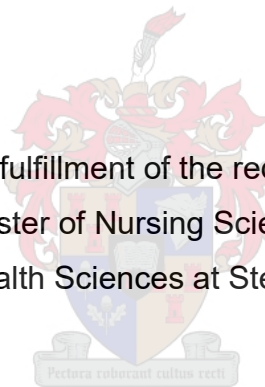


**PATIENTS' PERCEPTIONS OF PRIMARY HEALTH CARE SERVICE FACILITIES  
IN  
MITCHELL'S PLAIN, WESTERN CAPE**

**BY  
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Thesis presented in partial fulfillment of the requirements for the degree of  
Master of Nursing Science  
in the Faculty of Health Sciences at Stellenbosch University



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## DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or part submitted it for obtaining any qualification.

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## ABSTRACT

**Background:** A large percentage of the population in the Western Cape, living in disadvantaged communities, rely predominately on a Primary Health Care (PHC) delivery system for their health needs.

Despite progress legislation, that affords free health to the poor and vulnerable, and health reforms that ensure these rights, users of the PHC delivery system still face daily challenges of unmet needs. There is a sense of disillusionment with their perception of unfulfilled promises, lack of trust and a feeling of being marginalised, in favour of the private healthcare sector. PHC delivery and how it impacts on their health has a direct bearing on their health outcomes.

Listening to patients' perceptions of Primary Health Care services will not only provide insight into the gap between policy implementation and their experiences, but also provide patients with an opportunity to relay their concerns, expectations and fears.

**Method:** A descriptive qualitative research design, with the purpose to describe the perception of the study participants was used. Participants from two PHC facilities in Mitchell's Plain, Western Cape were invited to participate using a snowball networking sample. The participants were individually interviewed in a private setting away from the PHC facility.

A pilot interview was conducted. The aim of the pilot study was to refine the study sampling process and probe relevant responses from the participant, and to assist the researcher to lay aside any preconceived ideas.

Ethical principles, such as respect for the person, confidentiality and anonymity, beneficence and non-maleficence were maintained. Trustworthiness, consisting of credibility, transferability and dependability were applied throughout the study.

**Results:** Ten semi-structured one-on-one interviews were conducted in private areas away from the PHC facility. During the data analysis, themes emerged, pertaining to patient-centred care, participants' perception of healthcare providers at the PHC service facilities, participant's perception of PHC services and facilities, expectation and proposed solutions for improving PHC service delivery (see table 4.2.page 33).

With the expectations of a few participants, it has been found that the providers of the PHC were unhelpful, uncourteous and unprofessional. Gaps and barriers experienced in the PHC service delivery were highlighted, such as long waiting hours, fragmentation of service delivery, misinformation regarding medication delivery and appointments. Constructive suggestions on the improvement of the PHC service delivery and facilities were given.

**Conclusion:** This study provided a unique opportunity to listen to the PHC users' experiences and perceptions and the reality thereof. The participants highlighted perceived gaps and barriers in the PHC facilities and services and suggested possible improvements to the PHC facilities and services.

**Keywords:** Primary Health Care, Patient perception, Patient experience, Patient-centred care.

## OPSOMMING

**Agtergrond:** 'n Groot persentasie van die bevolking in agtergeblewe gemeenskappe wat in die Wes-Kaap bly, is hoofsaaklik afhanklik van 'n Primêre Gesondheidsorgstelsel se dienste vir hulle gesondheidsbehoefes.

Ten spyte van gevorderde wetgewing wat gratis gesondheidsdienste aan die armes en kwesbares verleen, en gesondheidshervorming wat die regte van die verbruikers van die Primêre Gesondheidsorgdienste (PGS) beskerm, staan verbruikers nog steeds daagliks die uitdagings van onbevredigende gesondheidsdienste in die gesig. Daar is 'n gevoel van ontnugtering weens onvervulde beloftes, 'n gebrek aan vertroue en 'n gevoel van marginalisering, met inagneming van die privaatgesondheidssektor. Die PGS diensverskaffing en die impak daarvan op die gesondheid van die verbruiker, het 'n direkte effek op hulle gesondheidsuitkomst.

Deur na die persepsies van pasiënte oor die Primêre Gesondheidsorgdienste te luister, sal nie alleenlik insig gee oor die gaping tussen beleidsimplementering en hulle werklike ervarings nie, maar ook geleentheid bied aan pasiënte om hulle besorgdhede, verwagtinge en vrese te deel.

**Metode:** 'n Beskrywende kwalitatiewe navorsingsontwerp met die doel om die ervarings van die deelnemers van die studie te beskryf, is gebruik. Deelnemers van PGS fasiliteite in Mitchell's Plein, in die Wes-Kaap is genooi om deel te neem aan 'n sneeubalnetwerk steekproef. Onderhoude is individueel met deelnemers in 'n private omgewing, weg van die PGS fasiliteit gevoer.

'n Loodsondersoek is uitgeoefen. Die doel van die loodsondersoek is om die steekproefproses van die navorsingstudie te verfyn, relevante response van die deelnemers te peil, en om die navorser te help om enige vooropgestelde idees ter syde te stel.

Etiese beginsels soos respek vir 'n persoon, vertroulikheid, anonimiteit, verootmoediging en skadeloosheid is eerbiedig. Geloofwaardigheid, geloofbaarheid, oordraagbaarheid en betroubaarheid is deurgaans toegepas.

**Resultate:** Tien ongestruktureerde onderhoude is een vir een met deelnemers in private areas, weg van die PGS fasiliteit gevoer. Gedurende die data-analise is temas geïdentifiseer wat met pasiëntgesentreerde sorg te make het; deelnemers se persepsies van die dienste

wat die PGS verskaf en die fasiliteite van die stelsel; hulle verwagtinge en voorgestelde oplossings vir die verbetering van PGS se diensverskaffing is bekend gemaak.

As gevolg van die verwagtinge van 'n paar deelnemers is bevind dat die PGS se diensverskaffers onbehelpsaam, onbeleefd en onprofessioneel is. Gapings en struikelblokke in die PGS dienslewering is uitgelig, soos lang wagtye, gefragmenteerde diensverskaffing, waninligting ten opsigte van medikasie-verskaffing en afsprake. Konstruktiewe voorstelle vir die verbetering van die PGS se diensverskaffing en fasiliteite is gegee.

**Gevolgtrekking:** Hierdie ondersoek het 'n unieke geleentheid verskaf om te luister na die ervarings van PGS verbruikers se persepsies en die werklikhede daarvan. Dit het ook geleentheid aan die deelnemers as PGS verbruikers gebied om hulle besorgdhede, frustrasies en opinies te lig om sodoende aktiewe deelnemers van die bestuur van hulle gesondheidsorg te word.

**Sleutelwoorde:** Primêre Gesondheidsorg, Pasiëntpersepsie, Pasiëntervaring, Pasiënt-gesentreerde sorg

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## ABBREVIATIONS

PHC	Primary Health Care
WHO	World Health Organization
DHS	District Health System
GDP	Gross domestic product
NHI	National Health Insurance
CD	Chronic disease(s)
NCD	Non-communicable disease
CVA	Cerebral Vascular Accident
CDU	Chronic dispensing unit
CDL	Chronic Diseases of Lifestyle
HIV/AIDS	Human Immune - deficiency virus/ Acquired immune deficiency syndrome

## CHAPTER 1: FOUNDATION OF THE STUDY

### 1.1 INTRODUCTION

A large proportion of South Africans rely on the public health sector for their health needs (Ataguba, Benatar, Doherty, Engelbrecht, Heunis, Janse van Rensburg, Kigozi, McIntyre, Pelser, Pretorius, Steyn, Van Rensburg & Wouters, 2012:482-484). The public sector in South Africa comprises of public hospitals and public health clinics. South Africa has adopted a Primary Health Care (PHC) approach (Kautzky & Tolman, 2008:18), which is regarded as a social justice philosophy and addresses the health needs of the poor and marginalized (World Health Organisation, 1978:5).

The perception of the patients' PHC delivery and how it impacts their views on health and illness has a direct bearing on health outcomes (Petrie & Weinman, 2012:60). The individual's views regarding this phenomenon are largely ignored or disregarded. This has resulted in feelings of dissatisfactions regarding healthcare services and personal feelings of disempowerment (Scheffler, Visagie & Schneider, 2015:9).

This chapter describes the rationale, research problem, research question, purpose objective and a brief outline of the methodology applied.

### 1.2 RATIONALE AND BACKGROUND

PHC is viewed as both a philosophy and strategy. As a philosophy, it has a strong development and empowerment aspect. It calls for radical change in both design and content (Dookie & Singh, 2012:2). As a strategy, PHC addresses the ways PHC services are organised and delivered (Ataguba *et al.*, 2012:484). It is the first point of entry into the healthcare system, bringing health care closer to the community (De Ryhove, 2012:2). It is more than primary care, primary medical care or primary curative care; it is a comprehensive approach to care and treatment specific to PHC (Dennill & Rendal-Mkosi, 2012:15). The comprehensiveness implies intervention based on scientific research and planning (Ataguba *et al.*, 2012:123).

At Alma Alta in 1978, the World Health Organisation (WHO) highlighted the essential needs and expectations of PHC delivery. It emphasised that PHC should be accessible to individuals, families and communities using society accepted methods and sustainable resources (WHO, 1978:60).

The WHO (2008:60-62) found that despite a government commitment to reforming PHC in Africa, comprehensive implementation of PHC delivery has not fully been achieved. They found that "the

lower structures are mere recipients of guidelines and instructions". This is largely due to the general lack of shared understanding of policymakers, health workers and the community at large (WHO, 2008:62). There appears to be distinct inconsistencies between policy formulation and implementation (Dookie & Singh, 2012:3).

South Africa is considered one of the world leaders in conceptualising the development of PHC (Magawa, 2012:2). This is largely due to a strong Constitution that guarantees the right of health for all and the protection of the vulnerable groups (Republic of South Africa, 1996). The National Health Act 61 of 2003 addresses inequity by ensuring free health care to women's productive health and children older than six years with moderate and severe disabilities, and stipulates the patients' rights (Republic of South Africa, 2003:18).

In a publication by the WHO (National health policies, strategies and plans), it was recommended that the health policies should be aligned to the real needs the community requires (World Health Organisation, 2011:1). Acceptance of these health policies and the implementation thereof rely on the perception of individuals and community gains within social and cultural norms (Allmark & Tod, 2005:461).

Historically, health care was driven by policy makers and professionals with little input from the end-users (O' Mara -Eves, Brunton, Olive, Kavanagh, Jamal & Thomas, 2015:2). However, validating the patients' experiences and considering the context in which the illness is experienced, can be the solution to paternalism in PHC (Pulvirenti, McMillan & Lawn, 2014:303-305).

**Personal experience** - The researcher's interest in the patient's experience in PHC services evolved from her personal and professional experience. She grew up in a previously disadvantaged community that predominantly relied on PHC services for the management of their communicable and especially non-communicable diseases. She was privy to stories of their experiences regarding the challenges they faced at the PHC facilities. The community constantly strove to make sense of their reality and their expectations. There was a sense of disillusionment with their perception of unfulfilled promises, lack of trust and a feeling of being marginalised in favour of the private healthcare sector.

As a registered nurse, the researcher was aware of the intention of legislation, policies and health reforms, to provide health service for all at community level. The plan for PHC in South Africa was to be a comprehensive service that respects the rights and culture of the patient and provide for the specific needs of the community (South Africa, 2000:9). The South African Patient's Rights Charter, is underpinned by the Constitution of South Africa and provides a framework for defending the rights of the patients and include amongst others, the right to be part of the decision making

regarding their health and treatment (Health Profession Council of South Africa, 2008:1-3). However, the challenges encountered in PHC service delivery includes lack of efficient management of health needs, delays in referrals to essential care, ineffective services and staff, and an unsafe and unhygienic environment (Adeniji & Mash, 2016:9).

The researcher was motivated to understand the patients' expectations, their subjective experiences and concerns regarding PHC services. Listening to the patients' lived reality provided an insight into the disconnection between policy implementation and experience. It also provided the participants with an opportunity to relay their concerns, expectations and fears.

### **1.3 PROBLEM STATEMENT**

The perception of the patient about PHC service delivery and how this impacts their views on health and illness has a direct bearing on health outcomes and how they utilize the PHC services. Yet, the individual's views regarding this phenomenon are largely ignored or disregarded. This has resulted in feelings of dissatisfaction regarding healthcare services and personal feelings of disempowerment.

It is recognised globally and nationally that patient participation and patient centredness is the cornerstone of PHC. However, very little attempt has been made to engage patients in meaningful dialogue and gain their views and concerns regarding PHC services, and the impact it has on their health and wellbeing.

### **1.4 RESEARCH QUESTION**

The study attempted to answer the following core research question:

What are the patients' perceptions of PHC services at PHC facilities of the Mitchell's Plain area, Western Cape?

### **1.5 AIM OF THE STUDY**

The aim of the research was to explore the patients' perception of PHC services at PHC facilities in Mitchell's Plain, Western Cape, to understand their concerns and what the patient deems important in PHC delivery. This will add to the body of knowledge and may influence PHC policy and improve PHC service delivery.

### **1.6 OBJECTIVES OF THE STUDY**

The objectives are to:

- Gain insight into how the patient perceives PHC service delivery.
- Explore how the PHC services live up to the patient's expectation and perception.
- Determine how well the PHC addresses the patient's perceived needs.

## 1.7 RESEARCH METHODOLOGY

This chapter will include a brief discussion of the researched methodology that was applied. Chapter 3 will have a more in-depth discussion.

### 1.7.1 Research design

The researcher used a descriptive qualitative research design, with the purpose to describe the perception of the study participants. The researcher attempted to systematically and accurately convey the patient's narrative as obtained during the study. Descriptive qualitative research allows the researcher to study the participants in their natural state, without manipulation of variables (Lambert & Lambert, 2012:255).

### 1.7.2 Study setting

The study was conducted within the community, with patients attending PHC facilities in Mitchell's Plain. The two (2) selected PHC facilities in Mitchell's Plain are situated in a low- to middle-income community in the Western Cape Metropole.

Mitchell's Plain is one of the largest townships in South Africa. It covers an area 43.76 km<sup>2</sup> with a population of 310 485 and the number of households 132 744 of which 91 % are Coloured. 61% of households have a monthly income of R3 200 or less (Western Cape Government, 2011:1). Approximately 35% have completed grade 12 or higher 95% of the population live in formal dwellings and have access to water, electricity and flushed toilets (Western Cape Government, 2011:2).



Figure 1: Map of Mitchell's Plain (Google Map; 2019).



Public health service delivery in Mitchell's Plain currently falls under the dual authority of the Metro District Health System of the Western Cape provincial Department of Health and local government, the health department of the City of Cape Town. Currently, there are seven PHC facilities and one district hospital (Western Cape Government, 2016:2).

