

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter presents an overview of the research and research findings. Conclusions and recommendations with regard to accessibility of primary healthcare services are presented.

5.2 RESEARCH DESIGN AND METHODOLOGY

A non-experimental, quantitative, descriptive survey was conducted to address the research problem.

The research problem was stated as follows:

- In terms of functional, geographical, financial and cultural accessibility, clients in the Molemole municipality area seemed to experience difficulty in accessing primary healthcare services.

The specific objectives of this study were to:

- Assess the accessibility of primary health care in the Molemole municipality with regard to geographical, financial, functional and cultural aspects; and to
- Identify factors that influenced the accessibility of primary healthcare services in Molemole municipality.

Data were collected mainly by means of a structured questionnaire completed by respondents. In some instances, respondents needed the assistance of the researcher and data were then obtained by means of a structured interview based on the questionnaire. Data were also gathered through information lists completed by the researcher, document analysis (e.g. the analysis of maps) and observational field notes taken by the researcher during her visits to Molemole municipality.

5.3 SUMMARY OF RESEARCH FINDINGS

Research findings are summarised and presented within the framework of the research objectives. The aim of the research was to determine the accessibility of primary healthcare services in Molemole municipality and to identify factors that impeded accessibility.

5.3.1 ACCESSIBILITY OF PRIMARY HEALTH CARE

Findings are categorised according to the geographical, financial, functional and cultural accessibility of primary health care in Molemole municipality.

➤ GEOGRAPHICAL ACCESSIBILITY

- The factor that impacted most negatively on geographical accessibility of primary health care was the distance between the client's place of residence and the clinic.
- The majority of the respondents (68.7%) had to travel for less than an hour, while nineteen respondents (14.2%) had to travel for more than two hours to reach the clinic. According to the WHO, the norm for geographical accessibility in terms of distance is 5km, *i.e.* the clinic should be within a radius of 5km from the community it is serving (Department of Health 2001:12). One hundred and eighteen (118)

respondents (88,1%) had to walk to the clinic, and forty (40) respondents (29.9%) walked for more than an hour to the nearest clinic. Reasons for this time lapse were the distance between the client's place of residence and the clinic, and elderly or ill patients who walked slowly.

- Geographical accessibility was also adversely affected by the non-appearance of the mobile clinic at service points. Clients at these service points would walk long distances to the nearest clinic or the district hospital, and some had to take taxis for this purpose.

➤ **FINANCIAL ACCESSIBILITY**

- In 1996, primary healthcare services became free of charge for everyone. This policy was reflected in the responses of the sample population. For the client, the only expenses relating to health care were transport costs. One hundred and twenty-two (122) respondents (91%) indicated that they did not pay any amount for primary health care while twelve respondents (9%) paid up to R10 for transport. (Refer to Figure 4.6).
- Primary health care in Molemole municipality seemed to be financially accessible. However, the researcher observed that some of the clients who had to pay for transport to a clinic were resident close to service points that were not visited by the mobile clinic. In another instance, the client had to visit another clinic as the local clinic was closed for the weekend. Suggestions made by respondents to increase the reliability and frequency of mobile clinic service points should therefore be taken seriously, and be further explored.

➤ **FUNCTIONAL ACCESSIBILITY**

- o The main causes for dissatisfaction regarding functional accessibility were related to clinics that were not operational during weekends, the unreliability of the mobile clinic visiting service points and the fact that community members were not involved in decision-making about opening hours and other health matters. Staff shortages further contributed to a perception of health services being inaccessible. The majority of respondents seemed to be satisfied with the outcomes of their visits to the clinics.
- o The researcher identified a need for 24-hour emergency services in the area.

➤ **CULTURAL ACCESSIBILITY**

- o Although inaccessibility (unacceptability) of primary health care within a cultural framework did not seem to be a major problem in the Molemole municipal area, it was evident that many respondents (28%) would prefer services rendered by traditional healers.
- o Practices around family planning, the use of condoms, and stigmatised diseases such as STIs and HIV/AIDS seemed to be culturally sensitive issues. Close collaboration between clinic staff and traditional healers could be beneficial for all role players.

With regard to the first objective of the study, it was found that primary healthcare services were mainly accessible to the majority of respondents.

Accessibility could be improved if the following areas received attention:

- Unreliability of visits of the mobile clinic to service points;
- Strategies to provide 24-hour emergency care;
- More effective strategies to involve the community in decision-making on health matters; and
- Strategies to improve collaboration between traditional healers and health workers.

5.3.2 FACTORS THAT INFLUENCED ACCESSIBILITY OF PRIMARY HEALTH CARE

Factors that influenced accessibility of primary health care in the Molemole municipal area corresponded largely with those identified in the literature study. The main factors that impacted on primary healthcare delivery were related to the nature of services, staff allocation and staffing levels of clinics.

