



**Factors Contributing to Non-Utilization of Primary Health Care Services by
Community in the Greater Tzaneen Municipality, Mopani District,**

Limpopo Province

by

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DECLARATION

I declare that “**Factors Contributing to Non- Utilization of Primary Health Care (PHC) Services by Community in the Greater Tzaneen Municipality, Mopani District, Limpopo Province**” submitted to the University of Limpopo, for an MCur degree in nursing has not previously been submitted by me for a degree at this or any other university, that it is my own work in design and in execution, and that all reference materials contained herein have been duly acknowledged.

Ms Masemola S.O

19/04/2021

Signature



DEDICATION

☞ To my late mother, Elizabeth, who passed away on 26/06/2016, who used to pray for me all the time and her prayers will forever hold me and her sincere love natured and encouraged me throughout my career.

☞ My son, Kopano, who missed me mostly when I was busy with my research work.

☞ My friends, Antoinette and Shale, guys you have indeed fulfilled the adage, that a friend need is a friend indeed.

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My beloved Father in heaven. “Our help in the name of the Lord, the maker of heaven and earth” (Ps 124:8).

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- ✎ The Limpopo Province Department of Health and Social Development, for allowing me to conduct this study in the various Outpatient Department (OPD) units of 3 public hospitals in the province.
- ✎ The Chief Executive Officers and nurse managers of the OPDs of three public hospitals, Limpopo Province, where I collected data.
- ✎ Respondents, who completed the questionnaires for this research study.
- ✎ The statistician, who made all collected data meaningful.
- ✎ Professor D.C. Hiss, for editing and typesetting assistance (*Appendix L*).

ABSTRACT

Background: The utilization of primary health care (PHC) facilities has declined as most patients are using the hospitals for minor ailments. The study aimed to investigate factors that contribute to non-utilization of PHC services by the community in Greater Tzaneen Municipality, Mopani District, Limpopo Province.

Methodology: quantitative research method was used, and data was collected using self-designed questionnaire. Total of 101 respondents out of 135 population participated in the study. Simple random sampling was used. The questionnaire was piloted to ensure reliability in a different setting. Data was analyzed using SPSS version 24. The outcome of the analysis was presented as frequencies and percentages in tables, pie charts and bar graphs. Ethical standards were adhered to throughout the study.

Results: Demographic results indicated that the most of the respondents were females, aged between 26-35 years, speak the Sepedi language unemployed, went up to secondary school level using public transport, and have used their local clinic before more than. Many indicated that they have visited the hospital for reasons other than maternal and child health, chronic diseases and medication and minor illnesses. 25 factors recorded and the respondents reported six major factors that contributed to non-utilizing their PHC services. Factors included long queues and waiting times, no drugs and essential medication, PHC not operating for 24 hours and not operating for 7 days per week and nurses' negative attitudes toward the community.

Conclusions: Demographic results did not impact on the non-utilization of PHC services, but community-related, administrative factors and health-related factors contributed to non-utilization of PHC services.

Keywords: Community, factors, non-utilization, PHC services

LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CEO	Chief Executive Officer
CHCC	Community Health Care Centre
DoH	Department of Health
DHIS	District Health Information System
DHS	District Health System
EDL	Essential Drug List
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
MDGs	Millennium Development Goals
MHCU	Mental Health Care Users
NPC	National Population Commission
OPD	Outpatient Department
PHC	Primary Health Care
SA	South Africa
SPSS	Statistical Package for the Social Sciences
TB	Tuberculosis
TREC	Turfloop Research Ethics Committee
UNDP	United Nations Development Programme
USSR	Union of Soviet Socialist Republics
WHO	World Health Organization

DEFINITIONS OF CONCEPTS

Factors	Refer to the influences that contribute to a result (Collins English Dictionary, 2017). In this study, factors were acts or omissions preventing the utilization of PHC services.
Non-Utilization	Refers to a lack of usage of health care services by individuals the service is provided for (Manzoor, Hashmi & Mukhtar, 2009). In this study, non- utilization refers to a community not using PHC services in the Greater Tzaneen Municipality, Mopani District.
PHC Services	Refer to essential health care that is based on scientifically sound and socially acceptable methods and technology, which make universal health care accessible to all individuals and families in a community (WHO, 2018). In this study, PHC services are all services that are provided at the PHC services and community health centers.
Community	Refers to a group of people living in the same place or having characteristics in common (Collins English Dictionary, 2012). In this study, community refers to people who seek health care services in the Greater Tzaneen Municipality, Mopani District.

TABLE OF CONTENTS

DECLARATION	<i>i</i>
DEDICATION	<i>ii</i>
ACKNOWLEDGEMENTS	<i>iii</i>
ABSTRACT.....	<i>iv</i>
LIST OF ACRONYMS AND ABBREVIATIONS.....	<i>v</i>
DEFINITIONS OF CONCEPTS.....	<i>vi</i>
TABLE OF CONTENTS.....	<i>vii</i>
LIST OF FIGURES.....	<i>xiii</i>
LIST OF TABLES	<i>xiv</i>
CHAPTER 1 OVERVIEW OF THE STUDY.....	<i>1</i>
1.1 Introduction and background	1
1.2 Research problem	5
1.3 Theoretical framework	6
1.4 Research of the study.....	6
1.5 Research question.....	6
1.6 Objectives.....	6
1.7 Research methodology.....	7
1.8 Significance of the study.....	8
1.9 Ethical Considerations	8
1.10 Bias.....	8
1.11. Outline of the dissertation	9
1.11.1 Chapter 1: Overview of the Study.....	9
1.11.2 Chapter 2: Literature Review	9
1.11.3 Chapter 3: Research Design and methodology.....	9
1.11.4 Chapter 4: Presentation and discussion of the Research Findings	9

1.11.5 Chapter 5: Summary, Limitations, Recommendations and Conclusions	10
1.12 Conclusion.....	10
CHAPTER 2 LITERATURE REVIEW	11
2.1 Introduction.....	11
2.2 Description of PHC	11
2.3 PHC utilization	11
2.4 Determination of healthcare utilization (Theoretical framework).....	12
2.5 Factors that contribute to non-utilization of PHC services.	15
2.5.1 Availability of services at the health facility	15
2.5.2 Drug Stock Out and Shortage of Equipment.....	16
2.5.3 Effect of Accessibility of health Services on Service Utilization	17
2.5.4 Socioeconomic Status	18
2.5.5 Lack of Infrastructure and Staffing.....	18
2.5.6 Prolonged waiting times and shortage of human resources	19
2.5.7 Lack of Awareness of Services.....	20
2.5.8 Confidentiality and stigma.....	21
2.5.9 Adverse events.....	21
2.5.10 Language, culture, and trust.....	22
2.5.11 Other Factors Affecting Utilization of PHC Services	22
2.6 Referral System: Level of Care.....	23
2.6.1 Level 1: Primary Health Care Clinic.....	23
2.6.1.1 Community Health Care Centre	23
2.6.1.2 District hospital.....	24
2.6.2 Level 2: Regional Hospital	24
2.6.3 Level 3: Provincial Tertiary Hospital	24
2.6.4 Level 4: Central Hospital.....	24

2.6.5 Specialized hospital	25
2.7 Conclusion	25
CHAPTER 3 RESEARCH DESIGN AND METHODOLOGY	27
3.1 Introduction	27
3.2 Research Method	27
3.3 Study Setting	28
3.4 Research Design	29
3.4.1 Cross-Sectional Research Design	30
3.4.2 Descriptive Design	30
3.5 Population	31
3.6 Sampling	31
3.6.1 Sample size	31
3.6.2 Inclusion Criteria	32
3.6.3 Exclusion Criteria	33
3.7 Data collection	33
3.8 Pilot Study	35
3.9 Data analysis	36
3.10 Validity and reliability	36
3.10.1 Validity	37
3.10.1.1 Content Validity	37
3.10.1.2 Face Validity	37
3.10.1.3 External Validity	38
3.10.2 Reliability	38
3.11 Ethical considerations	38
3.11.2 Permission	38
3.11.3 Informed Consent	39
3.11.4 Privacy	39

3.11.5 Anonymity	39
3.11.6 Confidentiality	39
3.12 Conclusion.....	40
CHAPTER 4 PRESENTATION AND DISCUSSION OF THE RESEARCH FINDINGS	41
4.1 Introduction.....	41
4.2 Respondents' response rate.....	41
4.3 Section A: Demographic Data	41
4.3.1 Age.....	43
4.3.2 Gender.....	43
4.3.3 Highest level of education.....	43
4.3.4 Home Language	43
4.3.5 Occupation	44
4.3.6 Mode of Transport to hospital.....	44
4.3.7 Have You Ever Visited The Clinic Before?	44
4.3.8 How Many Times?.....	44
4.4 Section B: Factors Preventing Community Members from Utilizing PHC Services.....	45
4.4.1 Reasons for visiting the hospital.....	45
4.4.2 Community-related Factors	46
4.4.3 Administrative-Related Factors.....	46
4.4.4 Health personnel-related Factors	47
4.5 Discussion of Research Findings	48
4.5.1 Section A: Demographic Data	48
4.5.1.1 Age of the Respondents.....	49
4.5.1.2 Gender of the Respondents.....	49
4.5.1.4 Home Language of the respondents.....	50
4.5.1.6 Mode of Transport of the respondents	51

4.5.2.1 Respondents' Reasons for Coming to Hospital.....	53
4.5.2.2 Community- Related Factors	53
4.5.2.3 Long queues and waiting Times	53
4.5.2.4 Clinic Medication Not Working	54
4.5.2.5 Afraid of Stigma	55
4.5.2.6 Staying Next to the Hospital.....	56
4.5.2.7 Administrative-Related Factors	56
4.5.2.8 Poor Community Involvement.....	56
4.5.2.9 No Drugs and Essential Medication at the Clinic	57
4.5.2.10 No Water and Electricity.....	58
4.5.2.11 Clinics Not Operating 24/7	59
4.5.2.12 Health personnel-related Factors and Nurses' Negative Attitudes towards Patients	60
4.6 Application of the theoretical framework.....	61
4.6.1 Predisposing Factors.....	61
4.6.2 Enabling Factors.....	62
4.6.3 Health System Factors	63
4.7 Conclusion.....	66
CHAPTER 5: SUMMARY, LIMITATIONS, RECOMMENDATIONS AND CONCLUSIONS.....	68
5.2 Restatement of the problem statement.....	68
5.3 Restatement of the Research Aim.....	69
5.4 Restatement of the Research Objectives	69
5.5 Achievement of the Objectives of the Study	69
5.6 Limitations of the Study	70
5.7 Recommendations.....	70
5.7.1 Long Queues and Waiting Times	71

5.7.2 Clinic Medication Not Working.....	72
5.7.3 Health Care Personnel Not Competent	72
5.7.4 Shortage of Nurses at the Clinic	73
5.7.5 No water and Electricity	74
5.7.6 No Drugs and Other Essential Medication.....	75
5.7.7 Clinic Not Operating 24/7.....	76
5.7.8 Negative attitude of nurses towards patients	77
5.7.9 Referral System.....	77
5.7.10 Research-Related Recommendations.....	78
5.7.11 Nursing Management-Related Recommendations	79
5.7.12 Nursing Education-Related Recommendation.....	80
5.8 Conclusion.....	80
REFERENCES.....	81
APPENDIX A.....	96
APPENDIX B.....	97
APPENDIX C.....	98
APPENDIX D.....	99
APPENDIX E.....	100
APPENDIX F.....	100
APPENDIX G.....	103
APPENDIX H.....	105
APPENDIX I.....	107
APPENDIX J.....	111
APPENDIX K.....	115
APPENDIX L	119

LIST OF FIGURES

Figure 2.1: Health Care Utilization Model Adopted from Andersen, McCutcheon, Aday, Chiu and Bell (1983).....	13
Figure 3.1: Geographical map showing the Greater Tzaneen Municipality	29
Figure 4.1: Reasons for visiting the hospital	45
Figure 4.2: Health personnel-related factors.....	48

LIST OF TABLES

Table 4.1: Demographic data of the participants	42
Table 4.2: Community-related factors.....	46
Table 4.3: Administrative factors	46

CHAPTER 1

OVERVIEW OF THE STUDY

1.1 Introduction and background

The need for the world communities to provide and promote essential health care for all led to the development of the concept Primary Health Care (PHC) as a key to achieving this goal. This was meant to aid in bridging the gap of existing inequality in health status among different people of various socio-economic backgrounds in developed and developing countries of the world (WHO, 1978).

According to World Health Organisation (WHO) (1978), PHC is essential health care based on practical scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It covers a wide range of health services, which includes diagnosis and treatment, health education, counselling, disease prevention and screening usually provided in a community by general practitioners, practice nurses, pharmacists or other health professionals working within a health facility. Service utilisation refers to the extent to which people are making use of whatever services are already available in the community or at their organization. Therefore, health care service utilisation is the extent to which people make use of the health care services available to them in their community (Hampton & Nagy, 2016).

The extent to which these health services are utilised in developing countries is still very low resulting in many different negative consequences. The mere presence of health facilities does not guarantee their utilisation as other factors could influence access and utilization (Adam & Awunor, 2014). Forty years ago the global community articulated a vision for primary health care in the Declaration of Alma Ata as the basis of 'health for all'. Ten years ago the World Health Organization reiterated that health systems needed primary health care 'now more than ever' and proposed four key reforms related to person-centeredness, realising universal coverage, a 'health in all

policies' approach, and leadership which is more responsive and accountable to society's needs (Gauld, 2015). Despite this global commitment to the principles of and need for PHC, actual implementation has not lived up to expectations. This is particularly true in low- and middle-income countries and on the African continent (Mash, 2018). PHC in Africa is often the Cinderella of the healthcare system rather than its foundation. African health systems tend to be under-resourced and hospital-centric with PHC delivered by low-level and poorly trained healthcare workers (Mash, 2018).

The 2009 World Development Reports released by the United Nations Development Programme (UNDP) and the Nigerian National Demographic Health Survey (2008) portrayed the extent of underutilization of PHC services in general. For example, overall national immunization coverage was reportedly 29% and national contraceptive prevalence rate 15%. The state had an antenatal coverage of 14.4% with only 4.7% of women delivering in primary health facilities. Despite the fact that appropriate resources have been dedicated and invested by the different tiers of government, patients still bypass the PHC to directly access the services at secondary and tertiary health facilities. This results in overburdened and overstretched facilities with consequent reduction in quality of services at higher levels of care.

According to the National Population Commission (NPC, 2009), the fundamental problems of PHC have been recognized and respected by all nations, yet there are divergences and ambiguities in interpretation across countries worldwide. A recent report by World Health Organization (WHO, 2017), African region put the level of PHC utilization at 5–7% in the region and this translates to about 95% underutilization of the services. In the Kenyan health system represented by Machakos country, a large number of patients seek hospital services directly, sidestepping services offered at the PHC, hence, weakening the efficiency and cost-effective management of health services at all levels (Minister of Health Kenya, 2013).

South Africa emerged from the Apartheid era with an underdeveloped and fragmented PHC system (Matsoso, 2015). Since the establishment of a fully democratic government in 1994, there has been a policy commitment to improving

PHC for the whole population. This has focused on improving primary care infrastructure and access to care.

PHC was taken on as a fundamental system to promote health care to the population of South Africa and it is provided through the District Health System (DHS). This mechanism brings health care as close as possible to where people live and work, and it creates the first element of a continuing health care process. It was formally introduced in South Africa in April 1994 and the South African government is the main service provider of PHC services (Department of Health/DoH, 2014).

PHC refers to essential health care that is based on scientifically sound and socially acceptable methods and technology which make universal health care accessible to all individuals and families in a community (WHO, 1978). Community-based PHC is the centrepiece of health care delivery to persons in South Africa. In South Africa, PHC must be reachable to the extensive greater number of the population to be successful. Poor access to PHC is associated with unfavourable pregnancy outcomes, infant mortality, decreased vaccination coverage and decreased contraceptive use. Inaccessibility of PHC may also affect adherence to treatment regimens for chronic diseases. The achievement of at least three of the United Nation's Millennium Development Goals (reduce child mortality; improve maternal health; combat HIV, malaria and other diseases) is chilled upon improved access to and acceptability of PHC (Masango-Makgobela, Govender & Ndimande, 2013).

The provision of PHC is a fundamental service developed to be cost-effective and bring health care accessible to the population in South Africa, specifically to those people of low socio-economic status. South African government provide this service without any charge by the and as part of millennium health. South Africa has committed itself to several reforms designed to improve the quality of PHC (Matsoso, 2015). These include the creation of district clinical specialist teams that focus on maternal and child health as well as the introduction of community health workers in ward-based outreach teams to strengthen community-based health promotion, disease prevention and home-based care. School health services have also been strengthened and a new speciality of family medicine has been recognised with

specialists in family medicine placed at district hospitals and health centres. This 'primary health care re-engineering' is part of a broader policy commitment to achieving universal health coverage through the introduction of national health insurance (Matsoso, 2015). National health insurance has the potential to integrate primary care resources from the public and private sectors into one system.

Introducing Batho-Pele principles all-inclusive intentions, the SA government was to attempt to make better access to high-quality effective care, to lessen inequalities between the PHC services and to help match the Millennium Development Goals (MDGs). Immunization, mother and child care services, antenatal and postnatal care as well as family planning, treatment of sexually transmitted disease, treatment of minor ailments and curative services, mental health, school health services (early discovery, rectifying and prevention of diseases from which school-aged children can suffer), treatment of chronic disease, e.g. hypertension and diabetes, treatment of communicable diseases, e.g. tuberculosis and HIV/AIDS, oral health, rehabilitative services and provision of essential drugs are types of services that are supplied. A comprehensive integrated PHC service should be provided by the clinic using a one-stop approach for at least eight hours a day, five days a week (DoH, 2001).

The Limpopo Province is one of the three most rural provinces in the country characterised by poor health outcomes. According to Statistics South Africa, Limpopo Province has a population of approximately 5.4 million people. It has five Districts. The Mopani District has a population size of 1 092,507 with five sub-districts: Ba-Phalaborwa with a population size of 150,637, Greater Giyani 244,217, Greater Tzaneen 390,095, Greater Letaba 212,701, and Maruleng 94,857. The three main sources of income are farming, mining and tourism (Stats SA, 2011).

According to the 2013/14, District Health Barometer Mopani is 95% rural with only 16.8% of households with piped water inside, 88.7% use electricity for lighting, and 16.9% of households have a weekly refuse removal service. The unemployment rate estimated to be 39.4% in 2013 (Massyn & Day, 2014).

Mopani has 104 fixed health facilities, 8 hospitals and 28 mobile health facilities. Of the fixed facilities, 96 are Primary Health Care (PHC) facilities and the remaining 8 are Community Health Centres (CHCs). The facilities are unevenly distributed across the District.

