

**ACCESSIBILITY OF
PRIMARY HEALTH CARE SERVICES
IN ALEXANDRA TOWNSHIP**

by

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DISSERTATION

submitted in fulfillment of the requirements for the degree

MAGISTER CURATIONIS

in

COMMUNITY NURSING SCIENCE



in the

FACULTY OF NURSING AND EDUCATION

at the

RAND AFRIKAANS UNIVERSITY

STUDY LEADER: DR S.D ROOS

JANUARY 2003

DECLARATION

I hereby declare that this project is the result of my own work and that all sources used have been acknowledged by means of a complete reference list.

EVELYN CHITSA BANDA (nee LISILIRA)



No system shall endure

That does not match



MY SOUL FINDS REST IN GOD ALONE;
MY SALVATION COMES FROM HIM.

HE ALONE IS MY ROCK AND MY SALVATION
HE IS MY FORTRESS; I WILL NEVER BE SHAKEN.

DAVID THE PSALMIST



GREAT AND MARVELOUS ARE THY WORKS
LORD GOD ALMIGHTY
JUST AND TRUE ARE THY WAYS.

JOHN THE REVELATOR

DEDICATION

This thesis is dedicated to my parents Mr and Mrs RM Lisilira for encouraging me to have a vision and achieve my potential.

Special thanks goes to my husband Alfred for his continuous support and assistance in making sure that my work was sent in time to Dr Roos.

And my children Yamikani and Melissa for being there for me through out my study and for believing in me.

Sincere thanks goes to my niece Stella for supporting me through out my study period.



ACKNOWLEDGEMENTS

I thank God for being sufficient to all my needs through out my study. For giving me good health, strength, courage and perseverance to carry on under trying circumstances.

My sincere gratitude goes to the following people who contributed to the success of my study:

- Dr. Steven Roos, for his continued support, encouragement and expert guidance through out this study. Your personal efforts are much appreciated. I owe it to you.

- Sandi Moloji Mhlanga (EMLS), for being more than a colleague throughout my study. You are my God send angel whose consistent support made my study possible.

- Peter Gama (Provincial Govt.), for helping me with the initial data analysis.

- Eiselen and Will (RAU statikon), for assisting me with quantitative data analysis. Your individualized student support is of great value.

- Sister Mapule Molosthwa (8TH Avenue clinic), for accommodating me and for her support during my study period.

- Vivian and Mpho, for assisting me with data collection.

- Lyness Nkungula, for empowering me with computer skills. (After giving me fish you saw it wise to teach me how to fish). You will be proud to know that all the typing of my study including the charts have been done by myself.

- Rahab Mphalele, for her expert assistance in library search. Thank you.

- Late Prof Annatjie Botes, for laying a firm foundation to research methodology in me. That was a time well spent. You did your job and you did it well. Rest in peace.

- Gugu Ngcobo (Provincial Education Dept), Sisters: Sandi Moloji, Daphney Mahube and Jephtheline Makgare for translating the tools into Zulu and back into English.

- Anneli Foul, for editing my study and translating the summary into Afrikaans.

- All sisters working in the public clinics in Alexandra, for their participation in the study.



SUMMARY

The overall aim of the study is to explore and describe the factors that influence the accessibility of PHC services in Alexandra Township. Most of the time the public clinics in Alexandra rely on part-time nursing personnel to render health services. Sometimes there are so few nurses on duty that they cannot manage to perform all the services required in the clinic and the community. There are long queues of patients and they are often turned away because they cannot be attended to. Statistics (Clinic Statistics, Jan 2000-Dec 2000) show that about 100 000 people out of the total population of 350 000 people (Community Statistics, 1999) attend these clinics in a year. This number includes people who come to the clinics three or more times per year for services such as family planning, Tuberculosis and well baby.

To achieve the objectives of the study a quantitative, non-experimental, exploratory, descriptive and contextual design as described by Polit and Hungler (1997:166, 456 & 466) and Burns and Grove (1997:52) was chosen. A pilot study (Burns and Grove 1997:52) was done in three phases with 12 patients, 10 community members and two professional nurses from the clinics. After that 300 interview schedules were administered to 160 randomly selected patients attending the four public clinics in the area and 140 members of the community. Ten questionnaires were distributed among the remaining 10 professional nurses. The researcher as a participant observer, made observations with the aid of an observation list, which was developed after the three phases of data collection to verify the data, collected.

A quantitative descriptive data analysis (Burns & Groove 1997:779) was done with the use of SPSS computer program. Content analysis was done on the open-ended questions and the results of the observations. The demographics of the residents reveal that the community is a vulnerable area (White paper, 1997:14) which should be the focus of the health service providers. Although the

services are geographically accessible, they are provided in an unacceptable, inefficient, ineffective and inequitable manner. Moreover services are functionally, socially, physically and financially inaccessible. Health education factors add to the inaccessibility of the services to the people. Guidelines to improve these factors were formulated to make public PHC services in the area more accessible. These findings have implications on nursing practice, education and research. A replica of the study in similar and different contexts in SA is recommended.



OPSOMMING

Die oorkoepelende doelstelling van die studie is om die faktore wat die toeganklikheid tot die Primêre Gesondheidsdienste in die Alexandra Township, Gauteng Provinsie, te verk en beskryf. Die meeste van die openbare klinieke in Alexandra maak staat op deelydse verplegingspersoneel om die dienste te lewer. Daar is somtyds so min verpleegkundiges aan diens dat hulle nie al die dienste wat in die kliniek en gemeenskap benodig word, kan voorsien nie. Daar is lang toue van pasiente en hulle word gereeld weggewys omdat daar nie aan hulle aandag gegee kan word nie. Statistieke (Kliniek Statistieke, Jan 2000-Des 2000) toon dat ongeveer 100 000 mense uit die totale bevolking van 350 000 hierdie klinieke per jaar bywoon (Gemeenskaps Statistieke, 1999). Hierdie getal sluit die mense wat drie of meer keer per jaar na die klinieke vir dienste soos gesinsbeplanning, tuberkulose en gesonde baba kom, in .

Om die doelstellings van die studie te bereik is 'n kwantitatiewe, nie-eksperimentele, verkennende, beskrywende en kontekstuele ontwerp soos deur Polit en Hungler (1997:166, 456 & 466) en Burns en Grove (1997:52) beskryf, gebruik. 'n Loods studie (Burns en Grove, 1997:52) is in drie fases met 12 pasiente, 10 gemeenskapslede en twee professionele verpleegkundiges van die klinieke gedoen. Daarna is 300 onderhoudsskedules aan 160 lukraak-gekoose pasiente wat die vier openbare klinieke in die area bygewoon het en 140 lede van die gemeenskap toegedien. Tien vraelyste is aan die oorblywende 10 professionele verpleegkundiges uitgehandig. Die navorser as deelnemende waarnemer het waarnemings met behulp van 'n waarnemingslys, wat na afloop van die drie fases van dataversameling om die data wat versamel is te verifieer, gemaak.

'n Kwantitatiewe beskrywende data-analise (Burns en Grove, 1997:779) is met behulp van die SPSS-rekenaarprogram gemaak. 'n Inhoudsanalise is op die oopeinde vrae en die resultate van die waarnemings gedoen. Die demografie

van die inwoners toon dat die gemeenskap 'n kwesbare area is (Witskrif, 1997:14) wat die fokus van die gesondheidsdienste behoort te wees. Alhoewel die dienste geografies beskikbaar is, word dit op 'n onaanvaarbare, ondoeltreffende, oneffektiewe en ongelykmatige wyse verskaf. Die dienste is funksioneel, sosiaal, fisies, en finansieel ontoeganklik. Gesondheidsvoorligting faktore dra tot hierdie ontoeganklikheid van die dienste aan die mense, by. Riglyne om hierdie faktore te verbeter is geformuleer om die openbare Primere Gesondheidsdienste in die area meer toeganklik te maak. Hierdie bevindinge het implikasies op die verpleegpraktyk, opvoeding en navorsing. 'n Herhaling van die studie in soortgelyke en verskillende kontekste in SA word aanbeveel.



ABBREVIATIONS

ANC (African National Congress)

CHW (Community Health Worker)

Denosa (Democratic Nursing Organization of South Africa)

F/p (Family planning)

HIV (Human Immunodeficiency Virus)

NGO (Non Governmental Organization)

ORT (Oral Rehydration Therapy)

PHC (Primary Health Care)

RN (Registered Nurse)

SANC (South African Nurses Council)

STI (Sexually Transmitted Infections)

TOP (Termination of Pregnancy)

TB (Tuberculosis)

WHO (World Health Organization)



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CHAPTER ONE

AN OVERVIEW OF THE STUDY ON FACTORS INFLUENCING THE ACCESSIBILITY OF PHC SERVICES IN ALEXANDRA TOWNSHIP.

1.1 BACKGROUND AND RATIONALE

“Health for all’ by the year 2000’ was the World Health Organisation's (WHO) slogan to promote health for the masses of the world as stated in the Alma-Ata Declaration in 1978 (Downie & Tannahill, 1996:61). This came as a result of a surge of support for the principles of public health, the ideal of which was that health should be attainable for and by the people in a comprehensive fashion (MacFarlane, Racelis & Muli Muisime, 2000:841-6). It was decided in their declaration that the main social goal of governments and the WHO in the coming decades should be that by the year 2000 all the people of the world should attain a level of health that will permit them to lead a socially and economically productive life.

According to Van Heerden in Thipanyama & Mavundla, (1998:23) “Health for all’ by the year 2000’ does not mean that disease and disability would be eliminated. The goal is to create the necessary infrastructure to make Primary Health Care (PHC) services accessible to all people and in this way teach them to live healthful lives. “Health for all” is a process leading to progressive improvement in the health of the people. It is the realisation that health begins and is fostered or endangered at home, in schools and in factories, where people live, work and play and the need to use better approaches for disease prevention, alleviating illness and disability. This will create better ways of growing up, growing old and dying with dignity (Dept. of Health, 1992:68).

The PHC-approach is the underlying philosophy for the provision of healthcare

services that include curative, preventive, promotive and rehabilitative care (White Paper, 1997:224). PHC is the key to attaining the 'Health for all' - goal as stated at the Alma-Ata conference. It requires that everyone in the community must have access to and be involved in it. PHC services should include educating the community on prevalent health problems, on methods to prevent health problems from arising or controlling them, the promotion of adequate supplies of food and proper nutrition, safe water and basic sanitation, maternal and child healthcare, prevention of locally endemic diseases, immunisation against the main infectious diseases, appropriate treatment of common diseases and injuries and the provision of essential drugs for the treatment of the common diseases (Dept. of Health, 1992:64).

In 1997 the executive board of the WHO examined the need to renew the 'Health for all' policy. It underlined the need for a clear, coherent policy based on equitable access to PHC. It reflected the diverse regional needs (WHO, 1997:72). In its 1999 report; the WHO suggested that governments must provide cost-effective services to prevent and treat their nation's most pressing health problems and so reduce the disproportionate burden of disease on the poor and help economic growth (Brown, 1999:1305). This report marked a significant shift in the WHO's stance. In 1978 it defined health as a state of complete physical, mental and social well being and not merely the absence of disease. Now it accepts the need to set priorities to make the best use of resources for all within the community. Choices have to be made in consultation with the people (Brown, 1999:1305). Priorities should be set according to the resources available to each government and the cost of top priority health interventions such as childhood immunisations, safe motherhood and tobacco control. The report stated that health systems should be financed from central government taxes by prepayments and not by charging fees at user point because this is unfair and inefficient.

In view of this notion of fairness or justice, equity in relation to healthcare delivery

would mean that basic PHC services must be accessible to all, even if this would be at the expense of more advanced care for the few (Stark, Nair & Omi, 1999:273-7). This requires that decision-makers should put the needs of the most vulnerable people first.

The WHO's principles of accessibility, affordability, equity, acceptability, availability, effectiveness and efficiency aim at creating healthful living conditions in which the people are responsible for and able to maintain a level of health at every stage of their development, in a spirit of self-reliance and self-determination (Vlok, 1991:20). The WHO's PHC principles are interrelated in the way that services that are not affordable are also not accessible. When services are not accessible to the people they are intended for, they are unavailable. When there is inequity and discrimination in the provision of services, those discriminated against do not have access to these services. When services are ineffective and inefficient they become unacceptable to the people intended for and if they are not acceptable they also become inaccessible (Barnes, Eribes, Juarbe, Nelson, Proctors, Sawyer, Shaul & Meleis, 1995:13).

"Health for all in the 21st century". In 1998, twenty years after the Alma-Ata, the WHO set out its thinking for the next 20 years in a new 'Health for all' policy (Jones, 1998:513). The policy stated among others, access to all to sustainable health systems and services whereby people everywhere throughout their lives, have the opportunity to reach and maintain the highest attainable level of health. According to Jones (1998:513) the translation of WHO's policies into action must be considered in the context of the overall economic and social situation of a country or locality and each country must select its own best mix of policies based on national needs, capacities and priorities.

'Towards a national health system' is a task set by the Department of Health in South Africa (SA) and the priority in PHC is to ensure increased access to health services by all people in SA. The PHC-approach is believed to be the most cost-

effective and efficient means of improving the population's health (White Paper, 1997:36). Primary Health Care also ensures the availability of safe, good quality essential services and drugs in health facilities (African National Congress (ANC), 1994a:5). There are four levels of health services delivery in the national health system, which uses PHC as a backbone for delivering healthcare throughout the country. The Bill of Human Rights contained in the South African Constitution (Constitution No. 108, 1996) gives every South African individual a right to access healthcare and health related services such as water and security. Access to decent public services is the rightful expectation of all citizens especially the previously disadvantaged (Dept. of Health, 1999:9). PHC is emphasised in both the White Paper (1997) on transformation of the health services and in the Reconstruction and Development Program (ANC, 1994b), which is the ruling party's plan to meet the basic needs of the people. The previous Government also supported this in the National Health Plan of 1986. The White Paper endeavors to deliver comprehensive PHC services as a vehicle for health transformation in the country by reducing disparities and inequalities in health service delivery and increased access to improved and integrated services based on PHC principles (White Paper, 1997:14). Among the objectives of the White Paper is the promotion of equity, accessibility and utilisation of health services through increasing access to integrated healthcare services for all South Africans focusing on the rural, peri-urban, the urban poor and the aged. Other objectives are the distribution of health services throughout the country in an equitable manner, extending the availability of and ensuring the appropriateness of health services through the establishment of a district health system in which all communities are covered by a basic health unit which offers an essential package of care, improving access to comprehensive health services and ensuring the universal availability of high quality, low cost essential drugs (White Paper, 1997:14-15).

The Truth & Reconciliation Committee (TRC) recommends fundamental health sector reform. Key findings on the health sector by the TRC as detailed in its final

report in 1998 indicated among other things, that the Department of Health failed to provide adequate healthcare facilities to black South Africans. It also failed to provide adequate training, support and ethical guidance to healthcare professionals in its employ (Jones, 1998:1538). The TRC recommended that legislation pertaining to healthcare should focus on PHC and should also take the need for transparency, evaluation, monitoring, the rights of service users and the primacy of confidentiality into account (Jones, 1998:1538).

South Africa has been practicing PHC for many years now. Active participation and involvement of community members, individuals, families, households and organisations are imperative to achieve goals. The increased accessibility to essential PHC services to the poor, the aged and the children who are amongst the most vulnerable (RSA, 1997:13) has been emphasised. The Department of Health embarked on re-orienting personnel in PHC to promote their competency in delivering services. PHC orientated curricula have been implemented and different academic institutions now offer courses in PHC. Resources have been deployed and authority devolved to ensure and facilitate easy access to essential PHC services where people live, work and play in order to provide services in tune with how they live, work and play. Access to healthcare has become a phenomenon of concern to nursing and an arena for nursing actions (Juarbe 1995:23). Access is also one of the Batho-pele (People First) principles. This calls for equal access to services such as health services (Dept. of Health, 1999:9). Much has been said about PHC services and their accessibility in South Africa. The question that remains is "What is being done in reality to achieve equal access to all in order to promote, maintain and restore health of the people?"

The Greater Alexandra Township lies in the northeast of Johannesburg on the banks of the Jukskei River. The area has a population of about 350,000 people and has about 4,000 formal houses and 34,000 shacks (Provincial Govt., 2001:4). The township has a long history. It was established in 1912 when a Mr.

Papenfus sold the land as freehold plots to black and coloured owners. Under apartheid in 1948 Alexandra became a black spot and was threatened with complete removal with the abolishment of freehold. Some of the families were removed but the majority stayed as government tenants. In 1960 hostels were built (Provincial Govt., 2001:4).

The 1980's brought both conflict and development. There were long school boycotts and conflicts with the government. It was during this time that the streets of Alexandra were first tarred, schools, new houses and nearly fifty blocks of flats were built. A new residential area was built on the eastern bank of the Jukskei river. It was during this period that influx control was removed and people began to move into Alexandra unrestrictedly (Provincial Govt., 2001:4). The years 1991-1992 saw both communal and political turmoil in which many were displaced from their homes, injured or killed. Then followed the peace process and the first genuine democratic and peaceful elections in April 1994 (Provincial gov., 2001:4).

Alexandra Township is a high-density, predominantly black township. Most of the people in this area are single, or single parents, unemployed, destitute, poor and or aged (Community Statistics, 1999). There are segments of the community that can be considered middle class, like some skilled and professional people who have a higher income and access to health insurance and therefore often choose not to attend the community's public PHC clinics. Health constraints such as poverty, unemployment, extreme over-crowding, lack of education, poor housing, violence and crime are evident in this urban area. The area is therefore one of the target areas for PHC services in SA (White Paper, 1997).

1.2 PROBLEM STATEMENT

A community health center is supposed to serve an average of 50,000 people (Dept. of Health, 1994:61). Alexandra Township has a population of 350,000

people (Community statistics, 1999), four public and one non-governmental (NGO) clinic that provide free services. The NGO clinic offers mother-child services, diagnosis and treatment for minor common diseases, rehabilitation services, geriatrics, communicable diseases and in-plant occupational health (for a fee). The public clinics provides family planning (f/p), well baby clinics, diagnosis and treatment of minor common ailments and TB management from eight in the morning to four in the afternoon, five days a week. Clinics' establishment indicates that there should be three nurses working in each clinic, making a total of 12 nurses.

Most of the times these clinics rely on part-time personnel to help in the rendering of these services. Sometimes the number of nurses on duty is so small that they cannot render all the services required in the clinic and the community. There are long queues of people seeking help and patients are often turned away because they cannot be attended to. According to the clinic's attendance statistics (Jan 2000 - Dec 2000) about 8,400 people attend the clinics per month, which makes a total of about 100,000 people per year. This number includes people who come to the clinic three or more times per year for services such as the well baby clinic, TB, f/p and STI follow-up. Based on the background information, the rationale and the problem statement described; the question in this context is. "Taking into consideration all the factors that may influence the accessibility of health services in the area, would any improvement in those factors bring changes in the way people access to the services in the area"?

1.3 RESEARCH QUESTIONS:

1. What are the factors that influence the accessibility of PHC services in Alexandra Township, Gauteng Province?
2. What guidelines can be recommended to improve the community's accessibility to PHC services in Alexandra Township, Gauteng Province?

1.4 PURPOSE AND OBJECTIVES

The purpose of this study will be achieved through the following objectives:

1. To explore and describe the factors that influence the community's accessibility to PHC services in Alexandra Township, Gauteng Province.
2. To recommend guidelines on how to improve PHC services in Alexandra Township, Gauteng Province.

1.5 PARADIGMATIC PERSPECTIVE

The researcher will use the theory for health promotion in nursing as a departure point (Dept. of Nursing, 2000). This theory focuses on the whole person, which is body, mind and spirit.

The following assumptions will be made applicable to the study:

1.5.1 META-THEORETICAL ASSUMPTIONS

The following assumptions are based on beliefs about the following:

1.5.1.1 PERSON:

The whole person embodies dimensions of body, mind and spirit. The person functions in an integrated, interactive manner with the environment. In this context the PHC services approach to the community focuses simultaneously on the spiritual, physical and social aspects of the person's wholeness.

1.5.1.2 NURSING:

Is an interactive process, where the nurse as a sensitive therapeutic professional

facilitates the promotion of health through the mobilisation of resources.

- The promotion of health includes the maintenance and restoration of health and is aimed at the facilitation of an individual, family, group and community's mobilization of resources.
- Promotion of health refers to health services such as health education, skill empowerment and nutrition services, which are aimed at contributing to a greater degree of health in the community.
- Maintenance of health refers to health services such as well baby clinic and family planning, which are aimed at sustaining and preserving the health status of the individual, family and community.
- Restoration of health refers to health services such as screening services, assessment, diagnosis and provision of essential drugs to treat common illnesses and prompt referral of patients to higher centers of health services with the aim of facilitating the return to the previously experienced levels of health of individual, family and community.

In this context promotion, maintenance and restoration of health requires the mobilisation of resources in the external and internal environments of the individual, family and community.

1.5.1.3 ENVIRONMENT:

Includes an internal and external environment. The internal environment consists of dimensions of body, mind and spirit. The external environment consists of physical, social and spiritual dimensions. In this context the physical environment consists of rooms and equipment. The social environment consists of human resources and the spiritual environment is the values and the culture which influences the accessibility to the PHC services in Alexandra Township.

1.5.1.4 HEALTH:

Is a dynamic interactive process in the patient's environment. These interactions reflect the relative health status of the patient. This interaction contributes to or interferes with the promotion of health. In this context the community nurse facilitates the promotion, maintenance and restoration of the community health and well being through the PHC delivery system.

1.5.2 THEORETICAL ASSUMPTIONS

Theoretical assumptions of the researcher will be based on the following:

The Primary Healthcare Package (WHO, 1978)

The National Health Plan (ANC, 1994).

Primary Healthcare Norms and Standards (Dept. of Health, 1999).

1.5.3 METHODOLOGICAL ASSUMPTIONS

A functional approach to nursing is accepted and the results or outcome and the recommendations of the research will be used to improve the practice of nursing. The knowledge gained from this study will be used to recommend guidelines to improve the community's accessibility to PHC services to assist them in the maintenance, promotion and restoration of their health and well being in the quest for wholeness. The usefulness of the recommended guidelines will be the criteria for validity.

GRAPHICAL REPRESENTATION OF THE ASSUMPTIONS



Fig 1.1 shows a graphical presentation of the researcher's assumptions of the paradigmatic perspective

Figure 1.1 shows that the environments of both the PHC clinic and the community are comprised of spiritual, social and physical dimensions. There is a continuous interaction between these environments which contributes to or interferes with the community's health promotion. Accessibility of PHC services requires a harmonious integration and interaction between the PHC clinics and the community's environments.

1.6 DEFINITIONS OF KEY CONCEPTS

1.6.1 ACCESSIBILITY

Refers to the provision of an acceptable and equitable level of healthcare that is efficient, effective and is readily available for all citizens; geographically, socially, physically, financially and functionally.

- **ACCEPTABLE** means the level and type of healthcare that is applicable and welcomed by the community and providers.
- **AVAILABLE** means the services are within reach of the individual, family and community who need them, when necessary.
- **EQUITABLE** means the absence of sub-group variability, discrepancy and discrimination.
- **EFFICIENT** means the end results achieved are in accordance with the effort expended in terms of money, resources and time.
- **EFFECTIVE** means that services provided achieve the intended goal in terms of improving the health status of the people.
- **GEOGRAPHICALLY** means the distance to and from the clinic, traveling time and means of transport are acceptable and affordable by the community.
- **SOCIALLY** means the availability of adequate well-trained, well motivated, competent and sensitive personnel for different services with proper support and monitoring structures.
- **PHYSICALLY** means the availability of enough room, medicines and equipment.
- **FINANCIALLY** means that both the community and the state can afford services.
- **FUNCTIONALLY** means the availability of appropriate types of care to the people intended for.

1.6.2 COMMUNITY

The community is an identifiable group consisting of individuals and families living within the same locality who share common characteristics and needs.

1.6.3 NURSE

A nurse refers to any professional nurse registered with the SANC. The nurse may or may not have extra qualifications i.e. community and PHC.

1.6.4 PHC SERVICES

PHC services are accessible essential healthcare services which are provided to individuals, families and community at first level of contact as close as possible to where they live and work.

1.7 RESEARCH DESIGN

To answer the research questions and achieve the purpose and the objectives of this study, a quantitative non-experimental, contextual, exploratory and descriptive survey as described by Mouton (1998:38) and Burns and Grove (1997:30,47-8) has been chosen by the researcher as the study design.

1.7.1 POPULATION

The population under study will be the patients attending the Alexandra public clinics, Alexandra Township residents and the nurses working in the clinics. There are 350,000 people residing in this township. About 100,000 patients attend the clinics in a year. A total of 12 nurses work in these public clinics.

The study will be conducted in four phases in the following manner:

1.7.2 PHASE 1

In this phase interviews will be conducted with patients attending the public clinics in Alexandra in order to determine their perceptions regarding the accessibility to the PHC services in the area (Annexure 1).

1.7.2.1 SAMPLING

The study will utilise all four of the public clinics in the area. Systematic random sampling as described by Brink (1990:106) will be used in order to draw the participants for the study in each clinic. The criteria for choosing the sample are: the person must be,

- 18 years or older,
- have lived in Alexandra for more than a year,
- have come to the clinic for the services.

1.7.2.2 DATA COLLECTION

An interview as described by Rossouw (2000:153-61) will be used as a method of data collection. The researcher will use the interview method because it will ensure that every candidate selected, literate or not, will be able to participate in the study. A structured interview schedule will be applied to 160 patients attending the public clinics. The questions will be based on the literature study done in chapter two and the norms and standards of PHC services as set out by the Department of Health (2000). The questions will be set with regard to their knowledge on services offered, personnel and other resources, availability of important documents in the clinics, service utilisation and community involvement. There will be both open- and close-ended questions. A pilot study as described by Treece and Treece, (1986) and De Vos (1998:178-88) will be

done using a group of people similar to the subjects. 160 patients will be interviewed in Zulu, Sotho (the main languages spoken by the majority of the residents) and English. To ensure consistency, the interview schedule will be translated from English to Zulu and Sotho and then back to English again.

1.7.3 PHASE 2

In this phase the interviews will be conducted with Alexandra Township residents in their churches, homes and in the streets in order to determine the perceptions of the people with regard to their accessibility to PHC services in the area (Annexure 2).

1.7.3.1 SAMPLING

A sample of 140 community members who are 18 years or older will be taken in their homes, churches and on the streets to determine the perceptions of the residents regarding their accessibility to PHC services in the area. The sampling criteria will be:

- 18 years and older,
- have lived in Alexandra for more than a year

1.7.3.2 DATA COLLECTION METHOD

Interviews will be used as a method of data collection and a structured interview schedule will be administered to 140 community members. As in phase one the literature study and the norms and standards of PHC services (Dept. of Health, 2000) will provide the guidance in the development of the research instrument. The instrument will be comprise of the same questions as in Phase One and will also be in Zulu and Sotho languages as most of the people in the area are conversant in these languages.

1.7.4 PHASE 3

In this phase a questionnaire as described by Rossouw (2000:137-50) will be administered to the nurses working in the four public clinics in the area for the purposes of exploring their perceptions with regard to community's accessibility to PHC services in the area (Annexure 3).

1.7.4.1 SAMPLING

The total population of 12 nurses working in Alexandra public clinics will be interviewed in this study. A total of 10 nurses will participate in the main study and 2 nurses will be used in the pilot study. The following criteria shall apply:

- they have to be professional nurses registered with SANC.
- they must have worked in public clinics in Alexandra for more than 6 months.

1.7.4.2 DATA COLLECTION METHOD

A questionnaire as described by Rossouw (2000:137-50) will be used as a method of data collection with the nurses sample. The researcher will use questionnaires to collect information because they are easy to distribute and will allow the nurses to complete them in their own time. The instrument will comprise questions regarding nurses' perceptions of the quantity and quality of the health services offered, personnel staffing and other resources, the community's utilisation of health services, the availability of important documents in the clinics and the community's involvement in the running of the health services. The questionnaire will be in the English language as all of the nurses speak English. Instructions on how to complete the questionnaires and a due date will be given.

1.7.5 PHASE 4

The researcher as participant-observer will make observations using an observation list which will be developed after the completion of the first three

phases of data collection, to verify issues raised by the respondents in all three of the sample groups. The researcher will go to all four public clinics with the list and make observations as a participant observer on certain issues that will need verification (Annexure 4).

1.7.6 DATA ANALYSIS

A quantitative descriptive analysis will be used to analyse the data obtained from both the interview and questionnaire schedules. This type of analysis will allow the researcher to organise the data in ways that give meaning and facilitate insights such as frequency distribution and measures of central tendency and dispersion (Burns & Grove, 1997:779). Content analysis will be used to analyse the open-ended items. The analysis will be limited to the characteristics of the text, that is, reading according to the lines. It will be limited to what the word stands for (Rossouw, 2000:174). The literature control will be done to determine the similarities or uniqueness of the study by comparing the research findings with relevant previous research findings. The analysed information will assist the formulation of conclusions and guidelines to improve the accessibility to PHC services in the area.

1.8 VALIDITY AND RELIABILITY

To ensure the validity and reliability of the study the following will be tested for.

1.8.1 FACE VALIDITY

Face validity (Seaman & Verhonick, 1986:238) will be achieved by studying the instruments and deciding whether the format is acceptable. The instruments will be given to the expert in the field of study to analyze them with regard to spacing, formatting and sequencing of the items on the instruments.

1.8.2 CONTENT VALIDITY

The instruments will be presented to expert in the field to analyse the extent to which the items on the instrument represent the variables under study. Any item rated as irrelevant to the study question will be deleted from the instruments.

1.8.3 CONSTRUCT VALIDITY

The instrument will be analysed to see if all the operational definitions are addressed and to see if the instruments address the problem under investigation. A pilot study will also be done to ensure this.

1.8.4 EXTERNAL VALIDITY

This will be achieved by consistently following a detailed procedure as designed, with specific inclusion criteria and a large representative sample for the study.

1.8.5 INFERENCE VALIDITY

According to Rossouw (2000:196) the researcher will justify the research decisions and its findings by presenting research arguments in a logical manner.

1.8.6 THEORETICAL VALIDITY

Theoretical validity, which is a precondition for measurement will be achieved through the literature study done in chapter two. This will help to define the main concept of this study.

1.8.7 PILOT STUDY

Three pilot studies will be conducted using three samples: twelve patients, ten

community members and two professional nurses working in the clinics.

1.8.8 TRIANGULATION

The following types of triangulation will be employed in this study, data triangulation, investigator triangulation and methodological triangulation.

1.9 ETHICAL CONSIDERATION

Ethical measures will be taken into account through the following:

1.9.1 CONSENT

The researcher will obtain a formal clearance from the RAU research committee, the Department of Nursing, the Eastern Metropolitan Local Council, Alexandra Public Clinics, potential participants namely: patients, community members and nurses and participation in this study will be voluntary (Denosa, 1998). An explanation of the study purpose will be provided to all stakeholders and informed consent will be obtained either in writing or by thumb print.

1.9.2 CONFIDENTIALITY AND ANONYMITY

All individual confidential statements will be properly secured (Denosa, 1998). the researcher will not ask the participants' names to guarantee anonymity and to ensure that no connection is made between the individual participant and the data. The participants will be ensured that their participation and the information provided will not be used against them in any way.

1.9.3 PRIVACY

Privacy during interviews will be ensured and environment conducive for one-to-

one conversations will be created (Mouton, 1998:157). The participants' self-worth and dignity will be maintained by not asking them embarrassing questions.

1.10 QUALITY OF THE RESEARCH

The researcher will ensure the good quality of the research by conducting the study under the leadership of an expert in the field in accordance with the principles and standards of scientific research.

1.11 ORGANISATION OF THE PROPOSED CHAPTERS

CHAPTER ONE

Overview of the study on factors influencing the accessibility of PHC services in Alexandra Township.

CHAPTER TWO

Conceptualisation: The theoretical foundation for the investigation of the factors influencing the accessibility of PHC services in Alexandra Township.

CHAPTER THREE

The research design and methodology for an investigation of factors influencing the accessibility of PHC services in the Alexandra Township.

CHAPTER FOUR

The research findings on the factors influencing the accessibility of PHC services in Alexandra Township.

CHAPTER FIVE

The overview, interpretation, conclusions, guidelines and recommendations of the factors influencing the accessibility of PHC services in Alexandra Township.

1.12 SUMMARY

In this chapter a study proposal on the factors influencing the accessibility of PHC services in Alexandra Township has been presented. The chapter consists of a short background and a synopsis of the research construct to be followed to execute the project. Arguments for the study have been put forward. As the services have been operating for some decades now it is imperative to investigate the accessibility of these services in the area in order to ensure that the people in the community do have easy access to the services intended for them. The objectives of the research highlight what should be achieved at the end of the day. The researcher's assumptions and the definition of the main concept have brought clarity to the study topic. The study design has provided an outline of the methodologies that will be followed in the execution of the project in order to achieve the study purpose.



CHAPTER TWO

CONCEPTUALIZATION: THEORETICAL FOUNDATION FOR THE INVESTIGATION OF THE FACTORS INFLUENCING THE ACCESSIBILITY OF PHC SERVICES IN ALEXANDRA TOWNSHIP.

2.1 INTRODUCTION

The purpose of this chapter is to clarify the concept of PHC and factors influencing its accessibility. Different world viewpoints pertaining to these concepts will be presented. The South African view point with regard to these concepts will be analysed to determine the differences and similarities between different Provinces and areas and Alexandra Township. The literature will focus on the different points of view and the theories followed in the development of PHC in various parts of the world and how these have facilitated or hampered the development, implementation and accessibility to PHC services. In conjunction with these factors; a consideration of the norms and standards for the delivery of PHC services in SA will form a basis against which the accessibility to PHC services in Alexandra Township will be measured.

2.2 ANALYSIS OF PHC CONCEPT

2.2.1 THE WHO'S PERSPECTIVE OF PHC

In theory PHC produces professionally and institutionally driven services that create community-based and driven services (Barnes et al, 1995:7). The PHC model targets social, political and economical environments as the key determinants of health for populations and individuals (Barnes et al, 1995:9). This is why the health of the disadvantaged is the focus of PHC, to facilitate accessibility to these services. In the developed world the concepts of primary care (PC) and PHC are often seen as synonymous. These concepts are not the

same but similar. PC is defined by the institution of medicine in United States of America (USA) (1994) as the provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal health services, developing a sustained partnership with patients and practicing in the context of family and community (Shoultz & Hatcher, 1997:23).

2.2.1.1 PHC AS DEFINED BY THE WHO

The WHO (1978) defines PHC as essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible through full participation and at a cost that the country and the community can afford to maintain at every stage of its development in the spirit of self-reliance and determination. It forms an integral part of the healthcare system and the overall social and economical development of the community and the country.

Both definitions focus on accessible services and community participation. While PC aims at personal good, PHC aims at the good of the majority in the community. The PHC model provides an approach for building interventions that lead to improved health outcomes for the entire population (Shoultz & Hatcher, 1997:23). PHC has the potential to avoid the pitfall of using an exclusive single-faceted approach that has failed to address the complex situation which influences health of individuals and families. In this definition we find the following underlying principles:

1. Essential services.
2. Accessible to all.
3. Focus on prevention and promotion in order to maintain health rather than cure.
4. The use of appropriate technology, methods, procedures and equipment. It should be scientifically based, adapted to meet local needs and acceptable to users according to individual countries' financial capabilities.

5. PHC, or first level healthcare delivered in community settings, is uniquely accessible and acceptable to the vast majority of the population. PHC therefore has immense potential to deliver not only first-level care and treatment but also prevention and health promotion (Naidoo & Wills, 1998:137).

6. Maximum individual and community involvement in the planning and operation of the services.

The definition of PHC in the Alma-Ata Declaration highlighted the dynamic balance between the population's self-reliance and responsibility on one hand and the effectiveness and efficiency of health services on the other hand. The requirement is not to choose between popular participation and the technical rationality of decisions, but to strike a satisfactory balance in each particular situation (Van Balen & Van Dormael, 1999:313-27). This implies participatory decision-making processes in the field of health and the existence of points of interaction between the general public and healthcare providers.

2.2.1.2 NATIONAL HEALTH SYSTEM (NHS) DRIVEN BY PHC-APPROACH

The WHO (1978) recommends that every country should have a structured national health system, driven by PHC-approach. PHC is an entry point to national health system. The type of services will vary from country to country according to needs and financial viability.

Comprehensive services should be provided at one-stop facilities. The concern is improving access to health services (Ferrinho, 1995:34-7). PHC must be implemented, maintained, co-ordinated, monitored and evaluated in terms of national policy, strategies and plans of action.

2.2.2 SOUTH AFRICAN PERSPECTIVE OF PHC SERVICES

South Africa like the rest of the globe experienced a population explosion which

increased the pressure on the already limited health facilities available for the majority of the population. When the 1977 Health Act (Health Act No 63) was enacted basic health needs were provided for. The provision of comprehensive health services was emphasised. The National Health Policy Council accepted the principles of the declaration of WHO's Alma-Ata as a basis for a health plan in South Africa. A national strategy for delivery of health services in South Africa was formulated.

2.2.2.1 PHC DEFINITION BY SANC

Both the Nursing Council (R48 1982) and Denosa then SANA (1985) (Barnes et al 1995:7-16) outlined the South African viewpoint on PHC as simple measures that are cost and technique effective and easily accessible to those in need. Also to improve living conditions of the individual, family and community and health care which includes preventive, promotive, curative, rehabilitative and community development activities.

In South Africa as is in many other countries; nurses are the key providers of PHC and as was concluded by WHO leaders, nurses would become resources to people and leaders of PHC teams. Nurses in SA are at the steering wheel of PHC (Barnes et al, 1995:7-16). Without them the program would not survive. The PHC nurse brings pride to the profession.

The need for modern PHC surfaced as a result of the population increase. The emphasis has changed from disease and curing to health and prevention of disease. The curative role of the PHC nurses' work only emerged because of the need for giving a curative service as well as a preventive service and the limited number of doctors available to provide primary medical care in most of the areas in country (Barnes et al 1995:7-16).

2.2.2.2 PHC POLICY AND LEGISLATION

The White Paper 1997 (RSA 1997) for the transformation of the health system in South Africa saw the reorganisation of the health service as a priority for PHC. The National Health Systems were organised into four levels.

National - the Department of Health, Academic and cardiac specialty hospitals.

Provincial - Academic and regional hospitals

District - community hospitals

Municipalities - health centers, clinics, mobile clinics and health posts.

• LEGISLATION

The PHC nurse is registered and practices under the Nursing Act (Nursing Act 1978 as amended). The other regulations guiding the PHC nurse are: Regulations of the Nursing Act no 50 of 1978, R45 (1) with regard to prescribed medicines, R45 (1) (q) with regard to the scope of practice of RN and R45 (1) (l) with regard to the Diploma in Clinical Nursing Science Treatment and Care.

• TRAINING

The regulation for the Diploma in Clinical Nursing Science Health Assessment, Treatment and Care as supplied by the SANC gives more detail of what is expected of the PHC nurse. The various training courses offered, range from six months to two years and the Registered Nurse (RN) is trained to assess, diagnose, prescribe and dispense medicines up to schedule four within the essential drug list. A RN is taught the importance of a timeous referral and consultation.

2.2.2.3 NORMS AND STANDARDS FOR THE DELIVERY OF PHC

The Norms and standards for the delivery of PHC in South Africa (Dept. of Health 2000) were first drafted in October 1999 by the Department of Health. They include:

◆ BATHO PELE - PEOPLE FIRST

Access to decent public services is the rightful expectation of all citizens especially the previously disadvantaged. Communities are encouraged to participate in the planning of services to improve and optimise service delivery for the benefit of the people.

➤ STANDARDS OF BATHO PELE

Posters displayed in the communities state the eight principles of Batho-pele, which are:

- **Consultation**
Communities will be consulted about the level and quality of public services they receive and where possible given a choice about the services offered.
- **Service standards**
Citizens will know the level and quality of public services they are to receive and know what to expect.
- **Access**
All citizens have equal access to the services to which they are entitled.
- **Courtesy**
Citizens should be treated with courtesy and consideration.
- **Information**
Citizens should be given full, accurate information about the public services they are entitled to receive.
- **Openness and Transparency**
Citizens should be told how national and provincial departments are run, how much they cost and who is in charge.
- **Redress**
If the promised standard of service is not delivered they should be offered an apology, an explanation and an effective remedy. When complaints are made citizens should receive a sympathetic positive response.
- **Value for money**
Public services should be provided economically and efficiently to give

citizens and communities value for money.

➤ **Implications of Batho Pele principles for health staff.**

In line with these principles the local health services for a community will provide:

- Services with a high standard of professional ethics.
- Services that are measured against the performance indicators displayed, so that the community can understand the level of achievement.
- Services in partnership with or that complement other sectors e.g. the private sector, non-governmental organisations and community-based organisations.
- Services that are customer friendly and confidential.
- Opportunities for community consultation.
- Types of outreach to all communities and to families in greatest need.
- Easily accessible and effective ways of dealing with complaints or suggestions for improvement.
- Current information on services available and hours that services are offered, staff changes of movements and extra activities such as health days.

◆ **PATIENTS' RIGHTS CHARTER**

➤ **SERVICE DESCRIPTION**

The purpose and expected outcome of the patients' rights charter and complaint procedure is to deal effectively with complaints and rectify service delivery problems and so improve the quality of care, raise awareness of rights and responsibilities, raise expectations and empowerment of users, change attitudes by strengthening the relationship between providers and users, improve the use of services and develop a mechanism for enforcing and measuring the quality of health services.

➤ **STANDARDS OF PATIENTS' RIGHTS CHARTER**

1. Each clinic displays the patients' rights charter and patient responsibilities at the entrance in local languages.
2. The patients' rights charter is observed and implemented. Every patient has

the right to:

- a healthy and safe environment,
- access to healthcare,
- confidentiality and privacy,
- informed consent,
- be referred for a second opinion,
- exercise choice in healthcare,
- continuity of care,
- participation in decisionmaking that affects his or her health,
- be treated by a named care provider,
- refuse treatment,
- have knowledge of their health insurance / medical aid scheme policies, and
- complain about the health services they receive.

3. The patients' responsibilities are displayed with the patients' rights charter.

They are:

- to live a healthy life style,
- to care for and protect the environment,
- to respect the rights of other patients and health staff,
- to utilise the health system optimally without abuse,
- to know the health services available locally and what they offer,
- to provide health staff with accurate information for diagnosis, treatment, counseling and rehabilitation purposes,
- to advise health staff on his / her wishes with regard to death,
- to comply with prescribed treatment and rehabilitation procedures, and
- to take care of their health cards and records.

4. There is provision for the special needs of people such as a blind person and a person in pain.

5. Services are provided with courtesy, kindness, empathy, tolerance and dignity.

6. Information about a patient is confidential and is only disclosed after informed and appropriate consent.

7. Informed consent for clinical procedures is based on a patient being fully

informed of the state of illness, the diagnostic procedure the treatment and its side effects, the possible costs and how life style might be affected. If a patient is unable to give informed consent the family is consulted.

➤ THE COMPLAINT PROCEDURE

1. At the first contact with the healthcare provider, the user is informed verbally of the health rights charter with emphasis on the right to complain and the complaint procedure is explained and handed over.
2. All clinics use a standard complaint form, which is used to lay a complaint.
3. The clinic has a formal, clear, structured complaint procedure and illiterate patients and those with disabilities are assisted in laying complaints.
4. All complaints or suggestions are forwarded to the appropriate authority if they cannot be dealt with in the clinic.
5. A register of all complaints and how they were addressed is maintained.
6. The name, address and telephone number of the person in charge of the clinic is displayed.



2.3 IMPORTANT ELEMENTS OF PHC

2.3.1 ESSENTIAL HEALTHCARE SERVICES

PHC services are considered to be essential, which means that the country cannot do without them. The Alma-Ata declaration points out that PHC should address the main health problems in the community and the functions of a PHC service should ensure the inclusion of services in order to promote, prevent, cure and maintain health (WHO 1978). The WHO (WHO 1978) listed the following as essential services:

1. Maternal and child-care including family planning.
2. Immunisations against the major infectious diseases.
3. Prevention and control of locally endemic diseases.
4. Appropriate diagnosis and treatment of common diseases and injuries.

5. Supply of essential drugs.
6. Health education on prevailing health problems and methods of preventing and controlling them.
7. Promotion of food supply and proper nutrition.
8. Adequate supply of safe water.
9. Basic sanitation (WHO, 1978:4).

2.3.2 COMMUNITY PARTICIPATION

“For many years it could be said that there has never been a better time to be in PHC. It forms the basis for our health services and provides quality care to the population close to where they live, play and work. The context in which PHC operates has also changed in demographical, social-political terms. This was the experience of the two Pietron brothers (Pietron and Pietron1996: foreword) in Marylebone UK. PHC recognises the significance of involving the patient and the public in decision-making about the quality of care provided (Pietron & Pietron, 1996:foreword).

Community participation means involving members of the community in the planning, implementation and evaluation of their local health services. It was during the fifties that community development was regarded as the process whereby the people united their efforts with those of the governmental agencies to improve socio-economic and cultural conditions thereby impacting their health positively (Searle, 1985:289). Community participation is client orientated and the individual, family and community are provided with the necessary knowledge and skills to influence their own health. It occurs at grassroot level and the individual, family and community participate as a partner (Barnes et al, 1995:12). It is a process aimed at achieving defined outcomes for the good of the majority in the community.

The Alma-Ata declaration states that people both individually and collectively

have the right and duty to participate in their healthcare. This is the cornerstone of PHC (Sawyer, 1995:17). Co-operation of the community through individuals accepting a high degree of responsibility for their own healthcare can only be obtained if the community participates in the planning of PHC activities. When the community participates, individuals can contribute labour and other resources necessary for PHC services (WHO, 1989:4).

The community is the focus of PHC nursing practice. Ideally PHC nurses work in partnership with the community and involve the community in decision-making. Crump, Gaston and Ferguson (1999:218-24) reported that at the nurse-managed community health centers in US, nurse practitioners in their quest to improve access have formed outreach teams (Models That Works) that work with Tenant Councils and foster a system of collaboration among organisations such as those providing jobs for public housing and an agency that supports community programs for grandparents who are raising grandchildren. One of the major lessons that Model That Works (MTW) staff has observed is the reduction in time that it takes to create a new program in community when people are brought in to share lessons from communities where such programs already increase access in primary care services (Crump et al, 1999: 218-24).

Community participation is seen as a way of rapidly improving the health services available for the majority of the world's people (WHO, 1989:3). It is a cost-effective approach and a way of extending a healthcare system to the geographical and social periphery of a community. Urban models emerge that extend healthcare beyond clinic or hospital walls to integrate a community-based mission, orientation, and strategy into urban health. Andrulli (2000:858-62) observed that the community programs at the Parkland Health and Hospital systems in Dallas, USA, work through a network of health centers, homeless shelters, school health settings, churches and senior citizens' centers with incorporation of diversity and language.

"Health is NOT something bestowed upon you by a system or a knowing other, it IS something you own. Just as all political is local, all health is personal" (Levine, 2000:10-1). Levine (2000:10-1) states that a path to achieving shared goals in USA contends that the movement to a more consumer-driven healthcare system is already under way. "It seems the inevitable outcome of the failed 1994 Federal Health Security Act and managed care's inability to set us on the course toward our professional ideal of universal access to high quality, affordable healthcare" he commented. At the same time we have seen the widespread adoption of advanced information and communication technology by other industries to "consumerise their business models - bringing service providers close to their users and reducing costs which increases quality and satisfaction" (Levine, 2000:10-1). He puts forward the challenge to focus on shared goals and use consumer-power to promote evolution to not only just a consumer-driven but a best outcomes-driven healthcare system that values and rewards outreach, innovation and the rapid translation of scientific advances into every day practice.

PHC is a practical approach to make essential healthcare universally accessible with full community participation (WHO, 1978). It is equally valid for all countries though the form it will take may vary according to social economical and cultural patterns.(Sawyer, 1995:17-22). The involvement of patients in the delivery and evaluation of their healthcare is something that is now widely accepted and to a certain extent implemented (Pietron and Pietron, 1996:74). Internationally the nursing profession has embraced the concept of community participation as an integral part of the strategy to improve the health of the world's peoples (Davidson, Smirnoff, Klein and Burdick 1999:1567-70). Advocating self-care is one of the principles of the community participation. However Davidson et al (1999:1567-70) state that patients identified the opportunity to receive good medical care as the most important aspect of the TB DOTS program. Also significant was the support of the DOTS staff. Half of the patients reported being better off with DOTS program than with self-supervised care. Good public health practice encourages people and communities to take part in decisions about their

own health. Countries need to recast their health systems and support peoples initiatives and new international relations are required to support countries to resolve their own public health issues. Experience during the past few decades have shown that people can organise themselves to solve their own public health issues and other concerns in partnership with government and non-governmental organisations (Davidson et al, 1999:1567-70).

Consider Idalia, Colorado with a population of 90 people, where residents opened a public health clinic after raising \$1 million for the clinic and adjacent community center (Dept. of Health 1995:11-2). The project which includes day-care and a technology center for the town 150 miles east of Denver, will bring local healthcare to an area where the closest doctor is 30 miles away and where the access problem has seen farmers bandaging wounds with tape to continue working the fields because a drive to the doctor would take too much time (Dept. of Health, 1995:11-2). The community development approach to health is positive and pro-active and can enable people to use existing services. Community participation can begin to reduce inequality to ensure that those with the greatest need have the highest share (Naidoo & Wills, 1998:155).

Communities can, with the support of civil society groups, learn to reject inadequate services and improve their well being. The principles of Alma-Ata can be achieved by providing a vehicle for people to speak for themselves and to be heard. For this to happen there must be a worldwide intersectoral commitment that enables people to organise freely around their interests and to support their health initiatives (MacFarlane et al, 2000:841-6).

Participation is one of the developing tenets of PHC and yet it raises difficult issues for professionals and patients alike. During a discussion at Maryleborne health center a patient summarized the drama: "what needs to be made clear is the patient's role as a patient and his / her role as a participant in the running of the center" (Pietron & Pietron, 1996:76). According to WHO (1989:6), community

involvement increases the possibility that health programs and projects will be appropriate and successful in meeting health needs as defined by local people, as opposed to medical needs as defined by the health authorities. At the Marylebone center patients are encouraged to participate in education and community activities and to provide ideas and feedback on health center services and management through the use of an informal complaint procedure within the practice that gives both patients and personnel a faster turnaround time for dealing with the complaints (Pietron & Pietron, 1996:82). As a result more complaints were received and most were solved within three days of being received (Pietron and Pietron, 1996:82).

Measuring patient satisfaction is now regarded as the method of choice for obtaining patients' views about their care. This is achieved through the incorporation of the following principles, that patients are an essential source of data about how services are performed and that patients as community members have the right to have their views taken into account when health services are planned and evaluated (Avis, Bond & Arthur, 1995:316-22). A secure environment must be established in which consumers can give researchers and providers feedback on outcomes and their experience, thereby enabling a prospective evaluation of the health system's effectiveness. Implementation will require reconciling legitimate privacy and liability concerns, while recognizing that in order to achieve a better functioning system and better health for everyone, all parties must be willing to share their experience (Levine, 2000:10-1).

It is critical that the context in which this information exchange takes place is one of learning for improvement, as opposed to judgment for blame, punishment, or discrimination Levine (2000:10-1) warns. This sentiment is shared by Naidoo and Wills (1998:179) who state that efforts in communicating about work and keeping participants on board is vital. Rodger and Watkins (1999:20-3) reveal that the extent of the use of patient participation forums at practice level in the UK appeared limited with most of the Health Authorities having only one or two

practices with active participation groups.

In Finland Koponen, Helio and Aro (1997:41-8) observed that decades of effort have failed because the remedies to Codman's "toxic mixture" have all lacked a key ingredient, a compelling demand for accountability by the only group with the power to effect real change- consumers. Consumers can bring change that can create improvement in outcomes, encourage broader and more timely use of new knowledge and demand mechanisms to evaluate and report the effects. They alone know the passion and urgency that results from living with the effects of illness, or seeing those they care suffer. The transition to a consumer-driven system should be seen as a move to a best outcomes-driven system, as defined by consumers, professional and scientific evidence. To participate as constructive and effective change agents, consumers will need good information, decision support instruments, access to resources and ongoing support from entities they trust (Levine, 2000:10-1).

There are many examples of how populations have empowered themselves to bring about substantial changes in their own communities. In the Mindanao municipality in the Philippines, health personnel rarely ventured into the rural villages some distance away because, they said this would not be economical in cost, time or service provisions. One community, concerned about health issues, organised its members to put pressure on the health team to visit, and the team finally agreed. When the health workers arrived they discovered, to their astonishment, that local leaders had arranged for people to come from mountain villages as far away as 10 km over extremely rough and sloping terrain. The leaders enlisted the assistance of local teachers and better-educated residents to screen and prioritize the waiting people by type of ailment and severity of conditions. Volunteers recorded the medical team's recommendations and in the following weeks undertook measures to reduce some of the diseases (MacFarlane, Racelis & Muli-Musiime, 2000:841-6).

Community involvement can make more resources available by drawing upon local knowledge and resources to complement what is provided by the formal health services. It can also help to extend the coverage of health services and to lower their overall cost (WHO, 1989: 5). This is evidenced by Haider, Ashworth, Kabir and Huttly, (2000) who found that with the intervention of trained peer counselors, mothers could be enabled to breastfeed exclusively for the recommended duration of five months. They started breast-feeding earlier and were less likely to give pre-lacteal and post-lacteal foods. Significantly more mothers in the intervention group breast-fed exclusively. This also supports health education as the most effective part and parcel of village activities (WHO, 1989:4).

Just before independence a catch phrase in Zaire was 'a technical mistake is less serious than a mistake that harms people's self-confidence. This implied that it is the population itself and not technical expertise in isolation that constitutes the main resource for development in the various areas of life. This led to the realisation that health problems would not be solved by experts alone, even if unlimited technological resources were made available but that all hands are needed on deck to make services efficient and effective (Van Balen & Van Dormael, 1999:313-27).

Communities that invest labour, time, money and materials in health promotion activities are more committed to the use and maintenance of what they produce (WHO, 1989:4). Jarganen and Kortebout (1999:36-40) shares WHO's sentiments when they found that the community is able to identify their own health problems, prioritize them, plan and implement appropriate strategies to meet their needs. They also observed that there seems to be a potential for the community to become more cohesive, to influence one another and to function effectively as a group. Communities that begin to understand their health status objectively rather than fatalistically may be moved to take a series of preventive measures (WHO, 1989:4).

It would appear from the literature that community participation has been enthusiastically welcomed as the fundamental change in direction required to improve access to health services and promote health development. Providing care with a community focus brings us back to our professional roots. When you emphasise patient self-care, prevention, care in the family, culture and community, continuity and collaboration, you participate in community-based nursing. It is about how we practice - not where we work (Hunt, 1998:46-7).

2.3.3 INTERSECTORAL APPROACH

Intersectoral collaboration means to labour together, to act jointly for a common effort and shared goals (Wills & Naidoo, 1998:168). The 1988 WHO conference in Adelaide, Australia on public health policy saw the need for health awareness to be threaded through all government departments. Good health cannot be achieved by the health sector alone. The WHO's essential list (1978) of health services is evident of this fact. The challenges in healthcare today require input and co-operation from everyone. This is so in both the developed and developing countries.

Crump, et al (1999:218-24) note that in 1998, East St. Louis, Illinois, had an immunisation rate of just 20% for 2-year-old children. Recognizing that a range of financial and non-financial barriers to access as well as a lack of information sharing inhibited local efforts to improve this rate, area organisations and agencies formed the East Side Healthcare Coalition to address the access and co-ordination problems. Member organisations worked together to develop an immunisation registry, which helped to overcome a fragmented and competitive local healthcare environment. Within 3 years, the immunisation rate of 2-year olds increased to 82%, PHC visits in the area increased by 500% and this implies an improvement in access to health services by the majority of the people.

“Healthcare today is a group effort and the nurse is a central figure in that effort” (Lucille as reported by Lindeke & Block 1998:213). To promote PHC in the US interdisciplinary collaboration, training and research is being promoted. Nurses are given opportunities and incentives to engage in interdisciplinary initiatives which are sponsored by private foundations e.g. Kellogg’s foundation, academic institutions and managed care entities, in order to increase the quality and efficiency of healthcare service (Lindeke and Block, 1998:213). McCloskey and Maas (1998:157) however warns that an emphasis on interdisciplinary research and practice could dilute nursing knowledge and further obfuscate the nursing role of the nurse in the planning and delivery of healthcare. Maintaining professional integrity in the midst of interdisciplinary collaboration is complex and warrants close examination.

Intersectoral collaboration is the co-operative efforts of different community and organisational sectors toward mutually agreed goals. It can occur at different levels of society from international to local efforts (Barnes et al, 1995:11). In America, continuity of care is particularly important for indigent populations since their medical conditions often call for regular visits, multiple referrals and complex behavioural regimens (Bibeau, Howell, Rife & Taylor, 1996:93-110). While health reform is being discussed at national and state level, many communities have begun to seek solutions to the growing problem of inadequate access to medical services among their poor and uninsured residents. The medical conditions may also be intertwined with a variety of social and emotional issues susceptible to intervention through referral to community social service agencies. Against such odds total participation is needed to keep care fair, available and accessible. Inevitably this spirit of self-reliance and determination led a registered nurse and her spouse, a physician in Greensboro, North Carolina, USA, to provide volunteer medical services at a night shelter one morning per week for 8 to 12 patients. Personal contacts and media exposure during the first year resulted in another 15 physicians and a variety of other nurses, social workers, dental professionals and lay citizens volunteering for regular weekly sessions serving 25

to 30 patients (Bibeau et al, 1996:93-110). The outcomes of this collaboration are inclusive of health and wellness as well as economical, environmental and social well being within the PHC context.

