

AN ASSESSMENT OF PRIMARY HEALTH CARE SERVICES FROM THE:
PERSPECTIVE OF THE RECIPIENTS IN THE KHAYELITSHA
COMMUNITY HEALTH CENTRE.

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The logo of the University of the Western Cape, featuring a classical building facade with columns and a pediment, positioned above the text 'UNIVERSITY of the WESTERN CAPE'.

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KEYWORDS

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2. Western Cape
3. Department of Health
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5. Decentralisation
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8. Human resources
9. Financial resources
10. Patients



ABSTRACT

Title: A critical assessment of the primary health care services from the perspective of the recipients in the Khayelitsha Community Health Centre.

Problem statement, nature and scope of the study

Decentralization through the introduction of the Primary Health Care (PHC) approach has been a key feature of the health sector transformation in South Africa. Primary Health Care is seen as the key element in the plan to transform health care services. Resources were decentralized from the centralist approach previously prioritized towards the primary health care services. These endeavours are aimed at ensuring greater accessibility and equity in health care service provision by the majority of people, in particular, the poor. Despite the decentralization of functions and the allocation of additional resources, evidence suggests that the quality of health care service delivery remains unsatisfactory according to the recipients.

Objectives of the study

The general aim of this study is to undertake an assessment of the health care service provision in the Khayelitsha Community Health Centre taking into consideration the underlying principles of the Primary Health Care. More specific objectives include: an overview and discussion of the framework approach to primary health care and its use; the documentation of the practice of primary health care in the Khayelitsha Community Health Centre; an analysis of the results and findings which will highlight the obstacles in the pursuit of a better primary health care service. The perspective of the patients and nurses will be solicited and examined with a view to highlighting factors that facilitate and constrain the delivery of service; and finally to draw conclusions and make recommendations.

Methodology of the study

The study will make use of a qualitative methodological approach and its design is a case study of the Khayelitsha Community Health Centre. Furthermore qualitative methodology techniques such as interviews, questionnaires, observations and perusal of related documents and newspapers are used to derive an understanding of the challenges confronting the decentralization of the primary health care in order to draw conclusions and make recommendations. Twenty-one key informants such as ten patients, ten nurses and one facility manager would be interviewed and is selected on the basis of expertise and convenience. The information will be analysed in terms of the key performance indicators outlined in the framework primary health care approach.

The preliminary findings from a brief literature review suggest that there have been significant shifts of selected responsibilities, functions and additional resources from the main hospitals in favour of the Primary Health Care services. However, despite the generally acknowledged tangible successes demonstrated by the Primary Health Care services, key weaknesses are identified. These weaknesses include: long queues and influx of patients resulting from the shortages of staff, in particular, primary health care nurse practitioners, doctors and pharmacists. This suggests that an additionally new hospital with more staff and more financial resources allocated may only be a partial solution to some of these challenges.

Ethics statement

Confidentiality of data gathered and anonymity of respondents will be ensured by not requiring any personal details from the survey questionnaires. The sole purpose of using the data gathered for research will be communicated to the respondents on the front page of the questionnaire. The choice of also not answering the questionnaire will be respected.

DECLARATION

I declare that *An Assessment of the Primary Health Care Services from the perspective of the recipients in the Khayelitsha Community Health Centre* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have indicated and acknowledged by complete references.

Full name..... Date.....

Signed.....



ACKNOWLEDGEMENTS

The completion of the study has been a collaborative effort. First and foremost, I would like to take this opportunity to thank patients, nurses and doctors from the Khayelitsha Community Health Centre who willingly gave their time to be interviewed. Their contribution forms the basis of the thesis. Thanks to my sister, Nikiwe for her support and words of encouragement. Finally, thanks to my supervisor, Dr. L. Pretorius for his supervision and valuable advises. Your contributions have made the thesis richer and comprehensive. Thank you very much.



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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
CHC	Community Health Care
DHS.	District Health System
DOH	Department of Health
HIV	Human Immuno-deficiency Virus
PHC	Primary Health Care
SA	South Africa
TB	Tuberculosis
WHO	World Health Organisation



CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1 Introduction

The thesis critical assess from the development perspective the Primary Health Care approach to the provision of health care services – a case, which can be made in terms of considering key principles of the primary health care. The thesis examines these principles in the context in which primary health care services are underway, at Khayelitsha Community Health Centre. A detailed discussion on the study is done as the following chapters unfold.

The study consider the Primary Health Care approach as an important endeavour to ensure a greater accessibility of health care services by the majority of people, in particular the poor.

The chapter is organised into six sections. After the introduction, Section 2 provides the back ground of the study. Section 3 identifies the research problem and question. Section 4 the purpose aims and objectives of the study and its significance. Section 5 discusses the methodology and its limitations and Section 6 provides the chapter outline and structure of the thesis

1.2 Background- Strategic context for the Primary Health Care services

For many decades the vast majority of the South African population has experienced either a denial or violation of fundamental human rights, including rights to health care services.

The evidence on the history of South African Health system during the apartheid era, clearly suggests that the delivery of health care services and the allocation of resources were conducted along racial lines. In addition to this fact Primary Health Care services were never prioritised (Business Day, 17.5. 90). This common knowledge has also been echoed in the Reconstruction and Development Programme (1993) and in the White Paper on the Transformation of the Public Service (1995). These two documents expresses that there were vast inequalities

in health status and access to services that were largely based on race, geographic location and socio-economic status. Under these circumstances, resources were channelled towards tertiary and secondary services above primary health care services. It was clear from the elected African National Congress led government in 1994, that a radical transformation of the entire health system was imminent. When the African National Congress came into power, it adopted both the Freedom Charter and the Reconstruction and Development Programme (RDP) as policies to be incorporated into all other policies. Aspects of the Freedom Charter such as equality, human rights and retribution for past injustices are all evident in the policies of the government.

Since 1994, the health care system has undergone a substantial transformation. The main goal was among other things to shift resources from tertiary and secondary health care services to primary health care services (i.e. decentralisation). The White Paper on the Transformation of the Health System in South Africa (1997), expresses that decentralisation introduces the District Health Systems (DHS) which deemed to be the most appropriate vehicle for the delivery of primary health care services. In general, decentralisation implies the shift of power, authority and functions away from central. Comprehensive and integrated essential primary healthcare services were made available to the entire population as an attempt to create a single unified but decentralised health care system. The Alma-Ata Declaration (1978) perceived Primary Health Care (PHC) to be more effective in achieving health outcomes, as it is more efficient and accessible to dispersed populations. This is widely accepted and finds resonance within the policies and programmes of the Department of Health (DoH) that were promulgated and implemented afterwards. Tshabalala-Msimang, M. (2008), reiterated this at the launch of the national core standards for health establishments that “several policies, guidelines and pieces of legislation that have been developed to facilitate the transformation of the healthcare system in South Africa. Many of these interventions were aimed at improving access to care, quality and efficiency of the health system”.

However in practice PHC has been criticised by various communities such as patients/clients and newspapers among others, the Cape Argus (1997), Cape Times (2003) and the Cape Times (2006) for delivering a deteriorating services. The critics expressed that despite strong policy initiatives, guidelines and legislations in place but the public healthcare service is ailing. The African National Congress (2008) echoed these views in its 96th January statement release, that although progress had been made, the country was still faced with significant challenges with respect to the quality of care provided. Anecdotal evidence among nurses and doctors suggests that the integrated services and free health care in the Community Health Centre (CHC), has increased the patient load while staffing levels among them has decreased. The strong view held by critics (patients, nurses-doctors and the media) is that primary health care services have been compromised. The Alma Ata Declaration (1978) and World Health Organisation (WHO) advocates for adequate resources to be channelled towards the primary health care services in order to achieve health care goals of 'Access to quality Healthcare for All', by the year 2000. Adequate resources mean PHC need to be prioritised in terms of resource allocations.

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If these views of the recipients are correct, it means that there appears to be a contradiction between goals of PHC and outcomes of service provision experienced by community. These concerns and views of the recipients warrants an in depth investigation.

1.3 Problem Statement and Research Question

Decentralisation through the introduction of the Primary Health Care (PHC) approach has been a key feature of the health sector transformation in South Africa. PHC is seen as the key element in the plan to transform health care services. Resources are decentralised from the centralist approach previously prioritised towards primary health care services. The aim is to increase accessibility and equity in health care service provision to the majority of people, in particular, the poor.

Despite the decentralisation of functions and the allocation of additional resources, evidence (long queues and influx, long waiting times) suggests that the quality of health care service delivery in the Khayelitsha Community Health Centre (CHC) remains unsatisfactory according to the recipients.

In order to fulfil the objectives of the research, the development of the study will centre on a number of basic research questions:

- a) Has the health care service provision in the Community Health Centre comply with the Primary Health Care principles?
- b) What factors facilitating, and what factors constraints health care service provision in the Community Health Centre?
- c) What need to be done to improve the accessibility of quality health care service provision?

1.4 Objectives of the study

The general aim of the study is to undertake a critical assessment of the Primary Health Care service provision in the Khayelitsha Community Centre taking into consideration the underlying principles of the Primary Health Care.

The specific objectives of the study include:

- a) An overview and discussion of the conceptual framework approach and principles of PHC and its use;
- b) Provide descriptive background and context of PHC services in Khayelitsha Community Health Centre;
- c) Identification and analysis of factors facilitating and constraining PHC service provision; and finally
- d) Draw conclusions and make recommendations.

