ASSESSMENT OF PATIENTS’ SATISFACTION WITH THE HEALTH CARE SERVICES PROVIDED BY THE CROSSROADS COMMUNITY HEALTH CARE CENTRE

by

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SUPERVISOR: MRS LV MONARENG

NOVEMBER 2009
DECLARATION

I declared that ASSESSMENT OF PATIENTS’ SATISFACTION WITH THE HEALTH CARE SERVICES RENDERED BY THE CROSSROADS COMMUNITY HEALTH CARE CENTRE 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 institution.

Signature: __________________ Date: 25th June 2009

(Ms Pearl Christine van Niekerk)
ABSTRACT

The study aimed to explore and described the assessment of patient's satisfaction with the quality of health care services rendered by the Crossroads Community Health Centre (CHCC). The target population comprised of adult male and female patients who have attended the clinic more than once. One hundred and twenty patients participated in the study. The convenience sampling method was used to select the respondents. A questionnaire was used to collect data. Validity and reliability were ensured. The Chronbach’s alpha reliability test was used to measure the internal consistency of the likert scale questionnaire items and was less than 0.4 for sections B-F, and 0.675 for section E. Descriptive and inferential data analysis was conducted using the Statistical Package for the Social Sciences 16.0 for Windows, release 16.0.1 with the assistance of a statistician. The findings indicated a positive perception of the quality of health care services rendered by the Crossroads CHCC. It was concluded that despite a positive perception of the health care services, there was a percentage of the respondents that rated the quality of the service as poor in relation to environmental cleanliness, staff attitudes, long waiting times, medications shortage, the complaints system reporting and health care service drainage to other CHCC where patient’s resided. The issue of quality improvement in these aspects was noted to be crucial and recommendations were made to improve the quality of the health care service at Crossroads CHCC.

Key terms:
Primary health care, Community Health Care Centre (CHCC), patient satisfaction, assessment, quality health care and perception
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- Mr F Hammann, the statistician who assisted me with the analysis of data
- The editor, Mrs Marthie Botha who edited my study
- The Department of Health PHC manager and the Crossroads CHCC management for granting me the permission to conduct the research study at their CHCC
- All the participants who volunteered to participate in the study
Dedication

I would like to dedicate this study to my sister, Sharon de Boer and her husband, George who helped me tremendously. Last but not least to my Lord who gave me the courage and strength to go on.

I cannot repay Him for what he has done for me, but I thank Him and will honour Him in all my ways in my profession.
# Chapter 1

## Orientation to the study

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>1.2</td>
<td>SOURCE AND BACKGROUND OF THE RESEARCH PROBLEM</td>
<td>2</td>
</tr>
<tr>
<td>1.2.1</td>
<td>Rationale of the research problem</td>
<td>5</td>
</tr>
<tr>
<td>1.2.2</td>
<td>Statement of the research problem</td>
<td>5</td>
</tr>
<tr>
<td>1.3</td>
<td>PURPOSE OF THE RESEARCH</td>
<td>6</td>
</tr>
<tr>
<td>1.3.1</td>
<td>Research questions</td>
<td>6</td>
</tr>
<tr>
<td>1.3.2</td>
<td>Research objectives</td>
<td>7</td>
</tr>
<tr>
<td>1.4</td>
<td>SIGNIFICANCE OF THE RESEARCH</td>
<td>8</td>
</tr>
<tr>
<td>1.5</td>
<td>DEFINITIONS OF KEY TERMS</td>
<td>9</td>
</tr>
<tr>
<td>1.6</td>
<td>CONCEPTUAL FRAMEWORK</td>
<td>11</td>
</tr>
<tr>
<td>1.6.1</td>
<td>Assumptions</td>
<td>12</td>
</tr>
<tr>
<td>1.7</td>
<td>RESEARCH DESIGN AND METHODOLOGY</td>
<td>13</td>
</tr>
<tr>
<td>1.8</td>
<td>ETHICAL CONSIDERATIONS</td>
<td>14</td>
</tr>
<tr>
<td>1.9</td>
<td>STRUCTURE OF THE DISSERTATION</td>
<td>14</td>
</tr>
<tr>
<td>1.10</td>
<td>CONCLUSION</td>
<td>15</td>
</tr>
</tbody>
</table>

# Chapter 2

## Literature review

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>INTRODUCTION</td>
<td>17</td>
</tr>
<tr>
<td>2.2</td>
<td>PRIMARY HEALTH CARE</td>
<td>17</td>
</tr>
<tr>
<td>2.2.1</td>
<td>Global view of PHC</td>
<td>18</td>
</tr>
<tr>
<td>2.2.2</td>
<td>PHC in South Africa</td>
<td>19</td>
</tr>
<tr>
<td>2.3</td>
<td>DISTRICT HEALTH SYSTEM</td>
<td>20</td>
</tr>
<tr>
<td>2.3.1</td>
<td>The dual role of the District Health System and the primary health care principles</td>
<td>21</td>
</tr>
<tr>
<td>2.3.2</td>
<td>The implementation of the District Health System in Crossroads</td>
<td>24</td>
</tr>
</tbody>
</table>
# Table of contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.4</td>
<td>PATIENT PERCEPTION OF HEALTH CARE</td>
<td>25</td>
</tr>
<tr>
<td>2.5</td>
<td>WHAT IS PATIENT SATISFACTION?</td>
<td>26</td>
</tr>
<tr>
<td>2.5.1</td>
<td>The importance of doing a patient satisfaction survey for the Crossroads community</td>
<td>28</td>
</tr>
<tr>
<td>2.6</td>
<td>UNDERSTANDING QUALITY HEALTH CARE</td>
<td>31</td>
</tr>
<tr>
<td>2.6.1</td>
<td>Approaches to quality assessment</td>
<td>31</td>
</tr>
<tr>
<td>2.6.1.1</td>
<td>Structure</td>
<td>34</td>
</tr>
<tr>
<td>2.6.1.2</td>
<td>Process</td>
<td>36</td>
</tr>
<tr>
<td>2.6.1.3</td>
<td>Outcome</td>
<td>37</td>
</tr>
<tr>
<td>2.7</td>
<td>THE LEGISLATIVE FRAMEWORK</td>
<td>38</td>
</tr>
<tr>
<td>2.7.1</td>
<td>What is Batho Pele?</td>
<td>39</td>
</tr>
<tr>
<td>2.7.2</td>
<td>The Patients’ Rights Charter</td>
<td>40</td>
</tr>
<tr>
<td>2.8</td>
<td>CONCLUSION</td>
<td>41</td>
</tr>
</tbody>
</table>

## CHAPTER 3

Research design and methodology

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>INTRODUCTION</td>
<td>42</td>
</tr>
<tr>
<td>3.2</td>
<td>AIM OF THE RESEARCH</td>
<td>42</td>
</tr>
<tr>
<td>3.3</td>
<td>RESEARCH DESIGN AND METHODOLOGY</td>
<td>42</td>
</tr>
<tr>
<td>3.3.1</td>
<td>Research context</td>
<td>43</td>
</tr>
<tr>
<td>3.3.2</td>
<td>Research design</td>
<td>49</td>
</tr>
<tr>
<td>3.3.2.1</td>
<td>Quantitative research</td>
<td>50</td>
</tr>
<tr>
<td>3.3.2.2</td>
<td>Explorative research</td>
<td>52</td>
</tr>
<tr>
<td>3.3.2.3</td>
<td>Descriptive research</td>
<td>53</td>
</tr>
<tr>
<td>3.3.2.4</td>
<td>Survey</td>
<td>53</td>
</tr>
<tr>
<td>3.4</td>
<td>RESEARCH METHOD</td>
<td>53</td>
</tr>
<tr>
<td>3.4.1</td>
<td>Research population</td>
<td>53</td>
</tr>
</tbody>
</table>
# Table of contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4.2</td>
<td>Sample</td>
<td>54</td>
</tr>
<tr>
<td>3.4.2.1</td>
<td>Sampling technique</td>
<td>55</td>
</tr>
<tr>
<td>3.4.3</td>
<td>Data collection</td>
<td>56</td>
</tr>
<tr>
<td>3.4.3.1</td>
<td>Data collection instrument</td>
<td>56</td>
</tr>
<tr>
<td>3.4.3.2</td>
<td>Pre-testing of the questionnaire</td>
<td>59</td>
</tr>
<tr>
<td>3.4.3</td>
<td>Administration of the questionnaire</td>
<td>60</td>
</tr>
<tr>
<td>3.4.4</td>
<td>Data analysis</td>
<td>60</td>
</tr>
<tr>
<td>3.5</td>
<td>VALIDITY AND RELIABILITY</td>
<td>61</td>
</tr>
<tr>
<td>3.4.1</td>
<td>Validity</td>
<td>61</td>
</tr>
<tr>
<td>3.5.2</td>
<td>Reliability</td>
<td>63</td>
</tr>
<tr>
<td>3.6</td>
<td>ETHICAL CONSIDERATIONS</td>
<td>63</td>
</tr>
<tr>
<td>3.6.1</td>
<td>Protecting the rights of the institution</td>
<td>64</td>
</tr>
<tr>
<td>3.6.2</td>
<td>Protecting the rights of patients</td>
<td>64</td>
</tr>
<tr>
<td>3.6.3</td>
<td>Scientific integrity</td>
<td>66</td>
</tr>
<tr>
<td>3.7</td>
<td>SCOPE AND LIMITATION OF THE STUDY</td>
<td>66</td>
</tr>
<tr>
<td>3.8</td>
<td>CONCLUSION</td>
<td>66</td>
</tr>
</tbody>
</table>

## CHAPTER 4

Data analysis and interpretation

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>INTRODUCTION</td>
<td>67</td>
</tr>
<tr>
<td>4.2</td>
<td>RESEARCH OBJECTIVES OF THE STUDY</td>
<td>67</td>
</tr>
<tr>
<td>4.3</td>
<td>DATA ANALYSIS</td>
<td>68</td>
</tr>
<tr>
<td>4.3.1</td>
<td>Section A: Biographical data</td>
<td>68</td>
</tr>
<tr>
<td>4.3.1.1</td>
<td>Item A1: Respondents' gender (N=120)</td>
<td>68</td>
</tr>
<tr>
<td>4.3.1.2</td>
<td>Item A2: Respondents' age (N=120)</td>
<td>69</td>
</tr>
<tr>
<td>4.3.1.3</td>
<td>Item A3: Respondents' ethnic background (N=120)</td>
<td>70</td>
</tr>
<tr>
<td>4.3.1.4</td>
<td>Item A4: Clinic attendance of respondents (N=120)</td>
<td>71</td>
</tr>
<tr>
<td>4.3.1.5</td>
<td>Item A5: Marital status of respondents (N=120)</td>
<td>71</td>
</tr>
<tr>
<td>4.3.1.6</td>
<td>Item A6: Respondents' highest level of education (N=120)</td>
<td>72</td>
</tr>
<tr>
<td>4.3.1.7</td>
<td>Item A7: Home language of respondents (N=120)</td>
<td>72</td>
</tr>
<tr>
<td>4.3.2</td>
<td>Section B: Environment</td>
<td>72</td>
</tr>
<tr>
<td>4.3.2.1</td>
<td>Item B1: CHC centre is in a good, clean and welcoming condition (N=120)</td>
<td>72</td>
</tr>
<tr>
<td>4.3.2.2</td>
<td>Item B2: There are adequate benches to sit on while waiting for consultation (N=120)</td>
<td>73</td>
</tr>
</tbody>
</table>
### Table of contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.3.2.3</td>
<td>Item B3:</td>
<td>The toilets are clean and in good working order (N=120)</td>
</tr>
<tr>
<td>4.3.2.4</td>
<td>Item B4:</td>
<td>The CHC centre is a safe place for patients (N=120)</td>
</tr>
<tr>
<td>4.3.2.5</td>
<td>Item B5:</td>
<td>The CHC centre is a wheelchair friendly environment (N=120)</td>
</tr>
<tr>
<td>4.3.2.6</td>
<td>Item B6:</td>
<td>There are visible directions for patients to know where to go (N=120)</td>
</tr>
<tr>
<td>4.3.2.7</td>
<td>Item B7:</td>
<td>There is a notice with the person in charge’s name should any problem arise (N=120)</td>
</tr>
<tr>
<td>4.3.3</td>
<td>Section C:</td>
<td>Accessibility and availability of the health care services</td>
</tr>
<tr>
<td>4.3.3.1</td>
<td>Item C1:</td>
<td>It takes more than 30 minutes to get to the CHC centre (N=120)</td>
</tr>
<tr>
<td>4.3.3.2</td>
<td>Item C2:</td>
<td>The CHC centre has convenient hours of operating (N=120)</td>
</tr>
<tr>
<td>4.3.3.3</td>
<td>Item C3:</td>
<td>The queues are not too long (N=120)</td>
</tr>
<tr>
<td>4.3.3.4</td>
<td>Item C4:</td>
<td>There is a shortage of medication (N=120)</td>
</tr>
<tr>
<td>4.3.3.5</td>
<td>Item C5:</td>
<td>The respondents are able to access the next level of care (N=120)</td>
</tr>
<tr>
<td>4.3.3.6</td>
<td>Item C6:</td>
<td>The respondents do not wait too long to receive medication after consultation (N=120)</td>
</tr>
<tr>
<td>4.3.3.7</td>
<td>Item C7:</td>
<td>There is a box for complaints and compliments to voice opinions or concerns (N=120)</td>
</tr>
<tr>
<td>4.3.4</td>
<td>Section D:</td>
<td>Affordability of care</td>
</tr>
<tr>
<td>4.3.4.1</td>
<td>Item D1:</td>
<td>It is not expensive to travel to the CHC centre (N=120)</td>
</tr>
<tr>
<td>4.3.4.2</td>
<td>Item D2:</td>
<td>Respondents can afford to pay the minimum fee required for service (N=120)</td>
</tr>
<tr>
<td>4.3.4.3</td>
<td>Item D3:</td>
<td>Respondents received health care even when they did not pay (N=120)</td>
</tr>
<tr>
<td>4.3.4.4</td>
<td>Item D4:</td>
<td>Respondents believed that the health care they received was worth the money they paid (N=120)</td>
</tr>
<tr>
<td>4.3.4.5</td>
<td>Item D5:</td>
<td>Respondents received the same good health care as the clients who paid (N=120)</td>
</tr>
<tr>
<td>4.3.4.6</td>
<td>Item D6:</td>
<td>Respondents felt that the treatment they received was of an acceptable quality (N=120)</td>
</tr>
<tr>
<td>4.3.4.7</td>
<td>Item D7:</td>
<td>The health care rendered does not discriminate against gender, race, status or types of sickness (N=120)</td>
</tr>
<tr>
<td>4.3.5</td>
<td>Section E:</td>
<td>Perception of patients about staff members</td>
</tr>
<tr>
<td>4.3.5.1</td>
<td>Item E1:</td>
<td>There was no shortage of staff at the CHC centre (N=120)</td>
</tr>
<tr>
<td>4.3.5.2</td>
<td>Item E2:</td>
<td>The individuals at the reception desk were helpful at the CHC centre (N=120)</td>
</tr>
<tr>
<td>4.3.5.3</td>
<td>Item E3:</td>
<td>The nursing staff treated respondents with respect at the CHC centre (N=120)</td>
</tr>
<tr>
<td>4.3.5.4</td>
<td>Item E4:</td>
<td>The doctor who treated the respondents was polite and respectful at the CHC centre (N=120)</td>
</tr>
<tr>
<td>4.3.5.5</td>
<td>Item E5:</td>
<td>The doctor at the CHC centre explained to respondents what was wrong with them (N=120)</td>
</tr>
<tr>
<td>4.3.5.6</td>
<td>Item E6:</td>
<td>Respondents can complain to staff at the CHC centre without being afraid (N=120)</td>
</tr>
<tr>
<td>4.3.5.7</td>
<td>Item E7:</td>
<td>Respondents were pleased with the way they were treated by staff at the CHC centre (N=120)</td>
</tr>
<tr>
<td>4.3.6</td>
<td>Section F:</td>
<td>Patient behaviour</td>
</tr>
<tr>
<td>4.3.6.1</td>
<td>Item F1:</td>
<td>Return to the CHC centre on the scheduled dates (N=120)</td>
</tr>
<tr>
<td>4.3.6.2</td>
<td>Item F2:</td>
<td>Still have the same folder from the first visit (N=120)</td>
</tr>
<tr>
<td>4.3.6.3</td>
<td>Item F3:</td>
<td>Do not mind to wait for hours before you are seen by a nurse/doctor (N=120)</td>
</tr>
<tr>
<td>4.3.6.4</td>
<td>Item F4:</td>
<td>Expect to receive medications every time you visit the CHC centre (N=120)</td>
</tr>
<tr>
<td>4.3.6.5</td>
<td>Item F5:</td>
<td>Use up all the medication they gave me (N=120)</td>
</tr>
<tr>
<td>4.3.6.6</td>
<td>Item F6:</td>
<td>Addressed in a language I understand, understand the information about my sickness (N=120)</td>
</tr>
<tr>
<td>4.3.6.7</td>
<td>Item F7:</td>
<td>Only attend this CHC centre because the care provided here is better than at other clinics (N=120)</td>
</tr>
<tr>
<td>4.7</td>
<td>CONCLUSION</td>
<td></td>
</tr>
</tbody>
</table>

Page numbers are indicated for each item.
# CHAPTER 5

Findings, limitations and recommendations

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>INTRODUCTION</td>
<td>92</td>
</tr>
<tr>
<td>5.2</td>
<td>OBJECTIVES OF THE STUDY</td>
<td>92</td>
</tr>
<tr>
<td>5.3</td>
<td>SUMMARY OF FINDINGS</td>
<td>93</td>
</tr>
<tr>
<td>5.3.1</td>
<td>Demographic data</td>
<td>93</td>
</tr>
<tr>
<td>5.3.2</td>
<td>Patient perception of the environment of the CHC centre</td>
<td>94</td>
</tr>
<tr>
<td>5.3.3</td>
<td>Accessibility to the CHC centre and available services</td>
<td>95</td>
</tr>
<tr>
<td>5.3.4</td>
<td>Perceptions about affordability of care</td>
<td>97</td>
</tr>
<tr>
<td>5.3.5</td>
<td>Perception of patients about staff members</td>
<td>98</td>
</tr>
<tr>
<td>5.3.6</td>
<td>Patient behavior</td>
<td>99</td>
</tr>
<tr>
<td>5.4</td>
<td>SCOPE AND LIMITATIONS OF THE STUDY</td>
<td>100</td>
</tr>
<tr>
<td>5.5</td>
<td>RECOMMENDATIONS</td>
<td>101</td>
</tr>
<tr>
<td>5.6</td>
<td>CONCLUSION</td>
<td>102</td>
</tr>
<tr>
<td></td>
<td>LIST OF SOURCES</td>
<td>103</td>
</tr>
</tbody>
</table>
List of tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1.1</td>
<td>Structure of the dissertation</td>
<td>15</td>
</tr>
<tr>
<td>Table 2.1</td>
<td>Patient rights and responsibilities</td>
<td>41</td>
</tr>
<tr>
<td>Table 4.1</td>
<td>Number of times respondents attended the clinic</td>
<td>71</td>
</tr>
<tr>
<td>Table 4.2</td>
<td>Marital status of respondents</td>
<td>71</td>
</tr>
<tr>
<td>Figure</td>
<td>Description</td>
<td>Page</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Figure 2.1</td>
<td>The PHC and DHS diagram</td>
<td>23</td>
</tr>
<tr>
<td>Figure 2.2</td>
<td>Donabedian Structure-Process-Outcome Model</td>
<td>33</td>
</tr>
<tr>
<td>Figure 2.3</td>
<td>Performance assessment framework to guide the study</td>
<td>36</td>
</tr>
<tr>
<td>Figure 3.1</td>
<td>The map of Crossroads</td>
<td>45</td>
</tr>
<tr>
<td>Figure 4.1</td>
<td>Age distribution of respondents</td>
<td>69</td>
</tr>
<tr>
<td>Figure 4.2</td>
<td>Ethnic background of respondents</td>
<td>70</td>
</tr>
<tr>
<td>Figure 4.3</td>
<td>Respondents' opinion of environment of CHC centre</td>
<td>74</td>
</tr>
<tr>
<td>Figure 4.4</td>
<td>Respondents; opinion on the accessibility and availability of the health care services</td>
<td>77</td>
</tr>
<tr>
<td>Figure 4.5</td>
<td>Affordability of care</td>
<td>80</td>
</tr>
<tr>
<td>Figure 4.6</td>
<td>Perception of patients about staff members</td>
<td>83</td>
</tr>
<tr>
<td>Figure 4.7</td>
<td>Return to the CHC centre on the scheduled dates</td>
<td>84</td>
</tr>
<tr>
<td>Figure 4.8</td>
<td>Still have the same folder from the first visit</td>
<td>85</td>
</tr>
<tr>
<td>Figure 4.9</td>
<td>Do not mind to wait for hours before I am seen by a nurse/doctor</td>
<td>86</td>
</tr>
<tr>
<td>Figure 4.10</td>
<td>Expect to receive medications every time I visit the CHC centre</td>
<td>87</td>
</tr>
<tr>
<td>Figure 4.11</td>
<td>Use up all the medication they give me</td>
<td>88</td>
</tr>
<tr>
<td>Figure 4.12</td>
<td>Understand the information about my sickness</td>
<td>89</td>
</tr>
<tr>
<td>Figure 4.13</td>
<td>Only attend this CHC centre because the care provided here is better than at other clinics</td>
<td>90</td>
</tr>
</tbody>
</table>
## List of abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>AUTOIMMUNE DEFICIENCY SYNDROME</td>
</tr>
<tr>
<td>ARVS</td>
<td>ANTIRETROVIRALS</td>
</tr>
<tr>
<td>CHCC</td>
<td>COMMUNITY HEALTH CARE CENTRE</td>
</tr>
<tr>
<td>DoH</td>
<td>DEPARTMENT OF HEALTH</td>
</tr>
<tr>
<td>HIV</td>
<td>HUMAN IMMUNODEFICIENCY VIRUS</td>
</tr>
<tr>
<td>IMR</td>
<td>INFANT MORTALITY RATE</td>
</tr>
<tr>
<td>MMR</td>
<td>MATERNAL MORTALITY RATE</td>
</tr>
<tr>
<td>PHC</td>
<td>PRIMARY HEALTH CARE</td>
</tr>
<tr>
<td>SA</td>
<td>SOUTH AFRICA</td>
</tr>
<tr>
<td>TB</td>
<td>TUBERCULOSIS</td>
</tr>
<tr>
<td>WHO</td>
<td>WORLD HEALTH ORGANIZATION</td>
</tr>
<tr>
<td>Annexure</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>Annexure A</td>
<td>Request for permission to conduct the study</td>
</tr>
<tr>
<td>Annexure B</td>
<td>Ethical clearance</td>
</tr>
<tr>
<td>Annexure C</td>
<td>Permission from the management of the research context</td>
</tr>
<tr>
<td>Annexure D</td>
<td>Consent form for participation</td>
</tr>
<tr>
<td>Annexure E</td>
<td>Questionnaire</td>
</tr>
<tr>
<td>Annexure F</td>
<td>Statistics document</td>
</tr>
<tr>
<td>Annexure G</td>
<td>Letter from the editor</td>
</tr>
</tbody>
</table>
CHAPTER 1

Orientation to the study

1.1 INTRODUCTION

The World Health Organization (WHO); co-sponsored an international health landmark event held in 1978 in Alma-Ata, capital of Kazakhan, Soviet Central Asia. The conference was a concerted international effort to expand and redirect health programs in countries throughout the world in addressing health problems that existed, particularly in the developing countries. Its goal was to increase and expedite inexpensive health service delivery, particularly preventive and curative services at the community level to address the health problems of these communities (Van Rensburg 2004:28-30).

