

CHAPTER 1

Introduction and background of the study

1.1 INTRODUCTION

The National Health Plan's Policy (ANC 1994b:4) addresses the restructuring of the health system in South Africa and highlighted the following health prerequisites: affordability, accessibility, availability and equity, especially focusing on the disadvantaged groups/communities. The White Paper on the Transformation of the Health System in South Africa (Department of Health 1997a:8), developed these principles even further and provides guidelines for their implementation.

The philosophy of primary health care (PHC) was adopted as a basis for health services in South Africa. PHC in its broader term was a solution to the above-mentioned issues and includes preventive, promotive, curative and rehabilitative care (Dennill, King & Swanepoel 1999:11).

A District Health System based on PHC is a more or less self-contained segment of the National Health System. It comprises of a well-defined population, living within a clearly delineated administrative and geographical area, whether urban or rural. It included all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private, or traditional (Department of Health 1995:6).

The District Health System's approach is a vehicle through which quality PHC will be supported and managed (Harrison 1997:1). This approach is an effective way of improving the health of people. The PHC package comprises of the following services, will be determined by the available resources and had to be implemented on a sustainable and incremental basis:

- Promotive and preventive services, including health education, nutrition, family planning, immunisation and screening for common diseases.

- Curative services for acute minor ailments, trauma, endemic and other communicable and chronic diseases.
- Maternal and child health care, including antenatal care, deliveries, postnatal and neonatal care.
- Provision of essential drugs.
- PHC level investigative services, including radiology and pathology.
- Basic rehabilitative and physiotherapy services.
- Basic optometry services.
- Community mental health services.
- Health education.
- Health-related nutritional support.
- Communicable, non-communicable and endemic disease prevention and control.
- School and institutional health services.
- Health-related water and sanitation services and other environmental health services.
- Occupational health and safety services.
- Community nursing and home care services.
- Essential accident and emergency services.
- Community geriatrics services and care of the elderly.
- Health service support (Harrison 1997:1-2).

According to the Department of Health (1997a:14), the principle of universal access to PHC for all South Africans was implemented in April 1996. In contrast to the previous model where the focus of health provision was on curative care rendered mostly in hospitals, accessible and decentralised clinics and health centers providing PHC, are now the main focus of service.

Most clinics in the metropolitan areas were in the past rendering preventive, promotive and rehabilitative care with the curative component only concentrating on the treatment of minor ailments and communicable diseases. This resulted in the local hospitals being overcrowded because the community went there for curative services. Clients had to walk more than 10 km to the local hospital and had to pay to be attended to at the hospital.

Curative services were rendered mainly at hospitals, because of the availability of doctors. The decentralisation of services according to the PHC philosophy, needed personnel with the necessary skills and knowledge to address health at primary level. This necessitated that personnel, specifically nurses, be trained in a curative setting for them to manage clients at clinic level. The diploma in clinical health assessment, treatment and care was introduced, with the aim to equip the nurse to be able to diagnose and treat the clients. The above-mentioned diploma was accredited by the South African Nursing Council (SANC) and was added on the register as an additional qualification.

Professional nurses who have undergone this one-year course are guided by section 38 of the Nursing Act (Act 50 of 1978, as amended). This act covers the scope of practice of this nurse practitioner and stipulates that she can only prescribe medicines from schedule 1-4. It also states that the 'nurse practitioner must be assessed yearly by a medical officer for competency (Nursing Act (Act 50 of 1978, as amended, section 38a)) (South Africa 1998:4).

In a meeting of the World Health Organization (WHO) Expert Committee on nursing practice in Geneva in 1995, Dr Chang Lie, Assistant Director General, pointed out that nursing has to meet the challenges of the changing profile of world health. One of the terms of reference of the committee was to describe and consider the nature and scope of nursing practice as it responds to the needs of society (Akinsola & Ncube 2000:50) and thus training in clinical health assessment treatment and care was emphasised.

The aim of training of nurses in clinical health assessment, treatment and care was to curb the overcrowding that occurred in the local hospitals and to provide a comprehensive health care service at primary level, which is the local clinics. These nurse clinicians are able to treat most common conditions and emergencies at primary level. Clients are referred to the local hospital for management of health conditions at secondary level and thus the overcrowding at the local hospital could largely be addressed through the establishment of this curative component at the clinic under study (Ushudi-Lumbu 1993:36).

The curative aspect of PHC entails history taking, physical assessment, diagnosing, prescription of medicine from schedule 1-4 and referral of clients to hospital or the clinic doctor for conditions beyond the nurse clinician's scope of practice (Nursing Act (Act 50 of 1978, as amended, section 38a)) (South Africa 1998:4).

The clinic under study is a clinic in the East Rand region, which is one of the four clinics rendering a comprehensive PHC service in the Eastern Ekurhuleni Metropolitan area. This clinic liaises with the local hospital, that is the Far-East Rand Hospital and there is a good referral system from the clinic to the hospital and vice versa.