The two (2) facilities under study were selected for the convenience of this study. Both facilities offer a wide range of services including amongst others, curative service for adults, Chronic Diseases of Lifestyle (CDL) clinics, pharmacy dispensary, specialised paediatric services for children up to 5 years, reproductive and Human Immune - deficiency virus/ Acquired immune deficiency syndrome (HIV/AIDS) services. These services are available from Monday to Friday from 7 am to 4 pm.

In order to gain the raw narrative of the participant and enhance confidentiality and trust, the data collection occurred within the community, away from the facility. Therefore, only the participants' consent was obtained.

### **1.7.3 Population and sampling**

The researcher used a purposive sampling and the selection was based on the representation of the study. Purposive sampling is non-probability sampling, which is based on the selection of participants that is representative of the study (Brink, Van der Walt & Van Rensburg, 2012:140). Sampling is the selection of a group of people that is representative of the population being studied (Grove, Gray & Burns, 2015:511).

A snowball networking sampling was used to identify ten participants who were invited to participate in the study. There were five participants from each of the two (2) selected PHC facilities. The researcher identified the first participant from each facility that met the study criteria. The participants had to be older than 18 years of age and had to have been attending the facility for more than one year. An invitation was extended to participate in the study. The participant was asked to identify a potential participant, who in turn identified another participant.

Interviews occurred face to face, by the researcher, using an exploratory approach. Participants were interviewed at their homes and other public areas where privacy and confidentiality were maintained. Approaching the participants in the community and conducting the interview away from the PHC facilities ensured confidentiality and anonymity, as well as encouraged the participants to freely express their perceptions.

The research study was verbally explained and each participant received a copy of the research. They were given the opportunity to consider the proposal. A signed consent was obtained prior to the interview (Appendix 2, 58-60).

#### **1.7.4 Interview guide**

Initially, a set demographic question was asked to confirm the eligibility of the participants. An interview guide, (see Appendix 3), was used to guide the semi-structured interview. The interview consisted of open-ended questions and probes to elicit the participants' perceptions and experiences of the PHC service delivery.

#### **1.7.5 Pilot interview**

A pilot interview was conducted, with one participant, who met the criteria of the study, to refine the interview guide and assist the researcher to lay aside preconceived ideas.

#### **1.7.6 Data collection and data analysis**

Data collection is a precise, systematic gathering of information relevant to the research purpose (Grove *et al.*, 2015:47). Collected data was analyzed according to the steps in Burns and Grove (2009:93) which will be discussed in chapter 3.

The taped interviews were transcribed and the recorded data was listened to in conjunction with the field notes and transcribed notes to identify themes and meaning. Using both deductive and inductive reasoning, emerging themes were identified and grouped together and interpreted.

#### **1.7.7 Ethical considerations**

The researcher has an ethical obligation to ensure that the rights of the participants are protected (Grove *et al.*, 2015:100). The researcher was guided by the ethical principles of respect for persons, beneficence and justice.

Ethical approval to conduct the study was obtained from the Health Research Ethical Committee at Stellenbosch University; reference number S158/05/106.

**Right to self-determination:** The researcher has an ethical obligation to ensure that the rights of the participants are protected (Grove *et al.*, 2015:100). It should be evident from the conceptual phase through the dissemination phase (Brink *et al.*, 2012:32). Participation in the study was voluntary. A detailed information leaflet was given to the participant prior to the study (Appendix 2,58-59), as well as a comprehensive verbal summary. It was made clear to the participants that they could withdraw at any stage of the interview and study. The participants were afforded time to consider their decision. A written consent was obtained once the participant indicated that she/he understood what was expected and was willing to participate in the study.

**Right to confidentiality and anonymity:** The participants' right to expect that the information collected will remain anonymous and confidential (Brink *et al.*, 2012:37) was achieved through

conducting the interviews in a private and secluded area. Priority was given to the comfort and privacy of the participant when conducting the interview away from the PHC facility and participants were informed that the researcher had no professional connection with the PHC facility and this prevented a power relationship between the researcher and participants. The participant's true identity was not mentioned in the study, instead, a unique code was used to identify each participant and in so doing, the participants remained anonymous. All participants were informed that their information would be stored in a locked and password located area.

**The principle of beneficence and non-maleficence:** In order to adhere to the above-mentioned principle, the researcher has to protect the participant from harm and discomfort; physically, psychologically, emotionally, socially and legally. (Brink *et al.*, 2012:35). The physical and psychological safety of participants was achieved through conducting the interviews in a private and secluded area at the participants' convenience and priority was given to their comfort and privacy. It was made clear to the participants that if they felt distressed at any stage during the interview, the interview would be ended. Provision was made with a social worker that psychological support would be offered. None of the participants indicated distress during or after the interviews. The participant's right to self-determination, privacy, anonymity and confidentiality, fair treatment and protection from discomfort and harm were upheld throughout the study.

## 1.8 OPERATIONAL DEFINITIONS

**Primary Health Care:** PHC is the first point of contact with the healthcare system, which deals with both chronic and acute health problems, provides patient-centred care and considers health problems in its social, cultural, physical, psychological and extensional dimensions (Greenhalgh, 2012:465-457).

**Patient/Community participation:** Patient/community becoming active participants in their health care, by generating their own ideas, assessing their needs, making decisions and evaluating the care that they received (Dennil Rendall-Mkosie, 2012:14).

**Perception:** Perception is a process of detecting stimulus and assigning meaning to it. The meaning is constructed based on both physical representation from the world and existing knowledge (Wolf, Niederhauser, Marshburn & LaVela, 2014:7).

**Lay belief:** Lay belief is the people's understanding and their interpretation of their health, including the causes and management of illness (Pretorius, Matebesi & Ackermann, 2013:112).

**Patient Experience:** It is the emotional and physical lived experience, personal interaction, which is influenced by the patient's perception across the continuum of care (Wolf *et al.*, 2014:9).

**Patient-Centred Care:** Care provision that is consistent with the values, needs, desires of the patient and is achieved when clinicians involve patients in their care (Constand, MacDermid, Bello-Haas & Law, 2014:1).

**Chronic Conditions:** Persistent communicable (e.g. HIV/AIDS) and non-communicable diseases (e.g. cardiovascular disease, cancer and diabetes), certain mental disorders (e.g. depression and schizophrenia) and ongoing impairments in structure (e.g. amputations, blindness, and joint disorders), which require ongoing management over a period of time (WHO, 2008:3).

## **1.9 DURATION OF THE STUDY**

The study commenced on receipt of ethical approval on 1 October 2018. Interviews commenced in October 2018 and were completed in November 2018.

## **1.10 CHAPTER OUTLINE**

### **Chapter 1: Foundation of the study**

This chapter provides an introduction and background to the study, as well as a brief overview of the research questions, objectives, methodology and definition of terms.

### **Chapter 2: Literature Review**

This chapter presents the existing literature pertaining to the perception of the PHC users.

### **Chapter 3: Research Methodology**

This chapter describes the research methodology for this study.

### **Chapter 4: Findings**

This chapter presents the research analysis of the data, as well as the interpretation of the results of the study.

### **Chapter 5: Discussion, and recommendations**

This chapter provides the discussion, conclusion, recommendations, and limitations identified in the study.

## **1.11 SIGNIFICANCE OF THE STUDY**

Knowing the patients' perception of PHC services, understanding their concerns, and what they deem important in PHC delivery, will assist positively managing their expectations in a positive way. The findings of this study will add to the body of knowledge and may influence PHC policy and implementation.

## **1.12 SUMMARY**

In this chapter, the reason for the study was discussed, as well as the research question, aims and objectives. The definition of relevant terms was provided, together with the outline of the study.

## **1.13 CONCLUSION**

Even though it is widely held that the patient's perception regarding the management of their health and illness needs have a direct bearing on health outcomes, their views are largely ignored and disregarded. Very little attempt has been made to engage the patients and allow them their raw narrative, outside the influence of the PHC delivery. This research will attempt to gain the

participants' views and listen to their concerns regarding PHC services and record the impact it has on their health and wellbeing.

## CHAPTER 2 LITERATURE REVIEW

### 2.1 INTRODUCTION

This chapter presents the literature review of the perceptions of PHC services in two facilities in Mitchell's Plain, Western Cape. A literature review is an organised written presentation to convey what is currently known regarding the topic (Dennill & Rendal-Mkosi, 2012:70). It contributes to a clearer understanding of the identified study (De Vos, Stydom, Fouche & Delpont, 2011:302).

The search for available literature was conducted by the researcher from electronic sources, such as PubMed, Subsolar, Google scholar and internet journals, as well as textbooks. The researcher attempted to, as much as possible, to access current sources, not older than 10 years, except for historical documents and other relevant legislation. Keywords used included, patient perception, illness perception, PHC services, PHC delivery, patient experiences, lay beliefs and patients' centred-care.

A literature review was conducted prior to and during the research, to gain a clear understanding of the study and explore what was known about the study internationally, as well as nationally. This chapter is aimed at presenting the synthesised literature for this study.

### 2.2 PRIMARY HEALTH CARE

PHC encompasses a political philosophy that calls for radical changes in both design and content to traditional health care (Dennill & Rendal-Mkosi, 2012:25). In 1978, at Alma Alta, the WHO, declared PHC to be the provision of essential services, which is universally accessible for individuals, families and communities, through their full participation (WHO, 1978:1-2). The intent of PHC requires adherence to the principles of PHC, namely, equity, community participation, universally access appropriate technology and resources, as well as intersectoral collaboration (WHO, 2008:np).

PHC is the first point of contact with the healthcare system, which deals with both chronic and acute health problems, provides patient-centred care and considers health problems in its social, cultural, physical, psychological and extensional dimensions (Greenhalgh, 2012:465-457). The fundamental aim of PHC is that it is universally accessible to ensure adequate coverage of the specific health needs of the intended people (Muhammed, Umeh, Nasir & Suleiman, 2013:64). Therefore, the strength of PHC lies in how it responds to the local needs of the individual, families and population (Dookie & Singh, 2012:2). Samuel Osahon views PHC as a sustainable healthcare delivery system which does not focus on the traditional and conventional health policies (Osahon, 2017:1).

The successful implementation of PHC requires a political commitment to the following principles:

Integration of service	Promotive, curative, preventive and rehabilitative services
Accessibility	Geographical, financial and functional accessibility of PHC services
Affordability	Health care must be affordable for the country and community. The inability to pay should not be a limiting factor for receiving health care
Availability	Adequate availability of resources to meet the need of the community it serves
Effectiveness	Health services should adequately meet the need of the community it serves
Efficiency	The outcomes should be appropriate to the resources used (Dennill & Rendal-Mkosi, 2012:10).

Globally, the principles of good primary health care are the same, whether in high-, middle- or low-income settings, and strong primary care sector is associated with better health outcomes and less inequality of provision (Greenhalgh, 2012:460-461). However, all countries interpret PHC from a broad definition, such as health care for all to a narrow definition of selective primary care (Bitton, Ratcliffe, Veillard, Kress, Barkley, Kimball, Secci, Wong, Basu, Taylor, Bayons, Wang, Lagomariso & Hirschhorn, 2017:566). In high-income countries, the emphasis is on improving patient experience, quality of care and reducing dependence on costly hospital and residential care (Mounier-Jack, Mayhew & Mays, 2017:8).

However, globally a large portion of health systems focus on illness, rather than on minimizing the burden of illness, especially within the vulnerable groups (White, 2015:104). White (2015:104) goes on to point out that the government tends to focus on high- cost items and lose sight of addressing priority needs and recognising the informal sector.

A study conducted by Papp, Borbas, Dobos, Bredehorst, Jaruseviciene, Vehko and Balogh (2014:12) in nine European counties on the perception of patients and professionals on PHC, found, that even though PHC delivery was guided by country-specific requirements, the shared challenges were access, equity, appropriateness and organisational responsiveness.

A major challenge experienced by middle- income countries is a rising aging population which leads to the rising burden of chronic diseases (CD) and often patients present with multimorbidity (Sum, Salisbury, Koh, Atun, Oldenburg, McPake & Lee, 2019:1).

With the demand for high-quality services, rising cost and emergence of non-communicable diseases (chronic conditions), health systems are increasingly recognising the importance of strengthening PHC to meet the evolved needs (Bitton *et al.*, 2017:566). Since 2012, the WHO has

been urging countries to adopt the concept of universal health coverage, which encompasses a strong, well-run health system, a system to finance health without causing financial hardship for the end users, access to essential medicines and treatment, a sufficient capacity of well-trained health workers and providers, and inclusion of critical role players in all sectors, such as education, labour, urban planning and policy makers (White, 2015:109).

White (2015:114) noted that it is important for policy makers and health care leaders in all countries to identify the needs of patients, plan for a more integrated approach, and to adjust strategic incentives to achieve the changes that are so clearly needed.

Developing countries have made marked progress in establishing health systems based on PHC principals (Dennill & Rendal-Mkosi, 2012:35-36). Yet most of the developing countries still struggle with implementing comprehensive PHC, largely due to rapid urbanisation, aging population due to increased life expectancy and lack of political backing for PHC (Dennill & Rendal-Mkosi, 2012:35-36). This is further exacerbated by under-funding, multiple, disease-orientated programmes (Magawa, 2012:1-4) and influenced negatively for both political and economic gain, rather than the health needs of PHC user and communities (Okpokoro, 2013:77). The focus has been on specific clusters of health services for a specific population at service delivery level, dictated by external donor priorities (Mounier-Jack *et al.*, 2017:7).

In 2008, a report by the WHO on PHC in African countries and developing countries, states that the elements of PHC is not being achieved, largely due to discrepancies between PHC policies and implementation (WHO, 2008:64). This has proven true in Malawi, as found by Makwero (2018:3), who reported that despite efforts made to base healthcare services on the PHC principles, policies and funding do not favour PHC prioritising (Makwero, 2018:3). A study in Nigeria concluded that the major weakness in its healthcare sector is the outdated, contradictory and ambiguous legislation (Muhammed *et.al.*, 2013:66). And more recently, the Ebola outbreak in West Africa in 2014, highlighted the severe shortage of healthcare infrastructure, human resources and essential supplies (Bitton *et al.*, 2017:567).

Despite the challenges, most developing countries continue to strive to attain the principles of providing comprehensive health care as envisioned by Alma Alta (De Ryhove, 2012:2). Even though comprehensive PHC is costly to implement, it provides a more holistic approach to address the health needs of individuals, promotes the development of health infrastructure and is critical for sustained improvements in the health of communities (De Ryhove, 2012:3). Britton *et al.* (2016:567) is of the opinion that PHC is the foundation for affordable, equitable, efficient and 4 sustainable health system to address the health needs of the majority of the people.



