EXPERIENCES OF FACILITY MANAGERS REGARDING PATIENTS' LONG WAITING TIME AT TSHWANE HEALTH DISTRICT COMMUNITY HEALTH CENTRES

by

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D E C L A R A T I O N

I declare that **EXPERIENCES OF FACILITY MANAGERS REGARDING PATIENTS' LONG WAITING TIME AT TSHWANE HEALTH DISTRICT COMMUNITY HEALTH CENTRES** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

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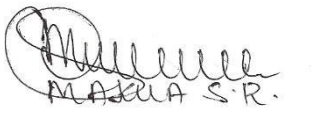

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Finalising this study coincided with the advent of Corona Virus Disease-19 (COVID-19) pandemic. Wrapping up whilst waging the war against COVID-19 was therefore never facile. Several ill-health setbacks compounded this academic journey further. It is thus befitting to convey my very heartfelt appreciation to the Omnipotent and Omnipresent God, whose Mercy and Grace saw me through this challenging academic expedition. It is additionally apt to recognise the following distinguished persons and entities:

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ABSTRACT

Excessive waiting is an annoyance to patients and other health care users. Lengthy waiting remains a noticeable incumber in Community Health Centres, therefore a thorny public health concern. The purpose of this study was to explore and describe experiences of facility managers regarding patients' long waiting time at Tshwane health district Community Health Centres. A qualitative, explorative, and descriptive research design was conducted. Non-probable, purposive sampling technique tailed the design to access a sample of eight Community Health Centre facility managers in Tshwane health district. Data analysis followed Tesch's eight-step method. Data collection employed in-depth interviews to elicit rich data from participants. Findings revealed negative and positive experiences, contributory factors and pertinent recommendations.

Informed by these encounters, recommendations amongst others underscored overhauling the entire records management systems, prioritising vacancy-filling and consistent provision of relevant and functional equipment.

KEY CONCEPTS: Community Health Centre, experience, facility manager, long, patient, waiting time.

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ABBREVIATIONS

CHC	:	Community Health Centre
CCMDD	:	Centralised Chronic Medicines Dispensing and Distribution
ICSM	:	Integrated Clinical Services Management
PHC	:	Primary Health Care
PSC	:	Public Service Commission
UNISA	:	University of South Africa
WHO	:	World Health Organization

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

It is derived from South Africa (2015b:7) that patients' waiting time is a period that a patient spends waiting for services in a facility per visit. This characterisation of what waiting time is, captures the essence that a request for service needs to be activated by physically presenting in a health care facility. The exercise of waiting will then begin depending on the dynamics at play, such as number of patients already in a facility, available capacity as well as essential resources to render services at the time such a request is made.

Tran, Nguyen, Nong and Tran (2017:3) provided additional scholarly account by mentioning that waiting time is the duration of stay endured by patients before meeting and engaging with health care workers or even just accessing health services needed during a visit. In cases where patients are escorted by relatives, friends or any other, they too will be subjected to the trend of waiting.

The submission by Daniels (2015:8) illustrated that waiting time forms an integral part of essential elements that determine and influence satisfaction levels of patients and other health care users alike. This stance has been supported by Ahmad, Khairatul and Farnaza's study (2017:14) whose citation highlighted that waiting time is not just a determinant of patients' fulfilment, but one performance measure that serves as a yard-stick in respect of organisational efficiency, competency and adeptness in health care institutions. The World Health Organization (WHO) (2018a:2) asserted that access to health care is a globally recognised fundamental human right. This declaration infers that the primary purpose of a health care system is to render exceptional patient care and services across the spectrum of different health establishments. In ensuring that the level of care meets or even surpasses patients' needs and expectations, WHO (2018a:2) places the responsibility on governments to ensure that quality and essential health services are available and accessible to patients.

In introducing the subject of long waiting times, Motloba, Ncube, Makwakwa and Machete (2018:400) stressed that patients' long waiting time presents as a threat in accessing healthcare services with adverse impression on quality of care provided. Motloba et al (2018:400) expounded further that this universal legitimate mission should not only be about just providing care but be expeditiously dispensed such that it expresses commitment to reduce patients' long waiting time. The investigator is accordingly inclined to mention that the need to discharge these services promptly should as far as it is possible and practical, be a demonstration that waiting time is not an impediment to accessing quality health care services.

In drawing our attention to the unappealing effects of patients' long waiting time, Van Rensburg-Bonthuyzen (2016:5) mentioned that patients' long waiting time is a hindrance responsible for participants' non-adherence to therapies, and therefore needs attention. Concurrence in this regard by Frost, Jenkins and Emmink (2017:3) highlighted that prolonged patients' waiting time leads to frustrations which influenced dishonouring of appointments in the main.

Egbujie, Grimwood, Mothibi-Wabafor, Fatti, Tshabalala, Vilakazi and Oyebanji (2018:311) made additional observation that the South African public health system is characterised by health care establishments that are confronted by immense pressure due to high demand for health care services and quadruple burden of disease. Understaffing and limited resources further exacerbate these facilities' impasses. High volumes of patients and diminishing operational capacities in clinics and Community Health Centres (CHCs) result in prolonged queues with subsequent long waiting times. Hunter, Asmall, Ravhengani, Chandran, Tucker and Mokgalagadi (2017:112), elaborate further to say regardless of some achievements in improving health care users' experience of care, many Primary Health Care (PHC) facilities in South Africa still battle long waiting times. As cited in Hunter et al (2017:112), the researcher observed that whilst waiting time is considered a measurable qualitative parameter to determine efficiency of services rendered, more than it is expected, patients are still compelled to wait longer in most clinics and CHCs.

According to Hunter et al (2017:112), this situation has led to perpetual negative experiences of care, thus compromising the important role that PHC services play in health promotion and disease prevention. The problem of long waiting time in healthcare institutions has been unequivocally ranked a top concern by patients, ahead of staff problems, communication, behaviour and attitude (Matsoso, Fryatt & Andrews 2015:107). Since long patients' waiting time threaten access to healthcare and impact undesirably on the quality of care provided, this makes long patients' waiting time a progressive public concern as it is most unlikely to expect anyone to embrace and endorse extensive waiting.

1.2 BACKGROUND INFORMATION ABOUT THE RESEARCH PROBLEM

Patients' waiting time as provided for by the National Department of Health in its draft guideline for management of patient waiting times is defined as time interval for which one has to wait after placing a request for a service and before such service is actually provided (South Africa 2019:4). This account of patients' waiting time infers that patients' health care needs compel them to present in a health care facility with the intent of requesting services. The expectation in return, is to receive the very services expeditiously. Although patients' waiting time has been described as an important indicator in determining quality and efficiency of patient care, long waiting time has been observed to be a challenge at PHC settings in many countries (Siciliani, Borowitz & Moran 2017:134).

In the United States of America, the average patient waiting time ranged from 60 to 188-minutes (Tran et al 2017:3), whilst in Ethiopia, 5% of the patients waited for more than 5-hours (Tegabu 2009:45). In addition, Umar, Oche and Umar (2011:79) in Nigeria, made the observation that patients who waited for about 60-minutes or longer expressed dissatisfaction with services rendered in the Out-patient Department. Comparative citation in Umar et al (2011:79) states that patients are least satisfied when the duration of waiting is longer than expected. These patients are rather fairly gratified when waiting times are perceived to be within expectations and highly content when waiting times are less than expected. This is a demonstration of the strain brought on by what is considered indefinite waiting.

In a Mozambican study, it is stated that patients queued for over one hour for registration, 180-minutes for outpatient consultation, and approximately 120-minutes for first antenatal care visits (Wagenaar, Gimbel, Hoek, Pfeiffer, Michel, Cuembelo, Quembo, Afonso, Gloyd, Lambdin, Micek, Porthe & Sherr 2016:4). These discoveries make it apparent that patients' waiting time varies from country to country and different settings. It is a further indication that long waiting time has adverse outcomes on patients. It is consequently evident that health care workers are not spared, but equally affected by this socially uncomfortable phenomenon.

Moreover, literature by Ansell, Crispo, Simard, and Bjerre (2017:2) alludes to the fact that waiting times in healthcare system of Canada are a growing concern for the Canadian population. According to Ansell et al (2017:2), the burden of sick adult population which is standing at 23% in Canada, reported waiting for over six days for primary care appointments as compared to only 2% and 5% for both Switzerland and New Zealand respectively. According to Almomani and AlSarheed (2016:734) and Al-Matar (2017:14), patients opted to postpone seeking help than wait longer, with much potential to present later with health complications. Furthermore, Ansell et al (2017:1), associated treatment defaulting with longer waiting times, thus leaving patients to rely on unnecessary urgent care interventions. Lehohla (2013:12) and Egbujie et al (2018:318) also stipulated that patients skipped appointments and moved from clinic to clinic in search of any with a shorter waiting time.

Several factors have been attributed to patients' long waiting time. Aguilera, Infante, Orme and Urriola, (2015:31) as well as Ahmad et al (2017:19) emphasised that prolonged patients' waiting time resulted from shortage of both human and non-human resources. Moreover, Viberg, Forsberg, Borowitz and Molin (2013:53) indicated that complex processes such as patients' registrations also prolong patient's waiting time in clinics and CHCs. Additionally, lack of impactful policy direction has been linked to prolonged patients' waiting time (Siciliani et al 2013:134). It is imperative to explore the experiences of facility managers regarding patient long waiting time at Tshwane health district CHCs.

The National Department of Health (2015b:7) and Hasumi and Jacobsen (2014:484) submit that South Africa is equally affected by patients' long waiting times, whereby they have to queue very early at most of public health facilities. According to Peltzer (2009:2), public hospitals and CHCs accounted for 41.5% and 38.1% respectively of patients' dissatisfaction regarding long waiting times. In this regard, Visser, Bhana and Monticelli (2012:8) recommended that patients' waiting time needed robust attention from policy makers.

Most studies done in South Africa, focused on patients' perspectives regarding long waiting times. Munyaka, Senekal, Phaswana-Mafuya and Davids (2010:14), McIntyre and Ataguba (2014:14); Nunu and Munyewende's study (2017:6) revealed that patients expressed displeasure regarding long waiting times. In this regard, the National Department of Health (2015b:8) stipulated maximum waiting time of 120-minutes for PHC facilities. Furthermore, the ideal clinic realisation model was conceived as a strategy to amongst others, combat long patients' waiting time (National Department of Health 2015b:3). However, Hunter et al (2017:112); Egbujie et al, (2018:318) revealed that as much as the ideal clinic realisation model has yielded some affirming outcomes, many health care facilities still battled long patients' waiting times. It is necessary to get experiences of facility managers regarding long patients' waiting time at Tshwane health district CHCs.

Tshwane health district is one of the 5 (five) districts that make up Gauteng Province of South Africa. This district is similarly affected by patients' long waiting time. It is a region made up of 08 (eight) CHCs. According to the 2018 electronic version of the District Health Information System (South Africa 2018a), these facilities serve an estimated uninsured population of 941 108 per annum. Evaluation of performance of these entities on waiting times for the financial years 2015/16, 2016/17 and 2017/18 demonstrated some difficulties to impact favourably on waiting time (Gauteng Department of Health: 2018). Table 1.1 summarises these trends:

TABLE 1.1: 2015/16 TO 2017/18 WAITING TIME AND COMPLAINTS REFLECTION			
WAITING TIME PERFORMANCE (TARGET = <120-MINUTES)		**COMPLAINTS CASES ON WAITING TIME**	
2015/16	168-minutes	***2015/16***	*50 Cases*
2016/17	200-minutes	***2016/17***	52 Cases
2017/18	209-minutes	***2017/18***	60 Cases

(Gauteng Department of Health:2018).

As provided for by South Africa (2015b:8), patients are expected to await services for 120-minutes at the most. Table 1.1 illustrates that as at the end of the 2015/16 financial year, patients waited an average of 48-minutes, whilst in the 2016/17 fiscus, additional waiting was 80-minutes longer. Excess waiting rose to a further 89-minutes by the end of the 2017/18 period.

Complaints on patients' long waiting times are further used as proxy measures of how health care facilities are responding to the phenomenon. A complaint is defined as expression of displeasure over dissatisfaction regarding services or goods received (National Department of Health 2017b:4). There are specifically no targets in respect of number of complaints a health facility should expect or receive. Ideally and contextually, the supposition is that there should actually be zero complaints. However, as and when these complaints are lodged, they mirror patients' displeasure over health care priority concerns. The CHCs registered 50 complaints in the 2015/16 financial year which subsequently increased to 52 in 2016/17 and 60 for 2017/18 financial years.

The gradual increase in the number of complaints on patients' long waiting time necessitates interventions. Root causes of quotidian complaints, such as long waiting time, need permanent resolve. Left unattended, their perpetual resurfacing and the need to instantly resolve them when they arise, will continue to gnaw into facility managers and nurses' valuable patient care time. The researcher is of the view that the experience of long waiting time is extremely distressing in itself. It leads to agitation and unnecessary confrontations, thus becoming a major source of discontentment, resulting in complaints and grievances.

Once these issues surface, they manifest as operational inefficiencies. In such instances, patients' confidence in CHCs' ability to manage long waiting time becomes eroded. The moment confidence levels diminish, reputational good standing of CHCs gets tarnished. Eventually, lustrous appeal to consult in future at these facilities becomes eroded.

Prolonged waiting may adversely affect patients' employment circumstances. The current socio-economic climate in South Africa is characteristically fragile. As it is, actively employed persons try their best to preserve whatever employment opportunity they have. Moreover, whilst subjected to long waiting time, patients' condition may deteriorate and result in unpleasant complications. The peril of these complications if not addressed, could eventually lead to very costly litigations for the very department owing to CHC facility managers' shortcomings to impact favourably on patients' long waiting time.

In addition, the likelihood of patients defaulting on their appointments owing to discouraging long queues cannot, therefore, be ruled out. This is the effect pointing to the assertion that "no one likes to wait." These consequences manifest as grounds for concern demanding of facility managers to demonstrate appetite to reverse them. As expressed by Egbujie et al (2018:318), waiting time as a significant performance indicator informs the extent of competency, capacity, efficiency and importantly, quality of health care provided to patients by health care entities. Responsibility is particularly placed on CHC facility managers to exercise accountability in safeguarding that patients are relaxed and at ease with waiting time. Facilitating processes directed at achieving reasonable and tolerable waiting time, will be indicative of a CHC that is well-organised, better managed and responsive to the waiting time phenomenon.

It needs to be noted that the main goal of clinics and CHCs is to provide quality health care and services timeously, such that the speed and pace are generally acceptable to patients, adds Motloba et al (2018:400). However, Daniels (2015:11) pronounced that despite great innovations and investments in health systems, dissatisfaction with related quality and expediency remains a major issue of discontentment for patients.

As alluded by Swart, Muller and Rabie (2018:3) and Naiker, FitzGerald, Dulhunty and Roseman (2018:287), extreme waiting time may potentially be a symptom of operational and managerial inefficiencies in a CHC.

It thus becomes the responsibility of facility managers in charge of these CHCs to alleviate long patients' waiting time. Naiker et al (2018:288) recommend managerial competencies that should portray and demand management skills. This requires of CHC facility managers to plan and allocate resources to meet day to day patients' expectations including paying courteous attention to demands of the very busy days.

Furthermore, queue management efforts should reflect active monitoring of areas in a CHC that are perpetually prone to congestions, thus causing delays. Patients whose visit to the CHC does not warrant extensive engagement with health care providers should be cleared by prioritising them. Additional expectation is that CHC facility managers need to similarly exercise oversight over existing staff's proficiencies. In seeking to achieve this expectation, multi-skilling and capacitating health care providers should take precedence. Eventually, clinical staff need to emerge equipped and competent to provide comprehensive package of integrated services in just a single consultation. By so aspiring, hopping from one room to the other for fragmented package of services will be averted. In all of the administrative strides, Naiker et al (2018:288) concluded that a health facility manager is duty-bound to provide overall leadership to staff and patients alike with emphasis on "walking the plant" to get the gist and first impression of patient flow in a CHC. Where there are bottlenecks, primacy should be to trouble-shoot any such hold-ups as prompt as it can be.

To this end, literature as cited in this study's background is testament that most scholarly scrutiny into long waiting time focused primarily on patients. The assertion is that little has been studied pertaining to experiences of the managers regarding patients' long waiting time. This information gap is deemed important to necessitate zooming the lens on facility managers' experiences regarding patients' long waiting times at Tshwane health district CHCs. These CHC facility managers make an ideal target in this study as they are the administrative custodians solely responsible for discharging quality patient care.

1.3 STATEMENT OF THE RESEARCH PROBLEM

Albeit existing strategies to alleviate prolonged waiting times, CHCs demonstrated an increase in respect of actual waited times. The researcher observed that patients' long waiting times at Tshwane health district CHCs still exceed set target of less than 120-minutes (Gauteng Department of Health:2018). Waiting time at these CHCs rose from an average of 168-minutes during 2015/16 fiscal year to 209-minutes at the end of 2017/18 financial year. That accounted for an increase in waiting times of 89-minutes.

In addition, volume of complaints is another performance indicator pointing to system inefficiencies. Number of complaints relating to long waiting times in the same period rose from fifty to sixty (Gauteng Department of Health:2018). Long waiting time incites impatience, resulting in agitation and confrontations whilst in the queues. The wrath of long waiting time in CHCs compels patients to wake up very early to book queues. In certain instances, patients opt to rather incur additional travelling costs, opting to by-pass facilities known for lengthy waiting in favour of those where waiting time is tolerable. Defaulting on their appointments is common too, pushing patients to present in CHCs when their overall health is already complicated. The latter is an undesired and unwanted adverse outcome for any health care system, especially if it is on account of extended patient waiting time.

Not only are patients affected. Due to rise in complaints pertaining to patients' long waiting time, health care providers feel unappreciated, leading to low staff morale. Investigating and redressing long waiting time-related complaints implies abandoning very significant administrative chores. Studies on long waiting time as contextualised in the background, rivetted rather on patients' experiences and perceptions as opposed to facility managers' encounters. The assertion is thus that little has been studied on experiences of CHC facility managers regarding patient' long waiting time. This information gap is considered significant, as these managers, local guardians of health care services, are responsible for ensuring delivery of timeous and quality patient care.

1.4 AIMS / PURPOSE OF THE STUDY

1.4.1 Research aim/purpose

Brink and van Rensburg (2018:50) impart that research purpose is generated from the problem; with identification of the specific aim and goal, thus giving reason for a study. Sentimental expression by Tonon (2015:6) is that purpose in qualitative research entrenches on seeking to understand participants' meaning in studying events and life situations in which they are involved. Polgar and Thomas (2013:31) confirm that it is the purpose of research that will have most influence on use of certain methods of data collection and analysis. The purpose of this exploratory, descriptive, and contextual study was to explore and describe experiences of facility managers regarding patients' long waiting time at Tshwane health district CHCs in a qualitative paradigm.

1.4.2 Research objectives

It is learnt from Creswell (2014:185) that objectives are the very specific goals, which the study intends to explore and achieve. Pertaining to this study, the specific objectives are:

- To explore and describe experiences of facility managers regarding patients' long waiting time at Tshwane health district CHCs.

- To make recommendations aimed at reducing long patients' waiting times at Tshwane health district CHCs.

1.4.3 Research questions

According to Leavy (2017:71), a research question is a brief, central, clear and probing statement that guides the investigation in producing evidence needed to solve the existing problem. In this study, the central research questions were:

- What are experiences of facility managers regarding patients' long waiting time at Tshwane health district CHCs?

- What recommendations may be made for facility managers and other vital stakeholders to lessen patients' long waiting time at Tshwane health district CHCs?

1.5 SIGNIFICANCE OF THE STUDY

The assertion is that once it is established what the likely impediments are, responsive legal frameworks can be formulated. These legal frameworks should be constructed to rather enable thawing of gaps responsible for non-attainment of reasonable patients' waiting time. Information, findings, and recommendations to be generated from this study can thus be used in further similar studies for comparison purposes or even better, make essential scientific improvements.

The recommendations might lead to improved health care delivery models resulting in shortened patients' waiting time, thus ultimately improving their experience of care and satisfaction levels. It is hoped that with improved satisfaction levels, facility managers are less likely to be confronted with complaints pertaining to patients' long waiting time. This will free much of the needed time to focus on other operational and administrative priorities of health care.

1.6 DEFINITION OF KEY TERMS

According to Creswell (2014:74) of importance is the researcher's obligation to define terms that go beyond common language to enable individuals outside the field of study understand them. The following are the defined key terms in relation to this study:

1.6.1 Community Health Centre

According to National Department of Health (South Africa 2017d:8), a Community Health Centre is a facility that provides PHC services, 24-hour maternity as well as accident and emergency services to the communities. In the context of this research, it refers to the eight facilities so designated and legislated as CHCs in Tshwane health district.

1.6.2 District

District refers to the responsible executing authority of region within a defined government structure (South Africa 2003 s:29). In this study, district refers to Tshwane Health District, one of the five making up Gauteng Province of the Republic of South Africa.

1.6.3 Experience(s)

It is learnt from Roth and Jornet (2014:107) that experience(s) encapsulate acquisition of knowledge and requisite skills learnt from doing, seeing, observing, touching or feeling over some period of time. In relation to this investigation, experience(s) implies knowledge or mastery of events and trends associated with patients' long waiting time as gained through involvement in or exposure to the phenomenon.

1.6.4 Facility manager

National Department of Health provides that a facility manager is a person appointed, delegated or so assigned to manage the overall activities and personnel in a clinic or CHC (South Africa 2009:5). In context of this research, facility managers would refer to the formally appointed or delegated persons tasked with overseeing overall day to day administrative and operational activities of Tshwane health district CHCs.

1.6.5 Long

Long, as an adjective means lasting more than bargained for or taking more amount of time than anticipated (*Thesaurus of English words 2014, "long")*. Relevancy to this study implies waiting for health care services by patients for periods exceeding the set target of 120-minutes.

1.6.6 Patient

The provision by South Africa (2003:s16) uses the term "user" to refer to "patient" as any person seeking and receiving health care treatment or services in a health establishment. With relevance to this research, patient refers to any individual whose health is compromised and thus presenting at a CHC to obtain necessary health care intervention(s).

1.6.7 Waiting time

The provision by National Department of Health is that patient waiting time is the period that a patient spends waiting for service(s) in a facility per visit, measured from arrival until departure (South Africa 2015b:7). In relation to this research, waiting time implies the stretch that a patient spends waiting to be provided with health care services in accordance with their expectations in a CHC. It is measured upon entering the facility building up to departing the institution.

1.7 THEORETICAL FOUNDATIONS OF THE STUDY

The demeanour of qualitative studies is not essentially to apply theoretical frameworks as the underpinning departure of studies. Study findings from a qualitative angle are often considered for use in developing theory (Creswell 2014:83).

In this study, meta-theoretical assumptions were postulated to support the theoretical argument, thinking, data collection and analysis whilst equally clarifying the concepts. The following are exhibited as meta-theoretical assumptions employed in this research: epistemological, ontological, teleological and methodological assumptions.

1.7.1 Meta-theoretical assumptions

Postulation by Collins and Stockton (2018:4) and Allana and Clark (2018:2) is that metatheories are those assumptions considered true as built on logic, reasoning and judgement, without necessary proof, substantiation or verification. In introducing metatheory, Sousa (2010:455) corroborates by referring to Fleetwood and Ackroyd (2004a) that a metatheory is "what lies beyond or outside any substantive theory, empirical research, or human practice." Scientific enquiries direct that assumptions influence the logic with subsequent appreciation that leads to more rigorous enhancement of the study. The assertion further by Allana and Clark (2018:6) is that meta-theoretical assumptions afford the opportunity for the utilitarian background of the theory that one is likely to generate or sanction.

1.7.1.1 Ontological assumptions

Neuman (2014:94) guides that ontological assumptions of research examine nature of the research object by confronting the "what is" of a phenomenon. According to Collins and Stockton (2018:5) and Sousa (2010:465), the world as it exists, constitutes apparent and distinguishable phenomena which in reality of existence can be observed and measured in a quantifiable manner to the extent of being able to make sense, explain the complexities and develop perceptions, including other meaningful conclusions. Reasoning from the deportment by Tolk (2013:4), one can infer that ontology is the study of all and every phenomenon that even existed before mankind.

The following ontological assumptions are made in this study:

- Several realities exist regarding the experiences of CHC facility managers on long patients' waiting time in Tshwane health district.

- The reality of long patients' waiting time differs from experiences of one CHC facility manager to the other as encountered by these individuals in a dynamic and intricate world through interactions with other stakeholders.

1.7.1.2 Epistemological assumptions

Epistemology, according to Allsop (2013:19), refers to philosophical nature of knowledge and the position we take on how we come to know that which we know about the world. In this study, the epistemological posture is that:

- Narrated qualitative data has the potential to provoke profound understanding of the actual and associated meanings that CHC facility managers attach to patients' long waiting time as experienced in Tshwane health district and further expressed in their account of this phenomenon.

1.7.1.3 Teleological assumptions

Kelemen (2019:513) allude that teleological assumptions imply the tendency to view existing phenomena as directed towards a particular goal, thus being purposeful. Tolk (2013:4) elucidates further that it is the study of the actual doing or action in itself. Some ambition and purpose of a particular phenomenon should influence these actions. This study's teleological assumptions thus referred to the ethical morals and standards in that the facility managers are duty-bound to do what is right and good to achieve desirable outcomes in the end. In this regard, the desirable results will be reduction of patients' long waiting time.

1.7.1.4 Methodological assumptions

Greene (2006), as cited by Tonon (2015:4) states that methodology, which is the logic of research, delves on study questions, design structure, gathered evidence, how it was gathered and all related including the analysis and reporting. In qualitative studies, it is appreciated when researchers methodically demonstrate that the choice and use of specific method is linked to the desired outcome. An emphasis by Pruzan (2016:193) is that methodology should exude evidence of critical discussion, comparison and diligent application of method. It therefore, should convey logic of implementing scientifically oriented methods in the study of reality.

This study was qualitative in nature and paid attention on subjectivity of verbalised experiences and observations as expressed by CHC managers. With regards to this inquiry, methodological assumptions were as follows:

- Use of language to attach and express meaning to phenomena and communicate the meaning to others is characteristic of human beings.
- Qualitative investigations appear to be supportive of naturalistic inquiry to collect descriptive data on reality, as constructed by persons.
- The investigator acquiesces with scientific provision that in-depth interviews are ideal in conducting a qualitative inquiry into a phenomenon.

1.8 RESEARCH METHODOLOGY AND RESEARCH DESIGN

Methodology, according to Brink et al (2018:19), refers to particular ways, yet scientific, of gaining knowledge about reality of what is enquired about in a study. Supplementary contribution by Pruzan (2016:186) emphasises that methodology should advance “why” instead of just “how” chosen choices are befitting of one’s way of approaching an enquiry. Research techniques, procedures, population sample, sampling methods, data collection, data analysis, trustworthiness and ethical considerations are characteristic of methodology as here-under justified.

1.8.1 Research design

Research design is an overall and comprehensive plan in which the investigator will engage with participants for the purposes of achieving research objectives (Polgar & Thomas 2013:18). A qualitative exploratory descriptive contextual design was adopted in this study on experiences of facility managers regarding patients’ long waiting time at Tshwane health district CHCs. Extensive elaboration on design and approaches will be provided in chapter 3.

1.8.2 Research Methods

Polgar and Thomas (2013:20) refer to method as informing study readers of how exactly the intended research will be executed. In this study, the following methods were applied:

1.8.2.1 Setting

Setting, according to Nelson (2014:12) refers to the environment and conditions in which the study will take place. The study took place in natural settings, which were the eight CHCs located in Tshwane health district of the Gauteng Province. Managers were afforded the liberty to choose the precise location within their respective CHCs where the actual interviews took place. An elaborate description of the setting will be provided in chapter 3.

1.8.2.2 Target population and sample

The definition of population by Leavy (2017:76) is that it is the collective of people or objects of interest to the investigator, as they basically possess common characteristics relevant to the study. In the proposed study, the target population consisted of all facility managers working at Tshwane health district CHCs. These are the managers who are responsible for ensuring dispensing of quality patient care.

1.8.2.3 Sampling method

Sampling, according to Yin (2016:93) is the process whereby a specific portion of the population is selected in a study to embody the entire population. Non-probability purposive sampling method was used to select a sample of CHC managers, owing to their relevancy in providing the researcher with insight into their experiences regarding the patients' long waiting time (Schreier 2018:88).

1.8.2.4 Sample Size

Schreier (2018:89) imparts that saturation denotes a stage whereby the researcher is not getting any newer information or that which is regurgitated is negligible. Sample size was not predetermined, but all emerging narratives or stories were recited until no new information emerged from the participants, and the same themes were re-occurring. Therefore, the sample size of facility managers working at Tshwane health CHCs was determined by data saturation.

1.8.2.5 Inclusion Criteria

Inclusion criteria as clarified by Polgar and Thomas (2013:36), refers to distinctively relevant characteristics that the study participants must possess for inclusion as part of the target population for this study. The inclusion criteria in respect of this study was consenting facility managers employed and working the eight CHCs in Tshwane health district.

Only those who had an experience of over a year as facility managers of CHCs were recruited. By virtue of being appointed and working at these CHCs positioned them as appropriate owing to their constant exposure of experiencing the dynamics of patients' long waiting time.

1.8.2.6 Exclusion Criteria

Exclusion criteria according to Nelson (2014:47), is defined as those distinct characteristics that could cause a person to be excluded from taking part in a study.
In this investigation, non-consenting the CHC facility managers, those with less than one year of experience as facility manager and those appointed and working at hospitals and clinics were excluded from this study.

1.8.3 Data collection

Flick (2018:7) mentions that data collection is the precise, step by step collection of vital information to the research purpose; question or hypothesis of a study. Data collection in this study employed use of in-depth interviews, face to face interviews by way of open-ended questions, observations, field notes and a reflective diary. Chapter 3 will provide further details on each of the collection methods.

1.8.4 Data analysis

Data analysis is the methodological organisation and synthesis of research data whilst at the same time, testing research theories using that data (Brodsky, Buckingham, Scheibler & Mannarini 2016:16). The purpose of data analysis was to provide structure that helped the investigator to extract and make sense out of chunks of complex data. Although in qualitative studies theories and hypothesis are not tested, findings contribute to theory development. As guided by Décima (2015:112), data analysis was undertaken to summarise, systematically organise and give meaning to data. Transcribing of collected data was verbatim. Tesch's 8-steps of data analysis were employed to analyse data. According to Creswell (2014:245), adopting Tesch's 8-steps implied applying method of open coding whereby the researcher read carefully through all the transcripts in order to gain sense of understanding data. Ample clarification on data analysis will be provided in chapter 3.

1.8.5 Trustworthiness

Korstjens and Moser (2018:121) guides that trustworthiness is the degree to which typical characteristics of confidence, credibility, and authenticity manifest in qualitative research findings. The investigator has applied these five physiognomies to ascertain that study findings are representative to the participants' viewpoints. It is in chapter 3 that each will be discussed in detail.

1.9 ETHICAL CONSIDERATIONS

Saks and Allsop (2013: 300) cite that ethics in research imply respecting dignity, rights, safety and overall well-being of study participants. The essence is to circumvent any risks of violating research processes. As stipulated by Brodsky et al (2016:18) and the Bill of Rights in the Constitution of the Republic of South Africa (Act No. 108 of 1996 as amended) ethical considerations were undertaken to ensure that respect for autonomy, prevention of harm, maintenance of justice and dignity of participants are upheld.

Ethical clearance for this study was granted by Research Ethics Committee of the University of South Africa (Annexure A) (REC-012714-039) and Tshwane Health District Research Committee (Annexure C). These ethical considerations will be deliberated on in chapter 3.

1.10 SCOPE OF THE STUDY

The study was limited and focused primarily on patients' long waiting times and probed circumstances responsible for perpetuation of the phenomenon. The study was undertaken at Tshwane health district's CHCs; located in Gauteng province of the Republic of South Africa. Participants were facility managers of those CHCs.
The researcher restricted this research to facility managers of CHCs who gave consent to participate and contribute to the study. Managers who did not consent as well as those responsible for clinics, hospitals, or any other health care establishment, other than CHCs were excluded.

1.11 STRUCTURE OF THE DISSERTATION

This study is made up of the following five chapters:

1.11.1 Chapter 1: Orientation to the study

It is in this chapter that background of the research problem is introduced and discussed, statement of the research problem explained, the aim of the study, objectives, research questions and the definitions of key concepts outlined.

1.11.2 Chapter 2: Literature review

Literature review with regards to the study is presented in relation to “Experiences of facility managers regarding patients’ long waiting time at Tshwane health district CHCs” are discussed.

1.11.3 Chapter 3: Research design and methodology

In this chapter the research methodology outlines the research design, population, sampling, data collection methods and the trustworthiness of the research design and the instrument of data collection. Ethical considerations and data analysis procedures.

1.11.4 Chapter 4: Presentation of findings

Results of the study are presented in this chapter, including interpreting them according to the set study objectives. The very results are further discussed in relation to findings from other research.

1.11.5 Chapter 5: Conclusions and recommendations

This chapter completes the study by discussing findings, limitation and conclusions of the study. Recommendations are provided with regards to improving health systems and for further research.

1.12 SUMMARY

This chapter introduced the topic “Experiences of facility managers regarding patients’ long waiting time at Tshwane health district” by narrating introduction and background to the study, the problem statement, and significance. Elaboration on the aims and objectives of the study has been provided. Attention has been given to the operational definitions and theoretical foundations of the study. Research methodology and design, ethical considerations, study scope and dissertation structure conclude chapter 1. The next chapter will focus on literature review applicable to the study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter presents background in respect of scientific work into what has been studied and published pertaining to patients' long waiting time as experienced by facility managers at Tshwane health district CHCs. Literature review is a scholarly process of studying, understanding and making meaningful conclusions on a theory, including published studies on a topic of interest (Aveyard 2014:2). According to Aveyard (2014:4), further emphasis is that the essence of literature review serves to assist in gaining sufficient, arguable and scientific insight for use in practice as well as a context for undertaking a study. Literature review irradiates the essence of the new study (Walker 2014:18). In whole, purpose of literature review in a qualitative study is to set the tone intended to place findings in context of what is already known about the subject. Literature sources consulted include books, Sabinet, Google Scholar, EBSCOHost, nursing and media reports, departmental citations and legislative frameworks pertinent to patients' long waiting times.

2.2 IMPORTANCE OF DOING LITERATURE REVIEW

It is through literature review that a researcher illuminates the extent to which scientific enquiry has been conducted on the phenomenon or subject matter being studied. Williamson and Whittaker (2014:30) stress that the researchers need to acquaint themselves with subject-matter of interest. By so doing, the investigator becomes better positioned to develop a rich repository into the scientific background of the topic's meaning.

The approach of this literature review in respect of "Experiences of facility managers regarding patients' long waiting time at Tshwane health district CHCs" sought to address the following captions:

- The phenomenon of waiting time
- Background on patients' waiting time
- Legal aspects of waiting time
- Contributory factors
- Effects of long waiting time
- CHC Facility Managers roles and responsibilities, with focus on waiting times.

2.3 PHENOMENON OF WAITING TIME

2.3.1 Definition of waiting time

The provision by National Department of Health guides that waiting time is the duration that a patient endures waiting to receive services in a health care facility per visit (South Africa 2015b: 7). Further elaboration by National Department of Health instils that it is time-length waited after indicating need for service in a health care facility (South Africa 2019:4). It is measured from arrival in a CHC at 07:00 until receipt of the first and subsequent services if it so warrants. The addition that Melesse, Wirkuzie, Negalign, Mastewal and Mastewal (2017:2) make is that waiting time is the total time from registration until consultation with a health care provider. This citation supports the notion that one is recognised as a patient after being so registered or admitted in a CHC.

According to Motloba et al (2018:400), the focus on waiting times is brought about the recognition that it is one important performance measure of the degree to which quality health care services are provided. It thus becomes an objective indicator of operational and administrative efficiency in a health care facility (Egbujie et al 2018: 318). Abdulsalam and Khan (2017: 5), cite further that long patients' waiting time remain a vital pointer towards determining the extent of satisfaction with health care services. Lehohla (2013:14) provided additionally that acceptable waiting time periods are directly linked to the degree of fulfilment and endorsement of healthcare services as experienced by patients. This assertion suggests that assessment of quality health care assessment and improvement thereof, should amongst other efforts focus on managing waiting times.

2.3.2 Waiting times dimensions

National Department of Health guides that waiting time has the following dimensions (South Africa 2015b:8):

2.3.2.1 Actual waited time to receive services

This refers to the instance whereby the patient awaits to be registered, open and/or receive a file from the administration clerks. Melesse et al (2017:2) expatiate further that it is the waited time from the moment patients submit a clinic appointment card or referral letter at the counter until a file is issued. During the registration time, the payment process and record classification are concluded. The second parameter in this regard will then be waiting to be consulted by any one or more of the health care professionals, which could be a professional nurse, doctor, social worker, physiotherapist and/or pharmacist.

2.3.2.2 Service Time

National Department of Health (2015b:8) and Daniels (2015:28) clarify that service time denotes the actual contact time spent by the patient receiving health care related services in a health facility. As Daniels (2015:28) puts it, this is the period that any patient would have waited for; which is to be seen, to be consulted, to be in engagement with a health care provider in a CHC. Service time is otherwise referred to as consultation time.

2.3.2.3 Total time spent

According to National Department of Health (2015b:8), total time spent in a facility comprises of the sum of time spent waiting for and ultimately receiving services. This encapsulates time from arrival, waiting to be registered and receiving a file. From this area, the patient would wait to be seen by the health care professional, including actual contact time spent consulting.

If dispensing or issuing of medicine is not carried out in the very consultation room, then the patient will proceed to await his turn to receive medication at the pharmacy. This will be the scenario, provided that they would not be referred to other members of the multi-disciplinary team for further management of other presenting and/or identified health care challenges. Waiting time thus refers to a period of time spent between when an action is requested or mandated and up to when it occurs, or such action is dispensed (Masutha 2017: 6). In principle, as Globerman (2013:5) sums it up, waiting would seem to encompass the delay between the time an individual wants to receive health care service and the time the service is actually acquired.

2.4 PATIENTS WAITING TIME BACKGROUND

2.4.1. Global situations

Aguilera et al (2015:31) provided that as observed by WHO, prolonged waiting time is now emerging as a public health issue. According to Aguilera et al (2015: 31), in countries such as Chile, the principle of universal access to health care should include the reverse of negative experiences felt by patients due to long waiting periods. Aguilera et al (2015:31) add on that the struggle to manage patients' long waiting times is not only confined to low and middle-income countries, but even those that are economically thriving. This then provides that long waiting time is a diverse phenomenon cutting across the wide spectrum of socio-economic divide.

