Patients' experiences at mobile health clinics: a case study of the KwaMachi in KwaZulu-Natal

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COLLEGE OF HUMANITIES

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Abstract

Primary health care remains at the top of the government's agenda. To address the issues of inequity, the Department of Health adopted mobile health clinics to ensure that the places that are hard to reach have access to primary health care. Without good health people do not have means to enjoy other aspect such as education and employment.

Apartheid policies implemented by the old regime resulted in many rural areas in South Africa remaining underdeveloped and underserviced. Hence, the introduction of mobile health clinic ensured that the population in rural areas have access to health care. Unlike fixed clinics, there are no specific sets of guidelines set up for the operations of mobile health clinic. This include, displaying health posters at mobile health clinics, providing patients with safe drinking water at the mobile site. With more and more mobile health clinics being added to the rural population there should be established scope of services to for rural population. This will ensure equality of service delivery between the mobile health clinics and fixed clinics. Thus, guaranteeing its acceptability to the users.

Using qualitative methods the study explored the experiences of patients at the mobile health clinic. Following the health equity model the study explored what the community of KwaMachi use the mobile health clinic for and the experiences of individual when accessing health care at the mobile health clinic.

The findings suggest that patients have both positive and negative experiences at the mobile health clinic. The majority of respondents commented that mobile health clinic offered them an entry point to the South African national health system. They also pointed out the services offered are limited. Hence, providing a range of primary health care services will ensure the maximisation of positive experiences at the mobile health clinic and this is likely to contribute positively to the morbidity and mortality rates in rural areas in South Afri**ca.**

List of Acronyms and Abbreviations

AIDS - Acquired Immune Deficiency Syndrome

ANC – African National Congress

CHIM – Centre for Health Market Innovation

DFID - Department for International Development

DoH – Department of Health

HCQI – Health Care Quality Indicator

HEF – Health Equity Framework

HIV – Human Immunodeficiency Virus

ICRC- International Committee of the Red Cross

IDP - Integrated Development Plan

IWHC – Immigrants Women Health Centre

MHC – Mobile Health Clinic

NHSME – National Health Service Management Executives

RDP – Reconstruction and Development Programme

WHO – World Health Organisation

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Chapter 1

Introduction

1.1 Background

Health care is vital to human existence. Without good health people are unable to enjoy other aspects of life such as recreational activities, financial stability, stable employment and so forth. According to the World Health Organization (WHO) (Irwin and Scali, 2010), health is not merely the absence of disease but a complete state of physical, psychological and social well-being. Hence, access to health care and the equitable distribution of health services are the fundamental requirements for achieving good health within a population. Taking care of health is often the starting point for improving people's lives.

The purpose of this study is to explore people's experiences when accessing health care at mobile health clinics (MHCs) in rural areas. A case study of one rural mobile clinic in KwaZulu-Natal will be used to describe the challenges patients confront when seeking health care services in rural areas. Recommendations will also be made for policy consideration.

Apartheid policies resulted in many rural areas in South Africa remaining underdeveloped and underserviced (Sookraaj, 2002). Many of those living in these areas do not have access to basic services such as running water, proper sanitation, and infrastructure amongst other things. Furthermore, the apartheid regime provided only minimal services to people living

in the ‘Bantustans’; this was reflected in the very low levels of education, housing and health care provision, amongst other things (*ibid*).

The democratic government that came to power in 1994 had the mandate to reverse apartheid discrimination. South Africa’s new Constitution contains a Bill of Rights that guarantees the rights of all citizens to human dignity, equality and freedom (*ibid*).The right to access primary health care services and the Patients’ Rights Charter are emphasized in the Bill of Rights.

The Bill of Rights makes it possible for individuals and groups to demand basic health care services and to challenge the government when these demands are not met (Dennill, 2002). The new government’s objective was to unify the fragmented health care system and ensure that resources were allocated rationally and effectively so that they are available to all South Africans including the most vulnerable groups (ANC, 1994). A health system includes all activities and structures whose primary purpose is to influence health in its broadest sense (Irwin and Scali, 2010). This notion is in keeping with the use of the term ‘health system’ by theWHO, which refers to all the activities whose primary purpose is to promote, restore or maintain health (*ibid*).

The new Constitution was followed by the launching of various programs, including the Reconstruction and Development Programme (RDP). The RDP is an integrated, coherent socio-economic policy framework which was launched in 1994. “It seeks to mobilize all South Africans and the country’s resources towards the final eradication of apartheid policies and the building of a non racist, non sexist future” (ANC, 1995). According to Foster (2005), the RDP led to several important primary health care initiatives. One such initiative was the

introduction of 25 MHCs in rural areas where primary health care was inaccessible (ANC, 1995).

While it is not known precisely when the first MHC was introduced in both South Africa and KwaZulu-Natal, there has been a progressive increase in the demand for MHCs particularly in this province, which led to an increase in the number of clinics (Statistics South Africa, 2008). In 2012 there were 170 MHCs in KwaZulu Natal, 17 were added in 2012 and another 26 were added in 2013(KznHealth; 2013).

A MHC consists of a vehicle especially designed to bring essential health care to a community from one designated service point to another (Habedi, 2007). Gish and Walker (1978) stated that MHCs are an integral part of health services. The advantage is that they visit patients at their place of residence. Some scholars have referred to these clinics as 'clinics on wheels'. The type of transport varies, depending on population distribution (*ibid*). Mobile health clinics have served as an effective alternative to non-functional facilities in many rural areas in KwaZulu-Natal and have become an integral part of the province's health care system.

Over the past two decades there has been a progressive increase in the number of MHCs operating in rural areas, particularly in KwaZulu-Natal. A study conducted by Statistics South Africa (2008) found that KwaZulu-Natal has the highest number of mobile medical facilities and visiting points (166 and 97, respectively) in South Africa. This is due to the scattered nature of the population distribution in the province (Statistics South Africa, 2008). The study was conducted at an MHC in KwaMachi which is situated in Harding in the province of KwaZulu-Natal.

1.2 Research problem and objectives

Health care delivery in South Africa has shifted from a deeply divided and fragmented system under apartheid to a more inclusive system as envisaged by the National Health Plan developed in 1994 when the new democratic government came to power. The main goal of the National Health Plan is to improve the population's health, particularly the health of women and children in the rural areas.

Statistics South Africa (2012) noted that health problems in South Africa are threefold. Firstly, life expectancy at birth is below 60 years. Secondly, the infant mortality rate is estimated at 37.9 percent. Thirdly, the estimated HIV prevalence rate (in 2011) is 10.6percent, representing 5.38 million people of the total population. Moreover, an estimated 16.6 percent of the adult population aged 15–49 years is HIV positive and people in the rural areas are the most affected.

To reduce morbidity and mortality, South Africa needs a strong, fully functioning health care system that caters for the health needs of the population. One of the strategies adopted in the National Health Plan is bringing MHCs to rural areas in order to bring health care services closer to the population.

This study explores patients' experiences at the MHC clinic with a view to understanding the role of MHCs in rural areas. It assesses the quality of the services that they provide and how people perceive the quality of health care provided at this facility. In order to achieve this objective, the investigation focused on the challenges patients encounter when accessing

health care at the MHC and how these challenges shape their health seeking behavior. These are the question that the research aims answer:

- What are the health needs of community members in KwaMachi District? This question will be answered during individual interviews. The objective of this question is to explore the level at which health is promoted and health seeking behavior of community members in KwaMachi district.
- What do community members use the mobile health units for? Through this question, the study will explore the purpose of their visit to the MHC. This will provide an understanding of the services rendered at the MHC and how helpful they are to people living in the KwaMachi district.
- What other health care services do community members use? The aim of this question is to explore whether or not there are health care alternatives.
- What are the barriers to accessing health care? The question will explore whether people find it easy to access the MHC; if not, what hinders them from doing so?
- What is the cost of using the service? The aim of this question is to ascertain whether or not there are any costs associated with service provision, such as travelling to the mobile clinic and user fees.
- What are the experiences of individuals when using MHCs? The aim of this question is to explore the quality of service delivery.

1.3 Significance of the study

As far as the researcher is aware, no studies have been conducted on the experiences and perceptions of the population receiving services at MHCs. This study contributes to the body of knowledge on health care in South Africa by describing the role of mobile health care in the country through documenting the experiences of people whose health care is provided largely by MHCs.

Furthermore, the research findings will allow us to track changes over time due to the evolution of government's health policies. The government has put many policies in place to ensure equitable access to health care. The study will provide insight into the impact of health policies adopted by the KwaZulu-Natal Health Department and explore how people's life have changed due to access to this form of primary health care.

1.4 Conceptual framework and operationalisation of concepts

Conceptual frameworks are maps constructed to define the causal relationship between a problem and the factors contributing to it. The conceptual framework guiding this study is based on the health equity framework (HEF) which focuses on the social determinants of health as well as health care quality indicators. Through these frameworks, the research study will investigate the influence place of residence or environment has on health; and the quality of health care they receive through their perceptions of the services offered at the MHC.

South Africa is one of the countries where inequality permeates almost all its sectors in comparison with the rest of the world (Bradshaw, 2008; Ensor and Cooper, 2004). This is

mainly due to the apartheid policies that impacted every aspect of life (DoH, 1997). To redress the legacy of apartheid South Africa seeks to promote equity in the health sector as well throughout society (DoH, 1997). One way in which the Department of Health is promoting equity in the health sector is the adoption of policies that encourage people-centered health care provision.

People-centered health care involves principles that encourage the protection of patients when they access care at any health facility in South Africa. The *Batho Pele* principles guide public service providers to protect the patient and ensure ease of access to services. "These principles include consultation, service standards, access, courtesy, information, openness and transparency, redress, value for money, encouraging innovation and rewarding excellence, customer impact and leadership and strategic direction" DoH (2002). The long-term goal of promoting equity is to improve health, particularly of the most vulnerable groups (*ibid*). Promoting health equity will ensure that the people who would otherwise not have access to health care, gain their access to health care.

Mckenzi (2005:31) argued that "if one saves people from one cause of death they can die from another unless the underlying health problems health are addressed and eradicated." The health equity framework examines the social determinants of health which are the conditions in which people are born, grow, live, work and age; these determinants include the health care system (Irwin and Scali, 2010). These conditions are produced by the lack of supply in resources and unequal distribution of funds both at the national and local level, and the unequal distribution is influenced by policies (*ibid*). Hence, this calls for interventions from several of stakeholders. Stakeholders that will donate funds that will ensure people have equal access to resources.

The Health Care Quality Indicator (HCQI) framework assisted the researcher to frame health care provision by MHCs in terms of its effectiveness, safety, equity, responsiveness and accessibility (Hurst and Kelley: 2006). These determinants shape patients' experiences at MHCs.