It is significant to note that the identified assessment framework in chapter 2, which is drawn from the principles of the PHC, will be used to assess healthcare service provision in the Khayelitsha Community Health Centre.

1.5. Rationale and significance of the study

The rationale of the study is to affirm the usefulness of PHC in addressing the majority of the health needs in developing countries like South Africa. It also aims to address patient's dissatisfaction in relation to the quality of PHC services they received at the Community Health Centre.

The study seeks to assist in identifying key factors that facilitates and constraints the Primary Health Care services provision in the Khayelitsha Community Health Care Centre. The fact that the study is more focussed will help to expand PHC knowledge and literature in an organised way.

The findings will inform the development and implementation of future policies and practices. Findings will also contribute to better delivery of services and lead to more satisfied patients.

1.6. Research Methodology

The researcher purposefully elected to conduct an assessment of the primary healthcare services at the Community Health Centre from Khayelitsha. The reason for choosing the community health centre was due to the easy accessibility to the area as he had already worked in the administration of the facility. The aim was to select a facility from a community that is experiencing multidimensional challenges such as socio-economic predicament and density of population.

It is important to note that midwifery and obstetric units, and 24-hour trauma units were excluded from the scope of the study, as most of the activities are of an urgent nature. Also, night staffs were excluded from the study, with direct and indirect observations, interviews and public hearings conducted during the 07 to 17h00 work shifts for both staff and clients. The researcher held a meeting with the nursing staff and doctors of the facility. The main purpose was to introduce the study and request their voluntary participation, and jointly discuss data collection tools.

1.6.1 Research design

In order to gain better understanding of the primary health care services in the Khayelitsha Community Health Centre, an in-depth investigation was conducted. The research took the form of an exploratory qualitative methodology using qualitative techniques. According to Mouton, J. (1996), this methodology has a point of departure the fact that in the human sciences the human being is the object of the study. Under this circumstance, Mouton suggests that methods such as case studies, in-depth interview of key informants, participant observation, questionnaires, and perusal of documents be used. It is in this regard that the qualitative methods were considered relevant to elicit the desired information from the study sample. This methodology would allow for a more flexible investigation of the various issues and enable the researcher to acquire insight into a diversity of, at times unforeseen, experiences and viewpoints expressed by key informants. The main reason for considering this methodology is to promote a people's driven delivery of the primary healthcare services. In order to achieve this objective, appropriate data collection techniques were employed.

1.6.2 Data collection techniques

Both the primary data sources and secondary sources were explored. The researcher and the participating staff of the facility decided on face-to-face in-depth interviews, direct and indirect observation, public hearings, as well as questionnaires, in particular for the clients or patients. Secondary sources such as the information from newspapers and electronic media about health care services in Primary Health Care facilities were of great value in the study.

The researcher and the key informants in the study have agreed to adhere to the ethical principles of gathering information. Confidentiality of data gathered and anonymity of respondents will be ensured by not requiring any personal details from the survey questionnaires. It was agreed that the sole purpose of using the data gathered for research will be communicated to the respondents on the front

page of the questionnaire. The choice of also not answering the questionnaire will be respected. The compliance of the respondents to participate was determined by the fact that their identity is not disclosed. They fear to be victimised in the long-run.

Primary Data Collection

One of the important data collection technique used was the semi-structured interview. Mouton (1996) advises researchers in the Public Administration to make widespread use of the interviews, not because other methods of data collection are inadequate, but rather because the interviews are an extremely useful method, which can secure valuable information. Questionnaires in the form of structured lists of probing questions were developed. Questions were lucid and concise, explaining exactly what is expected from informants. This type of data collection technique is considered useful as it allows for the interviewer and interviewees the opportunity to meet and expand on topics, as they saw fit based on their own experiences. The duty of the researcher was to direct the flow of ideas, to intervene when needed and to ask probing questions. Key question in the interview was to probe: What hinders the delivery of quality Primary Health Care service provision in Khayelitsha Community Healthcare Centre?

Semi-structured interviews were conducted with the following target sample groups of participants:

- Nurses (10) – in various categories (enrolled nursing assistants, enrolled nurses and professional nurses) from the facility.
- Clients (10) - chosen at random basis from a group in the facility.
- Facility Manager (1) – from the facility was interviewed lastly. The reason for electing to interview the manager at last was due to specialist knowledge perceived to have possessed.

In all the interviews and observations that were undertaken, notes were taken. Follow on from the individual interviews, the interviewer convened a focus-group discussion attended by all interviewees for feedback and brainstorming purposes.

The discussion enabled the interviewees to share individual viewpoints and to some extent reach a degree of consensus.

General spontaneous observation of the facility including physical layout of the facility and cleanliness, accommodation both for clients and staff (e.g. availability and condition of waiting area for clients, toilet facilities, storage facility for staff belongings) services rendered, interpersonal interaction between staff and clients, availability of support staff, and other general activities taking place in the facility.

Five nurses were tracked in order to observe how they spent their work time for a day, from the time they reported for work in the morning until the end of their shift. Observations were done between 07h00 and 17h00 in 5 consecutive days. Five patients/clients were tracked from the time they arrived at the health facility until they left in order to measure the waiting times at different service points.

A targeted sample of 10 clients was invited to participate or air their views regarding the delivery of services in the Khayelitsha Community Health Centre. These clients were also elected randomly from the flow of clients in the community health centre. The same questions in the questionnaire that has been developed during interview process were applied. The issuing and filling of questionnaires were done during the meetings and returned immediately (there and there). Follow-up interviews were also done in some cases for further information and explanations.

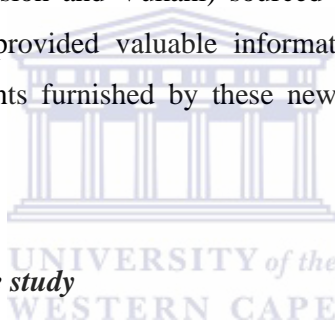
All these endeavours were aimed at establishing how clients perceive the services delivered to them and ascertaining what they believe to be their entitlements and obligations as clients.

Structured questionnaires were developed and also used in the study. These questionnaires contain standardised instructions on how to complete and the expectations. The use of this technique was minimal in the study due to the nature of illiteracy in the community. Key informants in this category were selected on

the basis of expertise and convenience. The purpose was to solicit more objectivity and professional information on the issue. The same standardised questionnaire applies to all the data collection processes aforementioned.

Secondary Data Collection

The secondary data was the perusal of relevant documents and policies of the Department of Health sourced from Intranet and Internet. These transformative documents (i.e. policies and legislations) were evaluated against what transpires in the Khayelitsha Community Health Centre. It is important to note that these policies and legislation form the basis for the background and context of the thesis. National and Community newspapers such as Cape Times, Cape Argus, Sunday Times, City Vision and Vukani) sourced from Masakhane Community Library (Khayelitsha) provided valuable information on PHC services. Some information and incidents furnished by these newspapers were as old as from 1998.



1.6.3. Limitations of the study

Firstly, the fact that the research is conducted from a single Community Health Centre, in the Western Cape, the case study cannot be transferable. It is not transferable because the context and the circumstances in the area may not be the same as the case study not the representative of whole South Africa. Secondly, the case study does not delve into the details of the Healthcare Plan 2010, as discussions around its implementation are still currently underway. Thirdly, the study discusses the expenditure and budgetary standpoint of the Community Health Centre that is not published, and therefore is difficult to verify.

1.7. The structure of the thesis

The thesis is structured as follows. **Chapter 1** begins with an introduction, background and context of the study. **Chapter 2** provides literature review/ Definitions, Analytical framework for data examining Primary Health Care approach. **Chapter 3** provides descriptive background and context. The chapter describes the context and background, and diverse nature of the socio-economic and health conditions, and Primary Health Care service provision in Khayelitsha. **Chapter 4** describes the research findings and analysis which identifies and assess the factors that facilitate and constrains the provision of the PHC services in Khayelitsha Community Health Centre. **Chapter 5**, which is the last chapter of the study, makes conclusions and recommendations.



CHAPTER 2: LITERATURE REVIEW / ANALYTICAL FRAMEWORK

2.1. Introduction

The chapter provides the literature review or conceptual context of data examining Primary Health Care. As the provision of literature reviews is on continuous basis in the thesis, the main focus of the chapter will be more on general theory as relate to the Primary Health Care model. This chapter is important in the overall completion of the study as will make explicit the theoretical basis of the analysis.

The chapter is organised into the following aspects from the literature survey of PHC. The first aspect provides a contextual discussion of key concepts which mainly include the Decentralisation and Primary Health Care. The study view PHC and Decentralisation concepts as interrelated. The second aspect identifies and discusses the objectives and principles of PHC. The third aspect discusses in general some important issues highlighted in the PHC literature that positively or negatively affect PHC delivery. The last aspect provides Framework for Assessing PHC services in the Khayelitsha Community Health Care Centre before summarising. It is apt at this stage to turn to the contextualisation.

2.2 Conceptual discussion of key concepts

2.2.1 Decentralisation

Decentralization through the introduction of the Primary Health Care (PHC) approach has been a key feature of the health sector transformation in South Africa. Decentralised governance is embodied in the Constitution. The Constitution (Act 108 of 1996) recognises the separation of powers and functions between national, provincial and local spheres of government which are distinctive, interdependent and interrelated. Since the inception of the democratic

government, constitution is the legislative framework which must be incorporated into all policies and legislation to needs to be formulated.