An indicator on “outpatient department new clients not referred rate” for Mopani reflects a high percentage (79.2%) on outpatient department utilisation by self-referrals and this is much higher than the national average (60.7%) (Massyn & Day, 2014) and Greater Tzaneen Municipality recorded 74.4% of self-referrals to outpatient department (DHIS, 2016/2017). This is an indication of how the health system has been hospital-centric with communities relying mainly on hospital care. It was in agreement with this background that there is under-utilization of PHC services, that this why the study investigated the factors that contribute to non-utilization of PHC services by community members in Greater Tzaneen Municipality, Mopani District, Limpopo Province.

1.2 Research problem

The utilization of PHC facilities has declined because most patients are using the hospitals for minor ailments. In the Outpatient Department (OPD), new patients who were not referred total about 74.4% at the district hospitals and 46.6% at the regional hospital (District Health Information System/DHIS, 2016/17). The Greater Tzaneen Municipality Hospitals encounter overcrowding of patients and/or clients who come without referrals from the PHC.

Surprisingly, Mopani District has a well-established health care structure which includes three hospitals: Letaba, Dr CN Phatudi and Van Velden, operate with 35 PHC facilities (31 Community Health Clinics and 4 Community Health Care Centres). Community members travel less than 5 km to reach their PHC facilities based on the set norms and standards of South African PHC Services (Primary Health Care Package for SA, 2013).

Besides having access to many clinics and health centers in their local communities, some patients go directly to the hospitals for non-emergencies and minor ailments

without first consulting their PHC facilities and pay for the service in the hospital and hire transport to go to the hospital. It was thus of interest to the researcher to identify and describe the factors preventing patients from utilizing PHC services and to further develop appropriate recommendations to improve their utilization from study results and literature (Visser, Marincowitz, Govender & Ogumbanjo, 2015).

1.3 Theoretical framework

A theoretical framework is a structure that can hold and support a theory of a research study by focusing on specific variables and defining the specific viewpoint or framework that will guide the researcher (Ravitch & Matthew, 2017). For the purpose of this study, the Health Care Utilization Model of Andersen, McCutcheon, Aday, Chiu and Bell (1983) was adopted and applied. This model encompasses three determinants: predisposing factors, enabling factors and health system factors that influence health care utilization, which will be discussed in chapter 2 and applied in chapter 4.

1.4 Research of the study

The study aimed to investigate factors contributing to non-utilization of PHC services by the community in the Greater Tzaneen Municipality, Mopani District, Limpopo Province.


1.5 Research question

The research question that guided this study was:

What are the factors contributing to non-utilization of primary health care services to the community in Greater Tzaneen Municipality, Mopani District?

1.6 Objectives

The objectives of this study were to:

-  Identify factors that contribute to non-utilization of PHC services by the

community in the Greater Tzaneen Municipality, Mopani District.

☞ Describe factors that contribute to non-utilization of PHC Services.

- Develop recommendations to improve utilization of PHC services by community in the Greater Tzaneen Municipality based on the results.

1.7 Research methodology

A quantitative research method was used to emphasize the collection of numerical data. A descriptive cross-sectional design was used in this study. In a descriptive cross-sectional design, the researcher should not manipulate any variable or even determine the relationship between variables (Brink et al., 2017). The researcher collected numerical data through a questionnaire whereby data was collected at one point and time on three consecutive days (17, 18 and 19 June 2019) and every third patient in the queue was selected and thus bias in the selection process was minimized since all the patients stood an equal chance of being selected. If a patient fell within the exclusion category, the next patient was selected.

Dr CN Phatudi Hospital consults a maximum number of community members (i.e. 45) at Outpatient Department (OPD), Letaba Hospital 50 and Van Velden Hospital 40. The target population of this study was 135 community members who seek health care services at OPD at Dr CN Phatudi Hospital, Van Velden Hospital, and Letaba Hospital. Simple random sampling was used to select 101 community members who participated in the study. Data were obtained from community members through a self-administered questionnaire.

Content validity was ensured by presenting the questionnaire to experts in the field of study for evaluation. Face validity was ensured by submitting the questionnaire to the statistician and the supervisors to be assessed for its ability to measure what it was expected to measure. Reliability was ensured by conducting a pilot study.

The Statistical Package for Social Sciences (SPSS) Version 24 for Windows was used to analyse numerical data. Descriptive statistics were used to obtain frequency tables, pie charts and bar graphs. In this study, factors to be identified and described

were community-related, administrative-related and health-related factors as independent variables, that contribute to non-utilization of PHC services, as dependent variables as reported by community members in the Greater Tzaneen Municipality, Mopani District, Limpopo Province.

1.8 Significance of the study

The study might help the local government responsible for the service delivery at these facilities target their education and community message to address the fundamental elements that act as factors preventing patients from utilizing primary health care services. The research will also help the policy makers to develop policies in addressing the identified factors which are considered to be preventing non-utilization of PHC services. It might also help the service providers at the facility level to implement the strategies that the researcher would have developed to encourage and improve the utilization of primary health care services. The research will also assist future researchers to be able to relate the study results to with what they will be intended to research in relation to the studied topic.

1.9 Ethical Considerations

To conduct this study, ethical clearance was granted by the University of Limpopo Turfloop Research Ethics Committee (TREC/55/2019: PG, *Appendix A*). Provincial Department of Health Limpopo Province (*Appendix B*), Dr CN Phatudi Hospital (*Appendix C*), Letaba Hospital (*Appendix D*) and Van Velden Hospital (*Appendix E*) permitted to collect data at the study sites. Informed consent (*Appendices F–H*) was obtained before the collection of data. The respondents were ensured that their names would not be reflected in the study to ensure anonymity. Privacy and confidentiality were maintained throughout the study and respondents were also informed that they could withdraw their participation from the study at any time.

1.10 Bias

According to Brink et al (2017), bias is an influence that produces distortion, which can affect the quality of evidence in a research study. In this study, all respondents were given the same questionnaire to answer and the researcher made certain that all respondents understood questions provided and made sure that questions that

were not clear are made clear because she was available when the questionnaire was answered.

Pre-testing was done in a different setting which is a Hospital in the Greater Maruleng Municipality using 10 respondents who did not form part of the main study. During the main study, the third patient in the queue was selected and thus bias in the selection process was minimized since all the patients stood an equal chance of being selected. If a patient fell within the exclusion category, the next patient was selected. A quiet consulting room/office was used for the sake of confidentiality. It was also hoped the setting would help the patient to feel relaxed.

1.11. Outline of the dissertation

1.11.1 Chapter 1: Overview of the Study

This chapter provides the introduction and background to the study. It introduces the research problem, theoretical framework, aim, research question, objectives as well as the research methodology and ethical considerations that guided the study.

1.11.2 Chapter 2: Literature Review

Chapter 2 covers the literature review on the description of PHC services and its concepts, levels of care, the theoretical framework and factors contributing to non-utilization of PHC services.

1.11.3 Chapter 3: Research Design and methodology

This chapter presents the research methodology, research design, study sites, population and sampling, data collection method, data analysis, validity and reliability, and ethical considerations.

1.11.4 Chapter 4: Presentation and discussion of the Research Findings

Chapter 4 deals with the presentation and discussion of the research findings in the context of the aim and objectives of the study.

1.11.5 Chapter 5: Summary, Limitations, Recommendations and Conclusions

This chapter discusses the summary, limitations, recommendations and conclusions based on the findings of the study concerning factors contributing to non-utilization of PHC services.

1.12 Conclusion

This chapter presented an overview of the research study, introduction and background, problem statement, aim of the study, research question, theoretical framework, methodology and descriptions of the research design, ethical considerations, the significance of the study and bias. The next chapter covers the literature review related to the subject under study.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

A literature review refers to the summary of theoretical and empirical sources used to generate a picture of what is known about a particular problem (Burns & Grove, 2017). This section included a brief description of PHC service and literature about factors affecting PHC utilization, referral systems (levels of care).

2.2 Description of PHC

According to WHO (2008), PHC addresses the majority of a person's health needs throughout their lifetime. This includes physical, mental and social well-being and it is people-centered rather than disease-centered. It is regarded as a whole-of-society approach that includes health promotion, disease prevention, treatment and rehabilitation and palliative care. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where the people live and work, and constitutes the first element of a continuing health care process (Agbenyo, Nunbogu & Dongzalga, 2017).

2.3 PHC utilization

Good health is a fundamental requirement for living a socially and economically productive life. Tran, Nguyen and Nong (2016) noted that health constitutes a priority in the life of every individual because it determines to a great extent, the level at which an individual functions in society. Health guarantees hope and progress for individuals in any society (Letty, 2016). This implies that good health is a determinant of success in the life of every individual and therefore, it must be developed and maintained by every individual. To do this, health services must be provided and effectively utilized.

Utilization of PHC is the quantification or description of the use of service by persons to prevent and cure health problems, promoting maintenance of health and well-being, or obtaining information about one's health status prognosis (Carrasquillo, 2013). An individual's decision to utilize health care services is a result of a complex

interaction of factors relating to the person's health self-perceived health status, and the availability of the health care services on offer. Health Services are relevant, regardless of age and gender and that is why every good government often emphasizes on the health of its citizens and that is the reason why the three tiers of government are concerned about good health delivery. Umunna (2012) pointed out that the Nigerian Governments have made a tremendous contribution to the provision of qualitative healthcare services to its population. However, utilization of these services remains dependent on the perception of individuals.

Good utilization of health services serves to improve the health of the population (Adams & Awunor, 2014). Healthcare service utilization is a major determinant of health. Its role in providing and maintaining optimum health status cannot be overemphasized. Gauld (2015) recommended the utilization of healthcare services as a basic primary healthcare concept. However, studies have shown that the presence of health services alone is not enough to guarantee their use as other socio-economic factors could influence access and utilization. Low health facility utilization is often a reflection of poor quality of services and attitude of the staff (Kuponiya, 2016).

2.4 Determination of healthcare utilization (Theoretical framework)

Andersen healthcare utilization Model is a conceptual framework used to highlight the factors that lead to the utilization of health services or to study access to medical or healthcare. The determinants of health service utilization can be grouped into three broad categories. These are personal attributes which may predispose individuals to seek care; the need for care as evidenced by both subjective (perceived or self-reported) health status and objective (assessed by a physician) health status; and enabling factors such as the financial capability to pay for care, ability to get to places where services are offered, and knowledge about the services available (Terfa, Germossa, Hailu, Feyissa & Jaleta, 2019) This is represented by the following illustration:

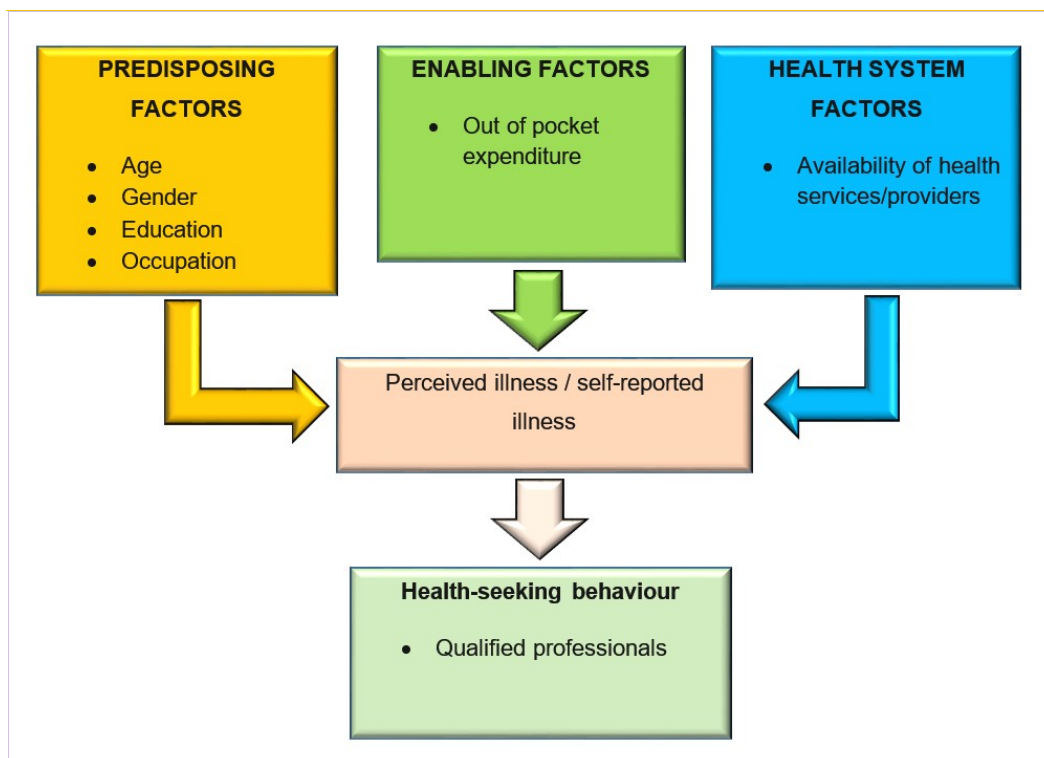


Figure 2.1: Health Care Utilization Model Adopted from Andersen, McCutcheon, Aday, Chiu and Bell (1983).

❖ **Predisposing factors**

These factors reflect the individual s’ propensity to use health care services (Jang, Chiriboga, Allen, Kwak & Halley, 2015). The predisposing factors include social, structural and demographic factors which influence health care attitudes and beliefs.

❖ **A Demographic factor**

These are factors that may influence the likelihood an individual needs a health service (such as age and gender, occupation, mode of transport and education). Age, gender differences, educational status and income level have been identified in some studies to determine the frequency of use and comprehensiveness of health care packages (Gong, Yin, Wang, Li, Qui, Liu et al. 2014).

❖ **Need for health care services**

Health status and the need for healthcare for health care services to improve or maintain health are major determinants of health care utilization. The World Health

Organization states that health is determined by a person's characteristics and behaviours, physical environment, and socio-economic environment (WHO, 2017). It also includes poor or ill health, chronic conditions, and limited physical activity performance. Need for health care is usually measured by symptoms of illness perceived by the individual, their responses and medical assessment of the condition by the physician.

People's characteristics include their biology and genetics such as inherited diseases and conditions that require medical care. The prevalence of those conditions differs by sex, age, race, and ethnicity, employment status and other factors. The physical environment can affect health because of pollutants or other environmental hazards. Individual behaviours, such as smoking or lack of exercise and overeating, also cause health conditions that require health care (ODPHP, 2017a). It further indicated that recent attention to social determinants of health, such as education, economic stability, community safety, and availability of adequate housing and healthful food, has shown that they correlate with a healthier population.

❖ **Enabling factors**

This concept refers to resources that may facilitate access to health care services (Jang, Chiriboga, Allen, Kwak & Haley, 2015). It includes out-of-pocket expenditure.

❖ **Out-of-Pock Health Expenditures**

These are direct payments made by the individual to health care providers at the time of service use.

❖ **Perceived Illness/ Self-Reported Illness**

This refers to how one view his or her general health and they assist in discerning health care use and health behaviours of individuals. Perceived factors that were identified as barriers to utilization of health facilities as documented in the Nigerian studies (Bresick, Christians, Makwero, Besigye, Malope & Dullie, 2019), and other studies in Ghana (Krumkamp et al., 2013), Ethiopia, Kenya (Saronga et al. 2014), Tanzania, India (Dala & Dawad, 2009) and Greece (Galamis et at., 2013), include

poor education about when to seek care; poverty; perceived high cost of services; inadequacy of available services such as lack of drugs, basic laboratory services; an inadequate number of healthcare workers; poor quality of care; and proximity to the facility.

❖ **Qualified Professionals**

This refers to any individual with appropriate training or experience in the field of health which includes nurses, doctors, therapists and pharmacists (US Department of Health and Human Services, 2014).

❖ **Health system factors**

This refers to the availability of health services/providers and sufficient supply and appropriate stock of health workers, with the competencies and skill-mix to match the health needs of the population (WHO, 2018).

The application of this framework to this study provides the analytical tool for identifying and evaluating the determinants of healthcare utilization and what contributes to non-utilization of PHC services by the community members in Greater Tzaneen Municipality, Mopani District, Limpopo Province. Andersen's model contextualizes the several variations and perspectives that individually or collectively capture the women's healthcare utilization narrative hence its suitability in this study.

2.5 Factors that contribute to non-utilization of PHC services.

Literature was reviewed in the current study based on factors that contributed to the non-utilization of PHC services. It includes the availability of services at the health facility, drug stock out, effects of accessibility of health service utilization, socioeconomic status, lack of infrastructure and staffing, lack of awareness of services, stigma, other factors and referral system.

2.5.1 Availability of services at the health facility

A frequent barrier to the utilization of the health service facility was the inconsistency of the availability of services. In qualitative research, community members in Oromia,

a Southern Nations, Nationalities, and Peoples' Region (SNNPR) in Ethiopia complained about limited opening hours of health facilities (closed at night and on weekends) and the frequent absence of health care workers from health facilities during working hours (Tefera et al., 2014; Save the children, 2013 (treatment of newborn illness); Shaw et al., 2015; & Save the children, 2013 (environment influencing community-Based new-born care). In Oromia, 21.10% of caregivers cited the health being closed as a reason for not using services. Another survey in Amhara, Oromia and Tigray found that only 52% of health posts received pregnant woman during non-working hours (Tefera et al., 2014).

Miller, Amouzou, Tafesse et al., (2014) on integrated community case management of childhood illness in Ethiopia indicated that even health care workers reported that health facilities only open 24 hours per week on average, about half of the hours the health facilities are supposed to be open. Health care workers also cited that the health facilities are not always open as one of the top reasons for low utilization. Even health care workers seems to be away from the health facilities for different reasons.

The study conducted in Ethiopia on summative external evaluation of the catalytic initiative/integrated health system program, they are often called away for training by other government workers or other activities, and sometimes they may be away for personal reasons (Doherty et al., 2014).

2.5.2 Drug Stock Out and Shortage of Equipment

Time LIVE (14 June 2018) reported a concern raised by some members of the public regarding the shortage of equipment in PHC facilities that leads to fatal delays in providing services and increase in long waiting times. This long waiting times for medical intervention potentially exposed patients to developments of complications or even loss of life (Times LIVE, 2018). In qualitative and quantitative research studies, caregivers mentioned lack of drugs at health posts as the key reason preventing utilization. Caregivers' (20%) said they did not use the health post because they thought drugs were not available (Doherty *et al.*, 2014). Bediako et al. (2016) found that patients expressed dissatisfaction with medicines and the availability of supplies in the Taung district of North-West province. The study concurs

with the study done by Ibebuike (2017), stating that a reasonable number of the respondents (above average) also indicated that the non-availability of essential drugs is another factor. Granted that the health facility is meant to attend to the patients, but this attention may not be useful if the facility lacks essential drugs which would be given to the patients.