According to Donabedian (1980) the quality of care is related to its effectiveness in improving a patient's health outcomes, and the way health services is provided in the health facilities should be carefully planned so that the patients' expectations are met. Furthermore, Higginson (1994) argues that the study of any phenomenon should comprise an investigation of its effectiveness, acceptability, humanity, equity, accessibility and efficiency. Measuring these dimensions helps to determine the quality of the health care provided, which directly shapes peoples' experiences in accessing care. Investigating people's experiences is critical, particularly in KwaZulu-Natal that has a growing burden of disease.

1.4.1 *The role of education in keeping healthy*

Education provides understanding and skills that enable those who receive it to gain better knowledge that will encourage individuals to take better care of their health (Long, 1994). The study focused on both formal education and health education. Education has a positive impact on people's health because when people are educated their life span is increased as the quality of their life increases (Lorig *et al*, 1996). In support of this, Long (1994) argues that education has a long term impact on the quality of health. In order words, when people are educated they have a certain level of self-efficacy. Hence, people need to receive both classroom education and health education in order to be able to grasp certain medical and

technical terms. This will enable the patient to be able to make decisions concerning their health and lifestyle.

Moreover, uneducated people have fewer opportunities to negotiate their rights compared with those who have been educated about their rights. As the former president Nelson Mandela (ANC, 1994) puts it "education is a powerful weapon which you can use to change the world". Hence for people to change their health outcomes they need both formal and health education. Low levels of education can also lead to language barriers between providers and patients. Due to the lack of health practitioners who are willing to work in rural areas, the department of health ends up having to source specialists who are not from the community and as a result there are sometimes language barriers. The majority of the health care workers are sourced from outside the local community. Hence, you find there are certain dialects that are often misunderstood between the patient and the service provider. In rural areas there not many programmes that are directed at health promotion, there is not much information shared on preventive measures. Therefore, it becomes the role of the health practitioner to educate people on issues of health. In the mobile health clinic setting the health practitioners have to educate people on their health rights since there are no posters on the walls with this type of information, unlike in the fixed clinics or hospitals.

Also, the practitioners should provide people information and necessary support that will benefit families that have sick family members or are living in poverty (*ibid*). Moreover, Long (1994) postulates that by educating people and supporting them during early childhood education you automatically contribute to their lifelong health.

1.4.2 *Income and health*

The burden of disease is greatest for those living in poverty (Hammet, 2007). While a minimum income provides a means of accessing health care; higher income provides better, nutrition, housing, education and recreation (*ibid*). Hence, income is a direct indicator of the health status of individuals within communities. Improving people's economic status will have a positive impact on their health and at the same time allow them to receive primary health care at the institution of their choice (*ibid*). Although others believe that access to health care is free at government hospitals a patient is expected to give a small admission fee. For a patient in rural areas this amount can be a barrier to them accessing health care mainly because people in the rural areas are poverty stricken. Although health care services are free at the clinics; the clinic is usually far from their place of residence. This means they have to travel long distances to access the clinics.

1.4.3 *Place of residence/ environment*

Overcrowded households appear to be more prevalent in rural areas. An overcrowded home might experience a higher incidence of illness more than a spacious home (Ensor and Cooper, 2004). Families in the rural areas are large; overcrowding facilitates and fuels the spread of infectious diseases such as Tuberculosis. According to WHO (2014) inadequate shelter and overcrowding are major factors in the transmission of diseases such as acute respiratory, meningitis, cholera and scabies. This logic also applies to waiting areas at MHCs, which are usually crowded. Hence, improving the conditions under which people live reduces

incidences of illness. WHO (2014) postulates that health facilities not only represent a concentrated areas of patients but also a concentrated areas of germs and this has resulted in the number of health facility based illness rising. Therefore, providing people in rural areas with properly built houses can reduce the spread of infectious diseases. Also, proper organisation of the health care sites must also be a priority.

1.5 Structure of thesis

This thesis comprises five chapters covering the introduction, literature review, methodology, research findings, and finally, conclusions and recommendations.

Chapter one introduces the study and provides a background, the context of the study, research objectives, the significance of the study and the conceptual framework for the study.

Chapter two presents a literature review which discusses the origins of MHCs, linking the social determinants of health and poor health and an appraisal of the literature on MHCs in different countries. However, most of the literature reviewed did not focus on patients' experiences at MHCs. The third chapter discusses the methodology used for the study and sets out the methods used during fieldwork such as the population sample and why these methods were chosen. The challenges and limitations that were faced in the field are also discussed. Chapter four presents the research findings on people's experiences at mobile health clinic with an emphasis on the perceived advantages and disadvantages of using MHCs. Finally, the fifth chapter discusses the research findings and makes recommendations based on the case study.

Chapter 2

Review of literature

"Good health is necessary for people to achieve and enjoy aspects of life such as employment, education and recreation". (Swanepoel, 1997:25).

2.1 Introduction and Overview

This literature review examines selected previous studies and uses them to guide the present study of patients' experiences at Mobile Health Clinic's (MHC's). The researcher reviewed previous studies on MHCs in both developed and developing contexts. However, literature focusing on patients' experiences at MHCs was not as abundant as that on primary health care. Hence, this chapter will briefly discuss the importance of primary health care as mobile health clinic are an integral part of the primary health care strategy. This will help in understanding what primary health care is and how is it delivered through mobile health clinic. The chapter is presented in subsections to allow for both the generalistic and specific domains of the literature to be explored, analyzed and interpreted.

In an attempt to make health care accessible to under-served communities, an international conference was convened in 1978 to set the agenda for primary health care services and the conference adopted the Alma Ata Declaration (WHO, 1986). The declaration stipulates that "the promotion and protection of the health of the people is essential to sustained economic and social development and contributes to the better quality of life and to world peace" (*ibid*). In this conference the policies that would govern the provision of primary health care services

were laid. These policies stipulated the kinds of services that should be provided at a primary health care facility. These are:

> "maternal and child health, including family planning; promotion of food supply and proper nutrition; immunization against major infectious diseases; prevention and control of locally endemic disease; appropriate treatment of common disease and injuries, provision of essential drugs; education concerning prevailing health problems and methods of prevention and control"(Ngema: 1996:18).

Since this conference a lot has been done by both the developing and developed countries to ensure that primary health care initiatives integrate these stipulated services. However, insufficient resources and growing burden of diseases continues to overshadow all these accomplishment in South Africa (DoH, 2010).

According to the Department of Health (2012) the challenges that are confronting the health sector continue to be insufficient health professionals in the public sector; accompanied by the poor quality of care. Moreover, there is a persistent skewed allocation of resources between public and private sector also in rural and urban (DoH, 2012). Hence, the introduction of mobile health clinic as a primary healthcare strategy to increase access to services has proven to be effective (to a certain extent) in increasing access to health. This is because populations who could not access a fixed health facility can now access it through mobile health clinics.

During the literature review it became clear that mobile health clinics do have their limitations; mainly because it does not embrace the entire package of primary health care simultaneously. In order for mobile health clinics to be effective they must have a well-

established framework in which they draw from. This will ensure that only priority community health problems are addressed.

2.2 Operationalisation of mobile health clinics

According to CHIM (2009) an MHC "is a unique model of health care service delivery conceptualized to enhance the coverage of primary healthcare in rural communities". It has been defined as a vehicle specially designed to bring essential health care to communities from one designated service point to another (Habedi, 2007). It has also been described as a medical van that visits people to provide them with primary health care while other scholars have called it "a clinic on wheels".

The notion of MHCs was pioneered by Ian Smith who, as a child growing up in Australia, recognized the need to make primary health care accessible to a population that otherwise would not have access to health care (MedicalCoaches, 2008). In 1949, he started delivering sorely-needed health care services to sugar fieldworkers in Cuba (*ibid*). Smith's idea changed the world, as people who do not have access to primary health care can now access it through MHCs.

In South Africa MHCs were adopted as part of the RDP strategy. On 3 November 1997 two clinics were donated to the Ministry of Health under the leadership of Dr Nkosazana Dlamini-Zuma (KZNDoH, 2013). These mobile clinics were earmarked for KwaZulu-Natal and North West Provinces to bring affordable and quality health care to the community (*ibid*). This meant that people in the rural areas who walked kilometers to the nearest health facility would have their health care delivered on their doorstep.

Essentially, MHCs were created to address barriers to health care access for under-served populations. Han (2001) observes that "mobile clinics are a way of bringing health care services to nomadic people who would otherwise be deprived of them". Mobile health clinics address the problems caused by poor access to health care in inaccessible regions. The growing burden of disease in South Africa requires that access to primary health care services are made affordable, acceptable and easily accessible to the people. If people in the rural areas can get their health on their doorstep, they will not have to spend money traveling long distances to the nearest clinic or hospital. Thus, having effective mobile health clinics operating in the rural areas will minimize the need for hospitalization; at the same time reducing morbidity in rural areas.

In many rural areas in the provinces, mobile health clinics are the only entry point to the national health care system. They are the first point of contact with the national health care system for the people living in these areas. As a result, mobile health clinics are becoming a necessity for thousands of people who could die unnecessarily without access to primary health care (Foster, 2005). This is especially true in KwaZulu-Natal, where there is a growing burden of disease and a number of chronic illnesses such as HIV/AIDS (*ibid*). The growing burden off disease in KwaZulu Natal includes "HIV/AIDS which constitutes 51.4 percent, homicide and violence 4.7 percent, diarrheal diseases 4.2 percent, lower respiratory disease and road accidents 2.8 percent, strokes 2.5 percent, tuberculosis 2.3 percent, ischaemic heart disease 2.1 percent, low birth weight 1.5 percent and diabetes mellitus 1.4 percent " (Bradshaw, 2006:9). Some of these diseases cannot be treated at the mobile health clinic because of the complexity of the health problem.

It has been more than 16 years since MHCs were introduced in KwaZulu-Natal and their deployment has had a positive impact in bringing sorely-needed health care services to the rural population. Yet, morbidity and mortality is still on the rise in KwaZulu Natal.

KwaZulu-Natal is considered to have a quadruple burden of disease; that are diseases and related to poverty and underdevelopment, chronic illness, injuries and HIV and AIDS (Bradshaw, 2000). Hence, it is necessary that before the MHC approach is adopted, a thorough investigation is conducted into the needs of the community which it will serve. The population dies due to malignancies that are manageable. This calls for a continuous monitoring and evaluation of the health care systems in order to curb the rising rates of morbidity and mortality in rural areas. Bradshaw *et al.* (2003:3) note that "timeous and accurate statistics on causes of death are an essential component of the information needed to plan and monitor health care services and respond to the health needs of the population."

Literature points out that MHC's as a health care model should be implemented with particular emphasis on priority health problems and the activities that are needed to solve those priority pathologies (Stephane Du Mortier and Rudi Coninx, 2006). This is important as it ensures the effectiveness of the MHC programmes.