In support, a survey by Siciliani et al (2017:11) in respect of Organisation for Economic Co-operation and Development countries revealed difficulties with waiting times in 13 (thirteen) of its 36 (thirty-six) member countries, namely Australia, Canada, Denmark, Finland, Ireland, Italy, Netherlands, New Zealand, Norway, Portugal, Spain, Sweden and United Kingdom. The magnitude of the problem was further observed to be diverse in that it affected several areas of care such as PHC, Out-Patient Department specialist clinics, emergency care and elective (non-emergency) care. It was this stance of affairs that prompted health policy reviews to reverse the impact of prolonged waiting (Siciliani et al 2017:11).

Further narration by Ahmad et al (2017:18) in an Asian study undertaken in Kedah, it emerged that patients were aware that they should wait to be consulted by doctors, nurses and other health care professionals. The contention, however, is that there is no known acceptable waiting or consultation time. Where waiting and/or consultation time has been determined, it is hardly achieved; hence it remains an area of public health concern. The expression from this study is that patients appreciate and tolerate to rather wait for 2hours or less.

Waiting time not only affects public PHC facilities like clinics and CHCs. Speciality clinics are similarly affected. This is demonstrated by Hirvonen, Tuominen, Seitsalo, Lehto, Paavolainen, Hietaniemi, Pekka, Rissanen Blom and Sintonen (2009:946) in citing that as much as the principle of equal access to medically justified treatment has been promoted by official health policies in many Western health care systems, actual practices do not completely meet policy targets. This citation denotes that policies do not actually translate into action such that they result in the desired outcomes, which in the context of this study is reduction of waiting times.

Hirvonen et al (2009:946) state that waiting time for elective surgery vary between patient groups and regions, and growing problems in the availability of services threaten equal access to treatment. It is these waiting time discrepancies that have attracted the attention of decision-makers, with subsequent introduction of several policy initiatives have been introduced to confront the scourge.

2.4.2 International context

Sztrik (2012: 11) provides that waiting is not a new phenomenon, but an ancient one. It is as ancient to even cite the renowned biblical wait by animals to embark on Noah's ark. Adan and Resing (2015:20) mentioned that queues and the waiting phenomenon remain a frequent observation even today. According to Sztrik (2012: 11), any instance in which arrivals place more demand upon a finite capacity and resources, will result in queues and ultimately waiting will result.

The study by Blendon, Schoen, Des Roches, Osborn, and Zapert (2003:116) discovered that in the United States, Canada, the United Kingdom, Australia, and New Zealand, sicker adults verbalised waiting longer to access PHC doctors, to be admitted and for non-complex procedures. This finding made policy makers to view long waiting time as an indirect non-financial barrier that needed decisive consideration. Furthermore, the study conducted in the United States of America by Saxon, London, Bacharouch, Smith, Santen and Perry (2013:221) revealed that emergency department waiting times were considered an important facet of patient satisfaction. This assertion was informed by the fact that patients consistently rated waiting time as an area of priority concern. In those instances where waiting time was less than expected, patients expressed increased gratification as opposed to discontentment stemming from lengthy waiting time (Saxon et al 2013:221).

Additional critique in Europe by Viberg, et al (2013:53) revealed that health care administrators acknowledged that waiting times in health care entities can't be left unattended. Viberg et al (2013:53) suggested that confronting the causes of bottlenecks should enable health systems to respond to the reduction of patients' long waiting time. In a Canadian investigation, Ansell et al (2017:2) provided in their study background that the country was confronted with 23% of sick adults who indicated waiting six days and beyond for a primary care appointment as compared to 2% and 5% in Switzerland and New Zealand respectively.

Such an experience prompted Ansell et al (2017:2) to explore identifying interventions intended to reduce wait times for primary care appointments**.** Al Khani (2015:18) alluded that decreased levels of patient satisfaction in Ireland, prompted conduction of a study to explore ways that can be adopted to investigate possible remedies to alleviate plight of long waiting time.

The study by Ahmad et al (2017:14) in Malaysia, similarly, highlighted that waiting time is one performance measure that gauges organisational competency and adeptness in health care institutions.

According to Ahmad et al (2017:15) patients in Malaysia regarded any waiting period of more than 45-minutes as unpleasantly long. The concession is that if waiting time is indeed an efficiency performance indicator for facilities, it then warrants receiving due attention. The impetus is to confront challenges associated with non-achievement of desired waiting time standards and benchmarks.
On the contrary, Tran et al (2017:6) in Vietnam revealed somewhat a different picture in that private patients with medical insurance waited longer than those without, thus seeking services in public entities. Tran et al (2017:6) stress that this divergent discovery remains a pressing matter for Vietnam. The recommendation by Tran et al (2017:6) is that stakeholders should pay attention on simplifying administrative procedures for insured patients.

Xie and Or (2017:7) in China, examined the associations between actual waiting time, perceived acceptability of waiting time, actual service time, perceived acceptability of service time, actual visit duration, and the level of patient satisfaction with care. The outcome of this enquiry yielded results that still showed that actual waiting time was negatively associated with patient satisfaction regarding several aspects of the care they received. This adds further to indicate the degree to which waiting time is an indicator of organisational competency.

2.4.3 African perspectives

The study by Tegabu (2008: 13) in Ethiopia revealed that extended waiting times have plagued health care systems for years. In this study, about 5% of patients who visited public facilities were turned away due to long queues that resulted in prolonged waiting. It was established during this study that patients' waiting time was 48-minutes for public facilities, whilst private entities were doing much better with a wait of just 6-minutes. As such, it became necessary for public facilities to benchmark on best practices from private ones. Significantly, longer waiting and shorter service times were a worrisome observation among public facility consultation rooms, registry and cashier's office, laboratory, injection and dressing rooms as compared to those of private facilities (Tegabu 2008:13).

The study by Umar et al (2011:79) in Nigeria yielded similar findings to those in Europe. According to Umar et al (2011:79), patients' waiting ranged from a minimum of 10-minutes to an unpleasant 165-minutes. Of concern in this study was that a considerable 69% of respondents felt the pinch of waiting for 165-minutes at the most. One could then contend that if in a CHC the mean waiting time observed and recorded is in excess of the patients' expectations, that could manifest as the platform for frustrations and disapproval over long waiting periods.

From the Mozambican study by Wagenaar et al (2016:4) it emerged that patients waited for over an hour for general registration, over an hour and half for outpatient consultation, and almost two hours for first antenatal visits, bringing the total waiting time to almost over 4-hours. Whilst patients waiting time in this study were long, consultation time lasted between 2.3 to 15-minutes, thus leading to the conclusion that healthcare wait times were long and consultation times were very short (Wagenaar et al 2016:5). The contention in this regard reflects imbalances by health care facilities over patients' legitimate needs and expectations over waiting and being served.

In the Niger state of Nigeria, Abdulsalam and Khan (2017:13) reported that in as much as 90% satisfaction rate with services was recorded in all the units under study, contributing to an overall satisfaction rate of 75.8%, patients were still specific to mention dissatisfaction with prolonged waiting particularly in the Out-Patient Department. Furthermore, this investigation by Abdulsalam and Khan (2017:14), as a limitation, cautioned that since the inquiry relied on self-reporting by the patients, some level of bias may have been introduced, largely due to the respondents' character, receptivity and overall state of mind primarily during the study. Noting this disadvantage, one is poised to suggest that it is scientifically necessary to diversify studies on waiting times to include other role-players. This could be achieved by supplementing such investigations by conducting population-based surveys to maximise representative outcomes on the patients' long waiting time.

2.4.4 South African outlook

Globally, health care delivery systems and models are under pressure from growing populations and increasing patient expectations. South Africa is not spared either. Besides the rise in population, Bradshaw, Nannan, van Wyk, Laubscher, Groenewald and Dorrington (2019:72) articulated that the country's health care system is faced with quadruple burden of disease namely:

- Maternal and perinatal morbidity
- HIV and TB
- Non-Communicable Diseases
- Violence and injuries

It is arguable that financial and human resource limitations further worsen attempts to meaningfully combat these four harsh-striking epidemics. Whilst these concoctions of anomalies are notable and disturbing difficulties, the very system is moreover overburdened with the scourge of patients' long waiting time. The extent of patients' long waiting time dilemma ranks it top-most as a compounding public health and quality improvement matter. The phenomenon of patients' long waiting time has unabatingly progressed as a societal challenge that needs imperious, long-lasting and realistic interventions.

The findings by Peltzer (2009:10) in the study indicated that 58% of the respondents expressed disapproval of patients' long waiting time as compared to Brazil's 35%, 31% for Israel and 28% for European countries respectively which censured this phenomenon. This is a further demonstration of some consistency of disappointment and discontentment over patients' long waiting times. The outcomes of the audit conducted by Visser et al (2012: 8) as commissioned by National Department of Health in 2011, added that out of the six priority areas, namely availability of medicines, staff attitudes and values, safety and security, infection prevention and control, cleanliness and waiting time, the very waiting time emerged as a concerning matter amongst these concerns that needed to be impacted on.

Lessons learnt from this audit is the fact that it was conducted country wide in all nine provinces and each of the 52 municipalities, thus making its outcomes representative of the nation-wide predicament on long waiting times. The displeasure of long waiting times as picked up by Visser et al (2012:8) finds further expression in the survey by Lehohla (2013:11) wherein long waiting time accounted for 16% of the respondents to by-bass facilities closest to their residences and opting to use others with better managed waiting time. Several studies pointed out that the most frequent complaints received from health care service users, was related to patients' long waiting time (Scheffler, Visagie & Schneider 2015:5).

Naidoo and Mahomed (2016:5) observed that prior to instituting lean strategy to mitigate for prolonged patients' waiting time in a Kwa-Zulu Natal district hospital, patients endured waiting for about 189-minutes in queues and approximately 75-minutes in the service nodes. In support, the comparative study by (Nunu & Munyewende 2017:4) established that time spent at clinics in both Free State and Gauteng provinces was a noteworthy factor that influenced patient satisfaction. This is a demonstration that acceptable waiting times carry considerable weight to influence outcomes of patients' satisfaction over quality of health care services. Egbujie et al (2018:318) backed this by revealing that almost all public health entities in South Africa, irrespective of their level of care, experience long waiting time and that has impeded on realisation of maximal and satisfactory performance by these facilities.

Additional contention by Sokhela, Makhanya, Sibiya and Nokes (2013:6) is that the influx of patients against over-burdened service has regrettably resulted in adverse effects on health care delivery with queues growing longer, thus ending with patients waiting many hours for service. According to Sokhela et al (2013:7), participants expressed gratification with shorter waiting times and equated longer waiting times with poorer service. Further substantiation by Sokhela et al (2013:7) identifies authors such as Thompson and Yarnold (1995), Eilers (2004), and Agaba, Bagul, Adenugba and Kenogbon (2002), who have concurred that patient satisfaction is directly linked to waiting time. It was further established by Hasumi and Jacobsen (2014:488) that 34.8% of participants mentioned long waiting time as a repeated type of health service problem. This still points to the difficulty that is experienced to impact favourably and meaningfully on this performance indicator.

In the Western Cape, magnitude and adversity of long patients' waiting time is highlighted by Kama (2017:68). The study revealed that patients arrived at the clinic as early as 04h00 to circumvent the long queues. Kama (2017:68) asserts that these early arrivals could only imply that the patients will then have to wait until the clinic opens at 07h00. Despite early arrival at the clinic, patients still had to wait for periods ranging between 60 to 240-minutes and some were even turned away without being assisted (Kama 2017:68). It is findings like these that demonstrate the unprecedented and adverse magnitude of waiting times in PHC facilities. It can be deduced that in-spite of arriving as early as they do, patients are still confronted with long waiting time. This is thus portraying deeper-rooted challenges within CHCs to respond to the call of effectively and favourably reducing patients' long waiting time to acceptable targets.

In respect of health care services, Motloba et al (2018:400) allude to the fact that waiting time remains a health care quality indicator that measures structural, administrative and operational efficiency of a CHC. This implies that waiting time serves as a substitutional measurement of how competent a CHC is with regards to providing quality care within the set waiting time targets. Further emphasis by Motloba et al (2018:400) points to the fact that the amount of time a patient waits to be seen has remained a contentious issue that for quite some time has not only bothered patients, but law-makers as well. In recognising that patients are subjected to long waiting times in the North West Province, Swart et al (2018:4) emphasised that it is unreasonable for patients to wait for hours before receiving care and went further to investigate the likely benefits of implementing the triaging system to relieve patients' long waiting time. Swart et al (2018:2) were able to establish and appreciate the relief brought by instituting the triaging system in PHC facilities.

2.5 WAITING TIME LEGAL FRAMEWORKS IN SOUTH AFRICA

The expressed disapproval and discontentment voiced by patients pertaining to long waiting time in CHCs and other PHC entities, as supported herein by the cited studies, has necessitated that considerations be made to find means to regulate waiting times and improve patient experience of care. The following are legal prescript milestones in this regard:

2.5.1 Patients' Rights Charter

Section 27(1) (a) of the Constitution of the Republic of South Africa confers the affirmation that everyone has the right to access to healthcare services, including reproductive healthcare (South Africa 1996:s27).

The implication of this section is that no one may get in the way of any citizen to access existing health care services, whether they are public or private entities. The expectation with regards to CHC managers would be to ascertain that intangible phenomenon such as long waiting time does not end up being a societal menace that discourage communities to access health care services. Section 27 (2) stresses that "the state must take reasonable legislative and other measures, within its available resources to achieve the progressive realisation of each of these rights." It thus becomes important for the state to protect this right by developing and implementing comprehensive legal frameworks to prevent anyone from denying any health care user access to such health care services. Once the necessary rules, regulations, policies and conditions are developed, it becomes incumbent of CHC managers to oversee to it that health care services are dispensed in accordance with these legal determinations.

Section 27(3) on patients' rights, also establishes that no one may be refused emergency medical treatment. Whilst this provision exists, there is no agreed upon definition of what emergency medical treatment is. Nonetheless, in South African context, Medical Schemes Act, (Act No.131 of 1998:s3) define it as "the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's life in serious jeopardy."

One is thus inclined to comment that it is incumbent of CHC managers to ensure that their facilities are capacitated with trained and competent staff and sufficiently equipped with necessary and functional medical equipment. The key aim is to ensure that prompt medical treatment is provided to defer risk of complications that may arise from patients' long waiting time.

2.5.2. White Paper on Batho Pele Principles

As far back as 1997, a policy document titled Batho Pele principles was developed (South Africa, 1997). Batho Pele, a Sotho translation for People First, recognised that public services are not a privilege in a civilised and democratic society, but a legitimate expectation. At its inception, focus was only on the first eight principles, but later three more were added. These under-pinning principles are:

2.5.2.1 Consultation

The emphasis is that citizens should be constantly engaged about the level and quality of the public services they receive in the public domain. In demonstrating the intent to meet this principle would basically include customer satisfaction surveys, stakeholder meetings, radio talk shows, suggestion boxes and help desks (South Africa 1997: s4).

2.5.2.2 Service standards

Service users need to be informed of the level and quality of public service they will receive so that they are aware of what to expect. The implication is to display service and operation times, package of services offered as well as values and commitment charter.

2.5.2.3 Access

The expectation is that communities need to be provided with equal opportunity to access the entire package of services without reservations. Accomplishing this encapsulates reasonable operation times, ramps, disability-friendly bathrooms, use of familiar language(s) as well as making directional and information signage visibly available.

2.5.2.4 Courtesy

Emphasis is that all due care needs to be given in treating all citizens with courtesy and consideration. To the great extent of it, fulfilling this principle involves friendly greetings, telephone etiquette, observing and complying with the code of conduct.

2.5.2.5 Information

Of importance regarding this principle is that service users must receive accurate information about the public services they are entitled to receive. This would include displaying the type of services offered, complaints management procedures, news-letters and information scrolls.

2.5.2.6 Openness and transparency

As far as it is possible, how a CHC or an entity is run, who is charge, and the associated costs should be shared with the service users. This principle includes providing for management structure, organogram, annual reports on operations, and accessible anti-fraud and corruption hotline.

2.5.2.7 Redress

In instances where promised standards of service have not been met, service users should be addressed, offering full explanation for the shortcomings and effective remedy. Complaints that have been raised need to be acknowledged, investigated and solutions found.

2.5.2.8 Value for money

The expectation is to provide public services in an economic and efficient manner to ultimately provide citizens with the best possible value for money. Meeting deadlines, fulfilling commitments and promises, improving on internal controls and continuously looking for better ways to improve services are amongst the issue of focus to realise this principle.

2.5.2.9 Encouraging innovation and rewarding excellence

It is expected of the public service employees to be innovative so as to improve processes and procedures. In the context of this study, it would refer to CHC managers exploring new ideas to bring about change in long patient's waiting time. Personnel going beyond the normal and expected call of duty should be appraised as such, recognised and rewarded.

2.5.2.10 Leadership and Strategic Direction

To accomplish this principle, it is expected of CHC managers to lead by example. CHC managers, as accounting officers need to endeavour to safeguard employer's vision, mission and goals.

2.5.2.11 Service Delivery Impact

In the process of dispensing health care services, the outcomes and impact made in respective CHCs must be measured. Where there are still gaps, concerted efforts should be directed towards areas in the CHC where bottlenecks would still be experienced.

2.5.3 National Health Act

The provision in the National Health Act spells out clear legislative mandates in respect of PHC entities and CHCs (South Africa 2003:s3). Subject to any conditions prescribed by the minister of health, clinics and CHCs funded by the state are compelled to provide the following:

- Pregnant and lactating women and children below the age of six years, who are not members or beneficiaries of medical aid schemes, with free health services;
- All persons, except members of medical aid schemes and their dependants and persons receiving compensation for compensable occupational diseases, with free PHC services.
- Women, subject to the Choice on Termination of Pregnancy Act, 1996 (Act No. 92 of 1996), free termination of pregnancy services.
- A health care provider, health worker or health establishment may not refuse a person emergency medical treatment.

This section of the act contests that PHC services are indispensable in nature. It is a provision that recognises the injustices of the past, particularly focussing on communities with limited economic means. By exerting use of the auxiliary verb “must,” this act thus determines that the provision of these services to designated populations cannot be wished away. It thus makes clinics and CHCs obligated to provide them without fail or delay.

According to the City of Tshwane 2017/18 Annual Performance Report (2019:17) the total population for the city stood at about 3.32 million as of 2017. An estimated 893 080 (26.9%) of this population is reported to be unemployed. About 49.2% of these citizens in Tshwane are said to be living below the minimum poverty level. Against the above prescripts of the National Health Act, these population trends thus reflect the likelihood of citizens who may at any given time need to access services at any of the eight CHCs concerned. It is therefore, for the CHC managers to plan considering these dynamics, bearing in mind the need to redress patients’ long waiting times.

2.5.4 Benchmarks for reduction of waiting times

A guiding document titled “Provincial benchmarks for the reduction of waiting times” was developed for use by all Gauteng Department of Health institutions in July 2014 (Gauteng Department of Health: 2014). This operating procedure prescribed that the total time spent in a CHC, which is inclusive of waiting and consultation time is 180-minutes. According to the benchmarks contained in this document, it is anticipated that patients should spent between 10 to 30-minutes at the clerical station, 60 to 20-minutes for health care consultation by a health care professional and 15 to 30-minutes at the pharmacy (where such exists).

2.5.5 National Core Standards

The survey findings by Visser et al (2012: 8) revealed that waiting times, values and attitudes of staff, cleanliness, patient safety and security, infection prevention and control and availability of basic medicines and supplies emerged as the top-most areas of concern by the respondents. These identified concerns became what is today known as the six ministerial priority areas. To monitor and measure compliance to improving on these priority areas, National Department of Health (2011:15) introduced a national quality program to fast track service improvement through establishment of core standards in South Africa. Performance domains were developed against which health institutions are to be assessed for compliance on each of the six priority areas.

These core standards were later modified and used as a cornerstone in paving way for the establishment of the standards enforcement body, Office of the Health Standards Compliance. Waiting time is one of these standards contained in the Abridged Version of 2011. These standards are consistent with Batho Pele principle on the aspect of access to care, in that they seek to ensure that all health care users receive health care services easily, comfortably, and promptly (Public Service and Administration 1997); (Health Professions Council of South Africa 2008) and (Mokgoko 2013:11). In line with the expectations of reducing waiting times, facility managers in respect of CHCs are expected therefore to ascertain compliance with regards to reducing long patients’ waiting times.

2.5.6 Ideal Health Facility Realisation and Maintenance programme

According to the National Department of Health (2018b:3), an ideal clinic is one with enabling infrastructure, capacitated with enough operational cadres, responsive to medicine and other consumables, practices sound and administrative processes using appropriate and relevant legal prescripts. Massyn, Pillay and Padarath (2019: 23) remind that the Ideal Clinic Realisation and Maintenance Programme was conceived by the National Department of Health in July 2013 as a proxy self-assessment strategy to achieve the national core standards expectations.

The primary intent in this regard is to respond to the experienced deficiencies in the quality of PHC services. Improving the latter would then be an enabler to lay solid groundwork for the implementation of National Health Insurance at grassroots level (Hunter, Asmall, Ravhengani, Chandran, Tucker, & Mokgalagadi, 2017:111). Accordingly, Hunter et al (2017:111), National Department of Health (2015c:3) and Visser et al (2012:8) added that long waiting times, staff values and attitudes, availability of medicines, safety and security, facility cleanliness and access to care remain deficiencies in need of attention.

Additional clarification by Massyn et al (2019: 23) is that Ideal Clinic Realisation and Maintenance Programme sought to systematically improve PHC facilities and the quality of care they provide and still aims at that. The strategy has received nation-wide popularity such that it has been rolled out to district hospitals, with the intention to extent it to all other levels of hospitals. As a result, the strategy is now known as Ideal Health Facility Realisation and Maintenance Programme.

2.5.7 National policy framework on management of patient waiting time

Operation *Phakisa* for Health conference was hosted by the National Department of Health from 13 October 2014 to 21 November 2014. “Phakisa” is a Sotho verb meaning hurry up.

Following this conference, a policy on "Management of patient waiting time in out-patient departments" was developed and ultimately got published on 14 November 2015 (South Africa 2015b). It recommends that all PHC facilities should monitor patients' waiting time using the prescribed tools. It furthermore, and importantly so, sets out the following dimensions:

TABLE 2.1: STANDARDISED PATIENT WAITING TIME TARGETS		
Level of a facility	**Patient waiting time (in hours) for service/s per visit**	**Total time (in hours) spent by a patient per visit**
Specialized hospitals	1-hour	2-hours
PHC facilities	**2-hours**	**3-hours**
District Hospitals	2-hours	3-hours
Regional hospitals	3-hours	4-hours
Tertiary hospitals	2-hours	4-hours

Source: (National Department of Health 2015b:8)

The table above provides that in respect of PHC facilities, which in this context include clinics and CHCs, patients should at the most be subjected to waiting for a maximum of 2-hours before been seen by a health professional. Overall, taking into consideration waited time before been consulted by a health professional, which is referred to as consultation or service time, the total time any patient should spent in the facility should at the most not exceed 3-hours.

2.5.8 White paper on national health insurance

National Department of Health gazetted white paper on National Health Insurance on 11 December 2015 (South Africa 2015c:s1). It is a model of care that aims at achieving amongst others, the following objectives:

- Ensuring universal health coverage for all South Africans;
- Improving the quality of health care services irrespective of socio-economic status of the user.

As a substantial policy-shift document, it recognises that amongst measures of quality health care, waiting time across all health care entities needs considerate and impactful attention.

Whilst it does not prescribe any waiting time dimensions, it emphasises that PHC facilities, as the first level of contact with the health system, need to have reasonable waiting times such that community members do not have to sacrifice their entire working day waiting to receive health care services (South Africa 2015c:s159).

2.5.9 Applicable norms, standards and regulations

For the purposes of enhancing the process of monitoring, evaluation, recording and reporting, National Department of Health gazetted in the National Health Act, "Norms and standards regulations applicable to different categories of health establishments" (South Africa 2017d:s9). These norms implore monitoring of waiting times against norms set by the relevant authority or targets set by health establishments and taking reasonable steps to reduce waiting times where necessary. Furthermore, it is expected of health care establishments to take appropriate measures to reduce the delays experienced by users in accessing and receiving health care services.

For the purposes of this study, contextualisation and inference on waiting time, will be based on the "National policy on management of patient waiting time in out-patient departments" as well as "Norms, standards and regulations applicable to different categories of health establishments" as the primary guiding legal prescripts.

2.6 FACTORS CONTRIBUTING TO LONG PATIENTS' WAITING TIME

Since the onset of democracy in 1994, government of the Republic of South Africa has continued to aim at improving access to health care for the poorest and marginalised communities by expanding the health care facility network and abolishing user-fees for PHC.

These significant strides have however, not been and are still not without challenges. Very concerning and affective impediments are still experienced in PHC facilities, particularly CHCs. Notably amongst them are long patients' waiting times. Several studies have been undertaken to establish reasons into long patients' waiting time.

2.6.1 Patient-related factors

Waiting more than the set time-frames is a consequence of amongst other considerations, patients' influences. The following are reflective of patients' contribution towards excessive waiting.

2.6.1.1 Large patient numbers

Umar et al (2011:83) alluded that 28% of patients who responded in their study ranked high number of patients as contributing to long waiting time. Further argument is that the situation is aggravated by limited human resources, in this instance, medical doctors and nurse in particular. This aspect of staffing will be elaborated further on when narrating "organisational factors." Additional concurrence by Belayneh, Woldie, Berhanu and Tamiru (2016: 8) is that 40.5% of respondents cited increased number of patients that need to access health care services as one factor responsible for extended patients' waiting time.

Dependence on the public health facilities by most South Africans is largely influenced by the exponential growth of the population. According to Statistics South Africa (2017:7) in the 2017 General Household Survey, the country's population rose from 45,9 million in 2002 to 56,5 million in 2017. Elaboration further is that of this 56,5 million, it is only an estimated 9,5 million persons who have access to medical aid. The implication is that about 47 million would most probably be left to rely on various public health entities for health care services (Statistics South Africa 2017:23).

The outcome of the enquiry by Pillay, Ghazali, Manaf, Abdullah, Bakar, Salikin, Umapathy, Ali, Bidin and Ismail (2011:517) pointed to the summation that heavy workload, as perceived by staff had influence on the length of patients' waiting time.
It so raises the argument that unexpected and/or unplanned for large volumes of patients would in certain instances out-weigh the available staff capacity to efficiently and effectively render quality health care judiciously to patients such that waiting time targets are met.

The finding of positive correlation by Egbujie, et al (2018:318) between patient load per nurse and time spent by the very patients accentuate importance of the noteworthy role patient load plays in determining the total time spent by a patient in a facility. Egbujie, et al (2018:318) summed-up by showing that facilities with higher patient load per nurse were observed to be having longer total patient waiting time. This is demonstration of the unwelcomed outcomes of scenarios where the demand and necessity for services surpasses the available provision to render quality care.

2.6.1.2 Concurrent arrival in a health facility

Wagenaar et al (2016:6) highlighted in their enquiry that besides large influx of patients arriving in facilities, it is their simultaneous arrival in huge batches as early as before the official opening time that worsens patients' waiting time. The assertion is that this trilogy, that is, concurrent arrival, large patients' numbers, and arrival before opening accounts for instant and excess presentation for demand of quality health service.

Similarly, so much of patients presenting at once and within a short space of time causes build-up of lengthy queues and subsequently, long waiting time. Accordingly, this influences the efforts of personnel to decongest such ugly scenes and just aggravate patients' waiting time in CHCs.

2.6.1.3 By-passing of facilities

According to Tana (2013:64), participants attributed overcrowding to fellow patients by-passing their own health care facilities in their respective catchment areas. Patients who relocated elsewhere but still preferred to return to their erstwhile CHCs instead of the one where they have moved, were mentioned as contributing to long patients' time at Vanguard CHC in the Western Cape (Tana 2013: 64).

One could further substantiate that CHCs with reputation of providing good and therefore acceptable services, are likely to attract more patients, including those that are not resident in the jurisdiction of the CHC.

2.6.1.4 Missing appointments

An appointment system is one of the strategies which seek to reduce patients' waiting time by scheduling their attendance, particularly stable chronic as well as maternal and child health patients. Scheduling of the appointment or booking needs to be done in such a way that a CHC will manage to attend to their health care service needs within set time-frames on any particular day. Samadbeik, Saremian, Garavand, Hasanvandi, Sanaeinasab, and Tahmasebi (2018:1) shared in their study background that an appointment system refers to scheduling the suitable date, time and place for a clinical visit to receive health care services.

This basically sums up an appointment as planning for the patients' next visit. Participants in the study conducted by Frost, et al (2017:4) mentioned quite a considerable number of reasons for missing their scheduled appointments at health care facilities. Reasons advanced amongst others were being unaware of their appointment, being away from home, confusion over date, unware of appointment date, recovering from acute ill-health, voluntarily disregarding the appointment, family responsibilities and appointment clashing with other priority appointments and work commitments. As such, this puts a strain on health care facilities when patients dishonour their appointments as they are most likely to present unscheduled on any other day, thus increasing the roll of already planned for patients on that particular day in a CHC.

2.6.1.5 Adverse behaviours

An overwhelming 91% of nurses and 89% of doctors in a study carried out by Aboukanda and Latif (2014:24) unanimously agreed that patients presenting with minor and non-urgent cases displayed the most difficult behavioural issues. These attitudinal issues were pointed out as being responsible for delays in rendering of timely and quality health service and further crashing systems of operation in a facility.

These non-acute patients' behaviour, were observed to mostly interfere in decision making by the treating doctors. Tendencies to argue that they are priority cases, self-involvement in wanting to decide what suitable diagnosis is and the type of tests to undergo were noticed amongst these delayers. It is such conduct that consume time and that of other awaiting patients as most of the time is spent handling these patients with their irrational and unreasonable demands.

These untoward attitudes were observed to further include jumping the queue and demanding to be ahead irrespective of their presenting condition and urgency in a health facility (Aboukanda & Latif 2014:24). Nurses in this regard asserted that the time spent trying to intervene in the treatment plans and the associated lengthy arguments, lead to delays in promptly serving qualifying and non-problematic patients in services, consequently increasing waiting time.

2.6.2 Organisational factors

Lengthy waiting for services manifests as a blend of factors. Institutional influences play role in determining the duration patients would wait in CHCs. The discussions below reflect on some of these facility-oriented contemplations:

2.6.2.1 Non-matching human resources

Wagenaar et al (2016:6) again mention unavailability of enough health care providers, particularly doctors, as fuelling patients' long waiting time. The submission in this regard is that that doctor and /or nurse patient ratio becomes affected by the demand. The very few available health care providers face the challenge of not only providing quality health care services in a CHC, but timeously such that patients' experience of care remains positive. The supplementation to the staffing dilemmas by Scheffler et al (2015:8) pointed to the observation that a CHC may have full staff-complement according to the existing departmental prescripts. However, actual daily availability of health care teams to render quality patient care within expected time-frames tends to be compromised by absenteeism.

The available few health care providers are compelled to work under pressure as a result. This obliges health care providers to now rush their consultations, with potential to compromise quality health care in order to circumvent long waiting times.

Additional and aggregable demonstration by Egbujie et al (2018:317) pointed to the fact that in such facilities, factors such as absenteeism due to unplanned leaves such as sick or family responsibility may mean that there are too few staff members to handle the usual patient load. For illustration purposes, a facility that has staff complement of five nurses will experience unimaginable increased waiting time if one nurse is on planned leave and another two are unexpectedly absent for any of the above unplanned leaves. The remaining two will be compelled to overcompensate to make up for the three absent colleagues.

2.6.2.2 Work process inefficiencies

Pillay et al (2011:517) made the observed that lengthy waiting time stemmed from disarrayed work processes. Accordingly, a facility manager in charge of a CHC is expected to schedule staff attendance as informed by the busiest days, taking into consideration personnel leave entitlements and attendance of developmental activities. Failure to properly plan becomes a manifestation of feeble management, lack of supervision or administrative inefficiency. Staff ends up being overburdened with having to deal with health care service demands that exceed the day's capacity. As a result, patients wait longer than projected, with ensuing disservice, mainly incomplete services or being attended to very late in the day when there is no more reliable means of transport back home (South Africa 2015b:7).

2.6.2.3 Lack of material resources

More factors associated with prolonged waiting time also considered insufficient material resources (Wagenaar et al 2016:8).

Material resources include items such as examination coaches, vital signs monitoring apparatus, surgical consumables and the very stationery used to record patients' clinical notes amongst others. Pillay et al (2011:517) demonstrated further that having insufficient tools of trade to perform necessary clinical activities is in fact operationally disabling.

The implication is that few of the available and functional equipment would have to be interchangeably used and shared by health care providers amongst several patients in different points of care in a CHC. Meanwhile personnel go up and about, waiting for one another in between, patients' waiting time is prolonged.

2.6.2.4 Lack of facilities

In further elaboration towards factors responsible for long patients' waiting time, Pillay et al (2011:517) established that lack of sufficient consulting rooms impacts on how long patients have to wait. The consequence is that available work space would not meet the needs and demands of the actual numbers of presenting patients in need of swift care. It simply means few of the available rooms will be available and accessible to few patients against the awaiting masses.

2.6.2.5 Location of existing facilities

One other factor associated with long patients' waiting time is location of the health care facility (Egbujie et al 2018:317). The findings herein established that CHCs in the inner-city, towns, townships, and other peri-urban areas, particularly with good access to public transport recorded high patient head-counts.

On the contrary, the isolated, distant and difficult to reach or those with poor access to public transportation system, clocked quite less numbers of patients consulting. As a result, for policy and decision-makers, it becomes imperative to consider this observation when determining interventions to combat long waiting times.

2.6.2.6 Clinical deficiencies

The South African Triage Scale (2012:3) defines triage as sorting process, with the aim of bringing the maximal good to the greatest number of patients. Achievement of this is through prioritising limited resources to realise the utmost possible benefits.

Patients are therefore subjected to being sorted with a scientific triage scale in order of urgency, with the expectation that the patient(s) with the greatest need is/are helped first. In recognising the good that triaging possesses, Swart et al (2018: 2) posited that it could decrease patients' long waiting time thus enhancing accessibility and the quality of care. In concurring, Cohen and Bruijns (2018: 584) concluded that improvements in patient-flow processes contribute significantly to the easy flow and prioritisation of patients which have proven benefits of reducing patients' long waiting time.

2.6.2.7 Poor filing system

The report authored by the Public Service Commission (PSC) revealed almost a decade ago that some clinics faced the challenge of insufficient filing space and cabinets store patients' records (PSC 2010:32). Lack of proper storage can only point to staff resorting to unconventional means of keeping patients' files. These unclassical ways ultimately demand of administration staff to spend some considerable time looking for patients' files, which prolongs patients' waiting time. Central and ample filing capacity is thus necessary to support seamless patients' files retrieval to evade delays. During the inspection by the PSC team, it further came to light none of the clinics visited had computer equipment (PSC 2010:51). These electronic apparatuses are deemed critical in enhancing operational efficiency for the sake of achieving effective service delivery aimed at amongst others, cutting down on extended waiting.

Not only is the unavailability of electronic technology a challenge, but also paper-based administration of admitting patients in CHCs. The findings by (PSC 2010:51) acknowledged how highly nomadic the countries' citizens are. This travelling compels patients visiting other health care facilities, to upon arrival, register anew and further open up new records. Patients end up subjected to the same delays they might have endured during the first CHC they visited.

The PSC (2010:51) stressed that this system and process is time consuming, and due to the unknown patient's medical history, unnecessary time will be spent on repeat of history collection, diagnosis, and necessary interventions. Electronic centralisation and sharing of patient data by all health institutions would therefore facilitate seamless administration and care upon arrival of an itinerant patient at any other facility. This background thus emphasises the value and importance of advancing efforts to invest in information technology to provide effective, efficient and quality health care services in CHCs.

The conclusion by Swart et al (2018:5) highlighted appreciation of the value of an orderly filing system. A well-arranged patients' filing registry should be characterised by neatly packed files, alphabetically arranged by surnames, unique numbers or even by identity numbers. The assertion is that an organised filing system carries much likelihood to advance the course for expeditious retrieval of patients' files. Patients' filing areas should be the first areas of contact with the health care system where waiting time is tremendously cut.

2.6.3 Health service provider related factors

Long waiting time observations are a sequela of several associated features. Below is a discussion of health service provider factors linked with this contentious social prodigy.

2.6.3.1 Late arrival of staff

Motloba et al (2018:404) shared that patients mostly singled out late arrival of dentists as common reason for their long wait, yet to then spend a while in consulting them. This finding is also articulated by Umar et al (2011:83) in that 16% of patients expressed that doctors arrive late for duty. The investigator thus postulates that arriving long after the scheduled and expected time can only mean extension of patients' expected waiting time due to late commencement of duties.

2.6.3.2 Delays in prompt commencement of duties

A concerning finding according to Tegabu (2008:13) was that efficiency of staff time usage (percentage of work time spent attending to patients) was low with typically less than 50% of staff time being used for patient care. This implies that staff would rather be immersed in other non-clinical or non-patient care related activities, hence patients would wait longer. Common of these delaying activities is the tendency of staff to "prepare" their consultation rooms in the mornings for what seems indefinite time.

2.6.3.3 Staff Attitudes

The study conducted by Pillay et al (2011:515) observed that lengthy patients' waiting time was caused by employees' attitude. Attitudes, according to Howe and Krosnick (2017:327) are perceived or learnt mind-sets that influence how we act in particular ways when in different circumstances secondary to both an individual's experience and temperament. In occupational context, attitudes could be attributed to personnel's lack of team-work, including sharing of responsibilities. The assertion is that deficiencies in exercising maximal supervision towards clinical care in a CHC influence how responsive and committed staff will be. Being swift and expedient in providing needed health care services, is thus a demonstration of acceptable attitude by health care providers in attenuating patients' long waiting time.

2.7 EFFECTS OF LONG WAITING TIME

Unhindered access to quality care serves as the basis to determine competencies and efficiency of health care systems. Aspects in provision of care that would emerge as impediments, such as patients' long waiting times in CHCs carry the risk of actually limiting much needed access to essential PHC services. Aguilera et al (2015:31) provided that as observed by World Health Organization (WHO), prolonged waiting time is now emerging as a public health issue as informed by the following:

2.7.1 Impact of long waiting time on patients

According to the PSC (2010:41), long waiting times gave rise to altercations in the waiting hall of City Central clinic. These confrontations are likely to be experienced where and when other patients jump the queue and receive medical attention before those that had been waiting since morning. This unfair practice carries the potential to upset patients that are tolerantly awaiting their turn to receive care. It is the ensuing agitation that results in altercations.

