

**VIEWS OF HEALTH CARE SERVICES
CONSUMERS IN RURAL COMMUNITIES
ON PROVISION OF HEALTH CARE IN
KWAZULU-NATAL PROVINCE**

by

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by

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Submitted in fulfilment of the requirements of

DOCTOR IN PHILOSOPHY

in the Department of Nursing Science
at the University of Zululand

Promoter: Prof. B.M. Zungu

Date: October 2004

DECLARATION

I declare that :-

*“Views of Health Care Services Consumers in Rural
Communities on Provision of Health Care in kwaZulu-
Natal Province”*

is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete reference.



NJ DLAMINI

30/10/2004

Date

DEDICATION

This work is dedicated to my late mother Bonisiwe Zungu who instilled in me love for education, my husband Johannes, my daughters Nomfundo and Sinenhlanhla and my son Thuthukani, who gave me support and unconditional love right through the study. It is also dedicated to my late grandparents Mr and Mrs Japhet and Hannah Dubazana who reared me up with lots of love.

- My husband and my children for their support and help in completion of this study.
- Mrs TG Mdletshe and Sthuli Mavundla for their support.
- Last but not least, the University of Zululand for giving me financial support right through the study.

ABSTRACT

The main aim of this study was to determine the views of health care services consumers on the provision of health care in rural areas. It also aimed at highlighting challenges that faced health care service managers about rural health care service delivery.

The study was undertaken in six (6) health districts in KwaZulu-Natal Province. A qualitative and quantitative descriptive survey was conducted. From six (6) health districts selected, six rural hospitals were selected, and out of each hospital two rural clinics were sampled. Twelve rural clinics were selected, and from each clinic twenty five (25) respondents were selected. The total sample consisted of three hundred (300) respondents.

The study revealed that people living in rural areas are still faced with a problem of inaccessibility and unaffordability of health care services. It was evident that rural clinics still experience shortage of nurses and doctors, and that health care services in rural areas are still faced with problems of lack of material resources, lack of electricity, insufficient water supply, absence of emergency services, absence of night health care services and inadequate obstetric health services. Poverty, lack of transport and inaccessibility of health care services are still a major

problem in rural communities.

Recommendations based on the findings of the study highlighted the need for health care authorities, health care planners and managers to focus more on equitable distribution of human and material resources.

Abstract

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CHAPTER 1

ORIENTATION INTO THE STUDY

1.1 INTRODUCTION

The Government of the National Unity has made attempts to satisfy large areas of the country in urban and rural areas in relation to provision of health care services to all people of South Africa. Organisation and functioning of a Health Service depends largely on the level of socio-economic development of the country. This involves a major role to play in allocating scarce resources to different types of Health Services, namely:-

- 1.1.1 Antenatal Health Care Services
- 1.1.2 Child Health Care Services
- 1.1.3 Family Planning and Women's Health Care Services
- 1.1.4 Minor Ailments' Services
- 1.1.5 Chronic Illnesses Health Care Services
- 1.1.6 Geriatric Health Care Services
- 1.1.7 Rehabilitative Health Care Services
- 1.1.8 Post-Natal Health Care Services

Specific objectives were set after major health problems had been identified. Populations in rural areas still faced a problem of not receiving services which meet their needs. Health services were probably less than what they actually expected (Larsen, 1996:1).

At present the trend and the focus to meet health care needs of all South African people is through primary health care system. Primary health care movement attempts to satisfy the public health care needs and also outreach the rural areas. It aimed at increasing the coverage reducing health care costs and improve health care delivery services. In most of the health care services, people who benefitted more, were those in urban areas. People in rural areas, especially those who receive their health services through rural clinics, benefitted less because some health services were inadequate, probably due to the fact that health professionals such as medical practitioners and nurses were reluctant to work in rural areas especially because they receive little support from health care service's authorities. In rural clinics there was still desperate short supply of facilities, such as: electricity, paraffin, stoves, and working phones. Sometimes the satellite phone installed, but worked only for a few days and in that way nurses were left with no form of communication. This problem also left the consumers of health care services with possibly inadequate and poor or no services at all (Strachan, 2000:22).

1.2 MOTIVATION FOR THE STUDY

The National Health System (NHS) of South Africa had been rearranged so as to provide basic public health services and essential clinical care for all, yet a huge number of people were without such services or such care. It was identified by the democratic government authorities, that health services had been fragmented, inefficient and ineffective and resources such as money, personnel and equipment mismanaged and poorly distributed. This situation had been found to be particularly worse in rural areas (Reconstruction and Development Programme (RDP), 1994:42).

According to the government of National Unity, all the role players and services had to be drawn into National Health System (NHS) so as to correct loopholes formed during the time of the former government. Communities had to participate actively in planning, managing, delivering, monitoring and evaluating of the health services in their areas (RDP, 1994:43).

Improved health service delivery had become an issue in the public service and the corporate world since South Africa joined the global community in 1994. South Africa as a community had a tremendous challenge to improve health service standards to all its people. This

process had become a priority, especially for the public health sector, where for various reasons service had dropped dramatically (Ntshona, 1999:19).

In a democratic country such as South Africa, it was important to note that an efficient public service is not a privilege, it was a legitimate expectation of the people. The constitution of 1996 stated the following principles:

- People's needs must be responded to
- A high standard of professional ethics should be promoted and maintained
- The public should be encouraged to participate in policy making (Ntshona, 1999:19).

The views of Health Service consumers in rural communities were investigated in view of the stated principles of the 1996 constitution. The World Rural Health Conference had made it clear that inequities faced by rural populations in relation to health services, in different areas of the world is remarkably similar. Physicians to work in rural areas are needed very much. They were recruited but cannot be retained probably due to poor conditions of service, scarce human and material resources and the health care workers had to make the best use of very limited resources (Topps, 2000:12).

1.3 STATEMENT OF THE PROBLEM

Health services rendered to the people in rural areas seemed to be inadequate especially because most of the professional nurses and doctors were still concentrated in urban and peri-urban areas. Shortage of personnel in rural clinics still exist. There is a cry, that nurses in rural clinics were overwhelmed by huge numbers of patients and they had actually verbalised a feeling of helplessness due to those huge numbers against staff shortage (Strachan, 1999:11).

shortage of human and material resources, as a result

Mortality burden still occurs in children and women in overseas countries, for example, in Papua, New Guinea, children in rural areas still died because of pneumonia, malnutrition, measles, meningitis, low birth weight, malaria, and neonatal sepsis, and so is the situation in South Africa. Poor maternal health and poor knowledge about feeding form major contributions to childhood malnutrition. Statistics show that the rate of maternal mortality range from 370 per 100,000 live births to 930 per 100,000 live births (Duke, 1999:1291).

of health care services, living in rural areas do not have access

The researcher is concerned about problems encountered by the consumers of health care services in rural clinics in KwaZulu-Natal province and wished to find out from them and hear their point of view in relation to health services provision in their areas.

The study aimed at achieving the following objectives:

1.3 STATEMENT OF THE PROBLEM

The province of KwaZulu-Natal is predominantly rural. Most people residing in these areas are poor, illiterate and end up in poor health. Common health conditions affecting people in rural areas are mostly preventable especially through effective health education and community development. However, literature maintains that rural people received inadequate health care services as they experienced shortage of human and material resources. As a result, according to Duke (1999:129) rural communities have a high mortality rate. The question to be addressed was, "Are the people in rural communities where health services are provided by rural clinics, benefitting maximally from these health provisions, if not, what are the problems?"

1.4 PURPOSE OF THE STUDY

The purpose of the study was to determine the views of consumers of health care services, living in rural areas on health care services provided to them.

1.5 OBJECTIVES OF THE STUDY

The study aimed at achieving the following objectives:

- To identify problems encountered by the consumers of health care services in the rural clinics in relation to health care provision.
- To ascertain expectations clients had from health care providers in their areas.
- To assess the appraisal of health care providers by consumers of health care services in rural clinics.

1.6 **ASSUMPTIONS**

The study was based on the following assumptions:-

- Rural clinics are still given less attention by the health authorities.
- Health problems that occur in the rural areas are basically due to shortage of personnel and material resources.

1.7 **SIGNIFICANCE OF THE STUDY**

The researcher hoped that this study will contribute by providing the health care authorities with facts from the people served by health professionals in rural clinics, which might be essential for strategising

and re-evaluating health services especially in rural clinics. May be views and suggestions of consumers of health care services, if highlighted in the form of research, may alert the authorities of KwaZulu-Natal province to focus more on areas facing health care delivery in rural areas.

1.8 DEFINITION OF TERMS

1.8.1 Consumer

Refers to biosocial being in constant interaction with changing environment (Fraser, 1996:44).

In this study a consumer is a recipient of health care services provided by health professionals in rural clinics. In this study words, consumers/clients/people will be used interchangeable and all of them will be referring to consumers of health care services.

1.8.2 Health Service

Health services are activities provided by health care professionals to the sick and those who are not yet sick, for

the purpose of promoting health and preventing diseases, rehabilitation, counselling and health education (Saunders & Carver, 1992:101).

In this study health services refer to professional activities rendered to patients and clients.

1.8.3 **Professional**

Refers to a person who has great skill or experience in a particular field or activity (Roberts, 1991:1229).

In this study a professional refers to personnel who had undergone nurses training and registered with the South African Nursing Council (SANC) and regulated by the stipulations of the Nursing Act No. 50 of 1978 as amended, as well as those registered with the Medical and Dental Council.

1.8.4 **Rural areas**

Rural areas refer to a country side with people that share the common characteristics of comparatively few people living

in the area, who have limited access to large cities and sometimes even smaller towns, and considerable travelling distances to "market areas" for either work or everyday living activities. They exist along a continuum, however, from more rural to less rural and vary extensively based on the factors:- proximity to central place, community size, population density, total population and economic/socio-economic factors (<http://www.ruralwomyn.net/rura.Ltml>).

In this study rural areas refer to all places which are geographically far from cities, towns, health care facilities, national roads, transport and hospitals. These are predominantly occupied by the poorest Black communities, and are still basically dependant on shared natural resources for their living.

1.8.5 **Communities**

This is defined as a group, population or cluster of people with at least one common characteristic such as geographic location, occupation, ethnicity or housing conditions (Anderson & McFarlane, 1996:261).

In this study community refers to a group of people living in the same geographical area, sharing the same language, ethnicity and the same housing conditions.

1.8.6 **Health**

World Health Organisation indicates that health is a state of complete physical, mental and social well being, not merely the absence of disease or infirmity in an individual (Phillips, 1990:2).

In this study, the same meaning refers.

1.8.7 **Primary Health Care**

Primary health care is essential health care based on 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 community and the country can afford to maintain at every stage of the development in the spirit of self reliance and self determination. It forms an integral part, both of the country's health systems, of which it is the

central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the National Health System, bringing health care as close as possible to where the people live and work and constitutes the first element of a continuing health care process (Vlok, 1996:26).

Chapter 2: Literature Review

1.8.8 Health care

Health care includes preventive, diagnostic, therapeutic, rehabilitative, maintenance or palliative care and counselling among other services. Health care also includes the safe and dispensing prescription of drugs or devices (www.google.com).

1.9 ORGANISATION OF THE REPORT

The research report is presented as follows:-

Chapter 1: Orientation into the study

1.1 Introduction

1.2 Motivation of the study

- 1.3 Statement of the problem
- 1.4 Purpose of the study
- 1.5 Objectives of the study
- 1.6 Assumptions
- 1.7 Significance of the study
- 1.8 Definition of terms

Chapter 4:

Data Analysis and Interpretation of Results

Chapter 2: Literature Review

- 2.1 Introduction
- 2.2 Health care delivery system in South Africa
- 2.3 The current health care delivery system in the Republic of South Africa
- 2.4 Restructuring and development era of health care service delivery in South Africa
- 2.5 Challenges facing consumers of health care services in rural areas
- 2.6 Actions taken by the government in meeting the health care challenges
- 2.7 Theoretical framework

Chapter 3: Research Methodology

- 3.1 Research design
- 3.2 Target population

- 3.3 Sampling techniques
- 3.4 Sample size
- 3.5 Data collection instrument
- 3.6 Pilot study
- 3.7 Ethical considerations

2.10 INTRODUCTION

Chapter 4: Data Analysis and Interpretation of Findings

This chapter provides

- 4.1 Analysis and presentation of data
- 4.6 Discussion of findings

The purpose of this

Chapter 5: Summary, Conclusions, Limitations and

of health care

Recommendations

Africa by health

a wide range of

challenges face

health care in

Africa. Thus

suggestions are

investigation.

- 5.1 Introduction
- 5.2 Summary
- 5.3 Conclusions
- 5.4 Limitations
- 5.5 Recommendations

Literature review

communities in

communities in

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter presents a review of selected literature, relating to health care service delivery in South Africa.

The purpose of the literature survey was firstly, to determine the system of health care delivery implemented in health care services of South Africa by health professionals. Secondly, the literature survey provided a wide range of information, opinion, comments, recommendations on challenges faced by health care service authorities as well as rural health care service consumers on health care delivery system in South Africa. Thirdly, the literature survey provided methodological suggestions and conceptual framework for the actual conduct of the investigation.

Literature review will also highlight challenges encountered by rural communities in relation to health care service provision. The rural communities in KwaZulu-Natal are still faced with the Third World

problems underlined by poverty and poor health. Many people in these areas are still illiterate and as a result of this, they still suffer mostly from preventable conditions such as for example, cholera, parasitic infections, tuberculosis, sexually transmitted infections and others.

2.2 HEALTH CARE DELIVERY SYSTEM IN SOUTH AFRICA

The health care delivery system of South Africa can be best understood when briefly historically traced back from the year 1909.

2.2.1 Historical overview of the health care system of South Africa

The Health Care Act of 1909, provided for a three level system of government which consisted of a central government at the highest level, four provincial administrations at the second level (Cape of Good Hope, Natal, Orange Free State, and the Transvaal) and the local authorities at the third level. Little attention was paid by the Act of 1909 to matters of Health, however, the central government was responsible for the prevention of epidemics of infectious diseases (De Haan, 2001:1).

The health care delivery system under the control of Health Act 1909, had shortcomings in the organisation and co-ordination of the health services. This was revealed by influenza epidemic of 1918, which claimed lives of approximately 142,000 people. The death of many South African citizens led to the promulgation of the Public Health Act 36 of 1919. The aim of the Act was to establish uniform control of preventive health services and to try and co-ordinate health care at national level. It also aimed at establishing an additional ministry of health (the Department of Health) which was responsible for the prevention of infectious diseases. The Provincial Administration were responsible for all aspects of curative health, and local authorities became responsible for environmental health (Van Rensburg, Fourie & Pretorius, 1992:59).

2.2.2 Fragmentation of health care services

The health care system controlled by the Health Act of 1919 as quoted by Harrison (2000:1) was not without problems. The health care services were fragmented with poor provision for overall co-ordination of health care services.

The deepening of rural-urban discrepancies and inequalities in health care still existed. Health care services were concentrated in urban areas, rural areas were left underprovided and understaffed (Harrison, 2000:8).

The health care problems encountered during the implementation of the Health Act of 1919 led to the promulgation of Act 63 of 1977.

The aim of the legislation was to co-ordinate the health services of the Republic of South Africa, to determine a national health policy and to make full use of all available health services in order to ensure that a comprehensive health service is implemented. The three levels of government remained intact even with the Health Act 63 of 1977. The Act emphasized that the three levels of government be involved in the delivery of health care, but the ultimate responsibility for the health of the people of South Africa was the responsibility of the State. Provision of a comprehensive health care service has been the most important part of the Act (De Haan, 2001:1).

The Health Act 63 of 1977 clearly delineated responsibilities between various levels of health care, but this still created problems in the provision of health care services to all citizens of South Africa. Rural communities remained underprovided. Services were poor with inadequate human and material resources. Standards of environmental hygiene remained poor as there was lack or total absence of sanitation and an adequate water supply in rural areas. In other words, health care services were inaccessible and unavailable to rural people. People in rural communities suffered from preventable conditions such as gastroenteritis, parasitic infections and other diseases caused by poverty, such as malnutrition. Medical services were poor and often inaccessible because of poor communication (De Haan, 2001:27).

Communities were not participating in planning, management and evaluation of their health services because of poor communication system even among health professionals. The referral system was also poor (Harrison, 2000:8).

2.2.3

The fragmentation on the organization of health care services caused by the existence of a three-level system of health care remained unsolved even after 1977. The Act perpetuated and reinforced fragmentation of health services. The unified health policy or structure for the whole country of South Africa was not established, there was a division between South African and homeland health care services brought about by the establishment of a homeland policy. The dualistic structure of providing health care services to black South Africans existed as those in areas surrounding white urban areas received better health services compared with the lesser and poorer provision to black South Africans in rural areas. Even with the implementation of the Health Care Act 63 of 1977, the emphasis was predominantly still on curative services on the budget (Van Rensburg, Fourie & Pretorius, 1992:74).

Act 63 of 1977 has been emphasizing a comprehensive health care approach, but due to various challenges and changes in health care delivery system of South Africa, between 1977 to date, the Act will now have to be revised, amended or repealed.

2.2.3 **Health Act 63 of 1977**

The aim of the Health Act 63 of 1977 was to coordinate and improve health care services for all people in South Africa. Health Act 63 of 1977 had to fill gaps and shortcomings of Health Act 63 of 1919, which promoted separate development, division and fragmentation of health care services. Health Act 63 of 1977 entrusted responsibilities to health authorities at three levels of government; namely, national level – which was responsible for overseeing and coordinating state health services, provincial level – which was responsible for the establishment and maintenance of a comprehensive health service within provinces and, local level – which was responsible for maintenance of clean and hygienic environment, promotion of health and prevention of communicable diseases (Health Act 63 of 1977:11).

