UNIVERSITY OF KWAZULU-NATAL

DETERMINING THE FACTORS RELATED TO PATIENTS IN THE UMUZIWABANTU SUB-DISTRICT OF KWAZULU-NATAL BYPASSING PRIMARY HEALTH CARE FACILITIES IN 2010 AND ACCESSING THE DISTRICT HOSPITAL AS THEIR POINT OF FIRST CONTACT

By

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DECLARATION

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ABSTRACT

Primary health care (PHC) is the first component of the health system that provides patients with first-level care. PHC must be supported by a strong referral system whereby PHC nurses can refer patients with conditions beyond their capabilities to medical officers for further management using referral letters. The medical officers also using referral letters refer stable patients back to the PHC clinics for follow up and management.

The aim of study was to determine factors related to patients bypassing primary health care facilities and accessing the district hospital as point of first contact in the Umuziwabantu health sub-district of KwaZulu-Natal.

This research investigates the referral patterns of patients as well as the factors affecting the referral patterns of patients between PHC facilities and the district hospital. The study was conducted at the Gateway Clinic of St Andrew's Hospital and its outpatient department. The following groups were excluded from the study: any patients who arrived at the clinic with a referral letter from another facility, any children who were brought there by another child, and any who were unwilling to take part in the study. The researcher made use of open-ended and structured questions to interview 720 patients over a period of six months.

The overall findings show that a large part of the Umuziwabantu sub-district is still served by mobile clinics. Since mobile clinics do not visit each point daily, patients from mobile points often go to the hospital for any health-related problems. There is the widespread perception that a hospital provides better service than a PHC clinic. The Local Government (LG) clinic only sees a limited number of patients. The main reasons given by patients for bypassing their local PHC clinics are:

1. Mobile clinic unavailability on that day;
2. The hospital is closer.
3. Patients are used to coming to the hospital.

4. Patients are doing things in town and then decide to combine this visit with hospital visit.

Three-hundred-and-sixty-one patients had only minor ailments and a further 95 required chronic treatment which could have been dispensed at PHC clinics. Only 264 of patients surveyed should have been seen at the Hospital.

Conclusions from the study were that patients would use their local PHC clinics if there were enough fixed clinics and the LG clinic had more staff to attend to more patients than the number they are currently attending. The clinic-upgrading programme needs to be improved and fast-tracked.

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
CHC	Community Health Centre
DH	District Health
DHS	District Health System
DOH	Department of Health
EC	Eastern Cape
EDL	Essential Drug List
HIV	Human Immunodeficiency
KZN	KwaZulu-Natal
LG	Local Government
NGO	Non-governmental Organisation
OM	Operational Manager
OPD	Outpatient Department
PHC	Primary Health Care
PMSC	Provincial Medical Supply Centre
THP	Traditional Health Practitioners
WHO	World Health Organisation

CHAPTER 1: INTRODUCTION AND OVERVIEW OF THE STUDY

1.1 Introduction

The primary health care (PHC) approach was described at the conference in Alma-Ata in 1978 as an effective strategy for improving the health status of populations around the world (South African Health Review, 2005). The PHC approach addresses the main health problems in communities by providing mainly promotive and preventive health services.

PHC is the health system's first level of contact with individuals, the family and the community; therefore it ought to be made accessible and acceptable to them. This will require their full participation. The health system should bring health care as close as possible to where people live on the basis of their needs. PHC needs to be sustained by an integrated, functional and mutually supportive referral system that exists at the local level, and that includes physicians, nurses, midwives, auxiliaries and community workers. PHC constitutes the first element of a continuing health care process (Alma-Ata Declaration, 1978).

At the National Consultative Health Forum Meeting on Primary Health Care that was held in April 2008, a few international speakers discussed their experiences in terms of implementing PHC. The EURO Regional Office of World Health Organisation (WHO) published research findings that suggest the following:

- Increased availability of PHC is associated with higher patient satisfaction and reduced health care expenditure.
- Health systems in developing countries with a strong PHC orientation are more pro-poor, more equitable and more accessible (30^{th} Anniversary of the Alma Ata Declaration, 2008).

The Health System Knowledge Network of the WHO Commission on the Social Determinants of Health reviewed global evidence with regard to how to strengthen health systems. One of the four key areas that were identified by the commission was the need to revitalise PHC by strengthening the district health system, which requires adequate funding and human resource strategies that will ensure the availability of appropriately skilled staff who are committed to achieving population health gains (30th Anniversary of the Alma-Ata Declaration, 2008).

According to South African Health Review 2005 experiences over the past thirteen years revealed that there have been both successes and challenges, for example:

- Access to PHC services has been improved by removing user fees and increasing the number of clinics that are geographically near to the general population.
- A new cadre of nurse – the PHC nurse – has been trained and deployed in all district clinics.
- An essential drug list (EDL) for PHC has been developed and implemented. Most surveys suggest that most public health facilities have the essential drugs almost all the time, there are very few instances of drug stock-outs (30th Anniversary of the Alma-Ata Declaration, 2008).

According to the District Health (DH) Model, a PHC facility is a first and one-stop station for PHC services and its provision as a facility is based on the needs of the community it services (Voce and Philpot, 1998). Therefore there should be a joint venture between the communities and the PHC providers to ensure the acceptability and accessibility of the PHC services to those communities.

1.2 Background To The Research

1.2.1 What is known thus far?

The main aim of the National DH System Committee that was formed in August 1994 was to ensure the successful transition from a curative-based health system to a PHC

approach, where PHC facilities are managed by PHC nurses. A district hospital is the ultimate referral point within the DH System. It provides the community with essential back-up services and gives support to community-based activities, community health centres and those clinics that are in closer contact with individuals, families and communities.

Other factors that relate to the utilisation of the health care facility include: the physical distance from the health facility; the cost involved in travelling between one's home and the facility; the long waiting time at the facilities; the widespread belief that doctors are more knowledgeable and capable than nurses; the difference between the EDL by nurses at PHC level and doctors at the hospital for the same category of patients; and the attitude of the health care workers.

The Government of South Africa wishes to ensure that its health services are closer to the people that need them and that health care is made accessible to all through proper planning and an adequate supply of suitably qualified and competent human resources that can staff the facilities.

1.2.1.1 Distribution of Primary Health Care Services

St Andrew's Hospital is in the Umuziwabantu sub-district, one of the Ugu sub-districts, which is on the N2 southern route between Port Shepstone and Kokstad. Umuziwabantu sub district is situated in southern KwaZulu-Natal, boarded on the north and west by the Sisonke district and on the south by both the Izinqoleni sub-district and the Eastern Cape (EC). The cross-border flow of patients, predominantly from the EC and the Sisonke district, constitutes about 21% of the St Andrew's hospital headcount.

St Andrew's Hospital supports seven Department of Health (DOH) feeder clinics, one Local Government (LG) clinic, and three mobile teams. Umuziwabantu sub district is made up of nine wards. All wards are served either by a fixed clinic or mobile clinics (see Annexure 1 and 2 for the distribution of health facilities and mobile points). Ward 1 has a

population of 10,503. This ward has no operational fixed clinic but there are two that are still under construction. This ward also has four mobile points that are served by two mobile teams (namely, Team 1 and Team 2). Ward 2 has a population of 10,523 people. There is one fixed clinic, called Meadow Sweet, and five mobile points. This ward is served by all three of the mobile teams.

Ward 3 has a population of 8,154 people. It is the smallest of all the wards. St Andrew's Hospital and the Harding LG clinic are situated in this ward. This ward has five mobile points and is served by all three of the teams. At three of these mobile points there are three teams that provide child health and reproductive health services only. Team 1 also visits the firm of Harding Treated Timber and Team 3 visits Guy Payne's farm. A large number of patients from this ward now visit St Andrew's Gateway clinic instead of the Harding LG clinic.

Ward 4 has a population of 9,880 people. It is served by the Pisgah clinic and has four mobile points that are visited by Teams 1 and 2. Ward 5 has a population of 11,029 people; it is served by the Elim clinic and has three mobile points. The Elim clinic is the busiest clinic in the sub-district. Its population is bigger than those of the first four wards but it has only three mobile points, whilst Wards 3 and 4 have five and four mobile points respectively. Ward 6 is served by the Xhamini clinic in and has only three mobile points, which are visited by all three of the mobile teams. This ward has a population of 11,406 people.

Ward 7 has a population of 9,327 people. PHC services are provided by one fixed clinic, called Weza. The DOH and Nsingizi forestry work in partnership here. The company provides the infrastructure and the DOH provides the medical equipment, the staff and the working material. This ward also has three mobile points, which are served by Team 2 and Team 3. Ward 8 is the largest populated area, having a population of 12,449 people. The Mbonwa clinic started to operate in this ward three years ago. It has four mobile points and is served by Teams 2 and 3. The last ward is Ward 9, which has a

population of 9,154 people. In this ward there is the KwaJali clinic as well as six mobile points, which are served by Teams 2 and 3.

Mobile teams also provide services across the boundaries of the Umuziwabantu sub-district. They serve two points: KwaNyuswa and KwaBlose. KwaNyuswa and KwaBlose are both within the Ezinqoleni sub-district and are between 58 and 71 km away from St Andrew's Hospital. The mobile teams also service the EC mobile point called Gundrift, which is 50 km away from St Andrew's Hospital. They refer these cross-border patients to St Andrew's Hospital for further management.

At the Umuziwabantu sub-district a large number of patients are bypassing PHC facilities to access St Andrew's Hospital as their point of first contact with the health system. Figure 1.1 shows the number of patients who arrived at the hospital without referral letters the first quarter of 2007.

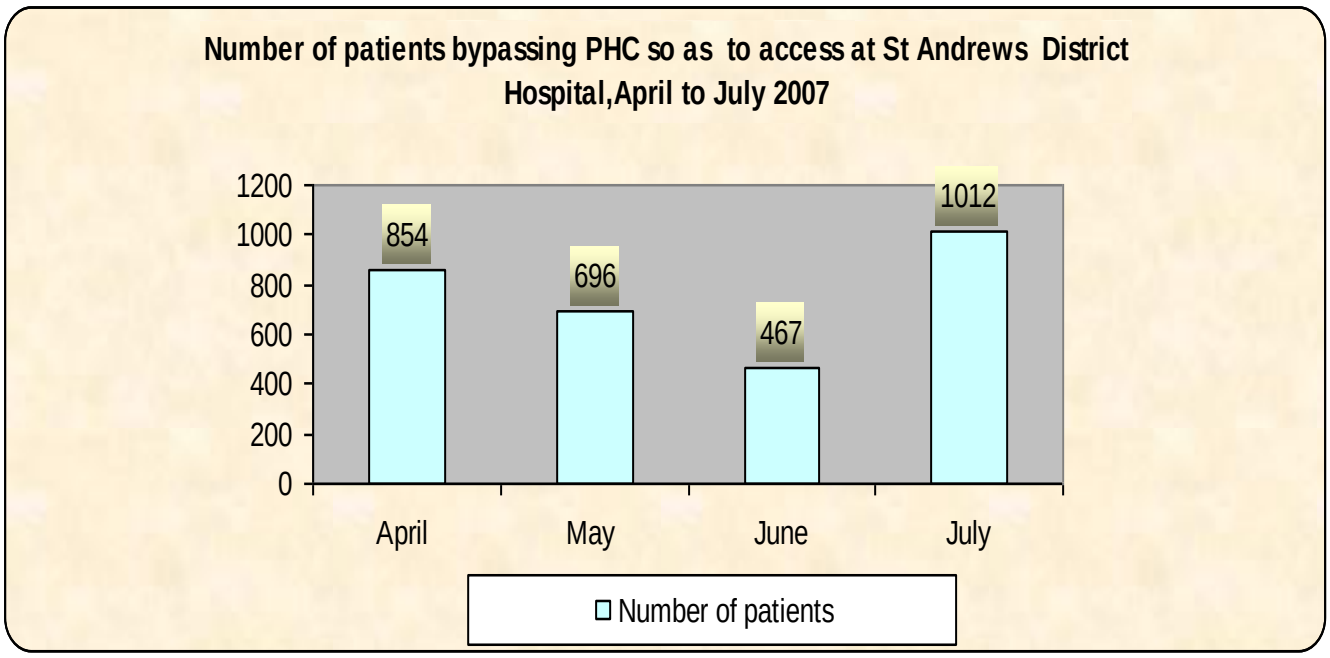

Figure 1.1 Number of patients bypassing PHC facilities so as to access St Andrew's Hospital

1.2.2 What needs to be known?

St Andrew's Hospital is supporting seven DOH feeder clinics as well as a LG clinic. There are also three teams of PHC mobile clinics that visit those areas with no fixed PHC clinics and there are two clinics under construction. However, the number of patients who come to the hospital without referral letters is increasing instead of decreasing. It is important to identify the factors that might be contributing towards patients bypassing their local PHC facilities so as to access St Andrew's Hospital as their first point of contact

1.2.3 What is the importance of this study?

The costs involved in providing PHC services at a district hospital are higher than those involved in providing them at a PHC facility (South African Health Review, 2005). Recruiting medical doctors is a big challenge being faced by St Andrew's Hospital; there is currently a vacancy rate of 66%. (St Andrews Hospital 1st Quarterly report 2008/2009), PHC therefore needs to be strengthened. The Harding LG PHC facility also has a shortage of professional nurses. The three professional nurses who serve in the facility can only cope with 180 patients a day and the two professional nurses who work at St Andrew's Gateway clinic can only cope with 90 patients a day. Both facilities provide eight-hour services for five days a week. Patients who report to the above-mentioned facilities exceed the numbers that the PHC nurses can handle.

1.2 4 How will the study solve this problem?

The present study will be of help in identifying the factors that contribute to patients in the sub-district deciding to bypass PHC facilities. Such knowledge can be of help in terms of strengthening the referral system, ensuring that patients are treated with the appropriate level of care, and improving the cost efficiency of PHC operations. The country's PHC services need to be strengthened; PHC facilities need to be prepared to

receive patients undergoing anti retroviral (ARV) therapy, their nurses need to be able to initiate patients on ARV therapy, and they need to be able to directly supervise tuberculosis treatment. By doing these things, health care interventions in the sub-district will be enhanced.

1.3 Statement of the Research Question

A large proportion of the patients who come to St Andrew's Gateway clinic and outpatient department (OPD) bypass their local PHC facilities. We do not know why.

1.4 Purpose of the Study

A large number of PHC patients come to St Andrew's Hospital for health care purposes without having a letter of referral from their local PHC facilities. The hospital has gone so far as to open a Gateway clinic in order to assist the few doctors working in that institution. Even more clinics are being commissioned in the Umuziwabantu sub-district. Ambulances are currently called to fetch elective patients from different areas and bring them to the hospital without the patient having obtained a referral letter from their local PHC facility. Doctors who are on night duty find themselves running the PHC Gateway clinic, the OPD, as well as attending to emergencies. The aim of this study is to investigate the factors that cause patients to bypass their local PHC facilities in the Umuziwabantu sub-district in the Ugu district in KZN.

1.5 Specific Objectives of the Research

The specific objectives of the present research are as follows:

a) To describe the demographics of those who bypass their local PHC facility and instead go directly to the district hospital OPD or St. Andrew's Hospital Gateway clinic. (Local patients are expected to go to LG clinic in the town of Harding.

Gateway Clinic is supposed to serve those who come to OPD without referral letters. Patients who were selected from OPD are those who were found in the queues to the doctors' consulting rooms without referral letters or appointment letters, after the Gateway clinic was closed after hours and during public holidays.

b) To determine the multiple factors (e.g. cultural, geographic, economic, and transport-related) that may be influencing patients in terms of their decision to bypass PHC facilities.

c) To investigate the multiple possible factors (e.g. staff, staff attitudes, the physical state of the facility, its convenience, the availability of comprehensive services, and the lack of service at certain times of the day or on certain days of the week) that affect patients' choice of facility.

d) To determine patients' knowledge, attitudes and beliefs with regard to the need for a proper referral process.

e) To make recommendations with respect to improving referral patterns and minimising the factors that lead to patients bypassing PHC facilities in the sub-district.

1.6 Underlying Assumptions of the Study

One of the underlying assumptions of the present study is that the patients who come directly to St Andrew's Hospital without referral letters do in fact have PHC clinics nearby to where they live. A second underlying assumption is that there are factors that cause these patients to bypass their local PHC clinics and the patients are aware of and thus would be able to articulate some of those factors. The third assumption is that the patients are likely to possess some good and helpful ideas that could assist in improving the situation for them with regard to local PHC clinics.

1.7 Operational Definitions Used in the Study

Primary Health Care total headcount is the average number of visits per person to a PHC facility per year.

Fixed facility refers to a PHC facility or community health centre that has permanent staff and equipment and that provides an eight- to twenty-four-hour service per day for five or more days a week.

Satellite clinics are PHC facilities that draw staff, equipment, drugs and supplies from a source facility and that provide services on a non-continuous basis, but at regular intervals.

Mobile clinics are vehicles equipped with PHC provisions that transport health workers from a source facility to stopping points where they render their services.

An *operational manager* is a person who is responsible for the day-to-day management of a PHC facility.

A *PHC supervisor* is a person who provides external supervision to PHC clinics.

A *Catchment area* is a geographical area that is served by a particular health facility.

Umuziwabantu is the name of the municipality where St. Andrew's Hospital and its feeder clinics are situated.

Umuziwabantu sub-district is one of the Catchment areas in the Ugu Health District

1.8 Organisation of the Report

This report has been organised into the following chapters:

Chapter 1 consists of the introduction and an overview of the study. It primarily focuses on the background to the research, the research problem, the purpose of the study, and the specific objectives of the study.

Chapter 2 offers a detailed report on the researcher's review of the literature on previous investigations into the problems related to patients bypassing their local PHC clinics. The focus of this chapter is on patient access, equipment and infrastructure, the availability of drugs, the package of service, referral and human resources.

Chapter 3 presents the research methodology that was used for this study. Research methodology deals with the type of research that was conducted, the study design, the target population, the sample, and the methods of data collection. It also covers any ethical issues such as the issue of obtaining participant consent.

Chapter 4 describes the results of the research and presents a report on the findings.

Chapter 5 offers a discussion of the results.

Chapter 6 presents the researcher's conclusions based on the findings drawn from the study. It also offers recommendations as to possible improvements to the health care system that could be made in order to ensure patients do in fact use their local PHC clinics.

Finally, a list of references, annexures and the appendices are provided.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The core function of PHC services is to render first-level health care to communities. The principles underpinning the PHC approach are contained in the Alma-Ata Declaration of 1978; these principles include accessibility, disease prevention, health promotion, and individual/community participation. Other factors for consideration are: the planning of PHC services, the provision of appropriate technology, and cost effectiveness (Health Systems CD, 2007). A third of total hospital costs could be saved if PHC patients are treated at a PHC facility rather than at the hospital (Lutge *et al*., 2003). The costs involved in providing PHC services at a district hospital's OPD are higher than those involved in treating them at a local government PHC. The Ugu district's PHC utilisation rate was found to be 1.9 as compared with the national goal of 2.2 (KwaZulu-Natal Department of Health Annual Report, 2005/2006).

2.2 Reasons for Bypassing Primary Health Care

In a study conducted at ten public hospitals in the eThekwini Municipality, it was found that 43.6% of the patients could have been managed at PHC level. It was also found that five of the ten common causes of ill health were chronic diseases (Lutge *et al*., 2003). In previous studies conducted on PHC utilisation, patients gave various reasons for bypassing PHC facilities. These reasons included:

- The hospital being closer to their homes than the PHC facility
- Hospitals offering the best care available
- Hospital care is superior because of the presence of doctors
- Hospitals are better equipped (Lutge *et al*., 2003)

In another study, it was discovered that the 37% of patients from low-income groups seek health care from the private sector. Surveys have also revealed that these low-income groups make use of the private sector even for PHC needs (South African Health Review, 1999). In a survey conducted in the Eastern Cape and Western Cape provinces, patients stated that they prefer using private providers because:

- They are easier to access
- They have extended hours of service
- They have a shorter waiting time
- They have doctors on staff as opposed to just nurses
- The clinics cannot treat all illnesses because they have no doctors
- The disrespectful attitudes of the nurses are unacceptable (South African Health Review, 1999)

2.3 Negative and Positive Results

2.3.1 Access

The National Primary Health Facility Survey (2003) that was conducted in KZN revealed both positive and negative results. The active time taken for ambulances to arrive at a facility in KZN during office hours was found to be longer than the norm. The majority of PHC facilities in KZN are located in rural areas. Twenty-nine percent of KZN's PHC facilities were shown to render 24-hour emergency services. Ninety-eight percent of PHC facilities in KZN were open five days per week, compared with 96% throughout the rest of the country. On average, facilities in KZN were open for nine hours a day at the time of the survey. The availability of various categories of health care personnel in KZN was similar to that of the rest of the country, with 33 professional nurses per 100,000 people (The National Primary Health Facility Survey, KZN, 2003).

2.3.2 Equipment and Infrastructure

Positive results were also revealed in relation to PHC equipment. The availability of equipment in KZN was found to be higher than the national average. Improvement was also noticed in terms of infrastructure, where 40% of the PHC facilities in KZN had adequate number of rooms, and 98% had a steady good water supply. All PHC facilities in KZN had a power source, compared with the 95% nationally (The National Primary Health Facility Survey, KZN, 2003).

2.3.3 Availability of drugs

The surveys also revealed improvement in the availability of drugs in some areas and that there had been deterioration in others. Satellite clinics were less stocked with drugs and supplies than fixed and mobile clinics. In KwaZulu-Natal, 84% of patients had received drug treatment compared with 72% nationally. The percentage of patients attending PHC facilities in KZN who received drug treatment was higher than the national average. The average number of drugs dispensed per patient at the time of survey in the province was 2.6 compared with national rating of 2.0 per patient (The National Primary Health Facility Survey, KZN, 2003).

2.3.4 Package of Service

The Ugu district's annual report revealed that all PHC facilities offer an 85% package of service, that 84% provide on-call services, and that 100% have fast queues (Ugu District Annual Report, 2006/2007). The frequency with which mobile PHC visited certain stopping points varied considerably at the time of the survey from once a week to once in seven weeks, with a national norm of once per month (The National Primary Health Facility Survey, KZN 2003). The PHC survey that was conducted in 2000 revealed that 80% to 90% of fixed clinics offer adult and child curative, nutrition and growth monitoring as well as chronic disease and HIV counselling services on a daily basis. The survey listed KZN as one of the provinces that has shown the most improvements in

terms of services availability. Regarding a continuation of services, mobile clinics in the EC and KZN experience the most problems when it comes to letting their patients know when their services will be interrupted. KZN received the worst ranking in terms of its failure to make alternative arrangements for service continuation (The South African Health Review, 2000).

2.3.5 Referral

The most important part of the district health system is its referral system. The proper referral system ensures that sick people are treated by appropriately trained personnel and that frontline health workers have support and backup when it comes to their decision-making. According to the guidelines for the correct implementation of PHC as set out in the Primary Health Care Core Package and *A Pocket Guide to District Health Care in South Africa*, the referral system within a district should ensure that:

- Patients who require further investigation into their case receive it and when the need falls beyond the scope of the competence of the PHC nurses, that need is referred straight to the district hospital.
- Health workers are able to consult other colleagues and seek a second opinion via telephone or fax in cases where a patient does not need referral from the PHC clinic to a hospital. Electronic communication should make this type of referral much easier.
- Every clinic is able to arrange transport within an hour for an emergency.
- The merits of a referral are assessed and discussed with the referring health professional as part of the continuing education of the PHC nurses and in order to improve the outcome of referrals (PHC Development Task Team, 2000; Health Systems Trust, 1997).