Adoption of the Declaration of Alma-Ata of 1978 at the International Conference on Primary Health Care (PHC) clearly stated that PHC is the key to attaining the target set at this conference of health for all. The WHO, as far back as the 1970’s, called on all governments to formulate national policy strategies and plans of action to launch and sustain PHC as part of a comprehensive national health system in coordination with other sectors (WHO 1979:7).

The National Department of Health (DoH) of South Africa has prioritised PHC by formulating legal and policy frameworks for a health care delivery system that is quality-driven, based on the tenets of PHC. Unfortunately the standard of health care in the public sector has been deteriorating during the past years, despite the implementation of PHC. The signs of failure of our public health care services are everywhere. This is stated in the printed media, television, voiced by the public at large (Maposa 2008:4; Mpshe 2009:4) and a similar notion has been found in studies conducted in the Eastern Cape province by Masondo (2008:1) and Netshandama, Nemathaga and Shai-Mahoko (2005:65). As well as in the Southern Cape in the Karoo region (Uys 2004:112-116); the Free State province (Janse Van Rensberg, Steyn & Matebesi 1999:51); by several studies conducted in the Limpopo province(Mabaso 2006:118; Rapakwana 2004:78; Makhubela 2002:2; Mashego & Peltzer 2005:19); in central Witwatersrand health...
region, Gauteng Province (Gasa 2003:7); and in the Taung district of North-West Province (Bediakp, Nel & Hiemstra 2006:14).

In many PHC clinic services, patients have to wait long before they can be attended to. Often they have to return home because some treatments were not available. They are often subjected to negative attitudes of health professionals (Jooste 2009:1). The quality of care provided is therefore of major concern (Maposa, Witten & Jooste 2009:1) and is revealed in the findings of several studies mentioned above.

The quality of public health care services urgently needs to be improved as the majority of our population utilises public health facilities for their health care needs (Moholo & Khoza 2000:34; Van Dyk 2008:1). Any shortcomings in health care delivery endanger the public’s health and lives, adding costs to the health care system and reducing productivity (Department of Health 2007:3). The calls for a paradigm shift to render quality health care service are firmly on the government agenda due to the increasing public pressure to provide quality care at the primary level (Heunis, Van Rensburg & Claassens 2006:38).

The government recognises this shift as essential to achieve and promote the health of all people in South Africa (SA) through a caring and effective quality-driven health system based on the PHC approach as a priority (Pillay 2002:2; Department of Health 2009:3). A quality-driven health care system that establishes the primacy of primary health care sees that the critical measure of that success is found in the extent to which the consumers of the health service benefit, as indicated by the improved health status of its people (Mbeki 2002:26; Department of Health 2009:3).

1.2 SOURCE AND BACKGROUND OF THE RESEARCH PROBLEM

The health status of hundreds of millions of people in the world, particularly in the developing countries, has been unacceptable (Skolnik 2008:1). According to the WHO more than half the population of the world does not have the benefit of adequate health care (Wagstaff & Claeson 2004:7). The WHO therefore co-sponsored an international health landmark event held in 1978 in Alma-Ata, capital of Kazakhan, Soviet Union.
declaring PHC an acceptable strategy to improve the health status of communities, particularly those living in developing countries (Steyn 2007:12-14). The rationale for the adoption of the Declaration of Alma-Ata of 1978 at the International Conference on PHC clearly stated that PHC is the key to reducing significant health problems in Africa and other developing countries. The PHC declaration called on all governments to formulate national policies and strategies to launch and sustain plans of action that would ensure that PHC is part of a comprehensive national health system in coordination with other sectors (WHO 1979:7). Due to PHC being the first line or first point of contact of individuals, families and communities in most countries’ health systems (Peltzer, Seoka, Babor & Obot 2006:17), PHC is a valuable point of health care delivery for communities to access health. At the conference the PHC concept was broadened to encompass a philosophy that went much further than the simple provision of first health care contact services, to include among others the level at which common complaints are treated, preventive measures such as immunisation are carried out, and community involvement inputs are obtained utilising quality techniques for assessing quality of health care such as the use of patient satisfaction surveys (Moholo & Khoza 2000:335; Hattingh, Dreyer & Roos 2007:61). This was necessary if PHC was to make a significant impact on the health status of communities (Department of Health 2007:5).

The WHO reported that South Africa was one of the countries with the most marked unequal distribution of health indicators, for example maternal, infant and peri-natal mortality rates, and had a large sector of the population who did not have adequate access to affordable health care (Strategic Plan 2007-2011:4). According to London (2005:1) these indicators are seen with increased rates of death and disability from preventive diseases amongst black South Africans. The health care approach was hospital-centered with a huge part of the health budget allocated to fund this expensive health care delivery system, while only lip service was paid to PHC (Hattingh et al 2007:60).

To address these problems a paradigm shift was necessary in order to move from a curative and hospital-based system towards the development of a district health care system with PHC guiding it (Gwagwa 2004:20). PHC is as stated, the first point of service, in other words the patients’ first encounter with health care workers. Its
purpose is to provide initial treatment and care and when specialist care is necessary patients are referred to hospitals. PHC is not simply health care of poor quality.

On this primary level of health care delivery, health problems are diagnosed early and prompt treatment is provided to prevent the development of complications which are more expensive to treat. The delivery of quality health care at PHC level is therefore just as important as on any other level of the health care delivery system. This approach ensures that 80% of the population in SA who make use of the public health care system have improved access to affordable quality health care (Pillay 2002:2, Department of Health 2009:3).

The South African National DoH is of the opinion that simply stating a belief in quality PHC service would not make it happen, but to make beliefs and intentions effective it would be necessary to back it up with appropriate processes and structures. These processes should include a quality assurance policy which will provide guidelines to support and achieve quality care, based on PHC principles and practiced at grassroots level (Skolnik 2008:82, 83).

As the delivery of quality health care is the goal of the national and also the provincial DoH, it is necessary to identify any gaps between standards and actual practice and to find ways to close these gaps in health care delivery (Department of Health 2007:9-10). One way to measure quality health care statistically is by determining patients’ compliance to medical treatment regimens. Another way to measure the delivery of quality health care is to study and assess patient satisfaction (Du Toit, Knipe, Van Niekerk, Van der Waldt & Doyle 2002:354).

Providers who deliver health care that is perceived as of good quality enhance patient satisfaction and improve return visits. This in turn contributes to the building of faith in the health system at large (Wagstaff & Claeson 2004:70), thus improving the overall health status of the communities. Patient satisfaction with PHC implies an improvement in the health status of communities since PHC has been designed to lower the morbidity and mortality rates of unnecessary and preventable illness, to effectively treat
preventive diseases, to offer promotive health, and to give curative and rehabilitative
care where needed (Wagstaff & Claeson 2004:70).

Stanhope and Lancaster (2004:398) regard PHC as meeting the basic health needs of
the community by providing accessible health services. However, at the Crossroads
community the morbidity and mortality rates are high for communicable diseases that
are preventable such as pulmonary tuberculosis (TB), parasitic diseases and diarrhea
(City of Cape Town 2006-2007 statistics). The question is, however, how effective the
PHC service rendered by the Crossroads Community Health Care Centre (CHCC) or
Crossroads Community Health Centre (CHC) is in delivering quality health care. The
focus of this research is on patient satisfaction with the PHC service delivery at the
Crossroads CHCC.

The rationale of the study is outlined in the next discussion.

1.2.1 Rationale of the research problem

It was on the basis of the following aspects that the research problem was selected.

- The standard of health care in the public sector seems to be deteriorating. Many
  problems have been identified in the PHC services and dissatisfaction with the
  current state of affairs is mounting.
- Patients have voiced their dissatisfaction with the services rendered.
- As patient satisfaction is important for compliance to treatment satisfaction rates
  should be increased.
- As the majority of the population in this geographical area utilises the Crossroads
  health care centre for their health needs and have the right to quality PHC (Rall &
  Meyer 2006:15) the level of satisfaction with the services rendered should be
determined.

1.2.2 Statement of the research problem
The residents of Cape Town have stated that health care delivery at community clinics is a critical area of under-delivery and of poor quality health care (City of Cape Town 2009:1). This is evident in the printed media and in research studies that the standard of health care practice has declined and communities express dissatisfaction with the quality of health provided (Johnson 2009:18). Satisfaction with health care and its assessment is important; as it also predicts compliance with treatment and medical outcomes and improves the overall health status of the community at large (O’Connor 2004:8). Meaningful satisfaction with health care services has implications on the health of communities at large. Although vast studies have been done on this topic, a survey is still necessary in this part of the community and has not been done before. The health care center provides care for mostly impoverished people whose health care choices and preferences seem constrained. Based on the background and rationale provided, the research question that the research study sought to answer was: What is the satisfaction level of patients with the quality of care provided at the Crossroads CHC centre?

1.3 PURPOSE OF THE RESEARCH

The aim of the study was to determine to what extent the patients of the Crossroads CHC were satisfied with the quality of health care services they received.

1.3.1 Research questions

The research questions that were derived from the problem statement were organised according to the theoretical framework of the study by Donabedian (1980), which is structure, process and outcome.

The research questions were arranged and asked under the following headings:

**Structure**

- To what extent were the patients of the Crossroads clinic satisfied with the physical environment of the centre?
• To what extent were the patients of the Crossroads clinic satisfied with staff behaviour and attitudes?
• To what extent were the patients of the Crossroads clinic satisfied with the accessibility, availability, affordability, equitability, effectiveness and efficiency of the PHC service?

Process

• To what extent were the patients of the Crossroads clinic satisfied with the consultation process?
• To what extent were the patients of the Crossroads clinic satisfied with the quality of PHC services provided?

Outcome

• What are the problems experienced by patients that contribute to poor compliance with care?
• What further research can be suggested?

In the light of the above-mentioned problem statement and the research questions, the following objectives for the research were compiled.

1.3.2 Research objectives

The main aim of the study was to explore and describe the extent to which patients were satisfied with the quality of care provided at Crossroads CHC. The study objective included more than one: that is to developed guidelines and protocols to guide health personnel in delivery of quality health care. The theoretical framework of structure, process and outcome was utilised to organise the research objectives in order to explore and describe the extent to which patients were satisfied with the health care provided:

Structure
• The physical environment and resources
• The staff behaviour and attitudes towards patients
• Accessibility, availability, affordability, equitability, effectiveness and efficiency of the PHC service

Process

• The consultation process
• The quality of PHC services provided in terms of safety, effectiveness or patient-centeredness as perceived by the patients who utilise the health care services

The last element of the theoretical framework provided guidance to explore and describe the following:

Outcome

• The problems experienced by patients that contributed to poor compliance with care
• The level of satisfaction of patients with the quality of care provided by nurses at the clinic
• What recommendations can be suggested to contribute to the improvement of quality of care at this clinic

1.4 SIGNIFICANCE OF THE RESEARCH

It was important to conduct this research as no recorded research could be found that described the level of satisfaction of the patients making use of the Crossroads CHC, Cape Town, SA. The level of satisfaction with health care service influences the health of the community. The study will contribute towards improvement of the quality of health provided at the clinic and a review of the standards, policies and practices of how this care is provided to the satisfaction of the consumers of care.
Knowledge that will be generated from this study will be utilised to plan in-service education for the staff at the clinic on how to implement policies and objectives that are related to quality of health care. On the other hand, findings of this study will provide recommendations to develop guidelines and protocols that will guide nurses with regard to the day-to-day provision of services to improve the health of the patients who utilise the PHC services of Crossroads clinic. Recommendations will be made from the findings for further research through qualitative methods of enquiry.

Findings of the current research will be used to improve the delivery of PHC to this area and other health services in the province where possible, to ultimately address the problems that cause the quality of health care provided to deteriorate.

1.5 DEFINITIONS OF KEY TERMS

The conceptual and operational definition of the key concepts used in the study is as follows:

Assessment

Assessment is defined as deciding the value or quality of something (South Africa’s Oxford Secondary School Dictionary 2006:34). Assessment refers to a process of collecting, organising, validating and recording data or information about a client’s health status or particular phenomena (Kozier, Erb & Wilkinson 2008:88).

In this study assessment refers to a process of investigating or collecting information about the perceptions, views or opinions of patients who are treated at CHC about the quality of health care services rendered, based on the structure-process-outcome model.

Primary health care services
The WHO at the Alma-Ata conference in 1978 defined PHC as essential health care based on the methods and techniques which are practical, scientifically acceptable and available to all individuals and families in the community with their full participation and at a cost which the community and the country can afford (Van Rensburg 2004:54). Stanhope and Lancaster (2004:398) refer to PHC as meeting the basic health needs of the community by providing readily accessible, available, affordable, equitable, effective and efficient health services.

In this study, PHC refers to health care services provided by the Crossroads CHC health staff to meet the health needs of patients who reside in the community of Crossroads, especially because it is their first point of contact with the health care system.

**Patient satisfaction**

The concept satisfaction is defined by the *Concise Oxford Dictionary* (1983:930) as payment of debt, fulfillment of obligation, something accepted by way of satisfaction, being satisfied with regard to desire or want, or something that satisfies desire. At its fundamental level, *satisfaction* is a positive evaluation of specific service dimensions based on patient expectations and provider performance (Du Toit et al 2002:310).

According to O’Connor (2004:9) patient satisfaction is a match between patient expectation of health care and the care actually received.

In this research, the term patient *satisfaction* is seen as a reflection on quality of PHC provided. It is also seen as a measure of success, or to what extent the provider has succeeded in meeting the client’s expectations (Smith & Engelbrecht 2001:5; Evans 2008:19).

**Quality**
Quality refers to a state of continuous striving for excellence and conformance to specifications and guidelines (Stanhope & Lancaster 2004:450).

Foster (2004:49) is of the opinion that there are no watertight definitions of quality as they are elusive, complex and have many different aspects. Quality is a term that has many different meanings for different people; therefore it should be subjected to further operational definition before it can be applied in context (Maylor 2003:166).

Quality refers to how ‘good’ something such as health service is, when judged against particular criteria (Orme, Powell, Taylor & Grey 2007:342) and investigated by means of the PHC principles. Providing quality health care is the link to providing quality PHC services to a community (Thoabala 2008:48).

In this study, quality refers to the standards of performance by the staff as perceived by patients at CHC in providing patient care to them. It is about the quality of care that will reflect the characteristics of excellence as described in pre-determined standards (Arries 2006:64). These standards form the criteria for evaluating the quality of a specific service rendered (Booyens 2002:596).

The *Concise Oxford Dictionary* (1983:1035) defines a standard as a weight or measure to which others conform or by which the accuracy or quality of others is judged. It is a statement about a desired and acceptable level of health care (Department of Health 2001:3).

A standard serves as a requirement for the evaluation of the cost and quality of care (Stanhope & Lancaster 2004:849) and a measure which current practice can be compared to. For the study the aspects of care that form part of the standard of delivery of care under standard are further explored in relation to the conceptual framework given below that guides the research and the research tool.

For the purpose of this study, the standard as suggested by Donabedian (1980) is a precise, quantitative specification of the state of a criterion that constitutes quality of a
given degree of excellence in terms of structure, process and outcome to evaluate patient satisfaction with health service rendered by the Crossroads clinic.

1.6 CONCEPTUAL FRAMEWORK

The conceptual framework is a less formal attempt to organise the phenomenon under study and underpins the research (Polit & Beck 2008:142). Burns and Grove (2007:171) define a theoretical framework as “a brief explanation of a theory or those portions of a theory to be tested in a quantitative study”. The conceptual framework forms the basis on which a researcher explains how it guided the choice of study methods and procedures followed in the study. At the end of a study findings are often interpreted within the context of the conceptual framework.

In this study, the research questions and objectives were based on the Donabedian model of structure-process-outcome (1980), as cited by Stanhope and Lancaster (2004:450), formed the basis for the study. The Batho Pele principles and Patients’ Right Charter were used as well and will be discussed in detail in chapter 2.

According to Burns and Grove (2007:37), in various studies assumptions are embedded in the philosophical base of the conceptual framework, study design and interpretation of findings. Assumptions that influence the logic of this study are briefly discussed below.

1.6.1 Assumptions

Assumptions are basic principles that are assumed to be true based on logic and reason, without proof or verification (Mouton & Marais 1994:11; Polit & Beck 2008:13-14). Sources of assumptions include universally accepted truths such as theories, previous research and nursing practice. The recognition of assumptions by the researcher is strength and not a weakness. The recognition of assumptions leads to a more rigorous development of the study. To this end ontological, epistemological and methodological assumptions were posited in this study.
Ontological assumptions, according to Mouton and Marais (1994:11-12), refer to the study of being or reality. The ontological assumptions regarding reality underlying this study are the following:

- A patient is an individual human being with personal health needs and expectations.
- Patients’ health care needs are often fulfilled within an organised health care system of service that is fair and that meets their needs to their expected satisfaction.
- Patients have a right to receive quality care from competent health service providers.

Epistemological assumptions are statements that embody the ideal of science, namely the quest for knowledge and truth (Mouton & Marais 1994:14-15). In this regard, the epistemological assumptions are as follows:

- The patient satisfaction questionnaire is useful as an objective tool to collect data.
- The Batho Pele principles are fundamental guidelines on how patients should be treated with courtesy, respect and dignity in PHC settings.
- The use of standards such as structure, process and outcome is comprehensive enough to evaluate the quality of care given to patients in a clinic setting.

Methodological assumptions, according to Mouton and Marais (1994:15-16), concern what may be called the how of research. In other words, how should research be planned, structured and executed to comply with the criteria of science. These assumptions refer to the logic of implementing scientific methods in the study of reality. Methodological assumptions regarding this study include the following:

- Quantitative research is most often associated with precise measurement and quantifying of phenomena and involves rigorous and controlled research designs (Polit & Beck 2008:729).
Survey studies, as in this case on patient satisfaction, are helpful to obtain information concerning views, beliefs, opinions or ideas through direct questioning by use of questionnaires.

Quantitative studies are based on theoretical or conceptual frameworks.

Use of random samples prevents contamination of data by the researcher’s values, feelings, opinions, experiences and personal perceptions.

Quantitative research employs deductive reasoning which moves from the general premise to a particular situation or conclusion (Burns & Grove 2007:17).

Burns and Grove (2007:37) conclude that assumptions are embedded (unrecognised) in thinking and behaviour, and uncovering these assumptions requires introspection and a strong knowledge base in the particular field of study.

1.7 RESEARCH DESIGN AND METHODOLOGY

Quantitative research is a formal, objective and systematic process in which numerical data is used to obtain information about the world, usually under conditions of considerable control (Burns & Grove 2007:17-18). A quantitative, non-experimental, explorative and descriptive study was conducted to determine the perception of patients about the quality of health care provided at the CHCC at Crossroads.