To promote health service access to the people, the Finnish government implemented the principle of population responsibility (community participation) and multi-disciplinary teamwork, in which the population was geographically divided into small districts. They also introduced multi-professional teams of nurses, doctors, receptionists, home help personnel and social workers. Each team was responsible for all the PHC services for the people within their area (Koponen, et al 1996:727-35).

Health is determined by many social, environmental and economic factors that go beyond health service provision. To promote health, different sectors like education, environmental services, housing, income support, transport, agriculture and social welfare need to collaborate (Naidoo & Wills, 1998:138). Goodburn and Campbell (2001:917-21) state that reducing the rate of maternal mortality by 75% by 2015 is one of the developing targets that has been endorsed at numerous international meetings. They claim that sector-wide approaches allow donors to support improvements in health systems. The approach also offers the opportunity to make a sustainable impact on maternal mortality. As recommended by WHO (1978), PHC must be co-ordinated with other sectors to be successful.

In its attempt to improve access to PHC services the Saudi government has increased the number of PHC centers used by the poorest of Saudi and non-Saudi people (Littlewood & Yousuf, 2000:676). Saudi nurses have little status and little access to power within the male and medically dominated health system (Littlewood & Yousuf, 2000:677). This questions the significance of nursing contributions in multi-disciplinary team efforts in the delivery of PHC services in Saudi Arabia.

WHO's Ottawa Charter of 1986 (WHO, 1989) states that building a supportive physical, cultural and socio-economic environment for people to live, play and work is important. This is based on the understanding that individual and community well being is determined more by social, environmental and economic systems than by healthcare provision. It follows then that the responsibility for the promotion and maintenance of health does not belong to one professional group or sector. Community outreach programs are an important component of healthcare delivery (Mwale, 1999:156-7).

In SA, Alant (1998:17-21) emphasises that close collaboration between community nurses and rehabilitation specialists is vital in ensuring that a difference is made in the lives of people with severe disabilities.

The utilisation of healthcare services is affected by a number of factors. Addressing one factor without addressing the others provides little help in guiding policy makers in developing programs that will improve healthcare accessibility to the populations of the world. An interdisciplinary approach is needed where the physical, social and spiritual needs of the individual are dealt with. It is important to take stock of existing models and explore new forms of intersectoral and multi-sectoral co-operation to ensure equitable exchange of views, information and knowledge (MacFarlane, et al, 2000:841-6).

2.3.4 ACCESS

Access is another important element in PHC, according to the WHO's agenda for healthcare reform and also a central component of nursing practice and an arena for nursing actions (Barnes et al, 1995: 13).

An analysis of the performance of healthcare system in 191 countries by the WHO in 2000, discovered that France was the best overall care provider (Ashraf,

2000:2225). "The main message from this report is that the health and well-being of people around the world depend critically on the performance of the health systems that serve them yet there is wide variation in performance, even among countries with similar levels of income and health expenditure" stated Brundtland, the WHO's Director General (Ashraf, 2000:2225). Unsuccessful attempts at healthcare reform in Maryland and Virginia over the past two years showed that the lack of health insurance and the shortage of PHC providers are the biggest problems of access to healthcare (Meyer & Naughton, 1995:22-8). Although more equitable financing and allocation of resources are key factors in the access equation, enormous, nation-wide, reform efforts will be necessary. Human service managers and policy-makers who want to effect more immediate change may want to direct their effort toward reducing the structural and organisational barriers to access (Meyer & Naughton 1995:22-8). Lack of insurance and provider misallocation cause real barriers to access but structural and organisational factors within the human services can have an even greater impact to access, argued the authors.

Delays in access to care plague our healthcare system laments Murray (2000:1594-6). These delays cause patient dissatisfaction, contribute to staff dissatisfaction and may lead to worsening clinical outcomes. There is a cost in maintaining a waiting list, the longer the wait the higher the 'fail to show' rate and there is the risk that the waiting patients will arrive with a more costly clinical condition. Improving access involves looking at the system's flexibility and capacity (Murray, 2000:1594-6).

Access to quality healthcare remains a pressing problem for the 43 million Americans who have no medical insurance or are medically under-served. The defeat of President Clinton's Health Plan makes major governmental national healthcare reform unlikely and issues of access to care and equity have not been priorities in the private managed-care movement (Chin, Cook, Jin, Drum, Harrison, Koppert, Thiel, Harrand, Schaefer, Takashima & Chiu, 2001:268-74).

The emergency department serves as the main source of care for many patients. Many fatalities can be prevented if an efficient system of primary care existed for patients in medically under-served areas (Chin et al, 2001:268-74).

The accessibility to health services is also determined by factors such as the ability of users to pay for healthcare, membership of health insurance schemes, the infrastructure by which health services are provided in the community, knowledge of available services, cultural preferences and obstacles of time and distance (Anyinam, 1987:805-806, Benatar, 1989, Van Rensburg & Benatar, 1993, Van Vuuren, De Klerk & Van Rensburg, 1993:8 in Van Vuuren & De Klerk, 1996:19).

The problem of access goes beyond issues of insurance and the supply of providers (Meyer & Naughton, 1995). Healthcare has always been rationed because differences in availability, accessibility and quality of healthcare have always existed (Wurzbach, 1998:63). There is an abundance of literature and research that demonstrate the inequalities of access to, uptake of and knowledge about health and healthcare facilities. This has done little to trigger action to relieve the plight of those deprived of healthcare (Editorial, 1997:1057-9), and so to speak wise words are nothing without action

In this context accessibility is therefore defined as the provision of an acceptable and equitable level of healthcare that is efficient, effective and is readily available for all citizens geographically, socially, physically, financially and functionally.

2.4 NATIONAL AND INTERNATIONAL FACTORS INFLUENCING THE ACCESSIBILITY OF HEALTH SERVICES

To measure accessibility of PHC services the above factors need to be examined on how they have hampered or facilitated access to services by the people, nationally as well as internationally.

2.4.1 FACTORS INFLUENCING THE FUNCTIONAL ACCESSIBILITY OF HEALTH SERVICES.

Functional accessibility is the availability of an appropriate type of care to the people intended for. Availability means services are readily within reach of the individual, family and community who need them when necessary.

The provision of disintegrated and unco-ordinated services is inappropriate for a person with multiple needs. An individual may be in need of medical care, f/p services, counseling and social services at the same time, but the facility may not provide these services in a well co-ordinated manner. The patient therefore has to endure several intake interviews, fill out redundant eligibility forms and visit multiple locations (Meyer & Naughton, 1995:22-8), in a situation where not even one staff member is well versed with the entire system. This type of system is categorical; alas people's needs do not fit neatly into categories for peoples' needs affects the whole.

In an attempt to improve health services accessibility, the Canadian government has introduced two types of no-appointment healthcare services namely walk-in centers and after hours services. Walk-in centers are defined as a facility that is physically separate from a hospital, has extended hours of services and which accepts patients without an appointment or a referral. Walk in centers are similar to general practitioner co-operatives in Britain. These centers provide a range of services: pharmacies, social services, and physiotherapy. Jones (2000:928-31) established that the most common reasons for attending walk-in centers were their convenient location, minor medical problems, the range of services offered, convenient hours and a long wait for an appointment with the patient's own doctor. It is evident that increasing the availability of services has facilitated more people's access to health services in Canada. Commenting on the future of walk-

in centers Jones (2000:928-31) says, " these centers are here to stay".

Consistent with the prevailing orientation several studies regarding prenatal care have been conducted. Curry (1989) in Sword (1999:1170-7) revealed that fragmented, unco-ordinated care and lack of resources for outreach programs are barriers to prenatal care. Sword (1999:1170-7) then concluded that utilisation behaviour is inherently related to issues of availability.

Making a health facility a one-stop facility through the provision of several functions at the same facility improves the availability of services to the people it is intended for, by improving the overall accessibility of services to the people. In another study on the availability of services in rural areas in Canada, (Buske, 2000:1193-6) it was found that almost all interviewees reported that they offer services such as normal deliveries, tonsillectomies, hysterectomies, trauma management, management of minor illnesses. They also have ambulance services and the majority has basic laboratory and X-ray services within the community. More than half could provide chemotherapy, two-thirds had ultrasound machines but only a few had dialysis services available locally. This implies provision of several services at a single facility that makes services more accessible to the people it is intended for.

In Prince Edward Island in Canada women have nowhere to go to terminate unwanted pregnancy because of long distances and service policies (Eggertson, 2001:847-9). Women travel up to 12km in order to access abortion services. Women must also get approval from two doctors for a publicly funded abortion in a hospital making it more difficult for women to get help in time.

Meanwhile in the USA efforts to expand access to emergency contraceptive pills were endorsed by the American Medical Association (AMA). The AMA called on the USA doctors to educate their patients about emergency contraceptives and to make the pills more available through hospitals, clinics, emergency rooms,

acute-care centers and physician offices (Ashraf & McCarthy, 2000:2071). They also recommended that the pills be sold 'over-the-counter'. Ironically surveys have found that relatively few women are aware of the availability of the emergency pill and only about 1% of women of reproductive age reported having ever used the pill to prevent pregnancy. Some people are sceptical about its impact on access because of the expenses involved, the provider's gender inconsideration and the paperwork involved (Ashraf & McCarthy, 2000:2071). Thus although the law in USA is progressive the same cannot be said of the practice.

The UK government announced, on advice from the Committee on Safety of Medicines, that an emergency pill will be available from pharmacies without a doctor's prescription, allowing it to be sold 'over-the-counter' (Ashraf & McCarthy, 2000:2071). The British Medical Association, however, believes that the government should have gone further and made the drug, which will be available even to under 16-year olds, free of charge. Harrison-Woolrych, Howe and Smith (2001:186-7) agree with this. They state that nurses, pharmacists and other health workers are allowed to supply pills to whole groups of patients who may not be individually identified before presentation for treatment.

Something as simple as the healthcare facility's operating hours can become a barrier to access. People are faced with the dilemma of missing school or being absent from work in order to access to healthcare services (Meyer & Naughton, 1995:22-8). A f/p clinic in Dayton, Ohio, USA, targeting adolescents is only open during school hours, a teenager would have to miss school to see a clinician (Meyer & Naughton, 1995:22-8).

There are wide variations between practices in the different Health Authorities (HA) in the UK (Rodger & Watkins, 1999:20-3). They show that more than half of the practices offered early morning surgeries and many also offered appointments after 6pm. The majority of these practices had no links with the

National Health System (NHS). The findings showed differences in make up and coverage of the General Practices (GP) in prescribing performance, services offered, practice infrastructure, information management technology and in all patient access to the services. To this end there has been an increasing involvement of the full primary care team in 24-hour care so that GPs, practice nurses, community nurses and a variety of other professionals are available to provide appropriate advice and treatment (Dale & Salisbury, 1999:24-7). Nurses are increasingly employed after-hours to provide telephone advice and triage, thereby making services readily available for the people when necessary.

In the USA intersectoral co-operation led to the establishment of a free clinic in Greensboro, North Carolina. Bibeau et al (1996:93-110) noted that clinic services were more available to the people because they offered services during the evening to accommodate those who work during the day, flexibility of the structure, easy access, client familiarity, efficiency and cost-effectiveness. The clinic also offers a wider range of comprehensive services including treatment for sexually transmitted infections and chronic conditions.

Under-immunisation continues to be a major public health challenge in the USA. The reasons are multifactorial and include family and parental factors such as culture, inconvenience and misconceptions and provider factors such as missed opportunities and healthcare system barriers (Hambidge, Easter, Martin, Melinkovich, Brown & Siegel, 1999:158-63). Most counties in the USA are required by law to provide free vaccines to children. Why then the under-immunisation? To answer this Hambidge, et al (1999:158-63) conducted a study into the immunisation fairs periodically offered as part of the immunisation campaign in Denver, Colorado. The families reported that they attend the free vaccine fair because of the convenient time, convenient locations, the availability of vaccines without an appointment, short waiting times and no cost. When services are brought to where people live, play and work, they are enabled to access them when they need them and this led the authors to conclude that

vaccines fairs may be needed to help fill in the gaps for the vaccine net.

Commenting on children's community nursing services (CCN) Eaton (2000:49-56) cited that in an ideal situation the CCN would be available twenty-four hours a day seven days a week, however only a few are available 24 hours, 7 days a week.

A comprehensive public health nursing system covering all municipalities in Finland was created in 1940s. Within each area one public nurse provided the necessary nursing care including primary, preventive and curative services. However poor continuity and long waiting times were the main problems in the 1980s. Today public health nurses mainly focus on specific preventive care programs for nationally defined target groups such as pregnant women and children under the age of seven (Koponen, Helio & Ario, 1997:41-8). The clients and professionals are basically satisfied with the Finnish PHC system. Koponen, et al, (1997:41-8) found that one third of respondents had potential access to services provided. Thirty-three percent had a particular source and five percent had a source-nurse that they could contact when they needed help and advice in health matters. However there is still sixty-six percent of the population who have no particular source and ninety-five percent who have no source-nurse to contact when in need of help.

In its attempt to increase access to health services to the people not covered by the Italian National Health Services, Bologna introduced a toll-free phone line, run by especially trained operators who speak Albanian, Arabic, English, Phillipino and French, to provide counseling and information about access to healthcare for two hours a day (Simini, 1999:1368-70). The initiative helped the providers to identify the health needs of these populations and as a result patients do not visit emergency departments inappropriately (Simini, 1999:1368-70). This makes services available when necessary.

Steele, Curtis and Choe (1999:28-38) state that there is a strong relationship

between the range of methods available in a country and contraceptive prevalence. Hotchkiss also found a significant positive effect of the availability of pills in local pharmacy on use of modern contraceptives (Steele et al, 1999:28-38).

As stipulated in the Norms and Standards for the delivery of PHC services in SA (Dept. of Health, 2000) a PHC clinic should render comprehensive integrated services using a one-stop approach for at least eight hours a day, five days a week. Services rendered should be preventive, promotive, curative and rehabilitative. Fonn, Xaba, Tint, Conco and Varkey (1998:697-702) observed that long waiting times at clinics and the inability of clinics to provide a combination of services on a single day are the most important problems in accessibility. Patients spent an average of 54 minutes waiting for a 10-minute consultation in TB services, 3 hours 11 minutes for a 7-minute curative consultation and 1 hour and 40 minutes for a 17-minute child health service. All patients arrive early in the morning and then wait to be seen. The authors pointed out that women want an appointment system, which would decrease patient waiting time, the number of people waiting and the pressure that clinic staff experiences. They recommend that to increase the quality of care given to patients, management should ensure the provision of a wider range of services including abortion services, plan to provide a reasonable 24-hour coverage, involve the community to ensure quality, do spot checks on clinics and provide quality training for staff, among others.

Jones (1999b: 112-4) reported that in 1998, 83% of clinics in SA provided daily f/p services and 67% daily immunisation services, this is up from 72% and 48% respectively in 1997, while 74% offered TB sputum testing, 56% HIV testing and 51% Pap smears. This would imply that a considerable number of services have been made available to more people when necessary.

Provision of appropriate care to those who need it, when they need it, increases accessibility of services to the people intended for. Richter (2000:76-81)

discovered that adolescents wanted services such as health education, f/p, sexually transmitted infection services, treatment of minor ailments, substance abuse and eating disorders management to be available in a clinic that they would call 'accessible adolescent health service'.

Having enough time to deal with a patient as an individual allows for the establishment of a rapport between the provider and the patient. This situation facilitates a proper diagnosis and management of the patient's needs for an acceptable outcome. McDonald and Blignaut (1998:8-11) observed that one of the main advantages of computerising a PHC clinic is having more time available for patient care, especially where personnel are computer literate.

At the Alexandra health center there are five different departments, three with non-descriptive titles, woman, man, chronic (Martinson, 1997:765-6). Even though this situation is not unique to this center, the provision of services such as antenatal, f/p, sexually transmitted disease, TB, immunisation, psychiatric, chronic disease and curative in different rooms or at different times and by different personnel poses a major problems even though they may seem to be efficient and effective. Patients have to go to a point of selection where they are told where to go. This is often done in the waiting room by a clerk or a guard with little regard for the patient's sensitivity and privacy. One department or room is under-utilised while the other is over-utilised and there is little incentive for personnel in the quieter department to assist in the busier department. Continuity of care is not assured especially if the patient has several health needs. In the end the desirable goal is sacrificed at the altar of efficiency and effectiveness argued Martinson (1997:765-6).

2.4.2 FACTORS INFLUENCING THE SOCIAL ACCESSIBILITY OF HEALTH SERVICES.

Social accessibility means the availability of adequate, well-trained, well

motivated, competent and sensitive personnel for different services with proper support and monitoring structures.

'Nurses lead the way'. Dr. H Mahler, the WHO Director General proposed that nurses would lead the way in PHC because they can provide a wide range of basic PHC services (Stark et al, 1999:273-7). Nurses have a long history of delivering health services to under-served and vulnerable populations. Nurses make up over 50% of the workforce in nearly every country. This percentage rises to 80% in the developing countries (Stark et al 1999:273-7). These nurses have been bringing health services to communities in need and have done much to contribute to the WHO goal of 'Health for all' (Stark et al, 1999:273-7).

The significant contribution made by nurses, midwives and trained community health personnel to healthcare for the poor in developing countries is well known (Robinson & Wharrad, 2000:28-40). Robinson and Wharrad (2000: 28-40) established that high numbers of health personnel correlated with low mortality rates and concluded that improvements in health indicators must be taken forward by countries on a number of fronts.

'Its definitely a two-sided issue, sometimes you can not just win'. Across Canada new telephone health services draw praise for their success in keeping patients from making unnecessary hospital visits (Mashall, 2001:31-5). When Ontario launched its first call-center in 1999 it hired nurses to give advice to anxious patients and caregivers in their homes. Instead of applauding the service, officials from two smaller community hospitals blamed it for luring highly trained bilingual nurses to the organisations, leaving their institutions short-staffed and unable to cope (Mashall, 2001:31-5). Deane, the Regional Health Director observed that no nurse would ever leave her job if conditions were what they should be. After years in a difficult and physical job the nurses saw the call-center work as an attractive alternative. As a result small hospitals in Sturgeon Falls and Mattawa still have vacancies they have been unable to fill (Mashall,

2001:31-5). Buske (2000:1193-6) observed that while many communities did not have specialists living within their boundaries they had access to regular visits from specialists such as radiologist, general surgeons, anaesthetists and psychiatrists who attended to their different health needs.

Personnel providing PHC services are expected to be competent and knowledgeable. Updating of clinical skills and knowledge is paramount in the provision of quality services. Canada has had walk-in centers for over 20 years in its attempt to increase access of health services. However, unlike the UK where walk-in centers, once established will be led by nurses, in Canada they are led by doctors. A survey conducted by Jones (2000:928-31) states that about 74% of users were satisfied and would visit again.

"The stories are getting less amusing, people come in off the streets and stand there waiting to be seen. ... There is a point where you feel very guilty, you feel like you are not fulfilling your mandate as a physician, at the same time you are pulled in the other direction" said Alexiadis in Moulton (2000:1039), whose own patients now wait three weeks for an appointment. In Canada a resource plan is required not to determine the numbers but to determine the needs of the population commented Cloutier in Moulton (2000:1039) who has observed the medical society's efforts in attracting more doctors to go and work in Nova Scotia by making it more attractive through the provision of maternity and parental leave programs for physicians (Moulton, 2000:1039).

Shortages of primary care physicians and allied health professionals have their impact on access particularly in rural areas and inner cities of the USA (Meyer & Naughton, 1995:22-8). Nearly two-thirds of all counties are under-served forcing many lower income people to receive costly and often inappropriate care in hospital emergency rooms as it is the only service available.

"That the population of nursing is aging is well known" (Buerhaus, 1998:105). RN

shortage is looming in the US. Nurses have shifted from clinical to home-based nursing, managed care and the entry point has also decreased. This will soon compound on an already existing mal-distribution in the US making services even more inaccessible to the vulnerable groups. Individuals living in states with a higher ratio of primary care physician to population are more likely to report good health (Shi & Starfield, 2000:541-55). Ferrinho (1995:34-7) has observed that in the USA significant reliance has been placed on nurse practitioners. Public health nurses have assumed an expanded role as co-ordinators of preventive and promotive care and as supervisors of the family health worker.

WHO leaders have concluded that nurses would become resources to people rather than to physicians and that nurses would become leaders of PHC teams (Barnes et al, 1995:7-16). Davidson, Smirnoff, Klein and Burdick (1999:1567-70) found that of particular interest was the patients' satisfaction with providers, referrals and support groups at the clinics. The patients were more satisfied with the nurses than with the doctors. Many patients also indicated satisfaction with medical care and the support of the staff. Almost all of the patients felt confident that they were getting the medical care they needed for their TB and that DOTS would cure them. They also said that the staff wanted them to get better and were willing to help.

Beal and Stein (2000:151-62) noted that satisfaction with sick care was greater among patients with a single source of care and that they felt that their providers were more available. Paine, Lang, Strobino, De Joseph, Declercq, Gagnon, Scupholme and Ross (1999:906-9) found that nurse-midwives make a considerable contribution to care of women in the USA and concluded that optimal use of nurse-midwives may be a valuable component of any effort to improve women's health access and outcomes. Kelly, Buckwalter and Maas (1999:8-14) concluded that for caregivers to provide appropriate knowledgeable care, it is essential that they have access to healthcare resources specifically nursing professionals. As the largest healthcare provider group in the USA,

nurses working in virtually every facet of healthcare shoulder a professional responsibility of getting services to the under-served. This sentiment is shared by O' Grady (2000:88-91) who commented that if health care provision was a baseball team, nurses would be its much valued utility player.

Henderson (2000:6) found that Asian-Americans were most likely to report dissatisfaction with the quality of care provided by their primary physician. They also reported that they would not go to their physician for new problems, preventive healthcare or referrals. This may indicate the inability of the physician to be flexible and sensitive to the needs of the patients.

Diaz M, Simmons, Diaz J, Gonzalez, Makuch and Bossemeyer (1999:1-15) in their study on contraceptive use in Brazil revealed major constraints in the availability of and access to f/p and reproductive health services and a lack of supportive supervision. They recommend intervention strategies focused on training and restructuring of providers' roles, service delivery patterns and the management process to improve the support system of the providers. Geographical distribution of health professionals in Brazil reflects the demographics and the education structure across the country (Csillag, 2000:370). The Brazilian government has recognised that health indicators are good in the areas where there is a high personnel availability per population (Csillag, 2000:370). Healthcare personnel living in urban cities tend to specialize early in their career thereby making it difficult for them to be transferred to rural areas. In its attempt to improve access to providers, Brazil's health ministry launched an ambitious program to send health professionals to municipalities that have limited healthcare resources (Csillag, 2001:370).

"Move over doctor"! The UK reform proposals for PHC sector intend to improve accessibility to healthcare. One of the proposals is to introduce walk-in primary care centers. The intention is to pilot a series of nurse-led centers which can be used on a "drop in basis" providing minor treatment, health information and self-

help advice (Mahony & Downer, 2000:928-31). Nurses can perform a large proportion of the current GP workload. Nurses could substitute GP's in the governments drive to avert a pending GP recruitment and retention crisis (Mahony & Downer, 2000: 928-31)

England now has 19 walk-in centers most open daily from early until late where people can get advice and treatment without appointment (Salvage 2000). Seven are officially nurse led and the Dept. of Health says that all will be run and led by nurses. "That's the point –accessibility. Services close to where I live, work and play are a living exemplar of Health for All" observed Salvage (2000).

De Palma (1997:120-22) in her study on feasibility and effects of nurse run clinics in England found that of 127 patients with epilepsy offered a first time appointment with nurses 83% kept it. 92% of these patients kept a second appointment with the clinic nurse. There was a significantly higher percentage of patient blood levels monitored, medication management, advice given and documentation of advice recorded by the nurse-run clinic in comparison with the physician in the traditional general practice. De Palma (1997:120-22) indicates a need for nurses to assess their impact on patients and their families once they (nurses) venture into new practice areas. This calls for the need to evaluate nursing services.

There are neither enough nurses nor doctors being trained nor the money to pay them (Mahony & Downer, 2000:928-31). In an attempt to make nurses more confident in their work, the Department of Health and Social Security, UK, recommended that there should be a distinct of nurses within the community with a combination of curative, preventive and rehabilitative knowledge and skills (Eaton, 2000:49-56).

Despite the fact that the number of medical graduates has increased, many developed countries still experience professional personnel shortages (Bundred & Levitt, 2001:245-6). These countries recruit from less developed countries and

this causes the mass-migration of physicians to the developed world. A call to all nations relying on doctors from poorer nations to consider how their policies affect the disadvantaged countries was made at the Durban Congress in SA (Bundred & Levitt, 2000:245-6). The UK government has been recruiting nurses from poorer countries, which have nursing shortages of their own they disclosed.

In Netherlands lack of personnel, particularly qualified nurses is an enormous problem (Jansen, 2000:38-9). Operations are canceled at the last minute due to personnel shortages. This lack of efficiency reduces accessible to services. The government in its attempt to improve access to the services has embarked on a campaign to attract nurses from the neighbouring countries (Roel, 2000:38-9).

In Finland the department of Health's major targets were developing PHC to be easily accessible to the total population based on local needs (Koponen et al 1997:41-8). The professional role of the PHC nurse is to promote and maintain health, security and welfare of the individual, family and community (Koponen et al, 1997:41-8). Their training covers all the fields of community nursing: family planning, mother and child health, school and occupation health and home nursing. Finnish nurses in health centers however have problematic relationship with their administrators because of the way the population responsibility principle (community participation) was planned and implemented, without their active involvement (Koponen et al, 1997:41-8).

Meanwhile the Tongan winding road is indeed a winding one. Lewis (1999:24-5) in his article titled: The Tongan winding road observed that doctors at Viola hospital, the only hospital on the Tongan's main island are multipurpose: the doctor can be a surgeon, paediatrician, gynaecologist and physician at the same time. Their salaries compare poorly with the rest of the South Pacific Region and they are lured abroad by the prospect of a higher salary.

Stark, et al (1999:273-7) argue that one of the principles of healthcare ethics is

justice and that justice is an expression of equity. Nurses in developing countries have led the way in bringing essential services to poor rural communities without adequate preparation for this role. Justice requires that patients should receive safe healthcare and that nurses should receive appropriate education. In this regard justice will only be served if nurses' programs are accessible to them in the areas where the need is the greatest.

A better understanding of provider behaviour is an important key in the design of training, supervision and logistic systems that maximise access and quality of care. Stanback (2001:37-42) found that in Ghana, f/p providers showed inadequate technical knowledge of the precautions against and side effects of modern contraceptive methods. Moreover the providers' lack of knowledge resulted in imposing their personal values and mistrust and restricting their clients' access to free choice of contraceptive method. Stanback (2001:37-42) states that Ghana's new protocols and standards for reproductive health services training should address these restrictive practices.

Many Ugandan doctors are poorly paid and leave for other parts of the world including SA where one of the medical schools has several senior faculty members from Uganda (Bundred & Levitt, 2001:245-6). This has left Uganda with a doctor population ratio of one to 24,000 compared to one to 3,000 in SA (Jones, 1999:112-4) making services more inaccessible there.

Since the Tanzanian government implemented its national population policy in 1992, the situation has changed dramatically. The number of health providers in government facilities who have received formal training in f/p has increased fourfold (Speizer, Hotchkiss, Magnani, Hubbard & Nelson 2000:13-22). However the fact that the doctors and nurses are located in primary hospitals restricts the availability of IUDs and implants in health centers and dispensaries (Speizer et al, 2000:13-22).

The WHO estimates that the Zambian Health System needs 1500 doctors. The

only medical school in Zambia- Lusaka has trained more than 600 doctors, but of these only 50 work in the Zambian Public Health Sector (Bundred & Levitt, 2001:245-6).

The Norms and Standards for the delivery of PHC services in SA, recommends that PHC clinics should receive scheduled support-monitoring visits at least once a month to support personnel, monitor the quality of services and identify the needs and priorities and that a record of these should be kept (Dept. of Health (2000). The clinic should have at least one member of staff who has completed a recognised PHC course. Doctors and other specialized professionals should be accessible through communication, for consultation, support and referral and provide periodic visits. Clinic managers should receive training in facilitation skills and PHC. Clinic personnel should be able to follow the disease management protocols and standard treatment guidelines and provide compassionate counseling that is sensitive to the patient's culture and social circumstances. Staff should be positive in their approach to patients, evaluate their needs, correct misinformation and give each patient a feeling of always being welcome. Patients should be treated with courtesy in a client-oriented manner to reduce the emotional barriers to access of health facility and prevent the breakdown in communication between patients and staff. Job descriptions for each staff category should be available in the clinic. Service tasks not carried out due to lack of skills should be identified and new training sought. In-service training should take place on a regular basis.

The extent to which poor countries are losing doctors to more affluent nations is obvious. SA has 600 of its medical graduates registered in New Zealand (Bundred & Levitt, 2001:245-6). A medical qualification is just another commodity on the market. Why should doctors not be free to go where they think they can get the quality of life they want? This migration has caused SA to recruit doctors from Cuba four years ago. In the description of the South African Medical Journal this is a "medical carousel" in which doctors seem to be continually moving to

other countries with a perceived higher standard of living. Pakistan doctors move to the UK, UK doctors move to Canada and Canadians move to the USA (Bundred & Levitt, 2001:245-6). The preferred destinations for South African medical personnel who emigrate are Australia, the UK, the USA and Canada (Jones, 1999a:18-9). A total of 369 GP's and specialists have left the country between 1994 and 1998 says Jones (1999a:18-9). According to Star News (2000:1) a total of 300 nurses leave SA every month to work in other countries. Jones (1999b: 112-4) also observed that personnel in SA are unequally distributed. Just more than 35% of the PHC clinics have at least one full time PHC nurse and more than 93% at least one professional nurse, while 40% had community health workers.

During 1998 an estimated 235 292 personnel were deployed in the public health sector, with 20% KwaZulu-Natal, 20 % in Gauteng and only 2% in the Northern Cape (Jones, 1999b:112-4). While the national health personnel - population ratio was an average of 77-10 000, KwaZulu-Natal's ratio was 77,4-10 000, Gauteng's ratio was 108,3-10 000 and 63,4-10 000 in the Northern Cape (Jones, 1999b:112-4). These varied ratios show the inequity in personnel distribution in the country. Pulse Track and MASA Media Scan compilations (1998:526) indicated that Mpumalanga and the Northern Province have the lowest proportions of doctors at one per 13 099 and 11 195 population respectively. Gauteng and the Western Cape have the highest ratio at one per 2067 and 2256. The compilations (1998:526) also indicate that more than 2,500 doctors who have graduated from Wits University during the past 35 years have migrated.

Herbst, Coetzer, Human and du Plessis (1997:89-92), found that in the Southern region of the Northern Province 97% of the patients were satisfied with the treatment received at the clinics. However nursing staff productivity measured low in terms of number of patients seen per day. On average, the nurses were seeing 14 patients per day per nurse when the expected maximum figure is 40 per day (Herbst et al, 1997:89-92).

PHC clinics should have adequate well-trained personnel to provide essential services (David & Hopkins, 1999:40). But Thipanyama and Mavundla (1998:27-31) found that PHC services were inaccessible in the 2 rural districts of the Eastern Province as the nurses felt that the workload at the clinic was heavy and there are personnel shortages. In this Province, the estimated shortage of 148 nurses has led to just 900 of the 1200 beds in Cecilia Makiwane hospital in Mdatsane being in use (Bateman, 2000:672-4). Eight wards stand empty because only 430 of the 660 beds in Port Elizabeth provincial hospital are in use and supervisory clinic inspections happen three times a year at best, disclosed Bateman (2000:672-4).

Jackson (1997:771) revealed some alarming figures of doctor shortages in the Eastern Cape, the authorities have admitted to some 800 vacant posts. He believes that the number could have been as high as 1600 and personnel turnover in the province was very high at an average of every six to 12 months.

Although the training of midwives to provide abortion services in SA was aimed at decentralising services from hospitals to PHC facilities and to increase accessibility of these services, some women have to go from one clinic to another to find a sympathetic health worker who would give a referral letter' while others are subjected to the provider's personal opinion about abortion (Varkey, 2000:87-9). Some of the midwives who provide these services feel that they are being alienated and not supported because of their colleagues attitudes. These judgmental attitudes affect those who want to use the services. The willing providers have to bear the brunt of understaffed services and an environment devoid of support (Varkey, 2000:87-9). Eggertson (2001:847-9) observed a similar situation in Canada. Varkey (2000:87-9) recommends that abortion must be de-stigmatized and a strategy be incorporated which will ensure a large cadre of technically capable and responsive personnel.

Management should build staff capacity through identification of staff potential, develop rational staff development plans, create more training opportunities, give bursaries and leave to staff interested in further studies and proper staff placement after training (Fonn et al, 1998:697-702). They also recommended that health workers should make use of existing opportunities, participate actively in training sessions / workshops and use information taught during in-service sessions.

2.4.3 FACTORS INFLUENCING THE PHYSICAL ACCESSIBILITY OF HEALTH SERVICES

Physical accessibility means availability of enough room, medicine and equipment. Provision of adequate and appropriate resources facilitates efficiency in the provision of the services and the subsequent access to the services by the people.

Access to healthcare resources is intricately linked with fairness, which involves equitable allocation of resource and care options according to the needs. Miller in Sword (1999:1170-7) noted that a number of factors including inadequate resources affected the success of a pre-natal program for the socio-economically disadvantaged in Canada. Sword (1999:1170-7) then warned that the provision of fragmented, unco-ordinated care and lack of resources for outreach programs were barriers to pre-natal care.

Clear information about and timely access to resources is important to improve access to services. Acquiring equipment and other resources is important in the care of sick children (Eaton, 1999:49-56). Lengthy processes to get equipment is a hassle and time-consuming, and the needed care is delayed. Owen-Davis (2001:628-31) observed that there is a need for major structural changes in the North Korean system, the hospital freezes during winter and has cracked windows. Devoid of modern equipment, surgical operations are done in a

'Spartan' way because of lack of medical supplies including anaesthetics and equipment in the hospital making services more unacceptable and therefore inaccessible to the people intended for.

Lewis (1999:24-5) reports that PHC at Tongatapu, the main island of Tonga, is provided through the Outpatient Department of Viola, the only hospital on the island. The department has only one thermometer which may indicate that not all patients are examined properly for a better outcome of their condition. Even though they have a laboratory, blood tests such as thyroid function have to be sent to New Zealand. Doctors at Viola hospital sleep in their cars at the car park when they are on call because there is no accommodation for them (Lewis, 1999:24-5).

The situation in Tanzania has improved since the implementation of the National Population Policy. There is a regular availability of multiple contraceptive methods and government PHC facilities (Speizer et al, 2000:13-22). However, stock unavailability is a common problem especially in hospitals and health centers, there are also gaps in availability of equipment such as lamps, needles and speculums from facility to facility. This may limit access to the services (Speizer et al, 2001:13-22).

With the new political dispensation, Malawi has had to make sacrifices, and unfortunately also in its health system. Most facilities have not been adequately maintained and are in a state of disrepair with no basic communication system or appropriate equipment (National Health Plan, 1999-2004). Patients are sometimes asked to buy their own supplies to have an elective surgery done. 'stock outs' has become the personnel's morning hymn, waiting and hoping for an aid their 'devotional prayer'. The Malawian road is indeed as winding as the Tongan.

The Norms and Standards for the delivery of PHC services in SA (Dept. of

Health, 2000) recommend that a PHC clinic should have enough rooms for the type of services it provides, standard treatment guidelines, an essential drug list manual, relevant national and provincial health related circulars, policy documents, acts and protocols that impact service delivery. Clinics should have enough equipment in good working order, enough medicines and supplies locked in a safe room. Clinics should provide comprehensive security services to protect the property and ensure the safety of all people at all times. The clinic should be able to arrange for emergency transport within an hour and must have a working telephone or radio.

Jones (1999b:112-4) reports that more than two-thirds of SA's PHC clinics do not have uninterrupted electricity and water supply and a functioning telephone. The worst off in terms of the consistency of supply is the Eastern Cape (Jones 1999b:112-4). Eight of the 17 clinics that serve 500,000 people in the Umtata district had faulty stethoscopes or inaccurate blood pressure cuffs, faulty scales, no phones or electricity, and unusable two way radio equipment (Bateman, 2000:672-4). Drug refrigerators worked on gas when gas was delivered. Forty mobile health unit stations around Umtata did not functioning because their bus broke down and once fixed, is booked for use by Umtata hospital (Bateman, 2000:672-4).

Fonn et al (1998:697-702) report that for a significant number of clinics in SA, basic infrastructure does not meet acceptable standards and in two provinces 50% or more of the clinics are in need of major repair. Poor electrification and inadequate or unreliable water supply means that sterilization of equipment is problematic and that deliveries at night have to be conducted in sub-optimal lighting which poses a greater risk to unsafe deliveries.

In the Northern Province 30% of clinics have a drug-supply system, but only 27% of the clinics have no problems with drug-supply (Fonn et al, 1998;697-702). 63% of the clinics in the province do not have oxytoxics. Pethidine, the drug of choice

for pain relief during labour in SA and the drug the midwives are licensed to prescribe, was only available in five percent of the clinics surveyed. Equipment supplies have improved but are still inadequate. The vast majority of clinics had baumanometers but not all were in good working order and the turn-around time for repair of equipment ranges from two weeks to months, with equipment often lost in the system and not returned at all. Seventy seven percent of clinics surveyed had no transport available for referral purposes (Fonn et al, 1998:697-702).

Fonn et al (1008:697-702) found that the staff of more than a third of PHC clinics rated lack of equipment, drugs and inadequate facilities as the worst thing about their jobs. Fonn et al (1998:697-702) recommended that management should increase budget, introduce a regular maintenance system, update dispensary and store management systems, provide generators / solar power where electricity is frequently interrupted and distribute drugs according to the clinic's needs and not a standard list. Health workers should use drugs before they expire and prescribe appropriately.

Fonn et al (1998:697-702) revealed that only 27% of the clinics in the Northern Province have no problems with drug supply. The majority of the clinics had baumanometers but not all were in good working condition and the turn around time for repair of equipment was reported to have ranged from 2 weeks to months with equipment often getting lost in the system. Seventy seven percent of clinics surveyed had no transport available for referral purposes.

Lack of material resources and inadequate security system led to an under-utilisation of a midwifery obstetric unit in one of the Eastern Gauteng's metropol area, SA (Mashazi and Roos, 1999:98-106). They discovered that mothers were not using the services because the facility was perceived as of lower status due to the lack of equipment and they did not want their babies to be born in a lower-class facility. They also feared for the safety of their babies and themselves

because they felt that the guard was not equipped provide optimal protection.

Pulse Track and MASA Media (1998:526) state that the Greater Johannesburg currently has six ambulances and response cars serving the city where as it should have about ten times that number. This may indicate possible inefficiency in response to emergencies.

2.4.4 FACTORS INFLUENCING THE GEOGRAPHICAL ACCESSIBILITY OF HEALTH SERVICES.

Geographical accessibility means the distance to and from the clinic, traveling time and means of transport are acceptable and afforded by the community.

More than 13 years after abortion became legal in Canada, access to abortion is becoming more and more restricted across the country. "Ironically, it seems to be getting worse rather than better since the Morgentaler decision in 1988" complained Wilson, director of the Canadian Abortion Rights Action League in Ottawa. "There are a number of barriers and the number is increasing" (Eggertson, 2001:847-9). The availability of abortion services in Canada now depends on the woman's location and the size of her pocket book. "There are huge discrepancies in the availability of reproductive services, including abortion from province to province" commented Jackman a constitutional professor at the University of Ottawa. "I can not think of another medically necessary service that is so inaccessible" (Eggertson, 2001:847-9).

Magilvy, Congdon, Martinez, Davis and Averill (2000:171-81) observed that many rural Americans find access to healthcare a serious problem because of distance and lack of transport, mal-distribution of healthcare providers and facilities and lack of resources. This inaccessibility problems has resulted in Hispanic elders to seek care at higher level of need and therefore in greater need of long-term care services than did the population at large.

Understanding how transportation works to facilitate or inhibit access to goods and services is vital to addressing the societal needs of today. "Most of us do not use transportation for the sake of transportation itself but rather to gain access to our jobs, schooling, medical care and recreation. We are dependent on it and when it is not available the quality of life is affected" (McCray, 2000:17-30). He also states that transportation could be a problematic issue due to cost, unreliable bus schedules, long travel times, bad weather conditions and safety at bus stops. Some African-American women from the central area of Detroit related stories of family members being attacked and were in agreement on routes considered to be the most dangerous due to conditions at bus stops. "Sometimes you did not have enough money to get there, or just did not want the hassle of catching 2 buses or walking that long walk or waiting for the bus" complained the participants (McCray, 2000:17-30). Access is a complex issue that greatly affects health care utilisation. The author argues that physical distance is an important measure of healthcare utilisation and is affected by the costs associated with transportation. Transportation and safety become a deciding factor determining whether or not the healthcare facility is accessible.

Meyer and Naughton (1995:22-80) shares McCray's (2000:17-30) sentiments when they found that in Fairfax County, Virginia, USA, the main reason for people not accessing mental health services was because of transport. Few public routes feed into the area and its wide catchment area compounds the problem. Some people in this area miss their lessons due to lack of childcare, making many volunteers spend time baby-sitting at the expense of other tasks.

Less developed countries could follow Oman's example (Ashraf, 2000:2223). Oman ranked 10th out of the 191 countries in the WHO's comparison of global healthcare systems and yet in 1970 Oman's healthcare system was very poor with a child mortality rate of 230/1000. To transform their health indicators, the government invested in health infrastructure thereby increasing geographical

accessibility to health services to the people where they live, work and play.

In Morocco; Steele et al (1999:28-38) found that the presence of a nearby public PHC center was associated with a higher acceptance of modern methods after birth and lower method failure rates. The presence of a pharmacy was associated with lower discontinuation due to side effects or health concerns (Steele et al, 1999:28-38). They concluded that geographical accessibility can improve utilisation and therefore quality of f/p.

The role of access to quality PHC services has long been of interest to program managers and policy makers. Despite this the relative importance of supply versus demand factors in PHC services, remains an area of concern. In Malawi there is low geographical access with only 46% of the population living within the 5km radius of a health facility (Health Information System, 1996). The facilities are inequitably distributed. In some areas health facilities are close to each other, in some areas are very far from each other and in some areas there are none (National Health Plan, 1999-2004).

In SA, geographical access is measured by the proportion of people living within 5km of a clinic (Dept. of Health, 2000). The Norms and Standards for the delivery of PHC services stipulates that clinic personnel are expected to map the clinic catchment area and draw specific and achievable objectives using the national, provincial and district goals and objectives as a framework. The planning and implementation is district focused and community-based where healthcare workers are familiar with their catchment area population profile, health problems and needs and use data collected at clinic level for this purpose.

With a population of 5,7 million children under the age of 5 years, SA's infant mortality rate is at 61 deaths per 1000 children. As in the developing world, the major causes of death are gastro-enteritis, pneumonia and malnutrition (Gie & Kling, 1997:1093-4). They argue that to reduce this mortality rate a multifaceted

approach with emphasis on PHC is required. Bringing healthcare to within 5 km of each person is certainly the most effective way of reducing the infant mortality. They also state that it has been shown that early resuscitation and rapid transport of critically ill children result in lower rates of mortality.

Thipanyama and Mavundla (1998: 27-31) state that services in two rural districts of the Eastern Cape Province were not geographically accessible as the majority of the people live in a radius of 6-20km from service points. This problem is compounded by a dysfunctional and inadequate transport system especially in the north-eastern rural areas of the former Transkei, which seriously affects the running of the clinics as nurses find themselves hitch-hike lifts with goods delivery vans and their working hours are therefore regulated by this (Bateman, 2000:672-4). In contrast Diale and Roos (1999:136-41) found that in a predominantly black metropolitan area services were geographically accessible as most of the people live within the 5km radius.

Richter (2000:76-81) found that pupils in Hammanskraal, North of Pretoria wanted the services to be within easy reach, that is services should be located at their school, in the clinic or the community center within their community.

2.4.5 FACTORS INFLUENCING THE ACCEPTABILITY OF HEALTH SERVICES.

Acceptable means a level and type of healthcare that is flexible, culturally sensitive, applicable and is welcomed by both the providers and the people it is intended for.

Services, which are flexible and sensitive to the needs of the people they are intended for, are required to ensure access for all people. Nursing lacks the diversity needed to effectively provide services to a populace of increasing ethnic variety observed Malone (Gonzalez, Gooden & Porter, 2000:56-7) a former American Nursing Association president.

People must realise that all cultures have their own 'ideal' and practical norms and lifestyles that they cannot or will not change without thoughtful consideration. Leininger (1997:33) argues that nurses of the 21st century should acquire trans-cultural knowledge in order to overcome cultural ignorance, ethnocentrism, cultural imposition and racism in their practices. Cultural competence is a critical factor in providing relevant health services to the growing culturally diverse patient population (Campinha-Bacote & Langenkamp, 1996:59). For it is culture that determines what we shall eat, how our food shall be prepared, how we shall rear our children, what language we shall speak and in general how we shall live our lives when we are healthy and when we are sick.

Culturally competent care is a critical issue that is too often overlooked and neglected in promoting access to healthcare for Hispanic women (Juarbe, 1995:23). Providing culturally competent care means being sensitive to issues related to culture, race, gender, and sexual orientation. It is the type of care provided by the nurses who use cross-cultural nursing theory, models and research principles in identifying healthcare needs and in providing and evaluating the care provided within the cultural context of the client (Juarbe, 1995:23). Lack of such skills in nurses can lead to misconceptions, non-utilisation and non-compliance as services become more and more unacceptable to the people. For utilisation behaviour is inherently related to the issue of acceptability among others (Sword, 1999:1170). Nurses must be prepared to be competent to provide congruent care to the global world. Leininger (1997:54) foresees an evolving body of trans-cultural humanistic and scientific knowledge and practices becoming a necessity in the 21st century as the world becomes more multi-culturally diverse and intense.

Alant (1998:17-18) states that socio-cultural understanding also refers to sensitivity towards the perceptions and attitudes of the community towards the services. One of today's healthcare challenges is meeting the healthcare needs

of clients from diverse populations in a culturally accepted way (Fongwa, 2000:291). Patient satisfaction as an outcome of care is related to a patient's perceptions of the quality of care received.

In Canada, Eggertson (2001:847-9) observed that many doctors refuse to provide abortions or to publicise that they do for fear of reprisals. Canadian physicians who perform abortions have been shot or seriously wounded by unknown assailants. "It takes a lot of courage, really to say I'm going to be an abortion provider these days" complains Morgentaler, whose Toronto clinic was bombed in 1992.

The growing diversity of the nation's urban areas and statistics concerning race / ethnicity and healthcare outcomes support the need for health professionals to understand the characteristics of these populations, to identify effective ways to deliver services and to focus on health beliefs, customs, attitudes, behaviours and perceptions that affect their willingness to seek and continue in treatment. These changes will also require healthcare organisations to more directly incorporate community perspectives in their health programs (Andrullis, 2000:858-62). In the USA many rural elders find access to healthcare a serious problem and for the rural ethnic minority populations such as Hispanics, language, cultural and economical barriers further compound the problem (Magilvy et al, 2000:512-9). The cultural aspect of healthcare is an important and influential variable to consider when providing nursing care to individuals from diverse cultural backgrounds. "For culture is tightly interwoven into the life of man and continually pervades his thinking, actions and feelings particularly his health state" (Campinha-Bakote, 1996:59-63).

Cousine (1997:70-82) states that eliminating or reducing restrictions on the use of programs for the homeless, and eliminating cultural and language barriers, will encourage voluntary participation in existing health, shelter and substance abuse treatment programs thereby making services more acceptable to the people.

It is estimated that more than 360,000,000 crossings occur every year along the 2 000-mile US - Mexico border. This presents unique challenges to healthcare providers on both sides of the border (Macias & Morales, 2001:77-87). The health systems of both countries are increasingly connected by shared populations that flow back and forth across the border. In Mexico, 63% of those seeking dental care preferred receiving it there. Individuals crossing the border were more likely to turn to those health services that are most accessible or culturally acceptable to them (Macias & Morales, 2001:77-87). Respondents may perceive medical care in Mexico inferior to that of US but still acceptable.

An extensive body of literature has demonstrated that insurance coverage, family income, race and ethnicity among other factors influence healthcare access and use by children. Few studies have examined these issues with respect to children's special healthcare needs and those that did have relied on data collected during the 80s. Fresh thinking led Newacheck, McManus, Fox Hung and Halfon (2000:760-6) to investigate the role of health insurance in access to care and use of services by children with special healthcare needs. The study revealed that non-financial barriers, such as language and culture, may also interfere with access. More-over, immigrant families often find it difficult to negotiate complex public insurance eligibility and enrollment processes. Weinick & Krauss, (2000:26) commented that this marked Hispanic disadvantage in access to care may be related to language ability and characteristics associated with being a non-English speaker, including differing knowledge of and beliefs about the healthcare system and primary care. This implies the need for interpreters and bilingual healthcare providers to meet the needs of children whose parents are not comfortable interacting with the healthcare system in English.

Henderson (2000:6) notes that the insured minorities, particularly Hispanics and Asian-Americans also face obstacles to healthcare. They frequently go without

the needed care and lack the assurance that family members could get necessary care. Nearly one third of Hispanics in the study reported a lack of usual source of care (either a clinic or a physician). They were also twice as likely to report long waits for care and that their provider failed to listen to them and provide them with needed information. Services that are inflexible and insensitive to the users' needs hinder access.

Research has indicated that ethnic similarity between client and clinician enhances the ability to identify cultural modes of expressing symptoms, to comprehend the meanings associated with particular experiences, and to understand linguistic variation in thought and expression (Malgady & Zayas, 2001:39-49). Hispanics represent the second largest minority group in the USA. Cantor and Shankar (2000:125-34) conducted a study among immigrants from El Salvador, 83% indicated a preference for a Spanish-speaking provider although they could speak English. The authors concluded that lack of Spanish speaking providers posed as a barrier for Hispanics to access health services. Snyder, Cunningham, Nakazono and Heys (2000:196-216) recommend better training for providers in cultural sensitivity to reduce barriers. They also recommended for translation services, which may play an important role in making services more acceptable. Developing appropriate, acceptable and culturally congruent healthcare services is a goal in culturally diverse community-based healthcare settings (Magilvy et al, 2000:171-81).

Accessible services should be welcomed by both providers and users. Meanwhile rural areas continue to struggle with issues such as the dwindling supply of PHC providers who are wooed by big city health plans, (Williams, 1995: 11-2). On the other hand the HMO's (Health Maintenance Organisation) find that patients will not accept constant cost cutting and restrictions on choice. Patients welcome models that push insurers into the background, give patients greater choice and permit medical practitioners to play a more powerful and innovative role (Kuijten, Leerink & Winsemius, 2000:12-6). This would make services more

acceptable to the people intended for.

“Evidently, despite Americans willingness to say they are “satisfied” with their healthcare plans, they harbor a lot of worries about the future, about treatment that could be denied them, about costs that could ruin them, and about loss of coverage, and that is unacceptable” says Texeira (2000:581).

The provision of services in a flexible manner increases the acceptability level of those services by the users. In the United Kingdom, children’s community nursing services have slowly become recognised as an important component in the care of sick children (Eaton, 2000:49-56). Parents whose children have oncological problems were asked how they perceived home visits. They said that the nurses seemed prepared to be flexible in the frequency of their visits thereby making services more acceptable (Eaton, 2000:49-56).

Lundberg (1999:31) in her study on Thai immigrant women in Sweden, observed that nurses and other health professionals need to understand the meaning of health for these women in order to help them negotiate a beneficial health outcome and to re-order their lifestyles for new, different and beneficial healthcare patterns while respecting their cultural values and beliefs. This implies the need for provision of culture-sensitive services in order to make services more acceptable by the users.

Systems that are not flexible or sensitive enough to meet the needs of its users and wishes of the providers are not welcomed. In Netherlands; Kuijten et al (2000:12-6) noted that the ageing population has put pressure on the budget on one hand and on the other hand the public is demanding modern treatment and they no longer accept the usual impersonal care and long waiting list. In the long run the system is paying too much attention to short-term curative care and too little to prevention to cope. This unacceptable system frustrates the dynamic healthcare practitioners who leave the system for other more challenging

opportunities.

Seton-Brown (1999:30-1) noted that the indigent Maori people of New Zealand have the poorest health because of poor access and culturally lacking health services. Of interest is that a program which involves local grandmothers in health promotion has produced significant results and the rate of immunisations has improved dramatically. By using local grandmothers who have firsthand knowledge of issues that the people have on daily basis, the services were made accessible to the people. Thus the people culturally followed in their "grandmothers' footsteps" in accessing the health services (Seton-Brown, 1999:30-1). Healthcare decisions must be firmly embedded in local cultures and moral traditions (Po-wah, 1999:571).

Messages unacceptable in their initial wording, could when reworded constitute a response in line with people's concerns hence making the message more acceptable. Efforts made in Rwanda to get people to accept modern birth spacing were divorced from the pre-occupations of the rural people who did not feel concerned (Van Balen & Van Dormael, 1999:313-27). However after listening to some Rwandese women, professionals realised that their desire to space out births was real but it was linked to their desire for a 'full term' child. According to the women, the mother-child relationship included an intra-abdominal pregnancy followed by an 'external pregnancy'. The sheepskin in which the mother carried her newborn on her back, is synonym to the placenta inside the womb. When the foetus move it means that it is suckling at the 'internal breasts' and after delivery the baby moves from her mother's womb 'internal pregnancy' to her back 'external pregnancy' and the mother continues to nurse it with her external breasts. If she had to stop nursing before 2 years the the child was somehow born prematurely. It was therefore understandable that contraceptives presented as a means of ensuring that the child borne on the back could be carried through to term became very acceptable in the system of traditional values (Van Balen & Van Dormael, 1999:313-27). Through this women

were enabled to access f/p services.

Understanding f/p provider practice is fundamental to designing training, supervision and logistics systems that maximise clients access and quality of care. Stanback (2001:37-42) conducted a situation analysis to examine the reason behind f/p providers' restricting clients' access to services in Ghana. He found that clients were unnecessarily restricted in terms of age, parity, marital status, spouse consent and that unnecessary laboratory tests that impede access to services were performed. He concluded that while protecting clients' health is an admirable goal, providers who lack technical knowledge of contraception, may exaggerate the dangers of various methods. In seeking to impose their personal morals on clients, providers violate clients' rights and make the services inaccessible. Speizer, Hotchkiss, Magneni, Hubbard and Nelson (2000:13-22) shares Stanback's views when they found that in Tanzania asking all non-menstruating clients to delay adopting contraceptives could reduce the acceptance rate because of cost and inconvenience. They argued that requiring a woman to wait until her next menses before receiving the contraceptive was a barrier. They pointed out that these barriers, which are imposed by individual providers with neither government policy endorsement nor valid medical justification, is unacceptable as it serves to restrict access to contraceptives.

The Norms and Standards for the delivery of PHC services in SA (Dept. of Health, 2000) indicates that acceptable PHC services should have strong links, with the community, civic organisations, political leaders, ward counselors, schools and workplaces within their catchment area for effective collaboration. There must be a functioning community health committee that is well sensitised and supports the clinic. The community's perception of services should be tested at least twice a year through patient interviews or anonymous patient questionnaires.

The introduction of the National Health Policy brought about changes, which

necessitated the availability of midwifery and obstetrical units in the previously disadvantaged communities. In Eastern Gauteng a unit was built in 1996 but mothers were still traveling to hospital for deliveries which threatened the unit's sustainability. This led Mashazi and Roos (2000:98-106) to investigate the matter. The authors found out that the under-utilisation was due to a lack of both material and personnel resources, which reduced the status of the services. The security measures were insufficient and mothers feared for their lives and their newborn babies' safety. There was a lack of ownership by the community due to uninvolved involvement and the nurses had poor communication skills. These factors made services unacceptable and therefore not accessible.

The tenth anniversary of the WHO's 'Safe Motherhood' initiative was celebrated in 1998 and the organisation used that opportunity to assess its gains, strengths and weaknesses (Fonn et al 1998:697-702). SA took some bold steps to address maternal health services by introducing free healthcare for pregnant women and children under 5-years old. Fonn et al (1998:697-702) found that the most common aspect of maternal health services is the way in which health service staff treat patients. The patients claimed that nurses instigate each other to scold and insult them. They claimed that mothers deliver without assistance and nurses leave them alone and go to sleep. As a result they (mothers) choose to deliver at home because they are treated badly at the hospital or clinic. The mothers described acceptable services as being treated with dignity and respect, that the nurses should be close to them and check the baby's condition and explain the progress of their labour to them.

Growing awareness of the unmet demands for contraception in cities, in developing countries has directed research towards the accessibility and quality of services (Bachman, Mtwazi & Barron, 1996:34-40). They noted that attendance statistics increased when teenage f/p services were being provided in small several clinics. This meant that previous low teenage uptake in the large health center suggested a stigma of publicly queuing for contraception - an

avoidable barrier to access. This was confirmed with young clients in informal discussion with nurses. The researchers observed that the provision of contraception by male staff might make services more acceptable to males and thus increase access.

Diale and Roos (2000:136-141) in their study on sexually transmitted diseases among the teenagers noted in their findings that the services were unacceptable to teenagers because the clinic did not offer confidentiality and did not involve the teenagers. They were treated like children and the nurses projected themselves, as 'smarter, more educated and better'. Richter (2000:76-81) found that adolescents preferred to be served in the language of their choice. If services are to be accessible they should be offered in a welcomed and applicable manner.

