Research Article

Community perception of quality of (primary) health care services in a rural area of Limpopo Province, South Africa: a qualitative study

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The aim of the study was to survey perceptions of quality of (primary) health care services provided in rural communities in the Limpopo province. Ten focus groups discussions were held with community members chosen by convenience from public places from four villages in the central region of the Limpopo Province. The sample included 42 women and 34 men (76 participants). Results indicated perceived quality discussed within the following categories: (1) conduct of staff (reception, communication, discrimination, care and compassion, respect for privacy), (2) technical care (examination, explanation of treatment, responsiveness, treatment outcomes), (3) health care facility, (4) health care organisation, (5) drugs (availability, explanation, effectiveness, payment), and (6) waiting time. The findings suggest some satisfaction with free basic and preventive health care and social services provided but there is a need to look closely into the interpersonal dimension of the services provided, provision of medication with adequate explanation to patients on the medication given, and on structural aspects, there is need for the government to give support to the clinics to provide adequate services. Improving drug availability, interpersonal skills (including attitudes towards patients) and technical care have been identified as the three main priorities for enhancing perceived quality of primary health care and health policy action.

Introduction

The quality of health care has until recently been regarded as a luxury reserved for developed countries. This happened as a result of multiple factors that range from the fact that primary health care does not rely on advanced technology and thus had less need for quality standards; the priority in the developing countries has been more on making services available than on evaluating the quality (Haddad, Fournier, Machouf & Yatara 1998a:381). In the past decade, increasing attention has been paid to quality of care as a means to enhance the effectiveness of health care systems in developing countries, and various actions have been taken to look into quality of primary health care, through either research and development or full-blown quality assurance (Baltussen, Ye, Haddad & Sauerborn 2002:42). Palmer, Donabedian and Povar (1991:5f.) make a distinction between observed quality of care and perceived quality of care. The former, focussing merely on structural and process measures, relates to professionally defined standards of care, and refers to whether health care services adhere to these standards. The latter relates to the views of patients, which are attracting more and more importance (Donabedian 1980:4ff.; WHO 1990:15ff.). Patients' perception of quality of care is critical to

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conducted separately for men and women in places with privacy in the community. Some refreshments were provided.

FGDs were conducted by trained researchers with a degree qualification and fluency in Northern Sotho, the language of the participants. The discussion was based on themes with a focus on documentation of the opinions of the group members without those of the researcher expressed in a way that it influences those opinions of the group. The focus group method was chosen as it places emphasis on the interaction between participants and emergence of group dynamics than on the exchanges between the participants and the moderators (Morgan 1993:5f.).

The researchers were trained to participate in a discreet non-directive manner and to maintain a neutral position. A seminar on the task as well as pilot focus group activities afforded the researchers an opportunity to refine their methods. The group discussions lasted one hour each and were recorded and transcribed the same day ensuring reproduction of participants' word as accurately as possible. Verbal informed consent was obtained from the participants. The study was approved by the University of North ethics committee. Permission was also obtained from the traditional authorities in the respective communities.

Measures

The questions for the focus group were based on a literature review (Al Qatari & Haran 1999:524; Andaleeb 2001:1365; Baltussen et al. 2002:43; Bruce 1990:64; Campbell, Roland & Buetow 2000:1619; Haddad et al. 1998a:385) reflecting Donabedian's (1980: 5f) attributes of quality of care (structure, process and outcome) including: (1) the health care providers available to them for different diseases, (2) the kind of services provided, (2) conduct of staff (attitudes, interpersonal relations, communication skills, privacy), (3) technical care (examination of patients, diagnosing, interventions (injections, minor surgery, administration of drugs, satisfaction with treatment outcome), (4) health care facility (space, cleanliness, availability of toilet, accessibility to drinking water for patients, etc.), (5) organisation of health care by type such as clinic, hospital, GP, traditional or faith healer, accessibility of service (opening hours), organised preventive care (e.g. immunisation, family planning, antenatal care on set days), mobile clinics, (5) drugs (availability, quality, willing to pay for it), and (6) waiting time (before seeing a nurse, doctor or healer).

