Is it just the prayer? Determining and exploring patients' reasons for choosing a faith-based primary health clinic over their local public sector primary health clinic.

by

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Table of Contents

Declaration

I, James Dudley Porter, hereby declare that the work on which this mini dissertation is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

Signed by candidate

Date: 25 January 2016

Part A: Protocol

Introduction

In 2009, the World Health Organization (WHO) issued a World Health Report calling for the renewal of Primary Health Care (PHC).[1] The report highlights the failure of countries to adhere to comprehensive PHC as per the Alma Ata declaration, and calls for four sets of PHC reforms. Relevant to this research is the second key reform, which is to reorganize health services around 'people's needs and expectations, so as to make them more socially relevant and more responsive to the changing world.'[1] This reform is further driven by the concept of person-centred care cemented by the WHO in its 2007 Policy Framework.[2] Person-centred health care is described as a health system which is designed around the needs of the stakeholders and in which individuals and communities are 'served by and able to participate in trusted health systems that respond to their needs in humane and holistic ways.'[2]

This global emphasis on holistic person-centred care has fuelled research into the area of faith-based health care. In Sub-Saharan Africa, there is a significant and growing body of research looking at faith-based organisations and health care, and particularly patient satisfaction with, and reasons for choosing faith-based health care.[3-6] Faith plays a vital role in shaping health-seeking behaviour and according to recent studies, 87% of Sub-Saharan Africans identify themselves as either Muslim or Christian.[7] Faith-based facilities account for a significant proportion of healthcare in many African countries, sometimes providing between 30% and 40% of hospital beds.[8,9]

There has been a general perception in Africa, but little firm data, that faith-based health care facilities provide a better quality of care than state facilities.[10] It was unclear whether this was due to their religious nature or other aspects of their function not strongly linked to their faith.[11]

However recent studies have provided more definitive data in this area. Research from Ghana shows that even with higher costs, faith-based health facilities still have higher rates of satisfaction. This was mostly attributed to intangible elements such as courtesy, trust and patient-centeredness.[11] Another Ghanaian study showed quality of care and patient respect were why patients chose faith-based care.[8] This was a recurring theme in research from Burkina Faso where the main reasons for choice of a faith-based health care facility were the good staff-patient relationship and overall quality of care.[9] Tying in with this, further research across 18 African countries showed that one of the main reasons for not choosing a particular clinic is a lack of respect shown to patients by staff.[12]

The assumption is that the religious aspect of faith-based health care is one of the main reasons for patient choice. However, recent research does not back this up. The work done by Shojo, Tsimpo and Wodon in Ghana suggests that only 6.3% of Christians, and 12.5% of Muslims, say that they choose to attend a faith-based health facility because of its religious affiliation.[13] Similarly in Burkina Faso, only 14.6% of patients mention religious affiliation as a reason for choosing a faith-based health facility.[9]

Despite the harmony of the above-mentioned studies, they cannot be extrapolated to the South African context. South African specific research in to faith-based health care is vitally important, particularly given the context where 79.8% of the population of South Africa identifies itself as being nominally Christian.[14] Historically, the church has made a significant contribution to health care in South Africa. Before and during apartheid, a large number of American and European missionary health services attempted to bridge the vast health care gap. Many effective mission hospitals and clinics were established throughout the country to meet the needs of the marginalised.[15]

However, very little research has been done on faith-based health care facilities in South Africa, and Cape Town specifically. This is partly due to the fact that

South Africa was one of the African countries that integrated colonial era mission-based hospitals and public sector primary care[16] and therefore no longer has an extensive network of faith-based health care facilities. Due to the HIV (Human Immunodeficiency Virus) epidemic and the South African government's initial slow response to it, faith-based organisations became active again in terms of health care provision for HIV particularly.[17] There has therefore been an increase in research into faith-based health care provision in South Africa. However, there is still a lack of knowledge with regards to patients' preference of faith-based facilities over state facilities when presented with the choice. A better understanding of the reason behind patient preference will help to improve primary care services generally. This is aligned with the Western Cape Department of Health's 2020 Strategic Framework, where the primary vision is that of achieving 'access to client-centred quality of care.'[18] Similarly, the South African Department of Health's policy paper on the proposed National Health Insurance also makes reference to a re-engineered PHC Model which will 'take account of the local context and acceptability' and which will be 'tailored to respond to local needs.'[19] Therefore there is clearly a national and provincial focus on patient-centred care.

Despite almost two decades of structural reform and a commitment to achieving the goals of PHC, a number of obstacles are preventing its full implementation in the South African context.[20] This is seen at the first contact level, with overburdened, poorly run community health centres, with less than ideal reputations and public perceptions.[21,22] Although free PHC has been implemented, access has remained a problem to urban and rural patients alike.[23,24] This was confirmed by the National Health Care Facilities Baseline Audit of 2012 where PHC facilities scored poorly across the country, especially with regards to person-centred care.[25]

In response to some of the above desired service features and the apparent lack of access to good quality, holistic health care, Jubilee Health Centre (JHC) was started in 2006.[26] It is a faith-based primary health clinic attached to Jubilee

Community Church, an independent, non-denominational Christian church based in Observatory, Cape Town. JHC offers 'professional, confidential and affordable primary health care to the needy within its sphere of influence' including voluntary counselling and testing for HIV, and a pregnancy help centre and 'each patient/client is cared for by a team, given professional attention and then ministered to in prayer.'[26] The permanent, salaried staff includes one doctor, three professional nurses, one counsellor and one administrator. There are also a further two doctors, three physiotherapists, one counsellor and three intercessionists who volunteer on a full time basis. Patients are charged R10.00 per consultation and a once-off fee of R5.00 for acute medication. Chronic medication is charged at cost price. Since 2006, the 'sphere of influence' referred to in the JHC mission statement has been rapidly growing. The patient population has increased significantly, with the clinic now seeing approximately 350 patients per month which is an increase of 160% from 2011.[26] They have also seen a dramatic widening of their drainage area, as well as an increase in the number and diversity (demographic, religious and geographic) of patients choosing to attend JHC, prompting the decision to explore their reasons for choosing to attend the clinic.

This study hopes to inform local policy and practice by providing data with regards to users' preference for JHC. The results will provide JHC with valuable information about patient needs and preferences. The management of JHC have committed to using the results to assist them in improving the quality of their health care. The study results will also assist the local public sector clinics with regards to patient preference and demonstrate specific areas which they could improve on, thereby enabling them to deliver more person-centred care. The study will also provide a starting point for collaboration between JHC and the surrounding public sector clinics to the benefit of their patients. As stated before, this will be in line with the provincial, national and global focus on providing person-centred care, responding to the needs of health care stakeholders and constituencies in a holistic manner[2] by 'putting people first.'[1]

Purpose of the study

This study seeks to determine whether the reasons that users of JHC (which strives to provide a holistic and accessible health care) choose this primary care service, reflect their need and expectation of person-centred care increasingly referred to in current literature and policy statements. This would thereby support the call for primary care reorganization/renewal and the patient's need to be 'served by and able to participate in trusted health systems that respond to their needs in humane and holistic ways' in which the health system is 'designed around the needs of the stakeholders.'[2]

Primary objective: To determine and explore the reasons for patients choosing to attend Jubilee Health Centre (a faith-based primary health clinic) over their local public sector primary health clinic.
Secondary objective: To determine to what extent demography influences reasons for choosing Jubilee Health Centre (a faith-based primary health clinic) over their local public sector primary health clinic.
Research question: Why are patients choosing to attend Jubilee Health Centre?
Research hypothesis: Patients are choosing to attend Jubilee Health Centre because it is faith-based and offers a spiritual dimension to its care.

Methodology

Study design

This study will be a cross-sectional, descriptive study. It is an appropriate study design to answer the question 'why do patients choose a faith-based primary health clinic over their public sector primary health clinic?' It will incorporate qualitative and quantitative data collection methods: focus groups, based on the Nominal Group Technique (NGT), which will then generate the content for a survey/questionnaire. It will employ correlational analysis linking the results with the various demographic details of the patients.

Study Site

The study will be conducted at Jubilee Health Centre, a faith-based primary health clinic attached to Jubilee Community Church, Nelson Road, Observatory, Cape Town.

Study Population

JHC has roughly 5 000 patients on file. They do not have firm demographic data available but estimate that 65% of their patients are from Central/Eastern Africa. The majority of these are illegal immigrants or refugees/asylum seekers. The next largest demographic includes local patients from the Woodstock, Salt River, Observatory area. These patients are mostly coloured and speak English or Afrikaans as their first language. The third major demographic comprises of predominantly black, Xhosa-speaking South Africans from Langa, Guguletu and Khayelitsha.

Sampling

The four focus groups will consist of between eight to ten patients in each. There will be an element of homogeneity within each focus group: one will be made up of JHC staff members, one will be made up of Central/East African patients and one will be made up of Xhosa-speaking patients and one will be made up of Afrikaans-speaking patients. The sampling for the focus groups will be both convenient and purposive. Participation in the staff focus group will be offered to all staff members working at JHC. Sampling for the other three groups will be focussed on finding key informants within the three demographics. This will be through staff recommendation as well as patient volunteers who will have responded to advertising in the clinic.

Sampling for the survey would be consecutive. This is because of the relatively small number of patients attending JHC. The questionnaire would be offered to

every patient attending JHC on that day. Due to time and resource constraints, data capturing would take place over the course of one month only.

Sample Size

A sample size of 163 was calculated using a Descriptive Categorical Sample Size Calculator. This was based on a confidence interval of 95%, a margin of error of 5% and an expected proportion on 10.4%. The expected proportion was determined as the proportion of patients who would cite religion as the main reason that they attend JHC. This was determined to be 10.4% based on previous research done by African Religious Health Assets Program in Sub-Saharan Africa, and specifically Burkina Faso and Ghana.[9,13]

The equation used is as follows:

$N = 4\ z_{\alpha}^2\ P(1-P) / W^2$

$N = 4 \times 1.96^2 \times 0.104(1-0.104) / 0.10^2$

$N = 163$

N is sample size, z_{α} is normal distribution related to 96% confidence interval, P is expected proportion, W is width of confidence interval.

Selection Criteria

The four focus groups will have their particular demographics as inclusion criteria. Patients involved in the focus groups must also be 18 years of age or above and able to consent. They must also have attended JHC on at least three previous occasions. They must also have attended a public sector clinic on at least one previous occasion. They must be fluent in English, Afrikaans, Xhosa or French. Due to the nature of the NGT they must also be literate. Exclusion criteria would be illiteracy, under the age of 18 years, or inability to consent.

The survey selection criteria would be any patient over the age of 18 years who is able to consent. They must also be fluent in English, Afrikaans, Xhosa or

French. Literacy is not an inclusion criterion for the survey as it will be interviewer-administered. If the patient attending JHC is below the age of 18 years, then the survey will be offered to their parent/care-giver/guardian if present.

Recruitment

Posters and leaflets explaining the research and asking for volunteers for the focus groups will be put up in the JHC waiting area for six weeks before start of data collection. The JHC staff will also recommend specific patients who fit the selection criteria for the relevant focus groups.

Information posters will also be placed in the waiting area on the days of data collection for the questionnaire. They will explain the survey and inform patients that they will be approached to participate in the survey after their doctor consult. Every patient on the day will be approached by a trained research assistant who will offer participation and obtain informed consent. The research assistants will not be staff members.

It will be made clear to patients that participation in the focus groups and survey is completely voluntary and their choice will not affect their health care at JHC in any way.

Research Procedures and Data Collection Methods

The initial research procedure will make use of four focus groups making using of NGT. They will be conducted by the principal investigator and a trained research assistant. These focus groups will be presented with a nominal question of ‘what are some of the reasons why you have chosen to attend Jubilee Health Centre?’ The various responses will be used to create ranked answers to the questions. The specific steps are described in the NGT appendix. Each focus group will last for roughly 90 minutes and be held in a

private conference room attached to JHC. It is impossible to ensure privacy and confidentiality in a focus group setting, however group members will be asked to respect each other's confidentiality. No identifying data will be recorded.

The resulting ranked answers from the focus groups will then be used to inform a questionnaire/survey which will be put to the wider patient population. The first section of the survey will obtain a range of demographic data from each patient. The second section of the survey will present the top five reasons for patient choice of JHC from each focus group as individual statements (I chose to come to JHC because…). The patients will then choose an answer ranging from 'strongly disagree' to 'strongly agree' based on a Likert scale. The draft survey is included as an appendix. In this draft survey the Likert-based statements are merely examples as the actual statements will only be generated by the focus groups. The survey will initially be piloted by applying it to the staff and patients who comprised the focus groups. After necessary modifications it will then be applied to the patient population as a whole. Validity will be established through the pilot process as well as methodological triangulation of the data derived from the focus groups and the survey. The surveys will be administered by trained research assistants (paid a stipend of R75 per hour) who will be able to conduct it in English, Afrikaans, Xhosa or French. The questionnaire will also be available in the above five languages. It will be written in English, translated into Afrikaans, Xhosa and French and then back-translated into English to maintain accuracy.

Data Analysis

The data collected from the focus groups will consist of ranked answers to the question 'what were the reasons for you choosing Jubilee Health Centre over your local public sector clinic?' These will have been recorded on flip-chart sheets which will be photographed and recorded digitally. No other recordings of the focus groups will be made. These ranked answers will then be used to inform the survey. The data generated form the survey will consist of a range of

demographic data and then the Likert scale based responses to the various statement of why patients choose to attend JHC. The Likert scale responses will then be converted into a binary variable and used to establish proportions. Discriminant function analysis will then be used to determine which demographic variables discriminate between the binary data generated from the Likert Scales.

