3.5.2 Exclusion Criteria

All nurses and other multi-disciplinary team working in medical and surgical wards including operational managers were excluded in the study.

3.6 SAMPLING

A sample of 58 subjects was selected from five institutions. The sample included 13 male general assistants and 45 female general assistants. The sample was derived from General Assistants who were on duty on the day of data collection. Potential respondents who matched in the definition of the sample criteria were identified by the researcher at the four district hospitals. The sample size of 58 General Assistants was the total number that was willing to participate and they met the criteria in all four district hospitals.

Sampling can be defined as the selection of some part of an aggregate or totality on the basis of which a judgement or inference about the aggregate or totality is made (Karthikeyan & Sangeetha, 2013). Sampling involves decisions about which people, settings, events, behaviours and social processes to observe and exactly what will be sampled in a particular study is influenced by the unit of analysis (Karthikeyan & Sangeetha, 2013). The researcher quite often selects only a few items from the universe for the study purpose. All this is done on the assumption that the sample data will enable him to estimate the population parameters. The items selected constitute what is technically called a sample; their selection process or technique is called a sample design, and the survey conducted on the basis of sample is described as sample survey.

A sample should be truly representative of population characteristics without any bias, so that it may result in valid and reliable conclusions (Karthikeyan & Sangeetha, 2013; Terre Blanche & Durrheim, 2002).

A stratified random sampling (by location) approach was used to select participants. The researcher selected 100% of day staff (general assistants) who were present during data collection days from each ward of the four district hospitals. The study targeted two rural and two urban hospitals in the Amathole Health District with ten (10) district hospitals. The fifth hospital was from Buffalo City Health District with two district hospitals. However, results obtained would be generalized to all district hospitals in the district.

- **The Sampling Criteria**

All General Assistants included in the sample were selected based on the following set criteria:

- ✓ At least 18 years old and above;
- ✓ Are in good mental and physical health to complete the questionnaire;
- ✓ Are present at the enumeration day;
- ✓ Are willing to participate; and
- ✓ Be of either sex or any race

3.7 DATA COLLECTION INSTRUMENT

A structured questionnaire was used as a data collection instrument to gather information on perceptions, attitudes and facts about the topic. It was chosen because it allowed the researcher to obtain data from a large sample relatively fast (Brink, 2000). The questionnaire was also advantageous because:

- It would help achieve the research objectives;
- It obtained the most complete and accurate information possible;

- A well-structured questionnaire made it easier for respondents to give the necessary information and for the interviewer to record the answer, and it was arranged so that sound analysis and interpretation were possible;
- It kept the interview brief and to the point and was so arranged that the respondent(s) remained interested throughout the interview; and
- It offered anonymity since names of respondents were not required on the questionnaire.

A questionnaire refers to a self-report instrument where the respondent writes his or her answers in response to printed questions or document. A well designed questionnaire is easy for the respondents to fill out and it is easy for the researcher to administer and score (Brink, 2000).

The researcher consulted with the supervisor regarding the design and structuring of the questionnaire to ensure that the questionnaire would fetch the desired data. The questionnaire was then submitted to a qualified statistician for verification of questions in order to ascertain whether it would yield statistically analysable responses. The questionnaire was further sent to a qualified language translator to be translated into *IsiXhosa* at the final stage, since the level of English proficiency among the respondents was expected to be low. The respondents were guided on how to easily complete the questionnaire through clearly explaining the instructions and guidelines.

Data is the vital and most elementary input with which researchers work, and this data could come from an observation, could be numbers; numeric or quantitative data or language; qualitative data. It should be valid and reliable so that the researcher draws out valid and reliable conclusions for the study (Terre Blanche & Durrheim, 2002).

The questionnaire was a five-point scale questionnaire consisting of positively and negatively phrased items grouped into two sections. Section 1 was constructed to address the demographic data of the respondents, and section 2 was constructed to get clear responses to 23 questions that were related to the objectives of the study.

3.7.1 Data Collection Procedure

The respondents were visited in their work areas so as to avoid or minimise the disturbance of the hospital routine. Questionnaires were personally distributed to the respondents and left for a week for them to engage and complete comfortably.

3.8 VALIDITY AND RELIABILITY

Reliability and validity are interrelated. The two qualities are considered when selecting a research instrument. In essence, reliability is very much a part of validity in that an instrument that does not yield reliable results cannot be considered valid (Brink, 2000).

3.8.1 Reliability

Reliability is defined as the ability of an item to perform a required function under specified conditions for a specific period of time (Defense, 2005). Joppe (2000) defines reliability as the extent to which results are consistent over time, and an accurate representation of the total population under study is referred to as reliability and whether the results of a study can be reproduced under a similar methodology, then the research instrument is considered to be reliable. Reliability can also be the extent to which the results of the research are repeatable. This applies both to subject's scores on measures and to the outcomes of the study as a whole (Terre Blanche & Durrheim, 2002).

The researcher did not participate in the activities under investigation but only collected the data from a distance. The information was collected and captured accurately. The responses from the questions asked in the questionnaires were almost similar and reliable on numerous occasions. Questionnaires from one hospital to another yielded similar and consistent results.

3.8.2 Validity

Types of validity include:

- **Internal validity** - the extent to which causal conclusions can be drawn;
- **External validity** - the extent to which generalising from the data and context of the research study to the broader populations and settings is possible;

- **Measurement validity** - the extent to which the constructs in the research question are successfully operationalised;
- **Interpretative validity**- the extent to which the appropriate conclusions are drawn from the data; and
- **Statistical validity**- the extent to which the study has used an appropriate design and statistical methods of analysis (Terre Blanche & Durrheim, 2002).

Joppe (2000) is of the view that validity in quantitative research determines whether the research truly measures that which is intended to be measured or how truthful the research results are. In other words, validity answers the question: does the research instrument allow the researcher to hit "the bull's eye" of the research object? Researchers generally determine validity by asking a series of questions and will often look for the answers in the research of others" (Joppe, 2000).

Validity and reliability were guaranteed through a pilot survey that would be conducted before the main data collection exercise. The instrument used measured exactly what it was supposed to measure. Moreover, there was consistency, stability and repeatability of the respondent's account as well as the researcher's ability to collect and record information gathered accurately (Brink, 2000). Questions were informed by the content on the literature.

The researcher used the same questionnaires approved by an experienced researcher. In order to check for validity, the research instrument was submitted to a researcher and statistician at the University of Fort Hare. As a result, eight more questions were added to ensure higher representativeness. All persons approached to participate in the study completed the questionnaires, and external validity was ensured. Generalising the findings to all district hospitals is, therefore, justified.

3.9 PRETESTING THE QUESTIONNAIRE

One method that researchers use to test practical aspects of a research study is to conduct a pilot study. The aim was to test the scales of the questionnaire items. Brink (2000) describes the pilot study as a small-scale study from the scaled sample extracted from the population that was intended for the eventual project. The purpose of the pilot study is further explained as one that investigates the feasibility of the proposed study and to detect possible flaws in the data collecting instruments

(Brink, 2000). The researcher pre-tested the questionnaire and adopted it accordingly. In pre-testing, 17 General Assistants were available at Bhisho hospital, and all were given questionnaires and responses were collected a week later.

3.10 DATA ANALYSIS

Data was analysed using Statistical Package for Social Sciences (SPSS) software with the assistance from a qualified statistician. According to Brink (2000), if the researcher ignores the use of statistics, the collected data would be of no use because statistical methods of analysing data assist the researcher to summarise, interpret and further communicate the data.

Descriptive statistical tools were used to give inferences and interpret the results of data analysis. Brink (2000), described it as the discipline of quantitative research that describes the main features of collection of information or quantitative description itself. Descriptive statistics are differentiated from inferential statistics in that, descriptive statistics aim to summarise a sample, rather than use data to learn about the population that the sample of data is thought to represent (Brink, 2000). This generally means that descriptive statistics, unlike inferential statistics, are not developed on the basis of probability theory. Even when a data analysis draws its main conclusions using inferential statistics, descriptive statistics are generally also presented. Some measures that are commonly used to describe a data set include measures of central tendency and measures of variability or dispersion (Brink, 2000). Measures of central tendency consist of the mean, median and mode, while measures of variability include the standard deviation (or variance), the minimum and maximum values of variables, kurtons and skewness (Brink, 2000).

3.10.1 Use Of Statistical Analysis

Descriptive statistics provide simple abstracts about results obtained from the selected sample and about the observations that have been made. According to Trochim (2011), such summaries may be either quantitative (summary statistics) or visual (simple to understand graphs). These summaries may either form the basis of the initial description of data as part of a more extensive statistical analysis or may be sufficient for a particular investigation. The use of descriptive and summary

statistics has an extensive history. Indeed, simple tabulation of populations and economic data was the first way the topic of statistics appeared (Trochim, 2011).

3.11 ETHICAL CONSIDERATIONS

In accordance with acceptable ethical practice, the researcher pledged to keep respondents' identities anonymous and to use the data provided by respondents only for the purpose it was collected for and ensuring confidentiality. Whilst respondents were encouraged to answer all questions in the questionnaire, they were given the liberty to refrain from answering any specific question or even quit the survey as and when they desire.

