AN EVALUATION OF ACCESS TO HEALTH CARE: GUGULETHU COMMUNITY HEALTH CLINIC

by

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DECLARATION

I Zukiswa Shirley Kama, declare that the contents of this thesis represent my own unaided work, and that the thesis has not previously been submitted for academic examination towards any qualification. Furthermore, it represents my own opinions and not necessarily those of the Cape Peninsula University of Technology.

Signed	**Date**

ABSTRACT

The purpose of this study was to examine the problem of access to health care centres in the Western Cape and to forward recommendations that will improve access to health care facilities in the Western Cape. The first objective of the study was to identify trends in primary health care looking at Nigeria, with the view of learning lessons of experience. Secondly, the study provided an overview of the South African health care system. The study further examined the problems around access to Gugulethu Community Health Clinic. The research objectives were directly linked to the composition of chapters.

The study utilised a mixed-method approach of quantitative and qualitative approaches. This method is called multi-method approach. The purpose of combining the two approaches was to understand the research problem from a subjective and objective point of view, as well as to provide an in-depth understanding of a research topic, which led to more reliable research results. Data collection was acquired by utilising a structured questionnaire and personal observations. Two groups of respondents participated in the study inter alia: the patients and the staff of Gugulethu Community Health Clinic.

The findings revealed that patients were dissatisfied with the service rendered by the institution for example, the reception of patients, cleanliness and medical care in general. Findings of the observations revealed that the shortage of staff, particularly in the Admissions Office, impeded effective and efficient service delivery, hampering access of patients to the health care facility.

One of the recommendations arising from the study included the introduction of an appointment/booking system to reduce the long waiting times of patients. Staff training especially around customer care, should occur on a continuous basis, facilitated by the Department of Health in general, to improve current strained relationships between employees and patients. A further recommendation is that health care policies implemented, be revised, to ensure that all South Africans have access to health care. The implementation of such policies should be monitored and evaluated on a regular basis and in this way, service delivery and access of patients to health care facilities will be improved.

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CHAPTER ONE
GENERAL INTRODUCTION

1.1 Introduction

In 1994 the democratic government inherited a highly fragmented and bureaucratic health system that provided services in a discriminatory manner. Services for whites were better than those for blacks and those in the rural areas were significantly worse off in terms of access to services compared to their urban counterparts. The White Paper for the Transformation of the Health Sector in South Africa which was released in April 1997 provided a significant departure from the past to create a unified but decentralised national health system based on the District Health System model. One of the main reasons for this was the belief that this system was deemed to be the most appropriate vehicle for the delivery of Public Health Care. In South Africa one of the objectives of the Provincial Health Plan, adopted by the Western Cape Department of Health, was to improve access to services especially at the Public Health Centres (South Africa, 2001:2). This research study examines the problems underlying access to Gugulethu Community Health Clinic.

1.2 Research problem

One of the objectives of the National Health Act (Act No 61 of 2003) is to regulate national health and to provide uniformity in respect of health services across the nation by:

- protecting, respecting, promoting and fulfilling the rights of
  the people of South Africa to the progressive realisation of the constitutional right of access to health care services, including reproductive health care (South Africa, 2003:18).

Despite the above, access to health care facilities in the Gugulethu area has been a perpetual problem experienced by the poor as evidenced by the examples below.

A one-year old baby died on his grandmother's back after she (the grandmother) was turned away from three different health care facilities. The child was taken to the Red

Cross Children's Hospital where he was treated for gastroenteritis and discharged with a letter to take him to a local medical facility should the symptoms come back. When the symptoms came back, the family took him to Nyanga clinic where he was turned away because they had reached the quota of sick children they could treat for the day. The family were forced to take him to Gugulethu Maternal Obstetrics Unit (MOU), but were again turned away by security staff because the facility no longer offered services to sick children. The security guard then referred the family to Gugulethu Community Health Clinic (CHC). After waiting for more than two hours at Gugulethu CHC they were told to come the following day as the nurses had seen the quota of sick children for the day. The child died while being carried on his grandmother's back during their two-hour walk home. (Prince, 2009:3).

In another incident, a teenager gave birth on the pavement outside the gates of the Gugulethu Maternal Obstetrics Unit just hours after nurses discharged her, telling her she was not in labour. When the baby fell on the pavement the security personnel refused to let her in and the night nurses inside responded that the birth was not their problem since it was happening outside hospital (Maposa, 2009:1).

It is against this background that the researcher decided to conduct research around the problems of access to health care centres in the Western Cape. The core problem that this study examines is the problem of access to Gugulethu Community Health Clinic in particular.

1.3 The objectives of study

The objectives of a research project summarise what is to be achieved by the study. These objectives are closely related to the research problem (Hendrickse, 2011).

The general research objective of the study was to identify the reasons for access dilemmas to the Gugulethu Health Clinic as to suggest optimum solutions.

Accordingly, the specific objectives of the study are to:

- identify trends in access to health care in a developing country such as Nigeria, to learn lessons of their experiences.
- identify the regulatory framework which informs health care in South Africa in general.

- make recommendations to assist all parties concerned with access to community health care clinics in South Africa such as NGOs, health care staff, support staff at hospitals, and all spheres of government.

1.4 Significance of the study

This study has a significant contribution to make as a systematic assessment of problems pertaining to access to the Gugulethu Community Health Clinic informs how processes could be changed at the institution by the implementers of public policy, for example hospital administrative staff and health care professionals.

1.5 Delineation of study

Basic knowledge about the National Health Plan in South Africa is important in understanding the District Health Plan. The scope of the research will be confined to the problems around access to Gugulethu Community Health Clinic.

1.6 Research methodology

According to Brynard and Hanekom (1997:28) research methodology or method of collecting data, necessitates a reflection on the planning, structuring and execution of the research in order to comply with the truth, objectivity and validity of the research. Research methodology is, therefore, aimed at a thorough demonstration, connection and scientifically systematic chronology of investigation.

Methodology is centrally as concerned with how we conceptualise, theorise and make abstractions, as it is with the techniques or methods which we utilise to assemble and analyse information. Methodology provides not just a way of organising ideas and evidence but a language and format for communicating what one has found in one's research. There are two common methodological approaches namely: quantitative and qualitative. This study lends itself towards both quantitative and qualitative approaches (Miller & Brewer, 2003:192). The study combined both quantitative and qualitative research approaches in order to gain a better understanding of the research problem that was identified. A comprehensive study will use both methods and thus cannot strictly be called either quantitative or qualitative (Bless, Higson-Smith & Kagee, 2006:44). For the purpose of the study, the quantitative data was obtained through the use of a

questionnaire. Qualitative data was obtained through participant observation; this opened the opportunity to get in-depth knowledge from different stakeholders (Biggam, 2008:109). These approaches will now be elucidated in more detail.

1.6.1 Quantitative research

According to Leedy (2005:94), quantitative research is used to answer questions about relationships among measured variables with the purpose of explaining, predicting and controlling phenomena**.** Quantitative research is a systematic and objective process that investigates a particular problem by using numerical data (Babbie & Mouton, 2001:230). In a quantitative study the focus is on control of all the components in the actions and representations of the participants – the variables will be controlled and the study will be guided with an acute focus on how variables are related. The researcher plans and executes this control in the way the study and its instruments are designed. Respondents or research subjects are usually not free to express data that cannot be captured by the predetermined instruments (Henning, Van Rensburg & Smit, 2004:4).

According to Babbie and Mouton (2007:270) a quantitative paradigm in social science has a number of related themes. These would include:

- An emphasis on the quantification of constructs. The quantitative researcher believes that the best or only way of measuring the properties of phenomena (e.g. the attitudes of individuals towards certain topics) is through quantitative measurement i.e. assigning numbers to the perceived qualities of things.
- A related topic concerns the central role of variables in describing and analysing human behaviour. In some circles, this has become known as variable analysis.
- The nature of the control in quantitative research is either through experimental control (in experimental designs) or through statistical controls (in multivariate analyses).

Bryman (1988:11) adds that quantitative research is associated with a number of different approaches of data collection, for example, the capacity for generating quantifiable data on large numbers of people who are known to be representative of a wider population in order to test theories or hypotheses. According to Terre Blanche, Durrheim and Painter (2006:47), quantitative researchers collect data in the form of

numbers and use statistical types of data analysis. A structured questionnaire is a quantitative means in which to collect data.

1.6.1.1 Questionnaires

Hair, Babin, Money and Samouel (2003:130) describe a questionnaire as a predetermined set of questions designed to capture data from respondents. It is a scientifically developed instrument for measurement of key characteristics of individuals, companies, events and other phenomena. Good survey research requires good questionnaires to ensure accuracy in the data. Miller and Brewer (2003:253) describe questionnaires as data collection techniques most commonly used by social surveys. It is traditionally in the form of a printed document and is essentially a list of questions. The defining features of the questionnaire are that the design itself is highly structured and that the same instrument is administered to all the participants in the survey. A questionnaire usually consists of a number of measurement scales, open-ended items for qualitative responses, and other questions that elicit demographic information from respondents. For the purpose of this study the questionnaire will have closed and open ended questions.

1.6.1.1.1 Population and sample

The target population for this research was drawn from patients using Gugulethu Community Health Clinic and permanent employees at Gugulethu Community Health Clinic. These individuals were selected because they have experienced the central phenomenon which is access to Gugulethu Community Health Clinic. The study was therefore, limited to the above mentioned group.

The respondents, who were patients (see further justification for the sample size in the discussion below) of the Gugulethu Community Health Clinic, as elucidated earlier, were chosen via random sampling technique. The reason for applying simple random sampling method is for every member of the population to stand an equal chance of being involved in the study (Maree, 2007:292). Another targeted group was 101 employees at Gugulethu Community Health Clinic, all employees participated in the study. Whilst questionnaires were administered to the 101 employees only 92 questionnaires were returned.

According to the statistics received from the Gugulethu Community Health Clinic Facility Manager, there are 1500 patients using the facility every month and 101 permanent staff members. According to Huysamen (1991), if the population is 500 then the sample should be 200. This means that with a population of 2500, the sample should be 379 and for a population of 120, the sample should be 92. The questionnaire was only handed to community members who met the set criteria. 380 questionnaires were distributed to patients using Gugulethu Community Health Clinic and 101 questionnaires were distributed to Gugulethu Community Health Clinic permanent staff members. In this instance Huysamen's (1991) formula sufficed therefore no formal calculations was required on the part of the researcher as Huysamen (1991) formula proved apt. The questionnaires had closed and open-ended questions. The questionnaire was constructed in a manner that prevented bias or unethical conduct. The researcher kept in mind the ethical underpinnings of CPUT which clearly calls for unbiased and ethical conduct on the part of the researcher. The questionnaire was also forwarded to other research supervisors who gave feedback on whether the questionnaire was constructed in an unbiased and ethical fashion (Department of Public Management Research Committee, 2010).

1.6.1.1.2 Data Analysis

Data that was collected through quantitative research was quantified into numbers via statistical analysis. The Statistical Package for the Social Sciences (SPSS) was used to analyse quantitative data (questionnaires) and was presented by using tables and bar charts to illustrate the percentage of responses to the different questions and statements.

1.6.2 Qualitative Research

According to Leedy (2005:94), qualitative research is typically used to answer questions about the complex nature of phenomena, often with the purpose of describing and understanding the phenomena from the participants' point of view. Welman, Kruger and Mitchell (2005:8) citing Denzin and Lincoln (1994:4) contend that "the word qualitative implies an emphasis on processes and meanings that are not rigorously examined or measured (if measured at all) in terms of quantity, amount, intensity or frequency". Therefore, according to these authors the aims of qualitative research methods are to

establish the socially constructed nature of reality, to stress the relationship between the researcher and the object of study, as well as to emphasise the value-laden nature of the inquiry.

According to Creswell (2009:4), qualitative research is a means for exploring and understanding the meaning that individuals or groups ascribe to a social or human problem. The process of research involves emerging questions and procedures, data typically collected in the participant's setting, data analysis inductively building from particulars to general themes, and the researcher making interpretations of the meaning of the data. The final written report has a flexible structure. Those who engage in this form of inquiry support a way of looking at research that honours an inductive style, a focus on individual meaning, and the importance of rendering the complexity of a situation.

Qualitative research distinguishes itself from quantitative research in terms of the following key features:

- Research is conducted in the natural setting of social factors.
- A focus on process rather than outcome.
- The actor's perspective (the 'insider' or 'emic' view) is emphasised.
- The primary aim is in-depth ("thick") descriptions and understanding of actions and events.
- The main concern is to understand social action in terms of its specific context (idiographic motive) rather than attempting to generalise to some theoretical population.
- The research process is often inductive in its approach, resulting in the generation of new hypotheses and theories.
- The qualitative research is seen as the "main instrument" in the research process (Babbie & Mouton, 2007:270).

In light of the aforementioned, this research study also employed a qualitative approach. The researcher chose to use qualitative research because it is linked to in-depth exploratory studies and it involves studying things in their natural setting. The data collection technique employed was participant observation.

1.6.2.1 Participant Observation

According to Babbie and Mouton (2006:293), there are two of types of observation, namely simple observation where the researcher remains an outside observer; and participant observation, where the researcher is simultaneously a member of the group she or he is studying and a researcher doing the study. When doing participant observation, one is faced with difficulty of simultaneously being one of the members of the group, and also observing everyone else from the researcher's point of view. One of the biggest advantages of observation is that you can do it anywhere. It is important to remember that in observation it is vital that you make full and accurate notes of what went on. Even tape recorders and cameras cannot capture all the relevant aspects of social processes. The greatest advantage of observation is the presence of an observing, thinking researcher on the scene of the action. If possible you should take notes on your observations as you observe. When that is not feasible, you should write down your notes as soon as possible afterwards.

Participant observers have to assume the roles of the group members in order to personally:

- experience what the group members experience
- understand their life-world
- see things from their perspective
- unravel the meaning and significance that they attach to their life-world, including their own behaviour (Welman et al, 2005:195)

Bless et al (2006:115) mentions that in all different types of observation, one should keep in mind the following rules.

- Observations serve clearly formulated research purposes. Thus, observations must be planned systematically, specifying what and how to observe.
- Observations should be recorded in a systematic, objective and standardised way.
- Observations should be subjected to control in order to maintain a high level of objectivity. Thus, any observers should be able to record the same phenomena or events, in the same way, with the same results.

The study observed general practices around access to Gugulethu Community Health Clinic and the effective evaluation of the facility. Particular aspects observed were the

arrival time of patients at Gugulethu Community Health Clinic, the waiting times, the admissions (reception) office, the atmosphere and the manner in which the clerks at the admissions office dealt with patients**.** The researcher conducted the observation herself at Gugulethu Community Health Clinic. A period of time was spent by the researcher at Gugulethu Community Health Clinic, where notes and questions were asked to get different opinions of people using the facility.

1.6.2.1.1 Population and Sampling

The target population comprised permanent staff members and patients using Gugulethu Community Health Clinic.

Staff and patients using Gugulethu Community Health Clinic were observed by the researcher. The researcher observed this group of people who have firsthand experience and knowledge around access to health care at the clinic.

1.6.2.1.2 Data analysis

Qualitative data was analysed using content analysis. Content analysis is a systematic approach in qualitative data analysis that identifies and summarises message content (Maree, 2007:101). Although Maree (2008:99) finds this approach of analysing data difficult, it was appropriate to utilise it for this study.

1.7 Preliminary literature review

As mentioned before, prospective researchers should acquaint themselves with previous research on a particular topic before they start planning their own research. Of course, it will be of little use to research a topic on which general consensus has been reached, unless the researcher intends to provide a new perspective on it. By compiling a review of research findings on a particular topic that has already been published, researchers may become aware of inconsistencies and gaps that may justify further research. Such a review enables researchers to indicate exactly where their proposed research fits in. Considered on its own, someone’s research may elicit little interest. However, if its relation to the body of knowledge is evident, it achieves greater importance and may even persuade other researchers to do research on the particular topic as well (Welman et al, 2005:38)

Bless et al (2006:24) mention that in order to conceive the research topic in a way that permits a clear formulation of the problem and the hypothesis, some background information is necessary. This is obtained mainly by reading whatever has been published that appears relevant to the research topic. This process is called literature review. Although acquaintance with different theories and models, as well as research results takes place, by necessity, before a clear statement of the problem can be formulated, a literature review is an ongoing process. This is the case not only because the relevant research results can be published at any time but also because, in the course of research, new aspects and problems arise requiring new information. In conducting a literature review, the following three broad issues should be kept in mind: the purpose of the review, the literature sources, and the reviewing techniques.

Miller and Brewer (2003:171) define a literature search as identifying relevant previous work as an essential skill in social research. The massive expansion in the volume and type of information, together with the increasing complexity of interrelated branches of knowledge, has given added importance to the need for systematic searching, and for critical appraisal and synthesised accounts of previous research. This entry addresses the task of searching for relevant literature in the “information age” and will focus primarily on a systematic and logical approach to literature searching using electronic databases. The emphasis will be on identifying research published in peer-reviewed journals, although similar principles and practices apply to searching for ‘grey literature’ (such as conference papers and theses) and indexes of current research.

Mouton (2001:87) mentions that the literature review is about reviewing a whole range of research products that have been produced by other scholars. There are a number of reasons why a review of the existing scholarship is so important:

- To ensure that one does not merely duplicate a previous study.
- To discover what the most recent and authoritative theorising about the subject is.
- To find out what the most widely accepted empirical findings in the field of study are.
- To identify the available instrumentation that has proven validity and reliability.
- To ascertain what the most widely accepted definitions of key concepts in the field are.

