

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

A literature study was conducted to obtain information on client satisfaction with regard to the accessibility of primary healthcare services. The literature review focuses on health systems, principles of primary health care, the nature and extent of services provided at primary healthcare facilities and patient satisfaction.

2.2 THE HEALTH SYSTEM IN SOUTH AFRICA

A health system can be defined as the organisation and distribution of all resources allocated by a society for the delivery of health care (Stanhope & Lancaster 1992:23). Health systems in South Africa include both public and private providers of goods and services for healthcare delivery and are organised at national, provincial, district and community levels (ANC 1994b:43).

The delivery of health services in South Africa is therefore managed by two systems, namely:

- The public health system that services the majority of the population and is subsidised by mainly the government; and
- The private healthcare system that services only members of medical aid schemes and is administered by health insurance schemes (<http://strategies.ic.gc.ca/SSG/dd74038e.html> 1998).

South Africa spends approximately 8.5% of its GDP on health care, and about sixty per cent (60%) of that value is spent on the private sector (<http://strategies.ic.gc.ca/SSG/dd74038e.html> 1998). Since 1994, a government priority has been to improve access to primary health care. The Department of Health has built new clinics in rural areas where health facilities were previously inaccessible. The department has also imported doctors from Cuba and Germany to help alleviate the shortage of doctors in rural South Africa. Although progress has been made, more is needed to ensure that all South Africans, especially those in rural and impoverished areas, have adequate access to healthcare services (<http://strategies.ic.gc.ca/SSG/dd74038e.html> 1998).

2.2.1 THE NATIONAL HEALTH SYSTEM

Before 1994, the healthcare system was planned in a fragmented manner. This was the legacy of the colonial era (when parts of South Africa was either under British rule or governed by the Boers). The healthcare system that developed out of these political influences was haphazard, and the situation was further exacerbated by the discovery of diamonds and gold (Dennil, King & Swanepoel 1995:30), and years of drought, depression, war and, since 1948, apartheid.

The urgent need for healthcare reform has been highlighted by political and social changes in South Africa, especially constitutional changes such as the election of the first democratic government in April 1994 (Mokhobo 1995:9). According to the National Health Plan for South Africa (ANC 1994a:68), a single, comprehensive, equitable and integrated national health system had to be restructured and coordinated at central government level. Principles of equity, comprehensiveness, accessibility and affordability had to be integrated into the national health system (Mokhobo 1995:9).

2.2.2 THE PROVINCIAL HEALTH SYSTEM

According to the White Paper on the Transformation of Health Systems (Department of Health 1997:26), a mission of the constitution of South Africa was to promote and monitor the health of the people in the provinces. This should be done within the framework of national policies, strategies and guidelines. The white paper further promotes a caring and effective provincial health system through the establishment of a decentralised DHS that is based on the principles of primary health care.

The former Provincial Health Administration, the former self-governing territories (Transkei, Bophuthatswana, Venda and the Ciskei, the so-called TBVC states) and the regional offices of the old Department of National Health and Population Development (DNHPD) were incorporated into new provincial authorities. Within the single national health system, each province has to support, monitor and evaluate district health services and is responsible for specific health services to improve the health of the people in the province (ANC 1994a:65).

2.2.3 THE DISTRICT HEALTH SYSTEM

The DHS is for the most part a self-contained segment of the national health system. It is based on primary healthcare principles. The DHS services a well-defined population within a clearly delineated administrative and geographical area, whether rural or urban. It includes all institutions and individuals providing health care in the specific district, whether governmental, nongovernmental, private or traditional. The DHS, therefore, consists of a large variety of interrelated elements that contribute to health in homes, schools, places of work and communities. It includes self-care, and involves healthcare workers and facilities such as hospitals, laboratories and other diagnostic and logistic support services (ANC 1994a:62).

The DHS provides the health sector with a management framework that can deliver health care in a cost-effective and integrated manner (Department of Health 1997:18).

Every part of every province is covered by the geographical boundaries of a health district. The size of each district varies according to local conditions. Each health district usually contains one, or more than one, district hospital, community health centres, clinics, and smaller facilities such as mobile units and service points (Department of Health 1995b:7).

At the primary healthcare level, the DHS is responsible for the overall management and control of its budget and the provision and/or purchase of a full range of comprehensive primary healthcare services within its area of jurisdiction. Effective referral network systems are ensured through cooperation with other health districts. Services are rendered in collaboration with relevant role players (Department of Health 1997:30). At this level, the responsibilities of the DHS include health care, administrative, financial and support services, as well as planning and human resources development.

2.2.4 THE COMMUNITY HEALTH SYSTEM

Communities in a geographical area are served by community health services. Communities are encouraged to form an intersectoral community development committee that could coordinate community projects and resources (Dennil *et al.* 1995:44).

Community health committees consist of elected community members who serve on a voluntary basis. Representatives are drawn from health services, nongovernmental organisations (NGOs) and the ranks of health practitioners in the area. It is their responsibility to liaise with those running the community health services and, especially, the community health centre of each district. They help to prioritise health needs and determine local health policy. The community health centre in each district forms the heart of the DHS and provides preventative, promotive, curative and rehabilitative care (Dennil *et al.* 1995:44). Clinics provide similar services at a less

specialised level. Clinics should have water, electricity and some method of communication. Some areas are served by mobile clinics (ANC 1994a:62).

2.3 THE PRIMARY HEALTHCARE APPROACH

The primary healthcare approach emphasises the development of comprehensive healthcare systems that encompass curative, preventive, promotive and rehabilitative activities. These systems are developed and implemented with the participation of and in equal partnership with the people who receive care and services. This approach aims to make health care more widely available and accessible, and encourages individuals, families and communities to partake in healthcare decisions for their own and the common good (Blackie & Appleby 2000:6,7).

2.3.1 PRINCIPLES OF PRIMARY HEALTH CARE

The primary healthcare approach emphasises the provision of cost-effective primary health care to all inhabitants of South Africa (Vlok 2000:29). This approach is based on the following principles: equity, accessibility, affordability, availability, effectiveness, efficiency, quality, fairness, responsiveness, acceptability, community participation, appropriate technology, preventive and promotive health care as well as decentralisation of decision-making powers. Although accessibility is the focus of this study, the principles are interrelated and have an impact on primary healthcare delivery, and will therefore be discussed and considered.