Written approval to collect data from human respondents for this research was obtained from University of Fort Hare Research Ethics Committee, the Research Committee of the Department of Health, Eastern Cape Province, District Health Managers of Buffalo City for Bhisho Hospital Pilot site and Amathole District for all four hospitals and all CEOs of hospitals where the study took place. Lastly, informed consent was obtained from the participants themselves before they completed the questionnaires.

The Office for the Protection of Research Subjects, University of Southern California (2009) defines informed consent as a voluntary agreement to participate in a research. It is not merely a form that is signed but is a process in which the subject has an understanding of the research and its risks. In this study, the participants were fully informed about the purpose of the research, their rights during the research, benefits of participation and information relating to completing the questionnaire. They were also assured that the exercise was risk-free with no cost implications.

3.12 CONCLUSION

The main aim of the study was to get answers from the target population through the use of scientific techniques which started by the definition of the problem, collection of data, organisation and evaluation of data and making informed conclusions. The researcher conducted a quantitative research design which comprised fact-finding

enquiries which were relevant to an existing problem. Bi-lingual, that is, English and vernacular questionnaires of the same meaning were used. The researcher personally distributed the questionnaires to 41 subjects of the identified hospitals and to 17 subjects of the pilot hospital. The questions in the questionnaires referred to, were 23 in number and were either positively or negatively framed. This chapter has discussed on how the data was gathered and arranged to appropriately answer the research question and contribute in solving the research problem.

CHAPTER FOUR

ANALYSIS AND INTERPRETATION OF RESEARCH FINDINGS

4.1 INTRODUCTION

The preceding chapter presented aspects of the research methodology and design strategy used by the researcher. The primary purpose of this chapter is to present, interpret, analyse and discuss the main findings of this research project. The main aim of the study was to explore factors influencing cleanliness in public hospitals of Amathole District in Eastern Cape Province, South Africa, with an intention to to develop strategies for improvement. The study also focused on investigating the attitudes and perceptions of General Assistant staff on their cleaning roles and how they maintain a clean environment in clinics and hospitals. These issues were chosen owing to the fact that, they are among the principal factors that determine cleanliness in the public hospitals. Furthermore, the study investigated the challenges faced by general assistant staff in ensuring cleanliness in the public hospitals.

For the purpose of extracting meaning from the data, the results are presented in tables, figures and graphs. The following sub-sections present the results as guided by the questionnaire.

4.2 RESPONSE RATE

An acceptable response rate should be above 55% (Coakes, 2005). For the purpose of achieving the objectives of this research, the following table presents the total responses provided by the respondents against the total number of questionnaires issued out for completion.

Table 4.1: Questionnaire Response Rate

Sample	Total	Percentage
Original	60	100%
Discarded	2	0.33%
Final Research sample "Response rate"	**58**	**99.967%**

According to the data in Table 4.1 above, a total number of 60 questionnaires were given to respondents. However, 58 questionnaires were returned, and two questionnaires were discarded. Analysis was done using the 58 fully completed questionnaires which gave the response rate of 99.9%. Considering the fact that the recommended response rate should be above 55%, then this percentage can guarantee accurate results.

4.3 THE NORMALITY OF THE DATA

Prior to conducting a detailed analysis of data, the data was checked for normality, as Coakes (2005:35) recommends that every research should ensure that data is normally distributed before continuing with statistical analysis. There are two common measures of normality depending on the sample size. Based on the proposition by Coakes (2005:35), a Shapiro-Wilks test is suitable for a sample size less than 100 respondents. On the other hand, for samples greater than 100, a Kolmogorov-Smirnov test (KMO) test is more applicable. For the purpose of this particular study, the sample size was sixty (60) respondents. As a result, the researcher chose to use the Shapiro-Wilks test to test normality of data. "The normality of data is assumed when the significance level is greater than 0.05" (Coakes, 2005:35). Based on the results, as obtained from the Shapiro-Wilks test, the data was normally distributed since it was significantly above 0.05.

4.4 RELIABILITY OF THE DATA COLLECTION INSTRUMENT

The questionnaire consisted of two sections. The first section (section 1) focused on the demographic aspects of the respondents. The second section (section 2) dealt with the factors affecting cleanliness in healthcare institutions.

The reliability of the questionnaire is important to establish the authenticity of the data collection instrument, thus giving the researcher the assurance that the research instrument can possibly be reliable and or produce desirable results if used to collect data using population with similar characteristics. The reliability of the scales for section 2 was measured using the Cronbach's alpha coefficient.

Table 4.2: Reliability test of the questionnaire

Variables	No. of items	Coefficient analysis
Demographic	4	0.715
Choice determinants	23	0.771

The reliability of the scales was presented in Table 4.2 above. The Cronbach's alpha for Section 2 of the questionnaire consisting of 23 questionnaire items was 0.771. This indicated high reliability of the questionnaire. The demographic section had 4 questionnaire items and a Cronbach's alpha of 0.715, which also revealed that the scales were reliable. With these results, it can be confidently concluded that the questionnaire was reliable and valid.

4.5 DEMOGRAPHIC PROFILE OF RESPONDENTS

Section 1 of the questionnaire aimed at establishing the distribution of demographic information of respondents in terms of the number of years in the Department of Health, gender, age, and marital status. This was done to check for variations in respondents' opinions, perceptions and experience on the factors that affect cleanliness in the public hospitals across different demographic divides.

Table 4.3 Demographic characteristics of the participants

		Frequency (n)	Percent (%)
Gender distribution of respondents			
	Male	13	22.4
	Female	45	77.6
Age distribution of respondents			
	21-30 years	2.0	3.4
	31-40 years	13.0	22.4
	41-50 years	15.0	25.9
	51-55 years	16.0	27.6
	Above 55 years	12.0	20.7
Marital Status of respondents			
	Married	23.0	39.7
	Single	23.0	39.7
	Widow/ Widower	9.0	15.5
	Divorced	3.0	5.2
Work experience in public hospitals			
	2 or less	13.0	22.4
	3 years	4.0	6.9
	5 years	4.0	6.9
	6 years	5.0	8.6
	Above 6 years	32.0	55.2
Distribution of respondents by Hospital			
	Cathcart	3.0	5.2
	Nompumelelo	10.0	17.2
	Butterworth	10.0	17.2
	Bhisho	17.0	29.3
	Tafalofefe	18.0	31.0

4.5.1 The gender of Respondents

The purpose of the question was to establish the proportion of each gender group that participated in the survey and to determine whether the variable *gender* has an influence on the respondents' perception of the factors that affect cleanliness in the Public Hospitals.

From Table 4.3 above, it is evident that female respondents dominated the study, constituting 77.6% of the respondents, while male respondents constituted only 22.4% of the total sample. This distribution suggested that the majority of general support staff in public hospitals were females. This trend was consistent with the findings by Armstrong (2013) which indicated that women dominate in assisting occupations such as in support of health services at 88%.

4.5.2 Age of the Respondents

The age of the respondents to some extent, influences their understanding of certain situations and events that happen in their workplace. This may either be controlled by the people they associate with or their experience with the work environment. The purpose of this analysis was to determine the distribution of respondents across age groups and also to use the distribution to establish the patterns of responses in terms of their knowledge and experience with factors that influence cleanliness of public hospitals.

The results presented in Table 4.3 show that most of the respondents were within the age range of 51-55 years and constituted 27.6% of the total sample, whilst 25.9% of the respondents were between 41 and 50 years of age. Only 3.4% of the sample was in the age range of 21-30 years. This meant that the general support staff members in public hospitals were elderly people. These results are consistent with the assertion by Armstrong and Armstrong (2002) in that the majority of cleaning staff in hospitals of Canada were elderly people.

4.5.3 Marital Status of Respondents

The purpose of the question was to make comparisons of the variations and distribution of respondents with regard to their marital status.

These classifications are also meant to establish the perceptions of each group in terms of their knowledge, perceptions and experience with regard to the factors that influence cleanliness of public hospitals. The classification of respondents by their marital status is shown in Table 4.3 above.

The proportion of married staff members and single staff members was equal (37.9%). The least from the distribution were the divorced respondents at 5.2% of the total sample; while the widowed was only 15.5%. This trend goes along with the results of the study by Madventure (2013) which posits that the majority of elderly single mothers in Ghana take up part-time jobs and volunteer to work in hospitals to support their families.

4.5.4 Work Experience in Public Hospitals

Working experience determines the level at which an individual gets to understand the working environment. The purpose of this question was to establish the variation of participants' responses against the time they spent working in the public hospital environment. The level of experience also influenced the propensity of respondents to understand the trends, challenges and factors that impact the cleanliness in public hospitals.

According to the results presented in Table 4.3 above, more than half of the respondents spent more than 6 years in a public hospital work environment. Less than 25% of respondents spent less than 2 years of working in a public hospital environment. This finding suggested that the majority of respondents who took part in this research had significant experience of working in the public health environment. This implies that they were knowledgeable of factors that influence cleanliness of public hospitals, which is vital for this research.

4.5.5 Distribution of Respondents by Hospital

The researcher was of the opinion that respondents' perceptions and experience may vary from one hospital to the other. As a result, the question of the name of the hospital was included in the research for respondents to indicate the hospital where they work. The distribution of respondents in terms of the hospital where they belong is presented in Table 4.3.