According to the comprehensive PHC package for South Africa that was issued in September 2000, the referral mechanism should ensure that:

- All patients approaching the referral section of the community health centre (CHC) or district hospital bring a referral letter from the PHC clinic.
- Those patients presenting directly to the referral section without a letter are sent to the clinic section of the CHC or hospital where the need for a referral letter will be assessed.
- The referral must be accompanied by a letter clarifying the diagnosis and the subsequent steps to be taken.
- Serious casualty cases are referred directly from the clinic to the hospital without having to go through the CHC.
- A concerted marketing campaign is undertaken to describe the respective roles of the clinics and the visiting specialist teams.
- There is a regular supply of drugs to the clinics. An inadequate drug supply at the clinics is an important contributing factor in the bypassing phenomenon

The PHC survey that was done in 2000 revealed that the majority of the workers at KZN's satellite and mobile clinics perceive the referral system as efficient, whilst the PHC providers at fixed clinics expressed their dissatisfaction with the referral system (The South African Health Review, 2000).

2.3.6 Human Resources

Human resources are still a big challenge in PHC facilities, but some improvements have been made since 1997. The survey for the year 2000 revealed that nurses at fixed facilities in KZN have a higher patient load compared with the national average. Furthermore, the patient load for mobile PHC facilities in KZN is more than double the national average (The National Primary Health Facility Survey, KZN, 2000). Nurses at fixed PHC facilities in KZN in 2000 had a substantially lower patient load than did nurses in 1997. Skills updating in the field of HIV and AIDS management has increased. The availability of doctors to consult with patients at clinics has increased since 1998 (The National Primary Health Facility Survey, 2003 KZN). Ugu district did, however,

report a shortage of doctors for its outreach programme (Ugu District Annual Report, 2006/2007).

The bypassing of PHC facilities by patients has a negative impact on resources; those resources that ought to be utilised on patients requiring hospital treatment are being expended on patients who do not require them, which leads to the inefficient use of scarce resources.

2.4 Primary Health Care Supervision

According to the Primary Health Care Policy for KwaZulu-Natal, *supervision* can be defined as:

- A planned, supportive, couching and monitoring relationship between the supervisor and supervisee.
- A continuous strategy that supports the provision of quality PHC services to clients whilst requiring the clients to participate fully in the process through the identification of their health needs and any perceived health service gaps, through problem solving, through resource allocation, and through people development (i.e. planning, monitoring, evaluation and feedback).
- A means of improving the quality of a service so as to decrease the burden of disease (KwaZulu-Natal Department of Health Policy for Primary Health Care Supervision, 2010).

Supervision is fundamental to the provision of a quality health service. It helps facilitate a safe environment for health care workers that is conducive to productivity. It also ensures the system operates cost effectively and makes appropriate use of resources. Finally, supervision is important when it comes to monitoring and evaluating interventions. PHC supervisors can, in their administrative role, positively influence the quality of the care that is provided at PHC facilities. PHC supervisors are expected to provide technical and

clinical support to health care workers, guide provider-client interactions, and direct staff development

2.4.1 The Structure of the Primary Health Care Supervisory System

The structure of the PHC supervisory system involves operational managers and PHC supervisors.

2.4.1.1 Operational Manager

The management structure of the PHC facility consists of on-site as well as external supervision. Each PHC clinic has an appointed Operational Manager (OM). Mobile PHC teams have team leaders who are responsible for the on-site co-ordination of the team, but an external person provides supervision and management of the staff. The OM of the facility is responsible for the day-to-day management of the service provided at that clinic in terms of human resources, occupational health and safety, supplies, and quality of service. The OM is also responsible for the local planning of services, any liaising, planning, and monitoring the community.

2.4.1.2 The Primary Health Care Supervisor

Each PHC clinic is supervised by a single, multi-purpose PHC nurse who is the liaison between that clinic and the authorities. The PHC supervisor provides external supervision to PHC clinics. He/she ensures the required resources reach the facility and that human resource development takes place. He/she also ensures the proper provisioning of quality clinical services. He/she provides contextual planning, and monitors, evaluates and co-ordinates PHC services in the area.

The recommended supervision ratio is at least one visit per month for at least four hours at each PHC clinic. Each PHC supervisor should be allocated five PHC clinics. The PHC supervisor should use the checklist from the Supervision Manual and reports should be

written (KwaZulu-Natal Department of Health Policy for Primary Health Care Supervision, 2010)

CHAPTER 3: METHODOLOGY

3.1 Introduction

In this chapter the research methodology is discussed. The chapter looks at the setting of the study, the study design, the target population, the study population, the sampling method, the data collection techniques and instruments, and the statistical analysis.

The approval to conduct the study was obtained from the following: the Biomedical Ethics Committee of the Nelson R. Mandela Medical School, the head of KwaZulu-Natal's Department of Health, the district manager of the Ugu Health District, the deputy nursing manager of St Andrew's Hospital, and the PHC supervisor of the Umuziwabantu sub-district. A systematic and simple design was used based on the average clinic headcount of the St Andrew's Gateway clinic. Seven-hundred-and-twenty participants were interviewed by way of a questionnaire. The research was carried out over a period of six months (from March 2010 to September 2010).

3.2 Study Setting

The study was conducted at St. Andrew's Gateway clinic and St, Andrew's Hospital OPD. Information on supervision and referrals was obtained from all the OMs of the clinics, from the PHC supervisor, from three of the doctors working in the OPD, from the nurse in charge of the OPD, and from the pharmacy manager.

3.3 Study Design

This study used an observational, descriptive, cross-sectional design with quantitative components.

3.4 Target Population

The target population for this study was patients from Umuziwabantu sub-district in the Ugu district in KZN.

3.5 Study Population

All those that attended St Andrew's Hospital OPD and the Gateway clinic as patients during the period of study (i.e. the summer and winter of 2010) formed a part of this study. Seven-hundred-and-twenty patients were interviewed

3.5.1 Inclusion / Exclusion

All patients who were at the Gateway clinic and OPD during the study period and were willing to take part in the study were interviewed. Excluded from the study were the following: all those patients who came with referral letters from their facilities, all children who could not sign a consent form, all children who brought other children along, and all those patients who were unwilling to take part in the study.

3.6 Sampling

Systematic sampling was used.

3.6.1 Method of selecting sample

Random systematic sampling was used. Every fifth patient among those who were still waiting to be seen either by the nurses or doctors was chosen to take part in the study. The number of participants that were interviewed depended upon the number of patients that were there on that day. The inclusion and exclusion rule did, however, affect the

number of patients that were interviewed each day. In the end, the size of the sample was 720.

3.7 Study Instrument

Data was collected from the patients that attended the Gateway clinic and OPD. This data was collected by way of a structured questionnaire. The questionnaires also included some open-ended questions. The data analysis was quantitative in nature. Structured interviews were conducted with clients in a language in which they were able to converse.

Further quantitative data was collected from PHC facilities as well as from hospital records. The clinical records of patients together with the clinics' and hospital's administrative records (which include, for example, equipment books, drug/medicine registers, and stock control tools) were used to determine the availability of resources to run the PHC clinics effectively and satisfactorily. Discussions were also held with other stakeholders and Clinic OMs with regard to pharmaceuticals, emergency and planned patient transport, staffing norms, clinic nurses' qualifications, mobile clinic operations, the management of chronic patients by both PHC clinics and the hospital and referral system.

The PHC inspection tool that is used by PHC supervisors was also studied in order to ascertain whether or not it actually assists the PHC supervisors in giving the necessary support that is needed by the PHC nurses in order to deliver quality PHC services which are accessible and acceptable to the clients.

3.7.1 Measures to Ensure Validity

The same questionnaire was used to collect data from all the different patients. The discussions with health professionals varied according to the information that was needed from them based on the service they provide.

3.8 Bias and Limitation

The study started on a Monday which is the beginning of the week in order to work out number of weeks the study had to take. There were 76 patients selected from Out Patient Department and 644 were selected from Gateway clinic.

The fifth patient in the queue was selected and thus bias in the selection process was minimised since all the patients stood an equal chance of being selected. If a patient fell within the exclusion category, the next patient was selected. A quiet consulting room/office was used for the sake of confidentiality. It was also hoped the setting would help the patient to feel relaxed.

In order to minimise information bias, structured interviews were conducted by trained interviewers, who used structured questionnaires. No recall problems were expected as the patients were interviewed on the day of their attendance at the Gateway clinic or OPD

The first limitation of the study was that during the interview there were patients who decided not to answer any further questions. Others insisted that their clinic is the Gateway clinic and stated that they know nothing about their local clinics. Some provided incorrect information with regard to the outreach services that are provided at their clinics. Others claimed that they were referred by PHC nurses or had appointment but did not have referral or appointment letters.

3.9 List of Variables

The variables in this study are mostly quantitative in nature and are related to the following:

- The demographics of the patients
- The mode of travel, travelling costs, and the travelling time to the bypassed clinic and to St Andrew's Hospital
- Clinics' operating times

- Factors related to the ambulance service operations
- Patients' knowledge, attitudes and beliefs about referrals and accessing the hospital or PHC facilities
- Clinic headcounts

3.10 Pilot Study

The questionnaire was piloted at St Andrew's Gateway clinic in July 2009. It was given to five patients. No modifications were needed but the researcher had to take some time to explain the meaning of the terms 'bypassed clinic', 'district' and 'type of accommodation' during the interviews. Other patients had more than one residential area, such as a rural area and an informal settlement near the hospital. This caused a problem for the researcher who had to decide which one to select. Most of these patients were found to stay at their homes in informal settlements most of the time (and only occasionally return to their rural homes), so the researcher chose to consider the informal settlement as their residential area and thus the clinic nearest to the informal settlements was considered to be the bypassed clinic.

3.11 Data Collection

Quantitative data pertaining to the bypassed PHC facilities was obtained from the patients through a structured questionnaire. Information on referral patterns was discussed either with PHC clinic OMs, their deputies, or the medical officers working in the OPD. The issue of clinic supervision was discussed with the PHC supervisor from the professional staff. Information on clinic headcounts was obtained from the quarterly reports of previous years.

3.12 Ethics Approval

Ethical approval for the study was obtained from the Biomedical Research Ethics Committee of the Nelson R. Mandela School of Medicine in South Africa (Reference number: Department of Medicine, UKZN. REF: BF087/09/). Permission was also obtained from the KZN Department of Health, Ugu's district manager, the deputy nursing manager of St Andrew's Hospital, and the PHC supervisor of the Umuziwabantu sub-district.

Before any patient was asked questions, the researcher explained to each participant the nature of the research, as well as its purpose and objectives. The participants who were interviewed were requested to sign a consent form, which they did voluntarily. Their right of refusal to participate was also explained. The interviews were conducted in consulting rooms and offices so as to maintain confidentiality. Copies of the ethical approval, the information sheet and the consent form are attached as Appendices A, B and C respectively.

3.13 Summary

An observational, descriptive, cross-sectional design was used in this study. The study was conducted at St Andrew's Hospital. Seven-hundred-and-twenty (720) patients were interviewed after each had given his/her consent to participate. Discussions with the OMs of PHC clinics and the medical officers of St Andrew's Hospital were conducted with regard to referral patterns. Further information was obtained from hospital and clinic records such as quarterly reports and registers.

CHAPTER 4: PRESENT THE RESULTS

4.1 Introduction

In this chapter the results of the study are described. The results are presented as follows:

4.1.1 The demographics of those who bypass their local PHC facilities

- Demographic details of the patients
- Profile of facilities bypassed

4.1.2 Multiple factors that may be influencing patients in terms of their decision to bypass PHC facilities

- Transport related factors (Mode of travelling, travelling costs, and travelling time to the bypassed clinic and to St Andrew's Hospital).

4.1.3 Multiple possible factors (e.g. staff attitude, physical state of the facility, its convenience, the availability of comprehensive services, and the lack of service at certain times of the day or on certain days of the week) that affect patients' choice of facility

- Clinics' operating times
- Waiting times
- Health care centre of choice
- Health care personnel of choice
- Accessibility of bypassed PHC facilities
- Facilities attended
- Disease profile of patients who bypassed their PHC facility
- Factors related to the ambulance service operations

4.1.4 Patients' knowledge, attitudes and beliefs about referrals and accessing the hospital or PHC facilities

4.1.5 Clinic headcounts

4.1.6 Recommendations

For the purpose of this study, people who were interviewed will be referred to as patients or participants. The participants will be regarded as a group that is representative of the population from the areas from which they come.

The findings are presented in tables and graphs and the results are also discussed in detail. A total of 720 questionnaires were analyzed.

4.2 Demographic Profile of the Participants

Seven-hundred-and-twenty patients were included in the study. No patient who met the inclusion criteria refused to participate in the study. Six-hundred-and-forty-four (89.4%) of participants were selected from Gateway clinic and seventy-six (10.6%) came from the hospital OPD. The demographic study included the age distribution of the participants, their gender, racial groups, and employment status, the places from which the patients are coming, and the type of accommodation in which they live.

4.2.1 Age distribution of the participants

The age distribution of the individuals that participated in the study is shown in Figure 4.2. This diagram is of assistance in comparing the age groups of the patients that visit St Andrew's Hospital without referral letters. The age group with the highest number of 450 (62.5%) patients to visit the hospital was the group between the ages of 24 and 60 years, 200 (27.8%) patients were between 18 and 23 years, and 70 (9.7%) patients were above 60 years.

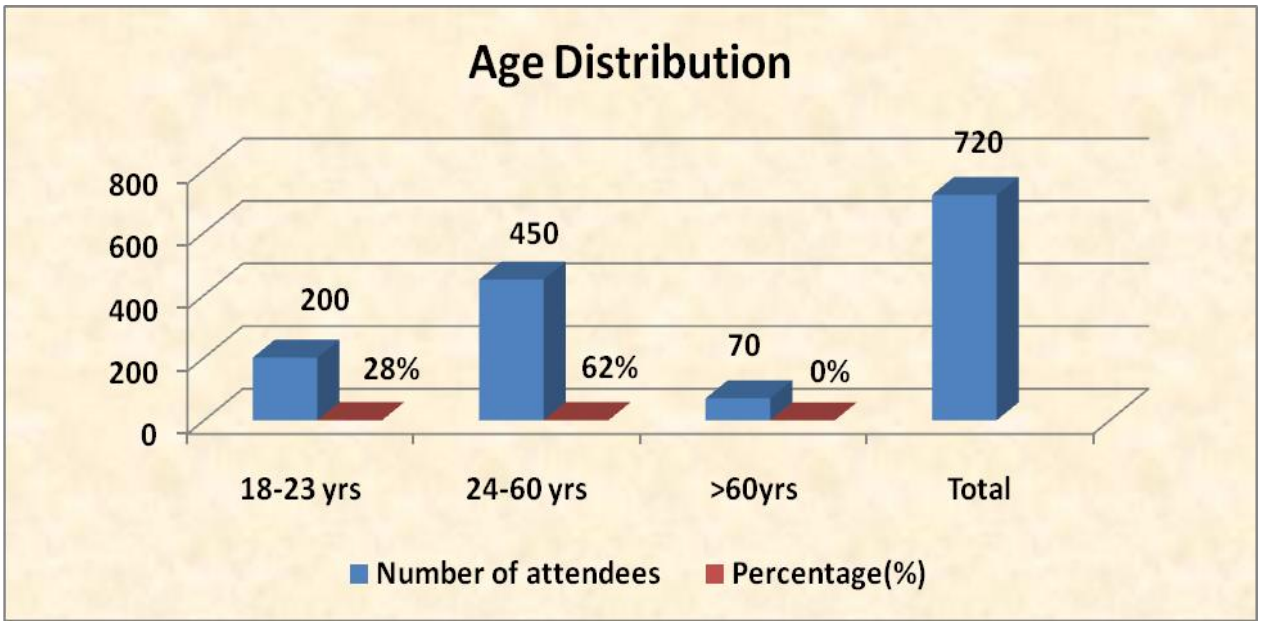

Figure 4.2 Age group of patients who participated in the study at St. Andrew's Gateway clinic and Out Patient Department.

4.2.2 Gender / Sex

The study reveals that 77% of the participants (i.e. 552 individuals) were female and 23% (i.e. 168 individuals) were male.

4.2.3 Racial groups

The catchment area is predominantly rural and has a population of 104,527. This population is distributed amongst the different races as follows:

- Africans: 100,648
- Coloureds: 1,733
- Indians/Asians: 1,741
- Whites: 406

Figure 4.3 shows the racial distribution of the participants. As can be seen, the population of the sub-district is predominantly African. The next largest racial group is the

Coloureds. The study also revealed that the majority of the patients who visit the Gateway clinic are Africans. Coloureds are the next most numerous. Whites and Indians form the minority of the population in the catchment area and no one of those two racial groups was selected for an interview.

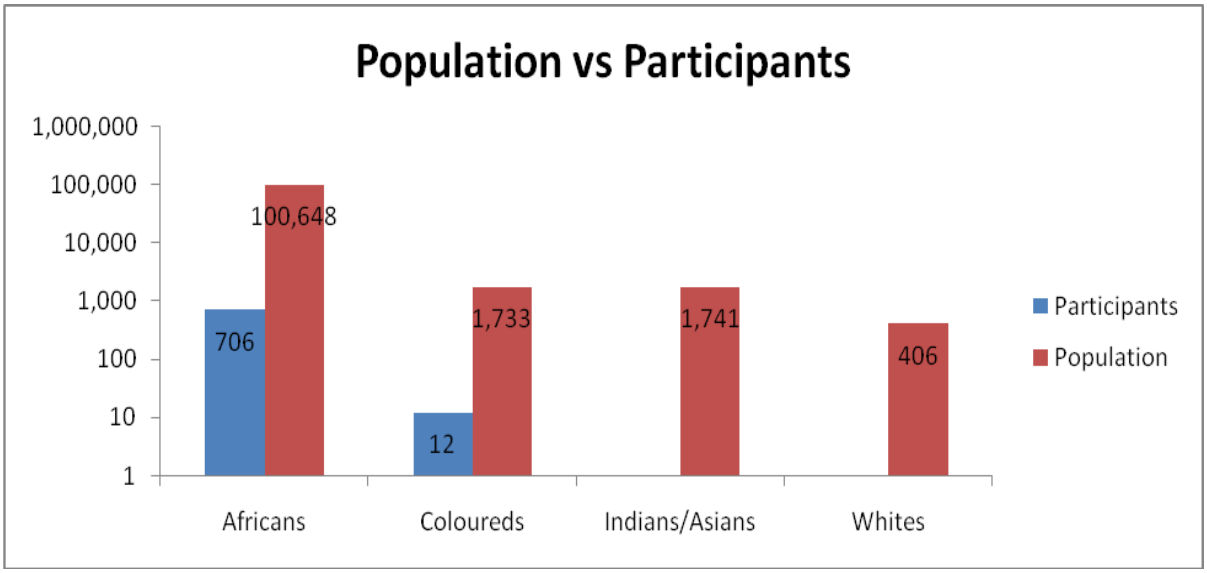

Figure 4.3 Racial groups

4.2.4 Employment status

Five–hundred-and-twenty-nine (i.e. 73.5%) of the patients who came to the hospital were unemployed and 191 (26.5%) were employed. As can be seen in Table 4.1 below, 97.9% of the employed patients were employed somewhere within the province of KwaZulu-Natal at the time of the study. Only two (1.05%) were employed in the EC and a further two (1.05%) were employed in other provinces. Ugu district, where St Andrew's Hospital is situated, had the highest number that is 166 (86.9%) of employed participants. Its neighbouring district of Sisonke had the second highest number, 13 (6.8%) of employed participants, while the other districts together had 11 (5.8%). Harding town had the

largest number, 167 (87.4%) of employed participants while 24 (12.6%) of the participants were employed in other towns.

Table 4.1 Place of employment

Place of employments	**Numbers (N=191)**	**Percentage (%)**
KZN	187	97.9
Eastern Cape	2	1.05
Other Provinces	2	1.05
Places of employment within KZN	**Numbers (N=187)**	
Ugu District	166	88.7
Sisonke District	13	7.8
Izinqoleni	1	0.53
Other Districts	7	3.7
Places of employment within the Ugu district	**Numbers (N=166)**	
Harding Town	165	99.4
Other towns	1	0.6

4.2.5 Type of occupation

The type of occupation in which the working patients are engaged is shown in Table 4.2. The biggest (36.6%) group is engaged in manual labour, either in the timber/forestry industry, as farm workers, as wholesalers or in shops loading and unloading stock. The nearest clinic for those involved in forestry and retail is the local government clinic in Harding. Farm workers can attend either fixed or mobile clinic points nearer to the farms where they work. Of the working participants, 22.5% are skilled workers (among them were teachers and other professionals from Harding). The teachers work in the local schools and other skilled workers work in town. All these people could easily go to the Harding LG clinic in town. A further 17.3% of the working group are domestic workers who work in homes in Harding otherwise they are from rural areas and their local clinics are fixed clinics or mobile clinics but they stay with their employers in Harding because

of work. Unskilled workers form 15.7% of the working group; they mostly work in shops and factories and their nearest clinic is also the LG clinic in Harding.

Table 4.2 Distribution according to type of occupation

Work category	Number of attendees N=191	Percentage (%)
Skilled	43	22.5
Unskilled	30	15.7
Manual	70	36.6
Domestic	33	17.3
Other	13	6.8
No response	2	1.05

4.2.6 Places from where sampled patients come

Out of the total number of patients who participated in the study, 708 came from KwaZulu-Natal while only 12 came from the EC. A distribution of the patients per district shows that the highest number, 590 (83.3%) of them came from the Ugu district, followed by Sisonke district with 118 (16.6%) patients. Of those who came from the Ugu district, 586 (99.3%) were from the Umuziwabantu sub-district and Harding town, while four (0.7%) were from the Izinqoleni sub-district and from other towns.

Table 4.3 Place of residence

Province	**Number N=720**	**Percentage (%)**
KwaZulu-Natal	708	98.3
Eastern Cape	12	1.7
KZN Districts	**Number N=708**	**Percentage (%)**
Ugu	590	83.3
Sisonke	118	16.7
Ugu District	**Number N=590**	**Percentage (%)**
Umuziwabantu	586	99.3
Izinqoleni	4	0.7
Towns	**Number N=590**	**Percentage (%)**
Harding	586	99.3
Other towns	4	0.7

4.2.7 Type of place and accommodation

The Umuziwabantu sub-district is predominantly rural and has only one town called Harding. Five-hundred-and-thirteen of the sample stays in rural areas. Harding is surrounded by residential houses and farms. About 142 (19.7%) of the sample (720) was from peri-urban areas and 64 of the sample was from urban areas. Out of eight clinics, excluding Gateway clinic, only one clinic – Harding's LG clinic – is situated in town while the rest are situated in rural areas.

Of the participants, 338 had houses, 118 had huts, 31 stayed in informal settlements, and just two had both a house and a hut. The rest of the participants (17) came from farm compounds, school residences, rented accommodation and employers' houses (where they are working as domestic workers). The study revealed that even those from rural areas own a house or some other type of accommodation.