Data analysis

The transcripts and notes from the focus group discussions were translated from Northern Sotho to English, and then analysed using content analysis by means of a set approach according to guidelines given by Krueger (1988:78ff.) and by Stewart and Shamdasani (1990:45ff.). At the first step of the analysis, the transcripts and notes were reordered to the topics addressed by the discussion. At the second step of the analysis, issues that were brought forward repeatedly or were discussed at length by the participants, and relevant parts from each FGD and notes were ordered by these issues, using a 'cut and paste' method. The third step was to make a summary of the results for each FGD, based on the issues that were addressed in the discussions. The summaries were reviewed by an external expert to test whether the summaries were good representations of the FGDs and the summaries were then revised based on her comments. Finally, an overall summary of the discussions was made.

Results and discussion

Results and discussion are divided into (1) conduct of staff, (2) technical care, (3) health care facility, (4) health care organisation, (5) drugs, and (6) waiting time.

(1) Conduct of staff (reception, communication, discrimination, care and compassion, respect for privacy)

The participants reported that staff shows different attitudes. Some staff members are reported to be polite whilst some are perceived as being overly sensitive and becoming very insensitive to patients. Male staff is reported to be less harsh whilst female staff tended to be harsh towards youngsters who present with sexually transmitted diseases and those who came to collect condoms. There were reports also of some insensitivity towards patients who needed urgent attention as well as general laxity in dealing with patients in very long queues. Differences were noted between private and public health services such that private facilities (GPs and healers) treated patients better than in public facilities. Rudeness characterised by being shouted seems to be reported more among clinic service providers and less in interaction with private practitioners. Reception at the clinics is perceived to be different from that of GPs and traditional healers that are regarded as being humanly. The nurses are said to discriminate between patients according to their class distinction. The higher the level, the better the service was perceived. Some nurses show respect and compassion towards the patient but many especially in the clinics and government hospitals do not. Other nurses are said to be insensitive to particular problems of patients.

Reception:

"If I go to the traditional healer I know I am going to be treated humanly from the onset. When you knock, it is homely, you are offered an African mat 'legogo' to sit down, you take your shoes off, the things will be thrown down to tell you what is wrong with you and you do not have to explain that you have pain here or there, they tell you. Unlike at the western doctor, they ask you what is wrong and why you have that pain, and how am I supposed to know why I have pains. I think they treat people better than doctors and nurses."

"At the clinic, the greetings come out as threats'. You are not offered a chair to sit except to throw questions at you like "are you attending school, what Grade are you doing, are you working and all that in front of other patients. They are not even writing anything down."

"At a private surgery they take good care of patients. You are given a chair on arrival, and then you will be given a bed letter (file with particulars). The doctor speaks to patients politely. The helpers show happiness and respect on their faces and they also greet patients. At the private practitioner there is more privacy. The doctor tells you your problems while you are in the examining room. He shows compassion and understanding, when telling him or her what you feel."

Communication:

"Some nurse at the clinic when one is ill said, from morning you knew that you were not feeling well, why are you coming here now? Then you will try to

understand the relationship between quality of care and utilisation of health services, and increasingly it is treated as an outcome of health care delivery (Baltussen et al. 2002:42; Reerink & Sauerborn 1996:131). For example, in family planning literature, discussions of quality centred most of the time on clinical operations which disregarded the interpersonal dimen-sions of care with suggestions that quality referred to technically sophisticated, expensive equipment found to be more important in other contexts (Bruce 1990:61).