The White Paper on the Transformation Health System in South Africa (1997), argues for the transformation of the health sector by creating a unified but decentralised national health system based on the PHC model. The White Paper (1997) articulates the vision of the department of Health to transform its health system into a unitary national health system that is also decentralised. It is very important to note that, the decision to decentralise the delivery of health care services is consistent with the overall policy to decentralise government.

According to the United Nation Development Report (2000), the concept 'decentralisation' implies the shift of power, authority and functions away from the centre.

The Alma Ata Declaration (1978) propagates for the decentralised health care services based on primary health care model. The Alma Ata Declaration (1978) considers decentralisation as a mechanism to achieve greater equity and efficiency, greater involvement of and responsiveness to communities, the reduction in the size of bureaucracy far removed from the communities being served and greater coordination between social sectors. It argues that in order to achieve the goals of health for all by the year 2000, adequate resources need to be channelled towards primary health care services.

Bossert (1996) contends that decentralisation can take many forms and suggests one set of typologies. These typologies are the following:

- Deconcentration;
- Devolution;
- Delegation; and
- Privatisation.

All these typologies speak to and reinforce decentralisation, and whatever form taken, they are bound to have a major impact on the way in which resources are planned for and managed.

2.2.2 Primary Health Care

The Constitution (Act 108 Of 1996) places an obligation on government to ensure that all South Africans have access to health care services, including reproductive health care. Constitution guarantees that no one may be refused emergency medical treatment. It goes on and enforces the state to take reasonable legislative and other measures, within its available resources to achieve the progressive realisation of these rights.

Theoretically and empirically, there is no homogeneous definition of the Primary Health Care. This is due to the fact that the health care 'in particular Primary Health Care' delivery in South Africa takes place in an enormously complex and diverse socio-economic contexts and conditions that makes the concept of primary health care even much broader. This means therefore that, health cannot be separated from other goals such as education and economic security, for instance. It means that government should create conducive healthy environment. Such an environment should focus on improved living and working conditions for example clean water and sanitation, electricity, adequate and safe housing and access to high quality food.

In general terms the 'Primary Health Care' implies the basic health care that includes teaching people how to live healthily (e.g. eating healthily and better hygiene) to prevent illness and disease. It might also mean the first point of contact between the patient and the health service, in other words, it can be regarded as the gateway to the health service.

Primary Health Care is delivered within the District Health Services (DHS) and is viewed as the foundation of an effective and efficient public health services as:

- It is frequently the first point of contact between the patient and the health services, i.e. it is the gateway to the health service;
- It should provide a comprehensive and integrated package of essential PHC services; and
- Efficiencies or inefficiencies at this level impact significantly on the entire health system, (Comprehensive Service Plan for the Implementation of Healthcare 2010).

The Alma Ata conference (1978) expressed that improving health require for a comprehensive approach. In this case primary health care is viewed as “the key to achieving an acceptable level of health throughout the world in the foreseeable future i.e. 2000 as a part of social development and in the spirit of social justice”.

Health is defined as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, but as a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector. This thorough description of health is by no means the product of the Alma Ata Conference (1978), rather bequeathed from the constitution (1948) of the World Health Organisation (WHO-UNICEF 1978, clause 1).

Rispel & Behr (1992) defined the purpose of health care as being ‘to contribute to sustained economic and social development by the promotion and protection of the health of the people’. This definition indicates a shift away from the perception of health care as a ‘science devoted to individual patient care to one in which scientific and technical skills are mobilised to achieve social goals’.

While acknowledging the fact that, there is no homogeneous definition of the Primary Health Care, it is widely defined as “essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford

to maintain at every stage of their development in the spirit of self-reliance and self-determination” (WHO-UNICEF 1978, clause VI).

Evian, C. and Olerk, J. (1999) expresses that primary health care addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly. They argue that since these services reflect and evolve from economic conditions and social values of the country and its communities, they will vary by country and community, but will include at least; promotion of proper nutrition and an adequate supply of safe water, basic sanitation, maternal and child care, including family planning, immunisation against the major infectious diseases, prevention and control of locally endemic diseases, education concerning prevailing health problems and the methods of preventing and controlling them, and appropriate treatment for common diseases and injuries.

Dixie, K. (1978: 37-39) asserts that if health care is primary, it must have a set of characteristics that make it distinct from secondary and tertiary care. Furthermore, characteristics should take into cognisance the following;

- 1) A variety of basic health care services must be available to take into consideration the interactional effects of physical, emotional, socio-economic, and cultural factors influencing the health status of individuals and families in situational and community context.
- 2) Health care and health services must be people-oriented, as opposed to disease-oriented, and must consider individuals and families in holistic and humanistic ways.
- 3) Timely access must be available for individuals and families to the health care system and its services, and first contact must be with a health professional that can assess and evaluate comprehensive health care needs and take appropriate clinical actions.

According to Dixie (1978), there must be a provision for comprehensive health services, which include health and education and appropriate interventions in less complex physical and mental health problems, the recognition and referral of

more complex health problems to specialists, and follow-up services and health care in all settings.

- Longitudinal responsibility must be undertaken for patients and families with a health care professional who are designated to maintain a constant relationship over time, place, setting, and health status.
- There should be coordination and integration of the parts and fragments of the patient's and family's health care by the constant provider so that it makes sense to the user.

The explanation mentioned above, in all aspects, helps to set some boundaries on what is, and what is not primary health care.

Evian, C (1994) argues (cited in the Mini-thesis by Edelstein, G. 1997) that PHC provides a special kind of health care to individuals and families. A distinctive argument between the social model perspective and biomedical model has been made. PHC subscribes to the social model perspective which views health as being caused not by disease alone but by social conditions. It is contrary to the biomedical model, where treatment is usually carried out by a trained, specialist doctor who diagnose the problem and prescribe drugs or surgery and the emphasis on curing diseases. Under social model perspective, Primary Health Care Nurse Practitioners are the backbone of the PHC services. They state that in order for Primary Health Care Nurse Practitioners to provide optimal services to patients, they need additional knowledge and competencies in the physical, social, psychological, and cultural aspects of health. All these aspects are said to be essential if care providers are to safely and effectively offer services involving expanded functions and roles. It is expected that Primary Health Care nurse practitioners in an ambulatory care settings to increasingly function in autonomous ways and to make a large variety of independent clinical decisions. This does not mean that other health care providers are not being used; rather these nurses are expected to be in the front line. They are providing health care services under very different circumstances than ordinary nurses in other health care settings.

While Lehmann, U (2008) acknowledged the important role plays by Primary Health Care nurse practitioners at the primary health care set up, but further elaborated that this does not necessarily mean that other workforce members, such as doctors in particular, are unimportant. Doctors also have an important role to play as they look at cases of serious nature. She made an acknowledgement that the majority of patients/clients visiting community health centres suffer from common diseases that could mainly be treated by nurses without doctor interference. It is generally the case, especially, in rural areas where many clinics and community health centres function without any personnel other than nurses. This fact is common knowledge and also has been attested in a number of source documents and newspapers reviewed for the particular purpose.

2.3 Objectives and principles of primary health care

2.3.1 Objectives of the primary health care

At Alma Ata Conference (1978), eight primary health care objectives were identified, of which the first six are preventative and the last two curative. The identified objectives were listed as follows;

- i. To ensure the promotion of proper nutrition.
- ii. To ensure that adequate supply of safe water is provided.
- iii. To ensure that basic sanitation is provided.
- iv. To ensure that mother and child care, including family planning services are provided.
- v. To ensure that immunisation against the major infectious diseases takes place
- vi. To ensure that education concerning prevailing health problems and the methods of preventing and controlling them takes place;
- vii. To ensure that appropriate treatment for common diseases and injuries are provided, and
- viii. To ensure the provision of essential drugs.

These objectives of the primary health care are important as they are aiming at informing managers about what should be achieved when applying the approach.

2.3.2 Principles of the primary health care

The principles of the primary health care are the building materials for what is inherent in the approach and what it is all about in terms of promoting health care, as well as other sectors of development. It is important to comply with, and adhere to the principles in order to achieve the objective of the Department of Health of a better health care for all. These principles are to ensure;

- i. Universal coverage of the population, with care provided to need.
- ii. Services are promotive, preventive, curative and rehabilitative.
- iii. Services should be effective, culturally acceptable and manageable.
- iv. Communities are involved in the development of services to promote self-reliance and reduce dependency.
- v. Approaches to health relates to other sectors of development (World Health Organisation 1978: 16-17).

De Beer (1987) suggests that one way of evaluating the health care system in South Africa (this applies to other countries as well) is to invoke some of the criteria established by the WHO. He suggests the use of two main principles in this regard:

- All communities should have access to ‘comprehensive essential-health care’ of adequate quality.
- There should be equity in resource distribution with priority given to those in need.

Although the two main principles mentioned above should be able to answer the question. To what extent do they comply with the primary health care services rendered in the community health centre under review? It is significant to note that for the purpose of the study, the key important issue of participation by the entire community and all sectors cannot be omitted.

2.4 General issues highlighted in the primary health care literature survey

The aspect discusses in general some important issues highlighted in the PHC literature survey that positively or negatively affect PHC delivery. These issues include;

2.4.1 Workloads and staffing norms

In an unpublished Nurses workload report (2004) conducted by the School of Public Health, literature on nurse's workloads and staffing norms were provided. The researcher finds the information on this report as more relevant and useful to be applied in analysing nurse's concerns of workloads.