In a cross-sectional study conducted by Pillay and Mahomed (2019), it was reported that the availability of medication at the pharmacy was noted as an important determinant for self-referral. These findings are consistent in studies in Tanzania and Kenya; were both showed that dissatisfaction with the shortage of medicines in facilities affects health-seeking behaviour (Noordam, Carvajal-Velez, Alyssa, Sharkey, Young & Cals, 2015). Contrary to those studies, patients from the study conducted in Limpopo reported that their local clinic consistently experienced pharmaceutical stock-outs and mostly indicated that shortage as the reason for self-referral to hospital. These findings indicated this perception of lack of medication at local clinics increases the likelihood to self-refer, resulting in underutilized PHC services (Visser, Govender, Ogunbanjo & Marincowitz, 2015).

A study conducted by Mokoena (2017) revealed the lack of material resources, equipment and supplies (such as glucometers for monitoring blood glucose and needles). Participants also mentioned that the other equipment is not in proper conditions and patients had to wait until the equipment is fixed, resulting in delayed diagnosis and treatment. Manyisa and Van Aswegen (2017) reported that lack of administrative equipment and skilled professionals adversely affects the quality of care offered in PHC facilities.

2.5.3 Effect of Accessibility of health Services on Service Utilization

People cannot access care if it does not exist in their geographical area, or if providers will not treat them because of insurance or other issues. Rural areas in particular have been identified as lacking a sufficient supply of specialist physicians and, in particular, mental health-care providers (Meit et al., 2014; Douthit et al., 2015). Accessibility can be discerned from various points of view such as availability of services, transport costs to obtain services or the distance or state of roads to be

travelled, excessive travel time because no public transportation is available and the person does not have a car or other alternative transportation and/or providers might be unable to communicate with patients because of the language problems. Excessive waiting times to obtain appointments or to see providers at their places of service might also deter the utilization (MACPAC, 2016; NCHS, 2016).

Andersen discusses four concepts within access that can be identified through the conceptual framework (Aday & Andersen, 1974). Potential access is the availability of the enabling resources (such as a high income) which allows the individual to seek medical care if needed. Realized access is the actual utilization of healthcare. The conceptual framework also distinguishes between equitable and inequitable access. Whereas equitable access is driven by demographic characteristics (age, sex, etc) and need, inequitable access results from social structure, health beliefs, and enabling resources available to the population.

2.5.4 Socioeconomic Status

Health service utilization is determined by the important factor called affordability and in this regards, the presence of paying for the health services user has been indicated by the several literature sources as a demotivating factor in health service utilization. Financial barriers to care, particularly among low-income people and the uninsured have been greater in the United States than in other high-income countries (Dickman, Himmelstein & Woolhandler, 2017). This is in agreement with what was discovered by UNICEF and Path (2016); they observed that an increase in user fees may not necessarily translate to reduced utilization.

2.5.5 Lack of Infrastructure and Staffing

Though distance and physical accessibility are critical to the utilization of services, other barriers such as infrastructure are critical to encouraging utilization. An effect of poor infrastructure was seen in South African clinics where non-functioning diagnostic equipment in a clinic with a high TB client load, had an X-ray machine that was described as forever broken down thereby affecting patient satisfaction with provided services (Getahun, Wubie & Dejenu, 2016).

The unavailability of basic infrastructures such as water and electricity were echoed in the two facilities in the Tshwane region and participants noted that this was a major hindrance to the proper functioning of the clinic. The absence of water especially seems to be severe that mothers who came for delivery at the facility are asked to bring water as part of the requirements for delivery. This was an added cost for the families who are finding it hard already trying to make ends meet and an extra burden to the women (Umunna, 2012).

The ability of the women to provide water during the delivery period determines if the delivery will be carried out or not, however, all the women interviewed said they could provide the needed water by buying from the water vendors in the community. This lack of safe water generally affects the quality of service provided at the clinics and their ability to maintain standard cleanliness requirements (Umunna, 2012). There is a particularly crucial need in South Africa for government to improve the infrastructure in rural communities, where some PHC centres even lack piped water-a clear sign, that the public health system is overburdened and incapable of providing consistent quality care (Heywood, 2014).

2.5.6 Prolonged waiting times and shortage of human resources

Waiting time as it is the time taken to receive medical attention at a facility has been frequently cited to influence healthcare utilization. A study conducted by Pillay and Mahomed (2019), it was found that waiting time as a health care facility is highly important among self-referred patients. Similarly, a Kenyan study showed that the patients who were satisfied with their facility waiting times were less likely to bypass that facility (Abeno, 2014). This inference is shared by other South African studies that reported increased waiting at their local facilities encouraged bypass behaviour (Becker, 2012; Masango & Govender, 2013; Pillay & Mahomed, 2019). Pillay and Mahomed (2019) further indicated that majority of the respondents from KwaZulu Natal study found that self-referred facility waiting time is more acceptable in comparison to time spent waiting at their local clinics.

A major weakness in Sub-Saharan health care systems is inadequate human resources. Africa is said to have less than one health worker per 1000 population compared to 10 per 1000 in Europe (Maphumulo & Bhengu, 2019). Maphumulo and Bhengu further indicated that participants affirmed that the insufficiency and inadequacy of health care workers which they described as leading to physical and mental exhaustion. Barron and Padarath (2017) noted that the health problems in South Africa are worsened by unequal distribution of health professionals between the health facilities.

Shortage of health care workers, caused by inadequate production, inadequate recruitment (especially in rural areas), poor retention and staff mismanagement is a worldwide problem (Veld & Van De Voorde, 2014). This is mostly felt at the nursing level because nurses are in the front line of service delivery in health care (Voget, 2017). This shortage of nurses leads to overcrowding in health care facilities causing a drop in quality of health care delivery (Kamndaya, Thomas, Vearey, Sartorius & Kazembe, 2014).

2.5.7 Lack of Awareness of Services

A major reason for not using health care services was a lack of awareness of the service offered, or of the benefits of services, among communities. The study in Tigray in December 2012 found that 60% of caregivers were aware of the services provided at the health facility. Of those who knew about services, 80% knew about malaria treatment, 64% knew about diarrhoea treatment, 55% knew about acute respiratory infection (ARI) treatment, and only 9% knew about malnutrition services. Lack of awareness of services was also the top reason given by the community for low utilization (Miller et al., 2019).

Some health indicators in Bangladesh remain poor. One of the foremost factors contributing to this situation is the under-utilization of community clinic services. Reason for under-utilization has been attributed to lack of awareness of the value of services (COMDIS-HSD, 2014). The study conducted by Yaya, Bishwajit, Ekholuenetale and Shan (2017), in Bangladesh, concurs with a study by Umunna (2012), which indicated that there are poor awareness and utilization of community

clinic services among women of reproductive age in Bangladesh. This is similar to the findings of studies on health care seeking behaviour in other parts of the world such as USA, Nepal and Nigeria (Spleen, Lengerich, Camacho, & Vanderpool, 2014).

2.5.8 Confidentiality and stigma

The study conducted the National Institute of Mental Health (2019), confidentiality persists a major concern that deters people across all ages from seeking health care services. Among adult women, confidentiality is of particular concern in the context of behavioural health. Women ages 18-44 are more likely than men to develop mental illness and twice as likely as men to develop an anxiety disorder. Despite the prevalence of mental health conditions, harmful stigma endures in a community that discourages the community from openly seeking behavioural health care services (Christine, 2018).

According to Graig, Daftray, Engel, O'Driscoll, and Ioannaki (2017), it was indicated that many patients in TB and HIV care stated that people in the community judged them negatively about their disease. They further indicated that a survey was done amongst adolescent women in the USA but is equally relevant in low incidence countries. This stigmatization contributed to patients using clinics that were located far from their homes. Patients who came for family planning were concerned about their confidentiality, therefore did not use the nearest clinic. However, these patients require continuity of care.

It was evidenced that antiretroviral services in South Africa are not utilized because of stigma; health worker's negative behaviour and people were to travel to a health facility frequently to collect their medication (Parikh & Veenstra, 2008). After removing user fees on the attendance of PHC, attendance for curative services increased, but subsequent clinic congestion and reduced consultation times may have discouraged some women from attending an antenatal clinic and bringing their children for growth monitoring and immunization.

2.5.9 Adverse events

Incidents reported were patients who developed complications, and in some cases

died, because they were turned away from the clinic. The *Sunday Tribune* (8 March 2015) reported on the family of a 35-year-old woman who died because she was turned away from health care facility despite being gravely ill. Kama (2017) reported the case of a 1-year old baby who died on his grandmother's back after they have been turned away for different clinics in one township in Cape Town. He further indicated that there was an incident in the same township was a teenager gave birth on the pavement outside the gates of health care facility because she was not allowed to access.

2.5.10 Language, culture, and trust

Language and cultural barriers, mistrust. And perceptions that health care providers are not listening to patients' concerns can deter PHC utilization and engagement. Multiple studies have shown that higher levels of perceived discrimination and lower levels of trust in the healthcare system from underrepresented communities are associated with lower utilization of preventative and routine services (Hye Chon Hong et al., 2018).

2.5.11 Other Factors Affecting Utilization of PHC Services

There seems to have a direct correlation with the utilization of health care services, particularly for children and maternal health services with the educational status of women and their partners. In the Vietnamese study, mothers who had higher educational levels will take their children to care more readily than those with lower education (Umunna, 2012). It was observed that there is a positive correlation between a higher level of education and utilization of PHC services in rural northern Nigeria and was also observed in middle belt region of Nigeria where mothers or husbands who had a primary school education will utilize antenatal services more readily than those who had a lower level of education or no education at all (Takai, Dlakwa, Bukar, Audu & Kwayabura, 2015). The study by Odetola (2015) concurs with the study by Umunna (2012) that the level of education is among other influences actively determining pregnant women's utilization of healthcare in Nigeria.

2.6 Referral System: Level of Care

A referral system is comprehensive health care systems used to manage client health care needs by referring clients from an initiating facility to an organization, service, or community unit that can better provide the level of care needed (DOH, 2007).

According to Adetola (2015), the referral system is vital in the provision of PHC services at the local government level. It is named two-way referral system and in this system clients that cannot be managed at the primary level can be referred to the secondary, likewise, clients that have been treated successfully at the secondary level can be referred back to the primary level for continuity of care and follow up.

In South Africa, there are four different levels of care in the health care system, each with different functions, resources and staffing. The referral system function as follows: community services refer to level 1 hospital, level 1 hospital refer to level 2 while level 2 hospitals refer to level 3 hospitals and level three hospital refer to central and specialized hospitals (DoH, 2007). Greater Tzaneen Municipality has three hospitals, two district hospitals (Dr CN Phatudi & Van Velden) and one regional hospital (Letaba).

2.6.1 Level 1: Primary Health Care Clinic

A PHC clinic is the first step in the provision of health care and offers services such as immunization, family planning, antenatal care, and treatment of common diseases, treatment and management of TB, HIV/AIDS counselling, among other services. If the clinic cannot assist, they will refer the patient to a Community Health Care Centre (CHCC).

2.6.1.1 Community Health Care Centre

This is the second step in the provision of health care but can also be used for the first contact. It offers similar services to a PHC clinic with the addition of 24-hour maternity services, emergency care and casualty and a short stay ward. The CHCC will refer a patient to a District Hospital when necessary.

2.6.1.2 District hospital

This is the third step in the provision of health care. These hospitals will normally receive a referral from and provide general support to community health centres and clinics such as diagnostics, treatment, care, counselling and rehabilitation services, amongst other services. Clinical services include Surgery, Obstetrics and Gynaecology, Outpatient Department, Medicine, Paediatrics, Mental Health, Geriatrics, Casualty and Clinical Forensic Medical Services amongst other services. These hospitals receive referrals from the CHCC and clinics. Most care was delivered by doctors and PHC Nurses. If the District Hospital cannot help a patient, they are referred to a local Regional Hospital for treatment.

2.6.2 Level 2: Regional Hospital

This is the second level of health care. These hospitals will normally receive referrals from and provide specialist support to some district hospitals. If the Regional Hospital cannot help, they will refer to the Provincial Tertiary Hospital.

2.6.3 Level 3: Provincial Tertiary Hospital

This hospital receives a referral from and provides sub-specialist support to some regional hospitals and is the third level of health care. These hospitals are staffed by specialists and generalists and offer services such as Neurosurgery, Neurology, Plastic and Reconstructive Surgery, Cardiology, Urology, Paediatric Surgery, Maxillofacial Surgery, Psychiatry, Occupational Health and Orthopaedics amongst other services. If a Provincial Tertiary Hospital cannot help, they will refer the patient to a National Central Hospital.

2.6.4 Level 4: Central Hospital

This is the fourth and highest level of health care. These hospitals will consist of very highly specialized referral units which together provide an environment for multi-specialty clinical services, innovations and research. People are referred to these hospitals by Provincial Tertiary Hospitals.

2.6.5 Specialized hospital

These hospitals will provide care only for certain specialized groups of patients. They will include Chronic Psychiatric and TB hospitals, as well as specialized Spinal Injury, and Acute Infectious Disease hospitals.

2.7 Conclusion

This chapter provides a review of the literature for the study. It covered the main concepts responsible for non-utilization of PHC services. The most common important concepts studied are the availability of service at a health facility, need for care, adverse events, drug stock out and shortage of equipment, the effect of accessibility of health service on service utilization, socioeconomic status, lack of infrastructure and staffing, lack of awareness of services including the educational status of women and their partners as part of factors contributing to non-utilization of PHC services. It seemed that in my countries they experience common problems that contributed to non-utilization of PHC services. The above mentioned factors identified by several Authors, all come to conclusion that quality of patient healthcare are compromised. Therefore it is of a useful to the researcher also to identify and describe the factors in South African context.

It also reviewed referral systems (level of care) and theoretical framework of health care utilization by Andersen et al (1983). The model was based on the determinants of health care utilization which included predisposing factors, enabling factors and health system factors. This health care utilization model guided the research study as it determined the factors that need to be taken into consideration for the community members to utilize PHC services as it emphasized ways to solve the factors identified to improve utilization rate.

The application of this model to the study results indicated that predisposing factors had no significant impact on health service utilization, while the enabling and health system factors determine health care utilization and developed ways to solve the problems identified concerning non- utilization of PHC services by community members in the Greater Tzaneen Municipality, Mopani District, Limpopo Province.

The literature review has revealed that there are a limited number of studies in South African context especially at the local level on factors contributing to non-utilization of PHC services and. Therefore, few sources are of the last five years old. This study will close the gap regarding focus in greater Tzaneen Municipality, Mopani District.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

This chapter presents the research method and design which included research questions, study setting, population and sampling method used, inclusion and exclusion criteria for selecting the respondents, data collection and data analysis methods used, ethical standards which were adhered to throughout the study, validity and reliability.

3.2 Research Method

Methodology in research is a systematic way of responding to a research question. It outlines various steps that a researcher undertakes to obtain, organise and analyse data in a logical way to respond to a research question. A researcher must understand the research methodology to determine the methods or techniques that are relevant to the study (Bryman, 2016). The researchers adopted a quantitative method, using a cross-sectional descriptive design to describe the factors contributing to non-utilization of PHC Services.

A quantitative research method is appropriate as the researcher intended to identify and describe factors contributing to non-utilization of PHC services by the community in the Greater Tzaneen Municipality, Mopani District, Limpopo Province. Quantitative methods emphasize objective measurements and the statistical, mathematical, or numerical analysis of data collected through questionnaires using computational techniques (Babbie & Roberts, 2018).

In this context, the researcher distributed copies a self-developed questionnaire to community members in Greater Tzaneen Municipality to describe factors contributing to non-utilization of PHC services. Statistical Package for the Social Sciences (SPSS) version 24 was used to analyse data and present it in a form of frequency tables, bar graphs and pie charts. Factors identified and described were community-, administrative- and health-related factors as independent variables. These variables

contributed to non-utilization of PHC services in Greater Tzaneen Municipality, Mopani District, Limpopo Province.

3.3 Study Setting

The study was conducted in three hospitals as indicated in Figure 2.1, which belong to Greater Tzaneen Municipality, namely:

- ✎ **Dr CN Phatudi Hospital** is situated in Maake Village, Shiluvane Local Area, Lydenburg Road is the (R36), 7 km to the North and 29 km South to Tzaneen Town, 127 km East of Polokwane.

- ✎ **Letaba Hospital** is situated in Nkowankowa Local Area, Tzaneen Lydenburg Road (R36), located 12.3 km South-East of Tzaneen and 105km West of Phalaborwa along R71 and R36.

- ✎ **Van Velden Hospital** is situated in Third Avenue, Tzaneen. The nearest main road is R36 to the North-West and North-East of the hospital (R36 bends to the North of the hospital). Other nearby main roads is the R71 North-West and R528 to the South-West, 21 km South of Modjadjiskloof and 10 km East of Polokwane.



Figure 3.1: Geographical map showing the Greater Tzaneen Municipality

3.4 Research Design

The research design involves a set of decisions regarding what topics to be studied among the population with what research method and for what purpose (Babbie & Mouton, 2014). De Vos et al. (2014) also explain research design as a plan that guides how the researcher will conduct a research study. A research design is a comprehensive plan for obtaining answers to research questions (Polit & Beck, 2018).

According to Moule, Aveyard and Goodman (2017), a research design is a map of how the researcher will engage with the research participants to achieve the outcomes that are needed to address the research aims and objectives. The purpose of the research design is to ensure that the evidence that gets collected answers the research question. In this study, the factors that contributed to the non-utilization of PHC services were identified and described.

According to Babbie and Mouton (2014), research design refers to all the decisions in planning the study, including sampling, sources and procedures for collecting data,

measurement and data analysis plans. In this study, a cross-sectional descriptive design was used. Simple random sampling technique was used to include respondents during data collection through questionnaires and data was analyzed using SPSS Version 24.

3.4.1 Cross-Sectional Research Design

The cross-sectional research design involves obtaining data from a cross-section of population at one point and time (Brink, Van der Walt & Van Rensburg, 2017). In a cross sectional study, the researcher measures that outcomes and the exposures in the study participants at the same time and are selected based on the inclusion and exclusion criteria set for the study. One the participants have been selected for the study, the researcher follows the study to assess the exposure and the outcomes (Seita, 2016).

A cross-sectional research design was used to identify and describe factors contributing to non-utilization of PHC services and data was collected from the community members who are seeking health services at the three hospitals. In this study, data was collected from the respondents on three consecutive days and one day at each hospital (17, 18 & 19 June 2019).

3.4.2 Descriptive Design

Variable was described through quantitative descriptive research design, which provided a fundamental for further quantitative research and theory testing, and further helped the researcher to give an accurate portrayal of the characteristics of target groups (Polit & Beck, 2018). According to LoBiondo-Wood and Haber (2018), descriptive designs collect detailed descriptions of the existing variables and use the data to justify and assess the current condition and practices to make plans for improving health care practices.

