# A STUDY OF HISTORICAL DEVELOPMENT OF KWAMASHU HEALTH SERVICES REGION 'F' OF KWAZULU-NATAL

BY

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## DECLARATION

I Gloria Nompumelelo (Matshitshi) Mkhize declare that the study of historical development of health services at KwaMashu Region "F" is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references.

07/07/02

# DEDICATION

1. My beloved parents Busisiwe and Qhubinqubo, who nurtured in me the will and enthusiasm to learn.

2. My family and my late husband, Moses Mkhize, for their unfailing support and encouragement.

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- The participants of KwaMashu, who gave me information and assisted me in the completion of this study.
- My friends and colleagues for their encouragement in the completion of this study.
- The authors whose work I consulted.
- Lastly I thank God the Almighty for guiding and giving me strength and courage to complete this piece of work.

# ABSTRACT

This study deals with the historical establishment of health services at KwaMashu. The establishment of health services in KwaMashu was very important to meet the health needs of the community, and it is imperative to make a written document available about the establishment of health services in this community, which will assist the health professionals to obtain as much background information as possible.

The people targeted were the staff who initiated the KwaMashu polyclinic, the KwaMashu community members and the staff working at KwaMashu. A questionnaire was used to elicit information from the retired staff who initiated the KwaMashu polyclinic, KwaMashu community members and the staff working at the KwaMashu polyclinic. During interviews tape recorder was used to elicit information and to control trustworthiness.

The findings indicated that the establishment of health services met the needs of the community and that there was improvement in care provided to the community, through promotion and prevention of health problems. Some problems identified need to be attended urgently for the provision of quality care to patients and clients.

# CHAPTER 1

## ORIENTATION OF THE STUDY

### 1.1 INTRODUCTION

Health services are needed by all communities but they are not usually fulfilled. Health needs can be regarded as basic needs. Basic needs are seen by Maslow to Fisher (1989:57) as developing where a person cannot survive without them. Health needs is one of the needs common to all human beings are required by individuals and families. The present situation in South Africa is that people are gradually being deprived off basic needs such as water, sanitation and food which further deprive them of their health.

The researcher will discuss the establishment of health services at KwaMashu. These services are important and they meet needs and provide the ideas foundation for a health promotion programme amongst less developed people. The KwaMashu health centre was developed for the purpose of promoting socio-medical care in the Black underdeveloped society. The study will be centered around the historical development of these services at KwaMashu.

### 1.2 BACKGROUND OF KWAMASHU

KwaMashu is a location for Black Communities established in 1959. Before the establishment of KwaMashu health clinic, people received medical help at King Edward Hospital which is $\pm$ 30km from KwaMashu.

Transport was a problem: Community members used trains to travel as far as Congella station, and to and from King Edward Hospital, but those who were seriously ill use NPA ambulances. People used to go to the nearest township office

for the request of ambulance services so that ill patients could be transported to the hospital. Those who had means of paying for transport, hired taxis to King Edward Hospital. Many people died because of the unavailability of medical help.

During the time of establishment of the polyclinic, the community of KwaMashu in 1962 had problems of infectious diseases and malnutrition. The KwaMashu health centre believed that the health of he people in its widest sense of the Blacks cannot be secured by curative medical services alone but required a broader socio medical approach. Most of the diseases which were seen at that time had its roots in inadequate nutrition, largely due to neglect and misuse of available resources, poor agricultural methods, bad cooking practices and increased reliance on processed foods (Ngiba, Mthalane and Hlophe: 2000).

## 1.3 MOTIVATION

The researcher is a Professional Nurse working in this health centre and is motivated by the improvements at the KwaMashu Health Centre which has no written history on the development of health services at KwaMashu. The history of the service is important for those providing the service as well as the health planners, because from the history one realizes where he or she comes from, where he or she is and where he or she is going to. It provides a framework that makes it easier to identify problems, to trace such problems and to eradicate the problems.

The researcher maintains that the availability of written documents about health services in a place such as the KwaMashu polyclinic is important so that information can be passed on from generation to generation, and thus improvement of the general health care of people can occur. The people, particularly the younger generation can take pride of structures such as clinics and government offices, including schools, in order to protect those structures acts of vandalism, theft and destruction.

## 1.4 STATEMENT OF THE PROBLEM

The non-availability of the written information as an evidence of health services that are provided by health professionals at KwaMashu polyclinic makes it difficult for health providers to do appropriate referrals. If there are no written document about the health centre the professionals fail to obtain the necessary background information which may interfere with the standards of patient care. Background knowledge helps the health professionals to make appropriate and relevant plans for the services to be rendered to the people.

## 1.5 THE IMPORTANCE OF THE PROBLEM

If there is no written document or information available about the development and the extent of health services at KwaMashu polyclinic, health care professionals would not know where the health care centre was started, what improvements had been made to provide health care services and what could be done in the future to make the service accessible and acceptable by the people of KwaMashu. Information which will be provided is necessary to forward planning and thus further improve health services at KwaMashu.

## 1.6 THE PURPOSE OF THE STUDY

### 1.6.1 AIM OF THE STUDY

- To explore the historical development of health services in KwaMashu with the aim of tracing and recording the past in order to plan for the future health services that will be appropriate to the people.
- To locate the position of KwaMashu Health Centre in the District Health System.
- To identify types of services that are offered and to determine if such services meet the needs of the people of KwaMashu.

## 1.7 DELIMITATION OF THE STUDY

The study will be conducted and limited to KwaMashu polyclinic. Data will be collected from health professionals who were present during the establishment or development of KwaMashu Health Centre. Data will also be collected from the community members who were present during the establishment or development of the health centre.

## 1.8 DEFINITION OF TERMS

### 1.8.1 COMMUNITY HEALTH CENTRE

Community health centres are polyclinics where medical, midwifery and nursing facilities are readily available to the community, the aim being to have the health centre within a 5km radius of each patient's home in density populated areas. Community health centres provide curative, prevention, psychiatric and midwifery services.

### 1.8.2 PRIMARY HEALTH CENTRE

Primary Health Care is an essential health care made universally accessible to individuals and families in the community by means acceptable to them through their full participation and at a cost that the community and country can afford to maintain in the spirit of self reliance. It provides preventive, promotive, curative and rehabilitative services and addresses certain basic health needs.

### 1.8.3 DISTRICT HEALTH SERVICES

District health services are based on Primary Health care, a more or less self-contained segment of the National Health System. It comprises first and fore most a

well defined population living within a clearly delineated administrative and geographical area.

### 1.8.4 HEALTH

According to the Word Health Organization (WHO) health refers to the state of physical, mental and social well-being of an individual and not merely the absence of disease or infirmity.

### *1.8.5 QUALITATIVE RESEARCH METHODOLOGY*

According to Brink (1996:119), qualitative research attempts to understand the phenomenon in its entirely rather than focusing on specific concepts. It has few pre-conceived ideas and stresses the importance of people's interpretations of events and circumstances rather than the researcher's interpretation. It collects information without formal structured instruments.

### 1.8.6 HISTORICAL RESEARCH METHODOLOGY

According to Brink (1996:116), historical research that seeks facts that will help one to interpret and understand past events and influences. Historical research generally involves the review of written materials, but may include oral documentation that may be considered.

### 1.8.7 NEEDS ASSESSMENT

According to Brink (1996: 117), needs assessment is a study in which a researcher collects data for estimating the needs of a group, community or organization for certain types of services or policies.

### 1.8.8 BASIC NEEDS

According to Maslow's theory, cited in Consumer Behavior (1997:95), basic needs are human needs which rank in order of importance from lower level needs to higher level needs. It suggests that individuals seek to satisfy lower level needs before higher level needs emerge. The lowest level of chronically unsatisfied needs that an individual experiences serves to motivate his or her behavior.

## *1.9 LITERATURE REVIEW*

Books, periodicals and journals will be consulted.

## 1.10 THEORETICAL FRAMEWORK

The study will be based on Maslow's Hierarchy of Needs Fisher (1989:57), this theory according to the researcher appears to be the most appropriate.

## 1.11 ETHICAL CONSIDERATION

Permission will be obtained from the Department of Health, the Superintendent of KwaMashu polyclinic and the Assistant Director of the Institution. The participants will be requested to take part in the study, but participation will be voluntary. The subjects will be ensured of anonymity, confidentiality and availability of results to the participants. Informed consent will be obtained.

## 1.12 ASSUMPTION OF THE STUDY

It is assumed that knowledge of the history of the service will encourage the health workers to identify the needs of the people and be more sensitive to such needs.

## 1.13 RESEARCH QUESTIONS AND HYPOTHESIS

The following questions are generated from the statement of the problem:

- Why are the records not available on the history and development of KwaMashu polyclinic?
- What records and individuals are available to provide the information needed?
- To what extent have the services contributed to the health of the community of KwaMashu?

## 1.14 RESEARCH DESIGN

The research design will be historical. Historical research will be more appropriate for this study because it is in narrative form, providing in depth knowledge about the health services of KwaMashu.

### 1.14.1 RESEARCH TOOL

Questionnaires will be used to collect data. Interviews will also be conducted.

### 1.14.2 PILOT STUDY

A pilot study will be conducted to pretest the instrument.

### 1.14.3 SAMPLE

In this research the sample will be nursing staff that are presently working at KwaMashu polyclinic as well as retired staff member who initiated the KwaMashu Health Centre, and the community members.

### 1.14.4 DATA COLLECTION

Data will be collected by means of questionnaires that will be distributed to subjects. Where subjects are prepared to provide in-depth knowledge, interviews will be conducted.

## 1.15 DATA ANALYSIS

Data analysis will be analysed using a coding system collected data will be captured in the computer.

## 1.16 SUMMARY, CONCLUSION AND RECOMMENDATIONS

The results of the study will be discussed. The recommendations including the summary and conclusion will be made.

# CHAPTER 2

## THE ESTABLISHMENT OF HEALTH SERVICES AT KWAMASHU

### 2.1 INTRODUCTION

This chapter presents a review of literature related to the establishment of health services at KwaMashu. Firstly, the purpose of literature review in this study is to examine or to determine what is already written and known about the topic to be studied so that a comprehensive picture of the state of knowledge on the topic can be obtained. The information was obtained from the participants who are the community members the staff working at KMPC and retired members.

