

THE EXPLORATION OF HEALTH SEEKING BEHAVIOUR  
OF CLIENTS PRESENTING WITH MINOR AILMENTS  
ATTENDING COMMUNITY HEALTH CENTRES  
IN KHAYELITSHA (MICHAEL MAPONGWANA, SITE B)  
AND PHILLIPI (INZAME ZABANTU, MZAMOMHLE)



**N.B. MTWANA**

SUBMITTED IN FULFILMENT OF THE REQUIREMENTS  
FOR THE DEGREE OF MSc (MEDICINE) AT CAPE TOWN UNIVERSITY

SUPERVISORS: G MJI  
CO-SUPERVISOR: J KEIKELAME

2005

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

## Table of Contents

	Page
Title	i
Table of contents	ii
List of tables	v
Declaration	vi
Abstract	vii
Acknowledgements	ix
Definition of Terms	xi
List of Acronyms	xiii
1 CHAPTER 1 EVOLUTION OF THE STUDY	1
1.1 The aim of the study	1
1.2 Background of the study	1
1.3 Evolution of the problem	2
1.4 The problem	4
1.5 Aim of the study	6
1.6 Objectives of the study	6
1.7 Motivation of the study	6
1.8 Significance of the study	10
1.9 Summary of Chapter 1	11
2 CHAPTER 2 LITERATURE REVIEW	13
2.1 Introduction	13
2.2 Health seeking behaviour	15
2.3 Factors that have impacted on the health system of South Africa	24
2.4 Model of Primary Health Care at primary level of care	38
2.5 The Status of Primary Health Care in South Africa today	41
2.6 Description of the study area: Khayelitsha and Phillipi	42

2.7	Summary of Chapter 2	44
3	CHAPTER 3 METHODOLOGY	46
3.1	Aim of the study	46
3.2	Objectives of the study	46
3.3	Study design	47
3.4	Study area, study population, study sample and sampling methods	48
3.5	Inclusion and exclusion criteria	51
3.6	Instrumentation and methods of data collection	52
3.7	Training of research assistants	55
3.8	Pilot study	56
3.9	Data analysis	58
3.10	Ethical considerations	60
3.11	Adjustments to methodology	60
4	CHAPTER 4 PRESENTATION OF RESULTS	62
4.1	Format for the results of this study	62
4.2	Section 1: The results from clients' data	62
4.3	Section 2: Doctors and clinical nurse practitioners' results	72
4.4	Limitations of the study	80
5	CHAPTER 5 DISCUSSION OF THE RESULTS	82
5.1	Introduction	82
5.2	Conclusion	92
6	CHAPTER 6 RECOMMENDATIONS	94
6.1	Health professionals	94
6.2	The clients	94
6.3	The community	95

6.4	The Public Health Sector	96
6.5	The researcher	97
	REFERENCES	99
	APPENDICES	106

University of Cape Town

## LIST OF TABLES

Table 1	Inclusion and exclusion criteria of CHCs, doctors, CNPs and clients	52
Table 2	Summary of problems experienced during piloting and adjustments made for the main study	58
Table 3	List of minor health ailments used in this study	61
Table 4	Adjusted table of list of minor health ailments	61
Table 5	Number of clients that were seen by the participating doctors and CNPs presenting with minor health ailments on the day of the research for each CHC	63
Table 6	Combined age group of clients that participated in the study from the four CHCs presenting with minor health ailments	64
Table 7	List of illnesses presented to the research assistants by the clients that were selected by the doctors and clinical nurse practitioners as having minor health ailments at Michael Mapongwana, Mzamomhle, Site B and Inzame Zabantu CHCs	65
Table 8	List of top ten illnesses mentioned by the clients	66
Table 9	List of minor health ailments that clients think can be treated at home	67
Table 10	Health facilities that clients use when they are sick presenting with minor health ailments	68
Table 11	Advisors known by the clients for management of minor health ailments using home remedies	70
Table 12	Resources used by clients if their minor health ailments become serious at Home	71
Table 13	Sources of education clients received about minor health ailments at the CHC	72
Table 14	Age group of doctors participated in the study	73
Table 15	Age group of CNPs who participated in the study	73

## DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis is my own original work, that I have not previously submitted it in its entirety or in part to any other university for a degree or examination in any other university, and that quoted material has been indicated and acknowledged by complete references.

Signed by candidate

Date:..... 17. 06. 05 .....

University of Cape Town

## ABSTRACT

After 1994, the democratically elected ANC government implemented Primary Health Care in South Africa. The aim was to make health services accessible and equitable especially to those communities that had minimal or absent health services. This resulted in a proliferation of community based health services including community health centres (CHCs). Despite this, CHCs in Khayelitsha and Phillipi are overcrowded and overburdened with clients who tend to present with minor health ailments. The problem of overcrowding of the CHCs with such clients pose a problem to the health professionals as they do not have sufficient time to manage clients with more serious ailments and to educate those with minor health ailments. This problem of overcrowding of CHCs in Khayelitsha and Phillipi with clients presenting with minor health ailments was brought to a community health forum meeting that constituted the management of CHCs, clinical facilitators from University of Cape Town (UCT), students from UCT and elderly persons from Khayelitsha and Phillipi in 2001. At this meeting questions were raised regarding the health seeking behaviour of the clients that are presenting with minor health ailments and overcrowding the CHCs.

The elderly persons had a perception that minor health ailments can be contained and managed within the home situation using resources that are available at home. It was further questioned why these clients were not utilising the resources that are available within the home?

After some discussions at this community health forum, it was concluded that the first step towards understanding why the clients were frequenting the CHCs and presenting with minor health ailments was to explore the health seeking behaviour of such clients. Hence the aim of this study: to explore the health seeking behaviour of clients presenting with minor health ailments attending CHCs in Khayelitsha and Phillipi for the management of minor health ailments.

To achieve this aim the researcher conducted a descriptive study. Self-compiled and self-administered structured questionnaires were used to collect both demographic data and information from both the clients and the health professionals (doctors and clinical nurse practitioners) with regards to their perceptions and attitudes on how minor health ailments should be managed. A hundred clients with minor health ailments and 15 health professionals were given questionnaires to complete individually. Data was analysed qualitatively and quantitatively to determine the perceptions and attitudes of these participants.

The results indicated that clients felt they were deprived of comprehensive health service including health education. The health professionals on the other hand felt frustrated by the number of clients who presented with minor health ailments. Since both the clients and health professionals were not satisfied with the management strategy that was used by both the clients and the health professionals, the researcher is recommending that the community and the health professionals need to discuss and develop an acceptable strategy for the management of minor health ailments in these areas. The platform of the community health forum that was used for this study could be further utilised for this.

University of Cape Town

## ACKNOWLEDGEMENTS

The author wishes to express her gratitude to the following people for their valued contributions, time, advice, support and encouragement during the course of this study:

**Ms G. Mji**, for recruiting me to be part of the masters programme, supporting me all the way till the last minute of my degree, supporting me when I experienced bad things in my life during my course of studies, who had a listening ear and understanding when I needed her to do so.

**Mrs J. Keikelamme**, for encouraging me to pull through the proposal and supported in finishing my studies.

**Mr M. Mlenzana**, for being emotionally supportive throughout my studies, for encouraging me to pursue this career and understanding that he has a student, a wife and a mother to our child.

**Ms S.Gcaza**, for supporting me at the beginning of my degree with the proposal of my study, allowing me to take her time to make her understand my study so that she can be able to assist me, for letting me use her computer and space when I did not have one, for still being a friend to me even though I did not have time for her during my studies.

**Community Health Services Organisation (CHSO)**, Ms. C. de Wet, Dr Bitalo and others for allowing me to pursue this career.

**All my friends**, who supported me emotionally through rough moments in my life and who are looking forward to this degree that I am doing.

**Mr. M. Zonke**, for the support and encouraging me to finish the study that we were both doing.

**My parents, grandparent and cousins**, who were supportive throughout the course of my studies.

**National Research Fund**, for financial assistance for three years.

**Mr Nkunkumana**, for assisting me with computer technology.

**All participants**, clients, doctors and clinical nurse practitioners from the four CHCs (Michael Mapongwana, Site B, Inzame Zabantu and Mzamomhle) in Khayelitsha and Phillipi for making this study possible.

University of Cape Town

## DEFINITION OF TERMS

- **Clinical nurse practitioner**

“A professional nurse registered with South African Nursing Council trained with clinical skills whereby she/he independently takes history, examines, diagnoses, treats and refers the patient if necessary” (Personal communication, Sr Mgidlana, 2002).

- **Clinics**

Places where medical advice, examination and treatment are available, generally only during office hours. Clinics provide mostly preventive and health promotive care and are run by the local authorities. Also referred to as health facilities (Department of Health and Social Services, 2000).

- **Community health centre (CHC)**

A centre that is responsible for coordinating primary health services to a defined community and its satellite clinics and outreach and community services, including those of environmental health officers and community health workers (Western Cape Province Ministry of Health and Social Services Strategic Management Team, 1996).

- **Elderly person**

A person who has experience about life and can approach daily problems using previous experience (Personal communication, Mr Mtyapi, 2001). According to the human developmental stages older persons ranges between ages 55-75 years (Froggat, 1990). In this study an elderly person is a person who gives people advice about indigenous health knowledge regarding the management of minor health ailments.

- **Health seeking behaviour**

The behaviour which helps to maintain good health; actions taken specifically to prevent illness; and actions taken to restore health (Habgood, 1999).

- **Minor health ailments**

Common aches and pains that can be treated at home without the need for prescribed medicine, for example back pains, burns, colds, minor cuts, stomach aches, insect bites, nose bleeds, and rashes ([www.boahc.demon.co.uk/ailments .htm](http://www.boahc.demon.co.uk/ailments.htm)2001/05/11).

- **Primary health care**

According to the Declaration of Alma-Ata Primary Health Care “is an essential health care made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community” (Fry & Hasler, 1986).

- **The Reconstruction and Development Programme (RDP)**

A plan that was invented and implemented by the African National Congress (ANC) as the government of South Africa to address the many social and economic problems such as violence; lack of housing; lack of jobs; inadequate education and health care; lack of democracy and a failing economy (African National Congress, 1994).

University of Cape Town

## LIST OF ACRONYMS

<b>CHC</b>	Community Health Centre
<b>UCT</b>	University of Cape Town
<b>UWC</b>	University of the Western Cape
<b>US</b>	University of Stellenbosch
<b>PHC</b>	Primary Health Care
<b>ANC</b>	African National Congress
<b>RDP</b>	Reconstruction and Development Programme
<b>CNP</b>	Clinical nurse practitioner
<b>WHO</b>	World Health Organisation
<b>CHSO</b>	Community Health Services Organisation
<b>DHS</b>	District Health System
<b>NPPHCN</b>	National Progressive Primary Health Care Network
<b>CASE</b>	Community Agency for Social Equity
<b>CT</b>	Cape Town
<b>SA</b>	South Africa
<b>ICPC</b>	International Classification for Primary Health Care
<b>TB</b>	Tuberculosis
<b>UTI</b>	Urinary tract infection
<b>CHW</b>	Community Health Worker

# CHAPTER 1

## Evolution of the study

### 1.1 The aim of the study

The aim of this study is to examine the problem of health seeking behaviour of clients presenting with minor health ailments at Community Health Centres (CHCs) in Khayelitsha and Phillipi. CHCs provide primary health care in these areas. This study was conducted at primary health care level. Chapter 1 introduces the background to the focal areas for this study (Khayelitsha and Phillipi), the evolution of the problem in these areas, as well as the problem *per se*. The chapter then outlines the aim of this research, its objectives, motivation and significance.

### 1.2 Background to the focal areas Khayelitsha and Phillipi

Informal housing (so-called shack dwellings) is a longstanding problem in South Africa, but in recent years this has become of increasing concern for government housing agents and other authorities because of the socio-political changes taking place in this country and the realisation that the coercive measures of the apartheid era have failed. There are a broad range of causes for the erection of shack dwellings in South Africa. These include rapid urbanisation of the population with an increase of youth mobility, widespread poverty, unemployment and under employment, and a severe housing shortage, largely a product of poor urbanisation management policies of the apartheid era (Johannes, 2002).

For these and other reasons, South African cities have in the last two decades experienced an increasing strain on housing and infrastructural resources and the mushrooming of squatter settlements in many parts of the country. Cape Town with its laid back atmosphere, lovely beaches, work opportunities and good weather attracted many people from the homelands and the rural areas somuchso that squatter settlements have become part and parcel of peri-urban Cape Town, a situation not unfamiliar to other urban cities in South Africa (Johannes, 2000).

Khayelitsha and Phillipi, the focal areas for this study, are two such black townships.

Khayelitsha started when the apartheid government planned to move all Africans living near the

city centre to areas further away from the city and suburbs (at that time by white people). Thus Khayelitsha was born. Two-roomed houses were built in Khayelitsha for the people who were staying, for example in backyards of homes in Langa and Gugulethu townships. Phillipi started at Brown's Farm where people working on the farm built shack dwellings as a form of housing. Khayelitsha and Phillipi are located approximately 26 and 20 kilometers respectively from Cape Town city centre. They are the result of informal settlement. One characteristic of informal settlements is rapid population growth. It is estimated that in Khayelitsha the population increase is 8.5% per year. The census of 2001 estimates that Khayelitsha alone has approximately 300,000-400,000 people. However, because of the rate of people coming to Khayelitsha the numbers could be more than this. In Phillipi the estimation is approximately 50,000 people. The population of these areas are mainly the young or Xhosa-speaking people.

Both Khayelitsha and Phillipi are overcrowded with shacks that have been erected from builders' rubble, zinc or aluminium, cardboard, wood and plastics. These housing structures are recognised as informal buildings because they are built on plots that were originally set aside for development projects. The result is overpopulated areas on plots where people forcefully built shacks. Consequently there is no space for infrastructure, such as sanitation, community centres, and playgrounds. The present government is struggling to develop resources for people staying in here. Thus the areas have come to be regarded as health hazards. It is not unheard of that fires such as the one that swept the Joe Slovo informal settlement in Langa, March 2005 should ravage settlements like Khayelitsha and Phillipi. This is but one example of the hazardous nature of the informal settlements. Another disaster that these communities face is flooding due to heavy rains. When these heavy rains fall problems such as blocked drainage systems are common. They predispose residents to infectious diseases like diarrhoea and skin disorders.

### **1.3 Evolution of the problem**

The majority of the people staying in Khayelitsha and Phillipi are unemployed. Bad conditions such as overcrowding and poor infrastructure leave these people prone to an array of sicknesses. Nsisi (1999a) conducted a study on the morbidity profile at Nolungile CHC. He explored the disease profile of clients attending at this CHC using the International Classification for Primary Health Care (ICPC). In his study, Nsisi mentions that the prevalence of respiratory problems in

clients visiting Nolungile CHC might be due to poor housing and overcrowding. When people in these areas are sick they not only seek help from CHCs, pharmacists and community health workers but also from other sources like traditional healers, faith healers, family and friends.

After the 1994 elections, the new government listed accessible health care as one of the basic rights of all South Africans. Their plan was to develop a national health system offering affordable health care with the focus on primary health care to prevent disease, promote health, and cure illnesses (African National Congress, 1994).

In 1996 the Provincial Administration of the Western Cape Department of Health, in line with the government's national initiatives, developed a district health plan to provide access to health care for all citizens. The district health system would be supported by the development of CHCs and clinics to enhance the services provided. Khayelitsha and Phillipi fall under Districts 7 and 3 respectively.

Khayelitsha has three CHCs, namely Site B, Michael Mapongwana and Nolungile. Site B is a 24-hour service CHC and consists of a general medical, rehabilitation, preventive and maternity section. Michael Mapongwana CHC has a general medical, rehabilitative and preventive section that opens at seven in the morning and closes at five in the afternoon as well as a 24-hour maternity section. Phillipi has four CHCs: Inzame Zabantu, Mzamomhle, Nyanga and Gugulethu. Inzame Zabantu and Mzamomhle CHCs function similarly to Michael Mapongwana CHC except that they do not have a maternity section.

The CHS in Khayelitsha and Phillipi provide curative, rehabilitative, preventive, promotive and maternity services. The daily statistics of clients in 2001 attending Michael Mapongwana CHC registered approximately 250 clients per day; Site B approximately 600 clients per day; Inzame Zabantu CHC approximately 250 clients per day; and Mzamomhle CHC approximately 300 clients per day. Clients registered are seen by doctors and clinical nurse practitioners and also other health professionals such as dentists, physiotherapists, occupational therapists and pharmacists who run services within the CHCs. The ratio of doctor:patient is meant to be 1:60 and the ratio of the clinical nurse practitioner:patient is meant to be 1:25. In reality both doctors

and clinical nurse practitioners see far more patients than this especially when there is shortage of staff.

The universities within the Western Cape Province adopted the Primary Health Care (PHC) approach in their curriculum. These universities are the University of Cape Town (UCT), the University of Stellenbosh (US) and the University of the Western Cape (UWC). Because of its focus on PHC in the curriculum, the Faculty of Health Sciences at UCT formed a partnership with disadvantaged communities such as Khayelitsha and Philippi to give students first hand experience of primary health care in these communities.

Different groups of UCT undergraduate students from the medical (MBChB), occupational therapy, physiotherapy, speech and audiology courses spend approximately six weeks at various CHCs in Khayelitsha and Phillipi where they gain clinical and community based experience in their field of training. The Ottawa Charter in 1996 identified three main focus areas for Primary Health Care delivery and for health promotion: advocacy, enablement and mediation (Coulson, Goldstein and Ntuli, 1986). This framework informs the health promotion activities that UCT students engage with during their clinical and public health training in the CHCs and when they provide other services in the community.

#### **1.4 The problem**

While conducting health promotion activities in the CHCs (Michael Mapongwana, Site B, Inzame Zabantu and Mzamomhle), UCT students noticed that they were overcrowded with clients. A mini survey conducted at Michael Mapongwana and Site B CHCs showed that CHCs were overcrowded and overburdened with clients who presented with minor health ailments. The results of these two mini epidemiological studies revealed that every day 24% and 33% of the clients at Michael Mapongwana and Site B respectively presented with minor health ailments (Brice, Mcgurk, Petkar and Philip, 2000; Keraan, Naidoo, Parker and Royker, 2000).

The health care providers see themselves as unable to fulfill the role of promoting health education and health maintenance because of this overcrowding by clients presenting with minor health ailments. Somuchso that on some days when there is shortage of doctors and clinical nurse

practitioners, health professionals end up seeing more patients than the projected ratio. This patient overload causes health care providers to feel that they are unable to fulfill the role of giving adequate health care to clients.

Clinical nurse practitioner (Personal communication, Sr Sigwela, 2001), stated that due to the large numbers of clients attending CHCs, health professionals have no time to educate clients on prevention and management of minor health ailments. The easiest way to manage the situation is to prescribe medication for the clients. In the long run this is costly to the CHCs as well as government because the clients in turn visit the CHCs more frequently with the same types of minor health ailments. It is assumed that this might be due to the fact that clients do not have adequate knowledge on the prevention and management of minor health ailments. Thus they do not utilise alternative methods and medicines, such as indigenous health knowledge of elderly persons, traditional healers, community health workers, pharmacists and other resources available in their communities for management of minor health ailments.

Consequently this situation raised questions like the following for the researcher: Do the community health centre staff serve their purpose by predominantly assisting clients presenting with minor health ailments? Do CHCs serve their role in providing accessible and affordable health services if they are often overcrowded by attendance for minor health ailments?

The problem of overcrowding of CHCs (Michael Mapongwana and Site B) came to be discussed in the community health forum with the facility managers of these CHCs, health professionals, clinical facilitators from UCT, students from UCT and elderly persons from Khayelitsha and Phillipi. The researcher attended one of these health forum meetings in 2001. There was a group of elderly persons residing in Khayelitsha and Phillipi who had the perception that minor health ailments can be managed at home using indigenous health knowledge. From these meetings it was decided that this matter must be investigated further by doing research on why CHCs are overcrowded on a daily basis with clients presenting with minor health ailments and what indigenous health knowledge could be used to manage minor health ailments. It was concluded at the forum that it is essential to explore the health seeking behaviour of clients presenting with minor health ailments at CHCs in Khayelitsha and Phillipi. Hence this study evolved.

## **1.5 Aim of the study**

The aim of this study was to explore the health seeking behaviour of clients presenting with minor health ailments attending CHCs in Khayelitsha and Phillipi (primary health care centres in their area) for the management of minor health ailments.

## **1.6 Objectives of the study**

1. To explore and review the literature that underpins the study (Chapter 2).
2. To determine the number of clients presenting with minor health ailments in the fourth week of April 2003 for four days (one day allocated for each community health centre: Michael Mapongwana, Site B, Inzame Zabantu and Mzamomhle) for the data collection.
3. To determine the demographic details of the clients presenting with minor health ailments, and the doctors and clinical nurse practitioners who participated in the study.
4. To describe the types of minor health ailments that the above mentioned clients presented with in the CHCs in Khayelitsha and Phillipi.
5. To describe perceptions and attitudes of clients at the selected CHCs that presented with minor health ailments with regard to the care of minor health ailments.
6. To describe the type of ailments that the doctors regarded as minor health ailments including their perceptions towards the management of these ailments.
7. To describe the type of ailments that clinical nurse practitioners regarded as minor health ailments including their perceptions towards the management of these ailments.
8. To make recommendations with regard to the care of minor health ailments to clients, health care professionals, community health workers and the community in general (Chapter 6).

## **1.7 Motivation of the study**

As mentioned 1.4 (the problem) mini epidemiological studies were conducted to explore the problem of overcrowding at Michael Mapongwana and Site B CHCs. They ascertained that the types of ailments that clients presented with were mainly backache, headache, stomach ache, cold, diarrhoea and influenza (Brice *et al*, 2000; Keraan *et al*, 2000).

Minor health ailments are defined in this study as common aches and pains that can be treated at home without the need for prescribed medicine by a medical professional. Minor health ailments are further defined as back pains, burns, colds, minor cuts, stomach aches, insect bites, nose bleeds and rashes ([www.boahc.demon.co.uk/ailments.htm](http://www.boahc.demon.co.uk/ailments.htm)2001/05/11).

Nsisi (1999a) conducted a similar study to Brice *et al* (2000) and Keraan *et al* (2000). He looked for the top ten reasons for all client visits to Nolungile CHC and found they were coughs, prescription for cardiovascular medication, local erythema/rash, throat complaints, back complaints, repeat prescription for respiratory medication, repeat prescription for neurological medication, repeat prescription for diabetic medication and generalised pain.

On the other hand Cooper *et al* (1991), in their study conducted in Khayelitsha to determine the relationship between urbanisation, health status and use of the health services, produced a list that included common acute illnesses mentioned by participants such as abdominal pain, diarrhoea/gastro and vomiting, flu/colds, upper respiratory tract infections, headaches and rashes. In their study acute illnesses were reported for 4.3% of the study population, the commonest complaints being diarrhoea, abdominal pain and upper respiratory infections.

Other studies by Myburgh (1997), Nsisi (1999b) and Loghdey, (2002) generated ailments similar to those of the above mentioned studies.

These studies assisted the researcher with regard to defining the scope of minor health ailments that clients presented with in Khayelitsha and Phillipi. The clients who participated in these studies proved to be mainly young people and predominantly female. The results of these studies assisted the researcher to see if there were any similarities or differences in the studies. The researcher noticed that they did not explore the health seeking behaviour of these clients. This helped to shape the focus of this research to examine the health seeking behaviour of clients attending CHC presenting with minor health ailments.

The researcher herself witnessed the problem of overcrowding at Michael Mapongwana CHC where she works as a physiotherapist. Patients come as early as 04H00 to the CHCs and wait in

long queues to be allowed to onto the premises, following the process of getting their folders, being seen by the health professionals and getting their medication. When the clients leave the CHC they still complain that they have waited too long to get just pain killers. According to the elderly persons who are part of the health forum, minor health ailments could be managed at home by using simple remedies and approaches that might limit the number of clients visiting CHCs. Why then are clients attending CHCs at Khayelitsha and Phillipi and not utilising the remedies recommended by the elderly persons for minor health ailments?

According to the Alma-Ata Declaration 1978, PHC addresses the main health problems in the community by providing promotive, preventive, curative, and rehabilitative services. Accordingly education concerning prevailing health problems and the methods of preventing and controlling illnesses underpins the comprehensive delivery of primary health care (Fry and Hasler, 1986).