Table 4.4 Type of place and accommodation

Type of Place	**Number N=720**	**Percentage (%)**
Urban	64	8.9
Peri-urban	142	19.7
Rural	514	71.4
TOTAL	**720**	**100**
Type of Accommodation	**Number N=720**	**Percentage (%)**
House & hut	212	29.4
House	338	46.9
Hut	118	16.4
Informal settlement	31	4.3
Hut and other	2	0.28
Other	17	2.4
No response	2	0.28
TOTAL	**720**	**100**

4.3 Profile of Bypassed Facilities

Of those who bypassed PHC facilities and attended the Gateway clinic and the hospital, 208 of patients bypassed the mobile clinics in Umuziwabantu sub-district, 71 patients bypassed Santombe mobile point, 51 bypassed kwaMbotho mobile point and 23 bypassed the Ocingweni mobile point.

The second highest group, 196 patients bypassed the Harding LG clinic, which is 1 km from St Andrew's Hospital. Of this group, 102 came from the informal settlement called Mazakhele.

The third highest group (118) which bypassed their PHC clinics came from the Sisonke health districts. Of this group of patients, 27 bypassed the Gugwini clinic, 24 the Rietvlei mobile clinic, 17 the Rietvlei fixed clinic, and eight the Gounlea clinic.

One-hundred-and-six patients (14.7%) by passed residential clinics in the Umuziwabantu sub-district. Of this group 42 patients bypassed Pisgah clinic, 39 patients bypassed the Mbonwa clinic and 25 patients bypassed the Meadow Sweet clinic. A very small number of patients (4) came from other sub-districts such as Izinqoleni.

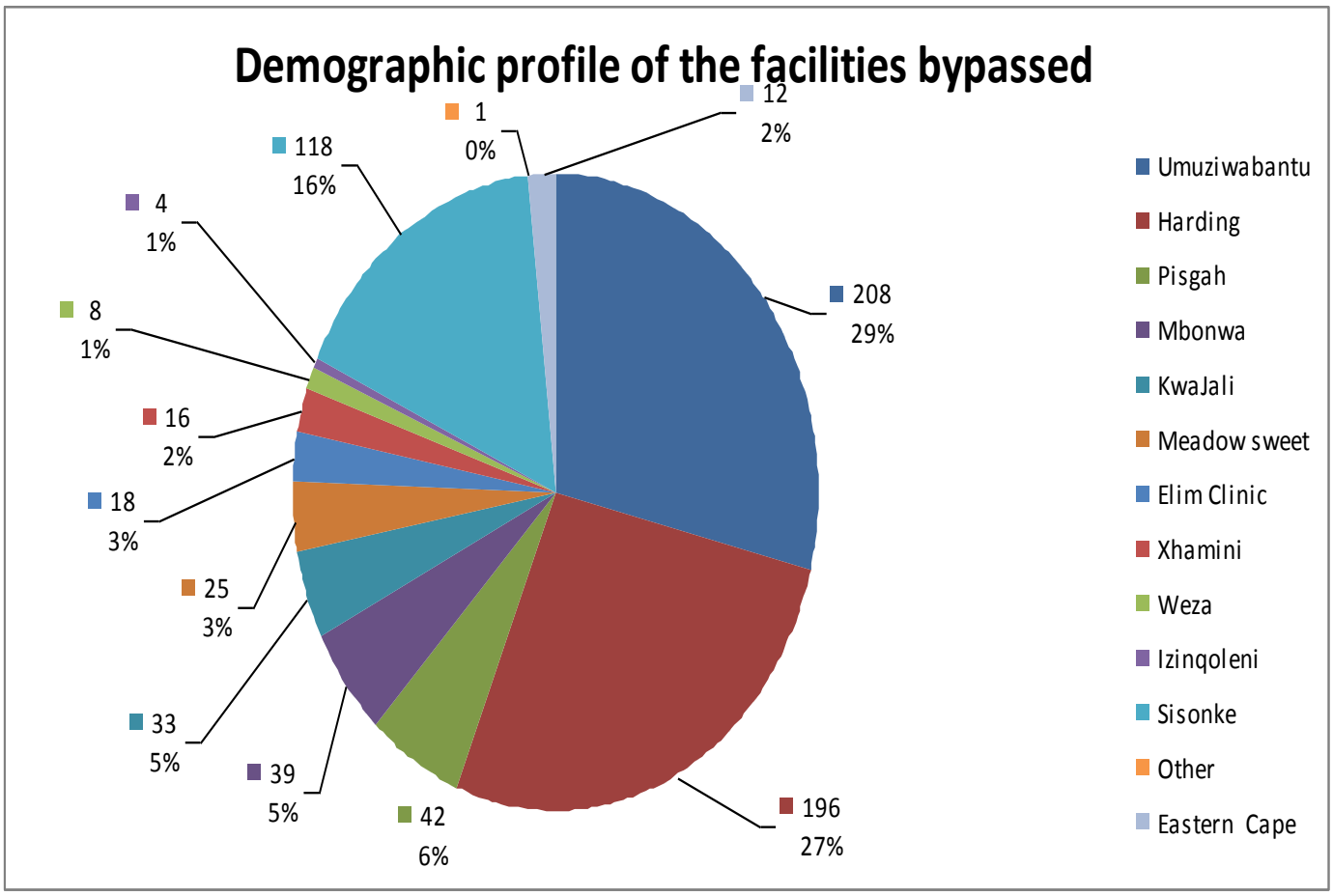

Figure 4.4 Profile of the facilities bypassed

4.4 Transport-related Factors

4.4.1 Mode of travelling to health facilities

Table 4.5 shows the mode of travel to both bypassed facilities as well as to St Andrew's Hospital. Four-hundred-and-ninety-seven of participants were able to walk to the bypassed facilities, while 164 patients were able to walk to the hospital. Five-hundred-and-thirty-eight patients to visit St Andrew's Hospital reported using public transport. Of the patients who walk to the hospital, the highest number came from urban and peri-urban areas. All those who came from rural areas used public transport to reach St Andrew's Hospital. Very few used their own transport to reach either the PHC facilities or St Andrew's Hospital. Other means of transport include employers' cars and 'bakkies' (i.e. small trucks with open backs), which are not considered as public transport.

Table 4.5 Mode of travelling to health facilities

Facilities	Walking	Public transport	Own transport	Other
Bypassed facilities	497	150	12	61
St Andrew's Hospital	164	538	14	4

4.4.2 Transport costs

One-hundred-and-thirteen of the patients surveyed paid less than ten Rand when using public transport to travel to PHC facilities. Thirty-three of the participants paid between ten and twenty Rand, three paid between twenty and thirty Rands and one paid more than thirty Rands.

Five hundred and thirty eight of the patients who participated in the study made use of public transport in order to reach St Andrew's Hospital, 127 of them paid less than ten Rand in transport cost to travel to the hospital, 383 (53.2%) paid between ten and twenty Rand, 21 paid between twenty and thirty Rand and seven paid more than thirty Rand.

Table 4.6 Public transport costs

Facilities	< R10.00	R10-R20	> R20-R30	> R30
Bypassed facilities	113	33	3	1
St Andrew's Hospital	127	383	21	7

4.4.3 Transport operating times

Table 4.7 shows the operating times of public transport to and from the Primary Health Care facilities. Transport to both the PHC clinics and the St. Andrew's hospital starts at 05h00. Two-hundred-and-eight-seven patients stated that during operating hours, more minibus taxis are provided by which people can reach the hospital. Sixty four patients stated that less minibus taxis are provided by which people can reach the clinics. Patients going to the hospital benefit from the large number of vehicles available for transporting workers and school children to Harding and its surrounds. According to 79 patients going to the clinics there is plenty of minibus taxis between 07h00 and 08h55, while 221 patients stated that the number of available minibus taxis to reach St Andrew's Hospital diminishes slightly. During the day the transport to both the clinics and the hospital is reduced in the late morning hours (i.e. between 09h00 and 11h00).

Transport away from all clinics and the hospital is available earlier than 10h00 but it is reduced between 10h00 and 12h00. It increases again between 12h00 and 15h00, most likely in order to accommodate shoppers. It is again reduced between 15h00 and 16h00 but becomes more available after 16h00 so as to accommodate workers who are returning home. This suggests that patients have enough transport to and from the hospital.

Table 4.7 The earliest transport times to and from the health facilities

Transport to the health facilities					
Facilities		05h00-6h55	07h00-8h55	09h00-11h00	Later than 11h00
Bypassed facilities		64	79	11	0
St Andrew's Hospital		287	221	24	2
Transport from the health facilities					
Facilities	Earlier than 10h00	10h00-12h00	12h00-15h00	15h00-16h00	Later than 16h00
Bypassed facilities	34	24	50	18	26
St Andrew's Hospital	100	68	189	68	106

4.4.4 Travelling time

Table 4.8 shows how long the patients surveyed had to travel between their residences and the health facilities. Four hundred-and-thirty-two of patients take less than an hour to travel between their residences and the clinic and 517 patients take less than an hour to travel between their residence and the hospital, albeit by walking or using public transport. One-hundred-and-seventy patients travelled between one to two hours to travel between their residence and bypassed facilities, 178 patients travel between one to two hours to the hospital 18 patients travelled two to three hours to the clinics and 14 patients travelled between two to three hours to the hospital. Three patients travelled three to four hours between their residence and their clinics. Three patients travelled three to four hours to the clinics and two patients travelled between three to four hours to the hospital. Though the higher number of patients came from rural areas, very few travelled more than three hours. This suggests that neither travelling time nor cost of transport is factor preventing patients from travelling to the hospital if they so choose.

Table 4.8 Time taken to reach the bypassed clinic using the travelling mode

Facilities	<1hr	1-2hrs	2-3hrs	3-4hrs	Do not know / No response
Bypassed facilities	432	170	18	3	97
St Andrew's Hospital	517	178	14	2	9

4.5 Factors Related to Clinic Operating Times

Table 4.9 shows the information that was gathered regarding clinic operating times and the convenience of the starting times. The participants gave different times when asked about the starting times of each of the clinics, which suggests that some of them do not actually know what time the clinics start to operate. One-hundred-and-ninety-six patients mentioned that their clinics start to operate between 07h00 and 08h00, 166/605 considered that time as convenient while 30/605 felt that it is an inconvenient time. Two-hundred-and-twenty-one patients mentioned that their clinics start to operate between 08h00 and 09h00; 169/605 patients were comfortable with that time but 52/605 felt that it is an inconvenient time. Seventy-one patients stated that their clinics start to operate between 09h00 and 10h00; 56/605 patients were comfortable with that time but 15/605 felt that it is an inconvenient time. Fifty-one patients stated that their clinics start to operate between 10h00; 37/605 patients were comfortable with that time but 14/605 felt that it is an inconvenient time. Only a small group (66) stated that their clinics start to operate from 11h00 onwards. Thirty-one patients still considered this a convenient time, while 35 patients regarded this time as inconvenient.

Those participants that are using fixed clinics stated that their clinics start to operate anytime between 07h00 and 10h00. All those who stated that their clinics start to operate from 10h00 onwards use mobile clinics. About 115 of the surveyed group did not know their clinics' operating times.

Table 4.9 The earliest time the bypassed clinic starts to operate

Time	07h00-08h00	08h00-09h00	09h00-10h00	10h00	11h00 and later	Do not know / No response	Total
Number	196 (27.2%)	221 (30.7%)	71 (9.9%)	51(7.1%)	66 (9.2%)	115 (16%)	720
Convenient	166 (166/605 =27.4%)	169 (169/605 =27.9%)	56 (56/605= 9.3%)	37 (37/605= 6%)	31 (31/605= 5.1%)	N/A	459
Inconvenient	30 (30/605= 5%)	52 (52/605= 8.6%)	15 (15/605= 2.5%)	14 (0.2%)	35 (35/605= 5.8%)	N/A	146

*Total number of patients responded by giving time the clinic start to operate in table 4.9 was 605

4.5.1 Reasons that cause the time to be inconvenient

Six-hundred-and-five patients gave reasons that cause a clinic starting time to be inconvenient. The researcher predicted that the reasons would relate to transport, work and personal issues. Only 39 patients out of 605 patients mentioned reasons pertaining to the above factors; while 566 patients stated other reasons. The top four reasons that were mentioned were: (1) the clinic starts late and the staff does not end up attending to all the patients (43 patients); (2) the waiting time is too long (24 patients); (3) the patients come early and have to wait for the nurses (14 patients); and (4) there are too many patients (14 patients).

The following problems, as related by the patients, relate to the clinics starting late:

- Patients are inconvenienced because they want to go home early in order to continue with their household chores.
- The patients are late to school when they have to go the clinic.

- The clinic does not accept latecomers.
- Mobile nurses are rushing to get back home and therefore rush through the patients so as to finish early.
- It is late when someone is very ill and needs emergency care or knows he/she will be referred to the hospital.
- The patients accumulate until there are too many and the nurses can no longer cope.

The problems related to a too-long waiting time and to patients coming early in order to wait for the nurses included:

- Waiting outside closed gates.
- Waiting in unfavourable weather conditions, such as sun, cold and rain.
- Waiting too long while very sick.
- Nurses socialising when they arrive instead of promptly beginning to work.
- Nurses having their breakfast or tea before attending to patients.
- Patients, especially children, becoming hungry.

Other clinics have many patients and if the clinic starts late the following problems are often encountered:

- Patients accumulate and the patients become too many for the nurses available.
- Some of the patients are sent home and told to come back the following day.
- Some of the patients do not receive any treatment.

Table 4.10 Reasons that cause the time to be inconvenient

Reason	Number
Transport	9
Work	21
Personal	9

Others reasons:	**566**
The clinic started late and its staff ended up not attending to all the patients	43
There was too long a waiting time involved	24
The patient came early and had to wait for the nurses	14
There were too many patients	14

4.5.2 Starting time recommended by the patients and their reasons

The starting times recommended by the patients ranged from earlier than 07h00 to 11h00. One-hundred-and-forty-nine-patients did not give reasons for the times they recommended. Table 4.11 shows the times recommended by the patients, excluding those who did not give reasons for their recommendations. Two-hundred-and thirty-three (40.8%) recommended 08h00 as a good starting time, 194 patients (33.9%) recommended 07h00. The last starting time that was recommended was 11h00. Only the top ten reasons given by the patients will be discussed.

Table 4.11 The time clients would prefer the clinic to start operating

Time recommended	**Number N=571**	**Percentage (%)**
Earlier than 07h00	25	4.4
07h00	194	33.9
08h00	233	40.8
09h00	61	10.7
10h00	45	7.9
11h00	13	2.3

* One-hundred-and-forty-nine patients did not respond to the question

One-hundred-and-forty-one patients gave similar reasons for the times they recommended. Many of the patients who supported their choices with reasons were among those who recommended a starting time of 07h00 or 08h00.

Reasons for a 07h00 starting time included:

- The patients want to be done at the clinic early so they can make it to work on time (15patiens).
- The patients are already at the clinic by this time, so the nurses must start attending to them (14 patients).
- The nurses will be able to see to all the patients if they start early and nobody will have to be sent back home without having received treatment (12 patients).
- This starting time will assist nurses in coping with the many patients (10 patients).
- If they start early, the waiting time will be reduced (7).
- They want to be attended to early (6).

Reasons for an 08h00 starting time included the following:

- This time is convenient for both the staff and the patients (55patients).
- The patients want to be seen at the clinic and then be able to go on and do other things (10).
- This starting time will allow the nurses time to travel to the clinics (6).
- This time is convenient with regard to public transport (6).

4.5.3 Factors relating to the registration of patients

This study also aimed to determine the times when the clinics stop registering patients since there was an assumption on the part of the researcher that some patients are being turned away from the clinic, irrespective of the time of the day, after a certain number of patients have been registered. There were also rumours that some clinics close as early as 13h00, yet nurses are expected to see all the patients that come to them for help. Table 4.12 shows the times when patient registration at the clinics stops and it also shows whether or not that time is considered to be convenient.

Five-hundred-and-eight-four patients responded to the question regarding the times that registration stops and 63 patients did not respond to this particular question. Seventy three patients stated that they did not know what time registration stops, 16 patients stated that registration stops earlier than 08h00. Two-hundred-and-sixty-six patients stated that patient registration at their clinics does not stop and that the time was therefore convenient, 49 patients stated that their clinics stop registration between 08h00 and 10h55, 52 patients stated that their clinics stop registration between 11h00, 157 patients stated that their clinics stop registration between 13h00 and 16h00 and 18 patients stated that their clinics stop registration later than 16h00. The last group of 26 patients stated that their clinics use a number system: as soon as a certain number of patients have been registered they stop registration and those patients who are not registered go back home and try the following day or go to other clinics.

Table 4.12 Time registration stops

Time	Earlier than 08h00	08h00-10h55	11h00-12h55	13h00-16h00	Later than 16h00	Does not stop	Number system	Do not know	No Response
N=720	16(2.2%)	49 (6.8%)	52 (7.2%)	157 (21.8%)	18(2.5%)	266 (36.9%)	26 (3.6%)	73 (10.1%)	63 (8.8%)
Convenient	16	36	23	110	17	265	2	N/A	N/A
Inconvenient	0	14	29	37	1	1	24	N/A	N/A

4.5.4 Inconveniences caused by stopping registration

Patients who stated the times when registration stops as inconvenient gave various reasons for their comments. The most common reasons that were stated are the reasons the researcher regards as possible causes of inconvenience. Out of the 584 patients who responded, 555 of them provided reasons that were different from the assumptions made by the researcher (namely, that they were related to transport, work and personal issues).

Only six of the participants stated transport-related reasons, 12 stated work-related reasons, and 11 stated personal reasons.

The group that stated other reasons mentioned the following problems:

- The time that registration stops means patients have to return home having not been treated even though they have already travelled to the clinic (35).
- The patients who come after lunch are not attended to (7). Registration at these clinics probably stops between 13h00 and 16h00
- Patients wait too long because of the registration process (3). These patients are affected by the number system; patients often come as early as 05h00 in order to be the first in the queue so that they receive a number before registration stops
- The clinic takes only 20 patients a day (2).
- The clinic arrives late and stops registration early (2).
- Registration stops while there are patients who still need help (2).
- There are still patients waiting to be attended to after 16h00 (2).

4.6 Factors Related to Waiting Times

4.6.1 Waiting times at the bypassed facilities

Long waiting times is one well-known reason that makes the patients avoid certain health care facilities. The study wanted to determine how long patients have to wait at their local PHC clinics. The times were grouped into three groups, namely less than one hour (< 1 hr), from one to three hours (1-3 hr), and more than three hours (> 3 hr). The researcher wanted to determine whether or not the hours mentioned were felt to be convenient or inconvenient. Table 4.13 shows the waiting times as given by patients from various clinics. Fifty-three (7.4%) of the patients either did not know the waiting time or did not respond to the questions. All the patients were in fact estimating the waiting times since no survey was conducted in order to ascertain the precise waiting times at the various clinics.

Three-hundred-and-eight (42.8%) of the patients stated that they wait less than an hour before the nurses attend to them, 293 of 308 (95%) of them stated that waiting less than an hour is convenient, while 15 (4.9%) stated that it is not convenient. The second group of 300 (41.7%) said that they have to wait between one and three hours. In the second group, 128 (128/300=42.7%) patients stated that this waiting time is convenient while 172 (172/300=57.3%) patients said this waiting time is inconvenient. The last group of 59 (8.1%) patients stated that they wait more than three hours; 56 (56/59=94%) of them said such waiting time is not convenient and three (3/59=5.1) said that such a waiting time is convenient.

Table 4.13 Waiting time at the bypassed facilities

Time	Less than 1 hr	1-3 hr	More than 3 hr	Do not know / no response	Total
Number N=720	308 (42 8%)	300 (41.7%)	59 (8.1%)	53 (7.4%)	720
Convenient	293 (293/308=95.1%)	128 (128/300=42.7%)	3 (3/59=5.1%)	n/a	424
Inconvenient	15 (15/308=4.9%)	172 (172/300=57.3%)	56 (56/59=94.9%)	n/a	243

4.6.2 Inconveniences caused by waiting times

Two-hundred-and-forty-three patients stated that the waiting time was inconvenient and stated their reasons for that. The researcher thought that the inconveniences caused by long waiting times was going to be connected to transport-related, work-related and personal issues, but 178 (73.3%) of the 243 patients stated other reasons. Of the inconveniences mentioned, 11(11/243=4.5% of the patients gave reasons related to transport, 45 (45/243=18.5%) to work, and nine (9/243=3.7%) to personal issues. (The

researcher concentrated on the reasons that cause waiting time of more than three hours to be inconvenient.)

A waiting time of more than three hours causes the following inconveniences:

- The waiting time is too long for very sick and elderly patients (28).
- The patients are kept from going home early where they need to carry on with their other tasks (20).
- The waiting time is too long for people who are in pain (16).
- The long waiting time is caused by the nurses, who are very slow (8).
- The patients come very early, that is why others had to wait so long (3).
- People who do not need specialist treatment wait longer because nurses start with those patients in need of treatment by special clinics (3).

Twenty patients stated that a waiting time of more than three hours is just too long, but they did not state any reasons for this statement.

4.6.3 Waiting times recommended by the participants

Six-hundred-and-thirty-one patients recommended the waiting times that they think will be more convenient and will be able to resolve the above-mentioned issues. Eighty-nine (12.4%) of the participants did not contribute to the recommendations. Those that did produced the following results:

- Four hundred and eighteen (58.1%) patients recommended a waiting time of less than 30 minutes.
- One hundred and ninety one (26.5%) patients recommended half an hour to one hour.
- Twelve (1.7%) patients recommended one to two hours.
- Ten (1.4%) patients recommended other times

4.7 Health Care Centre of Choice

4.7.1 Place preferred

The patients were also asked where they wish to be treated and to give reasons for their choices. Patients were given four options from which to choose, namely the clinic, the hospital, private doctors, and traditional healers. Table 4.14 shows the health centres of choice. Reasons that the researcher considered as possible or likely included ease of access, proximity, drugs, the competence of the staff, and the attitude of staff. Three-hundred-and-sixty-four (50.6%) of the patients prefer to be treated at the hospital, while 214 (29.7%) patients prefer clinic treatment. The third largest group of 101 (14.02%) of patients prefer to be treated by private doctors, whilst only one (0.14%) patient indicated that his preferred choice would be traditional healers. Just 5.6% did not respond.

4.7.2 Reasons given for preferred choice

Other patients gave more than one reasons for their choice hence the number of patients will not be the same with number of reasons stated.

- **Easy access:** Ninety-nine patients preferred to be treated at the clinic because it is easy to access, 83 said it is easy to access the hospital and 22 patients said it is easy to access private doctors.
- **Nearest:** Forty-one patients stated that the clinic is the nearest centre, while 39 stated that the hospital is the nearest centre.
- **Drugs issued:** One-hundred-and-ten of the patients prefer to be treated at the hospital because of the drugs they obtain from the hospital, 25 of the patients prefer private doctors for the same reason and 22 patients prefer to be treated at the clinics because of the drugs they get there.
- **Staff competence:** Eighteen patients who based their choices on the competence of the staff prefer to go to the hospital, (they believe that doctors are more

competent than nurses, three preferred to go to the clinics and two preferred to go to the private doctors

- **Staff attitude:** Eighteen patients who based their choices on attitude prefer to go to hospital, four patients preferred to go to the clinics and three patients preferred patients preferred to go to the private doctors.

4.7.3 Other reasons given for preferred choice

The following reasons were not on the questionnaire but came from patients without probing them:

Clinics: Those who prefer clinics stated the following reasons for their choice:

- The clinics provide a free service (20).
- The clinic is the first level of care (16).
- They provide a good service (4).
- They can refer patients to hospitals (4).
- Hospitals want a referral letter (3).

Hospital: Those who preferred hospital stated the following reasons:

- All services are available (33).
- Better service and good treatment and care (12).
- Doctors are always available (7).
- The hospital is well equipped (6).
- The hospital admits patients (6).
- The hospital provides a speedy service (5).
- The mobile clinic does not come everyday (5).
- The hospital is cheaper than private doctors (5).