➤ Equity

All people should have equal access to basic health care and social services, without any sign of subgroup variability or discrepancy in care (Dennil *et al.* 1995:6). Equal access implies fair distribution of benefits, goods and services. It is based on the

belief that people should be treated equally and that each person should receive a decent share of the goods and services available (Dreyer *et al.* 2000:9).

One of the key areas achieved since 1994 was the elimination of discriminatory structures and practices in the public health system (Department of Health 1997:7).

➤ **Accessibility**

Services such as primary health care and social development should be made available to all South Africans, especially the formerly disadvantaged and rural populations (Dennil *et al.* 1995:6).

Services should be:

- Geographically accessible, *i.e.* health services should be within reasonable distance (the WHO suggested 5-10 km) and transport should be available;
- Financially accessible to the individual and community; and
- Functionally accessible, *i.e.* appropriate care should be available to meet the needs of the individual or community (Dennil *et al.* 1995:6).

According to Blackie and Appleby (2000:5), essential services should be accessible to people regardless of age, gender, ethnicity, disability, or health status. Accessibility of primary health care received priority since 1994. This was illustrated by the following statistics: more than seven hundred (700) clinics were built or greatly upgraded, 2298 existing clinics were upgraded and received new equipment, one hundred and twenty-four (124) new service points were established, and one hundred and twenty-five (125) new mobile clinics purchased (Department of Health 1997:7).

➤ **Affordability**

The level of health care offered should be in line with what the community and the country can afford. No person should be denied basic health care because of an

inability to pay (Dennil *et al.* 1995:6). In South Africa, health care is provided free of charge to pregnant and lactating women, children five years and younger and at primary healthcare level (Department of Health 1999:7).

➤ **Effectiveness**

Health services should provide the types of services that they are intended to provide, and it should be done in such a way that the health status of communities improves. The provision of services should also be justifiable in terms of total cost (Dennil *et al.* 1995:6).

➤ **Efficiency**

The results attained should be proportionate to the input in terms of effort required, money, resources and available time (Dennil *et al.* 1995:6). According to Blackie and Appleby (2000:5), services should be based on evidence of clinical effectiveness, and resources should be used efficiently.

➤ **Quality**

Quality relates to the standard of service delivery. Professionals should be knowledgeable about the conditions that prevail in the primary healthcare environment and they should be skilled practitioners. Prevention strategies should be in place. Professionals should also be knowledgeable about the client, *i.e.* they should have insight into the client's understanding of health matters. Health practitioners should coordinate their services, they have to cooperate and collaborate on health matters and they should appreciate the contribution of every practitioner to the profession. There should be no service gaps. Premises and facilities have to be of good standard and fit for their purposes, and equipment should be up to date, well maintained and safe to use (Blackie & Appleby 2000:5).

The introduction of community service for newly graduating South African doctors was achieved since 1994 (Department of Health 1997:7).

➤ **Fairness**

Everybody has the right to reasonable and acceptable health services, and clients should be treated equally. Health services should not vary widely in terms of quality in different parts of the country and each service should receive an appropriate share of the national budget and resources (Blackie & Appleby 2000:5).

➤ **Responsiveness**

Services should reflect the needs and preferences of the individuals using them. They should also reflect the health, demographic and social needs of the areas they serve (Blackie & Appleby 2000:5).

➤ **Acceptability**

Cultural factors, types of services offered, the cost of services, distances clients have to travel to clinics, attitudes of clients towards health and health care and attitudes of healthcare providers determine the acceptability of health services (Dreyer *et al.* 2000:134).

➤ **Community participation**

Community participation in healthcare is enhanced by involving all major role players, for instance, elected community members from a chief's kraal¹, in decision-making relating to healthcare needs in an area. These elected community members again meet with all members of the community at the chief's kraal and information is

¹ A VILLAGE OR SETTLEMENT OCCUPIED BY A FAMILY, CLAN OR TRIBE

exchanged. Monthly meetings should be held with primary healthcare providers. Active participation in health planning at operational level results in more effective decision-making and promotes a commitment to ensuring that plans of action work (Dreyer *et al.* 2000:134).

➤ **Appropriate technologies**

The primary healthcare approach emphasises technologies that are appropriate to local circumstances. In the context of primary health care, technology refers to equipment and material (refer to 4.3.3), and includes skilled personnel (Dreyer *et al.* 2000:134). Since 1994, 2298 clinics have received new equipment, while four hundred and forty-six (446) Cuban, German and other foreign doctors were employed to strengthen hospital-based care for rural communities and to provide proper support to the primary health system (Department of Health 1997:7).

➤ **Preventive and promotive approach**

Primary health care should promote good health and prevent ill health. Services should be comprehensive, and curative and rehabilitative services should be provided. Among other preventive and promotive measures, the WHO in 1996 recommended the introduction of the Direct Observed Treatment Short-course (DOTS) strategy to combat tuberculosis (TB) in South Africa (Department of Health 1997:7).

➤ **Decentralisation of decision-making**

Delegation of decision-making power as close as possible to the operational level promotes a “bottom-up” management approach and ensures more realistic planning (Dreyer *et al.* 2000:135).

2.3.2 FACTORS INFLUENCING PRINCIPLES OF PRIMARY HEALTH CARE

Factors such as fees charged, costs of medication and transport, distances, travelling time, cultural issues and negative attitudes could adversely affect the principled approach to primary health care.

- **Fees charged**

Primary health care is:

- Essential health care;
- Based on practical, scientifically sound, and socially acceptable methods and technologies;
- Universally accessible to all in the community through their full participation;
- Affordable; and
- Geared towards self-reliance and self-determination.

(Anderson & McFarlane 2000:12.)

Primary health care should be affordable for the individual, family and community. In South Africa, primary health care is delivered free of charge to pregnant and lactating women, children under the age of six years, and all persons who use the public primary healthcare system (Department of Health 1997:7).

- **Travelling cost and lost of income**

According to the WHO (1988) in Dennil *et al.* (1995:2), primary health care is the first level of contact with the national health system. It brings health care as close as possible to the people (to where they live and work) and constitutes the first element of continuing healthcare delivery. The ideal situation is that clients do not have to meet any costs incurred as a result of visiting a health service. However, people do have to meet transport costs or experience lost of income due to time spent travelling to the health centre.