From the distribution in Table 4.3, most of the respondents came from Tafalofefe (31%). Bisho was also included in the pilot study and from the distribution above, 29.3% of respondents were from Bisho hospital, and the lowest number of respondents came from Cathcart (5.2%). Further, Nompumelelo and and Butterworth had the same number of respondents (17.2%).

4.6 FACTORS AFFECTING CLEANLINESS IN PUBLIC HOSPITALS

Table 4.4 below presents the output from the analysis of descriptive statistics for all the variables deemed to be factors that contribute to the cleanliness of public hospitals. In this regard, the respondents were asked to give their opinion on these pre-determined factors. The mean and the standard deviation are the major determinants of the importance of these variables. The *max* indicates the highest scale and *min* represent the lowest scale selected with regard to that particular variable. The ranking of the factors in terms of their highest mean values indicate the factors which respondents perceive to be the most important in determining how they can contribute and maintain cleanliness in public hospitals.

Table 4.4: Factors Affecting Cleanliness in Public Hospitals

Measured Statements	N	Max	Min	Mean	St-Dev
An improvement in cleaning standards requires more cleaning staff	58	1	5	4.81	0.606
To maintain cleanliness, cleaning staff needs the right physical resources	58	1	5	4.72	0.812
Hospital cleaning services should be made a general priority	58	1	5	4.60	0.748
I clean the ward more than once a day	58	2	5	4.48	0.800
I am aware of correct dilution rates for disinfectants in use	58	1	5	4.26	1.052
My contract tenure influences how I work	58	1	5	4.14	1.176
The hospitals are not clean because patients always mess-up	58	1	5	3.86	1.444
Nurses and doctors always mess-up for us to clean	58	1	5	3.78	1.377
I am aware of procedures to follow when removing blood and body spillages	58	1	5	3.64	1.471
Congestion in hospitals makes it difficult to maintain cleanliness	58	1	5	3.57	1.286
The supervisor/ house keeper inspects the ward at least twice a day	58	1	5	3.48	1.380
Individuals not knowledgeable about cleaning are supervising cleaners	58	1	5	3.47	1.441
Work morale is generally low	58	1	5	3.43	1.440
Policies regarding cleanliness are clear, accessible and understandable	58	1	5	3.34	1.264
Cleaning staff are viewed and treated as part of health care teams	58	1	5	3.24	1.490
The wards are having housekeepers	58	1	5	2.90	1.640
Cleaners do get advice or in-service training on ward cleanliness	58	1	5	2.86	1.504
There are up to date cleaning schedules, detailing all equipment and staff	58	1	5	2.78	1.464
The management is helpful and caring to us	58	1	5	2.55	1.453
If I do not clean well, no one will hold me accountable	58	1	5	2.19	1.263
Cleaning staff are given opportunities to develop their skills	58	1	5	2.16	1.335
The department values cleaners through salary and working conditions improvement	58	1	5	2.00	1.351
There are awards for the best cleaner	58	1	5	1.71	.991

Table 4.4 above presents findings with regard to comparative importance of these behavioural tools to influence cleanliness of a hospital or clinic. The results indicate that goal-oriented factors have a greater influence on improving cleanliness of public hospitals than incentive-driven factors. Looking at the mean scores, the following factors were regarded as the most crucial to maintain a clean environment in hospitals: an improvement in cleaning standards requires more cleaning staff "4.81", to maintain cleanliness, cleaning staff needs the right physical resources "4.72", hospital cleaning services should be made a general priority "4.60", and 'I clean the ward more than once a day' was "4.48". On the other hand, incentive-driven factors such as: cleaning staff are given opportunities to develop their skills "2.16", the department values cleaners through salary and working conditions improvement "2.00", and there are awards for best cleaner "1.71" received lower rankings as they have the least mean score, suggesting that they have little influence on the cleanliness of hospitals.

4.6.1 Principal Component Analysis

In order to lessen the amount of factors influencing cleanliness of public hospitals into useful pieces and a manageable number of factors, the *principal component analysis* was used. In order to confirm that the results and the sample could allow principal component analysis, a measure of sampling adequacy was done using the Kaiser-Meyer-Olkin (KMO) and Bartlett's Test. Table 4.5 below presents the KMO results.

Table 4.5: KMO and BTS

Variables	
KMO	0.733
BTS	466.524
Sig.	0.001

Sig. at 0.05 (2-tailed)

The results (BTS = 466.524; sig. =0.001) specified that the data were suitable to effect factor analysis. Statistically, this means that there is a relationship between the variables and thus it signifies that they can be applicably included in the factor analysis. More so, the result of the KMO measure of sampling adequacy was 0.733.

The results show that there are satisfactory items for each factor, and the two tests validate the relevance of the factor analysis procedure.

4.6.1.1 Factor rotation

The purpose of rotation is to lessen the number of factors on which the variables being investigated have high loadings. Rotation does not essentially change the meanings of the variables but makes the interpretation of the analysis easier, thus grouping factors with similar effects and meaning. The results from the rotation matrix are presented in Table 4.6 below.

Table 4.6: Factor Rotation Matrix

	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
Cleaning staff are given opportunities to develop their skills	0.772				
There are up to date cleaning schedules, detailing all equipment and staff	0.742				
The management is helpful and caring to us	0.652				
The department values cleaners through salary and working conditions improvement	0.594				
Cleaners do get advice or in-service training on ward cleanliness		0.729			
I am aware of procedures to follow when removing blood and body spillages		0.726			
Work morale is generally low		0.630			
Policies regarding cleanliness are clear, accessible and understandable		0.613			
I am aware of correct dilution rates for disinfectants in use		0.574			
My contract tenure influences how I work		0.477			
Congestion in hospitals makes it difficult to maintain cleanliness			0.804		
Individuals not knowledgeable about cleaning			0.666		

are supervising cleaners					
Nurses and doctors always mess up for us to clean			0.565		
An improvement in cleaning standards requires more cleaning staff				0.858	
To maintain cleanliness, cleaning staff need the right physical resources				0.790	
If I do not clean well, no one will hold me accountable				0.772	
I clean the ward more than once a day				0.770	
Cleaning staff are viewed and treated as part of health care teams				0.659	
The supervisor/ housekeeper inspects the ward at least twice a day				0.473	
Hospital cleaning services should be made a general priority					0.855
The hospitals are not clean because patients always mess-up					0.657
There are awards for the best cleaner					0.584
The wards are having housekeepers					0.537
Eigen values	18.044	10.797	10.254	8.815	7.494
% of variance	12.625	12.625	12.625	12.625	12.625
Cronbach's alpha	0.761	0.801	0.765	0.708	0.774

From 23 questionnaire items, the 23 factors were reduced to five different factors. The five factors that influence cleanliness of public hospitals are presented in the table above in the order of rank as specified by their contribution to the percentage of total variance, thus;

- Factor one was labelled as *Institutional support.* The factor included four items. Cronbach's alpha for the factor yielded a value of 0.761 indicating the reliability of the factor.
- Factor two was labelled *Institutional policy.* The factor consist six items. Cronbach's alpha for the factor yielded a value of 0.801 indicating the reliability of the factor.
- Factor three was labelled *work environment*. The factor consists of three items. Cronbach's alpha for the factor yielded a value of 0.765 indicating the reliability of the factor.
- Factor four was labelled as *availability of resources.* The Eigenvalue for the factor is 3.648. The factor consists of six items. Cronbach's alpha for the factor yielded a value of 0.708 indicating the reliability of the factor.
- Factor five was labelled as *work ethics*. The Eigenvalue for the factor is 2.532. The factor consists of four items. Cronbach's alpha for the factor yielded a value of 0.774, thus indicating the reliability of the factor.

4.6.1.2 Mean values of each factor

The table below presents the aggregate means of each factor in the order of importance when choosing the most influential factor towards ensuring the cleanliness of the hospital.

Table 4.7: Mean factor scores

Factor	Mean
Availability of resources	3.82
Institutional policy	3.61
Work environment	3.6
Work ethics	3.27
Institutional support	2.37

From the information presented in Table 4.7 above; availability of resources (3.82) plays an important role in determining the cleanliness of public hospitals.

This is indicated by the highest mean score from the information provided by respondents. Although it is regarded as important factor, institutional support (2.37) is the least of all the factors that influence cleanliness of public hospitals.

4.6.2 T-Test Factors Influencing Cleanliness and Gender

In order to understand the variation in perceptions, knowledge and experience of respondents across gender divides, a t-test was conducted. The results of the t-test are presented in Table 4.8 below.

Table 4.8: T-Test Factors Influencing Cleanliness and Gender

Variable	Gender	
	T	P value
Availability of resources	-1.643	.106
Institutional policy	.926	.359
Work environment	1.422	.171
Work ethics	-.463	.645
Institutional support	1.725	.090

The results assumed homogeneity of variances using Leven's test for equality of variances at ($p>0.05$). The two tailed test also revealed that there were no significant differences between the respondents' perceptions, knowledge and experience of the factors influencing cleanliness of hospitals. Table 4.8 reveals that "Sig. (2-tailed)" or the "p-value" was greater than 0.05 on all occasions with the highest being ("Sig. (2-tailed)" = 0.645) and the lowest being ("Sig. (2-tailed)" = 0.090). The results of this analysis reveal that there is no significant difference on the position of male and female respondents regarding their knowledge and experience on cleanliness of hospitals.