However, the problem of fragmentation of health services remained unsolved. Health care services were poor in rural areas which were predominantly occupied by black, uneducated people. The unified health policy for the whole country of South Africa was not established, instead, there

was a division between South African and homeland health care services brought about by the establishment of a homeland policy. Financial resources allocation within the health sector were not properly distributed. Therefore, optimal health care services to the entire population was not possible. Doctors and nurses were also unequally distributed with rural areas having a small number of nurses and no doctors. All this made health services to be inaccessible, unavailable and unaffordable. Homelands ended up having people with poor health and diseases which were related to poverty and poor living conditions, such as bilharzia, cholera and nutritional deficiency diseases (Van Rensburg, Fourie & Pretorius, 1992:74).

There was uncoordinated division of responsibility and functions among different health authorities at the national, provincial and local levels of government. There was also increasing degree of inefficiency and overlapping of services resulting from this division. There was lack of uniform policy for the whole of South Africa and the emphasis was on curative health care instead of emphasis on preventive health care services. The Health Act 63 of 1977 focussed only on health care services for whites.

De Haan (2001:27) also states that the Health Act 63 of 1977 clearly delineated responsibilities between various levels of health care, but this still created problems in the provision of health care services to all citizens of South Africa. Rural communities remained underdeveloped. Health services were poor with inadequate human and material resources. Standards of environmental hygiene remained poor as there was lack or absence of sanitation and an adequate supply of water in rural areas. This suggests that health care services were inaccessible and unavailable to rural communities.

Therefore, people living in rural areas suffered from preventable conditions such as gastro-enteritis, parasitic infections and other diseases caused by poverty such as malnutrition. Medical services too, were poor and often inaccessible mainly because of poor communication (De Haan, 2004:27).

Communities were not participating in planning, management and evaluation of their health services because this was not provided for or encouraged by the health policy and there was also poor communication system even among

health professionals. The patients referral system was also poor and this resulted in patients who needed further expert care poorly referred or not referred (Harrison, 2000:8).

Even with the implementation of Health Act 63 of 1977, the emphasis was predominantly still on curative services on budget. Although Health Act 63 of 1977 was also for a comprehensive health care approach, it did not materialize, and due to various challenges and changes in South Africa between 1977 and to date, the Act will now have to be revised, amended or repealed, especially because there have been so many changes in the delivery of health care such as the district health care system. Hopefully, changes will occur as the ANC government is presently working on a new National Health Act, as it was briefly revealed in television news recently (TV, e-news, September 2004).

2.3 THE CURRENT HEALTH CARE DELIVERY SYSTEM IN THE REPUBLIC OF SOUTH AFRICA

In April 1994, the Republic of South Africa was led by the African National Congress (ANC) government which was the government of National Unity, and it committed itself in redressing the effects of

apartheid in the delivery of health services. It inherited a highly fragmented and bureaucratic system that provided health services in a discriminatory manner.

Improved health care delivery had become an issue in the public service and the corporate world. The government faced challenges of improving service standards for the people of South Africa. The public health sector became a priority because of poor health care services. The health sector set out for major reform by commencing on the implementation of a single comprehensive, equitable and integrated public health system in South Africa in the form of a National Health System (NHS) (Ntshona, 1999:19).

To facilitate the process of reconstruction and development, the Act 108 of 1996 (Constitution of the Republic of South Africa) was drawn up by the Constitutional Assembly. According to the Constitution the terminology of "tiers and levels" was replaced by the word "sphere" hence the government is currently structured as "National Provincial and Local Spheres". The spheres are distinct, interdependent and interrelated (De Haan, 2001:2).

2.4 RESTRUCTURING AND DEVELOPMENT ERA OF HEALTH CARE SERVICE DELIVERY IN SOUTH AFRICA

In order to address the problem within the health sector, the Department of Health developed policies on a wide range of issues that are contained in the White Paper for the Transformation of the Health Sector of South Africa released in April 1997 (Pillay, McCoy & Asia, 2001:4).

A significant departure from the past is the decision to create a unified but decentralised national health system based on the district health system (DHS) model (Van Rensburg, Steyn & Matebesi, 1999:50).

2.4.1 The District Health System (DHS) in South Africa

The government of national unity published the National Health Plan. This was done in consultation with the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). The plan outlined the governments' vision for health care in South Africa in the post apartheid era. The district health care system aimed at improving health care for all people including rural

communities. The government committed itself to the promotion of health through prevention and education and to deliver comprehensive and integrated services up to and including district hospital services. District health care system decentralised management responsibility, authority and accountability. It encouraged community involvement in management and decision making and also in taking responsibility. Therefore services had to be planned, managed and delivered at district level (McCoy, Bush & Palmer, 2000:47).

The district health care system also aimed at achieving effective referral mechanism within and between districts and levels of care. This was achieved through designing levels of health care. Health care services in rural areas are delivered and managed in the clinics, which form the first level of health care delivery (McCoy, Bush & Palmer, 2000:48).

2.4.2 Implementation of the District Health System

The district health system was implemented throughout the

country from 1995 onwards. Provincial managers had to demarcate health regions and health districts' boundaries. By 1999 there were 39 health regions, 174 districts and 843 municipalities nationally (Pillay, McCoy & Asia, 2001:5). In KwaZulu-Natal province divisions were later changed to 10+1 districts (maps are attached for referral). All this was attempting to carry out the governments' decision to meet health care needs of the people in urban and rural areas (Pillay, McCoy & Asia, 2001:10).

Besides the emphasis on comprehensive and integrated services the district health system also emphasized the need for effective referral mechanism within and between districts and levels of care. In KwaZulu-Natal province four levels of health care were formulated, namely,

Level-1, which includes Primary Health Care, Community Health Centre and District hospitals as first, second and third steps respectively, where patients can present their problems and be referred as necessary, from level one step one to other steps of level 1.

Level 2, includes Regional hospitals. Level two includes step four where patients can be referred to from step three to be given specialized treatment.

Level 3, is the fifth step which involves Provincial Tertiary hospitals which receive referrals from Regional hospitals.

Level 4, is the sixth step and it involves Central hospitals and is the highest level of health care, which receives patients referred from Provincial Tertiary Hospitals, for multi-speciality clinical services (KZN Department of Health, 2000).

For the purpose of this study the emphasis will be on level 1 step 1 which is the primary health centre (clinics).

2.4.3 **Level 1 Step 1 – Primary Health Care**

At this level, the primary health care clinic is the first step in the first level of health care and is ideally the first place that the client visits when a health need has been identified. This

is the most significant level of health care because most people in rural areas are dependent on this level of health care delivery for their health needs. However, the provision of primary health care services is still a problem in developing countries like South Africa where there is shortage of human and material resources, and inaccessibility of health data and information (Thipanyana & Mavundla, 1998:22).

2.5 CHA The aim of introducing the primary health care centre at first level as the first step, was to emphasize on primary health care approach in trying to reach all people. To facilitate rendering of effective health care services, the primary health care centre (clinic) receives clinical support from the district hospital. Another facilitating factor for the purpose of effective utilization of the primary health centre was the emphasis by the government, to increase the number of primary health care nurses and doctors (Dennill, 1999:8).

transport In introducing the District Health System and their levels of health care, the government aimed at decentralizing the health care services so that the control of the primary health

The most care is by the local government which is nearest to the people and is aware of their needs.

In spite of all changes made by the government to ensure that all citizens of South Africa benefit from health care services, it is generally agreed that rural communities are still receiving inadequate health care services (Thipanyana & Mavundla, 1998:23).

2.5 CHALLENGES FACING CONSUMERS OF HEALTH CARE SERVICES IN RURAL AREAS

The barriers to health care in rural areas include distance, isolation and sparse resources such as human, and material resources. Availability and accessibility to health care providers and institutions are a real problem. In rural areas there are long distances travelled to obtain health services. There is lack of personal transportation because of poverty and lack of employment. The public transportation is also unavailable probably due to poor education and knowledge that public transport could be negotiated and requested to provide service to the community (Clarke, 1996:630).

The most common challenges will be discussed briefly:-

2.5.1 **Inaccessibility of health care services**

Rural community members live in areas which are far from health care centers. In these areas there is poor transportation and people travel long distances and roads are bad. Rural people have to pay large sums of money which they cannot afford because of poverty. In cases of acute illnesses and emergency health needs they resort to traditional medicines and home remedies which may sometimes be detrimental to their health. This is supported by the study which was conducted in 1995 by medical students at the University of Natal Medical School in Durban (now known as Rolihlahla Nelson Mandela) for the purpose of finding out if most of the black children in rural communities reach health care centers when they had already started with traditional medicines because of inaccessibility to health care centers as quickly as possible and how much rural people relied in traditional medicines.

Findings revealed that out of 400 children 320 had received

traditional medicines before they attended a hospital or a clinic. These medicines were for treating abdominal pain, cough, fever, constipation, diarrhoea and loss of energy (Clark, 1996:630).

This suggests that there is a need for health services to be accessible to rural communities as it had been implicated that traditional medicines have serious effects on children.

Patients from rural areas present themselves late when illnesses have advanced, the factor being living far from health care facilities as well as the effect of poverty. Boulle (1997:6) found that 56% of rural South Africans live more than 5 kilometers from a health care facility as compared to 13% of their urban counterparts. Specific areas where this has a significant impact are maternal and child health (Boulle, 1997:6).

2.5.3

Poor standards of environmental hygiene

2.5.2

Lack of education

Most people in rural communities have fewer educational opportunities which lead to fewer employment

opportunities. This is due to the fact that people with less education are employed as unskilled labourers and may consequently be unemployed or retrenched. Unskilled labourers receive less salaries. People in rural areas are therefore generally poorer and less healthy and prone to deficiency diseases like malnutrition, kwashiorkor and others. Many of the factors impacting on health care status of rural people are interlinked, and central to them is poverty. It is important to note that many of the health problems encountered by rural people are preventable conditions such as pulmonary tuberculosis, malnutrition, malaria and others, but because of the fact that health care services are still inaccessible due to poverty, poor transport and others, they still suffer from these preventable diseases (Boulle, 1997:6; De Haan, 2001:14). It is evident that in rural areas people need accessible and affordable health care services.

2.5.3 **Poor standards of environmental hygiene**

Rural communities still face a problem of poor sanitation and as a result they end up with filthy environments which put their health status at risk. Fewer homes have pit toilets and

many households have no toilets and as a result surroundings are contaminated with human excreta. Animals such as cattle, goats and others roam around and they also contaminate the surroundings with animal excretions. They have no way of disposing refuse and therefore many places in rural areas are contaminated by household refuse and papers as well as other kinds of refuse (De Haan, 2001:22).

2.5.4 **Lack of clean water supply**

In deep rural areas, there is no supply of clean water but people there are dependent on river or spring water. In many instances water is shared with animals such as the cattle which also contaminate water. This puts the health of rural people at high risk of waterborne infections. According to the South African Demographic and Health Survey (1998:17) 54% of households in KwaZulu-Natal fetch water from rivers, fountains, springs and other sources of water.

2.5.5 **Fewer multi-disciplinary health care services**

The rural area still face unavailability of health personnel in almost all disciplines, for instance among rural communities there are few nurses in relation to a large number of patients who attend clinics, there may be one doctor who rarely comes to the health centre to take care of rural people's health needs and in other deep rural areas there is no doctor at all. Psychiatrists, social workers, psychologists, genetic counsellors, pharmacists and other health professionals are only available in urban areas and rural areas there is none (Van Rensburg, *et al.*, 1992:284). Rural communities need these health professionals that form the multi-disciplinary health team but accessibility and affordability is still also a matter of concern.

2.5.6 **Large number of insect vectors**

Insects and vectors in rural areas are still a threat in the health of people living in rural areas. Rural communities are exposed to various types of insects such as mosquitoes, which put them at a high risk for malaria, and others such as

flies, fleas, ticks, bugs, cockroaches, ants and many others. All these insects make rural people to be vulnerable to diseases spread by insects and many eat food contaminated by insects and at great risk for various infections and insect bites (De Haan, 2001:22).

2.5.7 **Increased infant and child mortality**

The infant mortality rate of rural South Africans is 16 times that of urban counterparts mainly because they are presented late for health care services when they have already developed complications. This problem is also linked to poverty, long distances from health care facilities, poor transport facilities, ignorance (Boulle, 1997:6). According to the South African Demographic and Health Survey Department of Health (1998:266) KwaZulu-Natal province is rated as one of the provinces with high infant mortality rates, it had 52 deaths per 1,000 live births.

Rural areas are the mostly affected areas because of poverty and inaccessibility to health care services.

Nutritional status of rural pre-school South Africans is far more worse than that of their urban counterparts because most of the people in rural areas are unemployed and are very poor, and therefore cannot provide good nutrition for their children. A 1994 study revealed that rural children were 77% more likely to be underweight or underheight for age due to poor nutrition (Boulle, 1997:6).

2.5.8 **HIV/AIDS and other sexually transmitted infections**

This is still a serious problem in rural areas because though some people are aware of it but may in rural areas still lack knowledge and believe that it is due to witchcraft or is somehow linked with the demands of their ancestors. Sexually transmitted infections are higher among rural African men in KwaZulu-Natal (South Africa Demographic and Health Survey Department of Health, 1998:270; Van Rensburg, Fourie & Pretorius, 1992:194; Strachan, 2000:5). There is still a need to enlighten and empower rural communities with knowledge on HIV/AIDS and develop strategies which will convince them to understand HIV/AIDS because many of them have low standards of education.

2.5.9

Perception of own health by rural communities

This is a great health challenge in rural areas that people there would not seek medical help as long as they are still able to continue with their work. They consider themselves healthy even though they may be suffering from several chronic illnesses, instead they emphasize emotional and spiritual well being (DeSoto *et al.*, 2001:2).

According to Stanhope and Lancaster (1996:319) rural communities have a poorer perception of their overall health and functional status than urban communities. Rural residents access their health less favourably than urban residents, rural adults are less likely to engage in preventive behaviour probably due to illiteracy and lack of health education, and this increases their exposure to health risks. For example, rural people have been found to be less likely to use seat belts in motor vehicles, have regular blood pressure checks, have papanicolaou smears or do self breast examinations. Failure to be involved in these life-style behaviours affects the health status of rural residents, their level of functioning can result in physical limitations and

influence the degree of self-care activities. When compared with urban residents, rural residents have higher rates of chronic illnesses such as cardiovascular diseases, cancer and hypertension. They have higher infant and maternal morbidity rates. Rural residents have also been found to have unique health risks associated with occupational and the environmental factors such as machinery accidents, skin cancer from sun exposure and respiratory tract problems due to exposure to chemicals and pesticides as well as stress related health problems and mental illness (Stanhope & Lancaster, 1996:319).

2.6 ACTIONS TAKEN BY THE GOVERNMENT TO MEET THE HEALTH CARE CHALLENGES

Having identified all the discrepancies and challenges such as fragmentation of health care services, poor referral systems, shortage of nurses and others within the health care sector, the government has taken action to meet these challenges. These actions are briefly discussed here under:

2.6.1 **District Health System**

Health services have been decentralised into districts with the aim that health care services become accessible to all people of South Africa (McCoy, Bush & Palmer, 2000:4).

2.6.2 **Primary Health Care Nurses**

In KwaZulu-Natal in 1995, fifty (50) primary health care nurse trainers underwent a crash course so as to enable them to train 10 primary health nurses each by 1996 and the other subsequent years. Existing training institutions that were training primary health nurses, had to increase their numbers. This was an attempt to increase competent clinically skilled nurses and alleviate shortage of such skilled nurses in the years to come (South African Health Review, 1996:13).

2.6.3 **Levels of Health Care Delivery**

With the designing and defining levels of health care delivery the departments of health in South Africa were trying to

implement an effective and efficient referral system, because in the past there was a poor referral system.

2.6.4 **The Bill of Rights**

In the Constitution of the Republic of South Africa (1996) the government included the bill of rights, that, "everyone has the right to have access towards health care services ..., and that no one may be refused emergency medical treatment," and all patients have to know their rights (The Constitution of the Republic of South Africa, 1996:13).

2.6.5 **The Patient Charter**

In the patients charter the people are given information on their rights to access health care services as well as the responsibility patients have towards their own health care and that patients/clients have to be honest about their health problems to health care providers so that whatever is done by health care providers to meet their health needs become a success (Directorate: Health Services, 1998:1).

2.6.6 Batho Pele Principles

In order to improve health care service delivery, the ANC government committed itself to redress the inequitable provision and distribution of services and resources, through implementation of the Public Service Delivery Strategy, known as "Batho Pele" meaning "People First". It is a policy framework for the transformed public service, including the health care services. The message of Batho Pele is that the primary function of the Public Service is to serve all citizens of South Africa, ensuring that their needs come first, and giving the consumers of the Public Service the, "customer status." Consultation, service standards, access, courtesy, information giving, openness and transparency, redress and rewarding excellence, customer impact and leadership and strategic direction are the eleven principles through which the objectives of Batho Pele would be realised. To facilitate co-operation of the clients, publicising of Batho Pele was coupled together with the release of the Patient's Charter, through the office of the National Minister of Health (National Department of Health: South Africa, 1998).

With all these changes and strategies the government was actually taking the active part in meeting the health needs and challenges of all the people of South Africa.

2.7 THEORETICAL FRAMEWORK

2.7.1 Introduction

The aim of the conceptual framework is to organise concepts essential to understanding nursing as a major system within health care systems (George, 1995:210).

Models of nursing are representations of the reality of the nursing science, they make factors in a nursing situation clear. Models become tools which remind nurses about different aspects of nursing care which may be ignored or forgotten (Kershaw, 1994:4).

In research, the main purpose of utilization of a theoretical framework, is to explain different variables in the study (George, 1995:209).

2.7.2

King's open system framework

The study was guided by King's open system model.

King identifies the conceptual framework as an open system and the theory as one of goal attainment. The theory of goal attainment is derived from the open systems framework (George, 1995:210).