Risks and Benefits

As this is a descriptive study without an intervention, there is very little potential for risk or discomfort. The only potential risk has been covered in the establishment of a distress protocol, should a patient find the survey or focus group to be distressing.

The nature of the study also dictates that there are no obvious immediate benefits to individual patients. However, there is the possibility of a future benefit to the community as a whole, if this research can lead to an improvement in services at JHC as well as other facilities.

Vulnerable Population

Although patients who are refugees or illegal immigrants are a vulnerable population, it is still essential to include them in the study. This is because they make up the majority of the clinic patient population and there will be significant future benefits for this sub-group as a result of this research. Their confidentiality and privacy will be emphasised to them. They will not have to disclose their legal status and no identifying data such as date of birth or physical addresses will be recorded. As for all patients, it will be emphasised that whether or not they participate in the research will in no way affect the health care they receive at JHC or any other facility.

Distress Protocol

A distress protocol will come in to place should a patient become upset or anxious during a focus group or the survey. Should this happen, the focus group or survey will immediately stop and a trained counsellor employed by JHC will be made available to the patient. This has been agreed upon by the management of Jubilee Community Church and the staff of JHC. If the patient recovers sufficiently, they will be given the option of re-joining the focus group or continuing the survey. However, if they are unable to, it will be made clear that this decision will in no way affect their future treatment or health care.

Informed Consent Process

For the focus group, informed consent will be obtained by either the principal investigator or a research assistant in English, Afrikaans, Xhosa or French. The relevant information sheet will have been given to, and discussed with, the patients on recruitment. The consent will be taken on the day of the focus group. This will be done individually, in a separate, private room attached to the health centre. Staff members will not be involved in this process.

Patients will be informed about the survey whilst in the waiting room of the clinic. After they have finished their consultation with the doctor or nurse, they will be invited to participate in the survey. Informed consent will be taken by a trained research assistant in English, Afrikaans, Xhosa or French. This will be done in the same private room where the questionnaire will be administered.

The information sheet and consent form given to patients will make not of the fact that the study will have received ethical clearance from the University of Cape Town's Human Research Ethics Committee.

Privacy and Confidentiality

Privacy and confidentiality will be strongly emphasised to prospective study participants. Their privacy will be ensured by having a separate, dedicated cell phone for patients to call in response to the advertisements for focus group members, as well as a separate, dedicated email address. The cell phone will only be kept by the principal investigator. If it is turned off after office hours, patients will be asked to leave a voice message with their contact details. Alternately can send a text message or a 'please-call-me' to the cell phone with requests for contact. The cell phone and voicemail will only be accessed by a password which only the principal investigator will have. The email account will also be password protected and only be accessible by the principle investigator.

The questionnaires will be administered in a private room at JHC, separate from the waiting area and consultation rooms. The questionnaires will be anonymous, the only identifiers being serial numbers on the survey form. Specific identifiers such as date of birth and physical address will not be requested in the survey.

Questionnaires will be kept in a locked filing cabinet in the Health Centre, which the principal investigator and research assistants will have access to. Once the data is transferred on to computer, this will be password-protected.

Confidentiality will not be able to be guaranteed for patients who participate in the focus group. However, a strong emphasis will be placed on respecting privacy and confidentiality at the beginning of each focus group. Data generated from the focus group will also be anonymous and initially kept in a locked filing cabinet, and then a password-protected computer, as with the survey data.

Patients will also be made aware that legally-mandated information will have to be disclosed if obtained, such as child abuse or information sought under warrant or subpoena.

Resources

A budget of R10 000 will be available for the study. This comprises of R5 000 from the Division of Family Medicine and a further R5 000 which will be motivated for, if necessary, from the School of Public Health and Family Medicine. This will go towards paying for translation fees, as well as two research assistants to help with the focus groups as well as the administration of the questionnaires. The money would also go towards travel costs and refreshments for the patients involved in the focus groups.

Jubilee Community Church (from where JHC is run) has two spare rooms attached to the clinic which would be used for the questionnaire administration. There is also a conference room available in the facility which would be used for the focus groups. A lockable filing cabinet would be purchased and kept at the facility for storage of the completed questionnaires during data collection.

Counselling and support services will be provided for patients free-of-charge by JHC. This is laid out in the distress protocol.

Reimbursement for Participation

Reimbursement for travel cost will be made for patients participating in the focus group. This figure will be agreed upon with each participate before the time, and will be paid in cash on completion of the focus group. Refreshments and a snack will also be provided to participants.

There will be no reimbursement for participation in the survey.

Emergency Care and Insurance for Research-related injury

No provision has been made for emergency care or insurance for research related injury, other than the distress protocol already described. The risk levels for this study dictated that this provision would not be necessary.

What happens at the end of the study?

The findings of the study will be summarized and made available in the waiting area of JHC. They will also be presented to the staff of JHC, and they will be presented with copies of the full written report. An application will also be made to the Western Substructure to present the findings of the study to them, as JHC and its surrounding public sector clinics fall under this district. This will be done by presenting a report to the Director of the Western Substructure. A scientific paper will be submitted for publication to a peer-reviewed journal such as South African Family Practice Journal, South African Medical Journal and or Journal of Religion and Health.

It is hoped that the results of the study will help to emphasis the person-centred goals of the provincial 2020 framework[18] as well as the National Health Insurance policy paper[19] and further cement the working relationship between JHC and the public sector health system.

Stakeholder Participation

Jubilee Health Centre and Jubilee Community Church are the major stakeholders in this research. It is hoped that the results of the research will benefit them in assisting JHC to improve its service. It will also assist them in providing JHC with valuable patient demographic details which they did not previously possess.

Regular meetings have and will be held with JHC staff and management where they are able to express their views and provide input into the research. This will help to develop a sense of ownership in the research. As stated earlier, the JHC staff will also been involved in one of the focus groups which will assist with generating the survey. They will also be used to help pilot the survey. This will provide JHC with the opportunity to contribute to the research and be involved with process.

Bias

An argument can be made for the possibility of response bias during data collection as the focus groups and survey will be conducted at JHC. This could be seen to influence participants to give answers in favour of JHC. However, the objective of the study is to determine and explore the reasons for patient choice of JHC, rather than assessing the quality of care received at JHC. They will not be asked if JHC is better than public sector clinics but rather merely why they chose to attend JHC. This means that the potential bias is minimal as we are not asking patients to be critical of the service offered but rather to just explain their reasons for attending. There will therefore not be any undue pressure to provide positive or uncritical answers, as this aspect of care will not be explored in the data collection.

Another possible form of bias is that of translation bias. Although professional translation services familiar with health research will be used, there is still the possibility of inaccuracies when translating into three different languages.

Ethical and Regulatory Compliance

This study is compliant with the World Medical Association's Declaration of Helsinki 2013 [27] as well as the South African Department of Health's 'Ethics in Health Research: Principles, Structures and Processes' and 'Guidelines for

Good Clinical Practice in the Conduct of Clinical Trials in Human Participants in South Africa.'[28,29]

Permission has been to conduct the research at JHC from Pastor Jeremy Cons, the senior pastor in charge of JHC at Jubilee Community Church. A copy of the research permission letter is included in the appendices.

Conflict of Interest

Research staff or staff members of JHC will not receive any incentives for recruiting patients. None of the personnel involved have any proprietary interest in the research. No funding outside the University of Cape Town's School of Public Health and Family Medicine has been obtained.

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Part B - Literature Review

Aim and Objectives

The aim of this literature review is to review relevant literature so as to place the proposed study within a context of up-to-date academic evidence appropriate to the objectives and methods of the mini-dissertation. Furthermore, the aim is to critically assess those studies identified and in doing so to identify areas where further research, including the proposed study, might be justified.

This review seeks to address the objectives of the mini-dissertation. These objectives are as follows:

1. To determine and explore the reasons for patients choosing to attend Jubilee Health Centre (a faith-based primary health clinic) over their local provincial primary health clinic.
2. To determine to what extent demography influences reasons for choosing Jubilee Health Centre (a faith-based primary health clinic) over their local provincial primary health clinic.

The objectives of the structured review therefore stand as follows:

1. To identify all published literature pertaining to studies assessing reasons for patient choice of faith-based primary health facilities, in an African and South African context.
2. To consider the evidence provided by the literature regarding the two objectives of the mini-dissertation.
3. To review and report on the quality and results of the studies by critically reading and synthesising the findings and evidence regarding the reasons for patient choice of a faith-based primary health facility.
4. To synthesise this information and to identify areas where further research would be useful.

Review Process

Structure of the Review

The review shall present the process of the identification of literature and the assessment of the quality and comparability of the identified literature. Following this, a discussion of the findings of these studies shall be presented with further discussion of resulting issues of validity therein. The review shall conclude, in keeping with the above review objectives, with a summary of the information gained from these studies and propose a way forward regarding the study of the mini-dissertation.

Search Strategy

The literature review was conducted by searching a number of databases including PubMed,[1] Google Scholar,[2] the World Health Organization (WHO) website,[3] and the World Bank website[4].

The initial search strategy used had to be broadened significantly, especially when using the online PubMed interface due to the paucity of results. One of the difficulties with making use of PubMed was the lack of an available Medical Subject Heading (MeSH) which related to faith-based or faith-inspired.

The following broad keyword search was used for searching PubMed: ((((primary health care) OR clinic) OR facility) OR hospital) OR organization) OR organisation) AND faith based) OR (faith[All Fields] AND “inspired”[All Fields])

The following keyword search was used for Google Scholar: (“faith based” OR “faith inspired”) AND (choice OR choose OR choosing OR reason OR reasons

OR motivation OR satisfaction) AND (clinic OR hospital OR facility OR primary health OR ambulatory OR health OR “health care”)

Inclusion Criteria

- Articles from Africa reporting on faith-based or faith-inspired health care.
- An outcome being reasons for choice of faith-based health care.
- Due to the paucity of studies, grey literature such as reports and working papers were included.
- Priority was given to literature published since 01 January 2000 to ensure availability of digital copies.

Exclusion Criteria

- Studies focused on faith-based substance abuse programs only.
- Studies were not excluded on the basis of study design or sample size due to the paucity of available literature.
- Foreign language studies without an English translation were excluded due to lack of resources.

Titles, published abstracts, methodology, results sections and, where necessary for clarity, the full text of identified articles were read by the author and the above inclusion and exclusion criteria applied. In addition the bibliographies of reviews of faith-based health care were examined and studies found to be in agreement with the above criteria were added.

Articles Published

The initial search yield from PubMed was 828 published articles and Google Scholar was 16 500. Combined with further searches of the WHO and World

Bank websites, as well as bibliographies of review papers, a total of 19 studies were initially included. However on application of the inclusion criteria for the literature review, it was found that most of the studies did not address reasons for patient choice but rather looked at satisfaction rates. In the end, only two studies[5,6] met all of the inclusion and exclusion criteria for this literature review.

Quality and Comparability of Studies

Quality criteria applied for purposes of this review included primary aim and focus of the study, study design and sample size. Comparability criteria include the year of study and setting (Table 1).

Primary Aim and Focus of the Study

Neither of the two studies had reasons for patient choice as their main focus but rather as a secondary aim or research question. The primary aim of Gemignani et al was 'to understand the factors that lead households to rely on traditional as opposed to modern health providers in Burkina Faso'[5] and that of Shojo et al was 'to determine how satisfied are patients with the services they receive from faith inspire health care providers in Ghana.'[6] However both studies included reasons for patient choice as a secondary objective or research question: 'Within modern providers, to understand the factors that lead households to rely on faith-inspired as opposed to public facilities in Burkina Faso'[5] and 'To determine why patients are choosing faith-inspired providers for care in Ghana.'[6] The majority of the 17 papers excluded from the review looked at comparative satisfaction, the perception of faith-based care or the value-added nature of faith-based care. However it was felt that these were not accurate reflections of reasons for choice of faith-based care to justify loosening the inclusion criteria.

Study Design and Methodology

Both study designs were descriptive, observational and cross-sectional in design. Gemignani et al made use of semi-structured interviews as well as focus groups to collect their data which they then reported as quantitative as well as qualitative results.[5] Shojo et al made use of mixed methods to collect their data. The first part of their study reported on data collected by two very large household surveys in Ghana (which gave purely quantitative results) and the second part of their study reported on data collected by semi-structured interviews (which gave quantitative and qualitative results).[6]

Study Population and Inclusion Criteria

Both studies were conducted in Sub-Saharan Africa. Gemignani et al conducted their study in Burkina Faso, an ex French colony in West Africa. Their paper states that their analysis is based on data collected in two areas, one rural and one urban. They do not mention the specific areas. Nor do they provide inclusion or exclusion criteria for the interviews or focus groups. The interviews were administered to patients from three rural and three urban clinics (two were Catholic, two were Protestant and two were Muslim).[5] Shojo et al conducted their study in Ghana which borders Burkina Faso. The first section of their paper is based on analysis of data collected by two national household surveys of 8 700 and 50 000 households (roughly 209 000 individuals). The qualitative data collection (in the form of patient interviews) took place at six clinics/hospitals (four Christian and two Islamic) in Ghana. The authors do not mention the clinic names or where they are located except that they were in areas where both public and faith-inspired providers were available. They also do not record the inclusion or exclusion criteria.[6]

Sample Size

Gemignani et al interviewed eight patients from each clinic giving them a total of 48 interviewees. They do not record how many focus group participant were recruited.[5] Shojo et al made use of data from 67 000 households in their initial analysis. They then interviewed four women and four men from each of the six clinics they chose, giving them a sample of 48 interviewees.[6] Neither of the studies made mention of sample size calculations or if saturation sampling was used.