Fry states that "health has multiple dimensions. It is not a property of man, but a reflection of man's interactions with his environment. It is not an ideal state, but a changing condition dependent on man's ability to adapt from time to time to alternatives in this environment. It is neither a goal to be attained nor a level to be maintained (nor a right nor a purchasable product), but part of the process of the day-to-day living" (1980: 87).

Niven (1989), on the other hand, states that there is little doubt that the way we lead our lives, affects our health directly and indirectly. He further states that some people are keen to seek out advice from health professionals, while others actively deny that there is anything wrong with them.

The Foundation for Research Development committee (1985), sees the PHC approach as the critical operational strategy for meeting basic health needs. This PHC concept proposes a delivery system, which integrates health care, sanitation, water, nutrition and health education; recognising the importance of the non-health care components and the synergistic effects of all these interventions on health status.

The South African National Department of Health in 1996 developed a policy document which allows the people of South Africa to have access to primary care free of charge at the point of service. The researcher then questioned whether this non-payment might not be contributing to an overcrowding of the centres?

In the study done by Gessler, Msunya, Nkunya, Schar, Heinrich, Tanner (1985) many patients found in traditional medical treatment had already attended a dispensary or hospital before and were not satisfied with the care given. Some of the most common reasons for dissatisfaction included: long waits in line at the clinic; brief encounters with doctors or hospital staff (often less than five minutes); feelings of confusion and being alone in an unaccustomed environment; no opportunity to express their concerns; and being given medicine without any explanation as to the cause of the illness and without a proper prescription for the drug. The results of the study are similar to the results of the mini-epidemiological studies that were conducted by the UCT students at Site B and Michael Mapongwana CHCs (Brice *et al*; 2000; Keraan, *et al*, 2000).

Reekie (1995), confirmed that the queue and waiting list are endemic to any public system that does not allocate a price. Queuing discriminates between the wealthy and the poor. The poor are the productive mass that provides the resources in the public sector for today and further produce resources for tomorrow's health care. Yet the most likely to queue are the poor, the elderly and the unemployed because they lack financial resources to access better health facilities. In addition it is believed that there is a tendency to over utilise the public facilities for minor health ailments by the same grouping because they lack knowledge or resources to handle the ailments at home. It is difficult to reach a conclusion about these statements because there are other reasons that cause people to over utilise the public services. These reasons were investigated by the researcher.

Although there are assumptions that the clients do not pay for the primary care services and do not utilise available health resources within their communities, in respect of clients attending CHCs with minor health ailments, no study had been done at Khayelitsha and Phillipi to investigate their health seeking behaviour.

## 1.8 Significance of the study

Fry (1980) states that the health prospects of both developed and less developed nations in the last quarter of the twentieth century would depend on the quality of decisions made by government, by private sectors, by health professionals, and by individuals acting on their own behalf. These decisions would be influenced by how people think about health and the factors related to health and disease. The factors known to have major influences on health are: biological, behavioural, socio-cultural and environmental. These are defined as the primary determinants of health and are based on the belief that interventions to improve health must be directed towards the full range of factors that influence health.

According to the World Health Organization (WHO) (1983) in Africa before colonialism and for a long time thereafter, Africans had their own methods of diagnosis and therapy. The diviner diagnosed the cause of illness, suggested ways of either propitiating the ancestors through ritual or identifying the enemy who had supposedly “cause[d] the disease” and consequently providing medical protection. The common nomenclature used by colonials was that the diviner was a “witch-founder”, or a “witch doctor” rather than a traditional healer. Having made the diagnosis, the diviner handed the patient over to the medicine man, generally an experienced herbalist with considerable practical skills, for treatment.

The elderly persons attending health forums had the perception that indigenous health knowledge methods and approaches were useful in the olden days to take care of minor health ailments. It is not clear yet whether the clients that frequent the CHCs presenting with minor health ailments do use this indigenous health knowledge mentioned by the elderly persons. This study therefore explored whether the clients make use of alternative methods of dealing with minor health ailments using indigenous health knowledge of the elderly persons in their homes or communities.

The study also examined whether matters such as health education during consultation, accessibility of health services rendered at primary level of care, have any impact on health seeking behaviour of clients attending the focus CHCs since this would further impact on health, delivery systems, approaches and policies.

It was not clear why clients in Khayelitsha and Phillipi frequent CHCs presenting with minor health ailments or what type of health seeking behaviour prevails amongst these clients. Hence the researcher hoped that by exploring health seeking behaviour of clients presenting with minor health ailments and attending in the CHCs her research would contribute towards the debate between health professionals, students and elderly persons to resolve the problem of overcrowding.

### **1.9 Summary of Chapter 1**

This introduction presents the problem of overcrowding on a daily basis at Michael Mapongwana, Site B, Inzame Zabantu and Mzamomhle CHCs by clients presenting with minor health ailments. Mini epidemiological studies done at Michael Mapongwana and Site B CHCs by UCT MBChB students confirmed this. Studies by Myburgh (1997), Nsisi (1999a), Nsisi (1999b) and Loghdey (2002), confirmed that also in other CHCs outside Khayelitsha and Phillipi and private practices in other areas overcrowding by clients who are mainly presenting with minor health ailments dominate. It is not clear why clients do not manage minor health ailments at home. This problem of overcrowding the CHCs was discussed in a community health forums which consisted of management staff from the CHCs, clinical facilitators from UCT, students from UCT and elderly persons from Khayelitsha and Phillipi.

In these forums the management staff that included clinical nurse practitioners expressed how they are struggling to cope with the prevailing situation. There is a perception that it is because these clients do not pay for services rendered. It is also assumed through the discussions that happened in the community health forum that alternative methods of managing minor health ailments at home such as indigenous health knowledge carried by elderly persons is ignored. Discussions continued and postulations were made regarding the reasons why clients were not dealing with minor health ailments at home.

It became clear that there was a need to hear from both the clients and the health care providers of these CHCs the reason why clients are frequenting the CHCs and presenting with minor health ailments instead of using alternative resources for the management of these ailments; hence this

exploratory study on health seeking behaviour of clients presenting with minor health ailments attending CHCs in Khayelitsha and Phillipi.

The first objective of the study is to explore and review the literature that underpins this study. To achieve this Chapter 2 examines the literature including some health seeking behaviour models that underpin the health seeking behaviour and factors that have impacted on the health system of South Africa under the following sub-headings: impact of colonisation in South Africa, health problems due to migration to peri-urban areas, legacy of apartheid towards health in South Africa and steps taken by the South African government to reform the health system of South Africa (the implementation of PHC in South Africa), models of PHC at primary level of care, the status of PHC in South Africa today and the summary.

Chapter 3 explains the research design and methodology that underpin the study. In Chapter 4 results regarding the health seeking behaviour of clients presenting with minor health ailments from Khayelitsha and Phillipi are presented according to the objectives of this study. This is followed by the discussion of the results of the data for each objective in Chapter 5. Chapter 6 concludes the study with recommendations to various stake holders and suggestions for future research.

## CHAPTER 2

### Literature review

#### 2.1 Introduction

The aim of the study is to explore the health seeking behaviour of clients presenting with minor health ailments when attending community health centres (CHCs) in Khayelitsha and Phillipi for the management of these ailments.

Health seeking behaviour amongst black South Africans is a complex matter. Elderly people in black communities used to manage illnesses from home using home remedies that were found in their gardens. They would manage the illness and would consult traditional healers if the situation got worse (Personal communication, elderly persons, 2003). One would assume that the communities in Khayelitsha and Phillipi (predominantly black townships) would have some basic knowledge of managing minor health ailments at home. However, this does not appear to be the case since the CHCs are overcrowded with clients who are mainly presenting with minor health ailments that the elderly people claim they used to manage at home using home remedies.

According to Buhrmann (1983) the concept of “community involvement” implies that health care management is not only the responsibility of external agencies such as the CHCs and specially trained health practitioners and the family physician, but the concern of the whole community to ensure optimal health for every member. Thus each individual has a role to play to ensure the health of the group by passing on knowledge of healing from generation to generation.

Buhrmann’s (1983) perceptions regarding the approach of communities to health matters raises the question of the type of community that Khayelitsha and Phillipi are and whether they possess the knowledge of healing that is passed on from generation to generation as mentioned by Buhrmann. One is forced to examine the generations that reside in Khayelitsha and Phillipi. The mini epidemiological study conducted by Keraan *et al* (2000) showed that the age group of people attending the CHCs ranged between 20-49 years. Where do these people who are found in Khayelitsha and Phillipi come from and what type of health belief model do they practise?

The democratically elected government of 1994 emphasised that the health for all South Africans will be secured and improved mainly through the achievement of equitable social and economic developments. The government tried to improve equity regarding health especially for the disadvantaged communities such as Khayelitsha and Phillipi by implementing primary health care. According to Jeebhay, Hussey and Reynolds (1997) the Western Cape Provincial Minister of Health and Social Services, Mr Rasool, in 1997, made an opening speech in a conference that was held in Cape Town three years after the 1994 elections. Rasool mentioned that there was a struggle for equity between racial groups and a need to shift resources from the previously advantaged communities - the white community - to black communities. He also mentioned that there was a need to shift resources from tertiary levels of care to primary levels of care.

This shift of resources resulted by a proliferation of CHCs in areas such as Khayelitsha and Phillipi where health services were previously either inadequate or absent. Despite this, CHCs in Khayelitsha and Phillipi are overcrowded with clients. The Western Cape Provincial Minister of Health and Social Services in 1997 also mentioned the problem of fragmented health services in South Africa. He stated that the rich receive levels of care that can only be described as excessively high from the private sector for profit, while the poor are condemned to long queues to see overworked health workers in under resourced clinics and hospitals in the public sector (Jeebhay *et al*, 1997). This brings us to the question of how primary health care is implemented in these communities. Did they consider existing resources within these communities and what is the relationship between the CHCs and the communities that they serve?

Gilbert *et al* (1996), gives an example of the Nolungile project in Site C, Khayelitsha as one of the most successful primary health care projects. The vision of this project was to establish a model of primary health care based on experience gained by means of a participative interactive planning approach to health development within the Khayelitsha community. In this project it was emphasised that community participation is a social process in which specific groups with shared needs living in a defined geographical area actively pursue identification of their needs and take decisions and establish mechanisms to meet them. This raises questions as to what happened to this approach in areas like Khayelitsha and Phillipi? How sustainable are PHC projects as CHCs in these areas that are experiencing problems of overcrowding by clients that

present with minor ailments? Many questions do arise regarding the consumers of PHC, that is the clients and their health seeking behaviour. The researcher would like to start this literature review by discussing health seeking behaviour.

## **2.2 Health seeking behaviour**

Newsom, McFarland, Kaplan, Huguet and Zani (2004) maintain that, models of health behaviour begin with the notion that the individual is motivated to prevent disease or improve health.

Newsom *et al* (2004), state that the association between multiple health behaviours has a bearing on whether health motivation or other sociological or psychological factors are common determinants of healthy lifestyle activities. Understanding whether there are common determinants of health behaviours is important for choosing public health strategies that seek to target subpopulations at particular risk for disease as opposed to strategies that focus on the modification of individual behaviours.

The researcher wants to expand on the concept of health seeking behaviour by presenting models by three different authors. These models are Niven's health behaviour (1989) with its three sub-models which explains the health behaviour model; the cultural systems model by Kleinman (1980) that also has three sub-models; and the cultural model by Gilbert, Selikow and Walker (1996).

### **2.2.1 Niven (1989): Health behaviour model**

The health behaviour model is mainly concerned with understanding and predicting health behaviour. Health behaviour model consists of three sub-models: the health belief model, the locus of control model and the conflict theory model.

This health behaviour model of Niven used the ideas of Becker, Haefner, Kasl, Kirscht, Maiman and Rosenstock (1977) to explain the health belief model. Niven also supported his locus of control model and conflict theory model by using the ideas of Rotter (1954) and Janis (1984).

### **(a) The health belief sub-model**

Niven believes that the health belief sub-model is a useful tool for predicting the degree to which individuals are likely to play an active role in their and others' health care. In the description of the health belief sub-model readiness to take action and engage in health related behaviours depends on the following factors:

- **Susceptibility:** an individual's belief about whether they are likely to contract an illness.
- **Severity:** the degree to which an individual perceives the consequences of having an illness to be severe.
- **Benefits:** the potential to be gained from particular course of action that will reduce the health threat.
- **Barriers:** the consequences of any decision to act could include a degree of physical, psychological or financial distress associated with a form of action.
- **Cues to action:** internal or external stimuli that trigger appropriate health behaviour.
- **Diverse factors:** include demographic, ethnic, social and personality factors that may influence health behaviours.
- **Predisposition or motivation** of people to engage in health related practices (Niven, 1989).

Rosenstock 1974 and Rosenstock and Kirscht (1979) uphold that the health belief sub-model can be a useful guide to health behaviour under certain circumstances where actual behavioural outcomes are predicted, though there are a number of criticisms around it such as it constitutes more variables that can be included in one study. Leventhal, Meyer and Nerenz (1980) suggest that the health belief model should concentrate on the sensory experience of symptom perception for a more accurate analysis of health behaviour as it places too much emphasis on abstract and conceptual beliefs. Wallston and Wallston 1984 suggest that health belief predictors should be combined interactively to prove more fruitful outcomes of health behaviour.

### **(b) Locus of control sub-model**

In the locus of control sub-model, Niven believes that behaviour is a function of the individual's belief; that the behaviour will lead to reinforcement and how much that reinforcement is liked. Niven sees this sub-model as an important factor in determining generalised expectancies. There are two types of locus of control sub-models: the internal locus of control and external locus of control. The internal locus of control model is seen as a model where individuals believe that

they have the ability to influence and determine the features that affect life because they believe that they can have a significant say in how life is run. The external locus of control model is seen as a model where individuals are less likely to engage in behaviours that could have a positive effect on life, believing that it does not matter what one does since fate has already decided for an individual.

Newsom *et al* (2004), suggest that strong associations among major health behaviours would be suggestive of an underlying causal role of motivation to prevent disease or improve health. From the results of their study they found that the most important health behaviours related to the prevention of chronic disease, caused by alcohol consumption, smoking, exercise and diet are largely unrelated to one another.

#### **(c) The conflict theory sub-model**

The conflict theory sub-model is a model of personal decision making that attempts to specify the conditions under which individuals will give priority to avoiding subjective discomfort at the cost of endangering their lives, and under what conditions they will make a more rational decision by seeking out and taking into account the available medical information about the real consequences of alternative courses of action so as to maximise their chances of survival.

#### **2.2.2 Kleinman (1980): Cultural systems model**

Kleinman used the ideas of Lesley (1976) and Lewis (1975) to explain some aspects of the health care system presented in his model. These authors define illness as a cultural idiom, linking beliefs about disease causation, the experience of symptoms, specific patterns of illness behaviour, decisions concerning treatment alternatives, actual therapeutic practices and evaluations of therapeutic outcomes. From this Kleinman sees the health care system as a model that includes health, illness and health care related aspects of societies as articulated in cultural systems.

Kleinman suggested that in looking at any complex society one can identify three overlapping arenas of health care, the popular arena, the folk arena and the professional arena. Each arena has its own ways of explaining and treating ill-health, defining who is the healer and who is the patient, and of specifying how healer and patient should interact in their therapeutic encounter.

Most health care systems contain these three social arenas within which sickness is experienced and reacted to.

**(a) The popular arena**

The popular arena is known as the lay, non-professional, non-specialist domain of society, where ill-health is first recognised and defined and health care activities are initiated. It includes all the therapeutic options that people utilise, without any payment and consulting either folk healers or medical professionals. The popular arena is seen as the real site of primary health care as the family is the main health resource and most ill-health is recognised and then treated within the home or family. Most health care in this arena takes place between people already linked to one another by ties of kinship, friendship or neighbourhood or membership of work or religious organisations. This means that both the patient and the healer share similar assumptions about health and illness, and misunderstandings between the two are comparatively rare.

Fry (1980), says that the original setting for most primary care is probably the patient's own home and this tradition has persisted in some countries, although it is becoming less common all over the world. The advantages to the patient include concerns regarding health status, the avoidance of the discomfort and cost of traveling to the primary care unit, as well as a reduction in the real or imagined risks of catching infectious diseases from other patients. The disadvantage for the patient is that he or she may be examined and investigated less thoroughly in the clinically relatively inconvenient home situation. This view was further confirmed by a group of elderly persons residing in Khayelitsha and Phillipi who had a perception that minor health ailments can be managed at home.

Hammond-Tooke (1989), believes that illness is caused by a failure of human relationships within the home or community, either through the lack of respect and good behaviour to kin, or envy and jealousy between those who should love each other and cooperate amicably, but who for some reason or other do not.

Habgood (1998), says that people of Ganda believe that people's general knowledge and their understanding of how their healthy bodies function influence the actions they take to maintain

health. Women of Ganda believe that each of their pregnancies existed because of the support system they get within their communities.

Health seeking behaviour is best seen as a process during which the beliefs and actions of the people in the immediate social environment of the sick person initiating treatment and subsequently evaluating the perceived outcome of the therapeutic actions. The behaviour is not just a system of labeling and treatment, it is a stepped process in which the sequence continuously moves from explanation to therapy and on to evaluation, and, if healing fails, the process is repeated so that new explanations are developed and are then followed by alternative forms of therapy and then re-evaluation (Oberlander and Elverdan, 2000).

**(b) The folk arena**

In the folk arena certain individuals specialise in forms of healing that are either sacred or secular, or a mixture of the two. These healers are not part of the official medical system, and they occupy an intermediate position between the popular and professional arenas. Most folk healers share the basic cultural values and world view of the communities in which they live, including beliefs about the origin, significance and treatment of ill health. When they heal people who are sick they frequently involve the family in diagnosis and treatment. The healer is usually surrounded by helpers, who take part in the ceremony of healing, who give explanations to the patient and his family, and answer any of their queries. From a modern perspective, this type of healer with helpers together with the patients' family provide an effective primary health care team.

Mizrachi and Shuval (2004) did a study in Israel, which illustrated a significant increase in the use of alternative medicine by individuals from 1994-2000, as well as increase in the number of patients who were referred to alternative practitioners by physicians during the 1990s. This growing public demand for alternative medicine in Israel became a considerable economic force affecting health policy. The majority of patients that used alternative medicine in Israel stated that dissatisfaction or disappointment with conventional treatment was the main reason for consulting alternative providers.

Mizrachi and Shuval (2004), noticed that alternative practitioners in the informal arena in Israel appeared to focus on the patient's experience of illness: feelings, affective states, the alleviation of pain and suffering and efforts to improve the quality of life. The key informant in Mizrachi *et als'* study was a professor practising conventional medicine who said that he sees alternative practitioners as health care providers who can spend time with patients during consultation that they as conventional practitioners do not have and who are also successful in alleviating the pain of the patients. In South Africa , Africans especially in rural areas were, by and large, left to the ministrations of traditional healers, the good offices of missionaries and the patent medicines of traders. Previously the situation in rural areas regarding health services was very poor because professional health services were inaccessible to the people living in these far-flung areas (WHO, 1983).

### **(c) The professional arena**

The professional arena comprises of the organised, legally-sanctioned healing professions such as modern western scientific medicine or allopathy. It includes not only physicians of various types and specialities but also the recognised para-medical professions such as nurses, midwives or physiotherapists. The healers in this arena have the power to question or examine their patients, prescribe powerful and sometimes dangerous treatments or medication and deprive certain people of their freedom by confining them to hospitals if they are diagnosed as psychotic or infectious. The ill person when consulting the professionals is removed from family, friends and community at a time of personal crisis. Patients undergo a standardised ritual of 'depersonalisation', becoming converted into a numbered 'case' in a ward full of strangers. The relationship of the health professionals with their patients is characterised by distance, formality, brief conversations and often the use of professional jargon.

Some of the attributes of the professional arena are similar to the study of Gessler, Msunya and Nkunya (1995). They state that the type of health care delivery by health care professionals in CHCs is characterised by an overcrowded environment, long waiting times at the clinics, brief encounters with doctors or hospital staff (often less than five minutes) feelings of confusion and being alone in an unaccustomed environment, no opportunity to express one's own concerns and being given medicine without any explanation as to the cause of illness and without a proper explanation of the effects of drugs. The only difference is that Gessler *et als'* (1995) study was

based on CHCs while the professional arena which is a sub-model of Kleinman's model is based on hospitals.

According to Hjortdahl and Laerum (1992), in Atkinson and Haran's study (2004), the provision of health care measures of accessibility, availability and convenience are consistently associated with higher satisfaction in health care. Continuity of care providers has also been positively associated with satisfaction. Williams and Calnan (1991) in Atkinson *et als'* study (2004), noticed the importance of interpersonal aspects of the patient-professional relationship such as the amount and clarity of information regarding the condition of the patient, bed-side/chair-side manner during consultation, similarity of socio-demographic backgrounds and the extent that the patient can express opinions are positively associated with satisfaction about health.

Fitzpatrick (1991) in Atkinson *et als'* study (2004) states that user satisfaction is an important outcome in its own right since it predicts patient compliance with treatment, reattendance at the clinic, provider change and even improvement in health status. User satisfaction can assess communication in the consultation such as information transfer, user involvement in decision making and reassurance about the condition. It informs planning as part of a range of assessment indicators used to compare different alternatives of organising or providing health care.

Hart (1986), describes the concept of health as difficult to define or measure. He says that not everybody has the same threshold of pain or the same expectations about what counts as abnormal symptoms. Some people go to the doctor for complaints which others may not even notice.

De Vos *et al* (2004) clarified that the decision to visit a family doctor might depend on the perception of the problem or disease experienced and also might depend on the personality of the patient and his confidence in the physician, and the perceived technical ability of the physician, his accessibility and the existing material conditions in which he works. Also the patient's decision to visit health facilities is largely influenced by his personal expectations and preferences. Due to these reasons, inappropriate use of health facilities will be a continuous problem in the health facilities.

According to Myerscough and Ford (1996) most people who are unwell look to the doctor for help, advice, or reassurance and so they assume a dependent role as a sick person. This submission to their medical attendant derives from the feelings of uncertainty and fear that come with illness. This carries a danger of promoting a paternalistic attitude, which the doctor must guard against, since it may lead to overlooking the patient's wishes and concerns. Others find being unwell the only sure way of gaining the attention and concern of those around them. These attention seekers enjoy recurrent ill health year after year.

### **2.2.3 Gilbert, Selikow and Walker (1996): The cultural model**

Gilbert, Selikow and Walker (1996) suggest that illness behaviour is a culturally learned response which means that the experience of illness is defined according to the norms and values prevalent in a specific society or a community. This approach emphasises that when symptoms are perceived as abnormal one needs to take the initiative to do something about them, that is to seek help. Gilbert *et al* (1996) used Morgan's ideas to explain the collectivist approach that 'emphasises the differences in the values and attitudes to health among different social groups that have an implication for illness behaviour, as well as the particular social and situational forces which prompt or delay professional help-seeking behaviour.'

People who become ill typically follow a hierarchy of resources, ranging from self-medication to consultation with others. Self-treatment is based on lay beliefs about the structure and function of the body, and the origin and nature of ill-health. It includes a variety of substances such as patent medicines, traditional folk remedies or 'old wives' tales as well as changes in diet or behaviour (Gilbert *et al*, 1996).

Once symptoms of illness have been recognised as serious, the activity that follows will be determined by the way things are usually done or the dominant mode of operation in a particular culture. In most communities the first step to seek help involves consultation with family members, friends and neighbors. Following that, the person might decide to seek help from traditional healers, consult a modern health professional, approach alternative sources or a combination of some of the options. Hence the definition of health behaviour is the activity undertaken by persons who believe themselves to be healthy, for the purpose of preventing or

detecting disease in an asymptomatic stage (Gilbert *et al*, 1996). This approach is similar to the popular and folk arenas of Kleinman (1980).

All communities have their concepts of health integrated into their total culture. What is experienced as health represents a complex intimate and cultural understanding in a particular social context, not a fixed set of physiological and biochemical facts. World Health Organization defines health as 'a state of complete physical, mental and social well being, and not merely the absence of disease and infirmity' (Gilbert *et al*, 1996).

Even in a culture in which scientific medicine holds strong sway over people's minds and outlooks, some individuals seek health or healing through different modalities of treatment, in certain cases based on quite bizarre beliefs (Myerscough *et al*, 1996).

#### **2.2.4 Brief summary of the key concepts arising from the three health models**

There are similarities and differences in the three models described. Niven (1989), Kleinman (1980) and Gilbert *et al* (1996) have similar concepts for their models such as individuals that show their health related behaviours when they feel or have a fear of an illness. These models use different resources for individuals to seek assistance from home, alternative health practitioners such as traditional and faith healers and hospitals where one will get assistance from the health care professionals. The concept of choice of where the individuals go when they need help regarding their illnesses was an important similarities underpinning these three models.