- To save time and avoid duplication and unnecessary repetition. A good review of the available scholarship not only saves you time in the sense that it helps you to avoid making errors and duplicating previous results unnecessarily, but also because it provides clues and suggestions about what avenues to follow.

1.7.1 A brief overview of health care in South Africa

Tentative views from two sources namely Van Rensburg (2004) and the Department of Health (1996a, 1996b, 1997a) are forwarded below, to initially contextualise the study.

The transformation of the South African health care system is not a distinct event that occurred at a fixed point in time. It is rather a protracted process that had already set in before the change of government in 1994, gained momentum since 1994, and is still unfolding. The thrust, direction and the significant markers of this reform were in broad terms spelled out in the Reconstruction and Development Programme (ANC, 1994a), which subsequently became the government's framework for reform. Since then reform of a fundamental nature has indeed taken place – at a remarkable pace and generally in the direction the new government intended it to. This applies particularly to health policy and legislation, but also to the structure and the contents of the health care system (Van Rensburg, 2004:110).

The main reasons behind the health reforms since 1994 thus culminate in the confluence of the following:

- The suffocating undemocratic organisational culture created by policies of dominance and exclusion under colonialism and apartheid, which left a stark legacy of centralised, authoritarian, top-down and non consultative approaches; representative governance, community involvement and participatory decision making in health matters were either non-existent or reserved for the privileged few.

- The manifold fragmentation of the health system along sectoral (private/public), structural, functional, racial geographical and socio-economic lines, which resulted in a striking lack of coordination and integration and in the absence of a unitary health system.

- The major inequities and disparities in the provision of health care, again pertinently apportioned and accessible along racial, geographical and socio-economic lines, and favouring the white, urban, wealthy and medically insured clientele.

- Severe shortages of resources, some indeed real, but others of a secondary nature due to maldistribution, mismanagement and even wastage, with the cream clotted in the private sector and in metropolitan areas, leaving those who are dependent on the public sector, and who live in rural and peri-urban areas, as well as in the erstwhile homelands, notoriously underprovided and underserved.

- Highly inappropriate emphases and orientations in health care, with persisting emphasis on high-tech curative, hospital-based and doctor-oriented services, strongly provider-oriented and interest-driven by professionals and the market – obviously at the cost and to the neglect of preventive, primary and community health services.

- Striking discrepancies and inequalities in the health and health status of the population, partly as a result of the aforementioned structural deficiencies, with which health system has to cope.

The aims of the health reforms since 1994 are precisely targeted at allaying the above-described deficiencies and inadequacies through:

- unifying the fragmented health services into a comprehensive and integrated National Health System;
- reducing disparities and inequities in service delivery and health outcomes; and
- extending access to an improved health service (Department of Health 1996a, 1996b, 1997a).

As the transformation progresses, these aims have been and are being systematically converted into more detailed strategies of transformation and restructuring, specified in numerous White Papers, policy documents and legislation. All sectors of the health system have been deeply affected by these new policies and legislation, be it in the broad framework of health care delivery, or specific dimensions within the health care system (Van Rensburg, 2004:111).

Despite the aforementioned a lack of implementation of strategies, policies, and legislation pertaining to health care, bedevils the aims listed above.

1.8 Clarification of basic terms and concepts

National Health System

The National Health System is the system within the Republic of South Africa, whether within the public or private sector, in which the individual components (health care professionals, public or private institutions) are concerned with the financing, provision or delivery of health services (South Africa, 2003:14).

District Health System

A district health system is the vehicle for providing quality primary health care to everyone in a defined geographical area. It is a system of health care in which individuals, communities and all the health care providers of the area participate together in improving their own health (Harrison, 1997:3).

Primary Health Care Approach

The Primary Health Care (PHC) Approach is the philosophy and a conceptual model for an ideal health system. It formed the basis of the 1978 Declaration of the Alma-Ata which promotes essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible and equitable at a cost that is affordable, with community participation. It includes social upliftment of the community as a whole through, amongst other things, the provision of clean water, household food security, a clean and safe physical environment and mental well-being. The PHC Approach is more than the provision of “primary level services” that are typically provided in clinics and mobile services. It envisages a seamless referral system from the community all the way to the most sophisticated health care available (Hall, Haynes & McCoy, 2002:1).

Secondary Level Hospital

Secondary level hospital, also known as Level II, renders a service requiring specialist and non-specialist treatment in the areas of surgery, medicine, gynaecology, psychiatry, orthopaedics and so on. Somerset, Karl Bremer, George and Eben Donges Hospitals are examples of this level of health facility (Van Driel, 2005:10).

Tertiary Level Hospital

A tertiary level hospital, also known as Level III, these are also referred to as Academic Institutions/hospitals; these are the teaching hospitals and render the highest level of care, e.g. Groote Schuur, Tygerberg and Red Cross Children Hospital. Super-specialist services, mostly Level III care is rendered at this level (Van Rensburg, 2004:475).

District Level Hospital

The District Hospital support Primary Health Care in the district. Patients are referred to the District Hospital from community health centres and clinics. The District Hospital provides Level 1 (generalist) services to in-patients and outpatients and generally has between 50 and 200 beds. All have a 24 hour emergency service and an operating theatre e.g. Swartland Hospital in Malmesbury, Stellenbosch Hospital and False Bay Hospital (Health Systems Trust, 2000:1).

Decentralisation

Decentralisation implies the shift of power, authority and functions away from the centre. It is seen as a mechanism to achieve: greater equity and efficiency; greater involvement of and responsiveness to communities; the reduction in the size of the bureaucracy far removed from the communities being served; and greater coordination between social sectors (South Africa, Department of Health, 2001:2).

1.9 Outline of chapters

This study is organised into six chapters. Below is the sequence of the chapters:

CHAPTER ONE: General Introduction

The introductory chapter focuses on the background of the study, the research problem, objectives of the study, significance of the study, delineation of the study, research methodology, literature review and the clarification of basic terms and concepts.

CHAPTER TWO: Trends in Primary Health Care: The Nigerian example

Chapter Two explores trends in access to primary health care, specifically looking at Nigeria to learn lessons from the country's experiences.

CHAPTER THREE: An overview of the South African Health Care System

Chapter Three provides an overview of the South African health care system in general and explores policies and legislation of the South African health care system specifically.

CHAPTER FOUR: Research Methodology

Chapter Four focuses on the preparation and drafting of the questionnaire, the gathering of the data, formulation of the target groups, determination of the sample size, processes and procedures in obtaining the information.

CHAPTER FIVE: Data presentation, analysis and discussion

This chapter deals with an analysis of data, which was collected through questionnaires and observation.

CHAPTER SIX: Conclusions and Recommendations

This chapter concludes with complete summary, remarks and recommendations regarding the study.

1.10 Ethical statement

Confidentiality of data gathered and anonymity of respondents will be ensured by not requiring any personal details from the respondents. The sole purpose of using the data

gathered for research will be communicated to the respondents on the front page of the data collection tool/technique, whether as a questionnaire or an interview schedule. The choice of also not answering any of the questions will be respected.

The researcher contends that the research ethics statement will ensure that the research is undertaken on good ethical grounds.

The researcher further agrees to conduct the research in line with the published ethical rules of the Cape Peninsula University of Technology.

CHAPTER TWO

TRENDS IN PRIMARY HEALTH CARE: THE EXAMPLE OF NIGERIA

2.1 Introduction

Without strong policies and leadership, health systems do not spontaneously gravitate towards Primary Health Care values or efficiently respond to evolving health challenges. As most health leaders know, health systems are subject to powerful forces and influences that often override rational priority setting or policy formation, thereby pulling health systems away from their intended directions (World Health Organisation).

This chapter explores trends in primary health care and the focus would be on a developing country Nigeria. In considering health reforms in Nigeria it would be incomplete without mentioning the colonial period because the health care situation today originated from the colonial period. The challenges that pose a threat to the realization of equitable health care in Nigeria are also discussed**.** The reason for selecting Nigeria lies in the argument forwarded by Hendrickse (2006:45) where she asserts that other states influences policy-making processes in a locale due to globalization. Therefore lessons of experience could be learnt from other developing countries.

2.2 Background of Nigerian Health Care

The health system in Nigeria has been in persistent decline for years. This has resulted in poor performance, enduring burden of disease and poor. The government of Nigeria initiated the ongoing process of health sector reform in 2003, to remedy the level of decline in health care. The aim of these reforms was to strengthen the national health system in its mission to deliver effective, efficient, qualitative and affordable health service and thereby improve the health status of Nigerians. This was the health sector's contribution to breaking the vicious cycle of poverty and under-development (Nigeria 2007:12).

The public health services in Nigeria began with the services provided by the British Army Medical Corp before independence. The colonial government extended the health services to the local population living around government stations. At the time the

colonial government had a policy to provide free medical treatment to the army and the colonial service officers, while the treatment of other people commenced later (Gradkaja 2004:169). Ademiluyi and Aluko-Arowolo (2009:105) adds that it was in later years, when the British rule had been well established that the administrators created medical centres in the real sense of hospitals to take care of epidemics, such as sleeping sickness, small pox, malaria and other primary health concerns. Although hospitals were built, they were concentrated in the urban areas where there was a high concentration of Europeans and government officials. The rural areas were neglected in matters of health care.

According to Gradkaja (2004:169) there were missionaries who also participated in the development of health care services. At independence in 1960, the missionaries had about 75% hospitals, dispensaries and maternity centres in different parts of the country. The Nigerian people had little belief on medical services, because the services were culturally unacceptable to the people this resulted in underutilisation of the health facilities. Efforts, of the missionaries also formed the bedrock of subsequent development in the provision of health care services. Ademiluyi and Aluko-Arowolo (2009:105) mentioned that the medical centres established by the missionaries were largely concentrated in the rural areas because of the goal of evangelism, which was to get the rural people to embrace the new religion. These medical centres, however, were merely mobile clinics and were there mainly to treat primary health problem, snake bites and minor injuries.

Prior to the 1980s economic difficulties, the health sector witnessed robust growth, principally as a result of government support, coupled with assistance from international donor agencies. During this time access to health care was available at public hospitals and clinics at no charge, but not in rural areas. “However, by 1985, this positive development screeched to a grinding halt, owing to a plurality of factors, two of which clearly stood out: precipitous economic decline and military usurpation of power, the latter marking the genesis of many of the intractable challenges besetting the health care system” (Nnamuchi, 2007:1).

Gradkaja (2004:169) indicated that after the attainment of political independence in 1960, Nigerians became involved in health care planning and policy formulation. Health related matters were incorporated into the national development plans and policy measures of periodic budget plan. Below are the development plans:

2.2.1 The First National Development plan 1962-1968

It was two years after independence when the First National Development Plan was formulated. The objectives were development opportunities in health, education and employment and improving access to these opportunities. This plan failed because fifty percent of resources needed to finance the plan was to come from external sources, and only fourteen percent of the external finance was received. Collapse of the first Republic and the commencement of the civil war also disrupted the plan (Lawal and Oluwatoyin 2011:238).

2.2.2 The second National Plan 1970-1974

The second plan incorporated the development programmes outlined in the first plan. Despite seemingly high economic growth rate, the health sector suffered a great neglect. The objectives of this phase were well defined and good; but they were not matched well with articulated projects and closely defined policies. The health component of this phase identified and aimed at correcting of the deficiencies of the health sector carried over from the first phase. As at 1973, there were only five University Teaching Hospitals for training of doctors, medical technologist, nurses and other medical personnel. Plan had also reached advanced state then to establish a teaching hospital at the University of Ife (Gradkaja 2004:170).

2.2.3 The Third National Development Plan 1975-1980

According to Olayiwola and Adeleye (2005:92), the third plan’s concerns were for rural development at the national level. This plan had similar objectives to those of the second national development plan. The plan emphasised the need for reducing regional disparities in order to foster national unity through the adoption of integrated rural development.

The plan provided for:

- nation wide rural electrification scheme;
- the establishment of nine River Basin Development Authorities (RBDAs) in addition to the two existing ones.
- the construction of small dams and boreholes for rural water supply and the clearing of feeder roads for the evacuation of agricultural produce and
- the supply of electricity to rural areas from large irrigation Dams.

At the State Level, some governments, showed their intention to transform the rural areas through the provision of basic infrastructural facilities.

2.2.4 The Fourth National Development Plan 1981-1985

The civilian government that took office on October 1, 1979, postponed the beginning of the fourth plan for nine months. The plan's guidelines indicated that local governments were to be involved in planning and execution, such involvement was not feasible because local governments lacked the staff and expertise to accept this responsibility. The plan was also threatened by falling oil revenues and an increased need for imported food that had resulted from delays in agricultural modernisation. As exports declined, the capacity to import construction materials and related capital goods also fell, reducing growth in the construction, transport, communications, utilities and housing sectors.

2.2.5 The Fifth National Development Plan

The fifth plan was postponed until 1988-92. Continuing the emphases of the SAP, the fifth plan's objectives were to devalue the naira, remove import licenses, reduce tariffs, open the economy to foreign trade, promote non-oil exports through incentives, and achieve national self-sufficiency in food production. The drafters of the fifth plan sought to improve labour productivity through incentives, privatisation of many public enterprises, and various government measures to create employment opportunities.

In late 1989, the administration of General Ibrahim Babanginda abandoned the concept of a fixed five year plan. Instead, he introduced a three-year "rolling plan" for 1990-92 in the context of more comprehensive fifteen to twenty-year-plans. This plan led to the establishment of the National Health Policy Document in 1988 and 1998 (Gradkaja 2004:172). The goal of the national health policy is to provide a level of health that will enable all Nigerians to achieve socially and economically productive lives.

2.3 Organisation of health services in Nigeria

Nnamuchi (2007:3) mentions that health policy of Nigeria is embodied in the National Health Policy and Strategy to Achieve Health for All Nigerians; it was introduced in 1988 and was subsequently revised in 2003. The policy was based on primary health care

(PHC), it adopted the WHO's strategy page 3 for realising PHC as elaborated in the Declaration of Alma Ata.

Adeyemo (2005:151) mentions that the concept of Primary Health Care was formulated by the 134 countries that met at the Alma Ata conference in Russia on 12 September 1978, organised under the auspices of the World Health Organisation (WHO) and the United Children's Fund (UNICEF). According to W.H.O. "Primary Health care means essential health care based on practical, scientifically, sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost which the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination". Primary Health Care forms an integral part of the Nigerian social and economic development. It is the first level contact of the individual and community in the national health system, thus bringing health care as close as possible to where people live and work.

It implies therefore that the provision of health care at this level is largely the responsibility of Local Governments with the support of State Ministries of Health and within the pivot of national health policy Adeyemo (2005:151).

WHO 1987 specified the aims and objectives of Primary health Care as follows:

- To make health services accessible and available to everyone wherever they live or work.
- To tackle the health problems causing the highest mortality and morbidity at a cost that the community can afford.
- To ensure that whatever technology is used must be within the ability of the community to use effectively and maintained.
- To ensure that in implementing health programme, the community must be fully involved in planning the delivery and evaluation of the services in the spirit of self-reliance (Adeyemo 2005:151).

According to (Ademiluyi and Aluko-Arowolo, 2009:106) there are three health structures in Nigeria, which are arranged in a hierarchical order. These are primary, secondary and tertiary health institutions.

Primary health centres are known within the system by content of health centre, maternity home/clinic and dispensaries. The Medical and Dental Council of Nigeria (MDCN) in Badru (2003), add that primary health centres are also to undertake such functions as health education, diagnosis and treatment of common ailments, through the use of appropriate technology, infrastructure and essential drug list. Adeyemo (2005:151-2) mention here that the principle upon which the Primary Health Care is founded is that health is a fundamental human right to be enjoyed by the people, in all walks of life, in all communities. Primary Health Care system attempts to address peoples, 'health needs' through an integrated approach utilising other sectors such as agriculture, education, housing, social and medical services. In addition, fundamental to the Primary Health Care System is the realisation that the major killer diseases in rural communities in the Third World are preventable, and that the majority of victims of these diseases are children under the age of five. Therefore PHC system encourages countries to shift their national Health Care strategy from urban to rural areas, where childhood killer diseases most severely affect children.

The Primary Health Care system recognises local people with little or no formal education who could be trained to perform some basic health services. The use of traditional healers or traditional birth attendants or mid-wives in the villages, to perform the basic functions such as:

- Delivery of high-quality basic first aid
- Recognition of signs and symptoms of more serious conditions
- Delivery of babies under more hygienic conditions
- Educating their fellow villages in understanding disease process in their community.

Complimentarily, the PHC. system employs the concept of village health committees usually composed of local residents chosen without regard to political affiliations, sex, age or religion. These committees are expected to actively participate in planning, organising and managing the Primary Health Care system in the villages.

Patients are referred to secondary or tertiary health centres whenever a patient's medical needs exceed the capacity of that particular health centre (Mayers, 2010:11). Ademiluyi and Aluko-Arowolo (2009:106) describes secondary health centres as health centres that are involved with not only prevention but also all treatments and management of minimal complex cases. However the more complicated cases are referred to the tertiary or

specialist hospital. Examples of secondary types are comprehensive health centres and general hospitals. General hospitals have provisions for accident and emergency unit and diagnosis unit (including X-ray, scan machines and other pathological services) among other services.