Different components of perceived quality of health care have been studied. Haddad et al. (1998a:381) studied community perceptions of primary health care services in Guinea. From a taxonomy of perceived quality the following categories were identified: (1) technical competence of health care personnel; (2) interpersonal relations between patients and care providers; (3) availability and adequacy of resources and services (4) accessibility and (5) effectiveness of care. On Tanzanian women's views of the quality of primary health care services Atkinson and Ngenda (In Haddad et al. 1998a:382) found six dimensions: (1) conduct of health staff, (2) technical care including outcome, (3) convenience of the health facility, (4) organisation of the health care, (5) drugs (prescription, availability) and (6) structural aspects, including staffing. In a study conducted in Zaire, women were found in a study by Haddad and Fournier (1995:743) to value interpersonal qualities to technical and integrity values. Andaleeb (2001:1359) has studied several dimensions of perceived quality of care in Bangladesh including responsiveness, assurance, communication, discipline and *baksheesh* (unofficial payments) and found that these factors have a relatively greater influence on individuals' decisions regarding utilization compared with access and costs. Baltussen et al. (2002:42) studied perceived quality of care of primary health care services in Burkina Faso and found in a community survey that the respondents were relatively positive on items related to health personnel practices and conduct and to health care delivery, but less so on items related to adequacy of resources and services and to financial and physical accessibility. In particular, the availability of drugs for all diseases on the spot, the adequacy of rooms and equipment in the facilities, the costs of care and the access to credit were valued poorly. Variations in the perception of quality occur as a result of heterogeneous nature of the definition of quality. Studies have pointed to variations in perception of quality by different socioeconomic groups as well as the environmental aspects such as the social, organisational and technological context of the service (Goldstein & Price 1995:505). Van Vuuren & Botes (1994:2) found among a culturally diverse population in an urban area in South Africa (greater Bloemfontein) that variables such as population group, age and employment status influence their attitudes towards professional health care. They further emphasise the importance of bringing these issues to the attention of health care policy makers. Peltzer (2000:55) found in a community survey in rural South Africa a low acceptability of primary health care: 78% felt that the medical services are poor. There was a significant relationship between not being member of a medical scheme, poorer health status and availability of health care services. Thipanyana and Mavundla (1998:28) found among rural patients in the Eastern Cape, South Africa, that the majority (75.5%) commented about medicines which were usually out of stock in the clinics, 15% had no problems with the clinic activities, 0.5% stated that the clinics had shortage of water, and 3% mentioned good attitudes and 4.5% bad attitudes of clinic nurses.

The 1998 South African Demographic and Health Survey (Department of Health 2002:194) found that users of public health services were more dissatisfied with day hospitals, government clinics and government hospitals (12%), compared with only 7% of those using private hospitals.

Patients' views are being given more and more importance in policy-making. Understanding populations' perceptions of quality of care is critical to developing measures to increase the utilization of primary health care services.

Therefore this study is aimed at identifying perceptions of the quality of service provision in a rural area of the Limpopo Province. An attempt will be made to identify factors that are related to quality improvement in primary health care centres in the central region of the Limpopo province so that a more effective approach can be looked into to improve the quality of health care among the consumers of that region.

Methods

Setting

Limpopo Province is one of the provinces that are mostly rurally situated in South Africa with a population of 5.2 million. Health care centres are in line with the national plan recently built in the province to cater for the health needs of the people and especially to bring health facilities close to the rural communities and the vulnerable. The daily work done at the clinics involve immunisation, children ailments like diarrhoea, fever, etc; antenatal care and postnatal care as well as dealing with non-serious diseases like minor burns, physical ailments that are not too serious and sexually transmitted diseases, health promotion and preventive care, provision of treatment for chronic ailments like TB, diabetes, mental health, hypertension, etc. The clinics are feeders of hospitals in each region. The system of operation is in such a way that people should always start at their clinics for referrals into hospitals. The hospitals deal with cases that are too complicated for the resources available at the clinics (Limpopo Province Department of Health 2001:2f.). Primary Health Care (PHC) services are free of charge; follow a comprehensive or supermarket approach, and national norms and standards for PHC. PHC consists of fixed and mobile clinics (405), community health centres (21) and district hospitals (35) in the province. The average PHC utilisation in the province is estimated at 2.0 consultations/year (national goal: 3.5). One PHC facility serves 12002 people (target: one clinic for 10000), with an uneven distribution in the province. Clinics refer to the health centre or district hospital (Limpopo Province Department of Health 2001:5f.).