Kraus, R. (2004) developed staffing norms for district personnel in various South African provinces. Kraus explains,

“A workload variable of 25 patients per eight hour shift has been used in all clinic and PHC models. What proved interesting about applying this ratio is not only the general agreement that the workload variable of 25 is quite reasonable (if not too generous) but the remarkable variation in workload that PHC nurses are in fact handling in PHC facilities. It is uncommon to find services where nurses average 6 patients a day or 60 patients a day on a routine basis.” Therefore, Kraus argues, “what desperately needs to be addressed is not how many minutes a nurse should spend on a particular type of patient rendering a specific service, but rather how many hours of productive time a nurse can be expected to work in a day providing patient care, as opposed to attending seminars, performing administrative tasks, drinking tea, cooking, doing home visits and shopping, being on vacation or taking compulsory sick leave”.

Daviaud, E (2004) has asked similar questions in her work on staffing norms for PHC facilities in Cape Town (and more recently, in the Eastern Cape). She correctly pointed out that while norms and standards as well as mathematical instruments are undoubtedly needed and valuable in human resource planning

activities, they hide the fact that health care delivery in South Africa takes place in enormously complex and diverse socio-economic contexts and conditions, and that transformation (integration and decentralisation) of services is far from complete. She contends that workload is not, as Kraus seems to imply, primarily a question of individual nurse efficiency and productivity, although these are undoubtedly contributing factors which need to be taken account of. In both two stark illustrations (Cape Town versus rural clinic in the Eastern Cape) he contends that workload is quite fundamentally determined by dramatic structural differences. As he noted that a clinic in urban Cape Town may expect to be equipped with running water and electricity and staffed with a wide range of health care workers. About a clinic in Cape Town, he notes that:

“Despite needing a fresh coat of paint and the weeds growing through its once grand colonial-style veranda removed, the centre is an example of a well functioning clinic which has everything it needs. The centre offers district surgeon services, mental health, dental services, school health, family planning and curative services. It forms part of a strong network with the surrounding hospitals. Whenever a patient is referred to hospital, for example for surgery, there is a reply from the hospital, as well as a letter sent with the patient when s/he returns to the clinic. There is also a taxi service contracted to run between the centre and the hospitals.”

Compare this with the situation as described below for a clinic in the rural part of Eastern Cape:

“It has not rained in Mount Frere in the former Transkei for many months and the rain water tank at the Mntwana clinic has run dry. A truck has brought water to the outlying village of Dangwana and filled up the clinic’s tank, but the water comes straight from the river and is too muddy for drinking or for using during procedures such as childbirth. The clinic has also run out of its supply of vaccines, but Sister Nqolobe comes down the road carrying a cooler box filled with new stock on her head. She has caught a taxi and fetched the stock from the hospital in Mount Frere. Unlike the

situation a few years ago, the clinic can now get the medicines it needs, but still has very little else in the way of facilities. There is no electricity, although promise is made to install them.”

While these may be extreme examples, they illustrate the complexity and diversity of health care delivery and nursing practice at primary level in South Africa. Yet, workloads and staff allocations are measured against the same yardstick, i.e. number of patients seen at clinic per day, regardless whether the nurses in question have to spend hours travelling to town to collect medicines, organising transport for women in labour and cleaning their clinic, or whether they can concentrate on their core nursing duties in a well functioning PHC system.

2.4.2 PHC workload and utilisation calculator: health care 2010

Recently a PHC workload and utilization calculator was developed (Department of Health: Health care 2010) to determine the staffing of facilities. Key variables used in the calculator are utilisation rates and workload variables such as:

- The direct patient care factor which is the percentage of time spent in direct contact with patients.
- Minutes per consultation per category of staff.
- Number of contacts of a patient with health workers at different service points during one visit to a facility. This is particularly important as a patient may have multiple contacts with health personnel e.g. doctor or clinical nurse practitioner, member auxiliary services, pharmacy, etc during one visit to a facility, therefore it is the number of contacts that determine the workload.

2.5. Framework for assessing PHC services

The assessment framework underpinning the study is drawn explicitly from the principles and objectives of the primary health care as enshrined in Alma Ata Declaration (1978). The framework will be used as a guide and compass for analysing the study and the findings. This includes:

- i. All communities should have access to health care services of adequate quality.**

The assessment on this principle will take into account the following:

- a. Reflection of an Integrated Comprehensive Package of Primary Health Care Services as required at Primary Health Care model.
- b. There should be availability of essential medication to patients.
- c. Availability of trained and experienced nurses, doctors and pharmacists.
- d. Distance serving area as compared to 6 km's radius propagated at Primary Health Care model.
- e. Availability of transport arrangements for the ailing patients to their respective homes.
- f. Waiting time and queues in order to access health care services.
- g. Primary Health Care facility should be in a healthy state conditions i.e. cleanness.

- ii. Nurses need additional knowledge and expertise in Primary Health Care service provision**

- iii. Communities should be involved in their own health care.**

Structures of governance, support groups and Community Health workers forums should exist and be broadly representatively by all relevant stakeholders.

- iv. There should be equity in resource distribution or allocations with priority given to those in need.**

v. **Availability of essential medicines**

It means the availability of basic medicines and medicines for chronic illnesses.

vi. **Services should focus on prevention.**

This refers to information sharing sessions, education and training, posters and pamphlets, and availability of protection items.

The framework will be used to assess the overall study and utilised as the compass for soliciting information.

2.6. Summary of the chapter

The chapter began with conceptualisation of the two key concepts of the study. These two key concepts are Decentralisation and Primary Health Care which are considered by the study as interrelated. Decentralisation and Primary Health Care are viewed as ideal mechanisms to achieve greater equity and efficiency, greater involvement of and responsiveness to communities, reduction in size of bureaucracy and greater coordination between social sectors.

In terms of conceptual approaches, the chapter argued that health care service provision in South Africa takes place in an enormous complex and diverse socio-economic context and conditions. The underlying social and economic factors such as poverty, unemployment, decent housing, illiteracy, lack of access to adequate diets and sufficient clean water and sanitation have impacted on health status of the country.

On general issues highlighted in the literature survey, the aspect expresses the importance of Nurses with skills and experience in Primary Health Care service provision. It argued that workloads and staffing norms should not necessarily based numbers but nurses with required expertise in PHC. At the end of the chapter, the framework for assessing Primary Health Care services that is based on principles and objectives of PHC was drawn. The framework will be used as

the basis to assess, by checking the compliance with these principles and objectives, the PHC service provision in the Khayelitsha Community Health Centre.

With these general reviews and conceptualisations of PHC discussed in the chapter, we can now describe the actual sample and its characteristics. The next chapter will provide how Primary Health Care service provision is undertaken in the Community Health Centre.



CHAPTER 3: CASE STUDY OF PRIMARY HEALTH CARE SERVICES IN KHAYELITSHA

3.1 Introduction

In the previous chapter the key principles and objectives of the PHC were identified and an analytical framework for analysing primary health care was outlined [see chapter 2]. This chapter focuses on the Case study by recording the Primary Health Care current practices and service provision in Khayelitsha Community Health Centre during the period (1996-2009).

The chapter is organised into the following aspects. After the introductory aspect, the second aspect provides the descriptive background and profile of Khayelitsha, which will be done in terms of considering the case study conducted by the School of Public Health, UWC (2000-2002). The third aspect provides context and discusses in general the Primary Health Care service provision in the Khayelitsha Community Health Centre. The fourth and last aspect provides a framework complying with the norms and standards of Primary Health Care before summarising.

3.2 Background and profile of Khayelitsha

Khayelitsha, a large black township located in Cape Town was established in 1983 to cater for the increase in the overflow of squatters from other townships in the Metro (City of Cape Town, 2003). It is significant to note that various researchers have made contribution in this regard and estimations provided about Khayelitsha population vary. For example, the study conducted by the University of the Western Cape, School of Public Health (2004), estimated Khayelitsha to have a population at between 350 000 and 900 000. According to the study (2004), the population of Khayelitsha is estimated to be 12% of the total population of Cape Town. The study express that the average household size is 5.6 people/residents and 80 % of the population live in shacks while only 20%

live in formal housing. Khayelitsha is an area of multiple problems regardless of measures used.

Stern, R. Mokgatle, M.J. & Mayosi, B (2004) reiterates this fact as they described Khayelitsha amongst the worst areas in terms of social and economic problems in Cape Town and arguably, in the country as a whole. They argued that “only 36% of adults in Khayelitsha have some form of paid work, and where employment does exist, it is very insecure. More than half the households (52%) generated no income from wages at all, and two thirds of wage earners did not earn enough to push their households above the poverty line. Many have moved to this township from other provinces in particular from the Eastern Cape seeking employment, although opportunities are scarce. Subsequent to the existing socio economic predicament in the area, many people depend on social grants for their survival. The rates of violent crimes in the area are also disproportionately high”.

It is very important to note that the understanding of poverty varies depend on how one view it. According to an interview (18 May 2007, 17:00) conducted with an old single mother called Mamqwathi about her understanding of poverty. She explains that in her opinion, “*poverty means to sleep on an empty stomach, and wake up the next morning not knowing where and when my next meal is going to come from*”.