- **Cost of medication**

According to Dennil *et al.* (1995:36), a primary healthcare programme is required to meet the objective of providing essential, safe, effective and affordable medicines and vaccines to persons who need them. A national drug policy is being developed and an essential medicine list has been established based on WHO recommendations.

South Africa's national health policy was launched in 1996. The development of an essential drug list (EDL) and standard treatment guidelines for primary healthcare and hospital levels (paediatric and adult level of care) will positively affect healthcare delivery. There is already some improvement in the availability of essential drugs at primary healthcare facilities (Department of Health 1997:7). At these facilities, medication is available free of charge.

- **Distances travelled**

With respect to distance, the accessibility of a primary healthcare service is measured by the proportion of clients living within a 5km radius of the service (Department of Health 2001:12).

- **Cultural factors and attitudes**

Cultural factors and attitudes towards health and health care arise from guidelines (both explicit and implicit) that individuals inherit from being a part of a particular society. These guidelines tell them how to view the world and how to behave in it in relation to other people, to supernatural forces or gods, and the natural environment (McKenzie, Pinger & Kotecki 1999:6). Appropriate primary healthcare interventions should be planned with sensitivity to the beliefs, values and social networks of each specific community (Dennil *et al.* 1995:22). Cultural beliefs give meaning to health and illness experiences by providing the individual with culturally acceptable causes for illness, rules for symptom expression, interactional norms, and help-seeking

strategies. Cultural beliefs play a role in determining health outcome. (Anderson & McFarlane 2000:120.)

- **Types of services offered**

Services offered at primary healthcare level include basic and essential care such as growth monitoring, oral rehydration, promotion of breast-feeding, expanded immunisation, food supplementation, female literacy and family planning, normal deliveries, management of common diseases, and rehabilitation and management of chronic diseases. The emphasis is on disease prevention and health promotion (Dennil *et al.* 1999:11,12).

- **Attitudes of healthcare workers**

Situations in contemporary community health care can raise some difficult ethical questions. Community nurses should be familiar with ethical principles and their applications to advise and support clients when value-related or conflicting decisions have to be taken (Dreyer *et al.* 2000:10).

- **Appropriate referral system**

According to the patients' rights charter, a patient has the right to be referred for a second opinion (Department of Health 2001:11). For primary health care to be successful, it is necessary to have adequate and appropriate referral facilities. The emergency referral facility should be no further than two hours away by road (Dennil *et al.* 1995:20). People in need of more specialised services are referred to community health centres or referral hospitals.

2.4 THE SOUTH AFRICAN SITUATION

In South Africa, primary healthcare services are largely accessible in urban areas. However, accessibility still seems to be a problem in rural areas. Factors affecting access relate to geographical accessibility. Many people living in remote areas have to travel long distances to reach public services. The lack of infrastructure exacerbates communication with and travelling to and from remote areas. Other factors barring or hindering access to primary health services relate to social, cultural, physical, communication or attitudinal problems. (Department of Public Services and Administration 1997:11.)

2.5 A CANADIAN PERSPECTIVE

Principles of primary health care in foreign countries are similar to those guiding primary health care in South Africa. They also cover accessibility of health services to consumers.

As an example, primary healthcare principles of the Registered Nurses Association of Ontario (RNAO) are considered. The coalition for primary health care has twelve principles as a foundation for reform.

They are summarised under the following headings:

- Ensuring access to a wide range of comprehensive services.
- Providing primary health care 24 hours a day, seven days a week.
- Establishing interdisciplinary group practices.
- Services based on community needs.
- Primary health care should be not for profit.
- Community committees and boards.
- Enrolment.
- Funding.

- Information management.
- Coordination of care.
- Rights, responsibilities and accountability.
- Education.

([HTTP://STRATEGIES,IC,GC,CA/SSG/DD74038E.HTML](http://strategies.ic.gc.ca/ssg/dd74038e.html) 1998.)

2.6 SERVICES PROVIDED AT PRIMARY HEALTHCARE LEVEL

Although comprehensive in nature, primary health care in South Africa focuses on health promotion and disease prevention.

The spectrum of services usually available at a primary healthcare facility includes the following:

- Trauma and emergency services.
- Treatment of common non-communicable diseases.
- Prevention, surveillance and management of communicable diseases.
- Antenatal care.
- Normal deliveries.
- Postnatal care.
- Family planning services.
- Maternal and child welfare services.
- Health education.
- Management and monitoring of nutritional status.
- School health services.
- Preventing or managing human immunodeficiency virus/ acquired immunodeficiency syndrome (HIV/Aids) and sexually transmitted diseases (STDs).
- Mental health services.

Each will be discussed briefly.

2.6.1 TRAUMA AND EMERGENCY SERVICES

According to the Norms and Standards for Health Clinics, all clinics should provide trauma and emergency services. The community nurse should be able to tract and refer patients that have experienced trauma and/or injury, and should know how to deal with a disaster situation. Each clinic has an emergency box, containing items that are needed in cases of emergency, and a system in place for replenishing those items that have been used (Department of Health 2001:43,44).

2.6.2 TREATMENT OF COMMON NON-COMMUNICABLE DISEASES

Non-communicable diseases include acute diseases such as cough, vomiting and diarrhoea, and chronic diseases such as asthma, hypertension and diabetes (Anderson & McFarlane 2000:402).

Acute diseases such as injuries, cough, diarrhoea and vomiting are treated at clinic level. Every clinic should have a rehydration corner and facilities for intravenous therapy for dehydrated individuals (Department of Health 2001:19). Clinics provide treatment for minor ailments and acute illnesses based on the EDL.

Community nurses issue medication for chronic illnesses as prescribed by medical doctors. Medical doctors examine patients receiving chronic medication every six months. Patients are referred to the next level of healthcare delivery for diagnosis and initial treatment. After diagnosis, patients and caretakers are supported and their capacity developed regarding self-care, self-monitoring, compliance, prevention of complications, and management of diseases. Health education given is sensitive to the cultural and economic realities of the patient (Department of Health 2001:53).

A crucial and often deficient element in treatment of non-communicable diseases is an adequate supply of appropriate medicine. The objectives of the national drug

policy developed by the South African government clearly outlined the commitment to ensuring availability and accessibility of medicine to all people.