Secondly, some information obtained from the participants will provide the researcher with information on what has and has not been tried in regard to the documentation of information about the establishment of health services in KwaMashu. Relevant literature refers to those sources that are important in providing the in-depth knowledge needed to study a selected problem.

### 2.2 DIFINITION OF LITERATURE REVIEW

According to Brink (1999:203), literature review is a process that involves finding, reading, understanding and forming conclusions about the published research and theory on a particular topic.

### 2.3 THE DEVELOPMENT OF KWAMASHU

The first residents of KwaMashu arrived from Cato Manor into an uncompleted township in 1958, which was only completed in 1959. The township was being built by the Durban Corporation as a domicile for Africans working in the city. From the

early 1960's to 1975 the provision and maintenance of houses and services infrastructure and facilities were in the hands of the corporation.

The KwaMashu Health Centre was established in 1962. The provision of health services and the distribution of health services to the community were in the hands of the Natal Provincial Administration. Health care providers who initiated KwaMashu Health Care Centre were recruited at King Edward Hospital. Mrs V. Ntsalla was the pioneer for processing the applications at King Edward Hospital.

The clinics that were rendering care to the community at that time before the establishment of KwaMashu polyclinic were at Rydavale, which provided child health services and Goodwins, for sexually transmitted diseases and child heath care. These clinics were in the hands of the Corporation. There was no antenatal care services for pregnant mothers, they attended antenatal care and delivery at King Edward Hospital.

## 2.4 OPENING OF KWAMASHU POLYCLINIC

The KwaMashu polyclinic was opened on 1 June 1962. The few staff members who opened this health care centre were recruited from different hospitals. The health centre was opened by Dr Protche, who was the Medical Superintendent and Miss J, Keen, was the first Matron. She worked with Mrs Z. Nkosi and Mrs T.M. Mqadi. Mr Gardner was the Secretary in Administration. There was no post for a female clerk at that time, Mrs R. Mthembu was the general assistant but she also worked as a clerk for maternity patients.

## 2.5 PROVISION OF HEALTH CARE SERVICES

### 2.5.1 PRIMARY HEALTH CARE

According to Brink (1999:273), health care is essential health care mode universally accessible to individuals and families in the community by means acceptable to them through their full participation and at a cost that the community and country can afford to maintain in the spirit of self reliance. It provides preventive, promotive, curative and rehabilitative services and addresses certain basic health needs.

## 2.6 PROVISION OF PRIMARY HEALTH CARE AT KWAMASHU POLYCLINIC

Primary health care at KwaMashu was provided to treat patients at primary level, patients were seen by doctors and professional nurses in general departments and surgical patients were seen in the casualty section by professional nurses and doctors. Severe injured and seriously ill patients were transferred to King Edward Hospital for further management, as happens to date.

The provision of primary health care at KwaMashu was useful to the community and also relieved the pressure of patients to the regional level hospital, which is King Edward. Kwashiorkor and measles were most the prevalent problems amongst Black children. Pulmonary tuberculosis was a problem for adults as there were many socio-economic problems amongst the black communities.

Maternal and child health care services were opened to help the community of KwaMashu. Mothers were provided with antenatal care delivery and postnatal care. Maternal and child health care services were important to provide mothers with information and advice on how to care for themselves and children, to promote health and prevent illnesses. Mothers in labour were taken from home by an ambulance to

the clinic for delivery and after delivery they were taken back home (Ntsalla and Hlophe, 2000).

Primary health care forms part of such a wide national health care system that adequate facilities should be available for the prompt referral of people for secondary or tertiary, i.e. hospital or specialist care. Primary health care services must be designed to meet all daily personal health needs of the members of community and should be adapted to the lifestyle of that particular community (Vlok, 1982:170).

## 2.7 DISTRICT NURSING SERVICE

The district nursing service is the district care of patients in the community. A district nursing service is not geared specifically towards the care of the sick aged in the community. District nursing service cuts down the over-occupancy of provincial hospitals and is money savings. Nursing procedures done by the members of the patient's family, are carried out in the homes of patients by domicilliary nurses who are employed by the state health or provincial hospitals.

### 2.7.1 DISTRICT NURSING AT KWAMASHU

KwaMashu Health Centre provided district nursing to the community, midwives visited homes to do deliveries and do postnatal care. Mothers in labour were taken from home by the midwives to the clinic for delivery and post delivery they were taken back home, but this was stopped because of criminal elements in the townships. Nurses carried out procedures themselves where necessary, eg. washing of babies, vulval care for a week, administration of medicines, changing of indwelling catheters and wound care.

Nurses gave health education, especially with regard to the diet of the patient, personal hygiene, recreation and exercises. This was done through observation of

signs and symptoms and timely referral of patients to the doctor for medical examination and medication (Mdlalose and Hlophe:2001).

## 2.8 AVAILABILITY OF TRANSPORT AT KWAMASHU

During the opening of KwaMashu Health Care Centre transport within the institution was not a problem because there were ambulances fetching patients from their homes for medical examination and primary health care. These patients were sent back home after having been seen by the medical practitioners and primary health care nurses. The midwives used ambulances for home visits. King Edward was the referring hospital, and they used ambulances to take and return patients to King Edward Hospital, a practice that was stopped because of robbery in the township. Patients were thereafter requested to come to the clinic in their own transport (Mthembu and Ntsalla:2000).

As the KwaZulu Government took over on 1 April 1977 this practice continued. Ambulances continued to take patients to King Edward Hospital as it happened with Natal Durban Corporation. During that time nurses used to escort patients and pregnant mothers to hospitals. The KwaZulu-Natal Provincial Administration ambulances took over in 1997, these ambulances are now not controlled by the KwaMashu Health Centre Management, they are controlled by ambulance services.

## 2.9 SERVICES THAT ARE AVAILABLE AT KWAMASHU POLYCLINIC

The KwaMashu polyclinic serves about ∀15 000 community members.

### 2.9.1 MATERNITY SERVICES

The clinic attached to a 24 hour midwifery service. Antenatal care is done on a daily basis as well as routine antenatal care and treatment of minor ailments. A community obstetrician from King Edward Hospital visits the clinic twice a week that is on

Tuesday and Thursday to assess patients at risk. Complicated cases are referred to King Edward Hospital and Mahatma Gandhi Hospital. Postnatal care is done on a daily basis. The baby is seen in the postnatal clinic within 7 days post delivery and the mother for observation. The mother and the baby have a follow-up in the 6th week for the first immunization of the baby, for postnatal care of the mother and health education.

### 2.9.2 DENTAL CLINIC

The dental clinic is available for both preventive (conservative) and curative (extraction) work.

### 2.9.3 MEDICAL OUT PATIENTS (GENERAL DEPARTMENT)

Ill patients are generally seen in this department by the primary health care nurses and doctors, and seriously ill patients are transferred to King Edward clinic for chronic sick adults, e.g. those with hypertension, diabetes mellitus cardiac pulmonary diseases, mental disorders and epilepsy are seen by doctors and medicines for chronic treatment are collected from the dispensary.

### 2.9.4 SOCIAL ASSISTANCE FACILITIES

Patients are helped with social problems through liaison with a social welfare agency. A social worker sees patients at the centre.

### 2.9.5 CASUALTY SECTION/DEPARTMENT

This section deals mainly with general minor surgery and injuries which fall under the Workmen's Compensation Act.

### 2.9.6 FAMILY PLANNING CLINIC

The family planning will assist sterile couples by appropriate referral as well as those who wish to limit the size of their families. The aim to help mother to space their children so that each child will be able to get the necessary care during the vulnerable years of complete dependency on a stable mothering figure.

### 2.9.7 X-RAY UNIT

This unit is useful for the X-ray of small fractures for settling, where necessary.

### 2.9.8 LABORATORY DEPARTMENT

The laboratory is for used common tests on blood, urine and feces. A pharmacy is available for the dispensing of medicine.

### 2.9.9 SCHOOL HEALTH SERVICES

School health services are run by the community health nurses. The aim of the health surveillance function is to ensure that every child shall benefit from education through health. This aim is achieved through the inspection of children and through recommendations for treatment made to school principals, the child's parents or guardians and family doctors.

## 2.10 SERVICES THAT ARE PROVIDED BY KWAMASHU POLYCLINIC (SATELLITE CLINICS)

The KwaMashu polyclinic has Satellite clinics. They provide primary health care to the community and are run by primary health care nurses. These clinics have no community doctors because of criminal activities in the townships.

### 2.10.1 NDWEDWE CLINIC

Ndwedwe clinic is about 48km from KwaMashu. Ndwedwe clinic has a long history. It started as a mobile clinic in 1952 and provided primary health care to the Community of Ndwedwe. In 1961 nurses worked in a four roomed house from Mantobello Hospital but the community requested Osindisweni Hospital to take over with the doctor as a mobile, because there was no doctor from Mantobello Hospital and only nurses did the job. Immunization was done on Tuesday, and after hours the community did not receive primary health care, e.g. emergency care.

In 1967 nurses started to work in the four-roomed house as a clinic so as to serve the Ndwedwe community. In 1978 Ndwedwe clinic was built and in 1979 started to work as a clinic providing primary health care, delivery, school health and social welfare. In 1982 the Divine Life Society donated an ambulance, which was helpful to the community. In 1985 KwaMashu polyclinic took over from Osindisweni Hospital to be under the KwaZulu Government up to the present.

In 1999-2000 the community health center was built. The European Union donated money so as to build the community health centre. The Ndwedwe Community Health Centre was officially opened on 17 September 2001 by Dr Manto Tshabalala Msimang and the Minister of Health of KwaZulu-Natal, Dr Zweli Mkhize (Chili:2001).

### 2.10.2 LINDELANI CLINIC

Lindelani Clinic is the extension of Ntuzuma area. It is about 12km from KwaMashu Lindelani clinic started to function towards the end of 1990. This area was densely populated with squatters without any health care centre. This area is under Mr. Mandla Shabalala who is fully involved in the affairs of this community.

Murray and Roberts Building Company donated buildings in this area and developed the community's skills Mr. T.M. Shabalala the leader of Lindelani the area and Murray and Roberts Building Company erected the buildings. The community of Lindelani was actively involved by making blocks and erecting buildings. Those who had skills in electricity involved themselves with the installation of electricity. Block 5 was donated as a clinic to serve the community.