The three models have also differences regarding the approaches used when individuals are sick. The health behaviour model emphasises the feelings of an individual when feeling sick before consulting someone about the problem. Though the cultural systems model does give cognizance to the sick individual, its major area of focus is on the services that are available within one's society. These services might be the family members, traditional healers and faith healers and health care professionals in community health centres and hospitals. It gives individuals choices of where to go when they are in need of help regarding their illnesses as well as alternatives when they are not satisfied with the service they received earlier. The cultural model concentrates more on illness and how it is handled in a particular society. The individual is

included as part of trying to understand how a symptom of a specific nature of an illness should be dealt with.

The younger generation in Khayelitsha and Phillipi migrated from rural areas to Cape Town where health services are more accessible than in the rural areas. The pattern of health seeking behaviour according to the elderly people who were part of the health forums in Khayelitsha, changed in the cities as the elderly people were left behind in rural areas with their indigenous knowledge. There is also a problem of limited access of indigenous herbs that were found in the gardens in the rural areas. In the CHCs there is no payment for services rendered. Could the lack of availability of home remedies and guidance from elderly people be contributing to the problems of overcrowding of the CHCs by clients presenting with minor health ailments? In Khayelitsha and Phillipi there is high unemployment rate. If one is ill with minor health ailment and is unemployed or under employed, would it not be easier to get a pain killer from the CHC than buying it from the pharmacy or the grocery store?

The researcher hopes that the results of this study will shed light on the model that the clients who present with minor health ailments at the CHCs in Khayelitsha and Phillipi align themselves with and whether there is anything extra that could be added to the theoretical framework.

## **2.3 Factors that have impacted on the health system of South Africa**

### **2.3.1 Impact of colonisation in South Africa**

Myerscough and Ford (1996), state that each community has a varied store of traditional home remedies, especially for common ailments. In many cultures, a more formal system of traditional medicine exists, with its own explanations of how the body functions, and what promotes health or causes illness. African traditional medicine encompasses a wide range of practitioners including bone-setters, surgeons, and manipulators, as well as spirit-healers. Exorcism has been seen as an occasional remedy in Britain and other countries for many centuries.

Felhaber (1997), states that traditional healers are considered as people to whom the community looks to for guidance on health matters and other issues important to the people. They are also known as the observers of social order and harmony amongst families and individuals. They are

known as established health care workers within their communities. It has been estimated that roughly 80% of the South African population, mainly Blacks, consult traditional healers as their first contact for advice and/or treatment of health concerns. Hammond-Tooke (1989), says traditional healers, far from narrowing their focus to the merely technical, are open to a wide range of possible explanations, most of which are undoubtedly mystical in modern terms.

Van Rensburg, Fourie and Pretorius (1992: 320) state that “before the European colonisation of South Africa, traditional medicine intertwined with magic and religion exerted great political influence in public and private affairs. With the arrival of the early missionaries in Africa it was thought that African people could be won over by showing them that the Western health care was superior to the indigenous traditional care systems”. Rapport (1980: 81, In Van Rensburg *et al*, 1992) stated that all traditional healers were therefore regarded as “witch doctors” who exploited the ignorance and superstitions of the “unenlightened natives”. Under such missionary influence and also as a result of repressive and imperialistic political policy, colonial administrators prohibited traditional medical practices and condemned them as heathen and primitive.

### **2.3.2 Health problems due to migration to peri-urban areas**

According to the report of the technical discussions at the forty-fourth World Health Assembly in many countries urban populations are now so large that they have outgrown the capacity of the surrounding agricultural areas to provide the food and raw materials needed to sustain them, and they overload the natural water system with human and industrial waste. As a result there is a vicious circle of environmental deterioration, reduced agricultural production, “natural disasters”, and increased pauperisation and landlessness. Due to the above mentioned factors for both rural and urban populations, together with severe ecological pressures on the environment poverty and ill health affects them (WHO, 1993).

Urban growth is believed to be fuelled by poverty, the search for work, insecurity of land tenure, changes in farming and in industrial processes, and the growth of service industries. Policies for economic development that tend to lead to concentration of opportunities for work and of pools of skilled labour in towns and cities are accompanied by a widespread view that cities offer a better life than the increasingly depressed rural areas (WHO, 1993).

Temporal migrants or those who live for a time in the towns before returning to the villages, tend to use the services in towns they visited because of the lack of services in the places they have come from. This can overburden urban facilities, while weakening the government's incentive to improve rural facilities (WHO, 1993).

Van Rensburg and Mans (1982), state that in South Africa the vastness of the country, the long distances, extreme climatic conditions, a topography frequently characterised by insurmountable natural obstacles, coupled with the sparse population in certain areas, poor roads, inadequate transport and the absence of a sound infrastructure, have the effect of largely isolating certain rural communities and making them practically inaccessible to effective health services. WHO (1983) says the rapid growth of densely populated, predominantly low-income settlements in the cities of the Third World has come to constitute one of the most serious threats to health.

Due to the fact that persons of all population groups, also in South Africa are relocating to urban centres due to urbanisation and industrialisation, high-density occupation is progressively becoming a feature of urban existence. This naturally goes hand-in-hand with problems related to the deleterious psychosocial effect of high-density housing, the increased danger of infection and outbreaks of disease, particularly in vastly overpopulated areas and squatters' settlements.

It is assumed that in Khayelitsha and Phillipi people who live in these areas were originally from rural areas where they used to grow vegetables from their gardens; manage illnesses from home due to the long distances to visit the health centre; consult traditional healers when the condition was getting worse and maintain hygiene within their homes to prevent illnesses. Now in urban areas the majority of the population of Khayelitsha and Phillipi stay in the informal settlements under unfavourable health conditions. In urban areas people are prone to diseases because of the unemployment that limits them to purchase food, the building of shacks in places that were not meant for people to stay and the overcrowding of the shacks with many people who belong to the same family whereby sleeping space becomes the problem. Due to lack of space in the shacks CHCs become overcrowded with people who are presenting with illnesses that used to be managed at home.

Poor health is most frequent amongst so-called marginal or underclass populations, which are increasing in many cities in both the developing and the developed world. These are people who are classed as minorities, whose poverty is reinforced because they work for low rates of pay in the informal economy, who lack social organisation and who often have no legal status as citizens. Adequate nutrition, hygiene and housing are likely to be beyond their grasp and they may be exploited when they try to meet their basic needs. Unemployment and many types of insecurity affect their resistance to disease (WHO, 1993).

Communicable diseases flourish where resistance levels are low, immunisation is inadequate, and the environmental barriers against their spread are weak. Poor nutrition makes people, particularly the young and feeble, more vulnerable to infection. The situation is made worse by overcrowding, by the exposure of the population to diseases to which they have never been exposed before, and by the multiplication of animal and insect hosts because of environmental, behavioural and ecological changes. Environmental conditions favouring the spread of communicable diseases include insufficient and unsafe water supplies, poor sanitation, inadequate disposal of solid wastes, inadequate drainage of surface water, poor personal and domestic hygiene, inadequate housing and overcrowding (WHO, 1993).

De Beer (1984) did a study on tuberculosis (TB) which claims that it spreads easily if a number of people sleep in one room or crowd into trains or buses because they are more likely to breathe in the germs coming from people who are already sick. He further claims that the spread of the disease amongst the African population in the towns was due to the unhealthy manner in which they live, overcrowding, poor diet and want of ventilation and sunlight - too often found in the town locations, compounds and barracks in which these people congregate. The population of both Khayelitsha and Phillipi are prone to communicable diseases because of overcrowding and the unhealthy manner in which they live under. Hence large numbers of the population of these areas are mostly seen at the CHCs presenting mainly with minor as well as more serious health illnesses.

### **2.3.3 Legacy of apartheid towards health in South Africa**

According to WHO (1983), for the most part, then, settlers in the rural districts were dependent on herbalists and home remedies, many of them influenced by the indigenous African practices because of less provision of health services.

Voortrekkers in the former Orange Free State and the former Transvaal Republic relied on folk medicine of a peculiar type. The elderly people usually used dog's blood for fits, goat's dung for measles, wolf's dung for sore throats, bread poultices for abscesses and many other types of remedies for various ailments (De Beer, 1984).

The legacy of apartheid policies in South Africa created large disparities between racial groups in terms of socio-economic status, occupation, education, housing and health. These policies created a fragmented health system which resulted in inequitable access to health care (Gilbert *et al*, 1996).

*The Star* newspaper in 1995 had an article about health of needs of South Africans. According to the article the long-term vision of health care in South Africa was to recognise that the provision of health care goes beyond the dispensing of pills and advice, in fact the main vision was that health starts as early as with the provision of essential basic services. An independent health poll by the National Progressive Primary Health Care Network (NPPHCN) found that millions of South African blacks suffered from poor sanitation and had no access to basic health care (Gilbert *et al*, 1996).

The poll conducted by the Community Agency for Social Equity (CASE) in 1994 used face-to-face interviews as large numbers of South Africans were without telephones. The poll found that 31% of respondents said they had been in a position where they could not afford to feed their children aged five or younger. About 10% of blacks, compared with 75% of coloureds, 97% of Indians and 99% of whites had a flush toilet inside their dwelling. Only 33% of blacks had regular refuse removal compared with 100% for whites. 54% of blacks and 5% of coloureds, but no Indians or whites had to fetch water for daily use from a source outside their home or yard (Gilbert *et al*, 1996).

The findings of CASE showed that almost one in five (19%) of respondents said they had been refused medical treatment because they could not afford to pay. The other problem was that almost 62% of all houses were not electrified. Schools and clinics, especially in rural areas, had extremely limited access to electricity. The RDP aimed to electrify a further 2.5 million homes by the turn of the century (Gilbert *et al*,1996).

Chimere-Dan, in South African Health Review Committee study (1995) states that the official estimate of the 1994 national population was 40.4 million people, of which 76.1% are African, 8.5% coloured, 3.6% Indian and 12.8% White. Lund 1995, says pervasive political instability and extended drought in 1994 have contributed to the economic decline and have had an adverse effect on the lives of poorer people. South Africa has one of the highest levels of income inequality in the world. The policy of racial capitalism ensured a high level of privilege for white people and far lower standards of living for others.

Chimere-Dan in the above mentioned study states that in 1991, white per capita incomes were 12.3 times higher than per capita incomes for African people. An estimate of 17.3 million people and about 48.9% of all households, lived below the minimum living standards. Two thirds (67%) of African households and 38%, 18% and 6.7% of coloured, Indian and White households respectively, were estimated to live in poverty.

The socio-economic status of South Africa has a large bearing on housing and the well-being of the people. Housing in South Africa influences the quality of life. In most lower income groups a "house" is not solely where people live. The affixed, functional abode often serves also as a place of production from which informal economic activities emanate. The lack of such a space can serve to further lock lower income communities into poverty, as they have limited access to the formal economy and health services. In 1991 an estimated 12 million people in South Africa were without access to clean drinking water, and over 20 million are without adequate water-borne sanitation. South Africa is facing a severe water crisis as most of its water come from rivers which are fed by less than 470mm of rain per year (South African Health Review Committee, 1995).

The provision of sufficient and safe water and sanitation services is associated with dramatic decreases in deaths from diarrhoeal diseases, skin and other infectious diseases. The unsanitary conditions and poor environmental hygiene associated with limited and polluted sources of water are a serious threat to the health of both urban and rural communities, health risks being the greatest in informal settlements. The unsanitary conditions and poor environmental hygiene are clearly seen in Khayelitsha and Phillipi.

De Haan (1996) states that people in a poorly ventilated room experience a feeling of stuffiness and discomfort which is due to the stagnation of the air. The bacterial content of the air in a poorly ventilated room rises and one of the most serious consequences of poor ventilation is the spread of infections such as tuberculosis, streptococcal infections of the throat and meningitis. This situation of poorly ventilated rooms is common in the informal settlements of Khayelitsha and Phillipi due to lack of space and overcrowding within the houses. In most of the shacks you will find that there is one sleeping room and a kitchen. There are families of six members and one will wonder where they sleep at night. Families that are overcrowded in the house are prone to communicable diseases as a result they consult the health facilities for help.

De Haan (1996), states that inadequate housing and overcrowding are associated with problems that are experienced by people living under these conditions. These problems are: psychological problems which arise because of an unattractive and dilapidated house, overcrowding and lack of privacy, noise and an absence of the basic necessities that lead to dissatisfaction, depression and a loss of self-esteem and self-respect; increased frequency of home accidents due to a lack of separate facilities for cooking, sleeping, playing, etc, and also because the building is often in a state of disrepair with broken stairs, floors and windows. The situation explained above is clearly seen in some of the shacks in Khayelitsha and Phillipi.

According to WHO (1983), in their report of an international conference held in Brazzaville in 1981, they quoted facts about health care that was provided specifically in South Africa as incompatible with basic principles of the constitution of WHO. The constitution stated that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social status. Black people of South Africa do not enjoy such fundamental rights, within the meaning of the

constitution, for the discrimination of which they are victims affects virtually all aspects of their daily life. Economic and social inequality, the stratification of which is correlated with skin colour, determines the distribution of morbidity and health care in South Africa.

WHO defined health “as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”; in this conference that was held in Brazzaville, this organisation was saying that one cannot claim that the black population of South Africa is “healthy.” For the great majority of the population, the figures for morbidity and mortality testify to a poor distribution of physical well-being, while the high rate of alcoholism, suicide and acts of violence are indicators of an absence of mental well-being (WHO, 1983: 28).

WHO also noticed that unequal development in different countries in the promotion of health and the control of disease, especially communicable disease, is a common danger. In South Africa a wide range of the preventable infectious and parasitic diseases are common among the black population whereas they have almost totally disappeared among whites. The risk of infectious diseases are continually high because of overpopulation and poverty in the townships, which are officially reserved for Africans, or in the hundreds of squatter camps occupied by migrant workers (WHO, 1983). This problem of overpopulation and poverty exists in Khayelitsha and Phillipi. All the spaces that were reserved for development are occupied with shacks that are legal now in most areas, but there is supposedly a policy to replace shacks with better housing.

In this conference they also said that the achievement of any state in the promotion and protection of health is of value to all. They found out that health promotion and protection offered for blacks by the state in South Africa was often aimed at diseases, as opposed to whites who are protected by their better nutritional and socio-economical status (WHO, 1983).

The vaunted progress in organ transplants which has catapulted South Africa into the forefront of the scientific world is of benefit mainly to the whites. Not only are the majority of donors blacks, virtually all the receivers are whites, but furthermore the international prestige which is derived enhances the reputation of the medical profession and the state, both of which were controlled by whites at that time (WHO, 1983).

In this conference it was outlined that blacks in South Africa, mainly women and children experienced health problems due to the following:

- Lack of health infrastructures particularly in rural areas
- Manpower shortage: one doctor for 44000 black persons
- Lack of health and social service deliveries; absence of preventive medicine; no immunisation
- Unfavourable social environment; disastrous social conditions for women who must look after children; care for the elderly and do agricultural work; poverty of the population and illiteracy (WHO, 1983: 31).

The above factors have improved a little bit in South Africa since the introduction of primary health care in 1994. In rural areas health facilities are under resourced and far for the people to reach as a result younger generation prefer to move to urban areas to get assistance for their health needs.

The above factors are applicable to South African population especially the under served and those who live in informal settlements. The areas targeted for the study, Khayelitsha and Phillipi are subject to landslip, flooding and other health hazards because parts of the areas in these two townships are not serviced by the government.

#### **2.3.4 Steps taken by the South African government to reform the health system of South Africa (the implementation of Primary Health Care in South Africa)**

De Haan (1996) says the influenza epidemic forced the South African government which at that time was called the Union of South Africa to pass an act known as the Public Health Act 36 of 1919. This act established a Department of Health at national government level. This department became responsible for the prevention of infectious diseases and other aspects of public health, the four provincial administrations had responsibility for all aspects of curative medicine and the local authority became responsible for environmental health.

In 1977 the new Health Act 63 of 1977 was passed. The main aim was to coordinate the health services of the Republic of South Africa. The act was also there to assist the development of

health policies that would assist to co-ordinate the health services and to make full use of all available health services, thereby ensuring a comprehensive health service (De Haan, 1996).

De Haan (1996) says in 1994 the democratically elected government adopted the three-tier system that was used by the previous government. National Department of health oriented itself to the primary health care approach and with district health systems as the major vehicle of service delivery. Its functions were to promote the health for all South Africans through a comprehensive national health system using on a PHC approach, with the District Health System (DHS) as a vehicle for health care delivery. Its main function was to provide leadership in the formulation of health policy and assist and encourage provincial health departments to deliver an efficient and successful health service in its hospitals and clinics.

Provincial government, that is the second level, functioned in terms of the Interim Constitution. Then nine new provinces were created in South Africa. These provinces are Limpopo, Mpumalanga, Gauteng, North West, KwaZulu-Natal, Free State, Northern Cape, Western Cape and Eastern Cape (De Haan, 1996).

Chimere-Dan in the study done by South African Health Review Committee (1995) showed how these nine provinces had to address, in the short term, people's expectations of rapid improvements in the availability and quality of services. These provincial health departments had to develop a provincial health information system, upgrading health facilities and building new clinics, providing training to personnel in primary health care and management, providing emergency health services, and ensuring provision of services in maternal and child health, nutrition, HIV/AIDS and sexually transmitted diseases, substance abuse and TB. De Haan (1996) says the provincial health departments should also provide hospital services at general and specialist hospitals and clinics, coordinate the work of the district health authorities in the area and supply services where a district health authority is not able to do so.

The third level of this tier is local government. Local government takes orders from the provincial level and is responsible for providing intersectoral primary health care services, clean water, sanitation, housing and education, which must be accessible to all people living in the area (De Haan, 1996). The primary care services must be within the communities and easily

accessible (Gilbert *et al*, 1996). Khayelitsha and Phillipi have the structures of available primary care such as clinics and CHCs.

The slogan "Health For All by the year 2000" was included as a prospective view in the Declaration of Alma-Ata in 1978. The Declaration of Alma-Ata stressed the training of lay health personnel and also community participation when introducing primary health care. According to the Declaration of Alma-Ata 1978, PHC addresses the main health problems in the community by providing promotive, preventive, curative, and rehabilitative services accordingly. Education concerning prevailing health problems and the methods of preventing and controlling illnesses underpins comprehensive delivery of primary health care (Fry and Hasler, 1986).

Though South Africa was not part of this Declaration of Alma-Ata, the democratically elected government of South Africa in 1994, brought changes to peoples' lives because they engaged the concept of primary health care. The government introduced the Reconstruction and Development Programme health plan which focuses on restructuring the inherited health system to make it more effective and efficient.

The South Africa government developed a framework for socio-economic development in its Reconstruction and Development Programme (RDP), in which it has set out broad principles and strategies for development in all key areas and sectors in order to effectively address the various problems facing the majority of the people of South Africa.

The RDP sets the framework whereby the health of all South Africans must reflect the wealth of the country and lays the foundation for a process of democratising the state and the society that will foster the empowerment of all citizens and promote gender equality. The second major trust of the RDP concerns building the economy. The third component of the RDP is the development of human resources. Finally, within the RDP's focus on meeting basic needs, the development and improvement of housing and services like water and sanitation, the environment, nutrition and health care represent its most direct attack on ill health (Department of Health, 1997).

Regarding health care the RDP planned to develop a national health system offering affordable health care of which the focus will be on primary health care to prevent disease and promote health, as well as to cure illness (African National Congress, 1994).

The RDP's plan was to develop community health centres (CHCs) in districts. Each CHC will be responsible for health in its catchment area and, depending on needs and resources, will also run, as an integral part of its activities, fixed satellite clinics. As a guideline, a CHC will serve on average a population of about 50,000 but this may vary widely depending on population density, transport, access and other services in the district. Clinics will offer a comprehensive range of preventive, promotive, curative and rehabilitation services but at a less specialised level than CHCs (Gilbert *et al*, 1996).

According to the District Health Systems Committee (1995), every part of every province will be within a health district. The size of each district will vary according to local conditions.

Community health services are managed by a multi-professional team at the district level, usually based at a community health centre and at several smaller clinics, or at a district hospital. It is particularly at the community level that the opportunity exists for the concrete implementation of intersectoral health programmes. The community health centre and its staff have the potential to play a major role in the development of the community they serve. The district health system has also been implemented in the Western Cape Province as Khayelitsha and Phillipi fall under Districts 7 and 3 respectively and are managed by multi-professional teams.

### **2.3.5 Difficulties with the implementation of Primary Health Care**

According to Cueto (2004) Primary Health Care concept emerged when the United States was embroiled in a crisis of Cold War in the late 1960s and early 1970s. After this crisis the United Nations had a general assembly where they adopted a resolution in 1974 on the "establishment of a new international economic order" to uplift less developed countries.

WHO and UNICEF combined in 1975 to produce a report on "alternative approaches to meeting basic health needs in developing countries. These organisations outlined the causes of morbidity

in developing countries which were malnutrition and vector-borne, respiratory and diarrhoeal diseases which were the result of poverty, squatters and ignorance (Cueto, 2004).

The landmark event for primary health care was the international conference on Primary Health Care that took place at Alma-Ata from September 6-12, 1978. The conference was attended by 3,000 delegates from 134 governments and 67 international organisations from all over the world. Most of the delegates came from the public sector, specifically from the ministries of health (Cueto, 2004).

According to Cueto (2004), the WHO director general Mahler asked the delegates eight questions. Two of the most audacious questions challenging the delegates were as follows: “are you ready to introduce, if necessary, radical changes in the existing health delivery system so that it properly supports primary health care as the overriding health priority”? and “are you ready to fight the political and technical battles required to overcome any social and economic obstacles and professional resistance to the universal introduction of primary health care”?

WHO (1993), outlined factors that have an impact on health. They outlined factors that are problematic in urban areas such as rapid and massive urban population growth, both in an increasing number of “megacities” and in smaller cities; large populations in squatter settlements and shanty towns often occupying urban land subject to landslides, floods, and other natural hazards; increased population density, overcrowding, congestion, traffic, and the spread of unsuitable residential patterns; ever-growing numbers of people living in extreme poverty, many of them-especially woman and children-at high social risk and; financial and administrative inability to provide a sanitary infrastructure, promote adequate employment and housing, manage wastes and ensure security, environmental controls and health and social services.

Van Rensburg *et al* (1982) state that due to a steady rise in the standard of living in urban areas particularly among the blacks and coloureds, improved transport facilities and momentous developments in medicine and related fields of the health sector, the growing demand for health services is far greater and frequently out of all proportion to the actual population growth. As the quality of health services improves and health care extends to areas of prevention, health promotion, and rehabilitation, there is a consummensurate increase in the service load. As a

result of this rapid increase in the service load the service capacity cannot in the long run keep abreast and consequently the quality of existing service will be jeopardised.

In Western Cape Province the mission of the Western Cape Department of Health is “to improve the health for all people in the Western Cape Province and beyond by ensuring the provision of a balanced health care system.”

According to the Western Cape Department of Health (2002), its vision is the progressive building up of the primary health care services, addressing intra-provincial inequities between regions, increasing health management decentralisation, upgrading regional hospitals and downscaling tertiary services. These are the activities that the department of health of the Western Cape Province was hoping to achieve in order to fulfill the needs of the people in the province.

The Western Cape Department of Health (2002) states that in the Western Cape Province a proportion of clients for tertiary health services come from other provinces and outside the country. It is assumed that the population in the Western Cape multiplies quickly due to the above mentioned reason. The majority of people in Khayelitsha and Phillipi come from the Eastern Cape for different reasons, health problems being one of the reasons. Public sector health services are faced with significant challenges with respect to an increased burden of disease and a constrained resource base.

According to the Western Cape Department of Health (2002) the challenges that are facing the province require the following: restructuring of the pattern of health services delivery to ensure an efficient, effective and sustainable health service within an affordable framework; a balanced, integrated health care system based on a strong primary health care service with adequate emphasis on health education and promotion programmes, an optimal shape of health services for the Western Cape where patients enter the health system at the lowest appropriate level of care with adequate provision for referral up and down the system.

If the activities that are planned by the Western Cape Department of Health, the department will ensure that the public sector will be in a position to ensure the continued access to quality health

services by the population, often poor and disadvantaged who are dependent on these services (Western Cape Department of Health, 2002).