Table 1. Quality and Comparability Criteria

Author	Published	Data collected	Country	Setting	Study design	Methodology	Primary Aim	Related Aim	Sample Size
Gemignani et al[5]	2012	2010	Burkina Faso	Urban and rural clinics.	Descriptive, observational, cross-sectional.	Interviews and focus groups.	Understand factors that lead households to rely on traditional vs modern health providers.	Within modern providers, understand factors that lead households to rely on faith-inspired vs public facilities.	48 patients interviewed, 24 focus groups.
Shojo et al[6]	2012	2010	Ghana	National household surveys and clinic patient interviews.	Descriptive, observational, cross-sectional.	Two national household surveys and interviews.	Determine how satisfied are patients with services from faith-inspired health care providers.	Determine why patients are choosing faith-inspired providers.	Two household surveys (68 700 households). 48 patient interviews.

Summary and Interpretation of Literature

Evident from the results of the search strategy is that there is a significant paucity of literature concerning reasons for patient choice of faith based health care in Africa. Further compounding this problem is that the available literature (including the majority of the literature which was excluded from the review) comes from a single source: the African Religious Health Assets Programme (ARHAP) which has now been incorporated into the International Religious Health Assets Programme (IRHAP).[7] Having said this, ARHAP has produced a wide body of regularly cited literature, including contributing significantly to the July 2015 issue of The Lancet titled 'Faith-based health care.'[8,9]

The studies by Shojo et al and Gemignani et al are both set in West Africa and both make use of qualitative methods as their primary mode of data collection. This seems to be appropriate as both papers are describing situations which have not been reported on in detail elsewhere and where little is known. Thus qualitative methods are ideal for laying groundwork and generating hypotheses which can then be further investigated using quantitative methods.

Using the data generated by their qualitative methods, both papers reported on and analysed the results using quantitative statistics. Both sets of authors admitted that the small sample sizes were small but Gemignani et al stated 'we were more interested in in-depth analysis than statistical representativeness'[5] and Shojo et al explained that their study had been 'exploratory and descriptive in nature, and it was not meant to generate specific policy recommendations.'[6]

Another criticism of both papers is that neither provided any detail about inclusion/exclusion criteria, sampling methods or examples of questionnaire templates. Gemignani et al also did not mention how many focus group participants were recruited or what method was used to run the focus groups. This obviously makes it difficult to accurately compare data and results and

comment on reliability. Both papers were originally published as chapters within a World Bank Report: a 160 page document titled 'The Comparative Nature of Faith-Inspired Health Care Provision in Sub-Saharan Africa. Strengthening the Evidence for Faith-Inspired Health Engagement in Africa, Volume 2.'[10] This might explain the lack of detail reported with regards to methodology.

Neither of the papers has determined the reasons for patient choice of faith-based care as their primary aim of objective. The primary aim of Shojo et al is 'to determine how satisfied are patients with the services they receive from faith inspire health care providers'[6] and that of Gemignani et al 'to understand the factors that lead households to rely on traditional as opposed to modern health providers.'[5] However, both papers make reference to reasons for patient choice in their secondary objectives or research questions: Gemignani et al's secondary objective is 'within modern providers, to understand the factors that lead households to rely on faith-inspired as opposed to public facilities'[5] while Shojo et al are probably the most specific as they seek 'to determine why patients are choosing faith-inspired providers for care.'[6]

Results

Of the results which are relevant to this review, both studies report them using quantitative statistics (Table 2).

Although Shojo et al break down their reasons for patient choice of faith-based care into patients attending Christian and Muslim clinics, there are definitely similarities between the results of the two papers despite their different settings. Gemignani et al use slightly different wording and report their results as 'perceived advantages of faith-inspired providers for individuals.'[5] Both studies report that the religious aspects of the care provided are not significant reasons for patient choice of faith-based care. Gemignani et al report that only 14.6% of patients mention the religious affiliation of the clinic as a perceived benefit and only 12.5% of patients mention the spiritual healing practices (prayer,

counselling etc.) as a perceived benefit.[5] Likewise, Shojo et al report that 6.3% of patients attending Christian clinics mention the religious aspects as a reason for attending, while 12.5% of those attending Muslim clinics mention the religious aspects as a reason for attending.[6]

Both papers rank the quality of care and quality of workers as significant reasons for patient choose of faith based care. Shojo et al state that two thirds (65.6%) Christian clinic patients chose to attend because of the quality of service, while the quality of the staff was the second most common reason (59.4%). Muslim clinic patients top two reasons for choosing to attend were also the quality of the workers (37.6%) and the quality of the service (31.3%).[6] Gemignani et al reported that in Burkina Faso, 31.3% of the respondents mentioned quality of treatment as a perceived benefit (third most common benefit) while 60.4% mention the 'good relationship between patients and staff' as a perceived benefit.[5] This can perhaps be seen to fit in with the quality of the staff mentioned by Shojo et al.

The main difference between the results of the two papers is that Gemignani et al stated that the most common perceived benefit for choosing faith-based health care was the lower cost of treatment (87.5%),[5] whereas Shojo et al reported that it was a much less common reason for patient choice of faith-based care in both the Christian and Muslim clinic subgroups (12.5% and 19%).[6] This might be because of the recently introduced National Health Insurance Scheme in Ghana which has reduced patient payments especially at state facilities,[6] whereas in Burkina Faso, faith-based clinics typically charge less due to additional funding or support from non-state sources.[5]

Besides the analysis of Christian clinic patients and Muslim clinic patients separately by Shojo et al, neither of the studies addressed the second objective of this literature review: To determine to what extent demography influences reasons for choosing Jubilee Health Centre (a faith-based primary health clinic) over their local provincial primary health clinic.

Conclusions

Gemignani et al and Shojo et al both conclude that religion itself is not a major factor in influencing patient choice of faith-based care. Besides the issue of cost noted in the Burkina Faso study, both papers conclude that it is the perception of quality of service that is the main reason patients choose to attend faith-based clinics or hospitals. Both studies make use of qualitative data collected from interviews and focus groups to flesh out these conclusions. Gemignani et el state that it is especially the quality of the patient-worker relationship which is seen as a perceived benefit of faith-based care: 'Ways of speaking to patients, the ability to work within the local cultural context, and attention not just to disease but to a patient's sense of wellbeing'[5] are some of the reasons that appear to play a central role in determining why patients view the services provided by faith-based facilities as higher quality that those provided by public facilities. Shojo et al come to similar conclusions in that they emphasis that religion is not a key factor: 'Many patients use services from clinics and hospitals that are affiliated with a different faith from their own, and the main reason for the choice of facility is precisely the perception that they provide services of quality.'[6] They go on to state that two keys reasons seem to be the respect and attention paid to patients. Finally, Shojo et al conclude by reiterating the need for Ghana's public health sector to foster closer collaboration and partnerships with faith-based health care providers.[6]

Table 2. Results and Conclusions

Author	Country	Reasons for choosing faith-based health care		Conclusions
Gemignani et al[5]	Burkina Faso	1. Lower cost of treatment 87.5% 2. Good relationship between patients and staff 60.4% 3. Quality of treatment 31.3% 4. Religious affiliation 14.6% 5. Spiritual healing practices 12.5%		Faith-inspired facilities perceived as higher quality and cheaper than public facilities. Ways of speaking to patients, ability to work within the local cultural context, attention to patient's sense of wellbeing are key factors.
Shojo et al[6]	Ghana	Christian Clinics	Muslim Clinics	Religion itself not key factor. Patients use services affiliated with a different faith. Main reason for choice is perception of quality of service, including values of dignity and respect for patients.
		1. Quality of service 65.6%	1. Quality of workers 37.6%	
		2. Quality of workers 59.4%	2. Quality of service 31.3%	
		3. Recommendation from others 21.9%	3. Location 25%	
		4. Low cost 12.5%	4. Low cost 19%	
		5. Religious aspects 6.3%	5. Religious aspects 12.5%	

Identification of Gaps or Needs for Further Research

As stated earlier, there is very little published literature which deals with reasons for patient choice of faith-based health care in Africa. And according to this literature review, there is no applicable evidence from a South African context. This is obviously a significant gap in the literature, especially since South Africa has seen a resurgence of faith-based health care over the past two decades. Although previously extensive colonial-era missionary health services were integrated into public sector primary care,[11] South Africa has now seen faith-based organisations becoming active again in terms of health care provision. This is specifically since the advent of the Human Immunodeficiency Virus epidemic and the South African government's initial slow response to it.[12]

These two studies also demonstrate the perceived benefits offered by faith-based health care compared to public health care and conclude that more needs to be done to foster collaboration with the state. This represents a need for further research in a South African context, to determine what the perceived benefits are of faith-based care in this country, and what can be gained from collaboration between faith-based health care providers and the National Department of Health. Issues of quality of care and person-centred care have been made priorities by the National and Western Cape Departments of Health as well as the WHO.[13-16]

Given the complete lack of literature emanating from Cape Town with regards to reasons for patient choice of faith-based health care, it would be appropriate to conduct research using qualitative methods to lay the groundwork and establish a base from which hypotheses can then be generated and tested further with quantitative research.

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Part C – Publication-ready Manuscript

Introduction

In 2009, the World Health Organization (WHO) issued a World Health Report calling for the renewal of Primary Health Care (PHC).[1] The report highlighted the failure of countries to adhere to comprehensive PHC as per the Alma Ata declaration, and called for four sets of PHC reforms, the second of which is particularly relevant to this research: To reorganize health services around 'people's needs and expectations, so as to make them more socially relevant and more responsive to the changing world.'[1] This reform is further driven by the concept of person-centred care embedded in the WHO 2007 Policy Framework.[2] Person-centred health care is described as a health system which is designed around the needs of the stakeholders and in which individuals and communities are 'served by and able to participate in trusted health systems that respond to their needs in humane and holistic ways.'[2]

In this context, all aspects that contribute to the provision of holistic person-centred PHC are vital, including that of faith-based institutions. There is an increasing realisation that 'religious and spiritual concerns are important for understanding health-related behaviours'[3] which is particularly relevant in Sub-Saharan Africa where 87% of the population identifies as either Muslim or Christian.[4] Faith-based facilities account for a significant proportion of healthcare in many African countries, sometimes providing between 30% and 40% of hospital beds.[5,6] They are active in the most rural of communities as well as in urban areas, and are 'uniquely well placed to reach people to provide a range of services to those in need.'[7] Despite this close alignment with community needs, faith-based organisations often go unrecognized because they tend to operate outside of government structures and planning processes.[8]

This realisation has led to an increased emphasis on research into faith-based healthcare, particularly in the developing world. Through efforts led by the WHO, the World Bank and international collaborations such as the African Religious Health

Assets Programme, Sub-Saharan Africa has seen a growing body of research focussing on faith-based organisations and health care.[7-13]

There is a general perception in Africa, but little firm data, that faith-based health care facilities provide a better quality of care than state facilities.[14] It is unclear whether this is due to their religious nature or other aspects of their function not strongly linked to their faith.[15] However recent studies have provided more definitive data in this area. Research from Ghana shows that even with higher costs, faith-based health facilities still have higher rates of satisfaction. This was mostly attributed to intangible elements such as courtesy, trust and patient-centeredness.[15] Another Ghanaian study showed quality of care and patient respect were reasons why patients chose faith-based care.[5] This was a recurring theme in research from Burkina Faso where the main reasons for choice of a faith-based health care facility were cheaper costs, the good staff-patient relationship, and overall quality of care.[6] Tying in with this, further research across 18 African countries showed that one of the main reasons for not choosing a particular clinic is a lack of respect shown to patients by staff.[16]

While the assumption is that the religious aspect of faith-based health care is one of the main reasons for patient choice, recent research does not back this up. The work done by Shojo, Tsimpo and Wodon in Ghana suggests that only 6.3% of Christians, and 12.5% of Muslims, say that they choose to attend a faith-based health facility because of its religious affiliation.[17] Similarly in Burkina Faso, only 14.6% of patients mention religious affiliation as a reason for choosing a faith-based health facility.[6]

Despite the harmony in the findings of the above-mentioned studies, they cannot simply be extrapolated to the South African context where the literature is scarce. Research in to faith-based health care in South Africa is vitally important, particularly given the context where 79.8% of the population identifies itself as being nominally Christian.[18] Historically, Christian churches have made a significant contribution to health care in South Africa. Before and during apartheid, American and European missionary health services attempted to bridge the vast, institutionalised health care

gap. Many effective mission hospitals and clinics were established throughout the country to meet the needs of the marginalised.[19]

Very little research has been done on faith-based health care facilities in South Africa, and Cape Town specifically. This is partly due to the fact that South Africa was one of the African countries that integrated colonial era mission-based hospitals and public sector primary care and therefore no longer has an extensive network of faith-based health care facilities.[20] Due to the Human Immunodeficiency Virus (HIV) epidemic and the South African government's initial slow response to it, faith-based organisations became active again in terms of health care provision for HIV particularly.[21]

Notwithstanding this South African resurgence of faith-based care, there is still a lack of knowledge with regards to patients' preference for faith-based facilities over state facilities when presented with the choice. A better understanding of the reason behind patient preference will help to improve primary care services generally. This is aligned with the Healthcare 2030 policy document of the Western Cape Government, where the primary vision is that of 'access to person-centred quality care.'[22] It further states that the aim of developing a person-centred service involves engaging with patients by 'listening to their concerns, needs and perspectives' and 'treating them with dignity and respect.'[22] Similarly, the South African Department of Health's policy paper on the proposed National Health Insurance also makes reference to a re-engineered PHC Model which will 'take account of the local context and acceptability' and which will be 'tailored to respond to local needs.'[23] Therefore there is clearly a national and provincial focus on patient-centred care.