The objectives set out in the national drug policy are as follows:

- To ensure the availability and accessibility of essential medicine to all citizens;
- To ensure the safety, efficiency and quality of drugs;
- To ensure good prescribing and dispensing practices;
- To promote the rational use of medical drugs by prescribers, dispensers and patients by providing the necessary training, education and information; and
- To promote the concepts of individual responsibility for health, preventive care and informed decision-making.

(Standard 1998:iii.)

Achieving these objectives requires a comprehensive strategy that includes not only improved supply and distribution but also appropriate and extensive human resources development (Standard 1998:iii).

The criteria for drawing up a list of essential drugs for primary health care in South Africa were based on WHO guidelines.

The criteria are as follows:

- Any drug included should meet the needs of the majority of the population.
- Sufficient proven scientific data regarding effectiveness must be available.
- Any drug included in the EDL should have a substantial safety and risk/benefit ratio.
- Products must be of an acceptable quality and must be tested on a continuous basis.
- The aim, as a rule, is to include only products containing single pharmacologically active ingredients.

- Combination products, as an exception, will be included where patient compliance becomes an important factor, or two pharmacologically active ingredients are synergistically active in a product.
- Products will be listed according to their generic names only.
- Where drugs are clinically equally effective, they will be compared according to the following factors:
 - The best cost advantage;
 - The best researched;
 - The best pharmacokinetic properties;
 - The best patient compliance; and
 - The most reliable manufacturer.
- Scientific data and appropriate references on its advantages and benefits must support a request for the inclusion of a new product on the EDL over an existing product.
(Standard 1998:iv.)

2.6.3 PREVENTION, SURVEILLANCE AND MANAGEMENT OF COMMUNICABLE DISEASES

Communicable diseases in South Africa include tetanus, gonococcal ophthalmia neonatorum, dysentery, gastroenteritis, typhoid fever, malaria, whooping cough (pertussis), TB and measles. Not all communicable diseases are notifiable. The aim of notification of diseases is the prevention and control of communicable diseases. Several communicable diseases have been declared notifiable according to the Health Act. They include acute flaccid paralysis, acute rheumatic fever, malaria, measles and TB (Van Den Berg & Viljoen 1999:56). Notification should be done at the offices of the healthcare department or any other relevant department in the district. According to Regulation No.R703 of 30 July 1993, the medical practitioner or a healthcare practitioner who is registered with a healthcare statutory body or any other person who is legally qualified to practise should make notification. At a clinic, it is the responsibility of the community nurse.

Not all notifiable diseases are communicable diseases. Non-communicable notifiable diseases include food poisoning (an outbreak of more than four cases) and acute rheumatic fever. Where the notifiable condition is a communicable disease, notification has to be made without delay verbally (in person or by telephone) or within 24 hours in writing (fax, electronic mail or telegram). Other conditions have to be notified in writing within seven days (Van Den Berg & Viljoen 1999:56).

Venereal diseases such as syphilis, gonorrhoea, soft chancre, venereal warts, venereal granuloma, herpes simplex II and AIDS are not notifiable (Van Den Berg & Viljoen 1999:57).

The role of the community nurse is primary prevention, which include promotion of health and protection from diseases. The focus is on the individual, family and community. Health is promoted by means of health education, the aim of which is to improve or alter the attitudes and behaviour of the individual, family or community. A healthy lifestyle is encouraged. (Van Den Berg & Viljoen 1999:112.)

Immunisation is one of the most powerful and cost-effective methods of preventing communicable diseases. At clinics, children less than five years old are immunised according to the Expanded Programme on Immunisation in South Africa.

This programme faced key challenges such as:

- The eradication of polio by 2000;
- The elimination of indigenous measles in South Africa by 2002;
- Achieving ninety per cent (90%) full immunisation of one year olds by December 2003 with every province achieving at least eighty per cent (80%) coverage; and
- Establishing routine school vaccination programmes to deliver booster doses of hepatitis B, measles, tetanus and diphtheria vaccine. (Department of Health 1997:20.)

2.6.4 PROVIDING ANTENATAL CARE

Antenatal care means caring for the pregnant woman to ensure the normal birth of a normal child (Vlok 2000:368). Antenatal care is the care of the pregnant woman until the birth of her child.

Services rendered during this period include:

- Appointments for antenatal care: Pregnant women are encouraged to attend antenatal clinics from approximately eight weeks into the first trimester.
- Visits to the antenatal clinic: Pregnant women preferably should be seen by midwives every four weeks until the 28th week of pregnancy, whereafter the mother and unborn child should be assessed fortnightly until the 36th week and thereafter weekly until term.
- Health assessment during antenatal visits includes documenting the patient's medical history, measuring blood pressure, doing urinalyses, testing blood for blood group, haemoglobin (Hb), Wasserman reaction (WR) and HIV (consent is needed), cytological examination, height and mass control, assessing the health of the unborn child through fetoscopy and assessing the development and position of the baby.
- Other matters attended to during pregnancy are:
 - Genetic counselling;
 - Family planning;
 - Preparation for motherhood; and
 - Health education.

2.6.5 MANAGING NORMAL DELIVERIES

Competent continuous supervision and handling of the birth are essential for the sake of both the mother and infant. Confinement services are usually available at hospitals and health centres. Midwives also supervise confinements at home. In the rural

areas, traditional midwives frequently conduct confinements. Referrals from traditional midwives are associated with training of traditional birth attendants, and should be encouraged (Department of Health 2001:17).

It is imperative that a good referral system is established in a rural area. Transport should be available so that in the event of complications, the mother could be referred and transported as quickly as possible. Communication systems such as two-way radio links with ambulance, medical or hospital services should be available for high risk or emergency cases in remote areas.

2.6.6 PROVIDING POSTNATAL CARE

The postnatal period extends from birth to six weeks after birth when obstetric care ends with the postnatal check-up visit to the obstetrician or obstetric clinic (Vlok 2000:368). Six weeks after the confinement, both mother and child should undergo postnatal examination. Assessing the physical and emotional state of the mother during this period is important and contributes towards the wellness of the family.