The population for the study included both male and female adult patients who have attended the clinic or health care centre more than once for health care. The researcher used convenience sampling to select the sample for the study from one large clinic. Data was collected using a structured questionnaire, with the help of two volunteers over three days. A structured interview questionnaire was used to elicit information from the respondents in order to assess patient’s satisfaction with the health care services provided by the health care institutions. Data was analysed using descriptive and inferential statistics. The researcher, with the help of a statistician, calculated the frequency distribution of attendance for services at the clinic, as well as percentages and measures of central tendency such as the mean and standard deviation. A statistician was consulted for assistance on the use of the statistical software computer package for data analysis. Analysis was done at a significance level of 5%, at a p value
of 0.05 (at a 95% confidence level) and 1 degree of freedom. The following statistical analysis tests were performed: one sample median test, 2 tailed tests, and the reliability scales of all the variables (Polit & Beck 2008:574-576; Polit & Hungler 1995:18).

1.8 ETHICAL CONSIDERATIONS

Ethical considerations refer to procedures that are followed to protect the rights of the institution and the respondents and to ensure scientific integrity (Polit & Beck 2008:170).

The researcher endeavoured to protect the rights of the institution by:

- Obtaining permission from the Department of Health in the Western Cape (see Annexure C), management of the Crossroads clinic and the Research and Ethics Committee of the Department of Health Studies at Unisa (Annexure B).

Plans were put in place to protect the rights of respondents by

- obtaining a written informed consent from all the respondents who volunteered to participate in the study. Anonymity, confidentiality, respect, dignity and privacy of all respondents were ensured. Respondents were informed that they could withdraw from the study whenever they wanted to, and that no threats would be imposed on such individuals.

Scientific integrity

- Scientific integrity was maintained by acknowledging all the sources referred to in this study. Plagiarism was avoided and data was handled with honesty with regard to any fabrication of information provided by the respondents.

1.9 STRUCTURE OF THE DISSERTATION

The dissertation has been divided into the following chapters:
Table 1.1 Structure of the dissertation

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Content description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction and overview</td>
<td>Overview of the research problem, purpose, questions, objectives and significance of the study. Introduction of the theoretical foundation of the study and research design and method</td>
</tr>
<tr>
<td>2</td>
<td>Literature review</td>
<td>An in-depth review on the literature related to the topic under investigation to give the researcher information on what is published or discussed in the literature about the phenomenon and the theoretical framework</td>
</tr>
<tr>
<td>3</td>
<td>Research methodology</td>
<td>The overall plan for addressing the research question, objectives, data collection and analysis methods, ensuring validity and reliability including the ethical considerations</td>
</tr>
<tr>
<td>4</td>
<td>Data presentation and analysis</td>
<td>Presentation, analysis and interpretation of the research findings</td>
</tr>
<tr>
<td>5</td>
<td>Conclusion and recommendations</td>
<td>Discussions, conclusions and recommendation based on the research findings</td>
</tr>
</tbody>
</table>

1.10 CONCLUSION

This chapter gives introductory information regarding the entire study. The chapter highlighted the overview of the study. The background information to the research problem of patient satisfaction with the PHC service at Crossroads CHCC was discussed. The aim, objectives and research questions were also presented in this chapter.

The study aimed to explore and describe the patient satisfaction with health services at Crossroads CHC. A definition of key concepts was provided in this chapter as well as the concepts that would form the framework for this research. The chapter concluded with an overview of the ethical aspects that have been considered in this research and information on the organisation of the dissertation into the five chapters it comprises.

In chapter 2 a review of literature on the phenomenon under study and the conceptual framework suggested as a basis for the study are presented.
CHAPTER 2

Literature review

2.1 INTRODUCTION

This chapter discusses the literature review conducted for the study. Literature review is an important function as it adds much to the understanding of the research problem and helps place the results of a study in perspective (McMillian & Schumacher 2006:75). In this chapter a literature review on patient perspectives of the health service in South Africa was done. The quality improvement approach and monitoring tool was examined and the legislative framework explored.

The literature review done in this study was about linking findings in the literature about PHC principles, quality health care and patient satisfaction. Global literature from overseas, national and local literary sources regarding assessment of patient satisfaction with health care services was reviewed.

2.2 PRIMARY HEALTH CARE

PHC was designed at the World Health Organization (WHO) conference held at Alma-Ata in 1978 as a health care approach to lower morbidity and mortality rates of unnecessary and preventive illnesses and conditions (WHO 1979:8). The philosophy of PHC includes the following principles, namely equity, accessibility, affordability, availability, effectiveness and efficiency. These principles were converted into reality aspects of care to measure the quality of health services provided (Lee 2005:3).

Tshabalala (2002:25) states that the assessment of the key performance of PHC clinics and a comprehensive view of how a clinic really functions should be considered using the PHC principles. The WHO in 1979 and in 2008, including Green (1999: 53) research studies in the developing countries with regards to PHC evaluation; support the view that PHC service evaluation should be related to the application of these
principles. The users of the service should be involved in the process of evaluation. This process of evaluation of a PHC service was explored due to the fact that the concept of PHC had been broadened to encompass a philosophy that went much further than the simple provision of first contact services with health care providers. Community involvement is vital if PHC was to make a significant impact on the health status of communities. This same view was echoed in 1996 by Gilbert, Selikow and Walker (1996:107). The goal of PHC is to develop substantial, rapid and inexpensive improvements in the delivery of preventive and curative services at the community level (Van Rensburg 2004:28-30). This study has explored that area of evaluation of PHC principles at the Crossroads CHCC to assess patient satisfaction with the quality of the health service provided since there is a direct relationship between patient satisfaction levels, the quality of care, and the patient’s overall health status (Simon 2003:1; Evans 2008:19).

2.2.1 Global view of PHC

Europe and Asia

Since the declaration of PHC at Alma-Ata the health care in most countries has generally improved, as evidenced by the increased life expectations, lowered mortality rates and higher standards of living (Hattingh, Dreyer & Roos 2007:83). The declaration of PHC challenged the world to embrace the principles of PHC as the way to overcome gross health inequalities between and within countries (Lee 2004:2).

At a health care conference in Europe hosted by the WHO in 1985 it was reaffirmed that PHC was to be the most important part of Europe’s health system. Since the adoption of PHC principles in 1978 the health care of people in Western Europe has improved steadily while it remained stagnant for people in Central and Eastern Europe due to the poor application of PHC principles (Koop, Pearson & Schwarz 2002:38, 42).

According to the author’s research, health care in India has also seen success since using the PHC approach in the area of communicable diseases, for example in malaria eradication. The substantial improvements were found mainly in four areas, namely

**Sub-Saharan Africa**

Central to the work of Skolnik from the World Bank and WHO (2008:13,19) is the notion that studies done in developing countries such as Philippines and Sub-Saharan Africa indicate the strong link between PHC, health development, human development, labour productivity and economic development.

At the Sixtieth WHO assembly in 2007 the outgoing president, Dr Garrido, stated that on the Africa continent, countries such as for example Mozambique have achieved significant health gains with decreased mortality rates in infants and children and that some endemic diseases were under control. The focus of continuing improvement of the health status of Africa and the world should be the emphasis of a PHC health delivery system. Countries should move forward with the conviction that the Alma-Ata declaration on PHC is still valid and that the PHC approach is still very appropriate (Steyn 2007:13) for the improvement in health status.

The overall objective of PHC is seen as, the improvement of the health status of a defined population. It has been noted in literature and documented research at the WHO that, PHC has contributed more to the greatly improved health status of nations (Tlou 2005:2).

**2.2.2 PHC in South Africa**

Since 1994, PHC has been held to be the backbone of health care in SA (Heunis, Van Rensburg & Claassens 2006:37). The aim of the national government after 1994; was the improvement of health of all the population groups they served and responding to the people’s expectation of a quality heath care service (WHO Report 2000:8). The delivery of good quality PHC services was the way forward to achieved, health
improvement for all the people (Barron 2000:3). In South Africa, the public health sector is the main provider of primary health care and serves the 80% of the population who cannot afford private health care (Ward 2006:2). The PHC services are the foundation of the health system in South Africa and more specifically in Crossroads, where activities need to take place with regard to prevention of illness, the promotion of good health and treatment of disease (Skolnik 2008:75).

PHC is seen internationally and nationally as the foundation of an effective and efficient health service as it is frequently the first point of contact between the patient and the health service for the majority of the population. PHC efficiencies or deficiencies of delivery of health care impacts on the entire health system, therefore on the health status of patients who attend at Crossroads CHC (Summary Comprehensive Service Plan for Implementation of Healthcare 2010 2007:3).

With the majority of the population of South Africa having inadequate access to health care, the district health system has been introduced as it is a vehicle for providing quality primary health care to everyone (Norms, Standards and Practice 2005:1).

2.3 DISTRICT HEALTH SYSTEM

The district health system (DHS) is defined as a system of health care in which individuals, communities and all the health care providers of the area participate together in improving their own health (The Department of Health 2000:3). The DHS is the administrative level closest to the patient and provides the context within which the planning, management and implementation of health services takes place. PHC is the strategic approach guiding the DHS (Gwagwa 2004:20).

Rall and Meyer (2006:15) state in their research that the major policy objectives of the new government was to develop a DHS focused on the delivery of good quality PHC to all citizens that was based on the principles of providing health care, namely to be equitable, accessible, affordable, available, effective and efficient, incorporating patient satisfaction. Gwaqwa (2004:21) highlights that the DHS was introduced for the following reasons:
• To try to meet the health care needs of everyone who came to the clinic
• To provide a simple, logical service by integrating the health services
• To focus on improving health to really improve the quality of care
• To involve people in improving the services they use by expressing their dissatisfaction, or by helping to plan and implement better services

As seen in the studies conducted by Barker and Klopper (2007:36) in the Muldersdrift area, there was minimal success in the implementation of the PHC strategy. The study that was done by Leech, Van Wyk and Uys (2007:91) indicates that the health care service delivery at the PHC level suffers from significant inadequacies, and this was also documented in the research by Heunis et al (2006:37). The improvement in service delivery of PHC services at grassroots has been disappointing (Department of Health 2004:11)

The South African Constitution recognises the right of access to health care services. As has been noted from research mentioned above, inadequate access to basic health care services still plagues the lives of the majority of people in South Africa (Pillay 2002:1, Mpshe 2010:6). It is estimated that at large, PHC visits per person increased from 1.8 per year in 1992 to 2.3 per year in 2001 and in some provinces to 3.5 visits in 2003 (About South Africa Health 2005:3). The sad part is that, despite so many users of the health service, it is unfortunate that not a lot of research has been done to assess patients’ satisfaction with the health services in Crossroads.

2.3.1 The dual role of the District Health System and the primary health care principles

The DHS is the vehicle for providing quality health care to everyone in a defined geographical area (Gwagwa 2004:20) and the central purpose of the DHS is in keeping with the Alma-Ata PHC principles. Heunis et al (2006:38) state that the policy objectives of the DoH refer to priority health programs for the prevention and promotion of the community’s health. This is achieved by community involvement, their perception of
care received, and the quality of PHC services for the better health of the community (Hattingh et al 2007:62).

According to Wagstaff and Claeson (2004:61), simply redirecting the health service towards PHC programs and interventions will not necessarily result in lowering child and maternal mortality rates, for example, because despite these health care interventions, the health service providers have failed to deliver quality care (Pillay 2002:1; Mpshe 2010:6) that ensures access to such health services. These authors (Wagstaff & Claeson 2006:61) are of the opinion that the redirecting of the health service to PHC needs to be backed up with measures to improve the performance of PHC clinics.

These views are not new, as the WHO Quality Assurance Group in 1989, reported by St Leger, Schieden and Walsworth-Bell (1994:4), stated that four components are needed to be considered when improving quality care, of which one is patient satisfaction with the service provided. From this it is clear that satisfaction with quality of health care is important as it indicates compliance with treatment and positive health outcomes for the patient (O’Conner 2004:8).

The core functions of the DHS are assessment, policy development and quality assurance. The DHS is the foundation of the health system because at this level PHC principles are implemented (Hattingh et al 2007:88).

A diagram; showing how the components of PHC, the principles underlying the DHS and the pillars of the DHS all fit together, is shown on figure 2.1.
Figure 2.1 The PHC and DHS diagram
(Venter, Alexander & Rendall-Mkosi 2002:120)
2.3.2 The implementation of the District Health System in Crossroads

The components of a health programme at the PHC level includes the promotion of adequate nutrition and water supply, provision of basic sanitation, maternal and child care, family planning and appropriate treatment of common disease and injury (Hattingh et al 2007:61).

The types of PHC services rendered to patients at Crossroads are as follows: pediatrics, adult preventive and curative care, HIV/AIDS services, 8-hour emergency trauma care and nutritional services. The clinic has a reproductive health care clinic, a sexually transmitted infections clinic and a tuberculosis clinic. The referral hospital is the GH Jooste Hospital and at the tertiary level patients are referred to the Groote Schuur Hospital. The Department of Health (2001) states that a quality PHC service through the DHS should:

- respond to the health needs of the community. PHC helps the providers to view people as a whole and brings the services together in a one-stop shop. This approach will ensure that the service is concerned with people’s health in totality and not disease only, and that there are clear systems of referral

The DHS consists of facilities rendering health that includes the first level of health care. The Crossroads community is served by the CHCC that offers eight hours service from Monday to Friday. The clinic falls under the Klipfontein District. The first point of contact between the patient and the health service (DHS) is the PHC CHCC at Crossroads (Summary Comprehensive Service Plan for the implementation of Healthcare 2010 2006:2).

Quality health care delivery is central to the DHS, and is seen in the legislative policies and directives; the Batho Pele principles (Batho Pele White Paper on Transforming Public Service Delivery 1997) and the Patients’ Rights Charter (De Haan 2005:19) give credence to this. This aspect is discussed in the legislative framework later in the chapter.
A clear understanding of the health needs of Crossroads community is needed in order to determine whether PHC services respond first and foremost to the general health needs. It is essential to have accurate information when establishing the customers’ needs and priorities (Department of Health 2001:7). A community assessment should be undertaken to compile a health index of the community and ultimately to determine the health needs of that community. Through the assessment of the community, health priorities are highlighted and services may be planned and rendered in accordance with these priorities so that the health status of the community can be improved (Hattingh et al 2007:128).

2.4 PATIENT PERCEPTION OF HEALTH CARE

Central to the provision of a quality service is an assessment of the extent to which patients are satisfied; whether they perceive the service as meeting their health needs (Thomas 2000:15; Evans 2008:19, 172-173). Patient-centered outcomes have taken centre stage as the primary means of measuring the effectiveness of health care delivery and it is commonly acknowledged that patients’ reports of their satisfaction with the quality of services are as important as any clinical health outcomes measures (McLaughlin & Kaluzny 2004:130).

Research done by Myburgh, Geetesh, Smith and Laloo (2005:1) revealed that research examining patient satisfaction with health care provision in South Africa and more specifically the perceived quality of care given by the health care providers is limited. The national surveys conducted in South Africa have highlighted the levels of satisfaction according to race of patients attending public and private sector health providers. In 1994 a national survey showed that only 48% of White respondents reported receiving excellent services compared with 26% of Africans and 24% of Coloured respondents. A survey focusing on non-white races in 1998 found that in the public sector 26% of Indian respondents were dissatisfied with services provided at clinics compared with 12% of Black respondents (Myburgh, Geetesh, Smith & Laloo 2005:1).
Anecdotal evidence from the Argus news reporter Cawe (2009:3) states that patients had harsh criticism over the sidelining of communities on major decisions and poor service delivery at Community Health Centre’s; quoting “we are not impressed by what we (the communities) see” as the deteriorating level of health service delivery at health centre clinics and the lack of quality patient care.

Newspapers report of patients complaining of poor health service delivery, citing long queues, abusive health personnel, lack of care and respect, amenities such as benches not available and, poor record-keeping. These are common complaints given by patients attending the Community Health Care Centre’s (Maposa 2009:11, 12). It is evident that people are driven to seek or not to seek health care by the reputation of the health care service provider (Skolnik 2008:101). One of the measurements of evaluating health care quality is using patient satisfaction; as noted it reflects outcome measurement of quality (Bediakp, Nel & Hiemstra 2006:12).

Carrying out customer satisfaction surveys among the users of the health care services will prove to be helpful to the providers to enhance their care and thus improve the health status of the community, in this study being the Crossroads community (Skolnik 2008:74, 84, 85).

Studies by Press Ganey Associates (St Johns 2007:1) have reached the conclusion that there is a direct relationship between patients’ satisfaction levels, the quality of care and the overall health status of the patient. Satisfied patients respond more positively to medical management and experience better clinical outcomes (Simon 2003:4) than those that are dissatisfied with the quality of care given.

2.5 WHAT IS PATIENT SATISFACTION?

Patient satisfaction is the level of satisfaction that patients experience after having used a health service. It is of fundamental importance as a measure of the quality of care because it reflects the difference between the expected services and the perception or actual experience of the service (Guide to Measuring Client Satisfaction 2008:20).
Patient satisfaction studies done in other countries such as England, on this phenomenon, state that patient-centred care has become vital to current health policy and whether or not the health care service providers are succeeding in putting this into practice (Hunt 2008:16). According to Hunt (2008:16) studies done in England’s health service require that more needs to be done to address shortfalls in the area of health care delivery with regard to patient satisfaction with the quality of health care received.

In Northern India village people have little faith in the quality of staff at the government clinics due to staff attitudes, poor infrastructure and follow-up and will rather go to a provider that is reputed in their community to have good health results than a provider who does not enjoy this type of reputation of offering good quality health care service (Skolnik 2008:101). The emphasis on patient satisfaction with health care delivery is an important measure of experience with the health care system as reported in Canada, America and Europe (St Johns 2007:1). In Swaziland the people who attend the clinics have little faith in government clinics due to staff mistreatment of patients and the lack of medical resources. It was noted from patient satisfaction surveys done about the quality of health care service that there is a need to improve the quality of health care services (Mngadi, Thembi, Ransio-Alvidson & Ahlberg 2002:38).

If quality is about people then a framework for providing quality health care service must be capable of satisfying the requirements of purchasers of that care and should include the opinions from the users of the health service (Thomas 2000:12). According to Donabedian (1980), as far back as 1968 it was emphasised that: patient satisfaction is of fundamental importance as a measure of the quality of care because it gives information on the provider’s success at meeting those client values and expectations which are matters about which the client is the ultimate authority (Donabedian 1980:22).

One of the measurements of health care quality is patient satisfaction. Satisfaction is most often conceptualised as a multi-dimensional construct that includes distinct aspects of patients’ encounters with the health care system. However, perception of quality can be subjective and therefore patients tend to value the appearance of the service environment, privacy and respectful treatment as quality service (Raney, Joyce & Townsend 2003:1). This view by literature on patient satisfaction is acceptable for this
study and will include aspects of care that can be assessed, such as interpersonal, technical and amenity aspects of a health care system (Strommel & Willis 2004:238).

There are various reasons why health care professions should take patients’ satisfaction seriously.

- They reflect an outcome measurement of quality and a means to improve service to the public by identifying areas of improvement (Bediakp et al 2006:12, McLaughin & Kaluzny 2004:129).
- Patient satisfaction measures patients’ perceptions on quality of care aspects (Shane 2004:3).
- Patients' satisfaction measures the extent to which a client’s expectations for a good or quality service are met (Guide to Measuring Client Satisfaction 2008:2).
- The use of patient satisfaction surveys as a quality control measure has been discussed and is seen as essential as it refers to the evaluation of activities and service rendered, allowing the organisation to apply corrective strategies to improve health care (Hattingh et al 2007:128) which can be assessed using the patient satisfaction questionnaire (Helminen 2002:2).
- Patient satisfaction surveys tell the provider and the patients how well their health care needs are taken care of (St Johns 2007:1).
- Patient satisfaction studies are not an end in themselves but are a means to improve service to the public. Patient satisfaction measures are often used in studies of interventions that are designed to have an effect on patient health status and quality of life (Strommel & Willis 2004:238).

2.5.1 Patient satisfaction surveys

The patient satisfaction surveys serves two purposes for the community: it identifies areas of improvement in the quality of the services offered and highlights the need for corrective actions when patients’ expectations exceed what the service can afford to offer or what it is supposed to provide (Hattingh et al 2007:128) for the Crossroads community.
Patient expectations

Rall and Meyer (2006:16) are of the opinion that patient expectations are a means to elicit community input and that if you want to know what the patients want from a health service, ask them. It is important to have the skill to know what questions to ask. Satisfaction with health care services is influenced by the patient’s pre-existing expectations. Before entering a clinic, most patients have more or less precise expectations of the level and quality of service that it should be providing. These expectations may not be in line with what the PHC service is or should be delivering or what it can actually provide, given the resources available. However, different factors contribute to determining patients’ expectations such as education, age, occupation, cultural background, personal health needs, past experience with the service, and what they hear from other users (Knight 2008:40).

Regular usage is another key element in shaping patients’ expectations because people who use a health service regularly tend to have a more accurate expectation from that service than those who seldom use the service. According to Stanhope and Lancaster (2006:291), factors that are important in the perception of patients on quality expectations include the following: the outcome of treatment and care, the attitude of staff, the time made available to them and the nature of the environment. The actual experiences or perceptions of the patients about the service are influenced by the various dimensions of service quality that patients expect, such as reliability, responsiveness, empathy, assurance, access and general satisfaction (Guide to Measuring Client Satisfaction 2008:20). Simon (2003:3) and Rall and Meyer (2006:18, 20) identified more factors influencing patient expectations which are staff sensitivity to patient needs, cheerfulness of practice, care received during the visit and proper referral system. This upgrades the health services to be acceptable, and positively influences patient behaviour changes towards their health care.