Bhekimpilo Trust (NGO) started to work by providing preventive and promotive care under Dr. Standing. The staff from KwaMashu was mainly treating minor ailments and providing mother and child health care. Bhekimpilo Trust left in 1993 and KwaMashu staff over in doing preventive and promotive health and antenatal care. Deliveries of mothers are at present referred to Ntuzuma Clinic because the structure of buildings do not allow for deliveries.

The areas served by Lindelani are parts of Ntuzuma, Machobeni, Molweni, Richmond farm and the West Ridge area. Lindelani serves a population 98 650. It is anticipated that a community health centre will be erected at Lindelani within the near future (Ndimande:2001).

### 2.10.3 KWASIMAMA CLINIC

KwaSimama is an out-patient clinic for alcohol and drug dependent patients and is situated about ∀500m from KwaMashu polyclinic. KwaSimama Clinic was started in 1969 by the welfare section for Bantu Administration and in 1977, when KwaMashu polyclinic was taken over by the KwaZulu Government, the clinic was handed over to Health and Welfare. When the departments separated the clinic remained in the Department of Health. Dr. M.V. Gumede was the first person who started to work with the rehabilitation of patients who were alcohol and drug dependent. From 1980-1997 there were two social workers working under Social Welfare. In 1995 the social workers were working the informal job or duties running the affairs of social welfare

instead of Health and Welfare. In 1997, three social workers were employed to look after the affairs of KwaMashu polyclinic, Social work department.

The psychiatric side also started in 1969. This unit works from Monday to Friday. In the acute stage patients are seen and sedated then transferred to King Edward Hospital. When discharged from the hospital, patients come back to KwaSimama clinic and are seen as outpatients. The psychiatric clinic also falls under KwaMashu polyclinic. It was staffed by psychiatrists, social workers and psychiatric nurses before, but now there are no psychiatrists and is only the medical doctor who is experienced in the management of patients with psychiatric problems.

The medical doctor sees patients from Tuesday to Thursday. On Monday the psychiatric nurses visit the community as mobiles and they see psychiatric patients as far as Ndwedwe, Maphephetheni and Qadi areas. The existing files for psychiatric patients in the clinic are 1 503. The statistics of psychiatric patients is high because of HIV/AIDS and drug abuse psychotics.

In the alcoholic and drug departments unit there is no doctor. Since Dr. M.V. Gumede retired, there are no doctors who are interested to work in this area. Patients are seen by the doctor who manages the psychiatric patients (Sibiya:2001).

### 2.10.4 RYDAVALE CLINIC

This clinic is about 500m from KwaMashu polyclinic. This clinic is the maternal and child welfare or well-baby clinic, providing mother craft, counseling and immunization against infections diseases.

This clinic started to function as a maternal and child health care service in 1969. In 1977 when the KwaZulu Government took over it became part of KwaMashu polyclinic. This clinic caters for children from 6 weeks to 5 years old, and treats minor ailments, and gives family planning to mothers. The growth and development

of children are supervised and timely steps are taken to prevent malnutrition. Children who are seriously ill are transferred to King Edward Hospital by ambulances.

The Chest Clinic is part of the Rydavale clinic and provides the diagnosis and treatment of pulmonary tuberculosis. This is an outpatient clinic. It is staffed with nurses, community health workers and volunteers. The X-ray for patients are seen by the medical doctors at KwaMashu polyclinic. Community health workers work under the KwaMashu council and paid by government through NGO's. They provide care in the community, visit homes with the aim of health education and supervision of T.B. treatment. The volunteers that worked at the Chest Clinic are trained by Mrs. Thandi Mdlalose, the satellite clinics supervisor Direct Observe treatment supporters (DOTS) supporters are trained for three days so as to be able to support those on T.B. treatment. The volunteers also provide home-based care to the community for the care of patients with chronic diseases, e.g. HIV/AIDS.

### 2.10.5 GOODWIN'S CLINIC

Goodwin's clinic is the primary health care centre which provides primary health care to the community. It is about 4km from KwaMashu polyclinic.

This clinic started in 1969, under the hands of the Corporation. When the KwaZulu Government took over in 1977 it came under the KwaMashu polyclinic. This clinic provides primary health care, maternal and child health care services and treats sexually transmitted diseases. There are no doctors, only nurses to provide health care. If the patients are seriously ill they are transferred to Mahatma Gandhi Hospital (Mthalane:2001).

### 2.10.6 NTUZUMA CLINIC

Ntuzuma clinic is about 8km from KwaMashu polyclinic. It serves the areas of Ntuzuma and Lindelani. It is open for 24 hours casuality care and maternity deliveries. Maternity patients of Lindelani are referred to Ntuzuma clinic for delivery. It provides maternal, child health care and maternity services. This clinic was opened in 1982 by Mrs. T.M. Mqadi (Mthalane:2001).

### 2.10.7 QADI CLINIC

This clinic is ∀30km from KwaMashu polyclinic. It started to function in 1992. The community in this area had limited access to primary health care services. The tribal authority played the leading role for the opening of this clinic. Before the opening of the clinic, patients traveled from area to KwaMashu for primary health care.

This clinic is under Ndwedwe district, under the induna of Mr. Mzonjani Ngcobo who is fully involved in the affairs of the clinic as he is one of committee members. This clinic provides primary health care, maternity services, maternal and child health care services (Mdlalose:2001).

### 2.10.8 SIVANANDA CLINIC

This clinic is in the Inanda area. It is about 10km from KwaMashu. It serves the community of Inanda. This clinic was opened in 1991 and was later closed because of violence and hijacking of cars. It was re-opened in 1996. It provides primary health care, mother and child care and antenatal care services. Pregnant mothers are referred to Mahatma Gandhi for delivery.

### 2.10.9 MOBILE CLINIC

The KwaMashu community health centre has extended to provide care in rural areas. The mobile clinic started to function in 1995. It provides care to the following areas: Maphephetheni, Matata, Mbuyeni and Qadi.

According to Mthembu and Ntsalla (2001), the subjects who were interviewed there is now more developed at the KwaMashu polyclinic and more staff to provide care to patients.

## 2.11 ORIGINS AND DEVELOPMENT OF HEALTH AND SOCIAL CARE PROVISION

The National Health Service (NHS) came into existence on 5 July 1948 as direct result of the National Health Services Act, 1946. The legislation was preceded by an influential report from the British Medical Association on health insurance and report on social insurance and allied services.

The structure set up at the inception of the NHS was in place for almost 26 years, however, there were three problem areas that were highlighted in the 1960:

- The Gilli Report in 1963 recognized the greater emphasis being placed on primary health care teams and the integration of health and care services.
- In 1967 the poor quality of care given to certain patient groups was highlighted.
- The administration control of the NHS was becoming ever more cumbersome. In particular the need to provide balanced packages of care for all people in the community was being distorted by demands from acute specialities being favored over long term genetric and psychiatric provisions.

### 2.11.1 NATIONAL HEALTH SERVICES ACT 1973

In 1968 and 1970 the government produced papers proposing reforms in the NHS. It was another three years until the National Health Service Act, 1973 was passed and came into operation on 1 April 1974. The three main aims of the re-organization were:

- **The unification of health services under one authority:** This was not total as the General Practitioner's maintained independent contractor status and some post-graduate teaching hospitals retained separate boards of governors.

- **The co-ordination between health authorities and related local government services:** To this end, the area health authority boundaries were to a large extent the same as local authority boundaries. Joint consultative committees were set up between the two types of authority to discuss the delivery of services and common issues.
- **Improvement of management:** Job descriptions were provided for different personnel and a key feature was the introduction of multi-disciplinary teams and consensus management (De Beer 1976:431-432).
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### 2.11.2 NATIONAL HEALTH SERVICE AND COMMUNITY CARE ACT, OF 1990

The NHS and community care Act 116 of 1990 attempted to use market forces to improve the management of care provision. It also helped to rectify problems that had occurred when people in need of further care were discharged from hospital.

In the past people have occasionally been discharged into the community without their needs being met, and without referral to the social services. Local authorities have a long tradition of provision of health care. Over the years most of these responsibilities have been removed until personal services and environmental health

services remained. A White paper in 1988 called "Caring for People" had proposed that local authorities be given to local lead in planning community care. They would be required to prepare community care plans with the District Health Authorities or trusts. Thus, areas of personal social services were becoming linked more strongly to health issues.

The NHS and Community Care Bill, 1989 received Royal Assent in 1990. As with most legislation relating to care, there was a phased introduction with one of the earliest effects being the formation of 56 hospital trusts in April 1991. (Source: Government Gazette) (26.05.1977: 14-23).

### 2.11.3 ASSESSING THE NEEDS OF THE LOCAL POPULATION, De Beer (1988:36)

One of the main challenges facing purchasers of social care provision is to assess and map the needs and demands of the local population. Many authorities argue that it is futile to map needs when they have not got the resources to meet them. All local authorities and health authorities have to publish an annual community care plan whose purpose is to report progress with implementing the government's community care reforms. The other aim of the plan is to describe the plans for the provision and development of community care services for the locality.

### 2.11.4 HOW PROVIDER SERVICES ARE CHANGING TO MEET THE DEMANDS OF PURCHASING AND PROVIDING

According to National Health Policy Act 116 of 1990. The NHS and Community Care Act, 1990 urged local authorities to consider changes in their structure to separate the provision of services from the purchasing arm of the agency. The purchaser provider split was seen as essential to identify the true costs of provision and to ensure that there was no favoritism in the market for contracts.

This structure allows social service departments to purchase services from a range of agencies both statutory or voluntary and independent in the community. This system's intention is to improve the quality of services, involve the user (client and family) in the planning process, increase choice and obtain better value for money.

In 1991 the Department of Health expected that these changes, in the way local authorities managed services, would provide the following benefits:

- Give the client choice.
- Needs-led planning.
- Needs-led budgeting.
- Individual's assessment and care packages which were needs-led.
- Improved value of money.
- Develop a mixed economy of care.
- Develop service specification and standards.
- Development of monitoring of the quality of service. (McIntyere 1991:1-2)

## 2.12 THE NATIONAL PLAN (1994:62)

### 2.12.1 THE NATIONAL HEALTH SYSTEM

The state has two separate functions with regard to health. The first is to create, monitor and amend the framework within which health is promoted and health care is delivered. The second function is to be a major provider of services.