Sample and procedure

The sample consisted of 76 participants, 42 females and 34 males. The age ranged from 18 to 70 years, with a mean age of 36 (SD=11.2). Educational level ranged from no education to Std 10, 90% were unemployed, 2% self employed and 1% were students.

Focus Groups Discussions (FGDs) were held with community members chosen by convenience from public places from four villages Makotopng (n=16), Solomondale/Sebayeng (n= 18) and Dikgale (n=42) in the central region of the Limpopo Province. Ten focus groups were conducted each with an average of 5 to 10 members. The groups were

identifying tablets by their colours, which they think is a universal description. There seems however to be some explanation for contraceptives because the respondents even know the names of the pill they are given as well as the injection. Such explanations seem to be regarded as being an important part of seeing a service as user friendly.

Participants considered satisfactory outcome on straightforward illnesses which a patient can easily self-diagnose. The participants see the nurses as doing no examination and that they have to know what is wrong themselves to be treated successfully. Issuing of condoms did not seem to create problems except some sarcastic comments made towards younger patients. Some sarcasm is also reported on the regular complainants of STDs and teenage pregnancies. Such sarcasm is reported to be humiliating but since people do not have much choice, they still visit the clinics and ignore the utterances, which are somehow accepted as being characteristic of most clinics in the rural areas. Participants report frequent use of the clinics for information on HIV/AIDS, antenatal care, free child services and management, postnatal care, etc. The treatment outcome was sometimes good but mostly unsatisfactory from the clinic, generally from doctors and in some occasions good from traditional and faith healers.

Examination:

"The nurses do not examine you; they just ask what is wrong with you and give you medication. You actually have to know what is wrong with you when you go to these places otherwise you will not be helped. People who complain about feeling pain in general and do not point to any specific place on their bodies cannot be helped. The medication you get is based on the patient's 'own diagnosis' you get medication for what you report."

"Nowadays what you get at a clinic are those brown pills or alternatively you will be referred to the hospital. Some few years ago the nurses used to give children thorough examination by using a thermometer for body temperature. Now it is the mother who tells the nurse that my child's temperature is high."

"When I am sick I go to the medical doctor because he examines me thoroughly and gives me an injection. The doctor also tells me what I am suffering from. I never get that from the clinic."

"At the hospital they use a thermostat to see if the child's temperature is high or not, then they give you medicines. I went there the other day because my child ate 'thollo' (a yellow roundish wild fruit which is known to be poisonous). They checked him thoroughly and then gave him Panadol, oral rehydration solution and a black syrup, which they told me that it stops vomiting. We just got to the doctor or hospital, because they have an apparatus to examine the patients."

Explanations about treatment:

"When you are ill the first thing to do is to tell them what you are suffering from. They won't tell you what kind of illness it is, what causes it, and the functions of medicines they are giving you. They will only tell you that you must take 1 tablet 3 times a day. They do not tell you that with this kind of disease, you should not eat this and that..."

"They do not ask, they just take an injection and fill it up, then say undress the baby. They will then say you will massage the buttock on the way, while you are busy walking. It is the clinics and hospitals which do that. They do not tell us what the function of that injection is. We take children to clinic 6 weeks after birth, and we are not told what it is for. At the clinic they do not tell us the reason for injecting us..."

Responsiveness:

"The clinics seem to be useless because when you are pregnant, the feet become swollen, the nurses will then say, they can't take care of you, they rather refer you to the hospital."

"The nurses did not tell me to come for follow-up consultation; I just knew that if I wasn't feeling better I will go back."

"If one is complaining of the same illness for a long time the nurses write a letter of referral to the hospital. They also tell us that at the hospital you will be examined properly. At the private surgery a doctor never refers patients to hospital for thorough examination."