King assumes that human beings are open systems in constant interaction with their environment. She further assumes that nursing's focus is human beings interacting with the environment and that the goal of nursing is to assist individuals and groups maintain health (George, 1995:211). King believed that interactions between the nurse and the client lead to transactions that result in goal attainment. King used ten major concepts from personal and interpersonal systems to support the theory of goal attainment. Those concepts include human interactions, perception, communication, role, stress, time, space, growth, development, and transactions (Woods, 1994:66).

According to King, nursing phenomena can only assist individuals or groups to maintain health, if organized within interacting personal, interpersonal and social systems (George, 1995:211).

King views personal systems as individuals; interpersonal systems as dyads; triads; and small and large groups; and social systems as family; school; industry; social organizations; and health care delivery systems (George, 1995:211).

2.7.3 **Personal systems and interpersonal systems**

According to King, each individual is a personal system characterized by perception, self growth, and development, body image, space, learning and time. King views perception as a major concept of a personal system (individuals), that influences all behaviours or to which all other concepts are related.

Perception is selective for each individual since any given situation is experienced in a unique manner by each

individual (George, 1995:211-212).

King maintains that perception is action centred and based on available information. She emphasizes that, in perception, individuals are active participants in situations, and their identities are affected by participation (George, 1995:211-212).

The personal system concept is relevant to this study, as it views consumers of health care services as personal systems who interact with the environment as well as health care providers in matters related to their health care needs.

2.7.4 **King's theory of goal attainment**

According to King, goal attainment theory is derived from the open systems framework and thus assumptions and concepts are similar.

King maintains that goal attainment theory is a theory of nursing. She points out that the theory assumes that nurses and clients communicate information, set goals mutually,

and then act to attain those goals. King maintains that goal attainment theory is related to the nursing process. She describes the steps of the nursing process as a system of interrelated actions and identifies concepts from her theory as the basis for the nursing process and as a method (George, 1995:222).

King explains the concepts of goal attainment theory in relation to the nursing process method. She maintains that assessment occurs during the interaction of the nurse and the client, who are likely to meet as strangers. During the interaction (assessment) phase, the elements perception, communication, of the nurse and client occurs. King states that during the process of interaction, the nursing brings special knowledge and skills, whereas the client brings knowledge of self and perceptions of the problems that are of concern (George, 1995:222).

The concepts of the theory apply assessment service, growth and development, knowledge of self and role and the amount of stress influence perception and in turn influence communication interaction, and transaction. Perception is

the basis of collecting and interpreting data. It is the basis of assessment. Communication is significant to verify the accuracy of perceptions. The information shared during nurse-client interaction is used to identify the disturbances, problems, or concerns about which clients seek help (George, 1995:222).

Prior to implementation, planning occurs, where decision making about goals, exploring and identifying means to attain goals, are involved. All these steps involve mutual exchange with the client. Clients participate in decision making. At the end, goals attained are evaluated to determine whether or not the client got helped (George, 1995:223).

King believes that human beings are social, sentient, rational, reacting, perceiving, controlling, purposeful, action oriented and time oriented. From her beliefs she derived assumptions that are relevant to nurse client interaction, she assumes that: "perceptions of nurse and of client influence the interaction process", whereby nurse and client share information about their perceptions in the nursing situation;

275 "goals, needs and values of nurse and client influence the interaction process", because through communication, they set goals: "individuals have a right to knowledge about themselves", for an example, they need knowledge and information about their health status and how they can prevent illness; "individuals have a right to participate in decisions that influence their life, their health, and community services", this is due to the fact that human beings are rational, perceiving, controlling, purposeful and action-oriented (George, 1995:220).

King further assumes that: "health professionals have responsibility to share information that helps individuals make informed decisions about their health care", this assumption is supported by the fact that in assessment, the nurse needs to collect data about the client's perception of his or her current health status and understanding of why contact with the health care system is occurring; individuals have a right to accept or to reject health care, goals of health professionals and goals of recipients of health care may be incongruent (George, 1995:221).

Relevance of King's conceptual framework and goal attainment theory to the study

King's theory is applicable to the study in that the researcher had perceptions about the health of clients, health care received by clients from health care services and health care delivery system of South Africa. On the other hand, it is assumed that the clients as open systems had perceptions about the health care delivery system of South Africa, health care they receive from health care services as well as their health status.

According to King, each individual is a personal system whose behaviour is mainly influenced by perception (George, 1995:211). This is relevant to this study. The perceptions of the researcher (nurse) and the consumers of health care services (clients) influence their interaction process. The researcher is concerned with human beings interacting with their health through effective health care services. As supported by King, from the perceptions of the consumers and the researcher, assessment/investigation on how the consumers view health care services provided to them by

health professionals was undertaken.

The researcher needed information to prove her assumption originating from the perceptions that influenced the interaction process. As the researcher interacted with individual health care services. Consumers, according to King's theory that was interaction between personal systems. Interaction as a process of perception and communication between the researcher and the consumers of health care services, was represented by verbal and non-verbal behaviours that were goal directed. The researcher and the health care services (consumers) involved in the process of interactions, brought about different ideas, attitudes and perceptions to exchange.

King views perception as a process in which data is collected and obtained, organized, interpreted and transformed (George, 1995:211). This is applicable to the study as the researcher, through the process of interaction, was able to pick perceptions of health care consumers as well as their body language in relation to health care service provision.

As open systems (consumers of health care services) develop within their environment, they may set different goals at different times and choose different methods to attain them, but the ultimate goal is survival (Sullivan & Decker, 1992:13).

The researcher hopes that data obtained from the consumers of health care services, will be interpreted and transformed into action. Since according to King, human beings are rational and controlling, the researcher informed them about the purpose of the study in order to facilitate participation, because as individuals, consumers have a right to knowledge about themselves and have a right to participate in decision making that influence their life, their health and their community services (George, 1995:220).

In this study, the consumers of health care services were viewed by the researcher as having a right to participate in decisions that influence the provision of their health services. The goals, needs and values of the researcher influenced the interaction process.

King also explains a concept of social systems. She defines a social system as: "an organized boundary system of social roles, behaviours and practices developed to maintain values and the mechanisms to regulate the practices and rules" (George, 1995:215). In her theory, the major concept is organization which she defines as being made up of human beings who have prescribed roles and positions and who make use of resources to meet both personal and organizational goals (George, 1995:215).

King maintains that an organization has human values, behaviour patterns, needs, goals, expectations, natural environment in which material and human resources are needed for achieving goals. She further highlights that technology that facilitates goal attainment is essential in any organization (George, 1995:215).

In this study, which forms a nursing management perspective, the researcher attempts to identify material human resources, human values, behaviour patterns, needs, expectations and natural environment essential for achieving goals as viewed by consumers of health care services. The

2.7 CON researcher maintains that management of any organization, uses human and material resources for achievement of goals. The researcher assumed that, in order to achieve the goal of rendering quality health care services to people, it is wise to express their views about services they receive. The information obtained will facilitate decision making and planning for future health care delivery as suggested by consumers. The information/data collected will be given as feed back to authorities in charge of health care services who will utilize the information for future attainment of organizational goals.

The researcher hopes that the study will be useful for planning. In this study, the researcher views nursing management as an open system that is dynamic and which develops new strategies of managing care and setting new goals. Nursing management is aimed at keeping the nursing profession alive and achieving its main goal of giving quality care at times and help people maintain optimal health as much as possible through ongoing health education. The study attempted to obtain information from human beings as consumers of health care services on whether or not the organization is achieving its goals of health care at all.

2.7 CONCLUSION

The theory is relevant to the study as it emphasizes interaction, perception and communication between human beings who are aiming at achieving a specific goal. The researcher and the health care services consumers interacted in order to determine the views of health care services consumers on provision of health care in rural areas of KwaZulu-Natal. The study focused on the delivery of health care services to individuals within families and within the community (Riehl-Sisca, 1993:154).

The researcher hopes that the study will be able to assist in strategic planning, which will include reviews of written statements of mission, purpose, philosophy, objectives and detailed operational plans of health care services concerning quality management.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter deals with description of methods and procedures used in the study. The discussion includes description of the research design, the population, the nature and development of the research instrument, sampling method, sample size, pilot study and ethical considerations.

3.2 RESEARCH DESIGN

The study was a qualitative and quantitative descriptive survey which described the views of health care services consumers on health care services they received in rural clinics. The descriptive design was chosen because it accurately describes characteristics of an individual's situation or a group or examines the frequency with which an event occurs or associated with another event. This design was useful when frequency with which events occurred was required from the respondents in relation to health care services in rural areas (Polit & Hungler, 1995:150).

3.2.1 **Data collection method**

The descriptive method was used for data collection because the study determined and aimed at identifying and describing the views of health care services consumers about the health care services they receive in their rural clinics. It also aimed at identifying and describing problems health care consumers encounter in clinics, and describing their expectations from health care personnel. The descriptive method also helped to ascertain the impact and implications for nursing management and health care providers in rural areas. The descriptive method is also recommended by Brink (1996) that it is good when used to get information on opinions, attitudes, needs and facts from the people (Brink, 1996:109).

3.2.2 **The research instrument**

Data was collected by means of a structured interview schedule. The structured interview schedule was used as a guideline so as to elicit information needed from respondents. The language used to interview the

respondents was Zulu, because they were illiterate and were comfortable when their vernacular was used. Data was transcribed from Zulu to English by interviewers. The interview aimed at obtaining facts, ideas, impressions and opinions from respondents on health care services delivered to them.

3.2.3 **Designing the structured interview schedule**

The structured interview schedule was designed in consultation with research experts, research consultants and health care managers. Formulation of questions was guided by objectives of the study, literature reviewed, observations, and informal discussions with research experts

The interview schedule had three main sections. Section 1 was on demographic data. Section 2 was on views of respondents regarding the following health care services:-

- Antenatal health care services
- Minor ailments clinic services
- Services for chronic illnesses, e.g., diabetes,

• mellitus, hypertension, etc.

- Well baby clinic services
- Family planning clinic services

Section 3 was on the respondents' general views, opinions and suggestions about their health services. View on emergency services was included in this section. The questions included both open-ended and close-ended questions. Open-ended questions were included because they enable more in-depth probing into the superficial information that may have been obtained through close ended questions. Some respondents object to being faced into choosing from alternatives which do not reflect their exact opinions. A combination of the two types of questions was therefore recommended because it offset the weaknesses of each type as supported by Polit and Hungler (1995:283).

3.2.2 Research instrument

3.3.3 **Delimitation of the area of study**

The study was conducted in KwaZulu-Natal Province. It focused only on rural clinics sampled from different districts.

KwaZulu-Natal Province is divided into 10+1 health districts

(DC), namely:

- (1) DC 21
- (2) DC 22
- (3) DC 23
- (4) DC 24
- (5) DC 25
- (6) DC 26
- (7) DC 27
- (8) DC 28
- (9) DC 29
- (10) DC 43 + 1 (Durban)

(A map showing KwaZulu-Natal health districts is attached as Annexure 9)

3.4 ETHICAL CONSIDERATION

3.4.1 Permission for the study

The permission to conduct the research project was obtained from the Secretary General for Health Services in Natal, Pietermaritzburg. Permission was also sought from Heads of Community Services of rural areas covered.

Table 3.1: Table showing number of hospitals in each district

	District (DC)	Number of Hospitals
1	DC 21	8
2	DC 22	11
3	DC 23	5
4	DC 24	5
5	DC 25	3
6	DC 26	11
7	DC 27	5
8	DC 28	8
9	DC 29	3
10	DC 43	5
11	Durban	28
	10 + 1	92

(Information taken from Lower Umfolozi Subdistrict Office)

Table 3.1 shows the number of hospitals in each district in KwaZulu-Natal Province. Hospitals include public hospitals, state-aided hospitals and private hospitals.

3.4 ETHICAL CONSIDERATION

3.4.1 Permission for the study

The permission to conduct the research project was obtained from the Secretary General for Health's Office in Natalia, Pietermaritzburg. Permission was also requested from Heads of Community Services of rural clinics selected.

The research proposal outlining the whole study, and a structured interview schedule was also sent to the Provincial Head Office. The study was only commenced when permission from different authorities was obtained.

3.4.2 **Informed consent, anonymity, and confidentiality**

When the researcher arrived in each clinic selected, she introduced herself and her two research assistants and then explained to the respondents the purpose and objectives of the research, and ensured that respondents understood the information. The researcher also explained that respondents were free to choose whether to participate or not and that even in the middle of the interview they could still decline if they felt uncomfortable. Anonymity and confidentiality were ensured. The respondents were informed that their names and addresses were not going to be written anywhere in the interview schedule but only numbers were to be used to ensure that the researcher and her assistants did not interview one and the same respondents.

3.4.3 Ethical considerations

The respondents who formed the sample were met as a group in each clinic, and the purpose and objectives of the study were explained. Then, before individual interviews were commenced, informed consent was requested and confirmed verbally with each respondent. Freedom to participate was also explained.

All respondents were interviewed in Zulu as this was the language respondents used as home language, and which they understood well.

Confidentiality and anonymity were explained to respondents that their particulars were not going to be written on the tool used but only the information given was to be used. The researcher numbered the research tools from one to nine (1 – 9). Assistant number one used numbers from ten to seventeen (10 – 17) for his tools, and assistant number two used numbers eighteen to twenty-five (18 – 25) for her tools.

Although numbers were used on interview schedules instead of respondents' names, the names of clinics visited were written on each interview schedule used, for the purpose of identifying from which rural clinic data was collected.

3.5 TARGET POPULATION

The target population for this study included men and women who visited the clinics. The babies and children were excluded because they were too young to express their views. Only respondents aged from sixteen (16) years and above were included as they were regarded as adults who could share their views and state the facts as they perceived it, in relation to health care service provision, in their areas.

3.6 SAMPLING METHOD

Simple random sampling was used for selecting the sample. This technique was undertaken in phases, that is, sampling districts, followed by sampling of hospitals, then clinics and lastly, selecting of the respondents. Simple random sampling aimed at giving all clients who visited the clinic an equal and independent chance of being

selected, and that activity involved a one-stage selection process. This method of sampling is in line with what is recommended by Brink (1999:136).

3.6.1 **Sampling of Health Districts (DC)**

The districts that were to be included in the study were sampled first. A simple random sampling was used. The aim was to select six districts. Numbers of all ten (10+1) health districts in KwaZulu-Natal Province were written on small pieces of paper which were then folded so that numbers could be invisible.

Numbers of health districts that were written were:- DC 21, DC 22, DC 23, DC 24, DC 25, DC 26, DC 27, DC 28, DC 29, DC 43 + 1 (Durban). The folded pieces of paper were placed in a fish bowl, and a child was then requested to pick any six pieces of paper with district numbers. The six numbers of health districts that were picked were:- DC 24, DC 25, DC 26, DC 27, DC 28 and DC 29. Sampling of six districts aimed at ensuring representativeness of the districts in KwaZulu-Natal Province. Sampling of health districts was

followed by sampling of hospitals.

3.6.2 **Sampling of hospitals**

One hospital from each of the six health districts was selected. The aim was to have six rural hospitals. Firstly, the hospitals in each district were arranged in an alphabetical order, and then each was allocated a number. These numbers were written on pieces of paper which were then folded so that the numbers did not show. The folded pieces of paper with numbers were then placed in a fish bowl and a child was asked to mix them and pick one. The first picked piece of paper with a number of the hospital was included in the sample, that is, a hospital against which the number picked was allocated formed the sample. The same procedure of selecting hospitals was done for all six health districts that were selected to form the sample, until the required number of hospitals was reached. After sampling the six hospitals that were required, sampling of clinics was undertaken.

3.6.3

Sampling of clinics

The rural clinics were sampled from each of the six hospitals that were selected. All rural clinics that were under the control of each hospital selected were listed. The same fish bowl method of random sampling was repeated for selecting the clinics, as was done in the sampling of health districts and hospitals. The aim was to select two rural clinics from each hospital selected.

Table 3.2: Number of rural clinics in each hospital selected

	District Selected	Hospitals Selected	Total Number of Rural Clinics	Clinics Selected
1	DC 24	Hospital No. 1	12	2
2	DC 25	Hospital No. 2	09	2
3	DC 26	Hospital No. 3	09	2
4	DC 27	Hospital No. 4	13	2
5	DC 28	Hospital No. 5	12	2
6	DC 29	Hospital No. 6	06	2
Total	6	6	61	12

Table 3.2 shows the 12 rural clinics in KwaZulu-Natal that were selected for the study.

3.6.4 **Sampling of respondents**

After sampling of the rural clinics, sampling of the respondents followed. The aim was to select twenty-five (25) respondents from each clinic, which would end up with a total number of 300 respondents.

Simple random sampling was used to select the respondents. Sixty pieces of paper were numbered with numbers from 1 to 60. All respondents who visited the clinics were requested to pick a number from the table. Then, when all the numbers were taken from the table, 25 clients who picked a piece of paper with an odd number were requested to come for an interview. The same method was used for selecting the respondents from all the clinics which were selected for the sample until a total number of 300 respondents was reached.

3.7 **PRETESTING OF THE INSTRUMENT**

The structured interview schedule was pretested on three rural clinics which were selected through random sampling. Ten respondents were

obtained through random sampling from each rural clinic selected and formed a total number of thirty (30) respondents. The purpose of the pilot study was to test the instrument for face and content validity and reliability and to change or restructure unclear, sensitive or unnecessary questions and to determine the duration of each interview session. The purpose of the pilot study was clearly explained to the pre-test groups, and were also requested to make comments on how they feel about the interview sessions. The interview schedule was then modified according to the outcome of the pilot study. Each interview session took sixty minutes and contained fifty-eight questions.

It was also referred to research experts for review, comments and finalization.

3.9 CONDUCTING OF INTERVIEW

The pilot study revealed that the interview sessions were an hour long, which was too long for the respondents who had to be seen and examined by professional nurses and rush back to their homes by public transport. Some questions were eliminated where it seemed to be a repetition of issues. Sensitive questions were also restructured or eliminated.