The government's function as a health care provider is to ensure that everyone has access to good quality health care. At present private providers are often seen as being in opposition to each other, but if the framework is well constructed than the two sets of providers will complement each other.

The aim of re-organizing health services in South Africa is to improve health and health services for all. This will be done by adopting the Primary Health Care

Approach and bringing the services into line with international thinking and practices. the Primary Health Care Approach is centered on the individual, the family and the community. The support they receive for treating and preventing diseases, and for protecting, maintaining and improving their health is integrated across health and health related sectors.

### 2.12.2 CLINICS AND HEALTH POSTS

Clinics will offer a comprehensive range of preventive, promotive, curative and rehabilitation services but at a less specialized level than community health centres. When transport and communication are difficult, particularly in rural areas, arrangement will be made for a member of staff to sleep at the clinic and to be available to give first aid and to summon help in an emergency. All clinics must have water, electricity and communication systems.

## 2.13. COMMUNITY LEVEL

All communities will be encouraged to form inter-sectoral community development committees whose members will be elected from the community. The function of the community health committee will be to liaise with those employed to run their health facility, to examine the budget and to help determine local policies.

### 2.13.1 COMMUNITY HEALTH CARE

The community health centre team will include a full range of health workers in order to deliver a comprehensive service. An important part of its activities will be promotive and preventive services. Community health centres are community resources and ideally should be situated within or close to community development and recreation centres.

### 2.13.2 NATIONAL LEVEL

The single comprehensive equitable and integrated national health system will be planned and co-ordinate at the central government level.

## 2.14 FUNCTIONS OF THE NATIONAL HEALTH AUTHORITY

The National Health Authority will promote community involvement through liaison with the structures of civil society including trade unions, NGO'S involved in private providers and their organizations and other stakeholders with a view to rendering high quality health services in terms of the people's needs and to eliminating disparities between the regions.

### 2.14.1 HEALTH CARE

- Formulation of national policy including macro-economic analyses in respect of inter-and intra-sectoral activities.
- Determination of national priorities, plans and strategies and ensuring their implementation.
- Determination of national norms, guidelines and standards of care.
- Overall co-ordination of both public and health services.
- International liaison and co-ordination of international services.

The role of complementary health practitioners need to be recognized and mechanism to integrate them into the NHS require investigation.

### 2.14.2 STATUTORY BODIES

The objectives of those statutory bodies that govern the registration of health personnel shall be to:

- Uphold the rights of patients and safeguard their interests.
- Promote health standards and training standards.
- Authorize the education, training, registration and practice of all health professionals.
- Regularly review the curricula of health personnel education programmes to be in line with national guidelines.

### 2.14.3 RURAL HEALTH

All the principles of the primary health care approach become most evident in the need to provide adequate and equitable services in the rural areas. Provision of health care, appropriate health facilities and human and financial resources are of prime importance, especially as many of the rural areas have been so neglected and this imbalance should be redressed.

### 2.14.4 TRADITIONAL AND COMPLEMENTARY HEALERS

Traditional healers play an important role in the health care of a large proportion of the population and the need for a co-ordinating body will be investigated. Traditional healing will become an integral and recognized part of health care in South Africa. Customers will be allowed to choose whom to consult for their health care and legislation pertaining the consultation of traditional practitioners:

- People have the right of access to traditional practitioners as part of their cultural heritage and belief system.
- Traditional practitioners often have greater accessibility and acceptability than the modern health sector and this will be used to promote good health for all.
- Traditional practitioners will be controlled by a recognized and accepted body so that harmful practices can be eliminated.

### 2.14.5 THE PRIMARY HEALTH CARE (PHC) APPROACH

According to National Government Policy (1994:82). The new government must follow the primary health care approach to the delivery of health services. According to World Health Organizations (WHO) cited in Health of Southern Africa (1984:5). PHC itself is central and was defined in the declaration of Alma Ata as primary health care. PHC is essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, and at a cost that the country and community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

### 2.14.6 ACCOUNTABILITY AND COMMUNITY PARTICIPATION

An important principle in primary health care approach is accountability to community structures at local, district, provincial and national levels.
Effective community participation as envisaged in the PHC approach means the democratically elected community structures, integrated with representatives of the different sectors and stakeholders involved in health and community development, have the power to decide on health issues.

### 2.14.7 HEALTH PROMOTION

Promoting good health and preventing disease is central to the success of primary health care:

- Health promotion is central to the success of primary health care.
- Within primary health care the role of the health promotion should encompass responsibility for community. Participation, community development, inter-sectoral development, education, mass media campaigns and disease presentations and health promotion.

- Health promotion programmes will be set up with primary responsibility for national level mass media campaigns including impact assessment.
- District health promotion campaigns in collaboration with other sectors and with community participation will be the focus for health promotion activity through a district level unit.
- The primary task of community workers will act as local health promoters working from community health centres (Reconstruction and Development Programme (RDP) 1994:42).

### 2.14.8 MATERNAL AND CHILD HEALTH (MCH)

The strength of a health system is reflected in the health status of children. As young children are specially vulnerable and dependent on their mothers, they need special protection and support at all times, especially in times of conflicts, natural disasters and economic hardship.

The principal tenets of the policy (National Plan 1994:72) of maternal and child health include the following:

- Reduction in maternal mortality.
- Mothers and children should be treated with dignity and respect.
- Strengthening health promotion activities, including health education programmes.
- Promoting universal literacy among women.
- Facilitation of the health services, activities of local, provincial and national levels.
- The role and responsibility of new in supporting maternal and child health care must be emphasized.
- General family planning and educational services will be readily available.
- Rapidly improving immunization coverage through the expanded programme on immunization (EPI) using methods that will ensure its sustainability.

- Strengthening health education programmes in the management of diarrhea diseases.
- Promotion of breastfeeding through health education programmes and the development of supportive environments for working mothers to allow continuation of breastfeeding.
- Free health services will be available in the public sector to all children under the age of 6 years.
- Early identification of high risk pregnancy, improved antenatal care and provision of emergency obstetric services to reduce maternal mortality.
- Free antenatal, delivery, post natal care and support of women in the public sector.
- Promotive and preventive programmes directed at children of school age and adolescents regarding high risks behavior and sexuality with promotion of effective life skills, including safer sexual practises.
- Programme for the prevention of child abuse and neglected will be instituted, provincial multi-disciplinary child abuse management teams will be established to provide training and counseling services.
- Educational programmes that promote health within schools will be encouraged and supported.

### 2.14.9 MENTAL HEALTH

The aim of the mental health policy RDP (1994:47), will be to ensure the psychological well being of all South Africans and to enhance their ability to conduct themselves effectively in social, interpersonal and working relationships.

## 2.15 SUMMARY

This chapter stressed that the literature review is a vital and essential aspect of the research process.

In this study the literature review stressed on what is known about the historical development of KwaMashu. What improvements have been done by the community members and health care providers.

On doing the study about the historical development of KwaMashu the literature review has assisted the researcher in obtaining clues to the methodology and instrumentation to refine certain parts of the study.

## 2.16 THEORETICAL FRAMEWORK

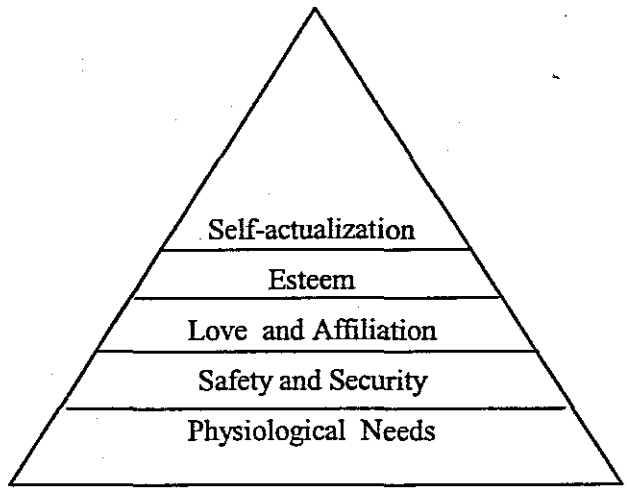
### 2.16.1 INTRODUCTION

People in the community have different ideas about the use of health services so as to fulfil their basic needs in the community and to be free from diseases. They need to be motivated to use health services which are accessible to them.

The basis of Maslow's approach to motivation cited in Consumer Behavior (1997:95), is that as one's basic needs are satisfied the next higher need become salient to the individual. In a society where the majority of people in occupations have the first and usually the second of these needs fulfilled, the "higher order" needs (love, belonging, social involvement and self-actualization) become the primary motivators.

If workers in different types of occupations are to be motivated, then the concentrations of needs should be on higher levels of motivation, since the lower level needs satisfied, there is a systematic move towards the need for self-actualization.

## 2.16.2 MASLOWS HIERARCHY OF HUMAN NEEDS




According Maslow (1970), he proposed that the needs are ordered in a hierarchical fasion with all needs lower in the hierarchy having prepotense over those higher. As lower needs are satisfied, the individual shifts his or her concern to higher order needs.

### i) PHYSIOLOGICAL NEEDS

Physiological needs are taken as the starting point and are conceited to be the most prepotent. An individual is dominated by physical needs. If one is unsatisfied all other higher needs recede. These basic physical needs are air, food, fluids, sleep, rest, activity, elimination, stimulation and maternal response. Sex is not essential for an individual but for group survival.

### ii) SAFETY AND SECURITY

Once the physiological needs are relatively well met, a new set of needs, categorized generally as safety needs, emerges. These are concerned with protection against

danger, threat, and deprivation. Protection against physical dangers is of less consequence now, in our civilization, than it was in the past.

### iii) LOVE AND AFFILIATION

Once the physical and safety needs are reasonably well fulfilled, the social needs become important motivators of behavior. These include needs for belonging, for association, for love, for acceptance by one's fellows, and for giving and receiving friendship. When needs are unmet, the individual feels unloved, rejected, friendless, abandoned and rest less. This applies to "rootless" and hospitalized children. Deprivation is the core of mal adjustment and psychopathology.