Further than that, Tana (2013:64) discovered interestingly that late arrival of doctors resulted in patients showing anger and bitterness when they had to sit and wait the whole day for service. This is indicative of personnel's role in causing emotional stirs by patients due to the anticipated long waiting time. Lehohla (2013:11) noted that long waiting time accounted for 16% of the respondents bypassing facilities closest to their residences and opting to use others with better managed waiting time. The study by Masango-Makgobela, Govender and Ndimande (2013:4) which investigated reasons patients leave their nearest healthcare service to attend Karen Park Clinic in Pretoria North yielded similar findings whereby 24% and 25% of respondents mentioned long queues and long waiting times respectively for not going back to their original facilities. With regards to these findings, the consequences would include financial burden as these patients will have to incur travelling costs to reach CHCs out of their catchment areas. It would further mean that patients who elect to bypass their local CHCs will be confronted with waking up earlier to make up for the additional distance they will be travelling.

Long waiting time continues to be public health subject as other patients have been observed to abandon and postpone their consultation (Aguilera et al 2015:31). This abandonment and postponement can only imply that such patients are likely to default on their treatment and other necessary interventions. As such, it is likely of them to present later for care. Such delays could end up with fatal complications. Ansell et al (2017:2) argue that health complications are undesired as they can be difficult to treat and reverse with serious financial implications should the patient now need to be managed at higher levels of care.

2.7.2 Effects of long waiting time on the CHCs

Patient satisfaction matters as it embodies their perceived needs, expectations and experience of health care. The study that looked at the impact of long waiting time in Debre Markos Referral Hospital revealed that waiting time that exceeded 180-minutes was at the most, associated with lower satisfaction rate by patients (Belayneh et al 2016:11).

Javed (2005), as cited in Mukhtar, Anjum, Bajwa, Shahzad, Hamid, Masood and Mustafa (2013:977) provided inference that a low 54% of patients in Islamabad expressed pleasure with waiting times as opposed to an impressive 85% in Charlotte, the United States of America. This insinuates that limitations that impede on processes intended for rendering acceptable, responsive and quality health care services in CHCs would result in discontentment and bemoaning by patients.

Xie and Or (2017:9) highlight that complaints over long patients' waiting time could lead interruption of facility work patterns and processes. This would arise in scenarios where more than expected number of patients presents in person to the facility managers of CHCs to physically complain about "non-moving" queues and long waiting time. These displeasures if left unattended can end up being mass grievances. The latter can be a trigger to publicly taint the corporate image of a CHC.

Xie and Or (2017:9) stress that such adverse expressions could have devastating effects on how a facility would appear appealing to its users. Umar et al (2011:79) expand further on lower satisfaction rates by citing that in a competitively managed health care environment, it would be challenging to sell services if individuals are dissatisfied with waiting time. The implication amongst others would be low utilisation rate of CHC services. The moment utilisation rated drops, funding and budget allocations are reduced, with adverse impact to provide desirable level of quality care. From this citation by Umar et al (2011:79) it can be deduced that long patients' waiting times affects perceptions of quality, satisfaction and likeability, as well as likelihood of recommendations and repeat visits.

2.7.3 Effects of long waiting time on staff

Patients' long waiting times not only affect the very patients and CHCs as entities, but even the very personnel who are supposed to provide essential and quality health care services. The responses by service providers in the enquiry by Scheffler et al (2015:4) revealed that whilst their entities would have full staff balances, as in accordance with the approved post norms, they are hardly complementary on duty to meet the patients' demands.

Gauteng Department of Health (2017:82) provides that over the last ten years, South Africa has experienced an overwhelming increase in number of patients requiring long-term therapies such as Antiretroviral Therapy (ART). The growth in the number of such patients has placed enormous strain on the available resources in the public sector, on the quality of care and on particularly on waiting times. In addition, the Gauteng Department of Health (2017:82) places it on record that over 70% of patients visiting the province's healthcare facilities every day are collecting repeat prescriptions. The argument is that these categories of patients do not necessarily have to present each month at a CHC to just collect repeat medications. In support, Masutha (2017:33) argued that over-burdened healthcare professionals tend to be easily fatigued, leading to reduced working pace and performance drag.

As alluded by Belayneh et al (2016: 3) one major cause of long patients' waiting time is because of large numbers of patients arriving all at once within short space of time. The argument is that upon reporting for duty and finding such large number of patients, facility managers of CHCs are likely to ask those colleagues who were scheduled to attend developmental activities such as short courses and workshops to defer attending such. The intension would be to have sufficient personnel to dispense quality care to the patients. If this picture is a daily occurrence, chances of ever attending any worthwhile developmental activities is unlikely to be realised and that is to the detriment of staff.

2.8 STRATEGIES TO REDUCE LONG PATIENTS' WAITING TIME

Whilst waiting times are a burdensome experience in health care facilities, several studies have recommended some direct and indirect, short term and long-term interventions to alleviate long patients' waiting time. Gauteng Department of Health (2017:83) in a bid to decongest PHC facilities and reduce long patients' waiting times, introduced and implemented Centralised Chronic Medicines Dispensing and Distribution (CCMDD) programme.

Private service provider has been contracted to manage the dispensing of repeat prescriptions for chronic patients and the distribution of repeat medicine parcels to public and private pick-up points. In the context of this study and provision herein contained, a pick-up point is an authorised service provider which will receive the patient's medicine parcels and hand them to the patient on the appointed day (Gauteng Department of Health 2017:83). In view of the fact that there is participation of private sector pharmacies, this programme is ideal in improving access in that they offer longer working hours, including weekends. Some clinics that were previously not operational on Saturdays, have now extended their operation days to include Saturdays. The essence is to alleviate the congestion in CHCs that leads to long patients' waiting times. Services such as family planning and male medical circumcision can be offered on Saturdays, thus freeing up some time to engage in seeing other patients during weekdays.

National Department of Health (2019:7) asserts that the initial step in solving the dilemma of unacceptable long patients' waiting time and its consequences is to determine processing time for all patients and developing custom-made solutions as per identified bottlenecks in various areas and streams of care. This would entail measuring waiting times using the appropriate tools for example, in the acute, chronic, rehabilitation or Ante Natal Care sections of a CHC. If it is discovered that in a particular stream of care there are obstructions, decongestion efforts should then be specific to those blockages.

Tegabu (2008:89) and Umar et al (2011:82) proposed opening of facilities earlier, scheduling appropriately-timed appointments for follow-up patients, encouraging staff to prioritise attending to patients as well as increasing service times where appropriate. These proposed solutions provide for improving on functional and system efficacies of a CHC. Additional trouble-shooting of long patient's waiting time aligned to that of Tegabu (2008:89) and Umar et al (2011:82) is by Viberg et al (2013:54) in asserting that system and/or organisational arrangements and availing resources to confront and deal with number of health care users that would present at a particular time should be considered in attempting to resolve long patients' waiting time.

In concurring with these recommendations to reduce long patients' waiting time, (Kama 2017:83) put emphasis on instituting appointment or booking system. Accordingly, not only should it be about an appointment system, but one with staggered time-slots. Similarly, (Kama 2017:83) appreciates that organisational arrangements need to be streamlined such that the booking system is seen to be efficient to yield the desired outcomes. The assertion is that once interventions such as appointment system are effective, patients can have faith and trust in health systems improvement measures.

Belayneh et al (2016:6) mentioned that 45.7% of respondents indicated that they would be better off watching television, whilst 37.9% preferred to listen to health talks. Whilst these two recommendations do not necessarily reduce waiting times, they are a means to acknowledge patients' waiting time and providing temporary relief to their distress.

In support, Hill and Joonas (2005:84) stressed that “occupied” time goes faster than “unoccupied” time, thus recommending that in instances where waiting is expected to be longer than the norm, it would be better to keep patients occupied. Besides watching health programmes on television sets, availing variety of current magazines in respective waiting areas should be encouraged and practiced in CHCs. Other than that, Hill and Joonas (2005:84) recommend patient-lead initiatives including reading novels, newspapers or knitting.

Whilst it is recognised that the problem of long patients’ long waiting time is difficult to positively impact on, modification of adverse staff behavioural conduct is seen as equally important to lessen the impact. This implies providing the awaiting patients with regular updates as to the delays and sharing useful information about services they are going to receive. Beyond this, Xie and Or (2017: 7) focused on staff attitudes to lessen the unpleasant impact of long patients’ waiting time by recommending that health care providers should be encouraged to offer respect, show empathy and behave in friendly manners to patients and their escorts alike.

2.9 CHC FACILITY MANAGERS’ ROLES AND RESPONSIBILITIES

Facility Managers as accounting officers, have occupational responsibilities to oversee to it that day to day operations in their respective CHCs meet the expectations of patients by amongst others, providing quality care within reasonably acceptable waiting times. The following are amongst the key guiding frameworks speaking to this obligation:

2.9.1 Primary Health Care supervision manual

In introducing the PHC supervision manual, National Department of Health stipulated that PHC supervisors should be well geared to recognise and identify affective issues that need to be addressed to enable steering PHC in the unsurpassed and desirable direction (South Africa 2009:2).

Accordingly, such needs include, but are not limited to, supplies, staff needs (knowledge and technical skills), information systems and patients' needs. In line with this study, patients' needs amongst others take into consideration long waiting time as lamented by several investigators herein cited. Further emphasis by the National Department is that a PHC supervision manual serves primarily to provide a structured and guided supervision that is evidence-based and whose requirements are easily implementable.

Notably, these supervisory activities should in the end be measurable to at least guarantee shepherding of quality PHC in health facilities (South Africa 2009:4). This supervision manual advocates that respective managers in charge of CHCs and clinics should immerse themselves in organising their facilities to reduce waiting times to a minimum and initiate an appointment system when necessary (South Africa 2009:1:3). Prime emphasis, according to the supervision manual, is the imperative that PHC managers should determine patients' waiting time in line with the local service standards. Amongst what can be implemented, flow charts can be developed and applied for technical standards dealing with the available streams of care such as acute, chronic, support as well as mother and child services (South Africa 2009:37). For the purposes of ascertaining that service standards around waiting time are met, National Department of Health recommends regular monitoring and instituting corrective measures to combat waiting time bottle-necks (South Africa 2009:188).

2.9.2 Job Description

A job description is defined as a legally binding document that prescribes assigning of essential tasks to a specific position (Mangaleswaran & Kirushanthan 2015: 30). According to Royer (2010:14), job description also identifies reporting relationships and may also describe required qualifications, minimum requirements, working conditions, and desirable qualifications. Accordingly, the job description provides that amongst other responsibilities PHC managers need to exude competencies in executing the following:

2.9.2.1 Plan and organise clinics

This implies implementing strategies that would work best to improve organisational efficiency. It is a managerial function that should be custom-crafted as informed by the demands placed on any particular facility. Amongst difficulties that need precedented attention through better facility design would therefore be long queues in health facilities.

2.9.2.2 Identify community needs

The crux in this regard entails conducting patient satisfaction surveys or rapid appraisals in aid of establishing areas of patient discontentment. These would be noted as matters that need betterment. As a contentious public health subject, waiting time and any other impactful issue would need to be remedied. It can thus be deduced that facility managers in charge of CHCs have a prime responsibility of determining whether community needs are met. This entails checking if patients are comfortable with duration of time they spend in the facilities.

2.9.3 National Core Standards

In 2011, what came to be known as National Core Standards for health establishments in South Africa were developed (South Africa 2011:8). Setting of standards in any setting primarily seeks to improve processes and activities that should uplift the level of quality in any service delivery platform. These tenets therefore sought to provide parameters for dispensing decent, safe, prompt and overall quality health care that meets or exceeds patients' expectations. According to National Department of Health (2011:19) CHC managers have the duty to ascertain fulfilment of the following five standards falling within the waiting time domain:

2.9.3.1 Queue and patient-flow management persons

Desirably, it is considered beneficial that in a CHC, some officers be delegated or assigned to receive and direct patients to the various right points of care. The essence is to avoid scenarios of patients getting lost in the complex structures of these facilities. Realisation of this good practice would alleviate time lost by patients whilst wandering about looking for the right service points.

2.9.3.2 Documentation on agreed-upon waiting time targets or benchmarks

This document should as per the CHC's capacity and available resources, outline what the agreed, yet acceptable time-frames are. The set minimum and maximum waiting times should then be publicly displayed in different strategic areas of a facility. In a conventional setting, it would be practical to indicate the expected waiting times in areas such as the registry, points of care including the pharmacy.

2.9.3.3 Patients are informed of how long they will wait in the queue

Besides exhibiting the set waiting time target in different areas, it becomes courteous to constantly inform the awaiting patients of the anticipated duration of waiting. This should be prioritised in instances where it is anticipated that the set targets will be exceeded. Patients consequently, need to be informed of such delays by the CHC manager. This good gesture not only allays patients' anxiety invoked by long waiting but restores confidence.

2.9.3.4 There is a system in place to reduce waiting time for files

Reduction of lengthy waiting times cannot be achieved through just one strategy. CHC managers are obliged to amongst others, allocate sufficient number of officers to register and create files for new patients and be able to retrieve files for existing patients within set time parameters. Additional and helpful strategy is to pre-retrieve file of patients whose appointment dates are known a day before.

2.9.3.5 Report on measured waiting times

The obligation rested on the shoulders of CHC managers is to monitor, evaluate, record and report on the entity's performance regarding measuring waiting times. Where non-compliance is identified, the expectation from CHC managers is to develop waiting time performance improvement plans.

2.9.4 Ideal Health Facility Realisation Framework

The National Department of Health (2018b:4) recognises that the purpose of a health facility is to promote health on an ongoing basis, timely prevent illnesses and mitigate against further complications through prompt and early detection, treatment and appropriate referral. To achieve this, a CHC should function optimally thus requiring a combination of elements to be fulfilled to render it an "Ideal CHC."

The following are Ideal Health Facility Realisation Framework elements, which are indistinguishable to the erstwhile National Core Standards on waiting times:

2.9.4.1 Availability of national policy on management of waiting times

The custodianship of this legislative document is with the National Department of Health. At the present moment, it is available in the draft form. Soonest it is signed off and made available to CHC managers, its contents will have to be understood and communicated to all personnel attached to a CHC.

2.9.4.2 Visible display of national target time to be spent in a facility

It is herein prescribed that notices with regards to commitment not to exceed the national target of 180-minutes is visibly displayed. Visibly displaying such notices will maximise that they are noticed by health care users for the purposes of holding the CHCs accountable and liable for waiting time more than the set targets.

2.9.4.3 Monitoring of waiting time using the prescribed tool

According to the expectations set by the department, waiting time performance needs to be monitored, evaluated, recorded and reported using the standardised tools. Use of standardised tool serves to ensure validity and reliability in terms of processes employed to monitor waiting times across all CHCs country-wide.

Average total time that a patient spends waiting for services in the facility should not be longer than 2-hours in either a clinic or CHC. The 2-hours combined with the recommended 1-hour for consultations result in 3-hours total time spent in a facility. From the reports generated above, it needs to be demonstrable that total time spent in a CHC does not exceed 3-hours.

2.9.4.4 Intermittent informing patients of delays and reasons thereof

It is a humane and considerate gesture to acknowledge factors responsible for impeding smooth-dispensation of quality health care services. The expectations are that facility managers and staff alike should as reasonable as it allows, constantly survey queues to assess speed with which they are moving. Where delays and interruptions are imminent, it is humanitarian and compassionate to engage health care users about such.

2.9.5 Waiting time-specific roles and responsibilities

As alluded by Swart et al (2018:3) and Naicker et al (2018:287), extreme waiting time may potentially be a symptom of operational and/or managerial inefficiencies in a CHC. It thus becomes the responsibility of facility managers in charge of these facilities to alleviate long patients' waiting time by amongst others. Naicker et al (2018:289) recommends amongst others the following:

2.9.5.1 Demand management

Managers in CHCs need to plan and allocate resources to meet the day to day patients' visits. To lessen the long waiting time, attention and priority should be on those "busy days." Swart et al (2018:5) further suggested that demand management would be better realised if all PHC nurses could collect patients' vital signs as early as it is permissible. This will at least assist in the sense that on arrival and commencement of duties, doctors and clinical nurse practitioners would not have to wait for patients. Clinical consultation will commence without delays caused by waiting for collection of vital signs.

2.9.5.2 Queue management

Realisation of unclogging congested queues relies on active monitoring of areas in the CHC that may be choked with large patient numbers, thus causing delays. Walking about the establishment can assist in early identification of bottle-necks in the patients' flow thus necessitating spontaneous institution of interventions. Patients whose visit to the CHC does not warrant extensive engagement with health care providers should be cleared by prioritising them. Patients whose chronic conditions such as Epilepsy, Diabetes Mellitus and Hypertension are stable, could be scheduled to visit the health care establishment once in three months, adds Swart et al (2018:5).

Gauteng Department of Health (2017:83) and Meyer, Schellack, Stokes, Lancaster, Zeeman, Defty, Godman and Steel (2017:7) have come to recognise CCMDD as a structured, safe, reliable and timely service delivery model to bring medication closer to a patient's workplace or home. This implies that as far as it is possible, patients would not need to physically present as frequent as before for "just" collection of medication. It thus exerts the need for managers to advocate for enrolment of chronically stable patients on the CCMDD programme.

2.9.5.3 Manage Capacity

Health care facilities do not always have the luxury of ample staff. Effective and efficient use of the available few would need facility managers of CHCs to be pro-active in determining the expected volumes of patients. The elaboration by Johannessen and Alexandersen (2018:11), Swart et al (2018:5) and Naicker et al (2018:18) indicate that this could take the form of scheduled appointments. Once this is determined, it becomes relevant to then explore implementing amongst others, flexi-hours by assigning personnel to be on duty during high volume periods. Capacity need not only be about number of staff allocated to render health care services, but capacity in terms of skills and expertise.

Swart et al (2018:288) concluded by emphasising the importance of having PHC trained professional nurses in facilities to enhance their clinical competence and reduce patients' waiting times at CHCs and clinics alike. It is important to multi-skill and capacitate health care providers, such that they are able to provide package of integrated services in just one room.

2.9.5.4 Provide Leadership

The imperative approach is to walk your plant to get the gist of patient flow in a CHC. Distinct of virtuous leadership, the resolve of identified bottleneck should be as prompt as possible. According to Naidoo and Mahomed (2016:8), demonstration of leadership should reflect amongst others the following:

Recognition that a problem exists
Noting and appreciating that patients' long waiting time is a malady, serves an indication for aspiring to find solutions. It is therefore, through acknowledging existence of challenges that improvements are needed.

Adopting a human-centred approach

This is the instance whereby officers in a CHC are involved and are part of the solution generation from the onset. This promotes sense of collective participation, thus paving the way to maximise achievement of desired outcomes, which is reduced patients' waiting time.

Guiding direction for sustenance

The imperative is for other stakeholders to drive and take ownership. It encapsulates possessing skills and other pre-requisites to associate and build socio-personal relationships. Pivotal to this leadership stewardship is the need to sustain and maintain the rapport with these community and social stakeholder.

2.10 SUMMARY

This chapter thus discussed several studies into patients' long waiting times. The review paid attention on previous scholarly insights by focussing on the waiting time phenomenon, global situations, international context, African perspectives and the South African outlook. This review further looked at existing legal frameworks within the South African context, discussed contributory factors, the effects of waiting long, mitigation strategies as well as and roles and responsibilities of CHC facility managers.

CHAPTER 3

RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

Chapter 2 provided literature review on patients' long waiting time trends globally, the Sub-Saharan Region and South Africa. This chapter provides an overview of methodology used in the investigation into experiences of facility managers regarding patients' long waiting time at Tshwane health district CHCs. The discussions in the chapter are crafted to reflect on the research design, sample, population sampling, ethical considerations and scientific measures to provide trustworthiness. Research methods, which are an account of how data was collected and analysed are similarly deliberated on (Houser 2018: 133).

3.2 RESEARCH SETTING

The account by Nelson (2014:12) and Leavy (2017:149) refers to study setting as the environment and conditions in which the study will take place. According to Tracy (2013:29), in qualitative studies, the researcher's intentions are to describe and understand events within the concrete and natural context in which they occur.

This study was conducted at eight CHCs in Tshwane health district. According to Department of Cooperative Governance (2020:5), the population of Tshwane district stood at 3 555 741 by 2017. Seven sub-districts make up the district, namely Sub-District 1 to 7. The district's PHC delivery platforms include sixty-five clinics and eight CHCs. These PHC entities provide promotive, curative, maternal and chronic care services through a well-defined and coordinated referral system. Five district, one regional, one tertiary and two academic hospitals support these PHC facilities. The health facilities included in this study were the eight CHCs; namely Kgabo, Soshanguve and Phedisong 4 in Sub-District 1, Temba in Sub-District 2, Laudium in Sub-District 3, Stanza Bopape and Eersterus in Sub-District 6 and Dark City in Sub-District 7.

3.3 RESEARCH DESIGN

Research design, referred to otherwise as a research paradigm or research strategy by Polgar and Thomas (2013:18) refers to a plan in which the investigator will engage with participants for the purposes of achieving study objectives.
Research objectives pertinent to this study which steered the researcher in the subsequent research processes were:

- To explore and describe experiences of facility managers regarding patients' long waiting time at Tshwane health CHCs.

- To make recommendations aimed at reducing long patients' waiting times at Tshwane health district CHCs.

Mainly, research design serves to guide that the evidence gathered enables arriving at answering or responding adequately to the initial research question(s) as explicit, credible and scientific as possible (Houser 2018: 133).

With relevance to this enquiry, the questions that needed to be responded to were:

- What are experiences of facility managers regarding patients' long waiting time at Tshwane health district CHCs?

- What recommendations may be made for facility managers and other vital stakeholders to lessen patients' long waiting time at Tshwane health district CHCs?

This study espoused a qualitative, explorative, descriptive design that was contextual to leverage profound insight and understanding experiences of the facility managers regarding patients' long waiting time at Tshwane health district CHCs.

3.3.1 Qualitative research approach

In this investigation, qualitative design was adopted. As expressed by LoBiondo-Wood and Haber (2014:111), qualitative designs primarily focus on human experiences, meaning and understanding from the point of views by research participants. As stated by Tilley and Long (2014:228), qualitative designs are distinguished by subjective and deep examination of experiences, perceptions as well as understanding of a phenomenon.

Tilley and Long (2014:228) elucidate further that qualitative investigations tend to examine complex, uncomfortable or even sensitive topics such as sex, religion, death penalty, racism and colonialism. In this enquiry, the complex matter being examined is patients' long waiting time from the perspectives of health care services custodians, facility managers of CHCs.

As mentioned by Polgar and Thomas (2013:79), qualitative research seeks to give meaning to idiosyncratic human experiences as lived by individuals. Brink et al (2018:14) caution that to achieve all these, it is in the best interest of the study that the investigator takes an impartial stance by standing back and allowing the research participants express themselves liberally.

The emphasis by Polit and Beck (2017:471) guides that qualitative research dips itself in reviewing social phenomena by providing deep and detailed narratives. Qualitative research was appropriate for this enquiry as it allowed the researcher to infiltrate participants' reserved and private occupational space.

3.3.1.1 Advantages of qualitative research

Taylor, Bogdan and DeVault (2016:7) arguing in favour of qualitative research cited that it takes place right in arenas where participants experience the phenomenon being studied. This is the natural and uncontaminated environment, which maximises participants' solid responses.

Rahman (2017:104) added that qualitative enquiries contribute in unravelling an array of amusing meanings which people attach to their worth-while daily experiences. It is therefore a platform to establish how the world is viewed from different perspectives without the influence by the researcher.

Polit and Beck (2017:472) posit that researchers in qualitative studies endeavour to be holistic, thus advancing to understand phenomena in whole. Participants' past and present experiences are not spared. Situations are entirely dissected. This compels the investigator to avoid reducing people and their settings to some kind of variables, but rather as a whole. A qualitative enquiry is therefore widely exhaustive and inclusive as it detaches from any numerical and statistical quantifications (Queirós, Faria & Almeida 2017:379).

Qualitative researchers are not bound by sample size; therefore, the researcher often collects data until there is no new information offered by the participants, that is, data is now repeating itself. According to Saks and Allsop (2013:27), in qualitative research knowledge is constructed by the participants, meaning that it seeks to understand the subjective meanings of the participants.

3.3.1.2 Disadvantages of qualitative research

Queirós et al (2017:379) have advanced that qualitative research can be time consuming with resultant ballooning of the associated costs.

Further criticism by Brodsky et al (2016:18) is that since the sampling approach in qualitative studies tends to be purposive and selective, it can be challenging to eliminate bias.

It has further been alluded by Merriam and Tisdel (2016:253) that smaller sample sizes despite reaching data saturation, raise the issue of generalisability to the whole population.

3.3.2 Descriptive research approach

Descriptive designs are studies in which detailed definition and description of some process, event, outcome or social phenomena is explicated to provide an exhaustive depiction of a phenomenon as it naturally occurs (Neuman 2014:38; Houser 2018:140).

Descriptive studies according to Reynolds and Guest (2015:45) are conducted to investigate issues apposite to health service needs, experiences or behaviours to inform necessary interventions. Once a subject of interest has been reasonably described, an exploratory study would follow to now set out discovering as much about the phenomenon to effectively derive meaning.

The design was chosen for this study as it allowed the researcher to obtain complete and accurate data through conducting audio-taped in-depth interviews. The process enabled listening to copious and detailed description of participants' experiences concerning the study phenomena. It further provided and allowed identifying meanings and making sense of the described experiences, thus assisting the researcher to disentangle complex issues into easily understandable reflections of the study phenomenon. The dense descriptions of experiences that emerged during data analysis enabled the researcher to develop insight and construct an in-depth understanding regarding facility managers' experiences of patients' long waiting time their daily roles and responsibilities as accounting officers in charge of CHCs.

3.3.3 Explorative research approach

Exploratory research, according to Neuman (2014:38) refers to a study whose purpose is to explore the dimensions influencing a particular phenomenon or develops if not refining hypothesis about relationships between phenomenona. It is a scientific departure when study phenomenon is new, implying nothing is known about it or little is known about it. Owing to the supposition that not much has been researched about the topic or the population being studied, the investigator dips in listening to participants and build an understanding based on what is provided and heard (Houser 2018:137).

To the extent of finding answers, the impetus of explorative research is to interrogate the "what" aspects of an investigation unique to a phenomenon. Burau (2013:404) drives the narrative that explorative studies aid in avoiding both "false particularism" which refers to concluding that 'everywhere is unique' and "false universalism," assumption that 'everywhere is the same.' It thus aims to scientifically identify what is different and what is similar. In the context of this study, literature on studies that have investigated experiences of CHC facility managers regarding patients' long waiting time at Tshwane health district is scanty.

Exploratory research in this study was conducted using qualitative, unstructured and individual in-depth interviews in order to advance the researcher's inquisitiveness and desire to extract and generate qualitative data for a better understanding of these experiences, particularly from the facility managers' point of view. This method was adopted as it implied that the researcher would be willing to study new ideas and possibilities without allowing predetermined ideas and hypotheses to direct the research.

3.3.4 Contextual make-up

Yin (2016:9) articulates that in qualitative research, contextual design takes place in environments and conditions under which the study phenomenon is occurring and experienced by participants. Tracy (2013:3) expands that contextual qualitative studies are about immersing oneself in the scenery and trying to make sense of it wherever that is. It is the qualitative stance whereby researchers purposefully examine and make note of small cues in order to decide how to behave, including making sense of the context and build larger knowledge claims about the study. Contextual qualitative inclination, according to Polgar and Thomas (2013:212), is otherwise known as naturalistic or field settings, referring to uncontrolled real-life situations.

This enquiry into experiences of CHC facility managers regarding patients' long waiting time was conducted in the actual participants' work-place, which is exactly where the phenomenon is encountered. This contextual tactic thus enhanced participants' prospects of meaningfully expressing their experience, attitude, behaviour and ultimate responses in relation to this study.

As asserted by Tracy (2013:29), the researcher aimed describing and understanding events within the concrete and natural background in which they occur. Research done in a natural setting refers to an enquiry done in a setting free from manipulation. The unique context used for the purpose of this research was at Tshwane health district's eight CHCs, where long patients' waiting time is experienced.

3.4 RESEARCH METHOD

Polgar and Thomas (2013:20) share that method refers to scientific demonstration by the researcher on how particular rules of evidence were instituted in collecting, analysing and interpreting study data. Further elaboration is that a research method serves to inform scientific bibliophiles of precisely how the study was executed such that the elaboration of details enables other researchers to replicate the study (Polgar 2013:20). This section thus provides description on sampling, determination of population, sample selection, data collection method(s), data collection instrument, ensuring validity and reliability, ethical considerations and data analysis.

3.4.1 Sampling

Sampling denotes a methodical process of selecting the sample from a population (Brink et al 2018:114). The associated intent of sampling is to obtain information regarding a study phenomenon such that it is eventually demonstrable to be representing the study population. The preamble by Neuman (2014:246) provides that investigators embark on sampling since it is not possible to study every case of whatever a researcher is interested in. The essence is that every scientific enquiry tries to find out something that will apply to everything of a certain kind by studying a few and applicable cases, the results of which should ideally be "generalisable."

3.4.1.1 Population

Population, according to Polgar and Thomas (2013:214) refers to a group of people, institutions, objects or cases of distinct interest that are defined to be under study by the researcher. Bloom and Trice (2014:180) add further in mentioning that it is the complete set of elements that fulfil specified criteria since they possess common characteristics pertinent to the study phenomenon. The target population referred to the entire population of CHC facility managers in Tshwane health district who met the inclusion criteria and findings applying to them. The accessible or study population were all CHC facility managers that were available and participated on the day of data collection.

3.4.1.2 Sampling

Sampling is a scientific process that focuses on selecting representative units of a population by the investigator during the course of a study (Haber (2014:232). Non-probability purposive sampling method was adopted to select sample. Rasmussen, Akinsulure-Smith and Chu (2016:24) narrate that non-probability purposive sampling is a deliberate selection of a sample, informed by the fact that participants meet eligibility criteria. This type of sampling is considered appropriate for qualitative studies where the researcher is interested in participants who apparently possess the rich and relevant knowledge concerning the research topic (Yin 2016:93).

In purposive sampling relevance of these cases provided the researcher with ample and significant insight into their experiences regarding their phenomenon of interest (Houser 2018:391). The adoption of purposive sampling, also known as convenience sampling has therefore allowed the researcher to specifically select facility managers working at Tshwane health district CHCs. This was solely to enable extraction of information rich understanding apropos to their experience about patients' long waiting time (Terrel, 2016:75).

3.4.1.3 Inclusion criteria

These are specific characteristics that participants need to possess in order to be eligible to participate in a study (Bloom & Trice 2014:183). In this regard, the investigator provides elaborative insight by specifying what the sample will look like. Facility managers who are working at Tshwane health district CHCs, with over a year's experience were selected for inclusion since they are appointed as accounting officers at those facilities. This thus makes them better placed to share information regarding their experiences about the patients' long waiting time. In this study, eligibility of facility managers working at Tshwane health district CHCs drew strength from the fact that they were relevant and regarded as information-rich to better respond to questions regarding the patients' long waiting time. This method was deemed appropriate to select specifically unique cases that are particularly informative apposite to the research objectives and questions (Neuman 2014:274).

3.4.1.4 Exclusion criteria

Bloom and Trice (2014:183) emphasise that exclusion criterion is not necessarily the opposite of inclusion criteria, but rather those features which if present, would make participants ineligible to be included in the study sample. In this research, managers working at clinics, hospitals and any other entity, other than a CHC in Tshwane health district were excluded. The exclusion further included CHC managers with less than a year's experience and those appointed in acting capacity due to limited delegations.

3.4.1.5 Ethical considerations related to sampling

Ethics, as echoed by LoBiondo-Wood and Haber (2014: 255) are concerned with the discipline that deals with principles and philosophical stances of observing, applying and complying with moral values and conduct during a scientific study. Polgar and Thomas (2013:42) impart that ethical considerations, as guided by the need to maintain scientific integrity, are values that direct the investigator on how to conduct research maintaining professional, legal and social obligations.

These ethical contemplations, as they pact on right or wrong, good or bad, govern a researcher's behaviour and conduct during the enquiry process (Summer & Cannon 2014:85). The researcher received ethical clearance; REC-012714-039 (Annexure A) to conduct the study from University of South Africa's (UNISA) Higher Degree Ethics Committee. Request to conduct the study was sought and subsequently approval granted by the Tshwane Health District Research Committee, (Annexure C).

For the purposes of establishing the rapport, the researcher had entry meetings with the participants and explained the aim and objectives of the study. The researcher further enlightened the participants on their rights, including providing them with a detailed information leaflet (Annexure E). The latter is a document ethically binding to the researcher to protect the participants from harm. Post these elaborations, voluntary conscription of the participants was obtained from all the eight CHC managers in Tshwane health district (Annexure F). These ethical considerations were ultimately concluded with signing-off of the consent forms. (Annexure G).

3.4.1.6 Sample

As imparted by Aveyard (2014:117), Fink (2019:84), Toles and Barosso (2014:100) and Leavy (2017:76), sample refers to reasonable, specific and accessible participants selected from the wider population to form part of a study. Bloom and Trice (2014:181) submit that samples, instead of the whole population are used in studies for efficiency and cost-effectiveness purposes.

The justification is basically the impracticability to study the entire population. It thus becomes rational to make valid inferences about the entire population without necessarily including and studying every element in that population. In qualitative studies, as mentioned by Toles and Barosso (2014:116), sample selection involves choosing participants who are confronted, experiencing or had experienced particular circumstances, events or incidents related to the study phenomenon of social interest.

This qualification consequently directs the researcher to adopt purposive type of a non-probability sample. Such a sample, against the qualitative study, is ideal as the participants are better suited to provide the researcher with best knowledge relevant to the research topic. In this study, inclusion and exclusion criteria informed the sample. The sample thus was made of facility managers of CHCs in Tshwane health district.

3.4.2 Data Collection

Data collection, according to Boswell and Cannon (2014:443) is a process of gathering and compiling information related to the intended study. The emphasis on data collection is to ascertain that it is conducted in a scientifically reputable manner that facilitates answers to research questions and objectives, leading to the outcomes. With regards to qualitative research, data collection is aimed at gaining insight and understanding persons in their socio-occupational environments. It thus seeks to provide and produce accurate descriptions based on researcher-participant interaction in a natural setting. Therefore, as mentioned by Brink et al (2018:132), data collection should provide an audit trail which includes a clear and specific explanation of how data were collected, how the results or findings were arrived at as well as the rationale for the selected method. This study was conducted onsite, at the respective CHCs in Tshwane health district, the natural setting where the CHC facility managers are employed, which allowed them to feel relaxed and engage freely.

3.4.2.1 Data collection approach and method

In this qualitative study, data was collected using unstructured interviews from the CHC managers. An interview guide (Annexure D) was developed and used by the researcher. Its use sought to warrant reasonable uniformity, ascertained desired coverage of the areas of enquiry and comparability of information across respondents in respect of all salient points in the study (Polgar & Thomas 2013:93-94).The credence by LoBiondo-Wood and Haber (2014:579) and Brink et al (2012:157), is that interviewing is a method of data collection in which the researcher asks germane questions to the study participants in a face-to-face encounter.

The good that comes from interviews is that they are suitable when participants cannot be directly observed. Interviews allow the researcher to take control over the line of questioning and further give the participants an opportunity to provide historical yet suitable information. Instead of being just an ordinarily interested listener, the researcher may engage meaningfully and constructively in the interview conversation. The essence is to encourage participants to share as much about the topics to be covered.

Relevant to this research, unstructured interviews were embarked on as they allowed participants liberty to spontaneously share their lived experiences. That further assisted the researcher to explore and describe experiences of facility managers regarding patients' long waiting time at Tshwane health district CHCs. Furthermore, the unstructured interviews also aided direct collection of rich information from the participants as the primary data collection instrument.

Unstructured interviews are also referred to as in-depth interviews wherein the researcher seeks to understand the experiences of others and the meaning they attribute to the experience. Tilley and Long (2014: 229) assert that the choice of unstructured interviews allows the researcher the leverage of using a list of fairly broad questions to be covered, particularly in relation to lived and shared experiences.

An interview guide, (Annexure D), which is an aid in navigating through as list of general areas to be covered with each participant, based on the research topic and the literature reviewed was used (Taylor et al 2016:123). It was characterised by containing pre-determined open-ended questions. Interview guide serves solely to remind the interviewer, who is primarily the researcher, to stay in track, focusing only certain and applicable study issues (Taylor et al 2016:124). Additionally, an audio recorder was used to record the interviews. Merriam and Tisdell (2016:131) justify the use of an audio device in that it safeguards and preserves data gathered during interviews for analysis later on.

3.4.2.2 Development and testing of the data collection instrument

An interview guide, (Annexure D) with four open-ended questions was developed with hindsight of study objectives to be achieved and questions to be answered. Terrel (2016:147) as well as Polgar and Thomas (2013:83) caution that crafting of a data collection instrument should take into cognisance the fact that the content and design of questions remain important for validity of the obtained information. Validity refers to the instrument's ability to measure consistently what is set to measure (Houser 2018: 205).

Testing the data collection instrument implied conducting a simple study as a run-up to the main or parent study (Haber (2014:245). This exercise assists in testing feasibility of the actual intended study, with the aim of detecting likely errors. As a novice researcher, testing the instrument assisted with sharpening needed competencies. The pilot was conducted on three participants at their respective CHCs on 29 November 2019. The three participants had given prior permission. During this testing phase, the functionality and sound quality of the audio-recorder was as well tested. The four open-ended questions as they appear on the guide were asked to the three CHC facility managers. This was followed by probing questions as dependant on the responses by the study participants. Supportive field notes were taken during testing phase to assist in better understanding of the phenomenon.

3.4.2.3 Characteristics of the data collection instrument

The data collection instrument characterised itself with four open-ended questions. This was to allow platform to gain elucidate responses from the participants. Over and above, probing and follow-up questions flow easily from this type. For the intention of arriving at understandable questions, the researcher developed simple, clear and brief questions, including avoiding double-barrelled and unambiguous ones (Brink et al 2018:141).

3.4.2.4 Data collection process

Data collection process, according to Zozus (2017:249) is a description of fundamental procedures which the investigator will espouse in answering the study questions. After obtaining approval to conduct the study from Research Ethics Committee of University of South Africa, REC-012714-039 (Annexure A) and Gauteng Department of Health; Tshwane health district (Annexure C), the researcher set to meet individually with facility managers of the eight CHCs in Tshwane Health District on the dates they had indicated their availability.