Private Doctors: The reasons for preferring private doctors were:

- They provide a fast service (14).
- There is a short waiting time involved (8).
- They provide a better service (4).

- They understand patients' needs (3).
- They provide the best care (3).

Table 4.14 Health care centre of choice

Place	Clinic	Hospital	Private doctor	Traditional healer	No response
Number N=720	214 (29.7%)	364 (50.6%)	101 (14.02%)	1 (0.14)	40 (5.6%)
Reasons *					
Easy access	99	83	22	0	n/a
Nearest	41	39	0	0	n/a
Drugs Issued	22	110	25	1	n/a
Staff competence	3	18	2	0	n/a
Staff attitude	4	18	3	0	n/a
Other	48	112	39	0	n/a

* Reasons do not correspond with the number of patients in each column because each patient could give more than one reason

4.8 Choice of Personnel

Another assumption on the part of the researcher was that patients bypass their Primary Health Care clinics because they want to be treated by doctors. Six-hundred-and-ninety-six of the patients responded to this particular question and 24 patients did not. Of those that did respond, 514 patients prefer to be treated by hospital doctors and 182 patients prefer to be treated by PHC nurses. The researcher was under the assumption that the patients would base their choices on the staff's degree of medical knowledge, on the type of drugs issued, and on the attitudes of the staff. Patients were given the opportunity to state other reasons if they had any. Table 4.15 shows choice of personnel and possible

reasons as provided by the researcher. Some patients gave more than one reason of their choice therefore number of patients does not correspond with the number of reasons given by patients.

Staff knowledge: Three-hundred-and-ninety-one patients preferred to be treated by doctors because of the doctors' knowledge, while only 32 of the patients prefer to be treated by PHC nurses for the same reason.

Type of drugs: One-hundred-and-five patients – in this category prefer to be treated by doctors because of the good quality or number of drugs doctors issue-discuss while only four prefer to be treated by PHC nurses because of the good quality and quantity of drugs PHC nurses issue-discuss.

Staff attitude: Forty-eight of the patients prefer to be treated by doctors because of the good caring attitude they get from doctors and only eighteen patients want to be treated by PHC nurses because of the good caring attitude of PHC nurses.

Table 4.15 Choice of personnel

Personnel	PHC nurse	Hospital doctor	No response
Number N=696	182 (26.1%)	514 (73.9%)	24
Reasons*			
Staff knowledge	32	391	N/A
Type of drugs	4	105	N/A
Staff attitude	18	48	N/A
Others reasons	132	40	N/A

*Reasons given by patients do not correspond to the number of patients because each patient could give more than one reason.

One-hundred-and-eighteen patients gave other reasons other than those out forward by the researcher. The researcher selected the top seven of these additional reasons. One-

hundred-and-twelve of those who stated other reasons prefer to be treated by PHC nurses and only six prefer to be treated by hospital doctors. The reasons they gave for their choices were as follows:

- **Availability of staff:** Forty-two (35.6%) respondents preferred to be seen by PHC nurses because they are always available.
- **Communication:** Thirty-five (29.7%) respondents preferred PHC nurses because it is easy to communicate with them as they speak their language.
- **First contact:** Eighteen (15.3%) respondents believe that one needs to contact a PHC nurse before one can be seen by a doctor.
- **Patient care:** Ten (8.5%) respondents believe that PHC nurses provide better care or that they are more caring.
- **Referral pattern:** Seven (5.9%) respondents preferred to be seen by nurses because they can still refer them to the doctor if there is the need.
- **Examination:** Six (5.1%) respondents preferred hospital doctors because they conduct a thorough examination of each patient.

4.9 Perceptions of the Participants

The perceptions of patients on medication, and the attitude of Primary Health Care staff and of hospital staff towards patients were investigated. The researcher wanted to know whether or not the patients are satisfied with the quality, number and type of medications being issued by PHC staff.

4.9.1 Medication

Six-hundred-and-seventy-one of the patients surveyed responded to the questions concerning medication. Of these 479 (66.5%) patients stated that they are satisfied with the medications issued by PHC nurses, while 192 (26.7%) stated that they are dissatisfied. Table 4.16 as well as the list show the reasons the patients provided as to

why they are dissatisfied with the medications currently being issued by PHC nurses. Reasons included:

- Reasons related to the quality of medications-poor quality (36 patients)
- Reasons related to the number of drugs (91 patients). The patients are given few medications and sometimes none and they are told to buy the necessary medications themselves from a private pharmacy.
- The type of medication (38 patients) that is given is not effective.
- Other reasons (33 patients).

Some patients gave more than one reasons therefore number of patients does not correspond with the number of reasons given by patients.

Table 4.16 Attitude of patients towards the medications issued by PHC nurses

Attitude	Satisfied	Dissatisfied	No response
Number N=720	479 (66.5%)	*192 (26.7%)	49 (6.8%)
Reasons			
Quality of the medicine	n/a	36	N/A
Number of drugs issued	n/a	91	N/A
Type of medicine	n/a	38	N/A
Others reasons	n/a	33	N/A

**Number of patient does not correspond with number of reason s because some patients gave more than one reasons*

4.9.2 Staff treatment

Table 4.17 shows the attitudes the patients have towards PHC and hospital staff. Five-hundred-and-thirty-one patients were satisfied with the way they were treated by the clinic staff, 131 patients were not satisfied and 58 patients did not respond to the question. Six-hundred-and-thirty-one patients were satisfied with the way they were

treated by hospital staff, 39 patients were not satisfied and 50 patients did not respond to the question.

The majority of the patients are satisfied with the way they are treated by both clinic and hospital staff. Six-hundred-and-sixty-two (91.94%) of them responded to the questions on patient treatment by PHC staff, while 670 (93.1%) responded to the questions concerning patient treatment by hospital staff. There are those who are not satisfied with the treatment received by both categories of staff. Those who are not satisfied gave various reasons. Table 4.17 shows the attitude the patients towards treatment they get from PHC and hospital staff. .

Table 4.17 Attitude of patients towards treatment by PHC and Hospital staff

Facility	Satisfied	Dissatisfied	No response	Total
Bypassed clinic	531 (73.8%)	131 (18.2%)	58 (8.1%)	720
Hospital	631 (87.6%)	39 (5.4%)	50 (6.9%)	720

Primary Health Care staff

Seventy-four-percent of the patients indicated that they were satisfied with the services provided at the bypassed clinic while 18% of the patients indicated that they were not satisfied with the treatment they receive from PHC staff. Of those who were dissatisfied the following reasons were given:

- They are scolded and shouted at by the staff and staff members are very harsh with them (38 patients).
- They complained about staff rudeness (24).
- The staff have a bad attitude (21).
- They receive poor patient care (9).
- There is no confidentiality (7) (nurses discuss their illnesses in front of other patients and they also examine them without providing them with any privacy).

- They complained about the long waiting times at PHC clinics (7).
- The nurses are too slow (6).
- Some patients are sent home without having received any treatment from the nurses (4)

Fifteen patients did not give reasons for their dissatisfaction with the treatment they received from the PHC staff.

Hospital staff

Of those (5.4%) who were not satisfied with hospital staff the following reasons were given:

- Long waiting time (8).
- Poor patient care (6).
- They are scolded by the nurses (4).

Twenty-one patients did not give reasons for their dissatisfaction with the treatment they received from the hospital staff.

4.10 Accessibility of the Bypassed PHC Clinic

The researcher wanted to determine whether or not the accessibility of the PHC facilities contributes towards patients bypassing them and so considered possible reasons such as inclement weather, poor transport, bad roads and flooded rivers. Patients were also given the opportunity to state other reasons if there had any. They were therefore asked if there are days when they cannot reach their local PHC clinics and were asked to choose reasons as predefined by the researcher as well as state any other reasons. Six-hundred-and-thirty-seven (88.5%) of the surveyed patients responded and 83 (11.5%) patients did not respond. Two-hundred-and-one (27.9%) of them stated that they usually access their clinics, while 436 (60.6%) stated that they sometimes fail to reach their clinics.

Two hundred and twenty two patients stated that bad weather sometimes prevents them from reaching their clinics, 57 said that poor transport or transport flow is the cause of them sometimes failing to reach their clinics, 34 patients stated that bad roads and seven patients stated that rivers (especially on rainy days) make it difficult for them to access their clinics. One hundred-and twenty-three patients gave other reasons which cause them sometimes fail to access their clinics fail.

Some patients gave more than one reason therefore number of patients does not correspond with the number of reasons given by patients.

Table 4.18 Accessibility of the bypassed clinic

Accessibility	Usually	Sometimes	No response
Number N=720	201	436	83
Reasons			
Bad weather	n/a	228	n/a
Transport	n/a	57	n/a
Road	n/a	34	n/a
River	n/a	7	n/a
Others reasons	n/a	123	n/a

Patients gave various other reasons as to why they fail to reach their clinics. These included factors such as:

- **Availability of the clinic:** Mobile clinics are not always available as they only come on certain days of the month (55).
- **Operational days:** Some clinics do not open on weekends and public holidays (21).
- **Work- and school-related problems:** Clinics' operating times make it difficult for patients to come for help (19).
- **Sickness:** When one is too sick it becomes impossible to walk to the clinic (6).

- **Distance:** The clinics are too far (3).
- **Schools:** Schools refuse to let scholars miss classes in order to visit the clinic (2).
- **Number system:** Patients cannot be seen due to the number system (2).
- **Time:** If one is sick after 16h00, the clinic is then closed (2).

4.11 Facilities Attended by the Participants when seeking health-related assistance

The researcher wanted to determine the types of facilities usually attended by patients when seeking health-related assistance. The study also sought to determine the names of the facilities they usually attend (which are not necessarily their local facilities). According to Table 4.19, 420 (58.3%) of patients indicated that they usually go to PHC clinics while 239 (33.2%) indicated that they always go to the hospital when in need of medical attention and 61 (8.5%) of the patients did not respond to these questions.

Table 4.19 Type of facilities that are attended by the participants.

	Number N=720	Percentage (%)
PHC	420	58.3
Hospital	239	33.2
No response / Not applicable	61	8.5

Table 4.20 shows the names of the clinics most frequently attended. A total of 233 (32%) frequently attend St. Andrew's hospital; 152 (21.1%) attend Gateway clinic and 60 (8.3%) attend Harding L.G. clinic. Twenty-three (3.2%) attend KwaJali clinic; 21 (2.9%) attend Santombe Mobile clinic, 17 (2.4%) attend Mbonwa clinic, 16 (2.2%) attend Pisgah clinic and 15 (2.1%) attend Meadow Sweet clinic. Twelve (1.7%) of the surveyed patients attend Elim clinic, ten (1.4%) attend Mbotho mobile clinic and nine (1.25%) attend other mobile clinics in the Umuziwabantu sub-district. Eight (1.1%) patients attend Xhamini clinic and seven (1%) attend Weza clninc. Of those who were from the Sisonke

sub-district nine (1.25%) attend Gugwini's fixed clinic; six (0.8%) attend Rietvlei's fixed clinic and four (0.6%) attend Gounlea's clinic. There are few patients (1%) who attend Weza fixed clinic, which is 22 km from the hospital

Table 4.20 Names of the facilities most attended by the participants

Name of the facility	Number N=720	Percentage
St Andrew's Hospital	233	32.4
St Andrew's Gateway clinic	152	21.1
Harding TL clinic (municipal)	60	8.3
KwaJali clinic	23	3.2
Santombe mobile clinic	21	2.9
Mbonwa clinic	17	2.4
Pisgah clinic	16	2.2
Meadow Sweet clinic	15	2.1
Elim clinic	12	1.7
Mbotho mobile	10	1.4
Gugwini clinic	9	1.25
Other mobile clinics	9	1.25
Xhamini clinic	8	1.1
Weza Clinic	7	1
Rietvlei clinic	6	0.8
Gounlea clinic	4	0.6
No response	118	16.4

4.12 Referral Pattern

4.12.1 Reasons for the visits

The present study wanted to determine whether or not the referral policy is being implemented and it also wanted to determine the type of illnesses the patients are

presenting with in order to ascertain whether or not those illnesses cannot be managed at a PHC level. The patients were therefore asked the reasons of that day's visit in order to discover the type of illness that caused them to come seek medical attention. Figure 4.4 shows the disease profile of the patients who participated in the study. Only the top ten reasons were captured and 70% of those conditions can be managed at PHC clinics. The remaining 30% require a further medical opinion.

List of patients who could be managed at PHC level (70%):

- Three-hundred-and-sixty-one (50.1%) of the patients presented with minor sicknesses (such as headache, cough, stomach-ache and common cold.)
- Ninety-five (13.2%) presented with chronic illnesses (such as follow up visit for high blood pressure, ARV treatment and diabetes mellitus).
- Sixty-six (9.2%) were mothers who had brought their babies for immunisation.
- Thirty-five (4.9%) were women who came for family planning (FP).
- Fifteen (2.1%) came with injuries that could have been managed at PHC level.
- Twelve (1.7%) of the patients came for antenatal care (ANC).
- Seven patients (0.97%) came for voluntary counselling and testing for HIV (VCT).

List of patients who needed medical intervention but did not bring referral letters or appointment letters (30%).

- Twenty (2.8%) patients came for laboratory test
- Eighteen (2.5%) came to see the dentist
- Twelve (1.7%) came to see eye doctor.

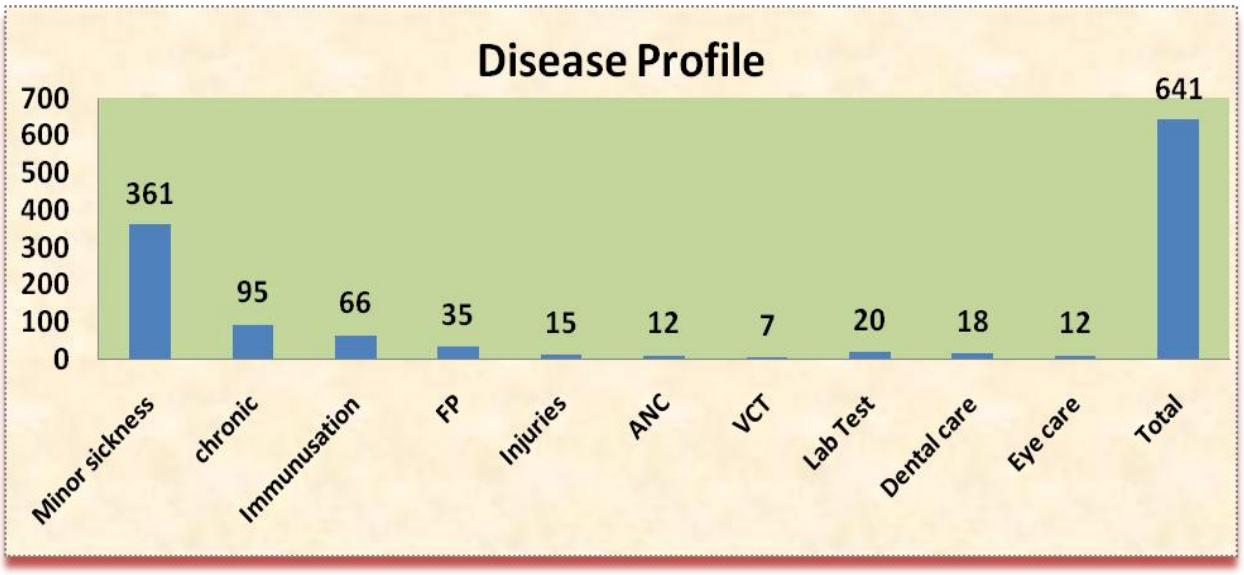

Figure 4.5 Reasons for visits

4.12.2 Referrals

During the survey the researcher inquired whether or not the patients came to the hospital with referral letters, had booked appointments, or if they simply came as self-referrals (see table 4.21). Seven-hundred-and-two (97.5%) of the patients responded to this question while eighteen (2.5) did not. All those (702) patients who responded came without being referred. Seventy-eight (10.8%) patients stated that they had follow up appointments but without appointment letters, 48 (6.7%) stated that they were referred by Primary Health Care nurses but without referral letters and 576 (80%) stated tat they were not referred.

Table 4.21 Referral pattern

Referral	Number N=720	Percentage
Referred by a PHC nurse *	48	6.7
Appointment*	78	10.8
Self-referred and reasons	576	80
No response	18	2.5

*****Patients who came without referral or appointment letters but stated that they were referred or had appointments

4.12.3 Top twelve reasons for self-referral

The patients that responded gave various reasons for not first going to their clinics. Figure 4.5 shows the top twelve reasons given for self-referral. Fifty-four patients stated that there was no clinic on that day in their area while 53 stated that St. Andrew's hospital and the Gateway clinic are nearer than their clinics. Twenty-four patients said they are no longer attending their local clinics, 19 patients stated that they were already in town, 19 patients said the hospital is closer to their workplace and 19 said they always fetch their treatment from the hospital. Eighteen patients came to the dental clinic, 12 patients came because it is easier to obtain transport to St Andrew's Hospital than it is to their clinics and another 12 said that they could not be seen at their local clinics because the nurses have reached the limit of patients they can see that day. Nine patients came because they had various problems with the medications issued at the clinic and eight patients wanted to access other services provided by the hospital. Seven patients stated that they have never attended a LG clinic.

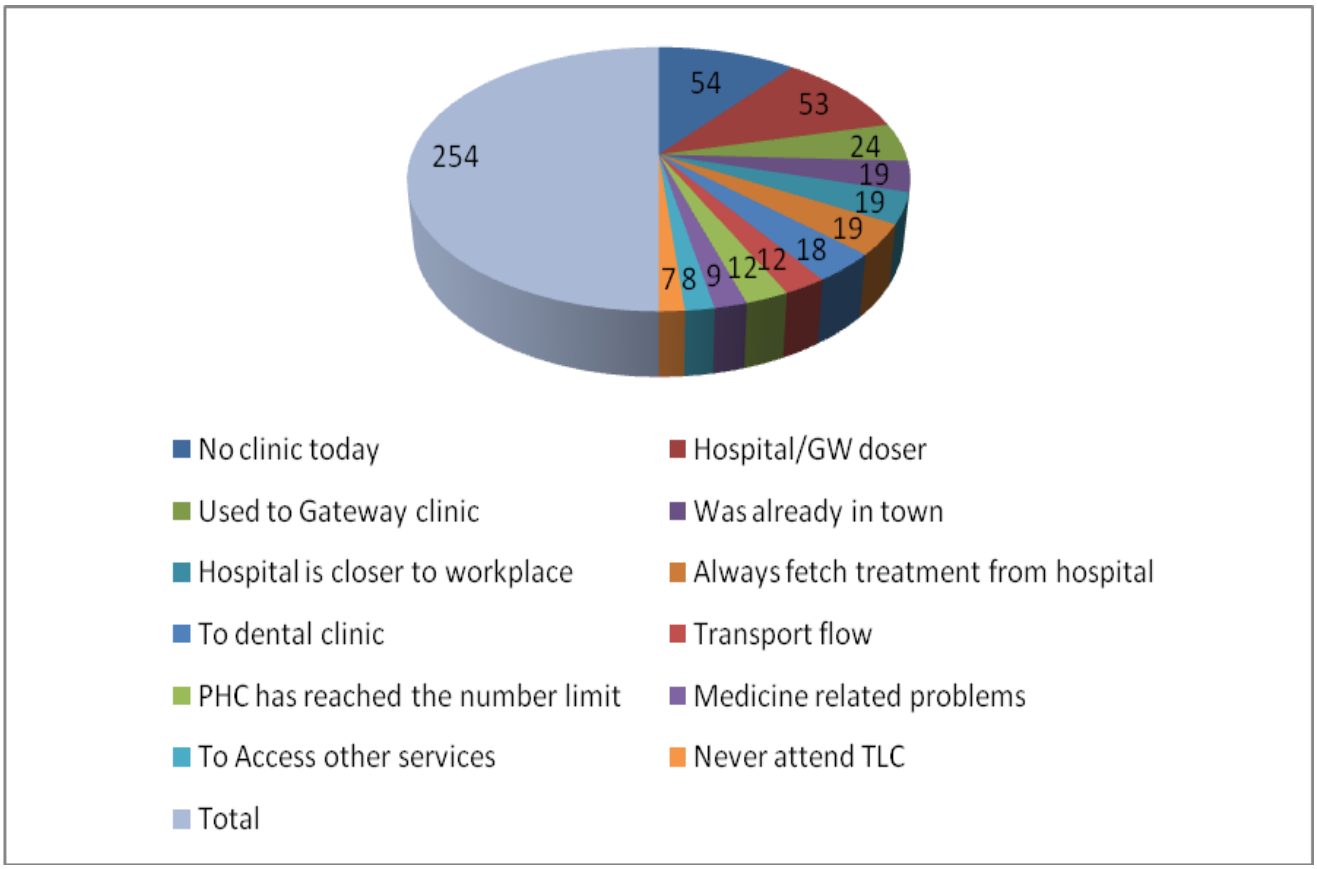

Figure 4.6 Top twelve reasons for self referral

4.13 Patients' Knowledge about Outreaches, the Referral System and Ambulance Services

4.13.1 Doctor visits

Doctors provide an outreach service to all the DOH fixed clinics in the Umuziwabantu sub-district. This service is provided on a weekly basis and the researcher wanted to know whether or not the patients knew about such visits to their clinics. This knowledge is important because some come to the hospital because there are doctors there. Patients from the mobile and LG clinics were not expected to respond to this question because doctors do not visit mobile points and LG clinic. The information regarding doctors'

visits was only captured from 181 patients from the seven St Andrew's Hospital feeder clinics.

Ninety-five (52.5%) out of 181 patients knew about the doctor's visits to their clinics while 74 (40.9%) did not know about these visits and 12 (5.5%) of the patients stated that no doctors visit their clinics.

4.13.2 Knowledge of the referral system

All the clinics in the Umuziwabantu sub-district are supposed to refer patients who need medical treatment so that they can be further managed at the hospital. This policy covers both the fixed and mobile clinics. This knowledge will encourage the patients to first attend their clinics as they will then know that if they are very sick and need hospitalisation they will be referred to the hospital. The highest number surveyed – 547 (76%) of the 720 patients surveyed – stated that there is a referral system between their clinics and the hospital, while only twelve (1.7%) said that there is none. One-hundred-and-one (14.03%) of the patients said that they do not know whether or not there is any referral mechanism between their clinics and the hospital and 60 of the patients (i.e. 8.3%) did not respond to this question.

4.13.3 The status of the ambulance service

A referral system is strengthened when it has a good ambulance service and patients can attend their clinic knowing that should the need arise they can easily be transported to the hospital. The patients were asked about the status of the ambulance service operating between their clinics and the referral hospital. Six-hundred-and-forty-seven patients out of 720 responded to this question. Three-hundred-and-eighty-three patients (i.e. 53.2%) stated that the ambulance service is good while 121 patients (16.8%) said that it is poor. Twenty (2.8%) of the patients said that there is no ambulance service in their areas, 123 (17.1%) patients said they know nothing about an ambulance service and 73 (10.1%) patients did not respond to this question.