## 2.3 PRIMARY HEALTH CARE IN SOUTH AFRICA

South Africa spends 8.5 % of its gross domestic product (GDP) on health care, which equates to approximately R332 billion. Half is spent in the private sector which caters largely to the medical-insured population and the remainder is spent on 84% of the uninsured population (Rispel, 2016:18), of which, 61,2 % attend the public sector clinics (South Africa, 2011:7).

In South Africa's post-apartheid health-system, transformation was established, amongst others, on equity, rights to access to health care, PHC approach, decentralisation of services, care for the most vulnerable, promotion of health and community participation in decision making (Dennill & Rendal-Mkosi, 2012:60). This demanded radical system re-structuring and was eventually translated into 2003, National Health Act 61 of 2003 (NHA) Gray (2017:60), which is underpinned by a progressive constitution that recognises health as a fundamental human right in South Africa (Republic of South Africa:1996). To address the specific PHC needs of South Africa, emergency, occupational and mental health services were added to the eight components proposed by the WHO (Dennill & Rendal-Mkosi, 2012:60). Other reforms to provide sustainable and comprehensive PHC services include:

- 1997 - the White Paper for the transformation of the health services, emphasising the shift from curative hospital to PHC (Ataguba *et al.*, 2012:132).
- 2003 - the National Health Act 61 of 2003, highlights the patients' constitutional right to health, legalises free health for female and children, and the vulnerable (Ataguba *et al.*, 2012:135). It also provides for the right to participate in decision making in one's health and make available health service that is equitable, efficient and to be delivered in a respectful manner (Moyo, 2016:8). It is the formulation of the legal status of the district health system (Ataguba *et al.*, 2012:135).
- 2010 - the PHC re-engineering strategy which reassessed the centrality of the PHC and emphasised the role of the district health system (WHO. 2008:65). PHC will be focused on meeting the needs of the community at the district level and include prevention and promotion equal to the curative aspect of health care (Dennill & Rendal-Mkosi, 2012: 66). This approach stressed the importance of social issues in health and the engagement of the community (Dennill & Rendal-Mkosi, 2012:67).
- 2013 - the Ideal Clinic initiative, which defines the function of the PHC clinic and to systematically improve the PHC (Dennill & Rendal-Mkosi, 2012; Gray, 2017:20).
- 2015 - National Health Insurance White Paper, that lays out South Africa's move towards Universal Health Coverage by ensuring that the population has access to people-centred and integrated healthcare services (South Africa, 2011:3).

Currently, PHC in South Africa is the entry level in the public health system and is nurse driven (Ataguba *et al.*, 2012:484). It is delivered within the District Health Services (DHS) and viewed as the foundation of an effective and efficient public health service (Kautzky & Tollman, 2008:26).

PHC is delivered through various facilities, namely:

- Fixed PHC clinics, serving ambulatory patients in catchment areas.
- Mobile clinics are specially equipped vehicles, delivering PHC service in an outreach style to ambulatory patients.
- Satellite clinics are a non-continuous service outpost within the community. The service is rendered from fixed clinics or hospitals and utilises resources from the fixed clinics.
- Community health centres that operate 24 hours a day, 7 days a week and provide emergency response.
- District hospitals that predominantly serve as referral facilities for the surrounding areas to PHC service delivery facilities (Ataguba *et al.*, 2012:505).

Despite high expenditure and legislated health reforms, health outcomes remain poor compared to other middle-income countries (Moyo, 2016: 32).

## **2.4 PHC CARE CHALLENGES**

### **2.4.1 Burden of disease**

South Africa faces a quadruple burden of disease with HIV and TB accounts for the highest decrease in life expectancy (Ataguba *et al.*, 2012:516) and (Maillacheruvu & McDuff, 2014:4). However, chronic disease is on the increase within the rural and urban population in South Africa, largely due to an unhealthy lifestyle (Folb, Timmerman, Levitt, Steyn, Bachmann, Lund, Bateman, Lombard, Gaziano, Zwarenstein & Fairall, 2015:643). A study by Lalkhen and Mash commented, that non-communicable diseases (NCD) also known as chronic diseases (CD) are estimated to contribute to 28% of the most leading reason for visiting primary health care facilities (Lalkhen & Mash, 2015:135). It has found to be the major part of the workload of health care providers was in treating patient with CD, such as hypertension, cardiovascular disease and diabetes. Hypertension being the leading reason for attending PHC and the most common diagnosis (Mash, Fairall, Adejayan, Ikpefan, Kuumari, Mathee, Okun & Yogolelo, 2012:8). Both Lalkhen and Mash (2015:135) and Folb *et.al.* (2015:645) found that many CD patients present with multimorbidity which places a further burden on the correct management of CD at PHC delivery.

### **2.4.2 Skills to render care**

Despite some positive improvement in areas of PHC services, such as increased and free access to PHC (Dookie & Singh, 2012:5) and encouraging move towards a primary care-centred and community-based health care system (Maillacheruvu & McDuff, 2014:3) underpinned by the

introduction of reform packages and norms and standards (Ataguba *et al.*, 2012:489). Challenges still exist with providing satisfactory and universal acceptable PHC services. Current challenges are largely due to a quadruple burden of disease, overburdened and understaffed clinics, resulting in long waiting hours and a fragmented and poorly coordinated PHC delivery system (Dookie & Singh, 2012:3; Maillacheruvu & McDuff, 2014:4). Folb *et al.* (2015:9-647) found that a lack of knowledge of managing CD by PHC providers, compounded by a shortage of medication, promotional material and shortage of nurses results in a lack of comprehensive PHC care. They recommended that a coherent chronic disease management program be adopted for PHC in South Africa (Mash *et al.*, 2012:9).

PHC facilities in the Western Cape have to introduce initiatives, such as The Integrated Chronic Disease Management and Primary Care 101 programmes, which will serve as a guideline to improve the treatment of CD care and multimorbidity (Folb *et al.*, 2015:645). CDL clubs are an initiative, which has been introduced in PHC facilities, in the Western Cape, to facilitate chronic disease screening, health promotion, education and act as a chronic support group for the attendees (Western Cape Government, 2018:np). A study by Puoane, Tsolekile, Igumbor and Fourie (2012:3) pointed out that CDL clubs can empower participants, be sustainable and culturally appropriate when facilitated by the community. However, Folb *et al.* (2015:646) found that poor disease control, high levels of multimorbidity and unmet treatment needs are still the norm in PHC delivery. Puoane *et al.* (2012:5) found that the barrier to successfully implementing CDL clubs are poor resources, poor management and patient attaching little importance to attending the CDL clubs.

### **2.4.3 Access to care**

One of the principles of PHC is the access of care which entails affordability, appropriateness and acceptability of the PHC service delivery, as well as empowering the community (Dookie & Singh, 2012:2).

Access encompasses non-discriminatory access, physical and economic access to an appropriate health facility, services and resources, as well as access to health information, co-ordination and continuity of care, which is stated in the National Patients' Health Charter (Moyo, 2016:14). It entails access to services over a spectrum of care in a timely manner (WHO, 2018:14). This is essential in the treatment and on-going health care of chronic and multimorbidity conditions (Maimela, Van Geertruyden, Alberts, Modjadji, Meulemans, Fraeyman & Bastiaens, 2015:2).

Despite improvements in providing access to health care in developing countries, a lack (or loss) of financial resources can create barriers in accessing healthcare services (Peters, Garg, Bloom, Walker, Brieger & Rahman, 2008:161). For example, although about 90 % of South Africans live within seven kilometers of a clinic and two thirds within two kilometers, associated with monetary

and time-related costs, such as time taken off from work and traveling to a local clinic can pose considerable barriers (Fusheini & Eyles, 2016:2).

Access to health also includes access to information, the right to ask, and receive information concerning health issues in a confidential way (Moyo, 2016:14). People need to be informed about their specific health issues so that they can be empowered to make informed decisions about their health (Dennill & Rendal-Mkosi, 2012:176). Health care remains inaccessible to some, such as lack of health information and communication barriers resulting in patients not understanding their treatment or health choices (Moyo, 2016:24).

#### **2.4.4 Fragmented service delivery**

As previously mentioned, there have been many initiatives to transform the previously fragmented PHC system. Despite this and the increase of 8.5% of GDP to healthcare provision, South Africa's health outcomes are relatively poor when compared to other middle-income countries (Kredo, Abrams, Young, Louw, Volmink & Daniels, 2017:2).

This could be accredited to a curative mindset entrenched in the PHC delivery, rather than the community-orientated approach with a focus on illness prevention and health promotion (Le Rouw & Couper, 2015:440). This curative mindset entails a vertical approach such as chronic disease, mother-and-child care and HIV/Aids which is seen as contrary comprehensive, preventative and patient-centred approach (Dennill & Rendal-Mkosi, 2012:15). Even though the vertical approach is more cost-effective and is valuable in combating certain diseases, it does not take into consideration the socioeconomic environment in which the disease is experienced (Ataguba *et al.*, 2012:489). On the other hand, it has been suggested, that combining the two approaches, using the vertical PHC programmes such as the CDL clubs to gradually strengthen patient-centred PHC delivery, in order to deliver a more comprehensive health care (Ataguba *et al.*, 2012:485).

Another area of fragmentation is the relationship between PHC facilities. One of the main supporting facilities for the PHC is the district hospitals, however, both facilities are managed completely separate with a silo-type approach which results in the duplication of resources and fragmented service delivery, as well as a delay of referrals (Le Rouw & Couper, 2015:441). Dookie and Singh (2012:2) point out that the delay in integration of health services is largely due to the lack of clear direction and accountability.

### **2.5 PHC IN THE WESTERN CAPE AND MITCHELL'S PLAIN**

The Western Cape Province has 6 116 324 or 11.3 percent of the total South African population, with the greater proportion (64.2 %) living in the Cape Metropole District, which significantly impacts the provision of PHC service (Western Cape, 2015/16:4). The PHC of the Western Cape

per capita expenditure is the highest among all nine provinces but it has an outdated curative service-delivery model, which is cannot cope with the growing non-communicable disease burden or able address changing the social determinants of health (Gilson, Pienaar, Brady, Naledi, Schneider, Pienaar, Hawkrigde & Vallabhjee, 2017:66).

The Annual Health Inspection Report of 2015 /2016, publishes findings from observational surveys and audits of the health facilities, found that in the Western Cape the overall performance of clinics performed below average. There is definitely a lack in clinical support service, which covers specific essential services, was performing at 45%; facility infrastructure performed at 41% (Western Cape, 2015-2016). Patient rights which entail respect, rights of the patient and include informed and dignified attention, were rated at 48 % and public leadership which covers direction and supervision by senior management were rated the lowest at 19% (South Africa, 2015-2016).

Mitchell's Plain was built to accommodate 250 000 people, however, currently approximately 310 485 people are living in an area of 110,2km<sup>2</sup> (South Africa, 2011:14). Challenges faced by Mitchell's Plain residents include, overcrowding living conditions, HIV/AIDS, crime and lack of access to public amenities. Many are unemployed and live below the poverty line (Republic of South Africa, 2011:4 -14).

Mitchell's Plain PHC care comprises of a community health care centre and seven clinics. The services range from management of chronic disease lifestyle, HIV/AIDS services, termination of pregnancies, reproductive health to general medical services and mental health services and serves a population of approximately 1.2 million (Western Cape, 2015:2).

All communities live within 2.5km of a PHC clinic (South Africa, 2011:4-14). However, due to the high population and density, and poor socio-economic factors, PHC clinics are still burdened with high volumes of patients. In a study conducted in a PHC facility in Mitchell's Plain, it was found that nearly 500 patients circulated through the clinic daily and faced long waiting times; some patients had to come two or more days in a row if they were not seen the previous day. As a result, many patients missed work or were unable to keep a regular job (Maillacheruvu & McDuff, 2014:7).

## **2.6 NURSE IN PHC**

PHC in the public sector is nurse driven with the support of the medical doctor. Nurses see 85% of all patients (Mash *et. al.*, 2012:2). The National Health Care Facilities Baseline Audit (2012:31) show that 47% of the PHC clinics are not visited by doctors. However, all the clinics have professional nurses. On the other hand, Mash *et al.* (2012:8) raises the point that not all nurses are trained as clinical nurse practitioners. The National Health Care Facilities Baseline Audit reported

that 57% of the PHC facilities do not have administrative staff and no Information Management staff, both of which increase the nursing staff's workload.

The PHC nurse practitioner was introduced to the clinic to improve the accessibility to care (Rispel *et al.*, 2010:97). The PHC nurse practitioner is a professional nurse who has additional training in clinical nursing science, assessment, diagnosis, treatment and care (Rispel *et al.*, 2010:97). Section 56 of the Nursing Act, 2005 makes provision for nurses (professional nurses and midwives) who meet the prescribed training and competence requirements to diagnose, treat and prescribe medication on a PHC level (South Africa, 2005:39).

The United States of America, Canada and the United Kingdom had nurse practitioners delivering a wide range of services with high levels of autonomy, largely due to a shortage of doctors (Delamaire & Lafortune, 2010:16). A study showed that advanced practice roles and nurse driven care in the PHC sector in Australia, France and Finland improved quality of care, and in some incidences had better health outcomes, because of more time spent with the patient (Delamaire & Lafortune, 2010:43).

Scheffler *et al.* (2015:9) points out that PHC provides experience significant stressors in their efforts at providing satisfactory health care (Scheffler *et al.*, 2015:9). This is especially true for nurse practitioners that have to cope with large volumes of patients on a daily basis (Mash *et al.*, 2012:2) but also with a community that has the traditional picture of the doctor as the PHC provider who was strongly embedded (Scheffler *et al.*, 2015:8). A nurse, according to Lalkhen and Mash (2015:136) faces the challenge of managing chronic conditions or non-communicable diseases. A study by Lalkhen and Mash showed out of a total of 5 695 patients with chronic conditions, 3 811 (66.9%) were seen by nurses and 1 884 (33.1%) by doctors (Lalkhen & Mash, 2015:136). Maimela *et al.* (2015:9) found that the nurses' knowledge and management of chronic conditions and the risk factors are poor. Likewise, Lalkhen and Mash (2015:137-138) questions the ability of nurses to deliver care with limited training in non-communicable diseases and strongly recommend greater involvement with doctors in managing patients with multimorbidity. The critical shortage of key and skilled personnel is one of the barriers to the sustainable implementation of PHC services (Dookie & Singh, 2012:3).

## **2.7 PATIENT RIGHTS TO HEALTH**

The WHO used the Universal Declaration of Human Rights, adopted by the General Assembly of the United Nations, as the basis for the development of the Right to Health (WHO, 2017:1). International law views threats to public health as rights that place the responsibility and accountability on the government to provide acceptable health policies for its citizens (Meier &

Onzivu, 2013:2). However, there is a school of thought that views infringement of human rights for the good of public health as acceptable (Meier & Onzivu, 2013: 5).