Free healthcare to pregnant women was introduced as one of the principal health priorities in the National Health Plan of SA (ANC, 1994a). Chiawelo clinic is a typical Soweto community health center serving about 150,000. Bachman (1997:31-5) noted that the women in this clinic appear to understand the value of antenatal care but appear to be unaware or unwilling to avail themselves of the benefits of services like syphilis screening, accurate gestational dating and potential for prenatal diagnosis. She observed that the clinic is well utilised by low risk mothers and is not bypassed in preference of the high-tech Baragwanath hospital. She adds that Chiawelo offers a reasonable model for South African urban health planners who need to render access to quality perinatal care. It is clear that while some services are accepted by the community there are still some that are rejected.

Utilisation of PHC services in Alexandra is a concern to providers as patient attendance is declining (Ferrinho & Phakathi, 1995:57). Ferrinho and Phakathi (1995:57) in their study on patient attendance since 1930 in the only NGO health center in the Alexandra revealed that patient attendance is declining. The authors then recommended the exploration of determinants of utilisation of care in the

area.

2.4.6 FACTORS INFLUENCING THE FINANCIAL ACCESSIBILITY OF HEALTH SERVICES.

Financial accessibility means both the community and the country can afford the services

In the USA the majority of the population (approximately 74%) is covered by private health insurance. The insurance premiums are paid either by employers or arranged individually (Nhs,1999 in Bibeau et al 1996: 93-116). It is estimated that approximately 50 million Americans are underinsured (Bibeau et al, 1996:93-116). Two public schemes cover the majority of those who are unable to have insurance, Medicare for the elderly and Medicaid for the poor. The schemes cover preventive, acute and long-term services for about 25 million people. This program is jointly financed by the Federal and State Governments (Nhs1999 in Bibeau et al 1996:93-116).

Based on firsthand knowledge most nurses reject the myth that people without health insurance still get the healthcare they need (O'Grady, 2000:88-91). Almost every nurse sees the effect that lack of health insurance has on individuals, families and communities. "The absence or postponement of preventive and secondary care makes late intervention costly in both human and financial terms", (O'Grady, 2000:88-91).

The 1998, USA census bureau report's on the statistics of uninsured gripped the nation's attention and positioned access to healthcare as a major priority issue for the 2000 presidential and congressional elections (Bureau of the Census, 1998). Between 1997 and 1998 the uninsured increased by one million to 44.3 million people and out of those, 1.1 million are children and 12 million are women of childbearing age. In the absence of solutions; the uninsured number is projected to grow to 55 million in 10 years time (Bureau of the Census, 1998).

Despite the clear importance of the health insurance many children with special healthcare needs are uninsured in America. This means that many children lack the assurance of getting the necessary care. Newacheck, et al (2000:760-6) revealed uninsured children were more likely to have unmet healthcare needs and one in every four children did not see a physician in the year before the study. The authors concluded that insurance is a critical determinant of access to care and use of services by children with special healthcare needs.

Patients' rights are once again a hot topic of discussion and debate in Washington D.C, claims Faris (2001:186-7) in his article titled: The rest of the story. However few are looking at the rest of the story: that patients' rights legislation will increase the cost of health insurance. Studies have shown that for every 1% increase in costs as many as 3000,000 people loose their coverage. Its an economical reality , the more something costs the fewer people will be able to purchase it lamented Faris (2001:186-7) and that is the rest of the story.

Access to PHC services for indigent citizens presents a dilemma for many communities in the USA as the established patterns of health service delivery do not address the needs of the low-income groups (Bibeau et al, 1996:93-116). The poor and uninsured in these communities often receive medical care in hospital emergency rooms or county health department clinics, facilities typically not organised for continuity of patient care (Bibeau et al, 996:93-116). This has special impact for the disadvantaged who seek medical care later and in worse condition than the advantaged insured.

An investigation conducted in the USA to determine the healthcare resources and perceived barriers to care of families attending free vaccine fairs (Hambridge et al, 1999:158-63), reported that both families with and without health insurance cited the free vaccines as the most important reason for attending the vaccine fair. This shows that cost is the most important determining factor to access, whether they have insurance or not.

Accessible health services should be afforded by both the country and the community. Guatemala, one of the poorest Latin America countries experiences some of the highest maternal and infant mortality rates in the region (Glei & Goldman 2000:5-22). Here ethnicity plays a major role in the distribution of resources. Inaccessibility of health services has resulted in under-utilisation of the healthcare services. Studies conducted in Guatemala suggest that access to formal services by pregnant women is hampered by financial constraints and compounded by long distances and lack of suitable transportation. Even though health centers charge very low fees for services transportation costs may make the services unaffordable and inaccessible to the people intended for (Glei & Goldman 2000:5-22).

The Finnish healthcare system is decentralised. Municipalities through government grants are the major funders and providers of healthcare. The central government also allocates money from the National Health Insurance System to cover the cost of drugs and earmark funds for large- and medium-sized provincial projects (Koivusalo, 1999:1198-2000). Koivusalo states that during the 1990's state subsidies to municipalities have reduced and municipalities have gained fewer resources from the national budget. Less resources means fewer people will be provided for and less access to health services.

Universal access to health by making the services free at user point in Catalonia, Spain, appears to enhance the use of services among children with health needs regardless of socio-economic characteristics. Rajmil, Starfield, Placencia and Segura (1998:771-91) in comparing the Spanish system with the developed countries such as the USA, UK and Canada; found that in the USA, needy lower income children receive fewer services than their more socio-economically advantaged peers. In the UK, which has universal access and strong PHC orientation, use of health services is greater among those children who have

greater needs and morbidity i.e. the economically disadvantaged. In Canada, which has universal access with moderate PHC orientation, morbidity is also the main determining factor in the use of health services (Rajmil et al, 1998:771-91). In their conclusion Rajmil et al (1998:771-91) commented that the ease of access to health services and its relationship to the need for care in Catalonia, could have an important impact on the level of health in children.

Services must be provided in consideration of the socio-economical needs and capabilities of the individual countries (WHO, 1978). Users of Hong Kong's public hospitals (which provides 92% of health services) pay only 3% of the average cost of the services. Exemption from payment can also be granted to those with financial difficulties to ensure equity in access to healthcare (Ho-mum, 1999:624-37). The Harvard Report of 1999 proposed a full subsidy for the unemployed, welfare recipients, those who receive a low income and the elderly only, and a system of compulsory membership to medical schemes. Fan (1999:555-70) argues that no nation has a perfect healthcare system. More importantly, every society has its own history, culture, social values, health needs, politics, institutional base and management capability. The Hong Kong people believe that it is not wise for them to copy another society's system, they have instead tried to incorporate the best features of different health systems which they believe are viable and workable for them (Fan, 1999:555-70). With this proposal the middle-income group which makes up the majority of the population will be confronted with issues of affordability and accessibility which will negatively affect their well-being as a result of the total withdrawal of assistance and support from the government (Ho-mum, 1999:624-37). Evidently the Harvard report did not get the support it hoped for in the transformation of Hong Kong's healthcare system in order to promote access to affordable health services.

User fees at government health facilities have been introduced or increased in many low and middle-income countries (Russell & Gilson, 1997:359-79). In their study in 36 developing countries throughout the world including SA, Malawi and

Zimbabwe, reported that two key strategies have been identified to promote access to the poor; perceptible service improvements such as decentralised financial control-retention and use of revenue at a point of collection, and policy guidelines for health service facility. The second strategy is to have carefully designed fee schedules with exemptions - a fee schedule that subsidises services essential for public health and a policy that exempts those who are unable to pay. The study showed that many countries lack policies that promote access to disadvantaged groups within the user fee systems. This finding is of concern as it has already been established that user fees are likely to impose greater access barriers for women and children. In their conclusion the authors commented that financial subsidy to promote health service access to disadvantaged groups does not exist in many countries making health services more inaccessible by this vulnerable group.

Utilisation of outpatient services in government-owned district hospitals in Dar es Salaam declined by more than 50% following the introduction of user fee charges. However this did not lead to an increase in the use of private health services (Anon, 1998:528), which means that those people no longer have access to any system of health services in the country.

The clinic as a cost center should have a budget divided into categories and monthly expenditure of each main category should be known, stocks should be kept orderly with FEFO (first expire, first out) followed and no expired stock (Dept. of Health, 2000). Jones (1999:112-4) observed that some progress was made from 1995/96 to 1996/97 in reducing provincial disparities and bringing health budgets closer to the national average. Within the provinces the disparities are even greater claims Jones (1999:112-4) citing case studies which were done in the Eastern Cape and North West Provinces which showed that at least a fourfold difference in resource allocation between the districts with the greatest and least budgets. Thus every R4 spent in Grahamstown and Potchefstroom districts only R1 was spent in Maluti and Odi districts.

2.4.7 FACTORS INFLUENCING THE EFFICIENCY OF HEALTH SERVICES

Efficient means the end results achieved are in positive relationship with the effort expended in terms of money, resources and time.

Waiting times, appointment difficulties, dissatisfaction with care and poor relationships with service providers have been identified as important factors that influence access to health services (Sword, 1999:1170-7). This affects the efficiency and access to the services. There is concern in Canada about the concept of 'double doctoring' (unnecessary duplication of consultations) (Jones, 2000:928-39). Forty six percent of patients attending walk-in clinics later attended their doctors offices for the same condition, 67% of them did so within seven days of attending the walk-in clinic. Follow-up rates at 72 hours after attending walk-in clinics was 27%, compared with the 22.2% in general practice consultations (Jones, 2000:928-31). This patient behaviour questions the efficiency of the walk-in centers in the promotion of the people's health in Canada.

Navarro (1999:894) claims that the US healthcare system is the most inefficient, costly and inhumane attempt at healthcare in the western industrialised world today. The author states that the US is the only major industrialised nation where the government does not guarantee the right of access to healthcare by providing universal access and comprehensive health benefits coverage to its citizens.

The health insurance system in the US; the Health Maintenance Organisations (HMO's) has decreased the quality of healthcare for patients and the quality of care for people who are sick. HMO's dominate the healthcare market place. Care and access to care have decreased in people's views and they want that trend stopped (Texeira, 2000:581-4). The benefits of access to PHC services for people with insurance include improved vision, more complete immunisations, better blood pressure control, enhanced dental status and lower estimated mortality (Texeira, 2000:581-4).

Over-drugging and under-treatment is becoming an important issue in the current healthcare and social climate that strategies are needed to promote a different ethic of treatment (Hoebischer, 1997:161-6). More than 600 over-the-counter products today have ingredients or dosages that were only available on prescription 20 years ago. The author notes that there is limited time for healthcare providers to spend with each patient. This makes writing a prescription easier and less time-consuming than patient education or counseling and follow-up phone calls or visits making services more inefficient, ineffective and costly. Brass (2001:810-5) states that in the year 2000 the USA spent approximately \$19.1 billion on over-the-counter drugs. He argues that data suggests that one third of consumers using an over-the-counter drugs exceed the recommended dosages. This raises questions on the quality and efficiency of healthcare.

Macias and Morales (2001:77-87), in their study on adults who cross the Mexican border for treatment, recommend that physicians serving this population should be aware of the dangerous consequences of simultaneously using health services and medication from the USA and Mexico. Patients may be using more than one care provider, thereby threatening the quality of care received and decreasing the overall efficiency of both healthcare delivery systems. A fragmented system of healthcare can adversely affect the patient's health in several ways. If a patient with multiple related problems encounters providers who are myopic in the management of their patients, he will only be treated for his superficial problems. The immediate crisis is resolved but not the underlying problems (Meyer & Naughton, 1995:22-8). This patient is more likely to come back with the same problem and may be in a worse condition. Similarly a patient receiving multiple medications from different healthcare providers who do not coordinate their efforts, may find that the therapy is not effective and the patient may suffer adverse drug interactions (Meyer & Naughton, 1995:22-8).

The healthcare system is often seen as a barrier to low income women due to long waiting times, interaction with insensitive healthcare providers and confusion over medical aid eligibility (McCray, 2000:17-30). He observed that women affirmed that the long times spent at the clinics was the most frequent barrier of access to health services.

Too often, local healthcare services for the elderly are fragmented, duplicated and biased toward institutionalisation (Meyer & Naughton, 1995:22-8). For an elderly person needing multiple services, this local system can be a confusing maze, with numerous access problems. In the quest to improve access to elderly people and better co-ordinate service delivery, the Commonwealth of Virginia awarded funds to three localities to pilot a case management approach. The program titled Care Network for Seniors serves low-income elderly people. One telephone call assures an intake into the Care Network system. The average Care Network client has nearly five out of a possible six deficits such as bathing, dressing, eating, toilet, getting in and out of bed and moving about the house (Meyer & Naughton, 1995:22-8). This shows that the Care Network efficiently reaches a very needy population.

Although inner-city children have a regular source of care, they are less likely to have continuity of care (Bael and Stein, 2000:151-62). The authors revealed that inner-city children are more likely to use the emergency room for sick care and are less likely to interact with their regular providers. Parents of inner-city children are also less likely to interact with their regular providers before using the emergency room and are less satisfied with healthcare their children receive. This inefficiency affects the accessibility health services to the inner-city children.

Newacheck, et al (2000:760-6) note that although pursuing expanded insurance coverage of children with special healthcare needs is of key importance, problems in accessibility are still present even with the children who have insurance. They noted that among those insured there were some without a regular clinician, some without after-hours care and families were also

dissatisfied with at least one aspect of their child's care. Inadequate reimbursement and accessibility problems can be attributable to managed care service authorization policies. These policies have an obvious disproportionate effect on families whose children have special healthcare needs causing them to receive care in an inefficient manner. Getting access to services can be complicated, time-consuming and expensive.

Waiting times and time spent with doctors and staff give indications of how easy it is for individuals to access to healthcare services. Longer waiting times are not merely an inconvenience but also increase the discomfort and may discourage people from accessing to the services. Snyder, et al (2000:196-216) have noted that having a limited time with doctors and staff can also mean that people may not have enough time to ask questions and receive feedback from the personnel. They found that the Asians and Pacific Islanders fared far worse on time-related measures such as longer waiting times, which may contribute to their delay in seeking needed care, resulting in complications that could have been avoided if there had been more timely care (Weissman et al, 1991 in Snyder et al, 2000:196-216).

Telephone is an important component of care. In some parts it serves as a first point of contact for people attempting to enter the medical system. Snyder, et al (2000:196-216) found that Asians scored significantly worse than any other group. Poor telephone access is likely to be related to verbal communication problems that affect minority groups in America. As a result Asian patients receive inadequate treatment, have poor compliance with prescribed treatments, may not receive the required referrals which would enable them to undergo tests and treatment that would optimise their care. This may result in unattended health needs, health outcomes can be affected negatively and costs increased.

Challenges are probably more severe in health center settings where clinics have fewer resources and more needy populations (Chin et al, 2001:268-74). In their

study on barriers to the provision of diabetes care in community health centers, they found that physicians who saw more patients per unit-time were less likely to perform screening tests for diabetes. This would result in inadequate diagnosis and undertreatment making services inefficient.

When access to care is a major barrier, the question of its quality becomes moot (Diaz M, et al 1999:1-15). The authors observed that in some clinical settings in Brazil, women were required to schedule a series of appointments, for an educational session, Pap-smear, receipt of Pap-smear results and a consultation with a specialist before they could finally obtain an Intra-uterine contraceptive device. In the provision of antenatal care, gynaecologists attended only to the medical aspects of the pregnancy and neglected the emotional, psychological and informational needs. Gynaecological examinations were not done thoroughly. Referrals, although indicated, were not always given and pertinent information was frequently not recorded. The patients' privacy was not maintained and consultations tended to be rapid, lasting an average of five or six minutes. Waiting time for a consultation ranged from two-and-a-half to four hours and records to allow for continuity of care were not kept (Diaz M et al, 1999:1-15). The most problematic areas are the long waiting times, short consultation periods, the women did not feel encouraged to ask questions and if they did they were not answered (Diaz M et al, 1999:1-15).

Hong Kong has benefited from improvements in certain aspects of quality and productive efficiency in specific areas (Fan, 1999:555-70). The author identified several areas that still require improvements like the variable quality of care, patterns of drug prescription, short time the physician spent with patients, little physician explanation of side effects of medication, excessive queuing time, relative consumer ignorance and questionable rankings of patient satisfactions. Ironically the same observations have been made in the USA as well (Snyder et al, 2000:196-216).

Ahmad (2000b:909-10) reports that despite Bangladesh's recent gains in reducing fertility rates and improving general health, the majority of its people still do not have access to modern health services. Less than 40% has access to PHC services beyond immunisation and f/p, only 25% of pregnant women receive antenatal care and the country's maternal mortality rate at 4.5 deaths per 1,000 is one of the highest in the world. Rates of malnutrition in the country are among the highest in the world (Ahmad, 2000b:909-10)

Communities in Malawi want access to efficient healthcare services covering health problems experienced by the people (Min. of Health, 1996). Most health centers provide integrated and comprehensive programs and have maternity beds. The patients, however, complain of long queues, short consultation period and virtually no physical examination.

The Norms and Standards for the delivery of PHC services in SA, recommends that community health needs should be assessed annually (Dept. of Health, 2000). The evaluation should be done using a situational analysis of the community's health needs and the regular health information data collected at the clinic. An annual plan must be prepared based on this evaluation. The clinic personnel should be able to organise the clinic to reduce waiting times to a minimum and initiate an appointment system where necessary. District personnel policies on recruitment, grievance and procedures must be available in the clinic for staff to refer to.

South African researchers have also received mixed reports concerning the efficiency of the health service delivery system. The use of antenatal services appears to have increased in recent years, the referral system appears to be functioning well and compares favourably with established models of regionalised perinatal care (Buchman, 1997:31-5). The author observed that despite the women's understanding of the value of antenatal care, they appeared to be unaware or unwilling to avail themselves to the benefits of syphilis

screening, accurate gestational dating and the potential for prenatal diagnosis. PHC nurses are also burdened with administrative duties like maintaining statistics and stock control which is time-consuming. This leaves them with little time to devote to direct patient care and to provide care in an inefficient manner, which makes services less accessible (McDonald and Blignait, 1998:8-11).

It is argued that the provision of certain selected services such as growth monitoring, oral rehydration therapy, breast feeding, immunisation, f/p and feeding (GOBIFF) could be the leading edge of PHC which could usher in a more comprehensive approach at a later stage (Chopra, Sanders, McCoy & Cloete, 1998:1563-4). Evaluations of this system at both national and provincial levels in SA, have found that it is only when these core service activities are embedded in a more comprehensive approach that real and sustainable improvements in the health status of populations are seen (Chopra et al, 1998:1563-4).

Appropriate and sustainable energy sources are required for the successful provision of rural PHC. Vaccine storage is inadequate in clinics relying on the solar system. Clinics without access to electricity experience problems (Ross, Lerer & Nxumalo, 1996:68-70). This is a sad reality for people living in rural areas who have long borne the brunt of inequitable planning, poor access to healthcare and limited development. Ross et al (1996:69-70) observed that provision of adequate lighting could facilitate emergency health services and offer the potential for longer opening hours thus making services more accessible to the community they serve. In concluding the authors recommended that energy requirements have to be addressed in order to ensure that health services that are offered to rural dwellers (who are the most disadvantaged) are appropriate, efficient, sustainable and more accessible.

Westaway, Viljoen and Chabalala (1999:131-4) noted that women were satisfied with antenatal services in terms of waiting times, client-provider communication and staff attitudes. These women, however, were concerned about maintenance

of contacts and service availability, which according to the authors may be due to the reduction in home visits and the provision of the weekly antenatal service. This reduces efficiency of service delivery and access.

2.4.8 FACTORS INFLUENCING THE EFFECTIVENESS OF HEALTH SERVICES

Effectiveness means that services provided achieve the intended goal in terms of improving the health status of the people.

PHC has been emphasised in the delivery of healthcare services to the people at grassroots level in developing and developed countries. Access to healthcare is a central component of both PHC and nursing. Ethical professional behaviour demands that nurses advocate access to healthcare for the entire population and use effective methods to improve health indicators (Shoultz & Hatcher, 1997:23)

The WHO in 1998, assessed the health system of the countries regarding overall performance and found that virtually all countries under-utilise the resources available to them, which leads to large numbers of preventable deaths and unnecessary suffering (Ashraf, 2000:2223). Albania, described as 'Europe's last remaining developing country, has increased its population's life expectancy by 19 years as a result of an introduction of maternal and child health services. A decline in infant mortality rate from 134 to 42 per 1000 live births has been attributed to the development of PHC services (Robinson & Wharrad 2000:28-40).

Recent research has demonstrated that access to effective health services can improve the lives of urban residents (Andrullis, 2000:858-62). Improving the health of the residents of urban areas has been a formidable and continuing struggle to meet complex and varied needs with limited resources (Andrullis, 2000:858-62). Entrenched chronic conditions such as asthma, diabetes and

cancer, infant and child mortality, drug abuse, violent crime and health risk behaviour have been accompanied by chronic health system problems of difficult access to and inconsistent quality of care (Andrullis, 2000:858-62). These conditions and the inner-city environments, require providers to recognise not only the unique medical challenge but also the complex social context within which individuals work, live and play. The Parkland's reorientation program benefits both healthcare providers and residents. There has been an almost two-thirds reduction in emergency room use and hospitalisation for diabetes, asthma and hypertension. In case of an admission there is a shorter hospital stay among these patients who are in the program. The program has also shifted its emphasis from sickness to prevention and those issues related to PHC (Andrullis, 2000:858-62).

The Milwaukee County General Assistance (GAMP) was created in 1998 (Lucey, 2001:12-7). GAMP purchases access to healthcare services for the medically indigent residents of the county through a network of community-based primary care delivery systems. The program is attracting national attention as other communities also try to address the issues of the indigent population. This program is effective in meeting its objective to improve access to healthcare services by the indigent population. The clients have access to care providers of their choice in terms of language, transportation and medical needs at 27 different sites. This has led to a decline in emergency department use and an increase in PHC visits (Lucey, 2001:12-7). GAMP seeks to serve a vulnerable population in a fashion which addresses their needs in a cost-effective manner. The program seeks to improve their health outcomes with an emphasis on preventive and primary care (Lucey, 2001:12-7).

The main objective of the Models that Work Campaign (MTW) is to improve access to healthcare for vulnerable and under-served populations (Crump et al, (1999:218-24). This initiative gives recognition and visibility to innovative and effective service delivery models. Models are selected using a set of a criteria,

which includes delivery of a high quality primary care services, community participation, integration of health and social services, quantifiable outcomes and replicability. The winning models are showcased and hired to provide training to other communities, to document and publish their strategies and to provide onsite technical assistance on request. The 1998 MTW winner, the Sunset Park Health Center Network in Brooklyn, New York, has identified and enrolled 500 previously uninsured children into a Child Health Plus Insurance. The center's School Health Outreach Project which serves 11,000 children without regard to income at 11 school-based sites, provides comprehensive primary and specialty services that provide the children with a regular source of care. There is also evidence that the program has increased immunisation rates and reduced hospitalisations and emergency room use. This effectiveness is attributed to better management of childhood conditions such as asthma (Crump et al, 2000:218-24). Another MTW winner consistently expanded primary care services by increasing the number of community-based clinics and through better integration of medical, mental, health, substance abuse and social services (Crump et al, 2000:218-24). The program has reported savings of over \$10,3 million per year in reduced hospital stay and \$8 million in emergency room care.

"Adolescent if not the age of reason is the age of risk", Hall (1995:936-7). Concern is escalating for the medical and social health of our adolescents under the current discouraging avalanche of statistics (Hall, 1995:936-7). There is an increase in the frequency of pregnancies in adolescence and a steep rise in sexually transmitted diseases, hepatitis-B infections, drug abuse and smoking in teens in USA. Despite this recognition and unanimity of purpose we have thus far failed to give most of our adolescents routine healthcare that encompasses counseling, health education and preventive measures confessed Hall (1995:936-7). Adolescents have fewer contacts with a physician and adolescent programs only served less than 10% of the population in 1990 (Hall, 1995:936-7) and the reasons are legion: inaccessibility, unacceptability, financial problems and both the infra- and supra-structures disclosed Hall (1995:936-7).

Fundamental to the solution of these problems is creativity, co-ordination of community capabilities and examination of the successes in the delivery of healthcare (Hall, 1995:936-7).

Only half to two-thirds of children at two years of age are immunised fully but at school entry 98% are fully immunised observed Hall, (1995:936-7). Hall (1995:936-7) inferred that recommendations work when they are enforced and tied to schools. The author wondered if the same method applied to the pre-schoolers can be applied to the pre-adolescent scholar to ensure optimal coverage of immunisations. Hambidge, et al (1999:158-63) shared Hall's (1995:936-7) when he reported that 76% of the population studied were not up to date with their vaccines and 23% had an unknown immunisation status, which means ineffective immunisation coverage.

Notwithstanding what will be possible tomorrow, we do not even apply what we know today, broadly, consistently, safely or effectively observed Levine (2000:10-7). He states that the USA has achieved global leadership in a remarkable number of areas, from computers to aerospace to biotechnology, but has failed dismally in healthcare (Levine, 2000:10-7). Fundamental to success of the system is the placing of the individual consumer at the center of the best outcomes-driven system. The consumer must also share the goals of universal access to high quality, affordable healthcare and the opportunity for everyone to achieve optimal health, related quality of life and function.

The WHO measured healthcare delivery performance on amongst others cost quality and access in its 191 member countries. The top five countries were France, Italy, San Marino, Andorra and Malta. The USA, the top spender internationally, fell short and ranked 37th because of its failure to deliver consistently good care across populations and its unfair distribution of costs. It was miserably out-performed by less developed countries like Oman, which ranked 10th (Fetter, 2000:282-4).

Fundamental to the success in reduction of morbidity and mortality are the preventive and maintenance services, states Cantor and Shankar (2000:125-34). The authors revealed that among immigrants from El Salvador approximately 60% had a routine medical check up in the past three years and only 23% indicated having a regular source of care. This ineffectiveness means that people suffer from conditions, which could have been prevented.

Gill and McClellan (2001:451-4) argues that referral to a primary physician had a positive impact on the rate of cervical cancer among women in Delaware, USA. The study showed that after referral to a physician, 38% of those referred had Pap smear taken. This referral program led to an increase in physician office visits and an 18% reduction in hospital emergency department visits (Gill & McClellan, 2001:451-4). This program promoted a shift towards primary care with a resulting increase in preventive care as well. All the women, however, did not follow through on the referral and those who did may not have been encouraged to receive preventive care or may have declined it. This affects the effectiveness of services negatively.

Wood (2001:42-4) in his article on preventive measures has observed that Health planners of the South Central, Kelonwa, USA, region, are improving the well being of their citizens in a cost-effective manner. Authorities are directing much of their energy in keeping people well and the results are impressive; increase in life expectancy rate and a reduced fertility rate.

In Nicaragua infant mortality rate decreased from 120 per 1000 births in 1966 to 64 per 1000 births in 1986 (Pena, Wall & Persson, 2000:64-9). The sharp decline has been attributed to improved availability of healthcare, expansion of basic education especially for women and food supplementation programs. These efforts were targeted at those in need, i.e. the poorest segments of the society. This intersectoral approach has facilitated the tackling of problems in a holistic

manner, dealing with them efficiently as well as effectively and completely.

Delays plague all healthcare systems, causing discontent, consuming resources and worsening medical outcomes. Most waiting systems rely on distinguishing between urgent and routine cases and so maintain two queues. This is not effective (Murray, 2000:1594-6). Real improvements in access come about when there is only one queue and is short enough to ensure prompt treatment for urgent cases. Improving access involves determining the demand and applying resources to match it or reduce it (Murray, 2000:1594-6). Murray (2000:1594-6) shows that a primary care group in Alaska erased their backlog by adding extra staff for six weeks. They also developed an approach which guaranteed patients to be seen by their own doctors with each visit and made sure that there were enough doctors working each day. The results were impressive, waiting time was reduced from thirty days to one day and the percentage of extremely satisfied patients increased by 20%. A 72% (from 21%) increase in staff satisfaction, increased the likelihood that patients would see their own doctor on a return visit. There was also an improvement in screening scores such as mammography, which has increased from 42% to 71%. This effective transformation improves accessibility of health services.

Fan (1999:555-70) states that in 1997, Hong Kong, with a population of approximately 6,5 million, 10,4% of which are elderly, life expectancy at birth was 76 and 82 for men and women respectively, infant mortality rate was 4/1000 live births, maternal mortality rate was 7/100,000 live births. Fan concludes that Hong Kong's basic healthcare indicators compare favourably with those of developed nations while Hong Kong spends little on healthcare. This view is shared by Po-wah (1999:571-90) who cited that the majority of the population use the public health system, which is not only affordable but also effective and trusted by the local community. In support Ho-mum (1999:624-37) added that in Hong Kong, there is a higher life expectancy and a lower infant mortality rate than in the USA. Ho-mum (1999:624-37) commented that service efficiency and effectiveness can

experience complications before, during or soon after birth, only about 50% of deliveries in developing countries are assisted by skilled attendants and in some countries the figure is as low as 20%. One woman dies every minute from pregnancy-related complications and nearly 99% of maternal deaths occur in developing countries. But the editor of the magazine (2001:22-5) argued that World Bank's president; Wolfensohn has never been to a maternity ward anywhere to know what he is talking about. The World Bank policies initiated by Wolfensohn require that the poorest countries charge for healthcare and hospital services and as a result women cannot afford to seek help for themselves and their children. Services that are not affordable, are not accessible and therefore ineffective.

Technical interventions needed to prevent maternal deaths are well understood. Traditional maternal and child health interventions such as providing antenatal care and training traditional birth attendants have failed (Goodburn & Campbell, 2001:917-21). The availability, accessibility, use, and quality of essential obstetric care for life-threatening conditions like abortion complications need to be improved. Some developing countries such as China, Sri Lanka and Malaysia have reduced the maternal mortality dramatically after improving the coverage and the quality of the health services (Goodburn and Campbell 2001:917-21). In Zimbabwe the progressive erosion of the general living standard is associated with rising maternal mortality, which has been proposed for use as an indicator of accessible and functional health services (Goodburn & Campbell, 2001:917-21).

Three million children die every year from diseases that can be prevented by vaccination disclosed Smith, (2000:952-3). Unfortunately existing vaccines cannot reach these children because of failures in delivery systems, lack of resources and the high prices of newer vaccines. New vaccines may not be developed because companies cannot foresee a good return. Of the 1223 drugs developed between 1975 and 1997, only eleven were for tropical conditions (Smith 2000:952-3).

The WHO's revealed that there has been substantial gains in life expectancy and in infectious diseases control. There has been a significant reduction in infant and child mortality rates and improvements in immunisation coverage rates, access to essential drugs, maternal and family planning services (Stark, et al (1999:273-7). Despite these gains, today three out of four people in developing countries die before reaching the age of 50 which was the global life expectancy half a century ago (Stark et al, 1999).

Obstetric complications are common in West Africa despite accessible care (Hollander, 2001:52). Even though West-African women have easy access to a maternity ward and essential obstetric care, many develop life-threatening complications. This is attributed to the fact that doctors or midwives do not attend to most of the deliveries in health facilities and since some complications are high risk, this would suggest the malfunctioning of public health services and therefore unsatisfactory quality of maternal healthcare in this part of Africa (Hollander, 2001:52).

Malaria remains the greatest survival threat for young African children, causing at least 750,000 deaths each year (Armstrong, Joanna, Abdullah, Nathan, Mukasa, Marchant, Kikumbih, Mushi, Mponda, Minja, Mshinda and Tanner, 2001:1241-8). Marketing of an insecticide-treated net has great potential for effective malarial control in rural African settings. The authors found that in rural Tanzania, insecticide-treated net coverage of infants increased from less than 10% to more than 50% in three years. The insecticide-treated nets were associated with a 27% increase in child survival of age one month to four years. Coverage was higher in children in areas with longer access to the program. The modest average coverage achieved by 1999 in the two districts (18% in children younger than five years) suggested that insecticide-treated nets had prevented one in 20 child deaths. The nets treated with insecticides have a substantial impact on morbidity, blood haemoglobin levels and weight gain in children when distributed

in public health setting (Abdullah, Schellenberg, Nathan, Mukasa, Marchant, Smith, Tanner and Lingeler, 2001:270-3).

It is reported that cerebral vascular accidents is the second leading cause of mortality worldwide with three million out of four million deaths in developing countries (Walker, McLarty, Kitange, Whiting, Masuki, Mtasiwa Machibiya, Unwin & Alberti 2000:1684-7). In a recent population-based survey in a middle-income district of Dar es Salaam, it was found that only 29% were aware of their diagnosis, and of these 65% were treated, 23% were controlled while in Hai 32% of patients knew the diagnosis of whom 68% were being treated and of those 15% were controlled. The higher rates observed in Hai were contributed to better coverage and effectiveness of PHC services in the area, inferred the authors.

Durrheim and Ogunbanjo (2000:130-5) observed that 30% of the children surveyed in Mpumalanga, SA, did not have a record of measles immunisation and were therefore potentially at risk for the complications associated with a measles infection. There was, however, a marked improvement on previous coverage surveys conducted in this area. Measles immunisation coverage increased from 59% in 1991 to 69,5% in 1994, this is in part due to the restructuring of health services in the province with a commitment to delivering immunisation on each clinic day and extension of clinic services to previously under-served areas. These immunisation campaigns aided in preventing the expected 1996 measles epidemic from materialising. This improvement in immunisation proves the effectiveness of the services.

SA is categorized by the WHO, as one of the 16 countries hampering global efforts to control TB (Dick, Mbewu and Matji 1999:132). The authors state that the historical neglect of the TB epidemic, a fragmented health service due to apartheid system and poor management of TB have left a legacy characterised by high rates of TB. In 1997, 108 382 cases of TB were reported to the National Department of Health. Only 60% of the positive sputum-smear patients

diagnosed were reported as cured at the end of their treatment period. The reported 18% treatment interruption rate of patients indicates that all is not well in the TB Control Program observed the authors.

Chiawelo clinic in Soweto is a community health clinic that provides antenatal, postnatal and outpatient services and a 24-hour, 7 days a week labour ward. Buchman (1997:31-5), found that the rate of unbooked pregnancies was 47% and the mean gestational age at booking was 4 weeks, 41% of the mothers deliver at the clinic and 3,2% at home. The perinatal mortality rate for clinic deliveries is 6 out of a 1000 births. Still more must be done to improve the effectiveness of the clinic, as the women appear to be unwilling to avail themselves of early booking.

As recommended in the Norms and Standards for delivery of PHC services in SA (Dept. of Health, 2000), PHC clinic should have mechanisms to monitor services and quality assurance and at least one annual service audit. Clinics should utilise an integrated standard health information system that enables and assists in collecting and using data. The monthly PHC statistics report should be accurate, done on time and filed/sent, monthly and annual data should be checked, graphed, displayed and discussed with staff and health committee.

2.4.9 FACTORS INFLUENCING THE EQUITTABLE PROVISION OF SERVICES

Equity means absence of sub group variability, discrepancy and discrimination.

It is important that health decisions and their effects should seek to provide fair and just services and outcomes. Research suggests that the unequal distribution of resources is closely linked to health status (Naidoo & Wills, 1998:74).

Affluent countries with unequally distributed resources have populations with

poorer health status than affluent countries with equal resource distribution (Ashraf, 2000:2223). This statement is made in view of the WHO report on its comparison of healthcare systems across the globe in which the USA ranked 24th out of 191. Eisenberg, (Ashraf 2000:2223) the Director of USA Agency for Healthcare Research and Quality who reportedly commented that some countries, the USA inclusive, need to address not only increasing and improving the average state of health but also improving the fairness and distribution of healthcare resources across the country. Poor countries with an egalitarian resource distribution mechanism and policies, such as Cuba, experience better than expected health status while worthy countries with redistributive policies such as Japan have the healthiest populations (Ashraf 2000:2223). The existing inequalities in health need to be reduced through the provision of appropriate services that can reach everybody. This entails fairer allocation of health resources according to needs.

Fairness is absolutely necessary if the public is to adequately understand what is ethically at stake when it comes to healthcare reform (Caplan, Light and Daniels (1999:853-67). Fairness focuses on equalising people's opportunities to participate in and enjoy life, given their circumstances and capacities. A commitment to fair equality of opportunity recognises that we should not allow people's prospects in life to be governed by correctable, morally arbitrary or irrelevant differences between them, including those that result from disease or disability. They argue that a benchmark of public accountability requires healthcare systems to provide adequate grievance procedures and dispute resolution measures and adequate safeguards of patient privacy and confidentiality. They recommended the use of these benchmarks to; (1) assess the fairness of a specific country's existing healthcare system, (2) compare the fairness of different countries healthcare systems and (3) assess the fairness of either on-going or proposed healthcare reforms in order to ensure equal access to all.

Discrimination by healthcare professionals is another perceived barrier as reported by women of ethnic minority groups in Canada (Sword 1999:1170-7). In Canada freedom guarantees women equal benefit of the law. Yet some provinces do not cover the cost of abortions thereby denying them that right (Eggertson, 2001:847-9). "There is no question that women do not enjoy full and equal access to reproductive services, including abortion services. Its sex discrimination," declares Jackman, "you have a service that is required by women and because of minority opposition to reproductive choice, you have no access and that is unconstitutional." (Eggertson, (2001:847-9).

Equality involves provision of resources according to needs. Because Canada is considered to be an egalitarian society with a commitment to comprehensive accessible healthcare, it is assumed that there are fewer health inequalities in relation to socio-economical status evidence, however, refutes this assumption (Wasylenki, 2001:214-6). In a large cohort study it became evident that individuals living in the wealthiest neighborhoods had 23% more coronary angiograms than those living in the poorest neighborhoods and had a 45% shorter waiting time to have an angiogram showing that some areas have got more access to health services than others within the country.

In the USA healthcare providers can pose a greater barrier to women accessing healthcare. Women with disabilities report that healthcare providers often ignore them, communicating instead with their companions or families (Smeltzer, 2000:11). As a result of this disabled women receive significantly fewer annual pelvic examinations, Pap smears and mammograms than women without disabilities which constitutes inequality in access. Improved access to healthcare for women and the disabled has been identified as a national priority observed Smeltzer, (2000:11), who recommended that nurses would do well to adopt the promotion of healthcare for women with disabilities as one of their own priorities, if for no other reason than that then many are likely to become disabled.

Inequity based on race or ethnicity is contrary to the USA's health policy goals (Snyder et al, 2000:196-216). As of 1998, ethnic minority groups make up 28% of the USA's population. Segregation, disparate treatment and racism continue to contribute to the epidemiological gap between minorities and whites (Gonzalez, et al 2000:56-7). The significant under-representation of minority groups in the health profession and healthcare industry is one of the reasons behind the disparity between the health status of whites and minority groups. Gonzalez, et al (2000:56-7) recommended that issues such as routine access to preventive care, cultural competence in providing care and proportional representation of minorities in health professions must be addressed to eliminate inequities.

Pena, et al (2000:64-9) found that economic structural adjustment policies introduced in Nicaragua in the 1990's further exacerbated social inequality as people with small incomes still have difficulties to access healthcare services. They argue that social inequity may be an independent risk factor for infant mortality in a low-income country.

Almeida, Travassos, Porto and Labra (2000:129-62) argue that the concept of equal opportunity for access to healthcare services refers to equality for equal needs and this implies a positive discrimination to compensate for existing inequalities in the determinants of the population health considered socially unjust. They observed that the implemented policies in Brazil have not guaranteed the effective exercise of these rights, thereby restricting their validity to no more than a formal definition or so to say; the law may be progressive, but the same cannot be said of the practice.

In the UK Carnell (1998:60-1) shares Almeida et al's views in an article on real lives, real solutions when she commented that policy documents express the desire to make services easily accessible to all but ensuring that those in greater need receive the highest share. But Moore (1999:12-3) revealed that disability benefits are threatened, alcohol duty is frozen and top wages still rising, thereby

increasing the gap between the rich and poor further. In this situation there can never be equality in which those who are more needy receive the highest share by increasing their accessibility to healthcare services.

Responsiveness and participation are key themes that will drive the primary care groups (PCG's) in the UK whose members will plan and resource service delivery (McCray and Carter, 1999:48). They argue that PHC professional nurses, in particular, have a major role in making the inclusion of people with disabilities possible. They also state that by making these people gain their full status as citizens through involvement in local decision-making within the PCG's and introducing an element of participation, these people can be an alternative process to reduce social inequalities in healthcare services therefore increasing accessibility of these services by these people.

Although there is so far no systematic evidence that there are major differences between areas in terms of service provision and access in Finland, there is still concern about the growing inequities (Koivusalo, 1999:1198-200). This concern is due to the fact that in Finland municipalities have tax powers and this means that resources gained are related to the taxable population with the danger of increasing inequity between areas. Higher costs in sparsely populated, poor, rural areas increase this risk (Koivusalo, 1999:1198-200). This makes services inaccessible to the most vulnerable- the poor.

In Spain health inequalities cause 35,000 premature deaths each year (Bosch, 1999:1886-9). Dardet (Bosch 1999:1886-9), a professor at the university of Alicante in Spain commented that there exists health inequity in different regions in Spain. Your life expectancy within the country depends on the region that you are from. This shows how inefficient, ineffective and unequal some of the health systems can be in providing access to health services in one region of the country and not in other regions, to the degree that health indices are effected.

Care requires virtues and the pre-requisite conditions of care cannot be simply romanticised. Caring has costs and requires resources (Po-wah, 1999:781-90). The author cited that in its assessment of Hong Kong, the Harvard Report said that Hong Kong has a relatively equitable healthcare system. Every resident has equal access to essential healthcare. The financial burden of health services is financed in an equitable manner, the health services are reasonably equally distributed by region. The report acknowledges the fact that both rich and poor residents spend a similar portion of their household income for healthcare, travel a similar amount of time to reach a provider and have similar utilisation rates. In essence almost no one has to reduce their use of health services due to inability to pay or because they have to travel long distances to receive care (Po-wah, 1999:571-90).

Since the Declaration of the Alma-Ata, the gap between the rich and the poor has continued to widen, both within and between the countries, leaving hundreds of millions of men, women and children trapped in grinding poverty (Stark et al, 1999:273-7). Most live in the least developed countries where the burden of ill health and inequality are the greatest. In that part of the world health services are often inadequate and in some areas non-existent. Ironically others live in pockets of poverty in the developed world. Equity in relation to health status and healthcare delivery has become a central element in the renewal of the WHO's global 'Health for all' policy (Stark et al, 1999:273-7).

Pakistan with its 141 million has the double burden of nutritional deficiencies which dominated mortality in the past and have not yet been conquered and the chronic diseases, associated with development, which have increased to become leading causes of death (Pappas, Akhtar, Gergen, Hadden & Kha, 2001:93-8). In comparison with the health status of the USA, Pappas et al (2001:93-8) disclosed that there are major inequities in health within Pakistan and between Pakistan and the USA.

Even though Australia's public health system currently provides a substantial amount of funding to ensure access, irrespective of income, to services as one of its goals (Schofield, 1999:79-97), there exists a small but growing body of evidence which suggests that there are still serious inequalities in terms of access to some of the health services. Schofield (1999:79-97) found that more than 95% of chiropractors, osteopaths and dentists work as private practitioners, indicating that these services might be least accessible to people with low income. In contrast 50% of physiotherapists and 16% of dentists were employed privately which would mean that these services are more accessible by people with low income (Schofield, 1999:79-97). This study demonstrates the importance of a balance between the provision of private and public services when equity issues are being considered. The maintenance of public funding and adequate staffing numbers should ensure that public services remain accessible to people who cannot afford private treatment.

The Zambian government's (Mwale 1999:156-7) attempts to reduce inequities in the health services are focused on procedure and policy issues. The implementation of the reform process was ushered in with the establishment of the central board of health, a body charged with ensuring equity of access to healthcare facilities and resources (Mwale, 1999:156-7).

It was recommended by the Dept. of Health, (2000) in SA, that clinics should have copies of the Patients' Rights Charter and Batho-pele and observe them. The clinics should organise outreach services for its catchment area. There must be a clear system of referral and feedback on referral in place. This will ensure that all patients are referred to the next level of care when their needs fall beyond the scope of competence of the clinic. Merits of referrals should be assessed and discussed as part of the continuing education of the referring health professional to improve outcomes of referrals. Staff should conduct regular home visits using the home visit checklist.

Jones (1999:112-4) indicates that in SA more than 70% of the clinics had selected PHC drugs but the proportions with TB drugs ranged from 20% in the Northern Province to 100% in the Northern Cape which indicates gross inequalities in resource allocation.

While SA has the commitment to maternal health and has a Constitution that firmly establishes the rights of women, it does not mean that there is good access to safe motherhood (Fonn et al, 1998:697-702). Fonn et al (1998:697-702) reported that significantly health workers themselves believe that they selectively deliver sub-optimal care to clients. They provide better treatment to educated and well-off women and worse treatment to illiterate or poor women. The health workers also acknowledged their lack of gender sensitivity in spite of being women themselves. Fonn et al (1998:697-702) recommended that health workers should have a written code of conduct and if they do not adhere to it disciplinary actions should be taken. They should maintain the patient's right to privacy, treat all patients equally, explain procedures, give information, refer patients and adopt systems like scheduling appointments and also see very sick patients first.

The information gathered from various research and monitoring efforts indicates that although the Choice on Termination of Pregnancy Act (RSA 1996) has increased the availability, the right to the services remains elusive (Varkey, 2000:87-9). The author argues that within the South African transformation agenda of achieving an equitable society, abortion serves as a litmus test to indicate the extent of work left to be done. The author then further emphasised that unless a concerted effort is made to maintain the rights as guaranteed by the Act, the right to self-determination and the right to equal access will remain a vision for South African women.

2.5 OTHER FACTORS INFLUENCING ACCESSIBLE TO PHC SERVICES

2.5.1 HEALTH EDUCATION FACTORS INFLUENCING THE ACCESSIBILITY OF HEALTH SERVICES

Health education is a major focus in the delivery of PHC services (WHO 1978). An awareness of available health services is a very important factor in determining the accessibility of health services. Low health literacy prevents many patients from accessing the latest treatments and up-to-date clinical information available on their illness (Pirisi, 2000:1828-30). As a result many patients are unable to make use of most of their healthcare services because they have difficulties understanding a diagnosis, medical instructions, health reforms or operation instructions for a medical procedure or surgery. There is also a stigma attached to low literacy, which affects the patient's ability to seek care and adhere to treatment (Pirisi, 2000:1828-30).

Female literacy has been acknowledged as an important factor in influencing health outcomes (Robinson & Wharrad, 2000:28-40). It strengthens the women's ability to create healthy households, make good use of health services and to bear and rear her children. Literacy increases their access to income and enables them and their families to live healthier lives.

People need freedom of choice, information on quality of care and alternatives to take responsibilities for healthcare. People should be free to choose and change doctors / systems, a right that they have in theory only and exercised practically with difficulties because of the lack of information about the personnel and services available to them (Kuijten, et al 2000:22-8).

Lobach, of Duke University, USA (Craft-Rosenberg, Powell & Culp 2000:863-78) is trying to develop health education materials for low literacy patients and integrate this information into a web-based system that will collect clinical information from the patient (Craft, Rosenberg, Powell & Culp, 2000:863-78). The two-year old project is being tested in two general care clinics. So far the system

covers six health topics, provided in English and Spanish which are accompanied by three minute videos offered to a patient based on the information the patient keys into the program. The aim, says Lobach, is to "enhance health literacy by guiding patients to health related information that they can self-select regardless of their reading literacy, health literacy, or computer literacy. The thought is that if the information is relevant to the patient, the patients will have a greater interest in the information and may better retain what they are taught" (Craft et al, 2000:863-78). Craft et al (2000:863-78) showed that half the homeless women they studied in rural USA, did not receive the needed healthcare in the previous year. They also reveal that clinical nursing interventions addressing the shame, fear, lack of information and eligibility for services and programs are badly needed by homeless women and children. Nurses also need to work to increase social awareness of health problems for rural homeless woman and their children to increase access to health services for this group.

Health literacy cuts across the urban socio-demographic spectrum as well as the elderly, culturally / ethnically diverse communities, immigrants and those in poverty (Cantor & Shankar, 2000:125-34). Along with its implications for individuals health literacy has far-reaching implications on the efficiency and effectiveness of health service delivery. Cantor and Shankar (2000:125-34) states that almost 50% of USA adults have less than adequate literacy skills to function in society, a fact that significantly affects their ability to understand and navigate the health system. The authors stress the need to include health education and promotion activities to help immigrants learn and negotiate the healthcare system. Improving health literacy will increase patient-provider interactions, adherence to treatment, home care and self-care thereby improving the efficiency and effectiveness of the healthcare system.

Pirisi (2000:1828-30) reveals that even patients with good literacy skills may not have adequate health literacy for a given medical condition if healthcare providers do not undertake sufficient education. Piris shares this view with

Mansour, Lanphear and De Witt (2000: 512-9) when they discovered that parents, despite being aware of their children's condition cited, health beliefs, family characteristics, their social or physical environments as barriers preventing them to access healthcare. The authors recommended health education on asthma and its treatment to both parents and children in order to improve asthma management and health outcomes for these urban children.

Research has shown that patients who are satisfied with their interactions with a health provider tend to adhere to treatment (Steyn, Van der Merwe, Dick, Borchards & Wilding, 1997:53-6). Steyn et al, (1997:53-6) provided training on communication skills, which resulted in a significant shift towards a more patient centered approach, co-operation and mutual satisfaction of both patient and nurse.

Koponen, Oksanen, Pertila and Ario (1996:727-35) discovered that in Finland most of the people who considered PHC services desirable did not have potential access to it although all PHC services were free at user point. The study revealed that there are some shortcomings in the equality of these services and most of the disadvantaged were elderly with chronic diseases or disability. The authors indicated the need to inform the public about the availability of the PHC nursing services and improve access to the services for the population groups in need.

Van Balen and Van Dormael (1999:313-27) reported that in Rwanda therapeutic instructions to TB-patients were given without any real two-way contact. The patients are required to return to the hospital every month to receive their medicine. A chest x-ray is taken every quarter and results are given to the patient. A doctor drew a patient's attention at the quarterly X-ray that he had not fetched his medicine during the previous quarter. The patient replied that he came very regularly for the X-ray anyway. The doctor then told him that he had to take the medicine to get better and that the X-ray had no healing effect. The

patient answered that the medicine hurt his stomach but that he felt much better after he had gone 'behind the machine'. When the doctor repeated that the X-ray had no healing effect, the patient asked, quiet logically why he had to have one done every three months. This incident shows how vital communication and education is to achieve the most acceptable outcome.

The main aim of providing free maternal child-care in SA is to improve access to health services by mothers and children who are amongst the most vulnerable (RDP 1994:46). PHC aims at reducing inequalities in the access to health services especially in poverty stricken rural areas. Solomon and Gordon (1997:20-6) discovered that pregnant women were uninformed about their free access to dental treatment and they demonstrated poor oral health knowledge. They recommend a comprehensive oral healthcare program for the pregnant mothers with oral health education into pre- and postnatal services.

Clinic personnel should be able to approach the health problems of the area with the clinic health committee and community civic organisations to identify needs, maintain surveillance of cases, reduce common risk factors and give appropriate education to improve health awareness (Dept. of Health, 2000). Clinics should train community healthcare promoters to educate and facilitate community action. Culturally and linguistically appropriate patient-educational pamphlets should be available on different health issues for free distribution. Appropriate educational posters should be posted on the walls for information and education of patients.

The problem is that patients are not well versed in the common medical terminology used by healthcare professionals who in turn do not recognise the problem faced by some of their patients (Pirisi, 2000:1828-30). Mofukeng and Roos (1999:4-9) reveals that patients in KwaZulu-Natal, South Africa, complained of 'lectures' given as waste of time and boring as nurses mixed their language with medical jargon, and no visual aids were used. This calls for health providers to explain diagnosis or treatment with more pictorial information rather than with pages of medical text.

Westaway, Wolmans, Wessie & Viljoen (1996:71-3) conducted a study with the aim to ascertain the health education needs of the people in Ivory Park Gauteng Province. The study revealed that 93% of interviewees liked to receive health education and they concluded that there is definite need for health education to focus on Aids, TB, child health and family planning.

Attitudes on abortion in the general community and among providers in SA do not support women's right to choose. Little has been done at community level to inform the people about the new Choice on Termination of Pregnancy Act (Varkey, 2000:87-8). A few of the people reported that their health facility had told them about the new Act, but a significant number cited radio and TV as their main source of information. Some participants said they had heard that legal abortions were now available, others were not aware that neither parental nor spousal consent was required. The author recommends initiatives to inform and build support for women having abortions.

2.5.2 DEMOGRAPHICAL FACTORS

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Demographical factors means the population's size and composition in terms of sex, age, educational attainment and employment, marital and medical aid status.

Economical growth and reductions in poverty are known to be among the most powerful determinants of good health at low-income levels (Robinson & Wharrad, 2000:28- 40). If you are vulnerable it means that you are susceptible to something undesirable. Vulnerable people are seen to be of less quality than a normal being. Vulnerability affects the individual's health status in terms of health indicators (Robinson & Wharrad, 2000:28- 40).

Access and utilisation problems are more prevalent among the poor, uninsured

and the minority groups. People in lower income groups experience more difficulties in getting access to health services (Almeida et al, 2000:129-62). Poverty is associated with lack of health insurance and this renders people vulnerable. This inability to pay causes higher rates of adverse outcomes as measured by deaths and longer hospital stays. Poverty not only excludes people from the benefits of a healthcare system but also restricts them from participating in decisions that affect their health. For the huge majority of the people access to medical care is light-years away from the care enjoyed by their elite counterparts (Enterz, 2001:1524-6). Level of education, language and culture, proximity to providers, health literacy and health beliefs are key factors that influence any effort to reach urban populations (Andrullis, 2000:858-62). Community and individual characteristics can exacerbate urban access problems.

Homeless people are at an increased risk of dying prematurely and suffer from a wide range of health problems due to exposure. In Canada homelessness affects tens of thousands and has significant health implications (Hwang, 2001:229-34). Homeless people also face barriers that impair their access to healthcare, Hwang (2001:229-34). The author argued that these people suffer from a high incidence of diseases due to poverty, delays in seeking healthcare, receiving care in emergency departments only, non-adherence to treatment, cognitive impairment, and the adverse health effects of homelessness it self.

Another influential factor for healthcare use is gender (Jones, 2000:928-31). Women are the most frequent users of health services. In Canada most of the walk-in center users were female and unemployed (Jones, 2000:928-31). Cantor and Shankar (2000:125-34) also noted that women use preventive services more often than men. Sword (1999:1170-77) discovered that in Canada those women who do not seek a reasonable amount of care tended to be young, less educated and single. He concludes that if the situated experiences and perceptions of socio-economically disadvantaged women are not assessed to inform healthcare delivery, these women will probably continue to encounter significant barriers to

prenatal care and relationships that reinforce positions of powerlessness.

In the USA, patients described as vulnerable to either poor access to health services or poor outcomes usually have the following demographic characteristics; they receive Indian health services, free care or self care, their race ethnicity is not European American, they are younger than 16 years, have fewer than eight years of education, they reside in a Federally designated health professional shortage area where more than 30% of the population live below the national poverty level and they are on Medicaid or Medicare (Paine et al, 1999:906-9). Low health literacy leads to poorer health outcomes. Piris, (2000:1828-30), found that patients with inadequate health literacy reported poor overall health status and had a greater chance of being admitted to hospital.

Geographic variations in health within the rich and poor counties are substantial. White men in the ten healthiest counties in the USA have a life expectancy of above 76 years. Black men in the ten unhealthiest counties have a life expectancy of 60 years (Marmot, 2001:134-6). The socio-economic characteristics of communities also contribute to higher incidences of morbidity and mortality.

It is believed that Americans perceive, value and behave toward each other through a lens of race (Freeman & Payne, 2000:1045-7). This can create false assumptions that result in unintended but serious harm to members of minority groups, especially those who are powerless and vulnerable. Freeman and Payne (2000:1045-7) claim that there is a growing body of compelling and disturbing evidence that points to inferior medical care for black Americans, even if they are on an equal economical footing with the whites. The differences in access to treatment and quality of care are at least part of the reasons why death rates from some diseases are higher among blacks than among whites concluded Freeman & Payne, (2000:1045-7).

Access to adequate health services by low-income and uninsured populations is an issue concern in the USA. Many groups have been left without access to needed health services. There is some evidence that low-income women are less likely to obtain services necessary for their health. Bubo and Dean (1999:405-6) in a study on factors that influence annual mammography screening, found that women with an income range of less than \$10 000 per year had the lowest percentage of mammograms in the previous year.

The lower the person's social status, the less power is available to control resources. Demographically the homeless population encompasses many other vulnerable populations like women, children, minorities, elderly and immigrants (Strehlow & Amos-Jones, 1999:261-72). Homelessness is a phenomenon with complex causes and the potential for tragic consequences. It is both a public and social problem in towns and cities worldwide (Plumb, 2000:172-3). Women, men and children be they refugees in Eastern Europe, street children in Uganda or what the developed world thinks of as "the homeless", make up a growing vulnerable population that is at an unacceptably high risk for preventable disease, progressive morbidity and premature death, declared Plumb (2000:172-3). Despite high levels of need, homeless people encounter difficulties in gaining access to main stream health services as a result of prejudice and discrimination. Craft-Rosenburg, et al (2000:863-78) found higher than expected rates of illness, accidents and adverse life events, high incidents of substance abuse and mental illness among the homeless.

"US reveals deficits in womens' health care" (Tanne 1999: 1374). The survey revealed that only half of the women interviewed had received preventive care in the previous year. The author also noted that regardless of insurance coverage, women have problems in accessing women's health services. On the other hand, Rich (2001:183-6) observed that young African American men have higher rates of mortality and morbidity from potentially preventable causes. Access to and use of preventive primary care services have been limited for these patients in the

past because of financial barriers.

Many homeless people in the USA report poor health status from multiple diseases and conditions including HIV and TB (Cousine, 1997:70-82). People living in these situations are exposed to multiple health problems including outbreaks due to overcrowding and the resultant poor sanitation. As a vulnerable group they find access to health services problematic.