Participants were informed that they will be phoned to set up interview appointments and that they would be reminded of the set appointments a day prior. On the arranged suitable date, CHC facility managers were allowed to find space within their facilities where they would be comfortable, with no distractions such as noise. Ventilation and illumination in the room were fit for purpose to ensure that participants felt free and safe. A “do not disturb” sign was put outside the arranged room with no telephone or cellphone interference. In each encounter, the investigator introduced himself to the CHC facility managers and informed them about the study. The researcher enlightened them on the aims and objectives of the study, as well as explaining the inclusion and exclusion criteria of targeted participants. Participants were also informed that taking part in the study meant they would be interviewed about their individual and particular experiences regarding patients’ long waiting time at their respective CHCs. Of importance, the researcher clarified that their consent to be part of the study was voluntary.

English as the medium of communication in Tshwane health district was used to conduct individual interviews with the participants. Permission to audiotape the interview was sought and obtained from participants. The individual interviews were recorded on an audio recorder and later transcribed (Annexure H). Field notes were also taken. The individual interviews lasted between 47 to 105-minutes per session. To reach the main objective, techniques such as probing, clarifying, reflecting and paraphrasing were used during the interviews. This was done to encourage participants to express themselves freely and to enhance in-depth descriptions of the required phenomena.

3.4.2.5 Ethical considerations related to data collection

The researcher to an extent possible and permissible by law, applied due scientific consideration to keep all records associated with this study private and confidential. Review of the study records was subjected only to persons responsible for ascertaining compliance with the academic and scientific protocols. This included subjecting data to members of UNISA's Research Ethics Committee.

A qualified co-coder (Annexure I) was sought to independently code data using the provided protocol by the researcher. Due contemplation was exercised to ensure that participants involved in this study are not in any way identifiable. This is essential in scientific studies to avert stressing and embarrassing participants who have entrusted the investigator to protect their identity (Neuman 2014:148). In this study, and for the purposes of ensuring participants' actual verbatim responses, an audio-recording device was used to capture the responses during the interviews. Merriam and Tisdell (2016:131) clarify that this approach assists in obtaining detailed information that is a truthful reflection of what the participants shared as their experiences.

The use of open-ended questions, an audio-recorder, and verbatim transcriptions aided in increasing data accuracy. In qualitative studies, these methods of data collection assist in staying close to empirical enquiry (Taylor et al 2016:10). Achievement of the most encapsulating, precise and rich description of this qualitative study phenomenon was arrived at through the use of field notes, together with the verbally transcribed information (Merriam and Tisdell 2016:17). The researcher invested in requesting and obtaining permission to use the audio-recorder from the study participants. After each session, the researcher obligated himself to keep recorded interviews in a safe, confidential and space inaccessible to any other parties. In protecting the rights of the study institution and participants as well as upholding scientific integrity, the following ethical principles were observed and adhered to.

3.4.2.6 Protection of the rights of the study institution

3.4.2.6.1 Permission

The research was conducted on CHC managers at Tshwane Health District; Gauteng Province of South Africa after obtaining the ethical clearance from UNISA's Research Ethics Committee; REC-012714-039, (Annexure A). Further permission was obtained from Tshwane Health District Research Committee, (Annexure C).

3.4.2.7 Protection of the rights of the participants

3.4.2.7.1 Obtaining informed consent

Informed consent implies participants' agreement to freely and without cohesion, partake in a study (Hughes 2013:111). In this study, participants were provided with a consent form containing elaborate information about the study purpose and objectives. English language was used in the information sheet as it is the medium of communication by CHC Managers in Tshwane health district. The three fundamental ethical principles for protection of human rights, namely respect for persons, beneficence and justice were observed and complied with during the study (Brink et al. 2018:29).

3.4.2.7.2 Respect for persons

Study participants, for purposes of autonomy were informed upfront of their cardinal right to withdraw from the study at any given time should the need arise. Sumner and Cannon (2014:89) provide that autonomy refers to an individual's ability to make careful choices and decisions about what they are confronted with at a particular time.

3.4.2.7.3 Principle of beneficence

As provided for by Sumner and Cannon (2014:89), beneficence refers to the practice of maximising study benefits whilst minimising risks and harm as far as possible. It implies that the participants and society stand to benefit from the outcomes of the study (Terrel 2016:89). In seeking to uphold this value, the researcher reassured participants that their participation would be absolutely voluntary, and uncontested. An emphasis was made regarding their right to omit responding to any question which could make them uncomfortable. Over and above, participants were duly informed that they could withdraw from the study any given time with no resultant repercussions.

3.4.2.7.4 The principle of justice

According to Sumner and Cannon (2014:89), the principle of justice obligates the researcher to treat each participant in accordance with what is morally appropriate and correct. Participants were fairly selected for the sole purposes of the research problem. If there had been eligible participants who declined to participate in this study, they would have been treated fairly and without any prejudice. Conditions and any agreements entered into with participants were further observed and respected.

3.4.2.7.5 Right to privacy

In this study, privacy was maintained by adhering to the following: Anonymity and confidential procedures. In order to ensure that the participants are anonymous, codes rather their names will be used. The right to confidentiality was guaranteed by ensuring the participants that the information provided would not be made accessible to any other unintended parties except those involved in the research.

3.4.2.8 Scientific integrity

Scientific integrity, as provided by Brink et al (2018:36) entails complying with ethical responsibilities associated with conduct and reporting of the research. Crucial to this study was the duty to enhance scientific integrity. The researcher exercised due diligence to avert any research misconduct. It was a central drive to evade plagiarism, falsification and fabrication.

The definition of plagiarism by Pruzan (2016:288) is citing literature from other sources or authors and omitting to appropriately acknowledge them. In avoiding plagiarism, the researcher acknowledged in-text all literature consulted and provided references of the very same literature.

Pruzan (2016:105) guide that falsification encompasses manipulating the research processes, material and the very data being reported. The researcher has endeavoured that data was collected in the natural setting and without errors. Over and above, data analysis systemically performed following Tesch's eight-step technique.

According to Wong and Nather (2016:173), fabrication involves making-up and recording data or study results. This results in fictitious or invented data. In avoiding fabrication, the researcher recorded participants' responses followed by verbatim transcription.

3.4.3. Data analysis

Qualitative data analysis according to Flick (2014:5), is a precise scientific process entailing orderly arrangement and sorting of voiced and pictorial depiction such that it is seamless to interpret in making statements about what is overtly understood. This includes even the dimensions and structures of meaning-making as contained in the material and what characterises it."

Transcribing of collected data was verbatim. Tesch's 8-steps of data analysis were followed to analyse data (Creswell 2014:198). This implied employing Tesch's method of open coding whereby the researcher read carefully through all the transcripts in order to gain sense of understanding data. A qualified co-coder was brought on board this study to independently code data using the provided protocol by the researcher. Both the researcher and the co-coder arrived at an agreement for the good and purpose of enhancing trustworthiness.

The steps are described as follows:

3.4.3.1 Step 1: Get a sense of the whole

The researcher read all transcripts and devoted in scripting down the ideas that were emerging. This assisted the researcher to get a clear and comprehensive background of all transcripts.

3.4.3.2 Step 2: Pick one transcript

This second step saw the researcher investing in picking transcripts one at a time, which were thoroughly read to get the topics that are revealed in each of the transcripts. These topics were then written down on the margin of the document.

3.4.3.3 Step 3: Listing all topics

After reading all transcripts, with a whole list of topics compiled, the researcher articled all the topics in one document. All topics were compared to enable grouping similar ones together. The investigator proceeded to use headings to distinguish the different topics. Main topics as they were coming out were highlighted.

3.4.3.4 Step 4: Abbreviating topics as codes

The identified topics were abbreviated with codes. These codes were duly indicated in the data in the appropriate sections. The essence was basically to rule out if there were no new categories and codes emerge.

3.4.3.5 Step 5: Assign descriptive wording and categorise

Descriptive words were assigned to the identified topics as well as grouping them together in categories. Categories which are similar or relate to each other were then be grouped together to avoid having several categories.

3.4.3.6 Step 6: Finalise abbreviation

It was necessary for the researcher to condense these categories by deciding on final abbreviation, including labelling each category and codes to avoid duplication.

3.4.3.7 Step 7: Assemble data

Data belonging to each category was grouped together. The content of each category was analysed to check whether they are relevant to the research question. All those that were identified as irrelevant to the study were discarded.

3.4.3.8 Step 8: Data recording

In order to get the whole meaning and general sense of data, the researcher re-coded the very existing data. One was compelled to be content in drawing inferences on the already generated codes and categories. It became cardinal to re-explore any data properties to further identify the missed relationships and uncover patterns, in order to present the analysis. This step was instrumental in enabling blending of emerging topics into what was already analysed.

3.5 ENHANCING TRUSTWORTHINESS

Lincoln and Guba (1985) as cited in Lincoln and Guba (2013:103) define trustworthiness as the quality of an inquiry to the extent that the findings and interpretations made are consequential to methodical processes followed. This further embrace concluding whether the findings and interpretations can be trusted.

Polit and Beck (2017:559) further mention Lincoln and Guba (1985) in demonstrating that trustworthiness is made up of four criteria which are applicable and relevant to qualitative research; credibility, dependability and conformability and transferability. These four principles are discussed below.

3.5.1 Credibility/truth value

Referring to Lincoln and Guba (1985), Polit and Beck (2017:559) describe credibility as the assurance that there is truth and accuracy of data including the associated interpretations. In (2016:85) elaborates that a credible study should provide assurance that a researcher has diligently collected and interpreted the data. It should therefore be demonstrable that the findings and conclusions accurately reflect and represent that which the study sought out to achieve. Prolonged engagement and member-checking are the two strategies employed to ensure credibility.

3.5.1.1 Prolonged engagement.

In the context of this study, the researcher stayed in the field until data saturation was reached. Korstjens and Moser (2018:121) imparted that this immersion in the field aided the investigator to gain in-depth understanding of the study phenomenon, including certain aspects of the participants. By spending substantial time with the participants, the researcher was able to establish meaningful rapport and build worth-while trust with participants.

3.5.1.2 Member-checking

During individual interviews, participants were engaged through intermittent probing for clarification of their responses. Frequently asking to review, validate and verify interpretations served to establish resonance with their experiences and deductions arrived at by the researcher. According to Korstjens and Moser (2018:121), this is done to ascertain that the participants' account of shared facts has not been misplaced.

3.5.2 Dependability/consistency

Dependability implies that if the investigation was to be repeated in the same context, using similar methods and participants, same results would be arrived at (Merrian & Tisdell 2016:251). In this investigation, stepwise approach that sought to scientifically describe study methodology, sample characteristics, data collection procedures and data analysis, was sequentially provided.

This was further enhanced by keeping notes and raw data, which assisted in verifying authenticity and accuracy. In the end, it was possible that if an audit to review the inquiry process was conducted findings, interpretations, and recommendations would most probably be consistent to confirm genuineness of the course of the study.

3.5.3 Conformability/neutrality

According to Brink et al (2018:159), conformability relates to ascertaining data neutrality and congruency with focus on accuracy and relevance. Emphasis is that the collected data should represent information shared and provided by the participants.

The researcher guarded against reflexivity. Reflexivity, according to Yin (2016:339) refers to the dynamic interplay whereby the researcher's own biases, preferences, and preconceptions could influence the study. Additionally, participants are as well likely to be influenced by the presence and very actions of the researcher.

To counter-act this limitation, the researcher used a reflexive or personal journal. The latter is a diary-like record, which was instrumental in capturing methodological choices, pre-conceived ideas, dilemmas, and discretionary judgments encountered throughout the course of the study (Yin 2016:338).

The interpretations of data were therefore, not left to be influenced in anyway by the researcher. Study findings were in the making, supported by verbatim quoting of what participants expressed. The study promoter was thus subsequently allowed the liberty of auditing the procedures to validate whether the transcripts resembled raw data on the audio tape.

3.5.4 Authenticity

The extent to which the researcher indicates a range of genuineness in a reasonable, justifiable, balanced and authentic way is known as authenticity (Yin 2016:86). As accorded by Brodsky, et al (2016:17), authenticity seeks to shed fairness, disentangle sophistication, yield mutual understanding, and empower participants and consumers of the knowledge to enable taking action. It relates to the degree the researcher's report conveys the actual feelings and tone as expressed by participants. As indicated by Neuman (2014:218) the researcher remained impartial by capturing only the inner-view and actual observations and experiences, thus providing a detailed account of how participants understood the phenomenon.

3.5.5 Transferability

Transferability as provided by De Chesnay (2015:15), Yin (2016:106) as well as Riger and Sigurvinsdottir (2016:39) indicate that it is the degree to which findings would be applicable in another setting and/or context. Streubert (2014: 156) use the express transferability as "fittingness" which they clarify as the criterion that provides the reader with an opportunity to determine the usefulness of the data outside of the primary study. In this undertaking, the investigator applied the following to realise transferability:

3.5.5.1 Sampling

The idealistic intension of non-probable purposive sampling, as shared by Brink et al (2018:159), to select participants that are best-placed to share wealth of insight due to their information-rich experience of the study phenomenon. The participants' exposure and encounter of the phenomenon enabled maximal extraction of the available information on and about CHC facility managers' experience of patients' long waiting time in Tshwane health district. This was enhanced by the fact that observations and experiences were shared within the context in which they occurred.

3.5.5.2 Thick Description

Tracy (2013:250) defines thick description as in-depth, contextual, and rich accounts of what researchers see as well as observe as missing in their fieldwork. This relative and detailed take on the study observations, enables readers to be shown the scene befitting as if it were with their own eyes.

Dense description of the study phenomenon demanded of the researcher to provide a rich, systemic yet detailed and vivid description of the research context. As encouraged by Leavy (2017:137) study participants were uninterrupted when sharing their experiences and explaining processes, including observations made during the inquiry. As a result, the researcher was able to provide wide range of related aspects of the phenomenon under scrutiny.

3.6 SUMMARY

This chapter discussed the research design and research method, covering sampling which detailed on population, ethical issues related to sampling and the sample. Data collection which outlined data collection approach and method, development and testing of the data collection tool, characteristics of the data collection instrument, data collection process and ethical considerations related to data collection was described. Data analysis and measures of trustworthiness have also been elaborated on. Chapter 4 will describe data analysis, presentation and description of the research findings.

CHAPTER 4

PRESENTATION OF RESEARCH FINDINGS

4.1 INTRODUCTION

In chapter 3, the design and methodology of the study were discussed. In this chapter, text, rather than figures and numbers were subjected to qualitative scrutiny. This data analysis was conducted with hindsight of the aim of the study, which was to explore and describe experiences of facility managers regarding patients' long waiting time at Tshwane health district CHCs. In seeking to address the study objectives, the researcher used unstructured interviews with the respective managers as the method of data collection. Fixed on their experiences regarding patients' long waiting time at their respective entities, eight facility managers participated in face-to-face interviews in this research.

- To explore and describe experiences of facility managers regarding patients' long waiting time at Tshwane health district CHCs.

- To make recommendations aimed at reducing long patients' waiting times at Tshwane health district CHCs.

4.2 DATA MANAGEMENT AND ANALYSIS

Flick (2014:5), proclaims that qualitative data analysis is a scientific process that entails arranging and sorting of verbal and/or visual material such that it can be interpreted to make statements about what is understood and explicit dimensions and structures of meaning-making in the material and what is represented in it. Appropriate and relevant to the qualitative approach, data scrutiny was concurrently performed with data collection. In lessening the scientific demands of data analysis, the investigator kept safe and accurate track of all data collected by primarily maintaining it (data) unaltered and in its original shape.

Additionally, the researcher proceeded with caution in ensuring that audio-recordings and associated field notes remain as intact and without any alteration. Of importance was safe-keeping them against any unauthorised access. For this qualitative study, more relevantly, descriptive interpretive data analysis guided by Tesch's eight step process as illustrated in figure below was followed. As an apprentice researcher, the essence was to arrive at being able to systematically demonstrate manually organise, categorise analyse and arrive at meaningful interpretation of data. The collected data in the form of audio-recordings was listened to, followed by word for word transcription in aid of checking and confirming data trustworthiness. In this qualitative study, data was manually analysed employing coding of words to develop meaningful themes.

The researcher proceeded cautiously in handling data without any preconceived theoretical coding frame. As a result, it was demonstrable that the resultant themes and sub-themes originated and were firmly entrenched within the study data. All transcribed raw data were submitted to the second coder for validation of the findings. An independent co-coder was sourced for the purposes of objectively aiding in analysing data. The co-coder's independent findings, of which the majority were comparable to the primary investigator's, were unanimously merged without coercion.

4.3 RESEARCH RESULTS

Findings from face-to-face and in-depth interviews as conducted with consenting facility managers of the eight CHCs are presented in this section. The interviews were conducted between 04 February and 19 March 2020 in areas/sites identified by participants themselves at their respective CHCs in Tshwane health district.

4.3.1 Sample characteristics

According to Moser and Korstjens (2017:8), qualitative phenomenological studies tend to lean towards criterion sampling. This is a scientific instance in which participants become ideal owing to them meeting predefined criteria.

Therefore, the researcher did not have any influence on the sample characteristics as the participants were purposefully selected in that as facility managers of CHCs in Tshwane health district, they possessed some experience regarding patients' long waiting time in their respective establishments. The following characteristics emerged during data collection from the participants (n=8):

TABLE 4.1: DEMOGRAPHIC DATA	
CHARACTERISTICS	**NUMBER OF PARTICIPANTS**
Age	
53 years	2
56 years	1
58 years	1
60 years	1
61 years	2
63 years	1
Years of experience	
0 - 5 years	2
06 -10 years	3
11 - 15 years	1
16 - 20 years	2
Gender	
Male	2
Female	6
Marital Status	
Married	8
Not married	0
Academic qualifications	
Diploma	2
Postgraduate diploma	2
Degree	2
Honours	1
Masters	1
Affiliation status	
Affiliated to professional body	8
Not affiliated to professional body	0
TOTAL NUMBER OF PARTICIPANTS	**8**

4.3.1.1 Age distribution

Participants' ages ranged from 53 to 63 years. Two sets of participants were 53 years and 61 years old respectively. The remaining four were 56 years, 58 years, 60years and 61years old respectively as demonstrated in table 4.1. This is thus pointing to the vast experience these CHC facility managers possess. It is however, indicative of the need to commence with succession planning.

4.3.1.2 Participants' years of experience

Table 4.1 depicts that two of the eight CHC facility managers had 0-5 years of experience, whilst three were 6-10 years experienced, one with 11-15 years of experience and two were well over 16 years experienced.

4.3.1.3 Gender distribution

In respect of this study, two of the participants were males whilst the remaining six were females as demonstrated in table 4.1 above.

4.3.1.4 Marital Status

As represented in table 4.1, all the eight participants were married.

4.3.1.5 Professional affiliation

Table 4.1 illustrates that all the eight participants were professional nurses and duly registered with the South African Nursing Council.

4.3.1.6 Academic qualifications

Two participants were in possession of a basic diploma, 2 had acquired post basic diplomas whilst a further two had achieved bachelor's communication. One each had an honours and master's degree respectively as shown in table 4.1.

4.4 OVERVIEW OF RESEARCH FINDINGS

The investigation into experiences of facility managers regarding patients' long waiting time at Tshwane health district CHCs resulted in four themes and twelve categories and twenty-five sub-categories as depicted in table 4.1 below:

TABLE 4.2: EMERGENT THEMES, CATEGORIES AND SUB-CATEGORIES FROM INTERVIEWS

THEMES	CATEGORY	SUB-CATEGORY
1. The negative experiences regarding the impact of patients long waiting time	1.1 Facility managers experienced negative impact of long waiting time on patients	1.1.1. Early birds to circumvent long queues 1.1.2. Economic impact 1.1.3. Compromised quality care
	1.2 Facility managers experienced negative impact of patients' long waiting time on staff	1.2.1. Burnout syndrome 1.2.2 Violence and abuse of staff by patients and the community 1.2.3 Extended working times
	1.3 Facility managers experienced adverse bearing of patients' long waiting time on the CHC	1.3.1 Increased patients' complaints 1.3.2 High turnover 1.3.3 Litigations
2. Factors that contribute to patients' long waiting time	2.1 Departmental factors	2.1.1 Records and patient administration systems deficiencies 2.1.2 Shortage of human and non-human resources 2.1.3 Untrained staff
	2.2 Staff factors	2.2.1 Poor time management 2.2.2 Absenteeism
	2.3 Patient-oriented factors	2.3.1 Lack of adherence to booking system 2.3.2 Patient overload
	2.4 Public health demands	2.4.1 Increased burden of disease
3. Positive experiences amidst patients' long waiting time	3.1 Patient-oriented experiences	3.1.1 Decrease in patients' waiting time
	3.2 Staff -oriented experiences	3.2.1 Improved stakeholders' relationships 3.2.2 Recognition and appreciation of staff
	3.3 Efficient systems in place	3.3.1 Prioritisation of patient care and flow *3.3.2* Appointment system
4. Measures that can reduce patients' long waiting time	4.1 Decreasing patients' waiting time	4.4.1. Embracing decongestion systems to mitigate patients' overflow at CHC
	4.2 Collaboration amongst different stake holders	4.2.1 Teamwork 4.2.2 Supportive supervision and delegation

4.4.1 Theme 1: The negative experiences regarding impact of patients' long waiting time

Participants expressed negative experiences regarding impact of patients' long waiting time. The phenomenon of patients' long waiting times was considered an institutional inadequacy responsible for much disregard for time as a resource investment. Inevitably, ramifications are evidenced as hostile effects on patients' waiting time. This theme produced three categories, namely impact on patients, stress related to long queues on CHC managers, nurses and other staff as well as adverse bearing on the image of health care professionals and the facility itself.

4.4.1.1 Category 1.1: Facility managers experienced negative impact of long waiting time on patients

The participants bemoaned that they experienced negative impact of long waiting time on patients. This category saw emergence of three sub-categories, namely: early birds to circumvent long queues, economic impact and compromised quality care.

4.4.1.1.1 Sub-category 1.1.1: Early birds to circumvent long queues

On average, CHCs open their doors for day operations at 07h00. However, the experience as narrated by facility managers has pointed to the prevalence of instances of arriving earlier than the normal day-time operating hours of the CHC. The following extracts bear testimony:

> "*Uhm, you see the problem with that is anything can happen between the time the patient arrives in the facility and the time the facility opens. Because they come here as early as 03h00 and at that time, there is no one to monitor them. So, it has not yet become a problem for the facility per se, but should anything happen, while they are waiting, it will create or it's going to expose us, yeah to say patients just come here and they wait for 07h30 (With a tense, worrisome expression)*". **P1**

In support, another participant said:

> *"They said they prefer to come earlier because now they want to be first, they can get services earlier in the morning. The others are staying in farms, you find that there is a bus which is collecting them earlier, and then so that they come for that bus and then they want to make sure that before that they are using school bus, they said before school-out they must be finished so that they can go back, earlier."* **P7**

4.4.1.1.2 Sub-category 1.1.2: Economic impact

During the interviews, it came out clear that participants had negative experience due to the fact that patients were economically affected by waiting for a long time at CHC. Two participants verbalised how detrimental the effects of long waiting time can be to the extent of compromising patients' economic status:

> *"And the patients were complaining about this long waiting time, which has also affected their socio-economic status, because most of them happen to be dismissed at work due to regular absenteeism."* **P7**

And

> *"Sometimes they will say that "you know what sister, I just wanted to come here and collect my medication and go back home or go back to work. But because now I have spent three to four hours, you know, I cannot just go there. It is either I'm not going to be paid for these hours or I'm gonna be dismissed. It will affect patients negatively so."* **P8.**

4.4.1.1.3 Sub-category 1.1.3: Compromised quality care

As expressed by the following two participants, quality and standards of care have come to be impacted upon:

> *"You need to understand that in June last year, we had a Patient Safety Incident (PSI) where in a lady gave birth at the gate, and then that the clinicians involved have since been taken out of the facility, you know, pending a disciplinary hearing."* **P1**

Another participant expressed similar experience and said:

> *"Those who are in operations say they are not coping and that leads to absenteeism that is chronic, quality of work is compromised and they just actually pushing the queue."* **P3**

4.4.1.2 Category 1.2: Facility managers experienced negative impact of patients' long waiting time on staff

The facility managers reported negative experiences regarding impact of patients' long waiting time on staff. This experience is summarised in the four sub-categories as burnout syndrome, abuse of staff by patients and the community, extended working times as well as absenteeism

4.4.1.2.1 Sub-category 1.2.1: Burnout syndrome

Facility managers in this study elaborated the negative experiences related to stress, fatigue and burnout due to long patients' long waiting times. These were some of the direct quotes from participants:

> *"But you find that the more experienced nurses tend to be focused on the long queues and maternity section, which tends to be very busy, they are the ones who tend to experience burnout and depression.* **P4**

Participant 5 echoed that fatigue leads to ultimate drainage of remaining energies which staff initially had.

> *"So, they (pharmacist assistants) were working but now they're working a little, they are now tired, the patients are too many now.* (Expression of pity noted)." **P5**

The determination and efforts to work hard by CHC's personnel has unintended consequences as highlighted by participant 8:

> *"And those people who were on duty today who have worked so hard, tomorrow they might absent themselves as well because they only say that they are having painful shoulders and whatever, because they are exhausted now."* **P8**

4.4.1.2.2 Sub-category 1.2.2: Violence and abuse of staff by patients and the community

The offensive effects of patients' long waiting time do not just affect facility managers. Evidence, as hereunder illustrated, points to the extent which CHC staff would similarly be affected. Participants vented out negative experience regarding violence and abuse of staff by patients and the community:

> *"The situation currently is going out of hand because not even single weekend can pass without a staff being harassed, during the day or night…The harassment of staff, its common now we know that month end, holidays and these prominent dates in the community staff will be harassed at some stage will be assaulted by patients and their relatives who are drunk."* ***P2***

> *"We recently had two attacks, I had to go and buy a chain and lock. Having 30 community members aggressively coming to the facilities, security is unable to control them. It becomes a problem. I bought a lock and chain, so that we can lock the main entrance, especially after hours. We only allow a patient and one escort instead of opening for the entire mob. The security officers are just not enough to deal with the mob, because we have three at the main gate, we have one at MOU (Maternity and Obstetrics Unit) and one at casualty. What do you do with more than 30 people who come at the same time? It just becomes chaos. If the door cannot be locked, it becomes chaos because everybody wants to get into the consultation rooms. Some of them come intoxicated and it is very difficult to reason with them. But, the issue of safety is also a problem. If the staff do not feel safe, you will have a high staff turnover because they are going to look for a safer place to work, which will affect waiting time and quality care".* ***P4***

Another participant confirmed this experience as follows*:*

> *"During the day the same procedure follows, I call the police and engage with them at that time trying to calm escorts if possible. But most of the time you find out that they are so angry they need police interventions."* ***P6***

4.4.1.2.3 Sub-category 1.2.3: Extended working times

Large volumes of patients seeking health care services in CHCs result in long queues, with a legitimate expectation to be attended to within the prescribed waiting time. Where and when the demand for services exceed handling capacity, that places pressure on the nurses and other health care providers, such that they find themselves working beyond the prescribed normal hours. This was evident in the following direct annotations, as experienced by the participants.

> *"If I have to mention, the ones that I know, "Facility A" is one of them. "Facility B", the other one. Those that experience long waiting times, you'll find that in many instances staff overlap just to cover the patients*." **P1**

Another participant shared the experience as follows:

> *"The problem is people stretch themselves, some of them, we even call them from home to come and assist. That doesn't assist us because the very same person who over-stretched would be absent on a particular day because he or she is tired*." **P3**

Another participant said:

> "*They end up working beyond 16h00maybe up to 17h00 or 18h00 and pharmacist as well."* **P2**

Furthermore, the effects of overlapping could not be any better for health care providers as one participant echoed:

> "*The staff indicates that they are not coping, and express that they want to keep abreast and deliver quality service, but however, they are always overlapping, which impacts families*." **P4**

4.4.1.3 Category 1.3: Facility managers experienced adverse bearing of patients' long waiting time on the CHC

As gathered from the participants, it surfaced that facility managers experienced adverse bearing of patients' long waiting time on the CHC. It came out clear that patients' long waiting time has undesired effects on the corporate image of the CHCs. This is as evidenced by the three sub-categories that attest to this, namely: an increase in patients' complaints, high staff turn-over and litigations.

4.4.1.3.1 Sub-category 1.3.1: Increased patients' complaints

In occasions of being confronted by patients' complaints, facility managers of CHCs can't simply ignore them, but to investigate and redress any such. As echoed by the participants, they are confronted with quite a number of complaints over this phenomenon:

> "*The other way is the informal, through informal complaint, and then you have the formal complaints where they actually use the complaint forms. In worst case scenario, they will report the facility to the presidential hotline or the Office of the Health Standards Compliance."* **P1**

One participant added that:

> *"Clients prefer to come to the office they don't prefer to write. Every week or two, there must be complaints about long waiting time. Some of them are solved before coming to the office but you will hear that there was a person complaining."* **P3**

4.4.1.3.2 Sub-Category 1.3.2: High staff turnover

The facility managers alluded that they experience high staff turnover, which is directly and indirectly attributed to patients' long waiting time. Intolerable working conditions such as harassment by patients result in emotional trauma, triggering resignations:

This is as expressed by one participant as follows:

> "*… that results in staff being laid off most of the time because they are emotionally affected, sometimes staff even had to resign from the facility*." **P2**

The experience shared by one participant is that delays by the district in filling up vacancies following resignations, intensifies the already troubled situation:

> "*I think the District to me is not doing much to beef up the facilities with staff, we have got high turnover of staff, some are migrating and resigning. For example, if you have got a person who's going on pension two months down the line the post is freezed, you don't have a vacant post, you can't fill up the post even if you make a motivation I don't know what's happening the challenge with human resources department, the posts are never filled."* **P2**

The experience of one participant revealed further that simultaneous resignations worsen the status quo:

> "*Sometimes we do not know how many people will resign at the same time. If you are going to have four (4) clinicians resign at the same time and their last working day is on the same day, it is going to affect waiting time."* **P4**

4.4.1.3.3 Sub-category 1.3.3: Litigations

Participants particularised negative experiences regarding incidents related to patients' long waiting times amounting to litigations. In most cases, these incidents emanate from having to choose between long queues and priority patients. In support of this sub-category, the participant said:

> "*My frustration is mostly at maternity section, where you have to deal with Mother and child, and you are so short staffed that it is only two people on duty. Maternity doesn't have waiting time; you cannot control when a baby is born. We also have a lot of litigation in that section and we don't want maternal death".* **P4**

4.4.2 Theme 2: Factors that contribute to patients' long waiting time

Participants reported experiences of factors that contribute to patients' long waiting time. The phenomenon of waiting influences total time that will be spent by an individual for services and/or goods. Prolonged waiting will most probably have influential and causative factors. Under this theme, four categories emerged as departmental, staff, patient-oriented and public health factors.

4.4.2.1 Category 2.1: Departmental factors

This category yielded three sub-categories namely, records and patient administration systems deficiencies, shortage of human and non-human resources as well as untrained staff. The three sub-categories were associated with impediment of seamless dispensing of health care services to patients as hereunder shared.

4.4.2.1.1 Sub-category 2.1.1: Records and patient administration systems deficiencies

As articulated by participants, the existing large volumes of patients' active files, which are further compounded by duplicate ones, aggravate patients' long waiting time. Three of the participants had the following experiences to share:

> "*It creates a big problem. We have 70,000 patient files. The problem with it, we are unable to manage it. Number one, you have a lot of duplication of files. Number two, you have a very small filing room…and then some files are in the box. And then, the mere fact that the files are in the box, that can explain why we have duplication because you can have an admin clerk bending for…you know, half the day and looking for files. That will be that will be bad*." **P1**

The participant went on to express that misfiling is a challenge they are faced with:

> *"And then, and then when you are running a number of files that we have we are at 70 000. Risks exist that misfiling will be there. That one is unnegotiable. Remember, it's a high volume of data with a limited number of people with ehh, improper filing cabinets, you know, everything is just not right, yeah."* **P1**

Two participants experienced flawed registration systems and processes, which incumber administration efficiencies:

> *"Now we are using new system which is HPRS (Health Patient Registration System). Previously we were using "Kwadiso" It was so simple but now because we are using HPRS with 10 numbers, it does not bear any fruit…At the begin they said we could trace patients from neighbouring sister facilities. But now, one person can have more and different file numbers since we are using last 4 numbers in the series. Three to four patients can have the same 4 numbers, so is not up to scratch, it does not assist with anything".* **P3**

> Another participant concurred:

> *"Some other things that can really make a patient to wait for a long time here is our system. The system that we are using is the HPRS system. Sometimes it is very much slow, sometimes when it's offline, you are unable to register to the patient on the system. We are having only one system and then we see a lot of patients."* **P8**

One participant elaborated further that delayed responses by information technology officers to their distress calls hamper smooth-running of CHCs' patient administration affairs:

> *"Most of the time network problems. And if the password has expired, Information Technology (IT) (or people at national take time to come reset those passwords. And not all admin staff have password. Because you struggle for IT, when they come, only one admin staff on duty. So, they can't reach all*." **P3**.

4.4.2.1.2 Sub-category 2.1.2: Shortage of human and non-human resources

Adequacy of human and non-human resources is key to enable provision of health care services that meet patients' expectations. Limitations regarding availability of these valuable resources suffice to result in discontentment, owing to amongst the several, long queues which by far result in patient delays. The following describe participants' experiences:

> *"I think if they can give us more computers and bring more personnel. Because at the present moment our facility has many components that are not served under one roof. We have a chronic section that doesn't have a network point where they can capture, meaning all the chronic patients are not captured on HPRS. We are still using the manual headcount register to capture them. Extra computers and network points at these registration points of patients will assist us*." **P3**.

> "*Ideally, if we had enough space at the waiting area and enough computers to register the patients on HPRS system, as the patient comes in. Acute has only five computers with one being the main computer. We don't have a computer at chronic and at the mother and child, but that's where the volume is. Patients just come through without being registered and to come and register afterwards. It's not a true picture of our processes. We need the technology and resources*" **P4**

Staff shortage impacts adversely on patients' waiting times. As a novice investigator, one is poised to assert that some aberrations in realising sufficient staffing in CHCs would yield experiences as hereunder vocalised by the following participants:

"*Uhm, as the CHC we are not having enough doctors. You find that our doctor, the one who are doing medico, they are supposed even to see the patients and then you find that you are having one doctor and then, uhm, that doctor sometimes find that is post call at other clinics that side, and then you find that when they are supposed to move to our place, is more than, I think it's more than 60 kilometres from Pretoria to here and then you find that when the doctor come this side, you find that the patients are awaiting".* **P7**

4.4.2.1.3 Sub-category 2. 1. 3: Untrained staff

The following are expressive of the imperative by the department to train staff as per needs of different cadres in a CHC:

> *"Our first experience is that people wait so long as compared to our target of 3-hours and secondly… filing is not done accordingly as we use EPWPs (Expanded Public Works Programme Cadres) who are not well trained on filing and record keeping".* **P3**

Two participants emphasised the need for staff skilling as here-under voiced:

> "*Because I can see now with the CCMDD, they're taking a little bit longer with the patients because you don't really need to be computer literate, but it will be faster if you knew how to type. But some of them, typing they can do it, some of them who do not having typing skills with computers will struggle a little bit with the machine. Then also if you in Primary Health Care, you must have skilled Primary Health Care nurses with a diploma, the queues go faster. And if they've got dispensing course, it will go much faster because you can put some medicine trolleys".* **P5**

The addition by one participant was that:

> *"Ohhh, sometimes you find, about the staff, I think I was supposed also to say the staff their knowledge, the skills the staff they have. Because if staff is not having enough knowledge and then maybe still maybe going to look at the EDL (Essential Drug List) or…it takes long".* **P7**

4.4.2.2 Category 2.2: Staff factors

Staff factors were classified as one of the dynamics which contributed to patients' long waiting times. Participants pointed out two subs–categories, namely: poor time management and absenteeism.

4.4.2.2.1 Sub-category 2.2.1: Poor time management

Employees who work continuously for more than 5-hours are entitled to a meal interval of at least one continuous hour. Dereliction of this directive by going over-board the stipulated one-hour meal break exacerbates patients' waiting time as hereunder experienced by three participants:

> *"I think one another thing again would be time management from staff, proper management of tea breaks, and lunch. The challenge with tea breaks, especially the EPWPs, they don't understand the fact that tea is a privilege, is not a right. And I think they take long tea breaks as time for normal lunch, but rightfully tea break is just for stretching, having a cup of tea and going back to work*". **P2**

Whilst one participant elaborated lengthily as follows:

> *"The second problem is common; our staff doesn't relieve each other when they go for lunch or tea time. You find that there is nobody at the reception and patients are just waiting there… Sometimes they take long lunches....Our clinicians who take their time to go and see the patients, they are supposed to report on duty at 7 O'clock but they start working at 9 O'clock saying they are waiting for the files and they are not even encouraging admin staff to look for those files quickly*". **P3**

Similarly, another participant lamented pro-longed meal breaks by staff as a contributing to patients' long waiting times:

> *"And then, it is also due to poor time management, more especially by the staff, whereby you find that they take long time for tea or for lunch, that is during lunch and tea breaks. We normally talk about these things that you know it is very much important to relieve one another and to take about 30-minutes a tea-break and 30-minutes lunch break so that we're able to relieve one another and to prevent this long waiting time; 'akere' (Tswana for isn't it). So, we always talk about this…"* **P8**

4.4.2.2.2 Sub -category 2.2.2: Absenteeism

Whilst health care providers may be absent from work due to a variety of legitimate reasons, any form of absenteeism present a major challenge to service delivery, including impacting inauspiciously on patients' waiting time. The following citations by three participants attest to that:

> "*Staff become so burned out and overwhelmed with everything, that results in absenteeism*". **P2**

> "*And then if you have also absenteeism that day in your filing room, then you find that you cannot retrieve these files as quickly as you wanted to retrieve them*". **P5**
>
> "*And then you find that for that day you are not having that staff or that professional nurse. You find that being the manager, you end up entering the ward and then ehhh, consulting the patients, you find that the other programmes are going to suffer, because now you are going to be slow. And then you are supposed address them, and you find that you are going to take long…. Absenteeism is still…an issue".* **P7**

4.4.2.3 Category 2.3: Patient-oriented factors

Participants experienced patient-oriented factors as influential in long waiting times at the CHC. In that regard, they highlighted two sub- categories, namely: lack of adherence to booking system and patient overload.

4.4.2.3.1 Sub-category 2.3.1: Lack of adherence to the booking system

It emerged from this study that participants have experienced patients that do not honour their appointments as scheduled, thus impacting unfavourably on patients' waiting time.