2.6.7 PROVIDING FAMILY PLANNING SERVICES

Women should be empowered to plan their families. They should know that they do have choices as to how many children they want and the spacing of pregnancies. Mothers are usually the caregivers, and information and knowledge about family planning will empower them to make informed decisions about matters that could affect their own health and that of their children (Dennil *et al.* 1995:10).

Measures to control population growth include sterilisation, abortion and contraception (Vlok 2000:344). Community nurses should be able to provide comprehensive information about the advantages and disadvantages of various methods of contraception, and should encourage couples to choose a suitable method.

2.6.8 PROVIDING MATERNAL AND CHILD WELFARE SERVICES

Growth monitoring is the regular monitoring of the growth of a child during its first five years. Among other things, the nutritional status of the child is assessed. Height and mass are recorded as indications of growth and health. Mothers are taught to conduct oral rehydration therapy. Making and administering a simple fluid replacement solution of boiled water, salt and sugar have saved many lives in the past and will do so in future. Breastfeeding is promoted. Other services include immunisation, food supplementation, female literacy, family planning and first aid (Dennil *et al.* 1995:10).

2.6.9 PROVIDING HEALTH EDUCATION

Health education provided at primary healthcare level includes topics such as environmental health (water supply and basic sanitation), nutrition, hygiene, prenatal care, immunisation, improved agricultural methods and pest control. Health education should be an integral part of every service rendered at a clinic.

2.6.10 MANAGING AND MONITORING NUTRITIONAL STATUS

Nutritional surveillance is done by health authorities to define nutritional problems in a population. Nutritional surveillance refers to the regular collection of data about the nutritional status of a population, with particular reference to the population subgroups at risk. In South Africa, subgroups among the black and coloured populations with low socio-economic status (and especially the children in these subgroups) are at risk of suffering underfeeding or malnutrition. Nutritional problems again result in children developing learning disabilities, or people contracting TB, gastroenteritis or pneumonia (Vlok 2000:205).

2.6.11 PROVIDING SCHOOL HEALTH SERVICES

School health services are comprised of health services traditionally provided by health workers such as doctors, nurses and other health professionals to schools in South Africa. Services have been provided within different organisational arrangements in South Africa. In some instances, school health professionals have been located within educational support services (e.g. school clinics) and, in other instances, services have been provided directly from primary healthcare settings. Currently, school health services are organisationally located within the Child and Youth Health Directorate of the Department of Health (Department of Health 2000:9).

The aims and objectives of school health services are as follows:

- To appraise the health status of pupils (and school personnel) and to ensure that every child may benefit from his or her education in an optimal state of health;
- To detect and correct any physical defects as early as possible and to alleviate the hardships that these might bring;
- To detect emotional and behavioural disturbances in children and to promote social well-being both at home and at school, thereby lessening anti-social behaviour due to frustration;
- To note and be aware of signs and symptoms of child abuse;
- To prevent and control infectious and contagious diseases in schools and hostels;
- To provide health education, giving advice and guidance to parents and teachers;
- To provide health education for school children, guiding them towards healthy ideals appropriate to their mental age and social background;
- To counsel and guide parents in placing children in special schools where education facilities are geared to their particular needs;
- To prevent overcrowding in classrooms and hostels;
- To maintain school clinics in main centres for the treatment of minor ailments in school children; and
- To arrange school exemption for ineducable children.

(Nzimande 1998:55.)

Responsibilities of the community health nurse in school health services include medical inspections, follow-up inspections and routine examinations. During routine examinations, a careful look is taken at pupils to determine whether there were any problems. Potential problems are listed below:

- Visual defects.
- Hearing defects.
- Defects of the nose.
- Defects of the throat;
- Dental defects.
- Defects in speech.
- Postural defects.
- Asthma.
- Enuresis (bedwetting).
- Epilepsy.
- Infectious and contagious diseases.
- Malnutrition.
- Obesity.
- The hyperkinetic child.
- Non-accidental injuries or battered children.
- The need for personal hygiene.
- The need for health education.

(Nzimande 1998:56.)

2.6.12 PREVENTING OR MANAGING HIV, AIDS AND STIs

The number of people infected with HIV grew very fast in the early 1990s. The number continues to grow, although less rapidly now, and South Africa has a high infection rate (Department of Health 2000:38). Screening and treatment of clients with sexually transmitted infections (STIs) are done at primary healthcare level. Pre-test counselling and post-test counselling are done after informed consent is

obtained. Rapid HIV and rapid plasma reagin (RPR) tests are performed at remote clinics where facilities have been set up (Department of Health 2000:28)

2.6.13 PROVIDING MENTAL HEALTH SERVICES

Mental health services form part of integrated comprehensive primary health care. The service seeks to improve the mental health and social well-being of individuals and the community. Promotion of the mental health of the community is included in clinic- and community-based services (Department of Health 2001:46). Mental health services perform preventive measures. Clients are screened, those with mental illnesses are treated, and defaulters are followed up.

2.7 NATURE OF PRIMARY HEALTHCARE SERVICES

Clinics offer a comprehensive range of preventive, promotive, curative and rehabilitative services but at a less specialised level than community health centres. Clinics are normally open on only weekdays but opening hours can be negotiated with local communities. Where transport and communications are difficult, particularly rural areas, arrangements will be made for a member of staff to sleep the night at the clinic. This member will provide first aid, manage normal deliveries and summon help in case of emergency. Clinics should have water, electricity and communications (ANC 1994a:62).

Clients who need specialised or sophisticated health care are referred to the next level of care at a community health centre or a referral hospital where a medical doctor and specialist facilities are available. Clients with a need for additional health or social services are referred as appropriate. Every clinic is able to arrange transport for an emergency within an hour. Referrals within and outside the clinic are recorded in registers. Merits of referrals should be assessed and discussed as part of the

continuing education of the referring health professional and to improve outcome of referrals (Department of Health 2001:14).

Community nurses work as a team to render comprehensive health care to the community. They collaborate with other members of the multidisciplinary team such as social workers and nutritionists, as well as health-related public sectors such as agriculture as appropriate. Clinic staff also collaborates with health-orientated civic organisations and workers in the catchment area to enhance the promotion of health (Department of Health 2001:14). Teamwork is defined by the WHO as coordinated action that is carried out by two or more individuals jointly, concurrently or sequentially. Teamwork must be seen as a process rather than an end in itself. (Dennil *et al.*1995:106.)