In South Africa, the Constitution emphasises the protection of the health rights of its citizens, especially the vulnerable (South Africa, 1996). This includes the right to equality, human dignity, life, education and access to health, and adequate service delivery (Ataguba *et al.*, 2012). Chapter 2 of the National Health Act (No.61 of 2003) reflects the patient's rights, which was endorsed and implemented through the Patients' Rights Charter (South Africa, 2018:1).

The Patients Rights Charter as specified by the Department of Health (South Africa, 2018:1) ensures

- A healthy and safe environment for mental and physical wellbeing.
- Participation in decisions on matters which affect health.
- Access to healthcare for emergency care, provision of special needs, courtesy, human dignity and tolerance.
- Knowledge of one's health insurance/medical aid scheme.
- Choice of health services, treatment and a provider.
- Confidentiality and privacy concerning health matters which includes, information concerning treatment.
- Treated by a named provider who is identified.
- Refusal of treatment provided if the refusal does not endanger the others.
- Informed consent; accurate information regarding, illness, diagnostic procedure and proposed treatment.
- Be referred for a second opinion.
- Continuity of care which includes correct referral and follow-up.
- Complaints about health services should be investigated

Moyo (2016:13) points out that the Patients' Rights Charter favours the curative mindset and pays little attention to promotive and preventive care.

## **2.8 PATIENT-CENTRED CARE**

Patient care has evolved from the paternalistic approach, 'doctor knows best' to patient-centred care (Delaney, 2018:119). Patient-centred care is seen as the individual's specific health needs and desired health outcomes that drive healthcare decisions (Epsteinn & Street, 2011:100). It focuses on the interpersonal and relational dimension that is often lacking in PHC delivery (Bitton *et al.*, 2017:568). The main components of patient-centred care include effective communication, and understanding the patient's healthcare experience, interpersonal collaboration, and effective

health promotion (Constand *et al.*, 2014:1). Epstein and Street (2011:101) point out that patient – centred care could be seen at odds with a clinically proven approach. However, Raven (2015:1) emphasises that patient-centred care focusses on the needs, beliefs and goals of the patient, rather than on the needs of the PHC systems and providers. Similarly, Pulvirenti *et al.* (2014:305) are of the opinion that patient-centred care takes into consideration the patient’s lived experiences and the broader context in which the illness is experienced.

It ensures that the patient actively participates in their health process and not become the passive observer (Delaney, 2018:120) that their opinion and experience are taken into consideration and effectively incorporated into the PHC delivery (Jayadevappa, 2018:2). It is widely accepted that chronic conditions and multimorbidity are best treated within a patient-centred approach (Dowick, 2018:1).

A patient-centred health care system has become critical to defining and measuring patient perceptions of healthcare quality and to understand more fully what drives those perceptions (Delaney, 2018:120).

## **2.9 PATIENT PERCEPTION**

Perception is the process of detecting a stimulus and assigning meaning to it (Woolfolk 2014:215). It involves subjective judgment and includes elements of volition and action (people choose to see certain things in a certain way), (Dowler, Green, Bauer & Gasperoni, 2008:40). It is influenced by the person’s frame of reference that includes internal and external factors, social and cultural beliefs and past experiences (O tara, 2011:22).

Betancouts (2017:241) noted that perception is a reality, therefore what the patient perceives of the services, PHC staff and health systems is their reality. The public involvement in health issues have their perceptions of health and illness. These lay beliefs, though they may evidence based, they are important as the clinical definition of health and illness, because they are relevant to the individual and community (Pretorius, Matebesi & Ackermann, 2013:112).

Lay beliefs are people’s attempts to understand and interpret their health, including the causes and management of illness (Pretorius, *et al.*, 2013:112). It is informed by their own and communities health experiences, the nation’s history, the history of medicine and the current political context (Betancourt, 2017:241). Lay beliefs could be viewed as a barrier to health care because people would rather believe the information obtained from media and the community than from health providers, which at times is contrary to the health messages (Dowler *et al.*, 2008:43). Dowel *et al.* (2008:44) argue that even though public opinion may appear superficial and illogical, the



underlying rationale may be very similar to those of the experts. He goes on to point out that public perception is relevant terms of the social and cultural context in which they are held.

Illness perceptions are the individual's views and concepts that guide their behaviour aimed at managing their illness, such as treatment adherence (Petrie & Weiman, 2012:60). It impacts how the individual perceives and interact with the health system, and influences their willingness to engage in participatory decision making (Petrie & Weinman, 2012:60-61).

The perception of health programmes and the individual's involvement in the service, affects their level of utilisation of the PHC facilities and programmes (Egbewale & Odu, 2012:11). Egbewale and Odu (2012:12) are of the opinion that poor perception and utilisation of PHC programmes are linked to weak management and poor adherence to basic principles of PHC delivery.

Public perception can improve the effectiveness of government policy and increase the patient's faith in PHC delivery. However, there is limited evidence that public perception is incorporated in policy in a meaningful way (Dowler *et al.*, 2008:55). Buccus (2011:20) concluded in his article, Civil Society and Participatory Policy Making in South Africa: gaps and opportunities, that there is a very little consideration for public participation and decision-making processes at policy level. He goes on to recommend the need for marginalised communities to influence policy makers by voicing their perceptions, experiences and concerns (Buccus, 2011:21).

Studies conducted at a PHC facility in Cape Town, South Africa, showed that unmet needs, fuelled by perception of inadequate care and unacceptable behaviour of staff, at times resulted in conflict. The researcher points out that the user's expectations and perceptions of what constitutes adequate care, is not the same as the providers (Adejeniji & Mash, 2016:7; Folb *et al.*, 2015). Similarly, Scheffler *et al.* (2015:10) found that patient perceived doctors as the designated PHC providers therefore viewed nurse-lead clinics as not providing quality care. Unmet expectation fuelled perceptions of inadequacy and unacceptability, which leads to feelings of disempowerment, which in turn affects the quality of care and patients satisfaction (Scheffler *et al.*, 2015:10). Patient perception of the relationship between primary health provider affected how they viewed their illness and the management thereof (Mead, Andres & Regenstein, 2012:80). It is therefore significant, according to Moyo (2016:10) to understand various perceptions of the acceptability of PHC.

## **2.10 PATIENT EXPERIENCE**

Patient experience reflects the occurrence and events that happen independently and collectively across the continuum of care (Wolf *et al.*, 2014:3). Raven (2015:2) is of the opinion that patient experience encompasses amongst others, communication (including being listened to) access to health care and coordination of multiple service.

An article posted in The New England Journal of Medicine, asked the question if the reports of patient health care experience reflect quality of care. The article goes on to say that there are different views on what constitutes quality. However the authors of the article concludes that the question should whether the patient can provide meaningful measures, but how to improve patient experience of the PHC delivery, such as coordination of services, patient interaction and meaningful and positive outcomes ( Manary, Boulding, Staelin & Glickman, 2013:202).

## **2.11 SUMMARY**

The literature review aimed to synthesise the relevant literature so as to form an image of PHC delivery, globally and nationally and patient perception. Emphasis has been placed on concepts influencing patient perception, such as patient-centered care and the patient bill of rights.

## CHAPTER 3 RESEARCH METHODOLOGY

### 3.1 INTRODUCTION

In this chapter the research design and methodology used to determine perceptions of Primary Health Care services in two facilities in Mitchell's Plain, Western Cape are described. The chapter also includes the aim and the objectives of the study, it describes the study setting and population sampling methods used, as well as the data analysis and interpretation methods applied. Finally, it explains the scientific rigour used to ensure the integrity of the study.

The research design is the logical steps taken to answer the research question (Brink *et al.*, 2012:96), and methodology refers to the way of obtaining, organising and analysing data (Brink *et al.*, 2012:53). The researcher's process will reflect the procedure of the design (De Vos *et al.*, 2011:312).

### 3.2 AIM OF THE STUDY

The aim of the research was to explore the patients' perception of PHC services at PHC facilities in Mitchell's Plain, Western Cape, to understand their concerns and what the patient deems important in PHC delivery. This will add to the body of knowledge and may influence PHC policy and implementation.

### 3.3 OBJECTIVES OF THE STUDY

The objectives of the research are to:

- Gain insight into how the patient perceives PHC service delivery.
- Explore how the PHC services live up to the patient's expectation and perception.
- Determine how well the PHC addresses the patient's perceived needs.

### 3.4 STUDY SETTING

The study setting refers to the place where the study occurred (Brink *et al.*, 2012:59). A natural setting for this study was used and no manipulation of the environment occurred. A natural setting is a real-life situation (Burns *et al.*, 2012:562).

The study was conducted in Mitchell's Plain, Western Cape with patients who attended two selected PHC facilities. Mitchell's Plain is the largest suburb of Cape Town and has a population of approximately 310 485 people living in an area of 110,2km<sup>2</sup> (South Africa, 2011:14). There are seven PHC facilities in Mitchell's Plain and most of the communities live within proximity to a PHC clinic (Republic of South Africa, 2011:4 -14). Mitchell's Plain has a high percentage of poor socio-economic factors that go with high unemployment rates, communities living below the poverty line

and high crime statistics (Republic of South Africa, 2011:4 -14). The population is predominantly coloured. 35% have completed grade 12 or higher and 38% of households has a monthly income of R3 200. 95% of the population lives in a formal dwelling and have access to water, electricity and flushed toilets (Western Cape Government, 2011:2).

Mitchell's Plain PHC delivery offers services ranging from management of chronic disease lifestyle, HIV/AIDS services, termination of pregnancies, reproductive health to general medical services and mental health services (Western Cape, 2015:2). However, a study conducted in a PHC facility found that not all services could be provided efficiently and effectively, because of understaffing and an overburden of communicable and non-communicable diseases (Maillacheruvu & McDuff, 2014:7-9).

The selection of the two facilities was purposively chosen, based on the number of patients that were accessible within the criteria framework. The research study occurred in a natural setting, away from the PHC facility, which was selected at the convenience of the participant. The natural setting is an uncontrolled real-life situation or environment (Grove *et al.*, 2015:277). The selected venue was conducive to privacy and confidentiality.

### **3.5 RESEARCH DESIGN**

Research design, according to Brink *et al.* (2012:53) is the overall plan for gathering data in the research study. It guides the researcher with planning and implementing the study in a rational to achieve the intended goal (Grove *et al.*, 2015:511).

The study attempted to describe and understand the patients' perceptions of their experiences. The study focused on exploring the concerns of the patient and what they considered important to PHC delivery. The researcher used a descriptive qualitative research design, with the purpose to describe the experiences of the study participants.

A qualitative research design, according to Burns and Grove (2012:122) is used to describe the participants lived experiences and perspectives. It elicits the participants' perceptions and lived meaning (De Vos *et al.*, 2011: 65). The descriptive aspect leads to a thicker description of the patient's experience by intensely examining the phenomena and its deeper meaning (De Vos *et al.*, 2011:96). The purpose of a descriptive qualitative is to provide a picture of a situation as it naturally happens, with no manipulation of variables (Grove *et al.*, 2015:212-123).

The descriptive qualitative approach allowed the researcher to elicit the participants' raw narrative regarding their perceptions. It allowed the researcher to gain a deeper understanding of the participants' experience in the PHC services in the PHC facilities in Mitchell's Plain, Western Cape.

The researcher attempted to systematically and accurately as possible, convey the patient's narrative as obtained during the interview.

### **3.5.1 Population and Sampling**

The population for the focus of the research study is individuals who meet the sample criteria (Grove, *et al.*, 2015:250). It is the totality of persons with which the research problem is concerned (De Vos, *et al.*, 2011: 232). Therefore, the researcher made use of purposive sampling. Purposive sampling is non-probability sampling, which is based on the selection of participants that is representative of the study (Brink *et al.*, 2012:140; Grove *et al.*, 2015:511).

The researcher made use of a snowball network sampling. The snowball technique is used in cases where a relatively unknown phenomenon is investigated (De Vos *et al.*, 2011: 392) and it ensures confidentiality (Brink *et al.*, 2012:142). The researcher identified the first participant from each selected facility. The potential participant was approached in the community away from the PHC facility and PHC setting, to avoid bias caused by closeness to the PHC setting and ensure anonymity. After establishing if the potential participant met the study criteria, namely, patients older than 18 years of age and attending the facility for more than one year, an invitation was extended to participate in the study. The participant was asked to identify a potential participant, who fitted the above-mentioned study criteria and who potentially could provide in-depth information; they, in turn, identified another participant.

The study was explained verbally to each participant, and a research study leaflet was given to the participant prior to the interview. Six to twenty-four hours were given for the potential participant to consider being part of the study. All participants approached, consented to participate in the study.

The sample size depends on the purpose; usefulness to what will be credible for the study and what can be done in the available time (De Vos, *et al.*, 2011:391). The size, if the population depends on the point of saturation. Saturation of data occurs when additional data provides no new information (Grove *et al.*, 2015:274).

The total study consisted of a total of ten participants. One (1) participant for the pilot interview, to assist with refining the interview process and 10 participants, five (5) from each selected PHC facility. Even though more participants were identified, saturation was reached when the same information was heard repeatedly and therefore the study interviews were suspended.

#### **3.5.1.1 Inclusion criteria**

The inclusion criteria stipulate the essential characteristics of the selected population (Grove *et al.*, 2015: 251). To ensure rich data, chronic patients older than 18 years of age and attending the facility for more than one year were invited to participate.

### 3.5.1.2 Exclusion criteria

The exclusion criteria are characteristics that will result in the population to be excluded from the study (Grove *et al.*, 2015: 251).

First-time visitors or those attending the PHC facility for less than a year were not considered. Family of the nursing staff working in the PHC facility were excluded to prevent bias and conflict of interest. Non-patients were not considered either.

### 3.5.2 Interview Guide

A semi-structured interview was conducted, which according to De Vos, *et al.* (2011:350) is used to gain the participants' perception of a particular topic. Data collection for descriptive qualitative research involves minimal to moderate structure and open-ended individual interviews (Lambert & Lambert, 2012:256). The aim of an interview was to gain authentic insight into the participant's perception and experiences (Grove, *et al.*, 2015:83). Open-ended questions were asked to guide the interviews as suggested by De Vos, *et al.* (2011:349).

Initially, an introduction was made, to establish rapport. The purpose of the study was clarified and a set of demographic questions were asked to confirm the eligibility of the participants. The interview was composed of open-ended questions which were based on the purpose of the study and aimed to elicit the participant narrative. Techniques used to gain rich in-depth data, were probes, reflective summarising, paraphrasing and clarification of statements.