The experience of one participant was elaborately resonated as follows:

> "*However, we have an uphill battle around that. We are not winning. Number one, we booked 350 patients, only 150 patients show up and now you have 200 patients not coming to the facility… The very same 200 will come tomorrow. Now we are gonna be having more patients and now the 200, these 200 patients that are there, there are files have not been retrieved. But, for mere fact that they don't stick to that, we do our work, we pre-retrieve files, we book them, they don't show up, wrong people come, now again we have to start from scratch to look for files to retrieve files, it's not….not adding up (Angry facial expression).* **P1**

4.4.2.3.2 Sub-category 2.3.2: Patient overload

It has emerged from participants 'experience that whilst their CHCs continue to experience pressures in patients' numbers, the situation tends to be aggravated by foreign nationals seeking health care services at their respective facilities. One participant did not stop short of expressing their experience on the matter of foreign nationals:

> *"You know, we have a large number of clientele and then you know with inadequate staffing levels. So, we are really not winning, and we still have other patients you know, Gauteng Health caters for the whole of Southern African Development Community region. The number of nurses or health professionals that we have cannot keep up with the high number of patients. That leads to a long waiting time, which frustrates patients and then eventually patients come to me and then, it's terrible* (Frowning)." **P1**

In order to elaborate the experience, the participant said:

> "*You know, we have a lot of illegal immigrants. I'm talking here about people who don't even have papers to be in the country. Ehhh…I'm talking here about people who do not even have passports who are sharing, and they come here, come to our facility, our MOU. Our responsibility as health care provider is not to chase patients away. We render service and attend to the other things later. So, the 258,000-catchment population only refers to people who are here legally*." **P1**

Whilst the other one added that:

> "*The other set-back identified with foreign nationals is that they tend to present once for particular services, and never to return, until after a long while. At that time, admission system would already have expunged them. It then becomes yet another cumbersome administration to admit them using the current departmental systems. Many of these patients are from far or they are foreign. They don't come regularly, and they are out of the system. The system automatically throws you out if you don't come every month to collect, if you don't collect the medication*." **P5**

The constitutional rights accorded to citizens regarding accessing health care services wherever one presents, makes it easy to by-pass facilities within their catchment areas. It is a practice that has been experienced by the participant below:

> "*But…. yeah, the last will be that this is the only facility that renders 24-hours this side of Mabopane. And we are at the soft border of North West and Gauteng Provinces. And it is common practice or experience that if you have 24hour service, even if it's not next to your home, you'll go to 24-hour service, because you know those 08h00 – 16h00 clinics, they close at 16h00."* **P3**

The experience by one participant reflected how the convenient location of her CHC closer to shopping amenities makes it easy "shoppers turned-patients" from the neighbouring North West to access the CHC for services:

> *"Furthermore, there is a shopping mall around the corner. The facility caters for North West people. It makes logic to everybody to come to the facility on their way to or from the mall. There is also a taxi rank, so people on their way back home, they might come to the facility. When you look at the registry, on Saturdays we see a lot of people who do not belong to us. We see people from Makapanstad, and Bosplaas, because people come to do shopping and go to funerals. They would pass by our facilities. We don't turn them back, but we try to curb it."* **P6**

4.4.2.4 Category 2.4: Public health demands

Participants have recognised that emergence of new health conditions places demand and additional burden on the health care system. Participants reported experience of increased disease burden as one category that emerged under public health demands:

4.4.2.4.1 Sub-category 2.4.1: Increased burden of disease

From this study, participants alluded to the increased need to be responsive in mitigating against the burden of disease. The latter has resulted in additional clinical interventions and administration, thus denting on patients' waiting time. Two participants had the following to share:

> *"…the ratio doesn't take the burden of disease into consideration and lot of programmes have been put in without consideration of the staffing to execute all those programmes. In our chronic services, HIV is regarded as one of the chronic conditions amongst the non-communicable ones, it takes, I think maybe 30% to 40% of the chronic patient they are HIV".* **P2**

The same experience was revealed by the following citation:

> *"Yes, and the other thing on the issue of waiting time is that target as set, but programmes are increasing day by day. For example, the time one took in seeing a PHC patient in 1990 was about 15-minutes, but today you take an hour assisting just one patient, meaning the waiting time will be extended for other patients who are waiting. Let me talk about the common one "HIV." If a person tests positive, firstly before you test you give counselling, secondly after test, you still give counselling and it takes time as you need to explain. Now with the UTT (Universal Testing and Treatment) you encourage patients to be initiated immediately. So is not easy, some patients have denial some don't understand the language we are talking".* **P3**

4.4.3 Theme 3: Positive experiences amidst patients' long waiting time

In as much as patients are subjected to long waiting times, not everything is as gloomy. Facility managers expressed positive experiences amidst patients' long waiting time. Consequentially, this theme, produced three categories recorded as patient-oriented experiences, staff -oriented experiences and efficient systems in place

4.4.3.1 Category 3.1: Patient-oriented experiences

From the lens of patients, positive experiences were shared. Decrease in patients' waiting time was the resultant sub -category.

4.4.3.1.1 Sub-category 3.1.1: Decrease in patients' waiting time

It was gathered from two participants of some gains in the decrease of patients' long waiting time:

> "*The only thing I would share is that currently our waiting time is not up to the bench mark, but it has reduced drastically since the streamlining of the filing. Our waiting time has reduced drastically from 300-minutes or even 195-minutes currently*". **P2**

> *"Patients have been complaining about waiting time for years, it is becoming better, and we can see the improvement, and we get positive feedback from patients. Looking at National Health Insurance, we can see that waiting time is an issue, we can have private clinics and hospitals, but we should not be left behind, we should also strive to better our service".* **P4**

4.4.3.2 Category 3.2: Staff-oriented experiences

Positive experiences have also been observed and experienced from the perspectives of staff. Staff have as well experienced praise-worthy encounters. The category on staff-oriented experiences has yielded two sub-categories, which are improved stakeholders relationships as well as recognition and appreciation of staff.

4.4.3.2.1 Sub-category 3. 2. 1: Improved stakeholders relationships

Verbalisation of stakeholders and partners participating in CHC operations and activities is evidenced by the following extracts from one participant:

> *"We have got private partners who were employed to assist, about 16 of them, they assisted in removing the access domain files that were still in the main filing areas and then line streaming HPRS numbers to follow each other and moving them from filing room to filing room".* **P2**

Two participants expressed appreciation of the role played by the clinic committees:

> "*But with us, we've got very active clinic committee. If we have any unpleasant experience, we do refer to the clinic committee*". **P5**

Evidence of patients embracing relationships with the CHC staff has been verbalised as follows by the study participant:

> *"They will call few days before to indicate that they will not be able to make it and request to reschedule their appointment. It helps us to know in advance because we can schedule other patients to use the time slot*". **P4**

4.4.3.2.2 Sub-category 3.2.2: Recognition and appreciation of staff

The study's participants shared their experience with regards to recognition and appreciation of staff, leaving them feeling valued. Below are extractions of excitation from appreciation of employees by patients as shared by two participants:

> "*Even when we open the complaint and suggestion box, we find a lot of compliments, they even know the staff members by names*". **P6**

Participant 7 went on to add:

> "*If they are telling us they are said, we are treating them well. They said that they like the attitude we are having them, because now even if the queues are long, but at the end they like the service they are getting from our facility. They say the service is very good, yes. And then they will recruit even their families from far so that they can come here*. **P7**

One participant went on to express appreciation of political support:

> "*We even had our MEC (Member of the Executive Council) coming to our facility at one time and he gave our staff awards because it was big, our district really shined because people were just saying this is like a private clinic and it made me very happy. I am still very proud of our staff members*". **P6**

> "*Some patients you know what, they will go to extend of calling me to say sister I was supposed to come on the 6th but because of other competing activities I won't manage to come. May you kindly schedule me for this date. You know, I feel very much impressed and great to say you are serving a very well-informed community, people who are able to communicate with us because it is very much important for us as community nurses to interact well with our community, as we are here for them*". **P8**

4.4.3.3. Category 3. 3: Efficient systems in place

Efficient systems are enablers of CHC operations to realise better patient outcomes and improve staff morale and satisfaction. The efficient systems were described as prioritisation of patient care and flow and the appointment system.

4.4.3.3.1 Sub-category 3.3.1: Prioritisation of patient care and flow

South Africa (2015a:34), recommends re-organising patient-flow according to different streams of care, followed by integrating clinical care, redesigning waiting and vital data collection areas, installing directional signage and allocation of staff according to their clinical expertise and competencies.

As quoted below, one of the participants spoke highly of the help desk:

> *"I've got many help desks. I've got the main help desk for patients coming to our entrance help where they give them numbers, where they write the date and where they write the time the patient comes in where the patient is going. They write it in red in the patient's file. So, that's my first help desk. Without that, I am lost. Then I've got the second helpdesk. It's where patients get their files. Then the third help-desk is the help-desk at mother and child. I've got a staff nurse there who is disabled and I'm going to add the professional nurse who doesn't have midwifery, who can then assist with the fast-lane because currently the mother and child unit is busy until four o'clock., sometimes until half past four seeing the patients*." **P5**

In clinical setting essence, triaging of patients should serve the purpose of reducing patients' waiting time. This is what was echoed by three participants:

> "*So, the triaging is done in the morning. We've got one professional nurse who does not have midwifery who is obliged to come in at half-past six with three clerks, who are all EPWPs, and one…uhm, two cleaners*". **P5**

> "*We have a triaging nurse, although our facility is space-constrained, but we have made ways and means of how to do that. The nurse will be triaging the elderly, the very sick and the pregnant woman. Whoever is very sick will go through this triaging nurse. The triaging has also helped in reducing the waiting time, because the person is taken straight to where they belong, they do not have to waste more time in a queue waiting to see the doctor. So, the triaging nurse is just there to triage these people accordingly and send them to their respective streams*". **P6**

4.4.3.3.2 Sub-category 3.3.2: The appointment system

As gathered from the study's participants, they recommended that scheduling of patients' attendance for health care services be embraced. It is in the context of scheduling some appointments that unnecessary visits to CHCs will be averted.

"*Appointment system) is assisting a lot. Previously we had problems with the retrieving of files while the patients are waiting for files on a daily basis. But with pre-retrieval, you find that there are still people who come early in the morning and the clerks will already have the files ready, they then give out the files according to the queue numbers. This accelerates the process and allows the people in the vitals to start sooner*." **P4**

"*Yes, appointment system is helping us because if we have retrieved the files, we find that, ehhh, half past seven, patients are leaving our clinic. So is helping us a lot. And then is also helping us, the staff so that they can plan for the next day, so they are having time and then to even check the files*." **P7**

4.4.4 Theme 4: Measures that can reduce patients' long waiting time

Participants expressed measures that can reduce patients' long waiting time. These adversarial effects thus necessitate finding solutions to mitigate against patients' long waiting time in the CHCs. The theme on measures to reduce patients' long waiting time yielded two categories, namely: measures to mitigate patients' overflow at CHCs and collaboration amongst different stake holders

4.4.4.1 Category 4.1: Decreasing patients' waiting time

The CHCs are at the most confronted with chronic, but stable patients. These cohort of patients do not necessarily have to wait in long queues as they are only there to collect their chronic medication. It is such scenarios that prompt decongestion initiatives to reduce waiting times. One sub-category known as embracing decongestion systems emerged and is hereunder discussed:

4.4.4.1.1 Sub -category: Embracing decongestion systems to mitigate patients' overflow at CHC

Data emerged from the study to propose embracing mechanisms to mitigate patients' overflow at the CHCs. Appetite for advancing technological strides was amplified by the participants. One participant advocated for changing of how conventional business is done in public health entities and had this to say:

> "*Yeah, okay, I strongly believe that we should be… ehhh, we should rather actually change the way we do…we do… we do business. Uhm, but then we also need our clients to assist us. Uhm, I believe that if we can improve our... our… our records management system. You know, this is…this is… this is very, it's a serious problem and I'm not sure…it's common in Africa, that we always advocate for mediocrity for our clients and then when we have to do things that we have to do for people to show that we respect, we don't do that. I mean, this manual records management has never worked, it will never work (Looking frustrated*)." **P1**

Two participants went further on to mention how other public service entities like police stations, home affairs and revenue services have advanced in the digital space, whilst health services are still lacking behind:

> *"We know, studies have shown that it… (Throwing hands in the air) you will never if... that is why even police stations and banks don't use manual anymore, because you can't be manual when you're managing a high volume of data. The filing system must be digitised. The filing system..., this is silly. We cannot always say, hide behind the budget. I mean, the budget will never be alright. If that was the case, we wouldn't be having the Constitution of South Africa, because you wouldn't say everyone will have the right to do that. The budget won't allow, then we would actually have settled for a very poor constitution".* **P1**

"*Okay, no, I went to Home Affairs and I've been to SARS (South African Revenue Services) also and been to private also. So, when I go out there usually go out and ask questions and go look how the system works, so that we can improve on our system, even if it's a manual system. So, that's mostly what I look, and I feel that the department must come up with the best biometric system so that we can improve waiting time (Looking rather unoptimistic). And, I think the one of the banks for me is a very good system, you press the button and if we can maybe add a system like Home Affairs or like SARS (South African Revenue Services), where we use maybe the fingerprint system or where we use the ID system to…to confirm the patient*..." **P5**

Participants suggested the use of automated dispensing. This is one of the health care innovations that aids in automatically dispensing medication. It functions just like the commercial Automated Teller Machine, except that this one dispenses medication instead of cash. One participant was particularly elaborate on this mechanism and expressed as follows:

"We have the "Pele-Box" here. I'm not sure if you have seen it as you are entering there? It's an automated system. Once your medication is ready…let me just explain how it works. How the Pele-Box works, we get the medication for the patient and then we put…we scan medication and put in the box. Immediately, the first time, actually communicate with a client to say your medication is ready, come and collect it. And then the system will send a PIN. The client will come here with a PIN number and then punching the PIN number, and then the medication, the box opens, and then the patient gets the medication. If maybe we can have, we can improve on those systems. And you wouldn't be, one this with this one, the patient can come at 12h00 midnight, you know. The convenience is that the patient won't be told that there is no medication, or the patient won't actually have to wait up until the facility opens at a particular time. You know you come get the medication. I strongly believe that we need to improve our filing system". **P1**

Participants also suggested the treatment adherence clubs in order to alleviate congestion from the CHCs. As echoed by two participants, treatment adherence clubs are embraced as follows:

> *"We also have the issue of clubs around where people stay, where we have people monitoring the patients, making sure that patients come to facility when they need to. I think it will also help decongest the facility*". **P4**

One participant added as follows regarding treatment adherence clubs:

> *"Okay, isn't it that it is not everybody who will be able to go to the pick-up points outside the clinic? You may find out that there are patients who are stable, chronic patients, but who are staying closer to the facility. So, we cannot expect those types of patients to go collect their medication at Clicks or Dischem. Rather, those patients are going to be referred by these clinicians to the adherence clubs, where they are going to be registered by the counsellors. There are sisters who are dealing with those*". **P8**

Over and above introducing electronic systems and promoting treatment adherence clubs, participants were vocal about Centralised Chronic Medicines Dispensing and Distribution (CCMDD). Below are their experiences with CCMDD encounters:

> "*Okay, the CCMDD is a system that government or department brought in for chronic patients to be able to be seen once a year. And they just collect the medication on a monthly basis, which makes it even easier and it's supposed to reduce the waiting time. And, patients, there are different pickup points. There are external pickup points, there are internal pickup points, that the patient can choose where he wants to go, near where he lives or nearer where he works".* **P5**

> "*CCMDD is a mechanism that is used to register patients that are chronic but stable. The main aim was to depopulate facilities so that registered patients can go to external pick up points such as Dischem, Post Office, Clicks etc.,) to collect their medication. Patients are registered according to their prescripts; the system has reduced the waiting time in the facility*." **P6**

Integrated Clinical Services Management (ICSM) is one clinical strategy that seeks to integrate care in holistic manner as per an individual user's needs, rather than fragmented facility programmes. This is what one participant had to say about ICSM:

> *"The main purpose of ICSM is to integrate services just like the former "supermarket" nursing. Patients will get different services under the same roof; this has also reduced the waiting time. For example, a patient will be coming for chronic and they will be tested for TB, HIV/AIDS and get family planning or whatever other services they required in the same room. Also, the ICSM prescripts talks about the correct management of patient records, where now all the information that is needed is recorded, including health education, return dates and so forth".* **P6**

4.4.4.2 Category 4.2: Collaboration amongst different stake holders

This sub-theme delves on strategies that are competencies of personnel to implement in assisting to combat the scourge of patients' long waiting time. This category resulted in two sub-categories which are: team work, and supportive supervision and delegation.

4.4.4.2.1 Sub-category 4.2.1: Team work

Team work is no new word in occupational arenas. Participants voiced the need for cohesion and cooperation if reduction of patients' long waiting time is to be realised. The following are the expressions by two of this inquiry's participants:

> *"We have a quality champion, infection prevention and control champion and in each stream, we have team leaders, although they may not join us on a day to day basis. Overall, it is teamwork, we are handling patients as a team".* **P6**

And further shared that:

> *"You know what, I always tell the clinicians that "you are supposed to work hand-in-hand with appointment schedulers (Participant's phone ringing). You're supposed to work together as a team with those ladies who schedule appointments for the patients. They're having 5 days a week. So, some will be given appointment on Monday, some on Tuesday and some on Wednesday, just like that".* **P8**

4.4.4.2.2 Sub–category 4.2.2: Supportive supervision and delegation

The occupational expectation from CHC facility managers is that amongst others, they should be able to work effectively and amicably with persons of diverse intellectual, cultural, racial or religious differences, including managing own work, and that of junior colleagues to ensure unhindered and swift dispensing of quality services.

The following excerpts are reflective of three participants' inputs regarding improving on staff supervision:

> "*Another issue is that we must do our supervision, coming in the morning you have to assess the queues, are the queues moving because you don't want to be caught with congestion during the day due to people idling*". **P4**

Another participant added:

> *"I think we are also managing our leave roosters properly and our duty roosters as well. So that staff is available at the facility at normal capacity, so that they can manage their patients properly, timeously so".* **P6**

One participant made an emphasis on delegating tasks and responsibilities as quoted below:

“If ever a delegation is not done according to expertise and skills it means that one will spent a lot of time consulting one patient. It is very much important that when you delegate, you must know that “I'm delegating this person to do this.” One should be very much aware that they really understand the job by the heart. If really you delegate someone who is not well conversant with tasks, it means that this particular person will take a lot of time trying to consult with all work-stations”. **P6**

4.5 SUMMARY

Chapter 4 presented a dissected and analytical description of the enquiry’s findings. The analytical description herein referred to, remained centred around experiences of facility managers regarding patients’ long waiting time at Tshwane health district CHCs. Participants’ demographic information was presented, highlighting the key background. Furthermore, Tesch’s eight step process directed the qualitative analysis, thus enabling emergence of four main themes, twelve sub-themes and thirty-four categories. Quoting participants’ experiences anchored the categories’ narrations citation of other similar scholarly publications. Chapter 5 will thus detail the study’s limitations, conclusion and recommendations.

CHAPTER 5

INTERPRETATION AND DISCUSSION OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

Chapter 4 presented data analysis and the associated interpretation of the study findings in relation to experiences of facility managers regarding patients' long waiting time at Tshwane health district CHCs. Chapter 5 reflects on the research design and method whilst capturing the summary, interpretation of results, recommendations, and conclusion. This research produced four themes, twelve sub-themes and 25 categories. In auditing the study findings, a rigorous literature review was undertaken for scientifically providing reference arguments for agreeable and contrary evidence as originating from other preceding investigations.

5.2 RESEARCH DESIGN AND METHOD

A qualitative, explorative, and descriptive design was adopted in this study to enable understanding experiences of facility managers regarding patients' long waiting time at Tshwane health district CHCs. This qualitative approach was influenced by the need to gain rich insight into human experiences and meaning from research participants, particularly in the context in which the phenomenon is occurring.

Non-probability purposive sampling was applied as informed by the supposed possession of best knowledge relevant to the research topic by the selected participants. The sample in this study was eight participants comprising of two males and six females. Audio-recorded, unstructured, and individual in-depth interviews were administered to these participants whose ages ranged from 53 to 63 years. The interviews took place at the eight Tshwane health district CHCs and lasted between 47 and 105-minutes. In ensuring trustworthiness and increasing the study's rigour, the researcher applied and maintained the criteria of credibility, transferability, dependability, and confirmability as imparted by Lincoln and Guba (2013:103).

5.2.1 Research purpose

The purpose of this study was to qualitatively explore and describe experiences of facility managers regarding patients' long waiting time at Tshwane health district CHCs.

5.2.2 Research objectives

In pursuit of answering the research question, this study's specific objectives were:

- To explore and describe experiences of facility managers regarding patients' long waiting time at Tshwane health district CHCs.

- To make recommendations aimed at reducing long patients' waiting times at Tshwane health district CHCs.

5.2.3 Research question

Answers to the following questions were sought in this study:

- What are experiences of facility managers regarding patients' long waiting time at Tshwane health district CHCs?

- What recommendations may be made for facility managers and other vital stakeholders to lessen patients' long waiting time at Tshwane health district CHCs?

5.3 SUMMARY AND INTERPRETATION OF THE RESEARCH FINDINGS

The findings of this research were deduced from study purpose as further guided by the identified objectives to ultimately arrive at the summary and interpretation of results. The emerging study's themes, sub-themes and categories were duly summarised. Interpretation of results relied and referred to relevant sources.

From this study's findings, it has been revealed that at the most, majority of participants had experienced adverse impact of patients' long waiting time in Tshwane health district's CHCs.

Theme 1 deliberated on time as a resource investment, whilst theme 2 paid attention to factors contributing to long waiting times, with theme 3 discussing positive experiences and lastly, theme 4 focussed on measures to reduce patients' long waiting time.

5.3.1 The negative experiences regarding the impact of patients long waiting time

The shared experiences by study participants resulted in adverse effects related to patients' long waiting time emerging as the first theme. According to Harahsheh (2019:1672), investing in time-organising strategies creates positive and meaningful relationships, thus resulting in better employee performance. Time constitutes a critical component of quality to quantify how expeditious tasks are completed (Sahito & Vaisanen 2019: 214). As expressed by participants, disinvesting in time, results in experience of unpleasant effects of prolonged waiting. From this study, the antagonistic impact is experienced by patients, staff, and the establishments themselves.

5.3.1.1 Facility managers experienced negative impact of long waiting time on patients

The much undesired effects of being stuck in unmoving queues are ostensible in these very CHCs. Facility managers, as administrators of these establishments have shared experiencing negative impact as contextualised below.

The first category emerging from the theme "expression of negative experiences regarding impact of patients' long waiting time" was noted as impact of long waiting time on patients. The associated sub-categories linked to it are early birds to circumvent long queues, economic impact and compromised quality care.

5.3.1.1.1 Early birds to circumvent long queues

It has been established from this study that prolonged patients' waiting time results in patients having to present in the early hours of the morning in attempt to avoid long queues. This practice is influenced by the principle "first come, first served." Waiting in snake-long queues to receive services is a frustrating experience for almost everyone. The social reality is that nobody is ever excited to be in a queue, there is hardly anyone ever looking forward to basically wait. Practically, nothing is gained whilst standing in some non-moving line.

Participants' frustration over early arrivals is supported by the findings in the study by Kama (2017: 68), which pointed to instances whereby patients arrived at the clinic as early as 04h00 to evade long queues. Kama (2017: 68) added that these early arrivals could only imply that the patients will then have to wait until the clinic opens at 07h00. Compounding the matters is the notion that despite early arrival at the clinic, patients still had to wait for periods ranging between 60 to 240-minutes. In worst-off case scenarios, some patients were even turned away without being assisted (Kama 2017:68). An additional emphasis by Caesar (2017:61) is that patients with appointments for later times during the day, still arrive substantially earlier nonetheless. Against these citations, whilst patients present quite early to circumvent long queues, it is this tendency that leads to long waiting time (Egbujie, Grimwood, Mothibi-Wabafor, Fatti, Tshabalala, Vilakazi and Oyebanji (2018:317). Findings from this study thus confirm that early birds to circumvent long queues is a contrary and worrying reality confronting and experienced by CHC managers. Other than early arrivals at the CHCs, additional hardships faced by health care users include economic impact and compromised quality care as discussed next.

5.3.1.1.2 Economic impact

Expressions of empathy and frustration were shared by participants on occasions whereby economically active patients would find themselves spending bulk of their valuable time awaiting services in a CHC. As imparted by Chu, Westbrook, Njue-Marendes, Giordano and Dang (2019:8), the economic cost of waiting long can have a substantial impact on patient's wait time experience.

This is largely due to the fact that patients whose occupations pay on an hourly basis stand to lose earnings for the period they were away. This compromise and threatens the livelihoods of patients. The risk of losing earnings may mean no income to commute to the CHC for future consultations, especially for chronic care patients. The most likely impact would be defaulting on the very essential treatment and care.

Defaulting can be detrimental with fatal and irreversible complications on the overall health status on an individual. Mabunda (2018:45) added that the anticipated economic malice has in some instances, prompted patients to end up pleading with health care staff to prioritise them in the queues in trying to avert waiting long, owing to work commitments.

These are patients considered economically active, whose presence at a facility is only to collect medication and hurry back to work. When such health care users spend most of their valuable working time queueing and waiting, it means their economic activities are compromised. Repeated late arrival at work following prolonged waiting for services as well as recurring absenteeism due to spending the entire day awaiting services in a CHC, disaccord patients' only sources of income. This in addition, does not translate to value for money, one of the underpinning Batho Pele principles (South Africa, 1997b). It was then from the study by Janzek-Hawlat (2015:9) where it emerged that patients waiting for a shorter period at the local hospitals, experienced minimal economic loss as opposed to those waiting longer.

5.3.1.1.3 Compromised quality care

The World Health Organization (2018b:5) declared that quality of care is the degree to which provision of health care services to the community results in the desired and intended health outcomes. The underpinning principles of this assertion is that such health care services should be safe, effective in nature, promptly provided, efficient, equitable and user-centred.

As accounted for by three participants, they have experienced lowered standards of care. Being confronted with substantial volumes of patients awaiting services, CHC staff finds themselves pressed to deliver on time. Personnel end up being pressed to rush patients' consultation. In the midst of it all, essential care processes and procedure are much likely to be missed, leading to undesired consequences. In their elaboration, this is primarily due to amongst others, absenteeism. Absenteeism depletes facilities of the expected number of health care providers who on any ordinary day would be enough to meet the day's operations. The available few staff are compelled to double-up and assume their absent colleagues' duties. Faced with this mammoth task, errors are bound to happen, some perilous to the well-being of patients.

One participant alluded to the fact that compromised quality care is noticeable during routine audit of patients' records as proven by imperfect and incomplete entries in those records. These experiences appear consistent with the discovery made by Aguilera, Infante, Orme and Urriola (2015:31) wherein long waiting time continues to be public health subject as other patients have been observed to abandon and postpone their consultation. This abandonment and postponement can only imply that such patients are likely to default on their treatment and other necessary interventions, thus compromising on their care. More findings in a study by Naidoo and van Wyk (2019:4) highlighted how frustrated the elderly health care users were at receiving sub-standard care from the health professionals. Same sentiments were expressed by participants in the study by Pillay (2017:59) in which some patients verbalised disappointment at the level of care rendered in the public hospitals, stressing amongst other contentions, long waiting hours before being attended to.

It has additionally been established that the decision to bypass facilities closer to patients' abode, has been largely influenced by the perceived low quality of care, including lengthy waiting periods, added Moscelli, Siciliani, Gutackera, Cookson (2018:301). Further observation by Gaynor, Propper and Seiler (2016:25) was that a considerable number of patients were more inclined to use hospitals with higher quality, even if it meant waiting longer.

The displeasure over poor quality of health care services is further demonstrated by Paling, Lambert and Clouting (2020:784) in citing that higher bed occupancy resulted in longer waiting periods in respective emergency units. Paling et al (2020: 784) elaborate further that quality of care deteriorates as patients complicate whilst awaiting admission for further interventions and management.

Martinez, Zhang, Bastias, Feijoo, Hinson, Martinez, Dunstan, Levi and Prieto (2019:9) emphasise further the grossness of sub-standard quality in mentioning that there is strong correlation between prolonged waiting and increased risk of demising amongst public health care users. This is largely attributed to complicating unnoticed whilst health care providers attend to other patients. Supportive of the above, Tana (2013:72) shared that some chronic patients opted to quit queuing as they feared missing their means of transport back home. The implications could only mean leaving without necessary examinations and treatment.

Additional discovery by Maphumulo and Bhengu (2019:4) pointed to a mix of factors responsible for the decline in quality care. Maphumulo and Bhengu (2019:4) lamented non-matching distribution of resources, migration and urbanisation, user-demand increase, rise in disease burden, management and leadership deficiencies as amongst contributors of compromised quality. It is thus demonstrable that long waiting time and associated compromise in quality care brew from not just single, but multiple factors, which need multi-pronged interventions by all stakeholders.

The article by Jordan (2019) highlighted the misfortune of long waiting times at a Mamelodi hospital. An elderly female mental-health user, who had waited long for the doctor, ended up being restless and was subsequently restrained to steel chair. This is yet another demonstration of sub-standard care owing to prolonged waiting. Hirvonen, (2007:63) reported further that patients described experiencing sleep disorders, distress, and sexual dysfunction, squarely at the thought of being subjected to inferior health care standards. Therefore, when patients conclude that services received are of inferior quality, they are then less likely to present for future consultations. In the main, Egbujie et al (2018:317), thus recommended that future studies should be directed at integrating assessment of patients' perception of quality care and satisfaction.

5.3.1.2 Impact of long waiting time on staff

Impact of long waiting time on staff is the second category. It resulted in three sub-categories namely burnout syndrome, violence and abuse of staff by patients and the community as well as extended working times.

5.3.1.2.1 Burnout syndrome

Several studies have been undertaken and documented on burnout. World Health Organization (2019) defines burnout as a disorder originating from perpetual occupational stressors that have not been efficaciously and successfully managed. These occupational stressors thus impede on individual staff performance to impact significantly on health care systems response.

Participants verbalised that health care professionals tend to cope less with daily demands. These work pressures are brought on by amongst others, high number of patients to be seen on any single day. Consequentially, they are obliged to perform under immense duress to complete consulting all patients for the day. Supportive of this deposition, De-Stefano, Philippon, Krastinova, Hausfater, Riou, Adnet and Freund (2017:12) recorded that amongst emergency care physicians, increased burnout levels were independently linked to prolonged patients' waiting times. Burnt out staff would stay away from work, in an attempt to recover. This compels the fewer remaining staff to face the day's work demands alone.

It has further been established from WHO (2019) that burnout is linked to increased and disruptive absenteeism as well as high turnover in worst case scenarios. These factors are infamous for reducing team productivity and disrupting organisational efficiency. The effect is a trajectory of patients waiting beyond normal. The impact on productivity-loss associated with burnout could aggravate the already lessened healthcare resources, adds Dewa, Loong, Bonato and Trojanowski (2017:13).

Corroborating this, Mabunda (2018:23), further mentioned that staff shortages, aggravated by staff burnout, are behind patients' long waiting times in primary health care facilities. In concurring, Azam (2017:498) pronounced that burnout is associated with job dissatisfaction, sick leave, turnover intentions and lower patient satisfaction with treatment and recovery time.

One participant emphasised that much tends to be expected from senior and experienced nurses, thus putting them under immense strain to perform. Comparable findings are recorded in a study by Schooley, Hikmet, Tarcan, and Yorgancioglu (2016:4) wherein they posit that undue expectations placed on high-ranking personnel, tends to be catalysts towards the development of burnout.

Participants in the study by Meissenheimer (2014:110) relayed being aware that accumulation of patients in the emergency unit results in overcrowding. This build-up is associated with hampering the normal business of providing coordinated care. Presence of more people in the emergency unit ultimately overwhelms and drains staff, leaving them fatigued and burnt out. De Lima Garcia, de Abreu, Ramos, de Castro, Smiderle, dos Santos, and Bezerra, (2019:9) pointed out that higher levels of burnout were also associated with obstinate stressing about unexpected patient outcomes, such as amputations and death. De Lima Garcia et al (2019:9) supplemented that persistent patient dissatisfaction and rise in patient and family complaints pressurise staff to do better, leaving them in distress and subsequently burnt out. In trying to evade facing these series of events, staff would rather defer engaging with patients, subjecting them to waiting a little longer.

Excessive workloads, long working hours, specialty choice, compacted duty schedules, elaborate records management, immersing in work activities at home whilst off-duty, fear of possible litigations, difficulties in dealing with poor patients' outcomes, decreased work-place autonomy, unsuitable work environment, lack of support from management and peers alike were cited as central to manifestation of burnout, concluded Patel, Bachu, Adikey, Malik and Shah (2018:5).

5.3.1.2.2 Violence and abuse of staff by patients and the community

It is not only patients that are guilty of perpetrating this social ill. Escorts have as well been found to be offenders. Acts of violence and any form of abuse towards CHC personnel is tantamount to violation of their constitutional right to a safe and sound working environment. Not only is it an offence but can be emotionally scaring and administratively time consuming. Furthermore, CHC facility managers are compelled to quiet a great extent to defend and soothe their staff of the emotional drain brought about such acts of violence and abuse.

Chappell and Di Martino (2006:10) define workplace violence as some form of action that departs from reasonable behaviour and conduct in which an individual, whilst in the course of their duty is assaulted, threatened, harmed or injured. Against the background of this definition, Efrat-Treister, Moriah and Rafaeli (2020: 3) documented in their study that “waiting” elicits stress from patients. As such, patients are inevitably poised to be frustrated and vent out their frustrations in a violent, aggressive, threatening and abusive manner.

The four participants vented their encounters of frustration at frequency and intensity of these violent acts. Their experiences are consistent with the findings by Nevo, Peleg, Kaplan and Freud (2019:3) where 59% of the doctors verbalised experiencing at least an episode of verbal abuse directly associated with long waiting time.

Shafran-Tikva, Chintz, Stern and Feder-Bubis (2017:5) documented further an assemblage of interacting exposés responsible for igniting violence towards staff. These include staff attitudes, organisational setting and patients’ behaviour. In this study by Shafran-Tikva et al (2017:5), 75% of respondents were unanimous in mentioning that waiting time remains a fuelling factor for violence. Aboukanda and Latif (2014:24) added that overcrowding in facilities is as a result of unprecedented increase in patient volumes, lack of beds for admissions, delays by support staff, shortage of health care professionals and insufficient physical space. The consequences then become prolonged pain and suffering, increased risk of clinical deterioration, prolonged waiting and followed by increased patient complaints.

According to Aboukanda and Latif (2014:24), this constellation of factors leads to restlessness and the ensuing patient violence toward staff. Patients' conduct goes a long way in adversely affecting their own waiting time. Aboukanda and Latif (2014:24) added that patients' behaviour such as meddling, over-involvement, irrational demands, confrontations, anger and disrespect contribute to delays. Instead of providing much needed services, personnel find themselves spending valuable time extinguishing the flames of errant behaviours. The discussion by Efrat-Treister et al (2020:10) thus supportively concluded that the longer patients wait to receive services, the less it is for them to perceive organisational processes as just and reasonable, resulting in emotion-provoking reactions towards staff. This is supported by what was established by Bloom (2014:72), whose study exposed that 36.2% of patients' families and 29% of patients themselves were perpetrators of violence towards staff.

5.3.1.2.3 Extended working times

The assent of the constitution of the Republic of South Africa has enabled the majority of citizens to access public facilities, namely clinics and CHCs, which are non-fee charging (South Africa 1996:s27). Consequentially, the CHCs have continued to experience relatively large volumes of patients seeking health care services, with unparalleled indentation on waiting times.

Study findings by MacPhee, Dahinten and Havaei (2017:12) confirmed instances where nurses in particular, find themselves having to go beyond normal hours. MacPhee et al (2017:12) go further to emphasise that these nurses, instead of overlapping, they would opt to compensate by reporting early for duty and working through breaks. Additional emphasis by Meno (2017:27) is that staff had found themselves obligated to perform unplanned overtime due to increased workload. This is necessitated by the empathetic need to ensure that no patients are sent back without the necessary care.

Manyisa and Aswegen (2017:35) shared same sentiment by mentioning that shortage of staff is primarily linked to the resultant over-lapping of health care professionals. The few staff on duty finds themselves compelled to compensate for their absent colleagues. Manyisa (2016:216) added that the very common inaction and delays in filling nursing cadres' vacancies worsens the already crippled CHCs. That on its own is a major obstacle to dispense seamless health care services to the needy communities. Matlala and Lumadi (2019:7) alluded further that perpetual staffing inadequacies per work-shifts, meant more work demands and additional workload. This has led to damaging impact on nursing staff's workload. Subjecting frontline medical and nursing personnel to extended hours, has undesired effects. Resultant fatigue and the associated burn-out means at some stage the affected staff will need to recover. The unpopular way to recuperate in this instance is by staying away from work. Against the already experienced staff insufficiencies, that may not be the option.

5.3.1.3 Adverse bearing on the CHC

The third category, adverse bearing on the CHC is hereunder discussed. This category produced three sub-categories: namely increased patients' complaints high turnover and litigations. Each of these sub-categories is particularised in line with the participants' experiences:

5.3.1.3.1 Increased patients' complaints

A complaint is defined as an expression, either in writing or verbally, of being dissatisfied, unpleasant or unfulfilled over any other particular encounter, in this regard, quality of health care services (South Africa: 2017b:9). Facility Managers have expressed being confronted with patients' complaints. When these complaints are raised, they just can't simply be ignored. The very facility managers become beholden to thoroughly investigate and redress as per the complainant's expectation. This process consumes much of facility managers' time, which in essence, could have been invested in other health care priorities. The implication is that a rise in complaints means more time spent administering their resolution.

In addition, more complaints are an indicator of operational ineptitudes, pointing to unfavourable processes happening in the facility. Xie and Or (2017:9) revealed further that complaints over long patients' waiting time could disrupt work patterns and processes in a facility. This is evidenced by instances where a number of patients would present physically to the CHC facility managers to complain about non-moving queues and long waiting time. This encounter is moreover stressed by Hardine (2017:34) in that experience of long waiting times necessitate that patients can invoke their right to complain and rightfully get some answers for the delays.

As expressed by the participants, the prevalence of complaints matches the study findings by Scheffler, Visagie and Schneider (2015:11) in which it was discovered that complaints over long waiting time surpassed all other forms of complaints. Further findings by Masango-Makgobela, Govender and Ndimande (2014:4) exposed long waiting time as prime driver that actually made patients to even by-pass facilities closest to where they are staying and rather opt for further ones with shorter waiting periods. The study by Ganpisetti, Susmitha, Sandeep, Keerthi, Gopika, Sneha, Lidiya, Sushmitha, Madhuri, Kushal, Amulya, Gottipati and Babu (2018: 793) exposed the low patient satisfaction and concentration of grievances over waiting time. These criticisms were mainly regarding waiting to be promptly consulted, diagnosed and further management if needs be, be instituted without delays.