The purpose of a descriptive design is to provide an accurate account of the characteristics of a particular individual, situation or group in a natural setting (Burns & Grove, 2016). In this study, the factors described included community, administrative and health-related factors, that contribute to non-utilization of PHC services.

3.5 Population

The population is defined by Brink et al. (2017) as a complete set of persons who possess some common characteristics that are of interest to the researcher. Population in this study referred to the community that seeks health care service in Dr CN Phatudi Hospital, Letaba Hospital and Van Velden Hospital in OPDs. At Dr CN Phatudi Hospital, the maximum number of community members seen in OPD is 45, Letaba Hospital is 50 and, at Van Velden Hospital it is 40 per day for those who do not have referral letters from their PHC facilities. In this study, the total population was 135 community members who are seen at the three hospitals in OPD without referrals from PHC clinics.

3.6 Sampling

Sampling involves selecting a group of people, events, objects, or other elements with which to conduct a study (Grove, Gray & Burns, 2015). Simple random sampling technique was used in this study to ensure that all the clients coming to Dr CN Phatudi Hospital, Letaba Hospital and Van Velden Hospital in the maternity ward and OPD without referral letters from the PHC clinics were included equally during data collection in this study.

To accomplish this simple random sampling, the researcher defined the population, created a sample frame, calculated sample size, assigned a consecutive identification number to each element in the sample frame and selected a technique to randomly sample the respondents. Every fifth patient among those who were still waiting to be seen either by the nurses or doctors was chosen to take part in the study (Brink et al., 2017).

3.6.1 Sample size

Slovin's formula was used in this research study which allows a researcher to sample the population with a desired degree of accuracy (Stephine, 2013). With regard to the level of accuracy, a confidence of 95%, this means that there are 95 chances in 100 that the sample results represent the true condition of the population within a

specified precision range against 5 chances in 100 in that it does not. The Slovin's formula is calculated as follows:

❖ Slovin's Formula: $n = N / 1 + N \times (E)^2$

N = Population size = 135

n = Sample size =

E = confidence level = standard confidence level is 95% for a better accuracy, which will give a margin error of 0.05

❖ A computer of the confidence level

e = 100%-95%

e = 5%=0.05

❖ Sample Size

$$n = 135 / 1 + 135 \times (0.05) (0.05)$$

$$n = 135 / 1.34$$

$$n = 100.7$$

$$n = 101 \text{ respondents}$$

3.6.2 Inclusion Criteria

The inclusion criteria specify the criteria that define who is included in the population to be studied (Polit & Beck, 2018; Grove et al., 2015). The inclusion criteria for the study were community members who came to OPD in DR CN Phatudi Hospital, Letaba Hospital, and Van Velden Hospital without referral letters from PHC Services and who can read and write; these community members were included during data collection. This is because these community members were the ones who have not

utilized their PHC facilities but went directly to the hospital without referral letters.

3.6.3 Exclusion Criteria

This refers to characteristics that result in a person or element being excluded from the target population to be studied (Grove et al., 2015). It excluded community members who came to Dr CN Phatudi Hospital, Letaba Hospital and Van Velden Hospitals OPD with referral letters from PHC facilities, who cannot read and write, who are considered emergency and mental health care users (MHCU); accordingly, they and community members who came with referral letters were excluded to participate in this study.

3.7 Data collection

A self-administered questionnaire was used to collect data from the identified sample (*Appendices I–K*). The questionnaire ensured that the respondents asked the same questions and that the information indicated factors preventing the community from utilizing PHC services. A questionnaire was designed using a Likert scale and was written in English, Sepedi (constitutes 48% of the languages) and Tsonga 42% (Stats SA, 2016/17). The questionnaire was translated to Tsonga by a Tsonga language specialist and translated to Sepedi by a Sepedi-speaking specialist. The questionnaire had the following two sections:

- ☞ **Section A:** Questions related to demographic data with 7 questions;
- ☞ **Section B:** Questions related to factors contributing to non- utilization of PHC services (divided into community-related, administrative-related and health personnel-related. There were 18 questions).

The questionnaire had a total of 25 questions. Variables in the questionnaires were as follows:

- ☞ Have you ever visited PHC before?
- ☞ Mode of transport,
- ☞ Age,

-
- ☞ Gender,
 - ☞ Highest level of education,
 - ☞ Home language and
 - ☞ Occupation.

Before actual data collection, the researcher received a clearance certificate from the Turfloop Research Ethics Committee (TREC, *Appendix A*); permission to conduct the study was also obtained from Limpopo DoH (*Appendix B*). Consequently, the researcher submitted the research proposal, ethical clearance certificate and DoH permission from the three selected hospital's CEOs and nurse managers for their approval (*Appendices C–E*). It was ensuring that data collection does not interfere with the planned patient care programs by the researcher and other essential activities for the day. The matter was referred to organizational research committees and nurse managers of OPDs and data collection dates were later communicated to the researcher.

A statistician was consulted to assist in assessing the relevance of the questions, i.e. if they will answer the research questions against the purpose and the objectives of the study. Questionnaires were given to the respondents in OPD of all the three hospitals according to the inclusion criteria and took 20-30 minutes to complete. The researcher was available during data collections so that if respondents had questions or needed any clarity about the questionnaire she could immediately answer or clarify them.

The researcher went to the three selected hospital OPDs for community members to fill the given questionnaires. The community members voluntarily agreed to participate in the research, after explanation, gave informed consent (*Appendices F–H*) and the anonymity was ensured on the questionnaires using codes.

The researcher recruited the respondents by means going to the hospitals early in the morning, as most of the community members woke up early to wait at the queue for service, then while they are busy completing the questionnaire, I assisted them by taking their vital signs so that when Doctors come to work they are ready to be

assisted as early as possible, which also help them for not waiting for a long time to receive service. After completion of the questionnaires, the community members gave the completed copies of questionnaires to the researcher and the entire batch of questionnaires completed indicated a response rate of 100%.

Response rate = number of people who completed the questionnaire X 100

The number of people in the sample = $101/101 \times 100 = 100\%$

Questionnaires which were all issued to community members in OPDs the day of data collection were given the questionnaire while waiting for the doctor to arrive. The data were collected on three consecutive days in three hospitals, where one hospital accounted for one day (17, 18, & 19 June 2019). Ethical considerations, particularly anonymity and confidentiality, the instructions of how the respondents were supposed to complete the questionnaires and the purpose, objectives were explained.

The completion of questionnaires which lasted for 20 to 30 minutes was done while waiting for the doctor's consultation. A total of 101 questionnaires were completed based on the sample size by community members according to the inclusion criteria. Completed questionnaires were collected by the researcher from all the respondents at the selected OPDs.

3.8 Pilot Study

The pilot study refers to a trial run of research (Nieswiadomy & Bailey, 2016). A pilot study was done with minimal populations that have similar attributes to the research population to test the questionnaires before is going to be used in the main study to prevent bias. Hospital in Greater Maruleng Municipality, Mopani District, Limpopo Province, is a context where the pilot study took place and conducted with a convenience sample of 10 community members. The questionnaire was tested for internal validity by questioning respondents about factors contributing to non-utilization of PHC services for the researcher to give results on the readability, difficult questions and time taken for completion of the questionnaires. Based on the results from piloting, there were no corrections to be made. The pilot study results also rendered the study tool to be reliable.

❖ Results of pilot study post-analysis were:

➤ Questions asked were all clear and easy and the respondents were able to complete all the questions in time without leaving any empty spaces.

3.9 Data analysis

Quantitative data analysis is the numerical representation and manipulation of observations for describing and explaining the phenomenon that those observations reflect (Babbie & Mouton, 2014). For this study, data collected from the questionnaire were collated and was analysed with the assistance of a statistician using SPSS Version 24 computer software. This is the statistical method that enables the researcher to reduce, summarize, organize, manipulate, evaluate, interpret and communicate quantitative data using graphs and tables.

Descriptive frequencies and percentages were applied in the analysis of data obtained in this study, and the data was presented using frequency tables, bar graphs and pie charts. The results obtained at this stage were used to guide the development of the strategies to improve utilization of PHC services by the community in the Greater Tzaneen Municipality. Strategies were developed and guided by reviewed literature related to the problem studied, the legislative framework that guides the development of strategies and the Health Care Utilization Model (Andersen, McCutcheon, Aday, Chiu and Bell, 1983).

3.10 Validity and reliability

To assess and evaluate the accuracy of the instrument, it was tested for validity and reliability. The questionnaire developed, was tested for validity and reliability before the data collection. This was done by doing pre-testing on the respondents which did not participate in the main study.

3.10.1 Validity

According to Brink *et al.* (2017), validity refers to the ability of an instrument to measure the variable that is intended to measure. The researcher did a thorough literature review to ensure validity in this study, the questionnaire's content; face and external validity were tested as follows:

3.10.1.1 Content Validity

Content validity refers to the degree to which an instrument covers the scope and range of information that is sought (Brink *et al.*, 2017). Furthermore, according to De Vos, Strydom, Fouché and Delport (2014), content validity is concerned with the representatives or sampling adequacy of the content of an instrument. In this study, the researcher gave the questionnaire to the supervisor of the research project to evaluate for content validity. The content was based on the literature review and the researcher's experiences which were validated by experts in the field of Nursing Education and Methodology, and who are Nursing Education lecturers, Faculty of Health Care Sciences lecturers from University of Limpopo Turfloop Campus. The content was rectified according to the results of the pilot study to ensure that there is no ambiguity, questions are accurate and to determine the feasibility of the study.

The questionnaires were submitted to the supervisor, co-supervisor and the statistician who are specialist in Quantitative Research Methodology and were facilitating modules on quantitative research. Furthermore, they have published articles in accredited journals and supervised postgraduate students who followed quantitative research methodology. By achieving content validity, data collection instrument reviewed by these experts in the field of Quantitative Research Methodology who made comments about the suitability, comprehensiveness, simplicity, readability, variables and phraseology of the items and the things agreed upon were used and removed those that were not important.

3.10.1.2 Face Validity

In this study, the questionnaire was considered to meet the requirements of face validity because all the questions in the instrument were focusing on the factors

preventing the community from utilizing PHC Services in Greater Tzaneen Municipality, Mopani District, Limpopo Province. This was achieved by having experts scrutinizing the items in the questionnaire and agreeing that the questionnaire is a valid measure of the variables under study.

3.10.1.3 External Validity

External validity refers to the degree to which the study results can be generalized to other people and other settings (Brink et al., 2017). In this study, the present research provided a detailed data set for other researchers to determine whether the findings of the study are applicable in other settings.

3.10.2 Reliability

Reliability refers to consistency, stability and repeatability of the informant accounts, as well as the researcher's ability to collect and record information accurately (Creswell, 2014). Reliability was ensured by ensuring consistency of questionnaire by other researchers in describing factors preventing patients from utilizing PHC Services. Pre-testing was done in a different setting using 10 respondents who were not participating in the main study to prevent bias. The pilot study refers to a trial run of research (Nieswiadomy & Bailey, 2016). The results from the pilot study indicated questions asked were all understandable and uncomplicated, thus the respondents completed all the questions in time with no empty spaces for. The pre-testing results also made the study tool to be reliable.

3.11 Ethical considerations

Ethical clearance was obtained from the Turfloop Research Ethics Committee (TREC).

3.11.2 Permission

Permission was obtained from the Limpopo DoH Ethics Committee to the Chief Executive Officer (CEO) of Dr CN Phatudi, Van Velden and Letaba Hospitals.

3.11.3 Informed Consent

A subject voluntarily agreed to participate in a research study before the study begins (Brink et al., 2017). The goal of informed consent is to allow the participants to make an informed decision about whether to participate in the research study or not (Burns & Grove, 2016). Informed consent was guaranteed by the researcher in the form of describing to the respondents in the language that the individuals understood what was going to be investigated, the required duration of the respondent's participation, the procedures that were to be followed during the investigation, the feasible advantages, and disadvantages of participating in the study.

The consent form included the title of the research study; the name of the researcher; the research supervisor; purpose, objective, and a brief description of the study. The respondents voluntarily agreed to participate in this study by signing the consent form and were informed that they had the right to withdraw from the study at any given time during data collection (*Appendices F–H*).

3.11.4 Privacy

The respondents have the right to determine the extent to which and the general circumstances under which their private information was shared with or withheld from others; privacy was ensured by questioning the respondents in the Hospital. Information gathered was not disclosed or made available to any unauthorized person (Brink et al., 2017).

3.11.5 Anonymity

Anonymity was ensured by not putting name indicators, numbers or codenames on the questionnaire. This means the identities of the research participants are unknown, even to the study investigator (Brink et al., 2017).

3.11.6 Confidentiality

In this study, confidentiality was maintained whereby information provided by the respondents and their names were kept confidential. Confidentiality refers to how the researcher manages personal information to ensure that only the researcher directly

involved in the study has the access to information (Botma, Greef, Mulaudzi, & Wright, 2017).

3.12 Conclusion

This chapter presented the methodology adopted to complete the study. A quantitative cross-sectional descriptive research design was chosen, and a self-administered questionnaire was used to collect data. The instrument was tested for validity and reliability. The respondents were community members at OPDs at Dr CN Phatudi Hospital, Van Velden Hospital and Letaba Hospital without referral letters from PHC services. The respondents' rights were respected throughout the study. Results from this study will be redirected to the Limpopo Province DoH for the upgrading of the health care services.

CHAPTER 4

PRESENTATION AND DISCUSSION OF THE RESEARCH FINDINGS

4.1 Introduction

Chapter 3 presented the research methodology used in the study. This chapter presents the results that have emerged during data analysis. Data gathered is presented through frequency tables, pie charts and bar graphs for entire variables which formed part of the analysis. The presentation of the findings is based on descriptive statistics was used to present the findings which allow for genuine optimization, organization, evaluation, interpretation and communication of numeric data. Descriptive statistics helps in making of a huge volume of data reasonable. The results are divided into two sections; Section A: Demographic Data and Section B: Factors Contributing to Non- Utilization of Primary Health Care Services to Community in Greater Tzaneen Municipality, Mopani District.

4.2 Respondents' response rate

Questionnaires were given to a total number of 101 community members and the entire questionnaires were completed which means the response rate was 100%.

4.3 Section A: Demographic Data

Age, gender, the highest level of education, home language, occupation, mode of transport used and if they ever visited the PHC clinic before represented the demographic data of the respondents (Table 4.1). The importance of using demographic information was to portray a precise picture of the group of respondents who participated in the study.

Table 4.1: Demographic data of the participants

Demographic Data	Frequency (n)	Percentage (%)
Age (Years)		
15-25	0	0%
26-35	46	45.5%
36-45	24	23.7%
46-55	5	4.9%
55+	26	25.9%
Gender		
Male	23	22.8%
Female	78	77.2%
Highest Level of Education		
None	0	0%
Primary	16	15.8%
Secondary	59	58.5%
Post-secondary	26	25.7%
Home Language		
Sepedi	61	60.4%
Xitsonga	36	35.7%
Other	4	3.9%
Occupation		
Employed	24	23.8%
Unemployed	77	76.2%
Mode of Transport		
Walk	21	20.8%
Own car	3	3.0%
Public transport	77	76.2%
Have you ever visited the PHC before?		
Yes	101	100%
No	0	0%
How many times?		
Once	8	7.9%
Twice	16	15.8%
More than twice	77	76.2

These demographic profiles of the community members are presented as follows:

4.3.1 Age

Ages of the respondents are represented according to the age intervals. The majority 45.5% (n=46) of respondents were aged between 26-35 years followed by 25.9% (n=36) of the respondents representing the age of 55+ and older. The age range of respondents between 36-45 years contributed to 23.7% (n=24) of the total sample, followed by the age 46-55 at 4.9% (n=5). This indicates that the most age population that uses the hospital are the middle age group between 26-35 and those who attend the hospital the least are between the ages of 15-25.

4.3.2 Gender

The results indicate gender differences of the respondents who participated in the study. The findings reflect that 77.2% (n=78) of respondents were females, whilst 22.8% (n=23) were males. This indicates that the majority of the community that seeks health care services is females as compared to males.

4.3.3 Highest level of education

The highest level of education of the respondents indicated that majority 58.5% (n=59) have passed secondary level, followed by 25.5% (n=26) who went on to post-secondary and only 15% (n=16) at primary level. This indicates that the majority of the community in Greater Tzaneen Municipality, who are not using PHC services, uses the hospital, and attended school up to secondary and few go post-secondary and also that all respondents attended school at different levels.

4.3.4 Home Language

The findings on the home language of the respondents who participated in the study show that the majority (60.4%; n=61) speak Sepedi, followed by 35.5% (n=36) speak Xitsonga at and 3.9% (n=4) communicate in other languages. This indicates that the majority of the community members in Greater Tzaneen Municipality, Mopani District

who are not using PHC services, but the hospital, speak the Sepedi language as compared to Xitsonga and other languages

4.3.5 Occupation

The results on the occupation of the respondents who participated in the study indicate that the majority (76.2%; n=77) are unemployed and the remainder (23.8%; n=24) are employed. These results indicate that there is still a high rate of unemployment among community members who do not utilize PHC services and seek health care services at the hospital.

4.3.6 Mode of Transport to hospital

The results on the mode of transport to the hospital for the respondents show that the majority (76.2%; n=77) of the respondents use public transport, followed by 20.8% (n=21) who walk to the hospital. Only a few (3.0%; n=3) of the respondents use their cars to reach the hospital. This indicates that the majority of the community members, who do not use PHC services, are using public transport to reach the hospital as compared to those who are using their cars and those who walk.

4.3.7 Have You Ever Visited The Clinic Before?

Respondents who participated in the study were asked if they have used their local clinics before coming to the hospital and, if yes, how many times? The results indicated that all (100%; n=101) the respondents have used their clinic before they decided on going to the hospital. This results also indicate that the previous utilization of PHC services determines the future utilization of health service.

4.3.8 How Many Times?

The results also indicated that the majority of the respondents (76.3%; n=77) used the clinic more than twice, followed by 15.8% (n=16) who used it twice, and lastly 7.9% (n=8) of those who went to the clinic once. The study results imply that all of the community members who participated in the study have used the clinic before and the

majority of them have used it more than twice as compared to those who used it once or twice. This indicates that the frequency in which the service is being utilized also determine the future utilization of the service.

4.4 Section B: Factors Preventing Community Members from Utilizing PHC Services

This section presents the results on the factors contributing to non-utilization of PHC service in Greater Tzaneen Municipality, Mopani District, Limpopo Province.