White children are more likely to have private health insurance than their non-white counterparts (McCormick, Kass, Elixhauser, Thompson & Simpson 2000:219-30). Hispanics are more likely to be uninsured, children with unemployed parents are unlikely to have a private health insurance, children with at least one parent with a higher school education are more likely to have a private health insurance and children in excellent or good health are more likely to be privately insured disclosed McCormick et al (2000:219-30). Children in the Northeast and Mid-West regions are more likely to have private insurance than those from Southwest and Mid-East regions. Interestingly also was the observation of the fact that regardless of health insurance status, adolescents are more likely to lack a usual source of care.

A call was recently made to US doctors to consider access to healthcare for all (Josefson, 2000:1491). A principle which states that a physician shall support access to healthcare for all was adopted by the American Medical Association to tie doctors to an ethical obligation of providing medical care for all sick people, regardless of means (Josefson, 2000:1491). In some health disciplines recommendations for special investigations are frequently made to people who have access to the healthcare system, such as those with regular physician and medical insurance. O'Malley, Earp, Hawley, Schell and Matthews (2001:49-54) found that recommendations for mammograms were less frequent among the most vulnerable: older women, women with lower educational attainment and low family income. They concluded that socio-economic status, age and educational

attainment were related to reports of the physician's recommendation for mammography. The authors recommend efforts to help women address socio-economic barriers to mammography use. In addition Newacheck, et al (2000:760-6) observed that insurance coverage was related to the socio-economical demographic characteristics of children and that the parents of four out of five uninsured children had an income of 200% below the poverty line.

In Brazil a study by Almeida et al (2000:129-62) revealed that life expectancy at birth increases with increase in income and in those coming from the richest regions rather than those coming from the poor regions of the country. This situation is similar to that of the USA (McCormick, et al 2000:219-30) and Spain (Xavier, 1999:1886-9). Higher utilisation of complex and emergency services by lower income groups may suggest less access to appropriate care, the poor waits for the situation to become complicated before they think of accessing health services.

Large differences in socio-economical status between the different race and ethnic populations can exacerbate differentials in access to modern health services. In their study Gleit and Goldman (2000: 5-22) found that in Brazil more educated women, older women, women having their first child and those with a history of poor pregnancy outcomes were more likely to use biomedical care. Social variables are more important than measures of access in accounting for the large ethnic differences in type of care.

"Walk north from Manhattan's museum district to Harlem, or east from London's financial district to its East End, and you will be struck by the contrast between rich and poor, existing cheek by jowl" (Marmot 2001:134-6). The situation becomes even more obvious as to why there are health differences between rich and poor areas of the same city (Marmot, 2001:134-6).

Lower social class may be a barrier to health services accessibility. According to

Burell, Rohlfs, Ferrando, Pasorin, Dominguez-Berjon & Plasencia (1999:743-64) in the UK, visits to the family doctor were more frequent among people of lower social class. It was also noted that the lower social class consult less for the same level of need, suggesting that they have less access to a family doctor.

“Walk the slums of Dhaka, in Bangladesh, or Accra, in Ghana, and it is not difficult to see how the urban environment of poor countries could be responsible for bad health” (Marmot 2001:134-6). Health inequalities are especially clear when noting that the inhabitants of the poor neighborhoods of Spain’s cities can have a life expectancy ten years shorter than those in richer areas. Worse still is the fact that these health inequalities are growing and Spain has no specific policies to face them (Bosch, 1999:1886-9). In Bangladesh women have shorter life expectancy than men, this is due to the discriminations against women in the provision of food and healthcare (Ahmad, 2000b:909-10).

‘Unvaccinated and vulnerable’. In Afghanistan lack of even the most basic services, means that thousands of children are paying the price of being poor, malnourished and unimmunised warned Ahmad, (2000:1439a).

‘Poor no longer afford medicines’. In Namibia a legislator has deplored that disadvantaged people in poor countries are being denied access to medicines whose cost is increasing yearly (Basson, 2000:2). “Medicines are associated with health of a person, accessing them is a right and not a privilege,” observed the legislator in Basson (2000:2).

Some racial groups can have easy access to services while other racial groups may not. Van Vuuren and De Klerk (1996:19-24), revealed that in Greater Bloemfontein, professional healthcare services were more accessible to the whites than to non-whites living in the same area. This situation concurs with that of the USA (McCormick et al, 2000:219-30) where white children were more likely to have private health insurance (which assures one of greater access to

the services) than their non-white counterparts.

According to the Health Systems Trust (Jones, 1997:1647) more patients are seen in urban clinics than in rural clinics. All the clinics were regularly visited by a nurse supervisor but urban clinics had more frequent visits from doctors than their rural counterparts. In terms of infrastructure almost all the urban clinics had telephones (>90%), electricity and regular water supply (98%), where as in rural areas less than 50% had working telephones, 80% had electricity and 55% had water (22% were without taps). Only 41% had an ambulance at their door within an hour of an emergence call. Drug supply in the rural clinics ranged from 97% availability for vaccines to 65% for diabetes drugs. Oxygen supply was at 61% overall with only 10% in the Eastern Cape and up to 100% in Gauteng. Accessibility of health services and therefore, the health status of a South African depends on the part of the country he is in.

2.6 SUMMARY

In this chapter the concepts of PHC and accessibility have been analysed. Different views and misconceptions have been presented. International and national views and examples have been highlighted to present a global view of how accessible PHC services are.

The researcher is convinced that PHC services are essential in both developed and developing countries and that accessibility to these services is of vital importance world-wide and especially in SA where decades of inequity in health services existed in disfavour of the poorest who are the most vulnerable. With the new political dispensation and the transformation of the national health system it is imperative that stock is taken of how many of the Alma-Ata goals SA has achieved to provide accessible PHC services to the people.

CHAPTER THREE

THE RESEARCH DESIGN AND METHODOLOGY FOR AN INVESTIGATION OF THE FACTORS INFLUENCING THE ACCESSIBILITY OF PHC SERVICES IN ALEXANDRA TOWNSHIP.

3.1 INTRODUCTION

It was demonstrated in the previous chapter that the accessibility of PHC services is a very important determining factor in the health of the world's people. The purpose of this chapter will be to describe the research design, which will be used in the study. Mouton (1998:107) defines research design as a set of guidelines and instructions to follow in addressing the research problem to achieve the intended goal. The purpose is to set up a situation that maximises the possibilities of obtaining an accurate answer to the objectives and questions. The research design includes the population, sampling, data collection, data analysis methods, measures of ethics and validity and reliability in exploration and description of the factors that influence the community's accessibility to PHC services.

3.2 THE GOAL OF THE STUDY

The goal of the study is to explore and describe the factors that influence accessibility of PHC services in Alexandra Township and to recommend guidelines on how to improve the accessibility of PHC services in this township.

3.3 RESEARCH QUESTIONS

1. What are the factors that influence the accessibility of PHC services in Alexandra Township?

2. What guidelines can be recommended to improve the community's accessibility to PHC services in Alexandra Township?

3.4 OBJECTIVES

The research purpose was generated from the research problem and gives a brief, clear statement of the purpose of the study. The purpose of this study will be achieved through the following objectives:

To explore and describe the factors that influence the community's accessibility to PHC services in Alexandra Township.

To recommend guidelines on how accessibility to PHC services can be improved in Alexandra Township.

3.5 RESEARCH CONTEXT

Alexandra Township is in the Northeastern suburbs of Johannesburg on both banks of the Jukskei River. The area covers about five square kilometers and the population is close to 350,000 people. It has about 4,000 formal houses and 34,000 shacks (Provincial govt., 2001:4).

3.6 RESEARCH DESIGN

The research design will be a blueprint for the conduct of this study, which will maximise the control over factors that could interfere with the study's desired outcome (Burns & Grove 1997:49). The design will provide guidance in the selection of population, sampling procedure, methods of measurement and a plan for data collection and analysis. To answer the research questions and achieve the objectives of this study a quantitative non-experimental, exploratory, descriptive and contextual survey will be chosen as the study design to explore

and describe the factors that influence the community's accessibility to PHC services and to recommend guidelines on how to improve accessibility of the services (Mouton 1998:38, Burns & Grove, 1997:30,47-8). This type of design required the development of a theoretical framework base which was done in the previous chapter. This will enable the researcher to organise the procedures to be followed. It will also assist in the analysis of the data in a manner that will aim at adding significance to the research purpose.

3.6.1 QUANTITATIVE DESIGN

The study will be quantitative as a means of striving for excellence and will involve scrupulous adherence to detail and strict accuracy. The researcher will be required to use precise measurement methods and representative samples. Critical examination of reasoning and attention to precision will be of tantamount importance (Burns & Grove 1997:41).

3.6.2 NON-EXPERIMENTAL

The design will be non-experimental because no experiments will be conducted. The study participants will not be divided into experimental and control groups for treatment and non-treatment purposes. However the researcher will control extraneous variables by accurately identifying relationships among the study variables and examining their effects on each other (Burns & Grove, 1997:41). This will be achieved through random selection of the patient sample and the development of sampling criteria for each study sample. Control of noise and discomfort will be done through the provision of privacy during data collection with the patient and community samples and by allowing the nurse participants to complete the questionnaires in their own time.

3.6.3 EXPLORATORY

The study will be exploratory because the researcher will explore the factors that influence the accessibility of PHC services in the area. Through this exploration the accessibility of the services in this area will be understood and guidelines to improve accessibility will be recommended to improve the general health of the people on whom the services are intended for.

3.6.4 CONTEXTUAL

The study has greater contextual interests because the phenomenon under study, “accessibility of PHC services” will be done in this unique setting, the Alexandra Township, Gauteng Province. The aim is not to generalise to a larger population but to increase knowledge of the field of study.

3.6.5 DESCRIPTIVE

The study will be descriptive because an accurate account of factors that influence accessibility of PHC services will be described. The aim is to identify and describe these factors and the way they influence accessibility to services in the area. Development of conceptual and operational definitions, which was done in chapter two, will assist in the identification of the variables within the phenomenon. The researcher will therefore be able to provide an accurate description of the factors and the way they influence the accessibility of PHC services in the area. Descriptive statistical analysis will allow the researcher to organise the data in ways that will give meaning and facilitate insights such as frequency distribution and measures of central tendency. Relationships among these variables will also be described.

3.7 RESEARCH METHOD

The study purpose will be achieved through interviews with the patient and community samples and questionnaires with the nurses sample. Since the researcher is actively involved in the delivery of services she will record her observations using an observational list, which will be developed after data is collected, to complement her findings. Data collection will be done with the help of two field workers.

- **TRAINING**

In order to counteract researcher effects and ensure collection of valid data, field workers will be properly and thoroughly instructed. The researcher will conduct an informal training session with the field workers. The study problem, purpose, questions and objectives will be explained to them. The type of data required will also be explained. Emphasis on the importance of accurate and consistent interviewing will be done (Mouton, 1998: 159). The importance of honesty and sincerity will be brought to their attention.

Data collectors will avoid taking advantage of the situation to exploit the subjects, by asking them questions that are only relevant to the aims and purposes of the study (Polit & Hungler, 1997:130). Strict adherence to the questions based on the interview schedules only and avoidance of detours will be emphasised. Field assistants will be given a token in a cash form for aiding in data collection.

3.7.1 TARGET POPULATION

The target population is all members or units with clearly defined characteristics, which are of concern to the researcher (Uys & Basson, 1996:86), upon whom the study findings will be generalised.

The area under study is the Alexandra Township, Gauteng Province. The target population is Alexandra Township residents. There are approximately 350,000 people currently residing in this township (Community statistics, 1999). There are four public clinics in Alexandra: 4th Avenue, 8th Avenue, East Bank and Thoko Ngoma clinics. An average of 8,400 people attend the clinics per month (Clinic Statistics, 2000). There are a total of 12 professional nurses working in the clinics. All the nurses are female.

Data collection will be conducted in four phases for clarity.

3.7.2 DATA COLLETION: PHASE 1

EXPLORATION OF PATIENTS PERCEPTIONS OF FACTORS INFLUENCING THEIR ACCESSIBILITY TO PHC SERVICES IN THEIR AREA.

The goal of this phase will be achieved through the development of a structured interview schedule for face-to-face interviews after the literature study done in the previous chapter. Face-to-face interviews will involve verbal communication between the researcher and the subject through which information will be provided to the researcher (Burns & Grove, 1997:353-4). The interview schedule is a questionnaire that is read to the respondent (Treece & Treece, 1986). Burns and Grove (1997:354) also indicate that the development and sequencing of interview questions is similar to those used in questionnaires, and they progress from broad and general to narrow and specific. Questions are grouped by topic with fairly safe topics being addressed first and sensitive topics reserved until later in the interview process. Demographic data such as age, educational level, income etc. is usually collected last (Burns & Grove, 1997:354).

In this phase the face-to-face interviews will be done with selected patients attending the PHC services to explore the factors that influence the community's accessibility to PHC services in the area. The researcher will use the interview

method because it will ensure that every candidate selected, literate or not, is able to participate in the study. This will also allow for non-verbal communication, which is important in observing the participants' response to questions regarding factors influencing the accessibility of PHC services. This method also ensures that no item on the schedule is overlooked or skipped by the respondent (Burns & Grove, 1997:355).

3.7.2.1 SAMPLING METHOD

Sampling is the process whereby the sample is drawn from the target population (Uys & Basson, 1996:87). To obtain the sample for the study, criteria are used to increase the validity of the results.

A systematic random method will be used to draw the sample from the target population. Systematic random sampling is a way of selecting members for the sample in a regular manner according to a system of fixed intervals such as every 7th or 10th on the list or in the queue (Brink, 1990:106). In this phase every 3rd patient who enters the clinic will be sampled for the study. A total of 40 patients will be selected in each clinic, this will make a total of 160 subjects interviewed in this phase of the study.

- **Criteria for inclusion in the study:**

The person must,

- be 18 years and older,
- be living in Alexandra for 1 year or more,
- have come to the clinic for the services.

3.7.2.2 DEVELOPMENT AND ADMINISTERING OF THE INTERVIEW SCHEDULE.

To obtain a wider knowledge of PHC services and the factors that influence its

accessibility, several national and international sources have been analysed as part of the literature study in the previous chapter. The literature study established the scientific foundation upon which questions for the interview schedule will be based. As it has already been indicated that there are several factors that influence the accessibility of PHC services, the development of the interview schedule will be done in such a way that the name of the sections are representative of these factors. Factor analysis will be done to examine the interrelationships among these variables and to disentangle those relationships and identify clusters of variables that are most closely linked together (Burns & Grove, 1997:782). The instrument will be comprised of both open and close-ended questions. The questions will be in Sotho, Zulu (the main languages spoken by the majority of the residents) and English. To ensure consistency of meaning, the interview schedule will be translated from English to Zulu and Sotho by professional nurses who are of Zulu and Sotho origin respectively and then translated back into English by another set of professionals who are also of Zulu and Sotho origin respectively, the researcher being of neither originality.

The interview schedule will consist of the following sections:

1. Services offered.
2. Personnel resources.
3. Other resources.
4. Important documents.
5. Service utilisation.
6. Community involvement.
7. Health education factors.
8. Demographical factors.

Eight major categories relating to the patients' perceptions with regard to their accessibility to PHC services have been identified and will be reflected in the interview schedule. The schedule (Annexure 1) will be used to interview patients who will come to all the public clinics for services.

3.7.3 DATA COLLECTION: PHASE 2

EXPLORATION OF THE COMMUNITY'S PERCEPTIONS WITH REGARD TO FACTORS INFLUENCING THEIR ACCESSIBILITY TO PHC SERVICES IN THE AREA.

The goal in this phase will be achieved through face-to-face interviews (Burns & Grove, 1997:353-4), which will be conducted with Alexandra residents in their churches, on the streets and in their homes in order to determine the perceptions of the people who may not be accessing the PHC services in their area.

3.7.3.1 SAMPLING

A convenient sampling method will be used to draw the participants for the study. According to Singleton (in De Vos 1998:199) convenient sampling (accidental sampling) is that any subject (case) who happens to cross the path of the researcher and has something to do with the phenomenon under study is included in the sample until the desired number is obtained. These man-in-the-street interviews are done with easily available subjects until the designated number is reached (Treece & Treece, 1986). This method will be used to draw 140 participants from different churches, the streets and their homes to obtain data with regard to factors that influence the community's accessibility to PHC services. Interviews will be done after church services on weekends, before or after special church meetings during the week, on the streets and in the homes of the prospective subjects according to the data collectors' discretion in terms of their safety. The researcher will not be interested in the participants' religious convictions, but only in their views with regard to their accessibility to the PHC services as members of Alexandra community.

- **Criteria for inclusion in the study:**

The person must,

- be 18 years and older,
- be living in Alexandra for 1 year or more,

3.7.3.2 DEVELOPMENT AND ADMINISTERING OF THE INTERVIEW SCHEDULE

The schedule will be developed with reference to the literature study done in chapter two and the norms and standards of PHC services as set out by the Dept. of Health (2000). There will be both open and close-ended questions. The instrument will comprise of the same sections as in phase one. (Annexure 2). Again the questions will be in Zulu, Sotho and English. To ensure consistency, the questions will be translated into Zulu and Sotho and then back to English again as described in phase one.

3.7.4 DATA COLLECTION: PHASE 3

EXPLORATION OF THE NURSES' PERCEPTIONS WITH REGARD TO THE FACTORS INFLUENCING THE COMMUNITY'S ACCESSIBILITY TO PHC SERVICES IN ALEXANDRA.

The goal in this phase will be achieved through the development of a questionnaire. The questionnaire (Treece & Treece, 1986, Rossouw, 2000:137-51) will be presented to nurses to explore their perceptions with regard to community's accessibility to PHC services in the area.

3.7.4.1 SAMPLING

In this phase the total population of nurses working in these clinics (4th Avenue clinic; 8th Avenue clinic; East Bank clinic and Thoko Ngoma clinic) will be drawn for the study purposes.

Criteria for inclusion in the study:

They must be:

- professional nurses registered with SANC,
- have worked in public clinics for more than six months.

3.7.4.2 DEVELOPMENT AND DISTRIBUTION OF QUESTIONNAIRE

A questionnaire is an instrument comprised of a series of questions that are completed by all the participants in the sample (Treece & Treece, 1986). It is designed to elicit information that can be obtained through the written responses of the subject (Burns & Grove, 1997:358). Questionnaires are designed to determine facts about events or situations known by the subject, or beliefs, attitudes, opinions and levels of knowledge. Questionnaires can have open-ended questions which require written responses from the subject, or close-ended questions which have options selected by the researcher (Burns & Grove, 1997:358). They may be distributed directly to the respondents at their place of work, classroom, homes or on the streets (Treece & Treece, 1986).

In this context the questionnaire will have both open and close-ended questions and will have the same sections as the interview schedules for patients and the community. The instrument will be in English because all the nurses are conversant in English. The questionnaires will be handed to the nurses by the researcher. The questionnaires will contain clear and concise instructions on how to complete them. A due date will be indicated to ensure a timeous response. A contact number will be provided in case the nurses need to contact the researcher for clarification of items.

3.7.5 PHASE 4: OBSERVATIONS

In this phase the researcher will make observations. This is a means of collecting data through occurrences that can be observed by visual sensors (Treece and

Treece, 1977:224) and through the development of a check list which is a technique of indicating whether or not a particular behaviour occurred (Burns and Grove, 1997:353) (Annexure 4). The list will be in English and will be administered by the researcher herself in all the four public clinics. This will be done with the aim of complimenting or verifying the data obtained in phases one, two and three.

3.7.6 DATA ANALYSIS

Mouton (1998:161) defines data analysis as the basic means to the resolution of a complex whole into its parts. Quantitative descriptive analysis will be used to analyse the data obtained from the interview and questionnaire schedules. Statistical analysis will be done through the use of SPSS (Statistical Package for Social Sciences) version 11, to determine the frequency of response from the participants. This type of data analysis will allow the researcher to organise the data in ways that give meaning and facilitate insights such as simple frequency distribution (De Vos, 1998:207) and measures of central tendency and dispersion (Burns and Grove, 1997:779). Univariate data analysis will be used in the individual analysis of the variables (Mouton, 1998:163). Graphic presentations such as the bar graphs, doughnut-graphs, histograms, tables and pie charts will be used in the presentations of the findings. Content analysis will be systematically used to measure the open-ended items' frequency of occurrence of words or phrases (Burns & Grove, 1997:564). Inferential statistical analysis will be done to infer whether relationships observed in a sample are likely to occur in a larger population of concern (Polit & Hungler, 1997:459). Chi-square tests, which are used to analyse nominal data to determine significant differences between the observed frequencies within the data and frequencies that are expected, will be done to determine whether there are significant differences between the patients (as people utilising the services) and the community (as the larger population of concern) samples. Statistical test of chance (p - value) will be calculated to determine the differences between the patient and community

samples. Literature control will be done to determine similarities and uniqueness of the study by comparing the research findings with relevant previous research findings. The analysed information will assist in the development of conclusions. Conclusions will be qualified based on the differences and similarities between the three groups namely: patients, community members and the nurses. Guidelines will then be recommended to improve the accessibility of PHC services in the area.

3.8 VALIDITY AND RELIABILITY

Validity refers to the degree to which an instrument measures what it is supposed to be measuring (Polit & Hungler, 1997:299). This helps to determine whether the findings are a true reflection of a reality and that the result is not due to other extraneous variables. It reflects the measurable variable outcome as it is intended to do (Seaman & Verhonick, 182:237).

Reliability refers to the degree of consistency with which the instrument measures the attribute (Polit & Hungler, 1997:295). This helps to determine whether findings can be replicated if the study is repeated in the same context. It deals with the instrument's dependability or the accuracy of the data in the sense of its stability or repeatability (Burns & Grove, 1997:327).

Research findings need to be valid and reliable, they should reflect the truth about the phenomenon under investigation. The researcher is expected to convince her scientific community by providing arguments in a logical and scientific manner. True findings contribute to the applicability of the findings to the larger population of concern. The same findings must be obtained when the research is repeated under similar conditions. The researcher must be unbiased and not prejudiced.

To ensure validity and reliability of the study the following will be investigated and

tested for.

3.8.1 FACE VALIDITY

Face validity is the extent to which an instrument appears to be logically appropriate (Seaman & Verhonick, 1986:238). An expert in nursing research will study the instruments and decide whether the format is acceptable to assess its face validity. The instruments will be assessed on whether entries on the interview schedules and questionnaire had enough specified spaces and blocks for answers. Corrections will be done as recommended by the expert.

3.8.2 CONTENT VALIDITY

Content validity refers to the degree to which the items on the instrument adequately represent the universe content (Treece & Treece, 1986). The instruments will be presented to the expert in the field to analyse the extent to which the items on the instrument are representative of the universe content. An item analysis will be done to assess the degree to which the variables, to be tested, are represented as well as the instruments' overall appropriateness for use (Treece & Treece, 1986). The correlation co-efficient that is an index that summarizes the degree of relationship between two variables, will be calculated (Polit & Hungler, 1997:454). All items rated as irrelevant by the expert will be edited from the instruments.

3.8.3 CONSTRUCT VALIDITY

Construct validity refers to the degree to which the instrument measures the variables under investigation (Polit & Hungler, 1997:454). The employment of both logical and empirical procedures in the study will help to achieve this type of validity. The factor analysis done in chapter two will help to identify the clusters of related variables on the scale. The instrument will be analysed to see if all the

operational definitions have been addressed and to see if the instrument addresses the problem under investigation. A pilot study will also be done to ensure this.

3.8.4 EXTERNAL VALIDITY

Refers to the extent to which the findings can be generalised beyond the sample used in the study to the target population (Seaman & Verhonick, 1986:239). This will be achieved through a consistent following of a detailed procedure, with specific inclusion criteria and a representative large sample for the study. The researcher will also ensure that data is collected within a short period of time to avoid extraneous variables such as history and instrumentation from influencing the study results (Seaman & Verhonick, 1986:239).

3.8.5 INFERENTIAL VALIDITY

Inferential validity refers to logical reasoning from evidence to conclusion (Rossouw, 2000:196). Qualified conclusions will only be made after consideration of the data from the three sample groups. The researcher will indicate the relevance of the premises to the conclusions which will be made (Rossouw, 2000:196).

3.8.6 THEORETICAL VALIDITY

Theoretical validity refers to good theoretical definition (Rossouw, 2000:190). Theoretical validity which is a precondition for measurement, will be achieved through the concept analysis done in chapter two which has helped to define the main concept under study (accessibility). Core characteristics of the concept have been identified and are reflected in the definition of the concept. The definition is not ambiguous, circular and is not described in figurative manner (Rossouw, 2000:190).

3.8.7 PILOT STUDY

This is a process whereby the research design for a prospective study is tested. A miniaturised walk-through of the entire study design (Treece & Treece, 1986:26) using a similar sample to that of the main study, same setting, same data collection and analysis methods (Burns & Grove, 1997:52) is done. The purpose is to investigate the feasibility of the planned project and to bring possible deficiencies in the measurement procedure to the fore (De Vos, 1998:179). This will refine the methodology process. A pilot study will be done using a similar group of people to the study subjects, patients attending Alexandra public clinics, the people in the community (church homes and streets) and nurses working in the public clinics in Alexandra. This will help to exclude ambiguity and ensure the clarity of the instruments.

➤ **The pilot study will be done in the following manner for clarity:**

3.8.7.1 Phase 1

In this phase a copy of the interview schedule will be administered to 12 patients attending the Alexandra public clinics. Three patients in each clinic will be drawn randomly for the interviews. All the necessary requirements for ethically accountable research will be followed in the drawing and conducting of the interviews.

3.8.7.2 Phase 2

In this phase a copy of the interview schedule will be administered to 10 community members residing in Alexandra Township. The sample will be conveniently drawn for the interviews. Again all the necessary requirements for ethically accountable research will be followed in the drawing and conducting of

the interviews.

3.8.7.3 Phase 3

In this phase, two professional nurses will be drawn from two of the clinics and a copy of the questionnaire will be administered to each one of them after obtaining their consent. The nurses will be given the same instructions as with the main study group and a due date will also be given to them.

3.8.7.4 RESULTS OF THE PILOT STUDY

Phase one and two of the pilot study showed that the following questions needed to be added, rephrased and clarified:

- 3.5 of phase one and 3.4 of phase two: if respondents answered yes, they were to be asked to indicate the time of the day they were turned away from the clinic.
- 4.1 of both phases: the interviewer was to explain the meaning of channel of grievance, to the respondents.
- 5.1 of phase one and 5.4 of phase two: the respondents were to indicate special reasons for preferring a particular clinic.
- 5.7 of phase one and 5.2 of phase two were added.
- 5.13 of phase one and 5.15 of phase two: respondents were to give reasons if their answer was yes.
- 6.2 of both phases: the interviewer was to explain to the respondents what suggestion boxes are used for and another column of 'I do not know' was added.
- Phase 3. It was discovered that the researcher needed to indicate on the information letter that the respondents must try not to leave blank spaces.
- Question 4.4 showed that it needed an example such as 'lab results' and it was inserted.
- It was also discovered that the researcher needed to identify the questionnaires for follow-up purposes.

3.8.8 TRIANGULATION

Triangulation is the use of more than one method in data collection, analysis and interpretation (Polit & Hungler, 1997:305).

The following types of triangulation will be employed in this study:

3.8.8.1 Data source triangulation

Several sources will be used to gather data namely: nurses, patients and community members (Polit & Hungler, 1997:305).

3.8.8.2 Investigator triangulation

The researcher will collect data with the help of two field workers using the same instruments (De Vos, 1998:359). The data collected will be analysed for differences and similarities that may be present due to researcher influence.

3.8.8.3 Methodological triangulation.

The researcher will use questionnaires, face-to-face interviews and observations with an observational list (Polit & Hungler, 1997:305). The observational list will be developed after the interviews from the patient and community samples and after the questionnaires are returned in order to confirm or reject what these respondents will say.

3.9 ETHICAL CONSIDERATIONS

Ethics refers to a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal, and social obligations of the study participants (Polit & Hungler, 1997:456).

In order to recognise and protect the human rights of all participants in accordance with the guidelines outlined by DENOSA (1998) with references in Polit and Hungler (1997:130-41), Burns and Grove (1997:200-18) and Mouton (1998:157-8), ethical measures will be taken into account in the following manner:

3.9.1 CONSENT

The researcher has obtained a formal clearance from the RAU Research Committee, the Department of Nursing and the Eastern Metropolitan Local Council. Clearance will also be obtained from Alexandra Public Clinics, potential participants: the nurses, patients and members of the community (Annexures five, six, seven and eight). An explanation of the study purpose will be provided to all stakeholders and informed consent will be obtained.

Participation in this study will be voluntary (Denosa, 1998) and potential participants will be reassured that they are not going to be victimised if they refuse to participate or choose to withdraw in the process of the interview or in the course of answering the questionnaire. The nature of the study purpose and the type of data to be collected will be explained to them. The potential participants will be assured that no information is going to be traced back to them and no names will be indicated or asked. The researcher will provide her contact number to the nurse participants in case they need an explanation of the questionnaire.

3.9.2 CONFIDENTIALITY AND ANONYMITY

All individual confidential statements will be properly secured (Denosa, 1998). To guarantee anonymity and to ensure that no link is made between the individual participant and the data, the researcher will not ask the participants' names. The participants will be assured that their participation and the

information they provide will not be used against them in any way. The data obtained will not be disclosed to any party, other than the authority responsible for the delivery of the services in Alexandra Township.

3.9.3 PRIVACY

Privacy during interviews will be ensured and an environment conducive for one-to-one conversations will be created (Mouton, 1998:157). Interviews with the patient sample will be conducted in the consultation rooms and boardrooms of the clinics. There will be one participant and one data collector in each room. With the community sample the interview will be conducted within the confinements of the church building and or in the participants' homes. Some will be done on the streets but the conversation will be conducted in low tones. Participants' worth and dignity will be upheld by not asking them embarrassing questions. The participants will only be asked questions which appear on the interview schedule.

3.9.4 QUALITY OF THE RESEARCH

The researcher will ensure for the good quality of the research by conducting the study in the following manner:

The study will be conducted under the supervision of the expert leader in the field who will keep a watchful eye on the rigor of the research process.

The researcher successfully underwent a one-year course in research methodology in nursing.

The researcher will follow the principles and standards of scientific inquiry throughout the research process.

The researcher will provide a formal training session to the field workers with the purpose of empowering them on how to collect reliable data.

The researcher will accept the responsibility and accountability of the research process and the results.

The researcher will thoroughly and completely document the research process and outcomes.

3.10 DISSEMINATION OF THE RESEARCH FINDINGS

The study findings will be disseminated in the following manner:

A copy will be sent to the Eastern Metropolitan Local Council.

A copy will be sent to RAU library.

An article will be sent for publishing in one of the accredited journals in South Africa.

3.11 SUMMARY

Research methodology is the theory of correct scientific decisions taken within the framework of the research process. It is a method of logical reasoning in the decision-making process. In this chapter, a methodology framework on how the study will be conducted was described. An explanation of each data-gathering step was provided to ensure adherence to the scientific way of enquiry. A scientific method will be used because logical reasoning is a human process and therefore liable to error. Bearing in mind that the study environment has a major impact on research outcomes, the researcher will ensure that all the subjects are only Alexandra residents who have lived in the area for more than a year. Those who will have been in the area for a lesser period will be rejected in both the sample groups (patients and community members). The sampling criteria will ensure the equivalence and homogeneity of the subjects selected for the study. Data collectors will be trained and observed for consistency. The researcher will use three different samples and two techniques of data collection. As a participant observer, her observations will be done using an observation list to be developed after data collection and will compliment the data to be gathered. The quality of research findings is directly dependent on the accountability of the research methodology. The researcher therefore has seen it necessary to follow a specific methodological process to exclude obvious wrong decisions and to enhance the validity of the research findings.

CHAPTER FOUR

THE RESEARCH FINDINGS ON THE FACTORS INFLUENCING THE ACCESSIBILITY OF PHC SERVICES IN ALEXANDRA TOWNSHIP, GAUTENG PROVINCE

4.1 INTRODUCTION

This chapter presents the findings from the data collected from the three sample groups (Annexures one, two and three), and the observations conducted by the researcher for the purpose of describing the factors influencing accessibility of PHC services in Alexandra Township.

Data analysis was conducted in order to reduce, organise and give meaning to the data collected.

As an exploratory descriptive design, the research purpose was realised by obtaining three types of empirical data from two different methods of collection: data from two sets of interviews conducted with the patients and community samples and data from the questionnaire from professional nurses. Responses were confirmed or rejected through observations conducted by the researcher as a participant observer. This was done in the months of November and December 2001.

4.2 DATA GATHERING INSTRUMENT

The interview schedule and the questionnaire had 8 main sections:

1. Demographic data.
2. Services offered.
3. Personnel resources.
4. Other resources.

5. Important documents.
6. Service utilisation.
7. Community involvement.
8. Health education.

These sections were used to investigate factors influencing the accessibility of PHC services in Alexandra Township.

All data was collected in November 2001 and the first part of December 2001 by the researcher with the help of two research assistants.

Annexure 1 is the interview schedule used in the interviews done with patients attending the four public clinics in Alexandra namely: the 4th Avenue clinic, 8th Avenue clinic, East Bank clinic and Thoko Ngoma clinic. For the purposes of anonymity these clinics were given other names namely: 1st clinic, 2nd clinic 3rd clinic and 4th clinic not necessarily in any order. A total of 160 respondents were interviewed in this phase. These respondents make up 51.6% of the total study sample. One-hundred-and-sixty patients (40 from each clinic) were interviewed in the public clinics.

Annexure 2 is the interview schedule used in the interviews done with Alexandra community members in their homes, churches and on the streets throughout Alexandra. A total of 140 respondents were interviewed in this phase. These respondents make up 45.1% of the total sample.

Annexure 3 is a questionnaire used to collect data from the professional nurses responsible for the provision of PHC services in the four public clinics in Alexandra. A total of 10 nurses were given the questionnaires and all 10 questionnaires were completed and returned. These respondents made up 3.2% of the total sample.

Annexure 4 is an observation list used to verify the responses from the respondents in the three phases of data collection. This was done in the month of February 2002

During the literature study eleven factors were identified that influence accessibility of health services worldwide. The researcher therefore organised the data according to these factors for clarity:

1. Demographic data.
2. Functional factors.
3. Social factors.
4. Physical factors.
5. Geographical factors.
6. Acceptable factors.
7. Financial factors.
8. Efficiency factors.
9. Effectiveness factors.
10. Equity factors.
11. Health education.



4.3 RESEARCH FINDINGS

4.3.1 PRESENTATION OF PATIENT AND COMMUNITY RESPONDENTS' DATA VERIFIED BY OBSERVATIONS DONE BY THE RESEARCHER WHERE APPLICABLE.

4.3.1.1 DEMOGRAPHICAL DATA OF THE COMMUNITY.

This section consists of personal particulars of the patient and community subjects. This information is relevant in this study as it has been found in Chapter Two that it also influences the people's accessibility to health services. The

information provided the researcher with a better understanding of the background of the respondents in the study.

i Gender

	Patients N=160		Community N=140	
	Female	Male	Female	Male
Frequency	134	26	88	52
Percentage	83.8	16.3	63.3	37.7

Table 4.1 The table shows that both samples had more females than males.

ii Race: Both patients and community samples were comprised of 100% blacks.

iii Name of street: All respondents came from the entire Alexandra area, from 1st to 22nd avenue, East Bank, Tsotsomane squatter camp, River Park and Marlboro.

iv Respondents' duration of stay in Alexandra: Range =1-20+ years

	Patients N=160		Community N=140	
	Frequency	%	Frequency	%
1-2 years	21	13.1		
2-5 years	43	26.9	2	1.4
5-10 years	16	10	4	2.9
10-20 years	36	22.5	28	20
20 years+	44	27.5	106	75.7

Table 4.2 The table shows that just above one quarter of the respondents in the patient sample had been staying in Alexandra for a period of more than 20 years while the majority (75.7%) in the community sample had been staying in the area for the same period.

v Age category:

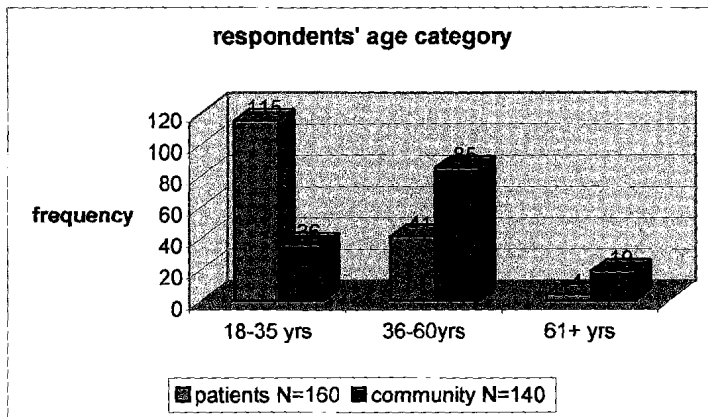


Figure 4.1 The figure shows that the highest percentage (75%) was found among the age group between 18-35 with the patient sample while the community sample's highest percentage (59%) was found in the age group between 36-60 years.

vi Educational background:

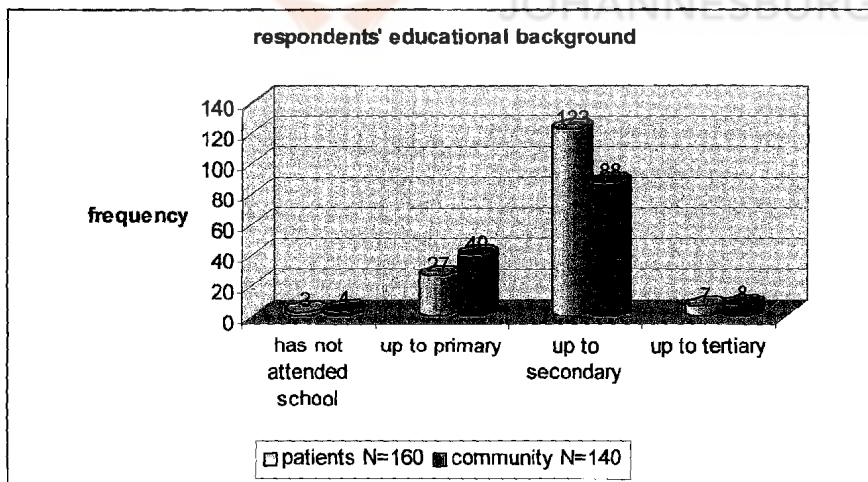


Figure 4.2 The figure shows that the majority of the respondents in both samples had reached secondary school.

vii Employment status:

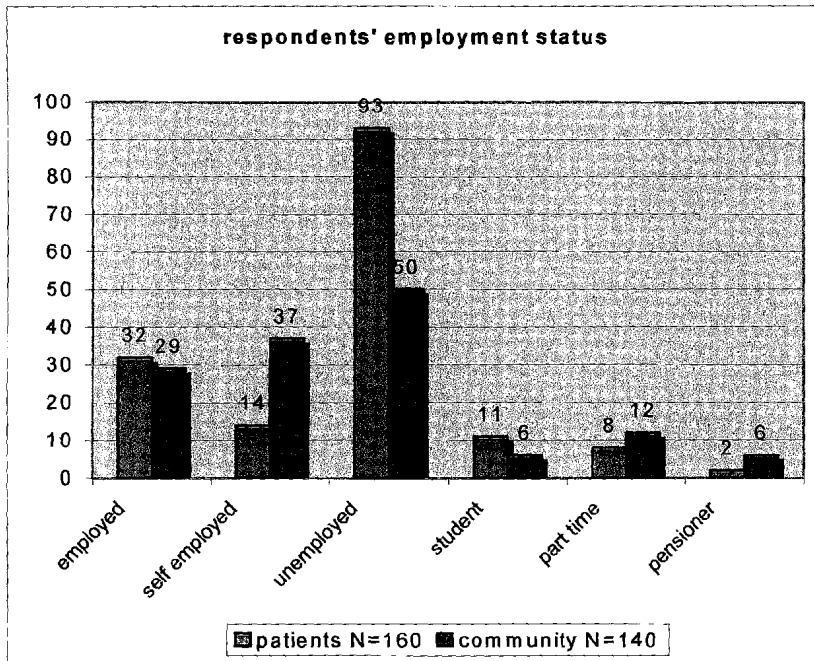


Figure 4.3 The figure shows that more than half the respondents in the patient sample were unemployed while more than a third in the community sample were unemployed

viii Respondents' monthly income: fig 4.4

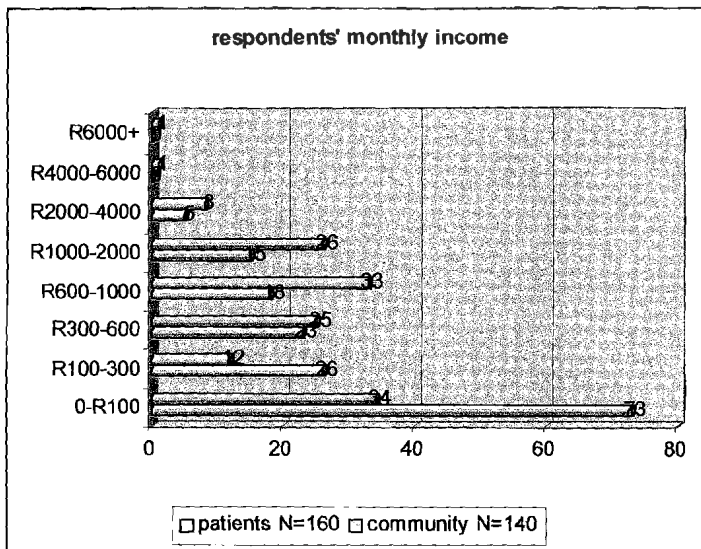


Figure 4.4 Figure illustrates that more than half (61.9%) in the patient sample and a third in the community sample earn less than R300 a month.

ix Respondents' marital status:

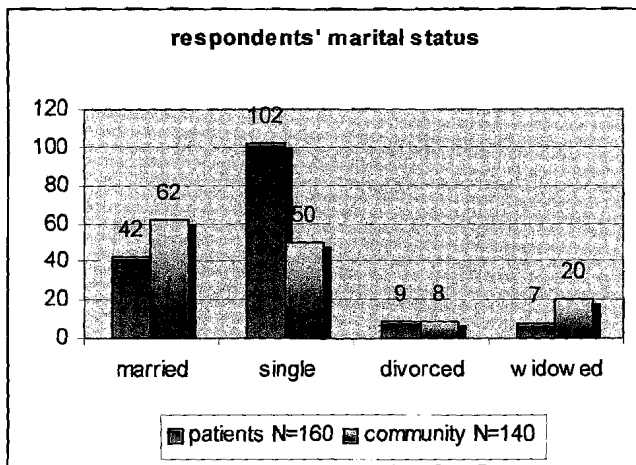


Figure 4.5 The figure shows that a total of 75% of the respondents in patients' sample and 36% in the community sample were not married.

x Medical aid:

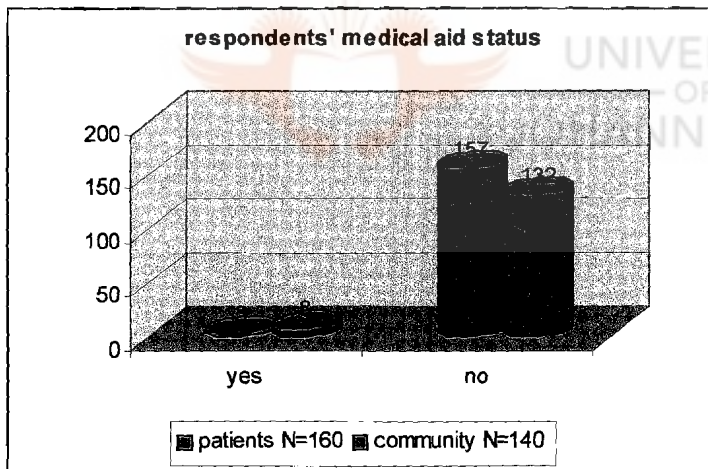


Figure 4.6 The figure shows that only 3 (2%) in the patient sample and only 8 (6%) in the community sample had medical aid.

4.3.1.2 FUNCTIONAL FACTORS OF ACCESSIBILITY TO PHC SERVICES.

i Awareness of services offered in the PHC clinics: 100% of the community respondents were aware of the existence of PHC clinics in their area. 100% in both samples were aware of the services offered in these clinics (p value 1.000).

ii Awareness of type of health services offered:

Type of services	Patients N=160		Community N=140	
	Frequency	Percentage	Frequency	Percentage
Minor ailments	113	71	76	54
Family planning	96	60	102	73
Well baby clinic	53	33	89	64
HIV Screening	39	24	25	18
TB Screening	44	28	72	51
STI	23	1	29	21
Pregnancy Testing	19	12	19	14
Health Education	19	12	8	6
Pap smear	12	8	5	4
Nutrition	1	.6	-	-
TOP counseling	-	-	1	0.7

Table 4.3 This table shows that the majority of the respondents were not aware of TOP counseling, nutrition, pap smear, health education and STI services in both samples.

iii Community's need of the services: 160 (100%) and 140 (100%) in both samples said that the community needs these services.

iv Respondents' reasons for visiting the clinic:

Respondents' reasons	Chi square tests (2 sided)				
	Patients N=160		Community N=140		Fisher's exact test p value
	Frequency	%	Frequency	%	
Well baby	17	11	5	4	0.025
TB	20	12	6	5.	0.049
STI	7	4.4	-	-	0.016
F/P	34	21.3	16	11.5	0.029
Minor ailments	75	46	115	62.7	0.000
Pregnancy test	1	0.6	-	-	1.000
Pap-smear	1	0.6	-	-	1.000

Table 4.4 The table shows that only 0.6% came for a pregnancy test and another 0.6% came for pap-smear in the patient sample and none in the community sample go to the clinic for these two services, both carrying ($p = 1.000$).

v Adequacy of services offered:

From the patient and community samples respectively; 131 (90%) and 63 (46%) said the services were enough for the people while 29 (10%) and 77 (54%) said that they were not enough. ($p = 0.000$).

vi Type of services to be added:

Out of 29 and 77 from the patient and community samples respectively who said that services were not enough; 11 (38%) and 16 (21%) said that they would like to have maternity services offered in these clinics, 11 (38%) and 23 (30%) said that they want pregnancy testing services. 8 (28%) and none said that they want HIV clinic, 3 (10%) and 20 (26%) said they want TOP services, 2 (7%) and none said that they wanted X-ray services, 1 (3%) and 32 (42%) said that they wanted nutrition services. From the community sample; 32 (42%) wanted dental services, 7 (9%) wanted laboratory services and 3 (4%) wanted emergency services.

vii Type of services not needed:

None (0%) from both samples indicated any type of service not needed by the community.

viii Level of satisfaction with the way services were provided:

From the patient and community samples respectively; 68 (43%) and 33 (24%) said that they were very satisfied, 49 (31%) and 62 (46%) were satisfied and 41 (26%) and 40 (30%) were not satisfied with the way that services were provided.

ix Reasons for their level of satisfaction:

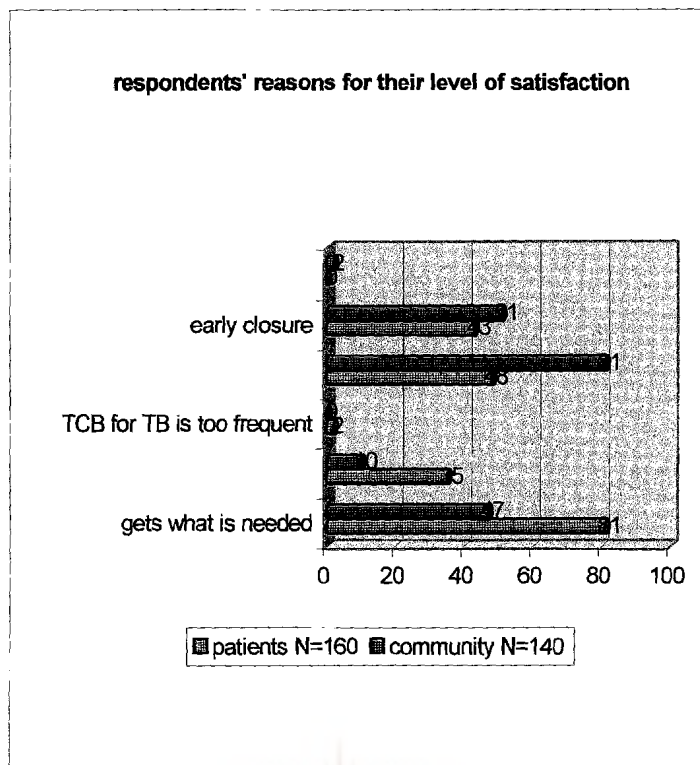


Figure 4.7 This figure shows that the majority of the respondents 81 (50.6%) from the patient sample said that they get what is needed while the majority of the respondents from the community sample 81 (57.9%) said that sometimes they do not get what is needed.

x Satisfaction with times services were offered:

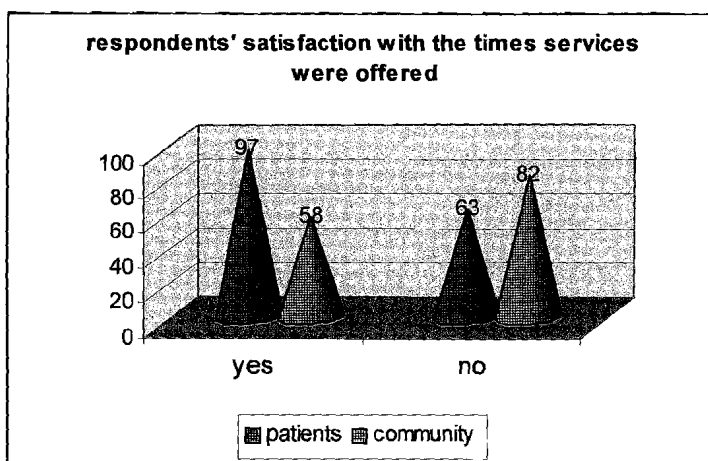


Figure 4.8 The figure shows that in the patient sample 63 (38%) and 82 (58.5%)

in the community sample said they were not satisfied with the times services are offered.

xi Preferred times:

		Preferred times of offering services				
		24hrs x 7 days	8hrs x 6 days	12hrs x 5 days	7am-5pm x 7 days	6am-7pm x 5 days
Patients N=160	Frequency	6	11	6	34	4
	Percentage	9.8	18	9.8	55.7	6.6
Community N=140	Frequency	64	3	5	5	5
	Percentage	78	3.6	6	6	6

Table 4.5 The table shows that the majority of respondents in the patient sample who were not satisfied with the times services were offered preferred that services be offered from 7am to 5pm, while the majority from the community sample preferred 24 hours, 7 days a week.

xii Respondents' suggestions to improve functional factors of accessibility to PHC services in the area:

Suggestions	Patients N=160		Community N=140	
	Frequency	%	Frequency	%
Be flexible	102	63.8	114	82
Open early	73	45.6	89	64
Open during weekend	-	-	65	46
Maternity services	11	6.9	16	11.4
Emergency services	8	5	11	7.9
School health & lab services	-	-	11	7.9
Dental services	-	-	3	2.1

Table 4.6 The table shows that about half of the patient respondents and more than half of the community respondents suggested that clinics should start early at 7am.

4.3.1.3 SOCIAL FACTORS OF ACCESSIBILITY TO PHC SERVICES.

i Opinion on whether the clinics have enough personnel or not:

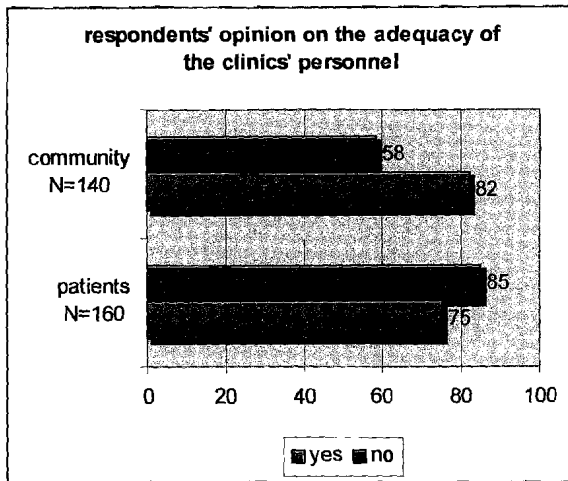


Figure 4.9 The figure shows that the majority (53%) of the respondents from the patient sample believed that the clinics had inadequate personnel while the majority (58%) of the respondents from the community believed otherwise ($p = 0.002$).

ii Opinion on the personnel's ability to deal with the people's health problems:

From the patient and community samples respectively; 137 (86%) and 102 (75%) said the personnel were able to deal with their health problems, 20 (13%) and 27 (20%) said not all were able and 2 (1.3%) and 6 (6%) said personnel were not able.

iii Respondents' satisfaction with personnel's attitude:

From the patient and community samples respectively; 108 (68%) and 24 (17%) were satisfied with the personnel's attitude, 28 (18%) and 35 (25%) were not satisfied with some of the personnel's attitude and 24 (15%) and 81 (58%) were not satisfied with all of them.

iv Respondents' reasons for their answer:

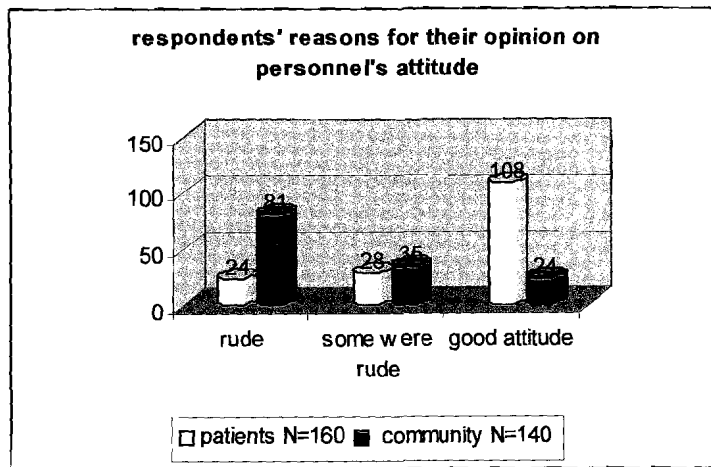


Figure 4.10 This figure shows that in the patient sample the majority of the respondents thought that the personnel had good attitude while in the community sample the majority of the respondents thought that personnel were rude.

v During phase 4 of data collection the researcher observed the following:
Personnel's attitudes towards the patients in the clinics: It was in the 4th clinic only where the researcher observed a cleaner shouting at a child for playing around. In the same clinic a nurse argued with a patient, lost her temper and ended up telling the patient (male youthful patient) not to consult in her room.

vi Respondents' suggestions to improve social factors: Table 4.7

Suggestions	Patient N=160		Community N=140	
	Frequency	%	Frequency	%
Improve attitude	54	33.8	117	83.6
Improve communication skills	53	33.1	116	82.9
Observe tea time	21	13.1	54	38.6
Improve employment skills	14	8.8	91	64
Monitor personnel	14	8.8	16	11.4
Change personnel	2	2	41	29.3

Table 4.7 This table shows that just more than one third of the respondents in the patient sample (33.8%) said that personnel had to improve their attitudes, while in the community sample the majority (83.6%) suggested that the personnel should change their attitude.

4.3.1.4 PHYSICAL FACTORS OF ACCESSIBILITY TO PHC SERVICES.

i Adequacy of the rooms:

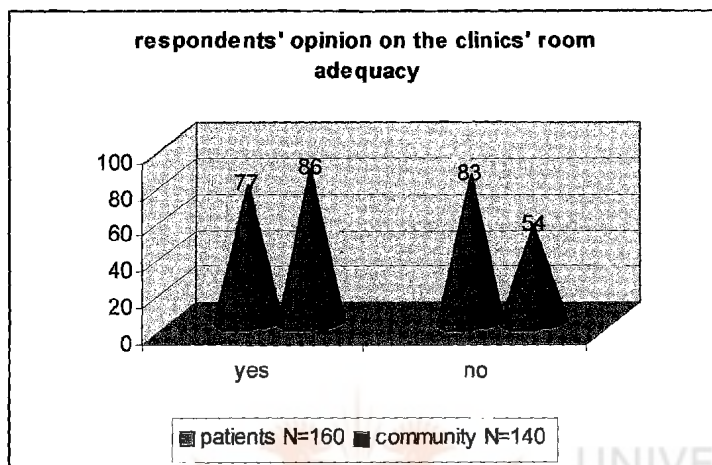


Figure 4.11 This figure shows that more than half of the respondents from the patient sample (51.8%) said that the clinics do not have enough rooms for the services they provide, while the majority (61.4%) of the respondents from the community sample believed otherwise.

ii Awareness of transportation for very sick patients who needed to go to the hospital: From the patient and community samples respectively; 77 (49%) and 44 (32%) said that they were aware of the transport system for very sick people while 81(51%) and 94 (58%) said that they were not aware.

iii Level of satisfaction with the transport system for very sick patients who needed to go to the hospital: : Out of 77 and 44 respondents who were aware of the transport system for very sick patients in the patient and community samples respectively, 28 (36%) and 6 (14%) said that they were very satisfied

with the transport system for very sick patients to go to hospital, 28 (36%) and 8 (18%) said that they were just satisfied while 21 (27%) and 30 (68%) said that they were not satisfied.

iv Level of satisfaction with the security system:

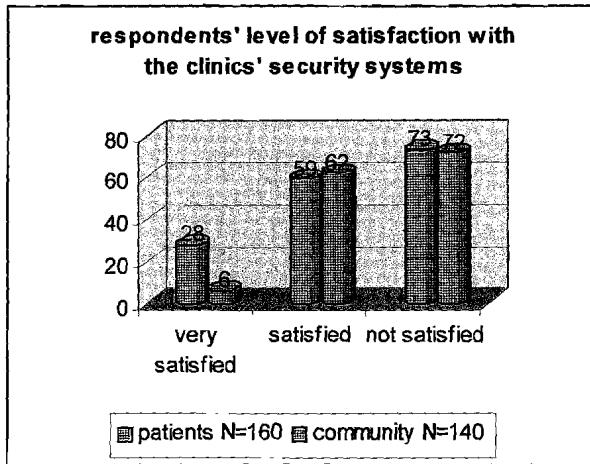


Figure 4.12 This figure shows that more than a third (36.8%) of the patient sample and only 3.5% of the community sample said that they were very satisfied with the security system of the clinics.

v Respondents' reasons for their level of satisfaction with the security system of the clinics: From the patient and community samples respectively, 28 (17.5%) and 20 (14.2%) said that the clinics were well manned, 59 (36.8%) and 41 (29.2%) said that there had never been any disruption while 61 (38.1%) and 49 (35%) said that they had never seen a guard, 12 (7.5%) and 30 (21.4%) said that the security system was weak.

vi Respondents' suggestions in order to improve physical factors:

Suggestions	Patients N=160		Community N=140	
	Frequency	%	Frequency	%
Improve security measures	69	43	90	64
Quick ambulance response	49	31	79	56
Enough equipment	26	16	17	12
Build more clinics	12	8	10	7
Extend clinics	12	8	6	4

Table 4.8 This table demonstrates that 43% of the respondents from the patient sample suggested that the security measures of the clinics must be improved while more than half in the community sample suggested the same.