Health service
Health service institutions are not merely structures that house people that work there or patients that attend the service, but also consist of the building, infrastructure, equipment and supplies without which no institution can provide an effective and efficient service (Geyer 2005:42).

Various studies done by Uys, Bhengu and Majumdar (2006:25); Rall and Meyer (2006:10) and Bediakp et al (2006:12) on PHC delivery in different South African areas, reflect that a health service should incorporate the PHC principles of accessibility, affordability, equitability, availability, effectiveness and efficiency, in order that optimal health for patients and communities is realised.

If the health service wants to satisfy a specific health need of a patient, and to ensure that the delivery of PHC services are successfully done, the PHC principles have to be implemented (Rall & Meyer 2006:19). Rall and Meyer (2006:18) have the opinion that patients will reject a service if they see one feature of that health care service as substandard. By empowering patients to make informed decisions about their health and by changing health behaviour to improve their health, the health services can create a climate that is conductive to health decision-making in this regard by ensuring a quality health care service delivery. The quality of health service should therefore have to exceed patients’ expectations.

Care of the patient is seen as the fundamental aim of health services and the assessment of the patient’s satisfaction is an important part of the management of a health facility as seen by the national and local DoH adopting of the Batho Pele principles and Patients’ Rights Charter (Smith & Engelbrecht 2001:2). The variables formulated on the data collection tool, the patient questionnaire, is link with the PHC principles, performance model guidelines, the Batho Pele principles (Batho Pele White Paper on Transforming Public Service Delivery 1997) and the Patients’ Rights Charter (White Paper on the Transformation of the Public Sector 1995) and therefore was utilised and expanded on for this study.

Smith and Engelbrecht (2001:1) support the fact that taking cognisance of the variables can significantly influence the patient’s perception of the health service rendering care.
If the health service meets or exceeds expectations then the client is satisfied. If the health service does not meet the expectations then the client is dissatisfied. Defining the questions that would assess patient perceptions on the major variables of satisfaction as identified as important to them as patients (Guide to Measuring Client Satisfaction 2008:2) and supported by the literature review, guided the format of the questionnaire.

In evaluating the quality of a health service, it is the sum total of the patient perception of that service that will count, as seen in the study of Rall and Meyer (2006:22), which indicate that patients' positive perception of health services will improve their health outcome. The quality of care is definable through a measurable set of variables. This will be further explored below using the Donabedian structure-process-outcome approach (1980) as cited by Stanhope and Lancaster (2006:293). This approach will be used to assess patient satisfaction with the health service rendered by the Crossroads clinic. With this approach, the study highlights the link with PHC principles and the performance model that guides this study.

2.6 UNDERSTANDING QUALITY HEALTH CARE

The focus on quality health care is seen as a means of achieving better performance of the health centre. The goals are improved health status, better clinical outcome, greater access to care, and improved satisfaction of patients and communities (Evans 2008:12, 19).

Quality is a continuous striving for excellence in health care delivery while adhering to set specifications or guidelines (Stanhope & Lancaster 2006:286).

Quality has a dimension of service specifications such as waiting time, staff attitudes, whether a service is performed consistently and as promised, and whether the service is accessible (Evans 2008:17). According to Bowling (2009:7) there is an added dimension to the service specifications which can be evaluated with regard to equity, accessibility, appropriateness, effectiveness, acceptability and efficiency. Given the quality characteristics, PHC principles and the performance model are seen to be
interrelated and this is set forth by means of the Donabedian model (1980) of Structure-Process-Outcome (cited by Stanhope & Lancaster 2006:293). This approach with the variables of the questionnaire has been placed in the relevant sections as will be seen in the questionnaire and discussed in chapter 3.

2.6.1 Approaches to quality assessment

The most commonly used model to assess quality of patient care was proposed by Donabedian back in 1980 as Structure-Process-Outcome (Kimberly & Minvielle 2000:24; Smith & Engelbrecht 2001:5; Foster 2004:379; Stanhope & Lancaster 2006:293; Guide to Measuring Client Satisfaction 2008:5; Bowling 2009:11). Bowling (2009:16) reiterates that the evaluation of health services is based on collecting data about the structure, process and outcomes of services. Kimberly and Minvielle (2000:24), state further that the role of quality assessment is to define relevant requirements and to design and implement a method to assess whether an institution is meeting these requirements or not.

For the purpose of this study, following the literature review of previous research on evaluation studies, the Donabedian model (1980), cited by Stanhope and Lancaster (2006:293) for the three key methods for evaluating health service delivery was used. This study was concerned with assessment of the quality of PHC for the Crossroads community as delivered by the Crossroads CHCC. To achieve this, the conceptual framework that uses the Donabedian model of Structure-Process-Outcome, as found in the performance assessment tool and within the research done by Smith and Engelbrecht (2001:5) and Bowling (2009:11) was used to answer the research questions and objectives. The link with the PHC principles is seen and incorporated in the model as evidenced in figure 2.2.
Figure 2.2 Donabedien Structure-Process-Outcome Model
(cited by Stanhope & Lancaster 2006:295)
Structure

Structure is a statement of evaluating the settings, resources and facilities used to provide care. It involves identifiable standards (indicators) and criteria (Stanhope & Lancaster 2006:293). The operationalisation of this concept for this study is the accessibility to and safety of the CHCC, comfort and cleanliness of the CHCC environment, the types of services offered, consumables (medication) available and waiting times to be seen by the clinician and at the pharmacy (Bowling 2009:11).

Standards are defined as statements of what constitutes an acceptable level of health care. Criteria accompany standards and describe and explain what needs to be done or to be in place to meet a standard (Norms, Standards and Practice Guidelines for Primary Oral Health Care 2005:1). A list of criteria developed is a screening device to separate between care of doubtful and of probably acceptable quality, when the care provided is compared with an objective for explicit criteria (Helminen 2000:5). By setting the service standards, one set’s out to improve the quality of PHC delivery (Heunis, Van Rensburg & Claassens 2006:38). The service standard is reflected within the Batho Pele principles (Batho Pele White Paper on Transforming Public Service Delivery 1997).

Tshabalala (2002:25) conducted a study that customised the model proposed by the WHO at the conference in 1978. This model had incorporated PHC principles together with the Donabedian model of Structure-Process-Outcome (Stanhope & Lancaster 2006:293), and was adapted to guide this study.

The quality characteristics that were used for the questionnaire have been supported by research derived from Sale (2000:57), Maylor (2003:166), Rall and Meyer (2006:18-23); and Skolnik (2008:83), together with the Patients’ Rights Charter (White Paper on the Transformation of the Public Sector 1995) and the Batho Pele principles (Batho Pele White Paper on Transforming Public Service Delivery 1997). The element of structure is closely related to the PHC principles which are:

- Effectiveness
The extent to which a programme, activity, service or treatment achieves the result it aimed for, that is, positive change in the population’s health. It denotes the ability of the clinic to intervene in patients’ health, to work for everyone who might need it, getting the best possible outcome.

- **Acceptability**

This principle deals with ensuring that services are delivered in a culturally competent fashion that is paramount for effective uptake and utilisation. Services may need to be tailored to reflect different socio-economic and ethnic backgrounds and different age ranges. For this study the principle aims at encouraging patients to adhere to treatment and care provided and to seek health care when needed because it is humanely and considerately offered in a therapeutic setting.

- **Efficiency**

This refers to the proper and efficient use of resources and ensuring that service is well-organised, managed and provides value for money. It is the best possible health outcome at the lowest cost. For the purpose of this study efficiency is investigated with regard to the variables of treatment plan, proper referral routes and whether medications are readily available.

- **Accessibility**

This concept is concerned with ensuring access to services that are free at the point of delivery. This implies that patients can get service when they need it and that there are no barriers to the service such as distance, inability to pay, waiting times and transport to access the service. (Refer to the questionnaire where these have been dealt with in the various sections).

- **Affordability**

No person should be denied health care because of an inability to pay.
PATIENT CARE

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<tr>
<th>Accessibility</th>
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<th>Availability</th>
<th>Affordability</th>
<th>Effectiveness</th>
<th>Efficiency</th>
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<td>The distance travelled</td>
<td>Languages used</td>
<td>Number of PHC clinics</td>
<td>Time costs to attend the clinic</td>
<td>Basic training and in-service training</td>
<td>Performance indicators</td>
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<td>The general attitudes of health providers</td>
<td>The range of PHC services currently rendered</td>
<td>Effort costs to attend the clinic</td>
<td>Supervision</td>
<td>Disease protocols</td>
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<td>Cleanliness and safety</td>
<td>Personnel, equipment, drug supplies and funds</td>
<td>Travel time</td>
<td>Management</td>
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<td>Staff meetings</td>
<td>Clinical audit and peer review</td>
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<td>Data collection</td>
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Figure 2.3 Performance assessment frameworks to guide a study

(WHO 1978 model, adapted from Dennill et al 1995:6)

These principles of PHC are expanded in detail in the performance assessment model in figure 2.4 as suggested by the WHO (1978) model, adapted from Dennill et al (1995:6).

2.6.1.2 Process

The second method of evaluating care is process. Process is a standard of evaluating activities as they relate to standards and expectations of health providers in the provision and management of health care. It describes the actions required to meet the specifications. The primary approach used for process evaluation is a patient satisfaction survey, as is suggested in this study (Foster 2004:379; Maylor 2003:17;
The process of care has two major components: technical interventions and interpersonal relations between the health care provider and the patient (Mngadi et al. 2002:40). Both are important in providing quality care, and both can be evaluated. This study focuses on the interpersonal relations between patients and staff and the patients’ perception of the quality of care rendered by the Crossroads clinic.

Process is referred to as the actual provision of care by Crossroads CHCC as perceived by patients, involving the consultation process, proper diagnosis and treatment plan. Process includes whether patients have confidence in the quality of care and any other procedures to be rendered by the clinician during the consultation. This concept can be applied in practice in relation to the study as accessibility of the CHC to the community, appropriateness of care rendered and analysis of the process of communication between the health care provider and the patient. This includes the provision of information to the patients about their treatment plans, the procedures followed and documentation thereof in their folders (Bowling 2009:11, 12).

2.6.1.3 Outcome

The third method that forms part of the model is outcome. It is the net change that occurs as a result of health care intervention. That means that health care has either a positive or negative effect on the patient’s health status (Stanhope & Lancaster 2006:295; Maylor 2003:171). The measured perception of outcome is the patient’s perception of the quality of care received from the Crossroads CHCC. A patient satisfaction survey will reflect the outcome measurement of quality (Bediakp et al. 2006:12; McLaughin & Kaluzny 2004:129).

The delivery of a quality health service and care for the patient is the fundament goal for the health service provider. Therefore outcome measurement is an important tool for the reason that outcome refers to the effectiveness of health activities with regard to people’s health as well as patients’ evaluation of their health care and their perspective about that care (Bowling 2009:14).
According to Craig and Lindsay (2000:224), the term outcome has also been used synonymously within the literature as outcome instrument and indicator. This implies that the term outcome instrument is used to denote the tool used to collect data in this study on patient satisfaction as a measure of the quality of PHC rendered in the Crossroads clinic. The outcome tool can be used to quantitatively describe the health of a group of people in a particular setting as well. Bowling and Ebrahim (2006:32) highlight that probably the most reliable and interpretable outcome indicator is that of patient satisfaction.

2.7 THE LEGISLATIVE FRAMEWORK

If health is also related to human rights the health services can impact on people’s health and rights, either positively, for example through affording them access to health care or control over their bodies, or negatively by depriving them access to health care or dignity in the way they may be treated as patients (London 2005:1). Maposa (2009:6) reflects on a newspaper article in which patients state that, “they would rather die at home” than approach the health care centre for help by pointing out that people are driven to seek or not to seek health care because of the reputation of the health care service provider denying them access to health care and the lack of quality offered.

According to London (2005:1) human rights are described as claims that individuals make on society. Therefore human rights are essential for people’s dignity and well-being and are incorporated in the Constitution and Bill of Rights, as in this instance the right of access to good quality health services. This human rights approach implies that rights can be used as a set of standards to develop policy or to monitor and analyse policy in order to hold government accountable. Human rights are also used as a lobbying and advocacy tool to mobilise civil society. This is seen in the Patients’ Rights Charter (De Haan 2005:19) and the Batho Pele policy (Batho Pele White Paper on Transforming Public Sector Delivery 1997:1) that will be discussed under the legislative framework that directs this study.

Government made a commitment to address these inequalities and improve public services, stating that a South African public service will be judged by one criterion
above all: its effectiveness in delivering quality services which meet the basic needs of all South African citizens. The real test of the health system is whether it delivers quality care or not. That is why a patient satisfaction survey is seen as an important feature of a fundamental indicator of success in any form of service delivery and is therefore a key component of such a test (Myburgh et al 2005:1).

Key policies influencing this study are the Batho Pele principles (Batho Pele White Paper on Transforming Public Sector Delivery 1997) and Patients’ Rights Charter (White Paper on the Transformation of the Public Sector 1995) that serve as an effective tool to gauge the quality of care rendered at Crossroads community. Chosen indicators from this legislative policy have been linked to the measuring of patient satisfaction with health services (Department of Health 2001:110; Guide to Measuring Client Satisfaction 2008:4).

2.7.1 What is Batho Pele?

Batho Pele is the name given to the government’s initiative to improve the delivery of public services. Batho Pele means in Sesotho, “People First”. The name was chosen to emphasise that it is the first and foremost duty of the public service (including the health sector) to serve all the citizens of South Africa (Batho Pele White Paper on Transforming Public Service Delivery 1997:1).

Batho Pele deals with communities who are encouraged to participate in planning services to improve and optimise service delivery for the benefit of the people who come first (Department of Health 2001:10). There are standards and criteria that were developed to serve as an acceptable policy and legislative framework regarding service delivery transformation in the public service. These eight standards and criteria encompass the PHC/DHS principles as demonstrated in figure 2.3. This is within the framework as discussed in the Structure-Process-Outcome section.

The Batho Pele principles are as follows:
Consultation: Communities will be consulted about the level and quality of public service they receive and where possible will be given a choice about the service offered. The way to consult users of services includes conducting customer surveys and holding meetings.

Service standards: Citizens will know the level and quality of public service and what to expect. This principle reinforces the need for benchmarks to constantly measure the extent to which citizens are satisfied with the service they received. The standards are precise and measurable so that users can judge for themselves whether or not they are receiving what was promised.

Access: All citizens have equal access to the service to which they are entitled.

Courtesy: Citizens should be treated with courtesy and consideration.

Information: Patients should be given full and accurate information about the public service they are entitled to receive.

Openness and transparency: They should be told how national and provisional departments are run, how much services cost and who is in charge.

Redress: If the promised standard of service is not delivered citizens should be offered an apology, an explanation and an effective remedy. When complaints are made, citizens should receive an empathetic positive response.

Value for money: Public service should be provided economically and efficiently in order to give people and communities the best possible value for money.

(City of Cape Town July 2009:6).

Through the Batho Pele policy, together with the Patients’ Rights Charter, significant efforts have been made by the government to improve patient care (Department of Health 2004).
2.7.2 The Patients’ Rights Charter

The purpose and expected outcome of this charter and complaints procedure is to deal effectively with complaints and then to rectify service delivery problems and so improve the quality of care, raise awareness of rights, responsibilities and expectations and give empowerment to the users (Department of Health 2001:110).

This empowerment leads to improving the use of services and developing a measuring tool to assess the quality of health services. This document sets the standard for quality patient care and informs both the patients and the health care worker of their rights. It balances the rights and the obligations of the patient and sets the basic standards of good patient care for the health worker to attain (De Haan 2005:19). Table 2.1 is the tabulated version of the patients’ charter with the rights and responsibilities of patients.

Table 2.1 Patient rights and responsibilities

<table>
<thead>
<tr>
<th>Patients have the right to:</th>
<th>Patient have the responsibility to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ A healthy, safe environment</td>
<td>➢ Take care of their health</td>
</tr>
<tr>
<td>➢ Participate in decision making in health policy development and in issues that affect a person’s own health</td>
<td>➢ Care for and protect the environment</td>
</tr>
<tr>
<td>➢ Access to health care and to health workers who are courteous, empathetic and tolerant</td>
<td>➢ Respect the rights of other patients and health care providers</td>
</tr>
<tr>
<td>➢ Knowledge of one medical aid or insurance scheme</td>
<td>➢ Utilise the health care system properly and not abuse it</td>
</tr>
<tr>
<td>➢ A choice of health service provider or health faculty for treatment</td>
<td>➢ Know the local health services and what the services they offer</td>
</tr>
<tr>
<td>➢ Confidentiality and privacy</td>
<td>➢ Provide health workers with relevant and accurate information regarding their health status</td>
</tr>
<tr>
<td>➢ Informed consent</td>
<td>➢ Advise the health worker of their wishes with regard to death</td>
</tr>
<tr>
<td>➢ Refusal of treatment</td>
<td>➢ Comply with the prescribed treatment or rehabilitation procedures</td>
</tr>
<tr>
<td>➢ Referral to a second opinion</td>
<td>➢ Enquire about the related costs of treatment and rehabilitation and to arrange for payment</td>
</tr>
<tr>
<td>➢ Continuity of care</td>
<td>➢ Take care of records in his/her possession</td>
</tr>
<tr>
<td>➢ Complain about health services</td>
<td></td>
</tr>
</tbody>
</table>

(Adapted from De Haan (2005:19).
These policies, together with the Donabedian model (1980) cited by Stanhope and Lancaster (2004:450) directed this study.

### 2.8 CONCLUSION

This chapter reviewed literature related to the research problem, questions and objectives. The literature review assisted in providing a better understanding of the patient perspectives on what constitutes a quality primary health care service as perceived by patients’ expectations. The link in the literature regarding PHC, quality of care, the Batho Pele principles and Patients’ Rights Charter has been clarified.

The next chapter deals with the research design and methodology used in conducting the study.

**CHAPTER 3**

**Research design and methodology**

### 3.1 INTRODUCTION

Prior to applying the empirical phase of a study, the researcher is required to make a series of decisions about the research design that would be appropriate for the study, methods of data collection that can be used and how data should be analysed (Babbie 2007:378; Mouton & Marais 1994:15-16). The research decisions taken in this study included determining the research context, approach, design and method. The research method included discussions on the quantitative paradigm, research population, sampling and sampling technique, and data collection methods and data analysis. Aspects of validity and reliability of the instrument and ethical considerations were described.

### 3.2 AIM OF THE RESEARCH
The aim of the study was to assess patient’s satisfaction with the health care service provided by the Crossroads Community Health Care Centre.

3.3 RESEARCH DESIGN AND METHODOLOGY

Research methodology refers to the plan, structure, strategy and methods for gathering and analysing data in a study (Polit & Beck 2008:758). It consists of stating in advance the research approach, target population, sampling process and data collection and analysis procedures. Validity and reliability of the research instrument and ethical considerations should also be highlighted (Parahoo 2006:49). The ensuing discussions will therefore briefly introduce the research context, design and methods that have been utilised to answer the research questions and attain the objectives.
3.3.1 Research context

Crossroads CHCC is situated in Cape Town in the Western Cape Province, South Africa and is governed by the provincial government of the Western Cape. The Crossroads clinic caters for the health needs of people residing in the Crossroads communities and the surrounding informal settlements of Boystown. The majority of the patients, who are mostly Xhosa speaking, come from a disadvantaged background. These communities are plagued with social problems such as high rates of unemployment, poverty, poor housing and sanitation, which aggravate communicable diseases such as tuberculosis (TB). The Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) are rife in the community. The context was described in more detail in chapter 2.

Community assessment of Crossroads

What makes Crossroads a community? Stanhope and Lancaster (2004:344) define community as a locality-based entity, composed of systems of formal organisation reflecting society’s institution and informal groups and aggregates. An aggregate is a collection of individuals who have one or more personal or environmental characteristics in common. The community includes three factors namely people, place and function of which two factors, people and place are explained below.

The people of Crossroads

The term “population” refers to people and can be defined according to Hattingh et al (2007:43) as a group of people resident within a specific geographical area. Little information is directly available about the population of the Crossroads area except what is documented in the only governmental paper on the Crossroads area (Aftermath of Struggle: Government Delivery in Crossroads 2003:10). From the census of 1996 the following data was obtained for this study purpose. The population of Crossroads consists of 14 000-15 000 for the two sections in the Crossroads area. The formal and informal settlements were roughly calculated into this total.
The female to male ratio was given as 5:3. The age distribution of the population was indicated as a third to be under the age of 15 years, and a few over retirement age. The socio-economic status of the population was as follows: 44% of the overall population who have gone as far as Grade 8 as opposed to 26% who had no schooling, and 26% who have achieved a level above grade eight. Only about 7% of the overall population as recorded have reached or passed metric. The unemployment figures are estimated to be at 44% to 50% (Aftermath of Struggle: Government Delivery to Crossroads 2003:10). The people of Crossroads could be summed up as follows:

*The majority of the residents are women and youth, with low levels of education and the vast majority unemployed, which fall in the low-income bracket. Figures pertaining to the above income and unemployed status of most of Crossroads' people indicate that income that is generated was expected to go towards basic needs, which includes food and clothing.*

The headcount attendance at the CHCC from 2005 to 2008 ranged from 4 800-8 500 per month (City of Cape Town 2009).