A tertiary health institution, also called specialist/teaching hospitals handle complex health problems/cases either as referrals from general hospitals or on direct admission to its own. It has such features as accident and emergency unit, diagnostic unit, wards units, treatment unit and outpatient consultation unit. All these units are to be equipped with the necessary facilities and staffed by skilled personnel. Teaching hospitals also conduct researches and provide outcomes to the government as a way of influencing health policies. This explains why this type of health institution is often a university-based. Furthermore, teaching hospitals are supposed to be fully developed and accredited for teaching of various medical disciplines. They are to conform to international acceptable standards. As a point of emphasis, the primary type of health institutions are associated with rural and semi-urban environments or mixed population, while general hospitals are located in the state capitals and a few other big town. Tertiary health institutions are controlled and funded by the Federal Government and by some states that have and run state universities. Therefore, specialist or teaching hospitals are mainly urban-based (Ademiluyi and Aluko-Arowolo 2009:106).

2.4 Problems in Nigerian Health Care

The health care in Nigeria during 1999 deteriorated to an unacceptable level. Abdulraheem, Olapipo and Amodu (2012:6) is of the opinion that there are innumerable problems within primary health care delivery system which affect the whole population. These problems make it difficult for easy accessibility to health care services especially by rural people. “Below are some health-related problems:

- Poverty associated with poor housing, unsatisfactory environmental sanitation, polluted water and food which predispose to malnutrition and infectious diseases.
- Uneven distribution of health services, and shortage of physicians, nurses and trained health personnel in rural areas.
- High mortality and low average life expectancy, due to lack of access to health services. Despite the availability of PHC services, some rural dwellers in Nigeria tend to underuse the services due to perceptions of poor quality and inadequacy of

available services. Various reasons can be adduced for the underuse of the services provided: a) difficulties associated with transportation and communications; b) high rates of illiteracy among rural peoples; c) traditional conservatism and resistance to ideas from outside; deep rooted traditions and customs, including health beliefs and practices, which increase the patronage of the services of traditional healers; and d) lack of understanding of PHC among health professionals and decision-makers resulting in poor quality services; and e) health worker attitude to work (frequent abstinence from the work place.

- A tendency to press older children into adult responsibilities early, resulting in psychological problems due to role conflicts.
- Endemic diseases prevalence, such as malaria and trachoma.
- Zoonotic diseases as a result of their close contact with animals as part of their way of life (Abdulraheem, Olapipo and Amodu 2012:6).

2.4.1 Equity

According to Abdulraheem, Olapipo and Amodu (2012:1) the goal of primary health care (PHC) was to provide accessible health for all by the year 2000 and beyond. Unfortunately, this is yet to be achieved in Nigeria and seems to be unrealistic in the next decade. The PHC aims at providing people of the world with the basic health service. Though PHC centres were established in both rural and urban areas in Nigeria with the intention of equity and easy access, regrettably, the rural populations in Nigeria are seriously underserved when compared with their urban counterparts. About two-thirds of Nigerians reside in rural areas therefore they deserve to be served with all the components of PHC.

2.4.2 Access and location

The facilities of health care services are largely concentrated in the upland localities where population is higher. Ideally anyone who requires medical treatment should first visit a health centre from where he could be referred to high level health care institutions but this is not the case. Generally the users/people use self-administered traditional remedies to cure various illnesses. They collect them directly from plants and other herbs which they believe will cure their illnesses or those of their families. In a few cases the traditional remedies are provided by relatives, friends, neighbours or directly from traditional practitioners. The list of ailments handled by traditional remedies include,

stomach-ache, pile, malaria, cold, period pain, high blood pressure, high temperature, toothache, pneumonia, sore throat, gonorrhea, vomiting, headache and convulsions. This list of self-administered traditional remedies is a reflection of the extent of the people's knowledge of medicinal plants (Onokerhoraye 1999:20).

According to Onokerhoraye (1999:21) the most common complaint concerning primary health centres is that they are not easily accessible because they are located in settlements where there are no fast means of public transport. In such circumstances it is easier to travel to the distant hospitals that are located in areas that are accessible by fast means of public transport. (Nnamuchi, 2007:23) While access to medical personnel is readily available in cities, rural dwellers often have to travel considerable distance in order to get treatment. This has significant consequences on the health of inhabitants of rural areas and unavailability of physicians and nurses within close proximity often leads to delaying and postponing visits to health care facilities until the conditions becomes unbearable. Transporting the patient on treacherous roads to urban facilities may take several hours and this may mean the difference between life and death.

The most common complaint concerning primary health centres is that they are not easily accessible because they are located in settlements where there are no fast means of public transport. In such circumstances it is easier to travel to the distant hospitals that are located in areas that are accessible by fast means of public transport (Onokerhoraye, 1999:21-22).

2.4.3 Shortage of staff

According to Ebuehi and Campbell (2011:2) among many challenges facing Nigeria's health system is an acute shortage of competent healthcare providers. As a result of inadequate infrastructure locally and poor compensation packages, a sizeable number of physicians, nurses and other health professionals migrate to developed countries in search of fulfilling and lucrative positions

(Nnamuchi, 2007:22) among the many challenges facing the health system in Nigeria, as in several sub-Saharan African countries, is acute shortage of competent health care providers. As a result of inadequate infrastructure and poor compensation packages, a sizeable number of physicians, nurses and other medical professionals are lured away to

developed countries in search of better fulfilling and lucrative positions. If fact, some of these countries have established recruiting agencies and examination protocols targeting the best and brightest medical minds in the country, prompting the government to require these agencies register with the FMH and operate within an established framework.

The major challenge Nigeria faces is how to ensure availability and retention of adequate pool of competent human resources in their right mix to provide health care in areas where their services are in most need. This is a challenge complicated by many global and disease burden issues, such as global changes in health trends, shifts in health needs and demands, declining resources, changes in global, economic, political and technological situations. Additionally, the Health Millennium Development Goals (HMDGs), the global initiatives to fight HIV/AIDS, Tuberculosis and malaria, and the Polio Eradication Campaign have implications for human resource for health.

Onokerhoraye (1999:17) mentioned that another related factor is that attracting health personnel to these isolated communities has always been a problem as medical staff particularly medical practitioners and nurses are not always willing to work in these areas. In many cases medical personnel posted to health establishments in these areas have resigned from their employment to avoid working in the area. There has been reports of poor utilisation of facilities which discourages staff posted to these areas from remaining in the communities doing nothing. The combination of these factors appears to encourage the perpetration of the existing inequity in the distribution of health facilities in the area. The circle must have to be broken to make health care accessible to the people of the region by a deliberate policy of dispersal of health establishments.

2.4.4 Queues and waiting times

According to Onokerhoraye (1999:21) the most common complaint common to clinics and hospitals is that of queues. Many people claim that at times the queues are so long that one can spend the whole day waiting without being seen by a doctor or nurse. This creates particular problems for those who have travelled far and who depend on catching public transport home. Once they miss it they are forced to spend the night in the locality in which the hospital is located. People who are ill find waiting in a queue particularly tiring and they complain bitterly about the queue systems that exist in the hospitals. The system forces a person to queue three times; first one queues for ‘registration’; then one queues to see a nurse or doctor and finally one queues at the dispensary to get

medication. The problem of long queues is aggravated by poor service. People complain about standing in line for hours only to be told that the medication the doctor has prescribed is not available. Others queue to see a doctor only to be told he or she is not available. With doctors being in short supply, the majority of those using clinics and hospitals are attended to by nurses. The hospital's system of screening patients, so that only serious cases can be dealt with by doctors, is unpopular. People feel entitled to the best services available and are easily upset if they are sent home after being seen only by a nurse (Onokerhoraye 1999:23).

Umar, Oche & Umar (2011:80) add that in Nigeria patients will have to wait longer on the queues before seeing their providers, as long as the imbalance in the doctor-patient ratio is not addressed. The commonest reason adduced by our respondents for the long waiting time was, few doctors to attend to the large numbers of patients on the queue. This is common finding in most health care centres across Nigeria due to the shortage of medical doctors and other health care providers. A disproportionate number of doctors and patients would increase patient waiting time. Over the years, population has increased several folds without a commensurate increase in the number of health care providers.

2.5 Conclusion

Nigeria does not have a flawless health care system. The main goal Nigeria wanted to achieve was universal health coverage, equity within health system, availability of health care providers as well as accessibility. This chapter has disclosed many challenges that are threatening the health care of Nigerians. There is a great need for government intervention to overcome these challenges. The challenges are ranging from inequity in the distribution of health care facilities and manpower, poor execution and coordination of primary health care services, inadequate financial allocation to health care. These issues need to be urgently addressed because the citizen's health depends on them issues being resolved. The next chapter will focus on the overview of the South African health care system

CHAPTER THREE

AN OVERVIEW OF THE SOUTH AFRICAN HEALTH CARE SYSTEM

3.1 Introduction

In 1994 the newly elected democratic government inherited a fragmented and disjointed health service. New policies, legislation and discussion documents were introduced to restructure the South African health care system. There has been growing interest in the South African health care system. This is due to the problems around health care. One incident as mentioned in chapter one of this study, of a baby that died on his grandmother's back after they were denied access to three health facilities in the Western Cape, sparked particular interest (Prince, 2009:3). Yet the Constitution of South Africa emphasises that "everyone has the right to have access to (a) health care services, including reproductive health care" (RSA Constitution, 1996:13).

In this chapter, attention will be focused on the review of the policies and discussion documents pertinent to restructuring and transformation of the South African health care system. The first part will start by evaluating the White Paper on the Transformation of the Health System in South Africa, which was formulated with a set of policy objectives and principles upon which the Unified National Health System will be based. The next part will describe Primary Health Care Approach and the District Health System. The last part will focus on the National Health Plan of 2003 and its objectives.

3.2 Legacies of the past

The South African Act of 1909 united four colonies in the southern tip of Africa – the Cape of Good Hope, Natal, the Orange Free State and the Transvaal – into a four-province union. The new country formed from this merger was known as the Union of South Africa. Through the Act, a three-tier government, central national, provincial and many local authorities was established. The three-tier government had a central national government at the highest level, four provincial administrations at the second level and many local authorities at the third level. Traces of this three-tier system have survived all the changes that have taken place from 1909 to date (De Haan, 2005:15).

The South African Act gave little attention to matters of health. Following a serious influenza epidemic in 1918, the Public Health Act (Act No 36 of 1919) was passed. This Act established a Department of Health at central government level and assigned to it specific functions, while the other duties were allocated to either the provincial administrations or the local authorities. Very briefly, the central government became responsible for the prevention of communicable diseases and other aspects of public health; the four provincial administrations were responsible for all aspects of curative medicine; and the local authorities became responsible for environmental health issues. This allocation of duties and responsibilities to the different bodies led to a very clear division between curative, preventative and promotive health services (De Haan, 2005:15).

In 1961, after a referendum of registered white voters, the Republic of South Africa Act (Act No 32 of 1961) was passed. South Africa became known as the Republic of South Africa; the head of State was the State President and no longer the Governor General. The three-tier system remained intact with separate services for white people and for people of colour (De Haan, 2005:15).

In 1977 a new Health Act (Act no 63 of 1977) was passed. This Act was designed to coordinate the health services of the Republic, to determine suitable health policy and to ensure the full use of all available health services, thereby ensuring a comprehensive health-care service. In order to achieve the objectives of a health-care service, all three levels of government – the central, provincial and local services – were all involved in the delivery of health care. However, the State at central government level had the ultimate responsibility for the health of the people of South Africa (De Haan, 2005:15).

3.2.1 A National Health Plan for South Africa

The South African government, through its apartheid policies developed a health care system which was sustained through the years by the promulgation of racist legislation and the creation of institutions such as political and statutory bodies for the control of the health care professions and facilities. These institutions and facilities were built and managed with the specific aim of sustaining racial segregation and discrimination in health care.

As a result of the aforementioned the “new” South Africa was left with a health care system that was highly fragmented, biased towards curative care and the private sector, inefficient and inequitable. The South Africans were faced with a challenge of transforming the national health care delivery system and all relevant institutions. Recognising this need for total transformation of the health sector in South Africa, the African National Congress (ANC) initiated a process of developing an overall National Health Plan based on the Primary Health Care Approach. This document (National Health Plan) focused on the health system, but it linked with the Reconstruction and Development Programme which involved all other sectors. Health would therefore be viewed from a development perspective, as an integral part of the socio-economic development plan of South Africa (ANC, National Health Plan, 1994).

The following are the principles and points of departure for creating post-apartheid dispensation in health and healthcare.

3.2.2 A vision for health in South Africa: guiding principles

Equity

The health of all South Africans can be secured and improved mainly through the achievement of equitable social and economic development such as the level of employment, the standards of education and the provision of housing, clean water, sanitation and electricity. In addition, reductions in the levels of violence and malnutrition, and promotion of health lifestyles should be addressed, as well as the provision of accessible health care service (Tsoabisi, 2004:76).

Right to Health

Every person has the right to achieve optimal health, and it is the responsibility of the state to provide the conditions to achieve the set goals. Health and health care, like other social services, and particularly where they serve women and children, should not be allowed to suffer as a result of foreign debt towards structural adjustment programmes (Mohale, 2004:18).

Public Health Care Approach

The ANC led government is committed to the promotion of health through prevention and education. The Primary Health Care Approach is the underlying philosophy for the restructuring of the health system. It embodies the concept of community development, and is based on full community participation in the planning, provision, control and monitoring of services. It aims to reduce inequalities in access to health services, especially in the rural areas and deprived communities (ANC, National Health Plan, 1994).

Priorities

Health services must be planned and regulated to ensure that resources are rationally and effectively used, and to make basic health care available to all South Africans; hence, giving priority to the most vulnerable groups. Individual respect must be afforded to members of the society and be treated with dignity and respect. Furthermore, individuals, interest groups and communities must be given the right to participate in the process of formulating and implementing health policy (Tsoabisi, 2004:77).

Coordination and Decentralisation

The provision of health care must be coordinated among local, district, provincial and national authorities. These can as far as possible coincide with provincial and local boundaries. Authority over, responsibility for, and control over funds must be decentralised to the lowest level possible that is compatible with rational planning and the maintenance of good quality care. Clinics, health centres and independent practitioners should be the main points of first contact with the health system (ANC, National Health Plan, 1994:10).

National Health System

The ANC National Health Plan at the time promised a single comprehensive, equitable and integrated National Health System (NHS) must be created. It promised a single governmental structure dealing with health, based on national guidelines, priorities and standards. It would coordinate all aspects of both public and private health care delivery, and would be accountable to the people of South Africa through democratic structures.

All existing public sector departments of health including local authority, homeland, military and prison services would be integrated into the National Health System. All racial, ethnic, trial and gender discrimination will be eradicated. Both public and private providers have major contributions to make and would operate within a common framework that will encourage efficiency and high quality care (ANC, National Health Plan, 1994).

Promotion of Health

Attention will also be given to health education on sexuality, child spacing, oral health, substance abuse, environmental and occupational health. Health workers at all levels will promote general health and encourage healthy lifestyles. The government will also seek to establish appropriate mechanisms that will lead to the integration of traditional and other complementary healers into the National Health System (ANC, National Health Plan, 1994).

Respect for all

Within the health system health workers must respect the right of all people to be treated with dignity and respect. A Charter of Patients' Rights will be introduced. Furthermore, individuals, interest groups and communities have the right to participate in the process of formulating and implementing health policy (ANC, National Health Plan, 1994).

Health Information System

Appropriate and reliable data will be systematically collected and analysed, as part of a comprehensive health information system essential for National Health System planning and management purposes. It will also allow for promotion of relevant research to address the most important health problems of the community. The public and private sectors will be required to collect and submit relevant data in order to facilitate planning at local, provincial and national levels. The health information system of the National Health System will thus gather universal, opportune, reliable, simple and action oriented types of data to inform the entire system and increase its effectiveness (ANC, National Health Plan, 1994).

The ANC formulated all the aforementioned NHP of 1994 as a government in waiting. It came into power in 1994, and implementation of plans such as the NHP was called on: To enable this process, the Constitutional Assembly drew up the Constitution of the Republic of South Africa (De Haan, 2005:15). The Reconstruction and Development Programme became the government's framework for reform. Since then reform of a fundamental nature has indeed taken place – at a remarkable pace and generally in the direction the new government intended it to. This applies particularly to health policy and legislation, but also to the structure and the contents of the health care system. For health care the reform has indeed brought significant achievements and gains on a wide spectrum (Van Rensburg, 2004:110).

3.3 The White Paper for the Transformation of the Health System in South Africa

The main health policy document after 1994 was the White Paper for the Transformation of the Health System in South Africa. The White Paper elucidates the aim to present to the people of South Africa a set of policy objectives and principles upon which the Unified National Health system of South Africa will be based. The document also presents various implementation strategies designed to meet the basic needs of all our people, given the limited resources available (South Africa, Department of Health, White Paper for the transformation of the health system in South Africa, 1997:1).

The health policy as outlined in the White Paper was based on the comprehensive Primary Health Care (PHC) philosophy and approach as advocated at Alma Ata in 1976. It is the means, adopted by the national government, of providing accessible and appropriate health care to the majority of the people of this country. The implementation model for this approach to health care is the District Health System (De Haan, 2005:18).

According to the White Paper, the establishment of the District Health System (DHS) is at the core of the entire health strategy, and its rapid implementation is therefore of the highest priority. The health district concept is based on the experiences of many countries that found that national and provincial levels of government are too far moved from the community to be responsible to local health needs. It is recognised internationally that many functions of government can be more effectively managed by decentralising them to small geographic and administrative units called districts (De Haan, 2005:18).