Table 4.22 Rating of the ambulance service

Rate	Number N=720	Percentage
Good	383	53.2
Poor	121	16.8
None	20	2.8
I know nothing about emergency transport	123	17.1
No response	73	10.1

4.13.4 Reasons for poor rating

One-hundred-and-eleven of the 121 patients who rated the ambulance service as poor stated that they wait too long for the ambulance to come. Seven participants said that the ambulance does not even end up coming when called. Two patients complained about the bad attitude of the ambulance staff and three patients did not state the reason for their poor rating. (Other patients gave more than one reasons)

4.14 Improvements Recommended by the Patients

The patients were requested to state what they feel needs to be done in order to improve the PHC facilities so that they will be happy to use them as a first port of call. The participants were not limited to one item but they could mention anything they think would improve the service delivery at their local clinics. The researcher predetermined that the following reasons would be main reasons mentioned: clinic operating times, waiting time, medication, staff knowledge and staff attitudes. The list was not limited to the aforementioned; participants could also mention other items. Figure 4.7 has shown things that were repeatedly mentioned by patients as needing to be improved upon in order for patients to be happy to use the PHC facilities.

- **Medication:** 179 of the patients mentioned that the clinics must improve in terms of the quantity and availability of their medications.
- **Waiting times:** 167 recommended that clinics should reduce patients' waiting time by starting earlier and reducing the nurses' tea or lunch breaks.
- **Clinic operating times:** 129 recommended that clinics should start earlier and open during the weekends. Mobile clinics should also increase the number of their visits.
- **Staff attitude:** 83 stated that nurses should stop scolding and shouting at them. They said that the nurses must show them some respect and stop being rude to them.
- **Staff knowledge:** 27 few of the patients mentioned that the clinic staff should be better trained in diagnostic procedures and the prescription of medication

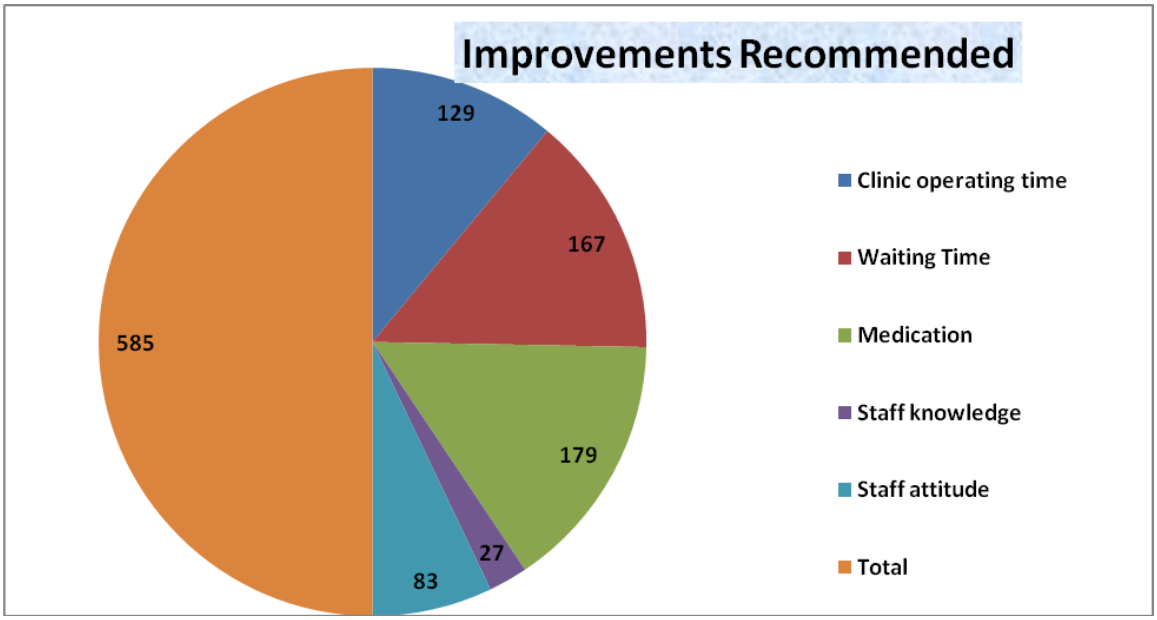

Figure 4.7 Improvements recommended for the bypassed clinics

Other recommendations mentioned by the patients were:

- Nurses should announce the days when there will be no mobile clinic (55). The patients complained that sometimes they walk to the clinic and wait for the mobile clinic, but it does not come.
- The Department of Health should build fixed clinics (33). Patients who are served by mobile clinic recommended that fixed clinics be built in order to provide them with a daily service.
- Employ more staff so as to reduce the long waiting times (26).
- Stop the number system (25). Patients who use local government clinics said that the clinic takes a certain number of patients and then leave others, who thus end up going to the Gateway clinic.
- Improve patient care (6).
- Improve confidentiality (4). The patients recommended that that nurses be made to stop discussing individuals' conditions in front of other patients. They should also provide privacy
- Provide a 24-hour service as well as doctors (4). The patients recommended that all fixed clinics operate daily, both during the day and during the night. They also argued that clinics should have permanently placed doctors, not just visiting doctors.
- Practice a first-come-first-served method of treatment (3). The patients complained that those who come for special clinics (e.g. family planning, the antenatal clinic, and immunisations) are seen first, even if they arrived later than did the others in the queue.

4.15 Summary

The results of this study – which are derived from the research questions as well as the discussions with Primary Health Care supervisors and clinic Operational Managers – have been discussed in this chapter. Valuable information has been collected with regard to the reasons as to why so many patients bypass PHC clinics. The quality input from patients concerning improvements that could be made would, if implemented, improve the referral pattern as well as the clinic utilisation rate.

CHAPTER 5: DISCUSSION

5.1 Introduction

The main purpose of this chapter is to discuss the results found in chapter four and also to relate the findings to what other studies have found in the past with regards to whether bypassing PHC services is a significant problem in the Umuziwabantu sub-district and in other areas, which category of the community bypassed their PHC clinics, the type of clinics the patients bypass and the reasons why patients bypassed their clinics. Recommendations from patients will be compared with reasons other studies found as causes which made patients bypass their PHC clinics.

The study found that there are numerous factors that contribute to patients bypassing their local PHC clinics. It is clear that, for various reasons, patients prefer the hospital to PHC facilities.

5.2. Bypassing of Primary Health Care services

Bypassing of Primary Health Care services is a significant problem in the Umuziwabantu sub-district. St Andrew's Hospital had to convert an old boiler room into a Gateway clinic in order to attend to all those patients who come to OPD without referral. The number of patients who come to Gateway clinic is increasing and the structure that is used as a clinic is small and was not designed to be used as a clinic. The study that was conducted in Ethekwini municipality in 2003 revealed that an un-disclosed but significant number of patients were bypassing their local PHC facilities and attended some hospitals (Lutge 2003). Over 43% of patients seen at specialist clinics in Durban's regional and tertiary hospital could be classified as primary care patients and the most appropriate level of care at which these patients should have been managed was the PHC clinics. That had very serious implications for Durban hospitals in that resources which should have been spent on patients who required specialised treatment were being spent on patients

who did not require that. That was regarded as an inefficient use of scarce resources. Another important implication was that the registrars in training were exposed to significant number of patients with primary care level problems, thus affecting the quality of their training.

The similar findings were obtained at King Edward Hospital in Durban in 1990 and at Dr. JS Moroka Hospital in Thaba Nchu in 2010. A large proportion of patients who attended Paediatric OPD in King Edward Hospital were unreferred and 42.2% could have been medically managed in a PHC facility (Rutkove SB, Abdool Karim SS and Loening WE). More than 50% of patients seen in OPD and Casualty of Dr. JS Moroka hospital could have been managed at PHC facilities but had bypassed the referral system and 25% of the patients brought by ambulance did not require hospital care (Mojaki ME, Basu D, Letsokokgohka and Govender M, 2010).

Bypassing of PHC facilities in the Umuziwabantu sub-district had also serious implications of inefficiency in that medical officers who are a scarce skill and are paid higher salary than PHC nurses found themselves attending to patients in OPD who could be treated at primary care level. These doctors do not gain anything by treating these patients and they always look for work in bigger hospitals in order to be exposed to the conditions which will increase their knowledge.

This study randomly selected 720 patients who had come to the Gateway clinic or the hospital OPD with no referral or appointment letters to try and determine reasons for patients bypassing the PHC clinics.

5.2.1 Who is bypassing the Primary Health Care facilities? (Age group between 24 and 60 years, Females, Africans, unemployed persons, from KwaZulu-Natal)

The highest number of the patients who bypass their PHC clinics are found among the age group between 24 and 60years, females, unemployed persons and from KZN province

5.2.1.1 Age group between 24 and 60years

The highest number (62%) of patients to visit the hospital during the survey was the group between the ages of 24 and 60 years. Among this group were many who are working in town at businesses, at schools, on nearby farms and as domestic workers. Among those in the age group of 18 to 23 years old ((27.8%), there were students from the high school in the town of Harding. These learners have to travel 1 km from town to reach St Andrew's Hospital, thereby bypassing Harding's LG clinic, which is in town. The lowest numbers (10%) of participants fell into the over 60 age group probably because most of them were unemployed at the time of the survey but are residents of the urban and peri-urban areas.

5.2.1.2 Females

More women (75%) then men attended health services, suggesting that women were accessing other services such as the reproductive and child health services that are mostly used by females. Some of the reasons might be because women are combining activities such as going to the hospital and also doing business in town. The study that was conducted by KwaZulu-Natal's Department of Health (2010), revealed that most of the diseases occur among women and the number of women visiting PHC facilities for illnesses almost double the number of men, 63.1% women as opposed to 36.1% men. The fact that more women attended to Gateway clinic than men might not be due to the fact that more women bypass their clinics but might be due to the fact that more women use health facilities than men. In the study that was conducted in hospital OPDs of the United States of America (USA) females (35.1%) had higher OPD visits rates than males (23.6 %) and females visit rate (7.8%) for preventive care was three times higher than that for males (2.6%) (Middleton KR and Hing E, 2004, USA).

5.2.1.3 Africans

The study also revealed that the majority (98.1%) of the patients who visited the Gateway clinic were Africans. Coloureds are the next most numerous (1.7%) and this can be attributed to the fact that these two racial groups form the majority of the population of the Umuziwabantu sub-district. This is similar to the findings of the study that was done in USA where black or African American persons had higher OPD visit rates (50.3%) than white persons (27%) in the hospital OPDs of the USA (Middleton KR and Hing E, USA, 2004).

5.2.1.4 Unemployed patients

Seventy-four percent of the patients who were surveyed were unemployed proving the point that they cannot afford to pay to see private doctors even if they wish to be seen by them. The best health care centre for them if they want to be seen by medical practitioners is the hospital because they are charged according to a fees manual. Some even fall into the category where they receive free medical service. The visit rates to hospital OPDs of the USA were higher for Medicaid enrolees than for those using Medicare while Physician office visit rates were higher for Medicare than Medicaid enrolees (Middleton KR and Hing E, USA, 2004).

The patients who might legitimately be bypassing their clinics because of work-related issues constituted only 26.5%. One-hundred-and-sixty-five participants worked in Harding and it might have been appropriate for them to bypass their clinics as their illnesses were due to work related activities. However the LG clinic in town is nearer to business centres and these patients should be attending this clinic and only coming to the hospital if the patients' condition is such as to warrant referral to the hospital. Even those who indicated that they were involved in manual labour should be able to access the LG clinic.

The employed participants who bypassed the LG clinic could not wait for consultation because of the number system the LG clinic is using. The reviewers of the primary health care package of health services, as well as PHC norms and standards in South Africa recommended that the competence of PHC staff should include the ability to organise the

clinic to reduce waiting times to a minimum and to initiate an appointment system when necessary. They also recommended that the proposed package of service should be flexible and tailored to the particular needs of the area being served (Rispel, Moorman, Chersich, Goudge, Nxumalo and Ndou, RSA, 2010). LG clinic needs to work out the mechanism that will assist the working patients to access the PHC services that they provide. Fast queue for working people should be organised. They can consider flexi-time where one professional Nurse would start earlier than the opening time to attend to the workers and learners. A person who started early should be allowed to go off earlier in order to work the same number of hours like everybody.

5.2.1.5 Patients from KwaZulu-Natal

Seven-hundred-and-two patients were coming from KwaZulu-Natal while only 12 came from the Eastern Cape. The management at other hospitals in the Ugu district such as Port Shepstone Regional hospital believe that there is a high number of patients who come to their hospitals from Eastern Cape (personal communication) though this cannot be confirmed with the result of the study. But this study revealed that there are few patients who came from Eastern Cape.

5.2.2 Which Primary Health Care clinics were mostly bypassed? (Mobile clinic points, Local Government Clinic, Sisonke district facilities and Pisgah clinic)

The large area of Umuziwabantu sub-district is still serviced by the mobile clinics. Ward 1, which has a population of 10,503, has no fixed clinics. This ward depends solely upon the mobile clinic service. Mobile clinics visit mobile sites on certain days, and patients in need of medical care often cannot wait for the mobile clinic, which comes just once a month. The majority (28.9%) of the patients who participated in the study bypassed the mobile clinics in the Umuziwabantu sub-district and had no referral letters because there was no clinic to visit in order to obtain one (either because it was not a clinic day or because the mobile clinic was prevented from visiting due to bad weather). The patients also complained that the staff of the mobile clinics do not inform them if or when the

service is going to be interrupted, and this causes patients to wait for them and they never arrive.

5.2.2.1 Mobile clinic patients from Santombe, KwaMbotho, Izinqoleni and Eastern Cape

Seventy-one patients bypassed the Santombe mobile point and 51 patients bypassed the KwaMbotho mobile point. Both Santombe and KwaMbotho mobile points are in ward I and the only ward that had no fixed clinics in the Umuziwabantu sub-district. These mobile points are visited on certain days of the month and on other days patients have no other health facility to visit except St Andrew's hospital Gateway clinic or Harding LG clinic.

St Andrew's Hospital was unaware and was surprised to learn from this study that the mobile clinics in Umuziwabantu sub-district provide services across the border of the Umuziwabantu sub-district into the EC and the Izinqoleni sub-district. On the days when there is no mobile clinic they also come to St Andrews hospital where mobile clinics are based. These patients are regarded as cross-border patients who have bypassed their clinics in other sub-districts or Provinces yet they have either bypassed Umuziwabantu mobile clinics or came because there is no mobile clinic on that day. St Andrew's hospital management should visit these mobile points to determine the distance between these mobile points and the PHC base from their mother hospitals and together workout how these mobile points should be served.

5.2.2.2 Local Government Clinic

The second highest group (i.e. 27.2%) bypassed the Harding local government clinic, which is 1 km from St Andrew's Hospital. Of this group, 102 (52%) came from the informal settlement called Mazakhele. These patients can easily walk 1 km to the LG clinic but are limited by number of the patients the PHC nurses can see per day. Many participants who bypassed this clinic mentioned that LG clinic is using a number system and this was confirmed by the Primary Health Care supervisor. The Nurses who are

working in this clinic use the number system in order to count the number of patient they will attend per day according to the professional nurse patient ratio. According to the PHC Supervisor each professional nurse should attend between 35 and 40 patients a day. The Operational Manager of the Gateway clinic stated that they have noticed that by 11h00 there is an influx of patients who say that they started at the LG clinic and were told by LG nurses that they have taken the number for the day and advise them to go to Gateway clinic which is run by three professional nurses or to St. Andrew's Hospital OPD. During the interview these patients came without referral letters but stated that they were referred because they started at LG clinic and were told to go to St. Andrew's hospital. They also mentioned that the staff at the clinic are not friendly, and they make them to wait outside the locked gates.

The Operational Manager in charge of the LG clinic stated that there are only three professional nurses in their clinic and they receive a large number of patients who are not from their clinic catchment area. She also said these patients use the direct transport to town and they come very early in the morning before the clinic opens and then stand in the queue. By the time the local patients from their catchment area come to the clinic, it is already very full. Local patients do not want to wait but instead prefer to go to the hospital to the OPD or the Gateway clinic. This clinic also has a space problem; many patients wait outside because the waiting area is inadequate. Gateway clinic also have the similar problem of space and many of their patients wait outside.

The St Andrews Management, the District Manager of Ugu district and the PHC Supervisor have already approached the Umuziwabantu Municipality Manager to discuss land where the Gateway clinic can be built and the possibility of combining LG clinic and the Gateway clinic in to one clinic in the new site.

5.2.2.3 *Sisonke district facilities*

The third highest group bypassed Sisonke health district mobile and fixed clinics which are under the authority of Umzimkulu. Umzimkhulu used to be part of the EC but was

transferred to KZN during the revision of boundaries. It has been observed that. St Andrews hospital is nearer to some of the patients than Sisonke health care facilities and the transport route to Harding is better than to Umzimkulu. Because of the transport route some patients go to Harding town for shopping and also combine their trip with hospital visit. The majority of people from Sisonke district work in Harding town and in the schools in Umuziwabantu sub-district and it also might have been appropriate for them to bypass their clinics at Sisonke district. Nurses in Gateway clinic stated that these patients mentioned that now that they also belong to KZN, they are now free to access health facilities in the Umuziwabantu sub-district if they so desire. They even wanted to have their records transferred to St Andrew's Gateway Clinic.

5.2.2.4 Pisgah clinic

Of all the St Andrew's feeder clinics, Pisgah clinic had the highest number (42) patients who had bypassed the clinic, when compared with the number from the other feeder clinics. The researcher visited Pisgah clinic and found that it is being upgraded and is currently in a terrible condition. Its completion is long overdue and the OM of the clinic informed the researcher that both the community and the staff are frustrated. The condition of the clinic might be the cause of a high number of patients bypassing Pisgah clinic than other clinics.

5.2.3 Why did patients bypass these facilities?

Accessibility of the health facility is one of the main factors that contribute to the bypassing of local clinics by patients. Lutge E. and Mbatha T stated that a traversable access road is necessary to enable patients to attend to the facility in the first place (Lutge E. and Mbatha T in PHC Facility Infrastructure analysis, 2007).

5.2.3.1 Accessibility

Patients preferred to go to hospital because the hospital is more accessible than clinics due to the following reasons:

a) Availability of transport to hospital.

St Andrew's Hospital is situated 1 km out of town, there is plenty of public transport from the rural areas, bringing workers to their places of work, learners to school, and others to town for whatever their reasons making the hospital to be easily accessible by public transport at a cost that more participants can afford as it was reported that cost of transport ranged from R10.00 to R30.00. Transport to hospital is available at convenient times and it does not take too long to get. Patients are able to combine visiting town with hospital visit. The transport is also available and reasonable even for patients from other districts making the hospital to be easily accessible for patients from outside Umuziwabantu sub-district.

Those living and working in Harding are able to walk to Gateway clinic from their workplaces during lunch times and they do not have to depend solely upon public transport.

b) Unavailability of transport to the clinics and long distances to be travelled

Access to the clinics was given as a reason for bypassing the clinics as patients found it difficult to walk to the clinics when they are sick and so they would rather use public transport and catch a ride to the hospital. Others stated that their clinics are too far and it is dangerous to walk through the sugarcane fields and bushes in order to reach their clinics. Availability of public transport to the bypassed clinic depends upon the weather, most especially during the wet season when the roads suffer from the rains. The Professional nurse at one of the clinics stated that she does not blame the patients for bypassing their clinic because their clinic is very far from the bus or taxi ranks and it is better for those patients to use public transport to reach the hospital. Another one mentioned that the clinic is too far from some of the areas that they serve and there is no

transport to the clinic from those areas. Another PHC nurse mentioned that people from her area need to hire private cars to bring very sick patients to the clinic, but there is always transport to Harding where the hospital is situated, and therefore patients prefer to go straight to the hospital. All these people find it easier to go to the hospital because of the good flow of transport to and from St Andrew's Hospital.

c) Ambulance service operations

The ambulance service practitioners bring patients from Sisonke district (around Gugwini clinic) without referral and theses patients are not from St. Andrew's hospital feeder clinics as the ambulance policy forces them to transport patients to the nearest health facility which in this case is St. Andrew's Hospital. St. Andrew's Hospital doctors stated that this creates problems for them when they receive patients more especially maternity patients with obstetrical complications that was not monitored by them and PHC nurses from Sisonke district do not attend meetings that are arranged for PHC nurses and doctors.

5.2.3.2 *Operating Times/Availability of services*

a) Mobile clinics found to be problematic

The hospital's Out Patient Department and the Gateway clinic start to operate from 07h00. This time is convenient for workers as they can visit the clinic before going to work. Clinics' operating times are generally convenient except Mobile points –Mobile clinics only come once a month, often only start at 10.00 and are not convenient when patients are acutely ill. Patients attending mobile clinics mentioned that mobile clinics starts late and that cause patients to be inconvenienced. They mentioned that patients come early and have to wait for the nurses. Mobile nurses are rushing to get back home and therefore rush through the patients so as to finish early and the staff do not end up attending to all the patients.

The Primary health Care Facilities survey (2000) revealed that the frequency of mobile clinics visits to mobile points varies from once a week in Gauteng to once in almost seven weeks in Northern Cape with a national average of approximately once per month. An interval of every six to seven weeks suggested that the large rural population of that province may have relatively little access to basic health services and 26% of the mobile clinic vehicles in the survey (2000) were out of order for one or more days in the month preceding the survey. The Umuziwabantu mobile clinics operate within the national norm because all their points are visited at least once a month and the vehicles are well maintained. Mobile clinics close for two to three weeks during the festive season in the Umuziwabantu sub-district. The reason for the Mobile clinic not to visit their points was not included in this study but it is important to know in order to deal with the similar problems in Umuziwabantu mobile clinics.

Mobile clinics are good for preventive services such as women's and child health and chronic care services. They are not suitable for acute care as they are not always available. However Rispel et al. (2010) suggested that basic curative service remain a critical component of PHC. Most common illnesses should be treated as per national standard treatment guidelines in all PHC facilities. All clinics should do clinical assessment and management of illnesses should be done as per protocols in all PHC facilities and mobile clinics are not excluded in this standard.

b) Local government clinic limits numbers

The Harding LG clinic in town uses the number system and once a certain number is reached, the staff stops registering patients. The hospital then receives an influx of patients, as those who were turned back from the LG clinic as early as 11h00 go to the hospital. These patients do not pay extra in order to reach the hospital as they can easily walk from the LG clinic to the hospital. Twenty-seven percent of the sample bypassed the LG clinic because of the limited number of patients that can be seen at the clinic. A number system is used and once the required number of patients has been accepted, all other patients must be seen at Gateway clinic or hospital OPD which operates 24 hours.

Others indicated that they are no longer attending LG clinic but are instead making permanent use of the Gateway clinic; this means that patients who should be attending the LG clinic are forced to come to the hospital for health care.

c) The general comments about other clinics' operating times.

The general comment of the patients who are working and attending school was that the times that the clinics start to operate causes them to arrive late at work or school. They also mentioned that the clinic opens too late especially when someone is very ill and needs emergency care.

The National primary Health Facility Survey (2003) that was conducted in KwaZulu-Natal also revealed that the majority of PHC facilities in KZN are located in rural areas and the majority of facilities in KZN (98%) and throughout the country (96%) were open for more than 5 days per week with facilities being open for a median of 9 hours per day. It will be helpful to conduct the similar study for Umuziwabantu sub-district facilities and compare with what the patients stated.

5.2.3.3 Waiting time at the bypassed clinics

Waiting time did not appear to be a problem and was not the reason why patients were bypassing the PHC facilities. The highest number (308) of the patients stated that they wait less than an hour before the nurses attend to them and 290 (95%) of these patients stated that this waiting time is convenient. Only 59 patients stated that they wait more than three hours and 94.9% of these patients said such a waiting time is not convenient but it was still interesting to hear their comments.