Community participation in healthcare delivery is more than a basic requirement for achieving the optimal health of the community. Interaction between people to achieve specific goals not only gives them the right and opportunity to be involved in decisions that affect their future existence, but also ensures the successful development of the community as a whole (Dennil *et al.* 1995:54). Effective community participation as envisaged in the primary healthcare approach means that democratically elected community structures, integrated with representatives of the different sectors and stakeholders involved in health and community development, have the power to decide on health issues (ANC 1994a:21).

2.8 MANAGEMENT FUNCTIONS OF HEALTH AUTHORITIES

In order to promote equity, the district health authority has to ensure that health services in the district are rendered within the norms, policies and guidelines agreed to at provincial and national levels (ANC 1994a:64).

Management functions of health authorities include management of health care and support services, administration, finance, planning and human resources management. These functions will be discussed briefly.

2.8.1 MANAGEMENT OF HEALTH CARE

Managing health care entails the following:

- Promotion of primary health care and the monitoring, evaluation and planning of services;
- Management and coordination of health promotion activities;
- Management and coordination of all of the following elements of comprehensive health care that are provided by primary healthcare workers:
 - Mental health.
 - Environmental health.
 - Mother and child health.
 - Nutritional services.
 - School health.
 - Oral health.
 - Control of communicable diseases.
 - Control of non-communicable diseases.
 - Care of the elderly.
 - Occupational health.
 - Care of common diseases and injuries.
 - Rehabilitation.

Management functions relating to health care also include:

- Provision of clinical services in community hospitals, clinics and community health centres;
- Provision of accident, emergency and response services; and
- Control of the acquisition, storage, handling and disposal of hazardous substances used by healthcare services in the district.

2.8.2 MANAGEMENT OF SUPPORT SERVICES

- Managing support services entails the procurement, storage, distribution and stock control of pharmaceuticals and medical and laboratory supplies and equipment.

2.8.3 ADMINISTRATION AND FINANCE

These functions include:

- Management and control of the district health budget;
- Procurement of additional local funds for projects; and
- Provision of transport and possibly ambulance services.

2.8.4 PLANNING AND HUMAN RESOURCES MANAGEMENT

Planning and human resources management include:

- Personnel management, *i.e.* management of public sector healthcare employees;
- Coordination of all health workers in the area (including those connected to NGOs or the private sector);
- In-service training of health workers;
- Collection, collation and analysis of relevant health data and forwarding of appropriate data to the provincial authority;
- Planning the provision of health services as part of the development of the district as agreed at the Intersectoral District Development Committee.

(ANC 1994a:64.)

2.8.5 QUALITY CONTROL AT PRIMARY HEALTHCARE SETTINGS

Donabedian (1996) in Knudtson (2000:405) defines quality as a reflection of the values and goals that are current in the medical care system and the larger society of which it is a part. Donabedian identified three categories that should be considered when the quality of health services was evaluated, namely structure, process and outcome (*i.e.* mortality, recovery and patient satisfaction).

The role of healthcare consumers is critical to the development of a service that should provide high quality care. Health consumers should ensure that their needs are met and that the quality of care provided is of acceptable standard. However, healthcare providers also have an important role to play in this regard (Department of Health 1999:14). Quality control is ensured at primary healthcare settings as managers visit clinics to inspect or evaluate their status. The following aspects are evaluated:

- Physical structure.
- Staff structure.
- Management of the clinic.
- Services rendered.
- Community profile.
- Infrastructure. (Department of Health 2001:1.)

Managers identify the needs of a particular area and make recommendations in this regard. A suggestion box is placed in every clinic. Health consumers have the opportunity to make suggestions (complaints, comments or recommendations) in written format and are requested to place them in the suggestion box that is locked. The box is opened only when the clinic committee meets. Suggestions are read and committee members decide on further steps or address problems in cooperation with clinic personnel. Managers of primary health services have decided on an open door policy. This means that they make themselves available for anyone who wants to talk to them. Grievances are addressed and information about health matters is provided.

A bottom-up approach to problem resolution is used to improve the quality of services. Clinic statistics are written monthly, and other reports such as the report on notifiable conditions is written weekly. The statistical report includes statistics about services rendered, total patients seen according to the type of service (e.g. family planning) and activities rendered such as health days. These reports enable management to consider and weigh the workload of each clinic. Consequently, more staff and/or extra equipment can be supplied if needed. Statistical analyses could also show the preferences of consumers for services or the incidence of diseases in a specific area.

Programmes for human resources development are planned and implemented. In-service training enhances the abilities of staff and, ultimately, leads to an improvement in the quality of care. The staff receives training in areas such as the EDL, TB, HIV/AIDS counselling, prevention of mother to child transmission (PMTCT), integrated management of childhood illnesses (IMCI) and management of STIs.

2.9 CLIENT SATISFACTION

2.9.1 DEFINING CLIENT SATISFACTION

Client satisfaction is a multi-dimensional concept that is rooted in human experience. It is judged subjectively by individuals. Client satisfaction results from the client's understanding and acceptance of his or her health status, the actual logistics of care, and the perception that treatment has resulted or will result in improved health (Lindsey *et al.* 1997:31). Client satisfaction is one of several criteria used to measure the quality of health services provided to patients (Knudtson 2000:405).

Research conducted on client satisfaction in nursing dealt with a wide variety of topics, *inter alia* the accessibility of a nurse-managed clinic, older adult satisfaction with primary healthcare services, client satisfaction with advanced practice nurses

and student services, satisfaction experienced by homeless patients, as well as satisfaction with nurse practitioner services in a rural setting and the mobile healthcare system (Bear & Bowers 1998; Bryant & Graham 2002; Hag 1993; Knudtson 2000; Lalloo & Khalfe 1995; Lindsey *et al.*1997; McCabe, MacNee & Anderson 2001; Pulliam 1991).

Satisfied patients are the only reliable means of expanding a public practice. Patients' needs should always be the focus of every interaction. The patient should never doubt the nurse's willingness to be of service or to refer the patient to any other health professional, should it be necessary (Booyens 2000:399). According to the Norms and Standards for Health Clinics (Department of Health 2001:11), each clinic should display the *patients' rights charter* and *patients' responsibilities* at its entrance in languages that are native to the area. The purpose and expected outcome of the patients' rights charter and the complaints procedure are to deal effectively with complaints and to rectify service delivery problems. In doing so, management wish to improve the quality of care, raise awareness of rights and responsibilities, raise expectations and empowerment of users, change attitudes by strengthening the relationship between providers and users, improve the use of services and develop a mechanism of enforcing and measuring the quality of health services (Department of Health 2001:11).