4.6.3 Analysis of Variance

The Analysis of variance (ANOVA) was done in order to make comparisons of the differences within groups of demographic variables (years working in public hospital "experience", marital status and age) with regard to their knowledge, perceptions and experience of the factors that influence cleanliness in public hospitals.

The Pearson correlation p-value is used to test the significance of the difference between the named factors that influence cleanliness and the demographic variables. In essence, a p-value of ($p<0.05$) is regarded as a perfect measure of the significance of the statistical difference. The F statistics state the strength that the demographic variable effect has on the factor variables.

4.6.4 Analysis Of Variance: Marital Status and Age

An analysis of the difference within age groups assists the researcher to have an insight of whether the age of the respondents has a bearing on their perceptions and opinion with regard to cleanliness of public hospitals. Furthermore, marital status is also regarded as a factor that may determine how people react to situations. In this regard, the researcher sought to find out whether differences exist between the perceptions of cleaning staff based on their marital status. Table 4.9 below presents the distribution of the results of the analysis of variance.

Table 4.9: Analysis Of Variance: Marital Status and Age

Variable	Age		Marital status	
	F	P-Value	F	P-Value
Availability of resources	0.946	0.445	0.473	0.702
Institutional policy	0.884	0.480	1.027	0.388
Work environment	1.521	0.209	0.068	0.977
Work ethics	1.215	0.315	0.512	0.676
Institutional support	1.668	0.171	0.207	0.891

From Table 4.9 above, we can observe that the significance level in each group, "sig" p-value, is greater than 0.05. The highest are ("Marital status" (P=0.977) and "age" (P=0.480), and the lowest are ("Marital status" (P=0.388) and "Age" (P=0.171). The F statistics state the strength that the demographic variable effect has on the factor variables. The strength of the effect is indicated by a higher "F value". Given the information provided in the table above, we can conclude that age and marital status do not impact the responses provided by respondents.

4.6.5 Analysis of Variance: Experience and Hospital

The Analysis of variance (ANOVA) was done in order to make comparisons of the differences within groups of demographic variable years working in public hospital, and factors that determine cleanliness. The analysis is based on the notion that the duration of stay within a work environment may be a measure of how much an individual understands the work environment. As a result, the researcher sought to examine whether there were significant differences within groups of the variable experience with regard to the factors that influence cleanliness in public hospitals. Table 4.10 below presents the distribution of the results of the analysis of variance.

Table 4.10 Analysis of Variance Hospital and Experience

Variable	Experience		Hospital	
	F	P-Value	F	P-Value
Availability of resources	1.859	0.131	0.710	0.589
Institutional policy	2.605	0.056	2.378	0.063
Work environment	2.129	0.090	1.558	0.199
Work ethics	1.436	0.235	1.230	0.309
Institutional support	1.486	0.220	1.149	0.344

From table 4.10 above, we can observe that the significance level in each group - "sig" p-value is greater than 0.05. The highest are "Experience" (0.235), and "Hospital" (P=0.589) and the lowest are ("Marital status" (P=0.056) and "Hospital" (P=0.063). Given the information presented in the table above, we can conclude that the number of years working in a public hospital did not affect the responses given by respondents.

4.7 CROSS TABULATION: CHI SQUARE TEST

The study employed the Pearson's chi-square test for association in order to determine if there is a relationship between two categorical variables. In order to determine the association between knowledge and experience of participants regarding the significant importance of the five factors in influencing cleanliness of public hospitals, cross tabulation was done.

The cross tabulation included the following variables from the factor analysis: availability of resources, institutional policy, work environment, work ethics and institutional support. This analysis is also important to assist in deciding whether the research objectives are achieved.

4.7.1 Relationship between Availability of Resources and Cleanliness

The cross tabulation of the factors for availability of resources was conducted and yielded the results as presented in Table 4.11 below.

Table 4.11: Chi-square Tests: Relationship between Availability of Resources and Cleanliness

	Value	Degrees of Freedom	Pearson Chi-Square (P-Value)
Pearson Chi-square	32.472[a]	16	.009
Likelihood Ratio	34.099	16	.005
Linear-by-Linear Association	12.220	1	.000
N of Valid Cases	58		

According to the data from Table 4.11 above, there is statistically significant association between availability of resources and cleanliness. Pearson Chi-square is significant at ($p<0.05$). We can observe that Pearson Chi-square is $p = 0.009$, and at $p\chi(1) = 32.472$. This means that availability of resources plays a significant role towards ensuring cleanliness in public hospitals. These results are consistent with the findings of Mahlatse (2011) who found that rural clinics fail to keep sanitary standards due to lack of resources, skills or suitable institutional support. As a result, it can be concluded that resource availability plays a critical role in ensuring a clean hospital environment.

4.7.2 Relationship between Institutional Policy and Cleanliness

Cross tabulation of the effect of institutional policy in ensuring a clean hospital environment was conducted and yielded the results as presented in table 4.12 below.

Table 4.12: Chi-Square Tests - Relationship between Institutional Policy and Cleanliness

	Value	Degrees of Freedom	Pearson Chi-Square (P-Value)
Pearson Chi-Square	24.601[a]	16	0.037
Likelihood Ratio	32.889	16	0.008
Linear-by-Linear Association	0.317	1	0.574
N of Valid Cases	58		

According to Table 4.12 above, there is statistically significant association between institutional policy and cleanliness. The results of Pearson Chi-square are significant at ($p<0.05$). We can observe that Pearson Chi-square is $p = 0.037$, at $p\chi(1) = 24.601$. Thus, we can conclude that the guiding principles of the hospital and the regulatory authorities in the health sector greatly impact the cleanliness of public hospitals. These results are consistent with the results of the study by Jeanes (2016).

4.7.3 Relationship between Work Environment and Cleanliness

The cross-tabulation of the effect of work environment on cleanliness of public hospitals was conducted to test whether there is a close association between the impact of work environment and cleanliness. The results are presented in Table 4.13 below.

Table 4.13: Relationship between work environment and cleanliness

	Value	Degrees of Freedom	Pearson Chi-Square (P-Value)
Pearson Chi-square	27.588[a]	16	0.035
Likelihood Ratio	34.370	16	0.005
Linear-by-Linear Association	8.709	1	0.003
N of Valid Cases	58		

According to the data in Table 4.13 above, there is a statistically significant association between the impact of work environment and cleanliness of public hospitals. The results of Pearson Chi-square are significant at ($p<0.05$). We can observe that "Pearson Chi-square" is $p = 0.035$, at $p\chi (1) = 27.588$. This means that in the eyes of the general support staff, the favourability of the work environment impact the way they keep it clean. These results are consistent with suggestions by NHS Estates (2004). As a result, a conclusion can be made that an improved work environment leads to clean public hospitals.

4.7.4 Relationship between Work Ethics and Cleanliness

Cross-tabulation of the effect of work ethics on cleanliness of public hospitals was conducted to test whether there is a close association between the impact of work environment and cleanliness. The results are presented in Table 4.14 below.

Table 4.14: Relationship between Work ethics and Cleanliness

	Value	Degrees of Freedom	Pearson Chi-Square (P-Value)
Pearson Chi-Square	33.508[a]	16	0.007
Likelihood Ratio	35.310	16	0.003
Linear-by-Linear Association	9.719	1	0.000
N of Valid Cases	58		

According to the data in Table 4.14 above, there is a statistically significant association between the impact of work environment and cleanliness of public hospitals. The results of Pearson Chi-square are significant at ($p<0.05$). We can observe that Pearson Chi-square is $p = 0.007$ at $p\chi(1) = 33.508$. This means that the general support staff is observing the ethical issues within the hospital environment and motivates them to ensure that hospitals remain clean. These results are consistent with suggestions by NHS Estates (2004) in the 'The Healthcare Facilities Cleaning Manual'. As a result, it can be concluded that ethics is a strong determinant of cleanliness in hospitals.

4.7.5 Relationship between Institutional Support and Cleanliness

Cross tabulation of the factors for availability of resources was conducted and yielded the results as presented in Table 4.15 below.

Table 4.15: Chi-Square Tests: Relationship between Institutional Support and Cleanliness

	Value	Degrees of Freedom	Pearson Chi-Square (P-Value)
Pearson Chi-square	30.002[a]	16	0.000
Likelihood Ratio	29.099	16	0.005
Linear-by-Linear Association	12.211	1	0.000
N of Valid Cases	58		

According to the reading from Table 4.15 above, there is statistically significant association between institutional support and cleanliness. Pearson Chi-square is significant at ($p<0.05$). We can observe that Pearson Chi-square is $p = 0.000$, at $p\chi(1) = 30.002$. This means that the support provided by the hospital and associated institutions plays a significant role towards ensuring cleanliness in public hospitals. These results are consistent with the findings of WHO (2002) as well as Mahlatse (2011) who found out that rural clinics fail to keep sanitary standards due to lack of resources, skills and adequate institutional support. As a result, a conclusion can be made that institutional support plays a critical role in ensuring a clean hospital environment.

4.8 SUMMARY

The chapter focused on analysis of data and interpretation of the results. The research findings were presented according to the format of the questionnaire. The distribution of respondents in terms of gender was skewed towards females. The results of the T-test showed that there are no statistically significant differences in the mean scores of males and females (gender) with regard to their knowledge, understanding and experience of the factors that determine cleanliness in hospitals.