4.4.1 Reasons for visiting the hospital

Figure 4.1 presents the reasons for the respondents for going to the hospital. The results indicate that the most (34.7%; n=35) of the respondents were coming to the clinics for other reasons followed by 28.7% (n=29) who were coming for maternal and 19.8% (n=20) for child health and minor illness, and lastly 16.8% (n=17) were coming for chronic disease and medication-related reasons. The results suggest that the majority of the community members who seek health care services in the hospital do not PHC requires services other than maternal and child health, chronic diseases and medication and minor ailments.

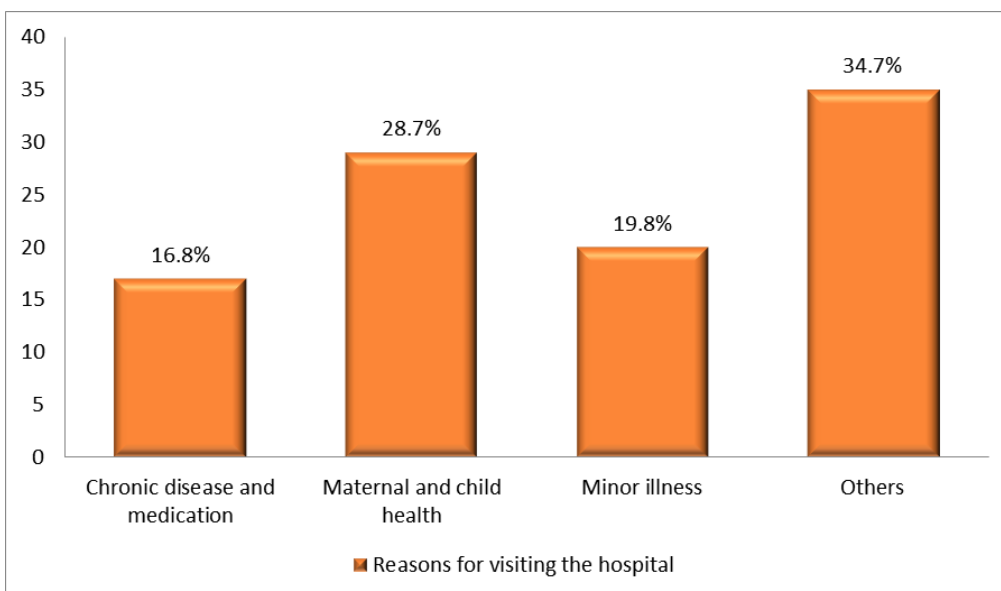


Figure 4.1: Reasons for visiting the hospital

4.4.2 Community-related Factors

Table 4.2 presents the community-related factors where the results show that the majority of the community members (90.1%; n=91) do not use their local clinics due to the reason that there are long queues and long waiting times.

Table 4.2: Community-related factors

Statement	Agree(%/n)	Disagree(%/n)
Clinic medication not working	45.5% (46)	54.5% (55)
Health care personnel not competent	43.5% (44)	56.5% (57)
Long queues and waiting times	90.1% (91)	9.9% (10)
Afraid of stigma	23.8% (24)	76.2% (77)
I stay next to the hospital	22.8% (23)	77.2% (78)
No different blood tests done at the clinic	19.8% (20)	80.2% (81)

Of the respondents, 45.5% (n=46) pointed out that the clinics' medication service did not operate on a 24-hour basis. It was also indicated that health personnel were not competent, and this was reflected in a total of 43.5% (n=44) answers of the respondents. Of the respondents, 23.8% (n=24) were afraid of the stigma. The respondents who indicated that no different blood tests were done at the clinic totalled 19.8% (n=20) and those who stayed next to the hospital were 22.8% (n=23) which correspond to the lowest contributing factor for preventing the community from utilizing those clinics. Community members who were travelling to the hospital represented 77.2% (n=78) of the sample. This indicates that community members do not take advantage of the fact that they stayed next to the hospital.

4.4.3 Administrative-Related Factors

Table 4.3 represents administrative factors that might prevent the community from utilizing their PHC services.

Table 4.3: Administrative factors

Statement	Agree(%/n)	Disagree(%/n)
Poor community involvement	28.7% (29)	71.3% (72)
Absence of medical doctors at the PHC (clinic)	25.7% (26)	74.3% (75)
Shortage of nurses at the clinic	79.2% (80)	20.8% (21)
No drugs and other essential medication	64.4% (65)	35.6% (36)
No water and electricity	43.6% (44)	56.4% (57)
Clinic not operating 24 hours	76.2% (77)	23.8% (24)
Clinic not operating 7 days per week	76.2% (77)	23.8% (24)

The majority of the respondents (79.2%; n=80) agreed that shortage of nurses at the clinic prevents them from utilizing PHC services, followed by 64.4% (n=65) who agreed that shortage of medications and other essential medication at the clinic and the cause of non-utilization prevented them to go to the clinics prior deciding to go to the hospitals. The majority of the respondents (76.2%; n=77) also indicated that clinics were not operating for 24 hours and 7 days per week (24/7).

The issue of shortage of medical doctors, water and electricity and poor community involvement were the least contributing factors that prevented the community from utilizing their PHC. The results indicated that the majority of the community members are no longer utilizing PHC facilities because there is a shortage of nurses at the clinic, shortage of drugs and essential medication and that the clinics do not operate for 24/7. These results also mean that community members do not trust any service provided where there is a shortage of health professionals who are supposed to provide quality care.

4.4.4 Health personnel-related Factors

Figure 4.2 represents health personnel-related factors as indicated by the respondents on their filled questionnaires. The greater number of the respondents (68.3%; n=69) pointed out that the nurses at the clinic have negative attitudes toward them which prevented them from utilizing their community health care services, while 31.7% (n=32) reported that nurses do not have a negative attitude towards them. The results indicate that community members who seek health care services also require respect for their

health needs satisfaction because the majority indicated that health care personnel have a negative attitude towards them as compared to those who were given a positive attitude during provision of health service. It also indicates that the community members do not have complete trust in health care service provided by negative attitude health personnel.

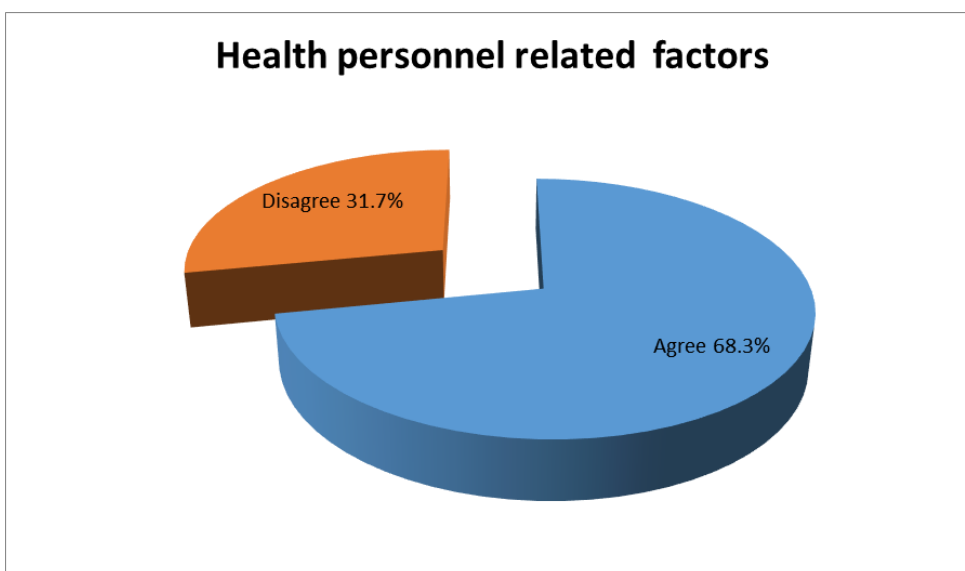


Figure 4.2: Health personnel-related factors

4.5 Discussion of Research Findings

The main purpose of this section is to discuss the results and to link the findings to what other studies have found in the past about factors contributing to non-utilization of PHC services in Greater Tzaneen Municipality, Mopani District, Limpopo Province. The study found that numerous factors contribute to patients not utilizing their local PHC clinics and prefer the hospital.

4.5.1 Section A: Demographic Data

The demographic data present the overall picture of respondents of this study who reflected that factors that affect the utilization of PHC services in the community. The demographic data of respondents include age, gender, the highest level of education, home language, occupation, mode of transport and whether they have visited the clinic before.

4.5.1.1 Age of the Respondents

This study found that the majority of respondent between the ages of 26-35 years utilize the hospital. The findings concur with those reported by Masango- Makgobela, Govender and Ndimande (2013) on reasons patients leave their nearest health care service to attend Karen Park Clinic, Pretoria North, i.e. most of the respondents who participated in their study who were passing by their local clinic to seek health care services in the health care facility, where the ages ranging from 26-35. This shows that the majority of the population that need to be provided with PHC services are the younger population of ages ranging from 26-45 years. Based on this study results, it implies that the younger population of ages ranging from 15-25 years are least likely to seek health care services.

4.5.1.2 Gender of the Respondents

The study findings indicate that there were more females than males who do not attend PHC services, but the hospital. Another study conducted by Visser, Marincowitz, Govender and Ogunbanjo (2015), found patients bypassing clinics to be predominantly females. Similarly, the majority of the respondents in this study were females which imply that the majority of community members are females. This indicates the fact that more females are using public health facilities than males. It is concerning that only a small number of males utilize public health services. By contrast, the study conducted by Abdurrahman (2016) on the evaluation of PHC centres services on the view of users, found that more males (67.72%) than females (32.22%) utilized hospital services.

According to Salganicoff *et al.* (2016), in support of the current study findings, women make more health care visits than males as also supported by the study that was conducted in hospital OPDs of the United States of America (USA) females (35.1%) had higher OPD visits rates than males (23.6%) and the female visit rate (7.8%) for preventive care was three times higher than that for males (2.6%) (Middleton & Hing, 2004).

4.5.1.3 Highest Level of Education of the Respondents

The study findings indicate that the majority of the respondents attended secondary

school. This shows that the majority of community members in Greater Tzaneen Municipality who utilize PHC clinics are those who attended school up to secondary level and only a few continued further to attend post-secondary education. The importance of education in the study is to determine the level of understanding community members have about health-related matters.

The study conducted by Umunna (2012) concurs with these study findings as it indicated that there is a straight connection between educational status and utilization of health care services. He further indicated that people who had higher educational levels use health care facilities preferably than those with lower education. The discussion indicates that people who are highly educated are more likely to frequently utilize the best health institution based on their informed minds. The current study results also agree with the abovementioned literature, as most of the study respondents who do not use PHC services have at least secondary education.

4.5.1.4 Home Language of the respondents

The majority of respondents in this study speak Sepedi followed by those who speak Xitsonga. Contrary to the study findings, the results according to Stats SA (2016/17) indicated that in the Greater Tzaneen Municipality, Mopani District, Limpopo Province, the majority of the population speaks the Tsonga language more than Sepedi and other languages.

According to the researcher's experience, this means that understanding the language spoken by people who utilize the hospital services is important and improves communication because language can be a blockage to the utilization of health care services. In support of the researcher's experience, Rispel *et al.* (2010) indicated that it is interesting to know that PHC nurses comply with the core standard of the PHC package which states that patients should be addressed in a language that they can understand, and health workers should be positive in their approach to patients and giving each patient a feeling of always being welcome.

According to Timmins (2002) indicated that utilization of health care suffers as a result of a barrier to communication. It further indicated that when the patient does not speak

the language of health care provider, the patient's health care might have a different detrimental impact. For example, a patient's who is unable to understand a provider's diagnosis or treatment plan can lead to underuse of the health care service. This result indicates that health care providers must speak and understand all the languages of people in the areas which they serve, and in this study, particularly Sepedi and Tsonga since they are the major languages spoken in the Greater Tzaneen Municipality, Mopani District, Limpopo Province.

4.5.1.5 Occupation of the Respondents

The study findings indicate that the majority of the respondents in the study are unemployed and only a few are employed. According to Adams, Jabulani and Jonathan (2019) study on health care utilization and associated factors, more than half (58%) of their respondents were unemployed. Though the services at the PHC level is not paid for the importance of occupation in this study is to determine socioeconomic status which will enable family members to access the PHC facility, especially when they are supposed to have money for transport to reach the facility. The results and the discussion indicate that the majority of the population not utilizing PHC services is unemployed as compared to those who are employed.

4.5.1.6 Mode of Transport of the respondents

Findings from the current study indicated that a greater number of respondents use public transport when going to PHC clinics followed by those who walk to the hospital. Only a few respondents use their cars to go to the clinics. The study by Masango-Makgobela, Govender and Ndimande (2013) affirmed that the utmost of patients' needs to use public transport even when attending the clinic near their homes. Additionally, for community members to arrive at the hospital, they had to travel much further, using two-mode of transport.

Mode of transport in this study indicates how community members are travelling to reach the hospital for health care services. In contrary to the study findings, in 1998, it was estimated that in South Africa that nationally 49%, 41% and 10% of black South Africans walked, used public transport and their transport, respectively, to access health care. The results also indicated that the most common form of transport used

by the respondents to access health care services was a taxi, secondly by walking and only a few people used their transport (Smith, Solanki & Kimmie, 2007).

Contrary to the study findings, a study carried out by Tanser et al. (2006) demonstrated that in accessing health care facilities at Hlabisa Health Sub- District, Kwa-Zulu Natal, South Africa, people often walked, and others use public transport. This indicated that transport was not a major issue that prevented people from utilizing their nearest health care facilities. This indicates that the majority of Greater Tzaneen Municipality community members, who do not utilize PHC services, but the hospital, depending on public transport as compared to those who walk and use their cars.

4.5.1.7 Have You Ever Used the Clinic Before? If Yes, How many Times

The findings indicate that all the respondents in the study have used their local clinics before coming to the hospital. According to Masango-Makgobela et al. (2013) on reasons patients leave their nearest health care services in Pretoria, also indicated that the majority of respondents used their clinics more than twice and all of the respondents used the clinic before considering the next level of care.

It is important to indicate the previous utilization of health care services to understand individuals' reasons that might cause them not to utilize their PHC services. Based on the results, the community members know the PHC services offered in that they have used the clinics before, and this will assist the researcher in determining the reasons why they are no longer utilizing their PHC services, but hospital OPDs. The study conducted by Visser and Marincowitz (2015) indicated that their respondents have used their clinics before coming to the hospital and this indicates that comprehension and judgment have a straight effect on utilizing health care facilities.

4.5.2 Section B: Factors Contributing to Non-Utilization of PHC Services

The previous section provided demographic data of the respondents. This section indicates the reasons for community members to come to the hospital and factors contributing to non-utilization of PHC services (community-, administrative- and health personnel-related factors).

4.5.2.1 Respondents' Reasons for Coming to Hospital

The study results showed that the majority of respondents were coming for other reasons such as for dentist, social worker and dietician, HIV testing, termination of pregnancy, no medication at the clinic, went to the clinic, but treatment failed, followed by those who were coming for maternal and child health such as antenatal care, family planning, Pap smear and immunization, which were only females, minor illness; lastly some were coming for chronic disease and medication.

The study conducted by Visser et al. (2015) indicated that patients come to the hospital to see a doctor, a dentist or to terminate the pregnancy. This also indicates that the majority of the community members who are not utilizing their PHC services are those who need other services and those who seek maternal and child health care.

4.5.2.2 Community- Related Factors

Community-related factors refer to factors that are possessed by the community in Greater Tzaneen Municipality, Mopani District, Limpopo Province, which can contribute to their non-utilization of PHC services. Factors include long queues and waiting times, clinic medication not working, afraid of the stigma, and staying next to the hospital.

4.5.2.3 Long queues and waiting Times

The study findings indicated that most of the community members do not use their local clinics due to the reason that there are long queues and long waiting times. The results also indicated that long waiting times were a common problem and most of the clinics close at 4 pm, causing the community members to use Hospital OPDs since

they operate for 24 hours. The study conducted by Bazie & Andimassie (2017) on understanding barriers to the utilization of PHC in low- income setting also indicated that long queues were the huge cause of non- utilization. These cause lead to people moving from one clinic to another to avoid long waiting times. The expansion of patients attending clinic results in increased waiting times (Masango-Makgobela et al., 2013).

Zhecheng, Liang and Hoon (2012) study on reducing consultations waiting time and overtime in Outpatient Clinics found that long queues and long waiting times are a major contributor to dissatisfaction among patients attending health care facilities. According to the South African National Policy on Management of Patient Waiting Time in Outpatient Departments (2015), it was indicated that the meaning of long waiting time is the amount of time a patient spends waiting for the service in a health care facility across SA, sometimes leading to patients skipping appointments and moving from one clinic or facility to another so search for shorter queues and waiting times (Masango-Makgobela et al., 2013). This indicates that the time spent in the clinic plays a role in determining health care utilization by community members.

4.5.2.4 Clinic Medication Not Working

The issue of clinic medication not working as indicated by the majority of the respondents implies that it is another factor that prevented the community members from utilizing the PHC clinics. In contrast to the current study, it was found that the shortage of medicine and medication not working was due to some patients' health-seeking behaviour such as non-compliance to treatment (Wong et al., 2015).

In support of the study results, Ntleko (2011) on determining factors related to patients in Umuziwabantu Sub-District of bypassing PHC facilities and accessing district hospital as their first line contact, indicated that 391 patients stated that the types of drugs issued by doctors are of better quality than what is issued to them by PHC nurses. This fact was also confirmed by the district's senior pharmacist and its institutional pharmacist that doctors are giving more than the number required by the hospital's Essential Drug List.

Some patients consult several clinics and got medicines on all visit and didn't wait to see if the medication that was given at the first visit is working and some even keep medication at home until it expires, which causes a shortage of medication to other community members who visit the health care facility (Wong et al., 2015).

The importance and implication of the study results are to determine if the clinics have sufficient medication to give community members during the consultation for their illness. The issue of medication may be due to the shortage of electricity at the PHC facilities. This is supported by the study done by Hatchett (2017) about the medicine refrigerator and the importance of cold chain in the safe storage of medicine and Khoza (2017) study on blood products critically low indicated that shortage of electricity in health care facilities have an impact as various medications and blood products need to be stored within specific temperature ranges, and the efficacy and safety of these products may be compromised during prolonged and unpredictable power outages.

4.5.2.5 Afraid of Stigma

According to the research findings, the majority of the respondents indicated that they are not afraid of stigma as compared to those who are afraid of stigma when they have to utilize their PHC services. In contrast to the stigma, the majority of patients in South Africa indicated that people judged them negatively because of their diseases especially those who are suffering from HIV and TB. Therefore, they use clinics that are far from their homes so that they are not seen by people who know them (Graig et al., 2017).