5.3.2.1 NATURE OF SERVICES

- *Organisation of the clinic*

Clinics should be organised and managed optimally in order to provide high quality primary health care and to meet the health needs in a community. That was not the case in Molemole.

Staff in Clinic A was still adjusting to the new clinic. Consulting rooms were sufficient, but the maternity room was also used as a consulting room. Clients were not used to the new clinic. An advisor paying particular attention to client relationships and orientation would have been helpful. Clinic D was temporarily operating in community

offices, with only one consulting room at nurses' disposal. Clinic E, the mobile clinic, was not operating according to schedule. Attendance of workshops and meetings was given priority over the needs of clients. The researcher experienced the mobile services as unreliable and fickle. When she tried to make an appointment with the staff of the mobile clinic, she experienced a perceived unwillingness and uncertainty as to whether they would be visiting the service point. The researcher therefore visited service points unaccompanied to obtain information from clients. (Refer to par. 4.3.1.)

- *Communication*

Communication between clinics and the district hospital was not perceived as a problem, as most of the clinics had telephones. Clinic C was the exception. Staff at this clinic had to use a public cardphone at the expense of staff to communicate with other clinics or the district hospital.

- *Types of services delivered*

Primary healthcare clinics in Molemole municipality did not offer the full range of primary healthcare services. Most clients were however satisfied that their health needs were met by the clinic. Emergency care seemed to be an urgent need.

- *Relationship between nurses and clients*

According to the White Paper on the Transformation of Public Service Delivery, ensuring courtesy was one of the principles of Batho Pele. (Refer to par. 2.10.)

Figure 4.10 illustrated the relationship between nurses and clients in Molemole municipality. One hundred and twenty-six (126) respondents (94%) indicated that the relationship between clients and nurses was acceptable, whereas eight respondents (6%) considered the relationship unacceptable.

- *Supplies*

The availability of supplies was assessed by the researcher and the clinic staff. (Refer to par. 4.3.3.) The EDL was used as an assessment tool. Most clinics had sufficient medication. In Clinic C, medicines were in short supply, apparently due to problems regarding the delivery of supplies by the hospital pharmacy and a lack of good stock control. Six respondents (27,3%) were dissatisfied because they did not receive proper treatment.

- *Referral system*

According to the patients' rights charter (par. 2.11), every patient has the right to be referred for a second opinion (Department of Health 2001:11). Clinics in rural areas refer clients to a district hospital if more specialised knowledge, equipment or facilities are necessary to diagnose or treat patients. (Refer to par. 4.3.5.) In the Molemole municipality, an ambulance from the district hospital was called in cases of emergency to transfer patients from clinics to the hospital. In all other instances, patients had to use own transport. The unacceptable situation at Clinic C, where nurses had to cope without an official communication system, has already been pointed out.

5.3.2.2 STAFF ALLOCATION AND STAFFING LEVELS

The availability of staff is directly related to clients' perceptions of accessibility of services. Thirty-two (32) respondents (21.5%) suggested that clinics should improve accessibility of services by appointing more nursing personnel. (Refer to par. 4.3.6.)

Table 4.2 illustrated the gaps in staff establishments. The number of positions filled with appropriately qualified staff determines to a large extent the nature of services provided and the operational hours. Regarding Clinic B, the lack of accommodation for nurses was identified as a limiting factor for service delivery. The number of

clients served by each clinic should be taken into account when staff are allocated to specific clinics. With regard to the mobile clinic, it is suggested that a balance between committed service delivery, human resources development and administrative procedures be promoted.

Staff at the clinics and supervisors (who visited clinics weekly) form a support structure for nurses working at clinics. The clinic staff meet once a month to air their views and to consult with the supervisor. Community health committees could also provide a forum for communication and support. (Refer to par. 2.2.4.)

5.3.3 CLIENT SATISFACTION

The level of client satisfaction in the Molemole municipality regarding primary health care was high as one hundred and seven (107) respondents (84.3%) expressed their satisfaction with services they received. Clients' reasons for being satisfied or dissatisfied were presented in Table 4.6 and Table 4.7 respectively. Client dissatisfaction related mainly to the attitude of staff, unavailability of treatment and unreliability of mobile services. These aspects as well as clinic facilities, distance to the clinic, health needs, the nature of available services and opening hours were the main factors that impacted on accessibility of primary health care. These findings relate to the second objective of this study.

5.4 RECOMMENDATIONS

Access to decent public services is the rightful expectation of all citizens, especially those previously disadvantaged. Communities are encouraged to participate in planning of services to improve and optimise service delivery for the benefit of the people (Department of Health 2001:10).