**The geographical area**

Crossroads was established during April 1975 when people were removed from other squatter camps in Cape Town and the Transkei area when that area was planning to become independent (Aftermath of Struggle: Government Delivery to Crossroads 2003:8). A map of the area of Crossroads is indicated in figure 3.1
The area can be described as a complexity of townships and informal settlements lying south of the Cape Town International Airport. The City of Cape Town authorities have been trying to regulate and formalise these settlements with services and housing, but
is falling behind as a result of the rate at which new informal settlements are forming. The cause for this housing backlog, according to the City of Cape Town (June 2009:6), is the waiting list of more than 400 000 and the influx of people from the Eastern Cape in search of employment.

The general area below the airport is congested with the townships and informal settlements. The original settlement (Old Crossroads) of the 1970s has given rise to two more communities, New and Lower Crossroads with the latest addition of Boystown (Aftermath of Struggle: Government Delivery in Crossroads 2003:8). The clinic caters for the people of the above areas rendering primary health care.

The health status of the community of Crossroads

Information on the community forms the basis of planning the number and types of services required to meet the needs of the community (Hattingh et al 2007:86). According to the report on the Aftermath of Struggle: Government Delivery in Crossroads (2003:82), the life expectancy for the population of the poor communities dropped from 55 to 40 by 2009 due to the Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) pandemic and co-infections such as Tuberculosis (TB).

There are no specific figures for the Crossroads community regarding life expectancy with relation to gender or age. The infection rate of HIV/AIDS is reported as 34% for the period 2004-2008 and for TB it was reported to be 38% (City of Cape Town 2006 and Department of Health 2009). The maternal mortality rate (MMR) for Crossroads has not been researched according to locality but for the whole Western Cape health district. The causes for the high MMR has been documented as hypertension in pregnancy and immunological diseases such as HIV-related illnesses and AIDS.

The infant mortality rate (IMR) for the Crossroads community stands at 30.30% (City of Cape Town 2009). The top five causes of infant death are: HIV-related / AIDS, diarrhea and gastro-enteritis, pneumonia, preterm births, low birth weight, ill-defined and unknown causes. The other morbidity and mortality trends of adult deaths are:
HIV/AIDS-related illnesses, assault by firearm, pulmonary tuberculosis, assault by a sharp object and ill-defined and unknown causes (Health Information System Statistics obtained from the Department of Health Information Cape Town: Crossroads CHC 2008).

**Summary of the Crossroads community**

The given data on the community of Crossroads gives an indication of the collective identities such as a high rate of unemployment coupled with poverty, vast areas that are underdeveloped with no sanitation and proper housing, female-led households, a young population with a high incidence of HIV/AIDS and a high TB rate. The data obtained from the patient satisfaction survey will benefit the community in addressing possible obstacles in obtaining or accessing essential primary health care.

**Benefits of a quality health service for the Crossroads community**

According to Jonas (2002) in Stanhope and Lancaster (2006:286), patients and providers of health care have a vested interest in the quality of the health care rendered. This implies that patients play an important role in defining the quality of care by determining what variables should be associated with the health service and that satisfaction can improve the health status of patients who are satisfied with the service (Raney, Joyce & Townsend 2003:1-2; Gwagwa 2009:23).

A key aspect of the PHC approach is working towards the prevention of ill health, therefore making quality health services available at the community level is important (Pillay 2002:3, Zuma 2008:52). Since the CHCC is the first place of assistance that people go to, and the early stages of treating health problems are crucial, it is an essential part of the whole health system (Sanders, Tesoriero & Baum 2002:40; Mochaki 2008:37).

Delivery of quality PHC is essential to this vast community. It is important to have an understanding of the health system. The main functions of a health system are to provide health services to the people they serve, which is prevention, diagnosis, treatment and rehabilitative services; to protect the sick and their families against the
cost of ill health and to carry out key public health functions such as surveillance and assessments of the quality of health care that will help to determine the quality gaps in their care (Skolnik 2008:85, 92).

Health is strongly associated with productivity and earnings. Healthier people can work harder, work longer hours, and work over a longer lifetime than those who are less than healthy. The relationship with poverty is evident, for if people work fewer hours because of ill health, then there is a risk that their income will decline. This is seen in countries where the direct and indirect costs to people of getting quality health services can itself push people into poverty (Skolnik 2008:53; Mpshe 2010:6) and poorer health.

The trend of people of a lower socio-economic status having higher rates of communicable diseases such as TB, illness and death related to maternal causes and malnutrition than people of a higher economic status is seen in the Crossroads community profile. The lower socio-economic status people also suffer from a larger burden of diseases related to smoking, alcohol and social problems related to alcohol (Skolnik 2008:31).

The non-compliance to treatment plans is a serious hindrance to effective health care. It is a gap that occurs between giving out a prescription and the patients actually following their treatment care at home (Pearce 2009:39). This point of non-compliance is seen with communities as Crossroads with high rates of TB and non-compliance to the TB regimen, which requires a strict adherence to treatment, programs (Mpshe 2010:6). Data from the patient satisfaction survey will give a clearer understanding of patients’ expectations of the health service and barriers to accessing the service.

As discussed already, people rely on their health in their everyday lives as their health is one of their major assets, especially for poorer households, and good health is one of the engines of economic growth and poverty reduction in a country (Skolnik 2008:53). The health care providers influence health related behaviors of people in communities (Maposa 2009:4). An example is the way in which health services are organised (hours of operation, waiting times), their amenities and facilities, and the disposition and
integrity of staff (Mpshe 2010:6; De Vries 2009:18). These all make a difference to the community seeking quality health care.

Many poor people do not utilise the health services when they fall ill or they wait until the illness has progressed and they need secondary or tertiary intervention, due to the perception of services not meeting their needs. The calamity of falling sick and, with that, the deprivation of income are some of the difficulties experienced (Wagstaff & Claeson 2004:69-70, 79-80). As seen in the community profile, Crossroads has a community that falls within the lower economic group. The health of those who are employed and the unemployed seeking employment is important to maintain. It is for this reason that improving the health of the Crossroads communities is what the health care centre should be about (Crossroads News One 2006:1).

The nature of services provided at Crossroads CHC

Crossroads CHC delivers PHC services to the community such as adult curative care, rehabilitative care, chronic care management of diseases such as diabetes, hypertension, HIV/ ARV treatment, reproductive care and tuberculosis, social services such as a social and disability grant clinic as well as an 8-hour trauma centre. After-hours trauma is handled at the 24 hour CHCC situated in catchment areas for the Crossroads community that caters for the ante-natal and post-natal care patients as well. The referral hospital for the secondary level of care is called GH Jooste Hospital found on the main transport route and easily accessible by taxi and bus, with a dedicated ambulance service where needed. The tertiary hospital is Groote Schuur Hospital and for the pediatric patients it is Red Cross Hospital.

The total headcount for the period of 2005 – 2006 was between 62 017 and 66 663 patients that visited the clinic for health care, and from 2007-2008, 65 000 – 80 000 patients (Provincial Administration of the Western Cape 2009). For the year 2009 the monthly headcount for the months of January to September was reported to be between 6 667 and 8 877. The average daily attendance for the year of 2009 from January to September was counted at 370 to 453 patients, which includes both children and adults.
3.3.2 Research design

Burns and Grove (2007:38) define a research design as a blueprint or detailed plan of how a research study is to be conducted in a way that maximises control over factors that could interfere with the study’s desired outcome. A quantitative, explorative and descriptive research design was used in this research as the researcher planned to determine to what extent patients of Crossroads primary health care clinic were satisfied with the various aspects of delivery of PHC services they received. A quantitative, exploratory and descriptive survey research design was adopted for the study. The concepts of the research design have been described below.

3.3.2.1 Quantitative research

Researchers using the quantitative research paradigm gather empirical evidence rooted in the objective reality and this can usually be generalised to a wider community (Polit & Beck 2008:16). The quantitative approach to research involves the use of data collection methods such as questionnaires, even though it is not seen as exclusive to the quantitative approach (Parahoo 2006:49, 283).

Burns and Grove (2007:551) define the quantitative approach as the “formal, objective systematic process used to describe and test relationships and examine cause-and-effect interaction amongst variables”. Polit, Beck and Hungler (2001:712) emphasise that quantitative approaches “lend themselves to precise measurement and quantification”. Quantitative studies are characterised by a general flow of empirical activities. Researchers in this paradigm believe that all human behaviour is objective, purposeful and measurable (Burns & Grove 2007:23). Quantitative research uses deductive reasoning to generate predictions that are tested in the real world. In this study the variables on the perception of patients satisfaction with the health care services rendered at the Crossroads CHCC is seen on the data collection tool.

Advantages of quantitative research are that it:
Focuses on a relatively smaller number of concepts and uses structured procedures and formal instruments to collect information (Brink 2006:11).

Provides a general set of orderly disciplined procedures which are used to obtain information. A series of systematic steps are followed in obtaining empirical data that is rooted in objective reality (Polit & Beck 2008:16).

Strives to go beyond the specifics of the research situation by testing the instrument for validity and reliability.

Is easy to analyse numeric information through statistical procedures in this approach (Brink 2006:11; Burns & Grove 2007:16).

Uses a set of orderly and disciplined procedures to acquire numeric information

Uses deductive reasoning strategies in the real world to make specific predictions from general principles.

Numeric information that results from a quantitative type of formal measurement can thus be analysed with statistical procedures (Polit & Beck 2008: 15, 16; Wiersma & Jurs 2009:14, 16).

The emphasis of quantitative research assists researchers to determine facts, relationships, effects and causes with the focus on individuals’ variables and factors (Wiersma & Jurs 2009:14). A traditional scientific approach used by the quantitative researchers enjoys considerable status as a method of enquiry, and has been used productively studying a wide range of problems in various disciplines (Polit & Beck 2008: 16). Quantitative research was used in this study, as it sees the world as stable and predictable and believes that the truth is discovered in common laws, principles and norms. The researcher’s goal was thus generalisability with the focus on objective reality. However, the sample size was too small to generalise the results to broader health care environments. The researcher had a belief that knowledge of the whole can be gained to enable clinicians to make inferences and changes on the smaller programs carried out at the clinic (Hood & Leddy 2003:214).

Disadvantages of the quantitative approach to research are that:
- It is unable to answer the how and why of a phenomenon. It can only answer the “what” of it (Burns & Grove 2007:240).
- It cannot be used to answer moral or ethical questions and no single study can ever definitively answer a research question; given that many moral issues that are linked to health care, it is inevitable that the research process will ever rely exclusively on scientific information.
- Quantitative research tends to focus on human beings who are inherently complex and diverse. They need other forms of enquiry such as qualitative modes to investigate human phenomena.

Accurate measurers of psychological phenomena like hope or self-esteem have not yet been developed by researchers. This means that not all data can be in numeric form (Polit & Beck 2008:16).

However, the quantitative approach was suitable for this study because the extent of satisfaction of patients with the quality of care provided was measured and presented in numerical data:

- It is tabled and compared with findings of other studies on the same phenomenon.
- It is compatible with the resources available, especially time, and is also the researcher’s personal preference.

Quantitative research was the paradigm of choice to conduct this study. The main purpose of applying the quantitative research paradigm in this study was to collect numeric information about the phenomenon under investigation from the respondents using a structured instrument and then to analyse it with the use of statistics (Polit & Beck 2008:16). However, the main intention of using this approach was not to generalise the findings from the sample population to other settings, because of which was not possible because of the sample size.

3.3.2.2 Explorative research
According to Polit and Beck (2008:20-21) explorative research begins with some phenomenon of interest and explores the full nature of that phenomenon. Babbie and Mouton (2001:79-80) state that research is exploratory when the researcher “examines a new interest or explores a topic especially where a phenomenon is persistent”. Polit and Beck (2008:19) add that exploratory studies are useful if the researcher wishes to “assess and understand a phenomenon in a new light, ask questions, and search for new insights”. In this research, patient satisfaction with the quality of the health care services received was explored in order to shed light on the different ways in which patient satisfaction with health care services is perceived, experienced and can be improved.
3.3.2.3 *Descriptive research*

All research findings are ultimately described for the benefit of other scholars and to improve health practices. Quantitative descriptions are made on the extent of the problem, incidence and measurable attributes of the phenomenon under study (Polit & Beck 2008:19). The research was descriptive as it portrayed the characteristics of the community towards the given aspects of care rendered, enabling others to study the research findings and apply it to benefit the community. In this research the findings of the research have been described in chapter 4 and recommendations made in chapter 5.

3.3.2.4 *Survey*

Surveys are used frequently to describe attitudes, perceptions, beliefs, opinions and other types of information (McMillian & Schumacher 2006:25; Wiersma & Jurs 2009:194). After the approach was selected, the appropriate method for gathering data about the variables was decided upon, depending on the purpose of the study (Hood & Leddy 2003:217). A descriptive survey was utilised for this study, as it was appropriate to determine and assess the extent of patient satisfaction with the quality of health care services provided.

3.4 **RESEARCH METHOD**

The research method represents the means, procedure or technique used to carry out some process in a logical, orderly and systematic way (Berndtsson, Hansson, Olsson & Lundell 2008:12). In this study a logical process was followed during the application of scientific methods and procedures to investigate the phenomena under study. The research method utilised included research population, sample and sampling technique, data collection and data analysis, ensuring validity and reliability and ethical considerations.

3.4.1 **Research population**
Polit and Beck (2008:337) define a population as “the total set from which the individuals or units of the study are chosen”. A target population, according to Burns and Grove (2007:324), is the entire set of persons or elements that meet the sampling criteria. An accessible population is the portion of the target population to which the researcher has reasonable access (Burns & Grove 2007:324).

In this study the research population comprises all patients who attend the PHC CHCC at Crossroads for health care. The respondents were selected to meet the following inclusion and exclusion criteria:

**Inclusion criteria**

Burns and Grove (2007:324) explain that inclusion criteria include a list of characteristics essential for membership of the target group. In this study, the following inclusion criteria were used:

- Patients who are 16 years and older
- Both males and females
- Patients should have attended the clinic more than once
- Ability to read English

**Exclusion criteria**

- Children under the age of 16 years
- Mothers or caretakers who brought children to the PHC

3.4.2 Sample

A sample is defined by Polit and Beck (2008:765) as a subset of the population that is selected for a particular study, and the members of a sample are the respondents. There are various types of samples with their advantages, disadvantages and degree of suitability for a particular study. According to Polit and Beck (2008:289) a quantitative
researcher seeks to select samples that will allow the researcher to generalise the results to a broader group. A sample is advantageous because it is more practical and less costly than collecting data from the population. Less time is spent on a sample as compared to larger populations and it gives more in-depth information and a better quality research outcome (Burns & Grove 2007:327). As it is impossible to study the whole research population, an accidental sample of available respondents who volunteered to participate in the study was chosen.

3.4.2.1 Sampling technique

Sampling technique defines the process for selecting a group of people, events, behaviours or other elements with which to conduct a study where the research population cannot be managed because of its size. There are two sampling techniques namely probability and non-probability sampling. The probability sampling technique is used to select research elements or participants randomly where each element in the population has an equal chance of being selected. This is mainly used for quantitative research, where statistics are used to present the results. The non-probability sampling technique is used to select research participants non-randomly. Examples of the sampling approaches under this technique include purposive, quota, convenience, snowball or network and judgmental sampling approaches. In non-random sampling elements are selected based on their contribution to data required (Burns & Grove 2007:40; Polit & Beck 2008:759).

In this study, a non-probability sampling method known as convenience sampling was utilised to select respondents from the population. The researcher used convenience sampling, also called accidental sampling. Respondents were included in the study as they happened to be at the clinic at the time the researcher needed them. Burns and Grove (2007:327) define convenience sampling as the selection of the most readily available people as study participants. Convenience samples are inexpensive, accessible and usually less time-consuming to obtain than other types of samples. This sampling was appropriate for this study and topic because it is commonly used in health care studies and the topic did not need probability sampling methods. The male and female adult patients who attended the clinic were included until the desired sample
size was reached (Burns & Grove 2007:337-338; Polit & Beck 2004:711). According to Polit and Hungler (1995:183) convenience sampling is considered more economical and practical than other types of sampling, particularly when the population is large and widely dispersed. A sample size of 120 respondents was achieved over a period of three days.

3.4.3 Data collection

Data collection is the process of acquiring the respondents and collecting the data for the study to answer the research questions and objectives of the study (Burns & Grove 2003:298). Data was collected by using a structured questionnaire with the help of two volunteers. The volunteers were trained on how to administer the instrument, maintain confidentiality, accurately translate the items into Xhosa to participants that did not understand English without changing the meaning, and how to assist respondents who could not write with filling in the questionnaire. A structured questionnaire was used in this survey research to elicit information from the respondents in order to investigate to what extent patients were satisfied with the quality of the PHC services rendered at Crossroads CHCC clinic. Although the number of patients was adequate per day, data was collected over a period of three days because of the hectic routine at the clinic and patients being anxious not to miss their appointments with doctors. A reasonable number of patients volunteering to participate were therefore available per day. A private office provided with the permission of the CHC managers was used for the respondents to complete the questionnaires. The respondents were informed that consent to conduct the study had already been obtained. All the respondents were informed of what the study was about and its benefits to contribute to the improvement of the quality of care was explained. Informed consent was obtained from each respondent and they thereafter completed the questionnaire. They were assured of confidentiality and anonymity. The researcher and the volunteers were present throughout to answer questions and translate items that were not understood or where needed, as the questionnaire was in English. All the questionnaires were collected by the researcher and kept under lock and key.

3.4.3.1 Data collection instrument
A questionnaire was the method of choice to provide data that would contribute deductively to the phenomena being studied. The study used a quantitative research design with a structured questionnaire with open-ended questions as a data collection method. This method of data collection was in relation to the research questions investigated.

**Advantages of a questionnaire**

According to Bowling (2009:282) the advantages of a questionnaire are that:

- it can be self- or researcher administered and can reach large numbers of people
- the collection of data is at a lower cost than other methods, such as observations
- there is a fair degree of reliability because questions are structured, pre-determined
- closed questions and rating scales can be pre-coded and can easily and quickly be analysed
- in self-administered questionnaires the respondents are anonymous
- there is the absence of the interviewer effect on respondents
- the questionnaire design can be improved by piloting or pre-testing the instrument many times before administering it to respondents, thus increasing its validity and reliability
- it can also be useful for other researchers to borrow and adapt for use in their own studies (Parahoo 2006:298; Burns & Grove 2007:289; Brink 2008:147).

In this study a questionnaire was appropriate to use because of the given objectives to assess and determine patient satisfaction with the quality of the health care services provided.

**Disadvantages of a questionnaire**
The disadvantages of the use of a structured questionnaire as a research instrument in this study were that:

- with the self-administered questionnaire, there was no opportunity to ask respondents to elaborate on, expand, clarify or illustrate their answers

- questionnaires do not suit everyone, in particular those who have difficulty in reading, in comprehension and in articulating written responses (Parahoo 2006:298; Burns & Grove 2007:289; Brink 2008:147; Bowling 2009:282)

The disadvantages were viewed as a legitimate concern regarding the socio-economic status and literacy level of the Crossroads community, as discussed in chapter 2. However, some disadvantages were eliminated by having volunteer assistants who were fluent in Xhosa, English and Afrikaans to assist the respondents.

**Development and testing of the data collection instrument**

A pre-defined structured questionnaire, using the literature review as a frame of reference, was developed by the researcher. Items relevant to this study were carefully selected and included in the multi-choice forced type of questions (Wimmer & Dominick 2009:1). The development and design of the closed-ended computer coded questionnaire was done with the assistance of the statistician and guided by the researcher’s supervisor.

The final questionnaire was discussed with the researcher’s supervisor, statistician and the clinic PHC staff and was accepted in terms of face and content validity.

**Format of the questionnaire**

The questionnaire was structured into six sections that covered aspects on 52 variables. The items on the questionnaire assessed the expectations and perceptions of patients regarding the quality of the health services rendered. Analysis and evaluation of the quality of health services by doing a patient satisfaction survey is well documented in
literature (Smith & Engelbrecht 2001:5). The questionnaire was in English, and the respondents were assisted with difficult parts and concepts were explained in their own language where needed.

The following sections A-F contained the closed-ended questions which provided fixed alternatives. The respondents were required to choose the answer which would be most suitable according to their opinion about the quality of care rendered.

Section A:
Questions related to the demographic information of the respondents

Section B:
This section covered questions related to the patient’s expectations about the environment of the clinic.

Section C:
This section dealt with the accessibility and availability of services.

Section D:
Questions related to the affordability of care

Section E:
Questions related to patients’ perceptions about staff members

Section F:
This section covered the patient’s behavioural choices to the given treatment care plan by the clinic.
Analysis of data covered all the sections indicated on the questionnaire.

