THE PROVISION OF PRIMARY HEALTH CARE

IN TWO RURAL DISTRICTS OF THE EASTERN CAPE PROVINCE WITH PARTICULAR REFERENCE TO HUMAN RESOURCES AND ACCESSIBILITY

PART 2: THE RESULTS AND RECOMMENDATIONS

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ABSTRACT

Part 1 of this article dealt with the introduction, problem statement and the research methods. This article details the results and the recommendations with the aim of improving the provision of primary health care in rural districts of the Eastern Cape Province. This article is dealt with in three phases: phase I gives the results of interviews of community people, phase II deals with the results of the questionnaire administered to professional nurses and phase III entails the recommendations.

The results indicated that the majority of the community people 82,5%, stayed within 6 to 20 kilometres from the clinics; 76% walked to the clinic, and 46,5% visited the clinic when it was necessary. The results also revealed that 50% of the professional nurses felt the workload at the clinics as heavy; 95% indicated that the communities served ranged between 8 and above 10 localities, whilst 75% showed that the clinic staffing was from average to poor.

Recommendations highlighted the need for building more PHC centres in Mqanduli and Elliodale districts; to recruit, select and train village health workers; and to staff clinics according to the WHO staffing norms. Further research is still needed on the guidelines of the provision of PHC in rural areas. In conclusion the Primary Health Care services in these districts were found to be inaccessible.

Research

RESULTS

SAMPLE DESCRIPTION

The sample for the study was drawn from all the residential clinics of Mqanduli and eastern area of Elliotdale districts; and also from all the professional nurses working in these clinics.

Two hundred interview schedules were administered to interview two hundred clients, and twenty questionnaires were distributed to twenty professional nurses. The response rate of both interviews and questionnaires was 100%.

Each clinic was assigned an alphabet for identification purposes. Alphabets from "A" to "J" were used for ten clinics.

Analyses of data collected was performed by using a computer soft ware package called SAS, since the University of Transkei uses SAS programme for the analysis of data.

The results in this study are presented in two broad sub - headings : Part I will address the results obtained from the use of the interview schedules among 200 clients attending at the clinics around Mqanduli and the Eastern part of Elliotdale districts. Part 2 will address results obtained from 20 professional nurses working in these ten (10) clinics.

PHASE I: CLIENTS RESPONSES FROM TEN CLINICS

The distance between homes of respondents and the clinic

The distance of the respondents homes from the clinics varied, ranging between 2km and 20kms. The majority of respondents, (N = 78), 39%, stayed within 6 - 10kms range (see Table 1).

Normal distance according to Vlok (1991) should be 2 - 5km from the consumer' homes to the Primary Health Care Centre.

The mode of transport used by respondents when visiting the clinic

The respondents revealed that (N = 3), 1,5%, respondents visited the clinics by bus,(N = 3), respondents, 1,5%, got on horseback in order to reach the clinic. The majority of respondents, (N = 152), 76%, walked to the clinic, and about (N = 42), 31%, used taxis to visit the clinic.

The frequency of visits made to the clinic

Twenty one respondents, 10,5%, visited the clinic weekly; (N = 63), 31,5% of respondents, visited the clinic bi - monthly, whilst (N = 10), 5% also visited the clinic bi - monthly. The majority of respondents, (N = 93), 46,5%, went to the clinic when it was necessary. About (N = 13), 6,5%, were visiting the clinic for the first time on the day of the study.

Clinic activities or comments

The respondents were asked to comment about the daily activities of their clinics. In addition to the services they got from the clinics they were requested to state problems they encountered at their clinics. The minority of respondents (N = 1), 0,5%, stated that the clinics had shortage of water. The majority of respondents (N = 151), 75,5%, commented about medicines which were usually out of stock in the clinics. About (N = 2), 1%, of respondents who stated that the clinic was too far. The respondents who commented about good attitudes were (N = 6), 3%. Those respondents who stated that nurses had bad attitude were (N = 9), 4,5%. About (N = 30), 15%, of respondents had no problems with the clinics activities, whereas (N = 1), 0,5%, of respondent stated that the clinic structure was too old.

Other sources of treatment visited by the respondents

The majority of respondents (N = 93), 46,5%, visited private doctors. Seven percent (N = 14) visited traditional healers when ill. Another great number of people 40.5% (N=81) preferred a hospital setting, whilst only 6% (N=12) had no preferences.