It was further demonstrated that prolonged waiting by patients, eventually results in nothing less than bad experiences, added Mokgoko (2013:112). It is these bad experiences that leave patients disgruntled and prompting them to raise their disapproval by laying complaints about poor services. In support, Motloba, Ncube, Makwakwa, Machete (2018:404) revealed that complaints over long waiting periods were more prevalent than other categories of complaints. This signified the need to direct efforts and resources at combating the plague of forever waiting in health care facilities.

5.3.1.3.2 High turnover

As cited by Mayhew (2019), turnover refers to situations whereby a certain number of employees leave their current organisation of employment. Turnover may either be voluntary, arising when an employee leaves the employer of his own choice. Reasons could include intolerable working conditions or low wages. Involuntary turnover results when it is the employer terminating employment due to amongst others, scaling down, under-performance or disciplinary determinations.

As established from participants, they are experiencing lack of support from the district with regards to timely filling of vacancies. Faced with unmatching staff numbers, it becomes facility managers' responsibility to re-assign the very limited personnel at their disposal. Personnel insufficiency, according to Manyisa and Van Aswegen (2017:35) remain an occupational ache responsible for adverse public health outcomes, which in this context include long waiting times.

Additionally, the experienced burden is that the duty to scrabble for staff is the solo and daunting obligation these facility managers must contend with. Time and attention that could otherwise be devoted to de facto efforts to combat long waiting time, end up being consumed by other administrative demands. Factors such as, long working hours, burnout, unavailability of equipment and uninviting working conditions exacerbate the situation.

Mmamma, Mothiba and Nancy (2015:4) have articulated that senior management is not supportive of nursing processes and agendas, particularly with regards to promptly appointing replacement staff. Further augmentation by Yang, Lv, Zhou, Liu and Mi (2017:34) is that shortage of human resources, particularly nursing and medical designations are mainly attributed to high staff turnover. Emotional stress due to inability to cope with high workload has been associated with the phenomenon of increasing resignations, added Yang et al (2017:34).

Atakro, Ninnoni, Adatara, Gross and Agbavor (2016:7) agreed by expressing that shortage of human resources was observed over long periods of time to be responsible for decline in improving long waiting time and improved care. This citation backs the deportment that sufficient and matching numbers of frontline staff remains key in ensuring uninterrupted provision of necessary care.

In the study by Tshitangano (2013:4), it emerged that professional nurses at one Limpopo hospital expressed uncompetitive remuneration as the driving factor responsible for staff attrition. Compensation related issues remain an influential denominator in attracting skilled and competent staff. Moyimane, Matlala and Kekana (2017:3) have corroborated that high staff turnover in South Africa stems from amongst others, insufficient working equipment, worsened by poor or even non-existence of the very available few. Functional tools of trade are crucial in delivery of quality patient care and would therefore impress on how staff tolerate whatever limitations associated with lack thereof.

5.3.1.3.3 Litigations

Incidents of medical and nursing care negligence carry much potential to result in litigations. The latter refers to practice or process whereby disputes arising from alleged medical or nursing negligence end up being settled in the court of law (Juretschke 2017:6); (Williams 2018:20). Kollapen, Carnelly, Jaichand, Lawrence, Oguttu, Sello, and Siwendu (2017:6) imparted that there has been a tranche of befitting claims for damages resulting from medical and nursing care negligence which have been instituted in South African courts in recent years.

As published in *The Times Live* newspaper by Mabuza (2019) it was further provided that the monetary magnitude that Gauteng Department of Health faced totalled about 29 Billion rands. In all fairness, this much money would better be invested in other key health system improvement priority interventions. Vocalised by one participant, poor record keeping, not only causes prolonged waiting in facilities, but is further a cause for litigations.

Supportive of this deportment are Hong, Kaur, Farrokhyar and Thoma (2015:4) and Medical Protection Society (2014:26) who assert that keeping of whole, comprehensive and adequate medical records serves as the mainstay to defend quality of patient care should the need arise. Hong et al (2015:49) accentuated that inaccuracies and incompleteness that were found in all other information fields were worth leading to lawsuits. Maphumulo and Bhengu (2019:2) agreeably noted in their study that litigations are exponentially rising and considered now considered reaching state of calamity.

The other participant shared that maternal and child health services carry quiet medico-legal ramifications. This is the view that has been expressed by Taylor, van Waart, Ranchod and Taylor (2018:149) who accentuated that maternal and child services in particular are facing the storm of rising litigations, an observation dating as far back as 2008.

Where lawsuits are instituted, the defendants who may either be nurses or doctors are compelled to appear before courts of law to testify. This process thus removes these key staff from their actual clinical area, leaving the facilities with very few colleagues to deal with work demands. Making the matters worse would be postponement of court hearings. This would mean future appearances by these very limited staff, further prolonging waiting times in CHCs. Additional concurrence has been learnt from the study by Maqgadiyane (2020:1039), whose participants indicated that they continue to participate in consultations with the state attorney over maternal health legal claims.

Owing to extensive time spent in engagements with legal representative, key staff find themselves removed from critical priority of serving the needy. Consequently, the remaining few staff is pushed to compensate for their unavailable colleagues. Further aggregable citation by Mbombi, Mothiba, Malema and Malatji (2018:3) exposed that 59% of nurses agreed that they made many medical errors due to increased pressure to complete clinical records comprehensively.

The study by Shihundla, Lebese and Maputla (2015:6) demonstrated further that increased nurses' workload poses a concerning challenge with regards to documentation of patient information and upkeeping of documents themselves. Complementary support by Shihundla et al (2015:6) indicate that multiple documents that are to be completed by few nurses on duty can be physically daunting, may lead to demotivation and even failure to record very critical and relevant information. The implication is that when nurses are meant to be consulting patients, priority then becomes completion of documents to avoid litigations. Time spent completing numerous records is the valuable one that could have been resourcefully spent on actual patient care.

Supportive argumentation by Rispel, Blaauw, Ditlopo and White (2018:28) indicate that shortage of staff has not only been linked to long waiting periods, but also the basis for occurrence of medico-legal cases. Fatigued and stretched-out staff tends to be prone to committing clinical acts of commission and omission. Further reporting by Jordan (2019) mentioned that an elderly female mental-health user who had waited long for the doctor, ended up being restless and was subsequently restrained to steel chair. This incident attracted the involvement of the South African Human Rights Commission, with uncontested intention to sue the Gauteng Department of Health. Swart et al (2018:2) emphasised the importance of triaging as a practice meant to screen patients' extent for need of emergency care, Furthermore, it aids in reducing extensive waiting. Ignoring to triage could result in the neglect of critically ill patients, thus leading to pile-up of litigations.

In support, Martinez, Zhang, Bastias, Feijoo, Hinson, Martinez, Dunstan, Levi and Prieto (2019:9) emphasised further that prolonged waiting with resultant increased risk of complicating or in worse circumstances, demising whilst awaiting care, is worth resulting in massive lawsuits.

5.3.2 Factors that contribute to patients' long waiting time

Factors contributing to long waiting times is the study's second theme. The theme is characterised by four categories namely: departmental, staff, patient-oriented and public health demands factors.

In introducing the subject on waiting times, Adan and Resing (2015: 20) and Reichert and Jacobs (2018:1772) articulated that waiting times are notable health care services sore, particularly in the public facilities. However, concerns arise when processes of dispensing this valuable care are not efficiently realised, such that patients' do not enjoy timely, useful and rewarding gain from their whole interaction with the CHC. This theme thus seeks to elaborate on participants' experiences of factors responsible for patients long waiting time.

5.3.2.1 Departmental factors

The first category, departmental factors has resulted in three sub-categories distinguished as records and patient administration systems deficiencies, shortage of human and non-human resources as well as untrained staff.

As gathered from the study by Valaitis, Meagher-Stewart, Martin-Misener, Wong, MacDonald and O'Mara (2018:2), departmental factors, commonly referred to as organisational factors, entail fundamentals that influence the way in which an entire organisation should behave in order to achieve the best performance outcomes.

These fundamentals include amongst others, staff, equipment, systems and adopted processes. Findings in this study indicated records and patient administration systems deficiencies, which is hereunder elaborated on.

5.3.2.1.1 Records and patient administration systems deficiencies

One of the factors contributing to long waiting times has been reported as records and patient administration systems deficiencies. Majority of participants decried the competency and efficiency of current patient administration system. Records management, including the associated systems should ideally serve the purpose of easing registration of patients, retrieval of records and back-filing.

Findings by Marutha and Ngulube (2012:47) revealed that manual records management has not been assistive in improving services. They lamented that the manual system is labour-intensive, thus consuming considerable bulk of service time. As a result, this conservative system impedes timely, effective and efficient records retrieval. In support, Mutale, Chintu, Amoroso, Awoonor-Williams, Phillips, Baynes, Michel, Taylor and Sherr (2013:9) have asserted that deficiencies with health systems are a profound problem in African countries. These health system deficits result in limitations to adequately measure facilities performance on efficiency indicators like waiting time. Mutale et al (2013:9) express further that disinvesting in capable health information systems leaves facilities to resort to paper-based means. This regrettably, leads to incomplete and therefore, inaccurate and unreliable data. Subsequently, patients' consultation time gets consumed as health care workers spend more time trying to correct data inaccuracies.

In a subsequent study, Marutha and Ngoepe (2017:6) revealed several causative factors for disarrayed filing systems. Amongst the linked factors are poor infrastructure, lack of policy guidelines, lack of management support and decision-making, as well as inadequate resources and staff. Marutha and Ngoepe (2017:6) went on to stress that these factors lead to missing files. The latter forces patients to wait longer whilst their files are still being located. One of the participants voiced similar experience in indicating that misfiling is responsible for delays in the patients' registration areas. As expressed by Belayneh, Woldie, Berhanu and Mastewal Tamiru (2017:8), 28,9% of responding patients were unimpressed with prolonged searching of their files.

The inquiry by Danso (2015:70) revealed further that 50% of respondents mentioned improper record management as being responsible for service time delays. These delays become the subject of discontentment amongst patients. Hardine's study (2017:61) emerged consistent when it was revealed that lack of computerised support was responsible for the long waiting time, including delays in providing necessary emergency care.

Groccia, Mselle, Rugakingira, Sangmo, Somboi and Ngure, (2016:32) alluded further that under-staffing of records personnel complicates prompt retrieval of patients' files. This is associated with the notion that the few available staffers would be overwhelmed by large volumes of patients awaiting their service. Speaking to service times, Daniels (2015:37) mentioned additionally that administrative systems deficiencies carry undesired bearing on time spent in facilities. This gap thus necessitates investing in competent tools of trade that will assist with the rapid retrieval of medical records, patient information and laboratory results to reduce waiting and service time.

As cited by the participants, majority of health care facilities get mostly overcrowded and congested in the early morning hours. This puts immeasurable strain on the clerical staff to quickly decongest the registry areas. Mutale et al (2013:10) thus concur that by installing effective, efficient and fully functional patient administration systems, the lengthy duration it takes to process registration of the awaiting patients would be alleviated, much to their relief.

5.3.2.1.2 Shortage of human and non-human resources

Resources are defined as necessary tangible and non-tangible substances of life that have the potential to capacitate individuals attain their work-place performance goals (Halbesleben, Neveu, Paustian-Underdahl, & Westman 2014:6). South Africa (2003:s1) expatiates further that human resources refer to health care personnel categorised as health care providers (made largely of professionals registered with regulatory and statutory councils) and health workers (of which registration not needed). Shortage of human and non-human resources has been acknowledged by participants as an aggressor of patients' long waiting times.

Additionally, in line with this definition, South Africa (2003:s48) further stresses that the National Health Council must develop policy and guidelines for, and monitor the provision, distribution, management and utilisation of human resources within the national health system.

As gathered from the majority of participants, inadequate staffing levels and delays in filling up vacancies degenerates the predicament. Staff insufficiencies can only imply that the available few will have to be confronted with large volumes of patients in need of PHC services.

Rispel and Bruce (2015:118) reported that, South Africa is confronted with unequalled staff shortage crisis, which largely includes nursing cadres. Manyisa and Aswegen (2017:35) have made emphasis that the phenomenon of health care personnel shortage is not only peculiar to developing countries, but a sore in developed countries too. The severity of staff shortages in Malawi is demonstrated by a population of 100,000 having access to only two doctors and 37 nurses, argues Manyisa and Aswegen (2017:36). Further observation by Manyisa and Aswegen (2017:35) was that shortage of health care personnel has in worst case scenarios, forced nurses and doctors to first clean up floors due to lack of cleaners. For highly skilled staff to immerse in non-key functions can only mean more waiting for patients.

Sokhela, Makhanya, Sibiya and Nokes (2013:4) have additionally imparted that whilst health care users tend to be empathetic with staff shortage, they still should receive good, efficient and expeditious service provision. It has been observed that staff shortages result in delayed commencement of duties since the very few have to sort out allocation problems in other areas. The resultant increased waiting time yields high levels of dissatisfaction. It has further been determined by Wagenaar, Gimbel, Hoek, Pfeiffer, Michel, Cuembelo, Quembo, Afonso, Gloyd, Lambdin, Micek, Porthe and Sherr 2016:6), that a blend of few human resources and a relatively large number of health care users result in short consult times. The brief time spent during the actual consultation is as a result of staff basically pushing the queues as they race to serve all patients.

Similar findings were arrived by Scheffler et al (2015:4) wherein the respondents stressed that in-spite of efforts to keep appointing staff, there is still experience of long waiting times. This, they attributed to the ever- escalating demand for services by even higher number of patients. Exacerbating this predicament, the Rural Health Advocacy Project (2016:14) detailed in 2016 that the weakening South African economy is circuitously curtailing employment opportunities for doctors and nurses.

These developments are as a result of ongoing post-freezing in a bid to manage remuneration expenditure. It thus leaves facilities with the chronic issue of being under-staffed against the competing long queues.

Manyisa and Aswegen (2017:35) support this stance by adding that increase in the number of patients is linked to the unaffordable high costs of private facilities, rapid population growth, inequality, unemployment, poverty and the associated disease burden. Further support is noted from the research by Cohen and Bruijns (2018:581) in which it surfaced that not only would high patient numbers surpass the few available human resources, but that patients' waiting time to receive care would be prolonged, consequentially increasing to the total length of stay at a CHC.

Whilst definition of non-human resources maybe vague from several literatures, Halbesleben et al (2014:6) refers to non-human resources as equipment, machinery, objects, intelligence, wisdom and skills needed for employment goals. The National Health Act (2003:s25) places it on the authority of the Provincial Health Department to provide and maintain equipment to enable continued dispensing of quality and timely health care services to the less privileged citizens.

Participants were particularly vocal about shortage of functional computers. Limited or unavailability of functional computers is associated with delays in electronically registering patients. Idowu, Adeosun and Williams (2014:62) appreciated the use of technology to enable seamless booking of patients' appointments. Idowu et al (2014:62) expressed concerns on occurrences of unavailability of necessary and relevant resources such as functional computers. Where technological advances are deficient, manual alternatives would be time-consuming and impact on patients' waiting time.

Speaking of illogical queuing, Caesar (2017:66) cited further that malfunctioning computers were responsible for delays in electronically retrieving patients' investigations results. Occurrences such as these, lead to skipping of patients who are rightfully next in the queue whilst staff grapple with fixing the broken computers. It thus suffices to mention that had the computers been functional, it would have been easy to swiftly retrieve laboratory results employing technology.

According to one participant, lack of funds has been associated with non-purchase of computers to enable execution of patient-care related activities. National Health Act (2003:s25) once again implores on the Provincial Health Departments to exercise oversight of adequately planning and financing of public health establishments. This legislative mandate serves to ensure that health technology and infrastructure are invested in to enable continuity of timely care. Failure to realise this, culminates in putting at abeyance purchasing of essential items like computers.

Mokoena (2017:54) added that shortage of essential medical equipment carries much potential to delay commencement of patient care and interventions. The challenge in this regard emanates from having to borrow items such as blood pressure monitors from other areas within the CHC. Washeya (2018:50) concurs that availing of enough, appropriate, essential and functional equipment not only facilitates rendering of quality care, but further enables smooth delivery of services.

Ballini, Negro, Maltoni, Vignatelli, Flodgren, Simera, Holmes and Grilli (2018:2) shared that whilst PHC services are cost-free, it is rather the budget constraints on goods and essential equipment that impede triumphs of efficient PHC services. In the ultimate end, patients end up being distressed by the disservice and lengthy waiting times.

5.3.2.1.2 Untrained staff

As provided for by Engetou (2017:1), training is an initial and primary form of human resource capacity building. Its purpose is to enhance the creative potential of the employees. What has been established from the study's participants is that Extended Public Works Programme (EPWP) cadres have not been subjected to various forms of developmental activities pertinent to their work imperatives.

Participants were vocal to say some of the delays in the admissions units are as a result of lack of direction and purpose by these group of officers. It thus needs to be borne in mind that these EPWP officers are semi-skilled and have been seconded to these CHCs with the intent of bridging the gap of personnel insufficiency around patient administration and cleaning amongst others.

It is again the National Health Act (2003:s25) that directs that the employer is obligated to plan, manage and developmental activities of employees and continue to advance such initiatives in order to sustain provision of quality health care services.

Nassazi (2013:49) has asserted that employees should be considered assets of any organisation. Underestimating their active role towards achieving the employer's business goals can be detrimental. Evidence of long queues in CHCs is typical of adverse consequences of training gaps in health establishments. By training personnel, they become better positioned to confront with confidence modern day challenges. Participants in this study by Nassazi (2013:49) were unanimous in mentioning that dynamic work environments, changing technology and diverse customer demands warrant frequent training so as to keep conversant with the latest developments.

Sendawula, Kimuli, Bananuka, and Muganga, (2018:3) imparted that the main purpose of training is knowledge acquisition and skills transfer so that an organisation can fulfil reasons for its existence. Engetou (2017:11) adds that training serves to eliminate risk, since trained employees are better poised to make economic and sensible use of employer's material and equipment.

Having this kind of workforce could elevate avoidance and reduction of waste. Over and above, performance is enhanced by staffs' efficiency whilst productivity is ultimately maximised, including noticeable improvements in staff confidence and moral. Swart, Muller and Rabie (2018:5) argued further that if excellence in service delivery is to be realised, amongst the training priorities should be on triaging. According to Swart et al (2018:5), where and when nursing and medical staff are trained in triaging, their clinical competence is favourably enhanced. It is such investments that result in queues being managed even swifter, with the focus of decreasing patients' long waiting times. Mpofu and Hlatywayo (2018:135) have added that it should be obligatory of employees to scheduled regular purpose-driven training.

Accordingly, periodic in-house or external training becomes part of strategies to improve public service delivery, an investment that should not be overlooked. It is thus apt to suggest that since these EPWP cadres perform mostly clerical and administrative duties, they be trained to enhance their efficiency in aiding the efforts aimed at decreasing patients' long waiting time.

5.3.2.2 Staff factors

Staff factors feature as the second category with regards to factors contributing to long waiting times. Poor time management and absenteeism are the resultant sub-categories. Both are hereunder deliberated on.

5.3.2.2.1 Poor time management

Different definitions of time exist. It is however not plainly unassuming to go with one particular definition. Osawe (2017:154) and El-Shaer (2015:18) are unanimous that time is the space in which a continuum of actions, processes, or conditions happen. As per this definition, the implication is that time therefore needs to be managed economically so that tasks, duties and any other similar are accomplished promptly.

Legislatively, South Africa (1997: s13) accords employees who work continuously for more than 5-hours a meal interval of at least one continuous hour. Dereliction of this legal prescript by going over-board the one-hour meal break, exacerbates patients' waiting time. It was thus established from the majority of participants that ill-management of meal breaks by staff contributes largely to delays in managing patients' long queues. Almomani and AlSarheed (2016:738) noted how frequent medical officers arrived late for patient care. On average, the medical officers were mostly late by between 20 to 49-minutes. Such, tardiness left patients bitter and totally dissatisfied. Supportive citation by Shahzadi and Annayat (2017:19) yielded that a number of patients expressed displeasure at non-availability of health care workers at their respective workstations when expected to. This unavailability could only mean delayed care and thus influencing how long patients will wait.

Steenland, Dula, de Albuquerque, Fernandes, Cuco, Chicumbe, Eduardo Gudo, Sequeira and McConnell (2019:7) have over and above raised the concern whereby nurses were observed to be non-compliant to their duty times. This poor compliance resulted in patients being seen over an hour after their scheduled visit hour. Being consulted an hour post one's arranged visit imply an undue delay in excess of what the patient had bargained for.

This expression by participants is unanimous with study findings by Aburayya, Alshurideh, Albqaeen, lawadhi and Al A'yadeh (2019:1272) which acknowledged poor management of shifts and tendencies to enjoy breaks as a collective or groups. Supportively, Caesar (2017:33), revealed that the fewer staff there is on duty, the more challenging it is to have relief staff during meal break times. The implication then means when personnel go for their meal breaks, there would basically be no colleagues remaining to continue working so that patients' waiting time is still reduced. Poor time management is therefore a call for concern as it gives rise to perceived poor service delivery, particularly in the public service. It is this deportment that incited the need for further inquiries directed towards ameliorating the ugly situation (Osawe 2017:153)

5.3.2.2.2 Absenteeism

The second category in relation to staff factors sub-theme is absenteeism. As gathered from Patel et al (2018:5), participants in this research reported absenteeism in their workplaces as a worrying occupational encounter.

Patel et al (2018:5) and Manyisa and Aswegen (2017:34), went on to stress concoction of notable factors that boil up to influence absenteeism, with devastating effects on the duration spent by patients awaiting ushering of quality care. Common amongst fuellers of absenteeism are heavy workloads, congested duty schedules, clinical records management demands, engaging in work-related activities whilst resting at home, pressures of dealing with unfavourable patients' outcomes, decreased work-place autonomy, depressive work environment as well as lack of support from management and peers alike.

Manyisa and Aswegen (2017:34) unequivocally added that staff is over-burdened by the inexorable work-loads as well as deplorable conditions they find themselves confronted with daily in their practice. The concurrence by Badubi (2017:34) is that prolonged working hours and insufficient resting whilst off-duty, leads to staff being over-burdened with work.

In support, Mbombi, Mothiba, Malema and Malatji (2018:3) have come out to mention that nurses who continued working while their colleagues displayed low morale. The latter, when left unattended, becomes a vicious cycle. Colleagues who held the forte whilst others were absent, will later on compensate themselves by being absent too. Perpetuated absenteeism thus ends up being detrimental on patients' waiting time.

Makhado and Davhana-Maselesele (2016:7) rave furthermore reported that nurses who are practically facing increased workload are much more susceptible to experiencing and reporting burnout, sequelae of absenteeism. Haskins, Phakathi, Grant and Harwood (2016:37) added that absenteeism was more a result of decreased resistance to endure and equally survive the workload staff is faced with. Badubi (2017:34) further related that understaffed entities are predisposed to higher incidents of burnout amongst their employees.

One additional matter of concern as raised by participants is that staff does not feel safe in their workplaces due to the prevalence of harassment. Adversities such as being violated in the workplace thus add to the woes of absenteeism. The study by Malangu (2012:16) agreeably provided that work-place violence and assault incidents resulted in loss of productivity stemming from more number of working days staff will spend at home recovering from the atrocities of violence. Whilst health care providers may be absent from work due to a variety of legitimate reasons, any form of absenteeism presents as a major challenge to service delivery, including impacting inauspiciously on patients' waiting time (Tomlinson et al 2019:6).

5.3.2.3 Patient-oriented factors

Patient-oriented factors are recorded as the third category which yielded lack of adherence to booking system and patient overload as sub-categories.

5.3.2.3.1 Lack of adherence to booking system

Samadbeik, Saremian, Garavand, Hasanvandi, Sanaeinasab, and Tahmasebi (2018:1) define an appointment system as scheduling the suitable date, time and place for a clinical visit to receive the necessary healthcare services. This basically translates to preparing for the patient's forthcoming visit. As expressed by majority of participants, they have experienced encounters of patients missing their CHC appointments. This encounter by the participants is reverberated by Daniels (2015:34) in mentioning that failure to show up at the clinic as initially scheduled, worsens waiting time in the facilities.

Findings from the study by Magadzire, Mathole and Ward (2015:4) additionally revealed that those missing appointments were females, with about 66% recorded as having missed their appointments. In acknowledging that there are tendencies of missing appointments, Alhamad (2013:263) discovered further that missing scheduled appointments was influenced by long distance to get to the facility, compounded by unemployment and poverty.

Additional aggressors, according to Alhamad (2013:263) include socio-economic factors such as ill-health, family responsibility, low literacy levels, being forgetful, dissatisfaction with facility services, and work demands. Frost, Jenkins and Emmink (2017:4) added the following as reasons for missing appointments: being unaware of their scheduled appointments, being away at the time of appointment, confusing dates, being sick, caring for a sick family member, death in the family, clashing appointments and electing "just not" to attend. Further consensus is noted in the study by Ramlucken and Sibiya (2018:3) in which distance to the facility and associated travelling costs were responsible for patients' missed appointments.

In all of it, appointments are scheduled to ease patients' volumes and relieve the work-loads. In the event such initiatives are not appreciated, and appointments dishonoured, it can only mean defaulters would most likely present unscheduled on any other day, thus increasing the roll of already planned for patients on that particular day in a CHC.

5.3.2.3.1 Patient overload

This study's participants overwhelmingly admitted that their facilities are facing large volumes of patients on a daily basis. According to Maphumulo and Bhengu (2019:4), initial construction of health care establishments was designed and constructed to provide services to a certain number of users. Patient overload is thus informed by the rapid increase of the population and growing influx of people in the metropolitan areas. Such determinants of health, compel health facilities to function beyond their intended capacity.

The survey by Statistics South Africa (2017:23) has shared light that about 81% of the estimated population of 55.5 million depend on public health care facilities. Accordingly, Johnston (2017) revealed that the prevalence of chronic conditions has to an influential state resulted in large volumes of patients queuing in different health care facilities. In the research by Umar, Oche and Umar (2011:79), the participants perceived large number of patients as a cause for long waiting time, aggravated further by few health care workers.

Nurses in the enquiry by Wagenaar et al (2016:7) agreeably mentioned that increasing patient volumes posed a challenge as it meant increased workload for them. Similar findings were arrived at by Groccia et al (2016:31) who established that overcrowding was responsible for extensive waiting. This overcrowding is largely attributed to patients bypassing their lower-tier facilities. Therefore, bypassing of their equally competent local clinics and rocking up at CHCs, patients actually add to their misery of unbearable long waiting.

Additional supporting discovery by Caesar (2017: 34) is that large number of patients arriving pretty early in the morning has not been helpful either, especially if the administration staff does not match such high patient volumes. The experience that patient workload influences waiting time is further accentuated by Egbujie et al (2018:316) by stating that facilities that are confronted with higher patient load per health care workers had experience stretched total patient waiting time.

It has further been verbalised by the study's participants that foreign nationals are worsening the current state of affairs in the CHCs. This deportment is supported by Mayosi and Benatar (2014:1344) who assert that the persistent influx of foreign nationals remains an add-on challenge to the already experienced high patient volumes in facilities. South Africa, as an emerging economy, has been observed to be attracting an increasing number of foreign nationals, who are often undocumented for a range of reasons, including health care, adds Maphumulo and Bhengu (2019:4). Over and above these findings, participants who were themselves immigrants in a Portugal study by Linhas, Oliveira, Meireles, Oliveira, de Melo, Lourenço, Ferreira, Gaio, and Duarte (2018:37) expressed long waiting times for a health services appointment as a frequently experienced impediment. Furthermore, it was expressed in a Parliamentary Report (2019) that undocumented migrants put a strain on the already burdened health care system by engaging in medical shopping, implying that they move from one health facility to the next, collecting medication.

On the contrary, the publication by Crush and Tawodzera (2011:18) revealed that patients of non-South African origin are mostly marginalised and discriminated against by being made to wait longer, even if they had arrived before South African citizens. This means foreign nationals are made to wait until the bulk of South African patients have been attended to. It was additionally discovered by Giuntella, Nicodemo and Vargas-Silva (2018:129) that no evidence implying that immigrants have any adverse bearing on the waiting times in several of United Kingdom's emergency units. This was attributed to the responsive policies of the National Health System that are in place in the United Kingdom.

5.3.2.4 Public Health Demands

Public health demand is the fourth category with only one sub-category, namely increased burden of disease

5.3.2.4.1 Increased burden of disease

The publication by Chan (2016:2) imparts that public health refers to efforts concerted at preventing disease, promoting health and thus extending quality of life through the collective of community participation. Where now, there are weaknesses in defending the course of maintaining public health efforts, burden of disease is likely to manifest. WHO (2018) mentioned in its periodical that South Africa faces a quadruple burden of disease resulting from communicable diseases *(HIV/AIDS and TB)*; non-communicable diseases *(hypertension, cardiovascular diseases, diabetes, cancer, mental illnesses, asthma);* maternal and child mortality; as well as injury and trauma.

As established from this study's participants, the burden of disease has been brought on by the advent of HIV and AIDS. The Joint United Nations Programme on HIV/AIDS (2019) has shared that of the estimated population of 56,6 million people in South Africa, about 7 500 000 are living with HIV. This translates to about 13.3% of the population living with HIV, thus making South Africa a country with the largest share of both local and global HIV burden (Mabaso, Makola, Naidoo, Mlangeni, Jooste, and Simbayi 2019:4). South Africa (2017c:6) estimated the prevalence of HIV and AIDS at 270,000 new HIV infections, thus accounting for a third of all new HIV infections in southern Africa.

Furthermore, it is estimated that 71,000 South Africans perished due to an array of AIDS-associated illnesses. According to Satoh and Boyer (2019), the Anti-Retroviral denialism stance during Mr Thabo Mbeki's presidency between 1999 to 2008 left the country with the highest morbidity and mortality rates of all time, with about 330 000 AIDS-related deaths.

The constitutional court ruled on 05 July 2002 that Anti-Retroviral drugs be issued to pregnant women, subsequently paving the way for mass-scale roll out of these vital pharmaco-therapeutic agents (Bruhn 2011:184). The legitimate imperative to expand roll-out of these drugs nationwide created increased need to access health care facilities, increased patient volumes in facilities and increased administration relating to dispensing the necessary care.

Regrettably, the situation has since resulted in long queues in health care facilities. Participants' experiences find congruency in the study by Mabaso et al (2019:9) that the burden of HIV and AIDS is by far, borne by the majority of Black South African communities. The Human Sciences Research Council (2019:133) and Bradshaw et al (2019:72) add further that socio-economic position, low literacy and education levels, joblessness, and poverty are amongst the HIV infection fuelling factors within the Black South African communities.

5.3.3 Positive experiences amidst patients' long waiting time

This study's third theme is positive experiences followed by three categories; patient-oriented experiences, staff -oriented experiences and efficient systems in place. Murphy and Bastian (2019:1) expressed positive experience as a meaningful and pleasant encounter. It is a personal judgement about what one has gone through (South Africa:2017a: 4).

Supportive of this position, the study by Sun, Lin, Zhao, Zhang, Xu, Chen, Hu, Stuntz, Li and Liu (2017:11) in a Chinese public tertiary general hospital, hailed the reduction in waiting times for consultation and repeat treatment scripts as a consequence of effective interventions, which brought about patient satisfaction. From this study, a handful of hostile experiences were shared by participants. Nonetheless, as the saying goes, every cloud has a silver lining. According to participants in this study, noteworthy and fulfilling experiences have been observed.

5.3.3.1 Patient-oriented experiences

From this study, it did emerge that notwithstanding the agonies brought on by patients' long waiting time, participants still managed to create moments befitting of patients' positive experiences. Decrease in patients' waiting time is a gain that has been appraised by the participants.

5.3.3.1.1 Decrease in patients' waiting time

Majority of participants mentioned that patients' waiting time may not be meeting the expectations. The observation is however reassuring. Concerted efforts by CHC facility managers are gradually leaning towards the direction of realising tolerable patients' waiting times. Rauf, Blitz, Geyser, Rauf (2008:43c) documented that a series of quality improvement initiatives are favourably associated with reduction of patients' waiting time in the emergency unit at a hospital in Tshwane. Moreover, instituting these wits did not cost an arm and leg, but achieved using the very few available resources.

It came further to light that situation-specific and oriented innovations yield the anticipated results of lessened waiting times as evidenced in an ENT clinic in Germany (Helbig, Helbig, Kahla-Witzsch& May 2009:6). As demonstrated in Syed, Parente, Johnson, and Davies (2013:52), it additionally emerged that patients who experience shorter waiting times tend to exude positivity and are more likely to express satisfaction with health care services and the system in general.

In the end, satisfied patients are cooperative and compliant with therapies, able to build meaningful rapport with their therapists, and keep much to their appointments (Syed et al., 2013:52). In concurring, Daniels (2017:101) expressed that where improvement plans are developed and implemented to decrease patients' long waiting time, the outcomes can be favourable. This is as evidenced by the much-welcomed decrease in waiting time by an average of 21-minutes between 2007 and 2011, translating to a reduction of 28% compared to prior 2007 (Daniels 2017:101).

5.3.3.2 Staff -oriented experiences

The magnitude of staff-oriented experiences emerged as the second category with regards to positive experiences. Participants expressed that positive outcomes are not just a unilateral encounter enjoyed by patients alone, but staff too. From this sub-theme, improved stakeholders and partners' relationships as well as recognition and appreciation of staff emerged as the two categories.

5.3.3.2.1 Improved stakeholders and partners' relationships

The positive role of private partnerships has been cited and acknowledged by the participants. National Business Initiative (2019:5) mentions that Private-Public-Partnership (PPPs) is an agreement between a public-sector entity and a private organisation. In this arrangement, the private party agrees to perform some or whole functions that would normally be provided by the public-sector, primarily for purposes of finance-bridging and service delivery improvements (Jomo, Chowdhury, Sharma & Platz 2016:4). This study's participants echoed that the resources and aid brought about by these PPPs has been a welcomed relief, such that the synergies were noted as supporting reduction of patients' long waiting time. Jokozela (2012:103) recorded that accessibility and quality of health care services improved where PPPs were successfully implemented. Owing to the notable betterment of health care services, subsequently, staff was able to divert much of their needed attention on fundamental clinical services.

In agreement, Ferreira and Marques (2020:4) noted as desirable that PPPs effort should concern themselves on yielding good health outcomes by amongst others, eliminating organisational barriers such as patients' long waiting times and surgery waiting lists. Perhaps the notable collaboration with private stakeholders to decongest facilities and reduce long waiting times was the introduction of Central Chronic Medication Dispensing and Distribution (CCMDD) programme by the National Department of Health in February 2014 (Smith & Nicol 2019:2).

CCMDD is an initiative intended for patients with stable and manageable chronic conditions that do not require monthly clinic visits for reviews and follow-up care (Menold 2017:1; Muthelo Nemagumoni, Mothiba, Phukubje Mabila 2020:478). Muthelo et al (2020:482) have since recognised the benefits of CCMDD as seeking to relieve primary health care system of the unending congestion with the aim of decreasing workload pressures for staff.

In this study, clinic committees were further noted as additional stakeholders whose participation and role in health care issues was dearly embraced. The National Health Act (South Africa 2003:s42) authorises establishment of these governance structures. Their role is fundamentally to provide support by becoming liaison between the community and the health establishments on affective matters (McKenzie, Schneider, Schaay, Scott & Sanders 2017:13). Clinic committee members who participated in the study by Padarath (2009:100) reported spear-heading an initiative to secure emergency medical transport for patients in their catchment area including monitoring availability of medical supplies at their clinic The other set of clinic committee members in Kwa-Zulu Natal reported having managed to successfully negotiate with the local traditional authorities to acquire land intended for constructing nurses' accommodation.

It is worth of mentioning that such initiatives by clinic committees help in freeing some much-needed time for managers of CHCs, thus allowing them to focus on other administrative and clinical priorities. Sustainability of this valuable structures is hampered by amongst others community disinterest in establishing committees, failure to quorate and hold meetings, lack of financial remuneration were the leading reasons for unavailability and/or dysfunctional state of these structures (Padarath and Friedman 2008:33).

In addition, McKenzie et al (2017:13) identified political support deficiencies, lack of participation and support from respective CHC facility managers, staff hostility towards the committees, unavailability of lack of resources (stationery, offices and telephones) as well as lack of financial support, specifically for incurred travelling costs.

5.3.3.2.2 Recognition and appreciation of staff

In this study, meanwhile there's an array of difficulties to navigate within the PHC system, participants expressed fulfilment at being recognised and appreciated for their unremitting obligation to serve.
Being recognised, valued and appreciated amounts to motivation. Motivation is thus defined as an employee's degree of preparedness and commitment to excel in achieving organisational aspirations (Sternberg 2017:10).

As substantiated by WHO (2007:3), motivation has become a catalyst of improving performance aimed at attaining health system goals as aspired for in the WHO's Sustainable Development Goals (SDGs). In favour of recognition and appreciation of staff, Gijo, Antony, Hernandez and Scaria (2013:265) authored that management of an Indian hospital resolved to befittingly reward those involved in the health systems improvement initiative, which amongst other imperatives, sought to decrease patients' waiting time.

Groccia et al (2016:33) added further that in Tanzanian hospitals, administration of rewards for excellence and chastisement and sanctioning for underperformance drove motivation towards reaching the employer's vision and mission to improve health care outcomes. Additional study findings by Potisek, Malone, Shilliday, Ives, Chelminski, DeWalt and Pignone (2007:3) in a North Carolina anti-coagulation, revealed that increasing support towards nursing is associated with improvements noticed towards patients' total time spent during a single visit. Over and above, it was demonstrated by Ho (2014:4) that patient satisfaction feedback of overall clinic and staff performance gained popularity. This was evidenced by rise in compliments whilst complaints decreased, primarily due to operational clinic flow.

Supporting literature on recognition and appreciation of staff, Abdullah, Shonubi, Hashim and Hamid (2016:48) concluded in their study that recognition builds up confidence in employees. This on its own instils confidence, which translates to more efficient workforce.

5.3.3.3 Efficient systems in place

The third category apposite positive experience is efficient systems in place. It resulted in two sub-categories, which are prioritisation of patient care and flow as well as appointment system.