### iv) ESTEEM

Next in the hierarchy are the ego needs McGregor distinguished two kinds:

- Those needs that relate to one's self-esteem – needs for self confidence, for achievement, for competence, for knowledge and
- Those that relate to one's reputation needs for status, for recognition, for appreciation, for the deserved respect of one's peers. In contrast with the lower needs the ego needs are seldom fully satisfied. These needs usually do not become dominant until the lower needs have been fulfilled.

### v) SELF ACTUALIZATION

Highest among the needs is that of self-fulfillment or self-actualization. The need for realizing one's own potentialities and for continual self-development. This need is seldom fully met by human beings.

Maslow (1970) found that a selected group of eminent public and historical figures, he regarded as self-actualizing individuals shared the following important characteristics among others:

- A democratic orientation
- A feeling of connectedness with people.
- Human "weaknesses" such as pride, selfishness and conflict.
- Resistance to acculturation and high conventionality.
- The ability for fresh appreciation and wonderment.
- An orientation that does not evaluate truth in terms of order and certainty.

### 2.16.3 APPLICATION OF MASLOW'S HIERARCHY OF HUMAN NEEDS TO THE STUDY

The basis of Maslow's approach to motivation has motivated the researcher to trace and record the written history of health services of KwaMashu. The researcher is also motivated by improvement of the KwaMashu health centre which has no written history on health services at KwaMashu.

As indicated in the introduction regarding historical development of health services at KwaMashu, health services are needed by all communities. Health needs are regarded as basic needs, but are usually not fulfilled. Basic needs are needed for survival. Community health is needed to fulfill the basic needs of the community. It is suggested that individuals seek to satisfy lower level needs before higher level needs emerge. The lowest level of chronically unsatisfied needs that an individual experiences serves to motivate his or her behavior (Maslow 1970).

### 2.16.4 PHYSIOLOGICAL NEEDS

Individuals need air, food, fluids, sleep, rest, activity, elimination, stimulation and maternal response. The community needs clean water for survival and to be prevented from infections diseases like cholera. Toilets should be built for safe elimination to be free from diseases. By the availability of health services where patients are given health education and measures to prevent cholera and to promote health care of the individual, the basic needs of the individuals are met.

### 2.16.5 SAFETY AND SECURITY NEEDS

There are basic needs that motivate an individual to be free from medical hazards, disasters and emergencies. The development of health services at KwaMashu promote the safety and security of individuals because the community health centres are accessible to the community to promote health and cure ill-health. Safety needs are applied in health services because the life of patients and clients should be safe and secured against medical or legal hazards by prompt management and referral where needed. These needs are achieved by personal survival.

The employment of personnel in health services in KwaMashu promote the financial security of people. Thus the low socio-economic status of the community is improved. The development of health services in KwaMashu also promote the well-being of mother and child health care. Complications are managed to secure the life of mother and baby.

### 2.16.6 LOVE AND AFFILIATION

Love and belonging needs should be met by individuals, so as to survive and to be free from stress. The community health centre should meet the needs of the community. The health centre should be acceptable to the community. The community should have love for the health centre and should know that it belongs to them so that it is acceptable to them. As they show their love for it, they will protect the health centre against vandalism when needs are unmet in the health centre, the health centre becomes unloved and rejected by the community. These needs are achieved by an emotional drive.

## 2.17 ETHICAL CONSIDERATION

Permission for carrying at the study was obtained from Department at Health, the Superintendent of KwaMashu polyclinic and the assistant director of the institution.

The participants were requested to take part in the study. The participation of subjects was voluntary. The subjects were ensured of anonymity, confidentiality and availability of results to the participants. Informed consent was obtained from the participants.

## 2.18 ASSUMPTION OF THE STUDY

In this study the researcher assumed that knowledge at the history of the services at KwaMashu will encourage the health care givers to identify the needs of the people in the community.

As the health care givers have identified the needs of the people at the clinic, the community have accepted the clinic as their own and not merely for the health care givers. This encourages the health care centre to be useful to the community members.

Knowing the history of the clinic, encouragement, is given to the staff working at KwaMashu polyclinic to know where they are, and where they are coming from as they compare the improvement of the service which offered at the clinic and the improvement of scientific nursing care of patients, with that of the past.

The history of the development of health services at KwaMashu gives motivation to the staff to identify the needs of self-development so as to meet the needs of the community. The history of the development of KwaMashu health centre will open the eyes of the younger generation to take pride of structures such as the clinic and to protect these structures from acts of destruction.

# CHAPTER 3

## RESEARCH METHODOLOGY

### 3.1 INTRODUCTION

Research methodology in this study describes the researcher's method used to conduct the study and how data was collected for the research.

According to Brink (1999:117) methodological studies are concerned with the development, testing and evaluation of instruments and methods used in research investigation.

The goal of methodological research is to improve the reliability and validity of data collections tools. The researcher used data collected from written records, as well as interviews. Questionnaires with close-ended and open-ended questions were used e.g. in what capacity do they the clinic, was the transport available to hospital for medical help and why was the clinic opened.

### 3.2 QUALITATIVE RESEARCH

In this study the researcher used the qualitative research method because she collected information without formal structured instruments. Qualitative research does not attempt to control the context of the research, but rather attempts to capture that context in its entirely. The researcher has also chose the qualitative method of research because it involves sustained interaction with the people being studied in their own language and on their own turf.

### 3.2.1 RELIABILITY AND VALIDITY IN QUALITATIVE APPROACHES

According to Brink (1999:124) reliability is concerned with the consistency, stability and repeatability of the informant's accounts as well as the investigator's ability to collect and record information accurately. It further requires that the researcher should have developed consistent responses or habits in using methods and scoring or rating its results and that factors related to subjects and testing procedures should have managed to reduce measurements error.

Validity in qualitative research is concerned with the accuracy and truthfulness of scientific findings (Le Complet & Goetz, 1982:32). To establish validity there must be some evidence that relates the scores on the test to behaviors such as academic ability, success on the job and abstract reasoning ability. Lincoln and Guba (1985) list the dependability criterion required to establish the trusthworthiness of the study. This requires that an audit be used to establish dependability. Miles and Heberman (1994:261-277) give a very detailed description of tactics and strategies for ensuring the validity and reliability (trustworthiness) of the study.

### 3.2.2 QUALITATIVE APPROACH

In this study the researcher used the qualitative approach as it is concerned with historical research.

#### 3.2.2.1 GUBA'S MODELS OF QUALITATIVE RESEARCH

This model is concerned with trustworthiness of the qualitative research as mentioned earlier. It consists of four criteria Lincoln and Guba (1985:152):

**(a) Trust value**

This refers to the extent that the researcher is confident about the trustfulness of the research findings. This criterion makes use of respondents lived experiences.

i.) Obtaining qualitative data

The researcher in this study ensured trustfulness and trustworthiness by conducting a follow-up interview of respondents who were freely verbalizing their feelings, opinions, and knowledge about the development and improvement of health services at KwaMashu. The information obtained from respondents was tape-recorded.

**(b) Applicability**

The second criterion is concerned with the ability to generalize the findings to larger populations. The researcher citing Guba (1981) states that applicability should be seen in the light of its ability to be fitted or transferred to similar contexts outside the area of study.

De vos (2000:34-350) citing Lincolm and Guba (1985) stresses that it is the responsibility of the person who wishes to transfer the study to see that the study is in fact transferable and this should not be the burden of the original researcher.

**(c) Neutrality**

The third criterion of trustworthiness in this model is concerned with freedom from bias in the research procedure and results. Neutrality, according to De vos (2000:350) is defined as the degree to which the findings are solely a function of the informants and that the conditions of the methodology are not biased. This means that the respondents give information uninfluenced and uncoerced by external

interferences. In this study the researcher ensured neutrality by giving questionnaires to the respondents to fill in and did follow up to collect the questionnaires.

**(d) Consistency**

The last criterion of trustworthiness in Guba's model as outlined by De vos (2000:350) seeks to answer the question that, in case the research is undertaken again, it shall consistently present the same results.

According to Treece and Treece (1994:120) reliability and validity can apply to a broad area of topics. They may apply to questionnaires that are developed. In research methodology it is necessary to consider the factors of reliability and validity. When the researcher develops a questionnaire, designs an interview technique or gathers data for a research study, the technique or method of obtaining data and the data itself need to be reliable and valid.

### 3.2.3 TRUSTWORTHINESS IN THIS STUDY

In this study validity in qualitative research is concerned with accuracy and worthiness of scientific findings. To establish validity in this study the researcher used a tape recorder when conducting interviews. The information she obtained from subjects during interviewing was recorded on tape. The subjects were informed about the tape recording of interviewed information so as to test validity and reliability.

Different subjects were interviewed using open-ended questions in unstructured interviews in their own languages so as to obtain a free response. The researcher visited subjects at their homes on different days so as to have enough contact time with them. The data which was collected was recorded on the tape. The questions were similar so as to prove the validity and reliability of the study. In the unstructured interview of subjects, the data which was collected was about the history and development of health services at KwaMashu.

In this study the researcher also distributed open-ended questionnaires to different subjects. Questionnaires were used to obtain information on the history development and improvement of health services at KwaMashu. Similar answers to questions in the unstructured interviews confirmed the study to be trustworthy. The evidence of reliability and validity is the tape recording in which the interviewed information was recorded and questionnaires that were distributed.

## 3.3 HISTORICAL RESEARCH

According to Notter (1986:72) Historical research is oriented to the past. Nevertheless, it is a scientific test for truth and makes use of careful methods of collecting and analyzing data. The purpose in doing a historical study will dictate the design for it as one cannot observe the events of the past or set up experiments to discover truths about past events.

In this study the research method will need to be documentary, and use will be made of such resources, manuscripts, official records, letters and moral histories on tape. The historical research on development of health services in KwaMashu will be documented for younger generations so that they can know where they are and where they are coming from. The goal methodology in this study, is to improve the reliability and validity of data collection tools.

The research design in this study is historical as the researcher discusses the establishment of health services at KwaMashu and services that were available before the establishment of KwaMashu. It is historical because it gives information on past events.