3.8 RESEARCH ASSISTANTS

The researcher was assisted by two research assistants who had matriculation, in conducting the study. The two assistants were trained by the researcher on how to use interview schedules and how to conduct the interview sessions. The assistants were also requested to participate in the pilot study interview sessions for the purpose of training them on how to conduct interviews as well as familiarizing themselves with the tools. The tools were given to the assistants two (2) days before interviews for the pilot study commenced. The pilot study that was conducted over five (5) days helped the research assistants to learn how to conduct interview sessions practically.

3.9 CONDUCTING OF INTERVIEWS

3.9.1 Reporting in the clinic

The researcher and two research assistants arrived at the clinics at 07h30, and met the professional nurse in charge who made introductions to the clients, and left at 15h30.

3.9.2 Place of interviewing

The professional nurses in charge of clinics did their best to offer places which allowed privacy for conducting interviews. Respondents were interviewed privately, away from other clients. Clinic personnel arranged quiet and less used rooms such as the duty room, store room or consulting room, for interviews to be conducted privately.

3.9.3 Duration of data collection

The interview sessions were conducted over twenty-four (24) days. Two days was spent in each rural clinic with the help of two research assistants. Each session was conducted for the duration of twenty (20) to thirty (30) minutes depending on how fast the respondent answered and expressed his or her views. Each research assistant interviewed eight (8) respondents over two days and the researcher interviewed nine (9) respondents over two days in each clinic visited for the purpose of research.

3.9.4 Collection of qualitative data

Field notes were used to collect qualitative data. Concerns of respondents are described and interpreted in chapter 4.

4.1 INTRODUCTION

In this chapter data collected and analysed in chapter 3 are analysed and interpreted. Data is presented qualitatively and quantitatively by means of tables and graphs.

4.2 DEMOGRAPHIC DATA

The sample consisted of the following demographic data:

4.2.1 Gender distribution

Gender distribution was of significance to the study as it determined whether the sample was equally distributed according to gender, so as to ensure data reliability for males and that information received from both genders.

CHAPTER 4

DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

In this chapter data collected from consumers of health care services is analysed and interpreted. Data is analysed qualitatively and quantitatively by means of tables and graphs and percentages.

4.2 DEMOGRAPHIC DATA

The sample consisted of the following characteristics:-

4.2.1 Gender distribution

Gender distribution was of significance to the study as it determined whether the sample was equally represented according to gender, so as to collect data from both males and females and that information received could be generalized.

Table 4.1: Gender Distribution (N=300)

No.	Clinic Number	No. of Males	No. of Females
1.	Clinic No. 1	07	18
2.	Clinic No. 2	10	15
3.	Clinic No. 3	08	17
4.	Clinic No. 4	12	13
5.	Clinic No. 5	09	16
6.	Clinic No. 6	06	19
7.	Clinic No. 7	07	18
8.	Clinic No. 8	05	20
9.	Clinic No. 9	04	21
10.	Clinic No. 10	11	14
11.	Clinic No. 11	08	17
12.	Clinic No. 12	10	15
Total		97 (32%)	203 (68%)

Figure 4.1: Percentage of Males and Females

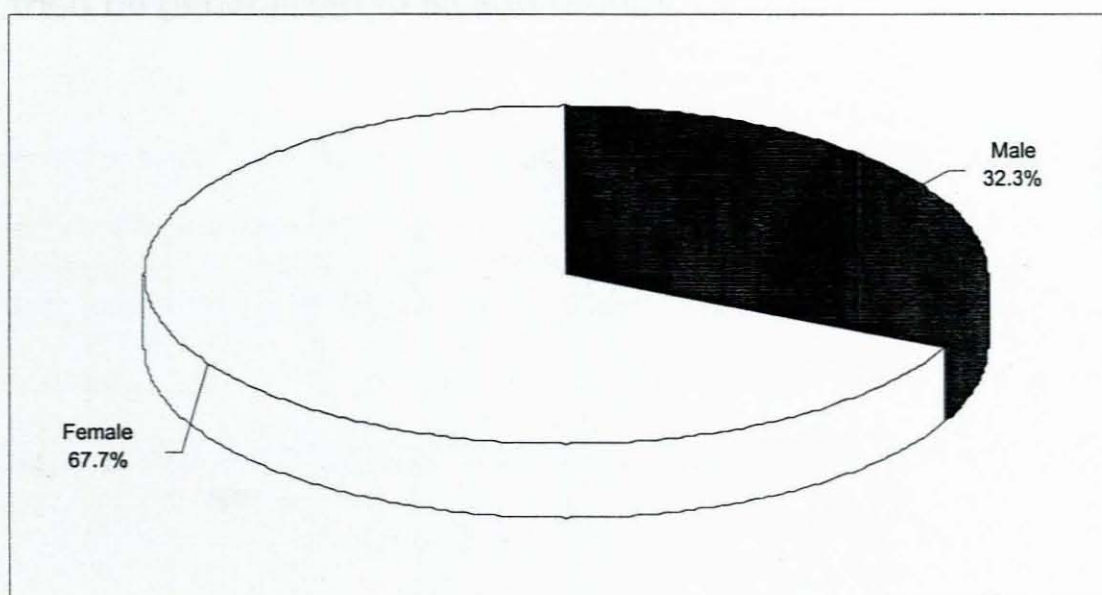


Table 4.1 and figure 4.1 shows that out of 300 (100%) respondents who formed the sample utilized clinic health services in rural areas, 203 (68%) were females and 97 (32%)

were males. This suggests that clinic services are mostly used by females. The information for the study will therefore be obtained mainly from females.

4.2.2 **Age distribution**

Age distribution was significant in the study because opinions and views were obtained from a variety of age groups. Different age groups could possibly have different views about health services they utilize, and information obtained could then be generalized to all age groups.

Figure 4.2: Age Distribution

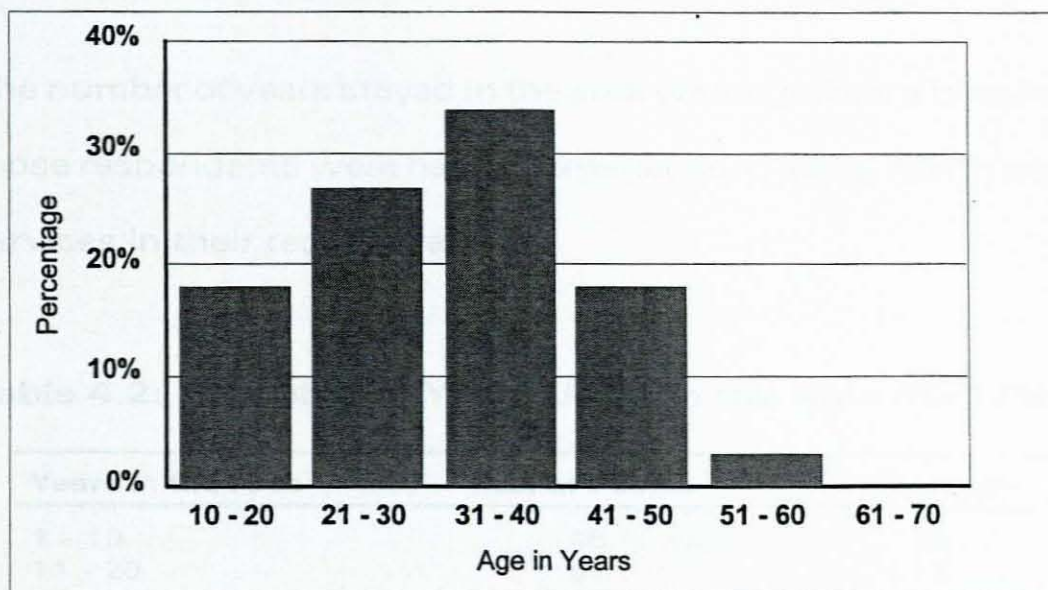


Figure 4.2 reveals that the sample consisted of respondents belonging to various age groups. However, the largest percentage was 34% which were respondents aged between 31 – 40 years, followed by 27% formed by respondents aged between 21 – 30 years. The results reveal that although the sample consisted of various age groups, the respondents between 31 – 40 years formed the largest group (34%). This suggests that mostly, all age groups receive health care services from clinics.

4.2.3 Number of years in the area of residence

The number of years stayed in the area was significant because those respondents were having experience in using health care services in their respective areas.

Table 4.2: Number of Years Living in the Area (N=300)

Years in the Area	No. of People	Percentage
1 - 10	45	15
11 - 20	51	17
21 - 30	83	28
31 - 40	96	32
41 and more	25	08
Total	300	100

Table 4.2 shows that respondents had stayed for varied periods of time in the rural areas. The results show that 96 (32%) respondents had stayed for a longer period between 31 - 40 years in their area of residence in the rural communities. The respondents, therefore, had an in-depth knowledge about health care services rendered in the rural area in which they reside.

4.2.4 Educational level

The educational level is significant in the study since it assisted in identifying the social class of people living in rural communities. Educational level also indicated the possible health status of individuals utilizing rural clinic health care services. The concepts, communication and information from King's framework are useful when working with rural clients. Good communication leads to positive interactions. The nurse must acknowledge that rural clients may not have the same educational level as urban clients. Once the nurse has established effective means of communication with rural clients, she/he may be able to implement health promoting behaviour.

Figure 4.3: Educational Level

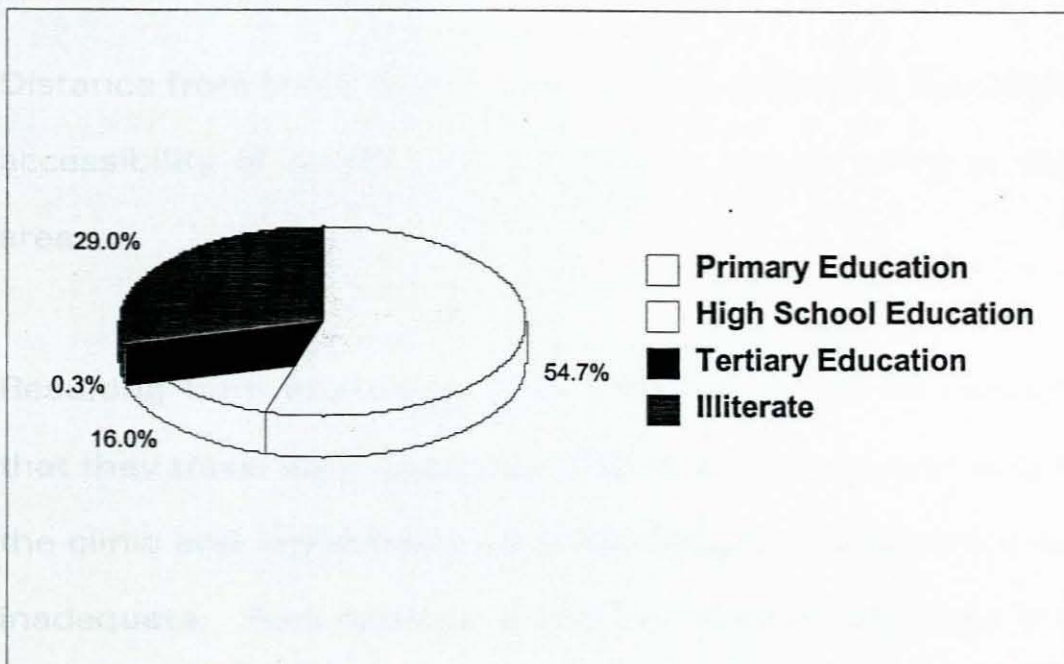


Figure 4.3 reveals that out of 300 respondents 164 (54.7%) had primary education, 87 (29%) were illiterate, 16 (48%) had high school education and only on (0.03%) had tertiary education. Research findings reveal that people utilizing health care services in rural areas have a low standard of education; due to lack of knowledge they are prone to diseases and therefore need to have adequate health care services. This is supported by De Haan (2001:14) who states that most people in rural communities have fewer educational opportunities which lead to fewer employment opportunities, low educational standards and poverty.

4.2.5 **Distance from health care services**

Distance from clinic health care services helped in identifying accessibility of health care services to people living in rural areas.

Resulting from interviews, 225 (75%) respondents indicated that they travel long distances, and had to leave very early for the clinic and arrive home very late because transport is also inadequate. Respondents could not indicate distance from clinics in terms of kilometers due to lack of education.

4.2.6 **Religion**

The aim of this item was to identify the respondents religious denominations. This was significant because religion may have an influence on how people view and understand the health care services, and this could affect their responses about the quality of their health care services.

Figure 4.4: Religion

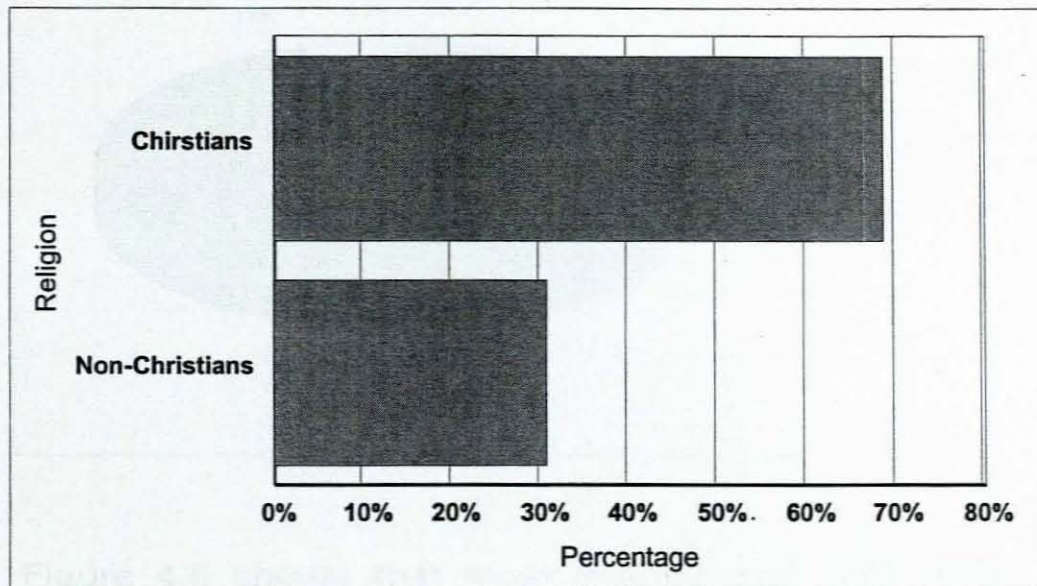


Figure 4.4 reveals that the majority of the respondents, 207 (69%) were Christians and 93 (31%) were non-Christians and indicated that they believe in their ancestors.

4.2.7 Employment

Finding out whether respondents were employed or not assisted in identifying the socio-economic status of the people utilizing clinic services in rural areas.

Figure 4.5: Employment Status of Respondents

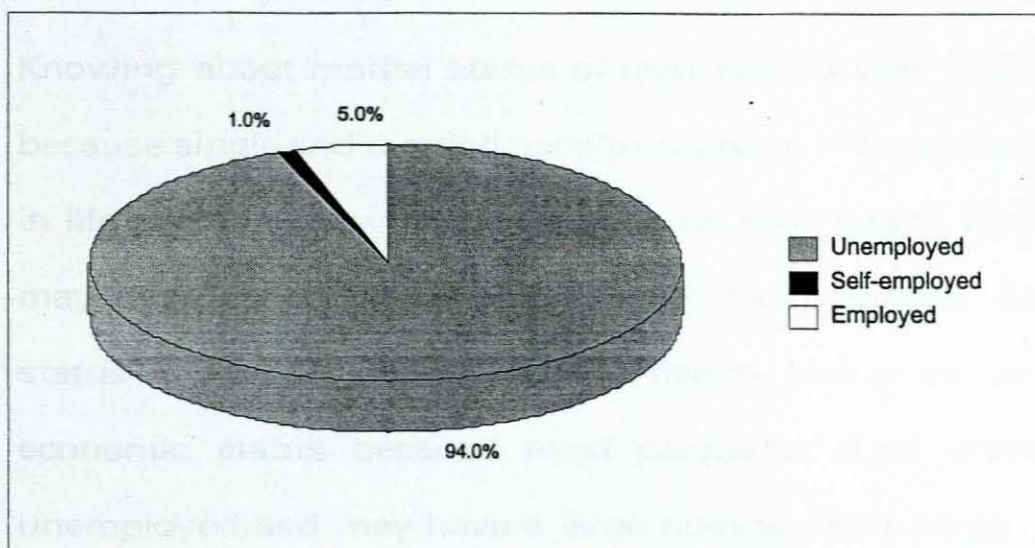


Figure 4.5 shows that most respondents, 282 (94%) were unemployed, 15 (5%) were employed somewhere around by an employer such as a farmer nearby, and 3 (1%) were self-employed for instance owning a stall and selling a couple of fruit or vegetables near the road or near a trading store. The results reveal that most respondents (94%) who formed the sample were unemployed. The results suggest that people in rural areas require health care services of high quality as they are susceptible to deficiency disease due the unemployment which cause poverty.

4.2.8 Marital status

Knowing about marital status of respondents was important because single and married people may have different outlooks in life and this may have an impact on their health and they may have varied views about health care services. Marital status is both a determinant of health status as well as economic status because most people in rural areas are unemployed and may have a large number of children. This may lead to poverty and ill-health.