2.9.2 FACTORS INFLUENCING CLIENT SATISFACTION

Client satisfaction is greatly influenced by the accessibility of services. The rural population in South Africa has often been neglected with respect to the delivery of health care. In rural areas, healthcare services were neither available nor accessible to the majority of the population (Lalloo & Khalfe 1995:69).

In primary health care, accessibility is defined as the continuing and organised supply of an equitable level of health care that is within easy reach of all citizens geographically, functionally, financially and culturally (Dreyer *et al.* 2000:132; Strategy

1994:10). According to the policy document for the development of a DHS for South Africa (Department of Health 1995b:69), access refers to the ease with which health services may be utilised. It encompasses geographical access (the distance from facilities), financial access (affordability of services) and social access (e.g. the attitude of health workers). Factors that may influence client satisfaction include geographical accessibility as well as staffing levels and operational activities at primary healthcare centres. Each will be discussed in more detail.

➤ **Geographical accessibility**

Geographical accessibility implies that distances, travelling time and means of transport should be acceptable to the community (Dreyer *et al.* 2000:132; Strategy 1994:10). Physical or geographical accessibility may have different meanings in different countries, e.g. in certain countries it may mean a half-hour drive by oxcart. According to the WHO (1981:27), physical accessibility can be assessed by measuring the proportion of the population within an acceptable distance from the essential service in the different geographical or administration areas (Dreyer *et al.* 2000:157). According to the Norms and Standards for Health Clinics (Department of Health 2001:12), access is measured by the proportion of people living within a radius of 5km from the clinic. Distances that people are prepared to walk appears to be a major factor in the utilisation of services.

According to Lalloo and Khalfe (1995:69), people are not prepared to walk great distances to obtain care, and are less likely to do so for preventive care. Transport costs and the availability of transport are important determinants in the utilisation of medical facilities. Transport costs incurred often far outweigh the cost of the medical service itself (Lalloo & Khalfe 1995:69). According to Vos *et al.* in Lalloo and Khalfe (1995:69), outreach services make it easier for people to attend clinics, and increase coverage. Regionalisation of health services has been defined as bringing some order to the allocation of health resources or service delivery in a geographical area

(Pick 1996:19). Organising health services and arranging for the fair distribution of health resources in a geographical area will improve accessibility of services.

➤ **Staffing levels of primary healthcare services**

To ensure efficient day-to-day management, a district hospital should have adequate staff and facilities. Staffing of rural hospitals has been problematic at all levels of professional health care (Clarke 1998:6). Nurses comprise more than fifty per cent (50%) of health professionals in South Africa and form the backbone of health services. The country's 175 810 nurses give a nurse:population ratio of 43:10 000 (=4.3 nurses for every 1000 people), which is more than twice the ratio recommended by the WHO for developing countries (Pick 1996:18). However, the distribution of nurses is unequal in terms of geographical and racial distribution, and between the private and public sectors. According to Pick (1996:18), South Africa's 2 218 clinics averaged 16 190 people per clinic. The WHO recommended one clinic per 10 000 people.

According to Clarke (1998:6), the consensus solution to the problem of staff shortages seemed to be the offering of incentives that could attract staff to rural areas. The Norms and Standards for Health Clinics in South Africa as set out by the Department of Health (2001:12) stated that:

- Each clinic should have at least one member of staff with a recognised primary healthcare qualification;
- Doctors and other specialists should visit the district hospital periodically, and they should be accessible for consultation, support and referral; and
- Clinic managers should receive training in facilitation skills and primary healthcare management.

➤ **Operational activities at primary healthcare services**

A large section of the South African population does not report for first treatment at a public clinic, but chooses either a public hospital or a private doctor. This is probably due to factors such as the inaccessibility and scarcity of clinics (particularly in rural areas), limited opening hours, and perceptions that standards of care are worse in clinics than in public hospitals (Department of Health 1995b:2).

According to the Norms and Standards for Health Clinics (Department of Health 2001:11), comprehensive, integrated primary healthcare services should be rendered for at least eight hours a day, five days a week. A one-stop approach is used. Services rendered at primary healthcare clinics include family planning, health education, health information, physical health care, counselling, monitoring of children and families in cases of child protection, facilitation of support groups, and home visits (Clendon & White 2000:175).

According to the Department of Health (1997:37), the following services are rendered at clinics in South Africa:

- Personal, promotive and preventive services.
- Curative services for acute minor ailments.
- Maternal and child health services.
- Provision of essential drugs.
- Basic rehabilitation services and physiotherapy.
- Basic oral health services.
- Basic optometry services.
- Mental health services.
- Medical social work services.
- Prevention and control of communicable and non-communicable diseases.
- School and institutional health services.
- Environmental health services such as health-related water and sanitation services.

- Community mental and substance abuse services.
- Community nursing and homecare services.
- Essential accident and emergency services.
- Community geriatric services and care of the elderly.
- Health support services.

2.9.3 MEASURING CLIENT SATISFACTION

Measuring client satisfaction has proven to be extremely difficult. Among the issues identified, critics have cited poor conceptual and operational definitions, variation in how it was measured by different healthcare organisations, poor psychometric properties (including reliability and validity of many inventories purporting to measure it) and data collection difficulties (including sampling and response rates). Critics said that these problems should be solved before customer satisfaction could be considered a useful component in guiding and evaluating a healthcare organisation's quality improvement programme (Olejnik, McKinley, Ellis, Buchanan, Kersey & Clark 1998:30).

The following are examples of measurements of client satisfaction:

- Bear and Bowers (1998:50) from the University of Central Florida used client satisfaction tool (CST) to determine the degree of satisfaction that clients had with primary healthcare services at a newly established senior health clinic.
- Several researchers used questionnaires as an instrument to measure client satisfaction (Hilton, Budgen, Molzahn & Attridge 2001:328; Lalloo & Khalfe 1995:69). Research conducted by Lalloo and Khalfe (1995:69-73) indicated that many of the clients of a mobile healthcare service in the Western Cape in South Africa were farm workers of low socio-economic status. They lived in houses of varying quality and many did not have access to clean water and sanitation. Clients were highly satisfied with the mobile health care provided by the Western Cape Regional Services Council. Some expressed

unhappiness with circumstances such as having to wait outside in bad weather conditions or missing visits to the mobile clinic due to being away from the farm or busy in the field.