**Table 3.1: Main questions to guide the engagement**

Introduction	<p>Introductions</p> <p>Purpose of the study</p> <p>Explain the steps of the interview</p> <p>Clarify if participant understood the step</p> <p>Allow the participant to ask questions</p> <p>Obtain consent</p>
Interview	<p>What do you think is a Primary Health Care facility?</p> <p>Tell me about your experiences at a PHC clinic?</p> <p>Describe how the clinic provides for your health and illness needs?</p> <p>Who sees you at the clinic?</p> <p>Tell me about the challenges you face when attending the facility?</p> <p>What would you change about the facility and why?</p>
Closing Question	<p>Is there anything about your experience and views that you feel are important that we haven't covered?</p>

Techniques used	Probes Clarification of statement Reflection summary Paraphrasing
Ending	Reconfirm the participant's consent Request permission to contact participant to clarify information given Reconfirm confidentiality

### 3.5.3 Pilot Interview

A pilot interview is a smaller version of the proposed study and could be used to refine the study process (Grove *et al.*, 2015:45). The approach of the one-on-one was exploratory. An exploratory approach is conducted to pilot test an operational aspect of anticipated qualitative design (De Vos, *et al.*, 2011:364).

The pilot interview was conducted with a voluntary participant that attended one of the selected PHC facilities within the Mitchell's Plain area, Western Cape and met the inclusion criteria. The participant then referred the researcher to a potential participant that agreed to participate in the study. Data collection and the finding of the pilot interview will be included in the study.

The pilot interview was a face to face, semi-structured interview and was guided by the purpose of the study. The pilot interview helped refine the main questions and the interview process, as well as assisted the researcher in setting aside preconceived ideas about the study topic.

### 3.5.4 Scientific Rigour of the Study

Scientific rigour of the study is determined by the value of the research findings (Grove *et al.*, 2015:125), and it refers to the openness, relevance, methodology consistency and thoroughness throughout the study, as well as the researcher's self-understanding (Brink *et al.*, 2012:126).

Throughout the study, the researcher applied the scientific rigour of credibility, dependability, transformability and conformability.

#### 3.5.4.1 Credibility

Credibility is about capturing the holistic representation of the phenomenon. It examines if the finding appears truthful (Billups, 2014:1). To ensure credibility, the researcher attempted to conduct, describe and reflect accurately what the participants were saying and what they meant.

In this study, the researcher adopted two of the strategies outlined by Lincoln and Guba (1985) as mentioned in De Vos, *et al.* (2011:420), namely peer debriefing and member checking.

- Peer debriefing involved securing feedback from the supervisor. It assisted in addressing questions of bias, errors of fact, competing interpretations, convergence between data and phenomena, and the emergence of themes as indicated by Billups (2014:2).
- Member-checking involved clarifying information with the participant during and after the interview. This was done to maintain internal validity and credibility. The researcher took care to ensure that the finding was the true reflection of the participant and not influenced by the researcher. During the interview, clarification was achieved through clarifying statements and reflections. After the interview, once the interview was transcribed, four participants had the opportunity to read the transcripts and indicate whether it was a true reflection of the interview.

The researcher, through a bracketing process, identified and set aside any preconceived ideas about the research subject. This occurred prior to and during the pilot interview. It ensured that the true narrative of the participant was reflected.

#### **3.5.4.2 Dependability**

Dependability considers whether the research process is logical, well documented and audited (De Vos, *et al.*, 2011:420) and whether the findings are stable and consistent over time and across conditions (Billups, 2014:3).

The following steps were applied by the researcher to ensure dependability:

- The researcher used the same steps and questions for each interview
- Audio-tape recordings in conjunction with accurately written field notes were used to ensure a reliable method of data collection
- The researcher set aside any preconceived ideas and opinions that she might have had of the phenomena under investigation. Bracketing occurred prior to the study
- The participant was asked to provide names of potential participants
- This study was audited by the supervisor and other researchers to verify processes and procedures used by the researcher.

#### **3.5.4.3 Transferability**

Transferability is when the results of the study are applicable to similar settings (De Vos, *et al.*, 2001:421) with similar participants (Grove *et al.*, 2015:392) with the aim of qualitative research findings that can be interpreted for similar settings (Billups, 2014:3). This study intended to explore the perception of the patient in a PHC setting, which may lead to further engagement, discussion and research in PHC and similar settings. The researcher applied transferability by:

- Applying the design inclusion criteria when recruiting participants
- Collecting and transcribing data as accurately as possible
- Using the participant's own words to support the researcher's interpreted data.



#### **3.5.4.4 Conformability**

Conformability looks at the accuracy of the study. Can the findings be corroborated? (Billups, 2014:4). The researcher's recordings of the interviews, transcripts, and field notes will be kept for five years in a secure location and password locked location, at which time all data will be discarded safely. All documents will be made available to the ethics committee upon request.

### **3.6 DATA COLLECTION**

#### **3.6.1 Bracketing**

Bracketing is a process where the researcher identifies and sets aside any preconceived beliefs and opinions about the phenomenon under investigation (Brink *et al.*, 2012:122). Prior to the commencement of data collection, the researcher made a list of preconceived ideas regarding her personal experiences, as she lived in a community that predominantly relies on PHC services and her professional knowledge of the intention of legislation, policies and health reforms. This process was aimed at ensuring that the researcher's personal beliefs, stories and experiences of the community she and family members interacted with, as well as her knowledge as a professional nurse, were set aside to present the true perception and experience of the participants.

#### **3.6.2 Interviews**

Data collection is a precise, systematic gathering of information relevant to the research purpose (Grove *et al.*, 2015:47). Semi-structured interviews were used to elicit the patients' raw narrative of their perceptions and experiences. The researcher engaged the participants on a one-on-one base. An interview is a social relationship designed to exchange information (De Vos *et al.*, 2011:342). The semi-structured interview assists in gaining the participants' perception of accounts on a particular topic (De Vos *et al.*, 2011:351). De Vos *et al.* (2011:3) points out that the structure in a semi-structured interview is guided by the direction of the interview.

The interview was based on exploring and gaining the participant's perception. The interview was audiotaped, with the permission of the participant to using a recorder. The researcher had access to a second tape, backup recorder as suggested by De Vos *et al.* (2011:329). The recorded interview allowed the researcher to give an accurate summary of the interview, as well as the comments of the researcher. In addition to taping the interview, field notes were made immediately after the interview. Field notes are notations of the researcher regarding the experience, observation in the course of data collection and reflection (De Vos *et al.*, 2011:329).

The researcher conducted the interview, as the researcher had training in interviewing and is fluent in English and Afrikaans. Provision was made with an isiXhosa interpreter who had PHC facility experience to assist, should isiXhosa-speaking participants be included in the study. However, the recommended participants were English and Afrikaans speaking.

### 3.7 DATA ANALYSIS

Data collection is a precise, systematic gathering of information relevant to the research purpose (Grove, *et al.*, 2015:47). In qualitative research studies, data analysis is done concurrently with data collection (Brink, *et al.*, 2012:184). Collected data will be analysed according to the steps in Burns and Grove (2009:93):

Transcribing the interviews. A verbatim transcript captures the participants' own language and expression and allows the researcher to decode behaviour, processes and cultural meaning attached to the participants' perceptions (Grove *et al.*, 2015:89). The recorded response of the participants was transcribed verbatim by a transcriber who signed a confidentiality agreement. Each recording was clearly identified with a unique number. The researcher read the transcriptions while listening to recordings and checked the field notes to ensure the accuracy of the transcribed version. All identifiable information was deleted. The digital recording and electronic transcriptions were password protected on the computer and hard copies are kept in a locked safe place at the researcher's home.

- Immersion in the data. The recorded data was listened to, in conjunction with transcribed notes and field notes several times to identify themes and meaning. As suggested by De Vos, *et al.* (2011:402), the transcriptions were read and reread, and the audiotapes were replayed, to become familiar with the data and discover their meaning and intentions.
- Coding and theme identification. It is a process of breaking the recorded text into subpart and giving it a label (Grove *et al.*, 2015:89). A line-by-line analysis was identified and highlighted. This resulted in the data being broken down in meaningful parts that were labelled. The labels allowed for the patterns to be identified (Grove *et al.*, 2015:89). This process led to trends being grouped together in which themes and subthemes emerged.
- Interpretation involves identifying the usefulness of the finding towards clinical practice (Grove *et al.*, 2015:89). Themes and sub themes were compared to the research questions, research aims and trends. To ensure credibility, the researcher searched for literature that confirmed or argued against initially formulated themes (De Vos *et al.*, 2011:403) which is presented in the discussion.
- Data analysis requires clear procedures to ensure rigour and credibility of the finding (Grove *et al.*, 2015:91). The researcher merged all data belonging to each category and developed a preliminary analysis.
- Reflection. The researcher kept field notes as suggested by De Vos, *et al.* (2011:406), regarding the emerging themes and patterns, connection between data and additional ideas and thoughts. The field notes are locked away with the hard copies of the transcriptions.

### **3.8 SUMMARY**

This chapter, a description of the research methodology applied in the study, was presented. It included a comprehensive description of the purpose of the study, the research design, population sampling and pilot interview. Also discussed were bracketing, which was utilised to reduce researcher bias and ethical consideration. Finally, the details of data collection and analysis steps were described and how rigour and trustworthiness of the study were ensured.

## CHAPTER 4 FINDINGS

### 4.1 INTRODUCTION

In the previous chapter the research methodology, pilot interview, data collection and data analysis used in the study, were discussed. The data was analyzed according to the steps in Burns and Grove (2009:544).

This chapter will detail the findings from the data that were collected on the patients' perception of two PHC facilities in Mitchell's Plain, Western Cape. The researcher conducted a semi-structured interview with ten participants. The researcher became immersed in the data by repeatedly listening to the recorded interviews, in conjunction with the verbatim transcripts of the interviews and field notes.

The researcher used a manual method to analyze the transcriptions. The interviews produced a thick description of perception, experiences and expectation which allowed the researcher to group similar words and statements together. Through an inductive process, themes and subthemes emerged. Themes and subthemes are patterns and ideas in the data that are repeated by more than one participant (Burns *et al.*, 200:402).

The data is presented in two sections. Section A describes biographical data that was elicited at the onset of each interview. Section B discusses the themes and sub-themes that emerged during the data analysis process. To ensure anonymity each participant, as well as the facilities were assigned a unique number.

### 4.2 SECTION A: BIOGRAPHICAL DATA

The participants' relevant biographical data will be listed in this section.

Ten participants were invited to participate in the study. All ten consented to the interview as previously indicated. The interviews occurred in a neutral location at the participants' and the researcher's convenience. The interview was conducted one-on-one by the researcher. A pilot study, discussed in chapter 3, was conducted to refine the interview process. There were five participants from each selected PHC facility, referred to in this study as Facility A and Facility B.

The inclusion criteria stipulated that the participants should be older than eighteen years and had been attending the clinic for longer than a year.

- **Gender and age**

Gender was not considered essential as a factor for the study. However, all participants were female. Ages ranged from 35 to 78 years old at the time of the interviews.

- **Years of attending the PHC facility**

Three of the participants attended the clinic for more than 10 years, 6 of the participants attended the clinic for approximately 10 years and 1 for approximately 5 years.

- **Reasons for attending the PHC clinic**

All of the participants who attended and who were interviewed had more than one chronic condition. Conditions included cardiac problems, diabetes, hypertension, epilepsy, arthritis and hypothyroidism. Two of the participants had a cerebral vascular accident (CVA) and two reported that they suffered a heart attack during the course of attending the PHC facility.

A biographical overview as per the PHC facility is present in table 4.1.

**Table 4.1: Demographic as per PHC facility**

	<u>FACILITY A</u>	<u>FACILITY B</u>
Age	61 – 76	35 – 76
Year of attending PHC facility	10 – 15 years	5 -10 years
Reason for attending PHC facility	5 Hypertension 1 Diabetes 1 Epilepsy 2 had CVA 2 Arthritis 1 Hypothyroidism 2 Cardiac problems	4 Hypertension 3 Diabetes 2 Heart failure 1 Psoriasis

#### **4.3 SECTION B: THEMES AND SUBTHEMES THAT EMERGED FROM THE INTERVIEWS**

The following themes and subthemes emerged from the semi-structured interviews conducted regarding the patient's perception of PHC services in two facilities in Mitchell's Plain, Western Cape.

**Table 4.2: Themes and subthemes that emerged from the interview**

<b>Themes</b>	<b>Sub-themes</b>
Patient-centred care	Communication Health education Chronic Health Lifestyle Clubs Management of complex disease Delayed treatment
Participant's perception of healthcare providers at the PHC service facility	Attitude and skills (negative and positive)
Participant's perception of PHC service and facility	Waiting time Medication delivery service Appointment management Complaints management
<b>Participant's expectation of PHC service and facility</b>	Respect and courtesy Consultation by a doctor PHC facility
Participants' proposed solution for improving the PHC service and	PHC facility PHC service

#### **4.3.1 Theme 1: Patient-centred care**

Patient-centered care is seen as the move towards improving PHC services and recognizing that the patient's perspective and opinions matter (Gray, 2017:67). It includes looking at what was meaningful to the patient, which may include health promotion, accessibility of service, and continuity of care and communication, amongst others (Pulvirenti *et al.*, 2014:305). Bitton (2017: 568) emphasized that patient-centred care captures the interpersonal relationship dimension of PHC which includes trust and respect.

##### **4.3.1.1 Communication**

Communication is central to healthcare service and can contribute to disease prevention, management of illness and chronic condition (Dennill & Rendall-Mkosi, 2012:173). Priebe and Strang (2016:2) are of the opinion that a two - way communication between provider and patient is vital for improving health and impacts the right to health and is central to patient-centred care.

All the participants expressed that there was little or no engagement between staff members and the participant. Most of the participants said that the nurses did not take the time to listen to them or ask their opinion.

**Participant A2:** *“They sit there; they don’t even look you in the face or ask how you are doing. She just opens my file and she start writing the repeats of the medication”.*

**Participant A4:** *“There are some nurses that are in a hurry, they don’t give you a chance to tell them about your problems, they just write (in your file). They don’t ask questions”.*

**Participant A5:** *“They don’t ask how are you doing...”*

Because of a lack of interaction, the nursing staff was perceived as uncaring, and participants felt belittled.

**Participant B3:** *“The people get angry and become belligerent (vloek) because they (patient) talk and talk but they (staff) don’t listen”.*

**Participant A2:** *“They don’t listen to me; they think I’m stupid. I know my body”.*

**Participant B3:** *“One expect them (staff) to be professional and more understanding”.*

**Participant B5:** *“So they make you feel like a criminal...we don’t want people to look down on us. Yah. Because it takes away from who we are”.*

**Participant A1:** *“They (staff) get edgy if you talk to them and you want to explain to them...they haven’t got patience”.*

The majority of the participants reported a lack of explanation concerning changes made about their care, medication or service delivery that affect them directly, such as changes in the appointment system or medication distribution points.