Mark, Armstrong, Andrade, Penazzato, Hutane and Taing (2017) report on interventions to improve or facilitate linkage to or retention in pre-ART care and initiation of ART in sub-Saharan African countries indicated that stigma is a barrier to care for people seeking services for disease prevention, treatment of acute and chronic conditions or support to maintain a healthy quality of life. It was found by Cremers, de Laat, Kapata, Gerrets, Klipstein-Grobusch & Grobusch (2015) on assessing the consequences of stigma, measured health-related that clients with

tuberculosis are also stigmatized. It was further indicated by Lakes, Siegel and Leider (2011) and Daftary (2012) that in many cases clients might experience more than one type of stigma simultaneously, such as HIV or TB-related stigma or substance-related stigma. The results of this study indicated that the community members who attend PHC clinics do not feel stigmatized in terms of their health and that does not force them to bypass the clinics to the hospital. Therefore, being afraid of stigma is not significant in determining health care utilization in this study.

4.5.2.6 Staying Next to the Hospital

According to the study results the majority of the respondents stay far from the hospital and a few stays next to the hospital. This indicates that the community members leave their nearest PHC facilities and choose to come to the hospital for health care services. It also indicates that community members are not worried about the distance and money they spent to reach the hospital and those who stay next to the hospital do not take advantage of that since they only constitute a minor percentage. They are concerned about their health and it implies that the community members are travelling more than the stipulated 5 km according to norms and standards of South African PHC Services (PHC Package for SA, 2013).

4.5.2.7 Administrative-Related Factors

This refers to factors that are possessed by health care systems which might contribute to non-utilization of PHC services by community members in Greater Tzaneen Municipality, Mopani District, Limpopo Province. Factors include poor community involvement, shortage of nurses at the clinic, no drugs and essential medication at the clinic, no water and electricity, and clinics not operating for 24/7.

4.5.2.8 Poor Community Involvement

The study findings indicate that the community is involved in health care-related matters and this does not prevent them from utilizing their PHC clinics. Lack of community involvement and awareness of services was also the top reason given by the community members for low utilization (Umunna, 2012). In countries such as South Africa, community involvement is a way to decolonization which is a process of

obtaining social justice (Cyril, Smith, Possamai-Inesedy & Andre, 2015). O'Mara-Eves et al (2015) in their study on the effectiveness of community engagement in public health interventions for disadvantaged groups indicated that community involvement can lead to improved health outcomes.

The importance of the results is to determine if the community is involved in health-related matters and they are also aware of the services provided in the PHC clinic because for them to utilize the clinic they need to be aware and be involved in the services provided. If the community is not involved in the services the clinic is providing, it will be difficult for them to come to the clinic if there is a shortage of nurses at the clinic.

The findings of the study revealed that the shortage of nurses at the clinic prevents community members from utilizing health care services. This is the major problem to our community and health care system as the health facility cannot function without nurses. This creates an impression that there will be long queues and long waiting times, and burnout and exhaustion will be experienced by available nurses because all the patients require total quality care from them (Masango-Makgobela et al., 2013).

Manyisa and Van Aswegen (2017) indicated that the country is facing a nursing crisis as it is characterized by shortage and the context of this crisis is South African quadruple disease burden, and nurses are the largest single group of health service providers as stated in Department of Health Strategic Plan for Nursing Education, Training and Practice (2012) and it further indicated that re-engineering of the PHC system to strengthen the District Health System (DHS) has increased the demand for nurses, advanced midwives and primary health care nurses. The results and the supporting literature indicate that availability of nurses at the clinic determines the utilization of PHC services by respondents, were staff shortage that influenced to them to bypass the clinic to seek health care services at the hospital.

4.5.2.9 No Drugs and Essential Medication at the Clinic

The majority of the respondents indicated that there is a shortage of drugs and essential medication at the clinic. In support of the study results, Masango-

Makgobela, Govender and Ndimande (2013) indicated that the most important cause of patient not attending their closest clinic was lack of medication and this caused a disturbance in the progression of patient care and lead to a deficiency in adherence to medication and patient displeasure. The research results are embraced by the study carried out by Doherty *et al.* (2014), caregivers mentioned lack of drugs at the health post as the key reason for prevention of utilization of the centre.

In another study conducted by Visser, Marincowitz, Govender and Ogunbanjo (2015), 41.30% of the respondents indicated that their clinic had a shortage of medication and only 12% visited the hospital with the reason that there was no medication at the clinic. Lack of medication in PHC facilities is a serious problem for community members because medication forms part of treatment for their health-related problems. Therefore, community members need medication for the treatment of their illnesses and the lack of medication at the clinic will prompt them to go to a hospital for services.

4.5.2.10 No Water and Electricity

The study findings indicated that water and electricity are not the major issues that cause community members to bypass their local PHC facilities, but in contrast to this, the study conducted by Umunna (2012) on the unavailability of basic infrastructure such as water and electricity was echoed in the two facilities in the Tshwane region and participants noted that this was major hindrance to non-utilization of the clinic. Additionally, Umunna (2012) indicate that the absence of water seems to be severe to an extent that mothers who came for delivery at the facility were asked to bring water as part of the requirements for delivery. This was an added cost for the families who were already finding it hard trying to make ends meet and an extra burden to the women. Therefore, water and electricity are not the major issues in PHC facilities that prevent community members from utilizing PHC services.

According to a study by Paul, Hunter, Alan, MacDonald and Cater (2010) on water supply and health, it was indicated that over 1 billion people in developing countries lacked access to a sufficient supply of water. Reasons indicated included insufficient rates of capital investment, difficulties in appropriately developing local water resources or ineffectiveness of institutions mandated to manage water suppliers.

According to the researchers' point of view, the impact of the shortage of water compromised most of the nurses' activities such as hand washing before and after each procedure as part of infection control. Hatchett (2017) on a study about the medicine refrigerator and purpose of cold chain in the safe storage of medicine and Khoza (2017) research on blood products being critically low indicated that shortage of electricity in health care facilities have an effect as different medicines and blood products to be stored within specific temperature ranges, and the efficacy and safety of these products are being maybe jeopardized during lengthened and incalculable power outages.

Health24 (2015) further indicated that health care staff cannot access laboratory results electronically, work cannot be captured on the computer system until power is restored, electric-using equipment cannot function and lighting and temperature control cannot be promoted, therefore staff cannot operate in the dark. The results and the supporting literature indicate that shortage of water and electricity is significant in determining health care utilization by the community members as the results indicated that 44.6% (n=44) of the respondents bypassed by their PHC facilities due to that shortage.

4.5.2.11 Clinics Not Operating 24/7

The results of the study revealed that the clinics are not operating for 24/7 which contributed to non-utilization of PHC services. In support of the study findings, inconsistency of availability of services was indicated as a frequent barrier to utilization of health service facility, and further, indicated that even health care workers reported that health facilities only open 24 hours per week on average, about half of the hours the health facility are supposed to be open and they also cited that the health facility is not always open as one of the top reasons for low utilization (Doherty et al., 2014).

The study conducted in Oromia found that community members complained about limited opening hours of health facilities (closed at night and on weekends) as a reason for not using the services and also found that only 52% of health posts received pregnant woman during non-working hours (Tefera et al, 2014). A study conducted

by Pillay (2019) indicated that mobile clinics only come once a month, often only start at 10 am, and is not convenient when patients are acutely ill. Patients attending mobile clinics mentioned that mobile clinics start late and that causes patients to be inconvenienced. Clinics not operating for 24/7 led community members to go to the hospital for health care services on those days that they are not operating. The study further indicated that this occurs especially during weekends, after 4 pm, on public holidays and during the night.

4.5.2.12 Health personnel-related Factors and Nurses' Negative Attitudes towards Patients

Health personnel-related factors include those factors that are contributed by health workers, including nurses, such as the negative attitude of nurses towards patients. The findings indicate that nurses at the PHC clinic have negative attitudes toward the community members which prevent them from utilizing their health care services. The negative attitude of nurses towards patients is a problem because patients are satisfied when treated by friendly staff and cannot tolerate rude nurses. The study conducted by Yilmaz, Toksoy, Direk, Bezirgan and Boylu (2017) stated that health care results, quality of care and behaviour are impacted by health workers' attitudes.

Type of care rendered to patients and other vulnerable patients is impacted by the negative attitude of health care workers (Buisman & Garcia-Gomez, 2015). According to Haskins, Phakathi, Grant and Horwood (2016), indicated that negative behaviours were observed such as rudeness in some nurses who do not care how they talk to patients, they shout, and they are rude.

The most important thing to smooth running of organizations is respect and good communication and is a prerequisite for the way people interact as members of a community (Hammett & Staeheli, 2013). Community members need to be respected by the health care providers and this will indicate consideration. Negative attitudes of nurse's cause dissatisfaction among patients about the care provided and they will thus decide to move to the next level of care.

4.6 Application of the theoretical framework

The study adopted the theoretical framework from the Health Care Utilization Model of Andersen, McCutcheon, Aday, Chiu and Bell (1983). The authors considered an individual's access to and use of health services to be a function of three characteristics. According to this model, an individual's decision is determined by three sets of health service utilization determinants, which are predisposing factors, enabling factors and health system factors. This model is guided by utilizing all the concepts of the model during the discussion of the theoretical framework.

4.6.1 Predisposing Factors

These factors reflect the individual s' propensity to use health care services (Jang *et al.*, 2015).

A Demographic Factor

These are factors that may influence the likelihood an individual need a health service. In this context, it includes age and gender, occupation, mode of transport and education. The study findings revealed that the community members who do not utilize PHC services and prefer to use the hospital, are those who are predominantly aged between 26-35 years, females, unemployed, using public transport and have a secondary level of education. Analysis of the demographic factors indicated all demographic categories need health care services, even though the demographic categories do not have much significance in determining health care utilization.

According to study done by Kim and Lee (2015) on factors associated with health service utilization between the years 2010 and 2012 in Korea, indicated that predictors for health utilization experiences of outpatient were examined more specifically sex and age as pre-disposing factors were the variables that had significant effect on health service utilization.

In this context, the results revealed that most of the respondents went up to secondary education, which implies that education does not determine utilization of

PHC services. Hamad, Elser, Tran, Rehkopf and Goodman (2018) disagree with the current study because in their study, it was revealed that educational level was negatively associated with the health service utilization.

The current study revealed that females are the vast majority in seeking health care services at the hospital OPDs and not utilizing PHC services. It was supported by the study done by Shao, Wang & Jin (2018) on analysis of utilization of health services of migrants in Beijing based on gender, which indicated that females have more health needs than males, and further indicated that gender equality is an important issue in health service utilization.

The Health Care Utilization Model can also be useful in utilizing demographic data in guiding the DoH, and the accompanying policymakers and management to determine health services required by the community members at PHC level, which will be provided for all age groups, for both males and females, employed or unemployed and which will be accessible and closer to the recipients, so that they do not travel using transport to receive health care services. This will improve the utilization rate of PHC services, as everyone has a right to equal health care.

4.6.2 Enabling Factors

This concept refers to resources that may facilitate access to health care services (Jang, Chiriboga, Allen, Kwak & Haley, 2015). It includes out-of-pocket expenditure.

Out-of-Pocket Health Expenditures

These are direct payments made by the individual to health care providers at the time of service use and they include cost-sharing, self-medication, consultation fees, and laboratory diagnostic tests (WHO, 2018). According to personal experience of the current researcher, PHC service providers render their services free of charge, therefore, in South African Context, in the hospital, patients do pay for service being provided (excluding pregnant women, children under the age of six years and the elderly over 60 years of age).

In this study, the community members are required to have money when coming to

the hospital to pay for the services that they would require. In this regard, out-of-pocket health expenditure determines health care utilization. Da Silva et al (2015) contradict with the South African policy, and indicated that the out of pocket expenditures are higher for older individuals and for children decreases from age 12 to 48 months. This is supported by the analysis of the determinants of out of pocket expenditures in India, which found that individuals age 65 and older were likely to have higher out of pocket expenditure compared to younger age groups (Brinda,Kowal, Attermann & Enemark, 2015).

A study in Agincourt, South Africa found that households experiencing illness spend about 5% of other total household expenditure on direct health care costs (Goudge et al. 2009). A cohort study in Pelotas, Brazil, found a large proportion of families spent more than 15% of their income on health care for their children (da Silva et al. 2015).

The Health Care Utilization Model will provide guidance to the DoH and related stakeholders to nationalize free health care services to all and allocate resources to PHC facilities. This is because some community members may not be utilizing health care services at the hospital level due to lack of money to pay for services rendered and also not utilizing PHC facilities and ending up complicating at their homes.

4.6.3 Health System Factors

This refers to the availability of health services/providers and sufficient supply and appropriate stock of health workers, with the competencies and skill-mix to match the health needs of the population (WHO, 2018). In this study, the results revealed that there is the availability of health care services, but there is a shortage of health care providers such as nurses in PHC facilities to provide health care services to community members as well as shortage of medication. This shortage plays a major role in determining health care utilization as it might be the cause of other problems such as long queues and long waiting times at PHC facilities.

Mwami, and Oleche (2016) in the study on determinants of utilization of health care services in Kenya, indicated that effective health service delivery is determined by

the existence of health facilities, staffing and availability of drugs and other equipment/ suppliers. They further indicated in their study facilities revealed to be having inadequate staffing of health workers.

The study findings revealed that there are no drugs and essential medication at the clinic. This makes it difficult to provide services as the medication is important in treating illnesses. Availability of drugs and essential medication plays an important part in determining health care utilization by the community members.

It was revealed in the study that clinics do not operate 24/7. This means that service availability is not 100% because some of the days and hours (for example, during weekend and holidays, and after 4 pm and during the night) services are not available. The availability of health care services is also determining the health care utilization rate, as when the service is available, it will be used. Water and electricity form part of the availability of services because if there is a lack of water or electricity, some of the services cannot be provided, such as hand washing before and after each procedure as part of infection control, vision will be poor if there is no electricity, machines operating with electricity will not be functional, and this will hinder the provision of service to the patient.

Health care utilization depends on the availability of nurses to provide service and medication to heal and control diseases must operate for 24 hours per day. Therefore, the Health Care Utilization model can be useful in guiding the DoH to provide PHC facilities with more competent staff as all patients are seen by nurses at the clinic, and also to provide nurses with resources such as enough medication to provide quality patient care, and when they are enough, they will be able to work for 24 hours per day in both day and night duty.

Perceived Illness/Self-Reported Illness

This refers to how one view his or her general health and they assist in discerning health care use and health behaviors of individuals. In this study, the results revealed that community members are concerned about their health as the majority has used PHC facilities before more than twice, so when they realized that the PHC does not meet their health needs, they further continued to self-report their illness at the

hospital. In this regard, how an individual perceives his or her illness will determine health care utilization. In this context, the Health Care Utilization Model emphasizes that community members must utilize PHC services as soon as they feel that they are sick for proper assistance and, if possible, referred to the next level of care.

Perceived factors that were identified as barriers to utilization of health facilities as documented in the Nigerian studies (Bresick, Christians, Makwero, Besigye, Malope & Dullie, 2019), and other studies in Ghana (Krumkamp et al., 2013), Ethiopia, Kenya (Saronga et al. 2014), Tanzania, India (Dala & Dawad, 2009) and Greece (Galamis et al., 2013), include poor education about when to seek care; poverty; perceived high cost of services; inadequacy of available services such as lack of drugs, basic laboratory services; an inadequate number of healthcare workers; poor quality of care; and proximity to the facility.

Qualified Professionals

This refers to any individual with appropriate training or experience in the field of health which includes nurses, doctors, therapists and pharmacists (US Department of Health and Human Services, 2014). In this study, it was indicated by the respondents that there is a shortage of nurses as they are the most qualified professionals that run the PHC services more than other professionals. This shortage implies that quality of patient care is compromised and causes long queues and waiting times. Therefore, sufficient availability of qualified professionals plays a significant role in determining health care utilization. It was also revealed by the current study results that 43.5% (n=44) of the respondents agreed that the health care providers are not competent. This indicates that competency and skills-mix match to meet the health needs of the population also determine the health care utilization because patients need adequate competent, multifunctional health care personnel to provide health care services to them.

The Health Care Utilization Model could also assist DoH and health care managers to support health care professionals in terms of personal career development for skills-mix to take place to provide quality patient care. The model also emphasized that competent and qualified nursing professionals will promote quality patient care

and will increase the utilization of PHC services.

4.7 Conclusion

Out of 101 respondents, demographic results indicated that the majority of the respondents were females, aged between 26-35 years, speak Sepedi language, unemployed, went up to secondary school level, use public transport to reach the hospital and have used their local clinic before more than twice before coming to the hospital. Many respondents indicated that they have visited the hospital for reasons other than maternal and child health, chronic diseases and medication and minor illnesses.

Respondents were no longer utilizing their PHC services and the reasons that were indicated included community-related factors such as long queues and waiting times; administrative-related factors included the shortage of nurses at the PHC facilities, PHC facilities not operating for 24/7, no drugs and essential medication at the PHC facilities; and health-related factors included that nurses have negative attitudes toward the community. Therefore, demographic results do not have an impact on the non-utilization of PHC services, but the community, administrative- and health-related factors such as the negative attitude of nurses towards the patient contributed to non-utilization of PHC services by community members.

The next chapter discusses the theoretical framework of the research study.

This chapter also discussed the theoretical framework application of health care utilization by Andersen *et al* (1983). The model was based on the determinants of health care utilization which included predisposing factors, enabling factors and health system factors. This health care utilization model guided the research study as it determined the factors that need to be taken into consideration for the community members to utilize PHC services as it emphasized ways to solve the factors identified to improve utilization rate.

The application of the model to the study results indicated that predisposing factors had no significant impact on health service utilization, while the enabling and health system factors determine health care utilization and developed ways to solve the

problems identified about non-utilization of PHC services by community members in the Greater Tzaneen Municipality, Mopani District, Limpopo Province.

CHAPTER 5:

SUMMARY, LIMITATIONS, RECOMMENDATIONS AND CONCLUSIONS

5.1 Introduction

Chapter 4 presented the discussion of the study findings. This chapter encompasses the summary, limitations, recommendations and conclusions of the research study. This includes restatement of the problem statement, research aim and objectives, achievements of objectives and study findings. Limitations of the study are the gaps identified during the execution of the research project. Recommendations were formulated based on the factors identified by the respondents that might promote the utilization of PHC services and conclusions were drawn from the findings of the study.

5.2 Restatement of the problem statement

The utilization of PHC facilities has declined as most patients are using the hospitals for minor ailments at the OPDs in the context of this study. The Greater Tzaneen Municipality hospitals encounter overcrowding by patients and clients who come without referral letters from the clinics for services that can be rendered at PHC level. More than 100 clients are seen per day (DoH Hospital Statistics, December & January 2018) and this seems to reduce provision of quality patient care at the three hospitals. The Greater Tzaneen Municipality has a conventional health care system which has three hospitals; Letaba, Dr CN Phatudi and Van Velden I. It also operates with 35 PHC facilities (31 community health clinics and 4 community health care centres). Community members all travel less than 5 km to PHC facilities.