Treatment outcomes:

"We are not satisfied with the outcome at the clinic, we just tell ourselves that God will heal us because the drugs they are giving us are just useless, they are not strong enough to cure patients. The nurses give us medication for other diseases, not for what we are really suffering from."

"The medication we get from the doctors is not diluted and we are satisfied. If you go to the doctor for flu, before the medication gets finished you will be feeling okay."

"Myself, I have a problem of 'badimo' (ancestors) or 'malopo' (ancestral spirits), I always dream of dead people. I dream of our great great grand fathers and mothers. I just dream being with them and watching them doing nothing. I get sick after having those dreams. So, I have to see the traditional healer immediately so that I can be able to 'wake up'. I go to traditional healers who know how to help me and I always feel better."

"I went to M. Hospital when I was in labour. A certain man at the hospital took me to where the nurses were; I think it was a male nurse. Then I found female nurses busy talking and laughing. They told me to sit on the chair because the baby was still far away. While I was sitting, I felt the baby was nearer and stood up, went into the delivery room and sit on the bed. The other old nurse said, 'what's wrong with this woman, why are you taking yourself to the delivery room?' I told her that I can't give birth while I'm seated on the chair. So, while I was in the delivery room alone, God helped me by bringing a certain girl, she was a nurse. She was surprised to see me delivering by myself when other nurses are busy laughing and talking. Then she helped me. Those other nurses came to check me because they heard the baby crying. They said, if you are a granny knowing how to deliver by yourself, it's better not to come to M. Hospital. The reason why I went to hospital was because on my bed letter it was written that I was going to deliver by operation..."

(3) Health care facility

Respondents complained of having small buildings that force them to queue outside sometimes in the sun or rain. There are no resting places, people have to sit under tree shadows. Beds are only available for pregnant women. Water was reported to be available and toilets which are reported not to be very clean.

explain that the pain was not very bad by then, it only got worse now. Some rude nurses will say: "there is no such, there's no such...you cannot tell me a thing I have been a nurse for years, you know nothing."

"If you can ask a nurse in a clinic for Panadol, she will say, it's me who knows what to give you, your illness does not need it, and you think you know it better."

"The nurses don't talk to patients well. May be these nurses have mood swings from home. If she had a problem with her family, she becomes crossed with patients for no apparent reason. The nurse will just scold you even if you did nothing wrong. For example, you are on the queue and she says, 'next', while you are still deep in thoughts, she won't speak with you well. She will shout, 'why did you not come here?'"

"At the private practitioner they communicate with us very well. They don't shout at us. They also tell you to come again when you don't feel better."

Discrimination:

"They treat you depending on your background, i.e. it depends on the kind of family you come from; your appearance also contributes towards the whole thing. If you come wearing nice clothes and jewelery they will give you first preference. If you come in tattered clothes, then things are different. Its as if they are smelling something bad (ba a nkgelwa)."

"They look at the kind of person you are, if they don't like you, they won't give you the urgent attention. The nurses look at the surname. If one patient is related to her, the service is faster. And if it happens that you get injured while at the beer halls, the nurses won't give you the urgent attention you deserve, especially if she does not like liquor..."

"The nurses should not judge us because of where we come from or which families we are coming from. They should treat us in the same way, equally. If I come from a two room house and the other one comes from a big mansion, treatment should be the same."

Care and compassion:

"Nurses do show respect and compassion. May be it is because they know that I am senior to them. When I arrived at the clinic the nurses would say "how are you granny, what can we do for you? Then I'll tell them that I came to collect some pills for high blood..."

"One cannot see that the nurse has compassion or not because all they do is to write down my problem and give me medication. If you go to the clinic having diseases like flu and broken leg, they do show compassion, but not with diseases that are caused by women (drop). The nurses like asking us guys if we don't know a condom. They don't understand that sometimes you meet a girl, she becomes attracted to you, then you decide to have sex, you won't even think of a condom..."