4.3.1.5 GEOGRAPHICAL FACTORS OF ACCESSIBILITY TO PHC SERVICES

i Distance to the clinic:

	Respondents' distance from home to the clinics			
	Patients N=160		Community N=140	
	Frequency	Percentage	Frequency	Percentage
< 1km	82	51.2	66	47
1-2km	64	40	56	40
3-5km	13	8.1	16	11.4
6-10km	1	0.6	1	0.7
>10km	0	-	1	0.7

Table 4.9 This table shows that the majority of the respondents from the patient sample, 82 (51.2%) travel a distance of less than a kilometer to reach their clinics and just below half in the community sample travel the same distance to reach the clinic.

ii Time taken to reach the clinic:

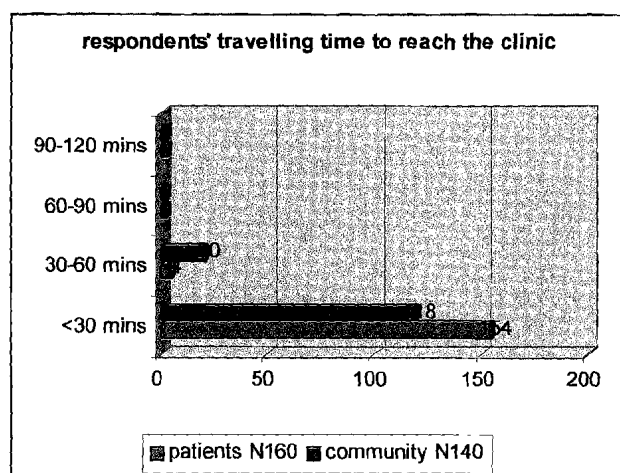


Figure 4.13 This figure shows that in both samples the majority of the

respondents said that they take less than 30 minutes to reach the clinic.

iii Respondents' means of traveling to the clinic

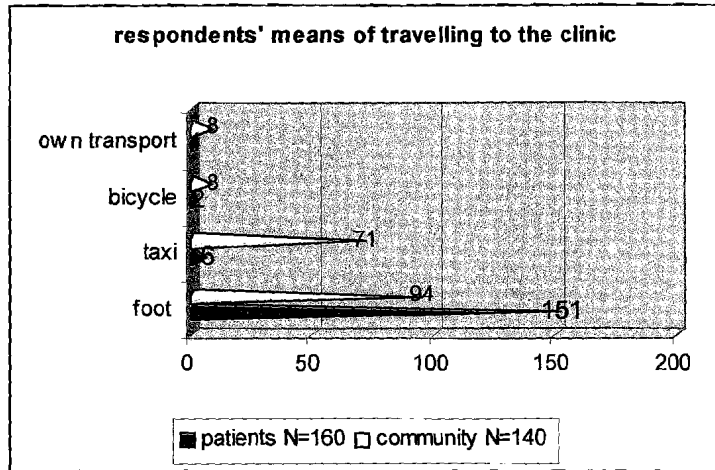


Figure 4.14 This figure shows that an overwhelming majority in both samples walk to the clinic.



4.3.1.6 ACCEPTABILITY OF PHC SERVICES

i Privacy provided in the clinics: From the patient and community samples 143 (89.3%) and 121 (86.4%) respectively, said that the personnel provide enough privacy during consultation, while 17 (10.6%) and 19 (13.5%) said they do not provide privacy as they allow more than one patient in the room at a time. One (0.6%) from the patient sample stated that there is no gender consideration as male patients are attended to by a female nurse.

ii Awareness of the way confidential records were handled: 35 (21.9%) and 2 (1.4%) from the patient and community sample, respectively, said that they were aware of how confidential records were handled in the clinics, while 125 (78.1%) and 138 (98.6%), respectively, said that they were not aware of how these records were handled in the clinics.

iii Level of satisfaction in those who were aware of the way confidential records were handled:

From the patient sample, out of 35 respondents, 23 (66%) said they were very satisfied, 7 (20%) said they were satisfied and 5 (14%) said they were not satisfied. In the community sample out of the 2 who were aware, one was very satisfied and the other was not.

iv Those who were sent back home without being attended to:

From both the patient and community samples respectively; 53(33.6%) and 43(30.7%) said that they were once turned back home without being attended to while 104(66.2%) and 94(67%) said that they had never been sent back.

v Respondents' reasons given to them for being sent back: Table 4.10

Reasons for being sent back	FISHER'S EXACT TEST 2 sided				
	Patient N=160		Community N=140		Fisher's test p value
	Frequency	%	Frequency	%	
Late	39	24.4	28	20	0.406
Do not do pregnancy test	0	0	6	4.3	0.010
Long delays	2	1.3	13	9.3	0.002
Can not open a vial for 1 baby	1	0.6	0	0	1.000
No card	2	1.3	0	0	0.501
Numbers finished	3	1.9			0.251
Do not treat babies < months	3	1.9	0	0	0.150

Table 4.10 This table shows that from both the patient and community samples 53 (33.6%) and 43 (30.7%), respectively, said that they were once turned away without being attended to while 104 (66.2%) and 94 (67.1%) said that they had never been sent back.

vi In phase 4 of data collection the following was observed: Clinics that send patients home without treatment. At the 1st clinic about 10 patients were sent back. At the 2nd clinic sent about 20 patients, specifically family planning patients back. At the 3rd clinic no patient was sent back. The researcher was told by one of the nurses that the clinic does not provide measles inoculations on a daily basis. At the 4th clinic about 6 patients were sent back.

vii Places of first preference to receive help: In both the patient and community samples 90 (65.7%) and 80 (50.3%) respectively, said that they prefer to go to the public clinic in Alexandra for treatment, 33 (20.6%) and 15 (10.7%) said that they prefer the NGO clinic first, 31 (19.4%) and 33 (23.5%) said that they prefer to go to private doctors, 11 (6.9%) and 1 (0.7%) preferred to buy medicines from the chemists and shops, 3 (1.9%) and 3 (2.2%) said that they prefer to go to public clinics outside Alexandra.

viii Those with special reason for visiting the particular clinic: 45 (28%) from the patient sample said they had a special preference for visiting the clinic other than staying near it while 114 (71.3%) said they did not. In the community sample 70 (50%) said that they had a clinic they preferred to visit to other clinics in the area while the other half did not.

ix Name of preferred clinics:

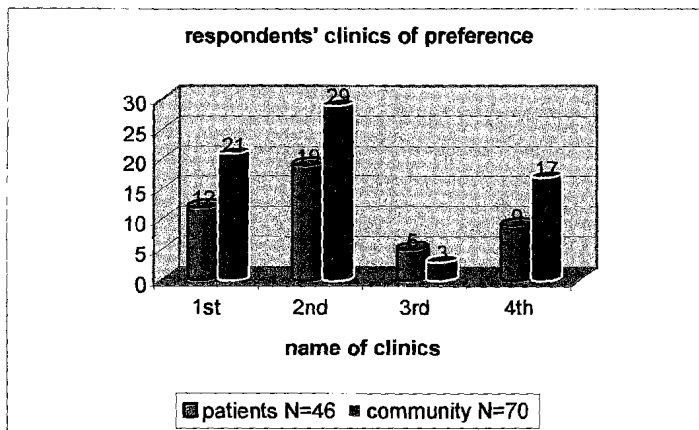


Figure 4.15 This figure shows that both the patient and community samples preferred the 2nd clinic more and the 3rd clinic less.

x Reason for the preference:

Out of 45 respondents from the patient sample and 70 from the community sample 37 (84%) and 40 (57.1%) respectively, said that the clinics' personnel were friendly to them, 7 (15%) and 17 (24.2%) said that the clinics were faster in providing the services and 3 (7%) from the patient sample said that the clinics had good reputation.

xi Level of user friendly services:

From both the patient and community sample 65 (40%) and 15 (10.7%) said that the clinics were very good, 70 (43.8%) and 100 (71.4%) said that they were good, while 11 (6.9%) and 11 (7.8%) said that the clinics were bad and 14 (8.8%) and 14 (10%) said that they were poor.

xii Availability of a suggestion box in the clinics:

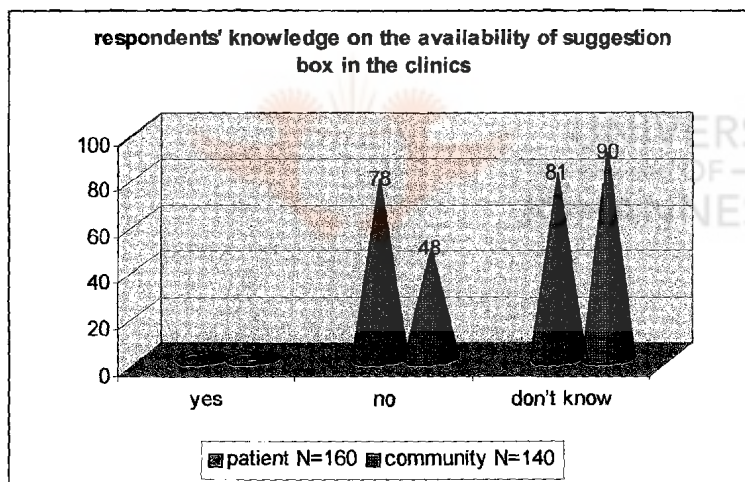


Figure 4.16 This figure shows that an overwhelming majority in both community and patient samples were not aware of a suggestion box in the clinics.

xiii Respondents satisfaction with the existence of the clinics in their community:

From the patient and community samples respectively; 148 (93%) and 127 (92%) said that they were satisfied while 12 (8%) and 13 (8%) said they were not satisfied.

xiv Level of utilisation by the community:

From the patient and community samples respectively; 105 (66%) and 71 (52%) said that the clinics were well utilised while 54 (34%) and 69 (48%) said that they were not.

xv Importance of community involvement:

From the patient and community samples respectively; 159 (99%) and 103 (74%) said that it is important to be involved in the running of the health services but 1 (0.6%) and 37 (26%) said it is not important.

xvi Respondents' suggestions in order to improve acceptability factors of accessibility:

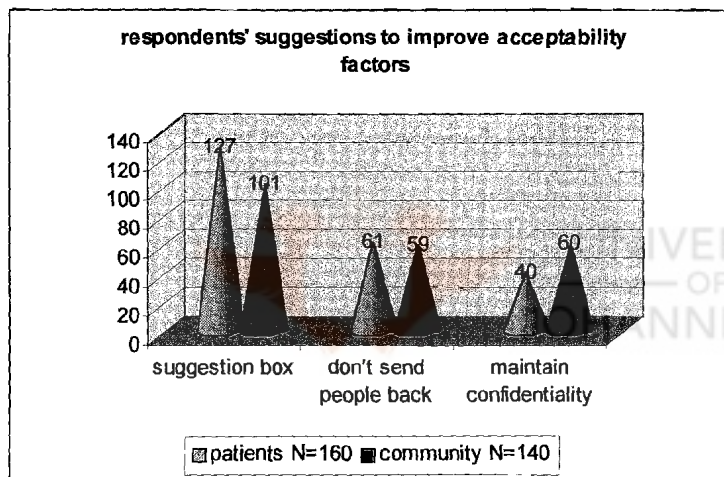


Figure 4.17 This figure shows that the majority of both the patient and community samples (79% and 70% respectively) said that they would like to have suggestion boxes in the clinics.

4.3.1.7 FINANCIAL FACTORS OF ACCESSIBILITY TO PHC SERVICES

i Drug supply:

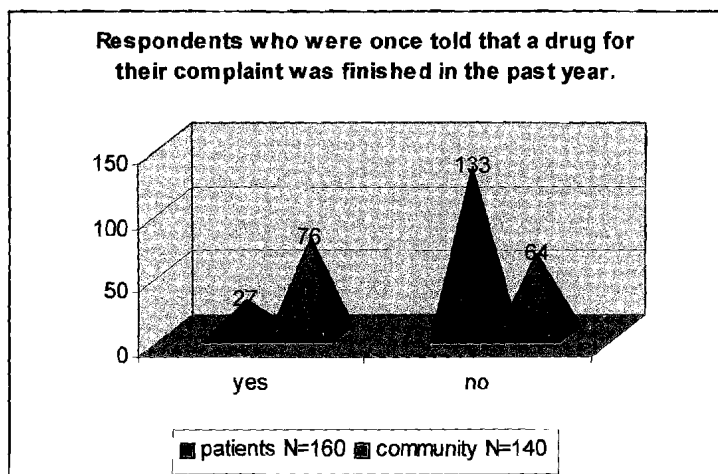


Figure 4.18 This figure shows that the majority of the patient sample said that they were never told that a drug for their complaint was finished while the majority in the community sample said otherwise ($p = 0.000$).

ii Ability to buy own medicine which was out of stock:

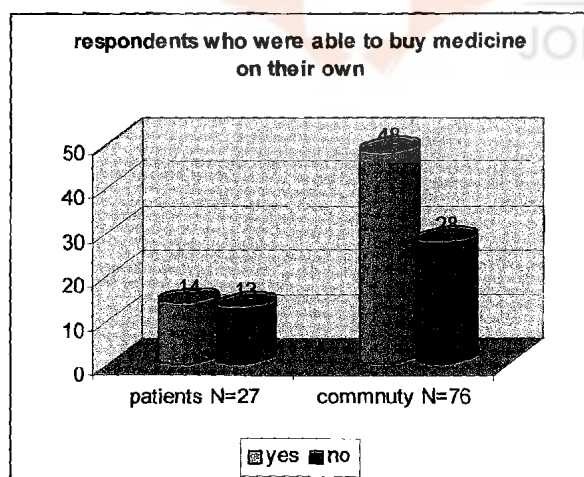


Figure 4.19 This figure shows that almost half of the respondents from the patient sample were unable to buy medicines on their own while the majority from the community sample were able to do so.

iii Respondents' financial viability for transportation to the clinic:

Out of the 5 and 71 respondents in the patient and community sample respectively who said that they use a taxi to go to the clinic 2 and 6 said that they sometimes fail to go because of lack of money.

iv Respondents recommendations in order to improve financial factors:

Fifty one (32%) from the patient sample and 91 (65%) from the community sample said that clinics should have enough medicines.

4.3.1.8 THE EFFICIENCY OF PHC SERVICES.

i Availability of grievance channels in the clinics:

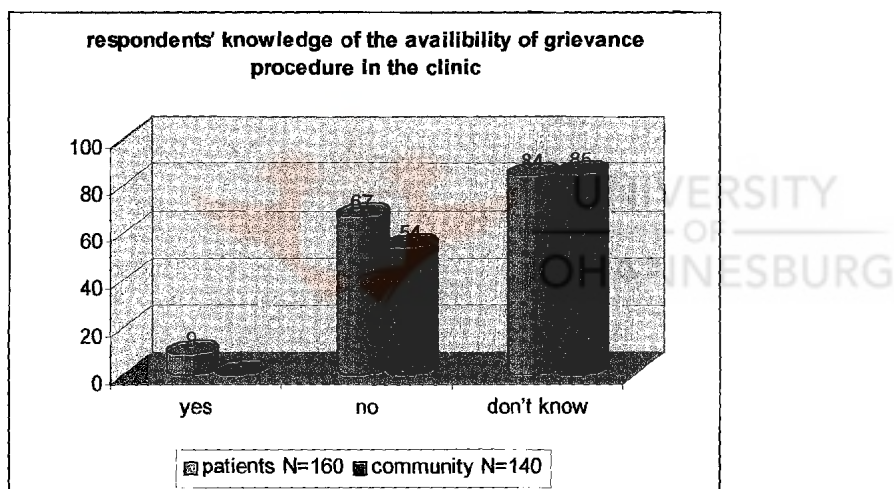


Figure 4.20 This figure demonstrates that few of the respondents in both samples said that there were grievance procedures in the clinics.

ii Respondents' waiting period at the clinics:

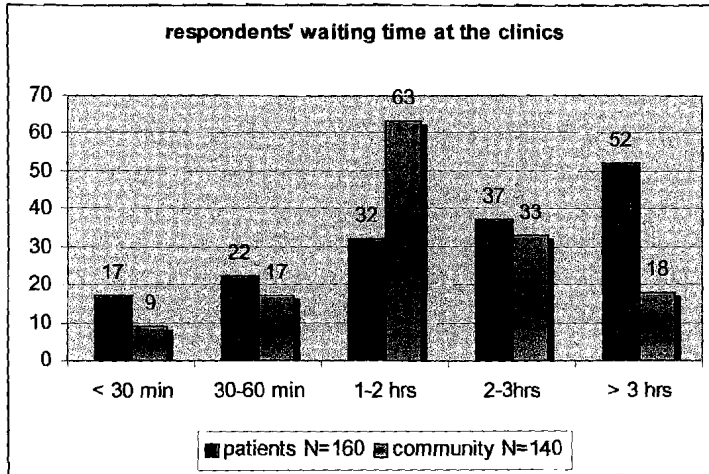


Figure 4.21 This figure indicates that 10% in the patient sample and 6.4% in the community sample said that it took less than 30 minutes of waiting in the queue before being attended to.

iii In phase 4 of data collection the following was observed:

Patients' waiting time:

1st clinic:

6.30am: Patients arrive and wait outside the closed gates. 7.00am: Clinic gates were opened, patients took their seats and reception was full. 7.30am: Prayers were said. 7.35am: Personnel started attending to the patients. Average waiting time more than 3 hours. Personnel alternated for tea (30 mins each, 2 nurses were on duty). Alternated for lunch (1 = 30mins, 1 = 1hour). Last patient left the clinic at 3.40pm. Nurses went home 4.30pm.

2nd clinic:

6.30am: Ten patients are waiting outside the clinic gates. 7.30am: Patients were allowed in and they rushed to take their seats. The clinic was not full to capacity. 7.36am: Prayers were said. 7.38am: Personnel started attending to the patients. Average waiting time more than 3 hours. Alternated for tea (20 mins) with the researcher (there was 1 nurse on duty). No lunch taken. Last patient left at 3.50pm. The nurse left at 4.10pm.

3rd clinic

6.30am: There were two patients waiting outside the clinic. 7.15am: The clinic doors were opened and the patients took their seats. The clinic was half-full. Patients kept changing their seats seemingly not knowing which queue to be in and the cleaners kept on showing them to different seats. No prayers were said.

8.15am: Personnel started attending to the patients. Average waiting time more than 3 hours. Alternated for tea (30 mins, there were 3 nurses on duty). All went for a 1-hour lunch at 1pm. The last patient left at 3.15pm. The nurses left at 3.55pm.

4th clinic:

6.10am: Two patients were waiting outside the clinic gates. 7.15am: The clinic doors were opened and patients took their seats. 7.30am: The clinic was full. 7.30-8.15am: All the nurses had tea. No prayers were conducted. 8.20am: Personnel started attending to the patients. Average waiting time more than 3 hours. All went for tea (1 hour). The last patient left at 1.30pm. The clinic doors were locked at 3.30pm.

iv Adequacy of consultation period with nurses in the clinics:

From the patient and community samples respectively; 116 (73%) and 78 (56%) said that personnel spent enough time with them, while 44 (28%) and 62 (45%) said that personnel did not spend enough time with them.

v Respondents' suggestions to improve efficiency factors:

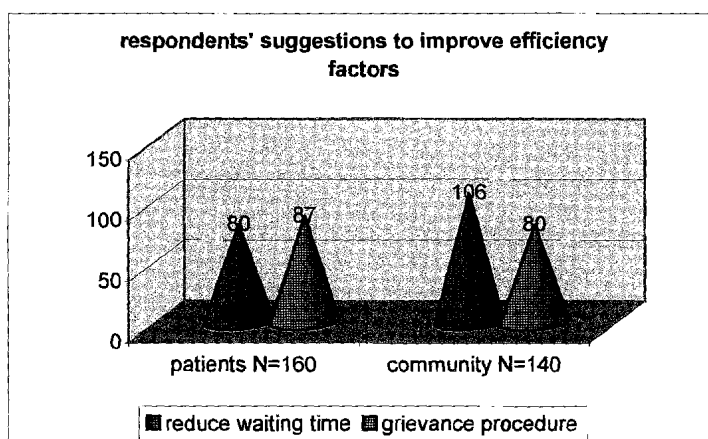


Figure 4.22 This figure shows that both the patient and community samples

suggested that the waiting time must be reduced and that grievance procedures should be provided.

4.3.1.9 THE EFFECTIVENESS OF PHC SERVICES.

i Frequency of clinic visitation:

	Cumulative percentage for frequency of clinic visitation					
	Patient sample N=160			Community sample N=140		
Clinic visitation	Frequency	%	Cumulative %	Frequency	%	Cumulative %
Monthly	69	43.1	43.1	9	6.4	6.4
3 monthly	62	38.8	81.9	79	56.4	62.9
6 monthly	12	7.5	89.4	29	20.7	83.6
Yearly	4	2.5	91.9	11	7.9	91
First time	13	8.1	100	-		
Stopped	-	-		12	8.5	100
Totals	160	100		140	100	

Table 4.11 This table shows that more than 81.9% from the patient sample and 62.9% from the community sample visits the clinic every three 3 months.

ii Lack of physical examinations on the patients visiting the clinics:

Twenty nine (18.1%) of the patient sample and 25 (17.8%) from the community sample said that sometimes they were not physically examined in the clinics.

iii Respondents who sometimes do not go to the clinic when sick:

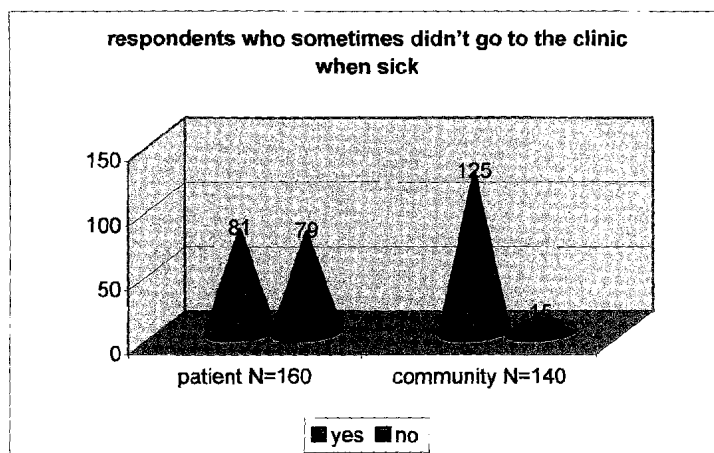


Figure 4.23 This figure shows that 81 (50.6%) from the patient sample and the majority 125 (89.2%) from the community sample said that they sometimes do not go to the clinic when sick.

iv Respondents reasons for not visiting the clinic:

Reason	Patients N=81		Community N=125	
	Frequency	%	Frequency	%
Too long waiting time	66	81	90	72
Unsuitable time of offering services	18	22	13	10.4
Needed services not available	11	13.5	15	12
Personnel's rudeness	7	8.6	35	28
No transport money	2	2.4	4	3.2
Long distance	2	2	12	9

Table 4.12 shows that in both samples; the majority of those who chose not to go to the clinic gave long waiting time as a reason for not visiting the clinic.

v Nurses' explanation of clinical procedures:

Figure 4.24

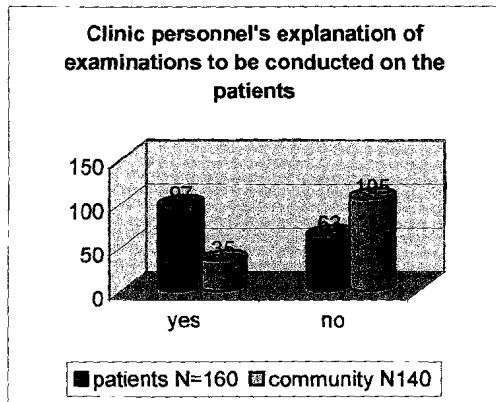


Figure 4.25

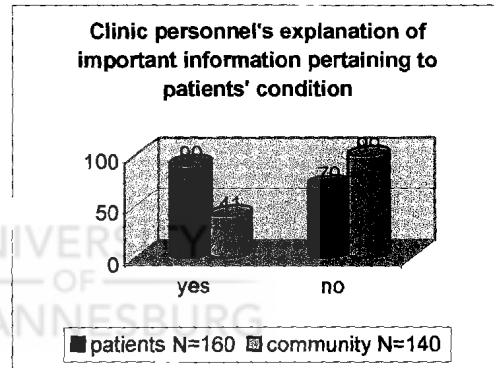
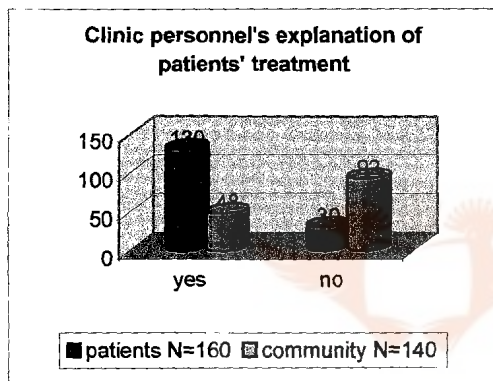
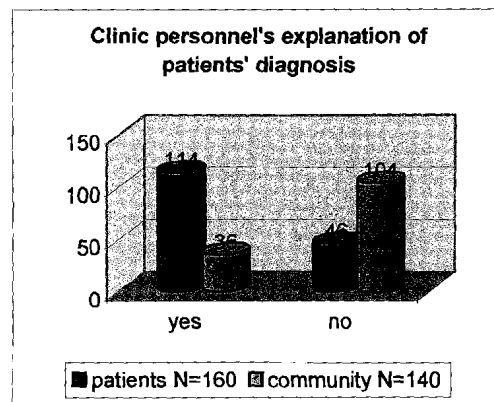


Figure 4.26

Figure 4.27

In figures 25,26,27,28 it was demonstrated that the majority of the patients said that personnel explained clinical procedures but did not give them important information about their conditions, unlike the community sample who said that the personnel do not explain clinical procedures to them.

vi Respondents' suggestions to improve effectiveness factors:

Forty seven (29%) of the patient sample and 99 (71%) of the community sample suggested that personnel should examine patients thoroughly and explain clinical procedures to them.

4.3.1.10 EQUITY ACCESSIBILITY OF PHC SERVICES

i Respondents' awareness of human rights in terms of health services:

From the patient and community samples respectively; 81 (51%) and 104 (74%) said that they were not aware of their rights while 79 (49%) and 36 (26%) said that they were aware of their health service rights (p value=0.000).

ii Rights which the patients were aware of:

Right	Chi square tests on the respondents awareness of their health rights				
	Patients N=160		Community N=140		P value
	Frequency	%	Frequency	%	
Complain about the health services	38	23.8	15	10.7	0.004
Access to health services	25	15.6	1	0.7	0.000
Privacy	20	12.5	5	3.6	0.006
Informed consent	17	10	5	3.6	0.025
Choice in healthcare	12	7.5	10	7.1	0.543
Refuse treatment	5	3.1	5	3.6	0.540
Be referred for 2 nd opinion	3	1.9	0	-	0.150
Confidentiality	3	1.9	0	-	0.103
Healthy & safe environment	2	1.3	3	2.1	0.437

Table 4.13 This table shows that only a few of the respondents mentioned some of their rights to health services.

iii Satisfaction with the way nurses deal with very sick patients:

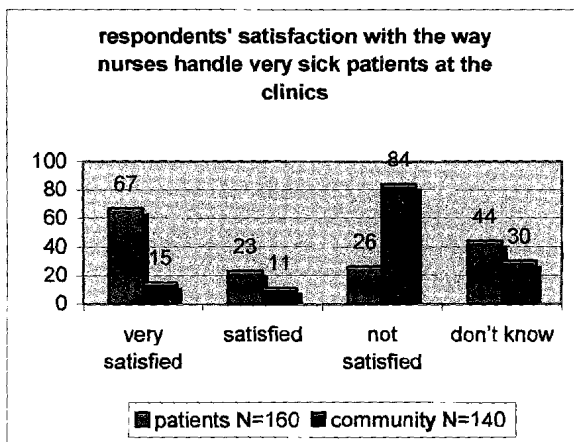


Figure 4.28 This figure shows that the highest percentage in the patient sample were very satisfied while the majority in the community sample were not satisfied with the way nurses handle very sick patients.

iv In phase 4 of data collection the following was observed:

Handling of very sick patients:

None of the nurses did a round to see if there are very sick patients in the queue.

1st clinic: Received a burnt baby that was handled as a priority case.

2nd clinic: Received a very sick patient who came with his guardians and was handled as a priority. The patient was later transferred to hospital and ambulance came within an hour of being called.

3rd clinic: Not one very sick patient visited the clinic that day.

4th clinic: The researcher found a child with a temperature of 38⁰ C. He was one of the last three patients who waited while the personnel were on their extended tea break (see 4.3.1.8 par iii).

v Those referred to see a visiting doctor:

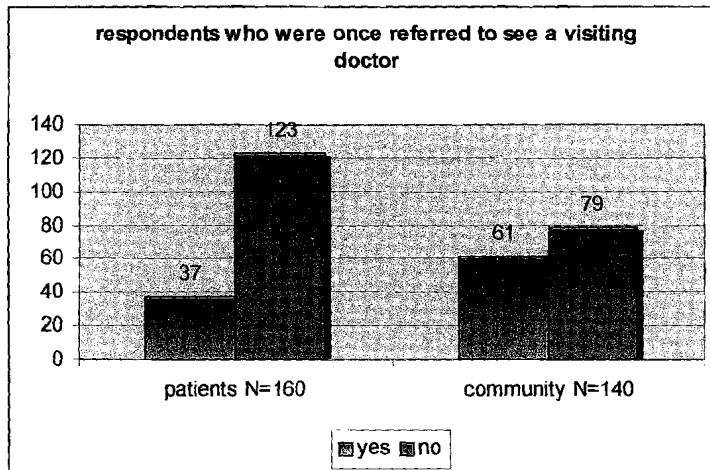


Figure 4.29 This figure shows that in both samples less than half of the respondents had been referred to see a visiting doctor.

vi Respondents who were once referred to go to hospital:

From the patient and community samples respectively; 117 (73%) and 92 (66%) said that they had never been referred to go to a hospital while 43 (27%) and 48 (34%) said that they had.

vii Respondents' opinion on whether the clinics were discriminatory when providing services: From the patient sample 112 (70%) said that the clinics provide services without discrimination while 48 (30%) said that clinics discriminate. In the community sample 70 (50%) of the respondents said that they did not have a clinic of preference because of their discriminatory practices, furthermore out of the remaining 70 (50%) with clinics of preference, 64 (47.1%) admitted that clinics were discriminatory.

viii Respondents' reasons why they believed that clinics were discriminatory: Out of those who said that clinics were discriminatory, 47 (97%) from the patient sample and 130 (97%) from the community sample said that personnel provide services to their friends and families first, 1 (3%) from the patient sample and 4 (10%) from the community sample said that receptionists keep earlier numbers for their friends.

ix Respondents' awareness of home-based activities the clinics were involved in:

From the patient and community samples respectively; 16 (10%) and 15 (11%) said that they were aware of homebased activities the clinics were involved in, while 144 (90%) and 125 (89%) said that they were not aware.

x Types of home-based activities as indicated by the respondents:

Out of 16 and 15 respondents in the patient and community sample who were aware of home-based activities, 14 (87.5%) and 13 (86.6%) mentioned home visiting, and 2 (22.5%) and 2 (13.4%) mentioned follow-up for TB management.

xi Respondents' suggestions to improve equity factors of accessibility:

Suggestion	Patients N=160		Community N=140	
	Frequency	%	Frequency	%
Educate people on their rights	123	77	111	79
Conduct home visits	73	46	43	31
Treat everyone equally	56	3	32	23

Table 4.14 This figure shows that 77% of the patient respondents and 79% of the community respondents recommended that nurses need to educate their patients on their rights to health services.

4.3.1.11 HEALTH EDUCATION FACTORS OF ACCESSIBILITY TO PHC SERVICES:

i Respondents who had attended health education sessions in the clinics:

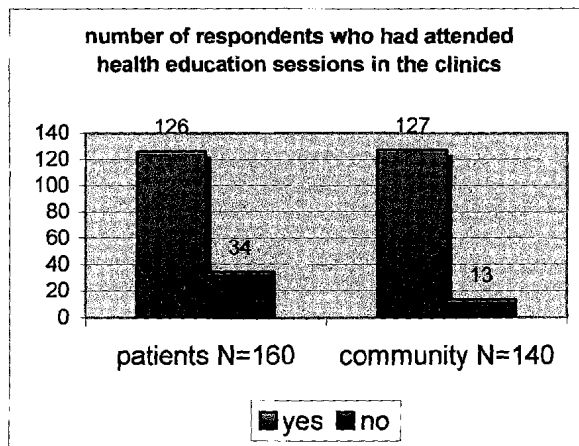


Figure 4.30 This figure shows that a higher patient percentage (21.3%) had not attended health education sessions than the community sample (8.5%).

ii Availability of health education sessions in the clinics: In phase 4 the researcher observed the following:

1st clinic: a Hope Worldwide volunteer taught on TB using relevant visual aids.

2nd clinic: no health education was given that day. Upon inquiry the researcher was told that the volunteers had gone to the 3rd clinic for a health education show. The researcher followed them to the 3rd clinic together with a co-ordinator of communicable disease and were told that no volunteer had come to that clinic that morning for any show.

3rd clinic: no health education was given that day.

4th clinic: no health education was given that day.

iii Level of satisfaction with the health education provider:

Out of 126 and 127 in the patient and community samples respectively who said that they had received health education; 119 (94%) and 117 (92%) were satisfied with the health education provider while 7 (6%) and 10 (8%) were not.

iv Personnel responsible for the provision of health education: In phase 4 the researcher observed the following: Health promoters were responsible in

providing health education services in the 2nd and 3rd clinics. Hope Worldwide volunteers were responsible for 1st and 4th clinics.

v Ability to understand the language used in health education sessions:

Out of 126 and 127 from the patient and community samples respectively; 112 (93%) and 123 (97%) said that they were able to understand the language used in health education session while 14 (7%) and 4 (3%) said that they were not.

vi In phase 4 of data collection the following was observed:

Language used in health education sessions: A mixture of Zulu, Xhosa, Sotho and English.

vii Health educator's use of relevant visual aids: Out of 126 and 127 respondents in the patient and community samples respectively 77 (61.2%) and 115 (89.8%) said that the provider used relevant visual aids, 46 (36.5%) and 13 (10.2%) said that the provider did not and 3 (2.4%) from the patient sample said that the provider does not always use relevant visual aids.

viii Periodical provision of pamphlets to the patients in the clinics:

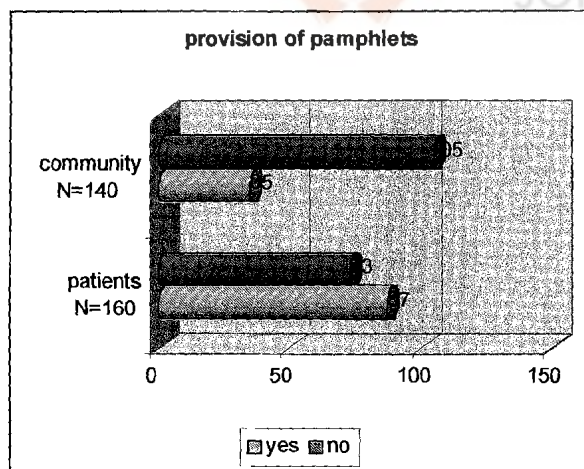


Figure 4.31 This figure shows that 87 (54.3%) in the patient sample and 35 (25%) in the community sample said that the clinics provide them with health reading-materials.

ix Ability to understand the language used in the reading materials: Out of 87 and 35 respondents from the patient and community sample respectively, who said that clinics do provide them with health reading-materials 85 (97.7%) and 35 (100%) said that they were able to understand the language, while in the patient sample 1 (1.3%) said they did not understand the language and 1 (1.3%) said that they did not always understand the language in the reading materials.

x Respondents' suggestions to improve health education factors:

Suggestion	Patients N=160		Community N=140	
	Frequency	%	Frequency	%
Provide pamphlets	71	44.4	103	73.6
Provide health education	46	28.8	35	
Use relevant visual aids	13	8.1	16	11
Have a multilingual provider	12	7.5	7	
Use an interpreter	10	6.3	0	-

Table 4.15: This table shows that a third of the patient sample and more than half of the community sample said that the clinics should provide health reading-materials.

4.3.1.12 GENERAL COMMENTS FROM THE PATIENTS AND COMMUNITY RESPONDENTS:

Comment	Patients N=160		Community N=140	
	Frequency	%	Frequency	%
Extend building	69	43.1	39	27.9
Add more nurses	68	42.5	51	36.4
Stop shouting	28	17.5	98	70
More doctors	28	17.5	21	15
Establish health committees	22	13.8	0	-
General clinic improvement	22	13.8	92	65.7
Treat people regardless of age	10	6%	0	-
White doctors / volunteers	4	2.5	12	8.6
Monitor personnel	14	8.8	16	11.4

Table 4.16: This table shows that the highest percentage in the patient sample (43.1%) asked for more nurses in the clinics while the majority of the community respondents (70%) commented that the clinic personnel should stop shouting.

4.3.2 PRESENTATION OF NURSE RESPONDENTS' DATA VERIFIED BY THE OBSERVATIONS DONE BY THE RESEARCHER WHERE APPLICABLE:

This data was procured from the questionnaire used to obtain information from the professional nurses responsible for the provision of PHC services in Alexandra public clinics regarding the accessibility of PHC services in Alexandra Township. These respondents made up 3.1% of the total study sample. Ten professional nurses were given the questionnaire to complete in their own time with instructions on how to complete the questionnaires and a due date. All 10 questionnaires were completed and collected by the researcher from the clinics.

The questionnaire had 8 main sections just as the other instruments used with the patient and community samples. For the purposes of clarity the data here is presented according to the factors as explained earlier.

4.3.2.1 DEMOGRAPHICAL DATA OF THE NURSE RESPONDENTS.

i Nurse respondents' gender : all 10 were females.

ii Age category: 7 were between 36-55 years, 2 were between 20-35 years and 1 was between 56-65 years.

iii Respondents qualifications:

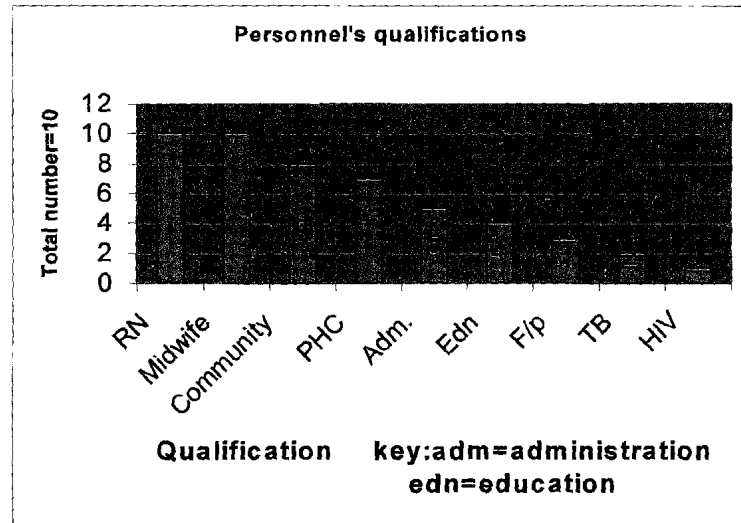


Figure 4.32 This figure shows that 10 were professional nurses and 7 were PHC trained.

iv Duration of respondents' employment in Alexandra public clinics:

Six indicated that they had been working for a period 2-5 years, 3 for more than 5 years and 1 between 1-2 years.

4.3.2.2 FUNCTIONAL FACTORS OF ACCESSIBILITY

i Respondents' opinion on whether the public was aware of the clinics' existence and the type of services they offer:

Nine respondents indicated that the public was aware of their existence and the services they offer, 1 indicated that not all people were aware of their clinic and the services they provide.

ii Type of services offered and personnel responsible as indicated by the nurse respondents:

Type of service	Frequency	Personnel responsible		
		R/N	E/N	CHW
Minor ailments	10	10	-	-
TB	10	-	-	6
F/P	10	1	9	-
Well baby	10	10	-	-
STI	5	5	-	-
Chronic diseases	3	0	0	0
HIV testing	2	0	0	0
Trauma	1	0	0	0

Table 4.17: This table shows that all the respondents indicated that their clinics provided services for the diagnosis and treatment of minor ailments and were managed by registered nurses.

iii Observations made by the researcher: The researcher as a participant observer noted the following:

1. Type of services offered: All the clinics provide the same services. They also deal with emergencies such as trauma, medical and emergency deliveries.

2. Type of personnel responsible for different services: In all four clinics professional nurses provide, minor ailments, well baby, STI, HIV testing, f/p and pap smear services. Community health workers provide nutrition and TB services except for the 1st clinic where the professional nurse had to evaluate every TB patient seen by the health worker and the 4th clinic where the EN was responsible for TB services. Home-based activities were done by the community health workers and the volunteers in all the clinics.

3. Personnel responsible for HIV counseling:

1st clinic: Hope WorldWide counselors.

2nd clinic: Friends for Life counselors.

3rd clinic: Rhema church counselors.

4th clinic: Hope World-wide volunteers and nurses

iv Respondents' satisfaction with the type of services offered: 7 indicated that they were satisfied with the type of services offered while 3 were not.

v Respondents' reasons for lack of satisfaction: 3 indicated that they were not satisfied because they do not provide antenatal services.

vi Satisfaction with the way services are provided: Fig 4.33 N=10

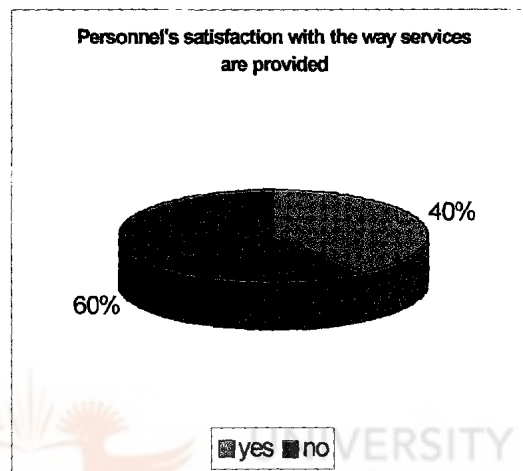


Figure 4.33 This figure shows that 6 said that they were not satisfied with the way services are provided.

vii Reason for the lack of satisfaction: 6 indicated that they were not satisfied because of insufficient personnel in their clinics.

viii Professional nurses' suggestions to improve functional factors of accessibility: 3 respondents stated that they would like to provide antenatal services in their clinics.

4.3.2.3 SOCIAL FACTORS OF ACCESSIBILITY

i Level of competency in the provision of health services: 6 indicated that they felt very competent when providing health services, the remaining 4 respondents indicated that felt competent when providing services.

ii Number of professional nurses working in each clinic on a permanent basis: 3 indicated that they had only 1, 3 indicated that they had 2, another 3 indicated that they had 3 and 1 stated that they had 4.

iii Professional nurses working on a sessional basis: 6 indicated that they had 1, 3 indicated that they had 2 and 1 indicated that they did not have a sessional nurse.

iv Professional nurses' basis of working: 7 respondents indicated that they were working on a permanent basis, while 3 indicated that they were on a sessional basis.

v Observations conducted by the researcher as a participant observer:

Personnel adequacy:

1st clinic: there were 2 nurses on duty with a community health worker. One of the 2 nurses (a sessional) was borrowed from the other clinic.

2nd clinic: there was 1 (sessional nurse) and a community health worker.

3rd clinic: there were 3 nurses (1 sessional), a community health worker and 2 health workers who were responsible for taking the patients' vital signs.

4th clinic: there were 2 nurses and an enrolled nurse.

vi Number of personnel who had clinic supervisors on the post:

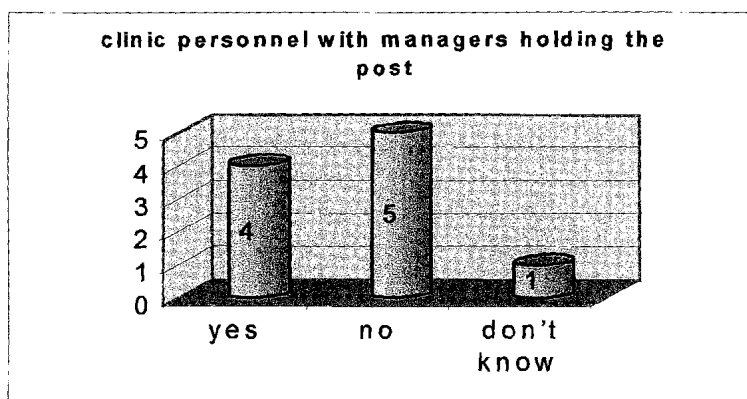


Figure 4.34 This figure shows that half of the respondents (5) stated that they did not have a clinic manager holding the post.

vii Satisfaction with the leadership style of the supervisor: 8 stated that they were satisfied with the leadership style of their supervisor, 1 respondent indicated she was not satisfied and another respondent indicated that she was not sure. It was noted in the observation phase that only the 1st and the 2nd clinics had supervisors.

viii Authorities' visits to the clinic for support and monitoring:

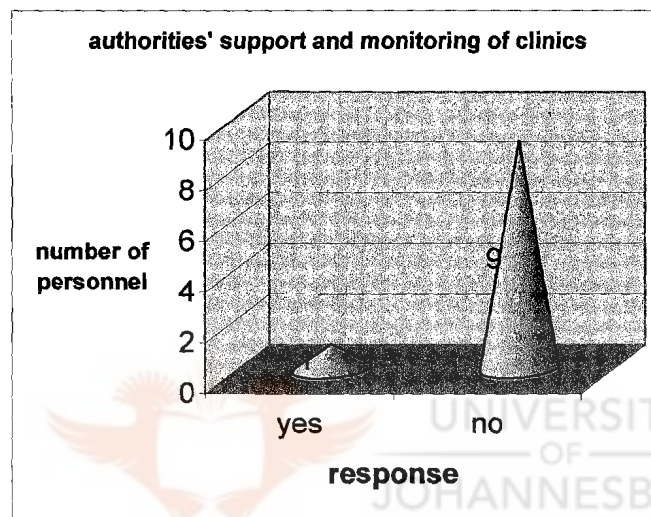


Figure 4.35 This figure shows that 9 indicated that they had never received authorities in their clinics for support and monitoring.

ix Availability of a career path for the personnel: 9 indicated that they were not aware of any career path for their personal and professional development while 1 stated that she was aware of such a well stated career path.

x Respondents' level of satisfaction with their job: 1 was very satisfied, 5 were satisfied and 4 were not satisfied .

xi Respondents' level of satisfaction with their salary: All 10 indicated that they were not satisfied.

Xii Frequency of in-service education attendance: 3 stated that they attended in-service education on average every 2 months, another 3 every 4 months, 1 every 3 months, 1 every 6 months, 1 yearly and 1 had never attended.

xiii Professional nurses' suggestions to improve social accessibility of PHC services: N =10

Suggestion	Frequency	Suggestion	Frequency
Increase salaries	8	Positive reinforcements	3
Deploy more nurses	7	Support & monitoring	3
Staff development	5	Customer care education	2
Reduce paper work	4		

Table 4.18 This table shows that 8 indicated that they must increase the salaries, 3 suggested that authorities should provide support and monitoring and another 3 indicated that authorities should provide positive reinforcements to those clinics that were doing better.

4.3.2.4 PHYSICAL FACTORS OF ACCESSIBILITY

i Adequacy of the number of rooms and space in the clinics: 9 indicated that they had enough room for the type of services provided and 1 indicated that they did not have enough room.

ii Observations conducted by the researcher as a participant observer:

Adequacy of the rooms:

1st clinic: has 4 consultation rooms with a 1-bed emergency room and a very small dispensary room.

2nd clinic: has 5 consultation rooms with a 4-bed emergency room and a sterilisation room. It has a large dispensary room.

3rd clinic: has 5 well-partitioned consultation rooms and small dispensary. The clinic does not have an emergency room.

4th clinic: has 6 consultation rooms (one of which was used by the Hope volunteers), a small dispensary and a 3-bed emergency room.

iii Respondents satisfaction with the transport system for very sick patients:

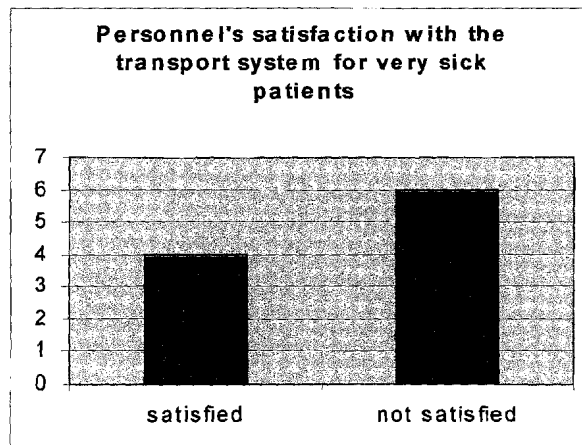


Figure 4.36 This figure shows that the majority of the respondents (6) indicated that they were not satisfied with the transport system for very sick patients who needed to go to hospital.

iv Respondents' reasons for lack of satisfaction with the transport system:

All 6 who were not satisfied with the transport system for very sick patients who needed to go to hospital said that there were long delays before the ambulance could come and get the patient, 3 also added that sometimes ambulances are reported broken which increases the delays.

v Time taken for an ambulance to arrive once called for: 5 indicated that the ambulance took about 1½ hours arrive, 2 indicated that it took 2 hours, another 2 indicated that it took more than 5 hours and 1 indicated that it took about 1 hour.

vi Respondents' level of satisfaction with the security system of the clinics: 7 indicated that they were satisfied with the security system, while 3 indicated that they very were satisfied.

vii In phase 4 the researcher observed the following:

Security systems: All clinics has a wall around them.

1st clinic: has a security alarm and a guard without a gun during the day.

2nd clinic: has a security alarm and guards with guns during the day and night.

Some guards are inside the clinic premises during the day.

3rd clinic: has 24-hour security guards with guns.

4th clinic: stands isolated from the community. It has a guard without a gun during the day and night and has an alarm system. It was broken into 2 weeks before data collection. Only the curtains were stolen.

viii Personnel's response on the adequacy of equipment in the clinics:

N=10

Name of equipment	Adequate	Inadequate
Examination couches	10	-
Working refrigerator	10	-
Vaginal examination equipment	10	-
Receivers	10	-
Trolleys	10	-
Oxygen administration equipment	10	-
Trays	9	1
Stethoscopes	9	1
Thermometers	9	1
Specimen containers	9	1
Condom dispensers	8	2
Scales for all ages	8	2
Diagnostic sets	7	3
Blood pressure machines	6	4
Working telephone	6	4

Table 4.19 This table shows that 6 of the respondents said that their telephones were working. 2 indicated that they do not have HB meter, 1 indicated that they

xii Respondents' suggestions to improve physical factors of accessibility:

Suggestion	Number
Improve ambulance services	7
Improve electricity	3
Specific ambulance for Alexandra	1

Table 4.21 This table shows that 7 respondents suggested an improvement with the ambulance services in Alexandra Township.

4.3.2.5 GEOGRAPHICAL FACTORS OF ACCESSIBILITY:

i Description of the clinics' catchment area:

Alexandra Township covers a 5-kilometer radius. This means that all the clinics fall within this radius.

4.3.2.6 ACCEPTABILITY OF PHC SERVICES:

i Provision of privacy in the clinics: All 10 respondents stated that they were able to provide privacy.

ii In phase 4 of data collection the researcher observed the following:

Provision of privacy in the clinics: All clinics provide privacy most of the times. However nurses often join each other during consultation and talk about issues not related to the patient's needs. Sometimes they are even oblivious to the fact that the patient is waiting. This was especially observed in the 3rd clinic.

iii Maintenance of confidentiality in the clinics: All 10 respondents indicated that they keep records in a confidential file in the office. Seven respondents indicated that they were then handed to the individual patient by the professional nurses, 3 did not indicate the person responsible in handling them.

iv Level of satisfaction with the way confidential records were handled:

Nine respondents indicated that they were satisfied with the way confidential records were handled, while 1 respondent was not satisfied because all the personnel in her clinic had access to the confidential records.

v Observations done by the researcher in phase 4 of data collection

Handing out of patients' lab (confidential) results:

1st clinic: TB results are handed out by the community health worker. RPR (for STI) and pap-smear results were handed out by the clerk at the reception. HIV results were handed out by the nurse and was kept in sisters' office.

2nd clinic: is done in the same way as with 1st clinic, only here the client with positive result for HIV is send back to the Friends for Life for counseling.

3rd clinic: all records are kept in the office. TB results are handed out by the community health worker and nurses give out the rest.

4th clinic: all records are kept in the TB room. The enrolled nurse hands out all the results to the patients. Patient may be send to the volunteers for counseling.

vi Respondents' opinion on community's preference to visit their clinic:

Six indicated that they believed that people prefer to come to their clinic, 4 indicated that they were not sure.

vii Respondents' level of satisfaction with their services being customer friendly:

Six respondents indicated that they were very satisfied that they provide customer friendly services, 3 stated that they were satisfied and 1 indicated that she was not satisfied.

viii Availability of suggestion boxes in the clinics: All the respondents indicated that they do not have suggestion boxes in their clinics, during observation phase all the clinics had suggestion boxes.

ix Clinics' community need assessment:

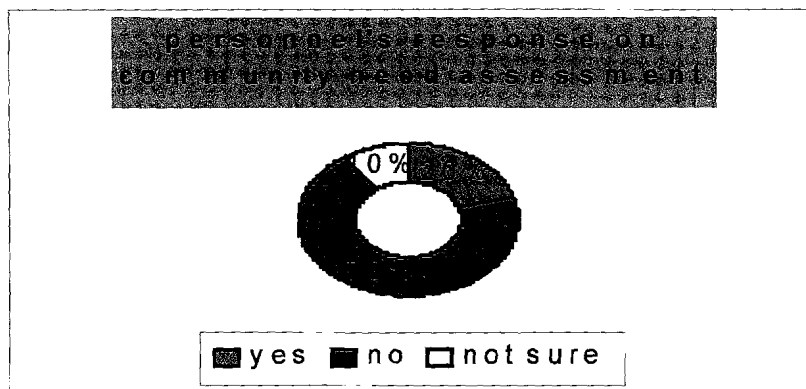


Figure 4. 38 This figure shows that 7 respondents stated that their clinics did not conduct community need assessment.

x Respondents' opinion on clinics' utilisation by the people: 7 indicated that they believed that their clinics were well utilised, while 3 indicated that they believed that their clinics were not.

xi Respondents' opinion on whether community involvement is important: 10 respondents indicated that it was important to involve the community in the running of the public clinics.

xii Public clinics' health committee membership: 9 respondents stated that their clinics were not members of the health committee and 1 was not sure.

xiii Public clinics' intersectoral collaboration committee membership: 8 respondents indicated that their clinics were not members of intersectoral committee collaboration, 1 was not sure and another indicated that they were members of the committee.

xiv During observations the following was observed: None of the clinics conducted community need assessments, there was no health committee in the area and none of the clinics were members of intersectoral collaboration in the area.

xv Professional nurses' suggestions to improve acceptability factors of accessibility:

Suggestion	Frequency
Establish health committee	4
Wants to be actively involved in the community	4
Establish intersectoral collaboration committee	3
Increase confidentiality	2

Table 4.22 This table shows that 4 respondents suggested that they would like to be actively involved in the community.

4.3.2.7 FINANCIAL ACCESSIBILITY OF PHC SERVICES:

i Adequacy of medical supplies (drugs) in the clinics: All 10 respondents indicated that they receive enough drugs to last them the whole month.

ii In phase 4 the following was observed: None of the clinics had nose or eardrops. A mother whose child had impetigo was told to go and buy 'Savlon' in the 3rd clinic.