Mr Rasool, former provincial Minister of Health and Social Services in the Western Cape mentioned that equity amongst the different levels of care is necessary to shift because inequity gives South Africa a poor health profile despite the relative abundance of health services for the poor when compared to other countries. The gap of availability of health resources between the richest and the poorest in South Africa was still a problem. Forty percent of economically active persons in 1997 were unemployed, and a third had access to only minimal sanitation, and fifteen percent had access only to untreated and non-reticulated water (Jeebhay *et al* 1997). This history of inequity that was mentioned by the minister is still a problem in Khayelitsha and Phillipi as some of the people experience problems of living under poor health conditions such as having untreated water, poor sanitation, and minimal health resources which make the existing ones overcrowded.

#### **2.4 Model of Primary Health Care at primary level of care**

According to Fry (1980) there are four levels of care and administration in all health care systems that relate to population size and the nature of disease and other problems at each level:

- **First level:** self-care within a family. The majority of symptomatic minor and chronic disorders are self-cared for at this level. Through self-medication, folk remedies and stoical acceptance, the public sees a good job of self-care.
- **Second level:** primary medical care which provides first level of professional care within a locality or neighborhood. Primary care in a neighborhood will deal with minor, major and chronic disorders.
- **Third level:** general special care which works at district level with patients who are referred from primary medical care level.
- **Fourth level:** subspecialty medical care which works at regional level. The special clinical problems referred to these units will be the very rare conditions that may occur less than once a year in primary care, but which will become the common everyday problem in a subspecialty unit.

The major focus of this study is on the first and the second levels. The population of Khayelitsha and Phillipi are frequenting the CHCs on a daily basis presenting with minor health ailments (Brice *et al*, 2000; Keraan *et al*, 2000). This shows us that the majority of people jump to the second level without monitoring their conditions and try to treat the symptoms. They do not consult resources within their communities such as elderly people from their homes, traditional healers within their communities and other health resources available within their communities. It is then assumed that when people suffer from anything whether it's minor or major health ailment they consult private doctors or CHCs.

Fry (1980), summarises the major aims of good primary care as the prevention of deviation from health wherever possible. The second aim is the definition and resolution of problems of health care with finite resources to provide for every system and demand which any patient may make. The third aim is the professional satisfaction of the primary care worker which he sees it as important, health professional may have totally unrealistic expectations of the nature of the service which is required presented as efficiently, effectively and economically as possible. The fourth aim is the optimum care of patients with chronic or terminal illnesses. Secondary aims include the satisfaction of the patient with the quality of care provided and the satisfaction of the primary care worker concerned with the job he is doing.

According to Fry (1980) there are six major requirements which should be met by an efficient system of the primary care. He says the service must be accessible to the population served, it must be available when required, it must provide for continuity of care of the family unit if possible. In addition, the service must be supported by a referral system so that services outside the scope of primary care may be provided and there must be some means of evaluating the effectiveness of the system.

The above requirements mentioned by Fry are in contrast with what is happening in Khayelitsha and Phillipi CHCs. The epidemiological studies done in Khayelitsha that were aiming to explore the cause of overcrowding in the CHCs in Khayelitsha which showed that the CHCs had 24% (Site B) and 33% (Michael Mapongwana) of clients were presenting with minor ailments (Brice *et al*, 2000; Keraan *et al*, 2000). What is happening in CHCs in Khayelitsha and Phillipi is further portrayed by Gessler *et al* (1995).

The restructuring of the national health system for universal primary health care policy document of South Africa (1996) states that there are basic principles that should be followed such as universal access, which stated that all permanent residents of South Africa will be guaranteed access on equal terms to all services provided by the publicly funded primary health care system. This implies that the financial, geographical and other barriers to access primary health care services and the quality of services delivered be equally available for all users of the system.

The access to primary care systems was further discussed by the department of health that access to all personal consultation services and all non-personal services provided by the publicly funded primary care system will be free of charge to all permanent residents at the point of service. The removal of the price barrier is likely to increase utilisation. It may exploit a free primary care system, and the lack of fee may lead to some users to undervalue the service (Department of health, 1996).

In the primary health care policy document of South Africa (1996), recent data has highlighted significant intra-provincial disparities in public sector resource allocation. These indicate that the public sector in the richest magisterial districts employ 4.5 times more general doctors, 2.4 times more registered nurses and 6.1 times more health inspectors than in the poorest districts and that the average public expenditure per person on health service in the richest districts is 3.6 times more than in the poorest districts. This implies for health delivery to be successful at primary level the focus must be more on health education and usage of available resources in the community for health management.

The National Minister of Health introduced a system of community service for newly qualified doctors and other health professionals to ensure that rural and under serviced areas have access to professional health care (Department of Health, 2004). There are fears about this arrangement of deploying newly qualified health professionals to the people from the rural areas who waited for so long for better health through better health services because the newly qualified are required to work under supervision which takes more time for the service to be delivered or be perfect. These newly qualified health professionals take long to assist the clients who are presenting with minor or major illnesses.

## 2.5 The status of primary health care in South Africa today

According to Gilbert *et al* (1996), Primary health care itself is central and was defined in the Declaration of Alma-Ata as: “Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination”.

In an opening ceremony of the conference of celebrating Alma-Ata 1978-2003, the National Minister of Health Dr Tshabalala-Msimang said that progress has been made in removing payment as a barrier to access to primary health care services. People with disabilities, for example, have free access to health services and more than 700 clinics have been built or upgraded to mainly serve the most vulnerable and needy communities such as Khayelitsha and Phillipi. Dr Ntsaluba, former Director General of the Department of Health, added that services such as Voluntary Counselling and Testing and home and community based care for frail people have been added to the package of services. The impact of this primary health care package of services means that 7 million people have improved access to primary health care services (Department of Health, 2004).

Ochala-Odhiamo in the conference of celebrating Alma-Ata 1978-2003 said there have been many achievements since the adoption of the Alma-Ata such as: increased community involvement and empowerment; development of a new cadre of health workers; increased demystification of health issues; application of available and appropriate technology; political commitment; and an increasing emphasis on the social context of health care management (Department of Health, 2004).

Cueto (2004) says that the British historian Thomas McKeown argued that the overall health of the population was less related to medical advances than to standards of living and nutrition. Cueto was inspired by primary health care in China. In China there were “bare-foot doctors” who had an interest in rural medical services than urban medical services. These “bare-foot doctors”

were a diverse array of village health workers who lived in the communities they served. Their line of interest in their communities was preventive rather than curative services. In this method they chose the combined Western and traditional medicines so that population can easily access health services.

## **2.6 Description of the study area: Khayelitsha and Phillipi**

Urban informal growth is believed to be fuelled by poverty, the search for work, insecurity of land tenure, changes in farming and in industrial processes, and the growth of service industries. Policies for economic development that tend to lead to concentration of opportunities for work and of pools of skilled labour in towns and cities are accompanied by a widespread view that cities offer a better life than the increasingly depressed rural areas (WHO, 1993).

Cape Town in the Western Province is an urban city that experiences the large numbers of people that are migrating from rural areas to urban areas. Khayelitsha and Phillipi are disadvantaged townships situated in the Western Province, in Cape Town (CT). These townships are situated approximately 26 and 20 kilometres from the city centre. Khayelitsha and Phillipi grew as people were slowly moving out of the backyards of their homes and others were coming from the rural areas to look for jobs, to get better health and better life. The space for those who came late to these areas was limited as a result they were forced to build shacks in the areas that were meant for development of Khayelitsha and Phillipi areas.

Khayelitsha and Phillipi existed due to the demolition of 3,445 shacks in KTC squatter camp in the year 1983. The aim of the apartheid government to demolish these squatter areas was to move all Africans away from the city centre of Cape Town. Also the people who were staying in Langa and Gugulethu townships were in the plan of being moved from their places but residents refused to move to Khayelitsha. The younger people who were staying in the backyards of their homes were under pressure to own their own houses and were forced to move to Khayelitsha. In 1984 sites and service plots were made available to both legal and illegal squatters in Site C which is in Khayelitsha one of the study area. The total number of legal and illegal squatters at that time was approximately 30,000. They occupied 5,000 core houses that were built in the plots that were reserved for them.

Another site and service area, Site B was opened in 1986 which accommodated 35,000 people. Large site and service areas have been developed over the period of three years from 1986. This development aimed at extending Khayelitsha towards the Monwabisi beach that is part of the Indian ocean. Areas such as Harare, Macassar are part of these developments. While trying to accommodate the ever expanding Khayelitsha population by making such developments, illegal occupation continued to develop in areas such as Town 2, Ndlovini, Nkanini, Makhaya and other areas that extended the population staying in Khayelitsha by 1989.

The majority of the people who were moved to these areas were from the backyards of Gugulethu, Langa and Crossroads townships. The ones who were mainly residing in the backyards were the youth and middle-aged people. They were given the opportunity to be independent but unfortunately the majority was unemployed. It was then impossible to upgrade the core houses that were two roomed houses as they had limited space to accommodate the families.

The volume of residents in Khayelitsha and also in Phillipi grew faster. The reasons why they grew faster were because the residents invited their relatives from other provinces to Cape Town for holidays. Also couples were expanding their families by having babies. Other reasons were that they invited their relatives to get medical help from the health services that are available in Cape Town. This was a recurring problem where elderly people also came for medical assistance for their chronic conditions.

At the present moment Khayelitsha is overcrowded. Khayelitsha alone consists of approximately 400,000 people and the population in Phillipi consists of approximately 50,000 people. The people who are staying in these areas some of them are from the backyards of their houses from the black townships within Cape Town and others migrated from other provinces to Western Cape Province. The majority of people staying in these areas is assumed to be young. The UCT students did mini epidemiological studies whereby they found out that the CHCs are overcrowded (Brice *et al*, 2000; Keraan *et al*, 2000). These studies showed that clients that visit the CHCs in Khayelitsha presenting with minor health ailments had their age group ranging between 20-49 years. Those who came to Khayelitsha and Phillipi areas at a very young age

have children who are teenagers now. There are areas that are situated in Khayelitsha that were developed without the cooperation of the government before 1994. These areas are overpopulated and overcrowded which causes people to be prone to infectious and communicable diseases. Health facilities are minimal to cover the population of both Khayelitsha and Phillipi.

In 1983 Site B CHC was developed to serve the health needs of Khayelitsha residents. In 1996 Michael Mapongwana CHC was built to assist with the health needs of Khayelitsha people and Nolongile CHCs was developed so as to minimise the numbers of people that attend Site B CHC. Site B CHC is the only 24-hour service CHC in Khayelitsha for curative services, after four in the afternoon clients visit this CHC when they are sick with serious, minor ailments and emergency cases as it is more central to the population of Khayelitsha.

All-in-all there are three CHCs in Khayelitsha and eight clinics which refer the serious cases to the CHCs in Khayelitsha. In Phillipi there are two CHCs and mobile clinics available. These mobile clinics provide services such as immunisation, family planning and serve as an outreach service for clients who are unable to reach the CHC for example clients who suffer from TB get their medication from these clinics. If there are serious cases that are found in these mobile clinics the clients are referred to the CHCs available in the area. These CHCs and mobile clinics refer their clients to Gugulethu CHC which is a 24-hour service as it is central to the people of Phillipi and clients who need to be observed after hours get help at this 24-hour service centre. If the client gets serious the client is referred to secondary or tertiary institutions by the 24-hour service CHC.

## **2.7 Summary of Chapter 2**

The aim of the study is to explore the health seeking behaviour of clients presenting with minor health ailments attending CHCs in Khayelitsha and Phillipi for the management of these ailments. Key concepts of this study such as, health seeking behaviour, factors that have an impact on the health system, difficulties about implementation of primary health care in South Africa, primary health care in South Africa, success stories about PHC, and description of the study areas Khayelitsha and Phillipi were discussed.

Health seeking behaviour is presented in this chapter according to models. Three models were identified by the researcher to explain the concept of health seeking behaviour. These are the health behaviour model, cultural systems model and cultural model.

There are many reasons that cause people to get sick to seek health care including poverty, poor living conditions and overcrowding. In Khayelitsha and Phillipi which are the study areas the majority of the population live in cramped and unhealthy conditions. The majority of them are unemployed which causes them to be at risk of poverty and poor health.

The democratically elected South African government adopted the PHC approach. This government developed Reconstruction and Development Programme (RDP). The RDP health plan was to develop a national health system offering affordable health care of which focus will be on PHC to prevent diseases and promote health, as well as to cure illnesses (African National Congress, 1994).

The adoption of PHC in South Africa resulted in proliferation of community based facilities in areas such as Khayelitsha and Phillipi, where health services had been minimal or absent. The present situation of CHCs is uncontrollable as they are overcrowded by clients that are presenting with minor health ailments. Questions had been asked regarding health seeking behaviour of clients presenting with minor health ailments and how was PHC implemented in South Africa. WHO when it introduced PHC emphasised that community must be involved during the planning and implementation phases through the introduction of District Health System (DHS).

The researcher aimed to conduct a descriptive cross sectional study to try and gain an understanding of the problem. Interviews using a structured questionnaire will be used for both clients with minor health ailments and health professionals (doctors and clinical nurse practitioners) with the hope of gaining insight whether clients are aware that they are frequenting the CHCs presenting with minor health ailments. Also whether health professionals are aware that clients who they consult are mostly presenting with minor health ailments, and what interventions they use for the treatment or management of these ailments.

## CHAPTER 3

### Methodology

#### 3.1 Aim of the study

The aim of this study was to explore the health seeking behaviour of clients presenting with minor health ailments attending CHCs in Khayelitsha and Phillipi (primary health care centre in their area) for the management of minor health ailments.

#### 3.2 Objectives of the study

1. A literature review that underpins the study (Chapter 2).
2. To determine the number of clients presenting with minor health ailments in the fourth week of April 2003 for four days, one day allocated for each community health centre for the data collection at Michael Mapongwana, Site B, Inzame Zabantu and Mzamomhle CHCs.
3. To determine the demographic details of the selected clients presenting with minor health ailments, doctors and clinical nurse practitioners.
4. To describe the types of minor health ailments that the above mentioned clients presented with in the CHCs that are under the study area.
5. To describe perceptions and attitudes of clients at the selected CHCs that presented with minor health ailments with regard to the care of minor health ailments.
6. To describe the ailments that doctors regard as minor health ailments including their perceptions towards the management of these ailments.
7. To describe the ailments that clinical nurse practitioners regard as minor health ailments including their perceptions towards the management of these ailments.
8. To make recommendations with regard to the care of minor health ailments to the following: clients, health care professionals, community health workers and community. This will be done in Chapter 6.

### **3.3 Study design**

This was a descriptive study that used both qualitative and quantitative methods of data collection. Clifford (1997) defines descriptive studies as research that 'describes' what is happening in a given situation and is a non-experimental that does not require a hypothesis.

#### **3.3.1 Qualitative approach to this study**

Qualitative approaches to research are those in which the information is generated in words by the participants, that is, research subjects. The data may come directly from the subjects themselves or is generated by the researcher observing the subject in a given situation.

Qualitative research deals with feelings, emotions and unearthing concepts for research which help inform practice by increasing awareness (Clifford, 1997). In this study qualitative approaches were used in the form of open-ended questions. These open-ended questions focused mainly on perceptions and attitudes of clients presenting with minor health ailments regarding the care of minor health ailments at home and in the CHCs (see Appendix 2).

This approach was also used for doctors and clinical nurse practitioners to ascertain attitudes and perceptions regarding the causes of large numbers of clients presenting with minor health ailments and the strategies they use for prevention and management of minor health ailments (see Appendix 4).

#### **3.3.2 Quantitative approach to this study**

Quantitative approaches to research are approaches where information or data is generated in a more structured manner using a pre-set questionnaire. In this case the researcher set the framework and the respondents indicated the extent to which they agree with the set of questions by giving a 'yes' or 'no' response to the question asked. The researcher counted the number of responses to each question. The responses can be categorised in numerical form. Quantitative research is designed to address issues relating to cause and effect (Clifford, 1997). Further on this approach was used during the study where qualitative data in relation to themes were categorised by checking how often they occurred.

### **3.4 Study area, study population, study sample and sampling methods**

#### **3.4.1 Study area**

Khayelitsha and Phillipi have seven CHCs. From these CHCs the researcher chose four CHCs, two in Khayelitsha that is, Michael Mapongwana and Site B CHCs and two in Phillipi that is, Inzame Zabantu and Mzamomhle CHCs. These CHCs were chosen because the problem of overcrowding of clients presenting with minor health ailments was noted in these CHCs (see Chapter 1).

#### **3.4.2 Study population, study sample and sampling methods**

This study aimed to explore the health seeking behaviour of clients presenting with minor health ailments attending CHCs in Khayelitsha and Phillipi for the management of minor health ailments. To achieve the objectives that are listed at the beginning of Chapter 3 aimed to answer the research question. In order for research question to be answered the study population had to involve three groups of people, the clients presenting with minor health ailments, doctors and clinical nurse practitioners working in the specified CHCs. This means all clients presenting with minor health ailments, all doctors and all clinical nurse practitioners working in the specified CHCs form the study population.

The following is a further explanation of the study population of the three groups (clients, doctors and clinical nurse practitioners) including both their study sample and sampling methods of each group.

##### **Group 1: Clients**

**Population:** In 2003, Michael Mapongwana admitted approximately 750 clients per day, Site B approximately 900 clients per day, Inzame Zabantu and Mzamomhle CHCs approximately 300 clients each per day. The mini survey that was done by fourth year medical students showed that daily, in 2000, 24% of clients that attended Site B CHC presented with minor health ailments and 33% of clients that attended Michael Mapongwana presented with minor health ailments (Brice, McGurk, Petkar and Philip, 2000; Keraan, Naidoo, Parker and Royker, 2000).

From the clients that visit the specified CHCs, only those clients who were presenting specifically with minor health ailments and were between the ages of 18-65 years will form the study population.

**Study sample and sampling method:** A convenient sample of 25 clients presenting with minor health ailments was selected in each CHC (that is, Michael Mapongwana, Site B, Inzame Zabantu and Mzamomhle CHCs) that made a total of 100 clients. The selection of clients was done during the fourth week of April 2003. During this fourth week the selection of the clients was done on one day for each CHC that makes up to four days of data collection. The researcher did not target any specific period except that at this time the research methodology was ready to be implemented, namely:

- The proposal was approved by the UCT ethics research committee
- The tools to be used in the research had been piloted and modified
- The facility managers, doctors and clinical nurse practitioners were consulted concerning the dated of conducting the study.

In each of the CHCs Michael Mapongwana, Site B, Inzame Zabantu and Mzamomhle, the clients who presented with minor health ailments were identified by the doctors and clinical nurse practitioners who participated in the study as having minor health ailments. This was done by the doctors and clinical nurse practitioners who participated in the study during consultation by putting the pink stickers on clinical files of those clients that presented with minor health ailments. This method of labeling the clinical files with pink stickers assisted the researcher and research assistants that day to identify clients who presented with minor health ailments. The 25 clients from each of the specific CHC under the study area were the first clients who agreed to participate in the study and the others who did not participate were identified to check how many clients per day were seen at the CHCs presenting with minor health ailments. This process of identifying the clients who presented with minor health ailments will be clearly explained in more detail under methods of data collection and the total number of clients who presented with minor health ailments will be shown under results in Chapter 4.

## **Group 2: Doctors**

**Population:** Michael Mapongwana has 8 doctors, Site B has 13 doctors, Inzame Zabantu has 2 doctors and Mzamomhle has one visiting doctor that comes once a week, as this CHC is a nurse driven service. The doctors were included in the study because the researcher wanted to explore their perceptions and attitudes regarding overcrowding of CHCs by clients presenting with minor health ailments. Also the clients consult them when they come to the CHC presenting with minor health ailments.

**Study sample and sampling methods:** A sample of convenience of doctors working in the CHCs was used for this study. The doctors that were included in the study were those who were willing to participate. The doctors were given a consent form (see Appendix 1) to show that they agreed to be part of the study. In Khayelitsha, Michael Mapongwana CHC had 5 doctors on duty on the 22/04/03 and three of them participated in the study. Site B had 10 doctors on duty on the 23/04/03 and six of them agreed to participate in the study. In Phillipi, Inzame Zabantu had 1 doctor on duty on the 24/04/03 and he agreed to participate in the study. Mzamomhle CHC had no doctors on the 25/04/03. The total number of the doctors who agreed to participate was 10. These doctors were the ones who assisted with identifying the clients who presented with minor health ailments and they were the ones who were validating the list of minor health ailments.

The doctors who were on duty on the specified dates for specific CHCs were all consulted individually regarding the list of minor health ailments that was going to be used in the study. They were requested to look at the list and agree if the ailments on the list that were going to be used for identifying clients with minor health ailments were regarded as minor health ailments by them. They were also asked according to their understanding of what minor health ailments are, to add or delete the health ailments that were in the list according to their understanding of what minor health ailments are. Adjustments were made in the list that was discussed with the doctors.

## **Group 3: Clinical nurse practitioners**

**Population:** Michael Mapongwana CHC has 5 clinical nurse practitioners, Site B also has 5 clinical nurse practitioners, Inzame Zabantu has 2 clinical nurse practitioners and Mzamomhle has 8 clinical nurse practitioners. The clinical nurse practitioners were included in the study because the researcher wanted to explore their perceptions and attitudes regarding overcrowding

of CHCs by clients presenting with minor health ailments. Also clients consult them when visiting the CHCs when presenting with minor health ailments.

**Study sample and sampling methods:** A sample of convenience of clinical nurse practitioners working in the CHCs under the study areas was used in the study. The clinical nurse practitioners who were included in the study were those who were willing to participate in the study by signing a consent form (see Appendix 1). There were 3 clinical nurse practitioners who were consulting clients at Michael Mapongwana on the 22/04/03, two agreed to participate in the study. Site B had 3 clinical nurse practitioners who were consulting the clients on the 23/04/05, two agreed to participate in the study. Inzame Zabantu had one clinical nurse practitioner on duty and was consulting the clients on the 24/04/05 one that was on duty agreed to participate in the study. Mzamomhle CHC had 5 clinical nurse practitioners who were consulting the clients on the 25/04/03, none of them participated in the study which will be explained in the limitations of the study. The total number of clinical nurse practitioners who agreed to participate in the study was 5. These clinical nurse practitioners were the ones who assisted with identifying the clients who were presenting with minor health ailments and they were the ones who were validating the list of minor health ailments. All the clinical nurse practitioners on duty and were consulting the clients were consulted individually regarding the ailments that were contained in the list that was going to be used in the study. They were requested to look at the ailments that were contained in the list and agree or disagree if the ailments that were in the list were the ailments that they regard as minor health ailments according to their understanding. There were adjustments that were made to the list.

### **3.5 Inclusion and exclusion criteria**

Table 1 will summarise how CHCs, doctors, clinical nurse practitioners (CNP) and clients were included and excluded in this study.

**Table 1 Inclusion and exclusion criteria of CHCs, doctors, CNP and clients**

	<b>INCLUSION CRITERIA</b>	<b>EXCLUSION CRITERIA</b>
<b>CHC</b>	<ul style="list-style-type: none"> <li>➤ Within the study area</li> <li>➤ Train UCT students</li> <li>➤ Having clients presenting with minor health ailments</li> <li>➤ Overcrowding of CHCs was seen as a problem</li> </ul>	<ul style="list-style-type: none"> <li>➤ Not within the study area</li> <li>➤ Does not train UCT students</li> <li>➤ Does not have clients presenting with minor health ailments</li> <li>➤ Overcrowding was not seen as a Problem</li> </ul>
<b>DOCTORS</b>	<ul style="list-style-type: none"> <li>➤ Working in the CHCs under the study area with clients</li> <li>➤ Agreed to participate</li> </ul>	<ul style="list-style-type: none"> <li>➤ Refused to participate in this study</li> <li>➤ Visiting doctors (locum)</li> </ul>
<b>C.N.P.</b>	<ul style="list-style-type: none"> <li>➤ Working in the CHCs under the study area with clients</li> <li>➤ Agreed to participate</li> <li>➤ Consult the clients</li> </ul>	<ul style="list-style-type: none"> <li>➤ Refused to participate in this study</li> <li>➤ Do not consult clients</li> </ul>
<b>CLIENTS</b>	<ul style="list-style-type: none"> <li>➤ Identified to have minor health ailments during the fourth week of April 2003</li> <li>➤ Between ages 18-65 years</li> <li>➤ Residing in Khayelitsha and Phillipi</li> <li>➤ Attended CHCs under the study area on the day of the research</li> </ul>	<ul style="list-style-type: none"> <li>➤ Does not present with minor health ailments during the fourth week of April 2003</li> <li>➤ Under age 18years and over the age 65years</li> <li>➤ Not residing in Khayelitsha and Phillipi</li> </ul>

Table 1 gives the sampling methods for CHCs, doctors, clinical nurse practitioners and clients.