The results of the ANOVA also revealed that there are no statistically significant differences in the mean scores of number of years working in public hospitals, age and marital status. The results of the Chi-square test reveal that the five factors (availability of resources, institutional policy, work environment, work ethics, and institutional support) play a contributing role towards cleanliness of public hospitals. The next chapter re-examines the research problems and the research objectives and provides the conclusions and recommendations of the study. In addition, the limitations of the research will be highlighted and the areas for further research suggested.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The previous chapters provided the foundation, direction, methodology and results. This chapter provides recommendations and concluding remarks on factors influencing cleanliness in Public Hospitals of Amathole District in Eastern Cape Province, South Africa with an intention to develop strategies for improvement. This chapter is outlined as follows: short summary of each chapter; the proposed recommendations relating to the research objectives; reflection on the achievement of objectives; the limitations of the study; the areas for further study and finally, concluding remarks.

5.2 SUMMARY

Based on the format of a formal research report, this report is made up of five chapters. The purpose of each chapter is given in the summary as presented.

Introduction and background information to the study (Chapter One)

The primary focus of this study was to explore factors influencing cleanliness in the public hospitals in order to develop strategies to improve the way hospitals ensure a clean environment. As a result, this chapter defines the research problems, the research objectives and the significance of the research. Furthermore, the chapter presented a brief outlook of study.

Review of literature on factors influencing cleanliness (Chapter Two)

Chapter two of this study focused on (literature review) on the factors influencing cleanliness in the public hospitals and suggested measures to enhance cleanliness in hospitals. The review of literature also focused on the trends in terms of cleanliness in hospitals, government policies and regulations governing the process of maintaining a clean environment in public hospitals. The theoretical review was also done as a way of determining, evaluating and measuring factors that influence cleanliness.

Research methodology (Chapter Three)

Chapter three of this research looked at the research methodology. This chapter looked at the major aspects of the process of research, including research design, data collection methods, data collection instrument and methods of data analysis.

Research findings (Chapter Four)

Chapter four focused on the analysis and interpretation of the results. The research findings were explained accordingly. Table 5.1 presents the null hypothesis for factor relationship tested.

Table 5.1 Assessment of Objectives Achievement

Factor Relationship Tested (null)	Results
There is no significant relationship between Availability of resources and cleanliness of public hospitals.	There is a statistically significant positive relationship.
There is no significant relationship between Institutional policy and cleanliness of public hospitals.	There is a statistically significant positive relationship.
There is no significant relationship between work environment and cleanliness of public hospitals.	There is a statistically significant positive relationship.
There is no significant relationship between Work ethics and cleanliness of public hospitals.	There is a statistically significant positive relationship.
There is no significant relationship between Institutional support and cleanliness of public hospitals.	There is a statistically significant positive relationship.

5.3 RECOMMENDATIONS

The study makes a significant contribution to the body of literature on the factors that influence the hospital support staff to ensure and maintain a clean environment in public hospitals, where empirical research is essentially non-existent. The theoretical underpinning of the study was the 'Environmental Theory's Model'. South African public hospitals are faced with the challenge of competitive pressure from private hospitals. Reports from the media outlets reveal that most public hospitals are

lagging behind in terms of hygiene and cleanliness, thus exposing patients to hygiene-related illness. As a result, patients opt for private hospitals.

Empirically, the study acknowledged the significant determinants of cleanliness in public hospitals. Looking at the opinions and perceptions of the general support staff with regard to the factors they consider to influential to cleanliness, the study also investigated the challenges faced by general assistant staff when working to ensure cleanliness in the public hospitals. Therefore, an understanding of the influence of these factors can help hospital management to define their strategies to attract, retain and motivate hospital support staff to ensure a cleaner environment. More so, that means support staff will always prioritize cleanliness in public hospitals.

The findings revealed that general support staff places much emphasis on resource matters as the most important factor that enables them to maintain a clean environment in hospitals. Given this perspective, hospital management should make it a priority to seek information from support staff on resources they need and make those resources available whenever they are needed. This will reduce or eliminate delays in action that might result from extended time between sourcing the required resources and actual cleaning of facilities.

Given that the study pointed to the importance of institutional policy in influencing cleanliness of public hospitals, there should be clearly documented guidelines of accountability amongst general support staff. This gives the staff members a sense of ownership and accountability, thus improving their effectiveness and efficiency in cleaning. This proposition is also in line with the specifications of the National Patient Safety Agency of England, which state that a clean environment sets precedence for a safer working environment for doctors and nurses as well as a safe environment for patients against hygiene-related infections.

The study pointed out that the work environment influenced how general support staff performed their duties of maintaining a clean environment in public hospitals. In this regard, the study recommends that the managers of hospitals should advance staff health and safety using workplace measures as people prioritise health and safety in their working environment. In this regard, it is evident that cleaning staff are exposed to employee healthcare related risk such as contracting infectious diseases from patients through airborne infections and surface contamination infections.

This means that adequate resources should be available to prevent such work-related risk in order to give assurance and motivation to general support staff so that they can deliver their duties with confidence.

Ethics in the workplace are very important to govern and direct the emotions and activities of employees. The study suggests that work ethics have a positive relationship with cleanliness of public hospitals. This entails that general support staff should always be informed of generally accepted work practice relative to the hospital setting. For instance, it is generally accepted that the facilities and equipment should always be clean no matter how many times these get dirty because it is the general norm of all healthcare institutions to prioritise cleanliness, which ultimately means avoiding unnecessary spreading of infections. This is not only the duty of the cleaning staff; thus the study recommends that the management must always communicate to the general support staff about acceptable behaviour of employees at the hospital in line with cleanliness.

The study revealed that institutional support plays a significant role in influencing general support staff to ensure cleanliness of public hospitals. Therefore, the study recommended staff development (skills development through training) as a measure that will help to increase staff efficiency, reduce errors, and elevate staff satisfaction. Institutional support may also come in the form of benefits of working in a well-structured and secure environment. Therefore, hospital managers should strive towards designing better workplaces that will attract employees with greater determination.

All these factors suggest that support from the institution, whether in material terms and or non-material terms, plays a significant role in supporting cleanliness. Therefore, it is the duty of all employees regardless of the position to ensure that a clean environment always prevails.

5.4 ACHIEVEMENT OF OBJECTIVES

This section gives an account of the measures leading to success of the study in light of the research objectives put forward in chapter one. The aim of the study was to determine the factors that general support staff in hospitals believed could influence their chances of keeping the hospital environment clean.

The main objective was to explore empirically these important determinants of cleanliness in public hospitals. This was achieved through the review of the literature in chapters two, the research methodology in chapters three and the presentation of empirical results, conclusions and recommendations in chapters four and five. The factors identified as significant in influencing cleanliness in public hospitals are as follows: availability of resources, institutional policy, work environment, work ethics and institutional support. These factors were extracted from twenty three factors recognised through the analysis of secondary literature and confirmed by field data.

5.5 LIMITATIONS OF THE STUDY

The study was limited to general support staff. Therefore, it may mean that generalisations of results with regard to factors considered to influence cleanliness be treated with caution. This is because patients, visitors, doctors and nurses may have different perceptions of the factors influencing cleanliness. The study concentrated only on one province and one district in South Africa. The small sample may have limited the size of responses. Due to the number of limitations mentioned, maximum care should be taken when interpreting, applying the results of this study and generalising the findings to the rest of South Africa.

5.6 AREAS FOR FURTHER STUDY

The current study focused more on the general support staff as agents responsible for maintaining a clean environment in rural and urban public hospitals. If we look closely, patients represent the most important segment in the health sector because they are the actual customers of healthcare services. Therefore, they should be actively involved in paving way for a cleaner environment by also sharing their opinions and perceptions of the environment they get their treatment from. This may be done through continuous patient satisfaction surveys. For comparative purposes, future research could look into the perceptions of patients on determinants of cleanliness in public hospitals. Moreover, future research could also strive to make comparisons between the factors that influence cleanliness in public hospitals and those that influence cleanliness in private hospitals.

5.7 CONCLUSION

The significance of this study can be observed from two dimensions; practical implications and theoretical contributions. Theoretically, the results of this study fill a crucial gap in literature, on factors that influence cleanliness in rural and urban public hospitals. As a result, the outcomes of this study can add to the existing body of literature and can also serve as a basis on which future research can be built. On the practical side, this study can help hospital managers and healthcare practitioners to choose the most important determinants of cleanliness and work towards improving them. Such information should help the management of hospitals in devising suitable workplace motivational strategies for motivating general support staff to keep up with the need to maintain cleanliness of hospitals.

The findings from this study revealed that general support staff working in most public hospitals is of the view that factors like availability of resources, institutional policy, work environment, work ethics and institutional support are crucial for maintaining a clean environment in hospitals. Therefore, such factors should be considered seriously by healthcare managers and hospital managers. Although the findings can possibly be generalised to other institutions in South Africa and beyond, especially those which share common characteristics such as; policies and regulations, resources, health and similar staff skills profile), it would be interesting to examine the applicability of the findings by replicating similar studies in other parts of South Africa, in African countries and beyond.