People preferred by the respondents for home visits

The respondents were requested to mention people whom they preferred to visit their homes. A few respondents, (N = 2), 1%, preferred to be visited by their neighbours. About (N = 8), 4%, of respondents wanted the relatives to visit them; (N= 67), 33,5% of respondents preferred to be visited by "Onompilo" or village health workers; whereas the majority (N =82), 41%, of respondents preferred nurses` visits. About (N =3), 1,5%, stated that they would like to be visited by the social workers; (N = 14), 7%, of respondents preferred traditional healers to visit them at their homes; and (N = 2), 1%, of respondents did not have any choice of people.

See table 2 which forms the basis of this discussion.

PHASE II :PROFESSIONAL NURSES RESPONSES

It has been indicated earlier at the beginning of this article that phase two of the results deals with the information obtained from professional nurses staffing ten clinics. Therefore, the following subheadings discusses such results.

GENERAL AGE DISTRIBUTION OF RESPONDENTS

The minority of respondent's age (N = 1), 5%, ranged between 20 - 30 years, whilst the majority of the respondents (N = 9), 45% were between 31 - 40 years of age. See table 3 for age range of professional nurses who participated in this study.

THE MARITAL STATUS OF RESPONDENTS

A few of respondents (N = 6), 30%, were single. the majority of respondents (N = 13), were married and only (N = 1), 5%, was a widow.

CLINIC STAFFING

About (N = 5), 25%, of respondents indicated that the staffing of the clinics was good; few respondents (N = 4), 20%, commented that the clinic staffing was average; and the majority (N = 11), 55%,indicated that the staffing of the clinic

Table 1

The SAS System

distance

Distance	Frequency	Percent	CumulativeFrequency	Cumulative Percent
2 - 5 kms	35	17.5	35	17.5
6 - 10 kms	78	39.0	113	56.5
11 - 15kms	73	36.5	186	93.0
16 - 20kms	14	7.0	200	100.0

Table 2

Other treatment places

Other treatement places	Frequency	Percent	Cumulative Frequency	Cumulative Percent
private doctor	93	46.5	93	46.5
traditional healers	14	7.0	107	53.4
hospital	81	40.5	188	94.0
nowhere	12	6.0	200	100.0

Table 3

The SAS System
Age of Professional Nurses

Age	Frequency	Percent	Cumulative Frequency	Cumulative Percent
below 30	1	5	1	5.0
31 - 40	9	45.0	10	50.0
41 - 50	7	35.0	17	85.0
51 - 60	3	15.0	20	100.0

Table 4

Clinic Staffing

Clinic Staffing	Frequency	Percent	Cumulative Frequency	Cumulative Percent
good	5	25.0	5	25.0
average	4	20.0	9	45.0
bad	11	55.5	20	100.0

Table 5

Workload

Workload	Frequency	Percent	Cumulative Frequency	Cumulative Frequency
Average	3	15.0	3	15.0
Heavy	10	50.0	13	65.0
Too heavy	7	35.0	20	100.0

was bad. See table 4 as the basis of this discussion.

THE CLINIC WORKING HOURS

All the respondents (N = 20), indicated that they work 8 hours per day for 5 days and are on call for 24 hours a day.

THE NUMBER OF COMMUNITIES SERVED

Only (N = 1), 5%, of respondents stated that the clinic served 5 - 7 communities; the majority of respondents (N - 11), 55%, served 8 - 10 communities; and about (N = 8), 40%, of respondents indicated that they serve about 10 communities.

THE CLINICAL WORKLOAD

The majority (N - 10), 50%, felt that the workload was heavy (see Table 4) very heavy workload (N = 7), 35% and (N = 3), 15% had no problem with the clinic workload. See table 5 as the basis of this discussion.

THE PERFORMANCE OF DAILY WORK AT THE CLINIC

The respondents were requested to explain how they find the duties performed at their clinics. The majority of respondents (N = 12), 60%, stated that they found it hard to perform well because of large numbers of clinic clients as against the number of clinic nurses, who were few. There were comments from the respondents like, "*...the duties done daily are heavy because the clinic is serving many localities, even during the week - ends the numbers are high...*" "*...it`s difficult because of overload, overwork and shortage of staff...*"; "*...there is work overload as there is gross shortage of staff ...*"; and many others.