### **3.6 Instrumentation and methods of data collection**

#### **3.6.1 Instruments used**

A self-compiled structured questionnaire with closed-ended and open-ended questions was used for clients and for community health centre staff (doctors and clinical nurse practitioners) (see Appendix 2 and Appendix 4 respectively) to collect data that answered the aim and objectives of the study. It consisted of sections which will be clearly outlined below.

## **Questionnaire for Clients**

**Section A:** consent form

**Section B:** demographic details of the clients

**Section C:** questions on visits to the CHC (see Appendix 2, questions 1, 3, 4, 14), on types of minor health ailments they presented with at the CHC and other minor health ailments that they know of (see Appendix 2, questions 2, 5, 6, 7), alternative methods towards the care of minor health ailments (see Appendix 2, questions 8, 9, 10, 11, 12, 13, 20), and service received at the CHC (see Appendix 2, questions 15, 16, 17, 18, 19).

## **Questionnaire for Community Health Centre staff**

**Section A:** consent form

**Section B:** questions on minor health ailments (see Appendix 4, question 1, 11), feeling towards clients who are presenting with minor health ailments when the CHC is overcrowded (see Appendix 4, questions 2, 3, 4), alternative approaches and resources for management of minor health ailments (see Appendix 4, questions 6, 7, 8, 9, 10), and how do they manage minor health ailments at the CHCs (see Appendix 4, question 5).

### **3.6.2 Methods of data collection**

#### **Identification of clients that presented with minor health ailments**

The researcher used the description of minor health ailments that were listed in the definition of terms as part of the list that was used in this study to validate individually with the doctors and clinical nurse practitioners that participated in the study whether they agree if the minor health ailments listed in this list were minor health ailments and to make adjustments where necessary.

The following was done to the list:

- Adjustments to the list were done to reach common agreement on what doctors and clinical nurse practitioners thought were minor health ailments (see Appendix 3). There are minor health ailments that are acute ailments in the list that were explained by the doctors and clinical nurse practitioners, whereby they defined acute phase of an illness as a phase that occurred within three days from the onset of the illness and if time of the illness exceeded the third day it is not considered as a minor health ailment.

- After validating the list of minor health ailments and coming to an agreement on what the researcher, doctors and clinical nurse practitioners thought were minor health ailments the researcher gave the doctors and clinical nurse practitioners the list of minor health ailments as a reminder of these ailments, small pink stickers to identify the clients who presented with minor health ailments on the day data was collected for each of the four CHCs (Michael Mapongwana, Site B, Inzame Zabantu, Mzamomhle).
- The list consisted of the following minor health ailments after validation: **Respiratory:** colds, upper respiratory tract infection, hay fever; **Abdominal and urinary tract infection (U.T.I):** diarrhea, stomach ache, gastro-intestinal, acute urinary tract infection; **Skin disorders:** insect bite, rash; **Body pains:** back pain, acute back syndrome, migraine, emotional problems; **Ears:** cerumen, acute otitis media; **Accidents:** minor cuts, nose bleed, minor accidents, burns.
- Pink stickers were given by the researcher to the doctors and clinical nurse practitioners to identify all those clients who presented with minor health ailments and were supposed to be put on the right corner of folder so that those folders of clients could be easily identified by the research assistants. This was done during consultation by the doctor and clinical nurse practitioners who participated in the study.
- Research assistants were waiting outside the consulting rooms for all those clients who were consulted by the doctors and clinical nurse practitioners and had small pink stickers on the right corner of their clinical files. They had questionnaires prepared for the clients to fill-in. Some of them were written in isiXhosa and some in English. They wore white T-shirts, jeans and name tags so as to be easily identified by the clients.
- The doctors and clinical nurse practitioners were to inform the clients of research assistants who will be approaching them and asking them questions regarding their ailments on their way out of the consulting room. The nursing assistants who assisted the doctors in the consulting rooms reminded the clients of the need to speak to the research assistants on their way out and this was further reinforced by the doctors and clinical nurse practitioners.
- After identifying the clients who presented with minor health ailments doctors and clinical nurse practitioners were asked to tick each and every patient in the daily statistics who came on that day presenting with minor health ailments. This was done by the doctors and clinical nurse practitioners who participated in the study.

### **Filling-in of questionnaires**

- After the clients were identified as having minor health ailments, the research assistants approached them and they:
  - Explained the study purpose.
  - Gave the 25 clients in each CHC identified by either doctors or clinical nurse practitioners and who had pink stickers in their folders a consent form to sign and a questionnaire to fill-in.
  - Assisted illiterate clients who agreed to participate with completion of a consent form and further.
  - Assisted illiterate clients that agreed to participate with filling-in of the questionnaire.
- The doctors and clinical nurse practitioners were approached by the researcher to answer the questions in the questionnaire in the form of a face-to-face interview. The researcher explained the study purpose to them. They were asked to read and sign the consent form if they agreed to participate in a face-to-face interview. This procedure of a face-to-face interview was done after the doctors and clinical nurse practitioners consulted the clients who visited the CHCs. The clinical nurse practitioners of Mzamomhle did not want to participate in a face-to-face interviews due to time constraints.

### **Record reviews**

- The gender of the clients that were included in the study was collected from the clients' files that were marked with pink stickers.

### **3.7 Training of research assistants**

Prior to the implementation of the study the researcher identified three research assistants who assisted in data collection. The research assistants were approached a month before the research was conducted for training purposes. Their training included how to handle the clients appropriately by doing the following:

- Showing a friendly relaxed face.
- Introducing themselves to the clients.
- Explaining the study purpose that they were assisting in.
- Explaining the consent form.

- Letting the clients sign the consent form so that they can participate in the study.
- Explain the sequence of the questionnaire and approximately the time that will be taken to fill-in the questionnaire.
- Explain to the clients that if there is a question that is not understood they are free to ask for explanation.
- Thank the clients for participating in the study.

During training sessions the researcher and research assistants read through the questionnaires so that research assistants could understand the questions asked in case the clients did not understand some of the questions. When the research assistants did not understand the questions and the procedures to be done, they were allowed to ask questions and the researcher would explain it in simpler terms.

A day before the implementation of the pilot study at the CHC that was chosen, the researcher and research assistants met for the last time to clarify the procedure to be followed and made sure that it was well understood.

### **3.8 Pilot study**

#### **3.8.1 The aim of the pilot study was to:**

- Check if the tools used were appropriate for the study (that is, answered the research question).
- Check whether questions asked were understood by the participants.
- Check whether the aim and objectives were answered by the questionnaire.
- Check time taken to fill-in the questionnaire and
- Check the procedure to be done by health professionals if it was clear enough for them to follow.

#### **3.8.2 Area of piloting**

Piloting was done in Gugulethu CHC. It is in district 3 which is the same district that Inzame Zabantu and Mzamomhle CHCs fall under. It functions similarly to Michael Mapongwana CHC and is also having a similar problem of overcrowding. A letter to the facility manager of

Gugulethu CHC (see Appendix 5) was hand posted by the researcher a week before the piloting date to ask permission for conducting a mini study preparing for the bigger study.

### **3.8.3 Procedure and comments related to the procedure**

The procedure used in piloting is the exact method that is explained above. The researcher targeted four doctors, one clinical nurse practitioner and ten patients who visited the centre on the 09/04/2003. The questionnaire used for the doctors and clinical nurse practitioner was clearly understood by them and it was easy for them to answer the questions. The procedure of identifying the clients with the pink stickers was forgotten by some of the doctors because of the patient load. The researcher had to run between the doctors reminding them of putting the pink stickers on the patients' folders. The researcher asked the assistant nurses assisting with interpretation for the patients to remind the doctors of the pink stickers. It took the doctors and clinical nurse practitioner 10-15 minutes to complete the questionnaire. There were no changes made in the questionnaire.

Clients who participated were identified by the doctors and clinical nurse practitioner as presenting with minor health ailments. The research assistants experienced problems when asking clients to participate in the study because of the pink stickers that were in their folders. The clients feared that they had incurable diseases. The research assistants explained to the patients why they had the pink stickers in their folders and it was easy for them to continue with the study after the explanation.

Clients had a choice of answering the questionnaire in English or IsiXhosa. Some of the patients had a problem of not clearly understanding some of the questions whereby the research assistant had to explain in simpler words what the question meant without changing the context of the question. It took the clients 25-30 minutes to complete the questionnaire. The researcher had to add eight questions in the questionnaire (see Appendix 2, questions 2, 6, 8, 9, 10, 12, 18 and 19) of the clients because Objective 6 from the objectives of the study which are listed at the beginning of this Chapter was not fully answered by the questionnaire.

Table 2 shows a summary of the problems encountered during the pilot study and the improvements done on the instruments prior to data collection.

**Table 2 Summary of problems experienced during piloting and adjustments made for the main study**

<b>PROBLEMS</b>	<b>IMPROVEMENTS</b>
Doctors forgot to put pink stickers to the patients' folders.	Nursing assistants to remind the doctors about the pink stickers.
Clients did not want to participate in the study due to having fears of the pink stickers in their folders.	Doctors and research assistants to explain why there were pink stickers on the folders to alleviate fears.
Question 17 was a difficult question to understand by the clients (see Appendix 2, question 17).	Simplified the difficult question.
Eight questions that were missing to answer some objectives.	Added eight questions to answer the objectives (see Appendix 2, questions 2, 6, 8, 9, 10, 12, 18 and 19)

### **3.9 Data analysis**

#### **3.9.1 Formatting and analysis of the collected data for this study**

##### **3.9.1.1 Clients**

The researcher had to first translate the responses of those clients who filled-in the Xhosa questionnaire into English. Afterwards the researcher combined all the hundred questionnaires of the clients who presented with minor health ailments. The responses of the open-ended questions were all listed and summarised into themes. The responses where there were yes and no answers were all counted to see how many responded yes and how many responded no. The responses where the clients had to describe or list were all listed and common responses were counted according to the number of clients who responded the same and the others were combined to form different themes. All the qualitative and quantitative data of the clients were captured in an Excel spread sheet.

##### **3.9.1.2 Doctors**

The responses from the face-to-face interview were recorded in a questionnaire that was prepared for doctors from the three CHCs (Michael Mapongwana, Site B and Inzame Zabantu) and were combined together. There were no doctors at Mzamomhle CHC. The responses of the questions that had yes and no answer were listed and were counted to find out how many responded yes and how many responded no as an answer to the question. The responses where the doctors had to describe or list were all listed and common responses were counted according

to the number of doctors who responded the same way for the listed responses and for those questions where the doctors had to describe the responses were summarised to form different themes. All the information from the face-to-face interview of the doctors was captured in Excel spread sheet.

#### **3.9.1.3 Clinical nurse practitioners**

The responses from the face-to-face interview were recorded in a questionnaire that was prepared for the clinical nurse practitioners from the three CHCs (Michael Mapongwana, Site B and Inzame Zabantu) and were combined together. There were no clinical nurse practitioners that participated in a face-to-face interview at Mzamomhle CHC reasons will be discussed in the limitations of the study. The responses of the questions that had yes and no answer were listed and were counted to find out how many responded yes and how many responded no as an answer. The responses where the clinical nurse practitioners had to describe or list were all listed and common responses were counted according to the number of clinical nurse practitioners who responded the same for the listed responses and those questions where the clinical nurse practitioners had to describe the responses were summarised to form different themes. All the information from the face-to-face interview of the clinical nurse practitioners was captured in an Excel spread sheet.

The results will be presented in Chapter 4 using tables that show the responses of the three groups that is, the clients, doctors and clinical nurse practitioners. Each objective from the study will be answered according to the information that is captured in an Excel spread sheet.

#### **3.9.1.4 How the list of minor health ailments was used in the study**

The list of minor health ailments used in the study was for identifying all those clients who consulted the doctors and the clinical nurse practitioners at the four CHCs under the study areas. The list of these ailments was used to compare the list of minor health ailments mentioned by the clients, doctors and clinical nurse practitioners who participated in the study.

#### **3.9.1.5 Comments between variables: clients, doctors and clinical nurse practitioners**

The perceptions and attitudes of clients presenting with minor health ailments regarding the care of these ailments at the four CHCs under the study areas were highlighted and comments of the

perceptions and attitudes of the doctors and clinical nurse practitioners regarding the care of minor health ailments were made. Also the attitudes of doctors towards the care of minor health ailments were highlighted as well as of those of clinical nurse practitioners to see where they differ in terms of the management of minor health ailments.

### **3.10 Ethical considerations**

- The protocol was submitted to the ethics and research committee of UCT health Sciences Faculty, the Provincial Administration of the Western Cape and Local Authority structures.
- The researcher wrote letters to the management of the CHCs and to ask permission to conduct the research.
- The researcher gave an explanation about the research to the clients waiting to be seen by the doctors and clinical nurse practitioners, thereafter when participants were chosen they were given consent forms to be signed before participating in the answering of the questionnaire.
- Permission to review clients' records was asked from the facility manager after explanation of the research process.
- All participants were interviewed only if they agreed to be part of the project and only after informed consent form has been gained.
- Participants were assured of confidentiality and anonymity during the research, and in the analysis and dissemination of the results. The results will be disseminated in the communities involved, health authorities, journals and will be published.

### **3.11 Adjustments to methodology**

#### **3.11.1 Adjustment to the reporting of results of doctors and clinical nurse practitioners**

Initially the results from the questionnaire of doctors and clinical nurse practitioners was reported using tables and percentages. This was challenged as the numbers of doctors and clinical nurse practitioners were too small. It was suggested that their results be presented qualitatively as themes. The results are going to be presented in two sections, Section 1 for the clients and Section 2 for the doctors and clinical nurse practitioners.

### 3.11.2 Adjustment done to the list and table of minor health ailments

Though the table of minor health ailments that was used by the doctors and clinical nurse practitioners to select clients with minor health ailments was also questioned in respect of the description of some of the minor health ailments, very little adjustment was done to this table. Adjusting the actual ailments would have a direct impact on clients that were already selected. The only adjustments that were done were to simplify the diagnosis into symptoms. Table 3 was used before adjustments and Table 4 after adjustments.

**Table 3 List of minor health ailments used in this study**

<b>RESPIRATORY</b>	<b>ABDOMINAL URINARY INFECTION</b>	<b>SKIN DISORDERS</b>	<b>BODY PAINS</b>	<b>EARS</b>	<b>ACCIDENTS</b>
Colds	Diarrhoea	Insect bite	Back pain	Cerumen	Minor cuts
Upper respiratory tract infection	Stomach ache	Rash	Acute back Syndrome	Acute otitis media	Nose bleed
Hay fever	Gastro-intestinal		Migraine		Minor Accidents
	Acute urinary infection		Emotional Problems		Burns

**Table 4 Adjusted table of list of minor health ailments**

<b>Respiratory</b>	<b>Abdominal and U.T.I</b>	<b>Skin disorders</b>	<b>Body pains</b>	<b>Ears</b>	<b>Accidents</b>
Colds/flu	Diarrhoea	Insect bite	Chronic back pain	Blocked ears	Minor cuts
Upper respiratory tract infection	Stomach ache	Rash	Acute back pain	Earache	Nose bleed
Hay fever	Vomiting		Migraine	Ear discharge	Minor Accidents
Tight chest	Burning urine		Emotional problems		Minor burns

## **CHAPTER 4**

### **Presentation of results**

#### **4.1 The results of this study will be presented in the following format:**

- a. Each aspect of the questionnaires will be presented according to each objective of the study.
- b. This presentation starts with Objective 2 as Objective 1 has already been presented in Chapter 2 as part of literature review.
- c. The results of the clients and health professionals will be presented separately, that is, Section 1 will contain the results of the clients and Section 2 will contain the results of the doctors and clinical nurse practitioners.
- d. The total number of the sample that is, clients, doctors and clinical nurse practitioners who participated in the study will be represented by the capital letter N.
- e. The total number of participants in the study who responded to specific questions in the study will be represented by the small letter n.

#### **4.2 Section 1: The results from the clients' data**

**4.2.1 Objective 2:** To determine the number of clients presenting with minor health ailments at Michael Mapongwana, Site B, Inzame Zabantu and Mzamomhle CHCs.

This objective was fulfilled by looking at:

- a. The number of clients that visited the four CHCs presenting with minor health ailments.
- b. Whether these clients presenting with minor health ailments had come to the CHC for the first time presenting with the same ailment or more than once.

##### **4.2.1.1 Number of clients presenting with minor health ailments**

Table 5 shows:

- The number of clients that were seen by the doctors and clinical nurses practitioners who participated in the study.
- The number of clients who presented with minor health ailments during consultation.
- The percentages of clients that presented with minor health ailments.

**Table 5 Number of clients that were seen by the participating doctors and CNPs presenting with minor health ailments on the day of the research for each CHC**

CHCs	CLIENTS SEEN BY DOCTORS AND CNPs	CLIENTS WITH MINOR HEALTH AILMENTS	PERCENT OF CLIENTS WITH MINOR HEALTH AILMENTS
Michael Mapongwana	167	118	71%
Site B	343	220	64%
Inzame Zabantu	85	50	59%
Mzamomhle	91	45	49%

The doctors and the CNPs that participated in the study consulted 686 clients who presented with different ailments. Of the 686 clients that were seen, 63% (n=433) of clients presented with minor health ailments and 37% (n=233) of clients presented with serious health ailments.

#### 4.2.1.2 CHC attendance of clients presenting with minor health ailments

From the clients that participated in the study 55% (n=55) of clients who presented with minor health ailments visited the CHC for the first time and 45% (n=45) of clients came to the CHC more than once for the same minor health ailment.

**4.2.2 Objective 3:** To determine the demographic details of all the clients (demographic details of the doctors and clinical nurse practitioners will be presented under Section 4.3.).

#### 4.2.2.1 Demographic details of the clients

Demographic details (gender and age) of the 100 clients, 25 from each CHC (Michael Mapongwana, Site B, Inzame Zabantu and Mzamomhle) were collected by the researcher. Below is the presentation of combined demographic details of the clients from the four CHCs.

## Gender

Of the total number of clients that participated in this study, 63% (n=63) of the clients were females and 37% (n=37) of the clients were males.

## Age

The age groups of the clients that participated in this study from the CHCs in Khayelitsha and Phillipi will be presented in Table 6.

**Table 6 Combined age group of clients that participated in the study from the four CHCs presenting with minor health ailments**

AGE GROUP	NUMBER OF CLIENTS	PERCENTAGE (N=100)
18-29 years	52	52%
30-39 years	26	26%
40-49 years	16	16%
50-59 years	5	5%
60-65 years	1	1%

Table 6 shows that the majority of the clients 52% (n=52) fell within the age group of 18-29 years. The least number of clients 6% (n=6) fell between 50-65 years.

**4.2.3 Objective 4:** To describe the types of minor health ailments that clients presented with in the CHCs by looking at:

- a. The type of illnesses presented to the research assistants by clients after they have been seen by the doctors and clinical nurse practitioners and have been diagnosed as having minor health ailments by these health professionals.
- b. The knowledge of clients regarding the types of minor health ailments that clients think can be treated at home.

**4.2.3.1 List of illnesses presented to the research assistants by the clients that were selected as having minor health ailments by doctors and clinical nurse practitioners in the four CHCs.**

Table 7 shows all the illnesses clients mentioned. It must be noted that some of the clients mentioned more than one illness.

**Table 7 List of the illnesses presented to the research assistants by the clients that were selected by doctors and clinical nurse practitioners as having minor health ailments at Michael Mapongwana, Mzamomhle, Site B and Inzame Zabantu CHCs**

ILLNESSES	MICHAEL MAPONGWANA	MZAMOMHLE	SITE B	INZAME ZABANTU
Fever	3	7	5	4
Chest pain	1	1	1	6
Rash	1	1	2	3
Swollen eye	0	0	0	1
headache	0	0	0	1
Coughing	1	7	1	1
Pimples	0	2	1	1
Back pain	1	0	3	2
Diarrhoea	0	2	0	2
Stab pain	0	1	0	1
Breast pain	0	0	0	1
Boil	1	0	1	1
Stomach ache	5	0	3	4
Wounds	1	1	2	1
Dizziness	0	0	0	1
Discharge	0	6	0	0
Nose bleed	0	1	0	0
Sexually transmitted disease	1	1	0	0
Burning urine	1	1	0	0
High temperature	1	3	0	0
Lower back pain	1	0	1	0
Kidneys	1	0	0	0
Arthritis	1	0	2	0
Glands	1	0	2	0
Body pains	1	0	2	0
Epilepsy	0	0	1	0
Knee pain	0	0	1	0
Sprain	0	0	0	1
Swollen breast	1	0	0	0
Minor injury	1	0	0	0
Painful uterus	2	0	0	0
Blocked nose	1	0	0	0

#### 4.2.3.2 Knowledge of clients regarding minor health ailments that can be treated at home

59% (n=59) of the clients knew of some minor health ailments that can be treated at home and 41% did not know. Table 9 shows the list of minor health ailments mentioned by the clients that can be treated at home.

**Table 9 List of minor health ailments that can be treated at home mentioned by the clients**

AILMENT	NUMBER OF CLIENTS (N=59)	PERCENTAGE
Headache	39	39%
Stomach ache	28	28%
Fever	15	15%
Coughing	10	10%
Diarrhoea	9	9%
High temperature	5	5%
Tuberculosis (TB)	4	4%
Vomiting	3	3%

Table 9 shows the list of minor health ailments that the 59 clients believe can be treated at home. The top three ailments that could be treated at home were headache = 39%, stomach ache = 28% and fever = 15%. There is a concern of those clients who mentioned TB as an ailment that can be treated at home as it needs intense investigations and monitoring of treatment.

**4.2.4 Objective 5:** To describe perceptions and attitudes of clients that presented with minor health ailments regarding the care of minor health ailments by clinical nurse practitioners and doctors.

This objective was fulfilled by looking at the following:

- a. Health facilities that clients utilise when presenting with minor health ailments.
- b. The service that clients received at the CHCs regarding the care of minor health ailments.
- c. The clients' knowledge about the people that can advise them for the management of minor health ailments using home remedies.
- d. Whether they would use home remedies for the management of minor health ailments, if they knew of them and whether they would recommend them to others.
- e. The ability to use home remedies by clients who are presenting with minor health

ailments and reasons of not using them this time.

- f. The clients' knowledge regarding the resources that they can utilise when their minor health ailments become serious at home.
- g. Education received by the clients regarding the minor health ailments they presented and the sources who educated them.

#### 4.2.4.1 Health facilities utilised by the clients

Table 10 will show the type of health facilities that clients use when they are sick with minor health ailments.

**Table 10 Health facilities that clients use when they are sick presenting with minor health ailments**

HEALTH FACILITIES	NUMBER OF CLIENTS	PERCENTAGE (N=100)
CHC visited	69	69%
Other CHC (not those under study area)	11	11%
Private doctor	11	11%
Hospital	8	8%
Other	1	1%

Table 10 shows that 80% (that is 69%+11%)(n=80) of clients visit the CHCs mostly when they are sick with minor health ailments. Only 20% (that is, 11%+8%+1%)(n=20) of clients use other health facilities.

#### 4.2.4.2 Help clients with minor health ailments received at the CHC

Clients were asked regarding the help they got at the CHC besides medication that is, pills when they came to the CHC presenting with minor health ailments. 53% (n=53) of the clients responded to this question as clients that were helped at the CHC when they visited the CHC presenting with minor health ailments and 47% were not helped from the CHC.

The responses of those who were helped were:

- They were referred to other departments besides pharmacy for further assistance.
- They felt better after they consulted the health professionals.
- They got advice for their ailments during consultation.
- They had their urine tested and were weighed before consultation.
- They were satisfied with the service received from the health professionals.

The responses of the 47% (n=47) of clients who were not helped at the CHC were:

- They have been waiting long hours to get the service.
- They were delayed at pharmacy department.
- They think that the problem was with the CNPs as they regard them as nurses without clinical examination skills.
- They think that other staff members do not treat them pleasantly when they are in the CHC.
- They say that the doctor left while they were waiting for the service.
- There was no medication prescribed for them.
- They say that medication does not help.
- They do not know what the problem was.
- They think that the problem is with them by not following the instructions given to them by the doctors and clinical nurse practitioners at the CHCs.

#### **4.2.4.3 Clients' knowledge of advisors for home remedies for the management of minor health ailments**

Only 21% (n=21) of clients knew of people who could advise them of home remedies for the management of minor health ailments. These advisors are in Table 11.