This is the kind of a situation that the majority of the people in Khayelitsha find themselves living under. Mbeki, T. (2001), acknowledged the existence of these social ills in Khayelitsha. He identified the area as one out of eight urban areas to be considered as Urban Node, so that it can be prioritised in terms of service delivery and budgets from the government. Great improvements in terms of development have been witnessed in the area. Many people have access to clean water, and many houses have been built and electrified. However, many informal settlements still exists, unemployment and poverty persists.

3.3 Context and PHC service provision in Khayelitsha Community Health Centre

3.3.1 Context of Primary Health Care services in Khayelitsha CHC.

Khayelitsha Day Hospital is one of three Primary Health Care services centres existing in the area. It is the oldest of the three and the only one that opens at night but only for trauma or emergency cases. According to some informants, this Community Health Centre was established in 1985. The other two community health centres, which are Michael M CHC and Nolungile CHC, were only established after 1994. There is no secondary or tertiary hospital currently existing in Khayelitsha. Khayelitsha Community Health Centre is situated at the centre (middle) of the township. The majority of people in the area rely on services from this public health institution for their health related needs. The reason for the embedment on this public hospital is due to the unemployment and poverty situation in Khayelitsha.

Stern, R. Mokgatle M.J. & Mayosi, B. (2004), expressed that the above mentioned living conditions inevitably have serious impact on the rates of diseases in the area. Typically, overcrowding and poverty give rise to diseases such as diarrhoea and parasitic diseases, tuberculosis and sexually transmitted diseases. They also give rise to family disintegration with increased violence, and abuse of women and children

According to Scott, V & Reagan, G (2003), 80% of the population in Khayelitsha live in shacks, 43 infants die for every 1000 live births. They expressed that most of these deaths are preventable, resulting from diseases such as HIV/Aids (22%), diarrhoea (13%) and pneumonia (12%). This article reiterated that the unemployment in this area is vastly higher than in other areas

3.3.2 Primary Health Care Service provision in Khayelitsha CHC

This section records the existing PHC practices and programmes that are currently underway. Discussions with staff personnel which include Senior Professional Nurses, a doctor and Senior Administration Clerk had shown that they had a clear

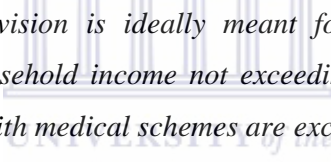
understanding of operations, programmes and practices of PHC in Community Health Centre. What they were concerned with, primarily, was the need for improved conditions of service as a means of resolving the problem. Their general complaint was mainly on shortages of staff, which include nurses, doctors and pharmacists. The main idea for the discussion with them was to get an understanding of operations, programmes and practices of PHC that are undertaken in the Community Health Centre.

In terms of programmes that are available in the Centre, a list of comprehensive Primary Health Care services rendered was provided. It is important that the very same list also displayed at the entrance in local languages. These Comprehensive Primary Health Care Services provision include immunisation, communicable and endemic diseases prevention, maternity care, screening of children, Integrated Management of Childhood Illnesses (IMCI) and child healthcare, health promotion, youth health services, counselling services, taking care of chronic diseases of older persons, rehabilitation, accident and emergency services, family planning, and oral health services. Sister in Charge, Ms 'J' indicated that "this Community Health Care renders health care services based on primary health care principles and objectives as required at primary health care model".

In terms of clinics in operational at the Centre, from observational point of view, a total number of 27 clinics were acknowledged. All these clinics which are also displayed at the entrance of the Community Health Centre are functional. Each clinic displays the patients' rights charter and patient responsibilities at the entrance in local languages. Clinics in operational include: Trauma or Emergency Unit; X- Rays; Physiotherapy; Occupational therapy; Pharmacy; HIV Clinic; Disability grants; INR clinic; Antenatal clinic; Postnatal clinic; Maternity obstetric unit; Child Health Clinic; Curative services; Eye clinic; Oral health; Social worker; Sexual and Reproductive Health; Health promotion; Community Based Care; Chronic Disease Care; Counselling; School Health; Women's Health; TB Clinic; Mental Health; Orthopaedics; ARV Clinic

In terms of Primary Care practices, two respondents who were Senior Professional Nurses indicated that Primary Health Care Nurse Practitioners are the backbone of health care service provision in the Centre. This according to them does not necessarily mean that the other health care practitioners, in particular doctors are not important in the primary health care set up. Most patients visiting PHC clinics are treated mainly by PHC- trained nurses, and those presenting some serious complications, by doctors. Those patients with complications that cannot be treated at PHC level are referred to secondary and tertiary hospitals such as JG Jooste Hospital, Groote Schuur Hospital, Tygerberg Hospital or Karl Bremer Hospital for higher levels of care”. *Sister- Dyasi and Sister- Poni.*

Further expression was also been made by another Senior Professional Nursing sister. She expressed that



“PHC service provision is ideally meant for patients who are unemployed or household income not exceeding a certain amount per month. Those with medical schemes are excluded from free PHC services catered for the poor. The socio-economic conditions in the area compelled the people in surrounding communities to make this Community Health Centre, their first stop for health care services. Complaints about shortages of staff, in particular doctors, nurses and pharmacists etc, were made”. Sister Kamvashe.

In terms of operational hours and administration activities, a respondent who was Senior Administration Clerk at the time, indicated that the Community Health Centre has two divisions. These divisions include the Day Care Unit that opens between 7 am- 16h00 pm, and the Maternity Unit that opens 24 hours per day. The existence of a Night Care Unit was acknowledged, but expressed that, it serves the trauma or emergency cases only. It is very important to note that closing time has been extended from 16h00 pm to 19h00 since 2009. In terms of the number of healthcare practitioners and patient’s intake per day, she expressed that “the CHC has a total number of 8 doctors, 56 nurses, 2 pharmacists and only

1 physiotherapist. This number of healthcare practitioners is serving a total number of patients' admissions' revolving from 600 to 780 per day". Ms Yamkela.

Ms Yamkela also explained procedures and processes for admitting patients in the Community Health Centre. She indicated that, *first-time visitors to the hospital are asked to fill out a form and a folder will be opened for the patient. Patients are advised to bring their Identity Document Book for registration purposes. A referral letter from other hospitals especially when the patient is a chronic case is required when visiting the Community Health Centre. The Community Health Centre asks for your most recent payslip/ income assessment (IRP5), to working people. You are asked to bring your Community Health Centre card if previously registered at the centre. Primary Health Care services are free, but there is a cost involved when visiting the hospital and this is based on how much you earn and on how many dependents you have, according to the hospital rating scale (telephonic interview, 5 March 2008. 13:00).*

Based on the my observations, the distance serving areas for the Day Care Unit coincides with the 5km radius required at PHC Model. The Night Care Unit does not meet the required 5km radius. The Night Care Unit is the only one servicing the whole community of Khayelitsha. Other Community Health Care Centre existing does not have night care units. In terms of safety in the CHC, the presence of security guards in the main entrance, as well as inside the building has been acknowledged. Random Searches are conducted at entrance points and exit points by security guards. It was noticed that the Community Health Centre is not taking responsibility for the transportation of patients for Day Care Services, Night Care Services or Maternal Care Services.

From the observation point of view, the Community Health Care Centre has a total number of 27 clinics. All these clinics which are also displayed at the entrance of the Community Health Centre are functional. Each clinic displays the patients' rights charter and patient responsibilities at the entrance in local languages. Clinics in operational include: Trauma or Emergency Unit; X- Rays;

Physiotherapy; Occupational therapy; Pharmacy; HIV Clinic; Disability grants; INR clinic; Antenatal clinic; Postnatal clinic; Maternity obstetric unit; Child Health Clinic; Curative services; Eye clinic; Oral health; Social worker; Sexual and Reproductive Health; Health promotion; Community Based Care; Chronic Disease Care; Counselling; School Health; Women's Health; TB Clinic; Mental Health; Orthopaedics; ARV Clinic.

a) Prevention and management of chronic diseases

From the observation point of view, the Community Health Centre staffs are doing their best in terms of prevention and management of chronic diseases. Prevention of diseases is done by educating people about the benefits of healthy lifestyle. The Community Health Centre has employed the Health Education Officer to conduct health education to patients.

In terms of management of chronic diseases, various suitable systems were acknowledged. It was noted that every clinic has a staff member who has the skills to diagnose and manage chronic conditions from young to elderly patients. Patients are able to see the same nurse for repeat visits if they come regularly on the diabetes, hypertension or asthma clinic day. They are given a special card or sticker on their folder and this is used to ensure continuity of care. Counselling and compliance are also part of the service. Medical practitioners undertake periodic visits to clinics to review chronic disease patients. Arrangements are made by the clinic to minimise patient travel (especially by the elderly) by prescribing supplies of drugs to last one to three months. Nurses often facilitate the initiation of clubs and special support groups for people with chronic illnesses. In this way a patient can get more information on special care and health education pertaining to their condition. If complications arise, patients are referred to the next level of care. Patients with chronic diseases are assisted with getting social service grants if they need them. In addition to this, the Community Health Centre has someone who is employed as health educator.

b) Communities should be involved in their own health care

One of the key principles of Primary Health Care is the involvement of communities in their own health care. In terms of community involvement, the existence of Health Committee in the Community Health Centre has been acknowledged. The Health Committee constitutes members of the Hospital management and members of the community. According to anonymous Nursing sister, 'sister Koester', *“the duty of the Health Committee is to ensure that there is a smooth running in the public health institution, and by so doing involving community members to participate in the development of health policies and participate in decision-making on matters affecting their health”*.