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APPENDIX I: ENGLISH QUESTIONNAIRE

University of Fort Hare
Together in Excellence

QUESTIONNAIRE

I am Xolani Tofu pursuing Masters in Public Health with the University of Fort Hare, East London Campus. I would like to inform you that this questionnaire will be kept confidential and will be solely used to compare the responses of the participants. This information will remain anonymous.

INSTRUCTIONS

Please answer all the questions by crossing (x) as indicated below in the appropriate block of your choice and also complete the blank spaces where applicable. For example:

Male	**X**
Female	

Section 1: Demographic Data

This section of the questionnaire refers to biographic information.

Age in years

17 – 20	
21 – 30	
31 – 40	
41 – 50	
51- 55	
>55	

Gender

Male	
Female	

Marital status

Married	
Single	
Divorced	
Widowed	

Number of years in the Department of Health including the current one

<2	
3	
4	
5	
6	
More than 6	

SECTION 2: FACTORS AFFECTING CLEANLINESS.

To what extent do you agree/disagree with these factors?

Indicate your opinion using the following 5 point scale by crossing (X)

1. **Hospital cleaning services should be made a general priority by management.**

Choice	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
Score	1	2	3	4	5

Comment_____

2. **An improvement in cleaning standards requires a major increase in numbers of cleaning staff.**

Choice	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
Score	1	2	3	4	5

Comment_____

3. **In order to maintain cleanliness, cleaning staff also need the right physical resources to work with.**

Choice	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
Score	1	2	3	4	5

Comment_____

Cleaning staff are viewed and treated as part of health care teams.

Choice	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
Score	1	2	3	4	5

Comment_____

4. Cleaning staff are given opportunities to develop their skills.

Choice	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
Score	1	2	3	4	5

Comment_____

5. The department values cleaners through salary improvements and better working conditions.

Choice	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
Score	1	2	3	4	5

Comment_____

_____

6. Cleaners do get advice or in-service training on ward cleanliness from infection control team.

Choice	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
Score	1	2	3	4	5

Comment_____

7. The wards are having housekeepers.

Choice	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
Score	1	2	3	4	5

Comment_____

8. There are up-to-date cleaning schedules, detailing all equipment and staff responsibilities for dedicated areas and equipment, are clearly displayed.

Choice	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
Score	1	2	3	4	5

Comment_____

The supervisor/ housekeeper inspects the ward at least twice a day.

Choice	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
Score	1	2	3	4	5

Comment_____

9. I clean the ward more than once a day.

Choice	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
Score	1	2	3	4	5

Comment_____

10. I am aware of procedures to follow when removing blood and body spillages.

Choice	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
Score	1	2	3	4	5

Comment_____

11. I am aware of correct dilution rates for disinfectants in use.

Choice	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
Score	1	2	3	4	5

Comment_____

12. Management is helpful and caring to us.

Choice	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
Score	1	2	3	4	5

Comment_____

Policies regarding cleanliness are clear, accessible and understandable.

Choice	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
Score	1	2	3	4	5

Comment_____

13. The hospitals are not clean because patients always mess-up (are not considerate)

Choice	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
Score	1	2	3	4	5

Comment_____

14. If I do not clean well, no one will hold me accountable

Choice	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
Score	1	2	3	4	5

Comment_____

There are awards for best cleaner

Choice	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
Score	1	2	3	4	5

Comment_____

19. My contract tenure (casual vs. contract vs. permanent) influences how I work

Choice	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
Score	1	2	3	4	5

Comment_____

20. The staff (nurses and doctors) are not considerate (they always mess-up for us to clean)

Choice	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
Score	1	2	3	4	5

Comment_____

21. The hospitals/ clinics are overly congested and it is difficult to maintain cleanliness

Choice	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
Score	1	2	3	4	5

Comment_____

_____

22. Individuals not knowledgeable about cleaning are supervising cleaners

Choice	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree

Score	1	2	3	4	5

Comment_____

23. Work morale is generally low

Choice	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
Score	1	2	3	4	5

Comment_____

In your view, what do you think needs to be done to improve cleanliness in our public hospitals?

General comment:

_____

THANK YOU

APPENDIX II: QUESTIONNAIRE IN ISIXHOSA

University of Fort Hare
Together in Excellence

ULUDWE LWEMIBUZO YOPHANDO (QUESTIONNAIRE)

NdinguXolani Tofu ofundela ukuba yinjinga (Masters) kwezeMpilo yoLuntu kwiZiko lemfundo enomsila eFort Hare (KwaNokholeji) kwiSebe eliseMonti. Ndinqwenela ukukwazisa kwantlandlolo ukuba iimpedulo zakho zolu ludwe lwemibuzo ziya kuba yindaba yakwamkhozi yona ingaxelelwa mntu kwaye ziya kusetyenziselwa kuphela ekuthelekiseni nezinye iimpendulo ezinikwe ngabanye abathathe inxaxheba kolu phando. Amagama abantu abanikeze ngolu lwazi akasayi kuchazwa.

IMIYALELO

Nceda uphendule yonke imibuzo ngokubeka ungxabalaza (x) kwibhokisi echanekileyo njengoko kuboniswe kulo mzekelo ungezantsi:

Indoda/ owasebuhlanti	X
Umama/ owasetyhini	

Kwakho gcwalisa izikhewu kwiindawo ekudingeka ukuba wenze oko.

ICANDELO LOKU-1: Iinkcukacha ezimayela nokuzalwa

Eli icandelo loludwe lwemibuzo yophando lungamagqabantshintshi ngobomi bomntu.

Ubudala ngokweminyaka

17 – 20	
21 – 30	
31 – 40	
41 – 50	
51- 55	
>55	

Isini

ndoda/ owasebuhlanti	
Umama/ owasetyhini	

Imeko ngokunxulumene nomtshato

Utshatile	
Awutshatanga	
Wohlukene nomyeni/ inkosikazi yakho	
Ungumhlolo/ umhlolokazi	

Inani leminyaka eliquka nalo umiyo uphangelela eli Sebe lezeMpilo

<2	
3	
4	
5	
6	
Ngaphezu kweminyaka emi- 6	

ICANDELO LESI- 2: IMIBA ENGQAMENE NOCOCEKO

Uvumelana okanye awuvumelani kangakanani nale miba?

Bonisa uluvo lwakho ngokubeka ungxabalaza (x) usebenzisa lo mlinganiselo unamanqanaba amahlanu.

1. **Iinkonzo zokucocwa kwesibhedlele zimelwe ukwenziwa ukuba yinto esemqoka/ ephambili ngokubanzi sisigqeba esilawulayo.**

Khetha kwezi	Ndivuma ngokupheleleyo	Ndiyavuma	Andiqinisekanga	Andivumi	Andivumi kwaphela
Amanqaku	1	2	3	4	5

Hlomla_____

2. **Ukuphuculwa komgangatho wococeko udinga ngamandla ukuba kwandiswe inani labasebenzi abacocayo.**

Khetha kwezi	Ndivuma ngokupheleleyo	Ndiyavuma	Andiqinisekanga	Andivumi	Andivumi kwaphela
Amanqaku	1	2	3	4	5

Hlomla_____

3. **Ukuze ucoceko lugcinwe lusemgangathweni abasebenzi abacocayo badinga izixhobo ezizizo zokusebenza.**

Khetha kwezi	Ndivuma ngokupheleleyo	Ndiyavuma	Andiqinisekanga	Andivumi	Andivumi kwaphela
Amanqaku	1	2	3	4	5

Hlomla_____

4. **Abasebenzi abacocayo bathathwa yaye baphathwa njengenxalenye yeqela labakhathalele impilo**

Khetha kwezi	Ndivuma ngokupheleleyo	Ndiyavuma	Andiqinisekanga	Andivumi	Andivumi kwaphela
Amanqaku	1	2	3	4	5

Hlomla_____

5. **Abasebenzi abacocayo banikwa amathuba okuphuhlisa izakhono zabo.**

Khetha kwezi	Ndivuma ngokupheleleyo	Ndiyavuma	Andiqinisekanga	Andivumi	Andivumi kwaphela
Amanqaku	1	2	3	4	5

Hlomla_____

6. **ISebe libonakalisa ukubaxabisa abasebenzi abacocayo ngokubanyusela imivuzo nokumimithekisa iimeko abasebenza phantsi kwazo.**

Khetha kwezi	Ndivuma ngokupheleleyo	Ndiyavuma	Andiqinisekanga	Andivumi	Andivumi kwaphela
Amanqaku	1	2	3	4	5

Hlomla_____

Abasebenzi abacocayo bayayizuza ingcebiso okanye uqeqesho emsebenzini oluvela kwiqela elithintela ukosuleleka.

Khetha kwezi	Ndivuma ngokupheleleyo	Ndiyavuma	Andiqinisekanga	Andivumi	Andivumi kwaphela
Amanqaku	1	2	3	4	5

Hlomla_____

7. **Amagumbi ezigulane anabalawuli abongamele ukucocwa kwamagumbi ezigulane.**

Khetha kwezi	Ndivuma ngokupheleleyo	Ndiyavuma	Andiqinisekanga	Andivumi	Andivumi kwaphela
Amanqaku	1	2	3	4	5

Hlomla_____

Kukho uludwe lwamaxesha okucoca eliquka inkcukhaca ngezixhobo zokusebenza kwakunye noxanduva lwabasebenzi abaphawulelwe iindawo ezithile kwakunye nobuxhakaxhaka/ izixhobo zokusebenza. Konke oku kucaciswe kwaselubala

Khetha kwezi	Ndivuma ngokupheleleyo	Ndiyavuma	Andiqinisekanga	Andivumi	Andivumi kwaphela
Amanqaku	1	2	3	4	5

Hlomla_____

Umlawuli owongamela ukucocwa kwegumbi lezigulane uhlola kabini ngemini ubuncinane ukucocwa kwegumbi elo lezigulana.