Other legislation and policy documents that have influenced the delivery of health care during this period are the following:

- *Batho Pele:* This is a policy document that provides a policy framework to transform Public Service Delivery and to improve client care through the process. It encourages health workers to be open and transparent, to treat all clients with respect and courtesy, and to accurately inform people about their individual needs.
- *The National Drug Policy:* This is a policy that determines an acceptable structure to improve the supply of suitable drugs for the services and to ensure appropriate treatment regimes at acceptable cost. Essential Drugs List have been developed, which guide good practice at hospitals and at primary care health services.
- *HIV and AIDS policy and strategy:* The policy was introduced in 1999 and was aimed at refocusing the country's response to the epidemic through an appropriate and effective programme. Through education the aim is to improve access to infections (STIs), and to improve the care and support of people living with HIV and AIDS (PLWA), it proposes to prevent new infections and maintain optimal health for those infected with the virus.
- *The Patients' Rights Charter:* This document sets the standard for quality patient care and informs both the patients and health worker of their rights. It balances both the rights and the obligations of the patient and sets the basic standards of good patient care for the health worker to attain (De Haan, 2005:19).

At the time of the study South Africa had a population of over 40 million, 73% of whom were women and children. Although classified as middle-income country and spending 8,5% of GDP on health care, South Africa exhibits major disparities and inequalities. This is the result of the former apartheid policies which ensured racial, gender and provincial disparities. The majority of the population of South Africa has inadequate access to basic services including health, clean water and basic sanitation. Statistics for 2011 suggest that 45.5% of the population live in poverty. Fifty three percent of the population lives in rural areas, the vast majority of whom are poor (seventy-five per cent of the poor live in rural areas). Women and children are amongst the most vulnerable groups in South Africa. Sixty-one percent of children in South Africa live in poverty, and women are also disproportionately represented among the poor. It is estimated that the Infant Mortality Rate (IMR), Under-Five Mortality Rate (U5MR) and Maternal Mortality Rate (MMR) are

much higher than expected of a country with South Africa's level of income. Existing disparities amongst the various race groups are well documented. The government developed a framework for socio-economic development in its Reconstruction Development Programme (RDP), in which it has set out broad principles and strategies for development in all key areas and sectors in order to effectively address various problems facing the majority of the people of South Africa (South Africa, Department of Health, White Paper for the transformation of the health system in South Africa, 1997:4).

Five key strategies are outlined in the White Paper based on the principles of the RDP. These are:

a. The health sector must play its part in promoting equity by developing a single, unified health system.
b. The health system will focus on districts as the major locus of implementation, and emphasise the primary health care (PHC) approach.
c. The three spheres of government, NGOs and the private sector will unite in the promotion of common goals.
d. The national, provincial and district levels will play distinct and complementary roles.
e. An integrated package of essential PHC services will be available to the entire population at the first point of contact (South Africa, Department of Health, 2000:12).

3.3.1 Health sector mission, goals and objectives

The mission of the health sector is to "provide leadership and guidance to the National Health System in its efforts to promote and monitor the health of all people in South Africa, and to provide caring and effective services through a primary health care approach" (South Africa, Department of Health, White Paper for the transformation of the health system in South Africa, 1997:5).

The White Paper spells out seven key goals and a range of related objectives in the main, the White Paper advanced a wide range of policy measures that would fundamentally transform health care delivery in South Africa. These include:

- "Unifying the fragmented health services into a comprehensive and integrated NHS to address the legacy and impact of apartheid on health.

- Promoting equity, accessibility and utilisation of health services by rendering PHC available to all South Africans
- Establishing health service units that offer essential PHC service packages within an effective referral system linking primary, secondary and tertiary levels of care.
- Developing health promotion activities, by ensuring access to health-related information, community support and health services for adolescents.
- Developing the human resources available to the health sector, through education and training programmes aimed at recruiting and developing personnel who are competent to respond appropriately to the health needs of the people they serve.
- Involving communities in the planning and provision of health services.
- Developing a national health information system (NHIS) to facilitate health planning and management, and to strengthen disease prevention and health promotion" (Van Rensburg, 2014:119).

The White Paper further acknowledges the Reconstruction and Development Programmes'_special emphasis on women in the planning and implementation of human resource development and the crucial role of women's educational status in the health of their families thus in the improvement of health. The five key strategies mentioned above are outlined to steer the reform of the health sector. The list of objectives, principles and strategies clearly foreshadowed the key policies that in subsequent years would become the building blocks of the reform of the health sector. These have been translated into the National Health Bill and will eventually constitute the essence of the National Health Act (Van Rensburg, 2005:118).

3.4 District Health System

The District Health System (DHS) is an organisational framework for a country's health care system. It is accepted worldwide as the most appropriate vehicle for the delivery of the Primary Health Care Approach. De Haan et al, (2005:18) add that a District Health System based on Primary Health Care is a more or less self-contained segment of the National Health System. It comprises first and foremost a self-defined population, living within a clearly delineated administrative and geographical area whether urban or rural. It includes all institutions and individuals providing health care in the district, government, private or traditional. A District Health System therefore consists of a large variety of interrelated elements that contribute to health in homes, schools, workplaces and

communities, through the health and other related sectors. It includes self-care and all health-care workers and facilities up to and including at the first referral level and the appropriate laboratory, other diagnostic, and logistic support services.

According to Van Rensburg (2004:133), the adoption of the DHS as the organisational framework or vehicle for the South African health system, pertinently dictated the decentralisation of certain responsibilities for health serviced delivery to provincial and local/municipal government spheres in order to more effectively provide health care to people in defined geographical areas. It is seen as a means or mechanism to achieve an equitable, efficient and effective health system, and to bring health care services closer to the consumers. The underlying assumption is that the diligent implantation of the DHS could democratise health services, and also substantially dilute the dominance of the national Department of Health and the provinces in the organisation and dispensation of health services. Referring to the district-based Primary Health Care system, McCoy & Engelbrecht (1999:132) strongly stress the point that the District Health System is the "core building block of the entire health system". Further, they add that the "Primary health Care approach and the District Health System model apply to the whole of the health system and at all levels of health care delivery". Too often however, the DHS is understood as one component of the national health system rather than the underlying framework for the organisation as a whole.

3.4.1 Long-term goals and role of the district health system

The goal outlined in the RDP is to have a single NHS, based on a district health system that facilitates health promotion, provides universal access to essential health care and allows for the rational planning and appropriate use of resources, including the optimal utilisation of the private health sector resources. The country will be divided into geographically coherent, functional health districts. In each health district, a team will be responsible for the planning and management of all local health services for a defined population. The team will arrange for the delivery of a comprehensive package of PHC and district hospital services within national and provincial policies and guidelines. In time, all district level staff should be employed on the same salary scales and under the same terms and conditions of employment that apply to public sector health personnel throughout the country (South Africa, Department of Health, White Paper for the transformation of the health system in South Africa, 1997:13).

In view of the variety of conditions that exist among and within the provinces, it is unlikely that a single system of governance can be implemented throughout the country. Therefore, three governance options are suggested.

i. The provincial option which implies a key role for the provincial authority in rendering health services, as well as the integration and absorption of local authority health services – staff and infrastructure – into the provincial framework. Due to the insufficient or non-existent capacity and infrastructure of local authorities in many parts of the country to take responsibility for comprehensive health service delivery at the local district level, a provincial authority will inevitably have to retain full responsibility for such services at this level. Although this option allows for a large degree of uniformity, the central control that it entails may hamper decentralisation. It may also jeopardise progress towards a true developmental approach to the provision of health services.

ii. The statutory district health authority option comprises the establishment of a new independent or statutory body in each health district to take responsibility for all district health services in that district. Such a body would have autonomous powers in respect of staff and finance, and an independent administrative infrastructure for each district health authority. This option has the potential of ensuring a large degree of uniformity and, due to its newness, may allow for rapid devolvement of powers and functions to the most appropriate level. It will also allow for true community participation in governance structures. The disadvantages of this option are obvious: no management structures were at the time (and even today) fully in place to give effect to this model and thus had/have to be created anew.

iii the local government option entails affording a single local authority (metropolitan, district or local) with the necessary capacity and the responsibility to render comprehensive district health services to its population in its defined area. A precondition for this option is the large-scale transfer of staff and infrastructure from provincial to local authorities. Due to varying capacities, uniformity and parity in service delivery will be difficult to achieve under such a dispensation. The main advantage of the option is that, being part of local government, the district health authority under this option would be able to deal more effectively with intersectoral and integrated health and development issues (Van Rensburg, 2004:135).

3.4.2 The characteristics of the DHS are:

- A number of discrete geographical sub-divisions, usually called "health districts", each with a clearly defined catchment population
- Clear guidelines being used for demarcation of the "health districts", such as
  - each to include a level 1 hospital
  - population not to exceed 500 000
  - geographical size to be such that the furthest clinic can be reached in approximately 3 hours from the district office
  - being of a reasonable size so as to ensure effective management
- Each "health district" has a decentralised health management team responsible for
  - delivery of a comprehensive and integrated package of health care to the population
  - planning, managing, implementing and monitoring health care delivery that is appropriate for the population
  - ensuring equitable and cost effective use of resources
  - establishing an appropriate referral system between parts of the district health system and with relevant services outside the "health district" (Hall, Haynes & McCoy 2002:1).

3.4.3 Principles

A national committee established to develop a DHS, comprising representatives of the national and provincial health departments, has agreed unanimously that there are twelve principles which must comply in the development of the DHS. These are:

i. Overcoming fragmentation of services and responsibilities
ii. Equity in service provision particularly in underserved communities
iii. Rendering comprehensive range of services
iv. Effectiveness – targeting resources appropriately with a view to achieving a demonstrable health
v. Efficiency – maximal health gain to be achieved at the lowest cost
vi. The highest possible quality, taking into account local needs and resources
vii. Access to services for all those in need of health care
viii. Local accountability to the community and its political representatives

ix. Community involvement and participation in management and service delivery at local, district and provincial levels
x. Effective decentralisation of decision-making powers to managers at the district level
xi. Development and intersectoral approach
xii. Sustainability of an acceptable standard of services and a secure financial base (Van Rensburg, 2004:134).

3.4.4 Implementation strategies

a. Each province will be subdivided into a number of functional health districts.
b. The district will serve both as a provider and purchaser of health services, and will select the appropriate strategy on the basis of equity, efficiency and assessment of local conditions.
c. Peri-urban, farming and rural areas will fall within the same health district as the towns with which they have the closest economic and social links. The fragmentation and inequity created by the past practice of separating peri-urban and rural health services from the adjacent municipal health services must be eradicated.
d. There will be parity in salaries and conditions of service for all public sector health personnel throughout the country, which include appropriate incentives to encourage people to work in underserved areas. This is essential in order to rationalise services, overcome fragmentation and promote equity, particularly between metropolitan, urban and rural area.
e. Financing mechanisms or formulae will be devised, to ensure that district level health services are financed in an equitable and sustainable manner.

The establishment of the DHS is at the core of the entire health strategy, and its rapid implementation, therefore, is of the highest priority (South Africa, Department of Health, White Paper for the transformation of the health system in South Africa, 1997:14).

The development of District Health System in South Africa has since 1994 taken its own unique course. The grand plan of the DHS set out to establish a single health service in each health district that provides a comprehensive range of services that has the necessary managerial and financial capacity to establish and sustain workable structures; that provides for communities to have a real say over their own health care; and that is accountable to local government. One health authority – the district health

authority – is to be responsible for PHC in the particular health district, including community-based services, clinics and district hospitals (Van Rensburg, 2004:135).

3.5 Primary Health Care

De Haan (2005:24) describes Primary Health Care (PHC) as an essential part of a comprehensive service. It is described by the World Health Organization (WHO) as 'essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation, and at a cost that the community and country can afford'.

The WHO has laid down certain basic principles for the organisation of PHC that can be summarised as follows:

- PHC should be shaped around the life patterns of the population and should meet all the daily health needs of the community.
- It should form an integral part of the national health system.
- PHC services should be integrated with other services concerned with community development, such as agricultural and educational services and communications.
- The local population should be actively involved in the health-care activities.
- It should use an integrated approach that links promotive, preventive, curative and rehabilitative care at the services offered.
- Treatment should be as simple as possible, and carried out by health workers who have been suitably trained to perform such treatment according to their level of competency.
- There should be adequate facilities for prompt and efficient referral (De Haan, 2005:25)

On the one hand, Van Rensburg (2004:133) mentions that the adoption of the concept of the PHC approach has conveyed a loud call for a fundamental shift in emphasis in the health care delivery, for a redistribution of public health resources, and for an inevitable rearrangement in the importance of the levels of care. Since 1994 universal access to comprehensive PHC has formed the crux of the government's health policy and plans. In the public sector, increasing emphasis has been placed on first-line care and facilities,

accompanied by a more pronounced positioning of community/district and regional hospitals to support the PHC referral network.

3.5.1 The PHC package

Primary health care is care that is provided at the first point of contact with the health system. It is characterised by a broad approach to basic health service delivery and community development. Primary health care focuses on the community in need of health care (McElmurry & Keeny 1999:241). It encompasses the main health problems and is provided in clinics, hospitals and communities. It addresses many of the determinants of health. A comprehensive focus is maintained by incorporating community development and health service delivery. Health professionals alone therefore cannot implement primary health care closer to where people live and work and as a result health services become more accessible (Barnes, Eribes, Juarbe, Nelson, Proctor, Swayer, Shaul & Meleis 1995:8; Denill, King & Swanepoel 1999:3; World Health 1998:7).

Table 3.1 PHC services to be provided through the district health system

Services	Relevant Health personnel
Personal promotive and preventive service: Health education Nutrition/Dietetic services Family planning Immunisation Screening for common diseases	PHC; health educators Nutritionists; dieticians PHC nurses PHC nurses
Personal curative services for acute minor ailments, trauma, endemic, other communicable and some chronic diseases	PHC nurses - Referral to generalist doctors as appropriate
Maternal and child health services: Antenatal care Deliveries Post-natal and neonatal care	Midwives - Referral to generalist doctors as appropriate
Provision of essential drugs	Pharmacists and assistants; PHC nurses
PHC level investigative services:	Radiographers; X-ray technicians

Radiology Pathology	Laboratory technicians - Referral to generalist doctors as appropriate
Basic rehabilitative and physical therapy services	Physiotherapists and assistants; occupational therapists and assistants
Basic oral health services	Dental therapists; oral hygienists - Referral to dentists as appropriate
Basic optometry services	PHC Nurses - Referral to optometrists as appropriate
Mental Health services	Psychiatric nurses; social workers
Medical social work services	Social workers
Services organised and provided at the district level	
Health education	Health educators
Health-related nutritional support	Nutritionists; dieticians
Communicable; non-communicable and endemic disease prevention and control	Epidemiologists; public health specialists, Epidemiology assistants Public health officers; generalist doctors
School and institutional services for children: Oral health Audiology Optometry	 PHC nurses Dental therapists Audiology technicians
Health-related water and sanitation services and other environmental health services	Environmental health officers
Community mental health and substance abuse services	Generalist doctors; PHC nurses, social workers
Occupational health & safety services	Health inspectors Epidemiologists; public health specialists Generalist doctors
Community nursing and home care services, including care of the terminally ill	Generalist doctors; PHC nurses
Essential accident and emergency services	Emergency trained personnel, drivers
Community geriatric services and care of the elderly	Generalist doctors; PHC nurses
Health services support: Epidemiology and health information	 Epidemiologists; health information system

system Health monitoring Planning and administration	specialists, Health planners; administrators
Basic medico-legal services	Pathologists; generalist doctors

(South Africa, Department of Health, White Paper for the transformation of the health system in South Africa, 1997:17)

3.5.2 Goals of primary health care

This discussion is the important part of context, rationale for introducing PHC approach. According to Strasser (1997:7), primary health care is needed in the Republic of South Africa as there is a serious mismatch between income and health outcomes. There is a disparity between the poor and the rich regarding basic conditions of life and health outcomes. Primary health care aims to reduce inequalities in access to health services, especially in rural and deprived communities, and to ensure universal coverage. It is aimed at addressing global inequalities in basic health status through development of sustainable health programmes that are accessible at a cost that the people can afford (McElmurry & Keeny, 1999:241-244). Shultz and Hatcher (1997:26) believe that such programmes could eventually improve the health of an entire nation.

3.5.3 Main characteristics and components of primary health care

The components of primary health care include:

- basic need provision (nutrition, shelter, water, basic sanitation, clothing, prevention of hunger and starvation)
- prevention of health problems (through health promotion, health education, sifting programmes)
- management of health problems (health education, curative services, home-based care, referrals)
- rehabilitation services (health education on optimal living with disabilities, disability care referrals (La Fond, 1995:16).

3.5.4 Strategy for the implementation of primary health care

According to Denill (1999:6), for a strategy to be determined, first and foremost there must be political commitment to primary health care by the government in power. Priorities must be identified and then detailed plans of action must be set out. This will vary from country to country, depending on its level of development, health needs and available resources. Most health systems need to be adapted to a more community-based or decentralised system, so that services become available to all.

(a) Principles on which a successful strategy should be based

Equity

Primary health care entails rendering essential services since it includes social and economic development as a way of attaining health for all. It concerns universal distribution of essential services. These are services without which a healthy life style is not possible, like safe water, a food supply and shelter (Barnes et al., 1995:11).

Primary health care aims to provide equal access to basic health care to all people. The poor, the aged and the disadvantaged especially in remote and rural areas should also have equal access to health services. The health needs of the whole population should be met. There should be no discrepancies in the provision of health care (Bryar, 1994:73).

Affordability

Services are provided at a cost that the community and the country can afford. People are not to be denied health care because of lack of money (Barnes et al., 1995:12; Denill et al., 1999:6).