"The nurses are not taking care of us. Nowadays they are full of self control. They will leave the patient losing a lot of blood just because they will be waiting for an ambulance. I do not think they have compassion because you will find that the queue is long and they are busy drinking tea. Some patients end up leaving without being helped."

"I once went to the hospital to check on my daughter who had just delivered. I pushed her on the wheel chair and the nurse said 'leave her, let her go on her own' and I could see my child was in pain, she was very weak, my heart was painful because these people are nurses and should help patients when they are still weak."

Respect for privacy:

"The nurses can undress you; they once did that to me. I told the nurse in the clinic that I feel pain somewhere under my navel. She said to me that I should undress. I think she wanted to see me naked. I then told her that I feel pain here (pointing underneath the navel); all you have to do is to give me medication.
The nurse told me she has the right to see different body parts of people. I told her that she does not have the right to undress me because it is a clinic, only the hospital nurses are allowed to undress me. I told the nurse that I am not feeling pain on my penis but it's under my navel."

"One time the nurse said to me, 'take off your shoes', I did. She said, 'and socks', I did. 'And trouser", I said 'no', I better leave with the drips on me. The nurses then called an ambulance with 7 doctors, they forced me to undress. We want to be examined by a male doctor or male nurse. These female nurses are clever and they have other thoughts apart from patient-nurse relationship."

"The nurses like asking us in front of women as to why did we come to the clinic. The way I understand some of the diseases you can't talk about them while you are with women."

(2) Technical care (examination, explanation of treatment, responsiveness, treatment outcomes)

The respondents reported that they are not examined at the clinic which thing makes the whole process of treating the patient seem like it does not require special skills and that anybody could do the work. Consultation is reported to be brief with no thorough examination except for discussions around the patient telling what is wrong with him/her and then given medication on the basis of those reports. The problem of diagnostic practice is seen to be related to the failure of the providers of services to examine the patients first before they can determine treatment.

Some respondents reported that on many occasions, they were not attended to urgently and the nurses were engaging in social interaction with each other and not giving them urgent attention. The lack of prompt attention to patients occurs as a result of long tea breaks and promptness at knock off time. One patient was taken to the centre and was very critical, the queue was very long and when the mother asked for help, she was told that she should have come earlier to avoid being at the end of a long queue; and the patient was struggling so much that she subsequently died after a few hours after getting some attention." Such delays occurred a lot with situations where urgent attention for delivery of a baby, collection of condoms, problems with sexually transmitted diseases and post delivery problems. Such slow reception of patients is seen in a bad light and make patients angry.

Respondents report that there is little communication between the service providers and the patients about their disease, the cause and medication thereof. The patients are only given the instructions on how to drink the medication. This leads to patients

blame and not the nurses. The government should understand how many people are there and how many fall sick and should ensure that medication is always there."

Explanation about drugs:
"The nurses don't explain how we should take the pills. At the clinic they give you medicines but they do not tell you the function of it. All they tell you are take 3 teaspoons 3 times a day and keep out of reach of children. But at the private practitioner they explain the function of the pill..."

Effectiveness of drugs:
"Sometimes the medicines we get from clinics help but most of the times they are useless. Sometimes you can clearly see that they have added water to the medicines, and they told themselves that the child will just drink. Clinic medicines are too weak. You can give those medicines to a child with flu; he or she won't get better. Two weeks can pass without any change. This thing of diluted medicines forces one to take a child to the private practitioner because he gives stronger medicines unlike in the clinics."

"If you give the child Panadol from the clinic, you will still take him back. On the contrary, hospital's Panadol works immediately after being taken. The hospital's Panadol is thicker whereas the clinic's is thin. Probably they added water to it in order to increase the contents."

"At the private practitioner you just pay and get good medicines."

Payment for drugs:
"As a solution to this problem of lack of medication the government should introduce fees for drugs. This will mean that we will get proper undiluted drugs. And if we start paying again we will stop going to the clinic for silly reasons. For instance, now when one goes to a clinic, she will call a friend to accompany her. The friend will just say let me just consult because I am already with you. The friend will claim to be sick so that the nurses will give her medication, which she is just going to keep at home."