Some patients still go directly to the hospitals for non-emergencies and minor ailments without consulting their PHC facilities regardless of having access to several clinics and health centres in their local communities, (Visser et al., 2015). Additionally, PHC services are free of charge and near, but community members still bypass the clinics and opt to hire transport to the hospital and pay for the services. It was thus of interest to the researcher to identify and describe the factors preventing patients and clients from utilizing PHC services and to further develop appropriate strategies from

study results and literature to improve their utilization.

5.3 Restatement of the Research Aim

The current study aimed to investigate factors contributing to non-utilization of PHC services by community members in the Greater Tzaneen Municipality, Mopani District, Limpopo Province.

5.4 Restatement of the Research Objectives

- ☞ Identify factors that contribute to non-utilization of PHC services by the community in the Greater Tzaneen Municipality, Mopani District.
- ☞ Describe factors that contribute to non-utilization of PHC services.
 - Develop recommendations to improve utilization of PHC services by community in the Greater Tzaneen Municipality based on the results.

5.5 Achievement of the Objectives of the Study

The objectives of the study were achieved by the following:

- ☞ A quantitative research method was used to execute the process that was followed in this study. The total population was 135 community members who are seen at the three hospitals in OPDs without referral letters from the PHC clinics. The sample size of 101 was guided by Slovin's sampling method.
- ☞ A self-administered questionnaire was used for data collection to obtain information from the respondents and it consisted of two sections (Section A, and Section B with a total of 25 questions written in Sepedi, Xitsonga and in English). Data was analysed using SPSS Version 24. A cross-sectional descriptive design was utilized to identify the factors contributing to non-utilization of PHC services by community members in the Greater Tzaneen Municipality, Mopani District, Limpopo Province. The results were

presented in the form of tables, bar graphs and pie charts in order to determine the distribution of the variables.

❖ Study Findings

The findings indicated that many of respondents (45.5%; n=46) were aged between of 26-35 years, followed by the age of 55+ which were 25.9% (n=36) and females at 77.2% (n=78) and males were 22.8% (n=24). The majority of the respondents speak Sepedi (60.4%; n=61) followed by Xitsonga (35.5%; n=36). The majority of respondents (76.2%; n=77) were unemployed and only few were employed (23.8%; n=24). It indicates that majority of the respondents (76.3%; n=77) used the clinic more than twice followed by 15.8% (n=16) who used it twice, and lastly by 7.9% (n=8) of those who went to the clinic once. The findings of the study revealed that respondents cited factors such as long queues and long waiting times (90.1%; n=91), shortage of nurses at the clinic (79.2%; n=80), clinics are not operating for 24 hours (70.3%; n=77) and for 7 days per week (70.3%; n=77), no drugs and essential medication at the clinic (64.4%; n=65), and negative attitudes of nurses toward the community (68.3%; n=69) contributed to non-utilization of PHC services by community members.

5.6 Limitations of the Study

The researcher conducted the study at three hospitals of the Greater Tzaneen Municipality. As such, the results cannot be generalized to other hospitals that have OPDs in Limpopo Province. The literature reviewed in South African context is limited to require less than 5 years period but available ones are more than 5 years and at least within 10 years period. The implications of the research study may not be applicable to nurses, health facilities and community members of other areas. Future studies should try overcoming the limitations in this study. Widening the coverage for the study, other PHC facilities to be included across Limpopo Province in the upcoming research.

5.7 Recommendations

To enhance the utilization of PHC Services in the Greater Tzaneen Municipality,

recommendations were made based on the findings of the study. The recommendations are categorized as follows:

5.7.1 Long Queues and Waiting Times

The study conducted by Egbujie (2018) on the impact of ideal clinic implementation, identified an urgent need for scale-up of the clinic appointment system in all PHC facilities and that the clinic appointment booking register need to be revised and standardized across the board and properly implemented.

In this study, the following is recommended to minimize the long waiting times at the PHC clinics:

- ✎ Enough complement nurses should be appointed at already available PHC facilities as all the patients are seen by nurses to reduce the issue of long queues and long waiting hours. Schneider and Barron (2009/2010) underscored that PHC is complex and requires additional staff, a diverse mix of staff, PHC-trained professional nurses and appropriate allocations.
- ✎ Available nursing staff should start to work on time to reduce long waiting times and queues. This means that when duty begins at 7 am, nurses should start their work at that time because most patients come to the clinic early before clinics open. All patients who visit the clinics should receive treatment. Each clinic should review its operating times and realign its working schedule with the periods of peak activity. By so doing, they will avoid too-long queues and waiting times and having to turn patients away.
- ✎ The Global WHO report recommended that models to deliver health services and policies will need to be adaptable and flexible to meet the rapidly changing population needs. Perceptions that PHC is for poor and disadvantaged population, PHC is for rural and not urban communities and PHC is for developing and not developed countries should be addressed (WHO, 2017).

5.7.2 Clinic Medication Not Working

The community members claim that clinic medications are not working, and this was indicated by 45.5% (n=46) of the respondents in this study. According to the study done by Baloyi (2009) on problems in providing PHC services in Limpopo Province, it was indicated that educational materials to all PHC facilities so that PHC nurses can educate the community on the importance of taking medication according to how it is prescribed, attending scheduled visits, and their rights, as well as their responsibilities in health care, should be provided by the Department of Health.

5.7.3 Health Care Personnel Not Competent

The respondents 43.5% (n=44) indicated that health care professionals are not competent. The competency of health care professionals can be enhanced by the following:

- ✎ Health care professionals must be committed to life-long learning through attending conferences and seminars and getting certification in specialization to enhance PHC nurses' competencies as required.
- ✎ Provision of in-service training for the personnel to PHC clinic staff members by the DoH.
- ✎ The employers should maintain a quality environment that supports nurses to continue enhancing their competencies and taking part in those programs that further their level of competency.
- ✎ Doctors should improve nurse's knowledge during their outreach visits to the clinics so that they can better manage patients. Doctors should also attend community forums to reassure community members that PHC nurses are competent to manage PHC conditions. Schneider and Barron (2009/2010) recommended that support from medical officers; pharmacy assistants and other mid-level workers should be strengthened.

5.7.4 Shortage of Nurses at the Clinic

The findings of the study revealed that shortage of nurses at the clinic was challenging (79.2%; n=80) and the respondents emphasized that this prevents community members from utilizing health care services. Medical Brief South Africa (2016) recommended that the only remedy is to rapidly expand training platforms.

About the shortage of nurses the study recommends the following:

- ✎ Additional nurses should be placed at already available PHC clinics as nurses are the ones that see the patients improve the issue of long queues and long waiting hours. The nurse-patient ratio should be at 1 nurse is to 18 patients per day in South African public health facilities, excluding in critical care units as outlined by Matlakala & Botha (2015).
- ✎ Allow duty scheduling flexibility to help nurses juggle their busy work schedules with home and educational opportunities in keeping nurses satisfied with their work environment and conditions. This will create a more positive work atmosphere and help to retain quality nurses and to prevent absenteeism which might be the cause of the shortage.
- ✎ The DoH should review the salaries of professional nurses in rural clinics, particularly the OSD, who should be given higher salaries. Furthermore, the government should increase the rural nurses' salaries by at least 10% higher than those in urban clinics within the next 5 years to attract more nurses to work in the public rural clinics.
- ✎ Nurses should be trained as PHC practitioners and other specialties in their field of interest as required by the clinics so that quality of care should be supplied to the community, as well as the retention of nurses, will be promoted. This is supported by a study was carried out by the KwaZulu-Natal DoH on disease profile and health services sought by clients attending KZN PHC facilities in 2010.

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- ✎ It is recommended that Professional Nurses should receive further training on diseases conditions and Nursing Assistants should be trained on other health-related activities such as family planning and well-baby clinics.

 - ✎ There should be programs of continuing professional development which allow PHC staff to regularly update their skills. Leadership capacity should be developed at a local level (WHO, 2017).

 - ✎ The DoH should recruit retired professional nurses to assist and reduce the shortage of professional nurses, especially in public rural clinics.

 - ✎ The DoH should increase the intake of newly qualified professional nurses (community service nurses) in public rural clinics to reduce the shortage of professional nurses.

 - ✎ Baloyi (2009) stated that there must be enough staff available at the clinic so that other staff could be granted attendance of workshops and other relevant courses to enhance knowledge, skills, morale and quality of care, relieve stress, allow more time with patients, and promote job satisfaction. He further indicated that patients' visits should be recorded daily so that staffing should be determined for PHC facilities and time needed for patient care. This would enhance the provision of quality PHC.

5.7.5 No water and Electricity

The study findings indicated that water and electricity were not the major issues that influence them to bypass their local PHC facilities, but 43.6% (n=44) of the respondents reported that they were affected by the shortage, therefore, they have to utilize their PHC services. The prevention of shortage of water and electricity can be enhanced by the following:

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- ✎ The DoH can arrange that the clinic must have boreholes and chargeable lights or torches, using electrical generator backups in cases of power outages.
 - ✎ The municipality can also provide the clinics with water tanks to store water.
 - ✎ The DoH can also arrange with the Greater Tzaneen Municipality to provide water tanks to the clinics and also to pay their water bills if it so happens that they owe the municipality.
 - ✎ Education should be provided to community members about safe water usage and the prevention of pollution that affect climate change.

5.7.6 No Drugs and Other Essential Medication

The majority of the respondents (64.4%; n=65) indicated that there are no drugs and essential medication at the clinic. Bateman (2017) study on drug stock-outs indicated that the National DoH is urgently trying to source and install countrywide computer software systems that will link health care facilities with drug depots and suppliers to relieve on-going essential drug stock-outs, which threaten the lives of patients. Masango-Makgobela et al. (2013) also indicated that the allocation of a budget and frequent ordering for the medication in PHCs indicated to be useful to ensure enough stock.

This study recommends the following to solve the shortage of medicines at PHC clinics:

- ✎ The DoH should cooperate with pharmaceutical stakeholders to ensure that proper and essential medication is available at all PHC service centres.
- ✎ Nurses must order the pharmaceutical stock on time so that they can be delivered on time.
- ✎ Health personnel must calculate their medicines monthly statistics correctly to address the supply and demand chain.

5.7.7 Clinic Not Operating 24/7

The results of the study revealed that the PHC clinics are not operating for 24 hours this was indicated by a total of 76.2% (n=77) respondents and those that indicated that clinic does not operate for 7 days per week were 76.2% (n=77).

The study recommends the following:

- ✎ The DoH should ensure that all the PHC centres operate 24 hours per day and for seven days per week to render all PHC services either in a form of night duty or call system. In the study conducted by Pillay (2019), respondents recommended that mobile clinics should increase the number of their visits to mobile points. The frequency of mobile clinic visits depends on the headcount of the mobile point. To avoid the problem of walking to the mobile point and the clinic does not come, patients suggested that nurses should have a schedule on the days when there will be no mobile clinic and when the clinic will be available.
- ✎ More staff to be placed at the clinics particularly the clinical nurse practitioners and midwives to run the 24-hour services and for 7 days per week to ensure that nurses has necessary breaks. Baloyi (2009) added a recommendation that the staff should be available for both shifts of day and night. There must also be other health care providers allocated at the clinic such as dieticians, medical doctors, social workers, counsellors and other multi-disciplinary to supply comprehensive service delivery.
- ✎ Mobile clinics should leave their mobile clinic base earlier if they visit far away from mobile points.
- ✎ The DoH also has to provide security at the clinics to ensure that nurses are protected especially those who will be working during the night.

5.7.8 Negative attitude of nurses towards patients

Most of the respondents (68.3%; n=69) indicated that the nurses at the clinic have negative attitudes towards them. Support by management is crucial because managers take overall responsibility for the facilities. The management requires members that are more committed and motivated to manage the organization (Baloyi, 2009).

This study recommends the following:

- ✎ The Department of Health should develop and implement an Employee Assistance Program (offered by employers to help employees to deal with their problems, e.g. counselling, budgeting or dealing with substance abuse), which might help to eliminate unfriendly and uncaring behaviour of health care personnel.
- ✎ In the study by Pillay (2019), the patients recommended that nurses should stop scolding, shouting at them and being rude to them, but show them some respect. They also suggested that nurses should improve confidentiality and provide privacy. It is further recommended that it should be compulsory that all staff employed at the PHC facilities be trained in the principles of Batho Pele which emphasize quality customer care. Operational Managers should also monitor and enforce the practice of these principles. Clinic committees should also be trained in Batho Pele principles and be involved in monitoring the implementation of them.

5.7.9 Referral System

- ✎ Health education should be given to the community regarding the importance of following the channels of levels of care. Koce, Randhawa and Ochieng (2019) indicated that the referral process does not simply entail transferring a patient from a lower to a higher level of care, but an effective referral system requires good communication and coordination between levels of care and

support from higher to lower levels to help manage patients at the lower level of care.

☞ All members of the community should have referral letters from PHC services when coming to the hospital; if not, they should be returned so that the levels of care should be clearly understood by the community. The study conducted by Pillay (2019) recommended that the health system needs a very effective mechanism for the implementation of the referral policy if the system is to be functional.

☞ The delivery of good quality essential care relies on effective referral relationships with and support from district hospitals, in addition to clinical competencies to identify when these referrals are needed (Rispel et al., 2010).

☞ Another possibility is to strengthen the implementation of the policy of charging bypass fees for non-emergency patients who come to Casualty after hours without referrals. The success of this will only depend on the ability of the patient to pay that fee. Koce et al. (2019) suggested that non-referred patients should be charged a penalty for failing to adhere to referral policy.

☞ Koce et al. (2019) also recommended that a queuing system should be redesigned to separate referred patients from non-referred patients so that referrals can be fast-tracked and explained to non-referred patients why other patients are being fast-tracked past them. This will encourage them to seek referral in future.

5.7.10 Research-Related Recommendations

☞ Further research should be conducted on factors contributing to non-utilization of PHC Services that can investigate the larger scale so that results can be generalized.

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- ✎ Studies should be done on the association between bypass rate and demography at the community level.
 - ✎ conducting community case studies at community level areas with very low and very high bypass rates will identify and examine bypass determinants.
 - ✎ The impact of PHC operating hours on PHC utilization rate will shed further light on this aspect.
 - ✎ Evaluation of the impact of the bypass on local PHC professionals is another dire need that can be addressed in a study.

5.7.11 Nursing Management-Related Recommendations

- ✎ The Department of Health must solve the problem of shortages of equipment and supplies, such as medication, as well as improving on the issue of delaying approving and delivering orders. PHC nurses should be involved in decisions on what equipment and supplies need to be ordered, and further makes provision for enough registered PHC nurses to be employed at the health facilities to allow managers to assist nurses, supervise junior staff, audit services regularly, do appropriate budgeting, communicate with staff, and attend to personnel problems.
- ✎ Appropriate departments, local authorities and stakeholders must be approached by the Department of Health to promote telecommunication systems and the supply of electricity and water to PHC facilities.
- ✎ To retain and recruit nurses, the DoH should introduce other fringe benefits such as car subsidies and danger allowances for professional nurses working in public rural clinics. This is because nurses see all patients, including aggressive and violent clients, who might be unstable, relapsed mental health care users in the absence of medical and psychiatric doctors.

✎ The DoH should introduce an incentive package; this will attract professional nurses to work in difficult public rural clinics. More professional nurses will assist with the provision of quality health care services.

✎ Getahun et al (2016) recommended that the government should subsidize transport services, such as a bus service to and from the hospital, since everybody has a right to health, especially during those times services are not provided at the clinic level such as on public holidays or weekends.

✎ Developing; reviewing and updating of policies, guidelines and protocols that will enable health professionals to upgrade their skills.

5.7.12 Nursing Education-Related Recommendation

✎ The nurse training institutions should train more nurses as there is a high demand for nurses and most patients are seen by nurses in any case.

✎ Strengthening of short courses and workshops for enhancement of their knowledge and skills.

5.8 Conclusion

The study identified and described the factors that contributed to non-utilization of PHC Services in the Greater Tzaneen Municipality were long queues and waiting times, PHC not rendering 24-hour service and not operating for 7 days per week, shortage of nurses, and lack of essential medication and negative attitude of nurses towards the patients were identified. Recommendations were developed that might be used to improve the utilization of PHC services.

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APPENDIX A

TURFLOOP RESEARCH ETHICS COMMITTEE (TREC) CLEARANCE CERTIFICATE



University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 3935, Fax: (015) 268 2306, Email: anastasia.ngobe@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE
ETHICS CLEARANCE CERTIFICATE

MEETING: 6 March 2019

PROJECT NUMBER: TREC/55/2019: PG

PROJECT:

Title: Factors contributing to non- utilization of Primary Health Care services by community in Greater Tzaneen Municipality, Mopani District, in Limpopo Province.

Researcher: SO Masemola
Supervisor: Mrs MA Bopape
Co-Supervisor/s: Prof TM Mothiba
School : Health Care Sciences
Degree: Masters of Nursing


PROF P MASOKO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: REC-0310111-031


Note:

- i) This Ethics Clearance Certificate will be valid for one (1) year, as from the abovementioned date. Application for annual renewal (or annual review) need to be received by TREC one month before lapse of this period.
- ii) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee, together with the Application for Amendment form.
- iii) PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

Finding solutions for Africa

APPENDIX B

PERMISSION FROM LIMPOPO PROVINCE DEPARTMENT OF HEALTH TO CONDUCT THE STUDY

 **LIMPOPO**
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Ref: LP_201903_014
Enquiries: Stander SS
Tel: 015 293 6650
Email: research.limpopo@gmail.com

MASEMOLA SO
University of Limpopo
Private Bag x 1106
Sovenga
0727

Greetings,


**RE: FACTORS CONTRIBUTING TO NON-UTILIZATION OF PRIMARY HEALTH CARE SERVICES BY
COMMUNITY IN GREATER TZANEEN MUNICIPALITY, MOPANI DISTRICT, IN LIMPOPO PROVINCE**


Permission to conduct the above mentioned study is hereby granted.

1. Kindly be informed that:-

- Research must be loaded on the NHRD site (<http://nhrd.hst.org.za>) by the researcher.
- Further arrangement should be made with the targeted institutions, after consultation with the District Executive Manager.
- In the course of your study there should be no action that disrupts the services, or incur any cost on the Department.
- After completion of the study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
- The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
- The above approval is valid for a 1 year period.
- If the proposal has been amended, a new approval should be sought from the Department of Health.
- Kindly note, that the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated.


Head of Department


Date

Private Bag X9302 Polokwane
Fidel Castro Ruz House, 18 College Street, Polokwane 0700. Tel: 015 293 6000/12. Fax: 015 293 6211.

The heartland of Southern Africa – Development is about people!