1.2 BACKGROUND

The clinic in this study is rendering comprehensive PHC services which are preventive, promotive, curative and rehabilitative and has a sessional doctor, who visits the clinic for two hours in the mornings, Monday to Friday. The doctor who is rendering sessional work at the clinic, is a district surgeon who also has to attend to, for example raped cases and disability grants.

The local clinic is providing services to \pm 3 000 community members per month as revealed by the clinic statistics, including those living in squatter areas in the said metropolitan area. The community members were predominantly White but because of the mushrooming of informal settlements, the status quo changed and more Black clients utilised the clinic.

The curative wing was established in May 1996 at this clinic as the other PHC components were already rendered in this abovementioned clinic. The curative wing was established to alleviate overcrowding at the local hospital, for accessibility and affordability. This wing was staffed by professional nurses who had undergone training for one year in the Diploma in Clinical Health Assessment, Treatment and Care.

The professional nurses rendering curative PHC services have a PHC diploma course whilst those rendering the other components of PHC services, have a

certificate in PHC.

The hospital records have shown that during May and June 2001, out of 1 328 clients who were referred to the clinic, 951 of this group of patients still went back to the hospital.

The hospital's outpatient department is seeing \pm 583 clients per week for minor ailments (Far-East Rand Hospital Statistics 2001).

Irrespective of the fact that the provincial government has introduced a bypass fee, paid by those clients who were supposed to have attended the clinic, clients still utilised the hospital (Department of Health 1999a:53). Clients who attend the hospital without a referral letter from the clinic, pay the hospital fees whilst those who go via the clinic and have a referral letter, do not pay at the hospital.

1.3 PROBLEM STATEMENT

Clients prefer to receive curative services at PHC level from the hospital rather than the clinic.

1.4 RESEARCH QUESTIONS

The following research questions were asked by the researcher:

- What factors have an impact on the utilisation of curative PHC services provided by the clinic to the community?
- What are the suggestions for improving the curative PHC services at the clinic?

1.5 OBJECTIVES OF THE STUDY

The objectives of the study are fourfold:

- To explore and describe the perceptions of members of the community on

the utilisation of the curative PHC services at the clinic.

- To explore and describe the suggestions made by the community to improve curative PHC services at the clinic.
- To identify limitations in the utilisation of curative PHC services at the clinic.
- To formulate intervention strategies to be utilised by the nurse clinicians to improve curative PHC services at the clinic.

1.6 CENTRAL STATEMENT

The exploration and description of the perceptions of the members of the community about curative PHC services and the suggestions made by them will provide the basis for generating intervention strategies to improve the utilisation of curative PHC services by the community members.

1.7 RESEARCH DESIGN

A qualitative, explorative and contextual design was followed in this study.

1.8 RESEARCH METHOD

The following research method was used by the researcher:

1.8.1 Population and sampling

The target population consisted of clients attending the Far-East Rand Hospital's outpatient department (OPD) for chronic medication and minor ailments, who were 18 years and older, members of the community health committee (CHC) and nurses rendering curative PHC services at the clinic under study.

The target population was chosen on the basis that clients with minor ailments were supposed to attend the local clinic as the first point of entry. The second target group was clients with chronic conditions which were chosen because

despite the fact that most of them were referred to the local clinic, still attended the hospital. The abovementioned clients were available at the hospital's OPD on that day and were also willing to participate. Their OPD files assisted the researcher in choosing the target group.

The CHC was the third target group because they liaise with the clinic staff and the community members. They attended ward committee meetings with the community and clinic meetings with the clinic staff. They also acted as mediators between the community and the clinic staff. They forwarded the community problems pertaining to health to the clinic staff and vice versa. They were elected by the community members and worked on a voluntary basis.

The nurse clinicians at the PHC clinic were included in the study as the fourth group, because they are responsible for rendering curative service and would be knowledgeable about the strength and weaknesses in the service that they render. By including the nurse clinicians, valuable information could be obtained about the perception of the nursing staff on patient satisfaction.

Criteria for inclusion as participants in the study were that all the informants should reside in the metropolitan area under study, except nurses and should be conversant in Sotho or English.

Sampling

A purposive convenient sampling involves conscious selection of population groups to include in the study (Polit & Hungler 1995:235). In this study, participants who complied with the specified selection criteria were selected in the four groups. The sample size was achieved when data was saturated (De Vos 1998:192).

1.8.2 Data collection

Data was gathered by means of focus group interviews with the four groups and were conducted in two phases.

Phase 1

In phase 1, focus groups were conducted at the hospital with the following two groups:

- Group A: Clients who attend the Far-East Rand Hospital's OPD for their chronic medication, for example diabetics and hypertensives.
- Group B: Clients who attend the Far-East Rand Hospital's OPD for minor ailments.

Phase 2

Phase 2 occurred at the clinic where focus groups were conducted on groups C and D:

- Group C: Members of the CHC who are from the community under study.
- Group D: Nurse clinicians rendering curative PHC services to the clients at the clinic.

A focus group interview was chosen in preference to other data collection methods, for example a questionnaire, because of the level of literacy of some of the participants.

A tape-recorder was used to record the interviews which were transcribed verbatim and translated in English.

Data collection will be discussed fully in chapter 2.