- Hilton *et al.* (2001:328) used evaluation methods such as fieldwork, interviews, document analysis, direct observation, critical incident techniques, paradigm case collection, as well as cost benefit and utilisation analyses. Triangulation of methods was used with the intention of strengthening validity and relevance of results.
- The patient satisfaction questionnaire (PSQ) represented the most comprehensive and rigorous patient-satisfaction scale development in medicine. A self-administered survey instrument for use in general popular studies, the PSQ measures attitudes towards the salient characteristics of physician and medical care services. The PSQ items represent the content of characteristics of providers and services (Marsh 1999:51).
- Weiler and Pigg (2000:362) used the client satisfaction survey (CSS) for data collection. This instrument was designed exclusively for the evaluation project. The CSS was developed on the basis of a literature study conducted on client satisfaction in business, medicine and education. Findings confirmed client satisfaction with the Coordinated School Health Programme Office's (CSHPO's) training programmes, technical assistance and staff. Information obtained through the CSS could assist the CSHPO in programme planning and resource allocation.
- The University of North Dakota Nursing Centre used a modified version of the consumer satisfaction survey compiled by the Group Health Association of America - GHAA (Lindsey *et al.* 1997:32). Results indicated overwhelming satisfaction with all aspects of care provided by students.
- In a study done by McCabe, MacNee and Anderson (2001:80), phenomenological face-to-face in-depth interviews were conducted with

homeless individuals. The semi-structured interview constituted the primary data source. An interview protocol served as a guide to illuminate the meaning of four broad dimensions that assisted in structuring the interview. The four areas discussed with participants were experiences of being homeless, the experience of what health is, experience of satisfaction with care and experience of dissatisfaction with care.

- Among other things, the Nurse Practitioner Satisfaction Instrument (NPSI) is used to measure client satisfaction. The NPSI evaluates patient satisfaction with nurse practitioner services and objectively examines the quality of services (Knudtson 2000:408).

2.9.4 IMPROVING CLIENT SATISFACTION

Satisfied clients are a health institution's best advertisement. *The following measures will improve client satisfaction:*

- Good cooperation between medical and nursing staff;
- Examining patients as soon as possible after arrival;
- Arranging for requested tests without delay;
- Executing prescriptions accurately and promptly;
- Effective record-keeping;
- Seeing to it that the environment is clean and aesthetically pleasing; and
- Seeing to it that the staff is friendly and helpful (Booyens 2000:199).

The White Paper on the Transformation of Public Service Delivery introduces a fresh approach to public service delivery. This approach puts pressure on systems, procedures, attitudes and behaviour within the public services, and reorientates them in the customer's favour (Department of Public Service and Administration 1997:6). It is appropriately named 'Batho Pele' (a Sesotho adage meaning 'people first'). Access to decent public services is the rightful expectation of citizens, especially those previously disadvantaged. Communities are encouraged to participate in the planning

of services. It is believed that participation will improve and optimise service delivery for the benefit of the people who should 'come first' (Department of Health 2001:10).

2.10 BATHO PELE PRINCIPLES

According to the White Paper on the Transformation of Public Service Delivery (Department of Public Service and Administration 1997:8), the Batho Pele approach is based on the following eight principles: consultation, service standards, access, courtesy, information, openness and transparency, redress, and value for money. Each principle will be discussed briefly.

- **Consultation**

Citizens should be consulted about the level and quality of public services and, where possible, be given the opportunity to choose between services.

- **Service standards**

Citizens should be informed about the level, quality and availability of services.

- **Access**

All citizens should have equal access to public services that they are entitled to receive.

- **Courtesy**

Citizens should be treated with courtesy and consideration.

Courtesy includes aspects such as:

- Greeting and addressing customers.
- Staff identifying themselves when dealing with customers.
- The style and tone of written communication.
- Simplified and user-friendly forms.
- A speedy response to enquiries.
- Proper conduct during interviews.
- Complaints procedures.
- Dealing with people who have special needs such as the elderly or the infirm.
- Gender and language sensitivity.

(Department of Health 1997:11.)

- **Information**

Citizens should receive complete and accurate information about services provided by the public sector.

- **Openness and transparency**

Information about management, projects and financing of national and provincial departments should be made available to the public.

- **Redress**

If services are not delivered or not up to standard, citizens should be offered an apology, a full explanation, and a speedy and effective remedy, and when complaints are made, citizens should receive a sympathetic, positive response.

- **Value for money**

Public services should be delivered economically and efficiently in order to give citizens the best possible value for money. Community perception of health services is tested at least twice a year through patient interviews or structured questionnaires (Department of Health 2001:12).

2.11 PATIENTS' RIGHTS CHARTER

The purpose and expected outcome of the patients' rights charter and complaints procedure are to deal effectively with complaints and to rectify service delivery problems. The effective implementation of the patients' rights charter and the complaints procedure will lead to improvement in the quality of care, raise awareness of rights and responsibilities, raise expectations, change attitudes by strengthening the relationship between provider and user and improve the use of services. These are mechanisms for enforcing and measuring the quality of health services (Department of Health 2001:11).

According to the patients' rights charter, every patient has the right to:

- A healthy and safe environment;
- Access to health care;
- Confidentiality and privacy;
- Informed consent;
- Be referred for a second opinion;
- Exercise choice in health care;
- Continuity of care;
- Participate in decision-making that could affect his/her health;
- Be treated by healthcare providers that identified themselves;
- Refuse treatment;

- Be fully informed about his/her health insurance/medical aid scheme policies; and to
- Complain about health services.

The patients' rights charter is published in all the official languages of South Africa and should be prominently displayed at each clinic.

2.12 CONCLUSION

From the literature review, it is evident that accessibility of primary healthcare services is significantly influenced by physical, geographical, socio-cultural, financial, legal, managerial and personal factors. Accessibility is directly related to the level of client satisfaction. Various ways to measure client satisfaction have been discussed.