## 3.4 THE RESEARCH INSTRUMENT OR RESEARCH TOOL

### 3.4.1 QUESTIONNAIRES

In this study questionnaires were used for data collection. Treece and Treece (1986:277) describe the questionnaire as a document containing a series of questions that must be responded to by all participants in the sample. It is the most common research tool. Questionnaires were used to obtain information on the history and development of health services in KwaMashu. In research methodology it is necessary to consider the factors of reliability and validity.

### 3.4.2 THE INTERVIEWS

In this study the investigator is interested in obtaining facts, ideas, impressions or opinions from the study subjects with whom she was personal contact. Interviews are of two types: structured and unstructured interviews. The type she used depended on the researcher's purpose in using the interview method of gathering data. In this study the investigator used the unstructured interview for collecting data from the participants, and structure questions.

According to Brink (1999:157) the interview is a method of data collection in which an interviewer obtain responses from subjects, in a face to face encounter or through a telephone call or by electronic means. They are the most direct methods of obtaining facts from the respondent. They can also be useful in ascertaining values, preferences, interests, tasks attitudes, beliefs and experiences.

The investigator used the unstructural interview in this study because it is the more free flowing, with its structure limited only by the focus of research. It leaves the wording and organization of questions and sometimes even the topic to the discretion of the interviewer. She has chosen unstructured interviews because unstructured interviews are conducted more like a normal conversation but with a purpose. The

participants were visited at home for unstructured interviews using a tape recording for information, as discussed in this chapter.

In this study the instrument also used for data collection in a structured interview, is the interview schedule. The interview schedule is a questionnaire with close-ended or fixed alternative questions. In this study, the interview schedule was presented to each respondent in exactly the same way. The interviewer was restricted to the questions, their wording and the order in which they appear on the schedule, with relatively little freedom for deviation. This was done in this manner to test reliability and validity.

### 3.4.3 SAMPLING OF PARTICIPANTS

A purposive sampling technique was followed, for instance, in this research the sample was the nursing staff that are presently working at KwaMashu, those who retired and who initiated the KwaMashu health centre and the community members.

### 3.4.4 DATA COLLECTION

Data was controlled by means of questionnaires that were distributed to subjects. Unstructured and structured interviews were conducted with those subjects who were prepared to provide in-depth knowledge.

### 3.4.5 DESIGNING THE QUESTIONNAIRE

The researcher visited the retired nurses and staff, the staff currently working at KwaMashu polyclinic and community members at their homes. The purpose of visiting them was to request the participants to respond to the questionnaires and interviews. She further explained that the information obtained would be confidential and anonymous.

# CHAPTER 4

## ANALYSIS OF THE DATA

### 4.1 INTRODUCTION

For an investigation to make a meaningful analysis of the data collected in a study, the methods used to collect it must be appropriate to study of the problem being investigated. Data that have been collected must be organized in some fashion so that they can be analyzed and so that the investigator can drive at a statement of results. Data can be organized in a variety of ways for inspection and analysis in order to give the researcher as much information as possible.

The reason for organizing data for analysis is to make manifest possible relationships and similar answers, that is to reveal the nature of the information that has been gathered.

Questionnaires were distributed to twenty participants and eleven participants were interviewed.

### 4.2 DISCUSSION OF QUESTIONNAIRES

#### 4.2.1 INTRODUCTION

The researcher deemed it necessary to discuss items in the questionnaire to make data analysis understood. The researcher visited the community members and retired staff of KwaMashu polyclinic with an aim of interviewing them and discussions about the questionnaire. During the discussion of the questionnaire the researcher used a tape recorder for trustworthiness.

### 4.2.2 AVAILABILITY OF MEDICAL HELP BEFORE OPENING

The majority of subjects stated that before the opening of KwaMashu Health Service, they used to go to King Edward and McCords' Hospital for medical help. Even pregnant mothers had problems of attending ante-natal care at King Edward Hospital.

**Response to question**

"My wife did not attend clinic to all my children because there was no clinic available. All my children were delivered at home and my wife had problem of bleeding after she delivered her sixth baby who was our last child. In previous years KwaMashu was in a mist in the provision of health services."

### 4.2.3 IS THE CLINIC USEFUL TO THE COMMUNITY

All participants agreed the clinic to be useful to the community because patients are no more going to King Edward Hospital for minor ailments. Patients are seen at the clinic by community doctors and nurses before they are being referred to hospital.

**Response to question**

"The clinic is useful for preventive and promotive health because health education that was given to me by nurses reduces ill health and promote health through prevention of communicable diseases. Measles to my children reduced because of advise we get from the health centre."

"The availability of the clinic helped those patients and family members with low socio-economic conditions because we were no longer hiring taxis and private transport to King Edward Hospital for minor ailments and seriously ill patients are taken by ambulances as it happens today."

"As far as I am concerned the opening of clinic at KwaMashu also relieved pressure of workload to the hospital staff of King Edward Hospital because many patients are seen at KwaMashu, and referred to hospital for further management."

### 4.2.4 BEFORE THE ESTABLISHMENT OF KWAMASHU HEALTH CENTRE WHAT WERE THE MOST PRACTICES USED BY THE COMMUNITY TO CURE ILLNESSES

The majority subjects stated that most people in the community attended traditional healers to cure illnesses like kwashiorkor and pulmonary tuberculosis. Few community members used spiritual and faith healers and there were those who used hospitals but were few because of the non-availability of hospitals and transport.

**Response to question**

"In those days we were used to traditional healers many people died of pulmonary tuberculosis and our children died of kwashiorkor and measles because traditional healers, spiritual healers and herbalists failed to cure the above mentioned communicable diseases to our children. I lost two children because of traditional healers."

"The majority of our community members visited the hospital after we had been seen by the traditional healers and herbalists, and did not get help, then decided to be seen by health care providers. Pregnant mothers delivered at homes, attended by the community traditional birth attendants. My neighbor delivered a premature baby and died because of cold."

### 4.2.5 THE AVAILABILITY OF TRANSPORT TO HOSPITAL FOR MEDICAL HELP IN THE 1960'S

The majority of subjects interviewed stated that the transport to take patients to hospital for medical help during the 1960's was a problem. Most people died at home

before they got medical help. Those that had means of hiring private transport did so to save the lives of those who needed emergency treatment.

**Response to question**

"There were few ambulances in the townships. We called ambulance at the township office, and we had to wait for ambulances in the township office. Pregnant mothers usually delivered next to the offices because of the unavailability of transport. The trains were available but were scarce to transport people to hospital during late hours."

**Retired staff response**

"In 1962 after the KwaMashu health centre was opened, transport was available at the clinic which took patients from the location or township to the health centre and after being seen by doctors and nurses at the clinic, were taken back to their homes. This was stopped because of hijacking."

"The maternal deaths were present because of post partum haemorrhage after delivery at home and ruptured uterus."

### 4.2.6 PROBLEMS OR COMMON MINOR AILMENTS AT THAT TIME OF DEVELOPMENT OF HEALTH SERVICES

The participants discussed that KwaMashu and measles were the most common illnesses amongst children. In adults the most problem was 'pulmonary tuberculosis' because of low socio-economic conditions amongst Black communities.

**Response to question**

"The equity distribution of health care amongst Black communities was the problem as compared with the provision of health services in White communities. We had few medicines to cure diseases and doctors were few to examine us. We were seen by Army doctors."

### 4.2.7 DEVELOPMENT OF KWAMASHU SINCE 1960'S

All participants mentioned the development of KwaMashu as compared before.

**Response to question**

"The KwaMashu health centre has developed because there are many services offered at the clinic and the transport has improved as compared before e.g. there are taxis, buses, trains and ambulances to take patients to hospital although there is a delay if we call ambulance to the clinic."

"During an emergency the helicopter is available to take patients to hospital urgently so as to save lives of patients. I have witnessed a helicopter which took the school child to hospital who was involved in a car accident. The statistics of KwaMashu have increased because of squatters or informal settlements. The community Centre is little to suit the needs of our community. At the clinic we follow long queues in extremely hot or cold weather."

### 4.2.8 IMPROVEMENT OF COMMUNITY'S HEALTH STATUS

The participants discussed that the health of people has improved as compared to before because no more kwashiorkor or measles are found amongst children. Communicable diseases are prevented through health education and implementation of the national policy on extended programmes of immunization of children, which was started in 1995.

**Response to question**

"There is no improvement of pulmonary tuberculosis amongst adults, the rate is very high because of HIV/AIDS which is the problem amongst youths. The health status is going down, no improvement of health. The volunteers of Home Based care are trying to improve the health status by giving care to patients who are HIV/AIDS positive on terminal stage through bathing them at home."

"There is improvement of communicable diseases like measles and poliomyelities in children, because of the Extended Programme of Immunization in South Africa. The immunization campaigns improve the status of children and grandchildren."

"The involvement of us as the community in decision making about our health, has improved the status of health in the community and also at the clinic as I am the member of the community committee board we are committed to the improvement of health services of KwaMashu."

**Staff member's response**

The improvement of health services at KwaMashu is seen on pregnant mothers. The mother-to-child transmission (MTCT) programme, started at KwaMashu polyclinic on the 12 June 200. This programme is voluntary counseling and testing of HIV to pregnant mothers. The volunteered pregnant mothers are tested for HIV/AIDS after pre-counselled if HIV positive they are post counselled and should be on going counseling even post delivered, those that are positive and wish to be on a programme are given Nevirapine which reduces the transmission of HIV/AIDS from the mother to the baby. There are lay counsellors who are employed to give guide to mothers and babies, and advise mothers on care of themselves and their babies post delivered. The lay counsellors are employed as contract. The growing of babies on MTCT programme is wonderful, they are healthy and free from infections because mothers are advised how to care for their babies. Thirty five babies are growing well together with their mothers, they are free from chest infections."

**The community response**

"The improvement of health status amongst children is going down especially at Lower Primary Schools. The raped cases amongst children is very high, those men who are HIV/AIDS are having that hope or belief that if they do sex with virgin teenagers and children they will be HIV negative which is untrue, they are being misled by Inyangas."

**School nurse Hlabisa of KwaMashu's response**

"In one of lower primary school I got 22 cases of school children being raped by uncles, brothers and neighbors with a hope that they would be HIV negative. These children are not reporting that they are being sexually abused, they are found by teachers and school nurses at school because of the problems that are being observed by teachers at school. These children are referred to the social worker at KwaMashu and also to the forensic nurse for further management. On examination, they are found to be long sexually abused. The rate of raped cases or victims of KwaMashu is very high."