**Table 11 Advisors known by the clients for the management of minor health ailments using home remedies**

ADVISORS	PERCENTAGE (n=21)
Community health workers	5%
Nurse	2%
Faith healers	2%
Mother	3%
Traditional healer	4%
Social worker	2%
My sister	1%
Friends	1%
Other people	1%

Table 11 shows a range of advisors, from the family, the community health workers, the health professionals, friends, the faith healers and traditional healers. These are the people that are found within the community.

#### **4.2.4.4 Knowledge of home remedies and whether to recommended them to others**

The clients were asked if they use home remedies for the management of minor health ailments. 46% (n=46) of clients uses home remedies for the management of minor health ailments and 54% (n=54) of clients do not use them. The same clients who responded to this question 54% (n=54) of clients said they can recommend the home remedies to other people for the management of minor health ailments and 46% (n=46) said they cannot.

#### **4.2.4.5 Clients' ability to treat minor health ailments using home remedies**

Clients were asked if they were able to treat minor health ailments at home using home remedies. 82% (n=82) of clients responded that they are not able to treat minor ailments at home. This number is higher than the 54% (n=54) of the clients who do not use home remedies. Below is a summary of reasons for not using home remedies:

- They do not have treatment available to treat their illnesses.
- They do not have money to buy medication.
- They do not have knowledge of managing minor health ailments at home.

- They have fears of complications of their illnesses when they are at their homes.
- They need to be examined.

The above reasons that were stated by the clients are the things that caused them not to treat minor health ailments at home. This shows that clients who visited the CHCs during the study period did not have adequate resources and knowledge to manage minor health ailments at home.

#### 4.2.4.6 Resources used by the clients when minor health ailments become serious at home

Table 12 shows us the responses of the clients regarding these resources.

**Table 12 Resources used by clients if their minor health ailments become serious at home**

RESOURCES USED BY CLIENTS	PERCENTAGE (N=100)
CHCs	70%
Pharmacists	8%
Community health workers (CHWs)	5%
Traditional healers	3%
Faith healers	3%
CHWs and CHCs	3%
Pharmacists, CHWs and CHCs	3%
Pharmacist and CHWs	1%
Pharmacists and CHCs	1%
Traditional healers and CHCs	1%
CHCs, CHWs and faith healers	1%
Other resources	1%

Table 12 rates the CHC as the preferred resource of people when their ailments are serious.

#### 4.2.4.7 Education regarding minor health ailments for the clients and the educators

When asked if they got education at CHC regarding the ailments they presented to the doctors and CNPs, clients responded that only 38% (n=38) received education about their ailments at the CHC and 62% (n=62) of the clients said they did not receive any education about their ailments.

Table 13 shows sources of education for clients regarding their minor health ailments.

**Table 13 Sources of education clients received about minor health ailments at the CHC**

<b>EDUCATORS</b>	<b>PERCENTAGE (n=38)</b>
CNP	66%
Doctor	26%
Doctor and CNP	3%
CHC	3%
God	3%

Table 13 shows that 66% (n=25) of clients received education about minor health ailments from the clinical nurse practitioners, 26% (n=10) of the clients received education from the doctors, 3% (n=1) of client received education from both doctor and clinical nurse practitioner, 3% (n=1) of client received education from the CHC (it is assumed that the 3% of the clients that received education from the CHC received it from the CHC posters), and 3% (n=1) of client received education from God.

#### **4.3 Section 2: Doctors and clinical nurse practitioners' results**

##### **4.3.1 Demographic details of the doctors and clinical nurse practitioners**

Part of Objective 3 that is, the demographic details of the doctors and clinical nurse practitioners will be presented in this section.

##### **4.3.1.1 Demographic details (gender and age) of ten doctors from three CHCs (Michael Mapongwana, Site B and Inzame Zabantu).**

###### **Doctors**

###### **Gender**

There are 24 doctors that are allocated to CHCs in Khayelitsha and Phillipi. In Khayelitsha the number of doctors who were on duty on the day of the research was 15. In Phillipi there was only one doctor on duty on the day of the research. The total number of doctors who agreed to participate in the study was 10 from both Khayelitsha and Phillipi CHCs. The doctors that participated in this study were mainly males (9 males and 1 female). The age groups of the doctors that participated in this study from the three CHCs will be presented in Table 14.

**Table 14 Age group of doctors who participated in the study**

AGE GROUP	NUMBER OF DOCTORS
20-29 years	7
30-39 years	2
40-49 years	1
50-59 years	0
60-65 years	0

Table 14 shows the majority of the doctors (n= 7) have ages that range between 20-29 years and 3 of them have ages that range between 30-49 years.

#### **4.3.1.2 Demographic details of CNPs**

Demographic details of the CNPs (gender and age) of the 5 CNP from the three CHCs now follow.

#### **Clinical nurse practitioners (CNPs)**

##### **Gender**

There are 20 clinical nurse practitioners in four CHCs (Michael Mapongwana, Site B, Inzame Zabantu and Mzamomhle) for the CHCs in Khayelitsha and Phillipi. There were only 5 female clinical nurse practitioners and no males who participated in the study from the three CHCs that is, Michael Mapongwana, Site B and Inzame Zabantu. Mzamomhle is a nurse driven CHC. All the CNPs working at this CHC did not participate in the study because they were short staffed and others attended a workshop. The age groups of the CNPs will be presented in Table 15.

**Table 15 Age groups of CNPs who participated in the study**

AGE GROUP	NUMBER OF CNPs
30-39 years	2
40-49 years	2
50-59 years	1

Table 15 shows that 2 CNPs were between the ages 30-39 years, 2 were between the ages 40-49 years and only 1 was between the ages 50-59 years.

### **4.3.2 Ailments regarded by doctors as minor health ailments**

Objective 6 describes the ailments that doctors regard as minor health ailments including their perceptions towards the management of these ailments at the CHCs. This objective was fulfilled by looking at:

- a. The knowledge of the doctors regarding the minor health ailments.
- b. The procedure that the doctors followed during consultation.
- c. The knowledge of the doctors of the people who can manage minor health ailments at home.
- d. The knowledge that the doctors have about the choices they have made regarding these people that are seen who can manage minor health ailments within the community.
- e. The willingness of the doctors to work with the traditional healers, faith healers and community health workers in future.
- f. The negative responses of why the doctors are not keen to work with traditional healers and faith healers.
- g. The feelings of the doctors when the CHCs are overcrowded by clients presenting with minor health ailments.
- h. Areas that are not covered due to overcrowding.
- i. The impact of overcrowding to service delivery.

#### **4.3.2.1 Knowledge of doctors regarding minor health ailments**

Though doctors were given the list of minor health ailments with which they agreed upon, they listed the minor health ailments that they know of that can be treated at home. They mentioned a long list of the ailments and the top ten minor health ailments were listed as: headache, diarrhoea, back pain, common colds, rash, abdominal pain, cough, arthritis, impetigo and penis discharge.

#### **4.3.2.2 Procedure followed during consultation**

The procedure doctors follow during consultation is as follows:

- Proper history taking
- Proper examination
- Proper prescription

- Health education
- Follow-up with clients presenting with minor health ailments
- Emotional support to the clients
- Depend on the ailment presented

The procedure that was seen as the mostly done by the doctors was proper examination (n=5), proper prescription (n=5) and proper history taking (n=4).

#### **4.3.2.3 Knowledge of the doctors regarding the people who can manage minor health ailments in the community**

The doctors are aware of the people that they feel can be utilised within the community by the people, for the management of minor health ailments instead of visiting the CHC. The responses were:

- Community health workers
- Professional nurses
- Faith healers and grandparents

The majority of the doctors (n=8) mentioned community health workers as people who can assist clients who are presenting with minor health ailments within the community.

#### **4.3.2.4 Rationale regarding the choices they made**

The rationale for the above choices were:

##### **Community health workers**

- They are trained to identify and treat minor health ailments.
- They are a link between the CHCs and the community.
- They have medical background/knowledge that is needed to identify minor health ailments.

##### **Professional nurses**

- They are qualified to treat minor health ailments and can also prescribe medicine to treat these ailments.

### **Grandparents**

- They have knowledge of cheap effective ways for dealing with common problems.

### **Faith healers**

- They have vast experience and can offer a strong psychological support to patients who have recurrent small minor health ailments.

#### **4.3.2.5 Willingness to work with the traditional healers, faith healers and community health workers**

Doctors have a background of how traditional healers, faith healers and community health workers assist the clients. In this study, 8 doctors said they were willing to work with the three groups of people, 1 doctor was not willing and the other doctor was not sure. The negative response regarding the unwillingness to work with the traditional healers will now be outlined.

#### **4.3.2.6 Negative response of the one doctor**

Some of the practices that traditional healers and faith healers do cause concern to doctors as many people come with exacerbated medical conditions after having consulted traditional healers. This results in the lack of faith towards traditional healers by some of the doctors.

#### **4.3.2.7 Feelings of doctors towards overcrowding of the CHCs**

Doctors' feelings when the CHCs are overcrowded by clients presenting with minor health ailments especially when there is a shortage of doctors and CNPs were expressed differently such as frustrated, lazy and the same. Seven doctors expressed that they feel frustrated, 1 feels frustrated and lazy and 2 feel the same when the CHCs are overcrowded by clients presenting with minor health ailments. The doctors who feel the same expressed that there is no difference with regard to their feelings whether the CHC is overcrowded or not.

#### **4.3.2.8 Areas of concern due to overcrowding**

Areas of concern that are not covered during consultation when the CHCs are overcrowded were as follows:

- Improper examination

- Poor doctor-patient relationship
- Limited time to listen to the patients' problems
- Limited time to educate patients about their conditions
- No time to review records of previous visit

The main area of concern that most doctors (n=4) mentioned is limited time to listen to the patients' problems.

#### **4.3.2.9 The impact of overcrowding at the CHCs on service delivery**

Seven doctors were not satisfied with the service they gave to the clients when the CHC was overcrowded, three doctors get satisfaction of service delivery even though the CHC is overcrowded.

#### **4.3.3 Ailments regarded as minor health ailments by CNPs**

Objective 7 describes the ailments that clinical nurse practitioners (CNPs) regard as minor health ailments. This objective includes:

- a. The knowledge of the CNPs regarding the minor health ailments that they know of.
- b. The procedure that the CNPs followed during consultation.
- c. The knowledge of the CNPs of the people who can manage minor health ailments at home.
- d. The knowledge that the CNPs have about the choices they have made regarding the people that can manage minor health ailments within the community.
- e. The willingness of the CNPs to work with the traditional healers, faith healers and community health workers in future.
- f. The negative responses why the CNPs are not keen to work with the traditional healers and faith healers.
- g. The feelings of the CNPs when the CHCs are overcrowded by clients are presenting with minor health ailments.
- h. Areas that are not covered due to overcrowding.
- i. The impact of overcrowding to service delivery.

#### **4.3.3.1 Knowledge of CNPs regarding minor health ailments**

Though CNPs were given the list of minor health ailments which they agreed upon with, they also mentioned the minor health ailments that they know of that can be treated at home. This list was reduced to the top ten: colds, respiratory tract infection, otitis media/blocked ear, minor burns, rashes, back pain, sore throat, impetigo, diarrhoea and cough.

#### **4.3.3.2 Procedure followed during consultation**

The procedure that is followed by the clinical nurse practitioners when they consult clients that are presenting with minor health ailments is:

- Proper history taking
- Proper examination
- Proper diagnosis
- Proper prescription
- Health education
- Explain the problem clearly to the client
- Refer the clients when necessary
- Listen carefully to the clients' concerns
- Give advice about home remedies to treat minor health ailment presented

The most common procedures done by the clinical nurse practitioners was proper examination (n=3), proper prescription (n=3), proper history taking (n=2) and health education (n=2).

#### **4.3.3.3 Knowledge of the CNPs regarding the people who can manage minor health ailments in the community**

The clinical nurse practitioners were asked to tell of the people that they feel can be consulted as alternatives for the management of minor health ailments to be utilised by the clients within the community instead of visiting the CHC. The responses were:

- Community health workers
- Grandparents

Community health workers were identified by 3 CNPs as people who can assist clients presenting with minor health ailments within the community.

#### **4.3.3.4 Rationale regarding the choices they made**

The rationale for the above choices were:

##### **Community health workers**

- They have basic medical knowledge about how to treat minor health ailments because of the training they received before practising.

##### **Grandparents**

- They have better knowledge of home remedies.

#### **4.3.3.5 Willingness to work with the traditional healers, faith healers and community health workers**

The clinical nurse practitioners were asked to comment about their feelings of working with traditional healers, faith healers and CHWs in future. Three (n=3) clinical nurse practitioners were willing to work in future with the three groups of people, 1 was not willing and another one not sure. The negative responses regarding the unwillingness to work with traditional and faith healers are outlined.

#### **4.3.3.6 Negative responses of the CNPs**

Reasons for not wanting to work with traditional healers and faith healers were:

##### **Traditional healers and faith healers**

- They are not familiar with their methods of healing
- They predict the patients' problem, they treat patients wrongly and also they do not have a stethoscope for examining the patients with chest problems.

#### **4.3.3.7 Feelings of the CNPs towards overcrowding of the CHCs**

The feelings of clinical nurse practitioners when the CHCs are overcrowded by clients presenting with minor health ailments and especially when there is shortage of doctors and clinical nurse practitioners were expressed as frustrated, lazy, energetic and the same. Two clinical nurse practitioners feel the same, 1 frustrated, 1 frustrated and lazy and 1 energetic.

#### **4.3.3.8 Areas of concern due to overcrowding**

Reasons for not helping the clients up to one's satisfaction:

- Improper history taking
- Improper examination of the clients
- Not enough time for health education
- No time to reassure the clients about their conditions

The majority of the clinical nurse practitioners (n=4) had limited time to listen to the patients' problems.

#### **4.3.3.9 The impact of overcrowding of the CHCs on service delivery**

Two clinical nurse practitioners were not satisfied with the service given to the clients when the CHC is overcrowded. On the other hand three of them were satisfied with service delivery even though the CHC is overcrowded.

### **4.4 Limitations of the study**

#### **4.4.1 The researcher**

- Inability to interview more than hundred clients that presented with minor health ailments due to time limitations.
- The researcher excluded the locum doctors participating in the study even though they also consult clients presenting with minor ailments
- Inability to look through the clients' files to compare the minor health ailments that they presented to the doctors and clinical nurse practitioners with the illnesses they mentioned to the research assistants.
- Inability to include all the doctors and clinical nurse practitioners to participate in the study as some of them refused to participate and others were not on duty.
- The validity of the list that was used to identify clients with minor health ailments and was validated by doctors and CNPs at the CHCs under the study area had flaws such as the diagnosis and symptoms regarding some of the ailments that were part of this list that is, acute otitis media and diarrhoea.

#### 4.4.2 Data collection

- The researcher could have gained better insight to the perceptions and attitudes of clients, doctors and clinical nurse practitioners with regard to the care of minor health ailments if she had included the following questions in the questionnaires of the clients, doctors and clinical nurse practitioners.

Questions related to clients such as:

- What was done to you previously when you presented with the minor health ailment?
- What was the doctor's or clinical nurse practitioner's reaction when you presented with your minor health ailment?
- What type of home remedies did you use to treat your minor health ailments?

Questions related to doctors and clinical nurse practitioners such as:

- When you see the client for the second time presenting with the same minor health ailment what is your reaction?
- When the client uses home remedies or consults traditional healers what is your reaction to the client?
- What type of home remedies do you advise the clients to use when they are presenting with some of the minor health ailments?
- The Mzamomhle CHC staff did not fill-in the questionnaires due to limited staff members. The ones who assisted with identification of clients that presented with minor health ailments did not have time to fill-in the questionnaires.
- All the doctors and clinical nurse practitioners were asked to continue ticking all the clients seen during that fourth week of April 2003 so as to be able to know approximately how many clients that visit the CHCs presenting with minor health ailments in a week, they only ticked those clients that visited the CHC presenting with minor health ailments on the day of the research.
- Translation of Xhosa questionnaires during analysis delayed the process of the research.
- Some of the doctors and clinical nurse practitioners refused to participate in the study which caused the results to have limitations with regard to the opinions that they could have given on minor health ailments.

## CHAPTER 5

### Discussion of results

#### 5.1 Introduction

In 1994 the South African government implemented primary health care with the aim of making health accessible and affordable to its people. This resulted in a proliferation of community health centres and clinics especially in areas such as Khayelitsha and Phillipi that lacked health services. To further improve access, health services were provided to the people utilising them free of charge.

Despite this CHCs are characterised as overcrowded environments with long queues, long waiting times and a brief encounter (often less than five minutes) with the doctor or medical staff, feelings of confusion and being alone in an unaccustomed environment, no opportunity to express one's own concerns and being given medicine without any explanation of the effects of the drugs (Gessler *et al*, 1995). This typifies the situation of overcrowding prevails in Khayelitsha and Phillipi CHCs. The perception given by the mini-epidemiological studies conducted by medical students is that close to a third of these clients present with minor health ailments that could have been treated at home. An attempt was made both to give a definition of terms for minor health ailments in Chapter 1.

Questions were asked regarding the reasons for clients not managing minor health ailments at home instead of coming to the CHCs. It was concluded in Chapter 1 that the first step to untangle the problem of overcrowding of these specific CHCs was to explore the health seeking behaviour of these individuals.

The literature reviewed in Chapter 2 discussed aspects such as models of health seeking behaviour, factors that have impacted on the health system of South Africa, models of Primary Health Care at primary level of care, the status of primary health care in South Africa and a description of the focal areas for this study, Khayelitsha and Phillipi.

This chapter now attempts to discuss the results of the data outlined in the previous chapter. This discussion will be presented in the following format:

- Section 1: Discussion of the results from the clients' data according to the objectives of this study.
- Section 2: Discussion of the results from the doctors and clinical nurse practitioners' data according to the objectives of this study.

### **Section 1 Discussion of the results from the clients' data**

Out of a total of 686 clients seen during the study period; 63% (n=433) of the clients presented with minor health ailments. The findings of this study are far larger than the findings in Brice *et al* (2000) and Keraan *et al* (2000). Their studies showed that at Site B and Michael Mapongwana CHC 24% and 33% respectively of the daily clients presented with minor health ailments.

It has already been ascertained by the research assistants that some of the clients who were identified by doctors and clinical nurse practitioners as having minor health ailments had ailments such as kidney problems, arthritis, epilepsy and uterus problems that cannot be regarded as minor health ailments according to the list that was used for identifying the clients presenting with minor health ailments. On the other hand when doctors and clinical nurse practitioners mentioned what minor health ailments were, amongst ailments they mentioned, were ailments such as abdominal pain, arthritis, impetigo and otitis media that cannot be regarded as minor health ailments. The list that was used to select clients with minor health ailments had been questioned regarding its validity. For future studies, there might be a need for doctors, clinical nurse practitioners and the researcher to come to an agreement as to what precisely constitutes minor health ailments. The research tool that was used to identify minor health ailments might need to be validated by experts in this field before being used as a selection tool for minor health ailments.

Nevertheless there is a case to be made regarding overcrowding of CHCs by clients presenting with minor health ailments as Nsisi's study (1999a) conducted at Nolungile CHC in Khayelitsha confirmed. He showed how CHCs were overcrowded on a daily basis with the majority of clients presenting mainly of upper respiratory problems which were categorised as minor health

ailments. Studies done by Myburgh (1997), Nsisi (1999b) and Loghdey (2002) show similar findings.

55% (n=55) of the clients in this research came to the CHC for the first time and 45% (n=45) were there for the second time or more, presenting with same minor health ailments. The most common gender amongst participants was female: 63% (n=63). Studies done by Myburgh (1997), Nsisi (1999a) and Loghdey (2002) showed similarly that the majority of clients were female. The studies of Nsisi (1999a), Brice *et al* (2000) and Keraan *et al* (2000) also confirm these findings. 94% (n=94) of the clients were aged 18-49 years and only 6% (n=6) ranged between the ages of 50-65 years.

The group of clients aged between 18-49 years claimed to be either working, school going or unemployed. The demographic details of these clients can be interpreted in many ways, for example: during the fourth week of April 2003 those who were the working age group between 25-39 years and those who were school going presented at the CHCs with minor health ailments. The question is why do they frequent the CHCs with these minor health ailments when some of them know of other resources that they can utilise to deal with these minor health ailments? These resources would require less time - unlike the CHCs where clients have to queue for long hours. On the other hand, the elderly people were the least common age group of people presenting to CHCs with minor health ailments. How do elderly people manage their minor health ailments? Do they attend to themselves at home as the elderly people of the Makhulu and Tatomkhulu project are doing where they use indigenous health knowledge to heal themselves? Or is it because the Khayelitsha and Phillipi generation are a younger generation who had come to the cities looking for jobs and lacking in the resources such as having a grandmother to handle minor health ailments at home?

The clients who were identified as presenting with minor health ailments by the doctors and clinical nurse practitioners were further questioned by the research assistants about the illnesses they had come for to the CHC. These clients mentioned a whole variety of illnesses, the most dominating illnesses being fever = 19%, stomach ache = 12% and coughing = 10%. As already mentioned earlier they also cited other serious illnesses as already mentioned earlier such as kidney problems, arthritis, epilepsy, and uterus problems.

This is a cause for concern as how did these clients with their conditions slip through doctors and clinical nurse practitioners' hands and be classified as having minor health ailments. Dr Malcolm (2005) raises concerns about consultation times that the general practitioners spend with their clients. He says that the most time spent by the general practitioners with the clients is ten minutes. In that ten minutes they are expected to listen, take an accurate history, explore the patient's ideas, beliefs and concerns about their problems, carry out an appropriate examination, arrange investigations, discuss and agree management and safety net. The risks that could occur in a short space of time for consultation are high as a result he decided to increase the times of consultation in order to be able to assist his clients effectively.

When clients were questioned regarding ailments that could be managed at home, 59 % (n=59) knew some ailments that could be managed at home. 75% (n=6) of these ailments are similar to the ailments that are in the list of minor health ailments that was defined in this study.

These ailments are also similar to the ailments that the elderly people from the health forums that were held in Khayelitsha claim can be managed at home using home remedies such as headache, stomach ache, fever, cough and high temperature. It appeared then that these clients need to refer themselves to these elderly people and gain knowledge on how these ailments can be managed. The questions that needed to be asked were: are these elderly people available in the households of residents of Khayelitsha and Phillipi to give advice about care of minor health ailments? How can this knowledge be made available for use to these clients?

The sub-model from cultural systems model by Kleinman (1980) that enlightens individuals about the resources that can be found within the society, Kleinman describes it as the popular arena. This arena shows us that illnesses are first recognised in a home and family members are the first health resources that can provide health care if one presents with an illness. Future studies regarding health seeking behaviour of clients presenting with minor health ailments should explore whether clients attempted to manage the ailments at home using any type of intervention strategy.

Though this knowledge of ailments that could be managed at home was encouraging to the researcher, there were also concerns as some of the clients (n=4) saw illnesses such as TB as

illnesses that could be managed at home. Tuberculosis needs medical attention whereby one needs to be monitored if they are taking their medication regularly and correctly and also how they are responding to medication. In Khayelitsha and Phillipi there are home based carers that issue pills from home for clients who suffer from tuberculosis and based on this clients may have a perception that it can be treated at home.

This perception is further increased by the fact that home based carers when they are introducing themselves to the community they mention that they also treat TB. This might require to be taken up in further investigations within the TB management strategies at community level to ensure that clients are not receiving confusing messages regarding the right approach to this curable disease.

80% (n=80) of the clients utilise the CHCs when they are sick and few clients consult other resources (refer to Table 12). Gessler *et als*' (1995) study already explained about the type of discomfort that is experienced by the clients that are attending CHCs. Though the clients utilise the CHCs for the management of minor health ailments they know of other resources that they can use to assist with the management of minor health ailments such as: CHCs, pharmacists, community health workers, traditional healers, faith healers, and other resources but they still select the CHCs over and above these resources.

It appears that clients in this study have similar approach to those explained in Niven's locus of control sub-model. Niven's locus of control sub-model says that if individuals want to make decisions they give priority to their problems, subjecting themselves to discomfort (which would be queuing for long periods for the clients at Khayelitsha and Phillipi) at the cost of endangering their lives, and under what conditions they will make a more rational decision by seeking out and taking into account the available medical information about real consequences of alternative courses of action so as to maximise their chances of survival.

53% of the clients were satisfied of the service that they received at the CHCs, they mentioned that they were referred to other departments so that their ailments could be improve, the fears that they had regarding their illnesses were overcome when they consulted the health professionals, they got advice regarding the management of their illnesses during consultation,

the urine and the weight was checked before they were consulted and they got the patients' rights from the health professionals. These are the positive things that clients pointed out about the type of service they received at the CHCs.