1.8.3 Pilot interview

A pilot interview was conducted with informants who fulfilled the required set criteria for the population. These informants were not included in the major study (De Vos 1998:181). The purpose of the pilot interview was to do a trial run of the interview in preparation for the major study (Polit & Hungler

1995:648).

1.8.4 Data analysis

The tape recorded interviews were transcribed verbatim and then analysed according to the method suggested by Tesch in Creswell (1994:155) and will be described in chapter 2. The data analysis of the study will be discussed fully as chapter 3.

1.8.5 Trustworthiness

To ensure trustworthiness, Guba's model (Krefting 1991:214-222) was used as discussed in chapter 2. Literature control was carried out as the results of the research are discussed in the light of relevant literature and information obtained from similar studies in chapter 4.

Triangulation of data was done based on the use of multiple data sources in the study which was through interviewing multiple key informants and literature control.

1.9 ASSUMPTIONS

An assumption is a basic principle that is accepted as being true, on the basis of logic or reason, without proof or verification (Polit & Hungler 1995:10, 96).

The study was based on the following assumptions:

- The curative services that are available at the Far-East Rand Hospital are comparable to and of the same quality as services that are available at the clinic under study.
- The clients/patients are aware about the availability of the services at the clinic.
- The members of the CHC are aware of the health needs of the community under study.

- The nurses working at the clinic are aware of the health needs of the community under study.

1.10 SIGNIFICANCE OF THE STUDY

The findings of this study should be valuable and significant to the community by providing them with good PHC facilities at the clinic.

The nurses working at the clinic should also benefit if relevant findings of the research are implemented.

1.11 DEFINITIONS AND CONCEPTS

The following are definitions of terms as used in the dissertation.

1.11.1 Community health committee

This consists of elected voluntary community representatives who comprise of representatives from health services in that area, non-governmental organisations (NGOs), local health practitioners and other members who are residents in the community concerned (ANC 1994b:61).

1.11.2 Curative management of diseases

Is when an expert practitioner develops skills in inductive reasoning to arrive at a diagnosis and treatment plan that is acceptable to the clients (Dains, Baumann & Scherbel 1998:4).

1.11.3 Curative primary health care

The curative aspect of PHC entails history taking, physical assessment, diagnosing, prescription of medicines from schedule 1-4 and referral of clients to hospital or the clinic doctor for conditions beyond the nurse's scope of practice (Nursing Act (Act 50 of 1978, as amended, section 38a)) (South Africa 1998:4).

1.11.4 Ekurhuleni Metropolitan Council

The Ekurhuleni Metropolitan Council comprise of nine independently functioning local authorities which have merged to form one metropolitan structure. It is divided into three regions: the South, the North and the Eastern region.

1.11.5 Health

Health is defined as a state of physical, mental and social well-being and not merely the absence of disease or infirmity (Mathew, Yach & Buch 1989:190). It can also be defined qualitatively on a continuum from maximum to minimum health (ANC 1994a:42).

1.11.6 Nurse clinician

Is a qualified registered nurse who has undergone a one-year course in Clinical Health Assessment, Treatment and Care.

1.11.7 Primary health care

It is essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and their families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development, in the spirit of self-reliance and self-determination (Ferreira 1992:6).

It forms an integral part, both of the country's health system, of which it is the central function and the main focus and the overall social and economic development of the community.

It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work and constitute the first element of a continuing health care service (Dennill et al 1999:2).

1.11.8 Registered nurse

Refers to a person who is trained according to the guidelines laid by the SANC and has acquired a certificate of accreditation from the same body to practice as a nurse and is registered as a nurse under section 16 of the Nursing Act (Act 50 of 1978, as amended) (South Africa 1998).

1.11.9 Research population

Refers to a group of people with the same interest or origin (Foule & Fowler 1994:188). Differentiation can be made between the accessible population and target population. The accessible population is the total number of cases that conform to the set criteria and that are accessible to the researcher. The target population comprises the total number of cases about which the researcher would like to make generalisations (Polit & Hungler 1995:230).

In this study the accessible population refers to clients attending the Far-East Rand hospital's OPD, members of the CHC and the curative nurse clinicians.

1.12 ABBREVIATIONS

The following abbreviations were used in the dissertation:

ANC	-	African National Congress
CHC	-	Community Health Committee
DENOSA	-	Democratic Nursing Organisation of South Africa
NGOs		Non-governmental Organisations
OPD	-	Outpatient Department
PHC	-	Primary Health Care
RDP	-	Reconstruction Development and Planning

SANA	-	South African Nursing Association
SANC	-	South African Nursing Council
USA		United States of America
WHO	-	World Health Organization

1.13 OUTLINE OF THE STUDY

The outline of the study will be as follows:

- Chapter 1 - Introduction and background of the study
- Chapter 2 - Research design and methodology
- Chapter 3 - Data analysis
- Chapter 4 - Literature control and conclusions
- Chapter 5 - Overview, strategies, recommendations and limitations

1.14 SUMMARY

In this chapter, the introduction, background, objectives and problem statement were fully discussed. Research design and methods were mentioned in this chapter but will be fully discussed in chapter 2.