Mobile health clinics do not provide all primary health care services simultaneously. They are provided according to the needs of the population. Hence, it is important that the choice of services is appropriate for the community concerned, and that all the health needs of the population are taken into consideration. These services that the mobile health clinic decides to offer to the community must respond to priority pathologies, determined by the morbidity

and mortality rates of that community (Hammet, 2007). Once the problem has been identified, it is important that all the activities that will solve the problem are deployed immediately so as to lower morbidity particularly when it comes to communicable disease; as they are detrimental, with the potential to spread fast and quick.

According to Stephane Du Mortier and Rudi Coninx (2006), the choice of services offered at MHCs may vary as it will become evident in the discussion of studies in both developed and developing countries. It is important that these activities respond to priority pathologies in order to encourage health seeking behavior. By offering health services that are of greatest interest to the population, people are encouraged to attend the health facilities, in turn keeping them healthy.

2.3 Appraisal of reviewed literature

The literature concurs that MHCs are useful to rural populations. A study conducted in Mali, a developing country, found that mobile clinics have allowed the Ministry of Health to provide healthcare services to communities in distant (Mali Ministry of Health, 2007). The piloting of MHCs in Mali aims to continually improve health care. As mentioned above, the monitoring of the mobile health clinic ensures their effectiveness. Due to strong monitoring mechanisms from the Mali Ministry of health the health workers and health committees have come to appreciate the reliability and the low running costs of mobile health clinics (*ibid*) Furthermore, the Mali Ministry of Health (2007) reported that a number of community leaders from the district of Bougouni East had written several letters asking for a mobile clinic in their community because they identified its value to the community.

However, shortcomings in the MHC system in Mali were also identified. The primary shortcoming relates to the effective utilization of these clinics. An example is the need to improve the performance of on-board refrigerators. It was found that they are not always in a good condition due to the fact that they are either old or are damaged when the vans travel over rocky terrains. Hence, the health workers in Bougouni East expressed the desire for a mobile health van that does not have a fixed refrigerator. The Mali Ministry of Health (2007) concurred and pointed out that when the on-board refrigerator is removed it allows room to load more vaccine carriers and medical equipment such as injection material, essential drugs as well as mosquito nets, condoms and so forth. It was also clear that during consultation, the patients had no bed to lie on during examination. Hence, the Ministry also suggested that a flexible bed should be incorporated on which to lay patients flat during emergency evacuations (Mali Ministry of Health, 2007).

A similar study in India found that MHCs were useful to the community. The study was conducted in the tribal areas of the country, where MHCs have been operating since 1951 (DFID, 2009). They were implemented to improve access to and utilization of health services for the people living in regions that are underserved or hard to reach (*ibid*). DFID (2009) notes that the long travelling distances and the cost of transport prohibited people from accessing health services, particularly during emergencies. Hence, since a large number of people in this community have no access to fixed clinics, the primary health centres need to assess and evaluate the effectiveness of mobile clinics so to ensure equality in health care provision.

Approximately 80 percent of the population uses MHCs and 90 percent travel less than one kilometre to reach the service (DFID, 2009). However, once again, several shortcomings were identified. The study revealed that, on average, 40- 60 people were given medical attention in a period of three hours, with each consultation lasting approximately three minutes. According to DFID (2009), this has raised considerable uncertainty about the quality of services they offer.

Furthermore, it was noted that the van's limited carrying capacity prevents the inclusion of diagnostic equipment such as blood and urine testing (*ibid*). Due to its inadequate carrying capacity it has been recognized that mobile health clinics offer limited health care services. When other important services are not catered for at the mobile health clinic it limits people's access to health as a result more people continue to fall ill to epidemics that are manageable and sometimes curable. Hence, if issues of carrying capacity of the vans can be considered during the planning stage, services could be improved for the betterment of the population's health. What's more, DIFD (2009) makes the point that the limited services offered by mobile health clinics means that required services or rather the service expectations of the population are not met; resulting in unmet health needs, such as, reproductive health and dental care. These (reproductive health and dental care) are some of the services that are direly needed by the population living in this region hence if they are not provided with necessary health care we then question how are the services chosen. Also, the study found that, in India, mobile clinics visited once a month. What this means is that there was no proper follow up on patients. As mentioned before, lack of proper follow up on patients undermine the achievements that are accomplished and will continue to do so until it is implemented. The study also points out that people are reluctant to use mobile health clinics in the area because of the lack of privacy during consultations, and the situation is worse when it rains.

According to DFID (2009) lack of privacy during consultation, has over the years become another barrier to people seeking health care particularly young girls and women.

DFID (2009) maintains that the state should set aside a budget for MHCs as an indication of its commitment to providing health care services to providing health care services to communities in regions that do not have access to fixed clinics. Furthermore, this has raised questions concerning the quality of health care that mobile clinics in this community provide, thus the ministry has put into consideration the budget for these clinics to ensure that they are able to deliver vital services.

In Canada, MHCs are mainly used by immigrants as well as people at the workplace (Egan, 2009). Employees who find it difficult to visit a hospital or a doctor can access health care from MHCs that visit their workplace. MHCs provide primary health care to communities located in inaccessible regions. In Canada MHCs have served the health needs of women who do not have or want to take a time off from work to visit a doctor or who are uncomfortable with being seen by a male health service provider.

Mobile health clinic have also been used to overcome language barrier (Egan, 2009). According to Egan (2009) Canadian MHC's provide linguistically appropriate and culturally sensitive health services within the mainstream for immigrant women. They have been recognized to breakdown physical, economic and religious barriers and have developed sexual health and outreach programmes for new communities coming into the country (*ibid*). Subsequently, it was realized that while the services provided to immigrant communities are laudable, it is also important to take into consideration the fact that some of the problems immigrants face are beyond the scope of the mobile health clinic. An example is difficulty

posed by lack of health insurance to immigrants making it difficult for them to access the health care system (*ibid*).

A study in Pakistan found that MHCs are an effective alternative to non-functional facilities (CHIM, 2009). Pakistan MHCs ensure access to quality primary health care services by providing health care services to rural communities and inaccessible regions of the country (*ibid*). Due to the number of people needing health care in Pakistan, the health sector is under immense strain. Mobile health clinics act as a functional system, which is pro-poor, accessible and cost effective while addressing the coverage and service delivery gaps in primary health care services for the poor and disadvantaged (CHIM,2009).

Mobile health clinics in Pakistan have provided a range of services, including free health services, health education, gender mainstreaming and livelihood support (CHIM, 2009). Furthermore, the mobile health facility has proven to be effective for both routine and emergency health coverage (*ibid*). This is mainly because doctors are selected from the local area; they are appropriately trained and are always available. The focus is maternal, neonatal and child healthcare services with an aim to improve the health status of women and children who are deprived of quality health care due to issues of access and affordability. People who could not afford health care can now access it through the MHCs (CHIM, 2009).

2.4 Critiques of mobile health clinics

Despite the acknowledged value of MHCs and their effectiveness in bringing health care to people's doorsteps, some researchers have pointed to their shortcomings. Han (2001) argues that although MHCs have solid foundations, implementation sometimes falls short of

principles. This is the reason a continuous monitoring and evaluation of the mobile health clinic is important. This will ensure that the mobile health clinic adopt a particular framework when implementing primary health care services.

The literature highlights the fact that MHCs should be used as a last resort (Han, 2001). The major hindrance for the MHCs is the fact that they are temporary, the mobile health clinic move on but the patient remain. . However, if MHCs are removed, many people in rural areas will suffer. As a result, it is suggested that there should always be a fixed health facility to which patients can be referred to when necessary (Han, 2001; Kroon, 2000).

While MHCs have been an effective strategy they have rarely lasting effects (Han, 2001). The most efficient MHCs are those that treat conditions that can be dealt with in a single visit. When used for screening, they are less effective, as serious pathologies such as leprosy, breast or cervical cancer are slow to develop (Aljasir and Alghandi, 2010). Moreover, MHCs have been criticized for the way in which they operate. They do not have a framework that they follow in their operation.

What is more, is that mobile health clinic does not have a particular grounded theory they follow, MHCs do not use formal evidence to inform their practices (Han, 2001). Also, MHCs along with their patients have not been part of the scholarly literature of academic medicine or public health (Mobilehealth maps.org, 2009). As noted earlier, most of the evidence for their programmes originated from experiential knowledge through informal qualitative feedback from the clients. Thus, it is suggested that before mobile health clinic are implemented there, it is beneficial to seek evidence in a more systematic manner so as to ensure effectiveness. Therefore, administering questionnaires or surveys to intended users

will inform practices (*ibid*). This may include having suggestion boxes at the mobile health facilities. Also, this may require a certain level of community participation because services that are implemented using community participation are often well received by the community concerned and they tend to be more effective. Furthermore, community participation could increase the evidence that can be used to strengthen the interventions and evidence that can be used when applying for funding to various stakeholders. However, Han (2001) argues that doing proper research may not always be easy due to financial and time constraints; nonetheless, commitment is required from staff and scholar to plan and implement such studies.

Mobile health clinics have been seen as the most cost effective way of providing health care; however, the literature concludes that this is not necessarily the case. The literature notes that MHCs are not as cost effective as it is claimed (Oriol *et al*, 2009, Dyer, 1996; Han, 2001). The cost of petrol is always on the rise. The van needs to be serviced regularly and that comes at a cost. The lack of proper storages inside the vans, some medicine gets damaged when the van is travelling on rocky terrains. These medicines are damaged before they reach the people they are intended for, as a result they have to be replaced and that comes at a cost. Moreover, they require highly trained personnel to dispense treatment and tackle all the health problems encountered at the service point (*ibid*). The fact that they do not come daily to the community they serve is a logistical nightmare because for the patients who require frequent follow ups they are unable to get those services. Hence, the work that has been achieve at the first visit is somewhat nullified by lack of needed follow up and it needs to be done again. Furthermore, most MHCs tend to drift towards the curative option rather than engaging in health promotion and preventive activities (Han, 2001). Unlike fixed clinics,

where extra information is given through pamphlets and posters, mobile health clinic mainly focus on curing rather than helping people prevent certain health problems.

2.5 Summary

There is a realisation that mobile health clinic are a viable strategy for providing health care to underserved community. In the above discussion we see how mobile health clinics are used to bridge the services gap. Hence, the purpose of this chapter has been a review of literature on mobile health clinics. According to Garrib (2007) "health is among the most important conditions of human life and a critically significant constituent of human capabilities which we have reason to value". This chapter demonstrates the fact that MHCs have a vital function in bringing health care to communities in inaccessible regions in both developed and developing countries.