About (N =2), 10%, remarked that they found duties heavy on certain days like Tuesdays and Wednesdays. A few of respondents (N = 5), 25%, commented that

the duties were interesting and the clinic work was running smoothly except that there were no material and human resources, "*...they are interesting except that there is no equipment, we are improvising all time...*"; "*...the duties are manageable and routine flows smoothly, the only problem is the shortage of equipment and staff...*" and many others. Only (N = 1), 15%, of respondents stated that, "*...the duties are not easy because most of the patients come from far homes and arrive late...*"

THE ATTITUDE OF THE COMMUNITY TOWARDS THE CLINIC

All the respondent (N = 20), 100%, indicated that the attitude of the community is positive towards the clinic.

HOME VISITS

The respondent (N = 19), 95% indicated that they conducted home visits, and (N =1), 5%, did not conduct home visits.

THE REASON FOR NOT CONDUCTING HOME VISITS

The respondents who did not conduct home visits gave the shortage of nurses and workload as the reasons for not visiting the homes.

THE NUMBER OF HOMES VISITED IN A MONTH

Only (N = 1), 5%, of the respondents visited 2 - 5 homes (N = 7), 35%, visited 6 - 10 homes; about (N = 3), 15%, of the respondents visited 11 - 15 homes; and the majority of respondents (N = 9), 45%, visited 16 - 20 homes in a month.

THE DISTANCE OF HOMES OF THE CLIENTS FROM THE CLINIC

A few of the respondents (N = 3), 15%, indicated that the homes visited were far from the clinic.

MODE OF TRANSPORT TO VISIT THE HOMES

A great number of respondents (N = 19), 95%, walked to the homes of the clients.

COMMENTS ABOUT HEALTH EDUCATION GIVEN TO CLIENTS

All the respondents (N = 20), 100%, indicated that formal and informal health education was given to individual clients and groups. There were comments like, "...but clients show a very negative attitude and if I evaluate them they know nothing, they continue giving birth at home, others with no toilets and vegetable gardens...."

FACTORS THAT EFFECT THE PROVISION OF PRIMARY HEALTH CARE

The distance between the respondents homes and the clinics is wide, the majority of respondents (N = 78), 39% staying within 6 - 10 kms range, with the majority of respondents (N = 152), 76% walking to the clinic.

The majority of respondents from professional nurses (N = 11), 55% indicated that there was shortage of staff in the clinics, which resulted in a heavy work load felt and a few homes, 16 - 20, visited in a month.

DISCUSSION OF RESULTS OF CLIENTS

Considering the distance between the respondents' homes and the clinic, only 17,5% stayed within the normal distance which is between 2Km and 5Km. Vlok (1991) states that "The PHC clinic must be accessible to the community, i.e. it should be within 5km of the consumers of health care". The majority of the respondents, 82,5%, stayed beyond 5Km but at different distances.

The respondents who used buses as the mode of transport to the clinic were 1,5%, the majority, 76%, walked to the clinic and 21% used taxis to the clinic; only 1,5% went on horseback to the clinic.

The clients who were visiting the clinic weekly were 10,5%; those who went monthly to the clinics were 31,5%; only 5%; of respondents went to the clinic at bimonthly interval, the majority 46,5%, went when it was necessary, to the clinic and 6,5% were going to the clinic for the first time during the interview.

The comments of medicines which got finished at the clinic was voiced out by 75,5%; 45% commended nurses for their good attitude; 3% was not pleased about the nurses' attitudes at the clinic and 1% commented about the clinic which was very far, 0.5% stated that clinic had water problems and 15% had no problems. Looking at other places visited by the respondents when not feeling well the majority 87% visited both the private practitioners and the hospitals, 7% consulted the herbalists and witch doctors and 6% went to the clinic only for treatment.

The 23,5% of respondents, stated that they wanted "Omompilo" to visit them at their homes; 11% preferred medical doctors to visit them; 7% said they wanted to be visited by herbalists and witchdoctors; whereas 41% stated that they wanted to be visited by the nurses; and 45% preferred social workers visit.