4.3.2.8 THE EFFICIENCY OF PHC SERVICES:

i Availability of complaints procedure in the clinics fig 4.39

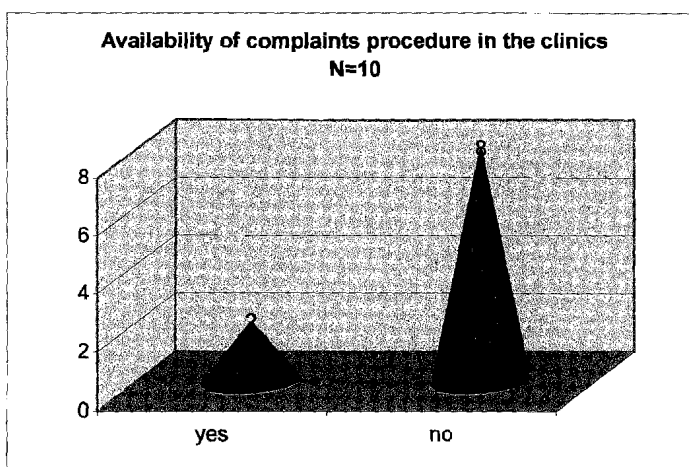


Figure 4.39 This figure shows that 8 respondents indicated that they did not have a complaint procedure for the patients in their clinics.

ii Availability of a complaint procedure for the personnel: 9 stated that they did not have a complaint procedure for the personnel and 1 did not respond.

iii Time taken to see a patient during consultation in the clinics: 3 indicated that it took an average of 15 minutes to see one patient, 3 stated an average of 10 minutes and the other 4 respondents an average of 23 minutes, 17 minutes, 12 minutes and 7 minutes, respectively.

Descriptive statistics: Table 4:23

Time taken to see 1 patient	N	Minimum	Maximum	Mean	Std Deviation
	10	7	23	13.40	4.600
Valid N (listwise)	10				

iv Evaluation of the way services were provided in the clinics: 6 respondents indicated that they evaluated how they were providing services, while 4 indicated that they did not.

v Frequency of evaluation of the way services were provided: Out of the 6, 3 stated that they did an evaluation every 6 months, 2 indicated every month and 1 indicated that there was no specific time period.

vi Preparation of year plan by the clinics: Fig 4.40

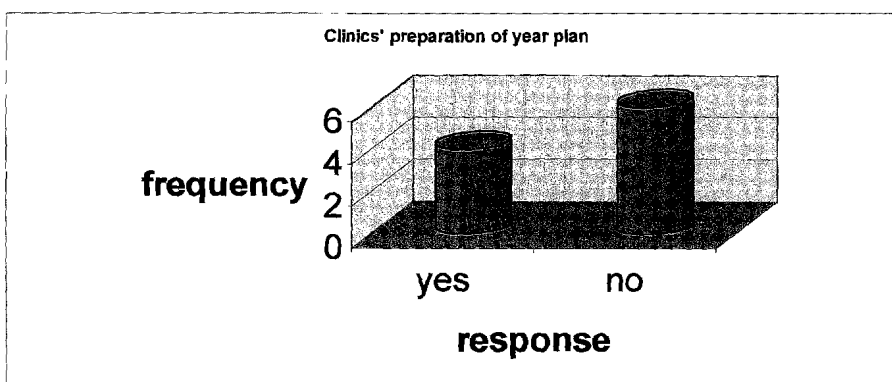


Figure 4.40 This figure shows that 6 respondents stated that their clinics did not prepare a year plan.

vii In phase 4 of data collection the researcher noted: that there was no clinic with either patients' or personnel's complaint procedure. None of the clinics evaluated the way they provide services and none had a year plan.

viii Nurses suggestions to improve the efficiency of PHC services:

Suggestion	Frequency
Year plan	3
Involvement in the planning of the services	3

Table 4.24 This table shows that 3 of the respondents would like to be involved in planning of the services.

4.3.2.9 THE EFFECTIVENESS OF PHC SERVICES:

i Number of patients seen in each clinic per day: 4 respondents indicated that they saw an average of 130 patients in their clinic per day, stated that they saw an average of 200 patients per day, 1 stated that they saw an average of 120, 1 stated that they saw an average of 100, 1 indicated 90 and another indicated 50 and 1 did not indicate (range 50-200).

Descriptive statistics: Table 4.25

No. of patients seen in the clinic per day	N	Minimum	Maximum	Mean	Std Deviation
	10	50	200	128.00	45.556
Valid N (listwise)	10				

ii During phase 4 of data collection the following was observed:

Number of patients seen: Clinic attendance statistics for the year 2000 January to 2001 December were observed as follows:

2000: 1st clinic saw an average of 1077 patients / month (54 patients per day). 2nd clinic saw an average of 933 patients / month (47 per day). 3rd clinic saw an average of 707 patients / month (35 per day). 4th clinic saw an average of 784 patients / month (39 per day).

2001: 1st clinic saw an average of 980 patients / month (49 per day). 2nd clinic saw an average of 775 patients / month (39 per day). 3rd clinic saw an average of 781 patients / month (39 per day). 4th clinic saw an average of 667 patients / month (33 per day).

iii Number of patients seen by the individual nurse per day:

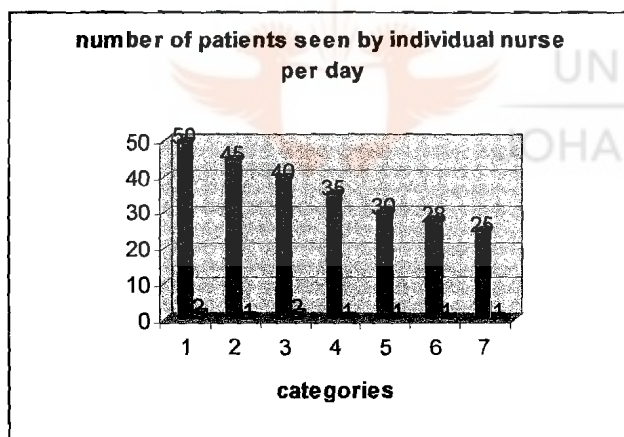


Figure 4.41 This figure shows that 1 respondent indicated seeing 25 patients a day.

v Maintenance of statistics in the clinics: 8 indicated that they were satisfied with the way statistics were maintained in their clinics, while 2 indicated that they were not satisfied.

vi Respondents' opinion on whether there was room for improvement in the way statistics were maintained in the clinics: 7 respondents indicated that there was room for improvement, 2 indicated that there was no need for improvement and 1 did not indicate.

4.3.2.10 EQUITY ACCESSIBILITY OF PHC SERVICES:

i Respondents' opinion on the community's awareness of their human rights with regard to health services: N=10

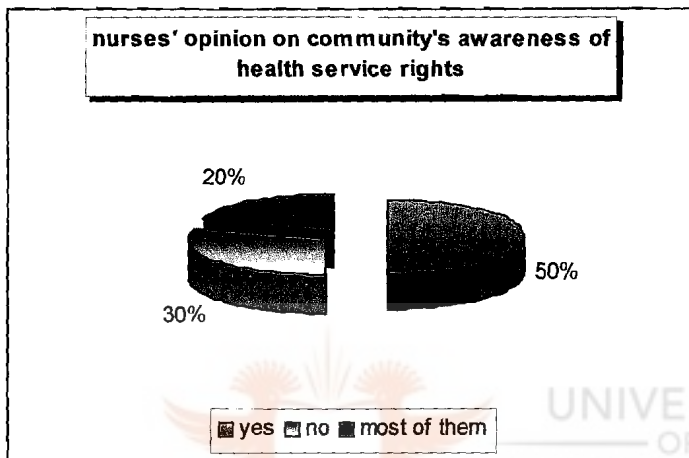


Figure 4.42 This figure shows that half of the respondents (5) stated that their community was aware of their rights with regard to health services.

ii Availability of patients' rights charter in the clinics: 7 respondents indicated that they display the rights charter in their clinics and 3 indicated that they did not.

iii During observations the following was observed:

Patients' right charter: All clinics have a patients' rights charter. The 1st and 4th clinics' charters are in the Zulu language. In the 1st clinic it was displayed behind where the patients sit. In the 4th clinic it was among other visual aids. The 2nd and 3rd clinics' charters were in English and were among other visual aids.

iv **Doctor's visits to the clinics:**

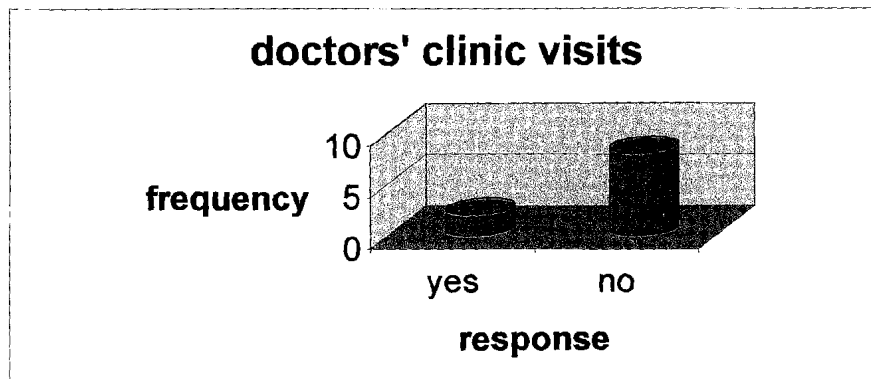


Figure 4.43 8 respondents indicated that they did not receive doctors in their clinics.

v Frequency of doctor's visits: Out of the 2 respondents who said that they receive doctors in their clinics, 1 respondent indicated that they receive the doctors weekly while the other indicated that they receive doctors 2-weekly.

vi Availability of measures to ensure equity in the clinics: 6 respondents stated that there were measures to ensure equity in their clinics, while 4 others stated that they did not have.

vii In phase 4 of data collection the researcher observed the following:

Measures of equity:

The 1st, 2nd and 4th clinics used the numbering system, 3rd clinic did not.

1st clinic: TB, family planning and well baby made their own queues up to 8.30am. Family planning patients who came after 8.30am join the minor ailments queue. Well baby parents were encouraged to come early in the morning while TB continued with their separate queue. Procedures such as pap smears were done daily.

2nd clinic: TB, family planning, well baby and minor ailments made their own queues. Well baby were seen before minor ailments if there was only one nurse

working. If there were 2 nurses, 1 started with well baby while the other went ahead with minor ailments. Family planning clients were seen early in the morning as soon as a nurse arrived. They adjourned for prayers and continued after. Pap smears were done daily. Well baby were also encouraged to come in the morning or they joined the minor ailment queue if they came later. Patients were told to jump the queue if given a follow-up date.

3rd clinic: there was no numbering system. If there were 3 nurses on duty, 1 started with well baby and 2 did family planning while minor ailments waited. Patients did not go into the nurses' room before their vital signs were checked by the health worker. Measles vaccine was given on a special day and mothers were sent back if they came on the wrong day for the vaccine. TB patients made their own queue. Pap smears were also done daily.

4th clinic: things were done in the same way as with 3rd clinic except the measles issue. Here pap smears were done on Wednesdays only.

viii Type of home-based activities the clinics were involved in:

Seven indicated follow-up for TB patients, 3 indicated HIV, 2 indicated that they were not involved in any home-based activities and 1 left a blank space.

4.3.2.11 HEALTH EDUCATION FACTORS OF ACCESSIBILITY TO PHC SERVICES:

i Personnel responsible for health education in the clinics:

Seven respondents indicated that all of the personnel were responsible for the provision of health education services, 3 indicated that health promoters were responsible.

ii Adequacy of health education materials in the clinics:

Six respondents indicated that they had adequate health education materials, while 4 respondents indicated that they did not.

iii Use of acceptable language in health education sessions:

All ten stated that acceptable language was used.

iv Use of relevant visual aids in health education sessions:

Eight respondents indicated that the provider used relevant visual aids, 1 indicated that the provider did not and another indicated that sometimes the provider did not.

v Provision of health reading-materials to the people:

All 10 respondents indicated that they provide health reading-materials from time to time to the people.

vi Language used in the materials:

Eight respondents indicated that the materials were in local languages, 2 stated that some of the materials were not in local languages.

vii Learning content presented to the people:

In phase 4 the researcher noted the following as the learning content presented to the people in the clinics: TB, HIV, STI i.e. signs and symptoms, treatment and prevention and PHC.

viii Respondents' suggestions to improve health education factors:

Suggestion	Frequency	Percentage
Relevant health education	3	30
Educate community on health rights	3	30
Relevant pamphlets	2	20

Table 4.26 This table shows that 3 suggested that they needed to educate their community about their rights with regard to health services.

4.3.2.12 NURSES' GENERAL COMMENTS

Comment	Frequency	Percentage
Employ more nurses	8	80
Statistical transparency	3	30
Implement findings	3	30

Table 4.27 This table shows that about a third of the respondents suggested that the clinics' statistics should be made available for all clinics to see (transparency) and another 3 suggested that they would like to see the findings of this research being implemented.

4.4 SUMMARY

In this chapter the data collected from patients, community members and nurses by means of an interview schedule and a questionnaire were analysed. The researcher also made observations as a participant observer with the aim of verifying what the respondents said in all the 3 phases of data collection. The following chapter will interpret and discuss these findings in order to conclude and recommend accordingly.

CHAPTER FIVE

OVERVIEW, INTERPRETATION, CONCLUSIONS GUIDELINES AND RECOMMENDATIONS OF THE FACTORS INFLUENCING THE ACCESSIBILITY OF PHC SERVICES IN ALEXANDRA TOWNSHIP.

5.1 INTRODUCTION

In this chapter the entire study process will be reviewed in order to determine whether the objectives of the study have been accomplished. Interpretation, discussion and conclusions of the study findings will be presented followed by the study's recommendations and limitations.

5.2 OVERVIEW

5.2.1 RATIONALE

The legal and professional requirements in the new SA put emphasis on equal access to public health services with a special focus on the previously disadvantaged areas. It is imperative that health services should be evaluated to determine if those in greatest need are indeed receiving the highest share in order to fill up the gap created by the apartheid government. Alexandra is a predominantly black urban Township which was therefore previously disadvantaged. Although several studies on accessibility of PHC services have been done elsewhere in SA; it is also important that health services in Alexandra be investigated in order to ensure access of services to this particular community and to determine the similarities and differences in the health care delivery between this unique setting and the rest of SA. As was recommended by Ferrihno and Phakathi (1995:57) that determinants of utilization of health care services in Alexandra be explored; exploration of the factors influencing the accessibility of PHC services in Alexandra Township is necessary in order to determine whether people in the area have got access to public health services.

5.2.2 OVERALL AIM OF THE STUDY

In this study the researcher's aim was to investigate the factors influencing the accessibility of PHC services in Alexandra Township, Gauteng Province.

5.2.3 LITERATURE STUDY

The literature study done in chapter two highlighted several factors which influence accessibility of PHC services: availability / functional factors, social factors, physical factors, geographical factors, acceptability factors, financial factors, efficiency factors, effectiveness factors and equity factors. Other factors include demographical and health educational factors. In this study context these factors carry the following meaning:

Demographical factors means the population's size and composition in terms of sex, age, educational attainment and employment, marital and medical aid status.

Functional factors means the availability of appropriate type of care to those individuals intended for.

Availability factors means services are readily within reach of the community who need them, when they need them and when necessary.

Social factors means the availability of adequate well-trained, well motivated, competent and sensitive personnel for different services with proper support and monitoring structures.

Physical factors means the availability of enough room, medicines and equipment.

- Geographical factors means the distance to and from the clinic, traveling time and means of transport are acceptable and affordable by the community.

Acceptability factors means that the level and type of health care is provided in a flexible, culturally sensitive and applicable manner and is welcomed by both the providers and the people intended for.

Financial factors means both the community and country can afford the services.

Efficiency factors means the end results achieved are in positive relationship with the effort expended in terms of money, resources and time.

Effectiveness factors means services provided achieve the intended goal in terms of improving the health status of the people.

Equity factors means provision of services in a fair manner without sub group variability, discrepancy and discrimination.

Health education factors means the level of awareness of the type and amount of health services available to the people.

5.2.4 OBJECTIVES OF THE STUDY:

1.To explore and describe factors influencing community's accessibility to PHC services in Alexandra Township, Gauteng Province.

2.To recommend guidelines on how to improve PHC services in Alexandra Township, Gauteng Province.

5.2.5 RESEARCH DESIGN AND METHOD

The study was quantitative, exploratory, descriptive and contextual in nature.

The researcher used interviews and questionnaires in order to collect data from the 3 sample groups namely: patients, community members and professional nurses. The researcher also acted as a participant observer in which responses from the participants were verified.

The research findings reported in chapter 4 will now be interpreted and discussed. The conclusions will be drawn after analyzing data from all the 4 phases in which comparisons are done in the description of how factors are influencing the accessibility of PHC services in Alexandra Township, Gauteng Province. Guidelines for the improvement of these factors in the area and recommendations for further study will be made.

5.3 INTERPRETATION, DISCUSSION AND CONCLUSIONS:

Interpretation is the "bringing it all together" stage in the research process by relating the various individual findings to the existing conceptual framework (Mouton, 1998:161).

5.3.1 DEMOGRAPHICAL FACTORS INFLUENCING THE ACCESSIBILITY OF PHC SERVICES IN ALEXANDRA TOWNSHIP.

The literature study in chapter two revealed that access and utilisation problems are more prevalent among the poor and uninsured, and that people in lower income groups experience more difficulties in getting access to health services (Almeida et al, 2000:129-62, Andrulis, 2000:858-62, Cousine, 1997:70-82). According to Jones (2000:928-31) one of the factors that influence healthcare use is gender. Women are the most frequent users of health services. Regardless of health policy changes to improve access to healthcare, major gaps continue to exist especially for the poor and minority women (Marmot, 2001:134-6, Freeman & Payne, 2000:1045-7, Van Vuuren & de Klerk, 1996:19-24 and Juarbe, 1995:23-7). This calls for the nurses to affect the practices and policies of the healthcare system and consider the wider environmental factors that perpetuate an ineffective approach to improving access to healthcare for the vulnerable (Juarbe, 1995:23-7).

There are significant statistical differences ($p = 0.000$) between patients and community respondents with regard to the number of females and males. As reflected in Table 4.1 there is a higher percentage (83.8%) of females in the patient sample compared to community sample (63.3%). This means that more women than men attend the clinics. However both samples have a higher percentage of women than men. This may indicate that the researchers were more free to approach women than men in phase two of data collection or that the population of the area is comprised of more women than men.

In both phase one and two (4.3.1.1 par ii) all respondents were black. This area is a predominantly a black urban township.

In both phase one and two (4.3.1.1 par iii) the home addresses of all the respondents' showed that they were Alexandra residents. Potential respondents who were not from the area were excluded from participation in the study. This was to ensure that the views obtained are only those of the Alexandra residents.

The results for both phase one and two (Table 4.2) show that the majority of the respondents have been living in this area for a long time (5 years and more) and should be familiar with the type, level and number of health services provided in the public clinics in their area. In the community sample (phase two) the majority of the respondents (75.7%) have lived in the area for more than 20 years. This may also mean that the longer the residents stay in the area the lesser they attend the public clinics.

There are statistically significant differences ($p = 0.000$) between the patient and community respondents with respect to age. Figure 4.1 shows that the majority of the patient sample (75%) was between 18-35, while the community sample's highest percentage (59%) was found to be between 36-60. This may indicate that the majority of the people who visit the clinics are young adults (bearing in mind that the study's criteria was to select subjects from 18 years and above), while

the findings of phase two may indicate that that age group was available during the data collection.

There are statistically significant differences ($p = 0.033$) between the patient and the community respondents in respect of educational status. Figure 4.2 shows that an overwhelming majority (76%) in phase one had reached secondary school and only 62% in the community sample had reached the same level. Furthermore while only 16% of the patient sample had reached primary level, 28% of the community sample had reached the same level. This may mean that the patient respondents were more educated than their community counterparts. The fact that only a few (4.3% in phase one and 6.7% in phase two) had reached a tertiary level means that the majority of the people are non-skilled workers and earn a low income and have no job security.

Figure 4.3 shows that the patient and community samples differ significantly ($p = 0.000$) with respect to employment. While a total of 58.7% in the patient sample are unemployed only 35.7% of the community respondents are unemployed. This shows that a poorer community (patient sample) access the clinics. This was also found in earlier studies (Borrell et al, 1999:743-64).

The findings in phase one and two (figure 4.4) are not the same. In phase one about half (45%) earn less than R100 per month while in phase two only a quarter (24%) earn less than R100 per month. This may indicate that a poorer community (phase one) access the services. However it is important to note that in both phases about three-quarters of the respondents were earning less than R1000 a month. This indicates a socio-economically poor community.

Figure 4.5 shows that there are statistically significant differences ($p = 0.000$) between the patients and community respondents with regard to marital status. While three-quarters (75%) of the respondents in phase one were not married only 55.7% of the community respondents were not married (single, divorced or

widowed). However both findings are significant in that more than half of the total respondents are single, unemployed and poor and this might lead to an increase of dysfunctional homes in the area. This is a typical description of a vulnerable urban area.

The data for both phase one and two (Figure 4.6) shows that very few of the people in the area have medical aid because they are single, poor, unemployed and rely on the public health services which are free at user point.

5.3.1.1 CONCLUSION:

In this study the researcher used a suitable sample which represented the target population by making sure that the respondents were only Alexandra residents. The results of the study show that Alexandra is a predominantly black urban town ship where young adult women access more to the public health services in their area. The majority of the residents are single, unskilled unemployed people who earn meager earnings and have no medical aid. Alexandra Township is therefore a vulnerable area, which is demographically disadvantaged in terms of gender, age, educational, employment, marital, income and medical aid status.

5.3.2 FUNCTIONAL / AVAILABILITY FACTORS INFLUENCING THE ACCESSIBILITY OF PHC SERVICES IN ALEXANDRA TOWNSHIP.

In 1999 the WHO suggested that governments provide cost-effective services to prevent and treat their nation's most pressing health problems and so reduce the disproportionate burden of disease on the poor and help economic growth (Brown, 1999:1305).

5.3.2.1 Type of health services offered at the clinics

At the NGO clinic in Alexandra there seems to be five different departments,

three of which have non-descriptive titles (Martinson, 1997:765-6). According to the Norms and Standards for the delivery of PHC services, it is recommended that the clinic should render comprehensive integrated PHC services using a one-stop approach (Dept. of Health, 2000).

There are no statistically significant differences ($p = 1.000$) between the patient and community respondents with regard to awareness of the clinics and the services they offer. Section 4.3.1.2 paragraph i shows that 100% of the community members were aware of the PHC services in their area and 100% in both samples were aware of the services the clinics offer. In both phase one and two some of the respondents were not aware of the services provided by the clinics (Table 4.3). In phase one only two types of services (minor ailments and f/p services) were known by the majority of the respondents and in phase two the majority of the respondents were aware of four types of services (f/p, immunisation, minor ailments and TB services) offered in the clinics. In phase three (Table 4.17) all the respondents said that they provide management of minor ailments, f/p services, TB management and immunisation services and half of them said that they offer STI management. This was confirmed in phase four (4.3.2.2. par. iii) when the researcher observed that the clinics offer the services as indicated. Services such as trauma are not necessarily offered in these clinics but if a patient comes they attend to her / him and then either refer the patient to hospital or tell him to go to the NGO clinic. Patients with chronic diseases are not encouraged to visit the clinics because of the unreliable doctors' visits.

This reflects that only few of the services offered in these clinics are known. About a third in phase one were aware of the immunisation services. Only 7% in phase one and 5% in phase two (85% and 66% of the respondents were females of 18 –60 years) were aware of the Pap-smear services despite the fact that this is a target group for this service. In phase one nobody was aware of the TOP counseling services and in phase two only 1.4% were aware. This shows that the community has not been educated about the services offered at the clinics. In

phase one only 2% mentioned nutrition services and in phase two none mentioned it. The fact that the demographics of the area shows that it is a vulnerable area means that problems such as malnutrition may be prevalent and yet the people do not know that the clinics provide nutritional supplements for babies two years old and younger.

During observation in one of the clinics the researcher came across a 7-month pregnant mother who had come to the clinic for antenatal services. It was 3.30pm. She had come into the clinic at 8am and was not told that the clinic does not offer antenatal services. She was visibly tired and hungry and after waiting for the whole day, was advised to go to the NGO clinic the following day. It is inconvenient when the nurses assume that everyone is aware of the services offered in these clinics. The nurses were also not aware (table 4.17) that they were supposed to provide services such as nutrition, pregnancy testing, counseling for TOP, health education and Pap smear.

- **Conclusion:**

Despite the fact that all the respondents were aware of the existence of the public clinics in their area, the majority of the people were not aware of all the services offered. Bearing in mind that all the services offered in these clinics have been designated as essential to the people, it is important that people should be aware of the available health services in their clinics.

5.3.2.2 Community's need of the services

According to Jones (1998:513), the WHO's 'Health for all' policies must be put into action and must be considered in the context of the overall economic and social situation of a country or locality. Each country must select its own best mix of policies based on national needs, capacities and priorities. PHC services should be preventive, promotive, curative and rehabilitative (Dept. of Health, 2000).

There are no statistically significant differences ($p = 0.467$) between the patient and community respondents with regard to their opinion on the community's need of the services offered in these clinics. Section 4.3.1.2 paragraph iii shows that 100% of the respondents in both phase one and two said that the community needs all the services offered in the clinics. This means that the community is aware of the strengths, weaknesses and capabilities of its health services.

There are statistically significant differences ($p = 0.000$) between the patient and community respondents in respect of reasons for visiting the clinics. About half in phase one and more than three-quarters in phase two (Table 4.4) have visited the clinic for minor ailments. While only 1% had come for Pap smear in phase one, none in phase two did. According to the statistics of the clinics for the years 2000 and 2001 all of the clinics attend more to minor ailments than any other service. From this, one can argue that most of the people visit the clinics for minor ailments, and in both phases some services such as nutrition and TOP were absent.

With a p value of 0.000 there are statistically significant differences between the patient and community respondents with respect to the level of satisfaction with the types of services offered in the clinics. Although the majority of respondents (90%) in phase one (4.3.1.2 par v) seem to be satisfied with the type of services offered in these clinics, the majority (54%) of the community respondents were not. This is also true for three out of ten respondents in phase three and is significant.

Section 4.3.1.2 par vi shows that most of the people are unaware of the services that the clinics provide. Some of the services mentioned are already available and yet the people the services are intended for are unaware. There is also a need for antenatal services according to the nurses (3 out of 10 see section 4.3.2.2. par v). The absence of antenatal services in public clinics can cause perinatal problems that could be avoided. It is tiring for a pregnant mother to

travel to the NGO clinic that offers antenatal services. She may need to pay for transport and if she does not have money she may find access to the clinic and antenatal care problematic. These services should be geographically accessible. Respondents stated that they do not have laboratory services and often have to refer patients to private doctors to have a pregnancy test done.

- **Conclusion:**

The health services in Alexandra Township are needed by the users. Some of the services are under-utilised because potential users are unaware of their availability. This lack of awareness directly affects utilisation. The clinics also lack certain services, such as antenatal services that are needed by the community.

5.3.2.3 Level of satisfaction with the way services are rendered in the clinics:

In seeking to impose their morals on patients, providers violate clients' rights thereby making services unavailable to the people they are intended for (Stanback, 2000:37-42).

There are statistically significant differences ($p = 0.003$) between the patient and the community respondents on their level of satisfaction with regard to the way services were provided. While 43% of respondents were very satisfied in phase one, 45.9% in the community sample were satisfied (4.3.1.2 par. viii) and 25.9% in phase one and 29.6% in phase two were not satisfied. In phase three (Figure 4.33) six of the ten respondents were not satisfied. One may therefore argue that a significant number of people in the area were not satisfied with the way services were provided. Notable is the fact that the nurses (6 out of 10 respondents) are the ones who are the most dissatisfied.

The findings in phase one and two (Figure 4.7) show that half and two-thirds of

the respondents do not get what they expect. They said that the nurses start late (after 8am), but when the patients come late they are sent back and nurses spend a lot of time doing nothing. They complained that three nurses attend to well babies at once while the other queues are ignored and that the nurses are inflexible, they shout at them if they want to terminate their pregnancy. This shows that the majority of the people in the community do not receive acceptable services. Six out of ten nurses supported this (4.3.2.2. par vii) and in phase four (4.3.2.10 par. vii) the researcher confirmed the allegations in two of the four clinics.

- **Conclusion:**

A significant number of respondents were dissatisfied with the way services are rendered in Alexandra and the majority of the nurses working in the clinics felt the same. The majority of the respondents said that they do not always get what they expect from the clinic.

5.3.2.4 Satisfaction with the times services are offered

Something as simple as the healthcare facility's opening hours can become an important barrier to access. People are faced with a dilemma of missing school being absent from work in order to access healthcare services (Meyer & Naughton, 1995:22-8). According to the Norms and Standards (Dept. of Health, 2000) comprehensive services should be provided for at least eight hours a day, five days a week.

There are statistically significant differences ($p = 0.000$) between the patient and community respondents in respect of their satisfaction with the times services are offered. Thirty nine percent of the patient sample and 59% of the community sample were not satisfied with the times (Figure 4.8). This may mean that time is a barrier to accessing the services and that is why there is a high dissatisfaction rate in the community sample, while with the patient sample who were at the

clinics, may not have a problem with the times the services are offered. The number of those not satisfied in phase one is still significant.

With a p-value of 0.000 there are statistically significant differences between the patients and community respondents with regard to preferred offering times of services. A small percentage of the dissatisfied, (9.8%) in phase one and an overwhelming majority (78%) in phase two preferred services to be offered for 24 hours, seven days a week (Table 4.5). The majority (55.7%) in the patient sample and only 6% in the community sample preferred services to be offered from 7am to 5pm for seven days a week. These findings may indicate that those who do not access the services (the community sample) find the offering times of services a problem and would like to gain access to the services.

- **Conclusion:**

Times of offering services in Alexandra public clinics may pose as a barrier to some of the people who would want access to the services, as the majority of the people in the community find problems with the times services are offered in the clinics.

5.3.2.5 SUMMATIVE CONCLUSION:

The majority of the people in Alexandra Township were not aware of some of the services offered in the clinics despite their need of them and because of this, the majority of the services were under-utilised. The clinics also do not offer some of the essential services such as antenatal services, which are necessary. Some of the people find the times that the services are available to be a barrier. The majority of the people are not satisfied with the way services are rendered as they dont get what they expect when they visit the clinics. All these could pose as access barriers to the people wanting to access the public health services in their area.

5.3.3 SOCIAL FACTORS INFLUENCING THE ACCESSIBILITY OF PHC SERVICES IN ALEXANDRA TOWNSHIP.

Understanding provider practice is fundamental to designing training, supervision and logistic systems that maximise clients access and quality of care (Stanback, 2001:37-42). According to Dr. H Mahler, the WHO Director General (Stark et al, 1999:273-7) nurses could lead the way in PHC because they can provide a wide range of basic PHC services. Nurses have a long history of delivering health services to under-served communities and among the vulnerable populations, he observed.

5.3.3.1 Nursing personnel's qualifications

Justice requires that patients should receive safe healthcare and that nurses should receive appropriate education and justice will only be served if nurses' programs are accessible, as they are most likely to work in the areas where the need is the greatest (Stark et al, 1999:273-7). According to the Norms and Standards (Dept. of Health, 2000) a PHC clinic should have at least one PHC trained member of staff.

According to the findings (Figure 4.32) nursing personnel from these clinics are well qualified to provide the PHC services in the area as the majority of them are PHC trained. During observations it was noted that all the clinics had at least one PHC trained nurse and this shows proper distribution of personnel in the clinics.

- **Conclusion:**

Nursing personnel working in Alexandra Township public clinics are well qualified to provide PHC services. All the clinics have professional nurses and at least one PHC trained nurse.

5.3.3.2 Nurses' capability in the provision of PHC services

Personnel providing PHC services are expected to be competent and knowledgeable (Jones, 2000:928-31). As stipulated in the Norms and Standards for the delivery of PHC services in SA (Dept. of Health, 2000) staff should be able to follow the disease management protocols and standard treatment guidelines and provide compassionate counseling that is sensitive to the culture and social circumstances of patients.

The findings in phase three (4.3.2.3 par iv) show that in general personnel had worked long enough in the area to be familiar with the community's health needs, problems and resources.

According to the findings in phases one and two (4.3.1.3 par ii) with a p-value of 0.017, there are statistically significant differences between the patient and the community respondents with regard to the personnel's ability to provide PHC services. This may mean that there are more in the patient sample who were satisfied with the personnel's skills than the community sample. Respondents said that nurses do not check patients thoroughly, that they are given poor treatment despite the fact that they are able to treat people effectively. One respondent complained that she attends the clinics but that her condition was not improving and they give her the same pills every time she goes to the clinic. Those who complained said that the nurses need to go back to school to improve their working skills. Surprisingly one respondent said that personnel are so few that sometimes it feels as though they fail to do their job. Another one commented that her sick child was treated well in the clinic and was happy about it.

Findings in phase three and four (Table 4.17 and 4.3.2.3 par iii) could mean that there are not enough nurses to provide services to the people. The clinics depend on other people like the health workers and volunteers for the provision

of services. This also indicates that professional nurses are burdened with the duty of supervising these unqualified personnel to ensure that services are delivered safely. They now have the double burden of performing their duties and supervising those under-qualified people.

- **Conclusion:**

The nursing personnel in Alexandra public clinics are able to deal with the people's health problems because the majority of the nurses have been working in the clinics for two or more years. This could mean that the majority of the nurses are aware of their community's needs, problems, strengths and weaknesses which puts them at a better position to impact on those problems. In addition the majority of the respondents (86% in phase one and 75.5% in phase two) are of the opinion that nurses are able to deal with the community's health problems. Some people believed that they were let down by the nurses. Furthermore, some of the services are provided by under-qualified and untrained personnel.

5.3.3.3 Number of professional nurses in the public clinics:

Robinson and Wharrad (2000:28-40) state that the availability of high numbers of health personnel correlate with a low mortality rate and this led them to conclude that improvements in health indicators must be taken forward by countries on a number of fronts. This is sustained by the Brazilian government, which noted that health indicators were good in the areas where there is high personnel availability per population (Csillag, 2001:370).

There are statistically significant differences ($p = 0.002$) between patient and the community respondents in respect of the adequacy of clinic personnel. Figure 4.9 shows that more than half (53%) of the patient sample believed that the clinics had inadequate personnel while the majority (58.7%) of the community sample believed otherwise. It is clear from the findings in phase three (4.3.2.3 par ii & iii)

that one nurse would attend to administrative duties, one would manage minor ailments and the other would manage well baby services. This leaves f/p, STI, HIV counseling and testing, TB management and emergencies unattended. The nurses find themselves managing several services in the end and to do this they have to dictate what time of the day well baby mothers and f/p clients should come to the clinic. This causes them to rely on unprofessional personnel and volunteers to provide services that should be provided by a professional. This also means that the nurses cannot afford to become sick or take leave because if they do, the services will be even less accessible. Some of the respondents highlighted the problem when they said that there were not enough nurses in the clinics. However, some respondents in phase one and two complained that the nurses are playful and lazy, that they start working after 8am, they go for tea for a long time (more than 30 minutes) and forget that they have come to work and not to drink tea. The respondents complained that many people end up going home without treatment because of this. Some respondents said that the personnel require discipline and a significant number of respondents (42.5% in the patient sample and 36.4% in the community sample) said that there is a need for more nurses, volunteer nurses and foreign volunteer nurses. One respondent even pleaded for more nurses for the 2nd clinic 'please'.

The findings in phase three (4.3.2.3. par iii) show that almost all the clinics have a sessional nurse to help them to provide professional services. This questions the quality of care provided to the patients as it lacks continuity.

The observations in phase four (4.3.2.3 par v) shows that these clinics are short-staffed and that staffing-patterns vary on a daily basis. Three-quarters of the clinics had either one or two nurses on duty. With this number of personnel it is impossible to render services in an efficient or effectively manner. To make matters worse the community health worker (CHW) who was helping at the 1st clinic was so incompetent that one of the nurses had to do TB with her. The sister complained that she had to scrutinize each and every patient the CHW

dealt with to make sure that things were done appropriately. Sometimes the sister had to cancel the whole patient file and start again because things were not recorded correctly. This is very inconvenient, time-consuming and inefficient.

- **Conclusion:**

A significant number of people believed that the clinics are inadequately staffed. This is evident in the fact that some of the services are provided by unprofessional, under-qualified personnel. Three of the four clinics depend on sessional workers to provide certain services. People also complained that nurses are playful and lazy. The clinics are short-staffed as some clinics can only have one professional nurse on duty. All these factors form a barrier to people wanting to access the health services.

5.3.3.4 Availability of supervision in the clinics

Wood (2001:42-4) disclosed that health planners of South Central, Kelonwa, USA are improving the well-being of their citizens in a cost-effective manner by directing much of their energy into keeping people well and the results are impressive: increased life expectancy rate and reduced fertility rate. Diaz et al (1999:1-15) reveal major constraints in availability of and access to reproductive health services and above technical oversight of municipal facilities. There was also little supportive supervision. The Department of Health, SA (2000) recommended that public clinics should receive a visit from the authorities at least once a month to support personnel, monitor the quality of services and identify needs and priorities and that clinic managers should receive training in facilitation skills and PHC.

The findings in phase three (Figure 4.34) show that five out of ten respondents do not have a supervisor on the post. The researcher discovered that the clinics without a supervisor are the 3rd and 4th clinics. The nurses in these clinics do not have a common data source as they gave different statistics of number of

patients seen in a day in the clinic. Their clinics were the least preferred by the respondents from both samples. Respondents complained about the attitude of nurses working in these clinics. It was also in these clinics that the researcher confirmed the respondents' allegations that nurses start work after 8am.

The data in phase three (4.3.2.3 par vii) shows that the majority of the nurses are satisfied with the leadership-style of their supervisors. One respondent indicated that she was not happy with the leadership style of her supervisor and another was still unsure of her level of satisfaction with her supervisor's leadership style.

It was found (Figure 4.35) that authorities do not visit the clinics to support the personnel, monitor the quality of services and identify the needs and priorities as recommended by the Department of Health. How can these authorities be made aware of the community's health needs and problems if they do not visit the clinics and involve the personnel in the yearly planning for the delivery of services in the area? Even the respondents from phases one and two complained that the authorities do not come to see for themselves what is happening in these clinics. Some respondents even suggested that the people should be given a chance to talk to the authorities about the services so that the authorities can talk to the clinic personnel. Respondents in phase one and two appealed to the authorities to monitor the clinic personnel's performance.

- **Conclusion:**

There is lack of supervision in Alexandra Township's public clinics because half of the public clinics in the area have no supervisor on the post. None of the clinics receive supervisory visits from authorities for support and monitoring.

5.3.3.5 Personnel's attitude towards their patients.

It was reported by Mwale (1999:156-7) that attitudes of nurses were perceived to be one of the barriers to the delivery of quality health care. According to the

Norms and Standards for the delivery of PHC services in SA (Dept. of Health, 2000), clinic staff should be positive in their approach to patients, evaluating their needs, correcting misinformation and giving each patient a feeling of always being welcome. Job descriptions of each staff category should be in the clinic file. Fonn et al (1998:697-702) reported that in a maternal health service in SA the nurses instigate each other to scold and insult the patients.

There are statistically significant differences ($p = 0.000$) between the patient and community respondents with regard to satisfaction with the attitudes of the clinics' personnel. Section 4.3.1.3 paragraph iii shows that 67.5% of the patient respondents were satisfied while 57.8% of the community respondents were not satisfied. A total of 32.5% in the patient sample were not satisfied with the attitudes of some of the personnel in the clinics. This is significant considering that phase one interviews were conducted within the clinic walls and the respondents may not have been as free to be open with their feelings as the phase two respondents whose interviews were conducted outside the clinic walls. Respondents complained (fig 4.10) that nurses were rude and shout at them. They said that if they complain about being mistreated, the nurses join forces against them. They said that nurses are rough and use strong language, they rush to pronounce judgment on patients without listening to their complaints, "they are impatient, negative and insensitive ... they can even kill you".

Some mentioned that they do not feel like coming again. A mother who went to the 3rd clinic with a burnt child complained that personnel at the clinic sent her home without help at 10am. Nurses at the 3rd clinic shout at patients for suffering from STI. Some respondents commented that nurses go for tea all at once leaving the patients wondering. They said that at this clinic patients are sent home as early as 12-noon even when the clinic is empty. Some phase two respondents pleaded that personnel at the 3rd clinic should be retrenched or sent back to school. Some complained that nurses are inflexible, they do not greet the patients in the morning and they do not pray with the patients before starting their

work in the morning, which is culturally unacceptable.

Some respondents said that the receptionists and cleaners are the problem. They said that they send them home without help, are cheeky, rude, hit children and shout at them. They also do not know what services the clinic offers.

Some respondents pleaded with the nurses to 'pretend' to be kind to patients so that they can approach them for help. Some respondents 'warned' that clinic staff should learn to treat people as humans otherwise one day they will 'regret' for having treated the people badly. The clinics need caring and loving personnel said the respondents.

A quarter of the respondents in phase one and more than three-quarters in phase two (Table 4.7) said that personnel should improve their communication skills. One respondent suggested a meeting between the authorities, clinics and the community where the community will show the authorities 'who these abusive personnel are'. All the elderly people interviewed (4 in phase one and 19 in phase two –Fig 4.1) complained that they are not treated with respect, they are insulted and the nurses wish them dead. They are told to go home since they are witches and wait for their death. One of the elderly said that she is afraid to go to the clinics because they may give her poison instead of medicine.

A few of the respondents in phase one and two, 2.5% and 8.6% respectively (Table 4.7), said that nurses should be changed. One of the respondents summarized the drama: "The Alexandra public clinic staff are rotten especially the 3rd clinic staff, forget those ones, we want dedicated people who will deal with our lives properly". Notable is the fact that none of the respondents complained about the attitude of nurses working in the 1st and 2nd clinics.

- **Conclusion:**

Alexandra Township residents are not satisfied with the public clinics

personnel's attitudes. This could pose as an access barrier to people wanting to access the health services in their area.

5.3.3.6 Nursing personnel's potential for personal and professional development

Justice requires that patients should receive safe healthcare and that nurses should receive appropriate training in this regard, justice will only be served if nurses' programs are accessible to them as they are most likely to work in the areas where the need is the greatest (Stark et al, 1999:273-7). Updating of clinical skills and knowledge is paramount in the provision of quality services (Jones, 2000:928-31). Fonn et al, (1998:697-702) recommend that management should build staff capacity through identification of staff potential, develop rational staff development plans, create more training opportunities, give bursaries and leave to staff interested in further studies and proper staff placement after training. According to the Norms and Standards for delivery of PHC services (Dept. of Health, 2000), services and tasks not carried out due to lack of skills should be identified and new training sought. In-service training should take place on a regular basis.

Findings in phase three (4.3.2.3 par ix) show that personnel in these clinics are not motivated to do anything for their personal or professional betterment, as there is no career path for them to see the potential for their development. To them there is nothing to look forward to, everything is a matter of chance and this is demotivating. This can result in nursing personnel not aspiring to further their education, thereby letting their skills to become out-dated

The findings in phase three (4.3.2.3 par x) that more than half (6 out of 10) of the nurses can say that they are satisfied with their job despite the odds is surprising considering the lack of support from doctors, inadequate equipment, inadequate personnel and no supervision.

All 10 of the respondents (4.3.2.3 par xi) were dissatisfied with their salary. Nurses in these clinics state that the nurses working in Alexandra public clinics are paid even lower salaries than those working in other metropolitan clinics, which makes them dissatisfied. With this level of dissatisfaction it is really an injustice to expect a nurse to smile at the clinic and greet people when her family had to go without a proper breakfast that morning.

The findings in phase three (4.3.2.3 par xii) reflects that not all the nurses are given the same opportunity for in-service training. Bearing in mind the fact that all the nurses have been working in these clinics for more than a year it is not acceptable that some receive in-service training every two months while others never do. As these clinics rely on the sessional nurses for services it is unacceptable that sessional nurses be denied a chance of in-service training because they are not permanent workers. Clinics are sometimes serviced by these sessional workers alone and justice will only be served if these nurses have equal opportunity for in-service education.

- **Conclusion:**

There is a lack of potential for personal and professional development in the nursing personnel working in Alexandra Public clinics because none of them has a career path for growth. A significant number were dissatisfied with their jobs and salaries and their attendance of in-service education was very inconsistent.

5.3.3.7 SUMMATIVE CONCLUSION REGARDING SOCIAL FACTORS OF ACCESSIBILITY TO PHC SERVICES:

Although all the public clinics in Alexandra Township have professional nurses, and the majority are community nurses trained in PHC, some of the services are provided by unprofessional and under-qualified staff. Even

though the nurses should be able to impact the community's needs, as the majority of them have been working in the public clinics in the area for 2 years and more, people still believed that they were being let down by the nurses because of their playfulness, laziness and their prolonged breaks. Although the community believed that nurses were able to deal with their health problems, most of the people were not happy with the personnel's attitude. A significant number of people believed that their clinics do not have an adequate number of nurses as some clinics have only one professional nurse on duty and all the clinics depended on sessional workers. Fifty percent of the clinics do not have supervisors on the post and supervision from the authority is a dream not yet come true. None of the nurses was aware of her career path and a significant number were dissatisfied with their job. None of them were satisfied with their salaries and in-service training attendance was very inconsistent.

5.3.4 PHYSICAL FACTORS INFLUENCING THE ACCESSIBILITY OF PHC SERVICES IN ALEXANDRA TOWNSHIP

Access to healthcare resources is intricately linked with fairness, which involves the equitable allocation of resources and care options according to needs (Sword, 1999:1170-7). According to the Norms and Standards for the delivery of PHC services in SA (Dept. of Health, 2000) PHC clinics should have enough equipment in all the required sizes and in good working order. Jones (1997:1647) reported that in SA, more patients are seen in urban clinics than in rural clinics. Almost all the urban clinics had telephones (>90%), electricity and regular water supply (98%), whereas in rural areas less than 50% had working telephones, 80% had electricity and 55% had water (22% without taps). Only 41% had an ambulance at their door (rural clinics) within an hour of an emergency call.

5.3.4.1 Adequacy of the rooms in the clinics

As stipulated in the Norms and Standards for the delivery of PHC services (Dept. of Health, 2000), PHC clinics should have a suitable dressing / procedure room and an adequate number of consultation rooms. There should also be a suitable medicine room that can be locked.

The findings in phase one, two and three (Figure 4.11 & 4.3.2.4 par i) reflect that the majority in phase two and three felt that the clinics have enough rooms, while the majority of the phase one respondents (who are the ones frequenting the clinics) said that the clinics do not have enough rooms. Some of the respondents who said that the clinics have enough rooms complained that nurses use these rooms as their chatting bays where they waste time.

Observations done in phase four (4.3.2.4 par ii) reveal that:

1st clinic: this clinic can only accept one emergency at a time and if there is an emergency no patients requiring dressing will be taken in. On the observation day a woman came to the clinic who had not taken her high blood pressure pills because she had been away to Natal for 3 months and when her pills were finished she did not have access to a clinic because of distance. Her daughter had died and she was now responsible for her newborn grandchild that she had brought home. Her BP was 240/180. She refused to go to hospital because she could not leave her grandchild. She was treated and asked to stay in the clinic for observation on the only emergency bed in the clinic. In the meantime a burnt child was brought into the clinic. The child was taken into the emergency room where the older woman was supposed to be resting. She did not get much rest because of the baby's cries. One and a half-hours later her BP was 220/170 and it was 3.40pm. She was released and told to come back the following morning.

2nd clinic: this clinic has enough rooms for the services they provide.

3rd clinic: this clinic no bed for the patients who require rest. To make place one of the nurses have to stop consulting and offer her examination couch for that

purpose.

4th clinic: the reception is too small. The clinic looks full even though there are only a few patients. There is no dressing room and dressings are done in the emergency room.

- **Conclusion:**

Not all the public clinics in Alexandra have an adequate number of rooms and space for the number of services they offer.

5.3.4.2 Efficiency of the transport system for very sick patients

Gie and Kling (1997:1093-4) report that early resuscitation and rapid transport of critically ill children result in lower rates of morbidity and mortality. As stipulated in the Norms and Standards (Dept. of Health, 2000) a clinic should be able to arrange for an emergency transport within one hour. Fonn et al (1998:697-702) revealed that in the Northern Province, 70% of the clinics had no transport available for referral purposes. According to Pulse Track and MASA Media (1998:526) the Greater Johannesburg has six ambulances and response cars serving the city where there should be about ten times that number.

There are statistically significant differences ($p = 0.004$) between the patient and community respondents in respect of awareness of the transport system for very sick patients. Section 4.3.1.4 paragraph ii shows that those who are the most needy (patient sample) are aware of the system. This shows that they or someone close to them was once in need of the services.

There are statistically significant differences ($p = 0.000$) between the patient and community respondents in respect of the level of satisfaction with the transport system for very sick patients who need to go to hospital. Section 4.3.1.4 par iii shows that the patient sample was more satisfied with the transport system than the community sample. This may mean that to the respondents in phase one the fact that they were given free transport to the hospital was the most important

thing while with the community sample who were more knowledgeable it was the issue of urgency which mattered most. The majority (6 of the 10) of the nurses (Figure 4.37) supported this fact.

The majority in phase three (6 out of 10 section 4.3.2.4 par iv) complained that there were long delays before the ambulance arrived to fetch the patient. Some respondents said that sometimes the ambulances were broken and this increased the delays. Respondents in phase one and two complained that the ambulance takes too long, "a person could die while waiting", in fact some said that they witnessed a patient dying while waiting for the ambulance. Some complained that the ambulance was not available and they had to look for alternative transport for the sick patient.

The findings in phase three (4.3.2.4 par v) show that the ambulance takes more than an hour to arrive at the clinic and this is unacceptable according to the Department of Health (2000). It is very demoralising for the nurses who try to save a person's life only to be let down by the unreliable transport system. This can cause the nurses to tell guardians to take their sick to the hospital because they don't want to witness another frustrating situation in their clinic when something could have been done to save a life.

- **Conclusion:**

The transport system for very sick people who need to go to hospital from Alexandra public clinics is inefficient. A significant number of people are dissatisfied with the system. The majority of the nurses are also not satisfied with the system as it takes more than one and a half-hours for an ambulance to come when it is called.

5.3.4.3 Level of satisfaction with security measures of the clinics

According to McCray (2000:17-30) safety is another deciding factor determining whether or not a healthcare facility is accessible. It has been stipulated in the

Norms and Standards for the delivery of PHC services in SA (Dept. of Health, 2000) that PHC clinics should provide comprehensive security services to protect property and ensure the safety of all people at all times. One of the reasons for the under-utilisation of a midwifery obstetric unit was that mothers feared for their safety and their newborn babies' because they felt that the guard was not equipped enough to provide optimal protection (Mashazi and Roos, 1999:98-106)

There are statistically significant differences ($p = 0.000$) between the patient and community respondents about security. A total of 55% in the patient sample were either very satisfied or satisfied while the majority in the community sample (51%) were not satisfied at all (see figure 4.12). In the nurses' sample (4.3.2.4 par vi) seven of the ten respondents were very satisfied while the remaining three were only satisfied. These findings may mean that the respondents felt that there was still something that could be done to improve the security of the clinics in the area.

Section 4.3.1.4, paragraph v shows that one respondent would give more than one reason for her / his level of satisfaction in the first 2 phases. In phase one and two about a third and more than a quarter respectively, were neutral as they did not have any reason to be unsatisfied with security of the clinics because they had never heard of any security disruption in the clinics. About 40% in the patient sample and 34% in the community sample complained that they had never seen a guard around the premises. This made them feel insecure. Some of the respondents said that they had witnessed people being killed inside the premises and even inside the clinic itself, that the guards are too playful and irresponsible, that they do not know their job, that they are handicapped and that they only look after the cars and not the people. Respondents also said that the guards have copied the personnel's behaviour, they search everybody except their friends and they chase patients from the clinics. They said that the guards come to sleep and wait for their payday. Some respondents said that a security guard was shot dead in the clinic-yard while other guards were there, that people

are raped next to the clinic and robbed to and from the clinic. Some of the respondents said that the guards do their job even though they may be killed because Alexandra is a cruel place and anything can happen. This can pose as barrier to people wanting to access the clinics.

The observations in phase four (4.3.2.4 par vii) show that the security measures of these clinics vary from one clinic to another. This can therefore justify the three phases' responses. There is more that can be done to make the clinics safer. The 2nd clinic is the safest (4.2.1.4 par vii) but not without cost; a security guard was shot dead in 2001 by thieves who laid in wait for the armoured vehicle that regularly comes to the premises. Since then the guards have been issued with guns, an alarm system was installed and a guard is now on duty inside the premises. All the clinics have a history of burglary. Important equipment was stolen from the clinics.

- **Conclusion:**

There is a lack of adequate security measures in Alexandra Public clinics and security measures are inconsistent from one clinic to another. People also get robbed and raped on their way to and from the clinics. Criminal activities occur within the clinic premises and this can cause people not to access the clinics.

5.3.4.4 Availability of equipment in the clinics

Timely access to resources is important to promote access to health services (Eaton.1999:49-56). The Norms and Standards for the delivery of PHC services in SA (Dept. of Health, 2000) stipulate that PHC clinics should have the required equipment in good working condition according to the type of services offered in the clinic. In the Northern Province, SA, the vast majority of clinics had baumanometers but not all were in good working order and the turnaround time for equipment repair ranged from 2 weeks to months with equipment often

getting lost in the system and therefore not returned at all (Fonn et al, 1998:697-702).

The phase three data (Table 4.19) shows that the clinics have most of the required equipment. The majority of the respondents said that they did not have adequate diagnostic sets and a significant number said that they did not have adequate BP machines. This equipment is essential. It was also indicated that they needed delivery packs in case of an emergency. The observations in phase four (4.3.2.4 par ix) support the findings by revealing that although the clinics have the majority of the required equipment, they still lack some important equipment such as diagnostic sets, blood pressure machines and emergency delivery packs.

Figure 4.37 shows that the majority of the respondents said that it takes more than two months to have their broken equipment repaired which shows that although Alexandra is in Gauteng Province; its turn around time for repair of equipment could be more than that of the Northern Province (Fonn et al 1998:697-702) and this is inefficient.

- **Conclusion:**

The majority of the public clinics in Alexandra do not have enough examination equipment and the turnaround time for repair of broken equipment was more than two months.

5.3.4.5 Reliability of the communication system, water and electricity

The telephone is an important component of care. In some parts it serves as a first point of contact for people attempting to enter the medical system (Snyder et al, 2000:196-216). According to the Norms and Standards for the delivery of PHC services in SA (Dept. of Health, 2000) every PHC clinic should have a working

telephone or radio, electricity and warm and cold water. Jones (1999b:112-4) states that in SA only two-thirds of the PHC clinics have an uninterrupted electricity and water supply and a functioning telephone.

Phase three findings (Table 4.20) show that a significant number of the respondents said that their phone was not working. Upon inquiry in phase four, the researcher was informed that the phone in the 3rd clinic has been out of order for more than year because the clinic had accumulated a heavy bill and surpassed their allocation. The bill has not been settled to date. This clinic is unable to call for transport in case of an emergency making services inefficient and unacceptable. This could be the reason why many respondents from this clinic complained that nurses sent them to find their own transport to take their patients to hospital.

Findings in phase three (Table 4. 20) show that about a third of the respondents said that their water supply is not reliable. It is difficult to function in a clinic with no water as this could facilitate contamination between patients and between patients and nurses and this is ineffective and unacceptable to both providers and the consumers. This was also observed by the researcher during her period in the 2nd clinic where water interruptions were common.

Table 4.20 shows that about a third of the respondents said that they do not have a reliable electricity supply. This makes it difficult to conduct some of the examinations whose equipment requires electricity.

- **Conclusion:**

A significant number of public clinics in Alexandra do not have reliable telephone, water and electricity systems, moreover the telephone in one of the clinics had been cut off for more than a year because of unsettled bills.

5.3.4.6 SUMMATIVE CONCLUSION:

The majority of the public clinics in Alexandra do not have enough room or space for the amount of services they provide. A significant number of people are dissatisfied with the transport system and the majority of the nurses are not satisfied as it took more than one and a half hours for the ambulance to arrive. A significant number of people complain that they get robbed and raped on their way to and from the clinics. Criminal activities also occur within the clinics' premises. The majority of the clinics do not have enough examination equipment and the turnaround time for the repair of the broken equipment was more than two months. Also a significant number of clinics' telephone, water and electricity systems were unreliable, one of the clinic's telephone had been cut off for more than a year because of an unsettled bill.

5.3.5 GEOGRAPHICAL FACTORS INFLUENCING THE ACCESSIBILITY OF PHC SERVICES IN ALEXANDRA TOWNSHIP

Many rural Americans find access to healthcare a serious problem because of distance, lack of transport, mal-distribution of healthcare providers and facilities (Magilvy et al, 2000:171-81). The presence of a nearby public clinic is associated with improved utilisation of services (Steele et al, 1999:28-38).

5.3.5.1 Distance from home to the clinic

McCray (2000:17-30) and Ashraf (2000:2223) state that physical distance is an important measure of healthcare utilisation and is affected by the costs associated with transportation. The Department of Health recommends that access should be measured by the proportion of people living within a five kilometer radius of a clinic (Norms & Standards, 2000).

There are no statistically significant differences ($p = 0.322$) between the patient

and community respondents with regard to distance from home to the clinics. In both phases one and two (Table 4.9) a total of more than 98% indicated that their homes were within 2km of a clinic. The majority of the people (99.4% in phase 1 & 98.4% in phase 2) live within the recommended radius of 5km. This shows that the people do not have problems with long distances to reach the public clinics for services and those who live further than 5km away were very few (one in each phase).

- **Conclusion:**

Residents in Alexandra travel an acceptable distance from their homes to the public clinics because the majority of the people live in a 5km radius from the clinics. This could mean that more people are able to attend these clinics. The public clinics in Alexandra Township are accessible in terms of distance as the majority of the people live less than 2km from a clinic.

5.3.5.2 Respondents' time taken to reach the clinics

Access is a complex issue, long traveling times may be associated with under-utilisation of health services (McCray, 2000:17-30).

Findings in both phase one and two (Figure 4.13) show that the majority of the respondents (96.2% of the patient sample and 84% of the community sample) take less than 30 minutes to reach the clinic. This information again corresponds with the fact that the township covers a radius of 5 kilometers.