Figure 4.6: Marital Status

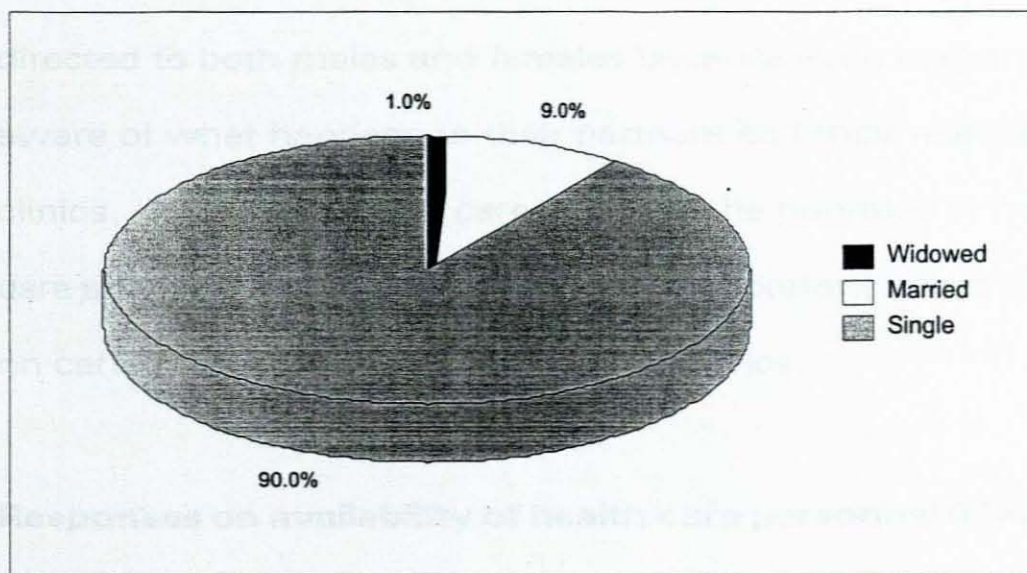


Figure 4.6 shows that respondents marital status was as

follows:- 90% were single, 9% were married and 1% were widowed. Research results reflected that people who formed the sample were mostly single people (90%).

4.3 VIEWS ON HEALTH CARE SERVICES

Information discussed hereunder, about health care services rendered to rural people, was based on various aspects of health care services as perceived by health care services consumers.

4.3.1 Antenatal health care services

The interviews about antenatal health care services were directed to both males and females because even males were aware of what happens to their partners and their relatives in clinics. Antenatal health care is one of the priorities in health care services, nationally, and so it was important to get views on certain aspects in this health care service.

4.3.1.1 Responses on availability of health care personnel (N=300)

Respondents were requested to answer on the issue of

availability of personnel in the clinics. Responses from all respondents, 300 (100%) were that there was a remarkable shortage of nursing personnel. Out of 300 (100%) respondents, 249 (83%) stated that because of shortage nurses were always in a hurry and had no time to attend to their antenatal health needs. The respondents further stated that nurses seemed to be short tempered and at times shouted at them and told them to go away. As stated by respondents, human relations were not good probably because nurses were exhausted and over worked and thus easily got irritated. The respondents further stated that this attitude of nurses scarred them away from requesting some explanations concerning their antenatal health.

In order to verify the statement of shortage as stated by respondents, the researcher observed and noted that most clinics, 9 (75%) out of 12 clinics had one professional nurse and one enrolled nurse attending to 80 – 100 patients per day. This shows that there is a shortage of health care personnel at the rural clinics because the accepted nurse patient ratio is one professional nurse per thirty-five (35) clients (KwaZulu-Natal Province District Offices).

4.3.1.2 Material resources

Out of 300 respondents 225 (75%) stated that there was a problem of insufficient medications. They stated that while they queued for medications, clients who came first and were in front in the queue were supplied with medications they needed, but supplies got finished before all clients in the queue could be supplied. Other examples that were stated by the same respondents were that uristics got finished before all pregnant mothers could have their urine tested, and scales were often out of order and their weights were sometimes not checked. The researcher observed and noted that in 5 (42%) out of 12 clinics visited, scales were out of order and weights of antenatal clients were not measured. The responses indicate that shortage of material resources are still a problem in rural clinics.

4.3.1.3 Responses on problems encountered in relation to antenatal health care services (N=300)

The respondents were further requested to state any problems they encountered in relation to antenatal health care services.

Out of 300 respondents, 249 (83%) stated that they encountered the following problems:-

- **Insufficient number of nursing personnel.**

Respondents who formed 83% of the sample stated that there were too many clients who attended the antenatal clinic, and yet nurses were too few to cope with such high numbers of clients. Respondents explained that at times a professional nurse went off sick and antenatal patients had to go back home without receiving professional antenatal health care services. Respondents further highlighted that nurses did their work in a hurry, trying to reach all patients before the clinic closed at 16h00.

- **Inavailability of medical practitioners.** This is another problem that was revealed by 83% (249) of the sample that no medical practitioners were available to take care of the health needs of the antenatal clients. Instead, the nurses referred patients to their nearest hospital. In most cases as

stated by the respondents, patients could not afford travelling expenses as they are poor. Therefore, these patients remained at home until complications occurred. These complications led to either death of the baby or the mother and at times it led to death of both the mother and the baby. This means that there is still inequality in the distribution of medical personnel, and they are still concentrated in urban areas.

- **Conducting of deliveries in the clinics.** Eighty-three percent (249) of the sample also revealed that deliveries were not conducted in most clinics especially at night. They further explained that nurse explained to them that they cannot conduct deliveries because there is shortage of nurses and water. The researcher also noted that out of twelve clinics that were sampled, only three (25%) conducted deliveries during the day only. Women in labour were referred to their nearest hospitals for deliveries. Respondents, 55% (165) also emphasized that some women gave birth outside

the clinic while waiting for public transport to the hospital, as there was no ambulance at the clinics and public transport was also scarce and expensive.

- **Absence of health care services after 16h00.**

During the interview, the respondents were requested to state if they had any health care services after 16h00 and 83% (249) of the sample revealed that clinics closed at 16h00. This meant that a person getting ill after 16h00 was not attended to. This is a serious problem because rural people are dependent on clinics that must refer patients to a hospital, according to the principles reflected on levels of health care delivery system.

- **Absence of emergency health care services.**

Out of 300 (100%) respondents who were interviewed, 249 (83%) revealed that after the clinics have closed at 16h00 there are no emergency health care services to attend to

pregnant women who needed urgent attention.

This means that health care services are still inaccessible in rural communities, there are no means to handle emergencies which indicate that rural people could end up losing their lives because of lack of medical help during acute illnesses and injuries that needed urgent attention.

4.3.2 **Family planning services**

It was important to have views about this service because rural people who wished to utilize it must have access to it as it is a free service and it is important to limit families of poor and unemployed people. The interviews that were done on 300 respondents reflected that 100 (33%) respondents made use of family planning facilities while 200 (67%) respondents did not make use of it. It was noted from the responses that people in rural areas do not utilize this service maximally. Methods of contraception that were commonly used by the respondents who utilized family planning were injection; pill and condoms.

The respondents who utilized family planning services were further requested to state if they encountered any problems in relation to this service. One hundred respondents (33%) who utilized family planning services stated the following problems:-

- **Inavailability of injectable contraceptive.** Out of 100 respondents who utilized the family planning service, 23 (23%) stated that at times they did not get injection and were told it was finished, but also stated that this problem was not common.

- **Complications from contraceptives.** The respondents were requested during interviews to state if they experienced any complications in relation to use of contraceptives. Out of 100 (33%) respondents who utilized family planning services, only two (2%) stated that they experienced heavy vaginal bleeding as a complication from an injection. Data collected through interviews shows that family planning services rendered by health care personnel in clinics was acceptable to clients

and that most people in rural areas as reflected by the sample, 200 (67%) did not utilize family planning services but was utilized by 100 (33%) respondents. Therefore, information obtained on utilization of family planning and related complications obtained from respondents cannot be generalized to all people in rural communities.

4.3.3 Responses on minor ailments clinic health services

The respondents were requested to give their views on health care services they received when they visited the clinics for minor ailments. This aimed at determining their perceptions on these health care services.

4.3.3.1 Frequency in using the clinic

It was important to ask the question on frequency in utilizing the clinic was to ensure that the information is obtained from people who frequently used the clinic services.

Table 4.3: Frequency in utilizing the clinic (N=300)

Frequency	No. of Respondents	Percentage
Fortnightly	50	17
Once a month	100	33
Twice a month	75	25
Only when sick	75	25
Total	300	100

Table 4.3 shows that 33% of the respondents utilized the clinic monthly, 25% used it at least bi-monthly and another 25% utilized the clinic only when sick and 17% utilized it fortnightly. This meant that respondents frequently used their clinics and had enough experience in the clinics to be able to give their views about health care services they received.

4.3.3.2 **Promptness of services**

This item was important to ascertain whether the respondents were attended to promptly or not. This was significant as the respondents had already indicated that they were coming from far and there was poor transport to their places of residence.

Table 4.4: Promptness of health care services (N=300)

Remarks on Health Care Services	No. of Respondents	Percentage
Satisfactory	80	27
Poor	120	40
Not sure	100	33
Total	300	100

Table 4.4 reflects that 80 (27%) respondents viewed their clinic services as satisfactory, 120 (40%) viewed services as poor, and 100 (33%) were not sure how to rate the clinic health care services. However, no client viewed the clinic services as fast or good. The fact that clinic health care services were not fast or good is probably related to the problem of shortage of health care personnel as many clients who attended the clinics have indicated and this has already been reflected in the responses. The cry that there is a very little number of nurses and doctors working in the rural areas, matches the reflection of the responses in Table 4.4.

4.3.3.3 Problems due to slow and poor services

Respondents were further requested to state problems they

4.3.3.4 encounter due to unsatisfactory health care services. They stated the following problems:-

- Elderly patients stood in long queues and some fainted while still waiting. The researcher actually witnessed this incident in one of the clinics while conducting interviews. Sick babies complicated in the clinic premises before getting any help. For example, one respondent stated that a baby once collapsed in the queue before being seen by a professional nurse. The researcher further asked respondents if similar incidences often occurred. Out of 300 respondents, 160 (53%) agreed that these incidences were common, 140 (47%) respondents said that though such incidents occurred in their clinics, they were not common. The contrasting ideas may be due to the fact that clients do not attend the clinic at the same day.

4.3.3.4 **Availability of medications for chronic illnesses**

Respondents were requested to state whether medications were available when they needed it. Responses were that 245 (82%) respondents did obtain their monthly supplies of medications from their clinics. However, 55 (18%) respondents verbalised that at times medications were not available, nurses told them that they were finished.

The study reveals that medicine for chronic illnesses were available at the clinics as indicated by 245 (82%) respondents. Only a smaller percentage (18%) of respondents stated that medications were not available at times. This poses great concern because these clients could develop complications, be subjected to high risks and relapses, if they missed their treatment. Responses revealed that medications for chronic illnesses are available in the clinics.

4.3.3.5 **Frequency of doctors visits to clinics**

Respondents were requested to indicate the frequency of

doctors' visits in the clinics. The majority of the respondents, 252 (84%) verbalised that doctors never came to clinics but patients are referred by the nursing personnel to go to the nearby hospitals to see a doctor. A small number of respondents, 48 (16%) mentioned that a doctor comes to their clinics fortnightly. This is substantiated by the fact that out of 12 clinics only 2 (17%) clinics were visited by a doctor fortnightly, and 10 (83%) clinics had no doctor at all. This means that there is still mal-distribution of medical practitioners in the health care services as they are still not available in rural communities.

4.3.4 **Responsibility for own health care**

Respondents were requested to answer questions that were related to self care and knowledge about their own health care. This item helped to identify if clients utilizing rural clinics were given health education on important health issues by the nursing personnel.

4.3.4.1 Utilization of the clinics for general physical examinations

Respondents were requested to state if they utilized the clinics for checking their health status, for example, blood pressure, blood glucose, physical examination. The response was that 67% (200) respondents did come for checking of blood pressure. These respondents also stated that they came to clinics for blood pressure checking because they were told to do so as they had hypertension as their diagnosis.

These responses show that patients with chronic illnesses are given advice by health care personnel, and that is why they do come for general physical examination.

4.3.4.2 Treatment of sexually transmitted infections (STIs)

Respondents were requested to indicate whether they utilized the health care service facilities for treatment of sexually transmitted infections. The responses were important because sexually transmitted infections are one of

the priority concerns nationally as they spread easily and affect many people in the community and result in death.

4.3.4.2 Out of 300 (100%) respondents, 231 (77%) stated that they utilized the health care services for treating sexually transmitted infections. However, 70 (23%) respondents did not use the health care facilities for this. One respondent actually verbalised that they actually use their herbalists for STIs because it was an embarrassment to them to bring sexually related problems to the clinic. Though the percentage of clients who have fear to use a health care service for STIs (70) (23%), it still suggests that there is still a need for continuous health education on this subject in the clinics.

4.3.4.3 **HIV/AIDS awareness**

The aim of this item was to determine whether the respondents are given health education and advice on HIV/AIDS at the clinics. This was important because HIV/AIDS is a world's concern that everyone must be aware of and be empowered with knowledge of what it is, how to

prevent it, how to live with it, and how to live with those who have contracted it.

4.3.4.3.1 Knowledge on what HIV/AIDS is

Respondents were requested to give responses on their knowledge of what HIV/AIDS is. Out of 300 (100%) respondents, 285 (95%) stated that they knew about HIV/AIDS, and 15 (5%) indicated that they have heard about it, but they were not sure whether they know what it is. This means that health education on HIV/AIDS is given to clients who attend the clinics.

4.3.4.3.2 Information on how to prevent infection and spread of HIV/AIDS

Respondents were requested to indicate if they had information on HIV/AIDS prevention methods and 255 (85%) respondents stated that it is not possible to prevent any disease which is a result of witchcraft, and 15 (5%) respondents stated that they knew the methods of preventing HIV/AIDS. These results indicate that health

education is given by health care personnel in the clinics. However, the clients in rural communities have their own perception about HIV/AIDS as 85% of respondents still believe that the disease is caused by witchcraft.

4.3.4.3.3 Health education on HIV/AIDS in the clinics

The respondents were requested to state if they were given health education on HIV/AIDS in their clinics. All respondents, 300 (100%) agreed that they were given information on HIV/AIDS by the nursing personnel in the clinics. These responses indicate that the nursing personnel try their best to give health education to their clients on HIV/AIDS in spite of shortage.

4.3.4.3.4 Health education

Whether or not respondent received health education was not asked directly, but was indirectly investigated when respondents were requested to state whether they were informed to take responsibility for their own health care.

4.4 GENERAL VIEWS ABOUT HEALTH CARE SERVICES

Respondents were requested to give an overview on their health care facilities, regarding health care service facilities, and environment and to give suggestions on how to meet the existing health care service challenge. It was important for respondents to give this information because it highlighted their needs and suggestions according to their views.

4.4.1 Environment in the clinic

Respondents were requested to state their views about the environment of the clinic. All respondents, 300 (100%) stated that clinic surroundings were clean. Cleanliness of clinic surroundings is important because health care services must be rendered within a clean environment conducive for health.

4.4.2 Disposal of waste

The respondents were further requested to state whether clinics had incineration facilities. Out of 300 respondents,

275 (92%) stated that the incinerators were available in the clinics, and 25 (8%) did not have an incinerator. The researcher also noted that out of 11 (92%) clinics, only one (8%) indicated that there was no incinerator in their clinic, but used a pit to destroy waste. These findings illustrated that waste was mainly disposed properly through incinerators, even one clinic that had no incinerator used the method of burning of waste.

The respondents were also requested to state if toilets they used were clean in the clinics. Out of 300 (100%) respondents, 210 (70%) stated that toilets were not repaired when they were out of order, and as a result they remained unclean.

They further explained that there were insufficient water supply, which further aggravated the problem of unhygienic conditions. However, the remaining 90 (30%) respondents stated that toilets in their clinics were clean most of the time, and further explained that if water was insufficient, there was a pit toilet which they used until water was enough again.

On the whole, the toilets were not working well in the clinics as indicated by 210 (70%) respondents. It is of great concern that toilets were not in good working order in clinics as dirty toilets are a source of infection.

4.4.3 **Fence around clinics, locking gates and security guards**

4.4.5 **Electricity**

Respondents were requested to respond on safety of the clinics and their users. All 300 (100%) respondents stated that clinics were well fenced, and they had security guards and there were gates that were locking well. These responses suggest that nurses are working within safe and secured environments because all clinics are fenced and have locking gates which are under the care of security guards.

4.4.4 **Water supply**

4.4.6 **Refrigerated**

Respondents were requested to indicate if the clinics had sufficient water supply. All respondents, 300 (100%) stated that clinics did not have enough water supply. Respondents further stated that water supply was through the tank

system and at times tanks went dry, especially during winter when there is less rainfall. This is of great concern as water is a necessity. These responses support those stated under disposal of waste where 70% of respondents indicated insufficient water for flushing toilets.

4.4.5 **Electricity**

The respondents were also requested to state if there was electricity in their clinics. Out of 300 (100%) respondents 240 (80%) stated that clinics used solar energy and further said that they regarded solar energy as no electricity because it is not effective on rainy and cloudy days. This means that it is possible that the back-up system of solar energy in the clinics was not working. This is of great concern because ineffective electricity may interfere with the effectiveness of medications and vaccinations that need to be kept refrigerated.

4.4.6 **Accommodation for health care personnel**

Respondents were requested to state if health care

personnel had accommodation in the clinic surroundings. Out of 300 (100%) respondents who formed the sample, 225 (75%) stated that nurses were provided with accommodation near the clinics but they were not using it because they were local residents and therefore used their own homes for accommodation. However, 75 (25%) respondents stated that health care personnel had no accommodation which was provided near the clinics. These responses indicate that health care personnel were offered accommodation nearer their clinics.

4.5 SUGGESTIONS TO MEET HEALTH CARE SERVICES' CHALLENGES BY RURAL PEOPLE

Respondents were requested to make suggestions which they thought would meet the health care service challenges. Requesting respondents to make suggestions was important as people are stakeholders in their health care and know better about their needs. Moreover, the community should be encouraged to participate in planning for their health care. Suggestions were as follows:-

4.5.1 **Communication system**

Out of 300 respondents, 210 (70%) suggested improvement on the telephone system of the clinic. One respondent actually verbalised that "telephone system that depends on solar system is a sick system; because when solar power fails, it dies." This means that communication is a problem in rural clinics, and therefore, interferes with effective functioning of health care personnel. This is a serious problem because it means that at times health care personnel cannot communicate important information to their authorities and to their colleagues and *vice versa*.