Accessibility

Primary health care contributes towards ensuring accessibility of services to all citizens because all citizens have a right to basic health care. Primary health care reaches out especially to disadvantaged communities. There is a continuing organised supply of health services to people by overcoming geographical and financial barriers. Providing care that is culturally sensitive increases the accessibility of the services, as more people will utilise the services offered. Ideally all clinic services are available to clients at any time of the day. Health services are within walking distance, and provide care that the

community needs and considers important. Such care is also concerned with availability of well-equipped clinics and a supply of essential drugs (Chalmers, Luker & Bramadat, 1998:68).

Availability

Primary health care ensures sufficient, appropriate and high quality health care delivery, which fosters lifestyle changes and positive health. Primary health care facilities provide the most appropriate care for the identified health needs of a community or for the problem the client presents with. Appropriate technologies are utilised. The simplest but not necessarily the cheapest technology is used with regard to equipment and procedures, considering the level of training of health professionals (Denill et al., 1999:6).

Effectiveness

A collaborative effort amongst sectors like housing, education, social welfare, business, agriculture and non-governmental organisations is required in order to meet the basic health needs of the people. Primary health care entails a multi-sectoral approach to health in order to bring about conditions which enhance health, and prevent or manage conditions influencing ill health (Chalmers et al., 1998:69; Shoultz & Hatcher, 1997:23).

For the success of any primary health care programme, full community participation is essential. It is the corner stone of actualising primary health care. The community participates in the planning, provision, control and monitoring, and evaluating services. There is an equal partnership amongst the beneficiaries, providers and managers. Communities take responsibility for their health and must prioritise their own needs. Community participation improves the acceptability and appropriateness of care (Barnes et al., 1995:11; Heaver, 1995:26; Mc Elmurry & Keeny, 1999:245).

Primary health aims to remedy the causes of health inequality through community empowerment. It also promotes self-reliance and reduces dependence on health professionals, as communities are encouraged to take responsibility for their own health. Civilians and communities are empowered to enable them to provide for their own basic health needs and to improve their quality of life. Primary health care can only be successful if it is part of an overall community development strategy (Denill et al., 1999:3; Heaver 1995:26; Unger & Criel, 1995:115).

Efficiency

Efficiency is another principle on which a successful strategy for implementing primary health care should be based. What is achieved should be proportional to the amount of money, resources, effort and time spent (Mohale, 2004:19).

(b) Reorganisation of health services

A shift in the emphasis of health care is necessary, from curative hospital-based care to community-based primary health care. The overall objective is to deliver health services efficiently and effectively through an infrastructure that covers the needs of communities at ground or district levels, with the necessary support and referral services at intermediate or provincial level and at national level. This process of change needs to be dynamic, as it will be influenced by the political, cultural, technical and financial factors of the country. It will also require the realignment of available resources to meet this new structure, with a shift of resources going to the community for community-based health care and basic health services. Problems arise when government bureaucracies look for easily manageable and replicable interventions to introduce across the whole country or province at community level. This does not allow for the flexible and adaptive approach necessary for the implementation of appropriate primary health care services to meet the needs of each community. To counteract this problem, much more autonomy needs to determine how to plan their own primary health care services to meet these needs. The success of primary health care depends to a large degree on the community “ownership” of its health services (Denill et al., 1999:7).

(c) Multi-disciplinary approach

The definition of health contained in the constitution of the WHO acknowledges the broader dimensions of health. It states that health is” the physical, mental and social well-being, and not merely the absence of disease and infirmity”. It can therefore be said that health is the product of a person’s positive interaction with his or her total environment. According to King (1996:23), the multidisciplinary team must include “the ordinary

individual in the community, be it the patient and his family, or any other concerned individual or group that can assist the community in one way or another towards improvements of their health status"

(d) Intersectoral collaboration

The Primary Health Care involves all those other environmental and societal dimensions that affect the health and well-being of populations in the true spirit of the well-known WHO definition of health namely: health is not only the absence of disease and infirmity, but it implies true physical, mental and social well-being. To secure and promote the health of people, other functions, apart from health care, should thus be activated amongst, others, sufficient food production and nutrition, proper education, safe sheltering, social safety nets and support systems, pure water and healthy sanitation apply. It is in this sense that interdepartmental collaboration becomes a prerequisite in efforts to implement the district-based PHC system (Van Rensburg, 2004:146).

(e) Community participation and involvement

An important principle in the primary health care approach is accountability to community structures at local, district, provincial and national levels. Democratically elected representatives will be involved in the appointment of staff and the control of budgets. This is seen as an important mechanism for increasing local control and responsibility over health matters. However, control over the executive functions in the health care system is not the same as community participation. Effective community participation as envisaged in the PHC approach means that democratically elected community structures, integrated with representatives of the different sectors and stake-holders involved in health and community development, have the power to decide on health issues. Community participation is an essential element that the NHS must develop at a local level in order to be fully effective, and is not an entity that can be prescribed and legislated into being (ANC, 1994:12). Yet subsequent policies and legislation was introduced to do just this. A Policy for the Development of a District health System for South Africa, 1996, and the National Health Act, 2003 were published and legislated to give impetus to the above statement.

3.6 National Health Act

The National Act was signed by the President on the 23 July 2004 and is an important step forward in the transformation of the South African health sector (De Haan, 2005:20). Since 1994, health policy has been developed but the implementation of the new policies has been handicapped because there has been no new health legislation to support the new health system, and because the old Act was entrenched in the policy of the previous government. (The National Health Act, 2003 Act No 61 of 2003) replaces the Health Act (Act No 63 of 1977). The National Health Act, 2003 (Act No 61 of 2003), is directly linked to the Constitution and sets out the framework within which the health system of the country must function. Regulations will now have to be developed to set out the broad legal and operational principles that are included in the Act.

The National Health Act, 2003 (Act No 61 of 2003) was introduced 'to provide a framework for a structured uniform system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services; and to provide for matters connected therewith (South Africa, National Health Act, 2004:5).

One of the objectives of the National Health Act, 2003 (Act No 61 of 2003) is to "regulate national health and to provide uniformity in respect of health services across the nation by:

(a) establishing a national health system which
  - (i) encompasses public and private providers of health services; and
  - (ii) provides in an equitable manner the population of the Republic with the best possible health services that available resources can afford:

(b) setting out the rights and duties of health care providers, health workers, health establishments and users; and

(c) protecting, respecting, promoting and fulfilling the rights of -
  - (i) the people of South Africa to the progressive realisation of access to health care services, including reproductive health care.
  - (ii) the people of South Africa to an environment that is not harmful to their health or well-being;
  - (iii) children to basic nutrition and basic health care services contemplated in Section 28(I)(c) of the Constitution; and

(iv) vulnerable groups such as women, children, older persons and persons with disabilities" (South Africa, National Health Act, 2004:16).

3.7 Chapter summary

This chapter focused on an overview of the South African health care system. The new government has brought about changes. This chapter assisted in providing a better understanding of the proposed primary health care and district health system. It further highlighted the goals and characteristics of the new health plan. Below are the key themes that the chapter focused on.

Legislation, policies and discussion documents have been introduced. The White Paper for the Transformation of the Health System in South Africa was evaluated in order to clarify the aim of restructuring the Health System, objectives, guiding principles and implementation strategies.

A detailed explanation of Primary Health Care Approach and DHS was also forwarded as the alternative and successful Health System to be used. However, the District Health System was mentioned as the best way for delivering the PHC.

The last part, the National Health Act, 2003 (Act No 61 of 2003) focused on the objectives of the plan and on recognition of:

- the socio-economic injustices, imbalances and inequities of health services of the past;
- the need to heal the divisions of the past and to establish a society based on democratic values, social justice and fundamental human rights;
- the need to improve the quality of life of all citizens and to free the potential of each person;

In order to unite the various elements of the national health system towards a common goal and to actively promote and improve the national health system in South Africa.

The study presented the key legislative and policy reforms of 1994 and post 1994. The previous context of apartheid and its impact on the quality of health care services was not discussed as it had no bearing on this study.

The next chapter deals with research design for evaluation of access to health care facilities in the Western Cape, South Africa: with specific reference to a Community Health Clinic.

CHAPTER FOUR
RESEARCH METHODOLOGY

4.1 Introduction

The purpose of this chapter is to forward the research methodology explored in the study. This chapter provides a detailed explanation of how the research design and methodology was developed. A theoretical background of different research methodologies is also provided. The purpose for this was to gain a better understanding of underlying methodological theories. It also describes research methods that were utilised and why they were selected. The target population, sampling size, research ethics and techniques employed for analysing data, are forwarded. Finally the chapter describes how data was collected and the reasons for using the instruments to collect data. The chapter concludes with an overview of the limitations of the study.

4.2 Research plan

According to Glatthorn and Joyner (2005:97), a research design is a specific plan for studying the research problem. Leedy and Ormrod, (2001:91) concur that research design provides the overall structure for the procedures that the researcher follows, the data that the researcher collects, and the data analysis that the researcher conducts. Simply put, research design is planning. Bryman (2004:27) adds that a research design provides a framework for the collection and analysis of data. A choice of design reflects decisions about the priority being given to a range of dimensions of the research process. These include the importance attached to:

- expressing causal connections between variables;
- generalising to larger groups of individuals than those actually forming part of the investigation;
- understanding behaviour and the meaning of that behaviour in its specific social context;
- having a temporal (i.e. overtime) appreciation of social phenomena and their interconnections.

This research followed both quantitative and qualitative research approaches through the distribution of questionnaire and observations. The objective of the research was to evaluate the problems around accessing the Gugulethu Community Health Clinic.

Mouton (2001:55) states that research design is a plan or blueprint of how the researcher plans to conduct the research. Research designs are made for a particular purpose i.e. to address different kinds of questions or problems. It is therefore logical to assume that the research design will have the research problem as a point of departure.

4.2.1 Problem statement

According to Bless, Higson-Smith and Kagee (2006:20), in the identification of a research problem, one can distinguish three steps in narrowing the range of interest. These are the selection of a topic area, the selection of a general problem, and the reduction of the general problem to one or more specific, precise and well-delimited questions. In general, the sources of a research problem are to be found in a combination of direct observations and experiences, theory, previous investigations and practical concerns, as mentioned before. This research examines the problems underlying access to the Gugulethu Community Health Clinic. The problem that this research addresses is around access to health care at the Gugulethu Community Health Clinic as mentioned in Chapter One.

According to Chalmers, Luker and Bramadat (1998:68), access ideally means all clinic services are available to clients at any time of the day. Health services are within walking distance, and provide care that the community needs and considers important. Such care is also concerned with availability of well-equipped clinics and a supply of essential drugs.

4.3 Research Methodology

Glatthorn and Joyner (2005:44) define research methods, as specific techniques used to collect data with respect to the research problem. Research method can involve a specific instrument, such as a self-completion questionnaire or structured interview schedule, or participant observation where a researcher listens to and watches others.

This research deals with a social context therefore, the use of quantitative and qualitative method was deemed necessary. The quantitative methodology will be discussed in the following section.

4.3.1 Quantitative Research Methodology

As mentioned in Chapter One, quantitative research is defined as a systematic and objective process that investigates a research problem by using structured questions and where a large number of responses are involved. In quantitative research one can use statistical inferences to process data and then to generalise the findings according to the selected population (Maree, 2007:145). According to Creswell (2009:145), a survey provides numeric descriptions of trends, attitudes or opinions of a population by studying a sample of that population.

Quantitative research is appropriate when addressing research objectives by enquiry regarding "how much or how often", and when one wants a profile of a targeted audience (Martin, 2005:122). Quantitative research tends to concentrate on generalisation and is based on assessing theory, which is composed of variables that are selected and measured against the research problem. The variables are under the control of the researcher (Singleton & Straits, 2005:130).

Using quantitative research allows one to reach out to a large number of respondents. The research findings can be generalised to the entire population under study if it is a representative sample (Singleton & Straits, 2005:140). The researcher if so chosen is not directly involved in the data collection process, which allows respondents to complete the questionnaire in their own free time (Maree, 2007:68). Hence, the researcher can obtain objective responses without allowing his or her personal bias to influence analysis and interpretation of the data.

Since quantitative research restricts respondents to only answering "what you know", it limits answers. Therefore, deeper insight that is provided by interviews or open ended questions is missed. There is a high potential risk of questions being misunderstood by respondents, and this may lead to respondents providing wrong answers (Babbie & Mouton, 2001:312).

The use of a questionnaire to collect data enables the researcher reach to collect data from a large number of people. Questionnaires are flexible because several questions can be posed from one topic, which ensures considerable flexibility in analysis (Babbie & Mouton, 2001:263). A questionnaire was used as an instrument to collect data. The questionnaire was designed with closed and open-ended questions to gather as much information as possible from patients and employees of Gugulethu Community Health Clinic.

4.3.2 Qualitative Research Methodology

Qualitative research is an inquiry process of understanding where a researcher develops a complex, holistic picture, analyses words, reports detailed views of informants, and conducts the study in a natural setting (Creswell, 2007:205). The qualitative researcher collects words (text) and images (pictures) about the central phenomenon. The data is collected from people immersed in the setting of everyday life in which the study is framed. The researcher serves as an instrument of data collections and asks participants, open-ended questions to allow them to share their views about and experiences with the phenomenon (Maree, 2007:257).

Characteristics of qualitative research

- Natural setting
- Researcher as key instrument
- Multiple sources of data (Creswell, 2009:175).

According to Blaxter, Hughes and Tight (2001:64), qualitative research is empirical research where the data are not in the form of numbers, in many forms, chiefly non-numeric. The focus of qualitative data is on exploring, and getting as much detail as possible. Its main aim is to achieve ‘in-depth’ rather than depth. It tends to focus on exploring, in as much detail as possible, smaller numbers of instances or examples which are seen as being interesting or illuminating and aims to achieve ‘in-depth’ rather than depth (Blaxter, Hughes & Tight, 2001:64).

A major strength of qualitative research is that it allows one to gain an in-depth understanding of the research problem (Babbie & Mouton, 2001:309), while it allows for

interpretation of results and discovery of new ideas. It is also useful to address research objectives with variables that are difficult to quantify into figures (Babbie & Mouton, 2001, Welman et al., 2006).

However, the disadvantage of qualitative research is that the research results are dependent on the interpretation of the researcher and thus make it prone to biases, making the results more subjective than objective, which in turn makes it difficult for findings to be generalised (Babbie & Mouton, 2001:309). Qualitative research is more interactive and therefore, requires someone that has good communication and analytical skills to report the social phenomenon in a more objective way.

There are different methods of obtaining data in qualitative research as the basic individual interviewing, in-depth individual interviews, focus groups interviews, observation and participant observation and the use of personal documents (Babbie & Mouton, 2001).

The qualitative methodology was used to gain views and experiences of the patients and employees of Gugulethu Community Health Clinic. The method used was observation. Observation was selected in order to determine what is occurring and what individuals are doing.

4.3.3 Multi-Method Approach

For the purpose of this study the researcher used a combination of quantitative and qualitative approaches. This method is called a multi-method approach or mixed method. According to Creswell (2009:4), a mixed method is an approach to inquiry that combines or associates both qualitative and quantitative forms. It involves philosophical assumptions, the use of qualitative and quantitative approaches and the mixing of both approaches in a study. Thus, it is more than simply collecting and analysing both kinds of data; it also involves the use of both approaches in tandem so that the overall strength of a study is greater than either qualitative or quantitative research (Creswell & Clark, 2007). The purpose of combining the two approaches was to understand the research problem from a subjective and objective point of view.

Mouton and Marais (1990) add that this approach of combining different research methods in a single research project provides a rich understanding of a research topic,

which could lead to more reliable research results. The strength therein lies in the diversity of the methods, specifically in bringing together the complexities of how the real world is viewed by the different methods.

The purpose for combining the two methods was to gain more reliable research results and to complement methodological weaknesses that flow from using a single method such as errors and bias. Qualitative methods can answer questions that quantitative methods cannot provide during the data collection process, which therefore permits the researcher to obtain different information from different perspectives.

The researcher used the multi-method approach with the view that it will increase the validity and reliability of the findings. Both quantitative and qualitative approaches were necessary because the researcher wanted first to survey a large number of participants to get a general picture of the patients, and then to observe them in order to explore the relationship of employees of Gugulethu Community Health Clinic and the patients. Applying both quantitative and qualitative methods within a mixed-method approach provided a deeper insight into the problems of access to Gugulethu Community Health Clinic.

To use a mixed-method approach was not easy, it needed knowledge and skills. The researcher did not find it easy, thus she sought information and knowledge through books on mixed-methods and the skills of the statistician.

4.4 Data collection instrument

According to Creswell (2003:185), the role of the researcher is to set the stage for discussion of issues involved in collecting data. The data collection steps include setting the boundaries for the study, collecting information through unstructured (or semi-structured) observations and interviews, documents, and visual materials, as well as establishing the protocol for recording information. This is important in increasing the reliability of a study. In this research study, the data collection instrument used was the questionnaire and observation (Leedy & Ormrod, 2010:189).

4.4.1 Questionnaire

The questionnaire was constructed using a combination of closed and open-ended questions. The first part of the questionnaire had close-ended questions, which provided the respondents with a selection of responses to choose from. The last part had open-ended questions in order to capture the feelings and experiences of patients and employees around the access to Gugulethu Community Health Clinic. Open-ended questions allow respondents to communicate their experiences or opinions about a specific issue in their own words without any restriction (Terre Blanche et al, 2006:486). The questionnaire allowed for the collection of objective perceptions from respondents and also helped to simplify the complexity in collecting subjective data. However, these types of questions influence the respondents less than the multiple-choice one and it allows for a considerable degree of bias.