Chapter 3

Research Design and Methodology

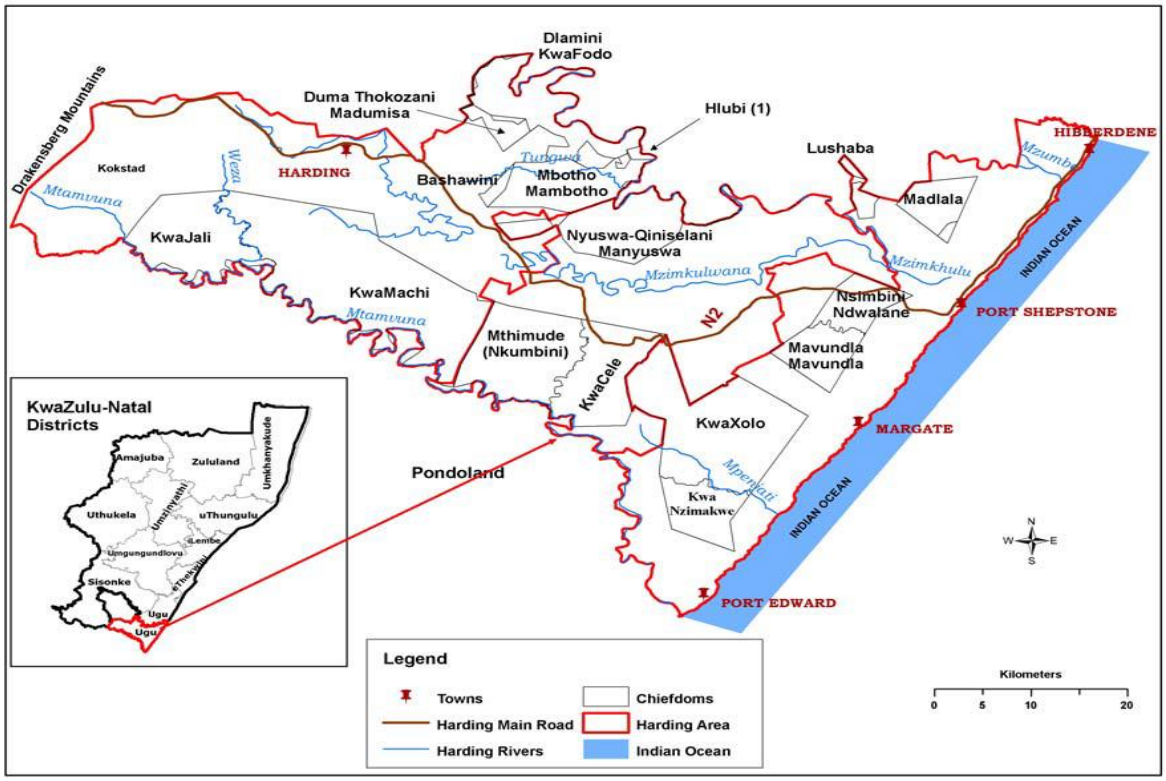
"If the principal aim of the public health sector is to improve the health of South Africans, then our focus must be the health of rural people"(Harrison,1997).

3.1 Introduction

This chapter discusses the study's research design and methodology. A research design is the overall plan for connecting the conceptual research to the pertinent empirical research (Kramptz and Pavlovich: 1981:10). The research methodology involved collecting primary data, the validity of which was enhanced by [1]triangulation of data using semi-structured in-depth interviews and focus groups with users of an MHC in KwaMachi. According to Brewer and Hunter (1989), methodological diversity enables a systematic exploration of new avenues of research and hence provides a rich opportunity for cross validation of research procedures and findings.

[1] [1]Triangulation is defined as the "use of multiple methods or perspectives to collect and interpret data about a phenomenon, to converge on an accurate representation of reality (Polit and Hungler, 1995:716)."

Figure 3.1: A Map of Harding showing the location of KwaMachi



Source:Cele (2009) Journal of Natal and Zulu History

The study was conducted at a MHC in KwaMachi. KwaMachi is located in Harding which falls under the UMziwabantu Municipality in the UGu District. "UGu district is one of the ten (10) district municipalities in the province of KwaZulu-Natal, South Africa" (UGu district IDP; 2012:08). The people within this district receive their health care services primarily through MHCs. This is their main entry point to the national health system.

KwaMachi is chiefdom with a unique history. According to Cele (2009), this area was long neglected as it was not clear whether it fell within KwaZulu or Mpondoland. In the early 1970s it was accepted as part of KwaZulu, mainly due to political expediency.

While the district is now part of KwaZulu-Natal, this has not had much impact on the way that people in this district are perceived and the delivery of basic services. This is evident in the provision of basic services to the community and in the lack of infrastructural development in the area (Ugu district IDP, 2012). People in the area still lack necessary amenities, such as proper housing, running water and poor sanitation amongst other things. The reason that has been put forward for this delay in service delivery is that the topography in the area makes the district hard to reach (ibid).

The KwaMachi community was specifically selected as a case study for two reasons. Firstly, the area is amongst many rural areas in KwaZulu-Natal which rely heavily on MHCs for access to primary health care. Secondly, the researcher was familiar with the area, allowing her more time to concentrate on the research. Furthermore, the researcher is fluent in IsiZulu and IsiXhosa, the languages mainly spoken by the people in this district.

3.2 Study design

A qualitative study was found to be an appropriate methodology. The qualitative method of investigation offers researchers the opportunity to ask questions of a specific sample and at the same time explore the environment and context in which interviewees respond to those questions (Ribbens and Edwards, 1998). As such, it provides the researcher with an in-depth understanding of the phenomena that is being researched; in this case the experiences of patients who use MHCs and how this affects their health seeking behavior. Bradley *et al.* (2006) suggest "that the qualitative methodology is well suited for understanding phenomena

within their context, uncovering links among concepts and behaviors and generating and refining theory."

Moreover, qualitative research allows the participants to give much richer answers to the questions at hand, subsequently producing more valuable insight which might have been overlooked by any other method (Gall *et al.*, 1996). This methodology enables the participants to explain their understanding of the phenomenon as they know it. It has the ability to evoke responses that are culturally salient to the participant that may be unanticipated by the researcher (Welman, 2005., Black et al., 1998). Another reason for using this approach is the flexibility which qualitative data provides to researchers. Various data collection methods can be used during different time frames without necessarily putting the authenticity of the results at risk (Miles and Huberman, 1994). The researcher was able to use in-depth interviews and focus group discussions to collect data.

The final reason is that qualitative data collects information on the daily lives of the men and women the researcher wanted to interview. Polit and Hungler (1995) point out that qualitative research focuses on understanding and examining the phenomenon under study by examining the lived human experience.

Understanding respondents' perspectives constitutes the strength of qualitative data. The researcher's observations and discoveries are also important to reinforce the validity and authenticity of the data collected. A triangulation method was used to minimize any form of bias that distorts the results. Triangulation implies that data and meanings emerge 'organically' from the research context, helping the researcher to explore people's experiences with MHCs in their village, and their perceptions and knowledge of MHCs

(Marshall, 1995). The use of various qualitative methods of data collection provides deeper insight. One advantage of qualitative research methods in exploratory research is that it uses of open- ended questions and probing gives the participants the opportunity to responding in their own words, rather than forcing them to choose from fixed answers. "Another added quality to qualitative methods is the flexibility to probe initial participant response asking them the what, why and how questions as a result the researcher must be able to listen carefully to the responses of the participant engaging them according to their individual personalities and style thus encouraging them to elaborate their answers" (Black *et al*., 1998). As a researcher it then becomes important to listen carefully and write down what the responded said so that all the answers are recorded; so as to enable an accurate report of results.

Schendul and Schendul (1999) identify a number of limitations of qualitative data. The data could be rejected or considered incorrect because other researchers maintain that important information was overlooked; this could include crucial information about participants or the environment in which the study was conducted. Conversely, the study could be authentic and accurate for the particular population, but not relevant to any other study. Ulin *et al.* (2003) argue that although qualitative methodologies have the ability to initiate a free flow of rich information on difficult subjects, it is impossible to generalize results. Marshall (1995) observes that this does not render such studies ineffective since qualitative studies are geared towards gathering rich and detailed information on the subject matter in its original context. This ensures that, even if the sample is small, the results are more reliable and credible than if a quantitative approach were used.

3.3 Methodology

This investigation aimed to understand the somewhat complex issue of patients' experiences at the MHC, particularly how their experiences shape their health seeking behavior. The fieldwork involved an in-depth investigation of people's experiences at MHCs.

A short questionnaire was administered to ascertain respondents' age, gender, marital status, and occupation. During the interviews, patients were asked about their health needs. This enabled an assessment of whether or not they are aware of their health issues so that the role the MHC is playing in meeting their health needs could be assessed. They were asked to describe their experiences at the clinic and their perspective on the advantages and disadvantages of using the MHC. They were also asked if they use health care facilities other than the MHC and the kind of the services they receive from these health facilities. Finally, the respondents were asked if they are satisfied with the services they are receiving at the MHC. These questions helped in understanding the experiences of people who access their health care at mobile health clinics.

3.3.1 Sample and sampling method

Sampling is a data collection procedure that systematically selects desirable research participants from the population (Henning, 2005:71). The sample was selected using the purposive and convenience sampling methods. This methodology helped to ensure that the selected participants would provide rich and relevant data responsive to the investigation. Woodsong *et al.* (2005) observed that purposive sampling techniques enable respondents to

be chosen on the basis of their particular features or characteristics that enable them to provide a detailed picture of the subject of the study. Hence, the aim was to target people that use the MHC in order to explore their experiences in-depth. This sampling methodology was appropriate for this study as not everyone living in KwaMachi uses the MHC; some members of the community still rely on traditional sources of health care.

The study sample of 20 patients was purposively selected comprising of ten (10) males of different ages and ten (10) females, of which three (3) had young children under the age of ten. Participants for the focus group discussions were selected from the in-depth interviews. From the 20 participant who were part of the in-depth interviews; due to time and financial constraints only fourteen (14) had the opportunity to be part of the focus group discussions. The reason for interviewing different age and gender groups was to assess whether MHCs cater for the health needs of the different age and gender groups within the community and this relates to one of the research questions. The respondents had resided in the area and had been using the mobile clinic for at least the past two years. The time span was important as it helped the researcher ascertain whether or not there had been any improvements in the services provided.

3.3.2 *Selection of research participants*

The following table summarizes the sample characteristics of each participant in the study.