Despite almost two decades of structural reform and a commitment to achieving the goals of PHC, a number of obstacles are preventing its full implementation in the South African context.[24] This is seen at the first contact level, with overburdened, poorly run community health centres which have less than ideal reputations and public perceptions.[25,26] Although free PHC has been implemented, access has remained a problem to urban and rural patients alike.[27,28] This was confirmed by the National Health Care Facilities Baseline Audit of 2012 where PHC facilities scored poorly

across the country, especially with regards to person-centred care.[29]

In response to the need for some of the above desired service features and the apparent lack of access to good quality, holistic health care, Jubilee Health Centre (JHC) was started in 2006.[30] JHC is a faith-based primary health clinic attached to Jubilee Community Church (an independent, non-denominational Christian church based in Observatory, Cape Town). It offers 'professional, confidential and affordable primary health care to the needy within its sphere of influence' including voluntary counselling and testing for HIV, and a pregnancy help centre. Every patient attending the clinic 'is cared for by a team, given professional attention and then ministered to in prayer.'[30] The permanent, salaried staff includes one doctor, three professional nurses, one counsellor and one administrator. There are also a further two doctors, three physiotherapists, one counsellor and three intercessionists (volunteers who pray with patients) who volunteer on a full time basis. Patients are charged R10.00 per consultation and a once-off fee of R5.00 for acute medication. Chronic medication is charged at cost price. Since 2006, the 'sphere of influence' referred to in the JHC mission statement has grown rapidly. The patient population has increased significantly; the clinic now sees approximately 350 patients per month which is an increase of 160% from 2011,[30] and on 27 September 2015 moved into larger, purpose-built facility on the Jubilee Community Church property.[31] It has also seen a dramatic widening of its drainage area, as well as an increase in the number and diversity of patients choosing to attend JHC, prompting the decision to explore patients' reasons for choosing to attend the clinic.

This study hopes to inform local public sector policy and practice by providing data with regards to users' preference for JHC. The results will provide JHC with valuable information about patient needs and preferences. The management of JHC have committed to using the results to assist them in improving the quality of their health care. The study results will also assist the local public sector clinics with regards to patient preference and highlight specific areas which they could improve on, thereby enabling them to deliver more person-centred care. The study will also provide a starting point for collaboration between JHC and the surrounding public sector clinics

to the benefit of their patients. As stated above, this is in line with the provincial, national and global focus on providing person-centred care, responding to the needs of health care stakeholders and constituencies in a holistic manner[2] by 'putting people first.'[1]

This study seeks to determine whether the reasons that users of JHC choose this primary care service reflect their need and expectation of person-centred care increasingly referred to in current literature and policy statements. Such a finding would support the call for primary care reorganization/renewal and the patient's need to be 'served by and able to participate in trusted health systems that respond to their needs in humane and holistic ways' in which the health system is 'designed around the needs of the stakeholders.'[2]

The primary objective is to determine and explore the reasons for patients choosing to attend JHC (a faith-based primary health clinic) over their local public sector primary health clinic. The secondary objective would then be to determine to what extent demography influences reasons for choosing JHC over their local public sector primary health clinic.

Research methods and design

Study design

The study design was that of a cross-sectional, descriptive study. Due to the lack of prior data and the focus on PHC, mixed methods were used for data collection: Three focus groups, based on the Nominal Group Technique (NGT), which generated the content for a questionnaire. Correlational analysis was used, linking the results with the various demographic details of the patients.

Setting

The study was conducted at Jubilee Health Centre, a faith-based primary health clinic attached to Jubilee Community Church (an independent, non-denominational church), based in Observatory, Cape Town. This is a middle-to-lower income urban area, with a significant immigrant population. There is good access to public health care with a primary health clinic, a community health centre and an academic hospital all within three kilometres.

Study population and sampling strategy

JHC has roughly 5 000 patients on file. They do not have firm demographic data available but estimate that 65% of their patients are from Francophone Central Africa. The majority of these are illegal immigrants or refugees and asylum seekers. The next largest demographic includes local patients from the Woodstock, Salt River, Observatory area. These patients are mostly mixed race and speak English or Afrikaans as their first language.

Phase 1: Focus Groups

The three focus groups were formed using convenient and purposive sampling with an attempt to have an element of homogeneity in each group. The first focus group comprised of all the available JHC staff. The second focus group consisted of patients from Francophone Africa and the third focus group was comprised of South African patients. The sampling for the patient focus groups was focussed on finding key informants recommended by the staff members as well as recruiting volunteers by advertising the focus groups in the clinic waiting area.

The desired demographics of the individual focus groups were inclusion criteria. Apart from that patients needed to be 18 years old or above, have attended JHC at least three times before, have attended a public health facility at least once, and be fluent in English, Afrikaans, Xhosa or French. Due to the nature of the NGT method, patients

also needed to be literate. Exclusion criteria were illiteracy, age below 18 years and the inability to provide consent.

Phase 2: Survey

A sample size of 163 was calculated for the survey using a sample calculator for a descriptive study of a continuous variable. This was based on a confidence interval of 95%, a margin of error of 5% and an expected proportion on 10.4%. The expected proportion was determined as the proportion of patients who would cite the religion aspects of the clinic as a reason for attending JHC. This was derived from combined data from the two papers which met the criteria for the literature review.[6,17]

Sampling for the survey was consecutive. The questionnaire was offered to every patient attending JHC across a three-week period in November 2014. Consecutive sampling was used due to the limited time available for data collection and the relatively small number of patients attending JHC.

The inclusion criteria for the survey included patients aged 18 years and above, able to consent, and fluent in English, Afrikaans, Xhosa or French. Literacy was not an inclusion criterion as the questionnaire was interviewer administered.

Data collection

Phase 1: Focus Groups

The three focus groups were conducted using the NGT. They were conducted by the principal investigator and a trained assistant/translator. Each focus group was presented with the question of 'what are some of the reasons why you have chosen to attend Jubilee Health Centre?' Individual participants were allowed to nominate as many answers as possible which were then collated and clarified. Each participant ranked his/her top five reasons of those collated and these scores were combined to give a final group ranking. See NGT Appendix for a more detailed explanation of the process.

Phase 2: Survey

The data generated by the focus groups was used to generate a questionnaire. The first section of the questionnaire was designed to obtain a variety of demographic data from the respondents. The second part of the questionnaire was informed by the focus group results. The top 10 ranked reasons from each focus group were combined to form 15 statements relating to why patients might choose to attend JHC. The respondents were then asked to agree or disagree with each statement by choosing an answer ranging from 'strongly disagree' to 'strongly agree' (including the option of 'unsure') based on a Likert scale for each of the 15 statements. A copy of the survey is included as an Appendix.

Data analysis

The data generated form the survey consisted of a range of demographic data and the Likert scale based responses to the various statement of why patients choose to attend JHC. It was recorded and analysed using Microsoft Excel. The Likert scale responses were converted into a binary variable and used to establish proportions. 'Definitely' and 'maybe' responses were combined and interpreted as a positive response while 'maybe not', 'definitely not' and 'unsure' responses were combined and interpreted as a negative response. Due to the small size of some of the demographic samples, a Fisher exact test was used to determine which demographic variables produced significantly different results for why patients chose to attend JHC.

Ethical considerations

As this was a descriptive study without an intervention, there was very little potential for risk or discomfort. The only potential risk was covered in the establishment of a distress protocol, should a patient have found the survey or focus group to be distressing.

Informed consent was taken for both the focus group and the survey by either the principle investigator or a research assistant and was offered in English, Afrikaans,

Xhosa or French. The survey was offered to each patient only after their consultation with the doctor or nurse.

The study did include immigrants even though they are considered to be pa vulnerable population. It was considered essential to include them as they make up the majority of the clinic patient population and there will be significant future benefits for this sub-group as a result of this research. Their confidentiality and privacy was emphasised to them. They did not have to disclose their legal status and no identifying data such as date of birth or actual physical addresses were recorded. As for all patients, it was emphasised that whether or not they participated in the research would in no way affect the health care they received at JHC or any other facility.

This study is compliant with the World Medical Association's Declaration of Helsinki 2013[32] as well as the South African Department of Health's 'Ethics in health research: Principles, structures and processes' and 'Guidelines for good clinical practice in the conduct of clinical trials in human participants in South Africa.'[33,34] It was approved by the University of Cape Town's Human Research Ethics Committee (HREC REF: 118/2014).

Results

Phase 1: Focus Groups

Six participants were recruited for the JHC staff focus group, 10 in the Francophone African focus group and nine in the South African focus group. The staff focus group produced 28 responses to the question of 'what are some of the reasons why you have chosen to attend Jubilee Health Centre?' The Francophone African focus group resulted in 19 responses and the South African focus group provided 36 responses. Table 1 shows the top 10 ranked answers from each focus group. The ranking system is explained in the NGT Appendix. These 30 reasons for choosing to attend JHC were collated to provide 15 statements which were used in the survey (see Table 3) to be agreed or disagreed with using a Likert scale.

Table 1. Top 10 focus group reasons for choosing to attend JHC

Rank[a]	Francophone African Focus Group	South African Focus Group	JHC Staff Focus Group
1	Staff take good care of me	The clinic is affordable	Patients' home languages are spoken
2	It is easier to see a doctor	Staff pray with me	The clinic is cheap
3	It is a Christian clinic	Staff have Godly wisdom	Patients feel respected
4	Staff take time to listen to me	The clinic is clean and neat	Staff are friendly
5	Staff pray with the me	Staff treat me with respect	Patients feel heard and listened to
6	The clinic is cheap	Staff are good listeners	Consultations are thorough
7	Staff give good medication	Often see the same doctor	Patients feel taken care of
8	Staff are friendly	Staff are good with children	Patients are treated with dignity
9	I trust the staff to be confidential	Staff have patience with me	Patients feel loved
10	The clinic is close to me	Staff are confidential	Recommended by word-of-mouth

[a], ranked by focus group participants according to NGT process

Phase 2: Survey

A total of 185 patients were invited to participate in the survey. Of those, 14 declined to participate and seven were excluded based on their inability to communicate effectively in English, Afrikaans, Xhosa or French. This left a total of 164 participants who completed the questionnaire.

A summary of the demographic data collected from the questionnaire is provided in Table 2. The patients surveyed were predominantly female, married and between the ages of 31 and 45 years old. Only 21.3% of the patients were from the Republic of South Africa (RSA) with the majority (57.9%) from the Democratic Republic of the Congo (DRC). Accordingly, French, Lingala and Swahili were the most commonly spoken home languages. Those identifying with the Christian faith made up 86.6% of the patients (only 12.8% attending Jubilee Community Church) with a small but significant number of Muslim patients (12.8%). The average socio-economic status is shown by the fact that 56.1% of patients were unemployed with the average, monthly household income between R1 000 and R5 000. The vast majority (82.9%) had attended a public sector clinic before, with Spencer Road Clinic (in Observatory) the most common closest public sector clinic. However only 54.3% of patients were able to correctly name their closest public sector clinic. Based on residential suburbs (actual physical addresses were not recorded), it was calculated that on average, unemployed patients travel just over five times further to get to JHC (9.7 km) than would be needed to get to their closest public sector clinic (1.8 km), with 34.2 km the furthest distance travelled to get to JHC by an unemployed patient.

Table 2. Demographics of survey respondents (N=164)

Category		n/N (%)
Age	18-30 years old	29.3
	31-45 years old	42.7
	46-60 years old	21.3
	> 60 years old	6.7
Gender	Female	68.3
	Male	31.7
Relationship status	Married	70.7
	Single	17.1
	Other	12.1
Home language	French	25.0
	Lingala	20.1
	Swahili	10.4
	Afrikaans	9.8
	English	9.8
	Other	25.0
Home country	DRC	57.9
	RSA	21.3
	Zimbabwe	4.9
	Malawi	4.3
	Burundi	3.7
	Other	7.9
Religion	Christian	86.6
	Muslim	12.8
	Jehovah's Witness	0.6
Monthly household income	<R1 000	34.8
	R1 000 - R5 000	56.7
	>R5 000	8.5
Employment status	Unemployed	56.1
	Employed	30.5
	Self-employed	13.4
Attended public sector clinic before		82.9
Jubilee Community Church member		12.8
Closest public sector clinic	Spencer Road Clinic	29.3
	Woodstock CHC	9.8
	Lady Michaelis CHC	6.1
	Maitland CHC	5.5
	Other	43.3
Correctly identified closest clinic		54.3

The second half of the questionnaire provided the results to the Likert scale responses to the various reasons for choosing to attend JHC. The responses were binarised by combining 'definitely' and 'maybe.' As seen in Table 3, the top five reasons were separated by only 3.7% (98.2% to 94.5%). 'The staff treat me with respect' was the highest ranked answer, followed by 'The staff are friendly', 'The staff take time to listen to me', 'It is easier to see a doctor', and 'The staff give the correct treatment for my illness.' Reasons related to the religious aspects of the clinic ('It is a Christian clinic'

and ‘The staff pray with me’) rank seventh and eighth out of the 15 reasons (70.1% and 61%). The cost of clinic was the least chosen reason for attending JHC with 39%.

Table 3. Survey reasons for choosing to attend JHC (N=164)

Rank[a]	Likert scale statements	n[b]/N (%)
1	The staff treat me with respect	98.2
=2	The staff are friendly	96.3
=2	The staff take time to listen to me	96.3
=4	It is easier to see a doctor	94.5
=4	The staff give the correct treatment for my illness	94.5
6	It was recommended to me by others	75.6
7	I can trust the staff to be confidential	74.4
8	It is a Christian clinic	70.1
9	The staff pray with me	61.0
10	The staff treat children well	57.3
11	I often am seen by the same doctor	52.4
=12	The clinic is clean and neat	49.4
=12	They speak my home language	49.4
14	It is close to me	44.5
15	It is cheap	39.0

[a], out of 15 statements

[b], binarised by combining 'definitely' and 'maybe' responses

The reasons for choosing to attend JHC were further broken down with various demographics as shown in Table 4. Patients from the DRC were compared with those from the RSA and three reasons for attending JHC were found to have statistically significant differences. Almost two-thirds of Congolese patients said they attended JHC because their home language was spoken while as opposed to 37.1% of South African patients. Close to 100% of Congolese patients attended JHC because it was easier to see a doctor compare to 88.6% of South Africans. Roughly a quarter of patient from the RSA chose to attend JHC because their children were treated well, while almost 60% of patients from the DRC agreed with the statement ‘I chose to attend Jubilee Health Centre because the staff treat children well.’