On the other hand 47% (n=47) were not satisfied with the service that is offered at the CHCs. They pointed out some important reasons for their lack of satisfaction with the service which were: long waiting hours for the service, doctors leaving whilst clients were waiting for the service and medication supplied previously not helping. These results are similar to the study that was done by Gessler *et al* (1995). The Gessler *et al* (1995) study was done in 1995 and this study was done in 2003. Primary health care in South Africa was introduced in 1994 after the democratically elected government was in place. It is now eleven years since primary health care approach was adopted in South Africa. The situation in the CHCs is similar to the situation explained by Gessler *et al* (1995) 8 years before the study was conducted in the CHCs in Khayelitsha and Phillipi. This brings about concerns regarding the strategies used to implement, monitor and evaluate PHC, as the problem of overcrowding is still prevailing as in Gessler *et als'* study of 1995.

There are advisors that clients identified as alternative managers of minor health ailments within the community. The people that were mentioned are found within the community such as family members, traditional and faith healers and health professionals. These people that were mentioned were core people that are in Kleinman's cultural systems model (1980). Kleinman has three sub-models popular, folk and professional arenas. In these arenas family members (popular arena) are seen as the main health resource that refers clients to folk healers (traditional healers/faith healers) or health care professionals when the condition is getting worse.

Forty-six percent (n=46) of the clients that participated in this study confirmed that they were using home remedies years ago (one assumes before they were relocated to Khayelitsha and Phillipi) for the management of some of the minor health ailments. These clients given a platform will recommend these home remedies to others as they saw them helpful for the management of minor health ailments. If we notice from the presentation of the results there are eight clients added to the 46 clients that also said would recommend the use of home remedies to

others. On the other hand an additional 38 clients from the 54 clients that is, 82% (n=82) of the clients mentioned that they are unable to manage minor health ailments.

This makes the researcher question the consistency of the responses of these clients. This might have been overcome by repeating the same question using different wording to see if same responses would be elicited. The following reasons were mentioned for being unable to manage minor health ailments: they do not have treatment available to treat their illnesses; they do not have money to buy medication; they do not have knowledge of managing minor health ailments at home; they have fears of complications of their illnesses at home; and they need to be examined.

Only 38% (n=38) clients received education from the clinical nurse practitioners, doctors, CHC and God. The few clients that received education in the consulting room regarding their illnesses gained knowledge about their conditions even though they are not satisfied with the service.

## **Section 2 Discussion of the doctors and clinical nurse practitioners' results**

The age group of doctors who were working in Khayelitsha and Phillipi ranged between 20-29 years. The majority of these doctors were young and new at community level as some of them are doing their community service for six months or one year at the CHCs. These community service doctors are introduced at community level to gain experience of working with clients from the community rather than seeing them at tertiary institutions when they are referred. They need to gain more knowledge and confidence of dealing with patients under stressful conditions such as working in public health sectors like CHCs. During their training they did most of their training at secondary and tertiary institutions which limited them of the opportunity of working directly in the community.

Clinical nurse practitioners that participated in this study in Phillipi had an age group ranging mainly between 30-49 years. They have experience of working with clients at community level and under stressful conditions. The majority of them were working at the CHCs as general nurses and when South African government introduced the concept of training nurses to become clinical nurse practitioners few nurses decided to do this special training of becoming clinical nurse practitioners. The CNP course was offered because "South Africa was unable to carry the

economic burden of training and paying doctors, who are over-skilled and inappropriately trained to provide basic PHC and are unwilling to serve in the most needy areas” (Kappa and Mash, 2004: 21).

Doctors and clinical nurse practitioners mentioned ailments that they know. These ailments were similar to the ailments that were used in this study. Some of these ailments were not minor health ailments as already mentioned earlier under discussion of selection of clients with minor health ailments. These ailments were abdominal pain, arthritis, impetigo and otitis media and are illnesses that need more medical attention as some of them are infectious while others are chronic conditions.

The demographic details had already showed us that doctors in these CHCs are young. Williams and Calnan (1991), say that interpersonal aspects of the patient-professional relationship such as amount and clarity of information, bed-side/chair-side manner, similarity of socio-demographic backgrounds and the extent that the patient can express opinion are very important factors on health especially when dealing with patients. These points need someone who has more experience working with people and someone who has skills of dealing with different people with different personalities. For example if patients need more information concerning their conditions, the inexperienced doctors will need to refresh their memories by referring to their knowledge they gained whilst training. Also they do not learn everything about each and every condition. It is hoped that this knowledge will be gained at the CHCs as the young doctors will be more exposed to the community.

When the doctors and clinical nurse practitioners consult the clients they follow a procedure that assists them with diagnosing the clients. The procedure mainly focuses on proper history taking, proper examination, diagnoses, proper prescription, health education and referring when necessary. This was seen by the researcher as a comprehensive approach for a client at this level of care. Dr Malcolm (2005) also said that during consultation doctors are expected to listen, take an accurate history, explore the patients’ ideas, beliefs and concerns about their problems, carry out an appropriate examination, arrange investigations, discuss and agree management and safety net. His approach is similar to the approach used by doctors and clinical nurse practitioners in these CHCs.

When the CHCs are overcrowded by clients that are presenting with minor health ailments problems regarding the procedure that is followed by the doctors and clinical nurse practitioners are encountered. When overcrowding is a problem doctors become frustrated by the situation before consulting the clients, and clinical nurse practitioners feel the same when the CHC is overcrowded. It is clear that motivation to assist the clients with their problems is occurring with the doctors, and clinical nurse practitioners are not affected with this situation. When health care professionals are demotivated what happens to the quality of service? Doctors feel that they did not assist the clients to their satisfaction as they miss out important procedures such as health education which is one of the most important aspects of primary health care. Clinical nurse practitioners are satisfied with the service that they provided to the clients even though they were overloaded with the clients that are presenting with the minor health ailments.

When asked if they knew of people within the community who can assist clients when presenting with minor health ailments, doctors and clinical nurse practitioners mentioned people which are within the clients' reach and are easily accessible to them such as family members and community health workers. These community based people are similar to those mentioned by clients in this study in the earlier discussion. The rationale for these choices are that community health workers are trained to identify and treat clients that are presenting with minor health ailments also in their training medical terms are familiar with them, grandparents have knowledge of cheap effective ways of dealing with common problems which require home remedies.

Though community health workers' organisations collapsed in these communities due to lack of funding, people can still utilise these community resources as they have skills of managing minor health ailments with regard to the medication that they can use at home. Grandparents within the families are few, as most of them were left behind in the rural areas due to migration of younger people to the cities. As the doctors mentioned in the results grandparents use what is available at home to manage minor health ailments. The elderly people from the health forums confirmed that they can manage minor health ailments at home using home remedies. Community health workers and grandparents if available are useful resources that can be utilised within the community. Kleinman's cultural systems model also encourages people to utilise what is

available within their environments/communities, especially the popular arena where the family is seen as the closest to the sick people.

Maybe then one is looking for partnership between doctors the community health workers and elderly people, as the doctors had a perception that both community health workers and elderly people could assist with minor health ailments.

When doctors and clinical nurse practitioners were asked their willingness to work hand-in-hand with the traditional and faith healers they felt that they can work with the faith healers as they have vast experience offering psychological support to patients who have recurrent minor illnesses, but for curing services of the clients' illnesses both doctors and clinical nurse practitioners felt that clients present with exacerbated conditions after seeing traditional healers which could have been managed better by health professionals.

On the other hand clinical nurse practitioners are confused by the roles the traditional healers play within the community. The reason why they do not feel comfortable to work with the traditional healers is because they do not have a stethoscope to examine the clients. According to Kleinman (1980), most folk healers share the basic cultural values and world view of the communities in which they live, including beliefs about the origin, significance and treatment of ill health. When they heal people who are sick they frequently involve the family in diagnosis and treatment. Traditional healers do have diagnostic measures that might not be understood by clinical nurse practitioners that are valued by traditional healers. In future there might be a need for clinical nurse practitioners to study these approaches. Traditional healers are part of a specific group of people and health belief cultural heritage. Recently in 2005, the minister of health had made an announcement giving recognition of traditional healers as part of South African health system.

Mizrachi and Shuval (2004) says that alternative practitioners focus on the patients' experience of illness: feelings, affective states, the alleviation of pain and suffering and efforts to improve the quality of life.

## 5.2 Conclusion

In 1994 the concept of Primary Health Care was well received by the democratically elected government of South Africa. The government introduced the Reconstruction and Development Programme Health Plan which focused on restructuring the inherited health system to make it more effective and efficient.

Khayelitsha and Phillipi areas are overcrowded with people who are forced to stay in areas that were set aside for development projects in these areas. Due to this problem some of these areas are not serviced e.g. no toilets, refuse removal, proper roads and space between the houses is limited. It is clear that the problem of overcrowding of the CHCs in Khayelitsha and Phillipi will be a continuous problem as people are staying under unfavourable health conditions. People become prone to sickness due to these bad conditions.

As a result people staying in these areas are frequenting CHCs. There is a perception that these people lack indigenous health knowledge for management of minor health ailments using home remedies from the elderly people as the health facilities are closer to them and are free of charge. Both the clients and health care professionals are frustrated by the situation that is seen at the CHCs. The health professionals feel that the service that they are providing to the clients is not up to standard due to overcrowding and very little time spent during consultation. Having said that, there is also a group of clients that are happy with the type of service offered at the CHCs. But shouldn't these clients be managing these minor health ailments at home?

There are people that clients and health care professionals have identified within the community that can assist with the management of minor health ailments such as family members, community health workers and faith healers. There are elderly people that are within the home, community health workers within the community that the clients, doctors and clinical nurse practitioners identified as resources that could assist with the management of minor health ailments. According to Kleinman's cultural systems model, these people that are mentioned here represent his part of model, the popular arena. There is also a belief that traditional healers could also assist with minor health ailments, and these traditional healers fall under the folk arena in Kleinman's model, this is one step out of the home. But then some other clients and doctors

mentioned health professionals for managing minor health ailments and this would fall under same model of Kleinman but a step even further away from the home, the professional arena.

One is hoping for a future whereby the three suggested approaches (popular, folk and professional) be discussed jointly by the family members (elderly people), the community members (traditional healers, community health workers) and the health professionals to come with an approach whereby minor health ailments are managed at home as in Kleinman's popular arena sub-model and equip clients to have an understanding when a minor health ailment start showing symptoms of becoming a serious ailment for referral purposes. These discussions should be underpinned by education regarding the care of minor health ailments as this part appeared to be grossly lacking in this study. It is of the researcher's opinion that it is when we reach this level that primary health care will be starting to be practised in its fullest.

University of Cape Town

## **CHAPTER 6**

### **Recommendations**

Fry (1980) states that the health prospects of both developed and less developed nations in the last quarter of the twentieth century would depend on the quality of decisions made by government, by private sector, by health professionals and by individuals acting on their own behalf. These decisions would be influenced by how people think about health and the factors related to health and disease.

Although there had been questions regarding how clients with minor health ailments had been selected, there is definitely a plausible case that CHCs are overcrowded by clients presenting with minor health ailments. This study went through many twists and turns in trying to ascertain the health seeking behaviour of these clients. It is apparent that in some clients there is lack of knowledge and confidence regarding how their ailments can be managed at home. There is also the perception (including amongst health professionals at the CHCs) that these clients cannot differentiate between a minor health ailment and a major health ailment.

#### **6.1 Health professionals**

It is recommended that health professionals at primary health care level should come together amongst themselves and draw up a list of minor health ailments, with their signs and symptoms, how to treat them and when they should be referred to the CHCs. This information should be known and understood by all health professionals. When this happens, it will prevent any confusion regarding which clients have minor health ailments and which ones have serious ailments as shown in this study.

#### **6.2 The clients**

Clients that visit CHCs presenting with minor health ailments have fears of managing their illnesses at home. On the other hand this study revealed that some clients had mentioned resources that could assist them in managing minor health ailments within their community. The researcher's perception is that they simply do not have confidence in these resources; hence they

come directly to the CHCs. Myerscough and Ford (1996) maintain that most people who are unwell look to the doctor for help, advice or reassurance. They assume a dependent role as a sick person. Recommendations to the clients that visit the CHCs presenting with minor health ailments are:

- To develop an interest in taking charge of their health issues by consulting the older people in both the rural and urban areas.
- To be curious about ailments whether they are minor or serious health ailments and to be able to differentiate between what constitutes a minor health ailment and what would be a serious health ailment. This could be achieved through education by health professionals in the CHCs.
- To make health a priority and a family issue, where family members feel free to share their health problems about what causes discomfort in the body with other family members to get support and to monitor their illness at home to see whether the discomfort is getting better or worse.
- To know when to present themselves at the CHCs when the discomfort is getting worse and, when so doing, to must ask health professionals to educate them regarding their minor health ailments during consultation.
- To ask health professionals to recommend strategies they could utilise at home to first manage the minor health ailment and to prevent it from occurring again in terms of Fry and Haslers' (1986) view that education concerning prevailing health problems and the methods of preventing and controlling illnesses underpin comprehensive delivery of primary health care.

### **6.3 The community**

Community members are aware of the situation at the CHCs because representatives of the health forum visit the CHCs on a weekly basis. However, the only platform to report the problems seen in the CHCs is the facility manager of the CHC. The facility manager utilised the platform of the Makhulu and Tatomkhulu project which consists of health professionals, traditional healers, community health workers, students and supervisors from UCT and Makhulus and Tatomkhulus, to address mainly the problem of overcrowding of the CHCs by clients that are mainly presenting with minor health ailments. The researcher suggests that this forum should continue. The researcher will report the results of this study to the forum for

discussion and for the development of a strategy for managing minor health ailments since Buhrmann (1983) holds that the concept of “community involvement” implies that it is not only the responsibility of external agencies such as CHCs and especially trained health practitioners and the family physicians, but the whole community to ensure that the health of every member is maintained at optimal level. Buhrmann argues that the health in many proliferate societies depends on the survival of the group through the ability of each individual to fulfill his or her role, as well as the knowledge of healing that is passed from generation to generation.

Traditional healers are considered as people to whom the community can look to for guidance on health matters and other important issues. They are also known as the observers of social order and harmony amongst families and individuals and as established health workers within their community (Felhaber, 1997).

This study has shown that the practices of traditional and faith healers are not trusted by the health professionals who participated in this study. Traditional healers and faith healers need to be given a chance in the health sector as they have both advantages and disadvantages with regard to practice. Not everyone is familiar with the way the traditional healers and faith healers manage illnesses. The health professionals, the traditional healers and faith healers need to come together to understand each others’ methods of managing minor health ailments and the researcher hopes that the above mentioned people will work together to resolve the overcrowding of the CHCs by coming up with a suitable model to manage the treatment of minor ailments.

#### **6.4 The Public Health Sector**

Some clients had shown dissatisfaction with the service delivery in the CHCs. There were also questions related to the proper examination of these clients, as clients that had serious health ailments were sometimes identified as having minor health ailments. This might be caused by the congested conditions that these health professionals work under. In 1997, the Western Cape Provincial Minister of Health stated that the rich people receive levels of care that can only be described as excessively high from the private sector for profit, while the poor are condemned to

long queues to see overworked health workers in under resourced clinics and hospitals in the public sector (Jeebhay *et al*, 1997).

This is the situation of the public health sector in Districts 3 and 7 where Phillipi and Khayelitsha are located respectively. They are described as the poorest districts by the district health structure of the Cape Town Metropole Region. In 2004 the National Minister of Health of 2004 introduced a system of community service for newly qualified doctors and other health professionals to ensure that the rural and under serviced areas have access to professional health care (Department of Health, 2004). These newly qualified doctors might struggle to cope when CHCs are overcrowded with clients and to differentiate which clients pose with minor health ailments and which ones have serious health ailments.

The Provincial Ministry of Health Western Cape committed itself to a vision of improved health care focusing mainly on primary level services, community based care and preventative care within the existing health resource constraints by implementing the 2010 health plan. The plan is to reshape the above mentioned services whereby contacts at the CHCs will be more than those at secondary and tertiary level of care.

For this 2010 health plan to work at the Khayelitsha and Phillipi CHCs, the provincial government will have to bring resources to the CHCs first of all; secondly to assign primary health care specialists at this level for community doctors to be mentored; and lastly to see that community service doctors receive further in service training regarding the difficulties that are experienced at under resourced overcrowded community health centres.

## **6.5 The researcher**

The final recommendation of this study is targeted at the researcher herself: that in future she should consult people who have knowledge and experience in working with clients who are presenting with minor health ailments so as to draw up valid instruments for the selection of clients. There are health professionals who are not included in this study because they were not on duty. Also some refused to participate because of time constraints. The researcher would have liked to continue until she had covered all health professionals, including the ones who refused to

participate in the study because they said they were too busy. She could also have targeted a day that was not so busy day when all doctors and clinical nurse practitioners would be available. For a study of this nature, data for clients would need to be collected at different times, days and seasons of the year. The researcher would have liked to have aimed at a larger sample of clients than 25 for each CHC. The use of an epidemiologist might have come handy to reach a representative sample. Lastly the questionnaire for clients and health professionals for future studies will have to include all aspects mentioned in the study limitation.

Kleinman (1980) mentions that in looking at any complex society, one can identify three overlapping arenas of health care: the popular arena, the folk arena and the professional arena. Each arena has its own ways of explaining and treating ill-health, of defining who is the healer is and who the patient is. Each specifies how healer and patient should interact in their therapeutic encounter.

“Health has multiple dimensions. It is not a property of man, but a reflection of man’s interactions with his environment. It is not an ideal state, but a changing condition dependent on man’s ability to adapt from time to time to alternatives in this environment. It is neither a goal to be attained nor a level to be maintained (nor a right nor a purchaseable product) but part of the process of the day-to-day living” (Fry 1980: 87). The researcher hopes that this study is the first step towards untangle the problem of overcrowding at CHCs by clients presenting with minor health ailments.

## REFERENCES

- African National Congress. 1994. *A basic guide to the Reconstruction and Development Programme*. Umanyano Publications, South Africa.
- Atkinson S., Haran D. 2004. Individual and district scale determinants of user' satisfaction with primary health care in developing countries. *Social Science and Medicine Journal* (60): 501-513.
- Baum A., Singer S.E., Singer J.E. (eds) *Handbook of Psychology and Health*. Hillsdale NJ: Erlbaum.
- Becker M.H., Haefner D.P., Kasl S.V., Kirscht J.P., Maiman L.A., Rosenstock I.M. 1977. *Selected Psychosocial models and correlates of individual health-related behaviors*. *Medical Care* 15: 27-46.
- Brice N., McGurk C., Petkar F., Philip S. 2000. *The health seeking behaviour of patients with minor ailments*. University of Cape Town. Public Health mini-thesis.
- Buhrmann M. 1983. Community health and traditional healers. *Psychotherapeia*:15-18 (Unable to trace volume number).
- Chimere-Dan O. 1992. Apartheid and demography in South Africa. *African Population Studies* 4: 26-36.
- Clifford C. 1997. *Nursing and health care research: A skills-based introduction*. Prentice Hall International Ltd, Europe.
- Cooper D., Pick W.M., Meyers J.E., Hoffman M.N., Sayed A.R., Klopper J.M.L. 1991. Urbanisation and Women's health in Khayelitsha. Part II. Health status and the use of health services. *South African Medical Journal*, 79: 428-432.
- Coulson N., Goldstein S., Ntuli A. 1986. Ottawa Charter. World Health Organization Conference. *Health Promotion Journal*, 1 (4): 3-5.

Cueto M. 2004. The origins of primary health care and selective primary health care: Public Health then and now. *American Journal of Public Health*, Vol 94, No.11.

De Beer C. 1984. *The South African Disease: Apartheid health and health services*. Johannesburg: Southern African Research Services.

De Haan M. 1996. *The health of Southern Africa*. 7<sup>th</sup> edition. Cape Town: Juta and Co. Ltd.

Department of Health. 2004. *Celebrating the achievements of Alma Ata: Strengthening Primary Health Care in South Africa*. South Africa.

Department of Health. 1997. *Government Gazette*. Volume 383. Pretoria.

Department of Health. 1996. *Restructuring the National Health System for universal Primary Health Care: Policy Document*. Pretoria.

Department of Health and Social Services. 2000. *Report of the Bi-Ministerial Task Team on the Implementation of a Municipality-Based District Health System*. Cape Town.

De Vos P., Murla P., Rodriguez A., Bonet M., Mas P., Van der Stuyft P. 2004. Shifting the demand for emergency care in Cuba's health system. *Social Science and Medicine Journal* (60): 609-616.

District Health System Committee. 1995. *A policy for the development of a district health system for South Africa*. Pretoria.

Felhaber T. 1997. *South African Traditional Healers' Primary Health Care Handbook*. Cape Town: Kagiso.

Fitzpatrick R. 1991. Surveys of patient satisfaction: Important general considerations. *British Medical Journal* (302): 887-889.

Foundation for Research Development Committee. 1985. *Basic needs in rural areas: A report on a seminar held in Cape Town on 19 February 1985 (Report number 116)*. South African National Scientific Programmes, Pretoria.

Froggatt A., 1990. *Family Work with Elderly People*. London: Macmillan Education.

Fry J. 1980. *Primary Care*. London: William Heinemann Medical Books Ltd.

Fry J., Hasler J.C. 1986. *Primary Health Care 2000*. New York: Churchill Livingstone Inc.

Gentry W.D. (ed) *Handbook of behavioural medicine*. New York: Guilford Press.

Gessler M.C., Msunya M.H.H., Nkuya A., Schar A., Heinrich M., Tanner M. 1995. Traditional healers in Tanzania: Socio-cultural profile and three short portraits. *Etho-pharmacology Journal* (48): 145-160.

Gilbert L., Selikow T., Walker L. 1996. *Society, Health and Disease: An introductory reader for health professionals*. Ravan Press (Pty) Ltd, South Africa.

Habgood L. 1998. *Health and livelihoods in rural Angola*. OxfarmGB, UK: 32.

Hammond-Tooke D. 1989. *Rituals and Medicines*. Cape Town: Creda Press.

Hart N. 1986: *Social inequalities in health. The Sociology of Health and Medicine*. Causeway Books.

Hjortdahl P., Laerum E. 1992. Continuity of care in general practice: Effect on patient satisfaction. *British Medical Journal* (304): 1287-1290.

Janis I.L. 1984. The patient as decision maker. In: Gentry W.D. (ed) *Handbook of behavioural medicine*. New York: Guilford Press.

Jeebhay M., Hussey G., Reynold L. 1997. *The new world order – A challenge to Health for All by the year 2000*. Health System Trust, South Africa.

Johannes C. P. E. 2002. *The history of the black townships and squatter camps of Cape Town*. Cape Town: Southern Tip Tours.

Kapp R., Mash B. 2004. Perceptions of the role of the clinical nurse practitioner in the Cape Metropolitan doctor-driven community health centres. *South African Family Practice*, 46(10): 21-25.

Keraan Q., Naidoo K.V., Parker A.A., Royker R. 2000. *Determining the health seeking behaviour of clients presenting with minor ailments attending Michael Mapongwana community health centre*. University of Cape Town. Public Health mini-thesis.

Kleinman A. 1980. *Patients and Healers in the Context of Culture*. University of California Press, Berkeley.

Leventhal H., Meyer D., Nerenz D. 1980. The common sense representation of illness-danger. In: Rachman S. (ed) *Medical Psychology* Volume 2. Oxford: Pergamon Press.

Loghdey R., De Villiers P.J.T. 2002. *Patient morbidity survey of a southern suburbs, Cape Town*. University of Stellenbosch. M. Family Medicine Thesis.

Lund F. 1992. *The way welfare works: Structures, spending, staffing and social work in South Africa's Welfare Bureaucracies*. Pretoria: Human Sciences Research Council.

Malcolm Dr. 2005. Pitfalls of practice. *Casebook, Medical Protection Society*, 1: 7.

Mizrachi N., Shuval J.T. 2004. Between formal and enacted policy: changing the contours of boundaries. *Social Science and Medicine Journal* (60): 1649-1660.