Table 3.1: Sample characteristics of Participants

Gender	**Age**	**Education level**	**Marital status**	**Occupation**
Female	65	Grade 4	Widowed	Pensioner
Female	27	Grade 9	Single	Farm-worker
Male	24	Grade 12	Single	None
Male	52	Grade 5	Married	Farm-worker
Male	67	-	Married	Pensioner
Female	17	Grade 10	Single	None
Female	23	Grade 11	Single	None
Female	32	Grade 7	Married	None
Female	21	Grade 12	Single	Retail
Female	23	Grade 8	Single	Retail
Male	16	Grade7	Single	Scholar
Male	38	Grade9	Married	Farm-worker
Male	17	Grade 12	Single	Scholar
Female	16	Grade10	Single	Scholar
Female	30	Technikon	Married	Grade10Educator
Female	50	Grade 6	Widowed	None
Male	64	-	Widowed	Farm-worker
Male	26	University	Single	None
Male	49	Grade 6	Divorced	Farm-worker
TOTAL		20 Participants		

The research sample consisted of participants between the ages of 16 and 69, with the majority being young people. The reason for interviewing different age groups was to establish whether or not MHC caters for the different age groups within the population (from children to the elderly). The majority of the respondents had average levels of education and is unemployed. Of the 20 participants only 2 had tertiary education. Of the remaining 18 participants two did not have any formal education. The majority of the respondents had less

than upper secondary education. The average number of years of schooling is 9 years. As noted in chapter one, socio-economic factors have a strong bearing on the health of a population. According to Kelley and Hurst (2006), poverty and vulnerable livelihoods determine the health status of a population and *vice versa*. In support of this, Taylor et al. (2000) note that low income is associated with poor health and that poor health leads to low income. Again, the marital status of the individual was important for the study because marriage as an institution is declining in South Africa (Shoko, 2011). Research has shown that married individuals have a health and mortality advantage; particularly for woman as they experience lower morbidity *(ibid).*

The respondents' educational, marital and occupational status was established during the introductory part of the interview and the researcher intended to end the interview if an individual did not meet the requirements. However, all the respondents met the criteria. Other characteristics that were considered when choosing eligible respondents included their ability to speak and write IsiZulu and IsiXhosa. These people were targeted under the assumption that it would not be difficult to engage them and they would be able to indicate their consent to participate in the study by signing consent forms.

3.3.3 In-Depth Interviews

Individual interviews were conducted with men and women of different ages who are MHC users. According to Rossman and Rallis (1998), talk is essential to understand how people view their world, and a deeper understanding is often developed through the dialogue provided by long, in-depth interviews, as the researcher and participants construct meanings. The purpose of the in-depth, semi structured interviews was to understand people's

experiences at the mobile health clinics. Interviews, as a tool, also allow participants to share and contribute their experiences and communicate the multiple realities and many truths that they encounter when they access health care.

Initially, the general questions were administered to twenty one (21) participants to capture patients' experiences at the MHC. The research participants were chosen during the researcher's visit to the MHC. The study sample was based on both men and women who had been using the KwaMachi MHC for at least the past two years. The researcher used a purposive sampling method. The purposive sampling was selected to fulfil the objectives of the study. The study sought to target people who use mobile health clinic in this area; with the aim to gauge appropriate data that is relevant and depth. The interviews were followed by focus group discussions.

3.3.4 Focus Group Discussion

There were two focus group discussions (FDG). The researcher asked the respondents who have been part of the in-depth interviews to participate in the focus group discussion. The researcher organized the FDG into two groups consisting of 7 people per FDG. One FDG had individuals who had reported negative experiences at the mobile health clinic and the other FDG consisted of people who had reported negative experiences during the in-depth interviews. The focus group consisted of both females and males who reside at KwaMachi. The interviews were recorded electronically, and then transcribed.

3.4 Data Collection

Data were collected between November and December 2012. Before the fieldwork the researcher made a preliminary visit to KwaMachi which is located in Harding under UMziwabantu municipality to establish when the MHC visits. This involved locating the MHC sites. There are only three mobile health clinic sites in the area, at Phumza, Zamani and Amba. During the first visit a meeting was held with the chief in charge to seek permission to conduct the interviews. This involved briefing the chief about the study focus and its relevance to the well-being of the community.

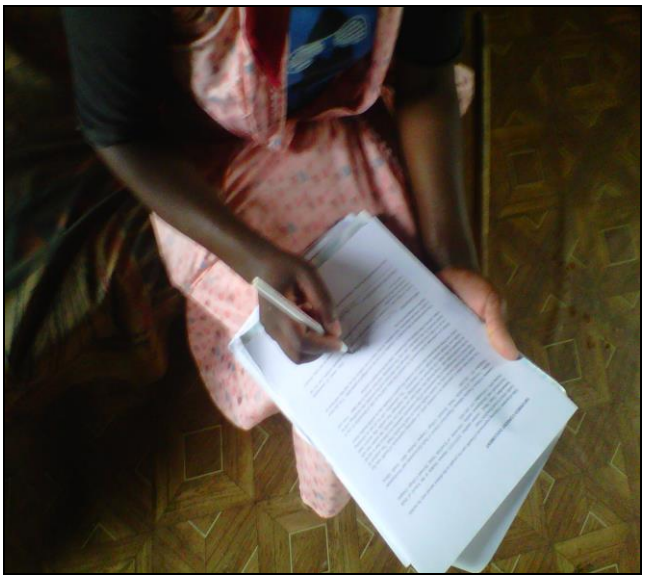
Fieldwork preparations commenced in early October of the same year. This included the preparation of interview schedules, and obtaining ethical clearance for the study. Recorders were hired for use during data collection. Further preparation included a pilot study to pre-test the research instruments; this exercise checked whether or not the designed research questions would elicit the data required for the study. The pilot study involved four people from KwaMachi. Finally, the researcher held informal talks with people residing in this area.

The interviews were recorded and careful notes were taken. Thereafter, transcripts were prepared, analyzed and reviewed. The questionnaire was translated into the local language in which the interviews were conducted. Data were collected using individual, semi-structured in-depth interviews. Before the interviews commenced, the researcher introduced herself, and explained the purpose of the study, its rationale and its relevance to the individual, the community and the country as a whole. Some patients were initially reluctant to talk. The researcher assured them of their anonymity and produced her student card to reassure the respondents that the work was for *bona fide* study purposes. Respondents were also

guaranteed that should they raise issues that could be of interest to other parties (i.e. the Department of Health supervisor); the information would be shared but would remain anonymous.

The interview schedule sought to ensure that women with children, youth, and the middle and old-aged were among the study participants. Five males turned down the invitation to participate. It became clear in the interviews that some respondents were reluctant to answer the question on the type of services they receive from the MHC, for fear of being judged on their lifestyle. This was common amongst the youth and male respondents. Again, the researcher assured them that the aim of the interviews was to assess their perception of the services provided at the MHC. The women with children were most responsive because the questions focused on their children's experiences; see below figure3.2 a photo of one of the women who participated in in-depth interviews).

Figure3.2:In-depth interview with a participant at KwaMachi



3.5 Analysis techniques

For the purposes of this study, thematic analysis was used. Aronson (1994) notes, that this technique uses ideas and views emerging from interviews, informal conversations with the participants and interactive observation of the issue under investigation. Interactive observation enabled the researcher to observe how people receive their health care at the MHC in order to validate the responses to issues emerging from the interviews.

The analysis of data was done at the end of each day of fieldwork. This ensured that the researcher reported rich data, as the researcher's memory might distort data if too much time lapses between the interview and the analysis. The process involved word-for-word translation of each interview into English. The researcher then coded the data according to already classified patterns and codes from the theoretical framework representing a particular viewpoint. The researcher kept referring back to the points raised in the literature in order to gain a deeper understanding of the themes that emerged during the interviews.

3.5.1 Ethical Clearance

Before fieldwork commenced, the researcher obtained ethical clearance for the study. Ethical approval for the study was obtained from the School of Built Environment and Development Studies at the University of KwaZulu- Natal. The researcher also obtained permission to carry out the study in the area from the chief in charge. To protect the respondents, the information they shared remained private and anonymous. The researcher visited the MHC and observed people receiving their health care. All the interviews were conducted in the

local languages. All interviewers were digitally recorded with the permission of the respondents. The interviews were transcribed and translated into English.

3.6 Limitations of the study

The first limitation of this research study is the nature of the methodology used; the results cannot be generalized to other populations or places. However, it stands as a case study that could be applied to a broader spectrum of patients' experiences of MHCs. The results have the potential to inform policy and practice.

Another limitation of the study was the sensitivity of the research focus. The research focused on individual experiences at the mobile health clinic. What this entail was asking people about their health which people do not feel comfortable discussing in the fear of being judged or discriminated. It was evident in the interviews and focus groups that some respondents felt uncomfortable speaking about their vulnerable situations and their health status. The researcher was often asked how the information shared during the interviews was going to be used. Ulin *et al* (2003) argue that people are generally uncomfortable discussing health issues openly, let alone with a stranger, since in many societies, discussing health issues is taboo. Sometimes the researcher would go to the field accompanied by a local member, so that she introduced her. This approach helped the researcher to gain some rapport with the community members particularly the older people. Although it was not clear why the older people were reluctant to participate; it dawned to me that they are the ones who take care of the ill members in their homes. Thus, they did not want to talk about their health issues at it was an emotional or rather sensitive topic for them. In some instances, people

refused to participate in the study. Those who refused to participate went around the neighborhood telling others that there is a young lady who is going around and asking about mobile health clinics. This did not discourage the researcher because when she started approaching even those who already knew through their neighbors they did not turn her away, they participated in the study. This goes to show how much of secrecy is there around the discussion of health related issues. Finally, due to the exploratory nature of the study, it would have been preferable to include a larger sample; however financial constraints rendered this impossible.

3.7 Summary

This chapter discussed the research design and methodology used for this study. The research study employed the qualitative research methods. The methodology employed for this study enabled the researcher to understand people's experience at MHC. The data collected enabled the researcher to understand the context in which people in KwaMachi receive their health care at the same time studying their health seeking behaviour. This is important because as we learnt in the first chapter that people in South Africa continue to die from curable diseases and women and children are the mostly affected. Through the sampling method we were able to understand the different characteristic of people living in KwaMachi. The context is always important in understanding people's daily living conditions, particularly where their health needs are concerned. Kelley and Hurst (2006) observe that socio-economic background has a direct influence on health and the way that people interpret their health needs and experiences. The chapter was concluded by looking at the limitations of the study.

Chapter Four

Research Findings

4.1 Introduction

This chapter is a synthesis of the research finding from the in-depth interviews and focus group discussion with the participants who are MHC users at KwaMachi. It emerged that MHCs have been operational in this area for the past ten years and are used by community members to access health care, irrespective of age and gender. The study found that people living in this area rely on MHCs for their health care as fixed clinics and hospitals are located far from their place of residence. During the interviews, respondents shared their experiences of the MHC. These experiences were classified as either positive or negative according to the respondents' responses to different questions. This chapter presents these experiences as perceived by the respondents.

4.2 POSITIVE EXPERIENCES AT THE MOBILE HEALTH CLINIC

4.2.1 Entry point to public health care system

Mobile health clinics have been operational in KwaMachi since the early 1990s. They have been used as an entry point to primary health care by the population residing in this village. The respondents stated that the MHC helps everyone in their community, although the service is not always available. They reported they use the MHC because it is free. Another reason for utilization of MHC is convenience. The respondents said that the MHC saves them the inconvenience of travelling long distances to a fixed clinic. This includes walking in the bush, which exposes them to the possibility of being mugged. Women, particularly the young

and old were worried about their exposure to the risk of rape along the way, especially if they walk alone. Meanwhile there have been reported cases of rape in the area but there is not much done to protect the women and children particularly since the police station is located more that 30 kilometers away from the community. The respondents also commented that it is not healthy for them to walk long distances, particularly when a woman is pregnant. A woman in the final stages of pregnancy could give birth on her way to the fixed clinic. Hence, the mobile health clinic ensured that their health care is easily accessible to them.