Patients stated that this long waiting time is caused: by clinics starting late; by nurses who are very slow while there are too many patients that need to be attended; by nurses starting with tea and socialising when they arrive instead of promptly beginning to work. They also stated that people who do not need specialist treatment wait longer because

nurses start with those patients in need of treatment by special clinics. The OM of one of the clinics mentioned that some patients are made to wait longer than others because the nurses attend to workers and school children first (this arrangement was apparently discussed with and agreed to by the community). Patients attending LG clinic stated that they wait longer because they come very early in order get numbers in order to be registered. Travelling time for mobile nurses cause the patients to wait longer.

The long waiting time was regarded as not convenient for very sick and elderly patients; patients who come very early and want to go home early to carry on with their other tasks and patients who are in pain.

In the survey that was conducted in the EC and Western Cape provinces it was found that the majority of patients from the low-income groups seek health care from the private providers because they are easy to access, they have extended hours of service and they have shorter waiting time (South African Review, 1999). One hour waiting time for patients is not unreasonable and it would appear from this study that waiting time at the PHC clinics is not an important reason for patients bypassing the facilities. Three-hundred participants stated they wait between one and thee hours in their clinics and very few found this waiting time being unreasonable.

5.2.3.4 Perception that medical care is better at hospital.

The participants felt that the medication was better at the hospital than at PHC facilities and also that PHC nurses give them few medication while doctors give them more. Three-hundred-and-ninety-one patients stated that the types of drugs issued by doctors are of a better quality than what is issued to them by PHC nurses. This fact was also confirmed by the district's senior pharmacist and its institutional pharmacist that doctors are giving more than the number required by the hospital EDL. One of the PHC nurses mentioned that patients come to their clinics and demand certain drugs, even if there is no need for that drug. If they do not receive that drug they go to another clinic and obtain a new card so as to try to obtain the drug they desire. Many patients thus have clinic cards

from more than one clinic since they do not pay for the services they receive from PHC facilities. They do not only bypass clinics in order to go to the hospital, but they also bypass their clinics and go to other clinics if they do not receive specific medication. This suggests patients use clinics like supermarkets, where they go medication shopping for free.

The National primary Health Facility Survey (2003) also revealed that in KZN 84% of patients had received drug treatment compared with 72% nationally. The percentage of patients attending PHC facilities in KZN who received drug treatment was higher than the national average. The extent of unavailability of drugs in the PHC facilities of Umuziwabantu sub-district has not been researched to confirm that it is a significant problem that can cause patients to bypass their PHC clinics.

5.2.4 Patients' preference of personnel

5.2.4.1 - 50% of patients would prefer to see a doctor

a) Perception that Doctors provide better care

Patients believe that doctors are more knowledgeable; 73.9% would have preferred to be seen by hospital doctors than by PHC nurses because of the superior knowledge of the former. Doctors are also praised for conducting more thorough examinations. In previous studies conducted on PHC utilisation the reasons mentioned by patients included that hospital care is superior to PHC care because of the presence of doctors (Lutge et al., 2003*)*. During the time between November 2008 and July 2010 when the hospital could not provide medical coverage to the clinics because of the shortage of doctors at the hospital, the numbers of patients who bypassed their clinics increased.

One of the PHC nurses confirmed that one of the reasons why patients bypass their clinics is that patients always prefer to be seen by doctors, even for minor ailments. Participants of the review (1999) had a belief that only doctors can give effective

treatment. Some participants were however positive about the clinic's services but feel that they are not useful because they cannot treat all illnesses as they do not have doctors or the best medicine.

b) Perception that Private Doctors provide better care

One hundred-and-one (14,2%) of patients would have preferred to be treated by Private Doctors than by PHC nurses and believed that it is easy to access Private Doctors, the medicine the Private Doctors supply is strong and of good quality, Private Doctors are more knowledgeable than PHC nurses and they have a good caring attitude. Participants of the review (1999) also doubted the effectiveness of the treatment that they receive from public funded facilities. They feel that they are not getting better and they have to go back again and again and most of the time they only get tablets having not been examined. The study also suggested that there is a high number of patients of low income category who prefer the service of the Private Doctors instead of public clinic. It has been estimated that private general practitioners in South Africa treat approximately five million cases of sexually transmitted diseases each year more than cases seen in the public sector. The reasons patients gave in that survey included easier access, longer hours of service, shorter waiting times, being seen by a doctor as opposed to a nurse, more personalised attention and the perceived better quality of care in private sector. There is a perceived link between payment for the service and its improved quality. Participants also expressed frustration with the poor treatment they received in public sector facilities and in many cases they felt that complaining would be pointless and may lead to worse treatment in the future (South African Health Review, 1999).

5.2.4.2 Perception of patients on staff attitude

Staff attitude will not be the significant cause of bypassing of PHC clinics by patients. Generally the participants were satisfied with the treatment they receive from the PHC staff as 531 patients were satisfied and only 131 of the participant stated that they are dissatisfied with the way they are treated by PHC staff. None of the attitude-related

factors were, on the day of the survey, mentioned as a reason behind self-referrals. But it is still interesting to take in to consideration what was perceived as negative or positive attitude and compare that with what other studies found.

a) Negative attitude

The few that were not satisfied mentioned that staff members sometimes scold them, that their attitude is bad, that they provide poor patient care, that they are too slow, and that they make patients wait too long and then sometimes send them home without having attended to them. In the survey conducted in the EC and Western Cape provinces, patients stated that they prefer using private providers because of the disrespectful attitude of nurses and that the way patients are treated in the public facilities is unacceptable. The poor attitude of public sector facilities discourages patients from attending the clinics. Nurses were criticised for having no respect for privacy, and some participants do not go there no matter how bad they feel. Not all the participants had the same attitude as one patient praised the clinics for its accessibility and said the relationship between the PHC nurses and the community is good (South African Health Review, 1999).

b) Positive attitude

There were also positive responses to questions regarding PHC nurses. High in the list was that PHC nurses are always available when needed. The participants also stated that it is easy to communicate with the nurses because most speak the same language as their patients. Others still praised the nurses for their good patient care. It is interesting to know that PHC nurses comply with the core standard of the PHC package which states that patients should be addressed in a language that they can understand, and health workers should be positive in their approach to patients and giving each patient a feeling of always being welcome (Rispel et al., 2010).

5.2.4.3 Shortage of staff

The participants had a belief that there is a shortage of staff in the PHC clinics and suggested that more nurses be employed because they realise that the workload is too much for the few PHC nurses currently working at the clinics. The survey for the year 2000 also revealed that nurses at fixed facilities in KZN have higher patient load compared with the national average and the load for mobile PHC facilities in KZN is more than double the national average (The National Primary Health Facility Survey, KZN, 2000).

When the researcher checked the staffing norm of the PHC clinics and compared it with the PHC package of service it was found that the average number of staff was: three Professional Nurses (P/N), one Staff Nurse (S/N) and one Nursing Assistant. The PHC clinic package of service has increased while the PHC structure has not been revised for a long time. This has led to a drastic shortage of staff in the PHC clinics. This shortage causes patients to have to wait too long before they are seen. One PHC nurse confirmed that patients have to wait too long at her clinic due to a staff shortage. She stated that the patients with whom they deal are very sick and are brought to their clinic in wheelbarrows. Very often the clinic staff spend more than two hours attending to one very sick patient. If there is only one professional nurse at the clinic it means that the other patients have to wait too long to be served.

One of Operational managers (OMs) had an assumption that patients bypass her clinic because of the shortage of staff. There are only two P/Ns and one S/N at this clinic. If one P/N is off duty, the clinic is left with one P/N and one S/N. Everyday they are faced with the problem of a grumbling community, which complains about the long waiting time. She also mentioned that more programmes have been added to their heavy workload but there have not been assigned more nurses. As is it is now, this OM is running a clinic without lay counsellors yet they are expected to conduct HIV counselling and testing campaigns. Patients cannot tolerate such a situation and end up bypassing the clinic.

5.3 Package of Service

5.3.1 Perception of patients to PHC services

All PHC facilities within the Umuziwabantu sub-district provide a full package of PHC services. The Ugu district's annual report also revealed that all PHC facilities offer 85% package of service (Ugu District Annual Report, 2006/2007). There was 100% medical coverage until late in November 2008 when, due to a shortage of doctors, the hospital failed to provide medical coverage to the clinics as indicated earlier on. Half (50.6%) of the participants stated that they prefer to be treated at the hospital and some stated that they prefer the hospital because doctors are always available there. Others recommended that each clinic have a permanent doctor. This suggestion shows that patients still believe that doctors provide a better service than do PHC nurses. The study revealed that only 30% of the patients needed medical intervention, while the rest could have been managed at PHC level.

There are services that are provided by the hospital as an outreach service to the clinics. Many of the patients from the fixed clinics knew about the outreach services. Some of the services are not offered as outreach services and as a result many patients come to the hospital to access those services. The dental team visits only two (KwaJali and Meadow Sweet) out of seven clinics, so patients from five of the clinics come to the hospital when they have dental problems, 18 of the patients who came to OPD without referral stated during the study that the reason for their visit was to see the dentist. The eye team also does not provide an outreach service to any clinic. Patients from all the clinics thus come to the hospital OPD if they have eye problems. During the study 12 patients came to OPD without referral to see the eye doctor. None of these patients went via their clinics and they stated that it is a waste of their time to first go to the clinic because they are not going to receive any help there. Such patients were not sent to Gateway clinic for screening and the researcher included them in the study as they came without referral and without doctors' appointment.

The National PHC facilities survey (2003) revealed that dental care services were not part of the PHC package and that dental health services were lacking in the overwhelming majority of facilities both in KZN and nationally. Rispel et al. (2010) also suggested that some of the services such as Oral health services and Optometry services the outreach teams provide to patients during their clinic visits should be included in the Primary Health Care package. It would be better if the PHC coordinators of the Umuziwabantu sub-district start preparing resources and skills to provide these services in the PHC facilities.

5.3.2 Perception of patients to confidentiality at PHC clinics

Though VCT is provided at all the PHC clinics, patients prefer to come to the hospital because of the greater confidentiality it affords one and for the fact that ARV treatment was only provided at the hospital during the survey. Rispel et al. (2010) stated that new polices and strategies to strengthen prevention, treatment and care support the decentralisation of treatment and care to Primary Care level in order to expand access to Anti Retroviral therapy. The targets for HIV/AIDS and TB are to improve the quality of life of people living with HIV and AIDS, reduce HIV incidence from 1.3% to 0.06%, ensure that eligible pregnant women are initiated in ART and ensure that 100% of HIV-TB co-infected patients are on ART. St. Andrew' hospital has started to down refer patients on ART to their clinics but other patients refuse to go back to their clinics because of lack of confidentiality. Other participants recommended that confidentiality should be strengthened at PHC facilities. They stated that their diseases are discussed in front of other people. The study that was conducted by Wayland and Crowder in Prosalud health centre in El Alto, Bolivia in April 1995 to July 1996 on disparate views of community in Primary Health Care revealed similar results. Because Prosalud felt it is necessary to include neighbourhood residents as members of their clinic staff to promote a sense of community, local patients feared that personal information would be leaked to individuals beyond their family circle, allowing others to take advantage of them in future. Their distrust of the local health care workers outweighed their need for local attention and they went to clinics where they were not known (Wayland and Crowder,

1995-1996). This suggests that even when health care is affordable and available, target population do not always utilise and support local services.

5.4 Infrastructure

Poor infrastructure has been cited in a number of studies, conducted primarily in middle and low income countries, as undermining health service delivery. Poor infrastructure has also been shown to significantly affect patient's perception of quality of care in South Africa and has a significant effect on health professionals' satisfaction with their working conditions (Lutge E. and Mbatha T in PHC Facility Infrastructure analysis, 2007).

5.4.1 Adequate Equipment

All the PHC clinics have more than 85% of the basic essential equipment, though one of the participants mentioned that she did not want to go to the local clinic because there were no functional baby scales there. Other patients also stated that the clinics are not as well equipped as the hospital. The study that was conducted in 2003 also revealed that the availability of equipment in KZN' PHC facilities was higher than the national average (The National Primary Health Facility Survey, KZN, 2003).

5.4.2 Inadequate space

Another big challenge is space, which is inadequate at all the clinics. Patients who have attended the mobile clinics complained about having to wait out in the open, even when it is raining or is very hot. They also complained about the lack of confidentiality and privacy that is afforded them because the nurses discuss their problems while other patients are listening and they are also exposed in front of others when receiving injections.

The buildings of the fixed clinics are also small considering the services they now have to render. One of the clinic's OMs stated that in her clinic they admit a few patients into the

wait room, but the others are left outside because of the inadequate space. She said that after the staff has finished attending to those patients, they take in some more.

There was a big demand by the participants for counselling rooms, something that was not considered when the clinics were constructed in the years before the HIV virus became so prolific. Even the consulting rooms are inadequate for the extended services that are rendered at the PHC clinics, while the hospital has to refer patients back to their clinics after ARV treatment initiation. Patients are reluctant to go back to their local clinics for further management. The study that was conducted in 2003 revealed that 40% of PHC facilities in KZN had adequate number of rooms but less than half of the facilities both nationally and KZN had adequate waiting areas. (The National Primary Health Facility Survey, KZN, 2003) but all PHC facilities in the Umuziwabantu sub-district have a problem of shortage of space. Rispel et al. reported difficulties with the implementation of the full package of the PHC services especially more specialised services because of challenges such as clinic infrastructure problems (space, lack of privacy, old infrastructure, etc.). All provinces reported that an infrastructure constraint was one of the reasons that hamper PHC package implementation (Rispel et al., 2010).

Lutge and Mbatha found the space in the PHC facilities inadequate for the needs of the clinic catchment populations. They also mentioned that the epidemic of HIV and AIDS has resulted in a new infrastructure needs not envisaged before such as private consulting rooms for VCT and a space for these additional staff (Lutge E. and Mbatha T, 2007). Schneider and Barron stated that although we have aimed at increasing PHC utilisation but posts and space are not available (Achieving Millennium Goals in South Africa through revitalisation of PHC and strengthen District Health System, Schneider and Barron, KZN, 2009/2010).

5.5 Referral

The health system needs a very effective mechanism for the implementation of the referral policy if the system is to be functional. Implementation of the referral policy is a

big challenge in the Umuziwabantu sub-district. There is no mechanism in the hospital for monitoring adherence to the referral policy. Motlalepula M. and Mokgalagadi stated in their report that a poor referral system impacts negatively on the overall patient survival rate, health outcomes and provision of health services (Motlalepula M. and Mokgalagadi, National Department of Health,2007).

According to WHO (2000) referral systems which are unique to health services and necessary to their performance, have proved particularly difficult to operate adequately. Lower levels services were often poorly utilized and patients who could do so commonly bypassed the lower levels of the system to go directly to hospitals as a result, countries continued to invest in tertiary, urban based centres (Van Rensburg, (2004) C1 Part 2 Failures of PHC WHO 2000C114, 2004).

5.5.1 Poor adherence to the referral policy by medical staff, PHC staff and ambulance services

5.5.1.1 Medical staff

The PHC survey that was done in 2000 revealed that the majority of the workers at KZN's satellite and mobile clinics perceived the referral system as efficient (The South African Health Review, 2000) however, there is a shortfall in the system since PHC nurses always complain that they do not receive feedback concerning patients they referred to the hospital as the patients then come back to them with no referral letters. Hensher M., Price M. and Adomakoh S. (2006) indicated that the referral process does not simply entail transferring a patient from a lower to a higher level of care but an effective referral system requires good communication and coordination between levels of care and support from higher to lower levels to help manage patients at the lower level of care. Motlalepula M. and Mokgalagadi (2007) found that there is no uniformity in referral criteria in the hospitals of all the Provinces and that hospitals lack communication feedback.

The PHC system can only achieve the desired outcome if it is supported by other levels of the health system in a coordinated and integrated manner. The delivery of good quality essential care relies on effective referral relationships with and support from district hospitals, in addition to clinical competences to identify when these referrals are needed (Rispel et al., 2010).

5.5.1.2 Ambulance Service

There is a good ambulance service and 59% of the participants regard it as good. Patients know that they can be referred to the hospital when there is need. The ambulance practitioners are supposed to take patients who need PHC care to the clinics first but they instead take them straight to hospital. The OM from one of the clinics said that the ambulances do not want to take patients to the clinic first, instead they take them straight to the hospital, saying that going via the clinic is a waste of time because the patients call the ambulance to take them to hospital anyway.

5.5.1.3 Self-referral by patients

Many patients who could have been treated successfully at PHC bypass PHC facilities and directly go to hospital due to number of factors. Other studies identified similar factors as this study such as: patients' perception of superior quality of care and resource availability at referral hospital, the desire to avoid delays in care if referral to a higher-level facility proves to be necessary, perceived lack of drugs, negative staff attitude and the fact that for many urban populations a referral hospital may simply be the closest health facility (Hensher M et al. 2006). The majority of the patients who bypassed their clinics were supposed to attend the LG clinic had come to Harding to do other things and decided to visit the hospital since they were already in town and it was nearby. There were those who reside in urban and peri-urban areas and who indicated that they have never attended a LG clinic.

In the study that was conducted in the public hospitals in Ethekwini municipality researchers found the similar problems as the problems found in this study. They categorised the problems in to two categories which they called *health worker behaviour* and *patient health seeking behaviour*. In the health worker behaviour they found that there was poor practice of referral back to clinics. Health worker apathy may result in sub-optimal use of existing publicised guidelines. There may be no clear guidelines for referral of patients between hospitals and clinics and even if those guidelines do exist, health workers may not be aware of them. In the patients' health seeking behaviour the patients understandably seek the care that they perceived to be of the highest quality, the presence of doctors and the sophisticated medical equipment, and these were reasons for the common perception that hospital care is superior *(Lutge et al. 2003).* Motlalepula M. and Mokgalagadi (2007) found that hospitals lack systems to record referrals and outcome

These problems have a number of negative impact and consequences in OPD. PHC conditions are unnecessary treated in a high cost environment, OPD become congested by patients requiring PHC causing long waiting time in OPD, scarce staff time is diverted from specialised areas and into inappropriate care

5.6 **Health Care Centre of Choice**

5.6.1 Hospital

Patients were asked where they would prefer to be treated; the majority (50.6%) prefer to be treated at the hospital because the hospital offers all the services they need, the hospital is well equipped and the hospital is open for twenty-four hours while the clinics close after hours. They also indicated that it is easy to be seen by Doctors because they are always available in the hospital and it easy to be admitted. Doctors are regarded as more knowledgeable than nurses and the drugs that the doctors give them are better than the drugs they get from PHC nurses.

5.6.2 Primary Health Care clinics

Some (29.7%) of the patients prefer to be treated at the PHC clinic because the clinics offer free service. They also stated that it is easy to access the clinics because the clinics are nearer to their homes than the hospital and they understand that the clinic is the first level of care. It is also easy to communicate with nurses at the clinic because they talk the same language as the patients.

5.6.3 Private Doctors

Other patients (14.02%) prefer to be treated by Private Doctors because their service is fast and they do not wait long in the Private Doctors' rooms. They also stated that Private Doctors understand the needs of their patients. This confirms what has been discussed previously about patients preferring treatment from Private Sector than Public Sector because of high quality of care the Private sector offers.

Only one patient stated that he prefers to be treated by Traditional Healers because of good medication he gets from the Traditional Healers.

In the study that was conducted in the public hospitals in Ethekwini municipality, some of the reasons that were given by patients were similar to the reasons given by participants in this study. The most common reason given by patients for attending the specialist clinic included the reasons such as: Clinic being closer to their homes (29%), patients stated that they had been referred by a health worker (26%) but only one percent of all those patients could show the interviewer a referral letter, 25% stated that hospital offered the best care available and 19% stated they come to hospital clinics because they had been coming there for a long time (Lutge et al. 2003).

5.7 Was it reasonable for the patients to bypass the PHC facilities?

5.7.1 It was not reasonable for patients who came for minor problems and for preventive care services

It was not reasonable for the patients to bypass their PHC clinics and come straight to hospital as 70% of patients had minor problems, preventive care such as family planning, immunisation and VCT – these should have been sorted out at PHC clinics. Only 30% required a further medical opinion and services such as dental and eye care that the PHC clinics do not offer and it was reasonable for them to come to hospital. Those who came for ARV treatment were not regarded as patients who have bypassed their clinics because the down referral system is not functioning well.

According to the comprehensive PHC package for South Africa that was issued in September 2000, the referral mechanism should ensure that all patients approaching the referral section of the district hospital bring a referral letter from the PHC clinic and all those patients presenting directly to the referral section without a letter are sent to the section of the hospital where the need for a referral letter will be assessed.

5.7.2 It was not reasonable for patients to bypass their clinic because of long waiting time, medicine related issues, patients' perception and to do other things in town

Results from this study suggest that waiting times are not excessive, medicine is available and staff attitude in general is positive. It was therefore not reasonable for the patients to bypass their clinics because of long waiting time, type and number of medication, staff knowledge and attitude and to be seen by doctors because of the perception that doctors are more knowledgeable than nurses because nurses can treat them effectively. It is not acceptable for patients to bypass their clinics because they want to do other things in town. During the district team meetings other hospitals in Ugu district used to complain about patients who bypass their PHC clinics because they want to do other things in Port

Shepstone town. They have strengthened their referral system in such a way that patients who come without referral are sent back to their local PHC clinics.

5.7.3 It was not reasonable for patients to bypass the LG clinic because of the number system

Patients who attend LG clinic had to go to hospital because of the number system that excludes some of them from being attended. Gateway clinic has the same number of P/Ns as the LG clinic and influx of patients from the LG clinic cause Gateway clinic to close their clinic late. This issue needs to be discussed with the management of the LG clinic and needs to be adequately resolved

5.7.4 It was reasonable for patients who were compelled by unavoidable circumstances

Among those who could be managed at a PHC clinic there were patients who were compelled by unavoidable circumstances to bypass their clinic, that list included patients who attend mobile clinics and became sick on a day when there was no mobile clinic, patients who were from those areas with bad roads on rainy days, working patients and school children who could not wait for the PHC clinics to open. Patients are walking long distances to the clinics and the transport was more accessible to the hospital compared to the PHC clinics which compelled patients to bypass the PHC clinics. Gateway clinic happened to be closer to their homes than the LG clinic and it is easy for them to walk a shorter distance to the Gateway clinic. However patients with chronic conditions should not be bypassing the mobile clinics to come to the hospital for chronic medication. These patients should be able to plan and access chronic care at mobile points

5.8 Organisation of health service

In a nation there are complex activities that result in the provision of health services to the population. These services put together form a health system (HS). The HS can be defined as a set of components that function together to support and improve the health of

the population (Katzenellenbogen 1997). In South Africa the National Health Act 2003 divided health departments in to four divisions namely national health department, provincial health department, district health, municipal health services and community level structures (National Health Act 2003). The study was conducted within the DHS based on PHC. The DHS comprises a well-defined population living within a cleared delineated and administrative geographical area, whether government or otherwise (District Health System in South Africa). This level of health care system should be responsible for the provision of a full range of comprehensive PHC services within its jurisdiction. Effective referral system will be ensured.

5.8.1 Organisation of health services in Umuziwabantu sub-district

Health facilities include one district hospital (St.Andrew's hospital) seven public primary health care facilities, three mobile teams, one local government facility and one school health team. There are also general practitioners, non-governmental organizations and traditional health practitioners. The general practitioners and traditional healers provide mainly curative services and NGOs provide home based care. PHC facilities provide free promotive, preventive, curative and rehabilitative services. Patients pay hospital fees according to the fees manual.