**Participant A5:** *“They change the system (administration and appointment systems), but they don’t tell you that the system has been changed, or why they have changed the system, you just have to adapt”.*

#### **4.3.1.2 Health Education**

Health education is seen as the provision of specific information to affected patients to reduce risk or improve health (McManus, 2013:15). It is one of the main components of PHC which strives to empower the individual, and communities (WHO, 2018:2).

All but one participant said that they did not receive health education. Most of the participants received information about their disease within the community from relatives and neighbours, who have similar problems and experiences. This impacts their views on health and illness and impacts health outcome (Petrie & Weinman, 2012:60).

**Participant B3:** *“They don’t ask you about your medication, they don’t ask you what you understand (regarding the medication) and if you are aware of what can happen if your blood (blood pressure) is high that is why some people collect their tablets but don’t take them”.*

**Participant A1:** *“She took my finger prick, it was high, she didn’t say anything. And I was sitting there and she was just writing”.*

**Participant A3:** *“You don’t get a sheet to tell what diet you should follow... you have to find out for yourself”.*

**Participant A5:** *mentioned how she was given an inhaler without education because she complained of shortness of breath. However, her friend told her not to use it because she is not an “asthmatic”.*

**Participant A2:** *“They didn’t explain, I just saw that I had cholesterol tablets in my packet. They didn’t explain, I read the packet, take one tablet at night”. The participant went on to explain that she reacted badly to the tablet (rash) and she stopped taking the tablet.*

One participant (**B1**) who said that she received education regarding management of her disease received a glucometer on the day of the interview. However, she did not receive instruction or demonstration on the use of the glucometer and values of the readings.

Participant **A5** said that she got her information from a poster on the wall. Most of the participants displayed poor knowledge of the management of their chronic disease of how to prevent complications.

#### **4.3.1.3 Chronic Health lifestyle Clubs**

Both of the selected PHC facilities in Mitchell’s Plain, Western Cape offered Chronic Diseases of Lifestyle Chronic Clubs service. Patients attended every 6 months on average with the aim to manage the chronic condition and prevent complications (Western Cape Government, 2011:np). All of the participants attended ‘chronic disease clubs’ which according to the participants focused on the disease, rather than the preventive and promotive aspect of PHC.

**Participant A5:** *“They don’t ask you questions on how you are doing today, you just have to go the the chonic club and they take your bloodpressure and then you have to wait for the doctor”.*

**Participant A3:** *was of the opinion that it is “as waste of time” as they did chronic disease specific test, but received no information or education regarding the disease that was done.*

One participant expressed her dismay that when she complained about her painful leg, she was immediatedly sent to the arthritis ‘club’, even though she firmly believed that she did not have arthritis.



Some of the participants expressed their concerns that everyone gets the same medication and treatment.

On the other hand a participant at facility B 4668290, mentioned that she attended the chronic club every six months, unless her blood pressure is high, then the nurse would request that she attends monthly until her blood pressure is stable.

#### **4.3.1.4 Management of complex disease**

PHC providers are faced with transmittable disease, rising non-communicable disease and long term disease (Maillacheruvu & McDuff, 2014:1) as well as an increase of patients presenting with multi-morbidity (Larken & Mash, 2015:134). Nurses see a large number of patients with chronic conditions. However, Larken and Mash (2015:134) question nurses' ability to effectively treat patients presenting with multi-morbidity (Larken & Mash, 2015:137).

All of the participants were treated for more than one chronic condition. Two of the participants had CVAs and two had heart attacks. Most of the participants expressed their doubts about the nurse's competence and the ability to manage their disease. Two participants were satisfied with the treatment they received, however, both of them wanted to be seen by a doctor at least every six months for a full physical examination. The participants unanimously reported that none of them were ever physically examined by an attending nurse.

**Participant A2:** *"...they discovered that I have high blood. But I said to the nurse, that I haven't got high blood. They gave me tablets for high blood, for water, for pain killers, which I did not take".*

**Participant A1:** *"Everyone gets the same medication everyone gets the same diagnosis".*

**Participant A5:** *"...I had high blood pressure, then I had a stroke and then a heart attack and later sugar (diabetes), they never explained the reason... they never explained, they just want you out of the way, they don't give you a chance to ask questions".*

The participants expressed their concern that nurses did not have the knowledge or education to manage their chronic conditions:

**Participant A3:** *"...I think the nurses need education, because it seems they don't know what is going on" (referring to the management of chronic conditions).*

**Participant A5:** *"I told the nurse I wasn't feeling well [points to her heart], she sent me for tests and when I came back she told me to use the tablet that you put under your tongue, I told her that I don't get that tablet any longer".*

Although participants from both facilities conveyed their preference for being seen by a doctor rather than a nurse, it appears that participants at facility B had more access to a doctor than participants at facility A. Four of the five participants said they were seen by a doctor more than

once, whereas participants at facility A reported they were never seen by a doctor or had only seen a doctor on request. Participant A4, who has had two heart attacks and a cerebral vascular accident, saw a doctor last year (2017), for the first time in twelve years.

**Table 4.3: Access to Doctor**

Facility A	Seen by a doctor	Facility B	Seen by a doctor
Participant A1	Not seen by a doctor	Participant B1	Seen by a doctor
Participant A2	Only on request	Participant B2	Seen by a doctor
Participant A3	Not seen by a doctor	Participant B3	Seen by a doctor
Participant A4	Saw doctor a month before the interview for the first time in 12 years	Participant B4	Not seen by a doctor
Participant A5	Not seen by a doctor	Participant B5	Seen by doctor

#### 4.3.1.5 Delayed treatment

Continuum and co-ordination of care is an integral part of PHC delivery which requires a patient-centered approach and involves community participation, intervention focused on the determinants of poor health, health promotion and an integrated referral system (Scheffler, 2015:3). Delayed treatment undermines the continuum of care that is considered one of the principals of PHC delivery (WHO, 2008:np) and access to suitable PHC services (Dookie & Singh, 2012:2).

Participants experience their encounter with the health care providers as rushed, with little regard for their opinions and complaints. They report that their request for referral to specialist doctors and other services was denied or delayed and promises of follow-up never materialised.

Participant B5 related that she had painful psoriasis which was not responding to the treatment received at the PHC facility, however her request for a referral to a dermatologist was denied.

**Participant B5:** “ ...every time I ask them to make an appointment by the skin specialist, they say no, you can come back, try this ointment, come back, try that ointment. I asked for a second opinion that is why I want to go to s a skin specialist”.

Participant A2 expressed her frustration and anger at a delayed diagnosis of a painful hip and knee. After two years of attending the ‘arthritis club’, she was seen by a doctor who, after seeing the x-rays referred her to the district hospital where she had a hip replacement.

Participants reported a lack of follow-up, which caused delay in receiving treatment.

**Participant A1:** *“first time I went for physio she said they were booked up, they are full but I must give my phone number they gonna phone me. That was last year, they never did”.*

**Participant A2:** *“I went for my eyes tested for specs. They tested my eyes in 2015 in March 2017 I got my specs...2 years. Now I can hardly see, my eyes are messed up”.*

Participant A3 mentioned that doctors at the tertiary hospital adjusted her medication, wrote a letter regarding changes, which she handed to the nurse at the PHC facility, however to her dismay she is still receiving the same medication every month:

*“ ... the doctors said that I only have to take the three tablets, gave the letter to the day hospital, but no... I am still receiving the tablets. But I don't take them”.*

The reason for a lack of continuum of care was highlighted by Participant B4, who mentioned that because of a shortage of permanent nursing staff, non-permanent nurses (contract workers) are employed, who according to her, is not aware of the process and didn't know what to do. This was confirmed by participant B2 who encountered different nurses every time she attended the PHC facility:

*“ there was a different nurse..”.*

Some of the participants experienced delayed treatment, due to confusion at medication collection points, poor follow-up of blood results and canceled appointments without notification.

On complaining of a shoulder ache, the participant (A3) was told that she would receive the prescribed medication the following month as the medication for distribution is prepacked.

**Participant A3:** *“...so she told me that it is only arthritis, but I will put something on the script but it won't be in the packet today. It will be in next month”.*

**Participant A5:** related that *“ first I received my medication at the Chronic club, then I was told to it collect at the pharmacy. I was told now recently that I have to collect it from the civic center...”*

#### **4.3.2 Theme 2: Participant's perception of healthcare providers at the PHC facility**

The perception of the provider's attitude influenced the participants' experience within the PHC facility and this, in turn, influenced their acceptance of service and treatment rendered (Egbewale & Odu, 2012:11).

Participants were mostly negative in the opinion of staff and especially the nurse's conduct and behaviour. However, some of the participants pointed out that there were staff that displayed

positive attitudes and were very helpful. Some of the negative and positive attitudes that the participants perceived are as follows:

#### 4.3.2.1 Attitudes and Skills

Comments of individual health providers that were seen as helpful, caring and passionate. Participant A2: relates how one doctor's attitude not only confirmed her instinct that her painful hip was more than arthritis but also restored her trust in the PHC system:

**Participant A2:** *"I feel grateful for the doctor for listening to me, took time to examine and sent me for x-rays and when she saw how bad the x-ray was, she referred me to the new hospital [district hospital] .... She [the doctor] took an interest in what I was talking about".*

**Participant B3:** *"there are three nurses here [facility B] that has a passion for their work and they enjoy what they do".*

**Participant B3:** referring to one of the nursing staff *"I don't have problems with that sister, she's on top, she will always see to you..."*.

Even those participants who had favourable things to say about individual staff members agreed that the majority of the staff were unhelpful, judgmental, uncaring and unprofessional.

**Participant A2:** *"there was no medication for me [at the medication collection point]. I was told to go back to the day hospital. I can hardly walk, and then she tells me I must come back on Wednesday, I just told her I can hardly walk".*

**Participant A2:** *"they haven't got any patience and they sometimes don't know how to talk to the people".*

**Participant A5:** related how the staff would at times address the patients *"...hey you, you must sit, if you don't like it just got to the private doctor..."*.

**Participant B3:** *"there is no passion for their work, they are here to receive a salary".*

**Participant B3:** *"they don't make any effort to improve".*

Most of the participants felt that the effort and time spent to attend the PHC facility and waiting to be seen, versus the short time spent in consultation with the nurse was unsatisfactory and a waste of time. They felt that the consultation was rushed and one sided:

**Participant A5:** *"they are so rushed, they just want you out of the way".*

**Participant B5:** *"they make you feel like they are doing you a favour".*

**Participant A2:** commented on a breast examination: *"... she just made a tapped in front (chest) and then she was done. I said "wow" why did they send me to such a youngster that doesn't even know, because I have big breasts and it hurts".*

In some instances, nurses were viewed as the gatekeepers to have access to service within the PHC delivery.

**Participant A2:** *"I asked the nurse to make an appointment for me at the dermatologist, still waiting. No appointment".*

**Participant A3:** *"she [the nurse] told me that I can't be seen by the doctor without an appointment, I told her to read the letter from the professor [name of tertiary hospital] and if she [nurse] has a problem she can phone the professor".*

Providers were seen to socialize with each other, rather than assist and provide care.

**Participants A3:** *"if you have a Monday appointment, then they first tell each other what happened before they attend to you".*

**Participant A5:** *"there were two doctors, but they were having a conversation while we have to wait".*

Providers were accused of preferential treatment for friends and relatives.

**Participant B4:** *"if their friends or family arrive in a car, he doesn't have to wait with the other patients, they would bring his tablets out to him in the car. This is so unfair because we have to wait for hours".*

**Participant A1:** *"if their friends come, they will help them first".*

Participants experienced stereotyping, retaliatory behaviour and punitive measures when complaints were lodged having to wait for service. Participant B3 related an incident where a patient was told to leave the facility because he became angry after having to wait for his medication. She felt that they should have understood and acted more professionally.

**Participant A3:** *"if you complain, they will put your folder at the bottom of the list".*

#### **4.3.3 Theme 3: Participant's perception of PHC service and facility**

Three participants commented on the condition of the facility.

**Participant B4:** *"the clinic [facility B] is too small and when it rains then people have to stand in the rain".*

**Participant 5:** *"there is not enough benches for all the patients, so people have to stand for long hours".*

More often, participants would comment on the waiting time, medication delivery, appointment management and their perception of negative consequences lodged when complaints were lodged.

#### 4.3.3.1 Waiting time

All participants experienced long waiting times and expressed their frustration. They viewed the lack of organization such as misplaced files, disjointed service and unconcerned staff as the reason for the long waiting time.

**Participant B4:** *“there is no filing system, is all lying on the floor and then you have to wait until the find your folder”.*

**Participant B2:** *“...the people have to wait because they can't find the file”.*

**Participant B3:** *“...then you have to wait to see the doctor, then you have to wait to see the pharmacist and then you have to wait for them to take your blood”.*

**Participant M2:** *“...then I must go very early., like 04H30, 05h00. Then I must sit there and there's people already sitting from 03h00, 04h00. They [PHC staff] come at 07h00, then they still go into a meeting. Then 08h00 they come out. Now the help desk gives you a number and then they take the first 30. Now if I'm not in that first 30 then I must go home and come the next day”.*

#### 4.3.3.2 Appointment Management

Most of the participants found the appointment system to be confusing and impractical.

**Participant B3:** *“when you have an appointment for the afternoon when you get there the morning people has been seen too”.*

**Participant A3:** *“they tell you to come early, but they know they can't help, so you go at 05H00 and you stay the whole day”.*

#### 4.3.3.3 Medication Delivery

According to the Western Cape Government, the community-based chronic medication point is aimed at improving the patient-centred care (Western Cape Government, 2015:np).

Chronic dispensing unit (CDU) collection points have been established for chronic patients to collect their chronic medication.

All participants expressed their gratitude for the free medication and treatment received at the PHC facility. However, all participants were of the opinion that the medication delivery system was bad since they introduced the “nearest point collection” system. Many of the participants either had to return multiple times or knew someone who had to wait for medication, because they were out of stock and sent to the incorrect collection point.

**Participant A3:** *“when you get there, they tell you that they are out of stock and then you have to come back the next day “.*

**Participant A2:** *“there was no medication for me [at the medication collection point]. I was told to go back to the day hospital”.*

Due to the shortage of medication, some of the participants admitted to medication being shared amongst neighbours, friends and family. Some of the participants have to rely on family to purchase the necessary medication.

**Participant A3:** *“I just stay away ...and if I run out of tablets, I just ask my neighbours”.*

**Participant A4:** *“my daughter bought my tablets ...”*

#### **4.3.3.4 Complaints management**

All participants were aware of the complaints system. However, their experience was that it was a futile exercise and they have become disillusioned with the complaints process.