- **Conclusion**

The majority of Alexandra residents take less than 30 minutes to reach the public clinics in their area. This could result in utilisation of the health services.

5.3.5.3 Respondents' means of travelling to the clinics

Understanding how transportation works to facilitate or inhibit access to services is vital in addressing the societal needs of today. "We are dependent on it and when it is not available the quality of life is affected" (McCray, 2000:17-30). Transportation could be problematic because of cost, unreliable bus schedules, bad weather conditions and safety at bus stops (McCray, 2000:17-30).

Findings in phase one and two (Figure 4.14) demonstrate that an overwhelming majority of the respondents (94.3% of the patient sample and 67.1% of the community sample) walk to the clinic. More than 50% of the community sample also use taxis to go to the clinics. As there is no difference between the patient and community sample with regard to distance from their homes to the clinic, half of the community indicated that they sometimes use a taxi to go to the clinics. This could mean that those who frequent the clinics more (who are poorer as argued already) walk to the clinics.

- **Conclusion**

In Alexandra the majority of the people walk to the public clinics. Those who do not attend the clinics frequently tend to use taxis rather than walking.

5.3.5.4 SUMMATIVE CONCLUSION

The majority of the people in Alexandra travel a distance of less than 2 km to reach the clinic and take less than 30 minutes to reach the clinic. The majority of the people who frequent the clinics walk to the clinic other than those who don't.

5.3.6 ACCEPTABILITY FACTORS INFLUENCING THE ACCESSIBILITY OF PHC SERVICES IN ALEXANDRA TOWNSHIP:

Services which are flexible and sensitive to the needs of the people they are

intended for are required to ensure access of all people (Gonzalez et al, 2000:56-7). Socio-cultural understanding also refers to sensitivity towards the perceptions and attitudes of the community towards the services rendered (Alant, 1998:18).

5.3.6.1 Amount of privacy assured at the clinics

Providing culturally competent care means being sensitive to issues related to culture, race, gender and sexual orientation observed Juarbe (1995:23). Bachman et al (1996:34-40) observed that the provision of contraception by male staff might make services more acceptable to males thus increasing access to them. Every patient has a right to confidentiality and privacy (Dept. of Health, 2000).

The findings in phase one, two (4.3.1.6 par i) and three (4.3.2.6.par i) may mean that the majority of the respondents are satisfied with the privacy provided in the clinics. However a few of the respondents (10.6% in phase 1 and 13.5% in phase 2) complained about the amount of privacy provided in the clinics and this is unacceptable. It is the right of every individual and should be respected by all personnel to all patients.

Respondents who said that no privacy is provided complained that nurses sometimes admit two patients into one consultation room at the same time. They also said that the nurses do not consider gender, two patients, a male and female may find themselves in the same consulting room. They said that other nurses or friends of the nurse enter the consultation room and talk to the consulting nurse. This was also observed by the researcher in phase four (4.3.2.6 par ii) and it happens in all the 4 public clinics especially the 3rd clinic. Nurses even seem to lose their sense of time once they start chatting and they become oblivious to the fact that the patient is still in the room, waiting.

- **Conclusion**

Although the majority of the people felt that personnel provide enough privacy in the clinics, it is still unacceptable that there are a few who are unhappy with the privacy provided and this is in violation of human rights.

5.3.6.2 Clinics' ways of handling confidential records

Ronald et al (1999:853-67) states that public accountability requires healthcare systems to provide adequate safeguards of confidentiality. The Department of Health (2000) states that clinics should provide services which are customer friendly and confidential and that information about a patient is confidential and is only disclosed after informed and appropriate consent.

It is evident in the findings of phase one and two (4.3.1.6 par ii) that the people do not know how confidential records are handled at the clinic. The findings may also explain the fact that the patient sample is sicker and therefore has a good number of respondents who had tests done on them, making them more aware of the way records are handled at the clinic. The figures for phase two are not significant enough to warrant an extensive argument.

The findings in phase three and four (4.3.2.6 par iii & v) establish that the 1st and 2nd clinics' system may not be fair to the people, as patients receive their results from the clerk in front of everyone. This brings the confidentiality maintained by the clerk at such a public place into question. In the 3rd clinic the patients receive their results individually away from other people which is acceptable. As for the 4th clinic's system one may argue that there is not enough privacy provided to ensure confidentiality, as anyone may enter during a confidential discussion and this is unacceptable.

Respondents complained that patients suffering from STI are exposed, they said that the nurses point out HIV positive patients and they shout on top of their voice

so that everyone hears what they are suffering from. They said that they talk anyhow and anywhere about people's illnesses. They complained that results are given to the clerks, which is unacceptable fact revealed by 1 of the nurse respondents also. This was also found by Martinson (1997:765-6).

- **Conclusion**

The majority of the clinics give confidential reports to patients in front of other patients or in rooms where anyone (patients inclusive) can come in at any time. Some of the respondents also said that personnel do not provide privacy during consultation time. This could infringe on the individual's right to privacy, which could lead to people not accessing the public clinics in their area.

5.3.6.3 Number of respondents who were turned away without receiving help.

The reasons for childhood under-immunisation are multi-factorial and include family and parental factors such as culture, inconvenience and misconceptions, provider factors such as missed opportunities and healthcare system barriers (Hambidge et al, 1999:158-63). Speizer et al (2000:13-22) said that service providers impose barriers with neither government policy endorsement nor valid medical justification and this is unacceptable as it serves to restrict access to health services

There are no statistical significant differences ($p = 0.342$) between the patient and the community respondents with regard to the number of people who are turned back home without receiving help. Section 4.3.1.6 paragraph iv shows that more than 33% in phase one and more than 30% in phase two were once sent back home without being attended to. The researcher believes that the figures are even higher considering the data from phase four (4.3.1.6 par vi). These figures were observed for only one day per clinic. Bearing in mind that patients are sent back almost on a daily basis the figures in reality should be

higher. However the figures are still significant considering that in both phases almost one in every three respondents was sent back home without receiving help. Surprisingly enough the 3rd clinic was not even full in the morning. In the afternoon only two patients arrived. When the researcher queried this she was told that they turn patients back after 9 or 10am regardless of whether the clinic was full or not. The people know that if they go later in the day they will be turned away and so they choose not to come if they are 'late'.

An overwhelming majority of those who were turned away in both phase one and two (Table 4.10) were told that they were late even though it was only 8am. Some of the respondents were turned away because the clinic (3rd) could not open a vaccine vial for only two children and this is unacceptable.

During observation in phase 4 (4.3.1.6 par vi) the researcher reaffirmed that the clinic (3rd) does not provide the measles vaccine to babies on a daily basis. The service providers in these clinics impose restrictions to services without endorsement from government policy or a valid functional reason and that is unacceptable. This is why there may be still under-immunisation despite the fact that vaccines are offered free at user point.

The respondents who were told that they were late because the clinic was full were told to go to the non-governmental clinic. Respondents complained that nurses should tell them in time that they can not be treated rather than leave them in the queue for the whole day and later tell them that they cannot be treated. One of those who were sent back from the 3rd clinic said that she was sent back because she did not bring her old card with her. The patient was not on any family planning method but had a gynaecological problem and when she came to the 3rd clinic the receptionist asked what her problem was. She explained and the receptionist insisted that she could only be helped if she has a family planning card. A pensioner was sent home and told to go to traditional healer or go home and wait for her death since she was old. She left without any help, not even for her high blood pressure. At the 4th clinic they told people that

the public clinics do not provide services for babies younger than 3 months, and at the 3rd clinic they said that they do not do pregnancy tests. These are all lies. This kind of behaviour can make one think that the personnel are neither professional nor interested in their work. They simply come to the clinic to inconvenience people and not to try and make a difference in the community they are supposed to be serving and this is unacceptable.

- **Conclusion:**

A significant number of people are turned away from Alexandra public clinics without receiving help. Some clinics even deny offering services that they are supposed to offer in order to turn users away and so limit their access to the services.

5.3.6.4 Respondents' preference of a public clinic in their area

It is estimated that over 360,000,000 crossings occur each year along the 2,000 mile US-Mexico border presenting unique challenges to healthcare providers on both sides of the border (Macias & Morales, 2001:77-87). In Mexico, 63% of those seeking dental care preferred receiving it in Mexico and this led the authors to conclude that individuals crossing the border were more likely to turn to the services that are most culturally acceptable to them.

In both phases one and two (4.3.1.6 par vii) the majority (65.7%, phase one and 50.3%, phase two) of the respondents said that they would first go to a public clinic within Alexandra if they become sick. Respondents said that the public clinic as first choice is due to the fact that people do not have any other choices. The majority of people are unemployed and do not have alternatives to attending these clinics. Some respondents (19.4% of the patient sample and 23.5% of the community sample) said that they go to private doctors and get services for a fee at user-point despite the fact that they are poor and this makes health services expensive for them. Going to other public clinics outside Alexandra requires

money for transport. The most vulnerable of this community cannot afford transport and have no choice but to go to these public clinics.

There are statistically significant differences ($p = 0.003$) between the patient and community sample with regard to having a preferred clinic among the four public clinics in the area. Only 28.8% in phase one and 50% in phase two (section 4.3.1.6 par viii) had a clinic of preference. Ironically more than half the respondents in phase three (4.3.2.6 par vi) believed that their clinics were preferred to the other clinics. Those who did not have a preferred public clinic believed that all the clinics were the same. They only go because they have no other choice. They believe that all the clinics are discriminatory, that they serve their families and friends first, that personnel in these clinics were negative, pompous and insensitive and that is unacceptable to them. One of the respondents summarised the drama, the 1st clinic's priority is their friends, the 2nd clinic only takes a few patients, the 3rd clinic's personnel are abusive and rude and the staff at the 4th clinic takes long tea breaks. The respondents said that they go to the public clinics because they have no choice since they do not work and do not have money to go to a private doctor. The preferred clinics as scored by both phase one and two (Figure 4.15), are from most preferred are the 2nd clinic followed by the 1st clinic, then the 4th clinic and the 3rd clinic as the least preferred.

Section 4.3.1.6 par x shows that those who preferred the first clinic commented that the services were provided in a friendly manner and without shouting. The personnel were sensitive and flexible in that they sometimes allow more patients to come in even though they may be closed. They said that personnel are happy and talk decently to the patients and provide effective treatment. Two of the respondents said that they skip two public clinics to come to that clinic. Those who preferred the 2nd clinic said that the nurses should keep up their good work especially the way they handle TB patients and that the clinic has a good reputation among the people it serves. They also said that it is better than the

others because the receptionist does not ask about their problem unlike the 3rd clinic. The personnel at the 2nd clinic also know how to communicate with people, they respond to queries and complaints and are better than those from the other clinics. A respondent also said that the personnel there work very hard even though there is shortage of staff. The researcher also observed that about half of these respondents came from outside the catchment area of this clinic and mainly from the 3rd clinic's catchment area.

In comments on the 3rd clinic, which scored the lowest in both phases, some respondents said that they were there because they had been sent there from the non-governmental clinic and another complained that she is sent back there from the other clinics because she does not fall in their catchment area. Respondents said that they prefer the 4th clinic because it is not full and services are faster there. This was also observed by the researcher and one can argue that services are perceived to be faster because it is not full.

- **Conclusion:**

Although some people feel good about the clinics in this area and have clinics that they prefer to visit, the majority (71.2% in phase one and 50% in phase two) feel different and do not have a preference among these clinics as they believe that all the clinics are discriminatory, with pompous, negative and insensitive personnel.

5.3.6.5 Public clinics' rendering of user friendly services

Measuring patient satisfaction has come to be regarded as the method of choice for obtaining patients' views about their care, and is achieved through the incorporation of two principles. These principles are that patients are an essential source of data about how services are performed and that patients as community members have the right to have their views taken into account when health services are planned and evaluated (Avis et al, 1995: 316-22). Levine (2000:10-

1) warns that it will be critical that the context in which this information exchange takes place is one of learning for improvement, as opposed to judgment for blame, punishment or discrimination.

A few of the respondents in phase 1 and 2 (section 4.3.1.6 par xi) and one respondent in phase three (4.3.2.6 par vii) believed that the clinics do not provide user-friendly services. They felt that the clinics do not make them want to come back again. Though the number is small, it is undesirable and unacceptable. The researcher notes that the respondents may not have understood the question because some thought that the question was posed for the validity of the clinics to remain in operation (despite a repeated explanation of the variable they seemingly did not want to commit themselves). This may be why despite all the complaints they paint a user-friendly picture. Those who complained made comments like, if we can not use these services the way we want then let them be closed. Those who understood the question commented that everything must change: more nurses, doctors and people should not queue the whole day.

There are no statistically significant differences ($p = 0.057$) between the patient and community respondents in respect of their knowledge regarding the availability of suggestion boxes in the clinics. An overwhelming majority (99.3 in phase one and 98.5% in phase two) (Figure 4.16) and 100% of the nurse respondents (4.3.2.6 par viii) supported this, which shows that there are no suggestion boxes. It is difficult to claim that they provide user-friendly services when they are totally ignorant of the users' feelings about the services. Another argument is that nurses in the clinics are not prepared to create a secure environment for feedback on the way the community perceives the services.

In phase four the researcher noted that suggestion boxes have been introduced in all the clinics. This was not done by the clinic personnel but by the authorities. One of the clerks in one of the clinics told the researcher that at the end of the day, the nurses take the patients' suggestions out and replace them with notes

that they wrote. He also said that the nurses are suspicious of each other thinking that one may have written something negative about a colleague and insert it in the box as if it's a patient who has written it. Note Levine's comment above. The fact that the boxes were not put by the nurses who provide the services means that the nurses are threatened by these boxes and may have lost their most important purpose - learning for improvement. This inefficiency is unacceptable.

In phase three, the majority of the respondents (Figure 4.39) said that their clinics do not conduct community need assessment. In phase four (4.3.2.6 par xiv) the researcher observed that none of the clinics conduct a community need assessment. This shows that services in this area are provided without taking the unique needs of this community into consideration and this is unacceptable. No two areas are the same and the needs of the communities differ as a result of this. Each community should be treated as unique.

Considering the demographics of the community it is expected that the people should be happy to have free services in their community. Some respondents (4.3.1.6 par xiii) said that they were happy with the clinics but what is happening in the clinics is unacceptable.

- **Conclusion:**

Even though the majority of the people are happy to have the clinics in their community and believe that the clinics are user-friendly, none of the clinics had suggestion boxes to obtain the users' views with regard to health services. The suggestion boxes, which were later introduced by authorities, were viewed negatively by the providers thereby losing the very objective of having them. It is obvious that none of the clinics conduct community need assessments to ensure provision of acceptable services.

5.3.6.6 Respondents' level of utilisation of public PHC services in their area

Roos and Mashazi (2000:98-106) revealed that the under-utilisation of a midwifery obstetric unit was due to the fact that there was a lack of material resources, personnel resources, poor security system, lack of ownership by the community and poor communication skills of the personnel. The lack of these skills in nurses can lead to misconceptions, non-utilisation and non-compliance as services become more and more unacceptable by the people, for utilisation behaviour is inherently related to the issue of acceptability among others (Sword 1999:1170).

There are statistically significant differences ($p = 0.018$) between the patient and the community respondents in respect of their opinion on whether the clinics are well utilised by the people. Section 4.3.1.6 paragraph xiv shows that while more than two-thirds of the patient sample believe that services are well utilised, about half of the community sample believes otherwise. One can argue that the respondents in phase one answered the question necessarily on their behalf (the fact that they attend the clinics) while the community sample answered the question on behalf of the community - the population of concern. This indicates that out of every two community members interviewed, almost one said that the public clinics are not well utilized, this is supported by a significant number of nurses.

In phase four the researcher observed at the 4th clinic that it was full in the morning. Considering the fact that the reception is a small area (carries about 40 patients) the clinic should have remained 'full' for most of the day. At 11.30am there were only three clients and at 1.30pm (after all the nurses had gone for a prolonged tea break) the last patient for the day was seen out. The 3rd clinic was never full, not even in the morning. In the afternoon only one mother with a child with TB came in. Some of the respondents felt that many people would like to come to the clinic but they know that they will be chased away. This way of

providing services is unacceptable.

- **Conclusion:**

A significant number of people believed that the clinics are not well utilised by the majority number of people in the community and a significant number of nurse respondents acknowledge the fact that their clinics are not well utilised.

5.3.6.7 Clinic personnel's level of community participation

Measuring patient satisfaction is regarded as the method of choice for obtaining patients' views about care. To do this a secure environment must be established in which consumers can give researchers and providers feedback on outcomes and their experience, thereby enabling prospective evaluation of the health system's effectiveness (Avis et al, 1995:316-22). According to the Norms and Standards (Dept. of Health, 2000) for the delivery of PHC in SA, the clinic should provide opportunities for community consultation by determining the community's perception of services at least twice a year through patient interviews or an anonymous patient questionnaire.

There are statistically significant differences ($p = 0.000$) between the patient and community respondents with regard to their opinion on the importance of community involvement in the running of the public clinics. Almost everyone in phase one (99.4%) and 73.6% in phase two (Section 4.3.1.6 par xv) agree that community involvement is important. This may mean that the community respondents do not see a benefit in participating in the running of the services as much as do the phase 1 respondents. This also means that they are unaware of their rights and see themselves as inferior and not qualified to argue on issues they do not have 'knowledge' of. One of the respondents said that only those who know something about health should get involved but not her. One can therefore say that they are brainwashed (obviously by the health personnel) and

this is unfair and unacceptable. Some of the respondents, who said that it is important for them to be involved, said that they felt good for having participated in the study.

Phase three findings (4.3.2.6 par xi) show that the respondents believe that the community should be involved in the running of the public clinics. Section (4.3.2.6 par xii) shows that none of the clinics (9 out of 10) are members of the health committee. This may indicate that the clinics provide services depending on what they (the providers) perceive or believe to be the needs of the community. This deprives the community of the opportunity to participate in the assessment, planning, implementation and evaluation of the services. This situation makes it difficult to instill a spirit of self-reliance and self-determination in the people who live with the effects of illness or seeing those they care for suffer. Some of the respondents complained that the clinic personnel and the authorities should listen to their views and do what the community wants.

Findings in phase three (4.3.2.6 par xiii) may indicate that this community has not been given the opportunity to organise themselves to solve their own public health issues and other concerns in partnership with the government and NGO's and this is not acceptable.

- **Conclusion:**

Despite the fact that all the stakeholders in the study agreed that community involvement was important, not one of the public clinics in Alexandra Township was a member of either a health committee or an intersectoral collaboration committee.

5.3.6.8 SUMMATIVE CONCLUSION:

Public clinics in Alexandra are violating people's rights because a significant number of people are dissatisfied with the quality of privacy provided at the clinics. The majority of the clinics provide confidential records to the patients in front of other patients or in rooms where anyone

(patients inclusive) could enter at any time. A significant number (33.6% & 47.8% in phases 1 & 2) of people believe that the clinics are not utilised properly as a significant number (33.6% & 30.7% in phases 1 & 2) of people are turned away without receiving help, also taking into consideration the way that the clinics actually take patients in. The majority of the people do not have clinics of preference as they believe that all the clinics are discriminatory, with pompous, negative and insensitive personnel. Although most of the people are happy about having the clinics in their community and believed that the clinics are user-friendly; not one of the clinics had a suggestion box to obtain the users' views with regard to health services. The suggestion boxes, which were later introduced by the authorities are viewed negatively by the providers thereby losing the very objective of having them. Despite the fact that all the stakeholders in the study agree to the fact that community involvement is important, none of the public clinics in the area are a member of a health committee or an intersectoral collaboration committee. Not one of the clinics conduct a community need assessment to make services acceptable to the people intended for.

5.3.7 FINANCIAL FACTORS INFLUENCING THE ACCESSIBILITY OF PHC SERVICES IN ALEXANDRA TOWNSHIP

Accessible health services should be affordable to both the country as well as the community. Studies conducted in Guatemala suggest that access to formal services by pregnant women is hampered by financial constraints, long distances and lack of suitable transportation. Due to the expenses for transportation, even centers and posts that charge very low fees for services become unaffordable and therefore inaccessible (Glei & Goldman, 2000:5-22). According to the Norms and Standards (Dept. of Health, 2000) public services should be provided economically and efficiently in order to give citizens and communities value for money.

5.3.7.1 Availability of essential drugs in the public clinics

Public clinics should keep a supply of the essential drugs on the essential drug list (Dept. Health, 2000). Jones (1997:1647) reports that the drug supply in the rural clinics in SA ranged from 97% availability for vaccines to 65% for diabetes drugs.

There are statistically significant differences ($p = 0.000$) between the patient and the community respondents with regard to number of respondents who were told in the past year that a drug for their complaint was finished. A few respondents (16.8%) in phase one and the majority (54.2%) in phase two (Figure 4.18) said that in the past year they were told that the drug for their complaint was finished. This may justify why a higher percentage of community respondents said that they go to private doctors for treatment because in the end they will have to buy the medicine themselves regardless of where they go for services.

All the respondents in phase three (4.3.2.7 par i) said that they always get a sufficient drug supply for one month. In phase four the researcher observed that the clinics do not have ear and nose drops (4.3.2.7 par ii). During the year 2001, the researcher as part of the work-force observed that the following drugs were in short supply: amoxil tablets, metronidazole tablets, paracetamol syrup, adult cough syrup, measles vaccine, eye ointment, oral rehydration solution, the BCG vaccine was expired and there has never been ear and nose drops. In view of this observation, the argument can be made that the lower patient sample rate may have been due to variables that influenced their responses. Respondents complained that sometimes they are just told that there are no medicines. Essential drugs were not always available in the clinics.

- **Conclusion:**

There is lack of essential drugs in the Alexandra public clinics as a

significant number of people were told that a drug for their complaint was finished within the past year. The drugs were also not consistently made available throughout the year 2001.

5.3.7.2 Respondents' ability to buy the out of stock drug

Basson (2000:2) reported that disadvantaged people in poor countries are denied access to increasingly expensive medicines. Medicine is associated with the health of a person and accessing them is a right, he observed.

Findings in phase one and two (Figure 4.19) may further support the argument that the patient sample is poorer. It is undesirable and unacceptable for even one patient be told that there is no medicine in the clinic, especially when you consider all the hassles patients have to see a nurse for a consultation. Respondents complained that they do not work and cannot afford to buy their own medicine. Some said that they had to ask relatives to buy it for them. This makes services inefficient.

Another observation is that some of the nurses unnecessarily ask patients to go and buy their own medicine. Some of the nurses would rather ask a patient to go and buy 'Savlon' to clean a wound instead of giving them the antiseptic soap that all the clinics have. Moreover clinics receive savlon when they order.

- **Conclusion:**

A significant number of people in Alexandra Township are unable to afford to buy out of stock medicines, some of them even have to ask relatives to buy it for them.

5.3.7.3 Respondents' financial viability for transportation to the clinic

Understanding how transportation works to facilitate or inhibit access to goods

and services, is vital to addressing the societal needs of today, warns McCray (2000:17-30).

The data in section 4.3.1.7 par iii indicates that 40% in phase 1 said that they are sometimes unable to go to the clinic due to lack of money while in phase two only 24% sometimes are unable to go due to lack of money. From this one may conclude that the patient population (phase one) is poorer than the rest of the community, which in turn means that the public services are accessed by the poorer sections of the population. One can therefore argue that the majority of the respondents in phase one who walk to the clinics do so out of financial restraint.

In addition one could assume that the patients would prefer to reach the clinic as fast as possible to save time. A sick person who is too weak to walk to the clinic may prefer to use transport.

- **Conclusion:**

Public services in Alexandra are more affordable to those who are within walking distance to the clinic. Those who sometimes require transportation, find access to the services problematic due to financial constraints.

5.3.7.4 SUMMATIVE CONCLUSION:

A significant number of people attending the Alexandra public clinics have been told that the medication they need is depleted. There has also been an irregular supply of drugs to the clinics throughout the year, 2001. With the levels of their income in consideration; a significant number of people are unable to buy the medication and some even have to ask relatives to buy it for them. Health services are more affordable to those within walking distance of the clinic and those who require transportation find access to the services problematic due to financial restraints.

5.3.8 EFFICIENCY FACTORS INFLUENCING THE ACCESSIBILITY OF PHC SERVICES IN ALEXANDRA TOWNSHIP

Delays for access to care plague our healthcare system (Murray, 2000:1594-6). These delays cause patient dissatisfaction, contribute to staff dissatisfaction and may lead to worsening clinical outcomes. They are also expensive. Patients often consume scarce resources while waiting, there is a cost in maintaining any waiting list, the longer they wait the higher the 'fail to show' rate, which prevents unused capacity and finally there is a risk that patients waiting will arrive with a more costly clinical condition. Sokoloski (1995) states that waiting times, appointment difficulties, dissatisfaction with care and poor relationships with service providers have been identified as important factors that influence access to health services, and this affects the efficiency of the services which influences people's access to the services (Sword, 1999:1170-7)

5.3.8.1 Availability of complaint procedures in the clinics:

At the Marylebone center in the UK (Pietron & Pietron, 1996:82) patients are encouraged to participate in education and community activities and to provide ideas and feedback on health center services and management through the use of an informal complaint procedure within the practice that gives both patients and personnel a faster turnaround time for dealing with complaints. As a result more complaints were received and most were solved within three days of being received. According to the Norms and Standards for the delivery of PHC services (Dept. of Health, 2000) clinical staff should provide easily accessible and effective ways of dealing with complaints or suggestions for improvement.

Findings in both phase one and two (Figure 4.20) show that an overwhelming majority of the respondents (94.3% and 99.2% respectively) had never seen or heard of a complaint procedure in the clinics and did not know who to contact if

they had a complaint. The overwhelming majority (9 out of 10) in phase three (Figure 4.39) said that their clinics do not have a complaint procedure for the patients. In the same phase an overwhelming majority (4.3.2.8 par ii) said that the clinics do not have a complaint procedure for personnel. This was confirmed by the researcher (4.3.2.8 par vii). This shows the clinics have not made provision for patients to complain about the services and if they do through the suggestion boxes their ideas are thrown out as alleged (see 5.3.6.5 par iv & v) This hampers the efficient running of the clinics for the benefit of the people.

- **Conclusion:**

None of the public clinics in Alexandra Township have a complaint procedure to ensure efficient solutions for problems. This was supported by the majority of nurses and confirmed through observations

5.3.8.2 Respondents' waiting time in the public clinics

The healthcare system is often seen as a barrier to low-income women due to long waiting times and interaction with insensitive healthcare providers (McCray 2000:17-30). Longer waiting times are not merely an inconvenience but also increase the discomfort and may discourage people from accessing the services (Snyder et al, 2000:196-216). Fonn et al (1998:697-702) say that the long waiting times at the clinics and the inability of clinics to provide a combination of services on a single day are very important problems.

There are statistically significant differences ($p = 0.000$) between the patient and community respondents with regard to waiting time in the clinics. Findings from phase one and two (Figure 4.21) show that while two-thirds of the respondents in phase one waited for more than two hours before being attended to, just more than a third in phase two waited that long. This may support the idea that the most vulnerable of this population (the patient sample) find access to services more problematic.

Phase four findings (4.3.1.8 par iii) show that patients wait too long in all the clinics. To queue for three hours or more for services is unacceptable and inefficient. Respondents pleaded with the providers to close the clinics at 4pm and not earlier. Patients wait the entire day to be seen, only to be told that there is no medicine. They said that all of the personnel do not work the expected number of hours. One respondent said that she was told to go to school first because she was wearing a uniform and when she came back after school she was not taken in because according to the personnel she was not sick since she went to school first. This way of postponing treatment can indeed worsen clinical conditions and make services inefficient. However one of the patients in the 2nd clinic said that it does not matter how long she has to wait, she wants to be treated in this clinic. Due to the fact that patients prefer to go to this clinic instead of their clinics, it appears that this clinic sends more people away (see 4.3.1.6 par vi).

- **Conclusion:**

People attending public clinics in the Alexandra Township have unacceptably long waiting times, the majority said that they wait for more than two hours to be attended to. This inefficiency may discourage people from accessing the public PHC services in their area.

5.3.8.3 Time taken with an individual patient during consultation

Having enough time to deal with a patient as an individual allows for proper establishment of a rapport between the provider and the one provided for, this situation facilitates a proper diagnosis and management of the patient's needs and for an acceptable outcome (McDonald and Blignaut, 1998:8-11, Jones, 2000:928-39, Snyder et al, 2000:196-216 & Diaz et al, 1999:1-15).

There are statistically significant differences ($p = 0.002$) between the patient and

community respondents in respect of time taken during consultation with the nurses. 72.5% of the patient sample and 55.7% of the community sample (4.3.1.8 par iv) said that they have enough time with the personnel when consulting. This finding may indicate that those who access the services are more satisfied than those who do not. However it is significant that more than a quarter of the patient sample and about half (45%) of the community sample thought that personnel did not spend enough time with them.

Fifteen minutes (4.3.2.8 par iii) is acceptable to effectively treat a patient. According to the authorities a nurse should take about 14 minutes with each patient to see 30 patients per day. A third of the respondents spend about 10 minutes and one spend about seven minutes. This is on the lower side. Some respondents (10%) said that they take between 23 and 17 minutes. This is on the higher side. One can argue that these may be the ones who waste time with friends and relatives during consultations (in view of what the respondents in phase one and two said). This makes a total of 70 % of personnel who either take too much or too little time in treating patients and this is neither acceptable nor effective.

Some respondents complained that they become angry whenever they think of the rapid examinations and lack of medicine at the clinics. The researcher as a participant observer in the 2nd clinic saw a mother who came in with a sick baby who had a fever of 39^o C and a lower chest infection. The researcher prepared the medicine for the child, explained what was wrong with the baby and how the medication should be administered. The mother interrupted the researcher and asked why when she had taken her baby to the 4th clinic the previous day, the sister there gave her only 'Panado' when the baby's temperature was 40^o C? She cried when she realised that her baby had not received proper care. In this situation one can argue that 'double doctoring' (as observed by Jones, 2000:928-39) may sometimes be beneficial to the people from this area. Some of the nurses who felt that they do not have enough time said that they have to do a lot of paperwork and suggested that the authorities should reduce the amount of

paper work.

- **Conclusion:**

The majority of the nursing personnel working in the Alexandra Township public clinics either spend too little or too much time during consultation. This inefficiency can result (in case of too little time) in incorrect diagnoses and subsequent incorrect treatment. It can also lead to inadequate explanation of clinical procedures, which may result in worsening of clinical conditions. On the other hand (in case of too much time) it could result in under-utilisation of services and resources as fewer patients will be attended to.

5.3.8.4 Evaluation of the services by the clinics' personnel

According to the Norms and Standards (Dept. of Health, 2000) clinics should conduct an annual evaluation of PHC service-provision using a situation analysis of the community's health needs and the regular health information data collected at the clinic. The clinics should have a mechanism to monitor services, quality assurance and at least one annual service audit.

Phase three findings (4.3.2.8 par iv) show that the majority of the respondents (6 out of 10) said that they do evaluate the way services are provided in their clinics. This was disconfirmed during phase four (4.3.2.8 par vii). The only type of evaluation is quantitative evaluation by keeping daily and monthly statistics. From this information one can argue that the public clinics are not aware of whether they provide efficient services and whether they effect people's lives and health positively or negatively. Ironically some of the personnel indicated that they evaluate services twice a year (4.3.2.8 par v) which means that they do not refer to the monthly statistical evaluation. When the researcher went to confirm this, they did not have any results on their evaluations available. This indicated to the researcher that the providers in these clinics are aware of what they should do but they dont. This is neither acceptable nor efficient and definitely not effective.

- **Conclusion:**

There is lack of efficiency in the way services are run in the Alexandra public clinics because none of the clinics evaluate the quality of services they offer.

5.3.8.5 Availability of year plan in the clinics

Koponen et al (1997:41-8) report that nurses in health centers in Finland have a problematic relationship with the administrators and this has a consequential outcome in that nurses are critical of the fact that the population responsibility principal (community participation) was planned and implemented without their active involvement. The Norms and Standards for the delivery of PHC services (Dept. of Health, 2000) stipulates that PHC clinics should have an annual plan based on the assessment done on the community's health needs.

Phase three (Figure 4.40) and four (4.3.2.8 par vii) findings shows that the clinics do not really have a sense of direction on what they should do to ensure that the services provided are efficient and effective for the benefit of the community. The individual clinics wait for the authorities to come and tell them what to do and when, but they themselves do nothing. Some of the respondents in phase three even complained that they are not consulted when the authorities prepare the annual plan. A significant percentage of the respondents from the 3rd and 4th clinics said that they have an annual plan, one wonders why.

- **Conclusion:**

None of the public clinics in Alexandra have an annual plan of activities as was indicated by the majority of the phase three respondents and confirmed by the researcher. The nurses working in the clinics are not involved in the preparation of the year-plan if such a plan exists.

5.3.8.6 SUMMATIVE CONCLUSION:

None of the public clinics in Alexandra have a grievance procedure to efficiently solve problems. People wait for more than three hours in the clinics to be seen and the majority of the personnel take either too little or too much time during consultation. None of the public clinics in the area evaluate the quality of services offered and they do not have an annual activities plan. The nurses at the clinics are not involved in the preparation of the year plan (if one was prepared).

5.3.9 FACTORS INFLUENCING THE EFFECTIVENESS OF PHC SERVICES IN ALEXANDRA TOWNSHIP:

In 1998 the WHO, assessed the health systems of countries regarding overall performance in which an observation was made that virtually all countries are under-utilising the resources available to them, and this leads to large numbers of preventable deaths and unnecessary suffering (Ashraf, 2000:2223).

5.3.9.1 Respondents' frequency of clinic visits

Shoultz and Hatcher (1997:23) state that ethical professional behaviour demands that nurses advocate access to healthcare for the entire population and use effective methods to improve health indicators.

There are statistically significant differences ($p = 0.000$) between the patient and the community respondents with regard to frequency of clinic visits. Table 4.11 shows that 43.1% of the patient sample goes to the clinic once a month while only 6.4% of the community sample goes once a month. This may indicate that the patient sample who visit the clinics is sicker than the rest of the population (the community sample).

A total of 81.8% of the patient sample and 62.8% of the community sample visit

the clinics on average every three months. This may mean that the area is a more vulnerable area in which people often find themselves in need of the health services. This may also query the representativeness of the average number of the clinic statistics for the year 2000, which showed that about 100,000 patients visit the clinics per year (see chapter 1.2 paragraph 2). This may mean that those who access the services are even less than is reflected. One may argue that the people in this community do not receive effective treatment as they visit the clinics many times in a year. Some of the respondents (Table 4.11) in phase two (8.5%) said that they no longer visit the public clinics in their area. Some of the first time visitors, 8.1% in phase one said that they were unaware that the 4th clinic also cater for the Alexandra community because it is situated outside of the Alexandra boundaries.

- **Conclusion:**

The Alexandra Public clinics are frequented by the same majority of people. This can mean that health services in the Alexandra Township are not provided in an effective manner as the same people frequently sees themselves back to the clinics. This can also question the representativeness of the clinics' attendance statistics in that even fewer people attend the clinics as the majority attend more than four times in a year.

5.3.9.2 Physical examinations done on the patients:

Jones (2000:928-39) revealed that in Canada patients who attended walk-in centers also saw a doctor for the same condition within seven days of having attended the walk-in center. This queries the effectiveness of the walk-in centers.

Findings for the three phases (4.3.1.9 par ii & Table 4.19) show that the majority of the people do get examined in the clinics. The number of respondents who said that they were not examined is very low, only 18% phase one and 17.5% phase two. However one may argue that the phase three figures (Table 4.19) are

significant which should mean that the numbers of those not examined are actually high. Phase one and two respondents complained that new or defaulted f/p patients are injected without an examination to rule out pregnancy and patients are not examined according to their complaints. Babies receive vaccines without an examination. Some of the respondents said that they were examined at the 1st and 2nd clinics only.

- **Conclusion:**

The Alexandra Township public clinics are effective in the number of physical examinations done on the patients. However lack of equipment may hamper the conduct of proper examinations.

5.3.9.3 Respondents' failure to show to the clinic when sick

According to Murray (2000:1594-6) the longer the wait the higher the 'fail to show' rate.

There are statistically significant differences ($p = 0.000$) between the patient and the community respondents with regard to failure to come to the clinic when sick. Findings in phase one (Figure 4.23) shows that 51% and 89% in phase 1 and 2 respectively were once sick but chose not to go to the clinic. This finding confirms that the patient sample was comprised of respondents who frequent the clinics more than the other sample. However both findings are significant and disturbing. How can people in need choose not to go for services?

There are statistically significant differences ($p = 0.000$) between the patient and the community respondents with regard to waiting time as a reason for not going to the clinic when sick. 81% of the patient sample and 72% of the community sample (Table 4.12) gave a long waiting time as the reason for not visiting. This may mean that the patient sample find access to the services problematic because of long waiting times. However despite the fact that the patient sample has a longer waiting time, they still go to the clinics. Long waiting times are

inconvenient, increase the patients' discomfort and discourage people from accessing the services.

Findings in phase one and two (Table 4.12) show that access problems in the area are legion indeed. Respondents in both phases complained that the personnel's rudeness kept them away from the clinics. One may argue that the phase one respondents accessed the clinics despite the personnel's rudeness, while in phase two more than one in every four respondents who do not access the clinics fail to do so because of the personnel's rudeness. The respondents in phase one seem to put up with personnel's rudeness unlike the phase two respondents. This is unacceptable as it makes the services inaccessible to the community. This also affects the effectiveness of the services in the area. Unsuitable service times is another barrier to services in this area. In phase one, one fifth of the respondents said that services in these clinics are offered at unsuitable times and in phase two only one twentieth of the respondents said that they did not go to the clinics due to unsuitable times. This may indicate that despite the fact that phase two respondents were most dissatisfied (Figure 4.8) with the times services are offered, they still negotiated with their time to access the clinics.

- **Conclusion:**

The majority of the people in Alexandra choose not to go to the clinic when they are sick and in need of the services because of long waiting times and inconvenient times services are offered. The personnel's rudeness also prevents sick people to go to the clinics. These delays could cause the clinical conditions to become worse and result in an unacceptable outcome.

5.3.9.4 Nurses' explanation of clinical procedures to the patients

Henderson (2000:6) observed that Hispanics are likely to report long waits for care and that their provider failed to listen to them and provide them with needed information. According to the Norms and Standards (Dept. of Health, 2000)

informed consent for clinical procedures is based on the patient being fully informed of the state of illness, the diagnostic procedure, the treatment and its side-effects, the possible costs and how it may affect their life-style.

There are statistically significant differences ($p = 0.000$) between the patients and the community respondents on the explanation of clinical procedures. Figures 4.24-27 shows that the majority of the patient sample said that personnel explain clinical procedures to them, while the majority in the community sample said otherwise. These findings show that the patient sample may have been affected by some extraneous variable i.e. the fact that interviews were conducted within the walls of the clinics.

During phase four a father with a sick baby came for consultation in the researcher's room. After the consultation he told the researcher that this was the first time that he was given important information on the examination, diagnosis, treatment and care of the sick child. The father appeared very satisfied.

It can be argued that almost all of the time, personnel do not explain the procedures to the patients and this may affect the patients' compliance. Patients complained that the personnel are rude and that before they have finished explaining their problem, the nurses have already written the prescription. The personnel do not know how to talk or listen to the patients and this can affect the patients' compliance to the prescribed treatment and make services ineffective.

- **Conclusion:**

The majority of the people who attend the Alexandra public clinics do not receive important information pertaining to examinations, diagnosis, treatment and modification of life-style where needed. This can result in patients not complying to the treatment given which could result in under-treatment or overdosing with subsequent complications.

5.3.9.5 Number of patients seen in the clinics

Trends for patient attendance to the PHC clinics in Alexandra are declining (Ferrinho & Phakathi, 1995:57). The authors recommend an exploration of determinants of utilisation of care in the area.

In phase three (4.3.2.9 par i & Table 4.25) respondents gave inconsistent data. Only 40% gave the same data. Clinics see an average of 50 to 200 patients per clinic per day. This shows that some clinics see a quarter of what other clinics see. The researcher observed that only the 1st and 2nd clinic respondents gave the same values for their clinics respectively. The others (with no supervisor) gave different values although they work in the same clinic.

Findings in phase four (4.3.2.9 par ii) show that patient attendance in the public clinics in Alexandra is declining indeed. In the year 2000, the clinics saw an average of 43 patients per clinic per day. In 2001, the clinics saw an average of 40 patients per clinic per day. One would therefore argue that most of the respondents supplied figures that were higher than real.

In phase three (Figure 4.41) the data shows that some of the personnel see half the number of patients that the others see per day. For one nurse to see 50 patients per day is very high and one can question the quality of care given. To see less than 30 patients per day is too little. The authorities daily statistics indicated 40 patients until it was changed towards the end of the year 2001 to 30 patients. The findings show that the nurses who see an average of 45 patients and more (30% of this study), see more patients per unit time and they cannot do everything that they are supposed to do on each patient, to facilitate a proper diagnosis and management of the patients' needs. The patients go home without proper treatment, which makes the services ineffective.

The nurses who see less than 30 patients per day (20% of this study) under-

utilise the resources. This means that the services do not positively effect the community's quality of life. This does not necessarily mean that they take a longer time consulting as it has already been argued that they waste a lot of time doing unnecessary things in the clinics. In summary 50% of the personnel in these clinics do not provide effective services.

- **Conclusion:**

Half of the nursing personnel in public clinics see either too few or too many patients per unit time. This can make services ineffective as patients end up being under-treated because of the lack of proper examinations, explanations and diagnoses (in cases where too little time is taken with an individual patient). On the other hand the services end up being under-utilised as nurses see fewer patients per unit time (in cases where too much time is spent with individual patient) and send the rest home without treatment.

5.3.9.6 Maintenance of clinics' statistics

McDonald and Blignaut (1998:8-11) have reported that PHC nurses are burdened with administrative duties such as maintaining statistics and stock control, which are time-consuming and leaves them little time to devote to direct patient care which is their primary function and this causes them to provide ineffective and less accessible services. According to the Norms and Standards (Dept. of Health, 2000) public clinics should have daily service registers and monthly reports which are kept up to date. The monthly PHC statistics report should be accurate, done on time, filed and sent to the authorities.

From the findings in phase 3 (4.3.2.9 par v) one could say that personnel are confident that they do a good job in maintaining the statistics in their clinics. It has already been argued that personnel from the same clinics (3rd and 4th) which comprised 60% of the total sample, supplied different figures for the number of

patients seen in the clinic per day, which shows that they do not have a valid data source to refer to. It is ironical that eight of the ten respondents said that they were happy with the way they deal with data in their clinics.

Phase three findings (4.3.2.9 par vi) show that although they are satisfied with the way they maintain statistics, seven of the ten still felt that they are lacking and in need of improvement. One can argue that it will be difficult for the clinics to measure their effectiveness if their data is inaccurately maintained. Some personnel said that there is no transparency among the clinics' statistics. Service providers are not aware of their performance, they just work in a vacuum not knowing what and how the other clinics within their area are performing.

- **Conclusion:**

The way that the public clinics in Alexandra maintain their statistics is ineffective as the majority of nurses from the same clinic do not have a common valid data source to refer to. The majority of the nurses also felt that there was a need to improve the way the clinics maintain statistics.

5.3.9.7 SUMMATIVE CONCLUSION:

The Alexandra Township residents who attend public clinics frequently see themselves going back to the clinics for services. Although many people are examined in the clinics, the majority of the clinics do not have the equipment to examine them with. Many people choose not to go to the clinic, even when they are in need of the services because of long waiting times, rudeness of the personnel and the unsuitable times that the services are offered. The majority of the people are not supplied with important information pertaining to examinations, diagnosis, treatment and modification of life-style where needed. The nurses either see too many or too few patients to render services effectively. The nurses in some of the clinics do not have a common valid data source to refer to, as nurses from the same clinics gave different statistics about the number of patients seen

per day. The majority of nurses also felt that the way statistics are maintained in their clinics must be improved.

5.3.10 EQUITY FACTORS OF ACCESSIBILITY TO PHC SERVICES IN ALEXANDRA TOWNSHIP:

According to the WHO (1978:429) the PHC-approach is a means to the equitable distribution of health resources and it enables people to attain a level of health that will permit them to lead a socially and economically productive life. It is important that decisions and their effects should seek to provide fair and just service outcomes (Naidoo and Wills, 1998:74). Equity in relation to health status and healthcare delivery has become a central element in the renewal of WHO's global 'Health for all' (Stark et al, 1999:273-7).

5.3.10.1 Respondents' awareness of their rights to health services

The principles and energy of Alma-Ata can be retrieved by providing a vehicle for the people to speak for themselves and to be heard (MacFarlane et al, 2000:841-6). To participate as constructive and effective change agents, consumers will need good information, decision support instruments, access to resources and on-going support from entities they trust (Levine, 2000:10-1). Kuijten et al (2000:22-8) observed that people need freedom of choice, information on quality of care and alternatives to take responsibilities for healthcare. People should be free to choose and change doctors and systems, a right that they have in theory only and exercised practically with difficulties because of very little information about the personnel and services available to them. According to the Norms and Standards for the delivery of PHC services in SA (Dept. of Health, 2000), Batho-pele - People First principles and the patients' rights charter are a means of ensuring fairness in the provision of public services.

There are statistically significant differences ($p = 0.000$) between the patient and

the community respondents with regard to awareness of rights to health services. Section 4.3.1.10 par i may support the findings that health literacy is associated with utilisation in that the patient sample, who frequent the public health services in the area, have a higher awareness of their rights than the community sample. The findings are significant in that the majority of all the respondents are not aware of their rights. The irony of it is that the majority of the nurse respondents believe that the community is aware of their rights (figure 4.42). Respondents complained that personnel take advantage of their ignorance. They are sent away without good reason and told to go to Linda clinic, which is far away, because they are old. The respondents who mentioned some of the rights (Table 4.13) complained that they are insulted by the nurses if they try to exercise their rights. This shows that the people in Alexandra may have the right to health services in theory only but are practically exercised with difficulties.

Findings in phase three and four (4.3.2.10 par ii & iii) show that all the clinics have the charters displayed in their clinics. While some are in a local language like Zulu the others are in foreign language-English. The charters are displayed among the other visual aids making their visibility difficult. The one in the 1st clinic is displayed on its own, but behind where the patients sit making its visibility difficult. This may justify why many respondents are not aware of their rights.

- **Conclusion:**

The majority of Alexandra residents are not aware of their rights to health services. Those who are aware of their rights have difficulties in exercising their rights in these clinics. This could pose as a barrier of access to the services.

5.3.10.2 Personnel's handling of very sick patients in the clinics

Existing inequalities in health care must be reduced through the provision of appropriate services, which can reach everybody, and this entails a fairer

allocation of health resources according to needs (Wills and Naidoo, 1998:74). Carnell (1998:60-1) expresses the desire to make services easily accessible to all, ensuring that those in greater need receive the highest share.

There are statistically significant differences ($p = 0.000$) between the patients and the community respondents with regard to the level of satisfaction with the way personnel handle very sick patients in the clinics. Findings in figure 4.28 may mean that the community sample has more access problems as they are the ones most dissatisfied with the way sick people are handled in the clinics. This may be the reason why they were found outside the clinics, than the patient sample (who were found in the clinics).

Those who were not satisfied complained that the very sick patients are left in the queue and the nurses take time to attend to them. The nurses are inflexible and do not consider the severity of the condition of the patients. One respondent at the 3rd clinic complained that she had taken her sick child to 3rd clinic the previous week around 9am. The nurses told her to take the baby to the hospital without even examining the child. She had to go to the hospital on her own, where the baby was admitted. At the time of the interview the child was still in the hospital.

- **Conclusion:**

There are inequalities in the way health services are provided in Alexandra public clinics. Nurses are not flexible in the way they provide health services because they do not attend to the very sick patients first. Nurses join up to provide a single service while the others, including the very sick, have to wait. None of the public clinics go through the queue to make sure that those in greatest need receive the highest share.

5.3.10.3 Availability of visiting surgeons in the clinics

Barnes et al (1995:71-6) said that WHO leaders had concluded that nurses would become resources to people rather than to physicians and that nurses

would become leaders of PHC teams. Many South African doctors have been recruited to work in Canada (Bundred and Levitt, 2001:145-6). Jackson (1997:771) reveals alarming shortages of doctors in the Eastern Cape. He disclosed that the authorities admitted to some 800 vacant posts. He says that the number may be as high as 1600 and that personnel turnover in the province was very high at an average of every six to twelve months. According to the Norms and Standards (Dept. of Health, 2000) doctors and other specialized professionals should be accessible by communication for consultation, support and referral and provide periodic visits to the clinics.

There are statistically significant differences ($p = 0.000$) between the patients and the community respondents in respect of referral to see a visiting doctor. The findings (figure 4.29) are alarming in that in the sicker group (phase one, as has already been argued) fewer respondents were referred to see a visiting doctor than in phase two.

The findings in phase three (Figure 4.43 & 4.3.2.10 par iv) may mean that nurses do not have access to doctors for consultation and support. Patients in the clinics complained that the clinics do not offer effective services because there are no doctors. Considering that this area is a vulnerable area (White paper 1997); indeed those in greatest need are not receiving the highest share.

- **Conclusion:**

The lack of doctors' visits in the majority of the clinics may result in a worsening of the patients' clinical conditions as nurses do not have support from the doctors. The doctor's services are even less accessible to the most vulnerable group of the community.

5.3.10.4 Respondents who were once referred to go to the hospital

When access to care is a major barrier, the question of its quality becomes moot (Diaz et al, 1999:1-15). The authors reported that referrals though indicated, were not always given and frequently, pertinent information was not recorded.

Although there are no statistically significant differences ($p = 0.169$) between the patients and the community, the patient sample has the lowest percentage (26.9%) of those who were referred to go to hospital unlike the community where 34.3% were referred to hospital (4.3.1.10 par vi). This shows that the poorer people (phase one) are not given referrals for the same level of condition as those who are well off (as in community sample) and this is inequality. The findings show that in phase one just more than one quarter of the respondents were referred while in phase two, more than a third of the respondents were referred. It has been argued that in this study the patient sample seem to be poorer and sicker than the community sample. Therefore the patient sample have more health needs than the community sample. However the community sample has a higher referral rate than the needy patient sample. Only one in four respondents in phase one were referred and almost one in every three respondents in phase two were referred. This was also found by Fonn et al (1998:697-702).

- **Conclusion:**

The most vulnerable of the community who are the ones in greatest need have lower rates of referral to the visiting doctor and the hospital unlike their well off counterparts showing that services in the area are provided inequitably.

5.3.10.5 Discrimination in the way services are provided:

Stewart in Sword,1999:1170-11, reports that discrimination by healthcare professionals is another perceived barrier. Having access does not mean that individuals and communities actually use the health services (Juarbe, 1995:23-7).

There are statistically significant differences ($p = 0.000$) between the patient and the community respondents with regard to their opinion on whether the clinics are discriminatory. Findings in phase one and two (4.3.1.10 par vii) may justify why the community sample was not found in the clinic, they find access to services problematic. One should remember that the phase one interviews were conducted in the clinics and this may have had an impact on the way the respondents answered questions, unlike the phase two respondents who were in their own environment. Respondents complained that the first priority of the nurses is to look after their friends and families, then there is tea and only then the patients. The nurses do not work on a 'first come - first served' basis. The elderly respondents in phase two (9%) complained that they are discriminated against, they have to go to faraway Linda clinic and are told to die. They said that they are shouted at for coming to the clinic and were apprehensive at the thought of coming to these clinics because they are made to believe that they can be given poison so that they die instead of medicine to cure their problems. Geographical access does not necessarily lead individuals and communities to use health services. So much staff is happening in the clinics and the people are encountering severe difficulties in gaining access to the health services. Access problems in this area are indeed legion.

Findings in phase three and four (4.3.2.10 par vi & vii) show that:

1st clinic: while others receive help early in the morning, the minor ailments queue is stagnant, waiting for a nurse to finish either f/p or well baby in order to come and start with them which is not fair. A patient may have arrived earlier

(7am) than a well baby mother (7.40am) and the mother will be served first.

2nd clinic: the same applies where there is only one professional nurse on duty, which is the norm at this clinic.

3rd clinic: no numbers for the patients means that clever patients can jump the queue. Personnel focus on one type of services and neglect the others. Mothers who come to the clinic with their babies for a measles inoculation are sent away if they come on the wrong day. She may have waited in the queue for hours only to be told that she should come back another day. This inefficiency is unacceptable, ineffective and unfair. Patients have to have their vital signs checked by a health worker. The nurse may have to wait and this wastes precious time when the nurse can also do it. The clinic has one BP machine and one thermometer making efficient service impossible.

4th clinic: the same arguments about the measles vaccine applies.

Respondents complained that the nurses allow patients to jump the queue without justifiable reason, they do not respect the queue and there are no numbers to properly follow the queue. They said that three nurses attend to well babies while the other patients have to wait. They also complained that the receptionist keep earlier numbers for their friends. In fact one respondent at the 2nd clinic admitted to have jumped the queue despite the fact that this clinic is one of the clinics which use the numbering system.

- **Conclusion:**

The majority of the people believe that the services in public clinics are discriminatory, as personnel treat their families and friends first. One of the clinics has no measures to ensure equity and clever patients could jump the queue. The nurses in all the clinics start with well baby and f/p and finish with minor ailments. In 50% of the clinics more than one nurse provide a single service while the other services are neglected.

5.3.10.6 Community/ home-based activities conducted by the clinics

Laphorne states that community participation can begin to reduce inequality to ensure that those with the greatest need have the highest share (Naidoo & Wills, 1998:155). Almeida et al (2000:129-62) note that the concept of equal opportunity for access to healthcare services refers to equality for equal needs and this implies a positive discrimination to compensate for existing inequalities in the determinants of the population's health considered socially unjust. As stipulated in the Norms and Standards for the delivery of PHC services in SA (Dept. of Health, 2000) the clinic should organise outreach services to the clinic's catchment area that can reach the communities and to families in greatest need. They also should conduct regular home visits using a home visit checklist.

The data in phase one, two and three (4.3.1.10 par ix & 4.3.2.10 par viii) shows that residents do not see clinic personnel visiting very sick people in their homes. The respondents who said that they do home visits indicated that the volunteers and community health workers do the home visits. Respondents complained that nurses do not visit the elderly who are unable to come to the clinic. This indicates that there is no professional home visiting, which is discriminatory and unacceptable as those in greatest need do not receive the highest share. It can be argued that in Alexandra the implemented policies however have not guaranteed the effective exercise of ensuring fair provision of health services; thereby restricting their validity to no more than a formal definition. The law may be progressive, but the same cannot be said of the practice.

- **Conclusion:**

There is inequity in the way PHC services are provided in the Alexandra public clinics as none of the professional nurses conduct home visits thereby limiting access to professional services to those in greatest need.

5.3.10.7 SUMMATIVE CONCLUSION:

The majority of the people in Alexandra Township are not aware of their right to access health services. This prevents the people from exercising their rights. A significant number of people are dissatisfied with the way very sick people are handled in the clinics. Not one of the clinics studied the queue to make sure that those in the greatest need receive care first. Referral to higher levels of care, especially to the most vulnerable of the population is infrequent. The majority of the people believe that there is discrimination in the provision of health services in the clinics. There are no measures to ensure equity in the clinics and in some cases, more than one nurse provide a single service while the other services are neglected. It is evident that there is no home visiting by professional nurses thereby limiting access to professional services by the most in need.

5.3.11 HEALTH EDUCATION FACTORS INFLUENCING THE ACCESSIBILITY OF PHC SERVICES IN ALEXANDRA TOWNSHIP

Pirisi (2000:1828-30) reports that low health literacy prevents many patients from fully accessing the latest treatments and up to date clinical information available on their illness and this results in many patients not being able to make use of most of their healthcare services. Craft et al, (2000:863-78) advise that nurses need to work to increase social awareness of health problems to the vulnerable if they are interested in increasing access to health services by this population group. Improving health literacy will increase patient - provider interactions, adherence to treatment, home-care and self-care thereby improving the efficiency and effectiveness of the healthcare system (Cantor & Shankar, 2000:125-34).

5.3.11.1 Availability of health education programs in the clinics

Low health literacy leads to poorer health outcomes (Pirisi, 2000:1828-30). The author found that patients with inadequate health literacy reported poor overall

health status and had a greater chance of being admitted to hospital. Koponen et al (1996:727-35) indicate the need to inform the public about the availability of the PHC nursing services and improve access to the services especially for the population groups in need. It has been stipulated in the Norms and Standards for the delivery of PHC services in SA that patients should be aware of the health services available locally and what they offer.

Findings in phase one and two (Figure 4.30) show that the majority of the respondents (78.7% in phase one and 91.5% in phase two) have attended health education sessions in the clinics. Even though phase one respondents attend the clinics more frequently they have a lower health literacy rate than the phase two respondents. This observation may be the reason why the phase one respondents reported a poorer health status. This was also reported by Pirisi (2000:1828-30). This may indicate that the nurses in this area have not done enough to increase social awareness of health problems and this questions their interest in increasing access to health services by this needy population group. The respondents who have never received health education said that the clinics do not provide health education. One of the respondents said that health education is only done at the 2nd clinic. In view of the data obtained in phase four (4.3.1.11 par ii) one may argue that health education is a scarce commodity in these clinics.

According to the findings in phase four (4.3.1.11 par iv) the nurses are not responsible for the provision of health education and those responsible are not accountable to the nurses. They come and go when they want and that is not acceptable. The nurses do not know when they will be at the clinics. There is no supervision for the educators or the nurses. This makes it difficult to control everything and this affects the efficiency and effectiveness of the services.

- **Conclusion:**

There is lack of health education programs in the Alexandra public clinics

because the clinics do not have health education sessions. There is also no supervision of health education providers. There is unfairness in the provision of health education programs, since those with better demographics have higher literacy rate than the vulnerable who frequent the public clinics.