The hospital provides outreach services to all public PHC facilities. Medical officers visit each clinic once a week and therapists visit each clinic once a month. Dental clinic team visit two clinics, that is KwaJali and Meadow Sweet clinics once a week. When PHC nurses realise that patients need higher level of care which they cannot provide, they refer those patients to the hospital with referral letters. There is well functional ambulance service for those patients who are very sick and for those who need emergency care.

5.8.2 Patients' knowledge about outreach, referral system and ambulance services

5.8.2.1 Outreach services

The high number (52.5%) of patients mainly from those clinics that are visited by doctors knew about the doctors' visits to their clinics and 41% of patients did not know about doctors' visits to their clinics. There was a time between November 2008 and July 2010 when the hospital could not provide medical coverage to the clinics because of the shortage of doctors at the hospital. According to the PHC facilities survey (2000) the proportion of facilities visited by a doctor in the month preceding the survey has improved to 63% compared to 54% in 1997 in all the provinces with the exception of KZN and Western Cape. About six percent of patients knew that their clinics were not visited by doctors. There is no medical coverage for all the mobile clinics and the LG clinic. All those patients who need medical treatment from the mobile clinics and LG clinic are referred to the hospital.

Information about other outreach services was only captured from those patients who bypassed those clinics where the outreach services are provided. The highest number (68%) of patients knew about outreach teams that visit their clinics. 31% of the patients knew nothing about outreach services. That number includes those patients who are no longer attending their local clinics but attend Gateway clinic.

5.8.2.2 Referral System

All the clinics in the Umuziwabantu sub-district refer patients who need medical treatment. The highest number (76%) of the patients knew about referral system between their clinics and the hospital. Those few that said there is none included those who bypassed clinics from other districts and provinces because those clinics do not refer their patients to St. Andrews hospital. Motlalepula M. and Mokgalagadi (2007) stated in their report on referral survey done in all the provinces that communities are not informed of referral pathways but at Umuziwabantu sub-district patients bypass their clinics knowing the referral pathways. Schneider and Barron stated in the summary of National Position Paper, 2009/2010 that there is poor coordination of referral systems (Schneider and Barron, KZN, 2009/2010)

5.8.2.3 Ambulance services

The patients were asked about the status of the ambulance service operating between their clinics and the referral hospital. 59% of patients rated the status of the ambulance service as good and 19% rated it as poor. Patients complained about delays when the ambulance is called. Doctors also confirmed that the ambulance response time is sometimes poor more especially if the ambulance is needed to transfer patients who need urgent treatment by specialists. There is a problem of shortage of ambulance service in Ugu district.

5.9 Recommendation from patients

5.9.1 Medication

The study allowed patients to make their recommendations which they think will improve the quality of service in their local PHC facilities. High in the list of their recommendations was medication. They recommended that medication must always be available in the clinics so that they are not told by nurses to go and buy prescribed medication from the private pharmacy. This is a reasonable recommendation since the facilities should ensure that there is always enough stock of drugs and the PHC supervisors and the district and hospital pharmacists should monitor the drug stock levels in the PHC clinics. The National PHC Facilities Survey (2003) revealed that very few facilities nationally had a full complement of Tracer EDL drugs available (16% in KZN and eight percent nationally). The patients also recommended that the number of medication they are given by nurses should be increased. During discussions with clinic Operational Managers they mentioned that patients sometimes dictate to nurses what they should give them. Patients should be told that prescription of medication depends on diagnosis made by health care professionals. The number of drugs dispensed per patient is based on the national guidelines (The National Primary Health Facility Survey, KZN, 2003).

5.9.2 Waiting times

Patients recommended that clinics should reduce patients' waiting times. They also stated that they sometimes prefer using private doctors because they have shorter waiting time. This also is a reasonable recommendation which can be achieved. They suggested that the department should employ more staff and the clinics should open early. The issue of new Primary Health Care organisational structure has been finalised but employment of more staff still depends on the availability of funds. The National Primary Health Facility Survey (2003) that was conducted in KZN revealed that the availability of various categories of health care personnel in KZN was similar to that of the rest of the country, with 33 professional nurses per 100,000 people (The National Primary Health Facility Survey, KZN, 2003).

The patients complained that those who come for special clinics (e.g. family planning, the antenatal clinic, and immunisations) are seen first, even if they arrived later than others. To deal with these problems patients recommended a practice of first-come-first serve method. The operational manager of Elim clinic stated that they discussed the issue of fast queue with the clinic committee and the idea of the fast queue was accepted by the community for working people and school children, as a result they have not experienced any problem.

5.9.3 Stop number system

The patients suggested that those clinics that practice number system should stop that system. Other clinics are using the number system to control the queue but the majority of patients who complained about the number system stated that nurses are using it to limit the number of patients they want to see a day and leave others who thus end up going to the Gateway clinic or St Andrew's Hospital OPD. This is a reasonable recommendation since patients visit a health care centre because they need assistance and it is not fair if the health care workers fail to assist them

5.9.4 Clinic operating times

The patients stated that clinic operating times is not convenient for some of them in terms of number of days clinics open and the time nurses start to work. They recommended that clinics should start early in order to accommodate the working people and the school children. This can be done if the nurses can take turns in starting early so that those who started early can go earlier than those who started at the usual time and everybody will end up working the official number of hours but patients will be satisfied. The suggestion that clinics should offer twenty-four hour service also depends on the number of patients that use the clinic after hours and whether the clinic conduct deliveries of pregnant mothers.

They recommended that mobile clinics should increase the number of their visits to the mobile points. The frequency of the mobile clinic visits depends on the head count of the mobile point. To avoid the problem of walking to the mobile point and the clinic does not come, patients suggested that nurses should announce the days when there will be no mobile clinic. This is a reasonable expectation from patients and the PHC supervisor should work out an action plan to improve the situation. The PHC survey that was conducted in 2000 revealed that mobile clinics in the Eastern Cape and KwaZulu-Natal experienced the most problems when it comes to letting their patients know when their services will be interrupted. KZN received the worst ranking in terms of its failure to make alternative arrangements for service continuation (The South African Health Review, 2000).

5.9.5 Staff Attitude and respect

Other patients complained about the bad attitude of the health care workers. They stated that they are scolding them and shouting at them. Nurses are discussing individuals' conditions in front of other patients. The clinic that uses number system locks the gates and makes them to stand outside the gates and only allows those patients with numbers to come in. The patients recommended that nurses should stop scolding, shouting at them

and being rude to them but show them some respect. They also suggested that nurses should improve confidentiality and provide privacy

5.9.6 Staff knowledge and patient care

The study revealed that 73.9% of the participants preferred to be treated by hospital doctors because of doctors' knowledge. Forty eight of the patients preferred to be treated by doctors because of the good caring attitude they get from doctors and only 18 patients wanted to be treated by PHC nurses because of the good caring attitude of PHC nurses. A few of the patients recommended that the clinic staff should be better trained in diagnostic procedures and the prescription of medication. This is a reasonable recommendation and it can be achieved. The National PHC facilities survey (2003) found that fewer nurses in KZN had received training updates during the 12 months preceding the survey, than nationally. Others recommended that clinics should have permanently placed doctors, not just visiting doctors. It is impossible to place permanently employed doctors in all the PHC facilities. Permanent doctors are employed in CHCs.

5.9.7 What other studies recommended?

A study was carried out by the KwaZulu-Natal Department of Health on disease profile of and health services sought by, clients attending KZN Primary Health Care facilities in 2010 (Disease profile of, and health services sought by clients attending KwaZulu-Natal PHC facilities). The recommendations made by the study for the KZN Department of Health are similar to the recommendations made by patients

5.9.7.1 Training of staff:

The study recommended that P/Ns should receive further training on diseases conditions and Nursing Assistants should be trained on other health related activities such as family planning and well baby clinics

5.9.7.2 Client Registration System

Registration system should include assigning a unique client registration or ID number for each patient.

5.9.7.3 Reducing workload

They recommended implementing of strategies to reduce the workload on existing staff by increasing access to medication for clients with stable chronic diseases without clients seeing nurses

5.9.7.4 Auditing of nursing staff in relation to the headcount

They recommended auditing of nursing staff in relation to headcount and assigning new nurses in priority facilities, and investigation into reasons for a low headcount in a clinic expected to have a high headcount (Disease profile, and Health service sought by-clients attending KZN PHC facilities, 2010).

5.9.7.5 Linking staffing norms and financial resources with package of service

Rispel et al. (2010) recommended that staffing norms and financial resources need to be linked with the service package, norms and standards. Levels of skills for different health and allied professional category and support staff should be clearly defined, the need for integrated referral pathways and ensuring that people access services at appropriate levels. The package should allow clients to know what services to expect and in line with Batho Pele principles clients could have redress if they do not get the services specified in the package.

5.9.7.6 Walk through services

The participants of the comprehensive PHC service package (2000) recommended that organisation of the services should consider walk through service, where no examination is needed the service should be made more user friendly. For patients with special needs, (including workers) service should be made available to suit their working hours as part of extended service hours or patients to be attended very early before other services start.

CHAPTER 6: RECOMMENDATIONS AND CONCLUSION

6.1 Introduction

This chapter presents the researcher's conclusions, which have been based on the study's findings. A discussion is made on each and every important issue that has been addressed in the study. This chapter also deals with the researcher's recommendations to the DOH when it comes to planning PHC structures, infrastructure, operations and community development and involvement.

It is quite obvious that there are unavoidable factors that can cause patients to bypass their clinics. The DOH does, however, need to address or reconsider certain issues in order for PHC clinics to deliver an effective service to the communities in which they are stationed.

6.2 Recommendations

6.2.1 *Increase The Capacity of Mobile Clinics*

The core function of the mobile clinic is to provide preventive service such as child health, women health, VCT and chronic treatment to the communities and the communities must be able to access these services in their local facilities. The mobile teams should identify mobile points with high headcount and plan more regular visits to those areas. The DOH should also provide more mobile vehicles and mobile teams to cover those areas that have high volume of patients. Mobile clinic should provide mobile gazeboes in order to provide temporary privacy. The DOH should provide covered waiting areas at mobile clinic points.

6.2.2 Strengthen LG clinic in town

The local government clinic in town needs to be strengthened. This clinic needs additional staff to be able to cope with the high numbers and the clinic needs upgrading in order to have more working space. This will help them to stop the number system.

6.2.3 Improving the clinic upgrading programme- clinics that need upgrading should be upgraded

The clinics' problem of limited space has increased due to the many programmes that have been down-referred to the clinics from the hospitals. It is easy to train PHC nurses so that they can manage the new conditions. Once this is done, the patients can be down-referred to their local clinics.

The DOH should ensure that the clinics that are still in the clinic-upgrading programme are redesigned and provide enough space for the clinic's needs. PHC nurses should be represented by individuals who are currently working in PHC when the clinic drawings are being done. When designing the clinic, the size of the population to be served by that particular clinic should be considered so as to avoid congestion.

There are three clinics- Pisgah, KwaJali and KwaMbotho-that are on the priority list and yet have not been completed. KwaJali clinic is being extended, in Pisgah they are building a new structure and KwaMbotho is a new clinic. Some have not even been started. Patients from those areas still depend upon the mobile clinics. When the mobile clinics are not around, they have to walk long distances to far-away clinics and thus face the challenges of insufficient transport and, in rainy weather, bad roads. It is recommended that the DOH closely monitor the department of Public Works that is responsible for clinic constructions in order to ensure that the plan is implemented and that the timeframes are met.

It is sometimes impossible for patients served by mobile clinics to wait for the clinic day; these patients will always go to the hospital when the mobile clinic is not available. St Andrew's Gateway clinic should be upgraded in order to provide all PHC services such as Ante-natal care. The DOH should combine the LG clinic and the Gateway clinic into one clinic and it should also obtain a proper clinic site and build a proper Gateway clinic as soon as possible. Schneider and Barron (2009/2010) also recommended that Local Government and Provincial services should be integrated in order to create an enabling environment for PHC operations ((Schneider and Barron, KZN, 2009/2010.).

6.2.4 Improving equipment

The issue of equipment was a concern raised by some of the participants. Though the clinics are well equipped, there are those that have equipment that is not in good working order. The PHC supervisor should not be satisfied that the clinics comply with over 85% of basic essential equipment but should check to see whether or not the equipment is in good working order. Hensher M et al (2006) recommended that adequate resources must be dedicated to strengthening lower levels of care to make them attractive and credible in the eyes of patients.

6.2.5 Improving human resources

6.2.5.1 Revision of Primary Health Care *structure and staff development*

It is not enough that nurses are able to treat new illnesses; the workload should also be considered and disease profiles of the clinics should be taken into consideration. PHC nurses are well trained and skills upgrading is conducted periodically. The patients who are seen at PHC facilities are no longer presenting with just minor aliments but are instead very sick. The time taken by PHC nurses to treat one such patient has become too long and other patients are made to wait in the queue. The restructuring of the PHC system is long overdue and the restructuring process that is currently in progress is very slow. The human resource planners ought to finalise the restructuring process and the

employment of additional staff according to the new structure ought to be fast-tracked. Rutkove et.al (1990) indicated that an improved PHC service in Natal and KZN would reduce the number of inappropriate outpatient visits. Schneider and Barron (2009/2010) said that PHC is complex and requires additional staff , diverse mix of staff , PHC trained professional nurses and appropriate allocation of staff.

6.2.5.2 Re-enforcing the Batho Pele implementation strategy

This study has revealed that bad staff attitudes, a lack of respect for patients and rudeness towards them is still common in PHC facilities. It should be compulsory that all staff employed at the PHC facilities be trained in the principles of Batho Pele which emphasise customer care. The Operational Managers should also monitor and enforce the practice of these principles. Clinic committees should also be trained in Batho Pele principles and be involved in monitoring the implementation of them.

6.2.6 Improving and monitoring PHC operations

6.2.6.1 Aligning clinic operating times to peak times

All patients who visit the clinics should receive treatment. Each clinic should review its operating times and realign its working schedule in connection with the periods of peak activity. By so doing, they will avoid having to turn patients away and having too-long queues and waiting times. Mobile clinics should leave their mobile clinic base earlier if they visit far away mobile points.

6.2.6.2 Increasing outreach services to PHC clinics

The mother hospital (i.e. St Andrew's Hospital) should review its outreach services and extend its services according to patients needs. Hensher M et al. (2006) recommended specialist attendance at lower-level facilities to provide regular outreach clinics. Oral health services should be extended to other clinics. This could be done in phases because

of the limited resources of the mother hospital. Mobile dental equipment is only really ideal if the service is going to be extended to more clinics as dental chairs and dental instruments are very expensive. The hospital should also consider providing an eye care service at those clinics in the most populous areas.

Doctors should improve nurse's knowledge during their outreach visits to the clinics so that they can better manage patients. Doctors should also attend community forums in order to re assure community members that PHC nurses are in fact competent to manage PHC conditions. Schneider and Barron, (2009/2010) recommended that support from medical officers; pharmacy assistants and other mid-level workers should be strengthened.

6.2.6.3 Improving the referral system

The medical manager should develop a mechanism for improving the referral system and monitoring adherence to the system. All chronic patients should be referred back to the clinics for follow-up sessions. Hensher M et al. (2006) recommended that referral hospital should offer significant support to personnel in lower-level facilities and specialist staff should ideally spend a significant portion of their time providing advice and support beyond the walls of their hospitals. Medical officers should, during their visits to the various clinics, continue to teach the PHC nurses according to the needs of the latter. The medical manager should also ensure that patients who could have been managed at the PHC clinics receive medication according to the PHC essential drug list in order to discourage them from bypassing their clinics and going to the hospital to obtain medications that they do not require.

During their visits to the various clinics, the staff of the DOH should monitor the capacity of PMSC with regard to the distribution of medications to various clinics so as to avoid drug stock-outs.

Medical Manager should develop systems for booked outpatient appointments. OPD management should consider and try a queuing system that will make the referred patients to be fast-tracked. Hensher M et al. (2006) also recommended that a queuing system should be redesigned to separate referred patients from non-referred patients so that referrals can be fast-tracked and explain to non-referred patients why other patients are being fast tracked past them. This will encourage them to seek referral in future.

Another possibility is to strengthen the implementation of policy of charging bypass fees for non-emergency patients who come to Casualty after hours without referrals. The success of this will only depend on the ability of the patient to pay that fee. Hensher et al. suggested that non-referred patients should be charged a penalty for failing to

PHC nurses should also be discouraged from sending patients who do not need medical intervention to hospital just because the patients demand to be transferred. The ambulance service should be trained so as to be able to assess the patients so that they will be able to take patients to the relevant levels of care.

Clinics with a high workload should be identified and upgraded so as to provide a 24-hour service. The DOH should fast-track the building of a CHC within the Umuziwabantu sub-district.

6.2.7 Community involvement and education

6.2.7.1 Community involvement

Community involvement is important so that community members understand why they need to start at the local clinic and only go to the hospital when referred

The communities served by PHC clinics should be involved in the operational planning sessions of the individual clinics so as to gain a sense of ownership with regard to the process and their specific clinic. The present study has revealed that the communities can

offer some valuable suggestion that if implemented can improve the utilisation rate of the PHC. Schneider and Barron (2009/2010) recommended that all PHC processes to common priority setting, target setting, planning and management must occur at District and sub-district levels ideally at catchment's level and include community outreach and interventions. They also recommended that there should be regular communication with local structures e.g. NGO's, LG, Community Care Giver's leaders and the public (Schneider and Barron, KZN, 2009/2010.)

6.2.7.2 Community education

Communities must be educated with regard to the health system's operations and the importance of utilising their local clinics. The communities must be informed where, how and when they should seek health care at different levels and to build their confidence that PHC facilities will be able to offer acceptable quality care when they need it. They should be educated as to the factors that influence the prescription of medications. They should also be educated as to the disadvantages of taking medications that are stronger than needed.

Community representatives should negotiate with transport and taxi associations so as to provide transport to take patients to their local clinics.

Ward councillors, Hospital Board members and Clinic Committee members should motivate during Local Government budget road shows for the upgrading of roads in their wards using the Local Government budget. The DOH should try and build clinics next to the roads in order for the clinic to be accessible.

6.2.8 Establish quality improvement programme

The Primary health care management should establish quality improvement programme in PHC facilities in order to improve the quality of service provided at PHC clinics. Rispel et al. (2010) suggested that there should be a mechanism for monitoring services

and quality assurance and at least one annual service audit. Community perception of service should be tested at least once a year through patient interviews or anonymous patient questionnaires. It would be better if such interviews are conducted in the Umuziwabantu facilities where patients are treated and corrective measures should be developed.

6.3 Recommendation by other studies

The recommendations that were made by Majoka et al.(2010) are similar to the recommendation of this study. Their recommendations included the following: Regular visits by hospital doctors to PHC facilities, flexible and longer operating hours of clinics, regular supplies of medication and education of patients and health professional about the referral system. This can improve the system and provide better patient care within the district health system

6.3.1 To Deal with inappropriate attendance to hospitals' special clinics

Lutge et al. (2003) concluded that at Ethekwini public hospitals the most important reasons for inappropriate attendance to hospitals was related to health worker behaviour and patient health-seeking behaviour. They recommended that interventions to reduce this problem should include raising the awareness of health professionals at hospitals of the importance of referring patients back to clinics for ongoing management and improving the quality of care at clinics in order to attract patients there *(Lutge et al. 2003).*

6.3.2 To deal with misconception about services available at the clinics.

The South African health Review (Briefing Summary, 1999) indicated that patients tend to make superficial judgements and misconceptions based on issues such as the quality of drugs, free services must be poor and disrespect. They recommended that the public

should be educated about the range of services available at PHC facilities. Patients must be treated with politeness and respect something that the public sector is capable to do. The clinics should start delivering services in a way that is acceptable to all patients. Misconception about services available at the clinic, the quality of drugs and the perception that free service must be poor should be addressed (South African Review, 1999).

The Global WHO report recommended that models to deliver health services and policies will need to be adaptable and flexible to meet the rapidly changing population needs. Perception that PHC is for poor and disadvantaged population, PHC is for rural and not urban communities and PHC is for developing and not developed countries should be addressed (WHO, 2003).

6.3.3 Local PHC services are seen as inappropriate and are bypassed by the communities they serve

The PHC review highlighted some recurring weaknesses in PHC implementation and one of the problems that were highlighted was that PHC services are seen as inappropriate and are bypassed by the communities they serve. The team recommended that health needs must be identified at the local level and communities should be involved in decisions about which PHC services they need most and how they are best delivered. They also recommended collecting community and user views on performance, systematically and continuously, improving accessibility and ensuring availability of basic resources such as drugs (WHO, 2003).

6.3.4 Multi-skilling of PHC staff

The report realised that PHC staff have the wrong skills and are not motivated and they recommended multi-skilling of PHC staff so that they feel confident to take on a wider range of tasks related to clear health priorities. There should be programmes of

continuing professional development which allow PHC staff to regularly update their skills. Leadership capacity should be developed at a local level (WHO, 2003).

6.3.5 Strengthening Primary health care services

PHC should be strengthened to meet the new challenges. The WHO review (2003) suggested that the process of strengthening PHC needs to be considered at both national and local levels. Strengthening PHC at local level will be to ensure that PHC models have the capacity and capability to respond quickly to emerging health and demographic challenges and the consequences of social changes. The model should ensure that locally based PHC is robust, flexible and adaptable.

6.3.6 Responding to a population health crisis

The report indicated that the challenge at local level is to be able to move out of the paradigm of the stable system and deliver rapid responses to an emergent health crisis such as HIV and AIDS. To do this successfully, the report suggested that future PHC will need a commitment to integration and collaboration, so that combined community and PHC solutions to the population health crisis are seen to bring together the elements of prevention, diagnosis, treatment and care. They also recommended access to information and training which will allow PHC practitioners to stay in touch with new knowledge and experience related to the population health crisis (WHO, 2003).

6.3.7 Infrastructure Plan

The government should ensure that infrastructure is of good quality and plan the infrastructure development to better meet the needs of the populations served (Lutge E. and Mbatha T, 2007).

6.4 Conclusion

This study has evaluated the factors that might cause patients to bypass their local clinics and go instead to the district hospital in the Umuziwabantu sub-district. The study was conducted at the Gateway clinic and at the OPD of St Andrew's Hospital. Seven-hundred-and-twenty participants were willing to participate in the study and were interviewed after they had each signed a consent form. Discussions also took place with individual Operational Managers from seven feeder clinics and LG clinic.

The results of the study have revealed that there are significant unavoidable factors that cause patients to bypass their clinics and come to the hospital without referral letters. They also revealed that it is unreasonable for the majority of patients to bypass their clinics.

The location of the hospital makes it convenient for the patients, who can more easily access the health services available to them at the hospital than they can those available at their local clinics. For other patients – such as patients from across the sub-district, as well as working patients and school children – the hospital just happens to be closer than their clinics.

A large area in the sub-district is still served by mobile clinics and it is impossible to visit these mobile points daily. Patients from those areas are compelled to come to the hospital on the days when there is no visit form the mobile clinic. A lack of transport or poor transport to the fixed clinics and bad roads pose more problems. The flow of transport forces patients to go to hospital rather than walk the long distances to their local clinics.

Long waiting times at the fixed clinics contributes towards patients bypassing their clinics. A shortage of staff and lack of space at the clinics significantly affect PHC operations. The weak referral system between the clinics and the hospital also contributes towards patients bypassing PHC clinics.

Patients still have the misperception that doctors are more knowledgeable than PHC nurses. It is because of this misperception that patients believe doctors offer a more thorough examination. Many patients prefer to be treated by hospital doctors than by PHC nurses. Some of the hospital's services have not as yet been extended to the PHC facilities, and patients thus have to come to the hospital to access those services.