It is expected that those representatives of the community got elected to Health Committee have at least qualifications and expertise in the field health. The qualifications and expertise in the field of health may assist these community representatives to influence decisions taken in the Health Committee as well as the promulgation and implementation of policies. According to one respondent, representatives of the community comprises old men and women with absolute no knowledge of health issues.



3.4 Framework complying with core norms and standards

The PHC Package contains a detailed comprehensive package of essential primary health care services that must be made available. The package describes all necessary components, and sets of norms and standards that need to be made available. These norms and standards are largely derived from existing policies of the Department of Health, and other authoritative sources such as World Health Organisation (WHO). Based on the Primary Health Care Package for South Africa, all PHC Centres are obliged to comply with it (White Paper on Transformation of Health Sector, 1997). The White Paper on Transformation of Health Sector (1997) defines norm and standard. A Norm is defined as “statistical normative rate of provision or measurable target outcome over a period of time”. A Standard is defined as “a statement about a desired and acceptable level of health care”.

Based on the observation made, all health clinics and at the entrance of the Community Health Centre, information conforming to the norms and standards of health care is displayed. These are aimed at making possible for individuals visiting the Centre to see what quality of primary health care services they can expect to receive. These are also supposed to act as guidance for the Community Health Centre to provide these services. All these endeavours are done in order to subscribe with the principles of PHC.

3.4.1. Basis for Standards

a) Batho Pele Principles and Implications for Staff Members

Access to decent public services is the rightful expectation those previously disadvantaged. Communities are encouraged to participate in planning services to improve and optimise services delivery for the benefit of the people who come first. The standards contend that all communities will know from displayed posters about the eight principles of Batho Pele, which are:

- i. *Consultation*: Communities will be consulted about the level and quality of public services they receive and where possible will be given a choice about services offered.
- ii. *Service Standards*: Citizen would know the level and quality of public service they are to receive and know what to expect.
- iii. *Access*: All citizens have equal access to the services to which they are entitled.
- iv. *Courtesy*: Citizens should be given full accurate information about the public service they are entitled to receive.
- v. *Openness and Transparency*: Citizens should be told how national and provincial departments are run, how much they cost and who is in charge.
- vi. *Redress*: If the promised standard of service is not delivered they should be offered an apology, an explanation and an effective remedy, when complaints are made, citizens should receive a sympathetic positive response.

- vii. *Value for Money:* Public services should be provided economically and efficiently in order to give citizens and communities the best possible value for money.

Implications for health staff members

In line with these principles the local health services is expected to provide the following: Service with a high standard of professional ethics; A missions statement for service delivery; Services which are measured with performance indicators displayed, so community can understand the level of achievement; Services which are in partnership with or complement other sectors e.g. the private sector and non-governmental organisations and community based organisations; Services which are customer friendly and confidential; Opportunities for community consultation; Types of outreach which can reach to all communities and to families in greatest need; Easily accessible and effective ways of dealing with complaints or suggestions for improvement; Current information on services available and hours of service, staff changes of movements and extra activities such as health days.

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b) Patient's Rights Charter and Patient's Responsibilities

- i. Each clinic displays the patients' rights charter and patient responsibilities at the entrance in local languages.
- ii. *The twelve patient's rights are observed and implemented.* These rights state that patient has the right to: A healthy and safe environment; Access to health care; Confidentiality and privacy; informed consent; Be referred for a second opinion; Exercise choice in health care; Continuity of care; Participation in decision making that affects his / her health; Be treated by named health care provider; Refuse treatment and; Knowledge of their health insurance/ medical aid scheme policies; Complain about the health service they receive.
- iii. *The ten patient's responsibilities are displayed alongside the patient's rights charter. These include:* Living a healthy lifestyle; Care and protect the environment; Respect the rights of other patients and health staff; Utilise the health system optimally without abuse; Know the health

services available locally and what they offer; Provide health staff with accurate information for diagnosis, treatment, counselling and rehabilitation purposes; Advise health staff on his or her wishes with regard to death; Comply with the prescribed treatment and rehabilitation procedures; Ask about management costs and arrange for payment; and, Take care of the patient carried health cards and records.

- iv. There is provision for the special needs of people such as a woman in labour, a blind person or a person in pain.
- v. Services are provided with courtesy, kindness, empathy, tolerance and dignity.
- vi. Information about a patient is confidential and is only disclosed after informed and appropriate consent
- vii. Informed consent for clinical procedures is based on a patient being fully informed of the state of the illness, the diagnostic procedures, the treatment and its side effects, the possible costs and how lifestyle might be affected. If a patient is unable to give informed consent the family is consulted.
- viii. When there is a problem the health care user is informed verbally of the health rights charter with emphasis on the right to complain and the complaints procedures is explained and handed over.
- ix. The clinic has a formal, clear, structured complaint procedure and illiterate patients and those with disabilities are assisted in laying complaints.
- x. All complaints or suggestions are forwarded to the appropriate authority if they cannot be dealt with in the clinic.
- xi. A register of complaints and how they were addressed is maintained.
- xii. The name, address, telephone number of the person in charge of the clinic is displayed.

3.4.2. Basis of Core Norms

- a) The clinic renders comprehensive integrated PHC services using a one-stop approach for at least 8 hours a day, five days a week.
- b) Access, as measured by the proportion of people living within 5km of a clinic, is improved.

- c) The clinic receives a supportive monitoring visit at least once a month to support personnel, monitor the quality of service and identify needs and priorities.
- d) The clinic has at least one member of staff who has completed a recognised PHC course.
- e) Doctors and other specialised professionalised are accessible for consultation, support and referral and provide periodic visits.
- f) Clinic managers receive training in facilitation skills and primary health care management.
- g) There is an annual evaluation of the provision of the PHC services to reduce the gap between needs and service provision using a situation analysis of the community's health needs and the regular health information data collected at the clinic.
- h) There is annual plan based on this evaluation.
- i) The clinic has a mechanism for monitoring services and quality assurance and at least one annual service audit.
- j) Community perception of services is tested at least twice a year through patient interviews or anonymous patient questionnaires.

These norms and standards are expected to assist staff members to assess their own performance and that of various health clinics. There is an assumption that Community members or patients of the Community Health Centre are able to see the range and quality of services to which they are entitled. The Community Health Centre may also use these as a planning guideline to assess the unmet needs of the community and draw up plans to bring services up to national standards.

3.5 Summary of the chapter

Basically, the chapter presented a descriptive background and profile of Khayelitsha. Complex and diverse social and economic challenges existing in the area were revealed. Furthermore, the chapter provided the context and recorded the Primary Health Care practices and service provision in the Community Health

Centre. At the end of the chapter, a framework complying with the norms and standards of Primary Health Care was tabled.

With this descriptive background, context and recording of Primary Health Care service provision provided in the chapter, we can now see what facilitates and constraints service delivery. The next chapter will identify and analyse findings.



CHAPTER 4: RESEARCH FINDINGS AND ANALYSIS

4.1 Introduction

The previous chapter recorded PHC practices and service provision in the Khayelitsha Community Health Centre. This chapter identifies and analyse the factors that facilitates and constrains the provision of primary health care services in the Khayelitsha Community Health Centre.

The chapter is organised into the following main aspects. After the introduction, the second aspect provides and discusses healthcare services provision in South Africa in pre and post 1994. This aspect reveals how the policies of the post 1994 democratic government attempts to shape the lives of the ordinary citizens with regard to health services. The third aspect thoroughly discusses some key principles of the primary health care identified in the chapter two. The fourth and the last aspect discusses key lessons of the Primary Health Care service provision from international experiences, before summarising.



4.2 Health care service provision in South Africa pre and post 1994

4.2.1 South African health experiences pre 1994

Before 1994, the vast majority of the South African population has experienced either a denial or violation of fundamental human rights, including rights to health care services. According to the United Nations Development Report (2000), the health care system was highly fragmented and bureaucratic that provided health services in a discriminatory manner. Health care service provision for Whites was far better than those for Blacks, irrespective of the geographic area in which someone lives. Health care service provision which included the allocation of resources was conducted along racial lines. Venter .R (1990), reiterated that there were shortages of 7000 beds in black people's hospitals and a surplus of 11 700 beds in white people's hospitals. In all the literature reviews conducted for the

particular purpose, revealed that Primary Health Care was neglected before 1994. For instance, Ntsaluba and Pillay (1998) contend that the expenditure on tertiary health care services was prioritised above Primary Health Care services.

In nutshell, the evidence on the history of South Africa's health service provision before 1994, clearly suggests that health services in general, in particular for black people were neglected. Subsequently, the accessibility to Primary Health Care services was very minimal.

4.2.2 South African health experiences post 1994

After 1994, the democratic government began its transformation of the health sector with the decision to create a unified but decentralised national health system based on the PHC model. Policies and legislative imperatives were promulgated and implemented that guide virtually every facet of the public sector. According to Tshabalala-Msimang, M (2005), complete overhaul of health care system was unavoidable immediately after 1994. The main intention was to ensure that health care services are generally accessible by all people, in particular the poor.

Access to health care services by all

Since 1994, access to health care services was made a constitutional mandate by the democratic government in South Africa. The Constitution (Act 108 of 1996) places an obligation on government to ensure that all South Africans have access to health care services. The right to have access to health care services, including reproductive health care by all people of South Africa is guaranteed in the Bill of Rights, which is contained in Chapter 2 of the Constitution. Constitution became the foundation of all policy documents and legislations that were promulgated and implemented since 1994. The intention is to ensure that everyone has access to health care services.