4.2.2 Provided with sorely-needed services

There was a general feeling that people utilized MHCs because when they go there for consultations they are given the attention they require; although the medicine they require is not always available. Although the respondents acknowledged that the MHCs offer limited services, they indicated that they go to the clinic for a range of services including child vaccinations; family planning; diabetes; health check-ups; HIV testing; tuberculosis testing. The nurses also assist patients who have epileptic or asthma attacks, but they do not treat them. Despite the unavailability of medication and the limited services offered, there was general consensus amongst the respondents that the MHCs were efficient in delivering the above-mentioned health services.

Asked what she used the MHC for, one young female respondent confidently stated that she goes to the clinic for family planning purposes. Previous studies on youth health indicate that many young people in South Africa engage in risky sexual behavior, including the early initiation of sexual activity, unprotected sex and sex with multiple partners (Jamali, 2007, Maharaj and Cleveland,2005; Shoko,2011; DoH,2012). The interviews with the young people

in this village confirmed that young people engage in sexual activity at an early age. The MHC therefore serves an important function in providing the youth with appropriate health care services.

Many older female respondents were pleased that the MHC provided diabetes testing services. Diabetes is a common chronic illness amongst the older population in this community. The majority of the families in this community is poor and suffers from nutritional deficiencies that expose them to diabetes. Diabetes and hypertension are both chronic illness caused by poor diet and poor lifestyles that result in the death of many older people in rural areas (Getahun and Raviglione, 2010; Wheal, 1997).

A respondent commented that:

> "*Although the mobile health clinic does not offer treatment of chronic illness however we are satisfied that the mobile health clinic does conduct tests for diabetes and then refer you to the nearest fixed clinic or hospital*." (P15)

Mobile health clinics also provide health care services for children. Routine vaccinations are offered free of charge to all babies and children. Respondents who are mothers expressed satisfaction with the child vaccination services offered by the MHC. For comprehensive pediatric care, they are referred to Elim Clinic or St Andrew's Hospital. This is important as morbidity is high amongst children in rural areas (WHO, 2012). The respondents felt that the health workers were competent in dealing with health issues; although the poor attitude of the nurses was a recurrent theme. One female respondent commented:

> "The *nurses at the mobile health clinics are well trained and qualified because they are also the one who train the health workers in our community*" (P7).

Asked to describe a typical day at the MHC one respondent said that they arrived early so that they could leave early. Overall, the experience seemed to be quite positive as outlined in the following comment:

> *"We wake up in the morning and prepare to come to the clinic. One has to come very early in order to be the first in the queue. I arrive around 08h30 in the morning and then I wait for 10h00 which is the time of arrival of the mobile health clinic at the Zamani crèche. I know when I come early I will be finished before 11h00 and then I go home to do other household chores. Nevertheless, when the mobile health clinic arrives, we start by singing and then we pray. This is done as a routine every morning before receiving our health care. Then the nurse who is doing administration asks for our cards. One nurse will do the consultation and the other distributes medication which makes the process very quick. This really saves us time. We get to finish early and go home to do other chores..."* (Focus group 1).

There was a general consensus amongst the respondents that the MHCs save time as they do not have to travel long distances to access healthcare. Respondents highlighted that the MHC brings health care to their door steps. They also save money on taxi fares. People in rural areas are often faced with the challenge of lack of resources, particularly money. Travelling to the nearest clinic can be costly especially if one is unemployed. Difficult choices have to be made between using R20 to visit a healthcare facility and using it to buy basic necessities for the household.

The MHC offers basic and sorely-needed health care to young people. One young female respondent said that if it were not for the MHC, she would have been pregnant long ago, but she is able to get contraceptives from the clinic. She noted that people often do not have money to visit a fixed clinic or a hospital. These findings concur with the findings in Bougouni East in Mali, where community leaders wrote to the department of health to express their desire to receive health care (Mali Ministry of Health, 2007). In KwaMachi one respondent said that:

> *"We love mobile health clinics because we can have ourselves checked for blood pressure and HIV...* (P14).

Another respondent said:

> "I *went to mobile health clinic and they did not have any medication for sore throat, however, they gave me aspirins just to ease the pain*" (P5).

The MHCs have two to three nurses. The respondents felt that the nurses are sometimes friendly and caring, but not all the time. One respondent who is a mother said:

> "*The nurses are friendly towards the children they would even play with them*" (P5).

Another respondent stated:

"*The nurses give enough medication for treatment and vaccination of children is done properly. They even give us sufficient information on how to breastfeed our children and the kinds of food that is good for their health*" (P1).

However, one respondent noted that the nurse would scold them if the children are not well protected against cold; this encourages them to ensure that their children are warmly dressed and neat when visiting the MHC. This is important because if children are not protected against the cold they are likely to fall prey to more infections which are likely to require more medication.

The mothers of children aged five and less felt that the MHC meets the health care needs of their children; particularly the infants. The nurses give the mothers information on how to monitor child growth through different measurement methods without being dependent on them.

"The nurses at mobile health clinics do give out a lot of medication if there is enough on that day and when they do not have medication they always give you at least a panado for the child" (Focus group1).

The respondents stated that MHCs provide valuable services to the community. Access to such services is important in order to achieve health equity and the improvement of the quality of life of the population in this village.

Despite setbacks in the health system, the community, especially children, benefit from the MHCs. One respondent said that they want the MHCs to continue to operate because they

really help them. During the interviews there was general consensus that closing the MHCs would create a huge gap. The MHCs are always full, demonstrating that people value their services. They are helpful to very ill patients because when patients are in a critical condition, the nurse will attend to them first.

4.3 NEGATIVE EXPERIENCES AT THE MOBILE HEALTH CLINICS

In general, respondents were happy with the MHCs, but still highlighted some negative experiences. These centered on privacy during consultation, non-availability of drugs, limited services offered at the MHCs; and a lack of doctors and follow ups on previous diagnoses.

4.3.1 Lack of privacy during consultation

Privacy during consultation was amongst the most negative experiences that people encounter at the MHC. This was of particular concern to male respondents. They stated that this prevented them from reporting all their health concerns to the nurse. One respondent noted that other people can hear what they are talking about with the nurse. They fear that people will spread the news of their state of health in the community. As a result, they are reluctant to share an accurate and complete history of past illness because of the fear of being judged and they consequently do not get all the medical help they need. Furthermore, KwaMachi is a traditional society where certain customs are observed. For instance, it is believed that when you are sick you must consult a traditional healer. Ill health is often associated with the lack of appeasing the ancestors. When some dies in the community there are perceived to have not be practicing traditional rituals. Hence, .there is a lot of secrecy

around health issues in the community. Therefore, there is a need for the department of health to do health promotion programmes that will conscientise people around certain health issues so that people and communities are able to seek medical attention in the early stages of their sickness.

While the nurses are equipped to dispense medical care the respondents felt that they are often judged by them. The respondents felt that the nurses tend to draw wrong conclusions about the health behavior of patients; causing them to scold the former. For instance, if a teenage girl presents with a sexual health-related issue the nurse would shout at her without giving her enough information on how to prevent a similar health issue occurring in the future. What this also does is that, it discourage these young people from coming back to seek medical help in the MHCs. Hence, the respondents expressed the need for MHC sites to be identified that provide optimal privacy. One respondent commented:

> *"...because of the lack of space in the mobile health clinic site, we end up receiving our medication when everyone is watching as a result it become easy for everyone to see what is our health problem is*" (P20).

The privacy issue is also a challenge with the community health workers who are currently working in the area. Two community health workers assist when the MHC is not available, providing first aid assistance. The respondents expressed their concern that the community health workers sometimes talk about their illness to other people who do not have the right to know. One respondent said:

> "...she *might be meaning well when she talks about us to others but we do not want people to know what our health problems are*" (P17).

The respondents value the services offered by the community health workers but do not trust them enough to tell them all their health problems because they fear becoming the subject of gossip. These may seem like small issues, but they are another barrier to people accessing health care. The community health worker plays a huge role in informing the community about the MHC schedules. She also takes care of the elderly. However the community health worker was criticized for not alerting everyone when there are changes in the schedules. She alerts a few people in the hope that they will tell others; this was perceived very negatively with some arguing that it was discrimination.

4.3.2 Lack of required medication

The issue of shortage of medication at the MHC was also raised by respondents. One female respondent said:

> "*The nurses do give out medication if they have enough on that day but the issue of lack of medication is happening more regularly now then before*"(P6).

There are also inconsistencies in the availability of medication. Interruption in drug supplies is likely to result in a negative perception of health care services.

The elderly on chronic medication said that they wished that their medication could be provided by the MHC. Their medical history is kept at Elim Clinic which is situated approximately 10 kilometers away from the local community. Chronically ill patients and those with disabilities want to be served by the MHCs because they are more accessible. This

would save them money in travelling to the clinic to collect their medication. One respondent observed:

> "*It might sound like a small amount of money but if you are faced with challenges in having to provide bread for the children everyday it is another thing*" (P15).

Another respondent said:

> "*For the disable persons mobile health clinic does not help not unless it is minor illnesses and it does not distribute medication for people with disability. Therefore, I collect all my medication for my disable son at the Elim clinic"* (P5).

The respondent added that if there were doctors at the NHCs, the situation would be different.

4.3.3 Lack of doctors at MHCs

Respondents feel that doctors should also serve the MHCs. The shortage of qualified doctors in rural areas impacts the quality of health care. One respondent noted:

> *"I went to a mobile health clinic for a check up because I had a very severe eye problem but they could not help me as I am speaking to you my eye is still sore. I am going to ask them to write me a doctor's letter to take with me to the hospital"* (PI).

On the one hand, the lack of doctors in the MHC compromised the quality of the health care the patients received because doctors are seen to provide higher quality health care than nurses. On the other hand, the nurses at the MHC do not provide referral letters for patients to be seen by doctors at the local hospital, St Andrew's that's is approximately 45 kilometers

away from this community. This was a serious issue of concern as more and older people needed to see doctors because of their deteriorating health conditions.

4.3.4 Insufficient information

A young respondent highlighted that the new system of referrals prevented people from accessing health care because they cannot just walk in to a hospital. They first need to obtain a letter from a fixed clinic. This is another barrier in accessing health care. The respondents noted that the only time they do not need a letter is in an emergency situation. As a result, health care is delayed and by the time the patient gets the letter to go and see a doctor their health has deteriorated. Intense prognosis is required which is expensive for both the patient and the service provider. The respondents indicated this is one of the reasons they prefer to receive their health care at the Elim Clinic because a doctor visits the clinic at least once a week.