4.5.2 **Electricity**

Respondents were further requested to verbalize their suggestions, and out of 300 (100%) respondents, 240 (80%) suggested a more reliable source of electricity and one respondent further said that "as it is cloudy today, look, it is not working, just open that refrigerator and see if it is working, you see, our nurses really have an unreliable source of electric power."

This means that in rural clinics resources are still inadequate. As there is lack of electricity in rural areas, it suggests that health care personnel have a problem in keeping treatments that need refrigeration.

4.5.3 **Emergency transport**

Out of 300 (100%) respondents, 216 (70%) verbalised the need of an official transport that would be used to transport very ill patients from the clinic to a hospital. This suggestion indicates that there was a possibility of very ill patients not reaching a hospital in time or not at all, and therefore, absence of an emergency transport has an impact on very ill patients' health.

4.5.4 **Human resources**

Out of 300 (100%) respondents, 270 (90%) recommended increase in the number of health care personnel in clinics. They stated that the number of nurses against the number of clients was too low and not acceptable to them. This means that shortage of health care personnel had affected

the delivery of health care due to shortage. This suggestion supported the responses and shortage of human resources.

4.5.5 **Operational hours for clinics**

Out of 300 (100%) respondents, 285 (95%) suggested that the clinics operational hours be extended beyond 16h00 to accommodate all clients who need services, so that no client could be returned home without being seen by the health care professionals. This suggests that clients were returned home before they received health care services when it was time to close the clinic at 16h00. This may be detrimental to the health of clients if health care is delayed because of the limited time.

4.5.6 **Night health care services**

Out of 300 (100%) respondents, 195 (65%) suggested that there should be nurses who will render health care services at night for emergency health care needs of clients in rural communities. This suggestion indicates that health care services in rural areas are not extended to the night, and this

means that people in rural areas have no health care services at night.

4.5.7 **Need for more clinics**

Out of 300 (100%) respondents, 225 (75%) stated that they lived far from their clinics and therefore there is a need for the establishment of more clinics so that they can also be able to walk to the clinics. This suggestion indicates that there is still a need to take health care services to the people so as to make health care services accessible to all people.

4.6 **DISCUSSION OF FINDINGS**

4.6.1 **Introduction**

The discussion will highlight the characteristics of the sample and the findings obtained. Findings also highlight general views and suggestions on health care services as suggested by consumers of health care.

4.6.2 **Characteristics of the sample**

The sample of respondents revealed the following characteristics:-

4.6.2.1 **Gender**

The findings of the study reveal that females formed 68% of the sample. Findings suggest that health services in rural areas are mostly utilized by females because the younger ones are still in child bearing age and still attend antenatal health care services. Those who are unemployed are exposed to ill health due to poverty. It is also generally assumed that females are more prone to infections such as sexually transmitted infections. Doyal (1995:14) is also of an opinion that females because of their biological and social factors they are vulnerable to communicable diseases and malnutrition. Therefore, health care services in rural areas need to be of high quality and accessible to all people.

4.6.2.3 **Educational level**

The findings showed that the sample consisted mainly of

4.6.2.2 **Age distribution**

The study reveals that the sample consisted of a variety of age groups ranging between the age of 10–20 years to 51–60 years. The findings showed that rural clinics are visited by people of various age groups presenting with health problems. Respondents between 31–40 years of age formed the largest percentage of the sample (34%).

The respondents between the age of 51–60 formed 3% of the sample. The results showed that few people of this age attend clinics, probably because they are older people who may be experiencing transport and financial problems in reaching clinics. The findings are supported by Poindexter, Valentine and Conway (1999:218) who maintain that old people have various reasons that prevent them from utilizing health care services, therefore, means to outreach them should be provided.

4.6.2.3 **Educational level**

The findings showed that the sample consisted mostly of

respondents with primary education as they formed 54.7%, followed by those with high school education. According to the findings, people in rural communities have low standard of education which contributes to unemployment, low income and poverty, low standard of living and consequently ill-health. Due to financial constraints health care services may be inaccessible and unaffordable. The study is suggestive of the fact that health care services in rural areas must accommodate needy people exposed to various preventable diseases such as communicable diseases and infectious diseases. The findings are supported by Van Rensburg, Fourie and Pretorius (1992:114) who maintain that people with low level of education are often lacking knowledge about diseases and are less informed about approaches to modern care, and this makes them fail to report the disease when it is still manifesting with its early signs. According to Poindexter *et al.* (1999:229) people with a low level of education require accessible health care services which will empower them to be able to take responsibility for their own health.

4.6.2.4 **Employment status of respondents**

The findings reveal that the sample consisted of 94% of unemployed respondents. This suggests that in rural areas most people are unemployed, and this supports the item where the findings revealed that the sample consisted of people with a low level of education. People with a low level of education are often unemployable. Unemployment has an impact on the health status of an individual because employment and income of an individual determine his/her lifestyle and thus his/her status of health. This is supported by McWhirter, McWhirter, McWhirter and McWhirter (1998:24) who state that poor families end up in poor health and that many rural families are having low economic status. The fact that the findings revealed high unemployment in rural areas is supported by Kingdon and Knight (2004:1) who state that in South Africa, unemployment is extremely high and rising and is seen as one of the most pressing socio-political problems facing the government.

4.6.3 **Views of consumers of health care services**

The findings revealed various challenges faced by health care services in health care delivery for rural communities. On interviews respondents revealed that health care delivery is still faced with mal-distribution and shortage of human and material resources. The findings are discussed under challenges/problems within health care services and challenges/problems within the rural community.

4.6.3.1 **Challenges/problems within health care services**

The discussion highlights challenges that exist within the health care services, as perceived by consumers.

4.6.3.2 **Human resources**

The findings revealed that the main problem faced by health care services is the shortage of human resources, nurses and doctors. It was identified that rural clinic services in general have a small number of nurses. All respondents (100%) stated and emphasized that many times patients had

to go back home without getting any services because of a small number of nurses compared to a large number of patients to be cared for. In all the clinics that were selected for the study, respondents who were interviewed emphasized that there were only two nurses, that is one professional nurse and one enrolled nurse. In one of the clinics, respondents highlighted that at times when the professional nurse is off-sick the health services are offered to them by the enrolled nurse.

Strachan (1999:11) emphasizes that the nurses in rural areas are overwhelmed by a huge number of patients against staff shortage. This is of great concern because the professional nurse is an independent practitioner and in-charge of the clinic and the enrolled nurse functions under supervision of a professional nurse, and under such circumstances one wonders how safe patients are, if they are cared for by the enrolled nurse without supervision. Moreover, the rights of the patient on safe care are violated. The findings reveal that some of the rural clinics are functioning contrary to the patients' charter for South Africa which emphasizes that everyone has a right to receive health

care services from competent and appropriately trained health care professionals (Patients Charter for South Africa, 1998:3).

The study also revealed that doctors are not available to rural clinic services. This was emphasized by 83% respondents who mentioned that no doctor ever came to their clinics to take care of their problems that were above the professional nurses scope of practice. Only 17% of respondents indicated that a doctor comes once a month to their clinics and emphasized that, however, the doctor did not come every month. The findings revealed that rural areas are still experiencing inavailability of medical practitioners, in spite of the attempt of the National Health Department of allocating the newly qualified medical practitioners for community services.

Physiotherapists, social workers, psychologists, psychiatrists, and other health professionals that form the health team are not available in rural areas. Respondents who formed 98% were not even aware of the other health care professionals.

The findings are supported by Newbury (1999:199) and Campbell (2000:150) who state that there is scarcity of medical practitioners in rural areas, and people in rural areas still travel long distances to access a doctor. Findings are further supported by Topps (2000:125) who states that although doctors are recruited for rural areas, they cannot be retained due to poor conditions under which they practice. Generally, shortage of competent and skilled health care personnel in rural areas is a matter of great concern because people in rural communities are less educated, poor, needy and prone to preventable diseases and thus require health personnel with expertise for their empowerment and self reliant.

4.6.3.3 **Material resources**

The findings revealed that medications for chronic illnesses were available and patients did receive their monthly supplies. This was stated by 82% of the respondents. This was a positive response from respondents which showed that clinics are well supplied with medications for chronic illnesses. However, a small percentage, 18% of respondents

from three (3) clinics stated that sometimes medications got finished while clients were still awaiting in queues. However small the percentage may be, this poses a problem because these clients could develop complications and be subjected to high risks and relapses if they missed their treatments at times.

The findings are contrary to what was identified by Thipanyana and Mavundla in 1998 in rural districts of the Eastern Cape Province that 75.5% of respondents commented that medications were usually out of stock in the clinics (Thipanyana & Mavundla, 1998:28).

4.6.3.4 **Emergency and night services**

The study revealed that rural clinics have no emergency services for patients presenting with acute illnesses, injuries and labour. This was emphasized by 83% of the sample who also pointed out that the clinics close at 16h00 and did not function during the night, because of shortage of nursing personnel. Findings are supported by Bubsy and Bubsy (2001:301) who identified that there is lack of emergency

services in rural areas and recommended that planning for rural areas should focus on emergency medical services and providers of primary health care. Bubsy and Bubsy's opinion is also supported by Simon-Meyer (1998:9) who pointed out that there are no emergency services in rural areas, which can provide life support emergency care in ambulances. Emergency and night services are needed in rural areas as rural communities cannot access health care services that are available in hospitals at night because of distance, transport problems and financial constraints.

4.6.3.5 **Water supply and sanitation**

The study revealed that all clinics that formed the sample had water supply through tank system. However, 85% respondents pointed out that the professional nurses informed them that tank water was not enough, that is why deliveries are not conducted at the clinics as water would get finished. Findings show that rural clinics still experience shortage of water supply probably due to the fact that generally in rural areas there is shortage of water supply.

Findings also revealed that toilets were not clean because they were not repaired in time when they were out of order, and the problem was compounded by shortage of water. This was stated by 70% of the respondents. The findings are supported by De Haan (2001:27) who states that in rural areas there is lack of sanitation and adequate or safe water supply. This is of great concern because it is contrary to the constitution of South Africa which states that everyone has the right to have access to sufficient water supply and everyone has the right to have the environment that is not harmful to their health (Constitution of the Republic of South Africa, 1996:11). Unclean toilets are of great concern because health personnel educate their clients about importance of clean toilets and therefore clinics must be exemplary to the public.

4.6.3.7 Health education

4.6.3.6 **Electricity and communication system**

Findings revealed that health education is given in the clinics

The study revealed that 65% of the rural clinics use solar electricity. The respondents who formed 32% of the sample stated that this type of electricity is unreliable because it depended on the sun, if the weather is cloudy and rainy

solar power did not work, and if solar power failed, the telephone system also failed, and they further stated that the back up system, if there was any, did not work at all.

Although solar energy was said to be unreliable by respondents, the ANC government has made an attempt in making electricity available in rural clinics.

The findings are contrary to what was found by Strachan (1999:12) that rural clinics in Eastern Cape still had no electricity. However, it is worth mentioning that, reliable electricity is still needed in rural clinics as disturbance of electric power jeopardizes storage of vaccines and functioning of telephones.

4.6.3.7 **Health education**

Findings revealed that health education is given in the clinics by health care personnel. This was evidenced by the fact that 100% of the respondents stated that they received information on health care issues and HIV/AIDS from health care personnel in clinics. In spite of shortage of health care

personnel, the research findings reveal that health care personnel do give health education on important health care issues to their clients in clinics. Clark (1996:637) supports the findings that in rural communities there are few formal health promotion programmes, therefore, it is very important that nurses in rural community health care centres educate their clients on important and current health care issues that people should be aware of.

4.6.4 **CHALLENGES/PROBLEMS WITHIN THE RURAL COMMUNITIES**

The discussion highlights challenges that exist within the rural communities as perceived by health care services consumers, to be affecting health care delivery in rural clinics.

4.6.4.1 **Poor transportation and inaccessibility to health care services**

Findings revealed that there is poor public transport in rural areas and therefore health care services are still inaccessible

due to this problem. This was pointed out by 75% of the respondents who formed the sample. The respondents further emphasized that patients arrived late in the clinics when there were long queues, and had to return home without being seen and given health care by health care personnel. This was pointed out by 75% of the respondent that they traveled long distances, and had to leave very early from their homes and arrived home in the evening. Though respondents could not state the distance in kilometers, they pointed out that they travelled by public transport. They further stated that at times when they ran out of money, they could not access health care services.

4.6.4.2 Fifty percent (50%) of the respondents highlighted that clients had to resort to home remedies, traditional healers and herbalists of the area because of poor transport. Findings are supported by Boulle (1997:6) who identified that 56% of rural South Africans still lived more than five (5) kilometers away from a health care facility, and specific areas where this had a significant impact was maternal and child health. These findings indicate the need for health care services to outreach the rural communities so as to make

health accessible to all South Africans. Clark (1996:631) further supports these findings as she points out that rural people live far from health care facilities, and because of distance and bad roads as well as lack of transport and lack of money, they cannot reach health care services.

The problem of distance in rural areas is further supported by Nicodemus (1999:1) who points out that some rural people walked up to 35 kilometers and slept overnight waiting for health care services. However, the study revealed that 25% of the respondents lived within a walking distance to a health care facility.

4.6.4.2 **Low income, unemployment and poverty**

The study revealed that only 5% of the respondents were employed and earned low wages. The findings are supported by Clark (1996:631) who points out that people working in rural areas get low income than those working in metropolitan areas. Findings confirm that few people are employed in rural areas and earn low wages and this has an impact on their health care as they cannot afford health care

services' expenses. The study also reveals that 94% of the sample was unemployed. The findings are supported by Clark (1996:631) who states that unemployment is higher in the rural areas. Unemployment leads to poverty and also determines the lifestyle and health status of an individual. Therefore, health care services must be accessible and affordable to needy people.

Findings suggest that low income and unemployment affect health care delivery in rural areas in terms of accessibility and affordability of health care services. In order to meet this challenge the ANC government attempted to make health care services accessible and affordable by deciding that free health care services be provided to pregnant mothers and children who are six years of age and under, to all South Africans.

4.6.5 **CLIENTS EXPECTATIONS FROM HEALTH CARE PROVIDERS IN RURAL CLINICS**

Findings revealed various suggestions on what consumers of health care services expected from health care providers

in the rural clinics. The suggestions are presented:-

4.6.5.1 **Human resources**

The findings revealed that consumers of health care expect that the health care authorities provide rural clinics with more nurses and a doctor. Respondents who formed 90% of the sample emphasized that they expect to be seen by a doctor at least once a week for their chronic illnesses.

The doctors are needed in rural clinics for their expert medical knowledge because a doctor would be able to pick up what a nurse would have overlooked. This expectation is supported by the item on inavailability of medical practitioners in which the respondents (83%) stated that some patients developed complications, as they could not afford travelling and health care services expenses. The respondents emphasized that inavailability of a medical practitioner was evidenced by mother and child care, where pregnant mothers complicated and that resulted to either death of the mother, the baby or both.

4.6.5.2.2 It was also highlighted in the item on insufficient number of nursing personnel that nurses were few and did their work hurriedly trying to reach all their clients before they closed at 16h00.

4.6.5.2 **Clinic facilities**

Findings revealed that respondents expected their clinics to have the following facilities:-

4.6.5.2.1 **More clinics needed**

The findings revealed that respondents expected more clinics to be erected. This was suggested by 75% of the respondents who formed the sample. They further stated that they also wanted to have a clinic within a walking distance. Suggestions of more clinics are supported by Nicodemus (1999:1) who stated that some rural people walked up to 35 kilometers to a health care facility.

4.6.5.2.2 **Emergency transport and emergency night services**

The findings revealed that respondents expected the health care facilities to have an ambulance provided for emergencies because patients who needed urgent transfer for an emergency treatment by expert medical personnel were transported through public transport or needed to hire their own transport. This appears to be problematic as patients could lose their lives while waiting or travelling by public transport. This was pointed out by 72% of the respondents who formed the sample. The findings on suggestions are supported by Bubsy and Bubsy (2001:301) who pointed out that there is lack of emergency services in rural areas.

The findings also revealed that the respondents expected to be provided by nurses who can be on call for the night, in cases of emergency deliveries and injuries.

Lack of emergency transport and emergency night services in rural areas is a challenge to health care providers as rural people are dependent on clinic health care services when

experiencing a health care need. This means that in rural areas there is a period on daily basis when people are without health care services. This is a great challenge as the clinic is the first step in the first level of the health care delivery in the district system, which must be visited by the client when a health need have been identified.

4.6.5.2.4 Operational hours for health centres

4.6.5.2.3 **Electricity and communication system**

The findings revealed that respondents expected the clinics to have a reliable source of electricity and not solar power. Seventy percent (70%) of the respondents referred to solar power as unreliable as it depended on the weather. It is worth mentioning that solar power has an effect on health care services because on rainy and cloudy days it is ineffective and affect medicines that must be kept refrigerated, such as vaccines.

The findings also revealed that 70% respondents expected their clinics to have reliable telephones as the clinic telephones did not work when solar power failed. This is of great concern because health care personnel need to

communicate with the other health personnel for expert advice regarding care of clients. Moreover, South Africa has a high rate of crime, and health personnel who are in deep rural areas have to have communication system for contacting police services.

4.6.5.2.4 **Operational hours for the clinic**

The findings revealed that respondents expected the clinics to open beyond 16h00 to accommodate all clients who needed health care services. This was suggested by 95% of the respondents. The respondents further emphasized that this was needed so as to accommodate all clients who visited the clinics, as sometimes other clients arrived late in the clinic due to transport problems, and returned home without being seen by health care personnel. This is in line with the item on absence of health care services after 16h00, where 83% of the respondents stated that there were no health care services after 16h00, and clients who become sick after 16h00 has not access to health care services.