**Participant B3:** *“everyone will complain among each other, but when that have to address the issue, then they will not stand together... the people are afraid to speak up”.*

**Participant B4:** *“the people complain and complain but they don't take notice ... they don't listen to people”.*

**Participant B4:** *“you can complain put a letter in because there is a box, you can write and put your letter in, you don't do anything”.*

**Participant B5:** comments about the complaint process *“There is a box...for the complaints and stuff...but nothing happen and it was in the newspaper a few years ago”*

**Participant B5:** was resigned to accept the status quo. *“I am [deurgetrek] not bothered any longer because it has been like this all the years. I will just carry on because that is how it is”*

#### **4.3.4 Theme 4: Participant's expectations of PHC service and facility**

This theme looked at participants' expectations of the PHC service delivery. The difference between what the participants expected from the PHC service delivery and what they received can be translated into an unmet needs.

##### **4.3.4.1 Respect and courtesy**

All the participants viewed respect, courtesy, caring attitude and dignity as being high on the list of expectations.

**Participant A1:** *“they (staff) should have a better way of handling (interacting) the patients”.*

A comparison was made between the treatment received at a tertiary healthcare facility and the healthcare service they received at the PHC facility. The tertiary institution was the gold standard that they based their expectations on.

**Participant A2:** *“the nurses [at the tertiary hospital] greets you and the doctor takes his time to talk to you”.*

**Participant A3:** whose husband attends the tertiary hospital, commented that *“he gets examined and referred for an eye test without being asked”.*

#### 4.3.4.2 Consultation by a doctor

All the participants wanted a doctor’s consultation at least once a year for a full physical examination. When prompted for the reason they said:

**Participant A4:** *“Because they talk to you...a doctor will give you information, the nurses don’t explain so well”.*

The majority of the participants were of the opinion that they would receive better service if they attended a private doctor.

**Participant B5:** *“whatever you tell the doctor what is wrong with you the (private) doctor will check it out because you are paying”.*

The general consensus by the participants were that the nurses do not do physical examinations and therefore they wanted to be seen by a doctor.

**Participant A2:** *“I feel grateful for the doctor for listening to me, took time to examine me...”*

#### 4.3.4.3 PHC facility

PHC is the first point of contact with the healthcare system, which deals with both chronic and acute health problems (Greenhalgh, 2012:465-457). The most defining feature of the PHC facilities in Mitchell’s Plain, Western Cape, according to Maillacheruvu & McDuff (2014:3) is the high volumes of patients seen daily.

**Participant B4:** said of facility B: *“we need a bigger hospital, we need nurses and we need a doctor, here is only one doctor”.*

**Participant 5:** *“there is not enough benches for all the patient, so people have to stand for long hour”.*

#### 4.3.4.4 Theme 5: Proposed solution for improving the PHC service and facility

Towards the end of the interview, participants were asked for possible solutions for improving the PHC service. The views ranged from prioritized care for the elderly and for those who are wheelchair-bound, so that they do not have to be subjected to such long waiting time and crowds, to improve the people skills of the nursing staff:



**Participant B3:** *“the only solution is for and inspector to do and inspection without telling them, he should sit amongst the patients and just observe”.*

Participants inferred that no one would believe the experience and therefore needed witnesses.

**Participant M1:** *“you [the interviewer] must just take time to sit there and you can see for yourself”.*

All of the participants were of the opinion that they need more nurses and doctors. A few of the participants expressed the lack of hope for change.

**Participant B4:** *“they make rules and things, they said that they are going to make changes’ but it never works out,”*

**Participant A2:** *“No man they must clean up their mess down there [PHC facility]. Get more staff and let the staff begin to work... then I think the patients will be more civil”.*

**Participant B5:** proposed that there should be more communication *“...they need to tell the patient, listen, we are short staff, this is how we gonna do today. Don’t sent the people home...everybody sacrifices to stand up early I the morning go to a clinic because they don’t have money for a private doctor...”*

Some of the participants indicated that they were prepared to wait if there were proper systems in place concerning dispensing of medication and a respect and a caring attitude.

#### **4.4 SUMMARY**

In this chapter, the findings of the study based on the patients’ perception of PHC services in Mitchell’s Plain were presented and discussed. Themes and sub-themes related to the objectives were identified from the data and analysed. In the next chapter, the key findings that emerged from the study will be discussed in relation to the aim of the study.

## CHAPTER 5 DISCUSSION AND RECOMMENDATIONS

### 5.1 INTRODUCTION

This study attempted to gain insight and explore the patients' perceptions of their experiences in PHC services in two facilities in Mitchell's Plain. In this chapter, the key findings that emerged from the study will be discussed in relation to the aim and objectives of the study. In addition, a description of the limitations of the study will be provided, as well as recommendations are proposed to assist in positively managing the patients' perceptions and add to the body of knowledge that may influence PHC policy and implementation.

### 5.2 DISCUSSION

The research aimed to explore the patients' perspective of PHC services at PHC facilities in Mitchell's Plain, Western Cape, to gain insight about their concerns and what the patient deems important in PHC delivery.

Perception is reality and therefore the patient's perception and experience of the health care system and the health delivery is their reality (Betancourt, 2017:241). In this study, the participants gave an insight into their experiences and expectations of PHC delivery in their community, as well as their health needs. It highlights the gaps, from the users' view, in providing an efficient, essential and safe PHC delivery to meet the needs of the community in two PHC facilities in Mitchell's Plain.

Patient perception and expectation of PHC delivery are evolving, because of their contact, either directly (through personal experiences) or indirectly (through media, family and friends), with the private healthcare sector and tertiary hospital, where health delivery service is of a higher-quality care. They are increasingly becoming aware of their rights to health care, the right to participate in matters affecting their health and continuity of care (South Africa, 2018:1). Either way, their expectations from healthcare providers are evolving. There is a bigger demand for better engagement and the need to be a part of their health management.

#### 5.2.1 Patient-centred care

Patient-centred care focuses on the interpersonal and relational dimension of health care (Bitton *et al.*, 2017:568). It incorporates effective communication and understanding of the patient's healthcare experiences and interpersonal collaboration (Constand *et al.*, 2014:1).

The study revealed that communication and patient engagement were sorely lacking in both PHC facilities. The participants found that the nursing staff lacked empathy and showed little interest in their wellbeing. They were seldom asked their opinion or when given, their opinions were disregarded. This resulted in feelings of humiliation and frustration, because they felt they do not

have much choice, due to their economic circumstances, and at worst, feeling of apathy, because they felt things were never going to change.

Patient-centered care requires an equal partnership, with a give and take relationship (Pulvirenti *et al.*, 2014:307). In this study some participants showed an interest in wanting to be more engaged in managing their medical condition, however, the advances were ignored or met with hostility. Other participants were satisfied with being the passive patient and accepting the status quo.

### **5.2.2 Chronic health clubs**

It was evident in the study that both the participants and by their accounts, more so the healthcare providers were still entrenched in the curative mindset. The focus of both the participant and the provider was on 'what is wrong' (the disease) rather than, what can be done to enhance the health disposition of patients. In the study, it was evident that the focus at the PHC facility was on illness or disease, rather than the prevention and promotion thereof.

The patients with specific diseases were channeled to chronic disease specific clubs. The Chronic Diseases of Lifestyle Chronic clubs are where patients with chronic disease are managed with the aim to provide screening, health education, nutritional service, as well as a therapeutic and community support groups (Western Cape Government, 2018:np). A study conducted in the Western Cape regarding the implementation of CDL clubs in a PHC setting by Puoane *et al.* (2012:2-4) reported good health outcomes when there was active engagement by the patients and community. However, the participants in this study perceived the clubs as "a waste of time", "... you go to the chronic club and they take your blood pressure and then you have to wait for the doctor". Britton *et al.* (2016:567) and Druetz (2018:90) found that this was typical in many low-income countries, where the focus was on the specific disease, rather than on the people and the promotion of holistic health. However, to create an integrated health system that prioritises PHC, and achieve universal health care will require moving away from the vertical programming (Britton *et al.*, 2016:567). The CDL club, if managed correctly as the clubs were intended, could be a space where health promotion, support group, patient participation and empowerment can be encouraged and facilitated. Atagabu *et al.* (2012:489) suggest that vertical approach, such as CDL clubs, can be used to gradually strengthen PHC delivery. Practicing empowerment within PHC delivery increases health autonomy and patient participation (Pulvirenti *et al.*, 2014:307).

### **5.2.3 Health promotion and education**

Findings in the study showed a lack of health promotion and education. The only participant who said that she received education regarding management of her disease, received a glucometer on the day of the interview but did not receive instruction or a demonstration on the use of the glucometer and values of the readings.

Participants indicated that they wanted health information and specific information about their disease management. The lack of health information from the professionals had a negative impact on health practice and the health behaviour of the patients. Participants engaged in unhealthy and hazardous health seeking behaviour, such as medication sharing and non-compliance. Two of the participants had a CVA and two reported that they suffered a heart attack.

Dookie and Singh (2012:4) noted that PHC services need to place greater emphasis on health promotion and education. Similarly, Mailiacheruvu and McDuff (2017:8) in an article describing their experiences in a PHC facility in Mitchell's Plain, concluded that expanding their health prevention and education programmes will lessen the cases and prevent complications arising from chronic disease. The lack of information regarding chronic conditions and management thereof, as well as medication interaction, leads to hazardous practices by the participants, such as medication sharing and non-compliance. This could be due to the lack of promotional resources, shortage of staff and high volumes of patients (Maimela *et al.*, 2015:9; Mailiacheruvu & McDuff, 2014:9).

#### **5.2.4 Participant's Perception of nurses**

Most of the participants showed to some degree interest to engage in their health and their chronic disease management. However, they perceived that their advances were ignored or met with hostility by the nurses.

Patient-centred care requires an equal partnership, with a give and take relationship (Pulvirenti *et al.*, 2014:307). The literature on patient-centred care entails the need for effective communication, interpersonal celebration and being sensitive to the patient's health needs (Constand *et al.*, 2014:1; Bitton *et al.*, 2017:568; Raven, 2015:1). In this study, all of the components were lacking. All participants perceived nurses as being disrespectful and unhelpful and displayed little regard to patients' needs and their rights. At times this resulted in conflict and mutual disrespect. An uncaring attitude during consultation fuelled the perception of incompetence. Similar findings of studies were noted by Scheffler *et al.* (2015:8) and Adejeniji and Mash (2016:7), where unmet needs resulted in a perception of unsatisfactory behaviour that lead to conflict between user and provider.

In this study, nurses were perceived as gatekeepers to access a second opinion or a request to consult with a doctor. The right to a second opinion and timeously referrals is guaranteed in the Patients' Rights Charter (Republic of South Africa, 2003:20). Three participants revealed that their request for referral to consult with a doctor or specialist was denied. Even though, according to them, the treatment prescribed by the nurse was not having the desired effect. These incidences

enforced the perception of incompetency, uncaring and 'I know best' attitude which result in patients becoming despondent or belligerent.

Scheffler *et al.* (2015:10), report that perceptions of inadequacy and unacceptability lead to disempowerment. Similarly, the participants reported feeling trapped with very little choices, because of their financial constraints. Some of the participants are of the opinion that they will have to accept the situation as things never get better or change.

### **5.2.5 Nurses versus doctor care**

PHC in South Africa is nurse driven and was introduced to improve access to care (Rispel *et al.*, 2010:97). Both Adejiji and Mash (2016:7) and Scheffler *et al.* (2015:10) argue that patients' perceptions of 'good care delivery' are embedded in doctors and not in nurses who manage caring services because they do not provide quality care. The majority of the participants preferred to be seen by a physician at least annually. Participants in this study preferred physicians to nurse, because they experienced nurses as uncaring and non-attentive which in turn is perceived as the nurse being incompetent: "...he (doctor) listens to me". The doctors are perceived to be more concerned because they enquire about the patient's health needs and paid attention. This was highlighted in this study when one participant, who, after several requests saw a doctor, and according to her, took the time to listen, acknowledged her concern and confirmed her suspicion that it was more than arthritis. She was subsequently referred to a surgeon and eventually had a hip replacement. Participants felt that nurses did not encourage conversation and were rushed with little regard for their opinion. Communication and effective engagement by the health professionals will promote a supportive caring attitude and encourage adherence to treatment (Maimela *et al.*, 2015:6).

It can be argued that nurses may not have extensive training in the management of chronic diseases (Lalkhen & Mash, 2015:136) and feel overwhelmed with having to deal with large numbers of patients with multiple comorbidities and a lack of support and supervision (Scheffler *et al.*, 2015:10). There is an urgent need for nurses to be trained in patient-centred care and PHC providers to receive training in communication skills as pointed out by a study conducted by Priebe and Stang (2016:219).

This study shows that there is a definite breakdown between relationship, trust and communication between PHC providers and PHC users.

### **5.2.6 Medication distribution**

All of the participants expressed their gratitude for free health and medication. However, their gratitude was tinged with frustration and anger regarding the distribution of medication. This was largely due to protocol and policy that did not take into consideration the patient's needs and

convenience. Participants experienced delayed access to prescribed medication which resulted in delayed and fragmented treatment. One participant related that the nurse instructed her to take her cardiac medication even though the prescription of the tablet was stopped. Another participant had not received medication for the past five months. Yet another participant was receiving medication that was stopped months ago. Medication is distributed monthly, but due to misplaced medication, confusion regarding collection points and lack of notification and information, it has resulted in long waiting times, noncompliance and out of pocket expenses with patients having to return the next day or buy the required medication. Findings are consistent with studies by Scheffler *et al.* (2015:10).

### **5.2.7 Management of expectation**

Unmet expectations fuelled perceptions of inadequacy and unacceptability, which led to feelings of disempowerment, which in turn affected the quality of care and patients' satisfaction (Scheffler *et al.*, 2015:10; Betancourt, 2017:241). A few of the participants felt that they have little choice because they could not afford private care. Private care affords them more time spent with a health provider who would acknowledge their reality and take time to listen.

All participants felt that the appointment system should be improved as they found it confusing and impractical. They felt that effort and time spent to attend the PHC facility and waiting to be seen, versus the short time spent in consultation with the nurse, was unsatisfactory and at times, a waste of time. Long waiting time was seen by the participants as an inability to organise, a confusing appointment system and unconcerned staff, and in some incidences, preferential treatment for staff acquaintances. The participants' perspective regarding the management of the facility, are that they need more permanent nurses and doctors, as well as a bigger facility. Participants indicated that they are prepared to wait if there was a proper system in place and service providers displayed a more caring attitude. These solutions proposed by the participants are in keeping with a patient-centred care approach, where patients' needs are taken into consideration and there is therapeutic communication and mutual respect.

## **5.3 LIMITATION OF STUDY**

This study was purposively conducted to gauge the perspective of the participant and how they perceived the treatment received at the PHC facility in Mitchell's Plain, Western Cape. As the participants were approached within the community, the researcher was unable to observe the interaction between the primary care provider and participant. Therefore, the narrative was one-sided.