Asked where they prefer to receive their health care, a female respondent said:

> "*Mobile health clinics are nothing like fixed clinics because when I am at the Elim clinic I get to read different posters that have useful information and I am able to get brochures that I can read to educate myself on certain health issues*"(P9).

Figure 4.1: An example of one of the posters at the clinic

The respondents mentioned that when they are at the fixed health clinic they may come for consultation on one health ailment, but they leave with information and knowledge on how to curb other sickness because of the posters and pamphlets that are distributed at the clinic. This was particularly true for the young respondents. On the one hand, the respondents recommended that the pamphlets should be made available at the MHC. On the other hand, they felt that MHCs are not the ideal facility for receiving some health care services such as a pap smear, pregnancy testing and HIV testing, amongst others. One respondent said that it was embarrassing when a urine sample is required since there is no secluded place and toilets are often located far from the van.

Figure 4.2: patients receiving health care at the mobile health clinic

Source: World health organization (2012)

Young female respondents were also not satisfied with the process when receiving contraceptives at the MHC. Getting inside the van for an injection signaled to everyone what they had come for; people know that a person who gets into the van has come for contraception. Injection at the mobile health clinic is given to patients who come for family planning purposes only. Other patients do not receive injection from the clinic. One young respondent said:

> "*That it is really embarrassing when the nurse begins to scold you for coming for contraceptives. The young patients are told that they are too young to have started using family planning; it is really embarrassing when the nurse begins to do that*."

While this could infer that young people do not realize that the nurse has a duty to educate them on different issues, the manner in which this is done is also important. Asked where

they prefer sexual and reproductive health services to be offered, they said that they liked the convenience of MHCs but their major concern is privacy during consultations. Furthermore, the respondents complained that the nurses shout at them if they lose their medical cards. The cards that are used at the MHC are also used at the Elim Clinic. The loss of cards makes it difficult for nurses to trace a patient's medical history; hence it is important that they do not lose them. Nonetheless, they said that they are happy that whenever they go to the MHCs they receive services. There was general consensus that while the standard of care is sometimes disappointing, it is comforting that people in this village are receiving health care. One respondent said that she was disappointed by the lack of follow up at the MHC. She maintained:

> "*... I went for voluntary counselling and testing for HIV five months ago but I have not received my results*" (P12).

Those who had gone to MHCs for the treatment of tuberculosis made similar comments. There was a general consensus that people prefer to receive tuberculosis treatment, pap smears and voluntary counselling and testing at a private doctor. This was because consultations are private, the doctor did not know them personally, and they did not have to wait in long queues to see a doctor. Moreover, the waiting period for result is not long compared to a mobile health clinic where you can wait for 3 to 5 months for your test results. This is often frustrating for the patients as sometimes they end up not getting their results and they have to test again. The respondents felt that if the mobile health clinic can return the result it would help them because most people get sick without them knowing what is wrong with them because they are tested but the results are not returned. They also indicated that if they could afford testing at the private doctor they would but the consultation fee of the

doctor is costly. The participants stated that they want MHCs to continue serving their community because there will be a huge gap if they were removed. It costs approximately R30 to travel to the nearest hospital and R20 to get to the nearest clinic.

4.3.5 Inadequate operating hours and infrastructure

There was general dissatisfaction with the MHC's operating hours. The majority of the respondents felt that a once a week visit by the MHC was not sufficient as illness is unpredictable. They argue that the MHC should visit at least twice a week. Asked how many hours the MHC spends at their site; they said it depends on the number of people that are there at the time. It serves the people who are there, even if it is three people, and then moves on. If there is no one at the site it does not wait until a particular time, but leaves immediately.

The MCH comes to the site and leaves early. The respondents also felt that the same nurses should staff the MHC on a regular basis. While changing nurses is good, it can lead to minimal follow up and changes in prescriptions that delay the healing process. One respondent with a sad look on his face made the following:

"*The staff at the MHC is changed regularly, hence each time I go to the MHC I always have to explain myself as mobile clinics do not keep our medical records. This is sometimes discouraging…*"

Asked where they prefer to receive their health care, the respondents stated that they would prefer MHCs if they had adequate monitoring equipment such as measurement scales for

children. One respondent pointed out that the scale does not always work properly and nurses resort to using a measuring tape to estimate the height of the child. It is important that medical equipment is always available and in proper condition for emergency situations. Again, the respondent noted that in an emergency (where the patient has to be referred to St Andrews Hospital) the MHC does not call an ambulance, unlike the Elim Clinic.

4.3.6 *Limited health care services offered*

During the interviews respondents commented that there have been no radical changes to improve the way patients receive health care. They stated that the services have remained the same for the past two years.

> "*I have been using the mobile health clinic since 2009. There has not been much progress made in the way things are done. They have always been the same*." (P19)

They added that the MHC site had not been changed despite the negative challenges experienced at the site. The site is located at the local crèche in the village and the challenge is that children are playing and making a lot of noise. There have also been many occasions when the keys to the crèche have gone missing; when that happens they are forced to receive their medical treatment on an open veranda as there is no community hall. It is difficult for the MHC to operate in bad weather conditions. When it rains the clinic site is crowded, making it difficult for nurses to dispense medication. Again, patients are exposed to cold conditions because the veranda is not properly enclosed. While the respondents felt that the MHC site should be moved, the challenge is that there is no better site.

The respondents also noted that there is no running water at the site; hence patients that need water have to bring their own water bottle. While patients have come to accept these conditions, they do cause some reluctance to seek medical assistance. The interviews revealed that the majority of patients start off using traditional remedies and visit the MHC only when they are severely ill and the clinic is not in a position to administer any medication to them.

From the interviews it became clear that people in this village are vulnerable to poor health because of socio-economic reasons such as low levels of education, unemployment and non conducive housing conditions. Moreover, there was a general feeling from the respondents that if they can improve their living conditions their health status could also improve. The majority of the respondents highlighted that their children suffered malnutrition related illness. One respondent said that if she had enough money she would consult a specialist whenever she is ill because the medication she gets from the mobile health clinic is sometimes not as effective.

Another one said that they would consult a doctor if they had enough money because the mobile health clinics are always overcrowded. Also, the respondents indicated that if they were employed they could afford to build better houses for themselves. One of the respondents lived in the home shown below, and the majority of the respondents are confronted by the same challenges and this worries them greatly, exposing them to a constant state of depression.

Figure 4.3: A house in KwaMachi and a dam where people obtain their drinking water

The socio-economic conditions in which people live are not conducive enough for them to maintain a good health status for a long period of time. Many households in this village have remained child headed households because the parents have passed on due to poor health. It is for this reason that McIntyre and Gilson (2007) suggests that in order to improve people in the rural areas health, there is an urgent call to the government and other stakeholders to improve their social and economic statuses. Poverty is the unfavorable health and life-threatening condition that dominates the context in which health care services are supplied. People's health conditions are further exacerbated by the lack of fully functioning health facilities.

4.4 Summary

It is pivotal that any public health intervention is continuously assessed so as to improve its effectiveness to potential clients. This study has revealed that MHCs play a critical role in providing health care in rural areas. Indeed, they are the main entry point to health care. The

people in KwaMachi utilize the MHC because its services are offered free of charge and are convenient. They do not have to travel long distance to access healthcare, thus saving them both time and money.

While the MHC offers limited health care services, people in this community still want it to operate in their area. They recommended that the MHC be staffed with at least one doctor. This will help people who are chronically ill and those who require emergency medical assistance. Health promotion in this area is difficult because people in this community often delay seeking health care. The reasons advanced by the respondents were that the MHC often delays the return of test results. This discourages them from seeking medical assistance.

With more and more people using MHCs, there is a need to ensure that the process of setting up the clinic is assessed properly so as to minimize the negative experiences that people have when accessing health care. Mobile health clinics are an effective tool to provide healthcare; however, they need to be well managed and staffed with doctors and visit at least a few times a week so as to curb the morbidity and mortality rates in the rural areas of KwaZulu-Natal.

Chapter 5
Discussion and Conclusion

5.1 Discussion

As indicated in previous chapters, maintaining a healthy body is vital because without good health people do not have means to achieve and enjoy aspects of life such as education, employment and recreation, amongst other things. If we are healthy we are able to contribute positively and productively to our communities. This study examined the experiences of a community in a rural area in KwaZulu-Natal in accessing health care at MHCs. Using the health equity framework, it investigated the main reasons for visiting MHCs and patients were also asked to provide their perceptions of the services received. It looked at some of their experiences in accessing health care at MCHs as well.

The results showed that the majority of respondents were satisfied with the quality of healthcare. The general consensus was that people in KwaMachi appreciate the convenience offered by MHCs. Mainly because they do not have a wide option when it comes to choosing the institution they want to receive their health care. Travelling to other health care institution is costly. Thus, because of mobile health clinics, they did not have to spend any money to access health care. In Mali it was found that MHCs are an undemanding and dependable way to provide healthcare to populations in far-off villages (Mali Ministry of Health, 2007).

Despite the commitment of the service providers, administering health care to the population can be difficult as health needs vary from one individual to another (Dennill, 2002). While much has been done to improve the healthcare system in South Africa, the growing burden of communicable and non-communicable disease continues to undermine the achievement that

have been accomplished (Coleman et al; 1998). Hence, these conditions under which health care is provided renders it impossible for everyone to be satisfied with the quality of health care services they receive.

Nonetheless, only a minority were not satisfied with the services they received at the MHC. As noted in the previous chapter, of health care in rural areas is constrained by many factors. These include privacy during consultation, the unavailability of medication, long waiting times at the clinics and expensive and inadequate transport. The study found that travelling long distances prohibited people from accessing care at fixed health centres. Consistent with the literature, is that MHCs play a significant role in bringing health care closer to the people (DFID, 2009; Mali Ministry of Health, 2007). Hence, the study used people's experiences to assess the significance of the role that MHCs play in improving health outcomes and at the same time curbing the high morbidity and mortality rate that has devastated many families in rural areas in South Africa.

It is important that the services offered at the clinic impact positively to the health needs of the community. The study found that people have both negative and positive experiences at MHCs. Positive experiences include the fact that the MHC offers this community access to health care and that its services are free. Although the majority of respondents indicated that they sometimes delay seeking medical help because they prefer to use traditional indigenous medicines; they highlighted that some primary health care services are not provided by the MHC.

The study also found that the high levels of morbidity in this community are perpetuated by the conditions in which people live. The context in which people live cannot be ignored as it

has a huge impact on them remaining healthy after they have received health care at the MHC.

As discussed in previous chapters the rates of HIV/AIDS infection are escalating, particularly in rural areas. According to the UGu district IDP (2009), there was an 8.1 percent increase in people infected with HIV in this municipality; hence more and more people will need to access health care without travelling long distances to receive it. Children are the hardest hit by different illnesses. According to Statistics South Africa, the mortality rate for children under five is 37.9 percent (Statssa, 2012). Mobile health clinics have a huge role to play in lowering this mortality rate to meet the Millennium Development Goals that the Department of Health has committed too. This will save patients the inconvenience and cost of travelling to the local fixed clinic.