The following recommendations are based on research findings discussed in the previous section (par.5.3).

5.4.1 ACCESSIBILITY OF PRIMARY HEALTH CARE

➤ **Geographical accessibility**

There is a need for the expansion of primary health care in villages such as Sekonye, Sekakene, Ga-Phasha and Soekmekaar because people from these areas travel long distances to visit clinics. If mobile clinics are used, service points should be visited strictly according to scheduled times and places.

➤ **Functional accessibility**

Operational times should be negotiated with community health committees, and the necessary facilities should be created for the provision of efficient emergency care services. Strategies such as establishing emergency care committees in the community or compensating nurses to extend their normal services to being on call for emergencies after hours, could be considered.

➤ **Cultural accessibility**

Improved collaboration between traditional healers and clinic staff is highly recommended. Regular discussions should be promoted, with inputs by important role players such as traditional healers, clinic staff, community leaders, and others.

5.4.2 COMMUNICATION

Efficient communication systems in all primary healthcare facilities are important for effective service delivery. In mobile clinics or in areas where renting of telephone lines is not feasible, one or more cellular phones could be made available for official use. The use of these phones should be controlled to avoid abuse.

5.4.3 RELATIONSHIP BETWEEN NURSES AND CLIENTS

The Batho Pele principles and the patients' rights charter should be displayed in all clinics, and the clinic staff should be encouraged to adhere to them at all times. In-

service training and the implementation of strategies to encourage open and transparent communication between staff and communities should be promoted.

5.4.4 SUPPLIES

Careful and accurate stock control should be implemented and audited by supervisors. Planning and ordering equipment and supplies in accordance to community needs should be encouraged.

5.4.5 REFERRAL SYSTEM

The improvement of referral systems between clinics and hospitals is recommended. Regular in-service training of clinic staff regarding health assessment protocols and appropriate treatment would result in the decline of unnecessary referrals. Effective communication with specialists at the district hospital will not only provide the necessary professional support to nurses in rural areas but also contribute towards improved primary health care.

5.4.6 STAFF ALLOCATION AND STAFFING OF CLINICS

Staff structures should be based on community numbers and health needs. Effective management of human resources by supervisors will form the basis of cost-effective primary health care by competent staff members. Attention should be given to the attitude of staff towards clients. Batho Pele principles should receive high priority.

5.4.7 FURTHER RESEARCH

Based on findings of this study, further research can be conducted to explore:

- Nurse/client relationship in primary healthcare services and strategies to improve this relationship;
- Cultural accessibility of primary healthcare services in a multicultural health environment.

5.5 SIGNIFICANCE OF THE STUDY

The study has highlighted some of the problems with regard to accessibility of primary healthcare services in the Molemole municipal area. The implementation of recommendations could contribute towards addressing these problems and would result in a more acceptable, equitable, accessible health service.

5.6 LIMITATIONS OF THE STUDY

According to Burns and Grove (1993:46), limitations of the study are restrictions that may decrease the generalisability of findings.

- It is acknowledged that some of the respondents might have experienced an uneasiness to communicate their true feelings to a person with whom they had no trust relationship.
- It is further acknowledged that the research findings are relevant to only the Molemole area and cannot be generalised to health services in other areas.

5.7 CONCLUSION

This non-experimental, descriptive survey aimed to describe client satisfaction with regard to accessibility of primary healthcare services in Molemole municipality. The study population included one hundred and thirty-four (134) adult clients (male and female) that were serviced by clinics of the Molemole municipality of Limpopo Province. Questionnaires, information lists, field notes, observation and document analysis were used as research instruments. Data analysis was conducted by means of descriptive statistics.

Study findings indicated that primary healthcare services were accessible to the majority of respondents. Primary healthcare services were provided free of charge as

stipulated by government policy. The majority of respondents also indicated that they were satisfied with service delivery. However, findings also indicated that the whole range of primary healthcare services was not provided by clinics, that operational hours were inconvenient and that some clinics lacked necessities such as running water and telephones.

Other factors that impeded accessibility of primary healthcare were staff shortages, the attitude of health workers, the lack of emergency care services, the unreliability of mobile services and the unavailability of medication.

The researcher recommended involvement of the community in decision-making regarding health matters, improved collaboration between traditional healers and clinic staff, especially with regard to the cultural accessibility of health care, the establishment of emergency care committees and the implementation of effective healthcare strategies.

Suggestions for further research included assessment of accessibility of primary health care in a multicultural environment.

In conclusion, primary healthcare services were accessible in the Molemole municipality in Limpopo Province and the majority of clients were satisfied with services rendered. However, factors that impeded accessibility should be addressed.