Two sets of questionnaires were developed using the literature review as a frame of reference. One questionnaire was aimed at the employees of Gugulethu Community Health Clinic. The other questionnaire was aimed at the people using the Gugulethu Community Health Clinic. A common set of issues was addressed in each questionnaire. When the first draft of the questionnaire was completed, a pilot study was undertaken before distributing it to a large number of participants. After compiling the questionnaire items, a pilot test was conducted at Gugulethu Community Health Clinic. Thirty (30) questionnaires were administered. Leedy and Ormrod (2010:111) describe a brief pilot study as an excellent way to determine the feasibility of your study. Bless et al (2006) concur that a pilot study involves testing the actual programme on a small sample taken from the community for whom the programme is planned. This allows the evaluator to identify any difficulty with the method or materials and to investigate the accuracy and appropriateness of any instruments (such as screening tests, biographical questionnaires, and so on) that have been developed. According to Welman et al (2007:148) when a new measurement instrument is developed, it is useful to ‘test it out’ before administering it to the actual sample. This process of ‘testing out’ is done by means of a pilot study, which entails administering the instrument to a limited number of subjects from the same populations as that for which the eventual project is intended. The pilot study is therefore a ‘dress rehearsal’ for the actual research investigation.

The purpose of the pilot study can be summarised as follows:

- To detect possible flaws in the measurement procedures (such as ambiguous instructions, inadequate time limits, and so on).
- To identify unclear or ambiguously formulated items. In such a pilot study the actual questions are put to the 'participants and they are then asked to indicate how they have interpreted the formulated questions.
- To create an opportunity for researchers and assistants to notice non-verbal behaviour (Terre Blanche et al, 2006:486).

The aim was to address the quality and validity of questions, thereafter, certain amendments were made to the piloted questionnaire before it was distributed to the participants.

After the pilot study patients using Gugulethu Community Health Clinic were given questionnaires with questions, about their experiences at the clinic and questions like, their arrival time, the time they spent before being assisted, whether they were assisted or turned away, documents required at the clinic, issues they were satisfied or dissatisfied with and suggestions on improving the service delivery at admissions office. The employees at Gugulethu Community Health Clinic were also asked questions relating to the service they offer, the tools they use to evaluate their service and the improvements they can suggest improving the service delivery at the admissions office.

Bless, Higson-Smith and Kagee (2006:99) describe population as the set of elements that the research focuses upon and to which the results obtained by testing the sample should be generalised. It is usually impossible to include the entire population in your study; the two main restrictions being time and cost. Consequently, in the majority of surveys especially where the population that is being studied is fairly large, you will have to make use of sampling. Since the goal of a survey is to use the sample to learn about the population, it is very important for the sample to be drawn in such a way that it would be valid to generalise its results on the population. Sampling theory has been developed to suggest ways of drawing "scientific" samples that are random and representative of the population and whose findings can tell us more about the population in general (Maree, 2007:172).

The target population for this research is all permanent employees of Gugulethu Community Health Clinic. All permanent employees were chosen because of their small

number. Another target population was patients using Gugulethu Community Health Clinic, ranging in the age group from eighteen years and older (the sample size in the discussion below). The research was therefore limited to the above mentioned group. The type of sampling technique used for the survey implies that sample members should conform to a certain criteria (Cooper and Schindler: 2003). In this case, the sample members had to be employees of and patients using Gugulethu Community Health Clinic. The questionnaires were only handed to patients who met the above criteria. According to the statistics received from Gugulethu Community Health Clinic, as mentioned in Chapter One. The researcher therefore distributed 380 questionnaires to patients using Gugulethu Community Health Clinic. 101 questionnaires were distributed to the permanent employees at Gugulethu Community Health Clinic. The determination of the minimum returned sample size for a given population is as follows: for a population size of 1500, 110 questionnaires should be returned and for a population size of 200, 75 questionnaires should be returned (Sekaran, 2000:295). From the 380 questionnaires distributed to the people using Gugulethu Community Health Clinic, only 190 responded to the questionnaire. From the 101 questionnaires distributed to Gugulethu Community Health Clinic employees, only 90 employees responded to the questionnaire.

The questionnaires were analysed by a statistician using application software, called Statistical Package for Social Science (SPSS) for Windows.

4.4.1.1 Questionnaire administration

Permission to carry out research was granted by the Gugulethu Community Health Clinic facility manager. In order to gain the confidence of the respondents and for ethical reasons, a confidentiality statement was made on the first page of the questionnaire. The statement clearly mentioned that responses would strictly be used for the purpose of the research and that the identities of the respondents would not be disclosed. This was important, in order to ensure that the respondents completed the questionnaires honestly and dispassionately. The researcher conducted the research according to the Ethics & Research clearance provided by the Faculty of Business, Cape Peninsula University of Technology.

The questionnaire was designed before going into the field. The researcher designed and developed the questionnaire herself, with the guidance from the statistician and approval of the supervisor. Two sets of questionnaires were developed; one

questionnaire was aimed at the employees of Gugulethu Community Health Clinic while the other was aimed at the patients using the Gugulethu Community Health Clinic. The questionnaire enabled the researcher to collect information on the problems around access to Gugulethu Community Health Clinic. More importantly there was also the need to reach as many patients and employees as possible in order to evaluate the causes of problems of access to Gugulethu Community Health Care. Hence, the questionnaire was important for this purpose.

The questionnaires were hand delivered to the Gugulethu Community Health Clinic by the researcher with two research assistants. Before permission was granted to the researcher, she was invited by Gugulethu Community Health Clinic facility manager to make a presentation of the topic to the Heads of Departments. During the presentation, the researcher explained the procedure for completing the questionnaire. The questionnaire was accompanied by a letter explaining the purpose of the research and clear instructions on how to complete it. Thus, the questionnaire was distributed to the employees and the respondents were given time to complete the questionnaire at their own pace. Appointments were made for the collection of the completed questionnaires from the employees. Only 90 questionnaires were returned from the 101 that were administered to the employees.

The patients questionnaires (patients using Gugulethu Community Health Clinic) were distributed and administered by the researcher with the help of two research assistants. The patients were taken to a side room to fill in forms to ensure that they have privacy. The research assistants were very helpful in assisting some members of the community with completing the questionnaire, which was necessary because of literacy constraints. The clients' (patients) questionnaire was formulated in Xhosa because Xhosa is the predominant language in Gugulethu. A total of 380 questionnaires were administered, however, only 190 were returned. Some patients left without filling in the forms because they were tired from spending the day at the clinic.

4.4.2 Observation

The researcher conducted observations at Gugulethu Community Health Clinic. The researcher spent extensive periods at Gugulethu Community Health Clinic when she was conducting the observations. Observation is a method of recording conditions, events and activities through the non-inquisitorial involvement of the researcher. The non-

participant researcher takes a detached stance to the phenomena, and aims to be invisible, either in fact or in effect (i.e. by being ignored). The participant observer is seen as involved in the process of activity (Walliman, 2005:287). The primary advantage of conducting observations is flexibility. The researcher can easily shift focus as new data come to light. The major disadvantage is that by his or her very presence, the researcher may alter what people say and do and how significant events unfold. The researcher conducted the observations from the early morning until late in the evening and on weekends. It was imperative for the researcher to observe the daily occurrences within Gugulethu Community Health Clinic in order to draw conclusions around daily occurrences. Particular aspects observed included atmosphere at the admissions office; the relationship between staff and patients; communication between staff and patients; processes and procedures at admissions office and general practices/conditions at the Gugulethu Community Health Clinic.

The target population for the observation was the Gugulethu Community Health Clinic employees and patients attending the facility.

Content analysis was used to analyse observations**.** Content analysis according to Maree (2007:101) is the process of looking at data from different angles with a view to identifying keys in the text that will help us to understand and interpret the raw data. Henning, Van Rensburg and Smit (2011:102) add that content analysis is the preferred choice of novice researchers because it is easy to access and it works on one level of meaning i.e. content of the data text.

4.5 Limitation of the study

Gugulethu residents appeared reluctant to participate in the research. Some people felt that there is no change that can be brought about by this research. They mentioned that this was not the first time they had filled in questionnaires but the situation was still the same, if not worse. The employees were also reluctant to fill in the questionnaire. They were afraid that their responses would be used against them at some stage. Another problem encountered was when the researcher went to collect the questionnaires. It was either that the HOD was not there or the questionnaires had not been completed. The researcher had to go and collect the questionnaires at Gugulethu Community Health Clinic on more than one occasion.

The budget was limited; it was difficult to print the questionnaires, to travel and to do fieldwork.

4.6 Chapter summary

This chapter discussed an in-depth research process, including research design and methodology. Limitations of the study and data analysis were also discussed. In the next chapter the researcher will summarise the results of the study and will present conclusions drawn from the study.

CHAPTER FIVE

DATA PRESENTATION, ANALYSIS AND DISCUSSION

5.1 Introduction

This chapter focuses on how data collected from questionnaires and observations were analysed. Statistical analysis was utilised to analyse questionnaires; content analysis was used to analyse observations. This chapter also explains/discusses how data collected from questionnaires were processed into a readable format before being analysing using Statistical Package for Social Science (SPSS).

5.2 Quantitative data processing

During this phase of the study the services of a qualified statistician was required to analyse and interpret the quantitative data. The researcher consulted various sources (Rose & Sullivan, 1993; Fink, 1995; Greenfield, 1996; Wright, 1997 and Byme, 2002) on statistics and data capturing, editing and analysis. In addition she consulted a specialist in the field of statistics. This is also recommended by Struwig and Stead (2001:150). They mention that data analysis is a specialised area of research procedures and that the researcher should use experts in the field. A descriptive, analytical and statistical data analysis was made and a thorough interpretation was done (by the statistician) from the information obtained through completed questionnaires. The researcher took sole responsibility for analysing and interpreting the qualitative data, which proved to be a difficult task due to the complexity of the study. Struwig and Stead (2001:156) mention that selecting the appropriate data analysis technique is a complex process. The researcher and the statistician discussed the variables to be analysed and the levels of measurement used. The data were once again screened for errors. The researcher had to capture a considerable amount of data manually from the completed questionnaires.

The questionnaires were collected and processed by a statistician using application software, called Statistical Package for Social Science (SPSS) for windows, available at Cape Peninsula University of Technology. An advantage of using SPSS is that it enables the researcher to score and analyse quantitative data quickly (Babbie, 2004:396).

5.3 Research results of the structured questionnaire

PATIENTS' RESPONSES

The arrival time

Table 5.1: Respondents' arrival time

Arrival Time

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Between 4 - 5 am	24	12.6	12.6	12.6
	Between 5 - 6 am	53	27.9	27.9	40.5
	Between 6 - 7 am	46	24.2	24.2	64.7
	Between 7 - 8 am	33	17.4	17.4	82.1
	Other	34	17.9	17.9	100.0
	Total	190	100.0	100.0	

Table 5.1 deal with the time the patients arrive at Gugulethu Community Health Clinic. The results showed that of the 190 respondents, 12.6% respondents arrive between 4am and 5am; 27.9% arrive between 5am and 6am; 24.4% arrive between 6am and 7am; 17.4% arrive between 7am and 8am and, 17.9%. The respondents that indicated otherwise meant that they arrived any time outside 4am and 8am, or even at weekends. According to the table, the majority of respondents arrives between 5 and 6am, and had to wait for the admissions office to open at 7:00**.**

Appointment

Table 5.2: Respondents' appointment

Appointment

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	32	16.8	16.8	16.8
	No	158	83.2	83.2	100.0
	Total	190	100.0	100.0	

The rationale was to find out if there is a booking system at Gugulethu Community Health Clinic. The above Table 5.2 state that of the 190 respondents, 16.8% of the respondents said yes and

83.2% said no. The respondents that said yes, elaborated by adding that the reason for their appointments were many and varied. They are either chronic patients who must see the doctor monthly on their appointment day or those who come for medication. Other patients came because they did not get their medication on previous day or they had to come in for X-rays. The ones that said no mentioned that there is no booking/appointment system at Gugulethu Community Health Clinic.

First Time Required Documents

Table 5.3: Respondents' first time document

First Time Required Documents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	ID	166	87.4	90.7	90.7
	Proof of Address	4	2.1	2.2	92.9
	Other	13	6.8	7.1	100.0
	Total	183	96.3	100.0	
Missing	System	7	3.7		
Total		190	100.0		

The rationale was to find out the kinds of documents required when patients visit the clinic for the first time. A reason for this question was to establish whether these documents make it difficult for patients to access the clinic. The respondents responded in the following manner. When coming to the clinic for the first time, 90.7% said an identity document is required; 2.2% said proof of address is required, 7.1% said Other. Those that said Other, mentioned that even if you do not have any documents, you will be assisted.

Documents required for repeat visits

Table 5.4: Respondents' repeat document

Repeat Required Documents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Clinic Card	171	90.0	97.7	97.7
	ID	2	1.1	1.1	98.9
	Other	2	1.1	1.1	100.0
	Total	175	92.1	100.0	
Missing	System	15	7.9		
Total		190	100.0		

The rationale was to find out which documents are required when patients visit the clinic on a second occasion. The results for the 175 respondents revealed the following: for returning patients to Gugulethu Community Health Clinic, 97.7% indicated that clinic card was required; 1.1% said an ID was required, 11% indicated that other documents were required and 7.9% did not respond. The responses revealed that when coming to the clinic on a second occasion, the perception is that a clinic card is a requirement.

Waiting Times after visiting Admissions Office

Table 5.5: Respondents' waiting time at admissions office

Waiting Time at Admissions Office

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 hour	7	3.7	3.7	3.7
	2 hours	17	8.9	8.9	12.6
	3 hours	49	25.8	25.8	38.4
	4 hours	44	23.2	23.2	61.6
	More than 4 hours	49	25.8	25.8	87.4
	I was turned away before being assisted	24	12.6	12.6	100.0
	Total	190	100.0	100.0	

The rationale for this question was to find out how long patients wait at the admissions office before being assisted; or whether they were assisted at all, even after waiting for a long period of time. Of the 190 respondents, 7 waited for 1 hour, 17 waited for 2 hours, 49 waited for 3 hours, 44 waited for 4 hours, 49 waited for more than 4 hours and 24 were turned away. The response from the respondents revealed that patients wait for up to 4 hours at the admissions office before being assisted. There are also those patients that are turned away before being assisted.

Waiting Times after Admissions Office

Table 5.6: Respondents' waiting time after admissions office

Waiting Time After Admissions Office

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less than 1 hour	43	22.6	30.1	30.1
	1 hour	38	20.0	26.6	56.6
	2 hours	34	17.9	23.8	80.4
	3 hours	13	6.8	9.1	89.5
	4 hours	6	3.2	4.2	93.7
	More than 4 hours	9	4.7	6.3	100.0
	Total	143	75.3	100.0	
Missing	System	47	24.7		
Total		190	100.0		

The rationale for this question was to find out the time patients spent waiting before being assisted or seen by the doctor or sister. 43 respondents waited for less than an hour, 38 waited for 1 hour, 34 waited for 2 hours, 13 waited for 3 hours, 6 waited for 4 hours, 9 waited for more than 4 hours. From the respondents responses, it is clear that patients do not wait long after they have been assisted at the admissions office.

Service Rating

Table 5.7: Respondents' service rating

How would you rate the registration service at the Gugulethu Community Health Clinic admissions office?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Excellent	1	.5	.5	.5
	Very Good	3	1.6	1.6	2.1
	Good	36	18.9	18.9	21.1
	Fair	68	35.8	35.8	56.8
	Poor	82	43.2	43.2	100.0
	Total	190	100.0	100.0	

The rationale was to find out how patients rate the service they receive at the Gugulethu Community Health Clinic. This is very important as the patients are the ones that receive the service. Table 5.7 illustrated how respondents responded to the question. 0.5% of the respondents rated the service as excellent, 1.6% rated the service as very good, 18.9% rated the service as good, 35.8% rated the service as fair, and 43.2% rated the service as poor. The respondents' results clearly indicate that service delivered was poor.

EMPLOYEE RESPONDENTS

Admissions Office Opening Time

Table 5.8: Respondents - admissions office opening time

Admissions Office Opening Time

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	6am	1	2.5	2.5	2.5
	7:00	19	47.5	47.5	50.0
	7:30	3	7.5	7.5	57.5
	7am	1	2.5	2.5	60.0
	8:00	16	40.0	40.0	100.0
	Total	40	100.0	100.0	

The rationale for including this question was to determine the time the admissions office opened. Of the 40 respondents, 1 said that the admissions office opened at 6am; 20 said 7am and 16 said 8am. These responses are contradictory and confusing, because some employees said that the reception office opens at 6am while others indicated 8am. These discrepancies are alarming and cause for major concern. Employees should be aware of the organisations' operating hours.

Registration

Table 5.9: Respondents' admissions registration

Admissions Registration

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	First come first serve basis	21	52.5	52.5	52.5
	Other	18	45.0	45.0	97.5
	4 - Made an appointment	1	2.5	2.5	100.0
	Total	40	100.0	100.0	

The rationale for this question was to find out if the Gugulethu Community Health Clinic has a booking/appointment system. Table 5.9 reflects that there is no appointment system in place. If the appointment system exists, no one is aware of it. Of the 40 respondents, 21 said people are assisted on a first come first serve basis; 1 said that this happens through an appointment; and 18 indicated other. Some of the respondents who indicated other mentioned that patients who are diabetic or have other chronic illnesses do come on their appointment dates.