### 4.2.9 OTHER IMPROVEMENTS IN HEALTH CARE PROGRAMMES AT KWAMASHU

#### 4.2.9.1 SEXUAL HEALTH AND HIV/AIDS STAFF RESPONSE

"A programme to combat the spread of sexually transmitted diseases (STD's) and active in early treatment of sexually transmitted and treatment of AIDS symptoms. Mass education organizations are continued to make clients aware of sexually transmitted diseases."

#### 4.2.9.2 WOMEN AND CHILDREN

Health care for all children under six years, pregnant mothers and adults are provided as a free service at clinics and health centres.

There are programmes to improve maternal and child health through access to quality antenatal, intrapartum and postnatal services for all women. Preventive and promotive health programmes for children have improved. Breast-feeding is encouraged and promoted to those babies on MTCT programmes. The effective expansion of immunization has reduced polio and neonatal tetanus in children.

**KwaMashu staff response on cholera prevention at Ndwedwe area**

The campaign for health education in the prevention of cholera at Maphephetheni and Mzinyathi (Qadi) areas has promoted the health of people. Many people's lives were saved because of preventive measures that were taken. Early transportation of patients to primary health care centres and prompt treatment, and early referral of patients to hospitals saved lives of patients, which indicate that there is improvement of patient care. Self-development of health care provider has added to the improvement and quality care of patients.

## 4.3 ANALYSIS DATA FROM QUALITATIVE STUDY

According to the researcher in this study the data in qualitative research is non-numerical, usually in the form of written texts, radio, tapes and photographs. Analysis of data in qualitative studies therefore involves an examination of words rather than numbers. As the researcher used a qualitative approach she frequently spent hours reflecting on the possible meanings and relationships of what has been recorded.

In this study the researcher used a series of common steps for analyzing her data, which begins at the start of the data collection phase. Typical steps are coding themes and categories and making memos about the context and variations in the phenomenon under study, verifying the selected themes. Coding and categorizing are generally initiated as soon as data is collected.

The researcher in this study used coding to organize data collected in interviews and other types of documents. The reliability of the coding to organize data collected in interviews and other types of documents. The reliability of the coding could be checked by having another person encode the same data. By checking for agreement, the researcher validated findings with her subjects and other forms of evidence e.g. radio and tape recordings.

# CHAPTER 5

## SUMMARY, CONCLUSION AND RECOMMENDATIONS

### 5.1 INRODUCTION

In this chapter the investigator discusses her findings by drawing some conclusion and making some recommendations of the possible meanings of her findings as shown by the data. It is important that the researcher avoid drawing conclusions that go beyond those indicated by the data and as making recommendations that cannot be justified by the results of the study.

### 5.2 SUMMARY

#### 5.2.1 THE TITLE

The title of the study which refers to the historical development of health services at KwaMashu, motivated the researcher to make the study on how KwaMashu polyclinic has developed and improved. The researcher maintains that written documents about health services in a place is important so that information can be passed from generation to generation.

#### 5.2.2 LITERATURE REVIEW

In the literature the researcher used books, periodicals and journals. The interviews and unstructured questionnaires were done to get information about development of health services, which services were offered before the development of health services and what medical services were available at that time.

A question that needed to be answered was:-

During the time of establishment of the KwaMashu polyclinic, which problems of infections diseases were present amongst adults and children? In the literature review information is provided on when the KwaMashu location was established.

### 5.2.3 THE METHOD

The researcher in this study used historical and qualitative research methods. The researcher has chosen the qualitative approach because she collected information without formal structured instruments. The research design was historical as the researcher discusses the establishment of health services that were available before establishment of KwaMashu.

The research instrument in this study was questionnaires, which were used for data collection. In this study the investigator was interested in obtaining facts, ideas and impressions from the study subjects through interviews.

#### 5.2.3.1 TRUSTWORTHINESS OF THE STUDY

To establish validity in this study the researcher used a tape recorder. The information she obtained from subjects during interviewing was recorded on tape. Different subjects were interviewed using open-ended questions and unstructured interviews in their own language so as to obtain free responses.

To establish validity there must be some evidence that relates the scores on the test to behaviors such as academic ability. Validity in qualitative research is concerned with the accuracy and truthfulness of scientific findings.

### 5.2.3.2 PARTICIPANTS OR SUBJECTS

The participants were the retired staff and nurses who initiated KwaMashu health care services, the community members and the staff who are still working at KwaMashu polyclinic.

## 5.3 DATA ANALYSIS

Data collected in this study were mainly qualitative and narrative in nature. Data analysis was done in order to give the researcher as much information as possible. To collect data and analysis of data, the researcher visited the community members and retired staff with an aim of interviewing them. The information obtained was recorded on a tape recorder and a coding system was used so as to organize data collected.

The researcher analyzed data through the discussion of questionnaires that were distributed to the subjects, that were interviewed. The subjects were very interested in the discussion about the development and the improvement of health services at KwaMashu. The subjects were informed about the anonymity and confidentiality of the information.

## 5.4 RESULTS

The results of this study as it is a qualitative study, are presented in terms of themes which emerged from the data.

## 5.5 DISCUSSIONS

In this study discussions were prosecuted in practice and concise language. The researcher restated the research questions and discussed the results with reference to

these questions in the order they were posed. The investigator used a tape recorder for trustworthiness.

## 5.6 LIMITATION OF THE STUDY

The study was limited to KwaMashu area and to the subjects that initiated KwaMashu health centres, the community members (residence) and the retired staff of KwaMashu. The researcher spent some hours in this researcher with the subjects because those retired staff who initiated KwaMashu health centre needed more time or recall what was happening before the development of KwaMashu health service, so that the information they gave was trustworthy, as it was recorded on the tape recorder. The questionnaire that was distributed to them needed to be collected and discussed with them on other days.

## 5.7 RECOMMENDATIONS

According to the discussions made with the subjects, they discussed the pressure that was relieved at King Edward Hospital to the staff and to the health care providers because of the development of health care services at KwaMashu.

### 5.7.1 BUILDING OF HOSPITAL

The pressure of patients to the health care services and other hospitals near KwaMashu needs to be relieved by the building of a hospital at KwaMashu centre so that patients need not be transferred to Mahatma Gandhi Hospital and King Edward Hospital. The population statistics at KwaMashu is very high because of informal settlements.

### 5.7.2 TRAINING OF PRIMARY HEALTH CARE NURSES

More primary health care nurses need to be trained to cater for the local communities they serve through a system of community health authorities and through district health authorities which must be part of a democratically elected local government.

### 5.7.3 MENTAL AND PSYCHOLOGICAL HEALTH

To promote the social welfare and to improve community care, rehabilitation and education for all mentally disabled and disabled people, they should be supported by the family members, social workers and care givers. A social worker is needed at KwaSimama clinic who will be dealing with mentally ill patients, to look after their social problems of getting pensions and to deal with families who do not support the ill person but use pension for their own use.

### 5.7.4 AVAILABILITY OF EMERGENCY TRANSPORT

Access to services must be improved by the development of emergency response centres and appropriate transport and ambulance services, especially to the health care centre where there are no doctors. Most patients complicate at the clinic whilst awaiting ambulances after being seen by nurses at the clinic, and the delay in ambulances to transfer patients to hospital aggravates patients' conditions. The emergency ambulance services must do something about the improvement of ambulances to take red code or emergency patients.

### 5.7.5 HUMAN RESOURCES

Core teams must be provided for every community health centre and clinic. There is an increased workload to health care providers because of HIV/AIDS and experienced nurses move overseas to greener pastures. Those that are left behind in

the community health centre providing quality care to patients, require incentives to attract staff to remain and work in community health centres.

### 5.7.6 HIV/AIDS

Because of the increased number of HIV/AIDS patients or suffers, the volunteers for Home Based care need to be paid, so that they will continue to take care of HIV/AIDS sufferers. The volunteers for Direct Observe Treatment Supporters (DOTS) need to be paid because of the prevalence of pulmonary tuberculosis.

## 5.8 FINDINGS

According to the history that was obtained from subjects of KwaMashu, it indicates that there is great improvement in the community of KwaMashu because of the development of KwaMashu poly-clinic. Previously, in 1960's there were problems in provision and distribution of health services amongst the Black population and there was poor quality of care given to certain patients.

When KwaZulu Government took over after 1976. There were ambulances which accompanied nurses from KwaMashu poly-clinic to do home visits with an aim to continue care in the community after the patients had discharged from the clinic. Because of political riots and the increased of crime in the locations, ambulances stopped to do home visits.

After the KwaZulu Government had taken over in 1976, there was change in the distribution of health services. The Health Act 63 of 1977 was designed to co-ordinate the health services in the Republic, determine health policies and to make full use of the available resources thereby ensuring a comprehensive health services. This was done to ensure equity of health services. In order to achieve its objectives all three levels of government, i.e. Central, Provincial and Local, were involved in the

delivery of health care although the ultimate responsibility for the health of people of South Africa rests with the State.

After 1976 KwaMashu polyclinic falls under level one. It provides a greatest number of people with a maximum health benefits at the least cost. The service is free to all categories of patients. In such a system the patient is perceived as belonging to a family and a community.

The KwaMashu polyclinic level one comprehensive health care system has 8 satellite clinics. The satellite clinics as they are Primary health care service form a vital part of a comprehensive health service. Primary health care services (Satellite clinics) were designed to meet all the daily health needs of the community i.e. promotive, preventive and curative care to their local communities, and include the environmental health, health education, maternal and child health, prevention of communicable diseases like measles which was a problem during the 1960's now it has been eradicated.

After 1994 when the African National Congress has taken over there is improvement in health care services. Health care for all children under six years of age and pregnant women are provided free service at all levels. There are programs to improve maternal and child health through access to quality antenatal, delivery and postnatal services for all women, which include better transport facilities and in-service training programmes for midwives, KwaMashu polyclinic is the one which provides those programmes.