The White Paper on the Transformation of the Health System in South Africa (1997) mandated the implementation of a unified but decentralised national health system based on Primary Health Care model. Primary Health Care was seen as the key element in the plan to transform health care services. Expectations were that, the policy will yield greater equity and efficiency, greater involvement of and responsiveness to communities, reduction in size of bureaucracy and greater coordination between social sectors. The White Paper (1997), lays out the vision, mission and goals of the Department of Health for the transformation of health system in South Africa.

Another important piece of legislation became the Health Sector Strategic Framework in 1999. The framework contained a comprehensive Primary Health Care Package of services that needs to be made available in all primary health care institutions. Significant components and sets of norms and standards are made available and reflected in the document. The intention was to ensure that accessibility to Primary Health Care services is not compromised, available to everyone in all Community Health Care Centres.

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There are many other legislations and policy framework that guarantees the right and accessibility to health care services. The following Acts and related regulations, apply to accessibility to health care services;

- The National Health Bill (2002)
- Primary Health Care Plan 2010

All these policies and legislations mentioned above, and some that may not be mentioned were intended at ending the legislated racial discrimination and prejudice. In addition, the aim was to create a health care service provision which subscribes to the principles and objectives of the Primary Health Care. Although these policies and legislations had succeeded in ending racial discrimination and prejudice in health, but many other problems still not resolved.

4.3 The perspective of the recipients against key principles and objectives of PHC

Results and findings are drawn from perspective of patients and nurses interviews, direct observation and concerns on primary health services gathered from print and electronic media. Some of these recipients are regularly users; others were participated with a view to highlight the obstacles in pursuit of better primary health care services in Khayelitsha Community Health Centre. The perspectives of patients, nurses and doctors as well as concerns from media were measured against the framework created for assessing PHC services identified in chapter 2. The framework is based on the principles and objectives of Primary Health Care.

i. Access to health care services of adequate quality by all communities

In terms of accessibility to primary health care services, results and findings are mixed. In generally, from the observational point of view, there has been a great improvement in accessibility to health care services since 1996. For instance, the comprehensive package of Primary Health Care services has been implemented. Secondly, the distance serving areas of the Community Health Care is within the 5km radius as required in primary health care model. Thirdly, the PHC services are provided for free of charge to poor people. Fourthly, the closing times in the Community Health Centre have been extended from 16:00 pm to 19:00 pm. Fifthly and lastly, the facility is in a healthy state condition in terms of cleanliness. Due to unemployment and poverty in the in Khayelitsha, the majority of people depend on the Community Health Centre for their health needs.

However, the evidence suggests that the increased access to primary health care services did not translate into better health outcomes. The Community Health Centre still faced with significant challenges with respect to quality of health care services provided. Key weaknesses were identified. These weaknesses include long queues and overcrowding in the Centre. Queues of patients were seen at the entrance as early as 04:00 am in the morning, although the centre opens at 07:00 am. The African National Congress (2008) acknowledged the progress made and the challenges experiencing in terms of improving the quality of primary health care services in South Africa. It contends that improving access to quality

healthcare services remains a key national priority. The statement argued for more investment towards primary health care services.

Quality of health care services according to the recipients

Predictably, there was unanimous dissatisfaction with the quality of primary healthcare services in the Community Health Centre. There were many reasons given for the poor quality of health care services. Respondents who are nurses and doctors complained about shortage of staff and better working conditions. According to them, these health care practitioners were resigning in the centre in search of greener pastures in Europe, and some left for private sector employment in South Africa. They contend that those who resigned and those who passed away were not been replaced accordingly. Although these concerns may be true, but the scenario cannot entirely only be blamed on the Centre. It is well known that the private sector medical companies are remunerating much better than the public sector. Another important aspect to acknowledge is the power of a dollar, euro and pound versus the rand. The culture of materialism bedevilling our society cannot be blamed on staff personnel such as nurses, doctors and pharmacists, but to the society as a whole.

Although these assertions of nurses and doctors may be true, however, this was not necessarily the case to patients. All respondents who were patients, complained about nurse's negative behaviour towards patients. For instance, Mhlekazi said: *Staff members of the health centre seem to be a law unto themselves. They don't care about the people and are not dedicated to their jobs. He appealed to the Department of Health to monitor the health centre in Khayelitsha. He suggested that if the department of health is experiencing some financial constraints it should rather contact the residents in the community and come up with solutions to the problems*

Another respondent suggested that the community health centre should have more doctors, pharmacists and nurses. She complained that patients still have problems such as long queues and have to wait long hours. Patients watch television while

waiting for a doctor. Nurses were accused for helping people who come late and attend to those who come early at a later stage. They were blamed for not doing things in an orderly fashion. “Some don’t wait as long as others do”.

In terms of medical treatment, some recipients complained that doctors and nurses were no longer actually touched patients while examining them, and instead simply asked questions. Complaints about the quality of medications were mixed. Some were satisfied and some not. One recipient complained that one time he to wait for very long hours, only to received a single pack of panado. Based on my observational point of view, concerns raised by patients and staff were not surprising. The community health centre was overcrowded beyond its capacity. The social and economic factors of the community are contributing negatively to the situation.

May be the community health centre is indeed facing a serious shortages of staff. Based on information from newspaper on health services, the shortage of nurses, doctors and pharmacists contributes negatively in terms of the provision of quality health care services. For instance, it is simply not feasible for a single pharmacist in a public community health centre to provide good quality services when, as they are, servicing many hundreds of patients every day. According to Craig, H. (2004), healthcare centres in the province, in general experiences shortages of staff. He noted that the Department of Health have in total 9500 nursing posts throughout the province. Of these about 1700 are unfilled.

Another interview was conducted with anonymous principal medical practitioner about the conditions in the health centre. The principal medical practitioner contends that health clinics are severely understaffed and many lack even the most basic medicines. The scaling back of curative services in favour of the primary health care has put public hospitals under severe strain. He stated; “*We have fewer doctors, nurses and fewer resources and more patients than ever before*”.

There were also comments about the lack of available transport arrangements for the ailing patients to their respective homes. Respondent complained that although the closing time at the centre has been extended to 19:00 pm, but the centre does not provide transport for ailing patients going back home. Walking on the street at night back home made them vulnerable to thugs. This concern may have truth in it taking into consideration the social and economic ills of the Khayelitsha.

ii. Nurses need additional knowledge and expertise in Primary Health Care service provision

Nurses are the backbone of the primary health care services in the Community Health Centre. This does not necessarily mean that other workforce members, such as doctors in particular, are unimportant. Doctors also have an important role to play as they look at cases of serious nature. Nurses are more important because the majority of patients visiting the community health centre suffer from common diseases that could mainly be treated by them without doctor interference. In order for them to provide optimal services to patients, they need additional knowledge and competencies in the physical, social, psychological, and cultural aspects of health.

However, evidence suggested that not all nurses were trained in Primary Health Care. The exodus of experienced nurses to Europe, and private sector are not being replaced in the same manner. The Community Health Centre cannot solely be blamed for this. In South Africa in general, the most valuable and scarce resource in the health sector is that of experienced health professionals. Those trained in PHC carry extra workload. Doctors had to examine huge numbers of patients, to avoid turning the back home. Under the situation, the quality of health care service may be compromised in favour of quantity. This view finds resonance in the arguments of respondents. They complained that doctors and nurses were no longer actually touching patients while examining them, and instead simply asked questions.

iii. Communities should be involved in their own health care services.

One of the key principles of Primary Health Care is the involvement of communities in their own health care services. Structures of governance, support groups and Community Health forums should exist and be broadly representatively by all relevant stakeholders. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

Based on observational point view, Khayelitsha has established a Health Committee Forum broadly represented by all stakeholders since 1994. In addition to this structure, the Community Health Centre has its own health committee. The Health Committee is expected to ensure that there is a smooth running in the public health institution and by so doing involving community members to participate in the development of health policies and participate in decision-making on matters affecting their health. Expectations were that, officials representing the community from the Health Committee should have at least qualifications or expertise in the field health management.

However, the evidence defeats the intentions of this principle. Representatives of the community comprises old men and women with absolute no knowledge of health management. The majority of them were illiterate. Should these committee members have qualifications and expertise in the field of health may have influence in decision makings. Feedback is not been given to the community. The umbrella health committee forum also seemed to be failing to monitor and give directions to the Community Health Centre. Communities have been misrepresented and their interests compromised.

iv. There should be equity in resource distribution or allocations with priority given to those in need.

This principle is addressed in generally, in the context of South Africa and not specifically based on the particular Community Health Centre. Although it does not specifically deal with this particular centre, resolved to engage with the issue because the effect of inequity resource distribution impacts negatively to the

delivery of health services everywhere. Although progress had been made in terms of accessibility of health care services since 1994, the country still faced with a significant challenge with respect to equitable distribution of health care resources. The problem of inequality in resource distribution or allocation between public health sector and private health sector are splashed across the front pages of newspapers. For instance, McIntyre (2009) argued that South Africa's healthcare services are badly skewed, with the bulk of spending serving a minority, rather than those in need. The division is between those with medical aid and those who have not. She expresses that from 1996, government spending on health care did not keep pace with inflation and population growth. It was only in 2005 that spending levels on public health returned to 1996 levels. Health budgets have increased in recent years, but the years of severe underfunding had taken their toll on morale of the staff and on buildings and medical equipment that could not be maintained.