Khetha kwezi	Ndivuma ngokupheleleyo	Ndiyavuma	Andiqinisekanga	Andivumi	Andivumi kwaphela
Amanqaku	1	2	3	4	5

Hlomla_____

Ndilicoca igumbi lezigulane ngaphezu kwesihlandlo esinye ngemini.

Khetha kwezi	Ndivuma ngokupheleleyo	Ndiyavuma	Andiqinisekanga	Andivumi	Andivumi kwaphela
Amanqaku	1	2	3	4	5

Hlomla_____

8. **Ndiyayiqonda kakuhle imigqaliselo elandelwayo xa kugutyulwa igazi nezinye izinto eziphaleleyo eziphuma emzimbeni.**

Khetha kwezi	Ndivuma ngokupheleleyo	Ndiyavuma	Andiqinisekanga	Andivumi	Andivumi kwaphela
Amanqaku	1	2	3	4	5

Hlomla_____

9. **Ndiwuqonda kakuhle umlinganiselo wokuxuba izibulala-ntsholongwane ekudingeka ukuba ndizisebenzise.**

Khetha kwezi	Ndivuma ngokupheleleyo	Ndiyavuma	Andiqinisekanga	Andivumi	Andivumi kwaphela
Amanqaku	1	2	3	4	5

Hlomla_____

Isiggqeba sabaphathi siluncedo kuthi kwaye sisikhathalele.

Khetha kwezi	Ndivuma ngokupheleleyo	Ndiyavuma	Andiqinisekanga	Andivumi	Andivumi kwaphela
Amanqaku	1	2	3	4	5

Hlomla_____

10. Imigaqo siseko yolawulo engqamene nococeko icacile iyafumaneka yaye iyaqondakala.

Khetha kwezi	Ndivuma ngokupheleleyo	Ndiyavuma	Andiqinisekanga	Andivumi	Andivumi kwaphela
Amanqaku	1	2	3	4	5

Hlomla_____

Izibhedlele zimdaka kuba izigulane soloko zingcolisa (azicingeli/ azikhathali)

Khetha kwezi	Ndivuma ngokupheleleyo	Ndiyavuma	Andiqinisekanga	Andivumi	Andivumi kwaphela
Amanqaku	1	2	3	4	5

Hlomla_____

Ukuba andicoci kakuhle, akukho mntu uza kundithethisa ukuba luxanduva lwam olo.

Khetha kwezi	Ndivuma ngokupheleleyo	Ndiyavuma	Andiqinisekanga	Andivumi	Andivumi kwaphela
Amanqaku	1	2	3	4	5

Hlomla_____

Zikhona iimbasa ekuwongwa ngazo umcoci obagqwesa bonke abanye.

Khetha kwezi	Ndivuma ngokupheleleyo	Ndiyavuma	Andiqinisekanga	Andivumi	Andivumi kwaphela
Amanqaku	1	2	3	4	5

Hlomla_____

11. Indlela endiqashwe ngayo (ukuba ngumsebenzi ongaqashwanga isigxina, okanye oqashwe okwethuba elithile, mhlawumbi oqashwe isigxina) inegalelo kwindlela endisebenza ngayo.

Khetha kwezi	Ndivuma ngokupheleleyo	Ndiyavuma	Andiqinisekanga	Andivumi	Andivumi kwaphela
Amanqaku	1	2	3	4	5

Hlomla_____

12. Abasebenzi (abanjengabongikazi kwakunye noogqirha) abanankathalo (basoloko bengcolisa ze balindele ukuba mayibe sithi abacocayo)

Khetha kwezi	Ndivuma ngokupheleleyo	Ndiyavuma	Andiqinisekanga	Andivumi	Andivumi kwaphela
Amanqaku	1	2	3	4	5

Hlomla_____

13. Izibhedlele/ iiklinikhi zixinene kakhulu ze oko kwenze ukuba kube zima ukuzigcina zicocekile.

Khetha kwezi	Ndivuma ngokupheleleyo	Ndiyavuma	Andiqinisekanga	Andivumi	Andivumi kwaphela
Amanqaku	1	2	3	4	5

Hlomla_____

14. Abantu abangenalwazi ngococeko ngabo abangabalawuli abongamela abasebenzi abacocayo

Khetha kwezi	Ndivuma ngokupheleleyo	Ndiyavuma	Andiqinisekanga	Andivumi	Andivumi kwaphela
Amanqaku	1	2	3	4	5

Hlomla_____

15. Ukuzijula ijacu emsebenzini kukwiqondo eliphantsi jikelele.

Khetha kwezi	Ndivuma ngokupheleleyo	Ndiyavuma	Andiqinisekanga	Andivumi	Andivumi kwaphela
Amanqaku	1	2	3	4	5

Hlomla_____

Kweyakho imbono ucinga ukuba yintoni engenziwa ukuphucula ucoceko kwizibhedlele zethu zikawonke wonke?

Hlomla
ngokuphangaleleyo_____

Ngxatsho ke! ndibamba ngazini, maz' enethole!

APPENDIX III: ETHICAL CLEARANCE

University of Fort Hare
Together in Excellence

ETHICAL CLEARANCE CERTIFICATE
REC-270710-028-RA Level 01

Certificate Reference Number:	MUP051STOF01
Project title:	**Revisiting challenges concerning cleanliness of the public Hospitals in Eastern Cape.**
Nature of Project:	Masters
Principal Researcher:	Xolani James Tofu
Sub-Investigator:	
Supervisor:	Dr W Mupindu

On behalf of the University of Fort Hare's Research Ethics Committee (UREC) I hereby give ethical approval in respect of the undertakings contained in the above-mentioned project and research instrument(s). Should any other instruments be used, these require separate authorization. The Researcher may therefore commence with the research as from the date of this certificate, using the reference number indicated above.

Please note that the UREC must be informed immediately of

- Any material change in the conditions or undertakings mentioned in the document
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research

The Principal Researcher must report to the UREC in the prescribed format, where applicable, annually, and at the end of the project, in respect of ethical compliance.

Special conditions: Research that includes children as per the official regulations of the act must take the following into account:

Note: The UREC is aware of the provisions of s71 of the National Health Act 61 of 2003 and that matters pertaining to obtaining the Minister's consent are under discussion and remain unresolved. Nonetheless, as was decided at a meeting between the National Health Research Ethics Committee and stakeholders on 6 June 2013, university ethics committees may continue to grant ethical clearance for research involving children without the Minister's consent, provided that the prescripts of the previous rules have been met. This certificate is granted in terms of this agreement.

The UREC retains the right to

- Withdraw or amend this Ethical Clearance Certificate if
  - Any unethical principal or practices are revealed or suspected
  - Relevant information has been withheld or misrepresented
  - Regulatory changes of whatsoever nature so require
  - The conditions contained in the Certificate have not been adhered to

- Request access to any information or data at any time during the course or after completion of the project.

- In addition to the need to comply with the highest level of ethical conduct principle investigators must report back annually as an evaluation and monitoring mechanism on the progress being made by the research. Such a report must be sent to the Dean of Research's office

The Ethics Committee wished you well in your research.

Yours sincerely

Professor Gideon de Wet
Dean of Research

25 February 2016

APPENDIX IV: APPROVAL LETTERS DEPARTMENT OF HEALTH

Eastern Cape Department of Health

Enquiries:	Zonwabele Merile	Tel No:	040 608 0830
Date:	01 March 2016	Fax No:	043 642 1409
e-mail address:	zonwabele.merile@echealth.gov.za		

Dear Mr. X.J. Tofu

Re: Revisiting challenges concerning cleanliness of the Public Hospitals in Eastern Cape (EC_2016RP13_480)

The Department of Health would like to inform you that your application for conducting a research on the abovementioned topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.
2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.
3. The Department of Health expects you to provide a progress on your study every 3 months (from date you received this letter) in writing.
4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Epidemiological Research & Surveillance Management. You may be invited to the department to come and present your research findings with your implementable recommendations.
5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

SECRETARIAT: EASTERN CAPE HEALTH RESEARCH COMMITTEE

Ikamva eliqaqambileyo!

Province of the
EASTERN CAPE
HEALTH

Room 111 • 1st Floor • Medical Centre Building • 19 St James Road • Southernwood • Eastern Cape
Private Bag X9015 • EAST LONDON • 5200 • REPUBLIC OF SOUTH AFRICA
Tel: +27 (0)43 707 6766 • Fax: +27 (0)43 707 6843• Website: www.ecdoh.gov.za,
Enquiries: Mr. T. Toko - Cell: 084 050 4243

Mr. X. J. Tofu
Nature of project – Masters

16/03/2016

RE: REQUEST FOR APPROVAL TO CONDUCT A RESEARCH PROJECT AT BUTTERWORTH, TAFALOFEFE, CATHCART AND NOMPUMELELO HOSP.