- Morgan M., Calnan M., Manning W. 1985: *Sociological Approaches to Health and Medicine*. London: Croom Helm.
- Myburgh G. 1997. *Morbidity profile of a family practice in Eerste Rivier, Cape Town*. University of Stellenbosch. Masters in Family Medicine Thesis.
- Myerscough R.P., Ford M. 1996. *Talking with patients: Keys to good communication*. 3<sup>rd</sup> edition. New York: Oxford University Press Inc.
- Newsom J.T., McFarland B.H., Kaplan M.S., Huguet N., Zani B. 2004. The health consciousness myth: implications of the near independence of major health behaviors in the North American population. *Social Science and Medicine Journal* (60): 433-437.
- Niven N. 1989. *Health Psychology (An introduction for nurses and other health care professionals)*. New York: Churchill Livingstone.
- Nsisi L.M. 1999a. *Morbidity profile at a community health centre in Khayelitsha, Cape Town*. University of Stellenbosch. Masters in Family Medicine Thesis.
- Nsisi S.N. 1999b. *Paediatric morbidity profile at Retreat Community Health Centre, Cape Town*. University of Stellenbosch. Masters in Family Medicine Thesis.
- Oberlander L., Elverdan B. 2000. Malaria in the United Republic of Tanzania: cultural consideration and health seeking behavior. *World Health Organization Bulletin* (78): 1352-1360, World Health Organization.
- Rachman S. (ed) *Medical Psychology* Volume 2. Oxford: Pergamon Press.
- Reekie W.D. 1985. *Health-care options for South Africa: Lessons from the UK and the USA*. Sandton: The Free Market Foundation.

- Rosenstock I.M. 1974. The health belief model and preventive health behavior. *Health Education Monographs* 2: 354-386.
- Rosenstock I.M., Kirscht J.P. 1979. Why people seek health care? In: Stone G.C., Cohen F., Adler N.E. (ed) *Health Psychology*. New York: Jossey Bass.
- South African Health Review Committee. 1995. *South African Health Review*. Health Systems Trust and the Henry Kasler Family Foundation, South Africa and USA.
- The Star* 29 August 1995. Majority still live without basic needs.
- Stone G.C., Cohen F., Adler N.E. (ed) *Health Psychology*. New York: Jossey Bass.
- Van Rensburg H.C.J., Fourie A., Pretorius E. 1992. *Health care in South Africa: Structure and dynamics*. Pretoria: Academica.
- Van Rensburg H.C.J., Mans A. 1982. *Profile of disease and health in South Africa*. Pretoria: Academica, Pretoria.
- Wallston B.S., Wallston K.A. 1984. Social Psychological models of health behavior: An examination and integration. In: Baum A., Singer S.E., Singer J.E. (eds) *Handbook of Psychology and Health*. Hillsdale NJ: Erlbaum.
- Western Cape Provincial Department of Health. 2002. *Western Cape Expenditure Review 2002*. Western Cape Provincial Treasury, Cape Town.
- Williams S.J., Calnan M. 1991. Convergence and divergence: Assessing criteria of consumer satisfaction across general practice, dental and hospital care settings. *Social Sciences and Medicine* 33(6): 707-716.
- World Health Organization. 1983. *Apartheid and Health*. Geneva, Switzerland.

World Health Organization. 1993. *The urban health crisis: Strategies for health for all in the face of rapid urbanization*. Geneva, Switzerland.

**Website:**

[www.boahc.demon.co.uk/ailments.htm](http://www.boahc.demon.co.uk/ailments.htm).2001/05/11: Minor Ailments.

University of Cape Town

## APPENDIX 1 (a)

### PARTICIPANT CONSENT FORM

I....., hereby give my consent to partake in the research project conducted by Nondwe Mtwana. The project is on the exploration of the health seeking behaviour of clients attending community health centres at Khayelitsha and Phillipi for the management of minor ailments. I understand that this will take place in a form of answering the questionnaire and that there will be no intervention from the researcher. During the answering of questions if the researcher identify harmful practices in as part of my approach to the management of minor ailments, the researcher (Miss Nondwe Mtwana) will inform me of the harmful practices and advise me to discontinue. She will further inform the management team of the community health centres of these (e.g. toxic substances in the home remedies) for preventive action.

I understand that all information (except identified toxic substances in the home remedies) gathered here will be highly confidential and will only be used in this study.

Signature

Date

.....

.....

## APPENDIX 1 (b)

### INCWADI YESIVUMELWANO

Mna,....., ndinikezela imvume yokubayinxalenye yezifundo ezenziwa nguNondwe Mtwana. Ndiyayiqonda ukuba ndizakuphendula imibuzo ebhalwe phantsi yaye andizokufumana siphazamiso kumfundi. Ezi zifundo zijonge ukuba kutheni abaguli besiza nezigulwana ezingephi kwizibhedlelana zengingqi yaseKhayelitsha nasePhillipi. Ukuba ngexesha endiphendula imibuzo umphandi (uNondwe Mtwana) uye waqaphela ukuba amanye amayeza endiwasebenzisa ekhaya anobungozi, ndimnika imvume ukuba andixelele ngawo ukuba ndiyeke ukuwasebenzisa. Ndiyamnika imvume yokuba aze aphinde axelele abaphathi bezibhedlelane ukuze bathi xa bexelela abantu ukuba izigulwana ezingephi zinyangwa njani, babaxelele ukuba mabangawasebenzisi lamayeza anobungozi. Ndiyayiqonda ukuba ndizakuphendula imibuzo ebhalwe phantsi yaye andizokufumana siphazamiso kumfundi. Ndiyayiqonda ukuba zonke ezinkcukhaca ndininike zona ziyakuba yimfihlelo (ngaphandle kwamayeza anobungozi) komnye umntu yaye ziyakusetyenziswa kwezizifundo kuphela.

Umsayino

Umhla

.....

.....

## APPENDIX 2 (a)

### IMIBUZO ELUNGISELELWE ABAGULI

#### Icandelo A

**Okubalulekileyo: Ndicela wenze isangqa kwindawo efanele wena**

Iminyaka yakho: 18-29 minyaka  
30-39 minyaka  
40-49 minyaka  
50-59 minyaka  
60-65 minyaka

Indawo ohlala kuyo: Khayelitsha okanye Phillipi okanye enye indawo(yibhale

apha kwesisithuba.....

Ikliniki oze kuyo: Michael Maphongwana

---

Site B

Inzame Zabantu

Mzamomhle

Icandelo B

**Okubalulekileyo: Ndicela uphendule le mibuzo ilandelayo**

1. Uyaqala ukuza kulekliniki? EWE.....HAYI (Korekisha kwindawo efanelekileyo)
2. Sesiphi isigulo oze ngaso apha ekliniki? Bhala kwesisithuba  
singezantsi.....
3. Yeyiphi enye indowo owawukhe waya kuyo ngaphambili ngesi sigulo unaso? Chaza igama  
layo kwesisithuba.....
4. Ikliniki yeyona ndawo endinokuza kuyo ukuba ndiyagula. (Korekisha endaweni  
efanelekileyo)
  - Ndiyavumelana
  - Andiqinisekanga
  - Andivumelani
5. Zikhona izigulo ozaziyo ezinokunyangwa ekhayeni? EWE.....HAYI (yenza  
umkorekisho endaweni efanelekileyo)
6. Ukuba ewe, chaza iindidi zezigulo ozaziyo ezinokunyangwa ekhayeni. Ndicela uzibhale  
kwesisithuba singezantsi. Bhala zonke ozaziyo ucingisise.  
.....  
.....  
.....
7. Ingaba esi sigulo uze ngaso sisigulo obunokukusinyanga ekhayeni? EWE.....HAYI  
(yenza umkorekisho endaweni efanelekileyo)
8. Ukuba hayi, kutheni ungenakusinyanga ekhayeni? Bhala kwesisithuba  
singezantsi.....  
.....  
.....  
.....

9. Wawukhe wava ngomntu onika abantu amacebiso okunyanga izigulwana ezingephi ezinokunyangeka ekhaya? EWE.....HAYI (yenza umkorekisho endaweni efanelekileyo)
10. Ukuba ewe, ngobani abo bantu? Bhala kwesi sithuba singezantsi.....  
.....  
.....
11. Akhona amachiza owaziyo onokuwasebenzisa ukunyanga izigulo ezingephi ezinokunyangeka ekhayeni? EWE.....HAYI (korekisha kwindawo efanelekileyo)
12. Wawukhe wawasebenzisa wena loo machiza ukunyanga izigulwana ezingephi? EWE.....HAYI (korekisha kwindawo efanelekileyo)
13. Ukuba ewe, ungamcebisa omnye umntu awasebenzise loo machiza? EWE.....HAYI(korekisha kwindawo efanelekileyo)
14. Ingaba uyaqala ukuza ekliniki ngesi sigulo unaso? EWE.....HAYI (korekisha kwindawo efanelekileyo)
15. Uye wulufumana uncedo obunqwenela ukulufumana apha ekliniki ngaphandle koncedo lokufumana iipilisi? EWE.....HAYI
16. Ukuba ewe, uncedeke njani? (Bhala iinkcukhaca kwesi sithuba singezantsi)  
.....  
.....  
.....
17. Ukuba hayi, ingxaki ibiphi? Bhala kwesi sithuba singezantsi.....
18. Ikhona imfundiso othe wayifumana apha ekliniki malunga nesi sigulo singephi uze ngaso apha ekliniki? EWE.....HAYI (korekisha kwindawo efanelekileyo)
19. Ukuba ewe, uyifumene kubani imfundiso? Bhala kwesi sithuba singezantsi.....  
.....
20. Ukuba unesigulo esingephi owoyisakalayo ukusinyanga ekhaya, ungayokulufuna phi uncedo phakathi kwababantu balandelayo (yenza umkorekisho kwindawo efanelekileyo):
- Amagqirha
  - Abathandazeli
  - oosokhemesti

- oonompilo besekuhlaleni
- ekliniki
- omnye umntu(bhala kwesisithuba)

University of Cape Town

## APPENDIX 2 (b)

### QUESTIONNAIRE FOR CLIENTS

#### Section A

#### **Important note: Make a circle where you fit in**

Years: 18-29 years

30-39 years

40-49 years

50-59 years

60-65 years

Place where you stay: Khayelitsha or Phillipi or other place (please write in this

space.....

Clinic that you came to: Michael Maphongwana

Site B

Inzame Zabantu

Mzamomhle

Section B

**Important note: Please answer the following questions**

1. Is it your first time to come to this community health centre? YES.....NO (tick the suitable one)

2. What kind of illness did you come for today at the community health centre?

Please write in the space below

.....

3. Where else did you go to seeking help presenting with the ailment you are having? Write the name of it in the space provided

.....

4. Community health centre is the best place I can come to if I am sick.

- Agree
- Not sure
- Disagree (Tick the suitable one)

5. Do you know of ailments that can be treated at home? YES.....NO (tick the suitable one)

6. If yes, name the types of minor health ailments that you know of that can be treated at home.

Please write as many as you can in this space below

.....  
.....  
.....  
.....

7. Do you consider your ailment as an ailment that you could have treated at home?

YES.....NO (tick the suitable one)

8. If no, why can't you treat it at home? Write in the space below

.....  
.....  
.....

9. Have you heard of anyone who advise people to use home remedies for management of minor health ailments? YES.....NO (tick the suitable one)

10. If yes, who were those people. Please list them below

.....  
.....

11. Do you know of any home remedies that you can use when you are presenting with minor health ailments? YES.....NO (tick the suitable one)

12. Did you use any home remedies to treat minor health ailments?

YES.....NO (tick the suitable one)

13. If yes, would you recommend it to others? YES.....NO (tick the suitable one)

14. Is it your first time to visit the community health centre presenting with minor health ailment? YES.....NO (tick the suitable one)

15. Did you get the help that you wanted to get at the community health centre besides getting medication? YES.....NO (tick the suitable one).

16. If yes, how were you helped? (please write in the space below)

.....  
.....

17. If no, where was the problem? (please write in the space below).....

.....  
.....

18. Did you get education here at the community health centre concerning your minor health ailment that you are complaining about today? YES.....NO (tick the suitable one)

19. If yes, who educated you? (please write in the space below).....

20. When you present with minor health ailment that become serious at home, which of the following people would you consult (make a tick next to your choice):

- traditional healers
- faith healers
- pharmacists
- community health workers,
- community health centre?
- Other(write in this space).....

### APPENDIX 3

#### LIST OF MINOR HEALTH AILMENTS

<b>Respiratory</b>	<b>Abdominal and U.T.I</b>	<b>Skin disorders</b>	<b>Body pains</b>	<b>Ears</b>	<b>Accidents</b>
Colds/flu	Diarrhoea	Insect bite	Chronic back pain	Blocked ears	Minor cuts
Upper respiratory tract infection	Stomach ache	Rash	Acute back Pain	Earache	Nose bleed
Hay fever	Vomiting		Migraine	Ear discharge	Minor accidents
Tight chest	Burning urine		Emotional Problems		Minor burns

## APPENDIX 4

### QUESTIONNAIRE FOR COMMUNITY HEALTH CENTRE STAFF

#### Section A

**Important note: Make a circle where your age ranging**

- Years:    20-29 years  
             30-39 years  
             40-49 years  
             50-59 years  
             60-65 years

#### Section B

**Please answer all the questions below**

1. Please list the minor health ailments that you know of as many as possible in the space below

.....  
.....  
.....  
.....  
.....

2. When there is a shortage of clinicians and the number of patients is the same as the days when all the clinicians are present, how do you feel?

3. If you are overloaded with clients, do you feel that you helped all the patients you have seen to your satisfaction? YES.....NO (tick the suitable one)

4. If not, what areas do you feel you did not cover in terms of management of minor health ailments in order for you to be satisfied? Write in the space below

.....  
.....

5. What do you do when you consult clients presenting with minor health ailments in terms of management? Please write in detail in this space below

.....  
.....  
.....

.....  
.....

6. As a health professional, an alternative approach for management of minor health ailments is best done by: (Tick the suitable one/s)

- traditional healers
- faith healers
- community health workers
- grandfathers
- grandmothers
- mention any other one you know
- none of the above
- 

7. Give reason for the choice you have made in 6 (Please write in the space below).....

.....  
.....  
.....  
.....  
.....

8. Do you see yourself in future working hand in hand with traditional healers, faith healers and community health workers? YES.....NO (tick the suitable one)

9. If yes, why? (please write in the space below)

.....  
.....  
.....  
.....

10. If no, why not? (Please write in the space below)

.....  
.....  
.....  
.....

11. How many clients you saw today presented with minor health ailments?

## APPENDIX 5

18 Jakaranda Street  
Old Straatford Green  
Eerste Rivier  
03 April 2003

The Facility Manager  
Gugulethu CHC  
Gugulethu  
7750

Dear Madam

**RE: Request to conduct a pilot study on health seeking behaviour of clients presenting with minor health ailments attending community health centres in Khayelitsha (Michael Mapongwana, Site B) and Phillipi (Inzame Zabantu, Mzamomhle)**

I write to request for permission to use your clinic for pilot study. I am a physiotherapist currently undertaking M.Sc. Medical Sciences (Public and Primary Health Care) part-time at the University of Cape Town.

The aim of the study is:

To explore the health seeking behaviour of clients presenting with minor health ailments attending CHCs in Khayelitsha and Phillipi for the management of minor health ailments.

The objectives of the study are as follows:

1. To explore the literature review that underpins the study. This has been done under Chapter 2.
2. To determine the number of clients presenting with minor health ailments in the fourth week of April 2003 for four days, one day allocated for each community health centre for the data collection at Michael Mapongwana, Site B, Inzame Zabantu and Mzamomhle CHCs.

3. To determine the demographic details of the selected clients presenting with minor health ailments, doctors and clinical nurse practitioners.
4. To describe the types of minor health ailments that the abovementioned clients presented with in the CHCs that are under the study area.
5. To describe perceptions and attitudes of clients at the selected CHCs that presented with minor health ailments with regard to the care of minor health ailments.
6. To describe the ailments that doctors regard as minor health ailments including their perceptions towards the management of these ailments.
7. To describe the ailments that clinical nurse practitioners regard as minor health ailments including their perceptions towards the management of these ailments.
8. To make recommendations with regard to the care of minor health ailments to the following: clients, health care professionals, community health workers, and community, this will be done in Chapter 6.

During the pilot process, I request that you allow me to have access to your staff members, patients visiting the centre, statistics and other relevant information that might be needed.

A personal follow-up will be made for your response although my contact numbers are:

Cell: 0832261916

Home:021-9046985

Thanking you.

Yours faithfully

Nondwe Mtwana

Student number MTWNON005

G, Mji (Research Supervisor)

## APPENDIX 6 (a)

18 Jakaranda Street  
Old Straadford Green  
Eerste Rivier  
7100  
09 April 2003

The Facility Manager  
Michael Mapongwana CHC  
Harare  
7784

Dear Madam

**RE: Request to conduct a study on health seeking behaviour of clients presenting with minor health ailments attending community health centres in Khayelitsha (Michael Mapongwana, Site B) and Phillipi (Inzame Zabantu, Mzamomhle)**

I write to request for permission to use your clinic for research. I am a physiotherapist currently undertaking M.Sc. Medical Sciences (Public and Primary Health Care) part-time at the University of Cape Town.

The aim of the study is:

To explore the health seeking behaviour of clients presenting with minor health ailments attending CHCs in Khayelitsha and Phillipi for the management of minor health ailments.

The objectives of the study are as follows:

1. To explore the literature review that underpins the study. This has been done under Chapter 2.
2. To determine the number of clients presenting with minor health ailments in the fourth week of April 2003 for four days, one day allocated for each community health centre for the data collection at Michael Mapongwana, Site B, Inzame Zabantu and Mzamomhle

CHCs.

3. To determine the demographic details of the selected clients presenting with minor health ailments, doctors and clinical nurse practitioners.
4. To describe the types of minor health ailments that the abovementioned clients presented with in the CHCs that are under the study area.
5. To describe perceptions and attitudes of clients at the selected CHCs that presented with minor health ailments with regard to the care of minor health ailments.
6. To describe the ailments that doctors regard as minor health ailments including their perceptions towards the management of these ailments.
7. To describe the ailments that clinical nurse practitioners regard as minor health ailments including their perceptions towards the management of these ailments.
8. To make recommendations with regard to the care of minor health ailments to the following: clients, health care professionals, community health workers, and community, this will be done in Chapter 6.

During the research process, I request that you allow me to have access to your staff members, patients visiting the centre, records of the patients, statistics and other relevant information that might be needed.

A personal follow-up will be made for your response although my contact number is:

- Cell: 0832261916
- Home: 021-9046985

Thanking you.

Yours faithfully

Nondwe Mtwana

Student number MTWNON005

G. Mji (Research Supervisor)

## APPENDIX 6 (b)

18 Jakaranda Street  
Old Straadford Green  
Eerste Rivier  
7100  
09 April 2003

The Facility Manager  
Site B CHC  
Khayelitsha  
7784

Dear Madam

**RE: Request to conduct a study on health seeking behaviour of clients presenting with minor health ailments attending community health centres in Khayelitsha (Michael Mapongwana, Site B) and Phillipi (Inzame Zabantu, Mzamomhle)**

I write to request for permission to use your clinic for research. I am a physiotherapist currently undertaking M.Sc. Medical Sciences (Public and Primary Health Care) part-time at the University of Cape Town.

The aim of the study is:

To explore the health seeking behaviour of clients presenting with minor health ailments attending CHCs in Khayelitsha and Phillipi for the management of minor health ailments.

The objectives of the study are as follows:

1. To explore the literature review that underpins the study. This has been done under Chapter 2.
2. To determine the number of clients presenting with minor health ailments in the fourth week of April 2003 for four days, one day allocated for each community health centre for the data collection at Michael Mapongwana, Site B, Inzame Zabantu and Mzamomhle

CHCs.

3. To determine the demographic details of the selected clients presenting with minor health ailments, doctors and clinical nurse practitioners.
4. To describe the types of minor health ailments that the abovementioned clients presented with in the CHCs that are under the study area.
5. To describe perceptions and attitudes of clients at the selected CHCs that presented with minor health ailments with regard to the care of minor health ailments.
6. To describe the ailments that doctors regard as minor health ailments including their perceptions towards the management of these ailments.
7. To describe the ailments that clinical nurse practitioners regard as minor health ailments including their perceptions towards the management of these ailments.
8. To make recommendations with regard to the care of minor health ailments to the following: clients, health care professionals, community health workers, and community, this will be done in Chapter 6.

During the research process, I request that you allow me to have access to your staff members, patients visiting the centre, records of patients, statistics and other relevant information that might be needed.

A personal follow-up will be made for your response although my contact numbers are:

Cell: 0832261916

Home: 021-9046985

Thanking you.

Yours faithfully

Nondwe Mtwana

Student number MTWNON005

G. Mji (Research Supervisor)

## APPENDIX 6 (c)

18 Jakaranda Street  
Old Straadford Green  
Eerste Rivier  
7100  
09 April 2003

The Facility Manager  
Inzame Zabantu CHC  
Phillipi  
7784

Dear Madam

**RE: Request to conduct a study on health seeking behaviour of clients presenting with minor health ailments attending community health centres in Khayelitsha (Michael Mapongwana, Site B) and Phillipi (Inzame Zabantu, Mzamomhle)**

I write to request for permission to use your clinic for research. I am a physiotherapist currently undertaking M.Sc. Medical Sciences (Public and Primary Health Care) part-time at the University of Cape Town.

The aim of the study is:

To explore the health seeking behaviour of clients presenting with minor health ailments attending CHCs in Khayelitsha and Phillipi for the management of minor health ailments.

The objectives of the study are as follows:

1. To explore the literature review that underpins the study. This has been done under Chapter 2.
2. To determine the number of clients presenting with minor health ailments in the fourth week of April 2003 for four days, one day allocated for each community health centre for the data collection at Michael Mapongwana, Site B, Inzame Zabantu and Mzamomhle

CHCs.

3. To determine the demographic details of the selected clients presenting with minor health ailments, doctors and clinical nurse practitioners.
4. To describe the types of minor health ailments that the abovementioned clients presented with in the CHCs that are under the study area.
5. To describe perceptions and attitudes of clients at the selected CHCs that presented with minor health ailments with regard to the care of minor health ailments.
6. To describe the ailments that doctors regard as minor health ailments including their perceptions towards the management of these ailments.
7. To describe the ailments that clinical nurse practitioners regard as minor health ailments including their perceptions towards the management of these ailments.
8. To make recommendations with regard to the care of minor health ailments to the following: clients, health care professionals, community health workers, and community, this will be done in Chapter 6.

During the research process, I request that you allow me to have access to your staff members, patients visiting the centre, statistics and other relevant information that might be needed.

A personal follow-up will be made for your response although my contact numbers are:

Cell: 0832261916

Home: 021-9046985

Thanking you.

Yours faithfully

Nondwe Mtwana

Student number MTWNON005

G. Mji (Research Supervisor)

## APPENDIX 6 (d)

18 Jakaranda Street  
Old Straadford Green  
Eerste Rivier  
7100  
09 April 2003

The Facility Manager  
Mzamomhle CHC  
Phillipi  
7785

Dear Madam

**RE: Request to conduct a study on health seeking behaviour of clients presenting with minor health ailments attending community health centres in Khayelitsha (Michael Mapongwana, Site B) and Phillipi (Inzame Zabantu, Mzamomhle)**

I write to request for permission to use your clinic for research. I am a physiotherapist currently undertaking M.Sc. Medical Sciences (Public and Primary Health Care) part-time at the University of Cape Town.

The aim of the study is:

To explore the health seeking behaviour of clients presenting with minor health ailments attending CHCs in Khayelitsha and Phillipi for the management of minor health ailments.

The objectives of the study are as follows:

1. To explore the literature review that underpins the study. This has been done under Chapter 2.
2. To determine the number of clients presenting with minor health ailments in the fourth week of April 2003 for four days, one day allocated for each community health centre for the data collection at Michael Mapongwana, Site B, Inzame Zabantu and Mzamomhle

CHCs.

3. To determine the demographic details of the selected clients presenting with minor health ailments, doctors and clinical nurse practitioners.
4. To describe the types of minor health ailments that the abovementioned clients presented with in the CHCs that are under the study area.
5. To describe perceptions and attitudes of clients at the selected CHCs that presented with minor health ailments with regard to the care of minor health ailments.
6. To describe the ailments that doctors regard as minor health ailments including their perceptions towards the management of these ailments.
7. To describe the ailments that clinical nurse practitioners regard as minor health ailments including their perceptions towards the management of these ailments.
8. To make recommendations with regard to the care of minor health ailments to the following: clients, health care professionals, community health workers, and community, this will be done in Chapter 6.

During the research process, I request that you allow me to have access to your staff members, patients visiting the centre, records of patients, statistics and other relevant information that might be needed.

A personal follow-up will be made for your response although my contact numbers are:

Cell: 0832261916

Home: 0219046985

Thanking you.

Yours faithfully

Nondwe Mtwana

Student number MTWNON005

G. Mji (Research Supervisor)