While the public health sector in South Africa has been drained of financial and human resources, the private sector has seen massive increases in funding. For example, Mkhize, Z. (2010) reiterated that in 1996, spending on medical aid scheme members was about 3.5 times greater than that spent by government per person dependent on public sector services. This gap had increased to nearly six times greater spending by medical schemes by 2006. What is important to note is that although medical aid schemes account for well over 40 percent of health care funds, they only benefit 16 percent of the population. This means that in reality, those who have the greatest need for health care do not get their fair share of benefits from using health services.

v. Availability of essential medicines

In terms of accessibility of medicines, respondents provided mixed findings. All respondent had acknowledged that chronic illnesses are provided with adequate medicines. Patients with chronic illnesses are issued with bulk of medicines that could sustain them for a month or two. For this, the community health care should be applauded. However, for patients with no chronic illnesses respondents projected opposing evidence. For instance, all respondents noted that the health

centre does not issue cough mixture for patients. They contended that Panado tablets are used as panacea. They argued that the centre was failing them for not issuing a basic medication such as cough mixture. A regular patient of the health centre reiterated that “When we ask for cough mixtures, we are shown guidelines on how to prepare a DIY (Do -It- Yourself) cough mixture. Sometimes someone has had to return to the hospital for an item on back order as the items prescribed are out of stock”. Based on my observational point of view, this is not always the case. Some patients with three to four packets of tablets were seen. These patients were not chronic patients.

vi. **Services should focus on prevention.**

From the observational point view, services are focusing on prevention. For example, the Community Healthcare Centre renders family planning clinic. Condoms are available for free of charge. The centre employed an official responsible for educating patients for lifestyle living. Documents with information on diseases are available at the entrance notice boards and walls plagued with posters. Education information clinics are undertaken almost every day. However, the people continued to be infected by diseases like HIV/AIDS. The Community Health Centre cannot be solely blamed for this. Communities should change their attitudes and behaviours and begin to take responsibility as well for their sexual activities.

4.4 Key lessons of the PHC service provision from international experiences

Primary Health Care is inevitable an ongoing learning experience. In South Africa, the focus on Primary Health Care started in 1996. Although it started 14 years ago, but the impact and interest is disproportionate high. Many lessons have been learnt during the implementation of the PHC, about process of community involvement and shortages of human resources such as nurses, doctors and pharmacists. Primary Health Care service provision in South Africa can learn many things from Cuban health system in this regard. In South Africa, the involvement of communities has not been given high priority, and the production

of more health professionals such as nurses, doctors and pharmacists also not given priority.

Contrary to South Africa's Nurse base primary health care model, Cuba's mainly physician (doctor) type of health care model remains the shining example in terms of achieving the goal of 'Health for All'. In a literature review in chapter 2, Mahler, H (2000) expressed admiration for the Cuban model of focusing on primary health care and social welfare. Mahler, H (2000) contends that no country has been as consistent in taking measures towards achieving the goal of 'Health for All' as Cuba. He asserts that *"Cuba is a small Caribbean country which has achieved some of the best health indicators in all of Latin America and the developing world. It is a country which has virtually all requirements of primary health care"*.

Martinez, D (1997) explains reasons behind Cuba's Public Health system's successes. He states that *'Cuban indicators have been in the forefront because the country's organisation in the health field gives special importance to disease prevention and the promotion of health, and to participation by the entire community and all sectors, on the principle that health is not just absence of disease. All people, both as individuals and the collective, are responsible for it'*.

Martinez contends that another important reason of success could be found in Cuba's education system. The education for all, free education at all levels and priority to the development of human resources, tens of thousands of physicians (1 physician for every 174 inhabitants) and hundreds of thousands of nurses, technicians, and other professionals, express the priority given to this important sector of life.

The example of Cuba, a country which had taken people's welfare as a priority and not gone blindly for economic growth alone, should be emulated. South African should learn Cuban government best practices in primary health care service provision. It is even more relevant in the South African context because South Africa is a country in transformation. It is significant to learn in order to improve the primary health care service provision.

4.5 Summary of the chapter

The chapter provided mixed results and findings. Since 1996, accessibility to Primary Health Care service provision have been improved, however, this did not translate into health outcome. The Community Health Centre still faced with significant challenges with respect to quality of health care services provided. Shortages of staff such as nurses, doctors and pharmacists were identified as a key problem. The chapter concluded that while the public health sector in South Africa has been drained of financial and human resources, the private sector have seen massive increases in funding. In term of lessons from international experiences, Primary Health Care service provision in South Africa can learn many things from Cuban health system. These include in the area of involvement of communities and the production of more health professionals such as nurses, doctors and pharmacists also not given priority.

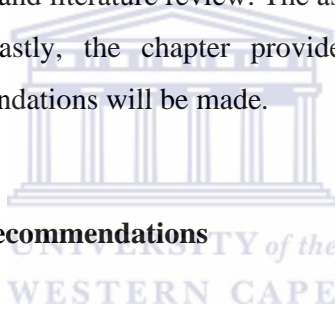
With these factors that facilitate and constrain the primary health care services provision identified and analysed in the chapter, we can now provide conclusions and recommendations. The next and last chapter will provide conclusions and recommendations.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The previous chapters provided an overview of an analytic framework and presented the case study as well as identified and analysed the factors that facilitates and constrains the provision of primary health care services in the Khayelitsha Community Health Centre. On the basis of evidence and experiences so far (chapter 2, 3 & 4), this chapter provides conclusions and recommendations.

The chapter is organised into the following main aspects. After the introduction, the second aspect draws together the main findings of the research and relate the to the research problem and literature review. The aspect also briefly discusses the policy implications. Lastly, the chapter provides pages with bibliography. Subsequently, recommendations will be made.



5.2. Conclusions and recommendations

5.2.1 Conclusions

In generally, the main findings of the research suggest that Primary Health Care has been a key feature of health sector transform in South Africa. Policies and legislations that were promulgated and implemented since 1994 had succeeded in ending racial discrimination and prejudice in health service provision but failed to turn around the inequality legacy. While the public health sector in South Africa has been drained of financial and human resources, the literature revealed that the private sector health sector has seen massive increases in funding. These experiences permeated to public health sector including Primary Health Care services. This scenario contributed negatively in lowering the quality of Primary Health Care services in all health care facilities. The solution to these experiences requires national intervention.

Main findings on Primary Health Care service provision in the Khayelitsha Community Health Centre were mixed. The delivery of quality Primary Health Care services to patients has always been one of the most challenging areas of service delivery for the Khayelitsha Community Health Centre. While great progress has been made and acknowledged in terms of accessibility of primary health services by the majority of people, the quality of Primary Health Care service provision still remained unsatisfactory.

5.2.2 Recommendations

On the basis of the key challenges and issues arising (chapter 3 &4), the following main recommendations are made.

In terms of improving quality health care services, the national government should take responsibility in this regard. It should invest more financial and human resources towards to Primary Health Care services. Necessary medicines should be made available. An additional Primary Health Care centre and a secondary hospital need to be built to accommodate ever growing population of Khayelitsha.

In terms of shortages of nurses, doctors and pharmacist, it is recommended that the retired nurses are recruited back to serve in Primary Health Care centres. Secondly, colleges for training nurses that were closed since 1996 are reopened. Thirdly, bursaries and incentives for students who want to become PHC nurses must be made available to encourage them. Fourthly, Studies and trainings for PHC nurses must be done at college level not at university level. Primary Health Care nurses should be paid better salaries.

In terms of doctors and pharmacists, more financial resources need to be allocated towards training new doctors and pharmacists. Bursaries and other monetary incentives need to be made available for studying towards these fields. Those who graduated towards these fields should be remunerated better in order to retain them in the primary health care service. This endeavour will solve the problem of

long queues and overcrowding by patients. Students should sign a contract stipulating years they are obliged to work in public health service. Students should be taught about the importance of serving in the Public Service.

In terms of community involvement, achieving health is dependent on the involvement of all sectors of the public ensure sustainable growth and development. Communities should be encouraged to participate in improving their own health, and in the health of the community through participating in structures such as health forums, health committees and on personal basis through local engagements. Community radio stations should also be utilised to encourage community participation in health issues. Members of health forums and health committees should be trained in health issues and management in order for them to play a meaningful role. Feedback should be given to communities by these elected representatives.



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APPENDICES

List of names used in the interviews are pseudonyms.

Anonymous Medical practitioner

Anonymous Patients X 6

Mamqwathi

Mhlehazi

Sister Dyasi

Sister Kamvashe

Sister Koester

Sister Nqolobe

Sister Poni

Ms Yamkela

Some authors used in terms of literature consultation

Dr. Carlos Dotres Martinez is the Minister of Public Health in Cuba. Master Plan of Investments in the Health of Cuba, Havana – September 1997.

Dr. Manto Tshabalala – Msimang is the Former Minister of Health in the Republic of South Africa.

Dr. Rina Venter, Former Minister of Department of Health Minister before 1994.

Dr. Zweli Mkhize is the chairperson of the African National Congress's National Executive Committee on health subcommittee.

Professor Di McIntyre is the South African Research Chair of "Health and Wealth", Health Economics Unit, University of Cape Town, Cape Times, June 18, 2009).

Professor Craig Househam is the Head of Department of Health in the Western Cape Provincial Government.

Ms Halfdan Mahler is former director-general of the World Health Organisation.

Mr. Thabo Mbeki is the former State President of the Republic of South Africa.