The suggestion on extension of business hours is supported

by the item on insufficient number of nursing personnel where respondents stated that because of shortage of nurses and that the clinic closes at 16h00, the nurses had to do their work hurriedly trying to cover all their clients before the clinic closed at 16h00. This may lead to inefficient care of clients by the nurses.

4.6.5.2.5 **Sanitation**

Findings revealed that respondents (70%) expected the clinics to have someone employed to clean the toilets and make sure that they remain in good working order. This suggestion is in line with the item on sanitation and water supply where respondents stated that the toilets were not repaired in time when they were out of order, and therefore remained unclean.

4.7 **CONCLUSION**

From the discussion of findings emanating from data analysed, it is evident that people living in rural communities still experience problems in health care delivery system. It was evident that they still have

barriers in health care such as distance from health care services, isolation and sparse resources such as human and material resources as well as financial constraints to access health care services. The findings also reveal that consumers of healthcare services do have suggestions on what their needs and expectations are, concerning health care delivery.

They emphasized a need for more health professionals, improvement of communication services and electricity, establishment of emergency services and night services, extension of clinic operational hours, and the improvement of sanitation.

5.1.1 Aims

The aim of this study was to determine the perceptions of people living in rural areas on health care services provided to them.

5.1.2 Objectives of the study

The study attempted to achieve the following objectives:

– To identify problems encountered by the clients in the

CHAPTER 5

SUMMARY, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter attempts to summarize the findings of the study, give conclusions, points out the limitations of the study and give recommendations according to the findings obtained.

5.1.1 Aims

The aim of the study was to determine the perceptions of people living in rural areas on health care services provided to them.

5.1.2 Objectives of the study

The study attempted to achieve the following objectives:-

- To identify problems encountered by the clients in the

5.1.2 **Significance** rural clinics in relation to health care provision.

- To ascertain expectations clients had from health care providers in their areas.
- To assess the appraisal of health care providers by consumers of health care services in rural areas.

5.1.3 **Assumptions of the study**

5.1.3.1 **Research methodology**

It was assumed that:-

- Rural clinics were still given less attention by the health authorities.
- Health care problems that occurred in rural areas were basically due to shortage of personnel and material resources.

5.1.4 **The research question**

The research question was "are the people in rural communities where health services are provided by rural clinics, benefiting maximally from the health care services provided, if not what are the problems?"

5.1.5 **Significance of the study**

5.2.1 The study was anticipated to be of significance in assisting health care planners and providers in improving health care delivery for rural communities according to problems and challenges identified by the study.

5.1.6 **Research methodology**

5.2.1 The study was a qualitative and quantitative descriptive study aimed at describing the views of health care services consumers on health care services provided to them.

5.2.1.2 The instrument used for data collection was a structured interview schedule. The research was conducted in rural clinics and the target population consisted of 300 clients who used the rural clinics and lived in rural area.

5.2 SUMMARY OF FINDINGS

5.2.1 Objective I

This objective attempted to identify health care related problems encountered by rural communities during provision of health care services by health care providers in rural clinics. This objective was achieved because the study revealed the following problems:-

5.2.1.1 Shortage of nurses and doctors

All respondents (100%) verbalised great concern that there was shortage of nurses and doctors.

5.2.1.2 Shortage of water supply

The respondents verbalised the problem of insufficient water supply which in turn affected the functioning of toilets which could not be flushed.

5.2.1.3 **Solar power failure**

The respondents raised a concern about solar energy in clinics, which does not function in rainy and cloudy days, which consequently affects effective functioning of health care services, for example, storage of vaccines.

5.2.1.4 **Absence of emergency and night services**

The majority (83%) of respondents raised a concern about absence of health care services after 16h00 and during the night, which are a consequence of shortage of health personnel.

5.2.1.5 **Distance between homes of respondents and clinics**

The respondents (75%) pointed out that clinics were far from their homes and this was compounded by the problem of poor public transport which resulted in respondents arriving late at the clinics and thus not receiving health care as clinics close at 16h00.

5.2.1.6 **Poverty**

The majority of respondents (94%) were unemployed and those who were employed were earning low income and therefore were poor. This may affect their health care because of inaccessibility and that they may not afford transport and health care services expenses.

5.2.2 **Objective 2**

This objective attempted to ascertain expectations rural, people have from health care providers in their areas, in relation to health care provision. This objective was achieved because the study revealed the expectations:-

5.2.2.1 **Establishment of more clinics**

The respondents (75%) expected health authorities to increase the number of clinics, so that clients who lived far from clinics could have health care services nearer their places of residence.

5.2.2.2 **Provision of more nurses and doctors**

The respondents (90%) expected health authorities to provide more nurses because there were few nurses in rural clinics, who at times could not reach all the clients who come to the clinics for health care services because of shortage.

5.2.2.3 **Emergency transport services**

The respondents (72%) expected health care authorities to provide an ambulance for the purpose of transferring patients who need urgent further management in a hospital, because in rural clinics patients who needed this service depended on public transport.

5.2.2.4 **Extension of clinic business hours**

The respondents (95%) expected the health authorities to consider extension of the clinic business hours beyond 16h00, because absence of health care services after 16h00 left the clients with a problem of inaccessibility to clinics for

advice and referrals, because clients cannot be accepted in a hospital which is a second level of health care delivery, without referral letters as per policy of the district health system.

5.2.2.5 Electricity and communication system

The respondents (70%) expected health care authorities to improve electricity in the rural clinics and referred to solar power as unreliable as it depended on the sun. If it was raining or cloudy solar power failed and also affected the clinic telephone system as it also did not work if solar power had failed.

5.2.2.6 Night health care services

The respondents suggested that health care authorities should provide nurses who could offer health care services at night for clients who may need health care services at night such as patients who suffer from acute illnesses and pregnant women in labour, at night.

5.2.2.7 **Improvement on sanitation**

Respondents (70%) expected the health care authorities to allocate an employee who would be responsible for keeping toilets clean and in good working order.

5.2.3 **Objective 3**

This objective attempted to assess the evaluation of health care providers by consumers of health care services in rural areas. This objective was achieved because the health care consumers stated the following information about health care providers:-

5.2.3.1 **Shortage of health care personnel**

5.3 ASSUMPTIONS OF THE STUDY

Respondents (100%) stated that health care services were affected by shortage of nurses and doctors, and that in spite of shortage nurses tried to reach all their clients before the clinics could close at 16h00.

5.2.3.2 **Nurse-client relationship**

Respondents stated that nurse-client relationship was not good because nurses were always in a hurry and did not have much time for individual needs.

5.2.3.3 **Health education**

It is revealed in the study that although there was remarkable shortage of nurses in rural clinics, nurses did their best to give health education on important and current health issues. This was evident when respondents (100%) indicated that they received information on health care issues from nurses in their clinics.

5.3 **ASSUMPTIONS OF THE STUDY**

Assumptions that were stated at the beginning of the study will be discussed briefly:-

5.3.1 **Assumption 1**

The assumption was that rural clinics were still given less attention by health authorities. This assumption was proved true because the study revealed that problems such as shortage of health personnel, such as nurses and doctors, lack of resources such as electricity and inadequate facilities, such as poor telephone systems still exist in rural areas.

This means that health authorities have not yet reached the rural communities like they have reached the urban areas.

5.3.2 **Assumption 2**

The assumption was that health care problems that occurred in the rural areas were basically due to shortage of personnel and material resources. This assumption was also proved to be true because the study revealed that health care services in rural areas were affected by shortage of human and material resources.

5.4 LIMITATIONS OF THE STUDY

The study aimed at obtaining views from consumers of health care services and views of health care personnel were not investigated. From findings it was identified that it was important to get views from health care professionals in order to get a better understanding of health care service delivery in rural areas of KwaZulu-Natal Province.

5.5 CONCLUSIONS

Findings obtained through data analysis show that people living in rural areas still experience problems in the health care delivery system. The main problem that affected health care delivery was shortage of nursing and medical personnel, lack of adequate facilities such as good communication facilities, inaccessibility of health care services due to poor public transport, living far away from clinics, and poverty which made health care services unaffordable. Insufficient water supply which led to poor toilet hygiene was identified. Insufficient water supply also interfered with provision of health care services such as maternal deliveries in the rural clinics.

It is, therefore, concluded that, although the African National Congress

government has made means to outreach the rural communities, more focus on rural areas is still essential. It was also evident from the study that people in rural areas must be given a chance to participate so that they can give input and also be involved in evaluation of their own health care services.

5.6 RECOMMENDATIONS

The recommendations made hereunder are based on the findings obtained during data analysis.

5.6.1 Staffing of rural clinics

- Planning of health care management for rural clinics must consider offering of incentives which will attract professional nurses and medical personnel to work in rural areas.
- Planning must also consider making of contracts with nursing and medical personnel that will oblige them to work in rural areas at least for a certain agreed upon number of years.

- Planning must also consider rotating allocation of health care personnel, in rural to urban areas, and urban to rural area.

It is hoped that considering these recommendations during health care planning could relax the problem of remarkable shortage of health care personnel in rural areas.

5.6.2 **Improvement of resources in rural areas**

- **Water.** Strategies for generating more water supply to rural clinics must be devised.
- **Electricity.** Health care planners should consider means of supplying a more reliable source of electricity for effective functioning of the rural clinics.

5.6.3 **Repair of clinic equipment and facilities**

Health care authorities must devise a repair system for rural clinics, which will ensure that facilities such as toilets in

rural clinics are in good working order all the time, as well as the working equipment such as weight scales and bau manometers.

5.6.4 **Training of nurses and doctors**

Training curricula of these health care professionals must emphasize the need for working in rural areas.

5.6.5 **Health Act**

Promulgation of the new Health Act which will repeal Health Act 63 of 1977, and include the New National Health Plan and the present District Health System, need to be considered by the government.

5.6.6 **Further research**

Further research is recommended that should include the views of health care professionals who work in rural areas.

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University of Zululand
Nursing Science Department
P/Bag x1001
KwaDlangezwa
05-08-2001

The Secretary General
Department of Health
Pietermaritzburg

Dear Sir

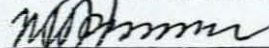
**Request for Permission to do Research in Rural Clinics in
KwaZulu-Natal Province**

Kindly grant me permission to do research in KwaZulu-Natal Province in randomly selected rural clinics on the topic- "**Views of Health Care Services Consumers in Rural Communities on Provision of Health Care in KwaZulu Natal Province: A nursing management perspective.**"

The research proposal for your perusal for information you may be interested in, is attached.

Thank you

Yours Faithfully



N.J Dlamini (Mrs)

ANNEXURE 2

PROVINCE OF KWAZULU-NATALISIFUNDAZWE SAKWAZULU-NATALIPROVINSIE KWAZULU-NA
HEALTH SERVICES EZEMPILO GESONDHEIDSDIENSTE

PRIVATE BAG X 9051
PIETERMARITZBURG
3200

TELEPHONE : (033) 953176
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330 LONGMARKET STREET
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3201

FAX :
ISIKHWAMA SEPOSI : (033) 3450792
FAXS :

Enquiries : Prof. Green-Thompson
Extension : 3176

15th August 2001

Mrs N. Dlamini
University of Zululand
Private Bag X1001
KWA DLANGEZWA

Dear Mrs Dlamini

REQUEST FOR PERMISSION TO DO RESEARCH IN RURAL CLINICS

Your previous correspondence dated 5th August 2001 is acknowledged.

This serves to inform you that this matter is receiving attention and a response will be forwarded shortly.

Yours sincerely

A handwritten signature in black ink, appearing to read 'R. Green-Thompson', written over a horizontal line.

PROFESSOR RW GREEN-THOMPSON
SECRETARY OF HEALTH
DEPARTMENT OF HEALTH : KWAZULU-NATAL
RWGT/sc/2954/01

PROVINCE OF
KWAZULU-NATAL
HEALTH SERVICES

ANNEXURE 3
ISIFUNDAZWE
SEKWAZULU-NATALI
EZEMPILO

PROVINSIE
KWAZULU-NATAL
DEPARTEMENT VAN GESONDHEID

NATALIA
330 LONGMARKET STREET
PIETERMARITZBURG

TEL. 033-3952111
FAX 033-3426744

Private Bag : X9051
Esikhwama Seposi : Pietermaritzburg
Privaatsak : 3200

Enquiries: Mr G.J. Tromp
Extension: 2761
Reference: 9/2/3/R – Vol. 5

22 AUG 2001

Mrs N.J. Dlamini
University of Zululand
Nursing Science Department
Private Bag X1001
KWA DLANGEZWA
3886

Dear Mrs Dlamini


RESEARCH IN RURAL CLINICS IN KWAZULU-NATAL PROVINCE

Your letter dated 5 August 2001 refers.

Please be advised that prior to granting approval for such a research to be undertaken, you will be required to submit the following to this office :-

- (a) Evidence that your research protocol has been passed by a recognised Ethics Committee of a tertiary institution; and
- (b) A copy of the structured interview schedule as mentioned in paragraph 3.5 of your Research Proposal.

Yours sincerely


SECRETARY: DEPARTMENT OF HEALTH
KWAZULU-NATAL

AJK/dlamini

DEPT OF HEALTH

PROVINCE OF
KWAZULU-NATAL
HEALTH SERVICES

ISIFUNDAZWE
SAKWAZULU-NATALI
EZEMFILO

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Privaatsak : 3300

REFERENCE : 9/2/3/R - Vol.6

ENQUIRIES : Mr G. Tromp

EXTENSION : 2761

26 JUN 2002

Mrs N.J. Dlamini
University of Zululand
Private Bag X1001
KWADLANGEZWA
3886

Dear Mrs Dlamini

REQUEST TO CONDUCT RESEARCH

Your facsimile dated 26 June 2002 refers.

Please be advised that authority is granted for you to conduct a research in Rural Clinics in KwaZulu-Natal Province, provided that:

- (a) Prior approval is obtained from Heads of relevant Institutions.
- (b) Confidentiality is maintained;
- (c) The Department is acknowledged; and
- (d) The Department receives a copy of the report on completion.

Yours sincerely



SECRETARY: DEPARTMENT OF HEALTH
KWAZULU-NATAL
FM/rural.clinic.research

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Zululand
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Fax (0351) 93130 (Rectorial)
Fax (0351) 93571 (Library)

Ref./Verw.

06 February 2002

TO WHOM IT MAY CONCERN

This serves to certify that MS N J Dlamini (850051) has submitted a proposal to the Faculty Research Committee (ARTS). The title of the proposal is:

Views of Health Care Services Consumers in Rural Community on Provision of Health Care in KZN Province

The Faculty Research Committee has approved the said proposal.

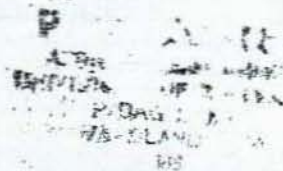
Thanking you in anticipation.

Yours sincerely

Handwritten signature of P M Lubisi in cursive script.

P M Lubisi

Secretary: Faculty Research Committee



ANNEXURE 6

Districts, hospitals and clinics which were selected for the study.

District Number	Name of hospital	Name of clinic
1. DC 24	CJM	Sandlwana Nondweni
2. DC 25	Madadeni	Osizweni Mndoza
3. DC 26	Benedictine	Njoko Ekubungazeleni
4. DC 27	Bethesda	Ophansi Gedleza
5. DC 28	Ngwelezane	Ndlangubo Ntuze
6. DC 29	Umphumulo	Oqaqeni Mbhekaphansi

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RESEARCH PROPOSAL

TOPIC

Views of Health Care Services Consumers in rural communities on provision of health care in KwaZulu-Natal Province.

1.1 INTRODUCTION

The Government of the National Unity has made attempts to satisfy large areas of the country in urban and rural areas in relation to provision of health care services to all people of South Africa. Organisation and functioning of a Health Service depends largely on the level of socio-economic development of the country. This involves a major role to play in allocating scarce resources to different types of Health Services, namely:-

- 1.1 Antenatal Health Care Services
- 1.2 Child Health Care Services
- 1.3 Family Planning and Women's Health Care Services
- 1.4 Minor Ailments' Services
- 1.5 Chronic Illnesses Health Care Services
- 1.6 Geriatric Health Care Services
- 1.7 Rehabilitative Health Care Services
- 1.8 Post-Natal Health Care Services

Specific objectives are set after major health problems have been identified. Populations

in rural areas still face a problem of not receiving services which meet their needs. Health services are probably less than what they actually expect (Larsen, 1996:1).

At present the trend and the focus to meet health care needs of all South African people is through primary health care system. Primary health care movement attempts to satisfy the public health care needs and also outreach the rural areas. It aims at increasing the coverage reduce health care costs and improve health care delivery services. In most of the health care services, people who benefit more are those in urban areas. People in rural areas, especially those who receive their health services through rural clinics, benefit less because some health services are inadequate, probably due to the fact that health professionals such as medical practitioners and nurses are reluctant to work in rural areas especially because they receive little support from health care service's authorities. In rural clinics there is still desperate short supply of facilities namely, electricity, paraffin, stoves and working phones. Sometimes the satellite phone is installed, but works only for a few days and in that way nurses are left with no form of communication. This problem also leaves the consumers of health care services with possibly inadequate and poor or no health services at all (Strachan, 2000:22).

1.2 MOTIVATION FOR THE STUDY

The National Health System (NHS) has been rearranged so as to provide basic public health services and essential clinical care for all, yet a huge number of people are without such services or such care. It was identified that health services have been fragmented, inefficient and ineffective and resources such as money, personnel and equipment mismanaged and poorly distributed. This situation had been found to be particularly worse in rural areas (Reconstruction and Development Programme (RDP), 1994:42). According to the government of national unity, all the role players and services had to be drawn into National Health System (NHS) so as to correct loopholes formed during the time of the

former government. Communities have to participate actively in planning, managing, delivering, monitoring and evaluation of the health services in their areas (RDP, 1994:43).