(6) Waiting time

There was a general perception that at clinics patients have to wait for a long time until they are served and are even sometimes turned back if coming late in the queue. Long queues are also experienced on antenatal and postnatal days. There is too much waiting where nurses take long breaks at teatime and lunchtime. The attitude of the nurses was found to be very poor in dealing with patients that needed urgent attention and the long queues that were caused by the nurses' delays at tea and lunch breaks. There was also a problem of lack of waiting space. People wait under tree shades. At private practitioners the waiting time was very little.

"At the clinic we stand on the queue for a long time and we become tired. You will read every pamphlet on the wall until your eyes are painful."

"At clinic the queue is always long because of free services whereas at the private practitioner there is absolutely no queue due to high payments."

Discussion

This study examines the quality of (primary) health care in a rural region of South Africa. Major components of quality of care were identified including (1) conduct of staff, (2) technical care, (3) health care facility, (4) health care organisation, (5) drugs, and (6) waiting time. Despite a tendency for participants to respond favourably to questions, as is systematically noted in research on perceived quality or satisfaction (Baltussen et al. 2002:46; Haddad, Fournier & Potvin 1998b:100), respondents' opinions were not very favourable in this study, as has also been shown by another study in the region (Peltzer 2000:55).

Participants were relatively negative on items related to health personnel conduct (poor reception, poor communication, discrimination, lack of care and compassion, and lack of respect for privacy), technical care (lack of examination, lack of explanation of treatment, poor responsiveness, and poor treatment outcomes), and drugs (lack of availability, lack of explanation and effectiveness of drugs).

Data from the 2003 primary health care facilities survey for the Limpopo Province (Health Systems Trust (2004:9f.) also found lack of equipment, poor and lack of infrastructure and lack of drugs:

- **Equipment:** All Limpopo facilities had refrigerators and thermometers in working order while more than nine out of ten facilities had stethoscopes, BP apparatus, infant and adult scales available. The survey found that only 1% of nurses at facilities in the province were each equipped with a thermometer, stethoscope, BP apparatus and otoscope compared to the national average of 7%.
- **Infrastructure:** Half the facilities in the province had adequate consultation rooms, which was below the national average. Only four out of ten facilities had adequate waiting areas. A high proportion (88%) of facilities had flush toilets, while a third had wheelchair accessible toilets. Seven out of ten facilities in Limpopo required urgent structural repairs. Almost all facilities had on-site water supply.
- **Drugs:** As with the national average, very few facilities in Limpopo (7%) had a full complement of EDL drugs available on the day of the survey. Seven out of ten patients attending PHC facilities in the province and nationally received drug treatment. Fewer drugs per patient were dispensed in Limpopo than nationally. Nationally very few facilities had expired drugs in stock on the day of the survey. Limpopo, however, had the highest proportion of facilities with expired drugs in stock compared to the other provinces.

In a study conducted in Zaire, women were found in a study by Haddad and Fournier (1995:743) to value interpersonal qualities to technical and integrity values. In a study about client satisfaction and quality of health care in rural Bangladesh, the most powerful predictor for client satisfaction with government health services was the provider's behaviour towards the patient, particularly respect and politeness. This aspect was much more important than the provider's technical competence. The second most powerful predictor for being satisfied was the respect for privacy (Aldana, Piechulek Al-Sabir 2001:515).

Many studies showed that being a regular user is a predisposing factor for satisfaction. It was, however, found in this study that participants' use of clinics is predetermined by the system in that they are not easily admitted at hospitals of their choice and should have the right address to be in a specific hospital or else have to start at the clinic in their own home town. Frequency of visits in this case does not indicate satisfaction as much as it shows lack of personal choice for a variety of clinics and health centres.