When comparing patients who identified with Christianity as opposed to patients who identified with Islam, four statistically significant differences were found in response to why patients chose to attend JHC. One fifth of Muslim patients chose to come to JHC because ‘The clinic is clean and neat’ compared to just over half of those identifying

with Christianity. The religious aspects of the clinic also recorded significant differences with 9.5% of Muslims choosing to attend JHC because it is a Christian clinic and 19% choosing to attend because they were prayed with. In comparison, almost 80% of Christians chose to attend JHC because of its religious affiliation and 66.9% agreed with the statement 'I chose to come to Jubilee Health Centre because the staff pray with me.' The final significantly different response was to the statement 'I chose to come to Jubilee Health Centre because it is close to me' with 66.6% of Muslims and 40.8% of Christians agreeing with it.

Those patient who were formally employed were also compared to those who were unemployed. Two statistically different responses were found. Of those patients formally employed, 84% said they came to JHC because they could trust the staff to be confidential compared to 68.5% of those who were unemployed. Just over half of the employed patients chose to come to JHC because it is cheap compared to just over a quarter of unemployed patients.

Table 4. Comparison between demographic groups' reasons for choosing JHC

Survey reasons for choosing to attend JHC	DRC (N=95)		RSA (N=35)	
	n/N (%)	Rank	n/N (%)	Rank
The staff treat me with respect	100.0	1	97.1	=1
It is easier to see a doctor*	**98.9**	**2**	**88.6**	**5**
The staff take time to listen to me	97.9	3	94.3	=3
The staff are friendly	95.8	4	97.1	=1
The staff give the correct treatment for my illness	94.7	5	94.3	=3
I can trust the staff to be confidential	77.9	6	74.3	=6
The clinic was recommended to me by others	72.6	7	74.3	=6
It is a Christian clinic	69.5	8	65.7	9
The staff speak my home language*	**61.1**	**9**	**37.1**	**=12**
The staff treat children well**	**58.9**	**10**	**25.7**	**15**
The clinic is clean and neat	55.8	=11	37.1	=12
The staff pray with me	55.8	=11	74.3	=6
The clinic is cheap	45.3	=13	31.4	14
I often am seen by the same doctor	45.3	=13	62.9	10
The clinic close to me	41.1	15	42.9	11
Survey reasons for choosing to attend JHC	**Christian (N=142)**		**Muslim (N=21)**	
	n/N (%)	**Rank**	**n/N (%)**	**Rank**
The staff treat me with respect	97.9	1	100.0	=1
The staff are friendly	95.8	=2	100.0	=1
The staff take time to listen to me	95.8	=2	100.0	=1
It is easier to see a doctor	95.1	=4	90.5	=4
The staff give the correct treatment for my illness	95.1	=4	90.5	=4
It is a Christian clinic***	**79.6**	**6**	**9.5**	**15**
I can trust the staff to be confidential	76.8	7	57.1	9
The clinic was recommended to me by others	73.9	8	85.7	6
The staff pray with me***	**66.9**	**9**	**19.0**	**=12**
The staff treat children well	57.0	10	61.9	8
The clinic is clean and neat**	**53.5**	**11**	**19.0**	**=12**
I often am seen by the same doctor	52.8	12	47.6	10
The staff speak my home language	50.0	13	42.9	11
The clinic is cheap	42.3	14	19.0	=12
The clinic close to me*	**40.8**	**15**	**66.7**	**7**
Survey reasons for choosing to attend JHC	**Employed (N=50)**		**Unemployed (N=92)**	
	n/N (%)	**Rank**	**n/N (%)**	**Rank**
The staff take time to listen to me	100.0	=1	94.6	3
The staff treat me with respect	100.0	=1	96.7	=1
The staff are friendly	96.0	=2	96.7	=1
It is easier to see a doctor	96.0	=2	93.5	=4
The staff give the correct treatment for my illness	96.0	=2	93.5	=4
I can trust the staff to be confidential*	**84.0**	**=6**	**68.5**	**=7**
The clinic was recommended to me by others	84.0	=6	73.9	6
It is a Christian clinic	66.0	=8	68.5	=7
The staff pray with me	66.0	=9	58.7	9
The staff treat children well	62.0	10	52.2	10
The clinic is clean and neat	60.0	11	42.4	14
I often am seen by the same doctor	56.0	12	50.0	11
The clinic is cheap**	**54.0**	**=13**	**27.2**	**5**
The clinic close to me	54.0	=13	43.5	13
The staff speak my home language	50.0	15	44.6	12

* $p \leq 0.05$ (Fisher exact test)
** $p \leq 0.01$ (Fisher exact test)
*** $p \leq 0.001$ (Fisher exact test)

Discussion

The primary objective of this study was to determine and explore the reasons for patients choosing to attend Jubilee Health Centre (a faith-based primary health clinic) over their local public sector primary health clinic. Although the patient focus groups gave high rankings to the religious aspects of the clinic (third and fifth in the Francophone African focus group and second and third in the South African focus group), the survey showed that the top three reasons for choosing to attend JHC were instead related to the quality of the care received, specifically with reference to the staff-patient relationship and the respect and attention paid to patients. The actual religious aspects of the clinic were not the predominant reasons for choosing the clinic, ranking eight and nine out of the top 15 reasons given by the survey respondents.

The secondary objective was to determine to what extent socio-demographic factors determine reasons for choosing JHC. The significant demographic results were that almost 60% of the patients were from the DRC with South Africans comprising the next biggest population group (21.3%). Although patients from the DRC placed equal emphasis on quality of care, they also ranked the treatment of children, home language spoken and ease in seeing a doctor higher than the South African patients. Despite the availability of a French, Lingala and Swahili translator and the higher ranking of 'the staff speak my home language' ($p = 0.0179$), patients from the DRC still only ranked it nine out of 15 reasons. Although it did not achieve statistical significance ($p = 0.0690$), it is interesting to note that more South African patients chose to attend JHC because 'the staff pray with me' than patients from the DRC (74.3% compared to 55.8%). Comparing reasons for choosing JHC by other demographic factors did not produce any surprising results. Muslim patients ranked faith-based reasons in the bottom two; employed patients ranked 'the clinic is cheap' higher than unemployed patients.

The data therefore suggests that the reasons that patients choose to attend JHC are not related to religion but rather to the quality of the care provided. Respect, attention

paid to patients and the friendliness of staff are particularly emphasised. This is in keeping with previous studies from Sub-Saharan Africa, particularly Ghana[17] and Burkina Faso[6]. Shojo et al also found that the reasons patients chose faith-based care were 'not related to religion per se, but rather to the quality of the services provided, including (but not only) through the values of dignity and respect for patients.'[17] Gemignani et al found that patients felt the quality of services were higher at faith-based facilities than public facilities due to 'ways of speaking to patients, the ability to work within the local cultural context, and attention not just to disease but to a patient's sense of wellbeing.'[6]

A potential divergence from the literature was the response rate to statements concerning the faith elements of the clinic. Shojo et al found that only 6.3% of patients making use of Christian clinics mentioned religious aspects as reasons for choosing to attend,[17] while Gemignani et al found that in Burkina Faso, 14.6% of patients mentioned religious affiliation as a reason for choosing faith-based care.[6] In contrast, this study found that although ranked eighth and ninth, 70.1% of patients chose JHC because it is a Christian clinic and 61% chose it because of the prayer offered by staff members. When considering the South African patient sub-group, 74.3% chose to attend JHC because the staff pray with them.

Limitations

The difference in response rates for religious factors when compared to the literature might be explained by the fact that this study was conducted on-site, a factor which is know to result in more favourable or optimistic responses. Another possible explanation might be that the element of choice (compared to other countries where local public sector primary care clinics might not be as accessible) could have introduced a self-selection bias in favour of the religious features of JHC.

The difference in rankings between the patient focus groups and the results of the survey might be explained by focus group selection bias. Focus group participants were mostly considered key informants and either volunteered or were recommended

by the JHC staff. This might have resulted in an over-sampling of Jubilee Community Church members or JHC advocates.

A possible reason for the overall higher proportions of the responses in the survey may be the use of Likert scale responses to determine reasons for choosing JHC i.e. patients were limited to a pre-determined range of options when responding to each of the 15 statements. Volunteering their own reasons (as in semi-structured interviews) may have yielded a different result. This may have resulted in the over-representation or over-reporting of various reasons but will hopefully not have affected the rankings or comparative proportions of the 15 reasons for choosing JHC.

The relatively small sample size of 164, especially when it comes to sub-group analysis by demographic variables (only 21 Muslim patients were surveyed), is also a limitation. The sample size calculation was based on the total number of respondents and not stratified by sub-group. This necessitated the use of Fisher exact tests when comparing sub-groups.

Recommendations/Implications

Despite these limitations, recommendations can be made from this study. JHC appears to be doing something different to, and possibly better than, public sector clinics in the area – as suggested by its increasing attendance figures and the distances patients are willing to travel to attend the clinic (up to a 68.4 km round-trip). Notwithstanding the fact that foreign patients have access to JHC staff who speak their home language, they still rank reasons such as staff friendliness, respect shown to patients and attention paid to patients much higher. These aspects of quality of care may however be mediated by language, as respect and friendliness are easier to convey when the patient is understood in his or her home language. The implication of the results from the survey is that the quality of care provided by JHC is of a high standard and is attracting patients to the clinic. This reflects the need and expectation of patients for person-centred care increasingly referred to in current literature and policy statements. The Western Cape Government is attempting to respond to this

need by placing quality of care, with a focus on patient experience, at the heart of its Healthcare 2030 policy document.[22] Part of this involves improved collaboration between non-profit and community-based organisations which 'have become increasingly important as providers of community-based services.'[22] This study provides a starting point for collaboration between JHC and the surrounding public sector clinics to the benefit of their patients. Future research should be directly comparative between public sector and faith-based health care to more accurately depict strengths and weaknesses. Exploring comparative satisfaction rates between JHC and its closest public sector clinics would help to highlight the differences and where public sector clinics (and JHC) can improve. Further research also needs to be done to investigate effective methods of implementation for the policy imperatives highlighted in the Healthcare 2030 policy document[22] such as staff training programmes, project management, public participation etc.

Further research is needed to explore the possible link between increased quality of care and faith-based health providers. A Ugandan study found that staff in faith-based facilities had higher performance than those in public facilities, attributed to their motivation by the 'faith-based organisational ethos.'[35] Another study by Schmid et al based in Uganda, Zambia and Mali makes mention of the impact on work ethic and quality of care by the religious commitment of health workers.[12] Other suggestions for the cause of greater quality of care have been made such as low patient numbers allowing longer consultations, governance structures and community ownership. However, as Olivier et al state in the recent faith-based healthcare series in the Lancet, 'the connection between faith-based values and health systems performance needs substantially more attention to be able to inform policy-level action.'[36]

This study also suggested that faith-based aspects of care might be more important to South Africans than suggested in the literature. Although the small sample size and limitation of the Likert-based study methodology might have influenced the response rates to faith-based reasons for patient choice, the data still suggests a possible difference in population preferences compared to studies from Burkina Faso and Ghana specifically.[6,17] This warrants further research into the area of faith-based

health care and patient preferences in a South African context and even a local Cape Town context. Olivier et al recommend that 'we need to move away from broad generalisations of the magnitude and character of faith-based organisations and instead find out how different kinds of faith-based health providers operate within different contexts and systems.'[36]

Conclusion

This study found that although there was a higher response rate than in the literature, the religious features of JHC were not the main reasons that patients chose to attend the clinic. Rather, the results show that the quality of the care received, with emphasis on the staff-patient relationship and patient-centeredness, determined patients' reasons for choosing JHC. This is in keeping with the findings of studies conducted elsewhere in Sub-Saharan Africa.[6,17]

When exploring the demographic factors of the clinic population, it was found that almost two-thirds of patients were from the DRC. Although more Congolese patients chose to attend the clinic because they were addressed in their home language when compared to South Africans, their top reasons for choosing JHC were still those relating to quality of care.

This emphasis on quality of care is in alignment with the provincial, national and global focus on re-engineered, person-centred PHC.[1,22,23] The findings highlight and support the vision and policy of the Western Cape Department of Health[22] – specifically its emphasis on quality and person-centred care. Further research should focus on informing policy implementation, training programmes and management approaches to help realise these goals and the implementation of policy imperatives. In addition, further research into the role and importance of faith-based health care in South Africa, differences in satisfaction rates between public sector and faith-based health care, and possible avenues for collaboration is recommended.

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Competing interests

The primary author is a member of Jubilee Community Church.

Authors' contribution

J.P. (University of Cape Town) was the primary author. The study formed the basis for his Master of Medicine in Family Medicine thesis. G.B. (University of Cape Town) was the principal investigator and supervisor.

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Appendices

Focus Group Advert

Jubilee Health Centre Study

Division of Family Medicine
School of Public Health & Family Medicine
University of Cape Town

Do you want to help improve the service provided at this clinic?

Are you 18 years or older?

Have you attended this clinic three times or more?

Have you ever attended a government clinic?

If you answered 'Yes' then you are invited to participate in a study looking at why patients choose to attend Jubilee Health Centre.