### 3.4.3.2 Pre-testing of the Questionnaire

A pre-test is a trial run of a developed instrument to identify flaws or assess that the instrument is properly worded (Polit & Beck 2004:728). For Babbie (2007:257) there is always the possibility of error because of an ambiguous question and this is the reason why the pre-testing of a questionnaire is the surest protection against such errors. Ways of doing pre-testing of a questionnaire are suggested by Babbie (2007:257), namely:

- The questionnaire should be completed by respondents that comprise a representative of the sample that is relevant to the study.
- The respondents should answer the questions rather than just read through it and give feedback on what can be altered to improve the validity of the instrument.

The pre-test of the questionnaire was done in order to eliminate the possibility of ambiguous sentences and to correct spelling and grammar errors.

A pre-test of the questionnaire was conducted with eight respondents who attended the CHCC for health care. The inclusion criteria were considered. This pre-testing of the questionnaire assisted in identifying questions that were difficult and ambiguous in terms of the English language. The researcher administered the questionnaire to patients that could read and write English and those respondents that could not were assisted by the volunteers who clarified some of the concepts in their language.

### 3.4.3 Administration of the Questionnaire

Administration of the questionnaire by hand raised the response rate because of the personal contact with the respondents. The two volunteer assistants and the researcher were present to clarify any difficulties in conceptualisation as the respondents were
completing the questionnaire. The limitations associated with this method were that most of the respondents completing the questionnaire themselves could not fully complete it and needed to be assisted (De Vos et al 2008:168).

This meant that for some of the respondents the questionnaires were personally and directly completed where needed on their behalf as they responded to the questions. All questionnaires were collected immediately after completion and those respondents who completed the questionnaire on their own placed it in the collection box made available for that purpose.

3.4.4 Data analysis

Data was analysed using descriptive and inferential statistics. The researcher, with the help of a statistician, calculated the frequency distribution of attendance for services at the clinic, percentages, and measures of central tendency such as the mean and standard deviation. A statistician was consulted for assistance on the use of the statistical software computer package for data analysis. Analysis was done at a significance level of 5%, at a p value of 0.05 (at a 95% confidence level) and 1 degree of freedom. The following statistical analysis tests were performed: one sample median test, 2 tailed tests, and the reliability scales of all the variables (Polit & Beck 2008: 574-576; Polit & Hungler 1995:18).

The data analysis is discussed in more detail in chapter 4.

3.5 VALIDITY AND RELIABILITY

The processes that are to be applied in the research findings should be reliable and valid to render the research credible. The research instrument used during this research was tested for validity and reliability.

3.5.1 Validity
Validity is a judgment regarding the degree to which the components of research reflect theory, concept or variables under study. The validity of the instrument is how well it measures what it is supposed to measure. The validity of the research design as a whole is an important criterion in evaluating the worth of the results of the research conducted (Brockopp & Tolsma 2003:210). The use of the research instrument by an independent researcher should therefore give the same results if used under the same conditions.

For this reason the research instrument was reviewed for content and face validity by clinical experts at the clinic who have clinical experience of providing PHC services to patients and theory experts who were the study supervisors. The services of a statistician had been obtained especially during the pre-testing of the instrument to ensure validity of the instrument. Consultation with the above-mentioned experts was done to determine whether the instrument would be suitable and reliable and would yield the appropriate data.

*Face validity* is defined by Polit and Beck (2008:753) as the extent to which a measuring instrument looks as though it is measuring what it purports to measure. Polit and Beck (2008:458) explain that face validity means that an instrument empirically appears to measure what is needed, given the construct that is supposed to be measured. Brink (2006:168) point out that this type of validity relies basically on the researcher’s subjective judgment. It asks two questions which the researcher must finally answer in accordance with his or her best judgment: Is the instrument measuring what it is supposed to measure? Is the sample being measured adequate to be representative of the behaviour or trait being measured? It is basically based on an intuitive judgment by experts in the field.

In this study, face validity was ensured by careful selection of items to be included in the questionnaire. These items reflected the concept of the extent to which patients of the Crossroads PHC CHC were satisfied with the quality of health care rendered at the Crossroads CHCC.
Content validity is defined as the degree to which the items in an instrument adequately represent the universe of content for the concept investigated (Polit & Beck 2008:750). This was ensured by consulting the statistician, study supervisors and experienced nurses who have been involved with the daily care of patients at the clinic. They read the content of the questionnaire and made their comments. These were implemented where appropriate to make the content as valid as possible.

Construct validity according to Brink (2006:170) is concerned with the question ‘What construct is the instrument actually measuring?’ It is the most important form of validity and most often used in combination with the other approaches.

In this study the construct under investigation was the ‘level of satisfaction of patients with the quality of care provided for them at the clinic’. Construct validity was ensured by conducting an extensive literature review and consulting a variety of dictionaries to define all the key concepts of the construct.

External validity is defined by Polit and Beck (2008:753) as the degree to which study results can be generalised to settings or samples other than the one studied. In this study one huge clinic was utilised as the study context. One hundred and twenty (120) questionnaires were distributed due to difficulties to secure patients who were willing to participate in the study. Most of the patients had appointments and were not comfortable to miss their turn of consultation because of long queues. This was experienced as a difficulty even if permission was granted and arrangements made for patients not to cue backwards again. Therefore, the size of the sample, given the situation at the clinic was targeted to 120 participants which was small and did not warrant generalisation of the findings to the rest of the district health facilities of the Western Cape.

Internal validity refers to the degree to which it can be inferred that the experimental treatment (independent variable), rather than the uncontrolled, extraneous factors, causes observed factors. No randomization procedures were done as a convenience sample was used. However, to enhance internal validity the researcher had to use a carefully designed questionnaire which was validated with literature and experts in the
field both in practice and in theory. The researcher also ensured that the conditions under which data was collected in terms of time, room arrangements and how the questionnaires were administered, were more or less the same during the three days of data collection.

### 3.5.2 Reliability

Reliability refers to the degree to which the instrument can be depended upon to yield consistent results. The instrument should be consistent in measuring the attribute it is supposed to measure. Reliability of an instrument can be defined as the degree of consistency and dependability with which an instrument measures the attributes it is designed to measure (Polit & Beck 2008:730). Chronbach’s alpha reliability index was used to ascertain the reliability of the instrument with the assistance of a statistician. Sections B to F showed a Chronbach’s alpha of 0.701. Therefore, according to the statistician, sections B, C, D and F showed poor consistency, while section E showed good internal consistency. The inconsistency could have been due to the fact that some questions were asked negatively and others positively.

### 3.6 ETHICAL CONSIDERATIONS

The ethics involved in the use of human subjects in research should not go without careful scrutiny. Polit and Beck (2008:753) define ethics as a system of moral values concerned with the degree to which research procedures adhere to professional, legal and social obligations of the study participants. The principle of ethical propriety should consider the following: fairness, honesty, openness of intent, disclosure of methods and the ends for which the research is executed. Informed willingness on the part of the respondent to participate voluntarily in the research activity is a vital ethical standard (Polit & Hungler 1995:136). The ethical considerations applied in this study to ensure that high standards were followed, are discussed below.

#### 3.6.1 Protecting the rights of the institution
Permission to conduct the study was obtained from the Department of Health, represented by the District PHC Manager for the area of Crossroads as well as the Facility Manager of Crossroads CHCC. Permission to conduct the study was also obtained from the Ethics Committee of the Department of Health Studies, University of South Africa. The health clinic manager and the district manager requested that the findings of the study be made available at the completion of the study as part of the clinic’s quality assurance program.

3.6.2 Protecting the rights of patients

Informed consent

Respondents should have full knowledge of how the research project will unfold and a clear understanding of what is expected from them. They should be able to participate of their free will with no deception or coercion practised by the researcher. The consent for participating in the research should not be exploited by the status of the researcher, but a clear agreement should be reached by explaining all the details of the research and how long the questionnaire would take (Polit & Beck 2004:145).

To ensure adherence to this stated ethical standard the respondents were fully informed of what the study was about, and what their contribution would mean to the quality of care given to patients attending this clinic. They were assured that their contributions and views would not jeopardise their attendance at the clinic, but would help to improve the quality of health care provided.

Confidentiality and anonymity

In terms of the South African Constitution (South Africa 1996:8) the rights of patients are upheld through maintaining confidentiality and anonymity (Devendish 1998:55). Respondents will behave and think without interference or the possibility that private behaviour or thoughts may be used to embarrass or demean them in any way later.
In this study, confidentiality and anonymity was maintained by making sure that the questionnaires did not include the respondents’ names to protect them from being identified. They were kept anonymous throughout. With anonymity there was no linking of responses or findings to the individual respondents. Anonymity was also maintained by not including the addresses of respondents on the data collection tool to avoid any unfair treatment or possible exploitation (Polit & Beck 2004:149). For the purpose of confidentiality, data was coded with numbers instead of names.

Privacy and dignity

Every person is entitled to the right of privacy and dignity. In this study, privacy and dignity was achieved through the provision of a socially conducive environment and secluded venue where data was collected. Respondents were addressed in their home language, which was Xhosa for the majority of them. Only data that was necessary for the study was collected. Full disclosure of how the results will benefit patients in general, the health department and the primary health care clinic was explained.

Right to withdraw from the study

The respondent’s right to refuse to participate or withdraw from a study should be respected (Polit & Beck 2008:177). The respondents were given the right to refuse to participate or to withdraw from participating at any stage of data collection without fear of discrimination. In this study, there was no risk of physical or psychological harm to the respondents. Only questions were asked and they were assisted to fill in the questionnaires where needed. It was explained to them that they could withdraw from the study at any time if they so wish or were feeling uncomfortable or afraid. They were assured that the care provided for them at the clinic will not be affected.

3.6.3 Scientific integrity

Scientific integrity refers to honest practices commonly accepted within the scientific community for proposing, conducting or reporting research (Pera & Van Tonder 2005:157-159). Plagiarism was avoided by acknowledging all sources and references.
utilised in the study. The research findings and presentation was done without falsification and/or fabrication of information obtained from the respondents. The research report is the work of the researcher and has not been presented anywhere else for whatever purpose. Those persons who contributed towards the successful completion of the study were duly acknowledged.

3.7 SCOPE AND LIMITATION OF THE STUDY

The focus of this research was on the level of satisfaction of patients with the quality of PHC services provided at the clinic of Crossroads. The sample size of only 120 respondents seemed too small for the findings to be generalised to other areas. The fact that the questionnaire was in English, although it was simple English, could have contributed to some information being missed even if translated.

3.8 CONCLUSION

This chapter described the research design and methodology used in conducting this study. A quantitative, exploratory, descriptive survey research design was utilised to conduct the study. All the aspects of the questionnaire in terms of development, pre-testing and administration during the data collection process were explained.

The aspects of ensuring reliability and validity of the instrument were discussed and the reliability test of this study indicated. Ways in which the principles of the research ethics were considered were also discussed.

The next chapter, chapter 4, deals with the analysis, interpretation and presentation of analysed data.

CHAPTER 4

Data analysis and interpretation
4.1 INTRODUCTION

Chapter 3 described the research design and methodology. The researcher conducted a quantitative, explorative and descriptive research study. This chapter discusses the data analysis and interpretation (see Annexure F).

4.2 RESEARCH OBJECTIVES OF THE STUDY

The objectives of this study were to make use of the Donabedien model of structure-process-outcome (cited by Stanhope and Lancaster 2006:295) to explore and describe the extent to which patients were satisfied with the quality of care as follows:

Structure

- Physical environment and resources
- Staff behaviour and attitudes towards the patients
- Accessibility, availability, affordability, equitability, effectiveness and efficiency of the PHC service

Process

- The consultation process
- The quality of the PHC services provided in terms of safety, effectiveness or patient-centeredness as perceived by the patients who utilise the health care services

Outcome
• The problems experienced by patients, which contributed to poor compliance with care
• The level of satisfaction of patients with the quality of care provided by staff at the clinic
• What recommendations can be suggested to contribute to the improvement of quality of care at this clinic

4.3 DATA ANALYSIS

The data was analysed using the Statistical Package for Social Sciences (SPSS) program, version 16.0 for Windows and release 16.0.1 for the data analysis. Data was collected from 120 respondents (patients) who attended the Crossroads CHC PHC clinic in October 2009. Data was collected by means of a questionnaire consisting of 6 sections with 52 items. The analysed data is discussed according to the sections of the questionnaire.

4.3.1 Section A: Biographical data

This section dealt with the respondents’ biographical data including gender, age, ethnic background, clinic attendance, marital status, highest level of education and home language.

4.3.1.1 Item A1: Respondents’ gender (N=120)

Of the respondents 59.2% (n=71) were female and 39.2% (n=47) were male. Two respondents (1.7%) did not respond.
4.3.1.2 **Item A2: Respondents’ age (N=120)**

The oldest respondents (2.5%; n=2) were 75 years and older; and the youngest (11.7%; n=14) respondents were younger than 24 years. The median age (28.3%; n=34) was between 25 and 34 years.

![Age distribution of respondents](image)

**Figure 4.1:** Age distribution of respondents
4.3.1.3 Item A3: Respondents’ ethnic background (N=120)

The majority of the respondents (90.8%; n=109) indicated that they were of the Black ethnic group; 5.8% (n=7) respondents indicated they were mixed; 2.6% (N=3) indicated that they belong to “other”, although they did not specify this.

Figure 4.2: Ethnic background of respondents
4.3.1.4 Item A4: Clinic attendance of respondents (N=120)

Most of the respondents (50.8%; n=61) indicated that they visit the clinic 7 or more times a month; 23.3% (n=28) visit the clinic 5-6 times; 5.0% (n=6) visit 1-2 times and 1.7% (n=2) of the respondents did not answer the question.

Table 4.1: Number of times respondents attended the clinic

<table>
<thead>
<tr>
<th>Clinic attendance</th>
<th>Number of respondents</th>
<th>Percentage of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2 times</td>
<td>6</td>
<td>5.0</td>
</tr>
<tr>
<td>3-4 times</td>
<td>24</td>
<td>20.0</td>
</tr>
<tr>
<td>5-6 times</td>
<td>28</td>
<td>23.3</td>
</tr>
<tr>
<td>7 or more times</td>
<td>61</td>
<td>50.8</td>
</tr>
<tr>
<td>No response</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td>Total</td>
<td>120</td>
<td>100</td>
</tr>
</tbody>
</table>

4.3.1.5 Item A5: Marital status of respondents (N=120)

Of the respondents, 53.3% (n=64) indicated that they had never been married, 22.5% (n=27) were cohabiting and only 1.7% (n=2) indicated that they were married. No response was received from 3.3% (n=4) of the respondents.

Table 4.2: Marital status of respondents

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Number of respondents</th>
<th>Percentage of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never married</td>
<td>64</td>
<td>53.3</td>
</tr>
<tr>
<td>Cohabiting</td>
<td>27</td>
<td>22.5</td>
</tr>
<tr>
<td>Separated</td>
<td>8</td>
<td>6.7</td>
</tr>
<tr>
<td>Divorced</td>
<td>8</td>
<td>6.7</td>
</tr>
<tr>
<td>Widowed</td>
<td>7</td>
<td>5.8</td>
</tr>
<tr>
<td>Married</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td>No response</td>
<td>4</td>
<td>3.3</td>
</tr>
<tr>
<td>Total</td>
<td>120</td>
<td>100</td>
</tr>
</tbody>
</table>
4.3.1.6 **Item A6: Respondents’ highest level of education (N=120)**

Of the respondents 64.2% (n=77) indicated that they had a secondary education; 18.3% (n=22) had a primary education; 8.3% (n=10) had some form of post-secondary school education; 5.0% (n=6) had a university education; 1.7% (n=2) indicated that they had no schooling and 2.5% (n=3) of the respondents did not answer the question.

4.3.1.7 **Item A7: Home language of respondents (N=120)**

The majority of respondents (86.5%; n=103) spoke Xhosa at home; 6.3% (n=8) spoke Afrikaans; 4.8% (n=6) spoke English; 1.6% (n=2) of the respondents’ home language was Shona and 0.8% (n=1) spoke Sotho.

**In summary:** More females (59.2%; n=71) than males were included in the sample; they were mostly between 25 and 44 years of age (49.1%; n=56); they were mostly of the Black ethnic group (90.8%; n=109); they visited the clinic 7 or more times per month (50.8%; n=61); were never married (53.3%; n=64); 64.2% (n=77) of the respondents had a secondary school education; and the majority (86.5%; n=103) were Xhosa speaking.

4.3.2 **Section B: Environment**

This section dealt with the environment where the CHCC is situated and to what degree the respondents are satisfied with it.

4.3.2.1 **Item B1: CHC centre is in a good, clean and welcoming condition (N=120)**

Of the respondents 44.2% (n=53) strongly agreed with the statement that the CHC centre is in a good, clean and welcoming condition, 31.7% (n=38) agreed, 4.2% (n=5) were undecided, 9.2% (n=11) disagreed and 9.2% (n=11) strongly disagreed. Two respondents (1.7%) did not answer the question. See figure 4.3.
4.3.2.2 Item B2: **There are adequate benches to sit on while waiting for consultation (N=120)**

Of the respondents 41.7% (n=50) strongly agreed with the above statement, 28.3% (n=34) agreed, 5.8% (n=7) were undecided, 10.0% (n=12) disagreed and 11.7% (n=14) strongly disagreed. Three respondents (2.5%) did not answer the question. See figure 4.3. As a result 24.2% of the respondents were not satisfied with the sitting and waiting arrangements at the clinic. In other words one in four of them were dissatisfied.

4.3.2.3 Item B3: **The toilets are clean and in good working order (N=120)**

Of the respondents 27.5% (n=33) strongly agreed with the above statement, 23.3% (n=28) agreed, 9.2% (n=11) were undecided, 10.0% (n=12) disagreed and 26.7% (n=32) strongly disagreed. Four respondents (3.3%) did not answer the question. Almost half of the respondents state that the toilets are not in a good condition or are undecided. See figure 4.3 below.

4.3.2.4 Item B4: **The CHC centre is a safe place for patients (N=120)**

Of the respondents 47.5% (n=57) strongly agreed with the above statement, 27.5% (n=33) agreed, 2.5% (n=3) were undecided, 8.3% (n=10) disagreed and 7.5% (n=9) strongly disagreed. Eight respondents (6.7%) did not answer the question. See figure 4.3.

4.3.2.5 Item B5: **The CHC centre is a wheelchair friendly environment (N=120)**

Most of the respondents either strongly agreed or agreed to the above statement, namely 44.2% (n=53) strongly agreed with the above statement, 32.5% (n=39) agreed, 5.8% (n=7) were undecided, 5.0% (n=7) disagreed and 8.3% (n=10) strongly disagreed. Five respondents (4.2%) did not answer the question. See figure 4.3.
Figure 4.3: Respondents’ opinion of environment of CHC centre

4.3.2.6 Item B6: **There are visible directions for patients to know where to go** (N=120)

Of the respondents 45.0% (n=54) strongly agreed with the above statement, 27.5% (n=33) agreed, 5.0% (n=6) were undecided, 3.3% (n=4) disagreed and 14.2% (n=17) strongly disagreed. Six respondents (5.0%) did not respond. See figure 4.3 above.

4.3.2.7 Item B7: **There is a notice with the person in charge’s name should any problem arise** (N=120)

Of the respondents 26.7% (n=32) strongly agreed that they were aware of the notice that displayed the name of the person in charge should they need it, 24.2% (n=29) agreed, 6.7% (n=8) were undecided, 9.2% (n=11) disagreed and 29.2% (n=35) strongly disagreed. Five respondents (4.2%) did not answer the question.

**In summary:**

The sign test was done on the data of this section and the results were as follows as to what the degree of satisfaction was:
• The respondents were very satisfied with the good, clean and welcoming environment of the CHC centre as the statistical results found a high satisfaction rate.

• The respondents were also very satisfied with the fact that there were adequate benches for them to sit on while waiting for consultation.

• The statistics revealed an average satisfaction rate for item B3, which investigated whether the toilets were clean and in working order.

• The respondents were very satisfied with the fact that the CHCC was a safe place for patients.

• The statistics also revealed that the respondents were very satisfied with the fact that the CHC centre was a wheelchair friendly environment.

• The respondents were very satisfied with the fact that there were visible directions for patients to help them to know where they are in the building.

• The respondents were also very satisfied with the fact that there was a notice with the name of the person in charge clearly visible should they want to report any problem.

4.3.3 Section C: Accessibility and availability of the health care services

This section dealt with the satisfaction of the respondents with regard to the accessibility and availability of health care services at the Crossroads CHCC.

4.3.3.1 Item C1: It takes more than 30 minutes to get to the CHC centre (N=120)

Of the respondents 24.2% (n=29) strongly agreed that they take more than 30 minutes to reach the CHC centre, 20.0% (n=24) agreed, 3.3% (n=4) were undecided, 23.3% (n=28) disagreed and 25.0% (n=30) strongly disagreed. Five respondents (4.2%) did not answer the question.
4.3.3.2 Item C2: The CHC centre has convenient hours of operating (N=120)

Of the respondents 37.5% (n=45) strongly agreed that the time the CHC centre is open is convenient for them, 35.8% (n=43) agreed, 5.8% (n=7) were undecided, 8.3% (n=10) disagreed and 8.3% (n=10) strongly disagreed. Five respondents (4.2%) did not answer the question.

4.3.3.3 Item C3: The queues are not too long (N=120)

Of the respondents 20.8% (n=25) strongly agreed that the queues are not too long, 15.8% (n=19) agreed, 6.7% (n=8) were undecided, 21.7% (n=26) disagreed. And 30.8% (n=37) strongly disagreed More than half of the participants disagreed that the queues are not long but the interpretation remain average satisfaction. Five respondents (4.2%) did not answer the question.