Although the researcher aimed to engage a purposeful sample, all of the participants were female, and presented with chronic conditions. Thus, the researcher was unable to elicit the specific

experience and perception of males attending the PHC facility, as well as those presenting with communicable conditions.

#### **5.4 CONCLUSION**

PHC in South Africa has undergone several reforms and restructuring throughout the years intending to provide a sustainable and comprehensive PHC service (Ataguba *et al.*, 2012:132-135). Currently, South Africa is joining the global community in the move towards universal health coverage that is underpinned by patient-centered care, where the focus is on what is important for the PHC user (Delaney, 2018:119). Mailiacheruvu and McDuff (2014:5) are of the opinion that South Africa has a long way to go to provide patient-centered health care.

The aim of this study was to explore the patients' perspective of PHC facilities in Mitchell's Plain, Western Cape, to gain insight into their experiences and understand their concerns and what they deem important in PHC delivery.

This study provided a unique opportunity to listen to the PHC users' experiences and perception, and therefore their reality. It also created a space for the participants as PHC users to voice their concerns, frustration and opinions, and in so doing became active participants in their health management.

The participants highlighted gaps and barriers that they have experienced in the PHC care system, such as long waiting time, discourteous nursing staff, fragmentation of service delivery and frustration with medication distribution. This was similar to studies conducted in other parts of Cape Town (Mailiacheruvu & McDuff, 2014:5; Scheffler *et al.*, 2015:10). However, they also had suggestions on improving the services, such as a need for improving the appointment system, recruiting more nursing staff and bigger facilities. It appears that given the opportunity, patients would want to be more active in the management of their health and illness. Therefore, it is becoming increasingly more important that providers should be trained in patient-centered care which includes; fostering mutual respect through communication, courtesy and participative decision making. Opportunities should be created to actively engage patients, such as utilizing the current vertical disease specific 'clubs', where patients can receive information to empower them, so that they can make informed and healthier lifestyle choices. This will also align PHC with personalized care, as set out on the PHC model, set out in the South African national healthcare plan (Mailiacheruvu & McDuff, 2014:5).

Empowering patients is more likely to result in the acceptance of PHC delivery and compliancy of proposed treatment, which in turn will lessen the burden in the PHC delivery. PHC empowering involves therapeutic communication, encouraging the patients to be participative in their care and

equipping them through information and education to make informed decisions regarding their health. This however, requires better organizational systems to be put into place, such as an increase of trained and patient- centered PHC staff, which is supported by management, civil society and government, and aligning resources with the needs of the patient.

With the advent of the NHI, which is South Africa's plan to ensure universal health coverage (South Africa, 2017:3), it would be in the best interest of government and policymakers to engage in the PHC users regarding their perception of their health needs. White (2015:1-7) warns about the failure to improve underlying conditions and meet the real needs of the population, which will be to the disadvantage of the success of the NHI. Who better to inform government and policymakers about their health needs than the people themselves? Findings in this study have shown that patients have their own and at times different perspectives of that of the healthcare providers and policymakers. However, they do offer relevant insight into the barriers encountered and possible solutions to overcoming them, as well as improving care to meet their needs.

## **5.5 RECOMMENDATIONS**

The recommendations emerged from the finding discussed in this study. The findings indicate that patient perception has an important part to play in contributing to identifying gaps and unmet needs in PHC service delivery.

The researcher acknowledges that a more diverse study population such as age, gender and disease profile would have resulted in a more in-depth outcome. It is with this in mind that the researcher recommends the following:

- Explore the barriers to patient-centred care engagement within the PHC service delivery
- A comparative study between private PHC facility and public PHC facility regarding patient experience and perception
- Explore the impact of inadequate skill and quality of service on the health- seeking behaviour
- Participative action study- introducing a horizontal approach in a vertical programme in a PHC delivery using a patient-centred care model.



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## APPENDICES

### Appendix 1: Ethical Approval from Stellenbosch University



Approved  
Response to Modifications

01/10/2018

Project ID #: 7350

HREC Reference #: S18/05/106

Title: PATIENTS' PERCEPTIONS OF PRIMARY HEALTH CARE SERVICE

Dear Ms Veronica Herman

The **Response to Modifications** received on 05/09/2018 09:09 was reviewed by members of the **Health Research Ethics Committee (HREC)** via Minimal Risk Review procedures on 01/10/2018 and was approved.

**Please note the following information about your approved research protocol:**

Protocol Approval Period: 1 October 2018 - 30 September 2019

Please remember to use your Project ID (7350) and HREC reference number (S18/05/106) on any documents or correspondence with the HREC concerning your research protocol.

Translation of the consent document/s to the language applicable to the study participants should be submitted.

Please note that this decision will be ratified at the next HREC full committee meeting. HREC reserves the right to suspend approval and to request changes or clarifications from student applicants. The coordinator will notify the applicant (and if applicable, the supervisor) of the changes or suspension within 1 day of receiving the notice of suspension from HREC. HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

#### After Ethical Review:

Please note a template of the progress report is obtainable on <https://applyethics.sun.ac.za/Project/Index/8830> and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.

#### Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health ([healthres@pgwc.gov.za](mailto:healthres@pgwc.gov.za) Tel: +27 21 483 9907) and Dr Helene Visser at City Health ([Helene.Visser@capetown.gov.za](mailto:Helene.Visser@capetown.gov.za) Tel:+27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.

For standard HREC forms and documents please visit: <https://applyethics.sun.ac.za/Project/Index/8830>

If you have any questions or need further assistance, please contact the HREC office at 021 938 9677.

Sincerely,

Ashleen Fortuin

Health Research Ethics Committee 1 (HREC1)

*Federal Wide Assurance Number: 00001372*

*Institutional Review Board (IRB) Number: IRB0005239*

*The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part*

*46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2015 (Department of Health).*

#### INVESTIGATOR RESPONSIBILITIES

##### Protection of Human Research Participants

Some of the responsibilities investigators have when conducting research involving human participants are listed below:

## Appendix 2: Participation information leaflet and declaration of consent by participant and investigator

### **PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM**

**TITLE OF THE RESEARCH PROJECT:** The patients' perceptions of Primary Health Care in two facilities in the Mitchell's Plain, Western Cape

**REFERENCE NUMBER:** 158/05/106

**ADDRESS:** 6 Forel Street Sonieke Kuils River

**CONTACT NUMBER:** 0618921062      **E-mail:** ronica\_za@hotmail.com

You are being invited to take part in a research project. Please take time to read the information presented here, which will explain the details of this project. Please ask me any questions about any part of this project that you do not fully understand. It is important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is entirely voluntary and you are free to decline to participate. If you do decline, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study will be conducted according to ethical guidelines and principals of the international Declaration of Helsinki, South African Guidelines for the Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research

#### **What is this research study all about?**

This research will attempt to investigate your perception of Primary Health Care services and understand your concerns and your understanding of what is important in Primary Health Care delivery.

#### **Why have you been invited to participate?**

You have been selected because you have been attending the clinic for longer than a year. Your experience and understanding will make us aware of your understanding of Primary Health Care and what is important to you, as the Primary Health Care users.

#### **Will you benefit from taking part in this research?**

The study will look at ways of improving the Primary Health Care services by making the service providers and policy makers aware of your perception and concerns. If you agree to participate you may benefit from the possible improvement in the services.

#### **Are there any risks involved in your taking part in this research?**

No risks are anticipated.

#### **Will you be paid to take part in this study and are there any costs involved?**

You will not be paid to take part in the study. There will be no costs involved for you, if you do take part.



What will your responsibilities be?

- Read the leaflet
- Sign the consent stating that you are a willing participant.

If you agree I will interview you for approximately 45 -60 minutes. In the interview I will ask you a few questions and give you an opportunity to share your experiences and understanding of Primary Health Care with me. The interview will not take place at the Primary Health Care facility to ensure confidentiality. The location of the interview will be at your convince and where you, the participant, feel comfortable and safe.

With your permission the interview will be taped recorded to ensure that I have captured all that has been said. The recorded tapes will be locked away and I will be the only one that has access to it. All information obtained during the interview will be treated as confidential and your identity will remain anonymous at all times. After a period of five years, the taped interview will be destroyed.

Should you feel uncomfortable with me recording the session you may refuse to have it recorded. Persons, who refuse to have the interview recorded, will not participate in the study. There are no consequences in not participating.

You would be asked to give the name of another person who will be willing to participate in the study. The person should be older than 18 years and has attended the PHC facility for more than a year. You have the right to refuse to give a name with no negative consequences.

If you do not agree to take part, what alternatives do you have?

If you do not agree to participate there will no consequences – you may continue to use the services as before.

You may withdraw your consent at any time and discontinue participation without penalty.

Is there anything else that you should know or do?

You can contact the Human Research Ethics Committee of the Faculty of Medicine and Health Science at 021-9389207 if you have any concerns or complaints

If you have questions regarding your rights as a research participants, contact Veronica Herman [ronica\_za@gmail.com: 0313925701][Ms Danine Kitshoff [danenek@sun.ac.za: 0219389823] at the Department of Nursing and Midwifery,, Stellenbosch University

Declaration by participant

By signing below, I ..... agree to take part in a research study entitled: Perceptions and experiences of nurses about the mobile clinic work environment.

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is voluntary and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the interviewer feels it is in my best interests, or if I do not follow the study plan, as agreed to.
- I confirm that I will keep confidential all information shared with me at the focus group or other discussions

Signed at (place) ..... on (date) ..... 2018

.....

Signature of participant      Signature of witness

Declaration by interviewer

I (name) ..... declare that:

- I have explained the information in this document to .....
- I have encouraged him/her to ask questions and have taken adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above.
- I confirm that I will keep confidential all information shared with me at focus groups or any other discussions.

Signed at (place) ..... on (date) ..... 2018.

.....

Signature of interviewer      Signature of witness

## Appendix 3: Interview guide

### INTERVIEW GUIDE

NAME	AGE	Reason for attending the clinic
GENDER	How long have you been attending the clinic	

### ENGLISH

Introduction	<p>Greet the participant and direct them to the chair</p> <p>Introductions</p> <p>Explain the steps of the interview</p> <p>Clarify if participant understood the step.</p> <p>Allow participant to ask Question.</p> <p>Obtain consent</p>
Interview	<p>What do you think is a Primary health care facility?</p> <p>Tell me about your experiences in at PHC clinic?</p> <p>Describe how the clinic provides for your health and illness needs?</p> <p>Who sees you at the clinic</p> <p>Tell me about the challenges you face when attending the facility?</p> <p>What would you change about the facility and why?</p>

<b>Closing Question</b>	<b>Is there anything about your experience and views that you feel is important that we haven't covered?</b>
-------------------------	--

<b>Elicit techniques used</b>	<b>Probes Clarification of statement Reflection summary Paraphrasing</b>
<b>Ending</b>	<b>Reconfirm the participants consent Request permission to contact participant to clarify information given Reconfirm confidentiality</b>

AFRIKAANS

Inleiding	<p>Groet die deelnemer en rig hulle na die stoel</p> <p>Introductions</p> <p>Verduidelik die stappe van die onderhoud</p> <p>Verduidelik of die deelnemer die stap verstaan het</p> <p>Allow participant to ask Question.</p> <p>Verkry geskrewe toestemming</p>
Onderhoud	<p>Wat dink jy is 'n primêre gesondheidsorgfasiliteit?</p> <p>Vertel my van u ervarings in die PHC-kliniek?</p> <p>Beskryf hoe die kliniek voorsiening maak vir u gesondheids- en siektebehoefes?</p> <p>Wie sien u by die kliniek</p> <p>Beskryf die uitdagings wat u in die gesig staar wanneer u die fasiliteit bywoon?</p>
Sluitingsvraag	<p>Is daar iets aan u ervaring en sienings wat u van mening is dat ons nie gedek moet word nie?</p>

Ontlok tegnieke  
 wat gebruik word

Probes  
 Toeligting  
 Refleksie-opsomming  
 Parafrasering

Sluiting

Bevestig weer die toestemming van die deelnemers  
 Vra toestemming om die deelnemer te kontak om die inligting wat gegee word duidelik te maak  
 Bevestig dit weer vertroulikheid  
 Reconfirm confidentially

## Appendix 4: Language certificate



3 Beroma Crescent Beroma Bellville  
Tel 0219514257  
Cell 0782648484  
Email [illona@tuptutoring.co.za](mailto:illona@tuptutoring.co.za)

English/Afrikaans  
Afrikaans/English

\* Translations \* Editing \* Proofreading  
\* Transcription of Historical Docs  
\* Transcription of Qualitative Research  
\* Preparation of Website Articles

### **TO WHOM IT MAY CONCERN**

This letter serves to confirm that the undersigned

**ILLONA ALTHAEA MEYER**

has edited and proofread the thesis of Veronica Cynthia Herman for language correctness and translated the Abstract.

**TITLE: PATIENTS' PERCEPTIONS OF PRIMARY HEALTHCARE SERVICE FACILITIES IN MITCHELL'S PLAIN, WESTERN CAPE**

Signed

**Ms IA Meyer**

**27 November 2019**

Appendix 5: Technical editing certificate

*"Unless you're willing to have a go, fail miserably, and have another go, success won't happen." Phillip Adams*

**SUCCESS YOUR WAY**

*"Most successful men have not achieved their distinction by having some new talent or opportunity reserved to them. They have developed the opportunity that was at hand." Bruce Barton*

**ADD VALUE**

*"Show me a man who cannot do little things and I'll show you a man who cannot be trusted to do big things." Lawrence*

**VISION**

*"Embrace failure."*

**Work hard.**

*"Experience shows that success is due less to ability than to zeal. The winner is he who gives himself to his work, body and soul." Sir Thomas Fowell Buxton*

**life... your way**  
yourway.net

*"IN THE MIDDLE OF DIFFICULTY LIES OPPORTUNITY." ALBERT EINSTEIN*

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**RUKSHANA ADAMS**  
COPYWRITING AND EDITING SERVICES

**CERTIFICATE OF FORMATTING AND EDITING**

This is to certify that the thesis titled  
**PATIENTS' PERCEPTIONS OF PRIMARY HEALTHCARE SERVICE FACILITIES IN MITCHELL'S PLAIN, WESTERN CAPE**  
 written by **VERONICA CYNTHIA HERMAN**  
 Was Reviewed for Technical formatting and editing by **RUKSHANA ADAMS**  
 Date: **27 November 2019**

*"Expect success!"*

*"For many people are thick of course and stand of opportunity they see more and of hope than death." Julius F. Björns*

**"THE TROUBLE WITH OPPORTUNITY IS THAT IT ALWAYS COMES DISGUISED AS HARD WORK." ANONYMOUS**

*"Since most of us spend our lives doing ordinary tasks, the most important thing is to carry them out extraordinarily well." Henry David Thoreau*