There is a comprehensive review of all policies and legislation regulating Social Welfare and Social Security Act of 1978, the Social Work Act of 1978 and acts dealing with child and family welfare has been changed. The new umbrella legislation which provides the framework for a development-oriented Social Welfare System based on the principles of equality, equity, access, user involvement and

empowerment and the public accountability as it has been developed at KwaMashu polyclinic e.g. disabled people get pension.

The community of KwaMashu feels great in this Comprehensive health care service because they get all services. The provision of V.C.T. and P.M.T.C.T. programmes made the community of KwaMashu to be aware of HIV/AIDS prevention, although people are dying of this incurable disease but now they are aware and others have committed themselves for blood testing so as to know of their status.

### 5.8.1 CONCLUSION

The development of health services at KwaMashu helped the community of this area to see and know where they are coming from, and where they are now and what improvement need to be done to overcome long queues in extremely hot and cold weathers.

The development and improvement of health services at KwaMashu polyclinic has opened my eyes to take an initiative to write a history about health care services at KwaMashu. The data obtained from the subjects about the development of health care services at KwaMashu will be kept as a document for the health professionals to make appropriate and relevant plans for future services to be rendered to the people of KwaMashu.

Through this document, I have emphasised the history of development of health services at KwaMashu and what were the needs of the people before 1960's and what improvements have been done to promote the needs of people and of the health care services. I hope in few years coming this health service will be extended to suite and to promote the needs of the community at large.

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## LIST OF ANNEXURES

# ANNEXURE A

# APPLICATION LETTER TO CONDUCT RESEARCH AT KWAMASHU

N 180 Kwa-Mashu
P O Kwa-Mashu
4360

21 June 2000

The Assistant Director/Superintendent
Kwa-Mashu Poly Clinic
P/Bag X 013
Kwa-Mashu
4360

**RE: APPLICATION TO CONDUCT A RESEARCH AT KWA-MASHU POLY CLINIC**

**TITLE : THE HISTORY AND DEVELOPMENT OF HEALTH SERVICES AT KWA-MASHU**

Dear Sir/ Madam

I hereby beg to apply to conduct a research at Kwa-Mashu Poly Clinic from July 2000 to August 2001 for the above mentioned title. The anonymity and confidentiality will be maintained.

Hoping that my application will be accepted in writing.

Yours Faithfully

GLORIA NOMPUMELELO MKHIZE (Mrs)

# ANNEXURE B

## PERMISSION LETTER TO CONDUCT RESEARCH

PROVINCE OF KWAZULU-NATAL HEALTH SERVICES
ISIFUNDAZWE SEKWAZULU-NATALI EZEMPILO
PROVINSIE KWAZULU-NATAL GESONDHEIDSDIENSTE
THE MEDICAL SUPERINTENDENT, KWA MASHU POLY CLINIC

Fax : 5031236 X 236
Tel: 5031236 X 216
Private Bag: X 013
Isikhwama Seposi:KWAMASHU
Privaatsak: 4360

Enquiries :. Date: Reference:
Imibuzo : A.B.MTHALANE Usuku:28.02.2002 Inkomba :
Navrae : Datum: Verwysing;

MRS GLORIA N. MKHIZE
N 180 KWA MASHU
P.O. KWAMASHU
4360

RE: APPLICATION TO CONDUCT RESEARCH AT KWA MASHU POLYCLINIC

TITLE: THE HISTORY AND DEVELOPMENT OF HEALTH SERVICES AT KWA MASHU

You have been granted permission to do above research on the following dates :-
O1.07.2000 to 31. 08. 2001

MRS A.B. MTHALANE
ASSISTANT DIRECTOR

# ANNEXURE C

## VISION AND MISSION STATEMENT OF KWAMASHU POLYCLINIC

## VISION

To achieve optimal heath status for all persons in the province of Kwa-Zulu Natal.

## MISSION

To develop a sustainable co-ordinated integrated and comprehensive health system at all levels of care based on the primary health care approach through the district health system.

## MISSION STATEMENT

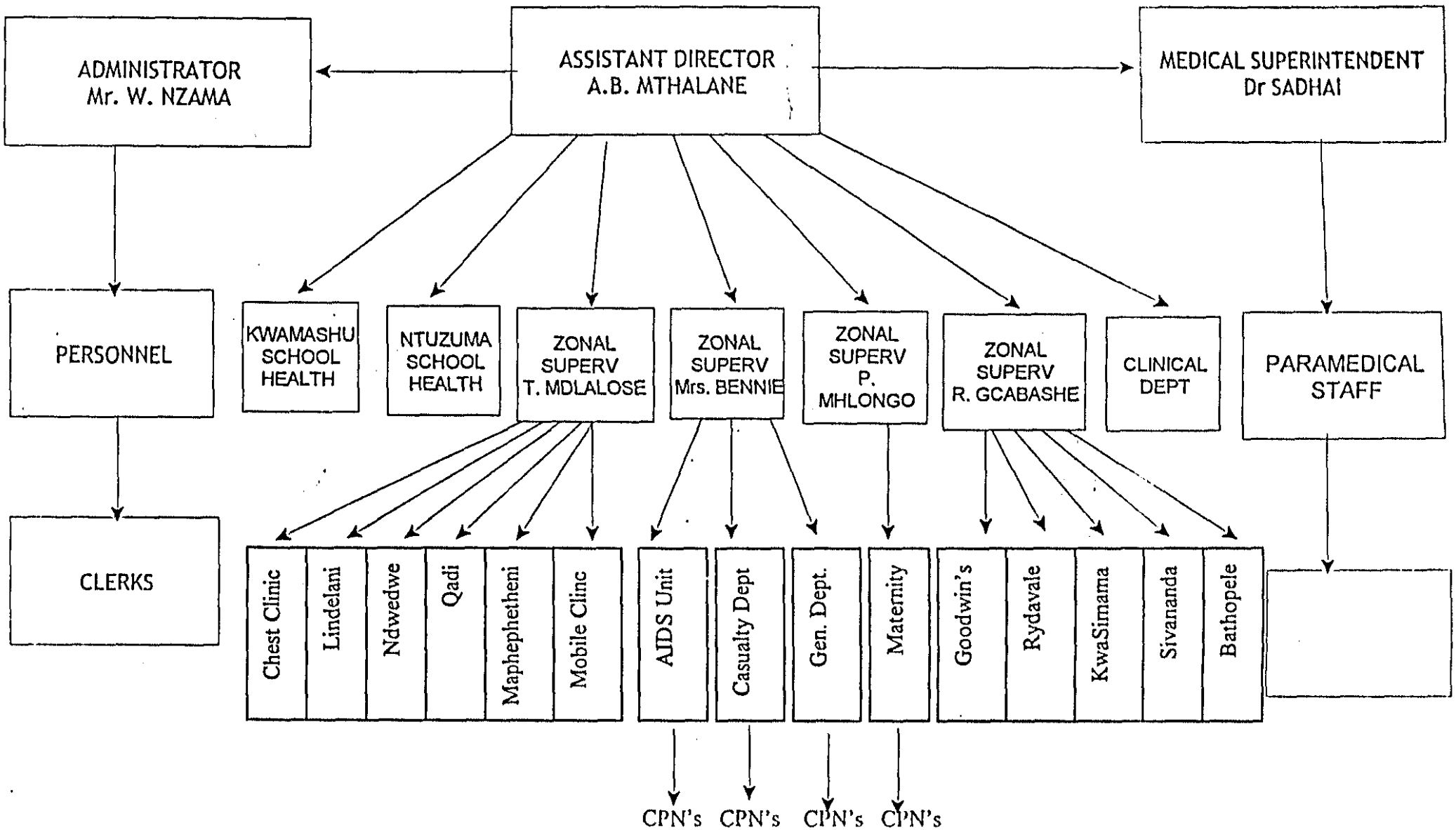
We at Kwa-Mashu Poly Clinic believe in the provision of a comprehensive quality care within the prevailing budgetary restraints. Promotion and integration of all departments and community structures to form an efficient health team. We also believe in respecting human dignity without discrimination. We are committed to maintain standards in health and safety care in order to protect both personnel and clients.

# ANNEXURE D

# KWAMASHU POLYCLINIC ORGANISATION

ANNEXURE D

KWAMASHU POLYCLINIC ORGANOGRAM



# ANNEXURE E

## RESEARCH QUESTIONNAIRE

**A QUESTIONNAIRE TO COLLECT DATA AND DEVELOPMENT OF HEALTH SERVICES AT KWAMASHU FROM RETIRED NURSES, STAFF AND THE COMMUNITY OF KWAMASHU.**

## ANNEXURE E

## RESEARCH QUESTIONNAIRE

**A QUESTIONNAIRE TO COLLECT DATA ON HISTORY AND DEVELOPMENT OF HEALTH SERVICES AT KWAMASHU.**

***NB:*** ***You are kindly requested to participate in the study, but your participation is voluntary. Please note that anonymity and confidentiality will be maintained.***

**Kindly respond by making a cross (x) in the appropriate block in closed ended questions.**

---

1. Age in years

| 45-50 | 51-61 | 61- 71 | 71- 85 |
|---|---|---|---|
| | | | |

2. Are you a male or female

| Male | Female |
|---|---|
| | |

3. Occupation

---

---

4. Marital Status ☐
   Married ☐
   Single ☐
   Wodowed ☐
   Divorced ☐

5. In what capacity do you know the clinic?

As a community member. ☐
As a staff working at clinic. ☐
As a retired nurse. ☐
As a patient at clinic. ☐

6. Before the establishment of KwaMashu Health Center what were the most practices used by the community to cure illnesses.

Hospital. ☐
Traditional healers. ☐
Spititual healers. ☐
Herbalists. ☐

7. In the 1960's was the transport available to hospital for medical help?

Yes ☐
No ☐

8. Is the Community Health Centre accessible to the community?

Yes ☐
No ☐

***Kindly respond to the following open ended questions:***

9. Why was the clinic opened?

_____

_____

_____

_____

10. Before the opening of KwaMashu Health Centre, where did the community get medical help?

11. What services were offered or available at KwaMashu before the opening of health service? (Clinic)

12. Is the clinic useful to the community? If "yes" on what basis?

13. What were the problems or common ailments at that time?

14. Is there any development from that time up to now, if not what can be done to improve the services?

15. Is the health status of the people improved as compared during the opening if not, what is the problem now?

16. Is the community involved in decision making about their health as compared before?