4.3.3.4 Item C4: There is a shortage of medication (N=120)

Of the respondents 30.8% (n=37) strongly agreed that there is a shortage of medication in the CHC centre, 23.3% (n=28) agreed, 6.7% (n=8) were undecided, 20.0% (n=24) disagreed and 14.2% (n=17) strongly disagreed. Six respondents (5.0%) did not answer the question.

4.3.3.5 Item C5: The respondents are able to access the next level of care (N=120)

Of the respondents 29.2% (n=35) strongly agreed with the statement, 31.7% (n=38) agreed, 11.7% (n=14) were undecided, 6.7% (n=8) disagreed and 12.5% (n=15) strongly disagreed. Ten respondents (8.3%) did not answer the question.

4.3.3.6 Item C6: The respondents do not wait too long to receive medication after consultation (N=120)
Of the respondents 35.0% (n=42) strongly agreed with the above statement, 18.3% (n=22) agreed, 4.2% (n=5) were undecided, 10.8% (n=13) disagreed and 25.0% (n=30) strongly disagreed. Eight respondents (6.7%) did not answer the question.

### 4.3.3.7 Item C7: There is a box for complaints and compliments to voice opinions or concerns (N=120)

Of the respondents 39.2% (n=47) strongly agreed that there is a box in the CHC centre where respondents can voice their opinions or concerns and that this box is clearly visible, 18.3% (n=22) agreed with the statement, but 4.2% (n=5) were undecided, 10.8% (n=13) disagreed and 20.8% (n=25) strongly disagreed. Eight respondents (6.7%) did not answer the question.

![Chart showing respondents' opinions on the accessibility and availability of health care services](chart.png)

**Figure 4.4:** Respondents’ opinion on the accessibility and availability of the health care services

**In summary:**

The sign test was also done on the data of this section and the results were as follows:

- The respondents were very satisfied with the hours the clinic was open as it was convenient.
• The statistics revealed average satisfaction with regard to the queues at the clinic.
• The respondents were very satisfied with the fact that they were referred to the next level of service delivery when necessary.
• The statistics revealed average satisfaction with regard to a shortage of medication.
• The statistics revealed low satisfaction with regard to the time it took the respondents to reach the clinic.
• The statistics revealed average satisfaction with regard to the fact that they had to wait for their medication.
• The respondents were very satisfied with the fact that there was a box in which they could place their complaints or concerns.

4.3.4 Section D: Affordability of care

This section dealt with the satisfaction of the respondents with regard to the affordability of health care services at the Crossroads CHC centre.

4.3.4.1 Item D1: It is not expensive to travel to the CHC centre (N=120)

Of the respondents 44.2% (n=53) strongly agreed that it is not expensive to travel to the CHC centre, 23.3% (n=28) agreed with the statement, but 1.7% (n=2) were undecided, 12.5% (n=15) disagreed and 13.3% (n=16) strongly disagreed. Six respondents (5.0%) did not answer the question.

4.3.4.2 Item D2: Respondents can afford to pay the minimum fee required for service (N=120)

Of the respondents 14.2% (n=17) strongly agreed that they can afford the fee required for service, 24.2% (n=29) agreed with the statement, but 7.5% (n=9) were undecided, 22.5% (n=27) disagreed and 29.2% (n=35) strongly disagreed. Three respondents (2.5%) did not answer the question.
4.3.4.3 **Item D3: Respondents received health care even when they did not pay (N=120)**

Of the respondents 54.2% (n=65) strongly agreed that the respondents received health care even when they were not able to pay the required fee, 32.5% (n=39) agreed with the statement, but 3.3% (n=4) were undecided, 2.5% (n=3) disagreed and 4.2% (n=5) strongly disagreed. Four respondents (3.3%) did not answer the question.

4.3.4.4 **Item D4: Respondents believed that the health care they received was worth the money they paid (N=120)**

Of the respondents 25.8% (n=31) strongly agreed believed that the health care they received was worth the money they paid, 30.0% (n=36) agreed with the statement, but 16.7% (n=20) were undecided, 10.0% (n=12) disagreed and 15.0% (n=18) strongly disagreed. Three respondents (2.5%) did not answer the question.

4.3.4.5 **Item D5: Respondents received the same good health care as the clients who paid (N=120)**

Of the respondents 53.3% (n=64) strongly agreed that the respondents received the same good health care as the other patients, even when they were not able to pay the required fee, 31.7% (n=38) agreed with the statement, but 1.7% (n=2) were undecided, 3.3% (n=4) disagreed and 6.7% (n=8) strongly disagreed. Four respondents (3.3%) did not answer the question.

4.3.4.6 **Item D6: Respondents felt that the treatment they received was of an acceptable quality (N=120)**

Of the respondents 42.5% (n=51) strongly agreed that the treatment they received was of an acceptable quality, 25.8% (n=31) agreed with the statement, but 2.5% (n=3) were undecided, 6.7% (n=8) disagreed and 15.0% (n=18) strongly disagreed. Nine respondents (7.5%) did not answer the question.
4.3.4.7 **Item D7: The health care rendered does not discriminate against gender, race, status or types of sickness (N=120)**

Of the respondents 54.2% (n=65) strongly agreed with the above statement, 30.0% (n=36) agreed with the statement, but 1.7% (n=2) were undecided, 3.3% (n=4) disagreed and 6.7% (n=8) strongly disagreed. Five respondents (4.2%) did not answer the question.

![Figure 4.5: Affordability of care](image)

In summary:

The sign test was also done on the data of Section D and the results were as follows:

- The respondents were very satisfied with the travelling fees to the CHC centre.
- The statistics revealed an average satisfaction level with regard to the affordability of the fee they had to pay for health care at the clinic.
- The respondents were very satisfied with the fact that they did receive health care at the clinic even when they could not pay the required fee.
- The respondents were very satisfied with the fact that the health care they received was worth the money paid.
The respondents were very satisfied with the fact that they received the same health care, even though they did not pay, as the patients who did pay the required fee.

The respondents were very satisfied with the treatment they received and believed that it was of an acceptable quality.

The respondents were very satisfied that the health care rendered did not discriminate against gender, race, status or type of sickness.

4.3.5 Section E: Perception of patients about staff members

This section dealt with the satisfaction of the respondents with regard to issues related to the staff at the Crossroads CHC centre.

4.3.5.1 Item E1: There was no shortage of staff at the CHC centre (N=120)

Of the respondents 54.2% (n=65) strongly agreed with the above statement, 30.0% (n=36) agreed with the statement, but 1.7% (n=2) were undecided, 3.3% (n=4) disagreed and 6.7% (n=8) strongly disagreed. Five respondents (4.2%) did not answer the question.

4.3.5.2 Item E2: The individuals at the reception desk were helpful at the CHC centre (N=120)

Of the respondents 39.2% (n=47) strongly agreed with the above statement, 22.5% (n=27) agreed with the statement, but 5.0% (n=6) were undecided, 10.0% (n=12) disagreed and 20.8% (n=25) strongly disagreed. Therefore more than 30% respondents think the help desk staff is not helpful. Three respondents (2.5%) did not answer the question.

4.3.5.3 Item E3: The nursing staff treated respondents with respect at the CHC centre (N=120)
Of the respondents 25.8% (n=31) strongly agreed with the above statement, 29.2% (n=35) agreed with the statement, but 5.0% (n=6) were undecided, 10.0% (n=12) disagreed and 27.5% (n=33) strongly disagreed. Three respondents (2.5%) did not answer the question.

4.3.5.4 Item E4: The doctor who treated the respondents was polite and respectful at the CHC centre (N=120)

Of the respondents 55.8% (n=67) strongly agreed with the above statement, 30.8% (n=37) agreed with the statement, but 4.2% (n=5) were undecided, 1.7% (n=2) disagreed and 4.2% (n=5) strongly disagreed. Four respondents (3.3%) did not answer the question.

4.3.5.5 Item E5: The doctor at the CHC centre explained to respondents what was wrong with them (N=120)

Of the respondents 36.7% (n=44) strongly agreed with the above statement, 31.7% (n=38) agreed with the statement, but 4.2% (n=5) were undecided, 5.8% (n=7) disagreed and 18.3% (n=22) strongly disagreed. Four respondents (3.3%) did not answer the question.

4.3.5.6 Item E6: Respondents can complain to staff at the CHC centre without being afraid (N=120)

Of the respondents 25.8% (n=31) strongly agreed with the above statement, 33.3% (n=40) agreed with the statement, but 6.7% (n=8) were undecided, 5.0% (n=6) disagreed and 25.0% (n=30) strongly disagreed. Five respondents (4.2%) did not answer the question.
**4.3.5.7 Item E7: Respondents were pleased with the way they were treated by staff at the CHC centre (N=120)**

Of the respondents 32.5% (n=39) strongly agreed with the above statement, 33.3% (n=40) agreed with the statement, but 4.2% (n=5) were undecided, 6.7% (n=8) disagreed and 19.2% (n=23) strongly disagreed. Five respondents (4.2%) did not answer the question.

![Figure 4.6: Perception of patients about staff members](image)

**In summary:**

The sign test on Section E came to the following conclusions:

- The findings revealed an average level of satisfaction with regard to the shortage of staff.
- The findings revealed that the respondents were very satisfied with the helpfulness of the individuals at the reception desk at the CHC centre.
- The respondents were very satisfied with the respectful way in which staff treated them.
The respondents were very satisfied with the polite and respectful way that the doctor treated them.

The respondents were very satisfied with the fact that the doctor explained to them what was wrong with them.

The respondents were very satisfied with the fact that they could log complaints with the staff at the CHC centre without being afraid.

The respondents were very satisfied with the way in which they were treated by staff at the CHC centre.

4.3.6 Section F: Patient behaviour

This section dealt with the satisfaction of the respondents as demonstrated by the behaviour of either complying with treatment and instructions given at the clinic or not. This behaviour determines whether the patients were satisfied with the quality of care rendered or not.

4.3.6.1 Item FI: Return to the CHC centre on the scheduled dates (N=120)

Of the respondents 54.2% (n=65) strongly agreed with the above statement, 31.7% (n=38) agreed with the statement, but 3.3% (n=4) were undecided, 5.0% (n=6) disagreed and 3.3% (n=4) strongly disagreed. Three respondents (2.5%) did not answer the question.
4.3.6.2 Item F2: Still have the same folder from the first visit (N=120)

Of the respondents 40.8% (n=49) strongly agreed with the above statement, 23.3% (n=28) agreed with the statement, but 4.2% (n=5) were undecided, 8.3% (n=10) disagreed and 19.2% (n=23) strongly disagreed. Five respondents (4.2%) did not answer the question.
Figure 4.8: Still has the same folder from the first visit
4.6.3.3 **Item F3: Do not mind to wait for hours before you are seen by a nurse/doctor (N=120)**

Of the respondents 35.8% (n=43) strongly agreed with the above statement, 20.8% (n=25) agreed with the statement, but 4.2% (n=5) were undecided, 12.5% (n=15) disagreed and 24.2% (n=29) strongly disagreed. Three respondents (2.5%) did not answer the question.

![Bar chart showing the percentage of respondents for each response category for Item F3. The categories are Strongly agree, Agree, Undecided, Disagree, Strongly disagree, and No response.]

**Figure 4.9:** Do not mind to wait for hours before I am seen by a nurse/doctor
4.6.3.4 Item F4  Expect to receive medications every time you visit the CHC centre (N=120)

Of the respondents 45% (n=54) strongly agreed with the above statement, 32.5% (n=39) agreed with the statement, but 4.2% (n=5) were undecided, 1.7% (n=2) disagreed and 12.5% (n=15) strongly disagreed. Five respondents (4.2%) did not answer the question.

Figure 4.10: Expect to receive medications every time I visit the CHC centre
4.6.3.5 Item F5: Use up all the medication they gave me (N=120)

Of the respondents 49.2% (n=59) strongly agreed with the above statement, 35.0% (n=42) agreed with the statement, but 0.8% (n=1) were undecided, 3.3% (n=4) disagreed and 8.3% (n=10) strongly disagreed. Four respondents (3.3%) did not answer the question.

Figure 4.11: Use up all the medication they give me.
4.6.3.6 Item F6: Addressed in a language I understand, understand the information about my sickness (N=120)

Of the respondents 37.5% (n=45) strongly agreed with the above statement, 34.2% (n=41) agreed with the statement, but 5.8% (n=7) were undecided, 5.0% (n=6) disagreed and 12.5% (n=15) strongly disagreed. Six respondents (5.0%) did not answer the question.

![Figure 4.12: Understand the information about my sickness](image)

F.6: I understand the information about your sickness.

**Figure 4.12: Understand the information about my sickness**
4.6.3.7 Item F7: Only attend this CHC centre because the care provided here is better than at other clinics (N=120)

Of the respondents 35.0% (n=42) strongly agreed with the above statement, 24.2% (n=29) agreed with the statement, but 5.8% (n=7) were undecided, 5.0% (n=6) disagreed and 25.0% (n=30) strongly disagreed. Six respondents (5.0%) did not answer the question.

![Bar chart showing percentages for different responses to Item F7]

**Figure 4.13: Only attend this CHC centre because the care provided here is better than at other clinics**

**In summary:**

The sign test on section F came to the following conclusions:

- The findings revealed that the respondents were very satisfied with the dates scheduled to return to the CHC centre.
• The findings revealed an average level of satisfaction concerning the aspect of still having the same folder from the last visit.

• The satisfaction level of respondents on the aspect of minding to wait for hours was very low as the majority of them disagreed in this item, which implies that they mind to wait long hours before they can be seen by a doctor.

• The findings revealed an average level of satisfaction concerning the aspect of expecting to receive medications every time they visit the clinic.

• The respondents were very satisfied with the fact that they use all the medication that is given to them during the clinic visits.

• The findings revealed an average level of satisfaction with regard to whether they understand the information about their sicknesses or not.

• The satisfaction level of respondents on the aspect of attending this clinic because the care is better than at other clinics was low as the majority of them disagreed in this item. This implies that they might be attending this clinic because of factors other than that it is better than other clinics.

4.7 CONCLUSION

This chapter discussed the data analysis and interpretation with the use of frequency percentages on a Likert scale, charts, graphs, description and inferential statistics. Although gaps were identified that require further investigation, the results of the study reveal generally positive perceptions and satisfaction by the patients about the quality of health care provided by the staff at the CHCC PHC at Crossroads.

Chapter 5 concludes the study, discusses its limitations, and makes recommendations for practice, education and research.
CHAPTER 5

Findings, limitations and recommendations

5.1 INTRODUCTION

This chapter discusses the findings and limitations of the study and makes recommendations for quality health improvement with regard to patient satisfaction with the quality of health care services delivery rendered by the Crossroads Community Health Care Centre.

5.2 OBJECTIVES OF THE STUDY

The objectives of this study were to explore and describe the extent to which patients were satisfied with the quality of care rendered by the Crossroads CHC centre according to the Donabedien model of Structure-Process-Outcome (cited by Stanhope & Lancaster 2006:295) as follows:

Structure
- Physical environment and resources
- Staff behaviour and attitudes towards the patients
- Accessibility, availability, affordability, equitability, effectiveness and efficiency of the PHC service

Process
- The consultation process
• The quality of the PHC services provided in terms of safety, effectiveness or patient-centredness as perceived by the patients who utilise the health care services

Outcome

• The problems experienced by patients, which contributed to poor compliance with care
• The level of satisfaction of patients with the quality of care provided by staff at the clinic
• What recommendations can be suggested to contribute to the improvement of quality of care at this clinic

5.3 SUMMARY OF FINDINGS

A structured questionnaire (Annexure E) was used in this study to collect data. The format of the questionnaire was structured in such a way that six crucial aspects of quality patient care were covered. The items on the questionnaire assessed the expectations and perceptions of patients about the quality of health care services rendered at Crossroads CHC centre using the statistical document referred to in annexure F.

The study found that most of the respondents (50.8%) utilised the clinic services either 7 times or even more per month, which was an assurance that the responses would be reasonably reliable based on the insight and experience the respondents had of the service centre. It was noted with concern, however, that although the majority of responses revealed satisfaction with the quality of care in different related aspects, there were some aspects of concern as presented in the ensuing discussion of the results.

5.3.1 Demographic data

In this study the findings reveal that more females (59.2%; n=71) than males were included in the sample. This could be because more females are unemployed and at
home taking care of their families and also take responsibility for their health care more than males do. Women and children are often noted to suffer sicknesses more than men do. One of the three major goals of the Patients’ Bill of Rights is to encourage patients to take an active role in staying and getting healthy (The Patients’ Bill of Rights 2008:1), which supports this finding as women evidenced this activity. However, the WHO (2004:7) reported that research results based on studies only involving men were assumed to be universally valid, without convincing evidence that they apply to men what may be harmful to women. The respondents were mostly between the ages of 25 and 44 (49.1%; n=56), which signified a group that has finished school and is more able than the other age ranges to make reasonable judgments on issues such as quality of patient care rendered. They were mostly of the Black ethnic group (90.8%; n=109) and the majority (86.5%; n=109) were Xhosa speaking. They visited the clinic 7 or more times (50.8%; n=61) per month as the clinic was situated in the fast developing settlement assigned as residence for the Black Xhosa-speaking people.

Marital status does impact how people view quality of a service, as married people utilise the services for themselves as well as their families. However, in this study 53.3% (n=64) who consulted the clinic for health care indicated that they had never been married, which was slightly more than the married respondents. It was interesting to note that although the majority of the respondents were staying in a settlement area, 64.2% (n=77) of them had a secondary school education which enabled them to understand the questions on the questionnaire and give answers for analysis.

5.3.2 Patient perception of the environment of the CHC centre

The overall rating of this section was that 75.8% (n=91) of the respondents were very satisfied with the good, clean and welcoming environment of the CHC centre. This finding is supported by Nightingale (1946:39), known as ‘the mother of modern nursing’ whose theory focused on the environment, in this instance linking it to the fourth environmental factor which was particularly on environmental cleanliness. The argument in the theory was that deficiencies in these factors produced lack of health or compromised quality of patient care (Nightingale 1946:40). The respondents indicated that they were very satisfied with aspects that included adequacy of benches to sit on,
safety of patients in the clinic and availability of visible directions. On the contrary, some
authors report that most waiting rooms in government facilities do not have clear
directions regarding patient movement (Bediakp, Nel & Hiemstra 2006:14). The recent
renovations at the Crossroads CHC centre have taken that fact into consideration and
have rectified the oversight in that the CHC centre has directional information in Xhosa
and English.

The CHC physical environment was agreed upon by the respondents to be wheelchair
friendly, and ensuring that people with disabilities have no barriers to access health care
services (WHO 2009:58) at Crossroads CHC centre.

However, respondents were not very satisfied with cleanliness and good working order
of the toilets as 37.0% (n=44) disagreed with the statement, which is a high statistic in
this regard. Provision of clean toilets or ablutions is part of indirect patient care and for
hygiene purposes. Although cleaning of toilets is not part of nurses’ duties, those
allocated to do so are part of the staff and their work contributes to improving the quality
of patient care. It should be understood that cleanliness of the health care service areas
is everyone’s responsibility. The Department of Health (2007:5) confirms this perception
by stating that quality supervision should be put in place to ensure that environmental
cleanliness, which includes the toilets, demonstrates improvement in order to reduce
the risks associated with environmental hygiene. A high quality environment is essential
for the delivery of health care and should be supported by high standards of
environmental cleanliness by all staff members. Patients who utilise the CHC services
expect all the facilities to be clean, which will improve their satisfaction about the quality
of care provided (Department of Health 2007:5).

Allies-Husselman (2009:15), speaking at the Provincial DoH annual Quality Assurance
Day awards, stated that all the employees (from the cleaner to the doctor) of the
Department of Health should deliver quality health care services because it was seen as
imperative to help the patients’ healing process by accessing a clean, welcoming and
therapeutic environment. The study conducted by Rall and Meyer (2006: 22) stated that
the environment is part of care for patients and that it contributes to patient and
employee satisfaction. In turn it also contributes to the effectiveness of services provided with better health outcomes for patients' health care.

5.3.3 Accessibility to the CHC centre and available services

With regard to the respondents’ perceptions of the accessibility of the CHC centre and the available services, the respondents indicated general satisfaction about aspects such as the hours the clinic was open, as this was convenient. There was, however, low satisfaction concerning the long queues at the clinic. The reasons for the average respondent’s dissatisfaction with the long queues at the clinic could be the long waiting times normally associated with consultation without appointment and the triage system rating for sorting patients with regard to the severity of their conditions. Bediako-p et al (2006:8) concur with this finding that long queues are associated with the waiting time between a patient’s desire for service and the time the actual service is rendered. Achieving high quality patient care is therefore associated with long waiting ques whether for consultation or to obtain medication.

The statistics revealed an average satisfaction with regard to the fact that there was a shortage of medication and that they had to wait for their medication. System delivery issues regarding medication shortages and long waiting times to collect the medications highlight gaps in the system that need to be attended to in order to improve the services. The City of Cape Town (2009:3) reported that medication shortages pose serious problems in the health care arena. Data regarding the quantity and type of physician prescriptions available at the clinic is monitored monthly. However, it was noted that medication for common ailments was reduced by 55%, which was a relative reduction and an average reduction of more than three orders each week. The use of recommended alternative medications increased by 49% for drugs prescribed for common ailments and other medical resources. These reductions in medication and the availability of medical resources had great potential for effectively altering physician prescribing behavior and the continuing problem of medication shortages.