Improved health service delivery has become an issue in the public service and the corporate world since South Africa joined the global community in 1994, South Africa as a community has a tremendous challenge to improve health service standards to all its people. This process has become a priority, especially for the public health sector, where for various reasons service have dropped dramatically (Ntshona, 1999:19).

In a democratic country such as South Africa, it is important to note that an efficient public service is not a privilege, it is a legitimate expectation of the people. The constitution of 1996 states the following principles:

- people's needs must be responded to
- a high standard of professional ethics should be promoted and maintained
- the public should be encouraged to participate in policy making (Ntshona, 1999:19).

The World Rural Health conference has made it clear that inequities faced by rural populations in relation to health services, in different areas of the world is remarkably similar. Physicians to work in rural areas are needed very much. They are recruited but cannot be retained and health care workers have to make the best use of very limited resources (Topps, 2000:125).

Health services rendered to people in rural areas seem to be inadequate especially because most of the professional nurses and doctors are still concentrated in urban and peri-urban areas. Shortage of personnel in rural clinics still exists. There is a cry that nurses in rural clinics are overwhelmed by huge numbers of patients and they have actually verbalised a

feeling of helplessness due to these huge numbers against staff shortage (Strachan, 1999:11).

Mortality burden still occurs in children and women in overseas countries, for example, in Papua New Guinea, children in rural areas still die because of pneumonia, malnutrition, measles, meningitis, low birth weight, malaria, and neonatal sepsis and so is the situation in South Africa. Poor maternal health and poor knowledge about feeding form major contributions to childhood malnutrition. Statistics show that the rate of maternal mortality range from 370 per 100 000 live births to 930 per 100 000 live births (Duke, 1999:1291).

The researcher is concerned about problems encountered by the consumers of health care services in rural clinics in KwaZulu-Natal province and wishes to find out from them and hear their views in relation to health care services provision in their areas.

1.3 STATEMENT OF THE PROBLEM

The province of KwaZulu-Natal is predominated by large rural areas. Most people staying in these areas are poor, illiterate and end up in poor health. Common health conditions affecting people in rural areas are mostly preventable especially through effective health education and community development. However literature maintains that rural people receive inadequate health care services as they experience shortage of human and material resources. As a result according to Duke (1999:129) rural communities have a high mortality rate. The question to be addressed is "are the people in rural communities where health services are provided by rural clinics, benefitting maximally from these health provisions, if not what are the problems?".

1.4 PURPOSE OF THE STUDY

The purpose of the study was to determine the perceptions of people living in rural areas

on health care services provided to them.

1.5 OBJECTIVES OF THE STUDY

The study aims at achieving the following objectives:

- to identify problems encountered by the clients in the rural clinics in relation to health care provision
- to ascertain expectations clients have from health care providers in their areas
- to assess the appraisal of health care provision by consumers of health care services in rural clinics.

1.6 ASSUMPTIONS

The study is based on the following assumptions:-

- rural clinics are still given less attention by the health authorities
- health problems that occur in the rural areas are basically due to shortage of personnel, working material and equipment.

1.7 SIGNIFICANCE OF THE STUDY

The researcher hopes that this study will contribute by providing the health authorities with facts from the people served by health professionals in rural clinics, which may be essential for strategising and re-evaluating health services especially in rural clinics. May be views and suggestions of consumers of health care services, if highlighted in the form of research may alert the authorities of KwaZulu-Natal province to focus more on areas facing health care problems.

1.8 DEFINITION OF TERMS

Consumer:

- refers to a biosocial being in constant interaction with changing environment (Fraser, 1996:44). In this study a consumer is a recipient of health care services provided by health professionals in rural clinics.

Health Services

- health services are activities provided by health care professionals to the sick and those who are not yet sick for the purpose of promoting health and preventing diseases, rehabilitation, counselling and health education (Saunders & Carver, 1992:101).

In this study health services will be referring to professional activities rendered to patients and clients.

Professional:

- refers to a person who has great skill or experience in a particular field or activity (Roberts, 1991:1229).

In this study a professional will be referring to personnel who have undergone nurses training and registered with the South African Nursing Council (SANC) and regulated by stipulations of the Nursing Act No. 50 of 1978 as amended, as well as those registered with the Medical and Dental Council.

Rural areas:

- rural areas refer to a country side with people that share the common characteristics of comparatively few people living in the area, who have limited access to large cities and sometimes even smaller towns, and considerable travelling distances to "market areas" for either work or everyday living activities. They exist along a

continuum, however, from more rural to less rural and vary extensively based on the factors:- proximity to central place, community size, population density, total population and economic/socioeconomic factors (<http://www.ruralwomyn.net/rura.html>). In this study rural areas will be referring to all areas which are geographically far from cities, towns, health care facilities, national roads, transport and hospitals. These are predominantly occupied by the poorest Black communities, and are still basically dependant on shared natural resources for their living.

Communities:

- this is defined as a group, population or cluster of people with at least one common characteristic such as geographic location, occupation, ethnicity or housing conditions (Anderson & McFarlane, 1996:261). In this study community will be referring to a group of people living in the same geographical area, sharing the same language, ethnicity and the same housing conditions.

Health:

- World Health Organisation indicates that health is a state of complete physical, mental and social well being, not merely the absence of infirmity in an individual (Phillips, 1990:2).

Primary Health Care:

- primary health care is essential health care based on 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 community and the country can afford to maintain at every stage of the development in the spirit of self reliance and self determination. It forms an integral part, both of the country's health systems, of which it is the central function and main focus, and of the overall social and economic development of the community.

It is the first level of contact of individuals, the family and the community with the National Health System, bringing health care as close as possible to where the people live and work and constitutes the first element of a continuing health care process (Vlok, 1996:26).

Developing country:

- this refers to a country that has considerable social and welfare change occurring but, whilst some conditions are improving, others are deteriorating, and there is excessive pressure on resources related to population numbers and age structure (Phillips, 1990:1).

Phelophepa:

- Phelophepa is a train that has 16 coaches, through which health care services are provided to hundreds of people from poorest rural areas. It is the first world health care train. Staff on the train include two nurses, a dentist, an optometrist, a pharmacist, a psychologist and several assistants and three security guards (Nicodemus, 1999:2).

2. PRELIMINARY LITERATURE REVIEW

2.1 INTRODUCTION

Literature search will present reviews of relevant literature pertaining to different opinions about health care services in rural clinics and rural areas in general.

Rural areas in KwaZulu-Natal are typical of the developing world, with diseases resulting from poverty, ignorance and lack of basic needs such as proper sanitation and clean water. Rural communities in developing world tend to suffer from shortage of health professionals, inadequate health facilities such as enough clinics and hospitals, immunisations and health

materials and equipment. They also lack educational opportunities, suffer disease outbreaks such as cholera, amoebic dysentery bilharzia and others. They suffer poor communication facilities and thus end up isolated geographically from new health developments (Duke, 1999:1293).

2.2 HEALTH CARE REFORM IN SOUTH AFRICA

There has been health care reform in South Africa, which attempts to shift away from a curative based and urban centred health system, to a health system based on primary health care. This health care reform attempts to encourage community participation in health care and also improve accessibility, redistribution of resources and change in the whole management approach which mostly came from the bottom to a more decentralised one (Power & Robins, 1996:35).

2.3 THE PHELOPHEPA HEALTH TRAIN

Phelophepa is a train that facilitates the provision of health care to the rural areas. It travels across rural South Africa for 36 weeks in each year. It has done so for the past six years. The train remains in each centre for one week to bring health care to the poorest communities. It functions in the areas of Transvaal and Cape. KwaZulu-Natal rural and poorest communities, do not have help like that one brought by the Phelophepa train (Nicodemus, 1999:3).

3. RESEARCH METHODOLOGY

3.1 RESEARCH DESIGN

The descriptive survey method will be used. This method has been chosen because it is suitable in the study and is aimed at gathering information from the sample of the

population. This method will help to describe variables in order to answer the research question. In this design the researcher does not manipulate any variables and there is no effort to determine the relationship between variables. Accurate information will be searched for, about opinions, attitudes, needs or facts from health care consumers in rural areas in connection with health care provision (Brink, 1996:109).

3.2 TARGET POPULATION

Population targeted will be the clients and patients utilizing health care facilities available in rural clinics. This population have been chosen because it is in a better position to give better information as it is in rural areas and is the community, according to literature review, which is disadvantaged in provision of health services.

3.3 SAMPLING TECHNIQUES

Simple random sampling will be used for the purpose of collecting data from clients and patients using different types of health care services such as antenatal care services, services for chronic illnesses such as diabetes mellitus, hypertension, tuberculosis and others. Hospitals which serve as mother hospitals of different rural clinics will also be sampled through simple random sampling.

3.4 SAMPLE SIZE

KwaZulu-Natal province has been divided into ten plus one health care management districts. The researcher will take 10% of the rural clinics from each district and 10% of patients/clients will be sampled from each health care service provided. Patients/clients attending the particular service on a particular day will form the population for that particular service. This will be applied to all services provided by the health care centre until all the different types of services available in rural clinics are covered.

3.5 DATA COLLECTION INSTRUMENT

A structured interview schedule will be developed. All the subjects will be asked the same questions in the same order and the same manner so as to be able to get objective results. This method has been selected because it is cheap and simple to use. All the interview schedule forms will be returned as it will not need to be posted. The subjects who cannot read and write can also be part of the sample as they will not need to read and write anything. The researcher will have two assistants who will be trained by the researcher on how to use the structured interview schedule.

3.6 PILOT STUDY

A pilot study will be undertaken on five (5) consumers of health care services who will be sampled from each health care service provided in the clinic. These subjects will not be included in the sample for the actual study. The pilot study will be done to test the instrument for validity and reliability, to correct errors, evaluate time needed and expenses incurred in the project.

3.7 ETHICAL CONSIDERATIONS

Permission to conduct the study will be requested from the Secretary General and the Directors in charge of the districts and situated in the district offices in different areas in KwaZulu-Natal. Informed consent will be obtained from the respondents after explaining the purpose of the study. Informed consent ensures that subjects have adequate information regarding the research, understand and are free to choose whether to participate or not (Pilot & Hungler, 1991:36). Anonymity and confidentiality will also be ensured. Findings of the research will be made available on request to respondents interested. The research report will be sent to the authority who granted permission.

4. **DATA ANALYSIS AND INTERPRETATION OF FINDINGS**

Each item of the interview schedule will be analysed and presentation of findings will be in the form of tables, graphs and percentages, and findings will be discussed.

5. **SUMMARY, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS**

Summary of the study will be made, conclusions will be drawn based on the data obtained. Recommendations will be made according to the main problems and needs identified.

6. **TENTATIVE SCHEME OF WORK**

Chapter 1: Orientation of the study

- 1.1 Introduction
- 1.2 Motivation of the study
- 1.3 Statement of the problem
- 1.4 Objectives of the study
- 1.5 Assumptions
- 1.6 Significance of the study
- 1.7 Definition of terms

Chapter 2: Literature Review

- 2.1 Introduction
- 2.2 Literature review
- 2.3 Theoretical framework

Chapter 3: Research Methodology

- 3.1 Introduction
- 3.2 Research design
- 3.3 Target population
- 3.4 Sampling technique
- 3.5 Sample size
- 3.6 Data collection instrument
- 3.7 Pilot study
- 3.8 Ethical considerations

Chapter 4: Data analysis and interpretation of findings

- 4.1 Introduction
- 4.2 Analysis and presentation of data

Chapter 5: Summary of Findings, Conclusions, Limitations and Recommendations

- 5.1 Introduction
- 5.2 Summary
- 5.3 Conclusion
- 5.4 Limitations
- 5.5 Recommendations

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Male	
Female	

18 - 20	1
21 - 30	2
31 - 40	3
41 - 50	4
51 - 60	0
61 - 70	0

1 - 10	1
11 - 20	2
21 - 30	3
31 - 40	4
41 - 50	0

ANNEXURE 8

INTERVIEW SCHEDULE

VIEWS OF HEALTH CARE SERVICES CONSUMERS IN RURAL COMMUNITIES ON PROVISION OF HEALTH CARE IN KWAZULU-NATAL PROVINCE: A NURSING MANAGEMENT PERSPECTIVE

SECTION 1

1. DEMOGRAPHIC DATA

1.1 Gender

Male		1
Female		2

1.2 Age group in years

10 - 20		1
21 - 30		2
31 - 40		3
41 - 50		4
51 - 60		5
61 - 70		6

1.3 Number of years in the area

1 - 10		1
11 - 20		2
21 - 30		3
31 - 40		4
41 & above		5

SECTION J

1.4 Educational standard

Primary education		1
Secondary education		2
Tertiary education		3
Never attended school		4

1.5 Name of residential area from:

.....

1.6 Religion

Christian		1
Non-Christian		2
Other, specify		3

1.7 Socio-economic status

High class		1
Middle class		2
Low class		3

1.8 Employment

Employed		1
Unemployed		2
Self-employed		3
Student		4

1.9 Marital status

Married		1
Single		2
Widowed		3
Divorced		4

SECTION 2

2. VIEWS ON HEALTH CARE SERVICES

2.1 Antenatal health care services

2.1.1 Do you have antenatal health care services in your area?

Yes		1
No		2

2.1.2 Do nurses have enough time for your needs?

Yes		1
No		2

2.1.3 If no, what are the problems that lead to this? State.

.....

.....

.....

2.1.4 Do you know about HIV/AIDS?

Yes		1
No		2

2.1.5 Do you know about family planing?

Yes		1
No		2

2.1.6 Is there enough equipment to take care of pregnant women?

Yes		1
No		2

2.1.7 Is there enough staff to take care of your health needs?

Yes		1
No		2

2.1.8 Does a doctor visit your clinic to assess pregnant women?

Yes		1
No		2

2.2 Minor ailments clinic services

2.2.1 How often do you visit the clinic?

Once fortnightly		1
Once monthly		2
Two monthly		3
Other, specify		4

2.2.2 Do you think the health care services for the sick is:

Fast		1
Satisfactory		2
Poor		3
Good		4
Not sure		5

2.2.3 Have you had any problems due to poor clinic services?

Yes		1
No		2

2.2.4 If yes, enumerate them

.....

.....

.....

2.2.5 Have you had a lot of similar incidences?

Yes		1
No		2

2.5.6 In your opinion, are there enough nurses in your clinic?

Yes		1
No		2

2.2.7 Are there a lot of people who attend the clinic per day?

Yes		1
No		2

2.2.8 Does the clinic give you a 24-hour service?

Yes		1
No		2

2.3 Special clinic services (e.g., diabetes, mellitus, tuberculosis, hypertension, sexually transmitted diseases, etc.)

2.3.1 Do you get your monthly supply of medication for your chronic disease in the clinic?

Yes		1
No		2

2.3.2 How often does a doctor visit the clinic to assess you?

Once a week		1
Once a fortnight		2
Monthly		3
Two monthly		4
Never comes		5
Other, specify		

2.3.3 Have you done any test during the past two years for your health assessment?

Yes		1
No		2

2.3.4 Do you come to the clinic to check your blood sugar/blood pressure?

Yes		1
No		2

2.3.5 Are you treated in clinic for any sexually transmitted disease?

Yes		1
No		2

2.3.6 If no, where do you got for treatment of this?
State.

.....

.....

.....

2.4 Well baby clinic

2.4.1 Do you bring your babies to the clinic for check-ups?

Yes		1
No		2

2.4.2 Do you bring babies for vaccination against infant diseases?

Yes		1
No		2

2.4.3 Do you often bring babies if there is a need?

Yes		1
No		2

2.4.4 Do you bring babies to the clinic only when they are sick?

Yes		1
No		2

2.4.5 Do you get advices from nurses when you need them?

Yes		1
No		2

2.5 Family Planning

2.5.1 Do you often use the family planning clinic?

Yes		1
No		2

2.5.2 Do you get pills, injections, loops, etc., when you need them?

Yes		1
No		2

SECTION 3

3. GENERAL VIEWS ABOUT HEALTH SERVICES

3.1 What are your comments about the services you received?

.....

.....

3.2 What can you say about the cleanliness of the clinics in your area?

.....

.....

3.3 Do you think you need more clinics?

Yes		1
No		2

3.4 Suggest what could improve clinic services in your area.

.....

.....

3.5 Is your nearest clinic within a walking distance?

Yes		1
No		2

3.6 If no, do you use transport to get to the clinic?

Yes		1
No		2

3.7 Is it a problem for the older people to travel to the clinic?

Yes		1
No		2

3.8 If yes, what could be the solution to this problem?

.....

.....

3.9 What problems do you think health care professionals have in the clinic?

.....

.....

3.10 Is there a way of avoiding these problems?

Yes		1
No		2

3.11 If yes, state what?

.....

.....

.....

3.12 Which are the worst problems to be attended first? State.

.....

.....

3.13 What are the urgent needs in relation to the clinic health services?

.....

.....

3.14 Is the clinic always open or does it close from time to time?

Always open		1
Closes at times		2

3.15 Does the clinic have accommodation for the nursing personnel?

Yes		1
No		2

3.16 Does the clinic have electricity?

Yes		1
No		2

3.17 Are there any incineration facilities in the clinic?

Yes		1
No		2

3.18 Is the clinic fenced and does it have a locking gate for security?

Yes		1
No		2

3.19 Are there security guards for the clinic?

Yes		1
No		2

3.20 Do you have safe water supply?

None		1
Tap		2
Borehole		3
Windmill		4
Protected spring		5

3.21 State any other comments you have about health care services in your area:

.....

.....

.....

.....

An Overview of the Kwa-Zulu Natal Province.

This review was done in terms of the(a) population and it's demographics, (b) the vision, mission, core values of the KwaZulu-Natal Provincial Department of Health, (c) the package of health services at the institutional level in KwaZulu-Natal, and lastly, (d) the expected management environment.

Figure 1. A Map reflecting the health districts and the provincial hospitals in KwaZulu-Natal: Adopted from KZN Department of Health's Annual Report Document; 2001/ 2002