As a participant in this study you will be asked to attend a focus group (8 – 10 patients) where you will discuss the different reasons for attending Jubilee Health Centre. Your participation will involve one session and will last approximately 45 minutes. In appreciation for your time you will receive refreshments and your travel costs will be reimbursed.

For more information about this study, or to volunteer for this study, please contact:
Dr James Porter
Tel: 081-247-0809 (phone, SMS or please-call-me)
Email: jubilee.health.centre.research@gmail.com

The University of Cape Town's Human Research Ethics Committee has approved this study.

Focus Group Information Sheet

Jubilee Health Centre Study

Division of Family Medicine
School of Public Health & Family Medicine
University of Cape Town

Who is doing the study? The study is being conducted by Dr James Porter as part of his Masters in Medicine (Family Medicine) at the University of Cape Town.

Purpose: The purpose of the focus group is to discover the variety of reasons why patients choose to attend Jubilee Health Centre. This information will be used in a survey and will help improve health care in your area.

Procedures: Only persons over 18 years of age are being invited to the focus group. There will be 8 to 10 people in the focus group and it will take approximately 45 minutes.

Cost, Compensation, Risks & Benefits: There are no immediate advantages to you for answering the questions. The results of this study are very important to help improve health care in your area. There are no risks to you in this study but the focus group will require some of your time. You will be compensated for travel expenses.

Confidentiality & Privacy: The study information will be used only as part of the study. Your name is needed only for consent; it will not be part of the focus group information and will not be reported in the results. We are not recording your address, folder number or any information in your folder. We cannot guarantee complete confidentiality in the focus group but will ask the other group members to respect your confidentiality.
Your participation in this focus group is completely voluntary. You have the right to leave the focus group at any time. Whether you decide to participate or not and whatever you say will not change the health care you usually get at Jubilee Health Centre or any other health care service. The results of the study will be available when it is finished.

Questions/Suggestions: If you have any suggestions or questions please contact:
Dr James Porter
Tel: 081-247-0809 (Phone, SMS or please-call-me)
Email: jubilee.health.centre.research@gmail.com

Questions about your rights as a study participant, comments or complaints about the study may also be presented to the University of Cape Town's Human Research Ethics Committee.
Tel: 021 406 6338 or 0800 212 123 (toll-free from a landline telephone)

Focus Group Consent Form

PARTICIPANT CONSENT
FOCUS GROUP

Jubilee Health Centre Study

Division of Family Medicine
School of Public Health & Family Medicine
University of Cape Town

I have read the above and am satisfied with my understanding of the study, its possible benefits, risks and alternatives. My questions about the study have been answered. I hereby voluntarily consent to participation in the research study as described. I have been offered copies of this two-page consent form.

* * *

_____	_____
Signature of participant	Date
_____	_____
Name of participant (printed)	Witness

Nominal Group Technique Method

The group was run by a facilitator and a scribe, one of whom was fluent in the predominant home languages of the group participants. The meeting room was set up for eight to ten participants with chairs and desks in a 'U' shape with a flip chart at the open end of the 'U'. The focus group was conducted in the format described below.

1. Introduction

The objectives of the session and the process of the NGT were explained, with respect for others as well as privacy and confidentiality emphasised.

2. Presentation of the question

The question to be addressed (what are some of the reasons why you have chosen to attend Jubilee Health Centre?) was handed to the participants - each on an otherwise blank page for the responses to be recorded. The question was explained to ensure that it was clearly understood.

3. The silent phase

Each participant was asked to write down on the provided sheet of paper his or her own responses to the question. Participants were encouraged to record as many responses as possible.

4. Item generation

Each participant in turn was asked to give one response to the question while the facilitator recorded the responses on a flip chart. This was continued in round robin fashion until all responses were given.

5. Item clarification

The meaning of all the items was clarified to ensure a common understanding by all. There was limited discussion on items that overlapped or were similar.

6. Prioritization

Each participant then ranked the five items most important to him or her on paper without discussion, in the order one (most important) to five (least important).

7. Final voting of group

The ranked choices of each participant were named by going round the group. The scribe recorded these on the flip chart. The answers ranked first were given a score of five, the answers ranked second were given a score of four and so on. The scores were tallied to give a final group ranking for the recorded answers.

8. Debriefing on NGT procedure

Participants were asked to reflect briefly on the exercise and given the opportunity to seek any final clarification.

Survey Advert

Jubilee Health Centre Study

Division of Family Medicine
School of Public Health & Family Medicine
University of Cape Town

Do you want to help improve the service provided at this clinic?

Are you 18 years or older?

If you answered 'Yes' then you are invited to participate in a survey looking at why patients choose to attend Jubilee Health Centre.

You will be approached after your visit to the doctor or nurse, and be asked by a trained research assistant if you would be willing to fill in a questionnaire about why you choose to attend Jubilee Health Centre. This is completely voluntary. Your future health care at Jubilee Health Centre will not be affected in any way if you chose not to participate.

The survey will take between 15 and 30 minutes to fill in. A trained research assistant will be able to assist you in English, Xhosa, Afrikaans or French. If you are unable to read or write, they will fill it in for you. None of your personal details will be recorded and your questionnaire will be kept private and confidential.

Your participation will help us to improve health care for you and your community in the future.

For more information about this study please contact:
Dr James Porter
Tel: 081-247-0809 (phone, SMS or please-call-me)
Email: jubilee.health.centre.research@gmail.com

The University of Cape Town's Human Research Ethics Committee has approved this study.

Survey Information Sheet

Jubilee Health Centre Study

Division of Family Medicine
School of Public Health & Family Medicine
University of Cape Town

Who is doing the study? The study is being conducted by Dr James Porter as part of his Masters in Medicine (Family Medicine) at the University of Cape Town.

Purpose: The purpose of the interview is to discover the most important reasons for patients' choice of attending Jubilee Health Centre. The information you give will help improve health care in your area.

Procedures: Only persons over 18 years of age are being invited to complete the survey. A research assistant will help you to complete the survey in English, Afrikaans, Xhosa or French. The survey will take approximately 30 minutes.

Cost, Compensation, Risks & Benefits: There are no immediate advantages to you for answering the questions. The results of this study are very important to help improve health care in your area. There are no risks to you in this study but the survey will require some of your time.

Confidentiality & Privacy: The study information will be used only as part of the study. Your name is needed only for consent; it will not be part of the survey information and will not be reported in the results. We are not recording your address, folder number or any information in your folder. Your answers are confidential you will not identify you. Because the answers you give are private and confidential, only the study team will see the surveys.
Your participation in this survey is completely voluntary. You have the right to skip certain questions or stop the interview at any time. Whether you decide to participate or not and whatever you say will not change the health care you usually get at Jubilee Health Centre or any other health care service. The results of the study will be available when it is finished.

Questions/Suggestions: If you have any suggestions or questions please contact:
Dr James Porter
Tel: 081-247-0809 (Phone, SMS or please-call-me)
Email: jubilee.health.centre.research@gmail.com

Questions about your rights as a study participant, comments or complaints about the study may also be presented to the University of Cape Town's Human Research Ethics Committee. Tel 021 406 6338 or 0800 212 123 (toll-free call from a landline)

Survey Consent Form

PARTICIPANT CONSENT
PATIENT SURVEY

Jubilee Health Centre Study

Division of Family Medicine
School of Public Health & Family Medicine
University of Cape Town

I have read the above and am satisfied with my understanding of the study, its possible benefits, risks and alternatives. My questions about the study have been answered. I hereby voluntarily consent to participation in the research study as described. I have been offered copies of this two-page consent form.

* * *

_____	_____
Signature of participant	Date
_____	_____
Name of participant (printed)	Witness

Survey

Jubilee Health Centre Study

Division of Family Medicine
School of Public Health & Family Medicine
University of Cape Town

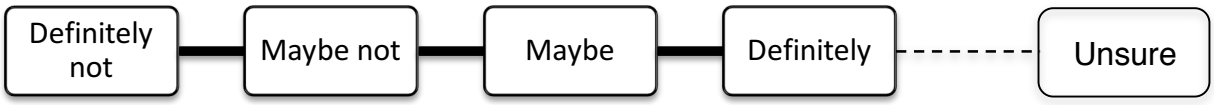
Answer questions in the spaces provided or mark an 'x' in the relevant block

What is your age?	☐ 18 – 30 years old	☐ 31 - 45 years old
	☐ 46 - 60 years old	☐ 61 - 75 years old
	☐ 76 - 90 years old	☐ >90 years old
What is your gender?	☐ Male	☐ Female
What is your home country?		
What is your home language?		
What is your relationship status?	☐ Single	☐ Married
	☐ Divorced	☐ Widowed
	☐ Cohabiting	
What is the suburb where you live?		
What is your employment status?	☐ Employed	☐ Self-employed
	☐ Unemployed	
Do you receive a Social Grant?	☐ None	☐ Disability Grant
	☐ Child Support Grant	☐ Pension
	☐ Care Dependency Grant	☐ Foster Child Grant
Did you take off work today to come to clinic?	☐ Yes	☐ No

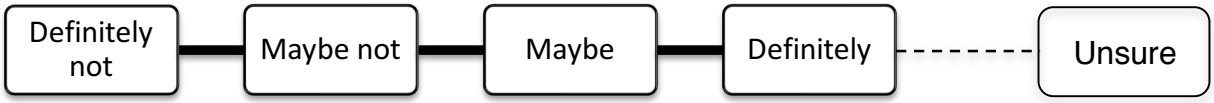
What is the suburb where you work?		
What is your monthly household income?	☐ <R1 000	☐ R1 000 – R5 000
	☐ R5 001 – R10 000	☐ R10 001 – R20 000
	☐ R20 001 – R50 000	☐ >R50 000
Have you attended a government clinic before?	☐ Yes	☐ No
Do you know what your closest government clinic is?	☐ Yes	☐ No
If yes, what is the name of your closest government clinic?		
What is your average one-way travelling cost to get to Jubilee Health Centre?	☐ <R5.00	☐ R5.00 – R10.00
	☐ R10.01 – R20.00	☐ R20.01 – R50.00
	☐ R50.01 – R100.00	☐ >R100.00
What is your average one-way travelling time to get to Jubilee Health Centre?	☐ <15 minutes	☐ 15 – 30 minutes
	☐ 31 – 45 minutes	☐ 46 – 60 minutes
	☐ >60 minutes	
How many times (including today) have you attended Jubilee Health Centre?	☐ 1	☐ 2 – 5
	☐ 6 – 10	☐ >10
What is your religion		
Are you a member of Jubilee Community Church?	☐ Yes	☐ No

Do you agree with the following statements? Decide if they are reasons that YOU came to Jubilee Health Centre. Choose an answer ranging from 'Definitely' to 'Definitely not' by putting an 'X' in the correct box.

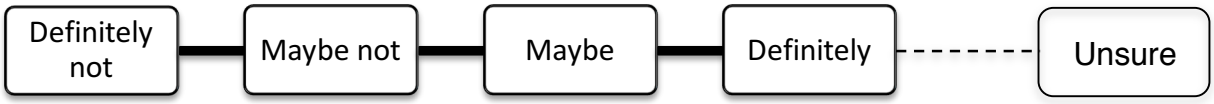
1. I chose to come to Jubilee Health Centre because the clinic is clean and neat.



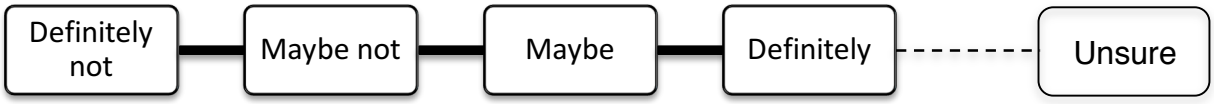
2. I chose to come to Jubilee Health Centre because it is cheap.



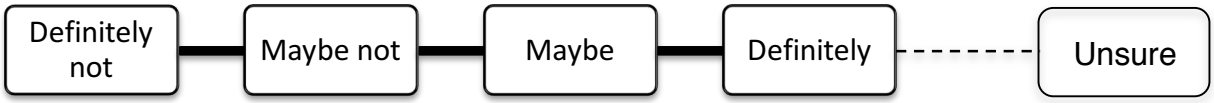
3. I chose to come to Jubilee Health Centre because the staff are friendly.



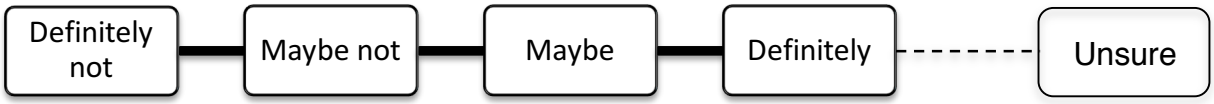
4. I chose to come to Jubilee Health Centre because they speak my home language.



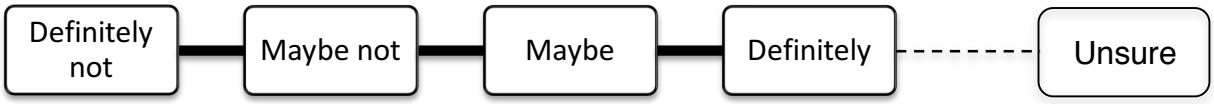
5. I chose to come to Jubilee Health Centre because it is a Christian clinic.



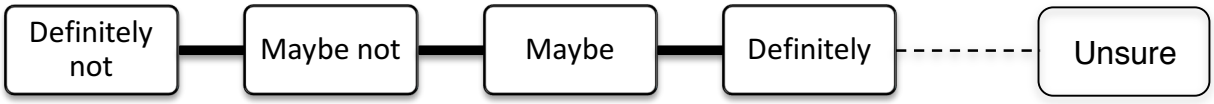
6. I chose to come to Jubilee Health Centre because it is easier to see a doctor.