The system decides on the use of hospitals which in most cases is done very slowly that some fatalities occur in the long waiting process. Participants reported that the only choice they can make is between the type of service provider they decide to see which depends on their beliefs concerning the illness and which provider is considered the best in dealing with that specific illness (e.g., go 'khutliwa' 'madi a magolo' 'tlhogwana' 'thwasa', etc. are all considered illnesses for the traditional healer). In a study by Al Qatari and Haran (1999:523), satisfaction with explanation dimension seemed to be influenced by the frequency of the use of centres. 72% of frequent users reported satisfaction with the explanation dimension as compared to only 54% satisfaction by infrequent users. This could mean that those who use the centre frequently become frustrated by the lack of explanation which they need for their daily survival especially that such centres are said to be mostly frequented by people on the lower social stratum who have no other choice; and need to get better from those frequent visits and otherwise become frustrated when things are not well explained and they end up coming back again and again. Auerbach (2001:197) found that across a wide variety of medical settings patients report that they desire detailed information about their condition and their treatment.

Andaleeb (2001:1359) has studied several dimensions of perceived quality of care in Bangladesh including responsiveness, assurance, communication, discipline and *baksheesh* (unofficial payments) and found that these factors have a relatively greater influence on individuals' decisions regarding utilization compared with access and costs

Mavundla (1998:28) also found among rural patients in the Eastern Cape, South Africa that the majority (75.5%) commented about medicines which were usually out of stock in the clinics. In a study by Gilson, Alilio and Heggenhougen (1994:772) on the community satisfaction with PHC in Tanzania, lack of drugs was expressed as a problem by some respondents and one expressed the sentiment as follows " to be frank, drugs are a big problem. It has reached a stage where we have to buy drugs from shops and take it in our pockets to the centre for the administration of the drug." This shows that the problem can be beyond the nurses' control hence their eagerness to help those who bring the drugs to the centre by themselves. Baltussen et al. (2002:42) studied perceived quality of care of primary health care services in Burkina Faso and found in a community survey that the respondents were relatively positive on items related to health personnel practices and conduct and to health care delivery, but less so on items related to adequacy of resources and services and to financial and physical accessibility. In particular, the availability of drugs for all diseases on the spot, the adequacy of rooms and equipment in the facilities, the costs of care and the access to credit were valued poorly.

Conclusion

In this qualitative study with community members about their perception of (primary) health care a number of positive aspects of primary health care delivery were acknowledged such as prevention (provision of HIV information, condoms and immunizations), family planning and antenatal care, home visits, social services and services that are free of charge.

However, there is a serious problem with adequate provision of drugs; the state is seen not to play its part in making enough medication available to the clinics for the nurses to use on the patients.

There is no culture of dealing with emergencies, nurses take their time at tea breaks and are not flexible with crisis situations even when other patients do not mind giving urgent cases time to be attended to when there are long queues. This applies also to knock off time where emergencies are not catered for after four o'clock.

Using the evaluation criteria used in this study, the findings suggest need to look closely into the interpersonal dimension of the services provided, provision of medication with adequate explanation to patients on the medication given, and on structural aspects, there is need for the government to give support to the clinics to provide adequate services.

It was demonstrated in the present study that people's own experiences have a potential to bring into focus problems that can influence their satisfaction with health care. Listening to the voice of the people in studies such as this one affirms the importance of the community in health care planning. This study has provided some information on the perceptions of health care in a rural area. This shows great need for more work in the area in order to put into place systems that can address the gaps in order to bring some improvement in health care delivery. Future research can engage the concerns raised by these communities in the present exploratory study in a broader survey using more quantitative data for further information towards intervention that encompasses the most important component of quality assurance viz. user satisfaction that is based on the experiences of the consumers themselves.

Recommendation

Improving drug availability, interpersonal skills (including attitudes towards patients) and technical care have been identified as the three main priorities for enhancing perceived quality of primary health care and health policy action. Policy makers should respect these patient preferences to deliver effective improvement of the quality of care as a potential means to increase utilization of health care.

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