In conclusion, the vast majority of people in these two rural districts are living far from the clinics, that is, health care services are inaccessible to the people in these localities

The inaccessibility of health services in these districts is aggravated by poor or no roads to the clinics where the majority of people, 76% walked to the clinic and only 1,5 used buses, 21% used taxies and 1,5% used horseback.

Since it was stated before, that the two districts are predominantly rural and grossly underdeveloped, these districts experience all the disadvantages of underdevelopment physically, socially, and psychologically.

The small percentage of people who visited the clinic bimonthly, 5%, as compared to 46,5% which visited when necessary explain that people stayed at their homes with their sufferings, probably because of financial constraints or inaccessibility of the health services.

The shortage of medicines in the clinic is a problem in delivering health care services to the localities as many people resorted to traditional healers who always had treatment for them.

The higher percentage of people, 41% who wanted to be visited by the nurses, and 33,5% by "Onompilo" when sick explains that the communities see health workers visiting them as an intervention in the inaccessibility of health services. The researchers appreciate the fact that there are people who wished to be visited by faith - healers, traditional healers and social workers. WHO, cited in Searle and Brink (1984:142) state that "No less than 80% people in rural area and poor urban areas and poor neighbourhoods still lack access to any form of health services".

DISCUSSION OF RESULTS OF PROFESSIONAL NURSES

Only 25% of the professional nurses indicated that the clinics were well - staffed, 20% saw them as average in staffing whereas the majority, 55% indicated a gross - understaffing. This percentage of understaffing corresponds with the percentage of heavy to too heavy clinic workload which is 85%.

The World Health Organisation's definition for Primary Health care states that, "...And it does mean that essential health care will be accessible to all individuals and families, in an acceptable and affordable way, and with their full involvement". (Who; 1981 : 79 - 85). The staffing norms of Who state that a Registered Nurse attends to 500 people.

The shortage of personnel is aggravated by the fact that nurses work 24 hours

because of the on - call system practised in these clinics.

Each clinic serves many localities, the greatest number being more than ten localities as indicated by 40% of the respondents. The number of the localities under one clinic explains the problem of home - visits which is not well done as reflected by the number of home - visits in a month, ranging from 2 - 20 homes.

Another reason of poor home - visits are the conditions of the roads which are not good, as well as the distance of homes from clinics and unavailability of transport for the nurses.

This was explained by the greatest of percentages of respondents, 76% who walked to the clinic inspite of the distance between their homes and the clinic and only 24% took buses, taxis and horseback.

The unhealthy practises by the community in spite of the health education given at the clinics by the nurses indicates the inability of nurses to visit the communities at their homes, because of shortage of personnel and the work overload.

(Researchers' personal experience).

PART III: RECOMMENDATIONS

The following recommendations were made in order to improve the provision of primary health care in rural districts investigated in this study.

PRIMARY HEALTH CARE CENTRES

There is a need for building more Primary health care centres in Mqanduli and Elliotdale districts as to facilitate accessibility of Primary health care to communities. Vlok (1991:264) states that "the PHC clinic must be accessible to the community, i.e. within 5km of the consumers of health care".

INFRASTRUCTURE OF RURAL COMMUNITIES

Attention to the infrastructure in the community is to be paid especially roads which are poor, they need to be reconstructed. "Rural health services will be made accessible with particular attention given to improving transport" (African National Congress 1994:19).

TRAINING MORE VILLAGE HEALTH WORKERS

Recruitment, selection and training of village health workers to establish formal and informal links between the communities and health care system, is necessary. "One approach is the use of the community health workers as the interface between the resources of the community and those of the health care system" (Bryant , 1988:144). According to Gray, Raudony, Martin, Bang & Cash (1990:92) the government of Mali did not pay much in salaries of the professional personnel because the village health workers who were utilised in the health services needed only incentives.

CLINIC STAFFING NORMS

Staffing of the clinics according to the Who staffing norms is needed, that is, one professional nurse to attend to 500 clients.

BUDGET FOR PRIMARY HEALTH CARE

Autonomy of the Primary Health Care should be considered so as to ensure that all the equipment needed for these services is having its separate budget excluded from the hospital budget.

FURTHER RESEARCH

A further research study needs to be conducted on the guidelines of the provision of P.H.C. in rural areas.

CONCLUSION

The results of this study could be used by district managers, community health nurses and community doctors.

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