5.3.3.3.1 Prioritisation of patient care and flow

The participants were vocal in raising their pleasure at gains resulting from prioritisation of patient care and flow. Prioritisation of patient care is defined as determining and putting first and foremost clinical cases in terms of their urgency and importance (Ludlow, Churruca, Ellis, Mumford, Braithwaite 2018:2). From the study by Aburayya et al (2019: 1272) several factors impacting patients' waiting time were mentioned, which included poor and unresponsive work processes and procedures.

Prioritisation of patient care and flow was thus necessary in the South African context and was achieved by introducing the Integrated Chronic Disease Management (ICDM) model in 2011 (South Africa 2016:26; Lebina, Alaba, Kawonga & Oni 2019:2). ICDM is a prototype of managed integrated care that prioritises prevention, treatment and care of chronic patients at clinics and CHCs to ensure a unified a shift in managing chronic conditions. Additionally, in seeking to strengthen the health systems response further, Integrated Clinical Services Management (ICSM) was announced (Sunpath 2014:8).

South Africa (2015a:34) stresses that ICSM as a vehicle for service re-organisation, should see facilities re-arranged into four streams of care namely, acute, chronic, maternal and child health as well as health support services. According to WHO (2018:5), integration is the whole re-arranging and managing disarrayed health services in such a way that health care users are able to access services on demand, in a user-friendly manner to achieve the desired health outcomes whilst getting value for money still. El-Shaer (2015:26) corroborated that staff satisfaction rate increased with improvements in organisational efficiencies, which eventually lead to top performance.

Ho (2014:4) supplemented that optimising provision of quality and best care is not only dependent on clinical competencies of health care personnel. Prioritising facility reorganisation, integrating clinical services as well as redesigning work and patient flow processes are treasured to aid in decreasing waiting time. Asfoor (2014:21) stressed further that facility reorganisation should at all seek to penetrate and impact in areas where there are bottlenecks. Asfoor (2014:21) asserts that easing of all blockages in a CHC is almost guaranteeing reduction in patients' long waiting time. Amongst the clinical efficiencies of value to reduce waiting time, Swart, Muller and Rabie (2018:5), Altema, Bien-Aime, Roger and Balise (2020:33)

5.3.3.3.1 Appointment system

It was established from this study's participants that the appointment system is one particular means to respond to health system gaps that has brought about much needed respite. An appointment system, according to South Africa (2015:51) refers to planning the next visit of a patient. Samadbeik et al (2018:1) add that date, time and place of a clinical visit to receive healthcare services are collectively determined with the patient. It was encouraging to learn from the study by Frost et al (2017:3) that the majority of participants (91.8%) understood why they had an appointment, with 85.1% affirming that it is even necessary to honour their appointments. Kama (2017:83) cherished the appointment system and was non-hesitant to recommend that it, (appointment system) be introduced so as to gradually abolish the practice of early arrivals by patients.

The positive side of the appointment system has over and above, prompted Kumthekar and Johnson (2018:2) to endorse that reminding patients of their due appointments via some phone call be considered to increase uptake of this system. A simple phone call reminder is an added thoughtful means to increase appointment attendance rates for realisation of minimal waiting, bettering clinic flow and improving continuity of care (Kumthekar and Johnson 2018:3).

It has further been established by Steenland, Dula, de Albuquerque, Fernandes, Cuco, Chicumbe, Gudo, Sequeira and McConnell (2019:6) that Ante Natal Clients benefited substantially by experiencing reduction in waiting time following introduction of the appointment system. Steenland (2017:7) added that higher volume facilities benefitted the most out of this significant intervention. Vijayan (2015:77) whilst supporting and endorsing the appointment system, there's been caution that facilities should not invest in just one blanket appointment system approach, but to be dynamic, flexible and custom-make it to suit the needs of patients.

5.3.4 Measures that can reduce patients' long waiting time

This study's fourth and last theme is measures that can reduce patients' long waiting time**.** Efficient decongestion systems to alleviate patient long waiting time emerged as a category, which yielded embracing decongestion systems to mitigate patients' overflow at CHC emerging as a sub-category. The second category; collaboration amongst different stakeholders produced two sub-categories, namely teamwork as well as supportive supervision and delegation.

5.3.4.1 Decreasing patients' waiting time

It has been gathered from this study's participants that efficient decongestion systems to alleviate patient long waiting time serve better as a means to reduce patients' long waiting time.

5.3.4.1.1 Embracing decongestion systems to mitigate patients' overflow at CHCs

The study's participants echoed several decongestion systems to mitigate patients' overflow at CHCs namely the CCMDD, treatment adherence clubs, ICSM and automated dispensing of medication.

In this context, the need to introduce the Lean process at a Kwa-Zulu Natal hospital by Naidoo and Mohamed (2016:1) was impelled by the high prevalence of quadruple burden of disease, which has resulted in a spike in terms of utilisation of facilities by patients. South Africa (2015a:46) in addition, endorsed redesigning service delivery efforts, scheduling of chronic care, maternal and child health as well as supportive rehabilitative services. It has further been noted that the taskforce in *an* interrupted time series study by Sun et al (2017:3) formulated a series of interventions targeted at simplifying the appointment scheduling aimed at decreasing waiting time for consultations and procedure changes amongst other priorities.

The publication by Johnston (2017) furthermore applauded CCMDD, the alternative repeat treatment collection strategy for stable chromic-care patients. A centralised dispensing system is employed for this model whereby bulk prescriptions are packaged and sent for dispensing. Patients have the option of collecting from the CHC, joining the rapid queue or any another designated opportune pick-up point. Further good and convenience about this system is that patients are also able to nominate two proxies, be they family, relatives, colleague or friend to collect their repeat treatment on their behalf.

A further addition by South Africa (2016:23) revered treatment adherence clubs. These are differentiated models of improving access to care for clinically stable patients, especially those on antiretroviral therapy. Patients meet periodically off-site, instead of in a fixed CHC or clinic to engage meaningfully on their different health care and treatment issues. Whilst it seeks to improve retention in care, it further lessens the burden placed by high volume of patients in the clinics and CHCs, thus easing the experienced pressures that stable patients place on healthcare facilities.

Participants eagerly added further that ICSM needs to be treasured and strengthened. In agreement, WHO (2018:2) stressed that a proper response to the fragmented services is realisable through integration of services.

Another decongestion strategy which came to the fore is advocating for automated dispensing of medication. Ramphal (2019) in support of such an initiative, mentions the *Pelebox*. It is a purpose-fit, cost-saving, express and efficient alternative treatment collection system. This is an innovation founded by Neo Hutiri, an electrical engineering graduate (Zali 2019). The name *Pelebox* was influenced by the Setswana word *pele*, which means "first." It is a digital solution, which only demands of patients to have a Personal Identification Number to unlock a smart-locker containing their medication, and off they go in less than 5-minutes. Ahtiainen, Kallio, Airaksinen and Holmström (2019:260) agreeably mentioned that automated dispensing systems save nurses time as all related logistics are handled by pharmaceutical by localising logistic phases of drug distribution to pharmacies.

Similar findings were arrived at by De-Carvalho, Alvim-Borges and Toscano (2017: 634) whose investigation discovered that is the first study to assess the impact and costs resulting from implementing automated dispensing technology in Latin America resulted in overall reduction in the need for actual personnel, time and cost. The good returns of the three factors were reduction in time nurses had to spend handling pharmaceutical duties instead of their nursing core functions. This freed much needed time for nursing personnel to focus on reducing patients' waiting time in other domains.

Majority of objectives of the published literature on automated dispensing systems delved on patient safety and profit in some cases, rather than improving on patients' long waiting time. As a researcher, one notes of course that patient safety is equally a clinical area of priority. The discussion in the study by Chapuis, Bedouch, Detavernier, Durand, Francony, Lavagne, Foroni, Albaladejo, Allenet and Payen (2015:4) provided financial gains and performance for the period 2011-2015. It came to conclusion that implementation of the automated dispensing project derived more financial profit that impacting on patients' waiting time.

The findings of another study by Sinnemäki, Sihvo, Isojärvi, Blom, Airaksinen and Mäntylä (2013:5) also suggested that the automated dispensing service provided reduced medication discrepancies, thus improving medication safety. In addition, Ahtiainen, Kallio, Airaksinen and Holmström (2019:259) concurred that majority of enquiries' attention was on refining ways to reduce medication errors so that medication safety outcomes are favourably impacted on.

5.3.4.2 Collaboration amongst different stake holders

The study findings revealed the second category, namely collaboration amongst different stake holders as one measure to reduce patients' long waiting time. According to Primary Health Care Performance Initiative (2015:11), stakeholders refer to key role-players with common interest towards optimising organisational goals.

They include but not limited to the community, employees, governmental and non-governmental organisations, religious formations, management, owners and customers. Teamwork was mentioned as a favourable approach to foster collaboration amongst different stake holders

5.3.4.2.1 Teamwork

Participants voiced that cohesion in the workplace goes along a long way to improve health outcomes. It is conveyed by Rodriguez and Walters (2017:5) that teamwork triggers creativity, creates sense of belonging, motivates staff and is responsible for sense of accomplishment. Additional stance by Babiker, El Husseini, Al Nemri, Al Frayh, Al Juryyan, O'Faki, Assiri, Al Saadi, Shaikh and Al Zamil (2014: 13) is that due to improved coordination brought about by teamwork, health care facilities experience in the end reduced operations and waiting time. In support, Liu, Masiello, Ponzer and Farrokhnia (2018:6) established the shortest length of stay where and when teamwork was at play during triaging as opposed to the lengthiest duration when triaging was solo-driven.

Epstein (2014:S295), supportively reiterates that supervisor's constructive and purpose-driven support is pivotal to enhance not just once off teamwork efforts, but to sustain them for better if improving quality and safe patient care is to be realised

5.3.4.2.2 Supportive supervision and delegation

As raised by the enquiry's participants, supportive supervision and delegation emerged as the second category. South Africa (2015d:29) makes it inherent of facility managers of CHCs to be competent in working effectively and amicably with persons of diverse intellectual, cultural, racial or religious differences, including managing own work, and that of junior colleagues to ensure unhindered and swift dispensing of quality services. Supporting this position, Alshutwi (2016:45), stresses that advisory support from supervisors is needed in the workplace, particularly when nurses need clarity on certain affective issues. Supervisors should be encouraged to improve their supportive roles and strengthen supervision since they are representing the best interest s of the organisation.

This will reduce many adverse events in the workplace and will improve quality nursing care. Mametja (2013:75), has additionally uttered that clinical staff stand to be motivated when their superiors lift them up psychologically by amongst others availing counselling and other psychotherapy services such that they remain inspired to promote and sustain quality-laden patient care.

5.4 CONCLUSIONS

The aim and design of this study sought to explore and describe experiences of facility managers regarding patients' long waiting time at Tshwane health district CHCs. This study concluded that CHC facility managers are experiencing unanimous blend of patients' waiting time impasses. Evidence from this study is indicative of existence of negative impact delivered by patients' long waiting at Tshwane health district CHCs. There is further evidence that there are several weighing factors that contribute to patients' long waiting time.

Whilst patients' long waiting time has sprouts of negative impact as well as influential factors on the health care system, the CHC facility managers have relayed some favourable and encouraging experiences, nonetheless. The wisdom gained by the CHC facility managers over the years of being in charge has further sharpened them to be flexible and adaptive to what could help in the plight of long queues and patients' lengthy waiting periods. Recommendations herein contained are demonstrative of the fact that CHC facility managers have the zeal and determination to improve the health systems efficiencies by amongst others, embracing several decongestion systems, advocating for teamwork and providing necessary supportive supervision and meaningful delegation. The conclusion herein contained suffices to posit that this study's questions were answered, and objectives achieved. The study has yielded valuable information on the researched topic.

5.5. RECOMMENDATIONS

The study findings inform these recommendations, and primarily seek to impact on facility, patient and department-oriented facades to impress favourably patients' long waiting time. The following are recommendations for practice, CHCs operations, health care users, employing organisation as well as further research.

5.5.1 Recommendations for CHCs operations

Recommendations for CHCs operations are founded on discoveries highlighting operational challenges. These difficulties thus impede on these entities' maximal potential to fulfil their expected roles. It is therefore recommended that:

- Implementation of the appointment system should be optimised. Whilst the appointment system has already been introduced in Tshwane health district's CHCs, it has not been without challenges. Optimising the mechanism should therefore seek to correct the incumbering gaps to aid in winning back the eroded patients' confidence and increase the uptake of the intervention.

- Time-slots should over and above the open-ended scheduling, should be considered. The appointment system should be a vehicle to assist in skirting dawn arrivals to book queues. Furthermore, patients whose economic livelihoods are dented by missing work owing to spending all day at CHCs will reap the benefit of this innovation. The appointment system should additionally be a platform to manage patient over-load in the CHCs.

- Facility re-organisation should as far as it is possible be prioritised. Efforts need to be concentrated on organising patient-flow in a way that minimises directional confusion, being lost and queuing in wrong sections amongst others.

- This exercise should seek to make patient's journey during their visit as seamless as possible. Amongst interventions to implement in re-organising the facility is visible labelling of room doors and/or areas, installing directional signage and arranging services into the relevant streams of care, namely acute, chronic, maternal and childcare as well as promotive services. Re-organisation should continuously be re-evaluated to establish if it is yielding the intended results. All else being contrary, further refinements should be instituted until the desired goal is achieved.

- Embracing stakeholder and partners' relationships should be embraced. Amongst others, clinic committees are important liaison structures between CHCs and local communities. CHC facility managers should strive to establish and strengthen their relationship with clinic committees. It is additionally important to avail resources such as telephones and some space from which their functions can be performed. Clinic committees' roles could be expanded to amongst others, marketing, promoting and advocating for the appointment system, assisting in resolving complaints as well as diffusing violence and abuse of staff by aggressive patients.

- Recognition and appreciation of staff should be incorporated as an administrative norm. Reducing patients' long waiting time in CHCs is a collective effort. Therefore, every little effort by every team member is worth been recognised. Recognition and appreciation need not always be materialistic. Positive feedback and messages of gratitude equally serve the purpose. When CHC staff know that their diligence is valued, they are more poised to be inspired to go extra miles. It is a gesture that motivates them to improve and maintain their great performance to continually decrease patients' waiting time.

- Teamwork and strengthening supportive supervision ought to be harnessed. The Tanzanian proverb "Two ants do not fail to pull one grasshopper" attests to the power of teamwork. It is herewith endorsed that CHC facility managers should always advocate and foster teamwork if reduction of patients' long waiting time is to be realised.

- Discordant and solo efforts will only reverse the gains of decreasing prolonged waiting. It is additionally serving the purpose for CHC managers to be present and support staff in their daily wok routine. Walking the plant and assisting with onsite troubleshooting of challenges is demonstrative of supportive supervision.

- Time management is one area that needs to be improved on. Arriving and commencing duties on time, observing meal-breaks and knocking off at stipulated time should be normalised as corporate culture, such that transgressors castigate themselves with less effort from management. Perpetual aberrations need to be consistently corrected. Where it needs be, consequential and/or disciplinary actions should be instituted without hesitation. CHC facility managers should oversee to it that timewasters such as chit-chats and fruitless meetings are avoided.

5.5.2 Recommendations for clinical practice

Recommendations for clinical practice are derived from deficiencies in prioritising patients according to the level and urgency of care. It is recommended that:

- The frail, elderly and sick children need to be screened and prioritised as per their presenting health status.

- All patients that present at CHC emergency units should be triaged to determine their urgency of care. This clinical intervention will not only assist in improving clinical outcomes, but ultimately reduce long waiting times.

- All other patients should be scanned and sorted from the pools of waiting areas.

- The displeasures and confrontations brought about the menace of lengthy waiting can be mitigated against by frequently informing patients about the delays. It should just not be about plainly notifying them but acknowledging and providing reassurance.

5.5.3 Recommendations for health care users

Health care users are the key role-player in any health care platform. These recommendations are arrived at to influence their behaviour in forestalling the long waiting time predicament.

- Patient scheduling is a prototype that needs to be better marketed and promoted for patients to adhere to. It is recommended that all stakeholders should use every opportunity to keep emphasising why and how beneficial it is to honour the set appointments. Additionally, the very clinic committees can play a critical role in seeking to realise this.

- Consenting to be enrolled in facility decongestion strategies should be encouraged. CCMDD, automated medication dispensing system and remote adherence treatment clubs are amongst the off-site treatment collection innovations that are recommended for enrolling as much of the qualifying patients as possible. These strategies reduce need for frequent presentation to the CHCs, thus aiding in decreasing waiting time.

5.5.4 Recommendations for development and training

The role of personnel development and training is of supreme importance. Raising functional performance and competence of staff can mainly be achieved through advances in education and training in all areas where there are skill deficiencies. The following recommendations seek to heighten the need to plan personnel training:

- Purpose driven orientation and induction for all categories of staff should be a mandatory priority. Focus areas could encapsulate the underpinning Batho Pele principles as well as organisational goals and objectives. For the sake of sustainability, periodical sessions to keep staff on track are necessary. Therefore, such initiations need not be a once off exercise.

- Underperformance resulting from skills deficit should be addressed through goal-oriented training. To achieve this, skills audit should be conducted for each staff member. Embarking in this exercise will assist in identifying areas where staff lack necessary competencies. Once these gaps are identified, the onus is on facility managers to prioritise who attends which development opportunity and when that will be. There is a further need to support and guide staff post training to ensure that such efforts translate into the intended outcomes to improve patients' long waiting time.

- Realisation and sustenance of quality nursing care should be driven through Continuous Professional Development (CPD) programmes. CPD programmes should provide practical solutions such as training clinical staff in triaging. and enabling.

- There is a further need to craft the CPD programmes such that they address professional conduct and guidance on caring attitudes. This should not only be targeted for nurses, but all employees. The latter should impact on time management in the workplace.

5.5.5 Recommendations for the employing organisation

The employer has obligations towards guaranteeing that her employees are best suited to fulfil apt business objectives. The following recommendations intend to address retardative factors to achieve reasonable waiting time.

- Appointment of skilled, experienced and competent staff is key in dispelling long waiting time. Dispensing of health care remains a human-driven responsibility. Qualified and knowledgeable cadres are better positioned to comprehend the employers drive and desire to reduce long waiting time. Focus should not only be on just skilled personnel, adequate numbers of staff to meet the facility demands.

- Corresponding staffing of CHCs is the cornerstone to evade the need for extended hours, lessen attrition rate, curbing spike in litigations and ultimately remedying prevalence of the burn-out syndrome amongst staff. Where CHC personnel are complementary to the facility needs, even the increased burden of disease will be less felt.

- Availing tools of trade should be hallmark of service delivery to impress on waiting time. The experienced challenges regarding unavailability of electronic enablers, necessitates recommendation for procurement of functional and competent computers amongst others. Furthermore, these technological contraptions need to be regularly maintained.

- Over and above, relevant stationery should be availed in sufficient quantities to render patients' registry areas competent and expedient. Providing point of clinical-care apparatus such as BP monitors, glucometers and etcetera can't be over-emphasised. These are enablers that by hook or crook should be planned for and resolutely procured.

- Investing in electronic records and patient administration systems is yet another recommendation for the CHCs. These facilities consult large volumes of patients. The current traditional and manual management of records further compounds this. Going the digital route suffices to overhaul this experience. This should assist in resolving complaints of lost and misplaced files to eventually reduce the total time it takes to register just one patient.

5.5.6 Recommendations for further research

The investigator submits the following for consideration into further research.

- Undertaking of qualitative studies to explore strengthening roles of clinic committees in aid of reducing long waiting times.

- Conduction of qualitative studies to explore how best to maximise operationalisation of Batho Pele principles for frontline staff.

- Commissioning of qualitative studies to determine impact of long waiting time on other categories of staff.

- Time and motion studies need to be undertaken to establish if the recommendations herein contained yield desired outcomes in reduction of patients' long waiting time.

5.6 CONTRIBUTIONS OF THE STUDY

It is expected that the findings of this study will contribute towards a broader and practical understanding of experiences of facility managers regarding patients' long waiting time at Tshwane Health District CHCs. This includes gaining further insight on bearing and contributory factors of patients' long waiting time.

It is anticipated that the experiences shared by CHC facility managers, including their proposed measures to improve patients' long waiting could provide senior officials at all government tiers, policy and decision makers, relevant stakeholders and the very functional staff with much needed practical insight on what to consider in the ongoing quest to mitigate against the phenomenon of prolonged waiting. Platforms such as workshops, seminars and conferences will be used to share this study's finding. Furthermore, publication in accredited health systems, nursing and medical journals will be embarked on.

5.7 LIMITATIONS OF THE STUDY

Qualitative design and purposive sample were used in this study, thus restricting wider representation of the population. The enquiry was confined to only the facility managers of the eight CHCs in Tshwane health district, consequently limiting generalisation of the findings to other CHCs.

5.8 CONCLUDING REMARKS

Time has existed since forever; it is likely to be forever. Time at our disposal for daily activities of our lives is nonetheless limited, making it worth comparable to money, it remains valuable, and therefore must be budgeted for, wisely used, and protected. Time is an asset to all human beings as well as to any organisation, most particularly, heath care facilities. They are today more than ever, obliged to confront the issue of time management effectively and without fail. The importance of time management remains every one's responsibility in health care entities today.

As a prestigious commodity that it is, an uncontested worthy resource, if health care establishments can manage it in sound manner, it will contribute to other health system factors in realising better health outcomes. Unrelenting studying of all factors associated with patients long waiting times by CHC facility managers and all other stakeholders, thus remains vital for continued efforts to remedy adverse situations as and when they occur.

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ANNEXURES

ANNEXURE A: Approval from the university

UNISA university of south africa

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES
REC-012714-039 (NHERC)

27 March 2019

Dear SR MAKUA

HSHDC/907/2018
Student: **SOLLY RATSIETSI MAKUA**
Student No.: 37320939
Supervisor: Dr SH Khunou
Qualification: MPH
Joint Supervisor: -

Decision: Approval

Name: SOLLY RATSIETSI MAKUA

Proposal: Perceptions of facility managers regarding patients long waiting time at Tshwane health district community health centre.

Qualification: MPH

Risk Level: Low risk

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted from 27 March 2019 to 27 March 2022.

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 27 March 2019

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*

2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there*

RECEIVED
2019 -03- 29
Executive Dean
College of Human Sciences

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.

3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *You are required to submit an annual report by 30 January of each year that indicates that the study is active. Reports should be submitted to the administrator HSREC@unisa.ac.za. Should the reports not be forthcoming the ethical permission might be revoked until such time as the reports are presented.*

Note:
The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,

Prof JE Maritz
CHAIRPERSON
maritje@unisa.ac.za

Prof A Phillips
DEAN OF COLLEGE OF HUMAN SCIENCES

ANNEXURE B: Letter seeking consent from Gauteng Department of Health

Unit 431 Wonderpark Estates
Cnr 1st Avenue & Heinrich Streets
KARENPARK
0182
21 September 2018

The Chairperson
Tshwane Research Ethics Committee
Fedsure Building
3319 Cnr Pretorius & Lillian Ngoyi Streets
PRETORIA
0001

Dear Sir / Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I, the undersigned Solly Ratsietsi MAKUA, a Master of Public Health student at UNISA, herewith requests permission to conduct research at Tshwane Health District's Community Health Centres.

Study title : Experiences of facility managers regarding patients' long waiting time at THD community health centres.

Objectives : To explore and describe experiences of facility managers Regarding patients' long waiting time at THD community health centres.

To make recommendations aimed at reducing patient's long waiting times at THD community health centres.

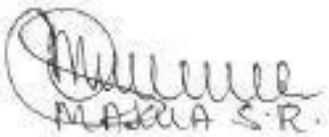
I undertake to share the study findings and recommendations with your Tshwane Health District Research Committee upon completion.

Request for permission to conduct research; 37320939

Kindly find herewith attached my study proposal for the ease of reference.

In anticipation that my request will receive your favourable consideration

Yours Faithfully



Master of Public Health student
Student no.: 37320939
21 September 2018

ANNEXURE C: Letter of approval; Gauteng Department of Health

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Enquiries: Mpho Moshime-Shabagu
Tel: +27 12 401 9036
E-mail: Mpho.Moshime@gauteng.gov.za

TSHWANE RESEARCH COMMITTEE: CLEARANCE CERTIFICATE

DATE ISSUED: 31/05/2019
PROJECT NUMBER: 30/2019
NHRD REFERENCE NUMBER: GP_201905_028

TOPIC: Experiences of Facility Managers Regarding Patients' Long Waiting Time at Tshwane Health District Community Health Centres

Name of the Researcher:	Mr Solly Ratsietsi Makua
Name of the Co-researchers:	Dr SH Khunou
Facilities:	Concealed for confidentiality purposes
Name of the Department:	UNISA

NB: THIS OFFICE REQUEST A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE AND

NOTE THAT RESUBMISSION OF THE PROTOCOL BY RESEARCHER(S) IS REQUIRED IF THERE IS DEPARTURE FROM THE PROTOCOL PROCEDURES AS APPROVED BY THE COMMITTEE.

DECISION OF THE COMMITTEE: APPROVED

.....
Mr. Peter Silwimba
Deputy Chairperson: Tshwane Research Committee
Date 31/5/19

.....
Mr. Mothomone Pitsi
Chief Director: Tshwane District Health
Date:

Annexure 1

GAUTENG PROVINCE

REPUBLIC OF SOUTH AFRICA

DECLARATION OF INTENT FROM THE PHC MANAGER FOR TSHWANE PROVINCIAL CLINICS

I give preliminary permission to **Mr Solly Ratsiets**i **Makua** to do his ~~or her~~ research on **"Experiences of Facility Managers Regarding Patients' Long Waiting Time at Tshwane Health District Community Health Centres"** in

Facility names withheld for confidentiality purposes

I know that the final approval will be from the Tshwane Regional Research Ethics Committee and that this is only to indicate that the clinic/hospital is willing to assist.

Other comments or conditions prescribed by the PHC Manager to the Researcher are

The researcher to have an entry meeting with potential facilities before starting with the data collection.

DR. SL PHOSHOKO
ACTING PRIMARY HEALTH CARE: TSHWANE
Date: 27/05/2019.

ANNEXURE D: Assessment of data collection instrument

INTERVIEW GUIDE

Researcher's Name	:	Solly Ratsietsi MAKUA
Institution	:	UNISA
Student number	:	37320939
Contacts	:	079 872 6077 / 082 426 5554

1. ***Research Title***

   Experiences of facility managers regarding patients' long waiting time at Tshwane health district community health centres.

2. ***The objectives of the study are:***

   To explore and describe perceptions of facility managers regarding patients' long waiting time at Tshwane health district community health centres

   To make recommendations aimed at reducing long patients' waiting times at CHCs at THD.

The definition of an interview guide by Lune and Berg (2017:71) is that it is a set of questions relevant to the objectives of the study.

The following shall guide the interview pertaining to this study:

a) According to your understanding, how would you define waiting time?

b) Elaborate on what your observation and experience of patients' waiting time has been in respect of your CHC.

c) What do you perceive and/or understand to be contributory causes of patients' long waiting time in respect of your CHC?

d) What suggestions or recommendations can you share with regards to reducing patients' long waiting time in your CHC?

Thank you

>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>End<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<<

ANNEXURE E: Information leaflet

PARTICIPANTS' INFORMATION LEAFLET

Researcher's Name	:	Solly Ratsietsi MAKUA
Study Title	:	Experiences of facility managers regarding patients' long waiting time at Tshwane health district community health centres
Institution	:	UNISA
Student number	:	37320939
Supervisor	:	Dr SH Khunou
Contacts	:	079 872 6077 / 082 426 5554

Dear participant

I am a Master of Public Health student at UNISA's Department of Health studies.

You are kindly invited to volunteer your participation in this research project titled "Experiences of facility managers regarding patients' long waiting time at Tshwane health district community health centres"

The following information is provided to enable you decide on whether to participate or not:

The objectives of the study are:

To explore and describe experiences of facility managers regarding patients' long waiting time at THD community health centres.

To make recommendations aimed at reducing long patients' waiting times at THD community health centres.

Why are you being invited to participate?

The phenomenon of patients' long waiting time has been observed at Tshwane health district community health centres. As a facility manager of a CHC, your inclusion as a participant was aided by sourcing your particulars from http://www.gauteng.gov.za/Document%20Library/Health/All%20Tswane%20Clinics.pdf.

You and other CHC facility managers in Tshwane health district have been deemed as primary and worthwhile sources of information pertaining to your perceptions about the phenomenon being studied. Your participation is thus valued as it is expected to shed insight, experiences and expertise on the subject matter.

Can you withdraw from this study even after having agreed to participate?

Participating in this study is voluntary and you are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason.

What are the potential benefits of taking part in this study?

It is expected that the findings and/or recommendations will serve to correct the identified shortcomings so that health care systems can be improved.

Are there any negative consequences for your non-participation?

The study seeks to obtain your perceptions on the study matter. There is therefore, no expected inconvenience and/or discomfort for you. Importantly, you will decision not to answer any question will be respected and observed.

Will the information you convey and identity be kept confidential by the researcher?

You have the right to insist that your name not be recorded anywhere and that no one, apart from the study supervisor and qualified external coder will have access to it.

With regards to this study, your answers will be given a code number or a pseudonym and you will be referred to in this way in the data, any publications, or other research reporting methods such as conference proceedings.

Your answers may be reviewed by people responsible for making sure that research is done properly, including the transcriber, external coder, and members of the Research Ethics Review Committee.

How will data be safely secured?

Electronic information obtained through voice-recording will be stored on a password protected computer that is safely secured in an access restricted office on the 12th floor of Fedsure Forum Building; 3319 Cnr Pretorius & Lillian Ngoyi Street; PRETORIA. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. Electronically stored data will be permanently deleted from the hard drive of the computer through the use of a relevant software programme.

Is there any compensation in any form, including gifts of any kind for your participation in this study?

There will be no compensation in any form, including gifts or of any kind for your participation in this study.

All cost will be borne by the researcher, you will therefore, not be expected to carry any costs in whatsoever form in relation to this study.

Has the study received ethics approval?

This study has received written approval from the UNISA's Research Ethics Review Committee of the College of Health Studies and Tshwane Health District Research Ethics Committee. Copies of both are herewith attached.

This study has received written approval from the Research Ethics Review Committee of the College of Agriculture and Environmental Sciences, Unisa. A copy of the approval letter can be obtained from the researcher if you so wish.

How will you be informed of the findings/results of the research?

If you would like to be informed of the final research findings, please contact Mr Solly Ratsietsi MAKUA on 079 872 6077 or at solly.makua@gauteng.gov.za or ratsietsi@hotmail.com.

Similarly, should any additional information be required, or want to contact the researcher about any aspect of this study, please contact Mr Solly Ratsietsi MAKUA on 079 872 6077 or at solly.makua@gauteng.gov.za or ratsietsi@hotmail.com.

Should you have concerns about the way in which the research has been conducted, you may contact the study supervisor, Dr SH Khunou on 0767240146 or khunosh@unisa.ac.za. You can further contact the research ethics chairperson of the CAES General Ethics Review Committee, Prof EL Kempen on 011-471-2241 or kempeel@unisa.ac.za if you have any ethical concerns.

Thank you for taking time to read this information sheet and for participating in this study.

Thank you.

Solly Ratsietsi MAKUA

ANNEXURE F: Preliminary permission

Preliminary Permission

Researcher's Name	:	Solly Ratsietsi MAKUA
Study title	:	Experiences of facility managers regarding patients' long waiting time at Tshwane health district community health centres.
Institution	:	UNISA
Student number	:	37320939
Contacts	:	079 872 6077 / 082 426 5554

Dear prospective participant:

I, the undersigned_____;
(Full Names of participant)

Facility Manager at _____hereby give Mr Solly Ratsietsi MAKUA, a Master of Public Health student at UNISA, preliminary permission to undertake his studies on and at a date to be determined and agreed upon by both parties.

I further confirm that the investigator has shared copies of **approval letters to conduct the study from both UNISA and Gauteng Department of Health** as well as the **information leaflet** prior commencement of data collection.

This preliminary permission is thus subject to signing of the informed consent on the day of the data collection.

Participant's full names & surname .....

Participant's signature: .....Date.....

Investigator's name: Solly Ratsietsi MAKUA

Investigator's signature ..... Date.....

ANNEXURE G: Informed consent

INFORMED CONSENT

Researcher's Name	:	Solly Ratsietsi MAKUA
Study title	:	Experiences of facility managers regarding patients' long waiting time at Tshwane health district community health centres.
Institution	:	UNISA
Student number	:	37320939
Contacts	:	079 872 6077 / 082 426 5554

Dear prospective participant:

I, the undersigned.....hereby agree to participate in
(Full Names of participant)

the research project by Mr Solly Ratsietsi MAKUA, a Master of Public Health student at UNISA as follows:

I confirm that the researcher has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the recording of the semi structured in depth interviews

I have received a signed copy of the informed consent agreement.

Participant's full names & surname .....

Participant's signature: .....Date.....

Investigator's name: Solly Ratsietsi MAKUA

Investigator's signature  Date 21/09/2018

ANNEXURE H: Interview transcript

Participant's Name	**:**	**P1**
Date	**:**	**04 February 2020**
Time	**:**	**12h16 – 13h37**
Duration	**:**	**01:21:38 (81-minutes)**
Venue	**:**	**Designated Office**
Codes	**:**	**P = Participant**
		R = Researcher

R: Thank you for seeing me, and as I have indicated, my name is Mr. Makua and currently doing Master of Public Health with UNISA. My research study or title is "Experiences of facilities managers regarding patients long waiting time at Tshwane district's Community Health Centres.

And for starters, can I just establish with you: What are your experiences regarding patients' long waiting time with regards to your facility or your health centre?

P: *Yeah, I hope actually I understand the question correctly. My experience has not been a very good one in relation to the waiting time (Frowning). The reason being our waiting time, especially here at our establishment is very long. At times it's outside actually the normal national benchmarks and that creates a dissatisfaction among patients. And then patients actually have only one person to blame when things are not coming together in a facility, and then, that's the manager. So, they will come to me as the accounting officer of the institution, to explain to them, why they have to queue for such a very long time and that's actually is kind of draining, if I have to use that, for lack of a better word. So, the experience actually is not really good in relation to the needs.*

R: *And thanks, thank you for that particular response. You said that the waiting with regards to your facility is quite long. Ehm, how long at the most are patients expected to wait?*

P*: The previous benchmark actually was recommending that 180-minutes,*
is acceptable for the patient to wait in a health establishment. But in our case, you know patients can even wait for close to 240-minutes, which is very much unacceptable. And it is not like there's something that we are not doing right. You know, we have a large number of clientele and then you know with inadequate staffing levels. So, we are really not winning, and we still have other patients you know, Gauteng Health caters for the whole of SADC region. So, the staff establishment of this facility, I think was made the last time, in, some five years ago, and then that was never reviewed. And then it was based on the catchment population then, but today, you know, things have changed. So, you have a lot of people around Mamelodi. People who are only coming to our facilities, you know, for services from other countries, you know, and things like that.

That contributes actually to the waiting time and then with inadequate staffing levels. The number of nurses or health professionals that we have cannot keep up with the high number of patients. That leads to a long waiting time, which frustrates patients and then eventually patients come to me and then, it's terrible (Frowning).

R: Ehm, thank you for…for…for that response. With regards to what you have mentioned, that at the most, patients have to wait for about 240-minutes. Ehm, have you done something to kind of intervene, so that it we lessen this long waiting time or period?

P: *We have some measures in place to improve the waiting time. Number one, we have introduced the booking system. So, with the booking system, we book a certain number of patients for the day.*

We say, for this number of clinicians, this number of clinician can only attend to this number of patients but then we still have a standard deviation maybe of 25 patients. So, we book 300 patients a day, chronic patients, to 350.

And then what we do before those patients come to the facility, because we don't want you know, patient to wait. We don't want time to be wasted while patients are waiting for their files to be retrieved. So, we retrieve files the day before the patients come to the facility. And then when they come in the morning, we just, you know, issue the files (with a glimpse of a smile). However, we have an uphill battle around that. We are not winning. Number one, we book 350 patients, only 150 patients show up and now you have 200 patients not coming to the facility….honouring the appointments.

The very same 200 will come tomorrow. Now we are gonna be having more patients and now the 200, these 200 patients that are there, there are files have not been retrieved. So, time is going to be wasted again in having the files retrieved by the admin clerk. Yeah, so the measure actually that we have implemented is that one actually it is a prescript of chronic management. So, that's number one.

Number two, our problem, because we…. the chronic patients actually make a bigger chunk of our… our…clientele, so I have beefed-up the chronic department with more personnel. So, we have three doctors and three sisters every day to make sure. So, one doctor and one sister will do what is called a fast queue or a fast lane. Yeah, so, in which all patients that are coming just to collect medication and then they don't have anything to complain about, will just be giving the medication. That's one other thing. So, number one is the booking system and with a pre-retrieval. Number two is the fast queue that we have introduced. And then, yeah, I think that was the farthest we have gone now.
Please allow me to also come back to this question should anything come up as I am giving answers.

R: Not a problem and I really appreciate your feedback. Thank you for that.
And you have further as we started earlier on mentioned that, you know, there's this one person to be blamed for this long waiting time which is yourself. Ehh, how I'm dealing with this sense of being blamed perpetually so?

P: *And there isn't really much I can do about that. But what I have done, I have written motivation to the chief director, quality assurance, my area manager, you know, requesting more staff. And then that's number one. Because it's only through that, that that can actually you know, minimise some of the complaints. And then, I have also engaged with the ward counsellor, with the view of getting him to communicate to his community, the importance of honouring the appointment. Yeah, these are two things that I have done.*

Ehh, but all in all, I go to patients, I speak to them, I explain to them the situation, I show them some of the factors that are responsible for the explanation of a long waiting time (Emphasising using hands &). But, you know, I also highlight to them some of you are not even booked for today. So, they are also you know, so that they can have a kind of a know, I am not sure if there is something that is called patient review, just to kind of catalyse a patient review mechanism among them. Yeah. So that's, that. I hope actually I have answered you appropriately.

R: Uhm, there would be no wrong or right answer. I really appreciate every answer that you are providing. Uhm, to the extent that you have engaged the district manager, quality assurance and the HR manager, have you received perhaps favourable responses?

P: *Uhm, not really, I wouldn't say it's actually favourable because thus far we have only received one professional nurse. Yeah, which is not actually that much help. You'll have to take into account am not sure if this is going to contravene my anonymity. You need to understand that in June last year (2019), we had a PSI (Patient Safety Incident) where in a lady gave birth at the gate, and then the clinicians involved have since been taken out of the facility, you know, pending a disciplinary hearing. So, that actually has taken a toll on the on the waiting time of the facility.*

R: Oh, that's regrettable, I'll come back to that later. Let's just move on.
You've also highlighted the fact that you know, it's more of draining on your person if you have now to bear the brunt of being blamed for long waiting time. As an individual, how are you how are you coping or how are you dealing with the draining that comes from this perpetual subjection to being blamed over long waiting time, how are you dealing with this stress?