RE: RESEARCH TOPIC – "REVISITING CHALLENGES CONCERNING CLEANLINESS OF THE PUBLIC HOSPITALS IN EASTERN CAPE (EC_2016RP13_480"

In view of the above subject request, the office of the District Manager at Amathole Health District acknowledges your request and is gladly granting you permission to conduct your research.

Please be advised

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the DOH in writing.
2. That the results of the subject matter must be presented to the District Manager and the Team
3. Your research must not, by any means violate people's rights and cultures.
4. You must maintain confidentiality of their identities and shall not collect any information which can be used to link the participants.
5. Your research must not contravene with the policies of the department of health
6. Must not in any way be harmful to the reputation of the department nor dent its image.

We wish you a very successful result with your adventure

Yours in service delivery

Mrs S. Gede
District Manager - Amathole
United in achieving quality health care for all

16/03/2016
date

APPENDIX V: APPROVAL LETTERS HOSPITALS

Fort Hare University
Nursing science Department
50 Church Street
East London
17 May 2016

The District Manager
Buffalo City Health District
East London
Eastern Cape Department of Health

Re: Request for a permission to conduct a Pilot Research project at Bhisho Hospital.

Dear Doctor Nkohla

I, Xolani James Tofu, a Master's of Public Health student of School of Health Science Department of Fort Hare University, hereby request permission to conduct a pilot research project at your institution as part of the requirements for the completion of the degree.
The title of the research study is: Revisiting challenges concerning cleanliness of the Public Hospitals in the Eastern Cape, South Africa.
The researcher will use day staff general assistants of the hospital, male and female, all age groups with or without any level of training, as participants for the study.
The findings of the study will be of benefit to the Department of Health in general because a clean hospital appearance contributes to its physical accessibility. This will also lift the standard of care, thereby leading to the communities utillzing our institutions appropriately. The department of Health will be free from being litigated due to hospital- acquired sicknesses. The value for money will be maintained as stated by Batho Pele Principles.

Attached is: The protocol for this project and the ethics clearance certificate from the University of Fort Hare Ethics Committee and the departmental approval letter.

I hope my request will receive your favorable it consideration.

Yours Faithfully

X.J. Tofu
MPH Student
XJ Tofu 20/05/2016

Supported/ ~~Not supported~~

District Manager: Buffalo City Health District Date 20/05/2016

Fort Hare University

Nursing science Department

50 Church Street

East London

01 March 2016

The Hospital CEO

Bhisho Hospital

Bhisho

Eastern Cape Department of Health

Re: Request for a permission to conduct a Pilot Research project at your institution.

Dear Sir/Madam

I, Xolani James Tofu, a Master's of Public Health student of School of Health Science Department of Fort Hare University, hereby request permission to conduct a pilot research project at your institution as part of the requirements for the completion of the degree.

The title of the research study is: Revisiting challenges concerning cleanliness of the Public Hospitals in the Eastern Cape, South Africa.

The researcher will use day staff general assistants of the hospital, male and female, all age groups with or without any level of training, as participants for the study.

The findings of the study will be of benefit to the Department of Health in general because a clean hospital appearance contributes to its physical accessibility. This will also lift the standard of care, thereby leading to the communities utilizing our institutions appropriately. The department of Health will be free from being litigated due to hospital- acquired sicknesses. The value for money will be maintained as stated by Batho Pele Principles.

Attached is: The protocol for this project and the ethics clearance certificate from the University of Fort Hare Ethics Committee and the departmental approval letter.

I hope my request will receive your favorable consideration.

Yours Faithfully

X.J. Tofu

MPH Student

X.J Tofu 22/05/2016

Student's signature Date

Approved / Not approved

P.N. Tshuqo 24/05/2016

CEO's Signature : Bhisho Hospital Date

Fort Hare University

Nursing science Department

50 Church Street

East London

01 March 2016

The Hospital CEO

Nompumelelo Hospital

Peddie

Eastern Cape Department of Health

Re: Request for a permission to conduct a Pilot Research project at your institution.

Dear Sir/Madam

I, Xolani James Tofu, a Master's of Public Health student of School of Health Science Department of Fort Hare University, hereby request permission to conduct a pilot research project at your institution as part of the requirements for the completion of the degree.

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The findings of the study will be of benefit to the Department of Health in general because a clean hospital appearance contributes to its physical accessibility. This will also lift the standard of care, thereby leading to the communities utilizing our institutions appropriately. The department of Health will be free from being litigated due to hospital- acquired sicknesses. The value for money will be maintained as stated by Batho Pele Principles.

Attached is: The protocol for this project and the ethics clearance certificate from the University of Fort Hare Ethics Committee and the departmental approval letter.

I hope my request will receive your favorable consideration.

Yours Faithfully

X.J. Tofu

MPH Student

31/05/2016

Student's signature Date

Approved/ Not approved

31/05/2016

CEO's Signature : Nompumelelo Hospital Date

Fort Hare University

Nursing science Department

50 Church Street

East London

01 March 2016

The Hospital CEO

Cathcart Hospital

Cathcart

Eastern Cape Department of Health

Re: Request for a permission to conduct a Pilot Research project at your institution.

Dear Sir/Madam

I, Xolani James Tofu, a Master's of Public Health student of School of Health Science Department of Fort Hare University, hereby request permission to conduct a pilot research project at your institution as part of the requirements for the completion of the degree.

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The findings of the study will be of benefit to the Department of Health in general because a clean hospital appearance contributes to its physical accessibility. This will also lift the standard of care, thereby leading to the communities utilizing our institutions appropriately. The department of Health will be free from being litigated due to hospital- acquired sicknesses. The value for money will be maintained as stated by Batho Pele Principles.

Attached is: The protocol for this project and the ethics clearance certificate from the University of Fort Hare Ethics Committee and the departmental approval letter.

I hope my request will receive your favorable consideration.

Yours Faithfully

X.J. Tofu

MPH Student

XJ Tofu

Student's signature

03/06/2016

Date

Approved/ Not approved

PP

CEO's Signature : Cathcart Hospital

03/06/2016

Date

Fort Hare University

Nursing science Department

50 Church Street

East London

01 March 2016

The Hospital CEO

Tafalofefe Hospital

Centani

Eastern Cape Department of Health

Re: Request for a permission to conduct a Pilot Research project at your institution.

Dear Sir/Madam

I, Xolani James Tofu, a Master's of Public Health student of School of Health Science Department of Fort Hare University, hereby request permission to conduct a pilot research project at your institution as part of the requirements for the completion of the degree.

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The findings of the study will be of benefit to the Department of Health in general because a clean hospital appearance contributes to its physical accessibility. This will also lift the standard of care, thereby leading to the communities utilizing our institutions appropriately. The department of Health will be free from being litigated due to hospital- acquired sicknesses. The value for money will be maintained as stated by Batho Pele Principles.

Attached is: The protocol for this project and the ethics clearance certificate from the University of Fort Hare Ethics Committee and the departmental approval letter.

I hope my request will receive your favorable consideration.

Yours Faithfully

X.J. Tofu

MPH Student

X.J. Tofu

Student's signature

08/06/2016

Date

Approved/ Not approved

CEO's Signature : Tafalofefe Hospital

08/06/2016

Date

THAFALOFEFE HOSPITAL
Private Bag X3024
BUTTERWORTH
4950
2016 -06- 08
ISEBE LEMPILO
DEPARTMENT OF HEALTH

Fort Hare University

Nursing science Department

50 Church Street

East London

01 March 2016

The Hospital CEO

Butterworth Hospital

Butterworth

Eastern Cape Department of Health

Re: Request for a permission to conduct a Pilot Research project at your institution.

Dear Sir/Madam

I, Xolani James Tofu, a Master's of Public Health student of School of Health Science Department of Fort Hare University, hereby request permission to conduct a pilot research project at your institution as part of the requirements for the completion of the degree.

The title of the research study is: Revisiting challenges concerning cleanliness of the Public Hospitals in the Eastern Cape, South Africa.

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Attached is: The protocol for this project and the ethics clearance certificate from the University of Fort Hare Ethics Committee and the departmental approval letter.

I hope my request will receive your favorable consideration.

Yours Faithfully

X.J. Tofu

MPH Student

XJTofu _____ 15/06/2016

Student's signature Date

~~Approved/ Not approved~~

_____ 15/06/2016

~~CEO's~~ Signature : Butterworth Hospital Date

APPENDIX VI: CERTIFICATE OF ENGLISH EDITING

University of Fort Hare
Together in Excellence

University of Fort Hare
Private Bag X 1314
Alice
5700

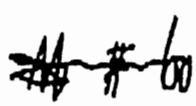
2016/09/20

To whom it may concern

This note serves to inform whoever may be concerned that I, **Mathew Marembo**, a PhD candidate in Industrial Psychology, at the University of Fort Hare, Alice campus, have edited the Masters Dissertation of **Xolani James Tofu**, student number: **201415833**, who is in the department of Public Administration, in the faculty of Management and Commerce. The topic of the research is: *Revisiting the challenges concerning cleanliness of the public hospitals at Amathole district in South Africa*.

Please do not hesitate to contact me from the contact details provided below if any need arise.

Yours faithfully



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