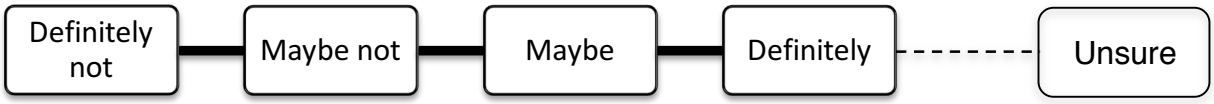
7. I chose to come to Jubilee Health Centre because I can trust the staff to be confidential.



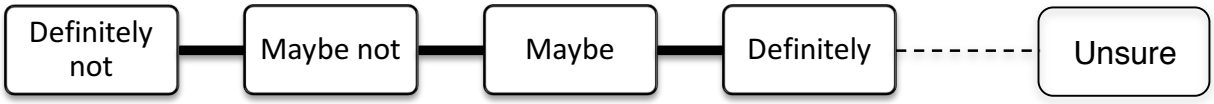
8. I chose to come to Jubilee Health Centre because the staff give the correct treatment for my illness.



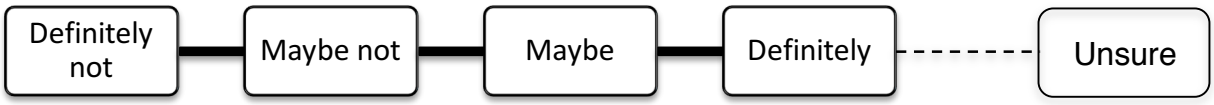
9. I chose to come to Jubilee Health Centre because the staff take time to listen to me.



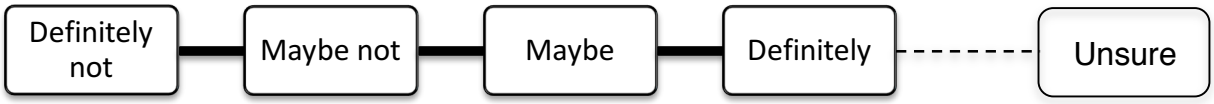
10. I chose to come to Jubilee Health Centre because it is close to me.



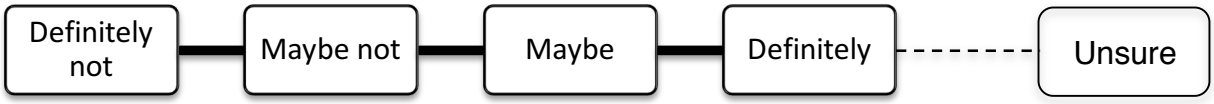
11. I chose to come to Jubilee Health Centre because the staff treat children well.



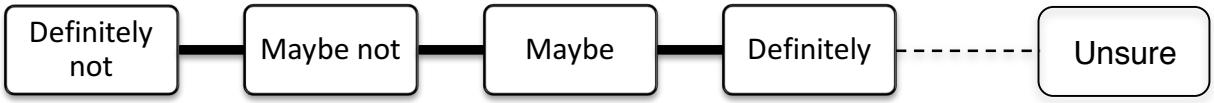
12. I chose to come to Jubilee Health Centre because the staff pray with me.



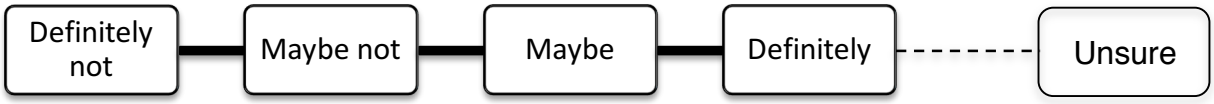
13. I chose to come to Jubilee Health Centre because the staff treat me with respect.



14. I chose to come to Jubilee Health Centre because it was recommended to me by others.



15. I chose to come to Jubilee Health Centre because I often am seen by the same doctor.


Definitely not
Maybe not
Maybe
Definitely
Unsure

Jubilee Health Centre Research Permission Letter

jubilee
community church
newfrontiers

Pastor Jeremy Cons
Jubilee Community Church
21 Nelson Rd, Observatory, 7925, Cape Town
06 June 2013

To whom it may concern
Human Research Ethics Committee, University of Cape Town

Dr. James Porter has approached me to conduct a research study for his Masters in Medicine (Family Medicine) at Jubilee Health Centre on "Exploring the reasons behind patient choice of a faith-based primary health care facility (Jubilee Health Centre) over their local state primary health care facility."

Dr. Porter has informed me of his study design, target population and ethical considerations. We have given him permission to conduct his research at our facility and will support him towards the successful completion of his study.

Sincerely

Pastor Jeremy Cons
+27 21 447 3630
+27 78 414 0636
jeremyc@jubilee.org.za
www.jubilee.org.za

Human Research Ethics Committee Approval

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room E52-24 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6338 • **Facsimile** [021] 406 6411
Email: shuretta.thomas@uct.ac.za
Website: www.health.uct.ac.za/research/humanethics/forms

24 March 2014

HREC REF: 118/2014

Dr G Bresick
Family Medicine
Falmouth Building

Dear Dr Bresick

PROJECT TITLE: TO DETERMINE AND EXPLORE THE REASONS FOR PATIENTS CHOOSING TO ATTEND JUBILEE HEALTH CARE (A FAITH-BASED PRIMARY HEALTH CARE CLINIC) OVER THEIR LOCAL PROVINCIAL PRIMARY HEALTH CARE CLINIC (MMed Dr James Porter)

Thank you for your response letter to the Faculty of Health Sciences Human Research Ethics Committee dated 19 March 2014.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30th March 2015

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/research/humanethics/forms)

We acknowledge that the MMed student Dr James Porter will also be involved in this study.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the HREC reference no ~~in all~~ your correspondence.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN ETHICS
Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938
This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines.

African Journal of Primary Health Care & Family Medicine Requirements

Publisher House Style

Publisher House Style for authors

Please select the applicable link below:

- Language usage
- Tables, figures and photographs
- Guidelines for Math
- Unicode fonts

Fonts: Please use standard (UNIcode) fonts such as Palatino, Times New Roman, Helvetica and Symbol. Fonts that have not been embedded will usually be replaced by Courier, resulting in character loss or realignment.

Creatives: Please supply images as the size intended for final publication. Resizing of images is time consuming and can result in loss of quality.

Language usage ↑

General elements

- **Quotations:** Use single quotation marks for quotations. For quotations within quotations, use double quotation marks. Quotations of more than 30 words are to be indented. Do not use quotation marks for indented quotations unless it is direct speech (e.g. interviewee responses).
- **En dashes and hyphens:** Use an en dash (i.e. extended hyphen that can be found in the Insert box under Symbols in Microsoft Word) in ranges of numbers and dates. Use hyphens only for words that are hyphenated.
- **Dates:** Format dates as '02 October 2006', except at the beginning of sentences where numerals and dates should either be spelt out or the sentence should be rearranged.
- **Percentage:** The per cent symbol (%) is used in conjunction with all numbers (e.g. 12%). Numbers that have been written out will appear with 'per cent' (e.g. five per cent). 'Percentage' is used in a general sense.
- **Numbers:** Numbers from one to nine must be written out. Numbers from 10 onwards, must be used as numerals, except at the beginning of a sentence.
- **Spacing and punctuation:** There should be one space (and not two) between sentences; one space before unit terms (e.g. 5 kg, 5 cm, 5 mmol, 5 days, 5 °C, etc.), but no space before the percentage symbol (%). Thousands and millions are marked with a space and *not* a comma (e.g. 1000, 1 000 000). Ranges are expressed with an extended hyphen (i.e. en dash), not with a short hyphen (e.g. 1990–2000).
- **Units:** The use of units should conform to the SI convention and be abbreviated accordingly. Metric units and their international symbols are used throughout, as in the decimal point (not the decimal comma), and the 24-hour clock.
- **Foreign language:** Foreign language words should be italicised, unless these words are part of normal usage. Consult the Oxford English Dictionary if in doubt.
- **Acronyms:** If a phrase with an established acronym or abbreviation is used and appears more than five times in your article, please include the acronym or abbreviation in brackets after first mention of the phrase, and then use the acronym or abbreviation only. Please note that you should not define acronyms or abbreviations in any of your headings. If either has been used in your abstract, you need to define them again on their first usage in the main text.

Sensitive and political terms

- **Race and ethnicity**: Try to avoid terms such as 'Blacks' and 'Whites' (please note the use of uppercase letters); use instead 'Black *people'*, 'White *people'*, etc. 'Caucasian', 'Mongoloid', 'Negroid', etc. are generally to be avoided except in human population studies. 'Mixed race' is preferable to 'half-caste' or 'Coloured'.
- **Disabilities:** Avoid using 'the disabled', 'the handicapped', and instead use 'people with disabilities not 'the disabled' or 'people with learning difficulties', not 'mentally handicapped'.
- **Disease**
  - Avoid health-determined categorisation.
    - Use 'people with diabetes'; not 'diabetics'.
    - Use 'people with cancer'; not 'cancer sufferers'.
    - Use 'sexually transmitted infection (STI)' and not 'sexually transmitted disease (STD)'.
  - Avoid phrasing that dehumanises a patient. Many authors use case (instance of a disease) when they mean patient (i.e. the person or individual who is ill with the

(disease).

- **AIDS**
  - Ensure that 'AIDS' is used for the disease and 'HIV' for the virus, e.g. do not use 'AIDS carrier', 'AIDS positive', 'AIDS virus' or 'catching AIDS or HIV/AIDS' (avoid using the solidus here).
  - 'AIDS sufferer/victim' is inappropriate; use 'people with AIDS**'.**
  - Refer to 'people who practise high-risk activities' and not '*high-risk groups'.*
  - The expression 'full-blown AIDS' is unnecessary if the correct distinction has been made between HIV and AIDS.
- **Male versus Female**
  - 'Male' and 'female' are *adjectives*, so be careful to use them as such (i.e. a *male* patient and a *female* frog, but a 35-year-old *man*, a French *woman* and a group of 25 *men* and 35 *women*).
- **Sexuality:** Avoid the terms '*homosexual activities'* (if achievable within the manuscript's context, specify which activity is being referred to, especially when dealing with medical research.) Avoid using '*homosexuals'* (specify homosexual men or homosexual women).
- **Gender:** Use gender neutral nouns. Avoid the use of 'man' if not specifically referring to men; for example:
  - for 'man' use 'humans'
  - for 'man-kind' use 'the human race'
  - for 'man-power' use 'workforce'
  - for 'man-made fibre' use 'synthetic fibre'
- **'He/she', 'him/her' and 'his/hers':** For 'he/she', 'him/her' and 'his/hers' rather use 'he o**r** she', 'her o**r** him', 'his or hers' (without a solidus) or change to plural 'they'. Use inclusive pronouns: use 'he or she', or rephrase the sentence (rephrasing to the plural form often works):

✗ … *Any observer* of changes in publishing technology will perceive that *he* has need of…

✓ **... *Observers*** of… will perceive that *they* have…

Beware of referring to people with stereotypical pronouns (e.g. 'the doctor treated *his* patient'; 'the secretary tidied *her* desk').

- **Geography**
  - The terms *Third World*, *poor countries* and *underdeveloped countries* should be avoided.
  - *Developing* or *non-developed country/society* is better, but it is best to specify countries or regions instead.
  - *Western society* and *Western World* should only be used in relation to geography; otherwise, use *developed world/society* or, even better, specify the countries themselves or the region.

Tables, figures and photographs ↑

In Step 4 of the online submission process, upload all tables, figures, images, and supplementary files. Tables should be saved and uploaded as separate Excel (.xls) files with no more than 10 figures and tables in total per article. Ensure that all personal identifying information is removed from the supplementary files as indicated in the provided instructions. All captions should be provided together on a separate page. Tables and figures should use numerical numbers.

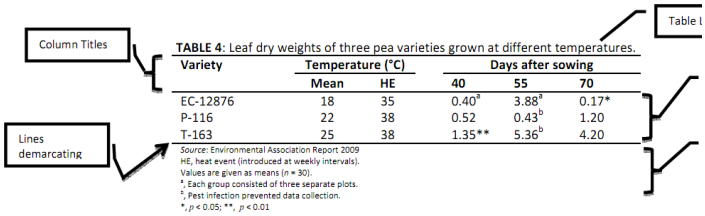
- **Organise your visual presentation:** Once you have read through the analyses and decided how best to present each table or figure, think about how you will arrange them within the article. The analyses should tell a story' that leads the reader through the steps needed to logically answer the question(s) that you as author are posing in the Introduction. The order in which you present the results can be as important in convincing the readers as what you actually are saying in the text.
- **How to refer to tables and figures in the text:** Every figure and table included in the paper *must* be referred to in the body of the text. Use sentences that draw the reader's attention to the relationship or trend you wish to highlight, referring to the appropriate figure or table only in parenthesis e.g.:
  - Germination rates were significantly higher after 24 h in running water than in controls (Figure 4).
  - DNA sequence homologies for the purple gene from the four congeners (Table 1) show high similarity, differing by at most 4 base pairs. (Avoid sentences that give

no information other than directing the reader to the figure or table, e.g. Table 1 shows the summary results for male and female heights at Bates College.)