On the one hand, patients that were satisfied with the MHCs said that the nurses were caring and that they received the medicine they needed. They stated that the MHC saved them in the region of R20 a month. Women's reproductive health care needs were provided by the MHCs. They are aware of the role that the MHC plays in making health care more accessible, but they noted that some services are not provided. Nonetheless, they still preferred to access health care at the MHC.

On the other hand, patients that were not satisfied expressed the need for life saving drugs that are always available. They voiced their dissatisfaction with the way that certain medical procedures are carried out at the MHC. For instance, injections are administered for contraception only; this belief amongst respondents was generated by the belief that injections work faster than tablets. They highlighted that everyone is watching when they

receive medication, unlike at the Elim Clinic where the patient enters the nurse's room, is given the medication and is able to put it in their bag without anyone seeing their prescription. Chronically ill patients felt that their medication should be delivered to them *via* the MHCs; this would save them the cost of having to travel to the local clinic. If people still need to travel to the fixed clinic to collect medication, the MHCs are not responding effectively to the community's needs.

The conditions under which people live cannot be ignored as they have the potential to aggravate the ill health. For instance, the majority of respondents reported that they were unemployed. Unemployment has adverse affects health (Bradshaw, 2008). The majority of the male participants reported they sometimes suffered severe depression, stemming from the pressure of trying to provide for their families and their lack of income. A lack of income not only inhibits them from travelling to the nearest clinic; but from buying sufficient food for their families. They therefore require regular access to healthcare services as lack of income places their family at risk of physical illness. The MHC does not provide services directed at such conditions. Again, the environment that people live in aggravates ill health (WHO, 2014). The majority of the participants said that they live in a household with five to 15 members; this results in overcrowding which facilitates the spread of communicable diseases such as tuberculosis.

Hence, there is a real need for regular MHC services. This also calls for an extension of the services offered at MHCs. People in this community live in poor conditions and their houses often collapse during the rainy season. KwaMachi is a chiefdom and the majority of the community still adheres to a traditional way of life and use traditional healers. Majority of participants' stated that they believe in traditional medicine over the western medicine. They

postulate that traditional medicine is affordable. In support of this, Patwardhan (2005:5) argues that "if there were no poverty in the developing countries, modern medicine would undoubtedly render traditional medicine. But is pointless throwing away traditional medicine if it works for a certain population. Particularly for the rural population traditional medicine is easily accessible to them. Where there is no western medicine, traditional medicine becomes the only source of hope.

The majority of people in the district still live in unfavorable socio-economic conditions which impact directly and indirectly on their health. These conditions include inadequate and low levels of education, lack of income and a low socio-economic environment. The most important factor is inadequate access to health care facilities. Inadequate access to health care facilities fuels the spread of disease resulting in premature deaths. According to Statistics South Africa (2008) in KwaZulu Natal the majority of people die of infectious diseases before their 50^{th} birthday. Hence, providing people with mobile health services will contribute to the reduction of premature deaths. This is also true of KwaMachi because the community realizes the role that the mobile health clinic plays in accessing health care. They concluded that MHCs are useful to the KwaMachi community, although there is a need to strengthen the mobile health care system. For the KwaMachi community they felt that if there could be more privacy during consultation it will make them feel more comfortable. Furthermore, amongst other services they felt that if they have voluntary counselling and testing (VCT) services it will help them. The community needs to have access to have access to voluntary and confidential counselling services.

Nevertheless, the majority of participants were satisfied with the levels of health care they recieved for their children. They reported that the nurses were friendly towards them and

their children and this encouraged them to return to the clinic. They highlighted that they valued the information that the nurses shared with them about breastfeeding and how to measure their children's growth. Breastfeeding plays a critical role in children's growth. According to the provincial Department of Health (2001) the highest risk of HIV transmission to a breastfed baby is during the early months of breastfeeding and continues as long as the child is breastfed. Hence, these children friendly initiatives will go a long way to ensure that children grow strong and this protects them from being sick.

The study revealed that women of childbearing age are frequent users of the MHC. Their experiences are mainly shaped by the poor conditions at the health facility and the lack of medication at the MHC. The poor conditions relate to the lack of drinking water and proper sanitation at the mobile clinic site amongst other things. The study revealed that fewer male than female patients use the MHC. This is mainly because the majority of males in this district place more value on traditional medicine than western medicine. Hence, there is still a lot that needs to be done to encourage men to participate in improving their health. They are forced to go to the clinic when the illness has advanced and by that time the symptoms are not easy to treat.

The male participants expressed the concern that the MHC does not provide privacy during consultations. What this suggests is the need for mobile health clinic setting should be designed in such a way that there is privacy during consultation. This was also common among the youth. Although the youth used the MHC, they said that they are sometimes afraid to ask the nurses questions relating to issues of sexual and reproductive health. They feel that the MHC should provide pamphlets explaining these issues. They feel embarrassed when the nurses scold them. The nurses need to create an environment where young patients feel

welcome and are able to share their important health concerns with them. Young people should not be too embarrassed to consult on issues of health, no matter what their neighbors and families think.

There should be commitment from both parties; that is, the community and the service providers to address the high mortality rate among South Africa's youth. Another important need is education and building schools that are easily accessible to young people. The construction of libraries would enable young people to learn and be exposed to new information. This would alleviate both poverty and ill health among young South Africans.

Again, "health promotion is not only the responsibility of the health sector, but goes beyond healthy lifestyles to well-being" (WHO, 1986). Collectively, people have the capacity to identify and resolve the challenges confronting them. The evaluation of patient experiences is therefore an important component of health services evaluation (Garrat *et al.*, 2008). The reason for the increased interest in monitoring and evaluation include rising cost, poor quality, inequalities and lack of accountability. Where there is no accountability there is chaos, we do not wish for our health facilities to be in a state of chaos because that trickles down to the communities.

5.2 Recommendations

The findings on patients' experiences have implications for health policy formulation and implementation. According to the UGu district IDP (2009), the government devotes a considerable portion of its resources to health care. However, there is a still a shortage of

fixed health facilities, trained doctors and medication. Aforementioned is that if we are going to improve the health of South Africans we really need to focus on rural population. Much has been done by the Department of Health to improve access to health care. This is noted in the increased access to healthcare through MHCs. In July 2013, the MEC for Health handed over another 22 MHCs that will be used throughout KwaZulu-Natal, focusing on rural areas (KZNDoH, 2013). However, the MHCs need to be restructured in that they do not allow for private consultations. Furthermore, if the vans were bigger, they could carry more medication and provide additional services such as eye testing and dental care services.

Again, it is recommended that government place health promotion in the rural areas at the top of its agenda. This will create awareness of the different diseases affecting people in the rural areas and how they can take precautions to curb such diseases. Health education should be a priority in order to curb the high mortality rate in rural communities, particularly in KwaZulu-Natal, where there is a growing burden of disease. The health needs of the people residing in this district should be assessed so that the services offered meet the needs of the community.

For the services that are already provided by the MHC, it is recommended that government ensure that there is adequate provision of drugs and equipment. This will encourage people to utilize the facility and at the same time assist in curbing the high mortality prevalent in rural areas.

While various researchers have pointed out that MHCs should be adopted as a last resort, the health risks confronting rural areas require that people access health care regularly and urgently. Therefore, if the Department of Health is to adopt MHCs as a permanent resort,

certain issues need to be taken into consideration. These include extending MHCs' services to include all the primary health care services provided at fixed facilities. Moreover, the MHCs should offer acceptable conditions and the necessary medication for all ages and both genders. In other words, the MHCs have to be an effective mode of health care delivery. Highly trained and specialist personnel are required to provide treatment. These personnel should be able to diagnose most symptoms that patients present with; this includes diagnosing illness that is slow to develop, such as breast and cervical cancer and many others.

The growing burden of disease of the population in rural areas necessitates wider access to primary health care services. Therefore, the challenge remains to strengthen existing health facilities.

As noted in chapter three, due to the exploratory nature of this study it was not feasible to conduct an in-depth analysis of the service provider's perceptions of the quality of health provided at MHCs. This study is a limited exploration of patients' experiences at MHCs. A larger sample of patients would have been desirable for wider coverage. Nonetheless, the study has yielded findings that could assist in improving current services and has identified areas for further research. It has also contributed to the body of knowledge in that, as MHCs in most developing countries are adopted as an emergency tool, there is a paucity of research on how effectively they operate.

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APPENDIX I

Project title: Patients' Experiences at Mobile Health Clinics: A case study of KwaMachi KwaZulu Natal

Questionnaire for community members

Participant Details:

Sex:

Age:

Education Level:

Marital Status:

Ethnicity

1. Please tell me about your health needs ----------
   ----
2. What services have you used from the mobile health units?----------
   ----
   ----
3. Please describe your experiences when going for (probe for each service mentioned above)----------
   ----
   ----
4. Where would you most prefer to receive (probe for each service mentioned above)

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5. Where else have you gone for health care services? (fixed clinic, hospital, private doctor)
6. Probes:

   What kinds of health services do you receive from (fixed clinic)? ----------

   ---

   Please describe your experiences when going to health clinics?----------

   ---

   Why do you access this service from fixed health clinic instead of the mobile clinic? -

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   ---

7. What kind of difficulties do you experience in accessing health care?----------

   ---

   ---

8. What is the cost related to service that you receive from a mobile health clinic?--------

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   ---

9. How many times the mobile health clinic does come a week?----------

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10. How many hours does it operate when it is there? ----------

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11. Is the mobile health clinic child/youth/women/men friendly?----------

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12. Does it cater for people with disability? Yes/No----------

13. Are the nurses friendly towards you and why? ----------

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14. Do you get all the medication that you require from the mobile health clinic?----------

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15. Are you satistified with the services you receive from a mobile health clinic?----------

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Consent Letter to participants at KwaMachi District

School of built environment and development studies

University of KwaZulu Natal

Durban

December 2012

Dear Sir/Madam

Research on 'Patients experiences at mobile health clinics: A case study of KwaMachi KwaZulu Natal'

I am Zama Portia Nkosi, a student at the University of KwaZulu Natal, Durban South Africa. I am required to undertake a research project in fulfillment of my postgraduate studies in the School of built environment and development studies at the university.

In view of the above, I am inviting you to participate in the above captioned study, designed to investigate your experiences with the mobile health clinics. The study will be conducted between November and December 2012.

You will be requested to give information about your experiences when using a mobile health clinic in your community.

Many thanks for your assistant in this regard

Sincerely,

Zama Portia Nkosi

Professor Pranitha Maharaj (Project Supervisor)

PARTICIPANT CONSENT FORM

I agree to participate in the study……

Name……

Signature……

Date…….