5.3.11.2 Respondents' satisfaction with the health education provider

According to the Norms and Standards for the delivery of PHC services in SA (Dept. of Health, 2000) health staff should train community healthcare promoters to educate and facilitate community action.

From the findings in phase one and two (4.3.1.11 par iii) one can argue that the majority (94.4% in the patient sample and 92.1% in the community sample) of those who have received health education are satisfied with the providers. This could mean that the people were able to understand what they were taught by these providers.

- **Conclusion:**

People attending public clinics in Alexandra Township are satisfied with the providers of health education.

5.3.11.3 Suitability of language used in health education sessions

Weinick and Krauss (2000:26) state that there is a need for interpreters and bilingual healthcare providers to meet the needs of the people who do not comfortably interact with the healthcare system in English. Cantor and Shankar (2000:125-34) indicate that 83% of Hispanics preferred a Spanish-speaking provider although they could speak English. This led them to conclude that a lack of Spanish-speaking providers posed as a barrier for Hispanics to access health

services.

Findings in phase one and two (4.3.1.11 par v) show that the majority of respondents who have received health education understand the language used in the health education sessions. Phase three and four findings (4.3.2.11 par iii & 4.3.1.11 par vi) show that the providers try to accommodate their audience by using different languages. This, however, requires that the listener should be multilingual to understand the entire session. Since the majority of the respondents understood the session one could argue that it is possible that they are multilingual. The personnel working in these clinics are multilingual and this helps the people to communicate in their language of preference. However one respondent complained that she was a Bemba and that the health education was given in Sotho, which she found unfair.

Findings in phase one and two (4.3.1.11 par ix) show that the majority (in both phase 1 and 2) who received pamphlets to read at home were able to understand the language used and this has also been backed by the majority of the nurses (4.3.2.11 par vi). This may mean that the residents of this area do not have a language problem although there is still a number with language problems.

- **Conclusion:**

The majority of Alexandra Township residents are able to understand the language used in the health education sessions and pamphlets handed to them. Since the education sessions are done in a combination of many languages, only a multilingual listener will understand everything that is said.

5.3.11.4 Availability of health education resources in the clinics

As stipulated in the Norms and Standards for the delivery of PHC services in SA (Dept. of Health, 2000) a PHC clinic should have supplies of health learning

materials in local languages, appropriate educational posters on the walls to inform and educate the patients and educational videos must be shown while patients wait for services (Dept. of Health, 2000). Mofukeng and Roos, (1999:4-9) reveal that patients complained that the 'lectures' given are a waste of time and boring as nurses did not use visual aids. This calls for healthcare providers to explain diagnosis or treatment with visual aids rather than with pages of medical text.

Findings in phase one and two (4.3.1.11 par vii) show that 62.6% of the patient sample and 89.8% of the community sample said that when health education is given the providers use relevant visual aids. This is not always the case as 35% of the patient sample and 10.2% of the community sample have indicated. This shows that a higher number of the patient sample than the community sample, said that the providers use irrelevant visual aids which may be the reason why the patient sample is sicker as lack of health literacy is related to poor health. Two of the ten nurse respondents (4.3.2.11 par iv) said that health education providers do not always use relevant visual aids. This makes the education ineffective. The people need to relate what the provider is saying with what is being shown in order to understand the content.

Findings in phase one and two (Figure 4.31 may mean that the patient sample receive pamphlets because they frequent the clinics more than the community sample. Again almost half of phase one and three quarters of phase two said that they do not receive pamphlets. The respondents said that the clinics do not provide health-reading materials. All of the respondents in phase three (4.3.2.11 par v) said that they provide health reading-materials. The respondents complain that the materials are put at the reception but that they are not told that they may take them home. This could explain why fewer of the community sample receive pamphlets as they may not be aware that when pamphlets are left at reception they are meant to be taken home as they do not frequent the clinics. With this an argument is made that it seems that the clinics do not provide reading-materials

to empower the patients on health issues to achieve better health for better productivity and to grow old and die with dignity.

The data in phase three (4.3.2.11 par ii) may explain why so many respondents in phase one and phase two said that the clinics do not provide them with health reading-materials as a significant number (40%) in phase 3 said that they did not have adequate health education materials. This contributes to lack of health literacy among the people for whom services are intended making services inefficient and ineffective.

- **Conclusion:**

Public clinics in Alexandra Township lack health education resources as the majority of the people do not receive pamphlets from the clinic to read at home. A few people said that the health education providers do not use relevant visual aids when they provide health education. A significant number of nurses complained that they do not have enough health education resources in their clinics.

5.3.11.5 Type of content used in health education sessions

According to the Norms and Standards for delivery of PHC services in SA (Dept. of Health, 2000) at the first contact with the healthcare provider, the user is verbally informed of the health rights charter with emphasis on the right to complain and the complaint procedure is explained. Clinic staff should be able to approach the health problems of the area with the clinic health committee and the community civic organisations to identify needs, maintain surveillance of cases, reduce common risk factors and give appropriate education to improve health awareness. Westaway et al (1996:71-3) reported that 93% of the people Ivory Park, Gauteng, enjoyed receiving health education and they concluded that there is a definite need for health education to focus on Aids, TB, child health and family planning.

Findings in phase four (4.3.1.11 par vii) show that these are important topics and people need to know about them. However other important topics like f/p, cervical and breast cancer, monitoring of growth and development, immunisations, ORT, stress management, breast feeding and people's rights to health services are left out. Also it seems that the providers do not have enough training to provide effective health education services to the population in need. This is not acceptable. Despite education on the type of services available at the clinics, all the respondents in phase one and two were not aware of all the services available in the clinics. This results in under-utilisation of certain services and this makes the services inefficient. One respondent pleaded with the health education provider to teach them their rights to health services.

- **Conclusion:**

Although health education providers teach people about important topics that are relevant to their health needs, many other important topics are left out.

5.3.11.6 SUMMATIVE CONCLUSION:

The majority of the people who attend public clinics in Alexandra are satisfied with the health education providers. The majority of the residents are able to understand the language used in health education sessions and in the pamphlets given to the patients in the clinics. However the majority of the clinics do not provide health education session in the clinics and the health education providers do not have any supervision. There is unfairness in the provision of health education programs since those with better demographics have a higher health literacy rate instead of the most vulnerable who frequent the public clinics. Furthermore the majority of the people do not receive pamphlets from the clinics to read at home and the health education providers do not use relevant visual aids when providing health education. Likewise a significant number of nurses complained that

they do not have enough health education resources in their clinics. People in the area are not aware of the majority of the services offered in their clinics. Some necessary, relevant and important topics are not taught.

5.3.12 PRESENTATION OF THE SUMMATIVE CONCLUSIONS

INFLUENCING FACTOR	SUMMATIVE CONCLUSION
DEMOGRAPHICAL FACTORS OF THE RESPONDENTS	In this study the researcher used a suitable sample which represented the target population by making sure that the respondents were only Alexandra residents. The results of the study show that Alexandra is a predominantly black urban town ship where young adult women access more to the public health services in their area. The majority of the residents are single, unskilled unemployed people who earn meager earnings and have no medical aid. Alexandra Township is therefore a vulnerable area, which is demographically disadvantaged in terms of gender, age, educational, employment, marital, income and medical aid status.
FUNCTIONAL / AVAILABILITY OF PHC SERVICES	The majority of the people in Alexandra Township were not aware of some of the services offered in the clinics despite their need of them and because of this, the majority of the services were under-utilised. The clinics also do not offer some of the essential services such as antenatal services, which are necessary. Some of the people find the times that the services are available to be a barrier. The majority of the people are not satisfied with the way services are rendered as they don't get what they expect when they visit the clinics. All these could pose as access barriers to the people wanting to access the public health services in their area.
SOCIAL FACTORS	Although all the public clinics in Alexandra Township have

	<p>professional nurses, and the majority are community nurses trained in PHC, some of the services are provided by unprofessional and under-qualified staff. Even though the nurses should be able to impact the community's needs, as the majority of them have been working in the public clinics in the area for 2 years and more, people still believed that they were being let down by the nurses because of their playfulness, laziness and their prolonged breaks. Although the community believed that nurses were able to deal with their health problems, most of the people were not happy with the personnel's attitude. A significant number of people believed that their clinics do not have an adequate number of nurses as some clinics have only one professional nurse on duty and all the clinics depended on sessional workers. Fifty percent of the clinics do not have supervisors on the post and supervision from the authority is a dream not yet come true. None of the nurses was aware of her career path and a significant number were dissatisfied with their job. None of them were satisfied with their salaries and in-service training attendance was very inconsistent.</p>
<p>PHYSICAL FACTORS</p>	<p>The majority of the public clinics in Alexandra do not have enough room or space for the amount of services they provide. A significant number of people are dissatisfied with the transport system, likewise the majority of the nurses are not satisfied as it took more than one and a half hours for the ambulance to arrive. A significant number of people complain that they get robbed and raped on their way to and from the clinics. Criminal activities also occur within the clinics' premises. Furthermore the majority of the clinics do not have enough examination equipment and the turnaround time for the repair of the broken equipment was more than two months. Also a significant number of clinics' telephone, water and electricity systems were unreliable, one of the clinic's telephone had been cut off for more</p>

	than a year because of an unsettled bill.
GEOGRAPHICAL FACTORS	The majority of the people in Alexandra travel a distance of less than 2 km to reach the clinic and take less than 30 minutes to reach the clinic. The majority of the people who frequent the clinics walk to the clinic other than those who don't.
ACCEPTABILITY OF PHC SERVICES	Public clinics in Alexandra are violating people's rights because a significant number of people are dissatisfied with the quality of privacy provided at the clinics. The majority of the clinics provide confidential records to the patients in front of other patients or in rooms where anyone (patients inclusive) could enter at any time. A significant number (33.6% & 47.8% in phases 1 & 2) of people believe that the clinics are not utilised properly as a significant number (33.6% & 30.7% in phases 1 & 2) of people are turned away without receiving help, also taking into consideration the way that the clinics actually take patients in. The majority of the people do not have clinics of preference as they believe that all the clinics are discriminatory, with pompous, negative and insensitive personnel. Although most of the people are happy about having the clinics in their community and believed that the clinics are user-friendly; not one of the clinics had a suggestion box to obtain the users' views with regard to health services. The suggestion boxes, which were later introduced by the authorities are viewed negatively by the providers thereby losing the very objective of having them. Despite the fact that all the stakeholders in the study agree to the fact that community involvement is important, none of the public clinics in the area are a member of a health committee or an intersectoral collaboration committee. Not one of the clinics conduct a community need assessment to make services acceptable to the people

	intended for.
FINANCIAL FACTORS	A significant number of people attending the Alexandra public clinics have been told that the medication they need is depleted. There has also been an irregular supply of drugs to the clinics throughout the year, 2001. A significant number of people are unable to buy the medication and some even have to ask relatives to buy it for them. Health services are more affordable to those within walking distance of the clinic and those who require transportation find access to the services problematic due to financial restraints.
EFFICIENCY OF PHC SERVICES	None of the public clinics in Alexandra have a grievance procedure to efficiently solve problems. People wait for more than three hours in the clinics to be seen and the majority of the personnel take either too little or too much time during consultation. None of the public clinics in the area evaluate the quality of services offered and they do not have an annual plan of activities. The nurses at the clinics are not involved in the preparation of the year plan (if one was prepared).
EFFECTIVENESS OF PHC SERVICES	The Alexandra Township residents who attend public clinics frequently see themselves going back to the clinics for services. Although many people are examined in the clinics, the majority of the clinics do not have the equipment to examine them with. Also there is a decline in attendance as many people choose not to go to the clinic, even when they are in need of the services because of long waiting times, rudeness of the personnel and the unsuitable times that the services are offered. Moreover the majority of the people are not supplied with important information pertaining to examinations, diagnosis, treatment and modification of life-style where needed. The nurses either see too many or too few patients to render services efficiently and effectively. It is evident that nurses in some of the

	<p>clinics do not have a common valid data source to refer to, as nurses from the same clinics gave different statistics about the number of patients seen in their clinic per day. The majority of nurses also felt that the way statistics are maintained in their clinics must be improved.</p>
<p>EQUITY OF PHC SERVICES</p>	<p>The majority of the people in Alexandra Township are not aware of their rights to access health services limiting their access to the services. A significant number of people are dissatisfied with the way very sick people are handled in the clinics. Not one of the clinics studied the queue to make sure that those in the greatest need receive care first. Referral to higher levels of care, especially to the most vulnerable of the population is infrequent. The majority of the people believe that there is discrimination in the provision of health services in the clinics. There are no measures to ensure equity in the clinics and in some clinics, more than one nurse provide a single service while the other services are neglected. It is evident that there is no home visiting by professional nurses thereby limiting access to professional services by the most in need.</p>
<p>HEALTH EDUCATION FACTORS</p>	<p>The majority of the people who attend public clinics in Alexandra are satisfied with the health education providers. The majority of the residents are able to understand the language used in health education sessions and in the pamphlets given to the patients in the clinics. However the majority of the clinics do not provide health education session in the clinics and the health education providers do not have any supervision. There is unfairness in the provision of health education programs since those with better demographics have a higher health literacy rate instead of the most vulnerable who frequent the public clinics. Furthermore the majority of the people do not receive pamphlets from the clinics to read at home and the health</p>

	<p>education providers do not use relevant visual aids when providing health education. Likewise a significant number of nurses complained that they do not have enough health education resources in their clinics. People in the area are not aware of the majority of the services offered in their clinics. Some necessary, relevant and important topics are not taught.</p>
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5.4 GUIDELINES TO IMPROVE THE ACCESSIBILITY OF PUBLIC PHC SERVICES IN ALEXANDRA TOWNSHIP

THE RATIONALE FOR THE GUIDELINES

Guidelines are formulated with the intention of improving accessibility to PHC services in the Alexandra Township, by showing providers of these services in the area the real meaning of the PHC concept as was renewed and accepted by WHO in 1997. The guidelines are not in any order of priority but follows the discussion sequence.

5.4.1 DEMOGRAPHIC DATA

In the discussion of the community's demographic characteristics, it was concluded that Alexandra community is a vulnerable, disadvantaged community. This raises the need for the health providers to ensure that the community has access to the services.

5.4.2 GUIDELINES TO IMPROVE THE AVAILABILITY / FUNCTIONAL ACCESSIBILITY OF PHC SERVICES IN ALEXANDRA

From the findings and discussion it was concluded that Alexandra residents have

no available / functional accessibility to the public PHC services in their area. The following guidelines are formulated to improve the availability / functional accessibility to public PHC services:

The authorities as the overall provider of services in the area should:

- i. Work on adding antenatal services to the public clinics to increase geographical accessibility to pregnant mothers to the services.
- ii. Work on increasing the hours of offering services to accommodate those who are working.

The clinical nursing personnel as the ones responsible in the provision of PHC services in the clinics should:

- i. Embark on educating the community on the types of services available in the clinics.
- ii. Develop a policy to provide for schoolchildren so that they do not queue for the whole day and end up missing school.
- iii. Start working at 7.30am and do not waste time with unnecessary things. The nurses should also ensure that they continue seeing patients for the rest of the day.

5.4.3 GUIDELINES TO IMPROVE THE SOCIAL ACCESSIBILITY OF PHC SERVICES IN ALEXANDRA

The discussion revealed that services in Alexandra Township are not socially accessible. The following are guidelines to improve the social accessibility to the services:

The authorities should:

- i. Employ more nurses to work in the clinics to ensure daily staff coverage and make provision for sick leave so the services can be provided in an efficient and effective manner.
- ii. Provide for in-service education on communication skills and customer

care for the personnel working in these clinics.

iii. Ensure that all the permanent and sessional nurses have equal chances of attending in-service education to improve their employment skills be effective in their functioning.

iv. Appoint nurses for the posts of managers for the 3rd and 4th clinics.

v. Plan to conduct periodical visits of the clinics for support, monitoring and supervision

vi. Exchange nurses who are working in different clinics within the area, some of those in the 1st and 2nd clinic should go to the 3rd and 4th clinics, and those from the 3rd and 4th clinics should go to the 1st and 2nd clinic to facilitate the exchange of ideas for improvement.

vii. Prepare a career path for the personnel working in the clinics and make them aware of its contents.

viii. Solve the salary problem, the nurses who work in these clinics should receive the same salary as those working in other metropolitan clinics.

ix. Acknowledge, recognise and encourage clinics and personnel who perform well.

The Nurses should:

i. Reduce the amount of time they spend chatting and increase the amount of time they spend in providing services to the people.

ii. Nurses from the 4th clinic should not have teatime in the morning while the patients wait unattended. They should also observe a proper teatime and not all go at once so that some can remain and continue with consultation.

iii. Work on improving their attitude towards their work and the patients with whom they deal and stop shouting at them. Especially the nurses from the 3rd and 4th clinic.

vi. Be flexible in the way they provide their services by accommodating the needs of the individual patient.

Receptionists and cleaners at the clinics should be advised not to shout at the patients but to talk to them in a friendly and respectful manner.

All clinics should have doctors who visit periodically in a reliable manner.

5.4.4 GUIDELINES TO IMPROVE PHYSICAL ACCESSIBILITY OF PHC SERVICES IN ALEXANDRA

It was revealed in the findings and discussion that the public services were not physically accessible in all the clinics. The following guidelines are formulated to improve the physical accessibility in these clinics:

The authorities should:

- i. Work on extending the 1st clinics' emergency room and build a separate wound-dressing room. They should build an emergency room for the 4th clinic close to the nurses' consultation rooms for fast response to emergency cases. They should also extend the dispensary room for the 4th clinic and build a wound-dressing room.
- ii. Pay the outstanding telephone account of the 3rd clinic and have it re-installed for efficient response in times of emergencies.
- iii. Ensure that all the clinics have a reliable electricity and water supply.

The people responsible for the ambulance services should ensure for a fast response in case of an emergency at these clinics if they cannot afford an ambulance for Alexandria.

The guards from the 1st and 4th clinics should be equipped with guns to ensure that they do not disappear in case of an attack but that they defend the property. The 3rd clinic should have an armed-response service.

The clinics should ensure that they have enough equipment like a BP-machine

and thermometer for the 3rd clinic and diagnostic sets for most of the clinics, by ordering on time.

5.4.5 GUIDELINES TO IMPROVE GEOGRAPHICAL ACCESSIBILITY OF PHC SERVICES IN ALEXANDRA TOWNSHIP

The findings and discussion revealed that the residents have geographical accessibility to public PHC services in their area in terms of distance and traveling time, but not in terms of financial means for transport. The following guidelines are formulated:

- i. The nurses working in the clinics should devote themselves to improve the social status of the community so that the members can afford to reach the clinic by taxi especially when they are sick and weak. This calls for the nurses to be actively involved in community development activities like self-help programs.
- ii. The introduction of mobile services within the community will also help those who might be too sick to walk to the clinic.

5.4.6 GUIDELINES TO IMPROVE ACCEPTABILITY OF PHC SERVICES IN ALEXANDRA

It was concluded in the findings and discussion that the Alexandra Township residents do not have access to public PHC services in their area because the services are provided in unacceptable manner. The following guidelines are formulated to make the services more acceptable:

The authorities should:

- i. Assist the clinics in the formation of a health committee and the intersectoral collaboration in which the nurses working in the clinics are

active participants.

- ii. Provide avenues for community need assessment to be done every year to provide services according to the needs of the community.
- iii. Sensitize nurses to issues of privacy and to ensure that they do not take more than one patient at a time for consultation.
- iv. Remind the nurses of the importance of using an opportunity to increase immunisation coverage and pap smear collection.

The nurses in the clinics should:

- i. Introduce suggestion boxes, which will be their responsibility to determine the needs of the people, as those put there by the authorities are a threat to the nurses working in the clinics.
- ii. Educate the community on the importance of keeping their health cards and taking it with them whenever they go to any clinic.
- iii. Negotiate with the NGO clinic in their area concerning queuing of patients who have been sent back from the clinics after queuing there.
- iv. Be honest as to why they are sending patients back home and not tell them that the queuing numbers are finished.
- v. Be flexible and accommodate the needs of the users such as greeting and praying with them in the morning.
- vi. Send patients back home themselves after assessing their condition if the clinic cannot take anymore patients.

The receptionists' job description should be clarified to them.

The personnel working in the clinics which the respondents complained about should learn from the clinics that are doing better.

5.4.7 GUIDELINES TO IMPROVE FINANCIAL FACTORS OF PHC SERVICES' ACCESSIBILITY

It was concluded from the findings and the discussion that the Alexandra residents have no financial accessibility to the public PHC services in their area. The following are the guidelines to improve the financial accessibility to PHC services to the public:

The nurses should:

- i. Try to avoid asking patients to go and buy their own medicine and be more creative in the use of the resources available in the clinics such as providing the best alternatives available.
- ii. Enquire what resources they can get from their suppliers and order them.
- iii. Ensure that they have ordered enough drugs to last them the whole month and not ask patients to buy.

5.4.8 GUIDELINES TO IMPROVE THE EFFICIENCY OF PHC SERVICES IN ALEXANDRA

In the findings and discussion it was found that PHC services in the area are provided in an inefficient manner. The following are the guidelines to improve the efficiency of the services:

The authorities should:

- i. Prepare a grievance channel through which patients can lay their grievances. This should be brought to the nurses' attention and there should be a higher authority to access if the problem is not resolved at the clinic level.
- ii. Work on reducing waiting times at the clinics. Patients should be able to enter and be received throughout the day. This calls for more nurses to be employed in the clinics.
- iii. Make sure that nurses in the clinics understand the impact of these delays

on the patients, to help patients to minimize the impact of the problems, to do something to lessen the frustration and keep them busy. This calls for the authorities to provide the clinics with videos again.

- iv. Try and reduce the amount of paperwork to be dealt with by the clinic nurses. This will give the nurses ample time to provide for the patients - their primary function.
- v. Provide the clinics with enough equipment and reduce the time spent in repairing the broken equipment. The 3rd clinic should order more thermometers and BP-machines so that the nurses can take vital signs in their consultation rooms.

Nurses should:

- i. Bear in mind that delays are sometimes unavoidable and should always provide an explanation as to why there will be delays and apologize before the patients start getting irritated. The nurse may tell them how long the delay will be e.g. three hours.
- ii. Spend enough time with individual patients during consultation to facilitate a proper diagnosis and management of the patient's needs for an acceptable outcome.
- iii. Periodically evaluate the way they are providing the services to determine the quality of care rendered.
- iv. Draw up their own year-plan, which should be in harmony with the regional plan to keep them focused for the entire year. The authorities should involve the nurses in the planning of the year-plan.
- v. Personnel working in the 4th clinic should work on making people from Alexandra Township aware of the fact that they cater for them and of the types of services they provide.

5.4.9 GUIDELINES TO IMPROVE EFFECTIVENESS OF PHC SERVICES IN ALEXANDRA

It was revealed in the findings and discussion that PHC services in Alexandra are not provided in an effective manner. The following guidelines are formulated to improve the effectiveness of the services in the area:

The nurses should:

- i. Examine patients thoroughly according to their complaints so that they diagnose and treat properly.
- ii. Make their clinics user friendly so that people would want to come again thereby utilising the services effectively.
- iii. Provide thorough information to the patients and answer their queries and work on gaining their trust so that the patients have knowledge pertaining to their condition and comply to the prescribed treatment.
- iv. Have a uniform way of maintaining their statistics. The nurses should be able to refer to the data. Nurses from different clinics should have access to the statistics from all the clinics and be aware of each other's performance.

5.4.10 GUIDELINES TO ENSURE EQUITTABLE PROVISION OF PHC SERVICES IN ALEXANDRA TOWNSHIP.

It was observed from the findings and the discussion that public health services in Alexandra Township are inequitably provided. The following are the guidelines to ensure equal provision of services:

The nurses should:

- i. Embark on a massive teaching campaign on people's rights and the Batho-pele - People First, principles. This will empower the people to make informed choices with regard to their health.
- ii. Ensure that those with the greatest need receive care first by scrutinizing the

- queue, identifying the very sick and treating them first before catering for the so-called 'fast queues'.
- iii. Always refer the cases that need referral for a better outcome of all cases.
 - iv. Ensure that the 'first come, first serve' norm is adhered to in their clinics. They should not treat their friends and families first by allowing them to jump the queue. Receptionists should not keep earlier numbers for their friends and families. The 3rd clinic should introduce the numbering system and adhere to it.
 - v. Equally provide medicine to everyone. When the medicines are finished they must be finished to everyone.
 - vi. Not discriminate against elderly people by sending them away without help because they are old. They should receive them and help them with their immediate need and advise them accordingly (that is in case the clinic does not get visits from the doctors).
 - vii. Not provide the same services together when other services are neglected. They should provide different services at one time.
 - viii. Be professional when dealing with people and their diagnosis. They should not shout people's diagnosis for everyone to hear, it is confidential.
 - ix. Prepare a plan for home visiting (i.e. quarterly) so that they monitor the work of those who assist them with this task.
 - x. Make sure that confidential records are properly secured and handed out by a responsible knowledgeable professional. People do not want to be handed laboratory results such as RPR + or abnormal Pap results in the presence of other people.

5.4.11 GUIDELINES TO IMPROVE HEALTH EDUCATION FACTORS OF PHC ACCESSIBILITY IN ALEXANDRA TOWNSHIP.

It was noted in the findings and discussion that health education factors in the area compound the problem of accessibility of public health services. The following guidelines are formulated to improve these factors to promote

accessibility of services in the area.

The nurses should:

- i. Ensure that they provide health education every day at a clinic level. There must be a monitoring system of those who are responsible for the provision of these services to ensure that services are rendered.
- ii. Seek and obtain enough health education resources so that health education can be more interesting. They should also tell the people that the pamphlets at reception are meant to be taken home.
- iii. Health educators should be educated on different methods of teaching and provide education on topics such as people's rights, Batho-pele principles, PHC services available in the clinics, f/p, cervical and breast cancer, growth and monitoring, immunisations, ORT, breast feeding and stress management.
- iv. Health education providers should ascertain the language of preference of their audience and use an interpreter if necessary to ensure that the majority benefit from these services.

5.5 RECOMMENDATIONS OF THE STUDY

Recommendations are made in terms of application of the guidelines in nursing practice, nursing education and nursing research.

This study conclusions and guidelines carry the following meaning:

5.5.1 NURSING PRACTICE

According to the Constitution of SA (RSA, 1996), every individual has the right to healthcare. This cannot take place if the clinics do not provide a conducive environment for the people to exercise these rights. It is recommended that

guidelines be operationalised to help the PHC nurse working in Alexandra Public clinics to function efficiently and effectively.

5.5.2 NURSING EDUCATION

The guidelines can be included in an in- service education for the nurses working in the area to empower them with knowledge, attitudes and skills acceptable to the community thereby making services more accessible to the people.

5.5.3 NURSING RESEARCH

In order to complement this study and create avenues that will ensure optimal access to health services for the people in the area, a replication of the study in other similar and different settings in SA is recommended so that a broader picture of accessibility to PHC services in SA can be obtained.

Research on the financial and effectiveness of PHC services in this area based on the authority as the target is recommended.

5.6 LIMITATIONS OF THE STUDY

The limitations of the study should not be overlooked. This study was contextual and the results apply only to the area under study. This means that a researcher in another area cannot just conclude and apply the results to another setting until s/he proves that the areas are the same.

The phase one data collection was done in the clinics and this might have influenced the respondents since they had come seeking for help. However the results were triangulated with the phase two data, which was collected in a favourable environment.

As has been discussed services are affordable when both the country and the community can afford it. In this study the researcher dealt with the community affordability only and not the authority's (who are responsible in the provision of services in the area), this may make the issue of financial affordability inconclusive.

The researcher did not investigate the indicators of effectiveness (health) fully in terms of child mortality, morbidity and general mortality of the area in order to compare with the country's health indicators.

The researcher did not correlate between the age of respondents and awareness of the services, sex of respondents and awareness of services. This is important because some services are influenced by the age and sex of users.

5.7 SUMMARY

In this study the researcher's aim was to investigate the accessibility of PHC services in Alexandra Township, Gauteng Province, SA. The objectives of the study were to explore and describe the factors that influence the community's accessibility to PHC services in the area and to recommend guidelines on how accessibility to services can be improved.

It was found that public PHC services in the area were largely inaccessible and guidelines to improve these shortcomings have been formulated. In support of the significant number of nurses in the study who said that study findings should be implemented; If implemented, the researcher believes that much will be gained and the personnel working in the area will regain the trust of the community which they have long since lost.

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ANNEXURE 1

INTERVIEW SCHEDULE

EXPLORATION OF PATIENTS' PERCEPTIONS ON THEIR ACCESSIBILITY TO PHC SERVICES IN THEIR AREA.

SECTION 1: SERVICES OFFERED

1.1 Are you aware of the type of services offered at this clinic?

Yes	1
No	2

1.1.1 If yes mention them:

Health education	1	TB screening & treatment	7
Well baby	2	HIV screening	8
Family planning	3	Screening & treatment of STI	9
Pap smear	4	Diagnosis & treatment of minor ailments	10
Pregnancy testing	5	Nutritional	11
TOP counseling & referral	6		

1.2 Do you think that this community need these services?

Yes	1
No	2

1.3 Do you think that these services are adequate for the people?

Yes	1
No	2

1.3.1 If no what services should be: 1.3.1 added? -----
-----1.3.2 Removed?

1.4 To what extent are you satisfied with the way services are provided at this clinic?

1	2	3
Very satisfied	Satisfied	Not satisfied

1.4.1 Give reasons for your answer-----

1.5 What suggestions are you recommending for improvement? -----

SECTION 2: PERSONNEL RESOURCES

2.1 Do you think that this clinic has got enough nursing personnel?

1	2	3
Yes	No	I don't know

2.2 Do you think that the personnel at this clinic are able to deal with your health problems?

1	2	3
Yes	No	Not all

2.3 Have you ever been referred to see a visiting doctor?

1	2
Yes	No

2.4 Have you ever been referred to go to hospital?

1	2
Yes	No

2.5 To what extent are you satisfied with the way they deal with very sick patients at the clinic?

1	2	3	4
Very satisfied	Satisfied	Not satisfied	I don't know

2.6 Are you satisfied with the attitudes of the personnel with the way they handle you as an individual?

1	2	3
Yes	No	Not all

2.6.1 Give reasons for your answer-----

2.7 what suggestions are you recommending for improvement? -----

SECTION 3: OTHER RESOURCES

3.1 Do you think that the clinic has got enough room for all the services it provides?

1	2
Yes	No

3.2 Does the personnel provide privacy during consultation?

1	2
Yes	No

3.2.1 If no explain-----

3.3 Have you ever not been examined at this clinic?

1	2
Yes	No

3.4 Have you ever been told (in the past year) that a drug for your complaint was finished?

1	2
Yes	No

3.4.1 If yes have you been able to buy the drug on your own?

1	2
Yes	No

3.5 Have you ever been sent back home without being attended to?

1	2
Yes	No

3.5.1 If yes what was the reason given to you? -----

3.6 To what extent are you satisfied with the security system?

1	2	3
Very satisfied	Satisfied	Not satisfied

3.6.1 Give reasons-----

3.7 Are you aware of the transport system for very sick patients who need to be transferred to the hospital?

1	2
Yes	No

3.7.1 If yes; to what extent are you satisfied with this transport system?

1	2	3
Very satisfied	Satisfied	Not satisfied

3.7.2 If not satisfied, why? -----

3.8 What suggestions are you recommending for improvement? -----

SECTION 4: IMPORTANT DOCUMENTS

4.1 Has the clinic provided the way on how you can channel your grievances?

1	2	3
Yes	No	I don't know

4.2 Are you aware of your rights in terms of health services provided at this clinic?

1	2
Yes	No

4.2.1 If yes mention them:

Confidentiality	1	Refuse treatment	6
Privacy	2	A healthy & safe environment	7
Informed consent	3	Be referred for a second opinion	8
Access to health care	4	Complain about the healthy services	9
Choice in health care	5	Other	10

4.3 Are you aware of the way patients' confidential records are handled at this clinic?

1	2
Yes	No

4.3.1 If yes to what extent are you satisfied with the way confidential records are handled?

1	2	3
Very satisfied	Satisfied	Not satisfied

4.4 What suggestions are you recommending for improvement? -----

SECTION 5: SERVICE UTILISATION

5.1 Have you got any special preference for coming to this particular clinic?

1	2
Yes	No

5.1.1 If yes give reasons -----

5.2 How far is it from your home to the clinic?

1	2	3	4	5
< 1KM	1-2KM	2-5 KM	5-10KM	>10KM

5.3 How often do you visit the clinic?

1	2	3	4	5	6
Weekly	monthly	3 monthly	6 monthly	Yearly	First time

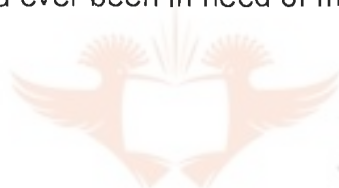
5.4 What means do you use to go to the clinic?

1	2	3	4	5
Foot	Bicycle	Taxi	Own transport	Other

5.5 How long does it take for you to reach the clinic ?

1	2	3	4
< 30 minutes	30-60 minutes	1-2 hours	> 2 hours

5.6 Have you ever been in need of medical help before and did not go to the clinic?



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1	2
Yes	No

5.6.1 If yes; what was the reason?

Distance is very far	1	Times of offering services not suitable	5
No transport	2	Too long waiting time	6
No money for transport	3	Use mobile services	7
Services needed not available	4	Other	8

5.7 What services are you here for? -----

5.8 How long does it take you to wait before you are attended to?

1	2	3	4	5
< 30 minutes	30-60 minutes	1-2 hours	2-3 hours	>3hours

5.9 When you are ill which places do you prefer to go for treatment first?

Public clinics within Alexandra	1	Buy medicines from the chemists & shops	5
Public clinics outside Alexandra	2	Traditional healers	6
2 nd Avenue NGO clinic	3	Other	7
Private doctors in Alexandra	4		

5.10 During consultation do you think the personnel spends enough time you as an individual?

1	2	3
Yes	No	Not all

5.11 Does the personnel explain to you the following?

		1	2	3
		Yes	No	Not all
5.11.1	Examinations to be conducted on you?			
5.11.2	Your diagnosis?			
5.11.3	Treatment for your problem?			
5.11.4	Important information pertaining to your condition?			

5.12 Are you satisfied with the times services are offered in this clinic?

1	2
Yes	No

5.12.1 If no which times would you prefer? -----

5.13 Does this clinic provide services without discrimination?

1	2	3
Yes	No	I don't know

5.13.1 If no explain -----

5.14 To what extent do you think that this clinic provides user friendly services?

1	2	3	4
Very good	Good	Bad	poor

5.15 Do you think that this clinic is well utilized by the people of this community?

1	2	3
Yes	No	I don't know

5.16 What suggestions are you recommending for improvement? -----

SECTION 6: COMMUNITY INVOLVEMENT

6.1 As a community member do you think it is important to be involved in the

running of the public clinics in your area?

1	2
Yes	No

6.2 Is there a suggestion box in the clinic?

1	2	3
Yes	No	I don't know

6.3 Are you aware of any community/home based activities this clinic is involved in?

1	2
Yes	No

6.3.1 If yes; name them: -----

6.4 As a community member are you satisfied with the existence of these services in your community?

1	2
Yes	No

6.5 What suggestions are you recommending for improvement? -----

SECTION 7: HEALTH EDUCATION

7.1 Have you ever attended a health education session in the clinic?

1	2
Yes	No

7.2 Are you satisfied with the person who gives you health education?

1	2
Yes	No

7.3 Does the provider give health education in a language you are able to understand?

1	2
Yes	No

7.4 Does the provider use relevant visual aids?

1	2	3
Yes	No	Not always

7.5 Does the clinic provide you with health reading material from time to time?

1	2
Yes	No

7.6 If yes; are the materials in a language you can understand?

1	2
Yes	No

7.7 What suggestions are you recommending for improvement? -----

SECTION 8: DEMOGRAPHIC DATA

8.1 Gender:

1	2
Male	Female

8.2 Race:

1	2
Black	White

8.3 Name of the street:-----

8.4 How long have you been living in Alexandra?

1	2	3	4	5
1-2 years	2-5 years	5-10 years	10-20 years	20 years +

8.5 Age category:

1	2	3
18-35 years	36-60 years	61 years+

8.6 Educational background:

1	2	3	4
Not attended	Up to primary	Up to secondary	Did tertiary education

8.7 Employment status:

1	2	3	4	5	6
Employed	Self employed	Unemployed	Student	Part time	Pensioner

8.8 Marital status:

1	2	3	4
Married	Single	Divorced	Widowed

8.9 Income category per month:

1	2	3	4	5	6	7	8
0-R100	R100- R300	R300- R600	R600- R1000	R1000- R2000	R2000- R4000	R4000- R6000	R6000+

8.10 Name of medical aid-----

9 Any other comments-----

Thank you very much for participating.



**ANNEXURE 2
INTERVIEW SCHEDULE**

**EXPLORATION OF THE COMMUNITY'S PERCEPTIONS WITH REGARD TO
THEIR ACCESSIBILITY TO PHC SERVICES IN THEIR AREA**

SECTION 1: SERVICES OFFERED

1.1 Are you aware of the public clinics in your area?

1	2
Yes	No

1.2 Are you aware of the type of services offered at these clinics?

1	2
Yes	No

1.2.1 If yes mention them:

Health education	1	TB screening & treatment	7
Well baby	2	HIV screening	8
Family planning	3	Screening & treatment of STI	9
Pap smear	4	Diagnosis & treatment of minor ailments	10
Pregnancy testing	5	Nutritional	11
TOP counseling & referral	6		

1.3 Do you think that these services are needed by the people in the community?

1	2
Yes	No

1.4 Do you think that these services are adequate for the people?

1	2
Yes	No

If no what services should be: 1.4.1 Added? -----

1.4.2 Removed -----

1.5 To what extent are you satisfied with the way services are provided at these

clinics?

1	2	3
Very satisfied	Satisfied	Not satisfied

1.5.1 Give reasons for your answer-----

1.6 What suggestions are you recommending for improvement? -----

SECTION 2: PERSONNEL RESOURCES

2.1 Do you think that the clinics have got enough nursing personnel?

1	2	3
Yes	No	I don't know

2.2 Do you think that the personnel at these clinics are able to deal with your health problems?

1	2	3
Yes	No	Not all

2.3 Have you ever been referred to see a visiting doctor in the clinics?

1	2
Yes	No

2.4 Have you ever been referred to go to hospital?

1	2
Yes	No

2.5 To what extent are you satisfied with the way they deal with very sick patients in the clinics?

1	2	3	4
Very satisfied	Satisfied	Not satisfied	I don't know

2.6 Are you satisfied with the attitudes of the personnel in the way they handle you as an individual these clinics?

1	2	3
Yes	No	Not all

2.6.1 Give reasons for your answer-----

2.7 What suggestions for improvement are you recommending? -----

SECTION 3: OTHER RESOURCES

3.1 Do you think that these clinics have got enough room for all the services they provide?

1	2	3
Yes	No	Not all

3.2 Does the clinics provide privacy?

1	2	3
Yes	No	Not all

3.2.1 If no explain-----

3.3 Have you ever not been examined in these clinics?

1	2
Yes	No

3.4 Have you ever been sent back home from the public clinics without being attended to?

1	2
Yes	No

3.4.1 If yes what was the reason given to you? -----

3.5 Have you ever been told (in the past year) that a drug for your complaint is finished?

1	2
Yes	No

3.5.1 Have you been able to buy the drug on your own?

1	2
Yes	No

3.6 To what extent are you satisfied with the security system of these clinics?

1	2	3
Very satisfied	Satisfied	Not satisfied

3.6.1 Give reasons for your level of satisfaction -----

3.7 Are you aware of the transport system for very sick patients who need to be transferred to hospital?

1	2
Yes	No

3.7.1 If yes to what extent are you satisfied with this transport system?

1	2	3
Very satisfied	Satisfied	Not satisfied

3.8 What suggestions are you recommending for improvement-----

SECTION 4: IMPORTANT DOCUMENTS

4.1 Have the clinics provided the way on how you can channel your grievances?

1	2	3
Yes	No	I don't know

4.2 Are you aware of your rights in terms of health services provided at these clinics?

1	2
Yes	No

4.2.1 If yes mention them:

Confidentiality	1	Refuse treatment	6
Privacy	2	A healthy & safe environment	7
Informed consent	3	Be referred for a second opinion	8
Access to health care	4	Complain about the healthy services	9
Choice in health care	5	Other	10

4.3 Are you aware of the way patients' confidential records are handled at these clinics?

1	2
Yes	No

4.3.1 If yes to what extent are you satisfied with the way patients' confidential records are handled at these clinics?

1	2	3
Very satisfied	Satisfied	Not satisfied

4.4 What suggestions are you recommending for improvement-----

SECTION 5: SERVICE UTILISATION

5.1 When was your last time you visited any of the public clinics in your area?

This week	1	2 months ago	6
A week ago	2	3 months ago	7
2 weeks ago	3	6 months ago	8
3 weeks ago	4	A year ago	9
A month ago	5	Stopped	10

5.2 Why do you visit the clinics? -----

5.3 If you become sick now where would you go for treatment? -----

5.4 Have you got any special preference among these clinics?

1	2
Yes	No

5.4.1 If yes which clinic do you prefer most?

1	2	3	4
4 th Avenue	8 th Avenue	East Bank	Thoko Ngoma

5.4.2 Give reasons for your answer-----

5.5 How far is it from your home to the clinic of your preference?

1	2	3	4	5
< 1KM	1-2KM	2-5KM	5-10KM	>10KM

5.6 How often do you visit the clinic?

1	2	3	4	5	6
Weekly	Monthly	3 monthly	6 monthly	Yearly	Stopped

5.7 What means do you use to go to the clinic?

1	2	3	4	5
Foot	Bicycle	Taxi	Own transport	other

5.8 How long does it take you to reach the clinic?

1	2	3	4
< 30 minutes	30-60 minutes	1-2 hours	>2 hours

5.9 Have you ever been in need of medical help and didn't go to the clinic?

1	2
Yes	No

5.9.1 If yes; what was the reason?

Distance is very far	1	Times of offering services not suitable	5
No transport	2	Too long waiting time	6
No money for transport	3	Use mobile services	7
Services needed not available	4	Other	8

5.10 How long does it take you to wait before you are attended to?

1	2	3	4	5
< 30 minutes	30-60 minutes	1-2 hours	2-3 hours	>3hours

5.11 When you are ill which places do you prefer to go for treatment first?

Public clinics within Alexandra	1	Buy medicines from the chemists & shops	5
Public clinics outside Alexandra	2	Traditional healers	6
2 nd Avenue NGO clinic	3	Other	7
Private doctors in Alexandra	4		

5.12 During consultation do you think the personnel spends enough time with you as an individual?

1	2	3
Yes	No	Not all

5.13 Does the personnel explain to you the following?

		1	2	3
		Yes	No	Not all
5.13.1	Examinations to be conducted on you?			
5.13.2	Your diagnosis?			
5.13.3	Treatment for your problem?			
5.13.4	Important information pertaining to your condition?			

5.14 Are you satisfied with the times services are offered in these clinics?

1	2
Yes	No

5.14.1 If no which times would you prefer? -----

5.15 Does this clinic (the one you prefer) provide services without discrimination?

1	2	3
Yes	No	I don't know

5.15.1 If no explain -----

5.16 To what extent do you think that these clinics provide user friendly services?

1	2	3	4
Very good	Good	Bad	poor

5.17 Do you think that these clinics are well utilized by the people of this community?

1	2	3
Yes	No	I don't know

5.18 What suggestions are you recommending for improvement? -----

SECTION 6: COMMUNITY INVOLVEMENT

6.1 As a community member do you think it is important to be involved in the running of the public clinics in your area?

1	2
Yes	No

6.2 Are there suggestion boxes in the clinics?

1	2	3
Yes	No	I don't know

6.3 Are you aware of any community/home based activities these clinics are involved in?

1	2
Yes	No

6.3.1 If yes; name them: -----

6.4 As a community member are you satisfied with the existence of these services in your community?

1	2
Yes	No

6.5 What suggestions are you recommending for improvement? -----

SECTION 7: HEALTH EDUCATION

7.1 Have you ever attended a health education session in these clinics?

1	2
Yes	No

7.2 Are you satisfied with the person who gives you health education?

1	2
Yes	No

7.3 Does the provider give health education in a language you are able to understand?

1	2
Yes	No

7.4 Does the provider use relevant visual aids?

1	2	3
Yes	No	Not always

7.5 Does the clinics provide you with health reading materials from time to time?

1	2
Yes	No

7.6 If yes; are the materials in a language you can understand?

1	2
Yes	No

7.7 What suggestions are you recommending for improvement? -----

SECTION 8: DEMOGRAPHIC DATA

8.1 Gender:

1	2
Male	Female

8.2 Race:

1	2
Black	White

8.3 Name of the street:-----

8.4 How long have you been living in Alexandra?

1	2	3	4	5
1-2 years	2-5 years	5-10 years	10-20 years	20 years +

8.5 Age category:

1	2	3
18-35 years	36-60 years	61 years+

8.6 Educational background:

1	2	3	4
Not attended	Up to primary	Up to secondary	Did tertiary education

8.7 Employment status:

1	2	3	4	5	6
Employed	Self employed	Unemployed	Student	Part time	Pensioner

8.8 Marital status:

1	2	3	4
Married	Single	Divorced	Widowed

8.9 Income category per month:

1	2	3	4	5	6	7	8
0-R100	R100- R300	R300- R600	R600- R1000	R1000- R2000	R2000- R4000	R4000- R6000	R6000+

8.10 Name of medical aid-----

9 Any other comments-----

Thank you very much for participating.



ANNEXURE 3

QUESTIONNAIRE

**EXPLORATION OF THE NURSES' PERCEPTIONS OF THE COMMUNITY'S
ACCESSIBILITY TO PHC SERVICES IN ALEXANDRA TOWNSHIP**

SECTION 1: SERVICES OFFERED

1.1 List the type of services your clinic provide and the type of personnel who provide the services

E.G. Antenatal services: professional midwives

2.1 Are you satisfied with the type of services your clinic provide?

1	2
Yes	No

1.2.1 If no explain-----

1.2 Are you satisfied with the way services are provided in your clinic?

1	2
Yes	No

1.3.1 If no explain-----

1.4 Does your clinic evaluate how services are rendered?

1	2
Yes	No

1.4.1 If yes how often? -----

1.5 Does your clinic prepare a plan annually on the provision of services?

1	2
Yes	No

1.6 What suggestion are you recommending for improvement? -----

SECTION 2: PERSONNEL RESOURCES

2.1 How many professional nurses work in your clinic on a permanent basis?

1	2	3
1 nurse	2 nurses	3 nurses

2.2 How many are sessional (part time) workers?

1	2	3
1 nurse	2 nurses	3 nurses

2.3 On what basis are you working?

1	2
Permanent	Sessional

2.4 Does your clinic have a supervisor holding the post?

1	2
Yes	No

2.5 Are you satisfied with the leadership style of your supervisor?

1	2	3
Yes	No	Not sure

2.6 To what extent do you feel competent when providing services?

1	2	3
Very competent	Competent	Not competent

2.7 On average how often do you attend in-service education per year?

1	2	3	4	5	6	7
Monthly	2 monthly	3 monthly	4 monthly	6 monthly	Yearly	Never attended

2.8 How often do you receive authorities in your clinic for support and monitoring?

1	2	3	4	5
Monthly	3 monthly	6 monthly	Yearly	Never

2.9 Do you have a visiting surgeon in your clinic?

1	2
Yes	No

2.9.1f yes how often?

1	2	3
Weekly	2 weekly	Monthly

2.10 Is there a clearly stated career path for your personal and professional development?

1	2
Yes	No

2.11 To what extent are you satisfied with the following:

		1	2	3
2.11.1	Job	Very satisfied	Satisfied	Not satisfied
2.11.2	Salary	Very satisfied	Satisfied	Not satisfied

2.12 What suggestions are you recommending for improvement? -----

SECTION 3: OTHER RESOURCES

3.1 Do you have enough room for the type of services your clinic provides?

1	2
Yes	No

3.2 Does it allow privacy?

1	2
Yes	No

3.3 Do you have enough equipment such as: (tick where appropriate)

		1	2			1	2
Diagnostic sets	1	Yes	No	Receivers	9	Yes	No
Examination coaches	2	Yes	No	Trolleys	10	Yes	No
BP machines & cuffs	3	Yes	No	Trays	11	Yes	No
Stethoscope	4	Yes	No	Condom dispensers	12	Yes	No
Scales for all ages	5	Yes	No	Specimen containers	13	Yes	No
Refrigerators	6	Yes	No	Working telephone	14	Yes	No
Thermometers	7	Yes	No	Oxygen equipment.	15	Yes	No
Vaginal exam equipt.	8	Yes	No	Other	16	Yes	No

3.4 How long does it take you to have a broken equipment repaired?

1	2	3	4	5	6	7
1 week	2 weeks	3 weeks	4 weeks	6 weeks	8 weeks	> 8 weeks

3.7 Do you receive enough medical supplies (drugs) to sustain you the whole month?

1	2
Yes	No

3.5.1 If no; list the type of supplies which are inadequate -----

3.8 Is your electricity system reliable?

1	2
Yes	No

3.9 Do you have a reliable water supply in your clinic?

1	2
Yes	No

3.10 To what extent are you satisfied with the security system of your clinic?



1	2	3
Very satisfied	Satisfied	Not satisfied

3.11 Are you satisfied with the transport system for referral of your patients?

1	2
Yes	No

3.9.1 If no explain -----

3.10 How long does it take an ambulance to arrive once you have called for it?

1	2	3	4	5
30 minutes	1 hour	1 ½ hours	2 hours	> 2 hours

3.11 What suggestions are you recommending for improvement? -----

SECTION 4: IMPORTANT DOCUMENTS

4.1 In your clinic do you have a patients' rights charter for them to be aware of what to expect and are expected of?

1	2
Yes	No

4.2 Does your clinic got a complaint procedure for the following:

		1	2
4.2.1	Patients	Yes	No
4.2.2	Personnel	Yes	No

4.3 Are you satisfied with the way statistics are maintained in your clinic?

1	2
Yes	No

4.3.1 Is there room for improvement?

1	2
Yes	No

4.4 How do you maintain confidentiality with the patients' confidential records such as lab results? -----

4.5 Are you satisfied with the way confidentiality is maintained in your clinic?

1	2
Yes	No

4.5.1 If no explain-----

4.6 What suggestions are you recomm ending for improvement? -----

SECTION 5: SERVICE UTILISATION

5.1 Describe your catchment area-----

5.1.1 What is the radius in square KM? -----

5.2 On average how many patients are attended to in your clinic per:

1	2	3
Day	Week	Month

5.3 On average how many patients do you personally attend to per:

1	2	3
Day	Week	Month

5.4 On average how many minutes do you take to attend to one patient? -----

5.5 Do you think your clinic is utilized well by the people intended for?

1	2
Yes	No

5.6 Do you have any measures to ensure equity at your clinic?

1	2
Yes	No

5.7 To what extent are you satisfied that your clinic provides customer friendly services?

1	2	3
Very satisfied	Satisfied	Not satisfied

5.8 What suggestions are you recommending for improvement? -----

SECTION 6: COMMUNITY INVOLVEMENT

6.1 Do you think that community involvement is important?

1	2
Yes	No

6.2 Do you think that the people are aware of your existence?

1	2	3
Yes	No	Not all

6.3 Have you got a suggestion box in your clinic?

1	2
Yes	No

6.4 List the type of community/home base activities in which your clinic is involved-----

6.5 Do you think that the people prefer to visit your clinic other than any other public clinic in your area?

1	2	3
Yes	No	Not sure

6.6 Does your clinic conduct a community need assessment annually?

1	2
Yes	No

6.7 As a clinic; are you a member of the health committee in your area?

1	2
Yes	No

6.7 As a clinic; are you a member of intersectoral collaboration committee?

1	2
Yes	No

6.9 What suggestions are you recommending for improvement? -----

SECTION 7 : HEALTH EDUCATION

7.1 Who is responsible for the provision of health education in your clinic? -----

7.2 Do you have enough educational materials in your clinic?

1	2
Yes	No

7.3 Does the provider use language acceptable to the people?

1	2
Yes	No

7.4 Does the provider use relevant visual aids when providing health education?

1	2
Yes	No

7.5 Does your clinic supply your patients periodically with relevant health learning materials to read at home?

1	2
Yes	No

7.6 If yes; are these learning materials in local languages?

1	2
Yes	No

7.7 Do you think that your community is aware of their rights in terms of health services?

1	2
Yes	No

7.8 What suggestions are you recommending for improvement? -----

SECTION 8: DEMOGRAPHIC DATA

8.1 How long have you been working in the public clinics in Alexandra?

1	2	3
1-2 years	2-5 years	>5 years

8.2 Age category:

1	2	3
20-35 years	36-55 years	56-65 years

8.3 State your qualifications -----

9 ANY OTHER COMMENTS-----

THANK YOU VERY MUCH FOR PARTICIPATING IN THE STUDY.

ANNEXURE 4

OBSERVATION LIST

SECTION 1:

SERVICES OFFERED:

Type of services offered in all the public clinics.

Personnel responsible for the services –in all the clinics.

Service evaluation- all the clinics.

Year plan- 4th Avenue, East Bank and Thoko Ngoma clinics.

SECTION 2

PERSONNEL RESOURCES

Career path –4th Avenue.

Security system –all clinics

Staffing patterns –all clinics.

Personnel's attitude – all clinics

Personnel's way of handling very sick patients –all clinics.

Clinics with supervisors holding the post.

SECTION 3

OTHER RESOURCES

Adequacy of the rooms.

Rest rooms for sick patients –all clinics.

Emergency rooms –all clinics.

Room partitioning –East Bank clinic.

Privacy- all clinics.

Equipment –all clinics.
Fridges all clinics
Condom dispensers –all clinics
Drug availability –all clinics.
Sending people back - all clinics.

SECTION 4

IMPORTANT DOCUMENTS

Well displayed patients' right charter – all clinics
Language used in the charter –all clinics.
Complaints procedure for the patients and nurses –East Bank clinic.
Person responsible for handing patients their lab results namely: Pap smear, TB
STI and HIV results –all clinics.

SECTION 5



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SERVICE UTILIZATION

Catchment area for Thoko Ngoma clinic.
KM in square meter –all clinics.
Measures of equity –all clinics.
Waiting time –all clinics.
Clinics statistics: from January 2000 to December 2001(From the authority).

SECTION 6

COMMUNITY INVOLVEMENT

Community /home based activities –all clinics
Person responsible for home visits –all clinics.
Community need assessment –East Bank clinic.
Health committee membership – 4TH Avenue clinic.

Intersectoral collaboration membership – 8th Avenue clinic.

SECTION 7

HEALTH EDUCATION

IN ALL CLINICS:

Availability of the services.

Person responsible.

Availability and relevance of educational materials and pamphlets.

Relevance of health education content.

Language used in health education sessions.



ANNEXURE 5

Rand Afrikaans University,
Faculty of Nursing Education,
P.O. BOX 524,
Auckland Park,
Johannesburg.

14th Sept. 2001.

THE CLINIC SUPERVISOR

Dear Madam,

PERMISSION TO COLLECT DATA AT THE CLINIC

I am a student at Rand Africans University currently studying for Masters' Degree in Community nursing. As part of my studies I am required to carry out a research project. The title of my research is: Accessibility of PHC services in Alexandra Township.

The purpose of this letter is to ask for your permission to collect data at your clinic. The subjects are the patients attending the clinic from the ages of 18 years and above. I would like to collect data in the month of October 2001.

Waiting for a favourable response from your good office

Yours sincerely,

Evelyn Chitsa Banda.

ANNEXURE 6

Rand Afrikaans University,
Faculty of Education and Nursing,
P.O. Box 524,
Auckland Park,
Johannesburg.

21st October. 2001.

The PHC nurse,
Alexandra Public Clinics.

My name is Evelyn Chitsa Banda. At present I'm registered with Rand Afrikaans University persuing a course in community nursing.

As a requirement of my course; I am expected to conduct a research project. The title of my project is: Accessibility of PHC services in Alexandra Township. I therefore would like you to assist me in my study by completing this questionnaire at your own time. Please I ask you to try and not leave blank spaces. I am also asking you to please complete the questionnaire by 15th November 2001. The information provided, will be treated with confidentiality. The results of the analysis of the research will be made available to you once I have finished the study and hopefully we will be able to benefit from it.

In case you have any queries you can contact me on 0837109331. Will you please sign below to show that you have consented to participa te in the study.

Thank you for your cooperation and I hope that you are going to enjoy being part of this project.

Your Signature:-----

Date :-----

Yours sincerely,

Evelyn Chitsa Banda.

ANNEXURE 7

INFORMATION LETTER

Rand Afrikaans University,
Faculty of Education and Nursing,
P.O. Box 524,
Auckland Park,
Johannesburg.

14th Sept. 2001.

Dear Participants,

I am a student at Rand Afrikaans University and I am currently doing a research study titled: Accessibility of PHC services in Alexandra Township.

I would like you to participate in the study by allowing me to ask you some questions concerning this topic. The interview will take approximately 20 minutes. The information given in confidence will be properly secured. Your name will not be identified on the sheet to ensure that no information is attached to you as an individual. There are no known risks associated with the study and if you happen to discontinue or refuse to participate in the study there is no punishment.

If you have agreed to participate in the study, please sign the attached consent form to show that you have understood the terms of the study and are willing to participate.

Thank you for your cooperation.

Yours sincerely,

Evelyn Chitsa Banda.

ANNEXURE 8

CONSENT FORM

I have been fully informed and have made a decision to participate in the study.
My signature/ thumbprint is endorsed below.

Signature/ thumbprint of participant -----

Date -----

Signature of researcher/assistant -----

Date -----