Documents required of patients visiting to the Gugulethu Community Health Clinic for the first time

Table 5.10: Respondents' first time documents

First Time Required Documents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Clinic Card	1	2.5	2.5	2.5
	ID	32	80.0	80.0	82.5
	Proof of Address	2	5.0	5.0	87.5
	Other	5	12.5	12.5	100.0
	Total	40	100.0	100.0	

The rationale was to find out which documents were required from patients who were visiting the clinic for the first time. Table 5.10 reveals that 2.5% indicated that a clinic card was required; 80% said an ID was required; 5% indicated that proof of address; and 12.5% indicated other.

Documents required from patients coming to Gugulethu Community Health Clinic on a second occasion

Table 5.11: Respondents' documents required for repeat visits

Documents Required for Repeat Visits

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Clinic Card	35	87.5	87.5	87.5
	Other	5	12.5	12.5	100.0
	Total	40	100.0	100.0	

The rationale was to find out which documents are required from patients who are not coming to the clinic for the first time. Table 5.11 reveals that 87% indicated that a clinic card was required; 5% indicated that an ID was required; and 12% indicated that other documents were required.

Reasons for Documents

Table 5.12: Respondents' reasons for documents

Why do you require all these documents?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Because most of the people got the same name & surname	2	5.0	5.0	5.0
	Ensuring that the patient is the one on the folder	2	5.0	5.0	10.0
	For making sure that you are assisting the right person	2	5.0	5.0	15.0
	For proper record keeping	2	5.0	5.0	20.0
	For proper record keeping. To make sure that the person using the facility is the one on the folder	2	5.0	5.0	25.0
	For verification of patient's information	1	2.5	2.5	27.5
	It is one of the requirements of the clinic	2	5.0	5.0	32.5
	It is the procedure to ensure that we are dealing with the right person. There's a lot of confidential patient information on the folder so it's important that the folder goes to its owner.	2	5.0	5.0	37.5
	It is important and will assist us in getting the folder	2	5.0	5.0	42.5
	N/A	1	2.5	2.5	45.0
	Record keeping and to ensure that the correct patient is getting the folder	2	5.0	5.0	50.0
	So that you can get the folder quickly	1	2.5	2.5	52.5
	So that you can get your folder quickly	1	2.5	2.5	55.0
	To check if the information on the folder corresponds with what the patient says	1	2.5	2.5	57.5
	To check if the person you are assisting is the right one	1	2.5	2.5	60.0
	To ensure that the doctor is treating the right patient	2	5.0	5.0	65.0
	To ensure that the folder is given to its owner and that the doctor is treating the correct patient	2	5.0	5.0	70.0

To ensure that you are delivering the service to the right patient	2	5.0	5.0	75.0
To ensure that you render the services to the right people	2	5.0	5.0	80.0
To know who you are dealing with	2	5.0	5.0	85.0
To make sure that the patient is the right person the date of birth is right	1	2.5	2.5	87.5
To make sure you are treating the right patient	2	5.0	5.0	92.5
To verify if the patient is the same as on the folder	1	2.5	2.5	95.0
You cannot assist a person without knowing who he or she is	2	5.0	5.0	100.0
Total	40	100.0	100.0	

The rationale was to find out the reason behind or the importance of all these documents. The respondents stated different reasons for requiring all these documents. The folder contains very confidential patient information which is why all the necessary precautions must be taken to ensure that the correct person receives the folder.

Admissions Office Closing Time

Table 5.13: Respondents - admissions office closing time

Admissions Office Closing Time

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	When everyone is assisted	4	10.0	10.0	10.0
	When the quota for the day is reached	10	25.0	25.0	35.0
	When there are no people coming for registration	6	15.0	15.0	50.0
	Other	20	50.0	50.0	100.0
	Total	40	100.0	100.0	

The reason for this question was to find out whether Gugulethu Community Health Clinic has a stipulated closing time. Table 5.13 reveal that 10% said the clinic closes when everyone is assisted; 25% said when the quota for the day is reached; 15% said when there are no patients coming for registration, and 50% said other. Those that said other confirmed that nobody is sent away even if it is after 4:00pm. The Out Patient Department closes at 4:00pm, at which time patients are either sent to the extended hour clinic or the Trauma unit.

5.4 Analysing open-ended questions in the questionnaire using content analysis

PATIENTS' RESPONSE

STATEMENT ONE

What services are you satisfied/dissatisfied with at the admissions office?

Response

Out of 190 respondents, 29 were satisfied with the service they received at the admissions office; 146 were dissatisfied; and 15 did not answer.

Interpretation

The respondents indicated that they were unhappy with a number of issues e.g. the long wait at the reception area, and the manner in which the staff treat them. The majority of the respondents were dissatisfied with services at the admissions office. The few that were satisfied were happy because they were assisted by friendly staff and did not wait long. From these responses, it can be gathered that the main issues that the respondents are unhappy about are waiting times and the manner the staff treat patients, as a result of this behaviour patients feel uneasy to approach staff.

Communication is the problem. It also emerged that the patients arrive early and wait long for the admissions office to open. When it is opened the staff takes their own time to assist them. The patients indicated that the facility manager or the managers should be visible to monitor the way the staff communicates with patients.

These results indicate that the patients fear or are always reluctant or afraid to come to the facility because of unfair or bad treatment.

STATEMENT TWO

What do you think can be done differently to speed up the registration process at the admissions office?

Response

It has emerged that the patients need the staff to change their attitude and be friendly and helpful when assisting patients. The patients raised concerns with the manner in which the pharmacy operates. They felt that both reception and pharmacy are short staffed which is why there are always long queues. The employees need training, to improve the manner in which they carry themselves when dealing with patients.

Interpretation

The patients revealed that the officials at the admissions office are rude and unwelcoming. The shouting and rudeness of officials when dealing with patients, makes it difficult for the patients to ask the officials anything. The patients revealed that in some instances, the behaviour of the staff is due to being over-worked as the admissions office is under-staffed.

EMPLOYEES' RESPONSE

STATEMENT THREE

How is patient satisfaction measured at the admissions office?

Table 5.14: Respondents' patient evaluation

Patient Satisfaction Measurement

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		15	37.5	37.5	37.5
	By getting patients to write down their suggestion and put them in the suggestion box	1	2.5	2.5	40.0
	By using information gathered from the patients	2	5.0	5.0	45.0
	By writing down the problems	2	5.0	5.0	50.0
	It is difficult to measure patient satisfaction, because not all the patients can read and write. It becomes difficult to write suggestion and complaints	2	5.0	5.0	55.0
	It is measured by using the information on the suggestion box	2	5.0	5.0	60.0
	Most of the people who come here are very sick and it is very difficult for them to make any suggestions after a long wait	2	5.0	5.0	65.0
	Sometimes the patient satisfaction is measured by the no of patients seen per day	2	5.0	5.0	70.0
	Suggestion box is a tool for this	2	5.0	5.0	75.0
	Surveys like this one	2	5.0	5.0	80.0

The majority of our patients do not respond to the suggestion box	2	5.0	5.0	85.0
There is a suggestion box where patients write about their experience on the service they have received.	2	5.0	5.0	90.0
We allow patients to evaluate us by using the suggestion box	2	5.0	5.0	95.0
We sometimes hear about things when patients complain in the corridor, but seldom receive anything in writing	2	5.0	5.0	100.0
Total	40	100.0	100.0	

Response

The rationale was to find out if there was a system in place to evaluate patient satisfaction. The employees are providing a service to the patients. It is therefore important to find out how the patients feel about the service they receive. As a service provider, Gugulethu Community Health Clinic must allow its patients (the patients) to evaluate the service they receive. Patients must be allowed to voice their dissatisfaction about the clinic. The suggestions box is the tool that is used to measure patient satisfaction. All 40 respondents indicated that there is a system in place to measure patient satisfaction.

Interpretation

The respondents revealed that patient satisfaction is measured by using the information on the suggestion box. The Gugulethu Community Health Clinic has a suggestion box where patients write down their experience in the clinic, be it good or bad. This information is used to benchmark the clinic and make improvements where necessary. The problem revealed is that patients do not submit complaints or suggestions in the suggestion box. It becomes difficult for the staff to know the feelings of the patients.

5.5 Researcher Observations

Researcher Observations

The Gugulethu Community Health Clinic was visited to observe the activities and understand the perceptions of the new health care approach in the Western Cape. Gugulethu Community Health Clinic was subjected to observation. When told what the study was about, the patients readily shared their experiences. Every month an average of 1500 patients attends Gugulethu Community Health Clinic.

The fundamental observations are bulleted below:

- Gugulethu Community Health Clinic does not have adequate signage. If you are coming to the clinic for the first time and you do not know where the reception area is, or the location of other departments, you have to inquire until you reach your destination.
- Patients arrive as early 4:00am to ensure that they are first in the queue. People have to wait outside in the cold or in the rain during winter before the admissions office opens.
- There is no appointment or booking system. People are assisted on a first come first serve basis. But patients returning for their chronic medication had to make a booking.
- The patients arrive at Gugulethu Community Health Clinic as early as 4:00am, and the reception or admissions office only opens at 7:00am. Once assisted at the reception or admissions office, they wait for the nurse at triage who then refers the patient to the sister or to the doctor. Doctors start work at 9:00am. There are always long queues at the reception or admissions office. Patients wait for their folders, which results in another long wait for the patient before the folder is found.
- Once the patient has been examined by the doctor, the patients are either referred to the pharmacy for medication, to X-rays or referred to other hospitals for specialist attention.
- The pharmacy is the place where patients spend time. It is always full, and there are always long queues. The pharmacy looks like it is under staffed. The majority of patients visiting Gugulethu Community Health Clinic are here to collect their chronic medication for diabetes, hypertension or HIV. Some patients have to wait for up to five hours to receive their medication or they have to collect their medication the next day. The pharmacy closes at 4:00pm.
- Staff, especially the cleaners, needs to pay more attention to the toilets.

5.6 Chapter summary

This chapter discussed the research findings from the questionnaires and observations. All the sections in the questionnaire were analysed. The findings revealed that patients are not happy with the standard of the service they receive at Gugulethu Community Health Clinic. It was also revealed that the employees at Gugulethu Community Health Clinic are unfriendly towards the patients. The employees at Gugulethu Community Health Clinic in turn revealed their unhappiness due to the unavailability of working tools which makes it difficult for them to provide a proper service to the patients.

The observations and opinions gathered through visiting Gugulethu Community Health Clinic were also highlighted in the chapter. One fundamental issue emanating from this visit pointed to short staffed admissions office. As a result of this problem, patients had to wait for long periods of time for their folders.

The next and final chapter of this research study will include a summary, conclusion and recommendations.

CHAPTER SIX
CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

The main objective of the thesis was to evaluate problems around access to Gugulethu Community Health Clinic and to propose recommendations that will improve access to health care facilities in the Western Cape. Although a number of policies and legislation were passed since 1994, implementation has been a problem. The National Health Act (Act No 61 of 2003) and the Constitution of the Republic of South Africa Act No (108 of 1996) clearly state that everyone should have access to healthcare. According to the findings not everyone has access to healthcare. It was mentioned in Chapter One and Chapter Five that there are patients that are still turned away from health facilities before being assisted or because the quota of the day has been reached. The findings of the access to health care in the Western Cape will now be highlighted.

A number of factors were identified which impacts on access to healthcare. These factors are lack of funding; lack of staff; and an uncaring and unfriendly attitude of staff. These factors will be addressed by the recommendations which are to follow.

6.2 Findings of research survey

Before 1994 South Africa health care was fragmented and disjointed. The South Africa government through its apartheid policies developed a health care system which was sustained through the years by the promulgation of racist legislation and the creation of institutions such as political and statutory bodies for the control of the health care professions and facilities. These institutions and facilities were built and managed with the specific aim of sustaining racial segregation and discrimination in health care. The net result has been a system which is highly fragmented, inefficient and inequitable and, biased towards curative care and the private sector. The government that was elected in 1994 had a challenge of transforming the South Africa health care system. The African National Congress (ANC) initiated a process of developing an overall National Health Plan based on the Primary Health Care Approach. Internationally and in the South Africa, Primary Health Care has been recognised for its success.

From the theoretical framework, it is clear that the South Africa government has introduced policies and legislations to improve access to health care. The policies and legislations were introduced in order to ensure that the majority of the population of South Africa has adequate access to basic services including health. However from the research it is clear that the community is still experiencing problems around accessing health care facilities.

After analysing the questionnaire and the responses of patients using Gugulethu Community Health Clinic, it became evident that the policies and legislation introduced after 1994, did not achieve their objectives. Many clinics and hospitals were built, but it is clear that the patients and health facilities' employees are still unhappy. The findings revealed that the majority of patients using Gugulethu Community Health Clinic were dissatisfied with the service they receive at the facility.

From the final data consolidation, it is evident that the patients are dissatisfied or unhappy with a number of things:

- They arrive as early as 5:00am and have to wait outside in the cold and rainy weather before the admissions office open.
- When there are no folders they are turned away.
- The staff attitude is bad. They are rude, unsympathetic and unprofessional towards patients.
- In some cases where patients' folders are lost, instead of explaining this to the patient, they let the patient wait (even though it is through their own negligence that they lost the folder).
- Unprofessionalism and no urgency at all.
- Lack of communication
- Turning away of patients due the quota being reached.
- No appointment or booking system; even patients with appointments have to wait in queues though they have appointments.

In contrast, there were a few patients that were satisfied with the manner in which things were done especially at the admissions office.

- They understand that the reason for the long wait before being assisted is due to the fact that there are more patients using Gugulethu Community Health Clinic now than before.
- The few staff members that are there, assist more patients than compared to the past.

The employees were dissatisfied with the following issues:

- The employees emphasised dissatisfaction over the fact that especially when they want to assist patients, they cannot due to unavailability of working tools e.g. printer, computer and new patients folders. This situation is really frustrating because the patients must be turned away when there are no folders. They must borrow printers or computers from other departments if their printer and computer are faulty.
- It has been revealed through the findings that staff members from other departments are unhappy with how things are done at the reception. They mentioned that on some occasions, Clinical Decision Unit (CDU) patients are asked to wait for a folder. This is unnecessary because no folder is needed for CDU patients.
- Sometimes patients do not get their folders because they are either missing or lost. This causes unnecessary delay and queues at the reception area.
- When patients arrive at the pharmacy most of them arrive without stickers/labels. The reception is supposed to check if there are stickers/labels in the folder. This is very important because the sticker/label is used for medication.
- The manner in which other colleagues treat or talk to the patients.
- Dissatisfied with waiting times at the reception and pharmacy.
- Certain patients receive preferential treatment because they know someone in the office.
- There are too few employees, which is not enough to assist the patients, and results in work overload.

There are certain things that the employees are satisfied about:

- The fact that they are assisting more patients than before.
- The approach towards patients is very good and sometimes excellent.

6.3 Conclusions

Gugulethu Community Health Clinic is a community health care facility situated in Gugulethu. It is one of the facilities that provide a 24 hour service. Its main focus is to deliver quality health care to the Gugulethu community. The quality of the service that the facility offers or delivers depends on the effectiveness and efficiency of the employees. Employees should at all times strive to deliver a service that is up to standard and should strive for efficiency and effectiveness. The effectiveness and efficiency of the employees would be determined by fewer queues especially at reception and pharmacy; and fewer problems when it comes to patients accessing the Gugulethu Community Health Clinic.

As mentioned earlier, the statement of the research problem was that there are problems around access to Gugulethu Community Health Clinic. Based on that assumption, the research objectives were set to evaluate these problems and to forward recommendations that will improve access to health care facilities in the Western Cape.

In order to achieve the set objectives, an investigation was conducted at Gugulethu Community Health Clinic via questionnaires, observations and legislation and policy documents were reviewed. Questionnaires were distributed to employees and patients of Gugulethu Community Health Clinic to obtain their views on issues that affect them. Observation was conducted in order to record events and activities as they unfold in their natural setting, through the non-inquisitorial involvement of the researcher. Relevant literature on the topic was also explored.

Chapter One of the study dealt with a background; defining the research problem; the objectives of the study; importance and motivation of the study and the research methodology.

Chapter Two explored international trends on primary health care, specifically looking at countries such as Germany, Canada, Australia, and Nigeria.

Chapter Three provided a theoretical framework of the South African Health System. It also explored policies and legislation of South African Health system. The researcher embarked on an extensive review of various sources of literature to obtain substantial background on South African health care system. All topics that were reviewed were relevant to issues that affect the effectiveness of South African health care system.

Chapter Four focused on the preparation and drafting of the questionnaire, the gathering of the data, formulation of the target groups, and determination of the sample size, processes and procedures in obtaining the information. This chapter also provided a research plan for evaluating a District Health Centre. The chapter explored various research methodologies and adopted a combination of quantitative and qualitative research methods, which is known as multi-method approach in order to gain an in-depth understanding of the research problem. The multi-method approach enabled the researcher to obtain trustworthy and valid results.

Chapter Five focused on data analysis. Statistical Package for the Social Sciences (SPSS) was utilised to analyse quantitative data (questionnaires) by using tables and bar charts. Content analysis was used to analyse qualitative data, which focused on key words in the text from respondents.