It is necessary to report that the results indicated that the respondents were very satisfied with the fact that they were referred to the next level of service delivery when
necessary. Primary health care nurses would normally refer patients with complex medical conditions to the primary physician at the clinic. This system brings satisfaction to patients as most patients prefer to be seen by doctors. London (2005:2) concurs with this finding that some of the health and medical needs require the opinion of a specialist concerning treatment. Sometimes specialist equipment or highly specialised care is needed; therefore the patient should be referred to the hospital for more specialised diagnosis or treatment. As this referral system to the next level of care is available and known at the CHC centre, it seemingly made the patients feel satisfied with the quality of care in this regard.

The statistics revealed little satisfaction with the time it took the respondents to reach the clinic. This can be attributed to the fact that the Crossroads CHC area is not limited only to the surrounding near catchment areas, but that the clinic accepts people from distant areas as well. This could be the contributing factor for the low satisfaction seen in the results.

However, the distance to the CHC centre from the areas that the CHC does serve, falls within the 5km which, according to the South African government plan in striving to meet the health needs of the population, is an acceptable distance. The CHC services are therefore accessible (City of Cape Town 2009:6).

5.3.4 Perceptions about affordability of care

This section dealt with the satisfaction of the respondents with regard to the affordability of health care services at the Crossroads CHC centre. The population of Crossroads has a high unemployment rate with increasing high prevalence of HIV/AIDS and TB, and this poses a serious threat to the health of the community if there is a disproportionate level of access and affordability of health care services. This state of affairs undermines the constitutional right of equal universal accessibility of health care to all (Molatthegi 2009:40-41). Mochaki (2008:38) states that the demand for health care is not in line with the cost related to the quality of the services provided and that poor households have their right and access to quality health care services limited. Therefore in practice quality is controlled through the standards of care provided.
Since PHC is the approach that embraces essential health care service which would provide accessible health care that is equally affordable by all, problems as evidenced by the results in this study still exist (Mafalo 2008:30; Thoabala 2008:49). The respondents were satisfied with all other aspects in relation to affordability of care except for the minimal fee they had to pay for health care at the clinic if they were working (Department of Health 2009:5). The majority of the respondents were satisfied that they were treated even if they could not pay for the service. Of the respondents 86.7% (n=104) agreed that they received health care even when they were not able to pay the required fee. This high statistic shows that the majority of the respondents could not afford to pay the required fee even if treated. There was still a debt against them and this perpetuated the spirit of poverty. One could deduce that the majority of the patients were unemployed and poor.

A study conducted in the US by Helminen (2008:3) revealed that 15% of patients who were uninsured were far less satisfied with the quality of their medical care, 50% were satisfied, only 27% were satisfied with their health care costs and 69% were dissatisfied with their costs. Close to 4 in 10 Americans (38%) -- by far the largest percentage mentioned for any issue - cite the cost or affordability of health care as the nation's biggest health care problem. It is interesting to note that dissatisfaction with the cost of care is not only experienced in developing countries, but that developed countries are also battling with this issue. Although the basic primary health care needs of the South African population are offered freely by the state, health care users are still expected to pay for specialised or high tech type of care. Government is therefore being challenged with regard to how to ensure that the rights of the poor to access quality patient care in this regard are protected without incurring more debts on them.

5.3.5 Perception of patients about staff members

This section dealt with the satisfaction of the respondents with regard to issues related to the staff at the Crossroads CHC centre. In the study findings on Section E the respondents expressed that they were very satisfied with the treatment received from the doctors, as this had the highest statistic of 86.7% (n=104). The doctors were
accepted as being polite and respectful. This finding is contrary to the finding on the item about whether the nursing staff treated the respondents with respect, as 37.5% (n=45) indicated the contrary. This is a matter of great concern as nurses are the first point of contact for patients in the services. Patients spend more time under the care of nurses than any other member of the health team.

According to Arries (2006:65), there is little time in the clinics to establish a relationship with patients, there is little privacy, and there may be an increased level of anxiety in patients due to the acuity of their health problems and lack of knowledge about their diagnosis. And because there is often little opportunity for private discussion, patients might feel that their privacy is not respected when their health matters are discussed in front of other patients, which affects their impression about nurses’ treatment. This finding is similar to how the respondents of this study experienced the care by nurses. This highlights that staff attitudes could hinder patient satisfaction with services rendered. These attitudes exhibited by staff are not seen as part of a quality health care service because it does not reflect ubuntu (Thoabala 2008:49). Positive attributes such as friendliness, approachability and confidence can influence the community positively towards the service delivered (Rall & Meyer 2006:20). Rall and Meyer in their study (2006:21) found that patients judge health care not only by its technical quality (was the treatment successful?), but also by its functional quality (was the staff caring/compassionate?). This should be realised by staff in practicing good interpersonal skills to build relationships with the community.

The other statistic of concern was the response of the respondents to the item on whether they can complain to staff without being afraid. Only 59.0% (n=71) of the respondents agreed that they are satisfied with the fact that they can complain to staff members at the CHC centre without being afraid. This may be that the very source of a complaint could be about the treatment by the staff themselves, as the majority reported that they were treated with disrespect. The percentage of respondents that were not satisfied with the fact that they could not log complaints to the staff at the CHC centre without being afraid were 30% (n=36) of the group. This should be communicated to the CHC centre management. Strategies should be devised that all patients should feel free to voice their concerns without fear.
5.3.6 Patient behavior

This section dealt with the satisfaction of the respondents with regard to issues related to their behavior. It demonstrates compliance or lack of compliance with medications or instructions given by the nursing and medical personnel. The findings revealed that the respondents were very satisfied with the dates scheduled to return to the CHC centre as 85.8% of them agreed in this regard. They could easily return on scheduled dates. This finding is supported by a high percentage of 50.8% respondents reporting that they attend the clinic seven times or more per month. The majority of the respondents, (98.3%), was unmarried and therefore had no marital responsibilities that could hinder them from returning for checkups or further medical or nursing consultations. This finding is similar to a comment made by Arries (2006:69) that to keep an eye on potential complications of diabetes, people with diabetes must have regular health check-ups and tests. These will continue throughout adult life.

Another finding of high satisfaction among the respondents was about the use of all the medication given. It is encouraging to note that 84.2% of the respondents used all the medication given. Heunis et al (2006:40) are of the opinion that for patients to commit considerable time to their treatment, to comply with strict dietary and fluid restrictions, and to take medication on a regular basis, they must perceive it as beneficial to them and their health.

However, there were other findings which had significance in that the satisfaction levels were low. With regard to the aspect of only attending the CHC centre because care was better than at other clinics, thirty percent of the respondents disagreed with this statement, which could signify that they attended for other reasons such as accessibility and that they would be treated even if they had no money to pay. As the profile of the study population was evidenced to be from a poor background, there could be other better clinics that they could go to but they can't afford to go there. The issue of medical insurance might be limiting too.
In 2005 Dubay, Holahan and Cook conducted a Current Population Survey (CPS) which was used to estimate share of uninsured Americans that were eligible for coverage through Medicaid or the State Children’s Health Insurance Program (SCHIP), that needed financial assistance to purchase health insurance, and that were likely to afford insurance or not. Only twenty-five percent were eligible for public coverage, 56 percent needed assistance, and 20 percent were able to afford coverage. This varied across uninsured populations: 74 percent of children were eligible for public programs, and 57 percent and 69 percent of parents and childless adults, respectively, needed assistance. A central conclusion in this survey was that a large percentage of uninsured adults needed help purchasing health insurance. This survey supports the finding in this study that uninsured people have no choice of services but to attend available clinics even if the care is not better.

The response of respondents who agreed on the aspect of minding to wait for hours was the lowest (56.7%). This implies that they mind to wait long hours before they can be seen by a doctor. Mamdani (2007:1) states that patients also contribute to the chaos of waiting long hours by their insistence to be seen by a doctor. PHC-trained nurses in a context like that of the CHC clinic have the skills to examine patients and write out prescriptions as their scope of practice allows this. Queues to see a doctor in this setup may be long and bring about a state of dissatisfaction with the quality of care provided.

5.4 SCOPE AND LIMITATIONS OF THE STUDY

The study was conducted in a PHC clinic at Crossroads CHC in the Cape Town region of South Africa. The attendees of the clinic come from the Crossroads settlement area which is medically under-served, poor and largely unemployed. Data was collected over three days which could have compromised or impacted on internal validity of as circumstances at the clinic are different and unique for each day. Some of the respondents were not literate and the English language was a challenge to them. Translation and interpretation of the items could have had influence on the responses to the research questions. The other limitation noted was that the population consisted only of adult patients who had attended the CHC centre more than once. Caregivers of
children were not included, which could have provided more valuable perspectives about the study phenomena.

5.5 RECOMMENDATIONS

The findings provided valuable information on the perceptions of patients with regard to the quality of health care services rendered by the Crossroads CHC centre. Although there was general satisfaction with the health care services provided by the Crossroads CHC centre, there are gaps that need to be addressed in certain areas of dissatisfaction to improve the overall quality of the health care services. Accordingly, based on the findings, the researcher makes the following main recommendations for improving the quality of the health care services rendered at the Crossroads CHC centre and for further research.

Clinical implications

The results of this study have implications for the policy-makers, program planners and practitioners to serve as a knowledge base on which to build strategies for improving health care delivery. This study is a baseline against which future assessments can be measured and it can be used to improve the management of the system in terms of supervision of the cleanliness of the environment, regular training of staff members with regard to the quality of patient care issues and interpersonal skills.

The need for additional staffing at the pharmacy should be addressed and new strategies for dispensing medications should be investigated in order to abate the long waiting times to obtain medication.

Educational implications

All staff members should receive in-service training on the Batho Pele principles and the Patients' Rights Charter to improve the levels of patient respect at the CHC centre.
Research implications

Further research should be undertaken on the following topics:

A similar study to be replicated in other CHC centres to assess the levels of patient satisfaction with the quality of health care services rendered in order to compare findings. This could involve the mothers or caregivers of children who attend the clinics.

A time survey to be conducted at the pharmacy area to identify gaps relevant to the area of dissatisfaction seems to be necessary.

Qualitative research is recommended to investigate the experiences of nurses and patients at the clinics to identify issues from their side that affect their attitudes towards patients.

5.6 CONCLUSION

This study sought to answer the question:” What is the satisfaction level of patients with the quality of care provided at the Crossroads CHC centre”. The question was answered and the objectives of the study were met.

This study found a general positive perception about the quality of PHC services rendered by the Crossroads CHC centre. At the same time the study identified gaps that need to be addressed and made recommendations.

LIST OF SOURCES


A Pocket Guide to District Health Care in South Africa. 1997. HST.


Johnson T. 2009. Department’s strategy is to cover up, deny and deflect. Cape Argus 25:18.


Rall, M & Meyer, SM. 2006. The role of the registered nurse in the marketing of primary healthcare services, as part of health promotion. Curatonis 29(1):10-25.


LIST OF SOURCES


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Rall, M & Meyer, SM. 2006. The role of the registered nurse in the marketing of primary healthcare services, as part of health promotion. *Curatonis* 29(1):10-25.


St Johns. 2007. *Patient satisfaction*. 

110


Dear Mr August/ Mr Binza

I am Pearl Van Niekerk, a Master student at the University of South Africa. I am reading for the Master's in Health Studies in Primary Health Care. I am requesting permission to conducted a patient satisfaction survey at the Crossroads Community Health Care Centre were I am currently working.

The purpose of the research is to determine patient’s perception of satisfaction about the health service at Crossroads CHC.

Yours truly,
Pearl Van Niekerk
Vanwyksing/Reference:
Navrae/Enquiries: Mr. LR August

The Facility Manager
Cross Rds Community Day Centre
CROSS ROADS

Dear Ms Pearl van Niekerk

CLIENT SATISFACTION SURVEY: CROSS ROADS COMMUNITY DAY CENTRE

Your request to conduct a client satisfaction survey at the above-mentioned facility has reference.

Approval to conduct the survey is herewith granted on the following conditions:
1. That your survey does not interfere with the day-to-day running of the services at Cross Rds CDC.
2. That you will liaise and consult with the facility management with regard to the processes you intend to follow.
3. That you avail your findings and recommendations to the Department of Health for possible implementation of the recommendations.

This office wishes you well with your survey and studies.

Yours sincerely,

LR August
PHC Manager: KLIPFONTEIN/MITCHELL’S PLAIN
CC: DR J CLAASSEN: DIRECTOR: SUBSTRUCTURE
CC: MR D BINZA: FACILITY MANAGER: CROSS RDS CDC

Klipfontein & Mitchell's Plain Substructure Office
Lentegeur Hospital
Highland’s Drive
Lentegeur
MITCHELLS PLAIN, 7785
Tel: 021-3705005
Fax: 021-4637441
PATIENT’S SATISFACTION SURVEY SAMPLE QUESTIONNAIRE

QUESTIONNAIRE ON ASSESSMENT OF PATIENTS’ SATISFACTION WITH THE QUALITY OF HEALTH CARE SERVICES PROVIDED AT CROSSROAD COMMUNITY HEALTH CARE CENTER Annexure B (September 2009)

All information herewith provided will be treated confidentially. It is not necessary to indicate your name on this questionnaire

INSTRUCTIONS

1. Please answer all questions by providing an “X” in the box corresponding to the chosen alternative
2. Please answer all questions as honestly, frankly and objectively as possible
3. Answer according to your own personal opinion and experience
4. Please hand in the questionnaire to the researcher immediately after completion

Answer the question by placing an “X” in the box corresponding to the alternative which is applicable to you
## SECTION A: PERSONAL DATA

<table>
<thead>
<tr>
<th>Ref no:</th>
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<tbody>
<tr>
<td>4</td>
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<table>
<thead>
<tr>
<th>Today’s date:</th>
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<tbody>
<tr>
<td>Day</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>What is your gender?</th>
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<tbody>
<tr>
<td>1</td>
<td>1. Male</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>What is your age range?</th>
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<tbody>
<tr>
<td>1</td>
<td>1. Less than 25</td>
</tr>
<tr>
<td>2</td>
<td>2. 25-34</td>
</tr>
<tr>
<td>3</td>
<td>3. 35-44</td>
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<tr>
<td>4</td>
<td>4. 45-54</td>
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<tr>
<td>5</td>
<td>5. 55-64</td>
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<tr>
<td>6</td>
<td>6. 65-74</td>
</tr>
<tr>
<td>7</td>
<td>7. 75 years or older</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>What is your ethnic background?</th>
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</thead>
</table>
**How many times have you attended the clinic?**

1. 1 – 2 times
2. 3 – 4 times
3. 5– 6 times
4. 6 or more

**What is your marital status?**

1. Never married
2. Cohabiting
3. Separated
4. Divorced
5. Widowed
6. What is the highest level of education you have completed?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>No schooling</td>
</tr>
<tr>
<td>2</td>
<td>Primary education</td>
</tr>
<tr>
<td>3</td>
<td>Secondary education</td>
</tr>
<tr>
<td>4</td>
<td>Post secondary school (e.g. college)</td>
</tr>
<tr>
<td>5</td>
<td>University</td>
</tr>
<tr>
<td>6</td>
<td>Other (specify)</td>
</tr>
</tbody>
</table>

7. What is your home language?

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<table>
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<tbody>
<tr>
<td>1</td>
<td>Xhosa</td>
</tr>
<tr>
<td>2</td>
<td>Afrikaans</td>
</tr>
<tr>
<td>3</td>
<td>English</td>
</tr>
<tr>
<td>4</td>
<td>Other specify</td>
</tr>
</tbody>
</table>

16

17
SECTION B: EXPECTATIONS ABOUT THE ENVIRONMENT

Please comment on the following aspects of your visit to Crossroads CHC experience by ticking your choice that best reflects your perception about the environment (Please answer by selecting the appropriate response in each instance)

| Scoring: | 1. SA=strongly agree; 2. A= agree; 3. U = undecided; 4. D = disagree; 5. SD = strongly disagree |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
|   | 1 | 2 | 3 | 4 | 5 | Official use |
| 1. The CHC is in a good, clean and welcoming condition. |   |   |   |   |   | |
| 2. There are adequate benches to sit on while waiting for consultation. |   |   |   |   |   | |
| 3. The toilets are clean and in good, working order. |   |   |   |   |   | |
| 4. The CHC is a safe place for patients. |   |   |   |   |   | |
| 5. The CHC is a wheelchair friendly environment. |   |   |   |   |   | |
| 6. There are visible directions for patients to know where to go to. |   |   |   |   |   | |
| 7. There is a notice with the person in charges’ name should any problems arise. |   |   |   |   |   | 18-24 |
## SECTION C: ACCESSIBILITY AND AVAILABILITY OF THE HEALTH CARE SERVICES

### Scoring

- **1. SA** = strongly agree
- **2. A** = Agree
- **3. U** = undecided
- **4. D** = disagree
- **5. SD** = strongly disagree

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Official use</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. It takes more than 30 minutes to get to the CHC.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2. The CHC has convenient hours of opening</td>
<td></td>
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<td></td>
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<tr>
<td>3. The queues are not too long.</td>
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<td></td>
<td></td>
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<tr>
<td>4. There is always a shortage of medications.</td>
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<td></td>
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<tr>
<td>5. I am able to access the next level of care when necessary eg, going to Jooste Hospital.</td>
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<td></td>
<td></td>
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<tr>
<td>6. I do not wait too long to receive my medication after consultation.</td>
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<td></td>
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<td></td>
<td>25-31</td>
</tr>
<tr>
<td>7. There is a visible complaints and compliments box to voice my opinions or concerns</td>
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<td></td>
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</tbody>
</table>
**SECTION D: AFFORDABILITY OF CARE**

<table>
<thead>
<tr>
<th>Scoring</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Official use</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. SA = strongly agree; 2. A = agree; 3. U = undecided; 4. D = disagree; 5. SD = strongly disagree</td>
<td>1 SA</td>
<td>2 A</td>
<td>3 U</td>
<td>4 D</td>
<td>5 SD</td>
<td>32-38</td>
</tr>
</tbody>
</table>

1. It is not expensive to travel to the CHC

2. I can afford to pay for the service the minimal fee requested.

3. I do receive health care even if I do not have money.

4. The care I received is worth the money I paid.

5. Even if I did not pay I still received good health care as if I did pay.

6. Treatment given is of acceptable quality.

7. The quality of care given does not discriminate according to gender, race, age, status or type of sickness.
## SECTION E: PERCEPTION OF PATIENTS ABOUT STAFF MEMBERS

### Scoring

1. SA = strongly agree; 2. A = Agree; 3. U = undecided; 4. D = disagree; 5. SD = strongly disagree

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Official use</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. There is no staff shortage at the CHC.</strong></td>
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</tr>
<tr>
<td><strong>2. The persons who assisted me at the reception desk are helpful.</strong></td>
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<tr>
<td><strong>3. The nursing staff treats you with respect and are friendly.</strong></td>
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<td><strong>4. The doctor who treated you was polite and respectable.</strong></td>
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<tr>
<td><strong>5. The doctor explained to me what was wrong with me.</strong></td>
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<tr>
<td><strong>6. You can complain to the staff without being afraid.</strong></td>
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<tr>
<td><strong>7. You are pleased with the way you are treated by the staff at the CHC.</strong></td>
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</tbody>
</table>

39-45
### SECTION F: PATIENT BEHAVIOUR

#### Scoring

| 1. SA = strongly agree; 2. A = agree; 3. U = undecided; 4. D = disagree; 5. SD = strongly disagree |
|---|---|---|---|---|---|
| 1 | SA | 2 | A | 3 | U | 4 | D | 5 | SD | Official use |

1. I return to the CHC on the scheduled dates.  

2. I still have the same folder from the first visit.  

3. I do not mind to wait for hours before I am seen by a nurse/doctor.  

4. I expect to receive medications every time I visit the CHC.  

5. I use up all the medication they give me.  

6. I understand the information about your sickness.  

7. I only attend this CHC because the care provided here is better than at other clinics.  

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46-52

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Thank you for your participation.
INFORMED CONSENT TO RESPONDENTS GIVEN VERBALLY BY THE DATA COLLECTING VOLUNTEERS

Ms Van Niekerk is a registered nurse conducting research for her Master’s degree at the University of South Africa. She will be studying patient satisfaction with the health care services rendered at the Crossroads Community Health Care Centre (CHC). The study will assist in improving service delivery and identify gaps within the service.

The Provincial department of health, Cape Town, has approved that the study can be conducted in their health care centre and the facility manager has been notified that such a study will be conducted.

You will not be at risk or you will not be harmed either physically or psychologically if you decide to take part in the research project or not.

You are expected to respond to the questions in the questionnaire which will take less than 20 minutes. You are free to ask any question if clarity is needed. Your participation in this study is voluntary and you are under no obligation to participate. You have the right to withdraw at anytime however your participation is highly appreciated and will have no effect on your service delivery needs.

Your identity will not be revealed during the study, reporting or publishing. Data will be collected by Ms Van Niekerk and well trained volunteers who will not share the information with any other person.