APPENDIX C

PERMISSION FROM DR CN PHATHUDI HOSPITAL TO CONDUCT THE STUDY

	LIMPOPO PROVINCIAL GOVERNMENT REPUBLIC OF SOUTH AFRICA
Ref 10/R	DR CN PHATHUDI HOSPITAL
Enquiries: Mola RS	P/Bag x4056
	Tzaneen
	0850
	02 April 2019
P.O BOX 3198	
SOVENGA	
0727	
ACKNOWLEDGEMENT OF REQUEST TO CONDUCT RESEARCH: MASEMOLA SO	
<ol style="list-style-type: none">1. The above bears reference:2. Your application to conduct research in OPD "ABOUT NON UTILIZATION OF PRIMARY HEALTH CARE SERVICES"3. Permission is hereby granted to be done at OPD Dr CN Phatudi hospital4. Hope you shall find the above to be in order	
Thanks 	
Acting nurse manager	Date

APPENDIX D


PERMISSION FROM LETABA REGIONAL HOSPITAL TO CONDUCT THE STUDY

	LIMPOPO PROVINCIAL GOVERNMENT REPUBLIC OF SOUTH AFRICA
	Letaba Regional Hospital Private Bag X 1430 Letaba 0870
Ref: S5/4/2/3 Enq: Malatji E.M Date: 12/06/2019	
ATT: MASEMOLA SO University Of Limpopo Private Bag X 1106 Sovenge 0727	
RE: OFFER FOR APPLICATION TO CONDUCT RESEARCH STUDY FOR FACTORS CONTRIBUTING TO NON-UTILIZATION OF PRIMARY HEALTH CARE SERVICES BY COMMUNITY IN GREATER TZANEEN MUNICIPALITY, MOPANI DISTRICT IN LIMPOPO PROVINCE	
1. The above matter refers	
2. It is a great pleasure to inform you that the Acting Chief Executive Officer has approved your application to conduct research study for factors contributing to non-utilization of primary health care services by community in Greater Tzaneen municipality, Mopani district in Limpopo province of the public hospital. It has been approved for a period of a year as per our department's approval. And you will be placed under Nursing Services Management.	
Starting Time: 07h30 Lunch Time: 13h00 to 14h00 Knock off Time: 16h30	
3. You will be expected to work from Monday to Friday.	
4. NB. Please note that you will not get remuneration/ Compensation during your Research study.	
Hoping that you will enjoy your stay in the hospital.	
 ACTING CHIEF EXECUTIVE OFFICER SIBUYI MV	13/06/2019 DATE
Private Bag X 1430, LETABA, 0870 Cnr. Tarentaal and Lydenburg Road, Tel: (015) 303 8200, Fax no: 015 303 8421	
<i>The heartland of Southern Africa – development is about people!</i>	

APPENDIX E

PERMISSION FROM VAN VELDEN HOSPITAL HOSPITAL TO CONDUCT THE STUDY

Confidential

 **LIMPOPO**
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

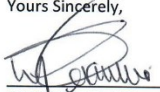
**DEPARTMENT OF HEALTH
VAN VELDEN HOSPITAL**

Ref: 8/4
Date: 17.05.2019
From: Head of Institution
To: Masemola S.O

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH STUDY.

1. Your letter dated 16/05/2019 is received with thanks.
2. Permission to conduct a research in our institution titled "factors contributing to non-utilisation of PHC services by community" is hereby granted on basis of Departmental approval, ref: LP201903_014
3. In the course of your study there should be no disruption of services of work flow.
4. You are requested to share the findings with our institution after completion of your study.
5. Please contact our nursing manager, Mrs Ragolane to arrange commencement date at 015 307 8809

Yours Sincerely,


DR SELATLHA J.M
Head of Institution

2019.05.17
DATE

Corner 3rd Ave & Claude Wheatley, Medipark, Private Bag X4041, Tzaneen 0850
Tel: 015 307 8800, Fax: (015) 307 3512, Website: <http://www.limpopo.gov.za>

The heartland of Southern Africa – *development is about people*

APPENDIX F

CONSENT FORM FOR RESPONDENTS

DEPARTMENT OF NURSING SCIENCE ENGLISH CONSENT FORM

Statement concerning participation in a PHCaI Research Project*

Name of Study: Factors contributing to non-utilization of PHC services in Greater Tzaneen Municipality, Mopani District, Limpopo Province.

I have read the information and heard the aims and objectives of the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way.

I am aware that this material may be used in scientific publications which were electronically available throughout the world. I consent to this provided that my name and hospital number are not revealed.

I understand that participation in this Study / Project is completely voluntary and that I may withdraw from it at any time and without supplying reasons. This will have no influence on the regular treatment that holds for my condition neither will it influence the care that I receive from my regular doctor.

I know that this Study / Project has been approved by the Turfloop Research Ethics Committee (TREC), Limpopo Province Department of Health CEOs from the hospital. I am fully aware that the results of this Study / Project will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

The Study/Project envisaged may hold some risk for me that cannot be foreseen at this stage.

Access to the records that pertain to my participation in the study was restricted to persons directly involved in the research.

Any questions that I may have regarding the research, or related matters, were answered by the researcher/s.

If any medical problem is identified at any stage during the research, or when I am vetted for participation, such condition will be discussed with me in confidence by a qualified person and/or I will be referred to my doctor.

I indemnify the University of Limpopo and all persons involved with the above project from any liability that may arise from my participation in the above project or that may be related to it, for whatever reasons, including negligence on the part of the mentioned persons.

I hereby give consent to participate in this Study / Project.

Signature of researched person

Signature of researcher

Signed at this day of 20_

Contact No:

APPENDIX G

XITSONGA CONSENT FORM

<p>UNIVERSITY OF LIMPOPO (Turfloop Campus) XITSONGA CONSENT FORM</p>

Xiletelo mayelana na ku nghenelela eka ndzavisiso wa xitadi.

Vito ra xitadi: Xivangelo xova vabyi va nga tirhisi ti klinika ka Greater Tzaneen Municipality, Mopani District, Limpopo Province.

Ndzi nyikiwile swikongomelo na maendlelo ya ndzavisiso, ndzi thlela ndzi nyikiwa nkarhi wo vutisa swivutiso na ku nyikiwa nkarhi lowu eneleke ku ehleketisisa hi mhaka leyi. Xikongomelo na maendlelo ya xitadi (ndzavisiso) swi basisiwile eka mina. Andzi sindzisiwanga ku nghenelela hi ndlela yihi kumbe yihi. Ndza swi twisisa leswaku ku nghanale eka xitadi (ndzavisiso) lexi I Ku tsakela ka mina naswona ndzi nga tihumesa eka swona nkarhi wun'wana na wun'wana handle ko hlamusela ku hikwalaho ka yini.

Ndza swi tiva leswaku xitadi lexi xi pfumeleriwile hi komiti ya swa vulavisisi leyi vuriwa Turfloop Research Ethics Committee (TREC) na ndzawulo yari Hanyo xifundzha-nkulu xa Limpopo na vha rangeri vha xipedhlele. Ndza swi tiva hi Ku hetiseka leswaku mbuyelo wa xitadi wu ta tirhisiwa eka swikongomelo swa tisayense nakona swi nga hangalasiwa. Ndza pfumela eka leswi, ntsena loko ndzi tiyisisiwa leswaku ndzi nga ka ndzi nga humelerisiwi kumbe Ku tivisiwa eka van'wana.

Ndzi nika mpfumelelo wo nghanela eka xitadi lexi.

.....

.....

Vito ra Mungheneleri

Nsayino wa mungheneleri/ muhlayisi

.....

.....

.....

Mbhoni Ndhawu Siku

Xiletelo hi mulavisisi

Ndzi nyikile vuxokoxoko hi ku vulavula na hi leswi tsariweke mayelana na xitadi lexi.

Ndza pfumela Ku hlamula swivutiso hi vuswikoti bya mina eka nkarhi lowu taka mayelana na xitadi

Ndzi ta landzelerisa eka maendlelo lawa ya pfumeleriweke.

.....

Vito ra mulavisisi

.....

Nsayino

.....

Siku

APPENDIX H

SEPEDI CONSENT FORM

<p style="text-align: center;">UNIVERSITY OF LIMPOPO (Turfloop Campus) SEPEDI CONSENT FORM</p>

Setatamente mabapi le go tšea karolo ka go Protšeke ya Dinyakišišo tša Teko ya Klinikhale *.

Leina la Protšeke / Dinyakišišo / Teko*

Mabaka ao a thibelago setshaba go berehisa di kliniki, Greater Tzaneen Municipalithi, Distrikting ya Mopani, provinging ya Limpopo.

e badile/ke kwele ka ga tshedimošo mabapi le *maikemišetšo le morero wa* dinyakišišo tšeo di šišintšwego gomme ke ile ka fiwa monyetla wa go botšiša dipotšišo gomme ka fiwa nako yeo e lekanego gore ke naganišiše ka ga taba ye. Ke tloga ke kwešiša maikemišetšo le morero wa dinyakišišo tše gabotse. Ga se ka gapeletšwa go kgatha tema ka tsela efe goba efe.

Ke a kwešiša gore go kgatha tema Protšekeng/Dinyakišišong tše tša Teko ya Klinikhale* ke ga boithaopo gomme nka tlogela go kgatha tema nakong efe goba efe ntle le gore ke fe mabaka. Se se ka se be le khuetšo efe goba efe go kalafo yaka ya ka mehla ya maemo a ka gape e ka se huetše le ge e ka ba tlhokomelo yeo ke e humanago go ngaka yaka ya ka mehla.

Ke a tseba gore Teko/Protšeke/Dinyakišišo tše* di dumeletšwe ke Medunsa Research Ethics Committee (TREC), Yunibesithi ya Limpopo (Khamphase ya Turfloop). Ke tseba gabotse gore dipoelo tša Teko/Dinyakišišo/ Protšeke tše * di tla dirišetšwa merero ya saense gomme di ka phatlalatšwa. Ke dumelelana le se, ge fela bosephiri bja ka bo ka tiišetšwa.

Mo ke fa tumelelo ya go kgatha tema Tekong/Dinyakišišong/ Protšekeng *.

Leina la molwetši/ moithaopi Mosaeno wa molwetši goba mohlakomedi.

.....

Ke fana ka tshedimošo ka molomo le/goba yeo e ngwadilwego * mabapi le Teko/Dinyakišišo/ Protšeke ye.* Ke dumela go araba dipotšišo dife goba dife tša ka moso mabapi le Teko/Dinyakišišo/ / Protšeke ka bokgoni ka moo nka kgonago ka gona. Ke tla latela melao yeo e dumeletšwego.

.....
Leina la MonyakišišiMosaeno Letšatšikgwedi Lefelo

*Phumola tšeo di sego maleba.

APPENDIX I

QUESTIONNAIRE (ENGLISH)

To be completed by patients

- Do not write your name or personal information on this questionnaire.
- Your institution name must not be written on this questionnaire.

SECTION A: DEMOGRAPHIC DATA

Please mark the appropriate box with an X

1. Age

15-25	1
26-35	2
36-45	3
46-55	4
55+	5

2. Gender

Male	1
Female	2

3. Highest level of education

None	1
Primary	2
Secondary	3

Post -secondary	4

4. Home language

Sepedi	1
Xitsonga	2
Other	3

5. Occupation

Employed	1
Unemployed	2

6. Mode of transport to the hospital

Walk	1
Own car	2
Public transport	3

7. Have u ever visited the PHC before?

Yes	1
No	2

If yes, how many times?

Once	1
Twice	2
More than twice	3

SECTION B- FACTORS PREVENTING PATIENTS FROM UTILIZING PRIMARY HEALTH CARE SERVICES

Reasons for visiting the Hospital

8 Chronic disease and medication	1
9 Maternal and child health	2
10 Minor illness	3
11 others	4

Community-related factors

SA=strongly agree A=Agree SD=Strongly disagree D=Disagree

Statement	SA	A	SD	D
12 PHC medication not working	1	2	3	4
13 Health care personnel not competent	1	2	3	4

14 Long queues and waiting times	1	2	3	4
15 Afraid of stigma	1	2	3	4
16 I stay next to the hospital	1	2	3	4
17 No different blood tests done at the PHC	1	2	3	4

Administrative-related

Statement	SA	A	SD	D
18 Poor community involvement	1	2	3	4
19 Absence of medical doctors at the PHC (PHC)	1	2	3	4
20 Shortage of nurses at the PHC	1	2	3	4
21 No drugs and other essential medication	1	2	3	4
22 No water and electricity	1	2	3	4
23 PHC not operating 24 hours	1	2	3	4

24 PHC not operating 7 days per week	1	2	3	4
--------------------------------------	---	---	---	---

Health personnel-related

Statement	SA	A	SD	D
25 Negative attitudes of nurses towards patients	1	2	3	4

THANK YOU

APPENDIX J

SWIVUTISO EKA VHANHU VAKU HLAMULA (XITSONGA)

- U nga tsalu vito ra wena
- U nga tsali xibedlele xa wena eka xivutiso

XIYENGE XA-A

Kwatihata ndzeni ka bokisi

1. Malembe

15-25	1
26-35	2
36-45	3
46-55	4
55+	5

2. Rimbewu

Wanuna	1
Wansati	2

3. Tidondzo tale henhla

A nga nghenanga xikolo	1
Primary	2
Sekondari	3

Endzaku ka tidondzo tale sekondari	4
------------------------------------	---

4. Ririmi rale kaya

Sepedi	1
Xi-Tsonga	2

5. Swa mintirho

Na tirha	1
Ani tirhi	2

6. Swifambo swo ya xipedhlele

Milenge	1
Xipandza mananga/mova	2
Xipandza mananga xa unwani na unwani	3

7. U tshama u endzela xibedhele?

Ina	1
E-ee	2

8. Loko kun ina, u endzele ka nkani?

Kanwe	1
Ka-mbirhi	2
Ku hundisa ka mbirhi	3

XIYENGE XA -B XIVANGELO XOVA VABYI VA NGA TIRHISI TI KLINIKI

Xikongomelo xo endzela xibedhele

8 Vuvabyi lebyi nga tshungariwiki	1
9 mavabyi a vhana na vasati	2
10 Mavabyi a tsongo	3
11 Swinani na swinani	4

Tamuvabyi

KN= Kupfumelelana Ngopfu K= Kupfumela KNP= Kuka ninga pfumelelani
Ngopfu A= Anipfumeli

	KN	K	KNP N	A
12. Mimirhi ya kliniki ayi tirhi	1	2	3	4
13. Vaongori ava tivi ntirho	1	2	3	4
14. Tilayeni na nkarhi wa ku yima wo leha	1	2	3	4
15. Ku chava ku poyileka	1	2	3	4
16. Ni tshama kusuhi na xibhedlhela	1	2	3	4
17. Akuna ku hambana kaku hlhluva ka ngati e kliniki	1	2	3	4

Ta adimini

	KN	K	KNPN	A
18. Vanu va mughanga ava ngheneleli	1	2	3	4
19. Ku hava madokodela e kliniki	1	2	3	4
20. Ku kala ka vaongori e kliniki	1	2	3	4
21. Akuna swidzidziharisi na mirhi ya nkoka	1	2	3	4
22. Akuna mati na gezi	1	2	3	4
23. Aku tirhiwi vusiku na nhlekani	1	2	3	4
24. Aku tirhiwi masiku hinkwawo	1	2	3	4

Ta vaongori

	KN	K	KNP N	A
25. Makhomelo yo biha ya vaongori ehenhla ka vavabyi	1	2	3	4

NDZA KHENSA

APPENDIX K

DIPOTŠIŠO GO BA FETODI (SEPEDI)

Di tle di fetole ke balwetsi

- a. Le seke la ngwala leina goba tse dingwe tsa bophelo bja lena mo dipotšišong.
- b. Leina la sepetlele le seke la ngwalwa mo dipotšišong.

KAROLO A: TSA BODULO

Bontšha ka leswao la X ka mo lepokising.

1. Mengwaga

15-25	1
26-35	2
36-45	3
46-55	4
55+	5

2. Bong

Monna	1
Mosadi	2

3. Dithuto tsa godimo

A ka tsena sekolo	1
Primari	2
Secondari	3
Morago ga secondari	4

4. Polelo ya ka gae

Sepedi	1
Xitsonga	2

5. Tsa mošomo

Kea bereka	1
------------	---

Ake bereke	2
------------	---

6. Senamelwa go ya sepetlele

Maoto	1
Sefatanaga sa lena	2
Senamelwa sa bohle	3

7. Esa la etela kliniki?

Ee	1
Aowa	2

Ge eba ee, le ile ga kae?

Ga tee	1
Ga bedi	2
Go feta ga bedi	3

KAROLO B- TSEO DIKA THIBELAGO BALWETŠI GO SOMIŠA DI KLINIKI

TŠA KGAUSWI.

Mabaka a go etele sepetlele

8 Malwetsi ago se alafege	1
9 Tsa maphelo a bana le basadi	2
10 Malwetsi a mannyane	3
11 Tse dingwe	4

Tsa balwetši

KK=Kea dumela kudu KD= Kea dumela KG=K ea gana kudu K= Kea gana

Setatamente	KK	KD	KG	K
12 Dihlare tša kliniki ga di šome	1	2	3	4
13 Bašomi gaba tsebe mošomo	1	2	3	4
14 Go ema nako e telele	1	2	3	4
15 Go tšhaba sepoulo	1	2	3	4
16 Ke dula kgauswi le sepetlele	1	2	3	4
17 A gona dihlahlobo tša madi tša go fapana kliniking	1	2	3	4

Tsa atimini

Setatamente	KK	KD	KG	K
18 Setšhaba ga se tsenelele ka tša maphelo kliniking	1	2	3	4
19 A gona dingaka di kliniking	1	2	3	4
20 Tlhokego ya baoki yeo e lekanego	1	2	3	4
21 A gona diokobatši le dihlare tše bohlokwa	1	2	3	4
22 A gona meetse le mohlagase	1	2	3	4
23 Kliniki gae šome bošego le mosegare	1	2	3	4
24 Kliniki gae šome matšatši a šupa a beke	1	2	3	4

Tša baoki

Setatamente	KK	KD	KG	K
25 Mekgwa ya go se loke ya baoki go balwetši	1	2	3	4

KEA LEBOGA

APPENDIX L

CONFIRMATION BY LANGUAGE EDITOR

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25 April 2020

To Whom It May Concern

This serves to confirm that I have edited the language, spelling, grammar and style of the **MCur** thesis by **Seepati Olga Masemola**, titled: “**Factors Contributing to Non-Utilization of PHC Services by Community in the Greater Tzaneen Municipality, Mopani District, Limpopo Province**” The manuscript was also professionally typeset by me.

Sincerely Yours



Cert. Freelance Journalism, Dip. Creative Writing, MSc (Med), PhD (Medicine)