Chapter Six dealt with a discussion of results, which was a core aspect of the research as it answered the research problem that was identified in Chapter One. According to the findings, there were a number of factors identified which impacted on access to healthcare. These factors include lack of funding; lack of staff; and an uncaring and unfriendly attitude of staff. The recommendations regarding the study were based on the findings of the research that the Western Cape Department of Health must increase the budget; employ more staff and buy more stationery; and salary packages must become competitive with those in the private sector. If this is not possible, other fringe benefits must be offered to attract staff to the service. Staff needs to be developed on various areas including customer care while managers should also communicate with employees regarding their functions and roles in the clinic. Staff should also be motivated to grow in the department and to embrace equally all different roles that they are expected to perform. The chapter concluded by noting that it is not only the responsibility of Gugulethu Community Health Clinic employees to improve the situation at the clinic but all stakeholders i.e. the Western Cape Department of Health and Gugulethu Community should work hand in hand to solve the problems at the clinic.

However, for the benefit of Gugulethu Community Health Clinic the researcher further proposes future research which evolves from the limitations of the study that can benefit the Gugulethu Community Health Clinic in the long term. A study should be conducted concerning the effectiveness of the suggestion box, because the suggestion box is used

to measure customer satisfaction and identify problems. Evaluating the effectiveness of the tool would bring about real change in the clinic.

6.4 Recommendations

The above findings inform the recommendations made in the study. Such recommendations propose to justify the significance of health care in Gugulethu and the need for that community to be actively involved in it.

6.4.1 Recommendation one

It is recommended that an appointment/booking system be introduced by the Gugulethu Community Health Clinic, to enable patients to come only at the time of their appointment. Emergencies will be dealt with as they come. The introduction of the appointment/booking system would reduce long queues and waiting times. Once the appointment system is in place there would not be a need for patients to arrive as early as 5:00am. Patients with appointments will arrive on time for their appointments.

6.4.2 Recommendation two

Communication is very important in any institution or organisation. It is recommended that clear signage be put at the gate by the Gugulethu Community Health Clinic facility manager. Clear signage will assist in directing patients to the right places or departments without asking around before they reach their destination.

6.4.3 Recommendation three

It is recommended that the Western Cape Department of Health should undertake restructuring at Gugulethu Community Health Clinic i.e. upgrading of infrastructure such as printers; as well as the renovation and extension of the reception area to make it look professional and to accommodate more patients.

6.4.4 Recommendation four

It is recommended that employees attend workshops on communication and customer/client service. Management must make a concerted effort to improve the

relationship between service providers (employees) and the recipients of the service (patients). The principles of Batho Pele must be entrenched. Public Servants must be reoriented and made aware of their role in enhancing service delivery.

6.4.5 Recommendation five

The admissions office is the first point of contact when the patients come to Gugulethu Community Health Clinic. The folders are made and kept here. It is therefore one of the important departments of the clinic. Should the patient not receive his or her folder, it means that the medical history of patient is lost and this may lead to an incorrect diagnosis. It is recommended that Gugulethu Community Health Clinic introduce an integrated record keeping system. The integrated system will link all departments in the hospital; in this way it will be easy to track where the folder is.

6.4.6 Recommendation six

It has arisen from the literature review that the government of South Africa has introduced policies, legislation and discussion documents to improve the health care system. These policies and legislation focused on restructuring the health care, to ensure that everyone irrespective of colour has access to health care. The introduction of Primary Health Care was to have a healthcare system that is universally accessible to individuals and families in the community by means acceptable to them, through their full participation, and at a cost that the community and country can afford. There was disparity between poor and the rich regarding basic conditions of life and health outcomes. Primary Health Care aims to reduce inequalities in access to health services, especially in rural and deprived communities to ensure universal coverage. The National Health Act (Act No 61 of 2003) clearly states its objective as regulating national and providing uniformity in respect of health services across the nation by: protecting, respecting, promoting and fulfilling the rights of the people of South Africa to the progressive realisation of access to health care services, including reproductive health care. With all these policies and legislations in place, there are still problems when it comes to accessing health care in South Africa. Implementation is a problem. Challenges confronting implementation has complicated service delivery. It is recommended that the Western Cape Department of Health or Gugulethu Community Health Clinic management conduct a strategic planning.

6.5 Concluding remarks

The aim of the study was to explore problems around access to Gugulethu Community Health Clinic, and in doing so also offered a number of possible recommendations that could be implemented to improve access to the facility. It is my hope that this document would be a great help to Gugulethu Community Health Clinic.

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APPENDIX A: Ethics approval letter from Cape Peninsula University of Technology (CPUT)

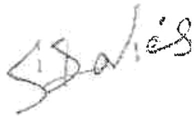
Faculty of Business Ethics Committee

Tuesday 18 November 2008

Ethical Review

The following proposal was accompanied by the Faculty Ethical considerations for a questionnaire form, and I can confirm that according to the responses indicated on the form that the study may proceed accordingly to the Higher Degrees Committee for consideration:

Author: Z Kama (196088941)
Title: An evaluation of access to health care facilities in the Western Cape, with specific reference to Gugulethu Community Health Clinic.
Level: MTech
Supervisor: Dr R Hendrickse



Prof. S. Davies
Chair: Faculty of Business Ethics Committee

APPENDIX B: Letter requesting permission to conduct research at Gugulethu Community Health Clinic

T:021 959-6334
F: 086 621 4086
M: 074 580 8167
E-mail: kamaz@cput.ac.za

24 March 2009

Gugulethu Community Health Clinic
Ny 3
Gugulethu
7750
Attention: RW Martell

Dear Sir/Madam

RE: Request for Permission to do Research at Gugulethu Community Health Clinic

I am a student at Cape Peninsula University of Technology (CPUT) for 2009 academic year. I am currently doing a Masters in Public Management. My topic is: **An evaluation of access to Health Care facilities in Western Cape, South Africa, with specific reference to Gugulethu Community Health Clinic**. I will use questionnaires and personal fieldwork observations with patients and employees which forms part of a survey gathering information.

I hereby apply for permission to conduct research at the Gugulethu Community Health Clinic. All information provided or gathered will be treated with strict confidentiality and anonymity and will not be used for any purpose other than this study.

I hope my application will reach your favourable consideration.

Yours sincerely

Zukiswa Kama (Ms)
Researcher
Student No: 196088941
Dr R Hendrickse
Supervisor
Hendrickser@cput.ac.za

APPENDIX C: Acceptance letter from Gugulethu Community Health Clinic

Verwysing
Reference
Isalthiso

Navrae
Enquiries
Imibuzo: Mr LR August

Telefoon
Telephone
Ifowuni 021 3705005

Department of Health
Departement van Gesondheid
iSebe lezeMpilo

01 April 2009

Ms Zukiswa Kama

Student at Cape Peninsula University of Technology

Dear Ms Kama

APPROVAL TO CONDUCT RESEARCH AT THE GUGULETHU CHC

Approval is granted to conduct the above study in the Gugulethu Community Health Clinic. Kindly make arrangements with the facility manager for suitable times and dates.

I hope that the results of the study will be used to improve the quality of Gugulethu CHC. **This management wishes you well with your studies**

Kind regards

Ms M Mabusela

Facility Manager: Gugulethu CHC

CC: Mr LR August: Primary Health Care Manager: Klipfontein/Mitchell's Plain Substructure

CC: Dr JC Claassen: Substructure Manager: Klipfontein/Mitchell's Plain Substructure

Klipfontein/Miitchell's Plain Substructure Office
Lentegeur Hospital
Highlands Drive Road
Lentegeur
MITCHELL'S PLAIN
7785
Telephone: 021-370 5005
Email: leaugut@pgwc.gov.za

APPENDIX D: Questionnaire to Patients - English

T: 021 959 6334
F: 086 621 3440
M: 076 769 3440
Email:kamaz@cput.ac.za

Dear Sir/Madam

RE: RESEARCH TO COMPLETE MASTERS THESIS: **AN EVALUATION OF ACCESS TO HEALTH CARE IN A COMMUNITY HEALTH CLINIC IN A TOWNSHIP IN THE WESTERN CAPE**

Your cooperation is sought for the completion of the attached questionnaire which forms part of a survey gathering information on the concept **"problems around access to Gugulethu Community Health Clinic.**

Your willingness to assist in this study will be appreciated as your feedback will provide valuable information which will be used to accomplish the purpose and objectives of this study.

All information provided will be treated in strict confidentiality and anonymity and will not be used for any purpose other than this study.

Thank you for your cooperation

Zukiswa Kama (Ms)

Researcher

Date:---------------------------

Dr R Hendrickse

Supervisor

hendrickser@cput.ac.za

GUGULETHU COMMUNITY HEALTH CLINIC
PATIENTS QUESTIONNAIRE

WHEN YOU FILL IN THE QUESTIONNAIRE PLEASE USE A PEN WITH BLACK OR BLUE INK. PLEASE TICK IN APPROPRIATE BOX OR WRITE IN BLOCK CAPITALS WHERE APPLICABLE.

Q1 What time did you arrive at the Gugulethu Community Health Clinic?

- ☐ Between 4 – 5 am
- ☐ Between 5 – 6 am
- ☐ Between 6 – 7 am
- ☐ Between 7 – 8 am
- ☐ Other

Other Comments:

Q2 What documents are required at the admissions office when you come for the first time?

- ☐ Clinic Card
- ☐ ID
- ☐ Proof of Address
- ☐ Other

Q3 What documents are required at the admissions office when **you are not** coming for the first time?

- ☐ Clinic Card
- ☐ ID
- ☐ Proof of Address
- ☐ Other

Q4 How long have you waited at the admissions office before being assisted?

- ☐ 1 hour
- ☐ 2 hours
- ☐ 3 hours
- ☐ 4 hours
- ☐ Other

Q5 How often do you use the Gugulethu Community Health Clinic?

- ☐ Once a week
- ☐ Twice a week
- ☐ Once a month
- ☐ Once a year
- ☐ Other

Comment:

Q6 How would you rate the service at the Gugulethu Community Health Clinic admissions office?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

Q7 What services are you satisfied or dissatisfied with at the admissions office?

Comments:

Q8 What do you think can be done differently to speed up the process at the admissions office?

Comments:

I SINCERELY APPRECIATE YOUR TIME AND COOPERATION. PLEASE CHECK TO MAKE SURE THAT YOU HAVE NOT SKIPPED ANY QUESTIONS.

THANK YOU.

APPENDIX E: Questionnaire to Patients – Xhosa

T: 021 959 6334
F: 086 621 3440
M: 076 769 3440
Email: kamaz@cput.ac.za

Dear Sir/Madam

Mhlekazi/Nenekazi elibekekileyo

ISIFUNDO SOTHEKELELO MALUNGA NEENGXAKI EZINGQONGE UKUFIKELELEKA KWINDAWO ZEENKONZO ZONONOPHELO LWEMPILO ENTSHONA KOLONI EMZANTSI AFRIKA: KWESINYE ISIBEDLELE SOLUNTU.

Uyacelwa ukuba uthabathe inxaxheba kolu phando ngokuthi uphendule iphepha elinemibuzo (questionnaire) elincanyathiselweyo. Eli phepha linemibuzo yindlela yokucholachola izimvo ezohlukileyo zabantu ngabantu.

Ukuthatha kwakho inxaxheba ngokuzinikeleyo kwesi sifundo kubalulekile njengokuba impendulo yakho iyakunika izimvo eziyakunceda ekufikeleleni kwimbangi nenjongo yesi sifundo.

Zonke iinkcukach ezifumanekileyo kwesi sifundo ziyakusetyenziswa ngokukhuselekileyo nangongazisi abantu abathathe inxasheba, zingasokuze zisetyenziselwe enye into ngaphandle kolu phando.

Enkosi ngentsebenziswano yakho.

Zukiswa Kama (Ms)
Umfundi
Date:---------------------------
Dr R Hendrickse
Umfundisi-ntsapho
hendrickser@cput.ac.za

GUGULETHU COMMUNITY HEALTH CLINIC
Iphepha Lemibuzo Labasebenzisi zinkonzo

XA UGCWALISA ELI PHEPHA LEMIBUZO UYACELWA UKUBA USEBENZISE USIBA OLUMNYAMA OKANYE OLULUHLAZA. UYACELWA UKUBA UKRWELE EBHOKISINI OKANYE USEBENZISE OONOBUMBA ABAKHULU APHO KUNYANZELEKILEYO KHONA.

Q1 Ufike ngabani ixesha apha e Gugulethu Community Health Clinic?

☐	☐	☐	☐	☐
Phakathi ko 4 – 5 am	Phakathi ko 5 – 6 am	Phakathi ko 6 – 7 am	Phakathi ko 7 – 8 am	Enye Nceda cacisa

Enye, nceda cacisa:

Q2 Ingaba ubuwenze idinga (appointment) phambi kokuba uze apha ekliniki?

Ewe, ngoba? ---

Hayi, ngoba? ---

Q3 Ngawaphi amaxwebhu afunekayo kwiofisi yobhaliso xa usiza **okokuqala**?

☐	☐	☐	☐
Clinic Card	ID	Isiqinisekiso sedilesi	Enye Nceda cacisa

Enye, nceda cacisa:

Q4 Ngawaphi amaxwebhu afunekayo kwiofisi yobhaliso xa **ungazi okokuqala?**

☐	☐	☐	☐
Clinic Card	ID	Isiqinisekiso sedilesi	Enye Nceda cacisa

Enye, nceda cacisa:

Q5 Ulinde ixhesha elingakanani kwi ofisi yobhaliso phambi kokuba ubhalise?

☐ Ngaphantsi kweyure

☐ Iyure

☐ Iyure ezimbini

☐ Iyure ezintathu

☐ Iyure izine

☐ Ngaphezu kweyure ezine

☐ Ndajikiswa phambi kokuba ndincedwe

Q6 Emva kokubhalisa eadmissions office, ulinde ixesha elingakanani phambi kokuba ubizwe uyokubona ugqira/usister?

☐ Ngaphantsi kweyure

☐ Iyure

☐ Iyure ezimbini

☐ Iyure ezintathu

☐ Iyure izine

☐ Ngaphezu kweyure ezine

Q7 Xa kunokuthiwa cacisa izinga lokubhalisa kwiofisi yobhaliso ungathini?

☐	☐	☐	☐	☐
Lubalasele	Lulunge kakhulu	Lulungile	Luphantsi	Luphantsi kakhulu

Q8 Yintoni kanye kanye othe waneliswa/awaneliswa yiyo kwiofisi yobhaliso?

Cacisa:

Q9 Yintoni ocinga ukuba ingenziwa hlobo lumbi/ngolunye uhlobo ukukhawulezisa iindlela ekusetyenzwa ngayo kwiofisi yobhaliso?

Cacisa:

NDIYABULELA NGEXESHA LAKHO NANGENTSEBENZISWANO.

ENKOSI.

APPENDIX F: Questionnaire to Employee – English

T: 021 959 6334
F: 086 621 3440
M: 076 769 3440
Email: kamaz@cput.ac.za

Dear Sir/Madam

RE: RESEARCH TO COMPLETE MASTERS THESIS: **AN EVALUATION OF ACCESS TO HEALTH CARE IN A COMMUNITY HEALTH CLINIC IN A TOWNSHIP IN THE WESTERN CAPE**

Your cooperation is sought for the completion of the attached questionnaire which forms part of a survey gathering information on the concept **"problems around access to Gugulethu Community Health Clinic.**

Your willingness to assist in this study will be appreciated as your feedback will provide valuable information which will be used to accomplish the purpose and objectives of this study.

All information provided will be treated in strict confidentiality and anonymity and will not be used for any purpose other than this study.

Thank you for your cooperation

Zukiswa Kama (Ms)

Researcher

Date:---------------------------

Dr R Hendrickse

Supervisor: hendrickser@cput.ac.za

GUGULETHU COMMUNITY HEALTH CLINIC

EMPLOYEE QUESTIONNAIRE

WHEN YOU FILL IN THE QUESTIONNAIRE PLEASE USE A PEN WITH BLACK OR BLUE INK. PLEASE TICK IN APPROPRIATE BOX OR WRITE IN BLOCK CAPITALS WHERE APPLICABLE.

Q1 What time does the admissions office open?

- ☐ 6 am
- ☐ 7 am
- ☐ 8 am
- ☐ 8 am
- ☐ Other

Q2 What documents do you require from people coming to Gugulethu Community Health Clinic for the first time?

- ☐ Clinic Card
- ☐ ID
- ☐ Proof of Address
- ☐ Other

Q3 What documents do you require from people who are not coming to Gugulethu Community Health Clinic for the first time?

- ☐ Clinic Card
- ☐ ID
- ☐ Proof of Address
- ☐ Other

Q4 Why do you require all these documents?

Comments:

Q5 What time do you close the admissions office?

- ☐ 8 am
- ☐ 9 am
- ☐ 10 am
- ☐ 10 am
- ☐ Other

Other Comments:

Q6 What do you think can be done differently to speed up the process at the admissions office?

Comments:

I SINCERELY APPRECIATE YOUR TIME AND COOPERATION. PLEASE CHECK TO MAKE SURE THAT YOU HAVE NOT SKIPPED ANY QUESTIONS, AND THEN DROP THE QUESTIONNAIRE IN THE BOX CLEARLY MARKED FOR THIS PURPOSE, AT THE ENTRANCE OF YOUR DEPARTMENT.

THANK YOU

APPENDIX G: Letter from Grammarian

EDITING AND PROOFREADING
Kasturi Behari-Leak
Master of Education (Language and Literature) UCT
Proofreader and Editor

Email: behurileakk@cput.ac.za

September 2011

This is to confirm that the Master's Thesis of Zukiswa Kama was proof read and edited by Kasturi Behari-Leak in preparation for submission of thesis for assessment.

Yours faithfully
K. Behari-Leak