The opening and closing times of the clinics sometimes force the patients to return home unattended. The issue of staff attitude is a stumbling block in terms of the utilisation of PHC facilities.

6.5 Recommendations for Further Study

Further research needs to be done in order to determine why it is taking so long to complete the construction of the new clinics and to upgrade the province's already existing ones. Another study that could be of value is one that would determine the criteria that ought to be used to choose the best sites for PHC facilities.

Another research on clinic operations needs to be done to determine:

- The causes of delay of mobile clinics to reach their mobile site early.
- Why mobile clinics at Umuziwabantu close for a certain period during the festive season and the impact that has on PHC utilisation rate.
- The impact of PHC operating hours have on PHC utilisation rate.

In addition, research can be used to determine whether the unavailability of drugs in the PHC facilities is a significant problem that can cause patients to bypass their PHC clinics.

6.6 Limitations

Some of the participants did not respond to all the questions, making some of the results unreliable.

Inclusion and exclusion criteria did not consider patients who came from Mobile points with acute condition and patients who came on the days where there were no mobile clinics, patients who came to for the services that the PHC clinics do not provide and patients advised by hospital doctors to come back to OPD with no appointment letters.

The researcher was consistently interrupted during the study since it was conducted in the same institution where she works.

The study took longer than initially planned since the Research Committee recommended that it should cover two seasons, namely the summer and the winter.

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Annexure 1 Distribution of PHC, population and distances from St Andrew's Hospital

PHC Facility	Ward	Distance in kilometres from St Andrew's Hospital	Population served
Meadow Sweet	2	25	10,523
Harding TLC	3	1	8,154
Pisgah Clinic	4	15	9,880
Elim Clinic	5	35	11,029
Xhamini	6	28	11,406
Weza Clinic	7	22	9,327
Mbonwa	8	15	12,449
KwaJali	9	26	9,154
St Andrew's Hospital	3		8,154

Annexure 2 Distribution of mobile points, population and distances from St Andrew's Hospital

Mobile team	Clinic Point Name	Ward	Kilometres from St Andrew's Hospital	Population served
Team 1	Mzokhanyayo	1	48	10,503
	Skhulu (Mbotho)	1	27	10,503
	Sabelweni	2	63	10,523
	Bashaweni	2	42	10,523
	Local Crèches / FP	3	03	8,154
	HTT (Factory)	3	1	8,154
	Salem	4	26	9,880
	Nkondwana	4	43	9,880
	Mshisweni	4	47	9,880
	Phumza	6	55	11,406
	Nyuswa	Izinqoleni sub-district	71	
	Blose	Izinqoleni sub-district	58	
Team 2	Mpumalanga	2	61	10,523
	Bashaweni	2	40	10,523
	Local Crèches/FP	3	03	8,154
	Ntlanza	4/6	40	9,880/11,406

	Hlekanjalo	7	36	9,327
	Mbuthuma	8	40	12,449
	Deemount	8	35	12,449
	Stezi	8	33	12,449
	Sivivaneni	9	58	9,154
	Skulu (Jali)	9	48	9,154
	Bhudlu	9	60	9,154
	Gundrift	Eastern Cape	50	
Team 3	Mbotho B.	1	41	10,503
	Mbotho L.	1	46	10,503
	Ndlovini	2	52	10,523
	Crèches/pap smears	3	03	8,154
	Guy Payne	3	19	8,154
	Phillip	5	51	11,029
	Madiya	5	67	11,029
	Mbangweni	5	63	11,029
	Hluku	6	28	11,406
	Gayiga	7	28	9,327
	Ngqolo	7/9	44	9,327/9,154
	Mkhoba	8	40	12,449
	Mbizweni	9	51	9,154
	Egoli	9	55	9,154

Appendix A: - Key Informant Interview Questionnaire

(T.L.Ntleko.) 206524361. MPH. Ref. No. MPH004/08

Annexure: 1

DETERMINING FACTORS RELATED TO PATIENTS BYPASSING PRIMARY HEALTH CARE FACILITIES AND ACCESSING THE DISTRICT HOSPITAL AS POINT OF FIRST CONTACT IN THE UMUZIWABANTU SUB-DISTRICT

KEY INFORMANT INTERVIEW QUESTIONNAIRE

Please answer the following questions as best as you can or put a cross in the appropriate column where applicable.

STUDY NO. | | | |

DATE (of the interview) ----------/---------/----------

Time arrived in the hospital ----------

Time interviewed----------

1. Age | | |

2. Gender | Male | Female |

3. Race: | African | Coloured | Indian | White | Other |

3.1. If other, please specify:

_____

4. Are you employed? | Employed | Not employed |

4.2. Where are you presently working?

_____

1

4.2.1 Province:

KZN	EC	Other

4.2 2. District:

Ugu	Sisonke	Izinqoleni	Other

4.3.1. If other please specify:

_____

4.2.3. Town:

Harding	Other

4.2.4. If other, please specify:

_____

5. What type of work are you doing?

Skilled	Unskilled	Manual	Domestic	Other

Skilled	Having special ability to do the job as gained by learning/education/academic	1
Unskilled	Doing the job with no formal skill or relevant education	2
Manual	Manual worker/using hands	3
Domestic	A servant who works in a house	4
Other	Specify	5

6. Where are you presently staying?

6.1. Province:

KZN	EC	Others

6.1.1. If other, please specify: _____

6.2. District:

Ugu	Sisonke	Izinqoleni	Others

6.6.2. If other please specify:_____

6.3. Type of place:

Urban	Peri-Urban	Rural

Urban	Living in town or in the city	1
Peri-Urban	Living in the area outside town	2
Rural	Living in the village or countryside	3

6.4. Type of accommodation:

House	Hut	Informal settlement	Other

House	A formal building for people to live in that has more than one room	1
Hut	A formal single roomed structure made of traditional material	2
Informal settlement	Informal dwelling/shack not in the backyard	3
	Informal dwelling/shack in the backyard of a formal house	4
Other	Specify	5

7. What is the name of your nearest clinic? (Bypassed): _____

8. How do you get to the clinic? (Bypassed):

Walking	Public transport	Own transport	Other

If public transport, own transport or other, how much does it cost a single trip?

_____ in Rands

8.1. How long does it take you to reach the bypassed clinic using the above mentioned means?

< 1hour	1-2hours	2-3hours	3-4 hours	>4 hours

8.2. How do you get to St Andrews hospital?

Walking	Public transport	Own transport	Other

If public transport, own transport or other, how much does it cost a single trip?

_____ in Rands

8.3. How long does it take you to reach St Andrews hospital using the above mentioned means?

< 1hour	1hour-1.55 minutes	2-3hours	>3hours

8.2 What is the earliest time can you get the transport to the bypassed clinic?

5-6.55hrs am	7-8.55hrs am	9-11hrs am	Later than 11hrs am

8.3. What is the earliest time can you get the transport from the bypass clinic back home?

Earlier than 10am	10-12	12-15hrs	15-16hrs	Later than16pm

8.4 What is the earliest time can you get the transport to St Andrews hospital?

5-6.55hrs am	7-9 am	9-11hrs am	Later than 11hrs am

8.5 What is the earliest time can you get the transport from St Andrews hospital back home?

Earlier than 10am	10-12	12-15hrs	15-16hrs	Later than16pm

9. At what time does your bypass clinic start to operate?

7-8 am	8-9 am	9-10 am	10 am	11 and later	Don't know

9.2 Is that time convenient for you?

Convenient	Not convenient

9.2.1 If the answer is not, are reasons related to?

Transport	Work	Personal	Other

9.1.2. If other please state the reasons:

_____

_____

_____

9.3. At what time would you like your bypass clinic to start operating?

7 am	8 am	9 am	10 am	11 am	Other

9.3.1 Please state the reasons of the starting time of your choice:

_____

_____

_____

9.4 At what time does the clerk stop registering patients at the bypass clinic?

Earlier than 8 am	8 -10.55 am	11 -12.55	13-16pm	Later than 16hrs	Other

9.4.1. If the answer is other please state the time: _____

9.5 Is that time convenient for you?

Convenient	Not convenient

9.6. If the answer is no are reasons related to

Transport	Work	Personal	Other

9.6.1 If the answer is personal or other will you please state your reasons:

_____

_____

_____

10. How long do you wait in the bypass clinic before you are seen and given treatment by a nurse who examines you?

Less than 1hr	1hr-3hrs	More than 3hrs

10.1. Is that waiting time convenient for you?

Convenient	Not convenient

10.2. If the answer is no are the reasons related to

Transport	Work	Personal	Other

10.2.1 If the answer is personal or other will you please state your reasons:

_____

_____

_____

_____

_____

_____

_____

_____

10.3 How long do you wish to wait?

< 30 minutes	1/2hr- to1hr	1hr to 2hrs	Other

11. Where would you prefer to be treated?

Clinic	Hospital	Private doctor	Traditional healer

11.1. Are the reasons for your choice related to?

Easy access	Nearest	Drugs issued	Staff incompetence	Staff attitude	Other

11.2. If your answer is others will you please state your reasons:

_____

_____

_____

12. Who do you prefer to treat you between a PHC nurse and a doctor?

PHC Nurse	Doctor

12. 1 Are the reasons for your choice related to?

Knowledge	Type of drugs	Attitude	Others

12.2. If your answer is others will you please state your reasons:

_____

_____

_____

13. Are you satisfied with the medication you get from the clinic?

Satisfied	Not satisfied

13.1. If your answer is no is it related to?

Quality of medicine	Number of drugs issued	Type of medicine	Others

13.2. If your answer is others will you please state your reasons:

_____

_____

_____

14. Are you satisfied with the way the bypass clinic staff treat you in the clinic?

Satisfied	Not satisfied

15. Are you satisfied with the way the hospital staff treat you in the hospital?

Satisfied	Not satisfied

16. Are there days when you cannot get to the clinic?

Always	Sometimes

16.1. Are your reasons related to?

Bad weather	Transport	Road	River	Others

16.2. If your answer is others will you please state your reasons:

_____

_____

_____

_____

_____

17. Name the facility you always attend:

PHC facilities	Hospital	Others

17.1 If the answer is others please state where else would you like to be treated

_____

_____

17.2. (a). What is your main reason for coming to the hospital today?

_____

_____

_____

17.2 b. Today's attendance:

Referred by PHC Nurse	Appointment	Self-referred

18. Do you know outreach services provided by specialist/therapist to the bypassed clinic?

I Know	Don't know

18.1 Mention those you know:

Physiotherapy	Occupational therapy	Dental therapy	Dietician	Social workers	Others

18.1.1 If there are other outreach services you know please mention them:

_____

_____

_____

18.2. Do you know when the doctors visit your clinic?

I know	Don't know	There is no visiting doctor

19. Is there a referral mechanism between your bypass clinic and the referral hospital?

There is	There is none	I don't know

20. How can you rate the ambulance service for emergencies from the bypass clinic to the referral hospital?

Good	Poor	None	I know nothing about emergency transport

21. What improvements would you like to see happening in the clinic for you to enjoy being treated there

Clinic operating hours	Waiting time	Medication	Staff knowledge	Staff attitude	Others

21.1 If the answer is others please please state the improvements of your choice

_____

_____

_____

_____

Appendix B: Information Sheet

Student No. 206524361 REF: BF087/09

PARTICIPANT INFORMATION

DETERMINING FACTORS RELATED TO PATIENTS BYPASSING PRIMARY HEALTH CARE FACILITIES AND ACCESSING THE DISTRICT HOSPITAL AS POINT OF FIRST CONTACT IN THE UMUZIWABANTU SUB-DISTRICT

Dear Participant,,

I am Mrs. Ntleko, one of the workers at St. Andrews Hospital and part time student of the University of KwaZulu-Natal MPH programme. I am doing research on the bypassing of Primary Health Care (PHC) facilities by patients in Umuziwabantu sub-district. This research will assist us to identify factors that contribute to the bypassing of PHC facilities, so that intervention strategies can be put in place. The study has received ethics approval from the University of KwaZulu-Natal Research Ethics Committee.

You are requested to participate in the research project that will help in determining the factors that are related to patients bypassing PHC facilities and accessing the district hospital as point of first contact in your area. The information that is required is related to accessibility, acceptability and affordability of the PHC and hospital outpatient services in different areas in our sub-district.

It will be very expensive to involve everybody who attends St. Andrews Gateway clinic and the Outpatients Department in the study, but you are part of 720 people that will be chosen to represent the population that we are targeting.

If you agree to participate, you will be requested to answer some questions about bypassing PHC facilities. It will take you not more than 20 minutes of your time to answer those questions.

Your participation is absolutely voluntary; you have a right to refuse to participate if you do not wish to and you may withdraw at any time during the study and there will be no penalties.

The study might be of benefit to you and your community should a need arise to improve service delivery and influence other factors that affect your access to PHC facilities in your area.

Confidentiality

All efforts will be made to keep the information that you give us during the study confidential though absolute confidentiality cannot be guaranteed. Each participant will be assigned a unique number on the questionnaire that will not be shared with other participants. You will not be asked your name. Your individual

1

answers and your identity will not be revealed to anybody except to the supervisor and / or the Research Ethics Committee who may inspect research records for quality assurance and data analysis. The questionnaires will be kept in safe custody for a certain period of time for reference purpose.

Your participation in this research is highly appreciated. Your consent to participate in the study will be confirmed by the completion and signing of the consent form and availing yourself for the interview.

If you would like to know the results of the study, you can contact the study investigator Mrs. T.L.Ntleko using the following contact details below when the results are available at the following address: St. Andrews Hospital, Private Bag x1010, Harding, 4680; tel: (039) 4331955; cell: 0726108955; e-mail: thandazile.ntleko@kznhealth.gov.za

For further details or queries do not hesitate to contact the study supervisor, Dr. A.J Ross at - tel: 031-2604485 or email at ross@ukzn.ac.za. If you wish to obtain additional information or to report concerns pertaining to the ethical aspects of the study you may contact the Biomedical Research Ethics Committee (BREC): **BREC Administrator or Chair** -for reporting of complaints or problems:

Biomedical Research Ethics, Research office, UKZN, Private Bag X54001, Durban 4000

Telephone: +27 (0) 31 260- 4769/2601074
Fax: +27 (0) 31 2602384
Administrator: Ms P NgwenyaEmail: ngwenyap@ukzn.ca.za
Chair: Email: Prof DR Wassenaar c/o ngwenyap@ukzn.ca.za

Thank you for participating in this research.

T.L. Ntleko

Appendix C: Consent Form

Student No. 206524361 REF: BF087/09

CONSENT DOCUMENT

INFORMED CONSENT TO PARTICIPATE IN RESEARCH THAT AIMS TO DETERMINE FACTORS RELATED TO PATIENTS BYPASSING PRIMARY HEALTH CARE FACILITIES AND ACCESSING THE DISTRICT HOSPITAL AS POINT OF FIRST CONTACT IN THE UMUZIWABANTU SUB-DISTRICT REF: BF087/09

Clinic/Hospital_____

You have been asked to participate in a research study for the Masters Degree in Public Health

You have been informed about the research study by Mrs. T.L. Ntleko the Principal Investigator.

You may contact Mrs.Thanadazile Ntleko at St. Andrews Hospital, telephone no.039-4331955, cell phone no.0726108955 anytime if you have questions about the research.

You may contact the Medical Research Administration office at the Nelson R Mandela School of Medicine at 031-26044769 or 2601074 if you have questions about your rights as a research subject.

Your participation in this research is voluntary, and you will not be penalized or lose benefits if you refuse to participate or decide to stop.

If you agree to participate, you will be given a signed copy of this document and the participant information sheet which is a written summary of the research.

The research study, including the above information, has been described to me orally. I understand what my involvement in the study means and I voluntarily agree to participate.

Signature of Participant	Print Name	Date
Signature of Witness (Where applicable)	Print Name	Date
Signature of Translator (Where applicable)	Print Name	Date

Appendix D: Permission from The KwaZulu-Natal Provincial Department of Health

HEALTH
KwaZulu-Natal

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM098/09
Enquiries : Mrs G Khumalo
Telephone : 033 – 3953189

24 August 2009

Dear Mrs T Ntleko

Subject: Approval of a Research Proposal

1. The research proposal titled **'Determining factors related to patients bypassing Primary Health Care facilities and accessing the district hospital as point of first contact in the Umuziwabantu Sub-district of KwaZulu-Natal'** was reviewed by the KwaZulu-Natal Department of Health.

   The proposal is hereby **approved** for research to be undertaken at **St Andrews Hospital, Gateway Clinic.**

2. You are requested to undertake the following:
   a. Make the necessary arrangement with identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mrs G Khumalo on 033-3953189.

Yours Sincerely

Dr S.S.S. Buthelezi
Chairperson, Health Research Committee
KwaZulu-Natal Department of Health

Appendix E: Permission from Ugu District Manager

HEALTH
KwaZulu-Natal

UGU DISTRICT OFFICE
41 Bissett Street, Port Shepstone, 4240
Private Bag X735, Port Shepstone, 4240
Tel.: 039 6883000, Fax.: 039 6826296
Email.:veeran.chetty@kznhealth.gov.za
http://www.kznhealth.gov.za/ugu.htm

Reference : Research Projects
Enquiries : Mr V. Chetty
Telephone : 039-6883000
17 August 2009

Mrs TL Ntleko

Re: Letter of Support: DETERMINING FACTORS RELATED TO PATIENTS BYPASSING PRIMARY HEALTH CARE FACILITIES AND ACCESSING THE DISTRICT HOSPITAL AS POINT OF FIRST CONTACT IN THE UMUZIWABANTU SUB-DISTRICT

- I refer to your letter dated 17/08/09 in the above matter
- This is to confirm that as District Manager, I support the project.
- Please note this is a letter of support only.
- Approval from our Departmental Ethics Committee is necessary before the research begins.
- Once you have obtained final approval from the Department and ready to implement the project, please liaise with Mrs Ntuli to facilitate informing the relevant Clinics
- Your contact person at head office for approval of the research is Mrs Gugu Khumalo-email details as above.

Yours faithfully
Mr Veeran Chetty
District Health Manager

Cc Mrs Ntuli
Cc Mrs Sokhulu
Cc: Ms Gugu Khumalo (Please note that Mrs Ntleko is a hospital manager and has been nominated by the Department to participate in the Hospital management programme and this research is part of this programme)

Appendix F: Permission from The Deputy Nursing Manager of St Andrews Hospital

HEALTH
KwaZulu-Natal

St Andrews Hospital
14 Moodie St
Private Bag X1010
HARDING
4680
Tel: 039 – 4331955
Fax: 039 - 4332439
E-mail: mandisa.vane@kznhealth.gov.za

Our Ref:
Enquiries:M.M Vane.
Telephone: 0394331955 ext 211
24th February 2010.

Dear Mrs T.L. Ntleko

Re: Approval of a Research Proposal

1. The research proposal titled 'Determining factors related to patients bypassing Primary Health Care facilities and accessing the district hospital as a point of first contact in the UmuziwabantuSub-district has been received.

This is to confirm that as a Deputy Nursing Manager on behalf of the Hospital Manager I grant you the permission to undertake the above mentioned research project to be conducted at St. Andrews Gateway clinic.

2. You are requested to make the necessary arrangements with the Gateway clinic Operational Manager and FIO for the assistant you will need.

3. Attached here is completed document of permission as requested.

We wish you every success with your study

Yours faithfully
Ms MM Vane
Deputy Nursing Manager (for Hospital Manager.)

Appendix G: Permission from PHC Supervisor of Umuziwabantu PHC

HEALTH
KwaZulu-Natal

St Andrews Hospital
14 Moodie St
Private Bag X1010
HARDING
4680
Tel: 039 – 4331955
Fax: 039 - 4332439

Our Ref:
Enquiries: T Ntuli.
Telephone: 039433 2458
24th February 2010.

Dear Mrs T.L. Ntleko

Re: Approval of a Research Proposal

1. The research proposal titled 'Determining factors related to patients bypassing Primary Health Care facilities and accessing the district hospital as a point of first contact in the Umuziwabantu Sub-district has been received.

This is to confirm that as a PHC Supervisor I grant you the permission to undertake the above mentioned research project to be conducted at Umuziwabantu Sub-district PHC facilities.

2. You are requested to make the necessary arrangements with the relevant Operational Managers for the information and assistant you will need.

3. Attached here is completed document of permission as requested.

We wish you every success with your study

Yours faithfully
T Ntuli
PHC Supervisor

Appendix H: Approval from The Biomedical Research Ethics Committee of the Nelson R. Mandela School of Medicine, South Africa

UNIVERSITY OF
KWAZULU-NATAL

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604769 - Fax: 27 31 2604609
Email: BREC@ukzn.ac.za
Website: http://research.ukzn.ac.za/ResearchEthics/BiomedicalResearchEthics.aspx

16 March 2010

Ms Lillian Ntleko
St Andrews Hospital
Private Bag x1010
Harding
4680

Dear Ms Ntleko

PROTOCOL: Determining Factors related to patients bypassing Primary Health Care facilities and accessing the District Hospital as point of first contact in the UMUZIWABANTU sub-district of KwaZulu- Natal. Ms. TL Ntleko, Dept. of Medicine, UKZN. REF: BF087/09.

The Biomedical Research Ethics Committee (BREC) has considered the abovementioned application.

The study was approved by a quorate meeting of BREC on **09 June 2010** pending appropriate responses to queries raised. Your responses received on 05 March 2010 to queries raised on 29 January 2010 have been noted by a sub-committee of the Biomedical Research Ethics Committee. The conditions have now been met and the study is given **full ethics approval** and may begin as from today; **16 March 2010**.

The study protocol and related study documents have been reviewed and approved:

This approval is valid for one year from **16 March 2010.** To ensure uninterrupted approval of this study beyond the approval expiry date, an application for recertification must be submitted to BREC on the appropriate BREC form 2-3 months before the expiry date.

Any amendments to this study, unless urgently required to ensure safety of participants, must be approved by BREC prior to implementation.

Your acceptance of this approval denotes your compliance with South African National Research Ethics Guidelines (2004), South African National Good Clinical Practice Guidelines (2006) (if applicable) and with UKZN BREC ethics requirements as contained in the UKZN BREC Terms of Reference and Standard Operating Procedures, all available at http://research.ukzn.ac.za/ResearchEthics11415.aspx.

BREC is registered with the South African National Health Research Ethics Council (REC-290408-009). BREC has US Office for Human Research Protections (OHRP) Federal-wide Assurance (FWA 678).

The following Committee members were present at the meeting that took place on 09 June 2010:

Professor D Wassenaar	Chair
Professor S Collings	Psychology
Ms T Esterhuizen	Faculty of Medicine
Dr R Govender	Family Medicine
Dr U Govind	General Practice - Private Practitioner
Dr T Hardcastle	Surgery - Trauma
Dr Z Khumalo	KZN Health - External
Professor D Pudifin	Medicine
Professor V Rambiritch	Pharmacology
Dr M A Sathar	Medicine
Prof R Bhimma	Paediatrics and Child Health
Mrs T Makhanya	External
Dr J M Titus	Obstetrics and Gynaecology (Pmb)
Dr S Paruk	Psychiatry
Prof T Madiba	General Surgery
Mr R Moore	Law/UKZN IP Officer

We wish you well with this study. We would appreciate receiving copies of all publications arising out of this study.

Yours sincerely

PROFESSOR D R WASSENAAR
Chair: Biomedical Research Ethics Committee

Appendix I: Map of Umuziwabantu Health Facilities