P: *Yeah, it's very stressful actually (Looking sad). So, the other thing is what I learned is that one has understand and accept, you know things that one can't change. That is number……that's the only thing that keeps you going. And also I have hope that one day, things will get better (with a gloomy face). We will be better people who will be….., I'm not I'm not talking here at a district level, I am talking here at the national, at the political level, at a national level, people who will come up with better decisions to improve public health. I strongly believe that the only hope is that keeping me going when I feel down, when I'm when I'm feeling down and out,*
you know, that hope that things will get better, keeps me going.

R: And thank you so much for that. And I'm going back to the other aspect that causes long waiting time, you mentioned the population to say you're seeing quite a large number of clientele. And roughly how…how how much of patients are you seeing per month or per day or per week?

P: *Our…, our…, our…,our headcount is actually…, let me give you the the monthly headcount, it's 23,000. Actually, we used to be at 25,000. And but I think that information was…,was was not healthy. Because when we reviewed our data collecting tools, we realised that at some stage or another, we were kind of duplicating the figures. So but now, we are at 23000*.

R: So, implying that you've managed to, more or less correct your way of reporting on patients that you are seeing?

P: *That is correct*

R: Uhm, okay. And, inadequate staffing, can you just tell me more on inadequate staffing.

P*: Yeah, we have 65 professional nurses and then we have four medical doctors. I'm not going to talk about the support staff like your rehab staff like dentists and radiographers, psychologists.*

Let me be specific to the nurses and the doctors because most of the dissatisfactions of waiting time are generated in their units. We have 65, but out of that 65 then we have five off-site, meaning that…… remember also managing Mamelodi Hospital Crisis Centre and Mamelodi West Clinic Mental Health component, because their municipalities or municipality; CoT does not actually render mental health services.

So, I have allocated professional nurses, you know, in those institutions. We are running a 24-hour facility; MOU and casualty. And those units have to be adequately staffed on a daily basis. So, after a distribution of staff in all the service points, it has emerged that we still need more staff to keep up with the number of patients. Like the chronic section is operating with only three professional nurses to attend to a 300 to 350 in worst case scenario a day. I must also indicate that the three sisters in the chronic section are working with the doctor….the three doctors.

So, but that as well I see that it's not actually enough. And then the acute, you know with the acute, you know, you know, it hurts most when actually a patient comes to you to tell you I've been….I arrived here at six o'clock (with a sombre face). Now, it's 10 o'clock. Yes, the facility actually opens at 07h30 for other programs. For MOU and casualty, that's 24-hours. But those delays actually can never be justified, you know. Yeah, so you know, I'm getting too many points, so I'm lost now. I'm losing track of the question.

R: Not a problem. Okay. We can still come back to that. But I think we're still on track. You were just mentioning that the work-load, against the staffing that you have.

P: *Yeah, it's not even enough even with the babies, you have one sister doing EPI, you have one sister doing family planning, you have one sister seeing chronic, children below 15 about five, one sister doing that, you know things are just not coming together and that creates a long waiting time, which comes back to me on a regular basis.*

R: No, I get…… I understand what you're referring to. And maybe proceeding further, let's talk about your catchment population. Your hinted that the population since we have grown to can you kindly elaborate more on the population?

P: *Our present population from the DHIS 2019 was standing it 258,000. So, I'm gonna have to verify. Let me say 250 000. And, remember some of these figures actually I'm told are sourced from the Stats SA. Stats SA will give you figures that do not contain people who are here illegally. You know, we have a lot of illegal immigrants. I'm talking here about people who don't even have papers to be in the country. Ehhh…I'm talking here about people who do not even have passports who are sharing, and they come here, come to our facility, our MOU. Our responsibility as health care provider is not to chase patients away. We render service and attend to the other things later. So, the 258,000-catchment population only refers to people who are here legally. Yeah, does not include people who are illegally here and that number of people who are here illegally, even based on the statistical figures, is really, is very high*.

R: Uhm, yeah, thank you so much. So, you also have the impact coming from foreign nationals

P: *That is correct.*

R: How huge is this impact?

P: *Ehh, and especially in the maternity is huge, because at one stage, I remember very well in October, I had to request for a diversion, ambulance diversion, meaning that all patients who must come to deliver at our MOU must be diverted to maybe go to the hospital or one I call it MMO; the Medical Manager on call and then I requested for a diversion. My reason being the facility, the MOU was full and I was granted the diversion, I mean the diversion was granted. Only to find that people who were there at the unit at the time of me requesting for a diversion, were all illegal immigrants.*

So, local had to be diverted. So, I'm actually trying to demonstrate here that the problem is huge (demonstrating magnitude with both hands). Ante-Natal, on a daily basis, you have five illegal, illegal immigrants. I'm not xenophobic. If people are here legally, it's fine. But if people are here illegally, then it's a problem. South Africans suffer from that.

R: And thank you for that response. Just taking you back, you mentioned request of diversion in October. Which year in October?

P: *2019.*

R: Thank you for that. And you were granted that particular ambulance diversion request?

P: *That is correct.*

R: If you can just elaborate what is it that happens with ambulance diversion, elaborate more, what's that?

P: *Okay, an ambulance diversion can only be granted if the reason behind the request is not operational, meaning that I can't allow nurses in the MOU to take time off and then 30-minutes after that, when patients are now flocking the MOU and there's only one or two sisters, then I call to say no…..*

For operational issues, diversion is not granted. But, if the unit is full and you have nurses, I mean you can't deliver people on the floor, that's number one. But if it's full, all beds are full, then you may be granted a diversion or in worst, in certain circumstances.

I remember in my case in December, I called the MMO because the nurses did not report for duty, because the previous night they had been attacked. So the following night, they did not come to duty. And then……what I did I request that for…for diversion and then it was not granted, because I was told that it's an operational issue…….You knew that people were attacked on Wednesday, so you should have actually come up with a plan to…to have plan B. So, for operational issues they don't give.

Let me not beat about the bush, for operational issues, is not granted, but for real life issues like when the water is full, when the……...yeah, for any other reason it can be granted. And in that case, ambulances will not take cases to your facility. But even if you have an ambulance diversion, you run the risk of having walk-ins. They walk in because I mean, but all the ambulances won't take patients to your facility. They will go to other facilities.

R: Thank you so much for that particular aspect, we'll still come back to that. And maybe just to take you back on once again, the issue of population. Do you have a way in which you identify foreign nationals within your facility?

P: *Yes, we initially we used to make a dot. But then we were advised actually to monitor that as well. So… so….we have a system of monitoring. And the system is assisting in coming up with features that more or less distinguish between your local and users us and foreign nationals?*

The system is not actually helping that much. Number one, it is not used consistently because remember our our…..we rely too much on EPWP Ps and you know if you rely heavily on EPWP Ps who have not undergone, you know, a formal training on how to, you know, managing the area that they actually are allocated in, it's a problem. So, it's not used consistently number one.

Number two, these people are very manipulative. When they come here. they change their names, you know we cannot even demand a proof of address number one. You can't be demand an ID…… you can demand an ID, But if a client say I don't have an ID, I don't have a passport, what shall we do? (Raising shoulders, with some despairing facial grimace).

We can't just send them back, we have to help them first and take over that later. Sisters are complaining every day. (Raising the voice tone). Even today, one sister will be coming to say I have a foreign national here who has used someone else's name and ID, and that person is on Anti-Retroviral and now the very same foreign national has tested positive, you have to start her or him on……You see, it's a problem.

R: I hear you, I get your on….on….on that. And maybe just to further dwell on this matter of foreign nationals. And you mentioning assistance of EPWP cadres. Who are these EPWP?

P: *These are people actually who have been brought onto the system and from…from… Public Works. It's an expanded programme …uhmmmm, something like that. Yeah, yeah. Public, it has to do with a public works tender. Yeah, I think that is, you know, coming from Public Works. So, these are people who have not undergone any formal training. So, they have matric, some of them don't even have matric and then they apply, accepted, and then yeah, and then they are placed in facilities.*

So we place them in…..in our facility, what we do, in our health establishment, we check those that have matric, then they will wake us admin clerks, they'll work as the data capturers service and those that don't have matric, they will work as cleaners, and then, yeah.

R: And with regards to formal training, what formal training that could be afforded to this EPWPs would assist in your challenge?

P: *I think ehh, basic…..basic records management, people management, because you see if if you take someone from school and then you give them responsibilities, that they are not equipped to handle, at times, you know that you are creating a serious problem. So, and that is what is happening today, even basic Batho Pele principles, not clued up about those things. But a sense of professionalism, if you take people through a certain training, you also instil in them a sense of professionalism and responsibility.*

R: Thank you so much for that. And still on this training of EPWPs, uhm, and who should then be tasked or who should then be responsible to train them so that you are assisted with this uhm…. patients' long waiting time?

P: *I strongly believe that our district training department should actually assume this responsibility.*

R: Have they been informed of the need to train this cadre of officers, these EPWPs?

P: *No, I mean the district….no, no.*

R: Would your office initiate some…some means to inform the district in the department of the need to train these EPWPs?

P: *Yeah, it's something actually that I was going to… to escalate, but I have not yet escalated.*
But I strongly believe that things are changing now. We also have to escalate that information to the training office with a view to getting them to train our EPWPs.

R: With that said, so, you are quite reassured that once they are trained, things could turn around?

P: *That is correct.*

R: Okay, thank you so much for that. Let's……let's continue. And you have further mentioned frustrations of patients. How do you observe that patients are frustrated with patients long waiting time?

P: *Yeah, besides them coming to me, I actually do rounds in the facility. Most of the patients know that I am the CHC Manager. Those who have, you know, the guts would come to me to say, but Sir, we've been waiting. What are you doing? We've been waiting here since… (tense facial expression). That's how…Others actually are just you know, having remarks.*

Yeah, they'll be just as I am passing by, then they'll say "Yaa, since motho a le mo go tloga ka nako ya so le so, eish Stanza …(Setswana, meaning: "Since one arrived very early). You know, all those spiteful remarks. Yeah, so that's one way.

The other way is the informal, through informal complaint, and then you have the formal complaints where they actually use the complaint forms. In worst case scenario, they will report the facility to the presidential hotline or the Office of the Health Standards Compliance

R: Okay, thank you so much for that. And going back to our booking system, which is a means to circumvent or mitigate against patients long waiting time. Uhm, is it yielding any positive results? Can you elaborate on that?

P: *Yeah. if used correctly, it would, it would actually, you know, they minimise long waiting time.*
But like I am saying, clients can't honour the appointment. What we have introduced, as some kind of a punishment to those that are not honouring their appointments, we serve them last. Yeah, but that is not always working because then they will come here to me to say, "I arrived at 03h00 here and now it's 10h00, the clerks are telling me that they will help everyone here", you know all those things and that creates a problem as well. But I'm trying my level best to speak to them. Because if I can, succumb you know to their pressure, then I'll be setting a very bad precedent and then the entire system will be doomed to failure. So, we are trying to serve them last, if they don't honour their appointment. But, essentially, your…your…. your booking system, your…, your… your…know retrieving files as you know, the day before clients come to the clinic, that actually is the best way of minimising waiting time.

I don't know if patients know that. But, that's the only way through which actually we can maximize patient satisfaction. But, for mere fact that they don't stick to that, we do our work, we pre-retrieve files, we book them, they don't show up, wrong people come, now again we have to start from scratch to look for files to retrieve files, it's not….not adding up (Angry facial expression).

R: I understand your frustration out of that. And how has your staff taken this booking system. This pre-retrieval system? How has your staff taken this system to mitigate for long waiting times?

P: *They are very…..they have accepted this, they are…But, you know, our admin clerks are not happy with the system, because then they spend more time retrieving files of patients who are not going to be coming on that day. So, that's kind of demotivating to them. But I told them that let's just soldier on, let's continue with it. As long as we are giving them this punishment of serving them last, maybe they'll change, and then this will improve our waiting time.*

R: Thanks for that. And I think alongside serving them last, you earlier mentioned something that talks to patient reviews and peer reviews of patients, I suppose. And in your own opinion, how would that work out? How would that unfold?

P: *Yeah, maybe just to just to draw a contrast here. Where I was…I once managed in the North West, so there was a very, very good sense of patient review mechanism. When you book patients for Monday, they will be having a brown tag, Tuesday, the green, just like that. And then those that do not honor the appointment, then if the appointment was Monday, and then you don't have a brown tag, when you come on Tuesday, patients who are there, it will be Tuesday, it will be green tag on your file, you know. But if your file is brown, then all these patients will see this….."But wena you should have been here yesterday" So, what they do, they would actually encourage one another, to speak to them, you know, to say man, please, in future make sure that you come, if you are unable to come, send somebody to come and collect medication for you. That's peer-review mechanism, was kind of improving how we interact with our clients. So, I strongly believe that the same thing can work here, whereby if patients can encourage one another to stick to appointments. Unlike defending people who are wrong, yeah, I think that patient system will assist us.*

R: Thank you so much for that particular input. Uhm And maybe just to chip in on the ward councillor that we have one engaged around defaulting patients, any good that has come out of your engagement with your ward councillor?

P: *No, no, nothing, nothing good at all. And I don't even think the ward councillor has communicated that to his constituency. But, I believe that is the responsibility of…of the manager… of the CHC Manager. That's my responsibility. Because as in one of my key result areas, I have community participation as a key result area, meaning that I have to attend an imbizo once in a quarter. And then four imbizos in a year. Ehhh, that's the only platform that I can use to communicate this information. So, our constituency, the community rather. Yeah. So, something that I'm revisiting now (Heavy sighing).*

So, I'm working very closely with the ward councillor because the ward councillor is our committee member and it's very helpful. We are working together. So, I think I'm going to be working with him to ensure that we communicate this to the patients.

And then last year I was using "Mindset" on this one. (Mindset is a free to air television channel on health matters) . Yeah. But now, you know, when we go to the radio as the manager to communicate one thing, the community automatically turns that into an electronic complaint mechanism. So, you end up not addressing what you wanted to address. But now they'll be coming now with complaints. But then I usually arrange with the producer and the presenter to say we are not going to take calls, we only going to address this.

R: Okay. Thank you for that. And, on this aspect of ongoing engagement of patients who are defaulting, how has it been in your facility?

P: *We don't seem to be we don't seem to be winning, but like I'm saying, the punishment is that they will be served last, is the only thing working now. But we are not winning. Remember, with our patients, you have to you have tof the attendance. You see, we have patients who are coming to the facility once in six months, patients who are stable and then patients who have been decanted to CCMDD. So, they come here once in six months. That's number one. I forgot to… (covering mouth in shy-look)….I must also add this one.*

That's one way of minimising waiting time, we are decanting as many patients as possible to make sure that at least we have a small, manageable number in the facility and I'm sure in Tshwane, Stanza is leading when it comes to decanting to CCMDD, yeah.

R: Okay, so it's more of your community engagement meeting?

P: *Wonderful, yes… yes*

R: Oh, thank you so much for that. And you're mentioning that you've quite good interpersonal relationship with the ward councillor?

P: *That is correct…(Smiling)*

R: So, you suppose it will assist?

P: *That's correct*

R: Okay, wonderful stuff. And do your mind elaborating on this decanting, what is it?

P: *Okay, all your stable patients, all your patients will, you know on antihypertensives, with high blood pressure, if the blood pressure of those patients is controlled, then over a period of three months, then you can happily conclude that the patient's blood pressure is controlled by the treatment the patient is on.*

Then you can decant. By the decanting we mean you take them out of the facility, and then you refer them to an external pick-up point where the client will get the medication from. We have a couple of pick-up points. If the client is working somewhere then they the external pick-up point could be at Clicks. But we also have other external pick-up points, your "Dischem" wherever it is. That means a number of patients that are coming to the facility is going to be reduced. And then there's going to be a manageability of patients. The manageability of patients will be improved as well. Because if you see a smaller number of patients, you can see them faster and that's that. With HIV-positive patients, if the viral load has been suppressed over time, and then we decant them as well. We are taking them to "Adherence Clubs". We have two "Adherence Clubs around Tshwane. Then, those patients will only be come into the facility once in six months. So, if they have been decanted. But, if they come back in six months, and then the BP is elevated or the viral load is, viral load is monitored annually, let's say they come, you know, the second six months and the BP is high or the viral load is high, then we bring them back to the facility where they will be seen on a monthly basis to ensure that we exclude issues. We establish actually issues of that could be responsible for that deviation.

R: Thank you so much for that elaboration. Earlier on you mentioned that chronic patients are a bigger chunk of what you see you. Can you elaborate on what you're referring to by a bigger chunk?

P: *Okay, by that actually, majority of our patients, actually is your chronic patients. Our…we don't have with the rationalisation of registers, we have done away with your chronic registers. You know, your hypertension, diabetes, asthma, epilepsy registers. So, I'm able to give you the number of patients who are HIV positive.*

We have…our TROA is 11,700 ***on the southern poverty****. But, it's the fluctuating, but know what the standard deviation of two, yeah. So, and then I'm talking here about HIV positive patients because that information is available on Tier.net. But other patients who are on hypertensive medication…antihypertensive medication, we don't have that sticker, but it's a big number. So, our chronic patients actually constitute 70% of patients that we see.*

R: Thank you so much for that. Maybe once, once it's still fresh throw off what is the *TROA?*

P: *Total Remaining on Ante-Retroviral Treatment……ehhm, it's the total number of patients that are remaining on antiretroviral treatment for that month, yeah*.

R: Oh, okay, thank you so much. And maybe associated with that input, you mentioned the *Tier.net,* what is it?

P: *The Tier.net, it's a system that is used to manage HIV/AIDS related data. So, you can access anything that's related to HIV. You are able to access it on Tier. It's kind of data management tool for TB and HIV.*

R: Thank you so much for participation. And as we just progress, and you hinted that most of the dissatisfaction around waiting time would be coming from professional nurses and doctors. Other professionals do not have that impact. Why…why is it that it comes from the professional nurses and doctors, side and others are not affected?

P: *Okay, I can happily conclude that other…other…other allied…I'm not sure if that word is still allowed, yeah. Your…your… your… your allied if I may put it that way, I can happily conclude that our allied department is adequately staffed. and even the number of patients that these departments see, is acceptable. We have one radiographer, yeah, it may look threatening, but the irony here is that that radiographer can see up to four people in a day and if she has been busy, then she would have seen maybe, 10.*

Those departments do not really generate much of dissatisfaction. They don't have a problem of waiting time. We have two dentists and two oral therapists. They can do basically what dentists do. So, they're adequately staffed, and you know, dental extractions, is simple thing that boom, boom. So, we don't generate much of a problem, much of dissatisfaction in those areas. But with our clinical, your chronic you know, where we have a large number of patients, that's where most complaints are generated.

R: Thank you for that elaboration, and as we just continue, I'll take you back to your management and or dealing with stress. You cited hoping for the best that perhaps national or your provincial department will do something. How do you see this happening?

P: *Uhm, I take solace in the fact that the, you know, we are moving away from the way we used to do things. National Health Insurance (NHI) is imminent. I strongly believe that very soon, it'll be an act and then you know, in line with that, and maybe our principals will deem it fit to ensure that staffing levels in most public-sector institutions are improved to meet the standards of NHI kind of approach.*

R: Oh, okay and thank you for a clarity. And arrival of patients as early as six o'clock as you hinted early, how does it affect your waiting time in the facility?

P: *Already, it doesn't actually affect it that much, except when they, when they come and complain, because when…when we, as they enter the facility, we give them numbers for time. You…like the time the patient enters the facility. But I've……even if a client arrives at 3'O clock, but for the mere fact that the facility opens at 07h30. Then when we capture that in our waiting time tool, we capture it, it from 7h30. But that does not necessarily mean that we disregard the time that patients do arrive in our facility.*

Then plan again, is to come up with time slots in our booking system, but that I think will have to come later as our patients are realising the importance of honouring the appointment. It's gonna be pointless a patient to come and get the medication at twelve o'clock and is seen at three o'clock. You know, I think it's something we gonna have to face-in very slowly. We shouldn't be overly hasty to do that.

R: Okay, thank you for the response. And this is early arrival, how much of a problem is it for your facility?

P: *Uhm, you see the problem with that is anything can happen between the time the patient arrives in the facility and the time the facility opens. Because they come here as early as 03h00 and at that time, there is no one to monitor them. So, it has not yet become a problem for the facility per se, but should anything happen, while they are waiting, it will create or it's going to expose us, yeah to say patients just come here and they wait for 07h30 (With a tense, worrisome expression). Ironically, we have nurses in the MOU, we have nurses in casualty, who essentially should be attending to the patient because they are still on duty anyway. But then they will tell you that you know, they are busy with something and then the patients must be seen.*

It's a big problem for the safety of the patients because on their way to their facility, they can be mugged on the way to their facility, they can be raped, you know, anything can happen and end of the day, is gonna bounce back to the facility to say but your systems, improve on your systems (Looking concerned/worried). If you had given this patient to come at eight, this would not have happened.

It's a problem, though it has not affected us negatively, but doesn't make it well. It's something that will happen. One day a patient will come here. 05h00 the patient will die and this is going to explode.

R: Thank you for that Sir. And in your opinion, why do you think the patients would arrive as early as 03h00?

P: *Ehh, they want to be served first. Others are going to work, so, they want to report to work. Basically, they come here to minimise the waiting time though technically, they're, you know, making it long. But then they just want to be served first so that we can go to workplaces or go to do some house chores*

R: Oh, thank you. Time slots…..in the future you going to introduce time slots. Mind sharing further what this time slots are and how they are going to unfold in your facility?

P: *Yes, the plan is actually to phase them in because I once tried it two years ago. It never worked. How it works is, we book 350 page and then, but before…before we book because that's where it has to start we cannot just impose time-slots on people. What...what… what we do is the lady who…who…who does the booking as well as the patient? "Will 08h00 be suitable for you to come to the facility next month?". If the client says: "No, 14h00", then you put the client in that time slot that will best suit the clients and not a facility.*

That we believe that, because we tell them to come at 08h00, because if we say come at eight, rather you can come at 10-minutes before eight, but don't come to the facility at 03h00, when actually….because by 08h00 we shall have prepared everything for you. So, that will work. So, you will have the 1st batch of patients to say, which will be seen from 08h00 to 10h00. And then second batch of patients will be in this time slot of 11h00 to 13h00 and then 14h00 to 16h00. Yeah, so, you, you, you, arrange with the patient first to say which time will best suit you. Then patients must to choose to say "I am knocking off at 12h00, no put me for 14h00 to 16h00 time slot."

Then you are breaking down the 350 patients, they don't come to the facility all at once. Then you will be having 110 from 08h00 to 10h00 and then you gonna be having 110 from 10h00 to 12h00. Then the last 110...which is a very highly manageable number of patients that six people can tackle in a short period of time. |That will minimise the waiting time in the facility.

R: Okay, so it's more of a package that speaks to your appointment system, that time slot that is that is favourable to the patients' conditions?

P: *That is correct*

R: Thank you so much for that. And so, we just about to conclude on this matter. Let me just check back to the systems that are not responsive to patient needs. And what systems would you be referring to that they are not responding patients' needs?

P: *Maybe, can you rephrase?*

R: You earlier mentioned that arriving as early as 03h00, you know, patients would in some instances be mugged, they would be exposed to being raped. And it's all on account of systems that are not responsive. Uhm, what are these systems?

P: *Yeah, okay, I strongly believe that we should be… ehhh, we should rather actually change the way we do…we do… we do business. Uhm, but then we also need our clients to assist us. Uhm, I believe that if we can improve our.. our… our records management system. You know, this is…this is… this is very, it's a serious problem and I'm not sure…it's common in Africa, that we always advocate for mediocrity for our clients and then when we have to do things that we have to do for people to show that we respect, we don't do that. I mean, this manual records management has never worked, it will never work (Looking frustrated).*

We know, studies have shown that it…(throwing hands in the air) you will never if... that is why even police stations and banks don't use manual anymore, because you can't be manual when you're managing a high volume of data. The only system that you can use…We have the "Pele-Box" here. I'm not sure if you have seen it as you are entering there? It's an automated system. Once your medication is ready…let me just explain how it works. The thing is, those patients that are decanted to CCMDD, their medication actually, they get the medication from the Pele-Box. How the Pele-Box works, we get the medication for the patient and then we put…we scan medication and put in the box. Immediately, the first time, actually communicate with a client to say your medication is ready, come and collect it. And then the system will send a PIN. The client will come here with a PIN number and then punching the PIN number , and then the medication, the box opens, and then the patient gets the medication.

If maybe we can have, we can improve on those systems. And you wouldn't be, one this with this one, the patient can come at 12h00 midnight, you know. The convenience is that the patient won't be told that there is no medication or the patient won't actually have to wait up until the facility opens at a particular time. You know you come get the medication. I strongly believe that we need to improve our filing system…number one.

And number two, we need to improve on human capital. Because really, if a patient comes to the facility at 03h00, you have nurses highly on duty. But seeing that they cannot attend to those patients because those patients must be seen by nurses who are coming at 07h30, to me it doesn't make sense. Whereas a manager cannot actually enforce it, because once you enforce that, you are saying that they must actually be what they are doing and attend to these one. It can never work, it won't… it won't.

R: No, thanks for the clarity. And what's this box that you are referring to?

P: *It's a Pele-Box*

R: How do you spell that?

P: *P-E- L- E Box. I'm not sure whether why Pele. Pele is Setswana because it was developed by a Motswana guy from Kuruman. I think it is "Pill" not Pele. It is Pele Box. And then yeah, it is an automated ehh, ehh treatment dispensing machine. It works like an ATM, but this one issues medication*

R: Wonderful stuff. And just to elaborate, what's wrong with the current records management system, as you mentioned that it needs to be changed. What was wrong with it?

P: *It creates a big problem. We have 70,000 patient files. The problem with it, we are unable to manage it. Number one, you have a lot of duplication of files. Number two, you have a very small filing room…and then the some files are in the box. And then, the mere fact that the files are in the box, that can explain why we have duplication because you can have an admin clerk bending for…you know, half the day and looking for files. That will be that will be bad.*

And then, and then when you are running a number of files that we have we are at 70 000. Risks exist that misfiling will be there. That one is unnegotiable. Remember, it's a high volume of data with a limited number of people with ehh, improper filing cabinets, you know, everything is just not right, yeah.

So the filing system, if we can, if we can have our bulk filers that will cater for the number of files. And then we, we, you know, expand our filing room. And then, I think it will kind of minimise, but still for the mere fact that you are manual. I was I was working for Anglo-Gold Ashanti, everything digital.

You will never have the problem that we are having, yeah. So, maybe we just have to get the right people at another level, who are passionate, who embrace the technology, who will actually appreciate that until we change the way we do things, we are not going to be successful. At a moment, we are forced.
And if you go to… to… to meetings, we are been chastised for…for… for… for… things that are actually obsolete. You know, I cannot understand why should we chastise managers, if they want to do away with things that are not working? (Shrugging the shoulders). Then it will be "Stanza you are not doing well, uhm, you have so many duplications you must???? We cannot. The only thing is to…just digitise everything, that's the solution.

R: Thank you so much for putting it out clear. And maybe just on the aspect of the records management, what is being done about what you're proposing, digitalisation, technology driven, what is been done about that?

P: *Nothing.*

R: Nothing?

P: *Yes.*

R: In your opinion who should own up or drive digitalisation process?

P: *Uhm, you see, the national, national actually came up with this system called HPRS. But the system actually, the people who stole the idea from one of us in Tshwane didn't know actually how it actually should be, because if you take something that does not belong to you, you won't to actually get to understand the dynamics behind that. But this is…it's recorded already, it's not a problem. But the problem is the system is not working. National, I believe that our district can pilot test, uhm, you know what constitutes the best records management in Gauteng. Because doing that you only need computers, you need internet, you need server. Tshwane is almost the size of the Northwest.*

You may be, in terms of population, you may be needing, you know bigger servers, but we can pilot that and see if it works here, then it works, there is not a big deal actually. And it's cheaper. Though HPRS was actually introduced with a price tag of 400 million, but that was a day-light robbery. We can come out cheaper even with a less than hundred thousand, sorry, hundred million. We can, we can, we can stop that as a district.

R: So, from what I'm gathering, this HPRS is another digital system introduced by national department?

P: *That is correct.*

R: Okay. And from your observation. It has not yielded any positive results?

P*: Yes, remember it's a Health Patient Registration System s. Ehhh, you see, there's a difference between a patient registration and the patient administration. I think the best that will work here, we should have patient administration because now, when the patient enters…this one is just to register patients. Actually, it is just like a register where you use it to just register patients. To me, it doesn't administer patients. If you move from casualty to X ray and from X-ray to casualty and to the hospital. You see, the system cannot track it. Even blood was ever taken, the system can't pick it up. It is just to register, it's a registration system. Yeah, even…even… in the registration duties, if I may put it that way, is still failing, because at times it's offline and then the guys must come every now and then. So, to load the 10-digit numbers, we have the HPRS numbers, we call an HPRS numbers; ten digits and they are loaded. It is because we don't have access to the server. Actually, the whole thing is just a joke.*

R: Thank you for that elaboration. Chastisation of the managers when you make input, tell me more about that.

P: *Yeah, ehh, you know, you will be told that you are…you are not…. you're not managing patients appropriately. And let me, let me cite an instance. Number one patient comes to your facility today, the patient is seen, blood is taken for viral loads or whatever. And next month, next month when the patient comes, the file cannot be found. Because we have a high volume of files, high volume of patients. Then the clinician who attends to the client, you know, sees now a whole new file. It's not even indicated that the blood was taken, whatever. What kind of clinical management does it then make?*

Either the clinician will redraw blood. Often patient unless otherwise the patient actually will say: They drew blood the last time I was here. Other patients will just say "Let me not tell nurses what to do, they know what they are doing. Know either we draw blood again and then we repeat examinations unnecessarily. But when we just you know, you know, just to be honest to you, all the problems that we see here in Stanza, are offshoots. Of shoots from the filing room. If we can digitise that filing room, there won't be problems, yeah,

R: Okay. So, you are lamenting mostly, the filing system,

P: *The filing system must be digitised. The filing system..., this is silly. We cannot always say, hide behind the budget. I mean, the budget will never be alright. If that was the case, we wouldn't be having the Constitution of South Africa, because you wouldn't say everyone will have the right to do that. The budget won't allow, then we would actually have settled for a very poor constitution. Yeah, because it was informed by availability of resources and not what actually people must.*

R: What…what are the narrations behind budget, what's the story regarding budget?

P: *We are told often, often when we face these things, we are told there's no money (with a despairing look). There's no budget for computers, and no budget for this and that.*

We are told that there's no money, we just have to continue. You as the manager, and you must go to you know, you know this this thing that's funny I take this a joke often because I have read all the processes in public service. I'm familiar with most processes in public service, especially procurement issues. If you want to procure, this is what you need. If you need a computer this is what you follow.

But then, there is this common practice in Tshwane. I am not sure if it's part of the legislation or regulation in public service. They say if you need something, don't follow procedures, just go somewhere and put your foot down. This "putting your foot down" kind of a thing, it's a process that I don't know. I, maybe started to learn about it here, that "No, sometimes don't follow all these legislations. Go there and put your foot down and then get what you want. (Looking perplexed). So, I'm told that if you do that, it's wonderful. get what you want, but I don't think I have never heard about this in all management books and procurement books, you know, yeah.

R: And would you know what this means; “putting your foot down?”

P: *No, it’s like, the way I understand it, is like you go to whoever. If you need, let’s say stationery, you go to the clerk at the district office, who's responsible for stationery and then you fight, not like you're literally fighting but then you…yeah, you just become unprofessional and then they will give you what you want.. (Looking confrontational)*
But then if you follow processes that they in public service, then you don't get what you want. So, you must follow things that are illegal as opposed to the legal ones.

R: Okay, so the systems in place, processes are not helping you get what you need. You’d rather follow unconventional means?

P: Yes, yeah. Actually, what I'm saying is something actually here in Tshwane that I learned lately. If you take a VA2, you order, or RLS01 you order things that you need submitted, you don’t get what you want.

And then somebody and some other facilities who are good at “putting their foot down” (stressing the point with a frowned forehead). then, they go there, they’ll get the very same things that you were told are not there, yeah, which actually does not make sense. Not sure if I am dwelling into the politics of procurement here.

Yeah, not to stay in reading too much into the politics of procurement. But really, if you check my memos, the district hospital and Mamelodi Regional Hospital had 2 Acting CEOs and now they have the appointed CEO.

Previous CEO was very close to them. And because we are working together. And then they would request 1…2…3…45 and then they wouldn't know the appointed CEO would request the very same thing that I requested but would get it. I don’t know maybe the way we request we are using RLS “*e e sa rapellwang”* (Setswana; meaning; we are perhaps submitting documents that have not been prayed for), we don't know (Look desperate and frustrated)

R: Okay, And Sir, what is VA2, what is an RLS01?

P: *Eish, yeah, they are acronyms. The…the…the…acronyms I as explained to me, but I can explain. RLS01, ehh, it's a, it's a kind of a form that we use to place an order of equipment that are not actually available in most of our stores, And then with a VA2, it's also a form that we use to place an order as well for equipment, or consumables that are available in our stores. Just that the RLS…the acronym is escaping me*.

R: Okay, thanks for that elaboration. And whilst we still talking about the filing system, do you mind sharing, how you dealing with duplicated files in your facility?

P: Yes, we started a clean-up programs last year in June with Wits RHI to make sure we…we have rid the facility of duplicated files…duplicated number one. Yeah, duplication. So, we rid facility of 46 000 files but this included your redundant files. So, the only thing that we…have done thus far was to do this file clean-up in the filing room. And then when we get to duplication, we locate its “partner”, whatever and then we put them together.

R: Okay, so that's how you're dealing with your duplicate files. And then with regards to the miss-filing, how do you manage miss-filed records?

P: *Ehh, misfiling, we have a team of our team of our permanent admin clerks. Actually, when I say team, they are four, so they are responsible for filing. So we have minimised the number of people who file back because like I said, we have a large number of EPWP Ps and then if you say they must file back, then they cause a whole lot of miss-filing. So filing back now is the responsibility of these four. They are always on duty. Ehh, if one is not in, but, everyday one of them will be on duty, that's why we have identified them. So, what they do, all the files after all the files have been captured on to the "Tier.net" system, and then all those files are taken back to the sorting table and then the responsible admin clerks who are highly experienced, then will sort them in the sorting table at the back and before they go to the filing room. From there, they go to (incomplete sentence) …So, no EPWP unless otherwise the P has been trained technically. No one is filing back except for the four. That's how we are actually managing the misfiling.*

R: Thank you for the elaboration. And taking you back on clean-up, you mentioned Wits RHI, who or what is Wits RHI?

P: *Ehh, Wits RHI is Wits Reproductive Health Institute. It's a developmental partner, it's an NGO that supports Tshwane now so…yeah, the developmental partner. They support us on HIV program.*

R: Okay, thank you so much for that. And just to recap or go back. Anything that you'd like to share as a contributory factor towards patients' long waiting time in your facility?

P*: Yeah, maybe just to list again, number one is our manual filing system. Number two, our patients as well. Number three; inadequate staffing levels. We have a large number of patients and then, yeah, these are these are the three main. The other thing you know, you know whether with an HIV guideline, they change more often. And then with the national guidelines as well. Now we have a system called "Synch" that we use to decant patients to CCMDD. The systems work very slowly. And also, that creates a problem because now if the clinician wants to decant the client, the clinician division has to do that on the system and the system actually runs very slow. I am not sure how they can improve that. Also, it's a problem. Other ones are more clinical, so you cannot say clinical activities must be curtailed…No, you can't do that. What I mean, there are many things that you do on patient than you would seven years ago because, you know, we have guidelines……new guidelines…..ehh PC 101, the new TLD guidelines, and then we have the "Synch". So, you know, things are changed. All those interventions actually aimed at improving the patient. So, we can't say they must be curtailed.*

This one….PC…..forgotten (covering the mouth) will say patient must do 1…2…3…4…5…6… and then this guideline will say do 1…2…3…, yes, but it you can't curtail that because that's, for the benefit of the patient. But, maybe we can actually deal with the time we start we start. Digitisation is the way, the fourth industrial revolution… we talk fourth industrial revolution, but we still cling to 1910 activities.

R: Thank you so much for the input. And, what would your then suggest or recommend to…to assist this patients' long waiting time over and above what you've mentioned?

P: *Ehhh, no…I can only….yeah, I think what I've already mentioned is if those can be improved, they will actually automatically improve the long waiting time. But, this will include will include the patient-related factors, like I said, they don't honour appointments, come to the facilities whenever they want to come, and when actually their files are not, you know, pre-retrieved. That's the problem because now a substantial amount of time will be wasted looking for this patient's file*

R: Any more information that you'd like to share on patients' long waiting time?

P: *Ehhh, already, yeah, we need staffing, we need digitisation. That's the only solution.*

R: And thank you so much for your time. I really appreciate your efforts and the inputs and in anticipation that post completion of this particular academic program we'll be able to provide feedback. Once again, my heartfelt appreciation for your time Sir. Thank you so much.

P: *You're welcome.*

ANNEXURE I: Confirmatory letter from co-coder

CONFIRMATION CERTIFICATE OF CO-CODING

DECLARATION BY THE CO- CODER

I, Dr. Botshelo Rachel Sebola, hereby declare that I analysed and co-coded the individual interviews of the study conducted by Mr Solly Ratsietsi Makua; Mater of Public Health student at UNISA; student no.: 37320939.

The focus of the study was on:

"Experiences of facility managers regarding patients' long waiting time at Tshwane health district community health centres".

I further declare that I held a meeting with Mr S.R. Makua on the 27th October 2020, to discuss the themes and to reach consensus on data analyses relating to the study.

B.R. Sebola

Dr. BR Sebola

05/04/2021

Date

ANNEXURE J: Editing confirmation

MK
— WORDS —

TO WHOM IT MAY CONCERN

FROM : Ms. Marcel Koortzen

DATE : 05 May 2021

SUBJECT : CONFIRMATION OF EDITING OF AN ACADEMIC DISSERTATION

Dear Sir/Madam

I hereby submit this letter to confirm that I have edited the following dissertation for the degree Master of Public Health:

Student's Name : Solly Ratsletsi MAKUA

Student Number : 3732 0937

Study Title : EXPERIENCES OF FACILITY MANAGERS REGARDING PATIENTS' LONG WAITING TIME AT TSHWANE HEALTH DISTRICT COMMUNITY HEALTH CENTRES

It is however the author's responsibility to make the changes suggested and to attend to any queries.

My LinkedIn page provides information on my personal profile.

Marcel Koortzen

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