- **Abbreviation of the word 'Figure':** When referring to a figure in the text, the word 'figure' is never abbreviated as 'Fig.'; the same rule applies to the usage of 'table'. Both words are spelled out completely in descriptive legends.
- **How to number tables and figures:** Figures and tables are numbered independently, in the sequence in which you refer to them in the text, starting with Figure 1 and Table 1. If, in revision, you change the presentation sequence of the figures and tables, you must renumber them to reflect the new sequence.
- **The acid test for tables and figures:** Any table or figure you present must be clear, well-labelled, and described by its legend to be understood by your intended audience without reading the results section. That is, it must be able to stand alone and be interpretable. Overly complicated figures or tables may be difficult to understand in or out of context, so strive for simplicity whenever possible.
- **Descriptive legends or captions:** To pass the acid test above, a clear and complete legend (sometimes called a caption) is essential. Like the title of the article itself, each legend should convey as much information as possible about what the table or figure intends to tell the reader:
  - the results that are being shown in the graph(s), including the summary statistics plotted
  - the organism studied in the experiment (if applicable)
  - a context for the results: the treatment applied or the relationship displayed, etc.
  - location (*only* if a field experiment)
  - specific explanatory information needed to interpret the results shown (in tables, this is frequently done as footnotes)
  - culture parameters or conditions if applicable (temperature, media, etc.)
  - sample sizes and statistical test summaries, as they apply

Do not simply restate the axis labels with a 'versus' written in between.

Example: Figure 1: Height frequency (%) of White Pines (Pinusstrobus) in the Thorncrag Bird Sanctuary, Lewiston, Maine, before and after the Ice Storm of 1998. Before, n = 137, after, n = 133. Four trees fell during the storm and were excluded from the post-storm survey.



Note: Questions frequently arise about how much methodology to include in the legend, and how much results reporting should be done. For laboratory reports, specific results should be reported in the results text with a reference to the applicable table or figure. Other than culture conditions, methods are similarly confined to the Methods section.

Footnotes to tables, figures and photographs

Do not introduce footnotes in the body of the article. Footnotes should be used as follows:

- Copyright and permissions to reproduce should be clearly stated.
- Notes about the table as a whole can be left unlinked (i.e. no linking letters or numbers or symbols) or linked to, for example, a relevant column heading.
- Notes about specific parts of the table should be linked using superscript lower case letters (preferred), superscript numbers or symbols.
- If lower case letters are used, it could be confused with the table data; use symbols or numbers instead.
- Do not make use of superscript numbers in parentheses (brackets).
- If an abbreviation is mentioned for the first time in a table (e.g. 'CE' in Table 1), it must be defined in a footnote to that table, (e.g. HE, Heat event (introduced at weekly intervals).
- Asterisk footnotes are reserved for probability values in tables and usually signify the following values: *, $p \leq 0.05$; **, $p \leq 0.01$; ***, $p \leq 0.001$. The asterisk is often used in mathematics and should therefore be avoided as a footnote symbol.

- Footnote links should be placed after punctuation. The preferred order of footnote symbols in tables (which should be superscripted) is †, ‡, §, ¶ (these are doubled if more footnotes are needed, e.g. ††).
- When superscript numbers or letters are used in text, beware of potential confusion with other superscripts (e.g. 2 for 'squared').
- Footnotes should be in the following order:
  - source notes
  - other general notes
  - notes on specific parts of the table (following the order in the table itself)
  - notes on level of probability

Guidance on submitting creatives electronically

Supply your manuscript creatives in one of the following three preferred formats:

- **TIFF:** This is an image made up of pixels and is the most universal and most widely supported format across Windows and Mac platforms. Most graphics packages can save a file as a TIFF. The higher the resolution (i.e. the number of pixels) the sharper the final image.
  - Colour or greyscale photographic images: 300dpi
  - Line art or combination images: 600/900dpi
  - We would recommend using this format for photographic images.
- **EPS**: An EPS is essentially an envelope for holding text and images. Line art can be produced as an EPS (in Illustrator, for example). There are virtually no limits to scaling line art saved as an EPS. It can also contain TIFF images. However, please ensure that all fonts are embedded (that is, saved as outlines) and that line weights are not defined as hairline.
- **PDF**: This format is, again, like an EPS in that it is an envelope for holding different kinds of images and line art. Great care should be taken to ensure that fonts are embedded and that original images are at the correct size and resolution before being saved as a PDF. It is possible to save or export as TIFF or EPS from most graphics applications, just as it is possible to save direct to a PDF from most graphics packages by using a postscript printer driver. PDF creation packages (e.g. Acrobat Distiller) are also now widely available.

Other file formats

- **JPEG**: A JPEG compressed TIFF is acceptable as long as the degree of compression is moderate. It is better to use a JPEG for online images as a good quality image is achievable even with a high degree of compression.
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- We cannot guarantee the quality of images supplied in other formats.

Colour:

- *Greyscale, CMYK, RGB.*
- **Greyscale** art should be saved in greyscale mode.
- **C**yan**M**agenta**Y**ellow**B**lack are the base colours used during the printing process.
- Any colour that is to appear in print must be in CMYK mode.
- **R**ed**G**reen**B**lue are the colours used by monitors and default scanner settings. Any colour that is to appear online must be in RGB mode.

Guidelines for Math ↑

- Set display equations in MathType. Each display equation should be in its own MathType object. Each MathType object should contain the entire equation, including final punctuation. The equation number should be set as Microsoft Word regular text, outside the MathType object, separated by either a tab or a space.
- Set in-text (inline) math in Microsoft Word regular text. Exception: If in-text (inline) math has elements that should be stacked or have rules, circumflexes, arrows, or other accents spanning over more than one character, set in MathType as 'Inline Equation.'
- If any characters cannot be found in Word's Symbol palette ('(normal text),' 'Times New Roman,' or 'Symbol'), please set in MathType.
- No display equations are allowed in figure captions, table titles, or table footnotes. If a display equation occurs in a text footnote, it is best to recast it as inline math. There are a few journals with lengthy footnotes with style exceptions to this rule.
- No numbered equations are allowed in table footnotes.
- Display and/or numbered equations ARE allowed in table body, but must be 'inline'

when converted to MathML equations.

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Journal Structure and Style Requirements

Structure and style of your original research article

The page provides an overview of the structure and style of your original research article to be submitted to the *African Journal of Primary Health Care & Family Medicine*. An original article provides an overview of innovative research in a particular field within or related to the focus and scope of the journal, presented according to a clear and well-structured format (between 3500 and 7000 words with a maximum of 60 references).

When presenting your article in English. Please use British English, that is, according to the *Oxford English Dictionary*. Avoid Americanisms (e.g. use 's' and not 'z' spellings). Consult the *Oxford English Dictionary* when in doubt and remember to set your version of Microsoft Word to UK English.

- **Language:** Manuscripts must be written in British English or French.
- **Line numbers:** Insert continuous line numbers.
- **Font type:** Palatino
- **Symbols font type:** Times New Roman
- **General font size:** 12pt
- **Line spacing:** 1.5
- **Headings:** Ensure that formatting for headings is consistent in the manuscript.
  - First headings: normal case, bold and 14pt
  - Second headings: normal case, underlined and 14pt
  - Third headings: normal case, bold and 12pt
  - Fourth headings: normal case, bold, running-in text and separated by a colon.

Our publication system supports a limited range of formats for text and graphics. Text files can be submitted in the following formats only:

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For full details on how to ensure your manuscript adheres to the house style, **click here**.

The structure and style of your original article

Page 1

The format of the **compulsory cover letter** forms part of your submission, is on the first page of your manuscript and should always be presented in English. You should provide all of the following elements:

- **Full author details:** Provide title(s), full name(s), position(s), affiliation(s) and contact details (postal address, email, telephone and cellular number) of each author.
- **Corresponding author:** Identify to whom all correspondence should be addressed.
- **Summary:** Lastly, a list containing the number of words, pages, tables, figures and/or other supplementary material should accompany the submission.

Page 2 and onwards

Title: The article's full title should contain a maximum of 95 characters (including spaces).

Abstract: The abstract, written in **English and French**, should be no longer than 250 words and must be written in the **past** tense. The abstract should give a succinct account of the objectives, methods, results and significance of the matter. The structured abstract for an Original Research article should consist of six paragraphs labelled Background, Aim, Setting, Methods, Results and Conclusion. The journal can translate into French if this is difficult for you.

- **Background:** Summarise the social value (importance, relevance) and scientific value (knowledge gap) that your study addresses.
- **Aim:** State the overall aim of the study.
- **Setting:** State the setting for the study.
- **Methods:** Clearly express the basic design of the study, and name or briefly describe the methods used without going into excessive detail.

- **Results:** State the main findings.
- **Conclusion:** State your conclusion and any key implications or recommendations.

Do not cite references and do not use abbreviations excessively in the abstract.

The following headings serve as a guide for presenting your research in a well-structured original article. As an author you should include all first-level headings, but subsequent headings (second- and third-level headings) can be changed.

Introduction (first-level heading)
The introduction must contain your argument for the social and scientific value of the study, as well as the aim and objectives:

> **Social value:** The first part of the introduction should make a clear and logical argument for the importance or relevance of the study. Your argument should be supported by use of evidence from the literature.
>
> **Scientific value:** The second part of the introduction should make a clear and logical argument for the originality of the study. This should include a summary of what is already known about the research question or specific topic, and should clarify the knowledge gap that this study will address. Your argument should be supported by use of evidence from the literature.
>
> **Conceptual framework:** In some research articles it will also be important to describe the underlying theoretical basis for the research and how these theories are linked together in a conceptual framework. The theoretical evidence used to construct the conceptual framework should be referenced from the literature.
>
> **Aim and objectives:** The introduction should conclude with a clear summary of the aim and objectives of this study.

Research methods and design (first-level heading)
The methods should include:

> **Study design (second-level heading):** An outline of the type of study design.
>
> **Setting (second-level heading):** A description of the setting for the study; for example, the type of community from which the participants came or the nature of the health system and services in which the study is conducted.
>
> **Study population and sampling strategy (second-level heading):** Describe the study population and any inclusion or exclusion criteria. Describe the intended sample size and your sample size calculation or justification. Describe the sampling strategy used. Describe in practical terms how this was implemented.
>
> **Intervention (if appropriate) (second-level heading):** If there were intervention and comparison groups, describe the intervention in detail and what happened to the comparison groups.
>
> **Data collection (second-level heading):** Define the data collection tools that were used and their validity. Describe in practical terms how data were collected and any key issues involved, e.g. language barriers.
>
> **Data analysis (second-level heading):** Describe how data were captured, checked and cleaned. Describe the analysis process, for example, the statistical tests used orsteps followed in qualitative data analysis.
>
> **Ethical considerations (second-level heading):** Approval must have been obtained for all studies from the author's institution or other relevant ethics committee and the institution’s name and permit numbers should be stated here.

Results (first-level heading)
Present the results of your study in a logical sequence that addresses the aim and objectives of your study. Use tables and figures as required to present your findings. Use quotations as required to establish your interpretation of qualitative data.

All units should conform to the **SI convention** and be abbreviated accordingly. Metric units and their international symbols are used throughout, as is the decimal point (not the decimal comma).

Discussion (first-level heading)
The discussion section should address the following four elements:

> **Key findings:** Summarise the key findings without reiterating details of the results.

Discussion of key findings: Explain how the key findings relate to previous research or to existing knowledge, practice or policy.

Strengths and limitations: Describe the strengths and limitations of your methods and what the reader should take into account when interpreting your results.

Implications or recommendations: State the implications of your study or recommendations for future research (questions that remain unanswered), policy or practice. Make sure that the recommendations flow directly from your findings.

Conclusion (first-level heading)
Provide a brief conclusion that summarises the results and their meaning or significance in relation to each objective of the study.

Acknowledgements (first-level heading)
If, through your study, you received any significant help in conceiving, designing or carrying out the work, or received materials from someone who did you a favour by supplying them, you must acknowledge their assistance and the service or material provided. **Authors should always acknowledge outside reviewers of their drafts and any sources of funding that supported the research.**

Competing interests (second-level heading): A competing interest exists when your interpretation of data or presentation of information may be influenced by your personal or financial relationship with other people or organisations that can potentially prevent you from executing and publishing unbiased research. Authors should disclose any financial competing interests but also any non-financial competing interests that may cause them embarrassment were they to become public after the publication of the manuscript. **Where an author has no such competing interests, the listing will read as follows:** 'The authors declare that they have no financial or personal relationship(s) that may have inappropriately influenced them in writing this article.'

Authors' contributions (second-level heading): This section is necessary to give appropriate credit to each author, and to the authors' applicable institution. The individual contributions of authors should be specified with their affiliation at the time of the study and completion of the work. An 'author' is generally considered to be someone who has made substantive intellectual contributions to a published study. Contributions made by each of the authors listed can follow the example below (please note the use of authors' initials):

> J.K. (University of Pretoria) was the project leader, L.M.N. (University of KwaZulu-Natal) and A.B. (Stellenbosch University) were responsible for experimental and project design. L.M.N. performed most of the experiments. P.R. (Cape Peninsula University of Technology) made conceptual contributions and S.T. (University of Cape Town), U.V. (University of Cape Town) and C.D. (University of Cape Town) performed some of the experiments. S.M. (Cape Peninsula University of Technology) and V.C. (Cape Peninsula University of Technology) prepared the samples and calculations were performed by C.S. (Cape Peninsula University of Technology).

References (first-level heading)
Begin the reference list on a separate page, and give no more than 60 references in all. The *African Journal of Primary Health Care & Family Medicine* uses the **Vancouver referencing style**, details of which can be downloaded from the journal website. **Note: No other style will be permitted.**

Systematic reviews

Systematic reviews should follow the same basic structure as other original research articles as described above. The aim and objectives should specific the focused clinical question that will be addressed in the review. The methods section should describe in detail the search strategy, criteria used to select or reject articles, attempts made to obtain all important and relevant studies and deal with publication bias (including grey and unpublished literature), how the quality of included studies was appraised, the methodology used to extract and/or analyse data. Results should describe the homogeneity of the different findings, clearly present the overall results and any meta-analysis.

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